maryland
health services
cost review commission

632nd Meeting of the Health Services Cost Review Commission

June 11, 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 May 14, 2025

Specific Matters

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

Docket Status – Cases Closed

2. Docket Status – Cases Open

2668R Johns Hopkins Howard County Medical Center
2671N 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

Subjects of General Applicability

3. Report from the Executive Director
    a. New Paradigms in Care Delivery Update
    b. Update on Financial Assistance Regulations

4. Confidential Data Request: University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for trauma and EMS

5. Final Recommendation: CRISP Funding for FY 2026
6. Final Recommendation: Update Factor for FY 2026
7. Hearing and Meeting Schedule

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MINUTES OF THE 631st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION MAY 14, 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., Adam Kane, Esq., Maulik Joshi, D.Ph., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Sabi and seconded by Commissioner Joshi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:00 p.m.

REPORT OF MAY 14, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on May 14, 2025, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM APRIL 9, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Sabi and seconded by Vice Chairman Elliott, the Commission voted unanimously to approve the minutes of April 9, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2670A	University of Maryland Medical Center

ITEM III
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

ITEM IV
PRESENTATION BY ADVANCING INNOVATION IN MARYLAND (AIM) WINNERS

Chairman Sharfstein outlined the purpose of the Advancing Innovation in Maryland (AIM) Awards and introduced four recipients of the Award: Rev. Terris King, Dr. Andrew Panagos, Ms. Miranda Ramsey, and Dr. Beth Fields.

Engage with Heart

Pastor Terris King of Liberty Grace Church of God, and Dr. Andrew Panagos from Johns Hopkins Healthcare, presented on the *Engage with Heart, A Trust-Based Model of Community Health.*

Pastor King presented the community health initiative centered on empowerment through informing, activating, servicing, and providing clinical expertise to communities that already possess inherent strength. A core component of the initiative is a partnership with the University of Maryland, to provide health screening events held at churches and community centers. These events offer participants a meal, food to take home, and access to clinical experts who provide information on chronic diseases. Attendees are screened for various conditions, and when high-risk results are found, the information is referred to a doctor. While this traditional screening model reaches thousands annually, Pastor King hinted that the truly unique aspect of their work lies beyond this established approach.

Dr. Panagos highlighted the critical importance of a two-pronged approach encompassing both prevention and reaction in addressing patient health, particularly concerning Intensive Care Unit (ICU) readmissions. He noted that in Baltimore's medical ICUs, roughly half of all patient issues are linked to preventable social factors. Data strongly suggests that combating these "social phenotypes" significantly reduces ICU readmissions, not merely by increasing medication compliance, but by addressing underlying issues that hinder medical care and overall health.

Dr. Panagos's program tackles this by identifying older adults and recent ICU discharge patients (within four weeks) and pinpointing their specific social needs. These patients can then be paired with a community health worker (CHW) from a local congregation. Since February, six to ten patients have enrolled, with a remarkable zero ICU readmissions. Patients have also seen better attendance at primary care appointments and less social isolation and food insecurity, thanks to "social prescribing" by the CHWs. This success highlights that true community empowerment comes from recognizing and supporting existing capabilities, not from "giving" power.

Meritus Health Food "Farmacy"

Ms. Miranda Ramsey, Vice President of Physician Services, along with Dr. Beth Fields Dowdell, Director for Community Health and Outpatient Care Management, presented on *Meritus Health Food "Farmacy."*

Dr. Fields Dowdell detailed several initiatives undertaken by Meritus to address social determinants of health (SDoH). A key success was the Care Caller program, launched to combat loneliness. Starting with one caller and two participants, it grew to 85 volunteer callers, two paid callers, and over 300 participants by the end of last year. Remarkably, 95 percent of surveyed participants reported feeling less lonely within four months, leading to a published article on the program's success. Meritus also significantly expanded their transportation program, which now transports approximately 17,000 patients annually to appointments across their campuses, preventing missed care. This expansion was made possible with support from Maryland Physicians Care.

Building on these achievements, Meritus is now focusing on food insecurity in Washington County, where 3,000 patients report food insecurity and over 1,200 inpatients experience malnutrition annually. Recognizing this as a food desert, Meritus began "care to share boxes" in 2023, providing about $100,000 in nutritious food last year. They are now launching a prescription-based food pharmacy. Through this initiative, providers can refer patients to receive a week's supply of personalized, healthy foods, especially beneficial for high-risk patients like those with diabetes, COPD, CHF, and pregnant individuals. This new program, aiming to serve 150 patients weekly, also offers dietitian access and cooking demonstrations. Integrated with EHR and CRISP for outcome tracking and financial analysis, the program has already received positive patient feedback and strong provider support.

No action was taken on this agenda item.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through December 2024 (for claims paid through March 2025). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is -2.29 percent below the nation through December

2024, and that Maryland Medicare hospital and non-hospital growth through August resulted in savings of $243 million.

Staff Update

Dr. Jon Kromm, Executive Director, announced that this will be Mr. Jason Mazique's final update to the commissioners. He will soon be departing to attend medical school. Dr. Kromm noted that he has made a profound impact during his time with the Commission; his brilliance and contributions will be greatly missed. He takes pride in knowing Mr. Mazique is advancing the pipeline of future medical professionals.

Calendar Year (CY) 2024 Quality Monitoring Update

Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies, Ms. Princess Collins-Taylor, Chief Quality Initiatives, and Mr. Jason Mazique, Population Health Project Manager presented the Calendar Year (CY) 2024 Quality Monitoring Update (see "*CY 2024 Quality Monitoring Update*" available on the HSCRC website).

Medicare Fee-For-Service Timely Follow Up (TFU)

Ms. Collins-Taylor provided a comprehensive review of Maryland's statewide quality performance for Calendar Year 2024. She focused on key metrics within the Total Cost of Care (TCOC) model, specifically addressing readmissions, complications, and timely follow-up after acute exacerbations. Maryland's performance was evaluated against both national benchmarks and internal programmatic goals, highlighting areas of success and ongoing efforts for improvement.

Regarding readmissions, Maryland demonstrated strong performance across both Medicare Fee-for-Service (FFS) and all-payer measures. While the unadjusted Medicare FFS readmission rate is no longer a contractual target, Maryland continues to outperform the nation. More importantly, on a risk-adjusted basis, Maryland has consistently performed better than the national average since 2018 and has achieved a significant reduction of over 7.5 percent in all-payer readmissions on a case mix-adjusted basis. The state also far surpassed its complications target, reducing Potentially Preventable Complications (PPCs) by over 40 percent since 2018, showcasing successful maintenance of improvements made under the Maryland Hospital Acquired Conditions (MHACs) program.

She covered the statewide performance on timely follow-up after acute exacerbations for six chronic conditions. Although Maryland has not yet reached its internal goal of a 75 percent timely follow-up rate, the state is performing better than the national average by more than half a percent across all conditions. She also noted the upcoming changes for Calendar Year 2025,

including new logic for the timely follow-up measure that will adjust timeframes and stratify patients by acuity.

Prevention Quality Indicators (PQIs)

Mr. Pack presented Potentially Preventable Admissions (PQIs), defined as avoidable hospitalizations resulting from chronic condition exacerbations that could have been prevented with access to high-quality outpatient or primary care. The program utilizes a composite measure, PQI 90, comprising 10 individual measures, risk-adjusted by age and sex, and further broken down into acute, chronic, and diabetic-related sub-composites. The established goal for the Total Cost of Care model was a 25 percent reduction across all PQIs by 2026.

He addressed prior concerns regarding PQI performance in 2023, where data initially suggested a plateau or even an increase from the 2018 baseline. Through further investigation, it was determined that this anomaly was primarily due to issues with the 2023 grouper, which had norms from 2019 and 2020 and suppressed volume. With the most recent 2024 grouper, the data now shows a 17.5 percent reduction in PQIs from 2018 to 2024**,** indicating significant sustained improvement. While this progress is encouraging, he noted that projecting the current linear trend might result in slightly missing the 25 percent target by 2026, though he hypothesized that a high respiratory season in 2023 and 2024 might have confounded recent performance.

A notable achievement highlighted by Mr. Pack is that this substantial PQI improvement has occurred without a standalone quality performance program specifically for PQIs; it is integrated into the broader Payment Update Waiver (POW) regime. He suggested that Commissioners might consider implementing a separate pay-for-performance program for PQIs in the future to further incentivize reductions. While there has been an increase in PQIs for observation cases (greater than 23 hours), these represent a small percentage of total PQIs (less than 20 percent), with significant reductions in inpatient PQIs observed. He noted that Maryland has been quite successful in reducing avoidable admissions under the TCOC model.

Readmissions Disparity Gap

Mr. Mazique presented the Readmissions Disparity Gap measure under the Statewide Integrated Health Improvement Strategy (SIHIS) initiative. The SIHIS goal aims for 50 percent of Maryland hospitals to reduce their readmission disparity gap by 50 percent or more by calendar year 2026**,** relative to a 2018 baseline. This disparity gap reflects how readmission risk changes for patients with varying levels of the Patient Adversity Index (PAI), where a higher PAI value indicates greater adversity. The Readmissions Reduction Incentive Program (RRIP) component incentivizes hospitals to reduce these disparities by offering rewards of up to half a percentage

point of their inpatient revenue for being on track to meet the 50 percent reduction target by 2026. For Calendar Year 2024, the reward threshold was -35.16 percent.

Mr. Mazique shared that no hospitals achieved the disparity gap reduction target in 2024. Staff hypothesized this due to a few key reasons: limited early resources for hospitals, challenges in addressing non-hospital social needs, and measurement complexities (like one PAI improvement offsetting another or model shrinkage). Concerns regarding the incentive structure were also noted.

Despite Maryland outperforming its two TCOC quality targets—Medicare FFS admissions were about 3 percent better than the national average, and All-Payer PPCs improved by roughly 41 percent since 2018—the readmissions disparity gap still needs significant attention. While Maryland shows promising results in most SIHIS quality measures, including timely follow-up (2.15 percent better than the national average) and avoidable admissions (20 percent improvement, exceeding the goal by 5 percent), targeted efforts are essential to successfully reduce readmission disparities.

Mr. Mazique concluded by stating that it had been an honor working with the Commission and the experience has brought his healthcare journey full circle. He noted that he couldn't have asked for a more exceptional team or a more supportive organization and thanked the staff.

No action was taken on these agenda items.

ITEM VI
FINAL RECOMMENDATION: NSP II COMPETITIVE INSTITUTIONAL GRANTS

Ms. Erin Schurmann, Associate Director, Strategic Initiatives, and her colleagues at the Maryland Higher Education Commission (MHEC), Ms. Kim Ford and Ms. Laura Schenk, presented the staff's *Final Recommendation for the Nurse Support Program II Competitive Institutional Grant* (see " *Final Recommendation for the Nurse Support Program II Competitive Institutional Grant*" on the HSCRC website). This report and its recommendations are jointly submitted by the staff of MHEC and HSCRC.

Ms. Ford presented the FY2026 NSP II grant recommendations aimed at strengthening Maryland's nursing workforce. A total of 24 grant proposals (selected from 30 submissions) are recommended for funding, totaling $17.2 million. These proposals address six priority areas, spanning from student recruitment to faculty preparation, and include a mix of planning, implementation, continuation, and resource grants ranging from one to four years in duration.

Thirteen institutions across all four Maryland regions will benefit, ensuring broad geographic equity and statewide impact.

The recommended proposals are categorized into three key areas.

- **Entry into the workforce and academic progression**, including initiatives like hybrid LPN to RN pathways, online RN to BSN and MSN programs, and a new Doctorate in Nursing Practice (DNP) track for Public Health Nursing. These are considered cost-effective, short-term projects designed to quickly grow the nursing pipeline.
- **Expanding and retaining nursing faculty**, including launching a new PhD in Nursing Education Program and supporting 94 additional Cohen Scholars who commit to teaching in Maryland, directly addressing the critical faculty shortage in nursing education.
- **Strengthening clinical education and teaching innovation**, include programs that expand preceptor models in high-need settings and train faculty to prepare graduates for technology-enhanced practice. These initiatives build upon successful statewide programs such as the Maryland Clinical Simulation Resource Consortium and the Faculty Academy and Mentorship Initiative of Maryland, extending their reach and sustainability. This focus ensures the alignment of nursing practice and education, which is crucial for producing job-ready graduates.

The staff's Final Recommendation regarding NSP II Competitive Institutional Grants, is as follows.

- **Total funding requested:** $17.2 million
- Targeted across six priority areas (NSP II Initiatives):
    1. Pre-licensure enrollment growth
    2. Degree advancement (BSN, MSN, DNP, PhD)
    3. Faculty pipeline development
    4. Practice-education partnerships
    5. Statewide teaching capacity expansion
    6. Cohen Scholars for future educators
- **Number of grants recommended:** 24 (30 proposals received)
- **Grant types:** planning, implementation, continuation, resource
- **Timeframes:** 1–4 years
- **Institutions Impacted:** 3 community colleges & 10 universities from all four regions in Maryland (3 capital, 7 central, 1 eastern shore, 2 western)

Commissioner Kane asked whether the new PhD programs in Nursing Education will require graduates to remain and work in Maryland, similar to the Cohen Scholars program.
Ms. Ford noted that the Cohen Scholars program specifically includes a service obligation requiring recipients to teach in Maryland upon graduation. However, the funding for the new PhD program in Nursing Education is directed towards its creation and establishment within Maryland, rather than directly supporting student tuition. MHEC experience suggests that the current Maryland faculty seeking doctoral degrees typically pursue them within the state. While there isn't a direct service obligation tied to this particular grant, she can certainly request the grantee to provide data on the proportion of graduates who intend to teach in Maryland. Based on her review of the proposal, their recruitment strategy for this PhD program is specifically focused on attracting individuals who will contribute to nursing education within Maryland.

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

ITEM VII
DRAFT RECOMMENDATION: CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP) FUNDING

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, and Ms. Megan Priolo, Executive Director of CRISP presented the Staff's *Draft Recommendation for CRISP Funding* (see "*Draft Recommendation for CRISP Funding*" available on the HSCRC website).

Mr. Henderson presented the staff draft recommendation on funding for the Chesapeake Regional Information System for our Patients (CRISP). This funding supports CRISP's general Health Information Exchange (HIE) operations and specific programs aligned with the HSCRC's Total Cost of Care (TCOC) model and other regulatory initiatives.

The draft recommendation for FY2026 proposes an increase in funding of approximately $4 million, from about $9 million to $13 million. After accounting for a $1 million reduction from accumulated reserves, the net request stands at $12 million. Henderson emphasized that the services provided by CRISP remain consistent; the primary driver for this increase is the anticipated loss of federal matching funds that typically leverage CRISP's spending. The increased HSCRC assessment is intended to cover this expected gap. He acknowledged Lynn Diven's significant work in managing the operational and administrative aspects of HSCRC's engagement with CRISP.

Ms. Priolo presented a comprehensive overview of CRISP, emphasizing its foundational role as Maryland's designated HIE and Health Data Utility (HDU). She highlighted that CRISP's extensive operations, encompassing both clinical and public health data, are inextricably linked to robust cooperation and collaboration with its diverse partners. This collaborative success was underscored by examples from the AIM winners, who effectively leverage CRISP's tools in their initiatives.

She detailed the substantial growth in CRISP's data utilization, evidenced by a steady increase in patient searches and queries, currently serving over 44,000 active users and delivering more than 15 million unique alerts in the past 90 days. She cited key accomplishments from the preceding fiscal year, including new data-sharing collaborations for asthma action plans and methadone data, and the successful in-house development of the CRISP Event Notification Delivery (SEND) system, which replaced a long-standing vendor solution, thereby enhancing agility and cost efficiency.

Addressing the financial aspects, Ms. Priolo reiterated that the primary driver for the increase is the anticipated shift in federal Medicaid matching rates for new development. She also outlined CRISP's proactive engagement with the state to explore new opportunities, such as clinical data clearinghouse initiatives and addressing health-related social needs, while simultaneously prioritizing efficiency and cost reductions. She concluded with an illustration of CRISP's funding trends over time, showing a diversification of funding sources with a notable reliance on federal Medicaid funds, and a commitment to judicious financial management.

Commissioner McCann noted that, while not a direct user of CRISP, she consistently receives positive feedback about CRISP from others, suggesting its opportunities are endless. She noted that she has never heard complaints regarding CRISP's funding. She asked whether there is an opportunity for CRISP to expand its activities, and if the Commission should consider being more aggressive in its funding requests, or if CRISP's capacity for new initiatives is naturally limited by time. Ms. Priolo emphasized CRISP's commitment to being nimble and flexible, ready to adapt to the community's evolving data sharing needs. She explained that while CRISP is always willing to take on more, any new initiatives would require a collaborative effort to scope the project and assess the necessary resources, including potential team expansion. Ms. Priolo noted that ideas for leveraging CRISP's capabilities are continuously emerging. She concluded by reiterating CRISP's collaborative stance, emphasizing that they are prepared to either expand or reduce data sharing efforts based on what best serves the community's needs, affirming their readiness to do more.

Mr. Henderson presented the staff’s Draft 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.

No action was taken on these agenda items.

ITEM VIII
DRAFT 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 Draft Recommendation for the Update Factor for Rate Year 2026 (see "*Draft Recommendation for the Update Factor For Rate Year 2026*" available on the HSCRC website).

Policy Objective and Update Factor Components

Ms. Cooksey presented an outline of the proposed update factor for hospitals, a formulaic recommendation designed to ensure hospitals maintain operational readiness and fairness to all stakeholders. The update factor incorporates various components to determine the total recommended revenue for Rate Year 26.

Components of the Update Factor

- **Inflation:** Staff utilized Global Insights' inflation data, with the 1st quarter book showing a **3.36 percent** gross inflation rate. This includes a 0.02 percent carve-out for high-cost drugs via the Cost of Drug Sold (CDS) policy.
- **Care Coordination/Population Health:** A net value of **0.03 percent** is allocated for care transformation and grant funding.
- **Volume Adjustment:** This includes a **0.74 percent** adjustment based on standard demographic and population policy, plus a significant **0.76 percent** revision to prior-year estimates, totaling **1.5 percent** for volume adjustment.
- **Other Adjustments:** This section has a net value of **0.78 percent**, and includes
    - **0.2 percent** (approximately $44-45 million) set-aside for unknown adjustments, which will revert to prior-year allocation methods (i.e., it will be used strictly for

unforeseen adjustments or for hospitals that are relatively efficient). Unlike Rate Year 25, the competitive process for this funding will not be used.
    - a **zero allocation** for low-efficiency outliers (revenue for reform) as inefficient hospitals are expected to buy out of their portion.
    - **0.2 percent** for Academic Medical Centers for complexity and innovation, with a small reversal of one-time drug adjustments,
    - **0.13 percent** for full-rate application and capital funding, and
    - **0.3 percent** Uncompensated Care (UCC) fund revision.
- **Quality and POW Savings:** These include reversals of prior-year adjustments and current-year volume adjustments for Quality-Based Reimbursement (QBR), Maryland Hospital Acquired Conditions (MHAC) readmissions, and Potentially Avoidable Utilization (PAU), resulting in a net **-0.25 percent** impact.

Total Revenue Growth

These components bring the total update for hospitals' revenue for FY 2026 to **5.41 percent**. Additionally, revenue offsets with a neutral impact on financial statements, such as uncompensated care (-**0.44 percent**) and the payer portion of the deficit assessment (**0.7 percent**), bring the total recommended revenue growth for hospitals to **5.5 percent**.

Overview of the Demographic Adjustment, UCC Regression Error, and Integrated Efficiency Policy

Mr. Pack presented the proposed demographic adjustment and addressed the uncompensated care policy misapplication, as well as a proposed amendment to the integrated efficiency policy.

Demographic Adjustment

The demographic adjustment is the mechanism for funding volume increases in the model, acting as a "governor" for new volume-related funding. It leverages Claritas' proprietary data to project zip code-level population growth, allocating this growth to hospitals based on their market share. This ensures that hospitals losing market share do not continue to receive robust population funding. The population growth is then age-adjusted to account for higher per-member per-year hospital expenses in older populations, although the age adjustment does not influence the total funding. This year, the demographic adjustment is substantial due to revisions from the Census Bureau and the Maryland Department of Planning.

Historically, population growth was projected to be 0.75 percent (approximately 46,000 lives). However, accounting for prior restatements of population growth, particularly the correction of an error in the 2020 census and upward revisions to net migration estimates (adding 37,000 lives), the demographic adjustment has effectively doubled to **1.5 percent**. Mr. Pack

emphasized the prudence of incorporating these material revisions now rather than waiting until the 2030 census and noted that the policy would involve two-sided risk for future revisions.

Uncompensated Care Policy Misapplication

Mr. Pack then addressed a misapplication of the uncompensated care (UCC) policy that occurred between FY 2023-2025. The policy typically incorporates the prior year's statewide actual uncompensated care into rates, followed by a pooling mechanism where hospitals with below-average UCC contribute, and those with above-average UCC withdraw. The pool is determined by using 50 percent of a hospital's actual UCC and 50 percent of a hospital's predicted UCC value based on logistic regression, which includes payer status, site of service, and Area Deprivation Index (ADI). The error stemmed from using the hospital's average ADI instead of the patient-specific ADI as the default, which inadvertently applied the default to all patients. This adversely affected hospitals serving more affluent populations while benefiting safety net hospitals. The misapplication resulted in approximately **$33 million** per year (totaling $102 million over three years) in incorrect distribution among 27 disadvantaged hospitals, though it did not increase overall payer costs.

Staff proposed two solutions:

1. **Budget-Neutral Correction:** Distribute additional funding to disadvantaged hospitals by taking it away from advantaged hospitals.
2. **Hold Harmless (Staff Recommendation):** Hold benefited hospitals harmless, acknowledging they are often rural and safety net hospitals that relied on the incorrect information for their global budgets. This would entail adding approximately **$67 million** to rates (across the system, not individual hospitals) to mitigate the impact on payers, with a small portion coming from the uncompensated care fund balance. This option is recommended given overall positive TCOC and per capita test performance.

Integrated Efficiency Policy

Finally, Mr. Pack discussed a proposed amendment to the integrated efficiency policy, which evaluates hospitals' operational efficiency (cost per case) and TCOC performance. Hospitals are scored and arrayed into quartiles, with the worst quartile typically facing funding penalties. Currently, hospitals in the best quartile with performance better than one standard deviation from average in the Inter-Hospital Cost Comparison (ICC) can access additional funding. However, the worst quartile is automatically penalized without similar consideration of their distance from the average. Mr. Pack presented visuals demonstrating the tightening of the ICC, indicating that hospitals are becoming more efficient and that the interquartile range has

narrowed. He expressed concern that perpetually penalizing the lowest quartile, even if they are not significant outliers due to overall tightening, creates a "cliff effect."

The proposed amendment seeks to introduce a standard in the ICC, ensuring that hospitals are not penalized if they are in the third quartile or better, OR if they are better than one historical standard deviation from average ICC performance. Using the historical standard deviation value is crucial, as it would lock in a value to prevent constant resetting as the field narrows, providing a more predictable benchmark for hospitals. This amendment aims to align the policy symmetrically with how the first quartile is handled and prevent penalizing hospitals that are not true outliers.

Converting Fiscal Year Revenue Growth to Calendar Year Revenue Growth

Ms. Cooksey continued with the formulaic process for determining the update factor, specifically focusing on how the estimated fiscal year update factor translates into calendar year revenue growth for model projections, savings, and guardrail calculations.

She started with the **5.68 percent revenue growth** for the fiscal year. She then explained the multi-step process for converting this into calendar year growth:

- **Step one** involves estimating growth for the first six months of the calendar year by using the fiscal year's budgeted Gross Budget Revenue (GBR) and actual charges for the first six months of the fiscal year.
- **Step two** estimates the growth for the full Fiscal Year 2026, making crucial adjustments for one-time factors that are not part of the standard inflation calculation. This includes:
    - removing extraordinary one-time funds from Rate Year 2025, such as surge funding, $25 million for "AHEAD" preparation, and any set-aside funds exceeding what was approved in the previous year's update.
    - adjustments for miscellaneous one-time additions in Rate Year 2026, which encompass the remaining surge funding and a $25 million contribution to the Population Health Trust Fund.
- **Step three** utilizes the full fiscal year growth estimate for Rate Year 2026 to project the remaining six months of the calendar year.
- Finally, **Step four** calculates the projected calendar year growth for Calendar Year 2025 over Calendar Year 2024.

Guardrail Tests – Proposed Scenarios

Mr. Henderson presented on evaluating the update factor against Maryland's Medicare Savings Test and various all-payer benchmarks, employing a scenario-based approach.

Medicare Savings Test Scenarios

Each year, the HSCRC assesses the update factor's impact on Medicare savings, using different historical trend periods for Maryland non-hospital and national hospital/non-hospital spending, while plugging in expected Maryland hospital outcomes. For CY 2025, four scenarios were developed:

- **Scenarios 1 & 2 (Pre-Pandemic Trends):** These utilize pre-pandemic trend periods (e.g., 2017-2019 for Scenario 1, 2015-2019 for Scenario 2), projecting 2025 performance based on a 2024 baseline. While these trends may eventually be phased out due to post-pandemic shifts, they currently serve as reference points.
    - **Scenario 1 (2017-2019 trends):** Projects Maryland to be 1.4 percent over the nation, resulting in about $638 million in savings. This would be a technical failure of the guardrail (which allows for a maximum of 1.0 percent over in 2025) but still well above the 2025 savings target.
    - **Scenario 2 (2015-2019 trends - most pessimistic):** Projects Maryland to be 1.9 percent over the nation, exceeding the guardrail by 0.9 points, with savings of $565 million. This remains above the 2025 savings target but highlights the guardrail's constraint against significant backsliding.
- **Scenario 3 (Two-Year Post-Pandemic Trend):** This scenario uses the average trend over the last two post-pandemic years (CYs 2022-2024), shifting from last year's single-year (2022-2023) analysis. The 2023-2024 single-year trends were excluded as a standalone scenario due to being extreme outliers, particularly on the non-hospital side.
    - **Scenario 3:** Projects Maryland to be 0.1 percent over the nation, well within the guardrail, with strong savings of $810 million, indicating a more reasonable position based on recent data.
- **Scenario 4 (USPCC Trends - AHEAD Model Approximation):** This scenario, replacing the usual OACT projections (which are not yet available), uses trends from the United States Per Capita Claim Cost (USPCC), which is the trend built into the upcoming AHEAD model.
    - **Scenario 4:** Projects Maryland to be 0.9 percent over the nation, close to the guardrail limit but with robust savings of $718 million. Mr. Henderson noted the uncertainty in USPCC projections, as their 2024 projection (3.4 percent) was

significantly lower than the actual (7.2 percent). This scenario approximates the future AHEAD model's test, which will be more precisely defined next year.

All-Payer Affordability Test

Mr. Henderson also presented the All-Payer Affordability Test, which focuses on hospital costs as per the current agreement, allowing Maryland to grow at 3.58 percent annually. Historically, Maryland's actual hospital revenue growth has been considerably below this 3.58 percent benchmark and significantly below actual Maryland Gross State Product (GSP) growth. While the 2025 GSP number is not yet projected, current trends suggest that Maryland is in very good shape regarding the cumulative test, with hospital revenue growth well below GSP. He noted that beginning in 2026, the agreement will require an All-Payer TCOC test, which will incorporate non-hospital costs.

Discussion on Trend Periods

Mr. Henderson acknowledged that these long-term trends may become less relevant but explained that they were initially used as the best available estimate and that the AHEAD model will introduce a risk-adjusted test. He indicated that the use of these older trends will likely cease next year as more post-pandemic data becomes available, allowing for a more accurate assessment that accounts for overall secular declines in utilization, even among older populations. He also noted that developing such a comprehensive methodology is challenging but is being actively worked on, with a recommendation expected within the calendar year, aligning with the AHEAD model's January 1 implementation.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

Ms. Cooksey concluded the presentation by addressing the update factor for hospitals operating under non-global budgets, specifically specialty hospitals, psychiatric facilities, and Mount Washington Pediatric Hospital. For these facilities, the HSCRC sets rates exclusively for non-governmental payers, and the update is based solely on price, not volume.

For Rate Year 2026, staff are proposing a base update of **3.36 percent**, consistent with GBR hospitals. However, a **productivity offset of 0.8 percent** is being recommended, resulting in a proposed inflation rate of **2.56 percent** for these specialty hospitals. Ms. Cooksey noted that this reintroduction of a productivity adjustment, which had been suspended for the past five years, reflects a consideration of the "new normal" in the post-COVID era. This reevaluation will help determine the appropriate update, particularly in assessing whether current volume trends for these hospitals will persist compared to pre-pandemic levels.

Ms. Cooksey presented the staff's Draft Recommendation regarding the Update Factor for Rate Year 2026 as follows.

For Global Revenues:

1. Provide all hospitals with a **gross inflation increase of 3.36 percent**. Additionally, allocate **0.02 percent** of this total inflation allowance based on each hospital's proportion of drug costs to total costs.
2. Provide an **overall increase of 5.68 percent for revenue** (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2 of the recommendation. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.
    - Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target, and the remainder of the revenue will be applied to the year-end target.
    - Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
3. Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. **Failure to report on targets and outcomes will result in a take back of 0.27 percent** of inflation removed in the RY 2026 rate orders.
4. Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives.
    - These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than annual percentage growth rates, thus improving accuracy and better reflecting actual population changes.
5. To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (**0.30 percent**), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.
6. Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency:
    - 3rd quartile or better OR

- better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.

For Non-Global Revenues, including specialty hospitals, psychiatric hospitals, and Mt. Washington Pediatric Hospital:

7. Provide an overall update of 3.36 percent for inflation and apply a productivity offset of 0.80 percent for a total update of **2.56 percent**.

Vice Chairman Elliott raised concerns about applying the productivity offset to non-global budget hospitals, especially psychiatric facilities, whose volumes haven't recovered to pre-COVID levels. He questioned the appropriateness of this offset now, given that psychiatric hospitals already face low reimbursement rates. Mr. Schmith acknowledged these points, explaining that the offset is a standard annual adjustment designed to encourage productivity in hospitals with 100 percent variable cost reimbursement. He noted it had been suspended for the past five years due to pandemic-related volume drops. While volumes have indeed rebounded, they haven't hit pre-pandemic levels. Staff are currently working with these hospitals to determine if the proposed 0.8 percent offset, which aligns with federal rates, is fair, especially since it's uncertain if pre-COVID volumes will ever fully return, suggesting a potential "new normal" in care delivery.

Chairman Sharfstein requested details on the next steps and timeline. Ms. Cooksey explained that the comment period concludes at the end of business on May 21st. After that, staff will gather all stakeholder comments and prepare thorough responses. This information, along with the original comments, will be presented to the Payment Model Work Group on May 29th. During this session, staff will share the public responses with all involved stakeholders, including representatives from payers, hospitals, physicians, and consumers. Any additional feedback from this Work Group will then be incorporated into the staff's final recommendation, ensuring it reflects a comprehensive review of all input.

No action was taken on these agenda items.

ITEM IX
HEARING AND MEETING SCHEDULE

June 11, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:10 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

May 14, 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 motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at 12:06 p.m.

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

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

Also attending: 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 March FY25.

The Closed Session was adjourned at 12:34 p.m.

PARTIAL-RATE APPLICATION

Deon Joyce
Chief, Rate Setting
Revenue & Regulation Compliance
Email Address: Deon.Joyce@maryland.gov

maryland health services cost review commission

Staff Recommendation:

Introduction

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.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or a rate based on the hospital's projections. Based on the information received, the requested rates are lower than the statewide average for similar services offered for child sites of 340B programs. Staff is working to reconcile the associated revenue shift that was included in this request and intends to ensure that this shift remains revenue neutral.

Recommendation

After reviewing the application, staff recommends that the Luminis Health request be approved because it will enable LHDCMC to provide lower cost services to current oncology patients; and it will generate future saving to the Maryland healthcare system and to oncology patients through lower drug costs at the LHAAMC location.

Staff recommends that the approval be 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.

Staff also recommends that the following rates for the infusion clinic services provided at LHAAMC be approved and added to LHDCMC's approved rate order:

1) Clinic rates of $52.43 per RVU be approved effective June 23, 2025
2) 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 RY26 rate orders.

Questions?

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
LUMINIS HEALTH	*	**DOCKET: 2025**
DOCTORS COMMUNITY	*	**FOLIO: 2481**
MEDICAL CENTER		
LANHAM, MARYLAND	*	**PROCEEDING: 2671N**

Staff Recommendation
June 11, 2025

Introduction

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 that:

1) In FY25, a total of $662,882 be transferred from LHAAMC's Global Budget Revenue (GBR) cap to LHDCMC's GBR.
2) In FY26, a total of $29,577,979 be transferred from LHAAMC's GBR to LHDCMC's GBR.
3) New Unit Rates on LHDCMC's Rate Order as follows:
    - CL-340 set at $52.4321 (equivalent to LHAAMC's FY25 rate)
    - LAB-340 set at $1.7793 (equivalent to LHAAMC's FY25 rate)
4) Exclusion from Rate Realignment:
    - The Commission exclude the new unit rate revenue from rate realignment.
5) An adjustment of Rate Order Volumes as follows:
    - That volumes in the rate orders for both LHAAMC and LHDCMC be adjusted to ensure revenue neutrality regarding rate capacity.

Maryland 2015 legislation (Senate Bill 513) altered the definition of "hospital services" in HSCRC law to include hospital outpatient services of a hospital that is designated as part of another hospital under the same merged asset system to make it possible for the hospital to participate in the 340B program.

As per the statute, LHDCMC requests that effective June 23, 2025, infusion clinic services provided at LHAAMC be approved to begin operations as part of the LHDCMC oncology program. The outpatient infusion clinics located at LHAAMC will be able to operate as an off-site provider-based child-site of LHDCMC in accordance with Medicare's rules for provider-based status. As a result of this request, the child-site at LHAAMC will be able to participate in the 340B outpatient drug discount program under LHDCMC eligibility.

Additionally, Luminis Health is requesting that the revision of rates and revenue between

LHDCMC and LHAAMC take effect on June 23, 2025.

Staff Findings

HSCRC policy is to set the rates for new services at the lower of the statewide median or a rate based on the hospital's projections. Based on the information received, the requested rates are lower than the statewide average for similar services offered for child sites of 340B programs. Staff is working to reconcile the associated revenue shift that was included in this request and intends to ensure that this shift remains revenue neutral.

Recommendation

After reviewing the application, staff recommends that the Luminis Health request be approved because it will enable LHDCMC to provide lower cost services to current oncology patients; and it will generate future saving to the Maryland healthcare system and to oncology patients through lower drug costs at the LHAAMC location.

Staff recommends that the approval be 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.

Staff also recommends that the following rates for the infusion clinic services provided at LHAAMC be approved and added to LHDCMC's approved rate order:

1) Clinic rates of $52.43 per RVU be approved effective June 23, 2025
2) 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 RY26 rate orders.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

June 11. 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:	2482
BALTIMORE, MARYLAND	*	PROCEEDING:	2672A

I. INTRODUCTION

On April 30, 2025, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospital, Johns Hopkins Bayview Medical Center (the "Hospital"), for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with self-pay patients for reproductive health services. The Hospital requests that the Commission approve the arrangement for one year beginning June 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 Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital 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 Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between JHHC and the Hospital holds the Hospital 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 no activity has been reported under this agreement; however, Staff believes that the Hospital can achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with self-pay patients for reproductive health services for one-year beginning June 1, 2025. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital 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

June 11, 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:	2483
BALTIMORE, MARYLAND	*	PROCEEDING:	2673A

I. INTRODUCTION

On April 30, 2025, Johns Hopkins Health System ("System") filed a renewal application 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 is requesting approval to continue to participate in a revised global price arrangement with Blue Cross and Blue Shield Association Blue Distinction Centers for Transplants (BDCT) for solid organ and bone marrow transplant services. The System requests that the Commission approve the arrangement for one year beginning June 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 updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement between JHHC and the hospitals 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 System's application for an alternative method of rate determination with Blue Cross Blue Shield Association Blue Distinction Centers for Transplants for solid organ and bone marrow transplant services for one-year beginning June 1, 2025. The System must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the System for the approved contract. This document would formalize the understanding between the Commission and the System 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

June 11. 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:	2484
BALTIMORE, MARYLAND	*	PROCEEDING:	2674A

I. INTRODUCTION

On May 21, 2025, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospital, Johns Hopkins Hospital (the "Hospital"), for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with self-pay patients for facial feminization services. The Hospital requests that the Commission approve the arrangement for 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 Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

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The Hospital 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 Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between JHHC and the Hospital holds the Hospital 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 no activity has been reported under this agreement; however, Staff believes that the Hospital can achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with self-pay patients for facial feminization services for one-year beginning July 1, 2025. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital 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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Alternative Method of Rate Determination

Johns Hopkins Health System

Request for Extension

June 11, 2025

Johns Hopkins Health System- Request for Extension

- On February 5, 2025 staff approved a 3-month extension of the alternative rate arrangement between Johns Hopkins Health System (JHHS) and Optum Health (Optum), Proceeding 2644A.
- On May 27, 2025 JHHS requested the Commission extend the rate arrangement an additional two months to complete contract negotiations with Optum.
- Staff's review of historical data has shown the rate agreement has been favorable.
- Staff recommends the 2-month extension be granted contingent upon completion of negotiations by August 31, 2025. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.

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Request For Extension of Approval

Johns Hopkins Health System

June 11, 2025

Background

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.

Request

JHHS requests that the Commission extend its approval for an additional two months, to August 31, 2025, to complete negotiations.

Findings

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

Staff Recommendation

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

New Paradigms in Care Delivery Update

New Paradigms in Care Delivery

Purpose

Provides matching funding to hospitals to **accelerate innovative solutions that avert the need for traditional hospitalization** through targeted investment in **transformative solutions.**

Funding

- Funding supports initiatives that may be too expensive or speculative to fund in the normal course of business.
- This funding is intended as a one-time adjustment to approved hospital rates.
- Hospitals that receive funding will implement programs in FY 2026.

Initiatives

- Received sixteen proposals ranging from palliative care, sepsis, heart failure networks, social determinants of health, to forensic nursing and maternal health.

Heart Failure Proposal Examples

- Alternatives to hospitalization that provide specialized clinic-based settings for the treatment of heart failure exacerbations.
  - Clinic innovates heart failure management through three key approaches: clinic-based IV diuresis; extensive case management and leveraging technology.
  - Partnership with community cardiologists is critical in this model.
- Fully integrated heart failure network that connects every care setting—home, community, ambulatory, hospital, and post-acute—into a seamless system of support.
  - Network will unify multidisciplinary teams using standardized communication tools and NCQA-aligned workflows, ensuring smooth transitions, and reducing fragmentation throughout the patient's journey.
  - Remote Patient Monitoring (RPM) and centralized telehealth services, will scale system-wide and allow for early detection and rapid intervention, reducing preventable hospitalizations.

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Final Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to The University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for Trauma and EMS (NSC)

Health Services Cost Review Commission 4160
Patterson Avenue, Baltimore, MD 21215

June 11, 2025

This is a final recommendation for Commission consideration at the June 11, 2025, Public Commission Meeting.

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SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), and the National Study Center (NSC) for Trauma and EMS, is requesting access to the Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital Data, that includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES). The Commission last approved access to the Data for this project on March 13, 2024.

OBJECTIVE

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office (MDOT MDHSO) and other partners on the Crash Outcome Data Evaluation Systems (CODES) project for more than a decade.

Investigators received approval from the Maryland Department of Health (MDH) IRB on February 7, 2024, and the MDH Strategic Data Initiative (SDI) office on May 15, 2025. The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries, and has no end date. However, the Project Principal Investigator will notify the HSCRC if the project were terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

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

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

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

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UMSOM for the Data for Calendar Years 2016 through 2021 be approved.

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

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Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2026 Funding

Final Recommendation

June 11, 2025

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

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Table of Contents

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List of Abbreviations

AHEAD	Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
EQIP	Episode Quality Improvement Program
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes in order to further the goals of improved health equity under the Model.

Summary of the Recommendation

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,[1] this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2026 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($3,229,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($9,831,000). Staff propose using $1,000,000 of accumulated reserves to reduce the revenue generated through rates for FY2026 to $$8,831,000 for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $ 12,060,000 for FY 2026. As a result, the HSCRC will be funding approximately 26 percent of CRISP's Maryland funding, compared to budgeted 20 percent in FY 2025. The increase in funding from $8,420,000 to $12,060,000 is primarily related to an anticipated change in the Federal matching grants and some increase due to additional work related to care transformation. The increase in the share of CRISP funding being paid through hospital rates also relates to the Federal funding change. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

[1] MD. CODE ANN., Health-Gen §19-219(c).

This recommendation continues the approach used in prior years of spending down reserve funds accumulated due to a better than anticipated Federal match.

Background – Past Funding

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 14 Years

CRISP Budget: HSCRC Funds Received	
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	$4,800,000
FY 2024	$4,800,000
FY 2025	$8,420,000
FY 2026	$12,060,000

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability. Starting in FY 2023, CRISP's reimbursement from the HSCRC was provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. In addition, in FY 2024, the Reporting and Program Administration payments will similarly be split into fixed recurring costs and a periodic true up. These changes are made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below.

Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. However, we anticipate the 75 percent match reduced to 50 percent, effective October 1, 2025 and we are providing additional funding to cover that risk. The assessment funding will provide the State's portion of this match as well as the State's Fair Share amount. The Fair Share represents the amount that benefits Medicaid before considering the federal and state match. Starting in FY 2024 the methodology for calculating the State's Fair Share amount was changed resulting in a greater portion being borne by the State.

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue. User fees represent approximately 12% of total funding for FY 2026.

Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by Staff for FY 2026 for the HIE function is $3,229,000.

Category 2: Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, the AHEAD Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the Total Cost of Care (TCOC) Model and the Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

[2] MD. CODE ANN., Health-Gen §19-143(a).

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model;

(2) Funding for program administration related to programs under the TCOC Model; and

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount recommended by Staff for FY 2026 for the activities described above is $8,831,000.

Staff Recommendation

Staff is recommending the Commission approve a total 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.

Table 2 shows the funding through hospital rates and the federal match that will be generated from the MES funding as well as the user fee and MDH funding.

Table 2. FY 2026 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$3,229,000	$9,440,000	$5,952,000	$3,165,000	$21,786,000
Reporting and Program Administration	$9,831,000	$9,729,000	$0	$3,095,000	$24,238,000
Other non-HSCRC programs	$0	$3,560,000	$0	$2,309,000	$4,300,000
Total Funding	**$13,060,000***	**$22,729,000**	**$5,952,000**	**$8,569,000**	**$50,310,000**
% Of Total	**26%**	**45%**	**12%**	**17%**	**100%**

*Note: Prior to reduction for use of accumulated reserves to reduce FY2026 assessment.

maryland
health services
cost review commission

Update Factor Final Recommendation

June 11, 2025

Final Recommendations

For Global Revenues:

- Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.
- Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.
- Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than annual percentage growth rates, thus improving the accuracy and better reflecting actual population changes.
- To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.
- Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.
- Transition to a percentage-based allocation model for the Deficit Assessment Allocation (14.5 percent for hospitals & 85.5 percent for payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.36 percent for inflation and suspend the productivity offset of 0.80 percent.

STAKEHOLDER COMMENTS

Comment Letters Received

Letters were received from:

1. Sheppard Pratt
2. Mount Washington Pediatrics
3. The Maryland Hospital Association
4. University of Maryland Hospitals
5. Adventist Health
6. Luminis Health
7. Frederick Health
8. Johns Hopkins Health System
9. Lifebridge Health
10. MedStar Health
11. CareFirst

Comments generally focused on 7 areas:

1. Provide Additional Inflation
2. Fully fund Age-Adjusted Demographic Growth
3. Pass on Medicaid Deficit Assessment to Payers
4. UCC Fund Revision
5. Reinvestment of Excess Medicare Savings
6. Integrated Efficiency Policy Modification
7. Suspend Productivity Adjustment for non-GBR hospitals

1. RY2026 Update Factor Comments: Address Inflation Pressures

- The Maryland Hospital Association and its member hospitals requested that the Commission consider funding additional inflation funding. Hospitals suggested that the 3.36% outlook for Q1 provided through S&P was likely to be conservative and the actual inflation value would come in higher. Hospitals requested an additional 0.67%, which was calculated by the average relative difference of funded versus actual inflation for RY23 and RY24. One hospital system, requested the 0.52% that is the current calculated underfunding as calculated through the inflation catch up methodology.

1. RY2026 Update Factor Comments: Address Inflation Pressures

HSCRC Response: As part of the RY 2025 Approved Update Factor Recommendation an inflation catch-up methodology was adopted. This methodology aims to:

- *Consider historical overfunding allowances*
- *Allow for two-sided risk*
- *Utilize multi-year solutions to ensure savings tests are met*
- *Establish formulaic methods that are predictable to hospitals and payers*
- *All additional inflation values still need to be considered against required savings*

The current calculation of the catch-up methodology indicates an 'unfunded' inflation rate of -0.52%. This figure does not activate the 1% guardrail threshold, meaning no additional inflation funding is provided for Maryland hospitals at this time, per policy. Should actual inflation exceed the funded inflation for Rate Year 2026 (RY26), the catch-up methodology will automatically adjust to account for any variance, triggering additional inflation support if the 1% guardrail is breached.

It's important to note that the 1% guardrail was established as an acceptable tolerance level, reflecting historical inflation funding patterns since 2013. Additionally, hospitals have not provided supporting evidence suggesting a significant deviation between actual and funded inflation rates.

1. RY2026 Update Factor Comments: Address Inflation Pressures

Max Tolerance =	1.00%					1.00%							
HSCRC Scenario/Table 1 - Inflation Resolved after First	Historical											Projected	
Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.35%	3.24%	3.36%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.24%	3.36%
Actual Inflation Correction												1.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	-0.35%	1.00%	0.00%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.51%)	-0.52%	-0.52%
Guardrail/Tolerance **(A)**											1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.52%)	(0.52%)	**(0.52%)**
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)								**1% for stub period**		1.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.35%	4.24%	3.36%

2. RY2026 Update Factor Comments: Fully Fund Age Adjusted Demographic Growth

- The Maryland Hospital Association and its member hospitals requested that the Commission go beyond the proposed 0.76% correction and fully fund age-adjusted demographic growth. They stated that the current adjustment does not reflect the true cost of serving an aging population. MHA estimated that 2.6% in age-adjusted growth from 2020 to 2024, or roughly 0.65% per year, remains unfunded and recommended including this amount in the update.

HSCRC Response: Staff propose moving forward with recommending an additional 0.76 percent to reflect revised historical data from the Maryland Department of Planning. Staff also propose that RY 2026 and future demographic adjustments be reconciled to cumulative population count from 2020 through the most recent year.

In addition to the aforementioned policy correction, hospitals have requested additional funding related to a proposed revision of the demographic policy, specifically concerning updates to age and risk adjustment calculations. Staff are committed to continued collaboration with hospitals and other stakeholders to revise this policy and will work over the coming months to review and align it with the implementation of the AHEAD Model. It is important to note that this process involves a fundamental change to the underlying methodology, not merely a revision related to source data or calculation errors. Therefore, it is essential that this process is conducted through a thorough stakeholder engagement process.

3. RY 2026 Update Factor Comments: Pass on Medicaid Deficit Assessment Increase to Payers

- The Maryland Hospital Association and its member hospitals requested that hospitals not be required to directly remit any portion of the $150-million increase to the Medicaid Deficit Assessment, citing financial vulnerability.

HSCRC Response: The Maryland Legislature has approved a $150 million increase to the Medicaid Deficit Assessment, bringing the total amount to be collected in Rate Year (RY) 2026 to approximately $444 million. Given the magnitude of this increase, staff believe it would be inequitable to pass the entire burden onto payers and patients.

Staff propose a hospital-payer split consistent with the historical allocation used in RY 2015, which was 14.5% for hospitals and 85.5% for payers. Applying this split would result in an additional $8 million in hospital costs statewide, representing 0.04% of revenue. Staff propose transitioning to a percentage-based allocation model (14.5% hospitals & 85.5% payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

4. RY 2026 Update Factor Comments: UCC Fund Revision

- The Maryland Hospital Association and all member hospitals supported the proposed correction to the uncompensated care (UCC) fund calculations for RY2023 to RY2025. They agreed with providing additional funding to hospitals and health systems that were underfunded, while holding harmless those that were overfunded. MedStar requested clarification on how the UCC correction will be implemented, specifically whether it will be applied as a one-time rate adjustment in RY2026.

HSCRC Response: Staff appreciates the hospital support and understanding regarding the need for policy corrections when errors occur. In an effort to ensure that undue burden is not placed on hospitals when corrections need to be made, staff is proposing holding hospitals harmless who were overfunded based on this policy correction. If approved by the Commission, HSCRC staff will implement this policy correction as a one-time adjustment in RY 2026, not as an increase to mark up.

5. RY 2026 Reinvestment of Medicare Savings Above Target

- The Maryland Hospital Association, along with several hospitals including UMMS, LifeBridge, and MedStar, noted the state's estimated $795 million in CY 2024 Medicare Total Cost of Care savings and identified it as an opportunity to support hospital funding. LifeBridge and MedStar more directly urged the Commission to reinvest a portion of the surplus and cited the role hospitals played in generating the savings and the need to stabilize operations in preparation for the AHEAD model. The MHA cited several hospital cost pressures in their comment letter. These cost pressures included:
  - Expected Impact on Tariffs
  - Potential Funding Cuts to Medicaid
  - Increase in Payer Denials
  - Rising Physician & Other Staffing Costs
  - Medical Liability Costs
  - Cybersecurity and Campus Security

5. RY 2026 Reinvestment of Medicare Savings Above Target

HSCRC Response: Staff modeled four different scenarios to project the CY 2025 guardrail position. In all four modeled scenarios, Maryland is expected to achieve the savings target for CY 2025 with varying degrees of cushion. However, it is important to note that the guardrail can not be above the nation by 1 percent in any year or above the nation by any percent in two consecutive years. The guardrail position in CY 2024 was below the nation, so Maryland will only trigger the guardrail if growth is more than 1 percent above the Nation. In two of the scenarios modeled, Maryland exceeds the guardrail by more than 1 percent. In another scenario, the estimated guardrail is 0.8 percent above the nation, 0.2 percent away from tripping the guardrail.

The HSCRC received a large number of comments regarding potential rate increases above the formulaic update factor methodology. At this time, Staff are not making recommendations related to reinvestment of savings above target and above the formulaic adjustments outlined in this presentation.

6. RY 2026 Integrated Efficiency Policy Modification

- The Maryland Hospital Association, along with JHHS and MedStar, specifically supported the recommended modification to the Integrated Efficiency Policy. They agreed with limiting penalties to hospitals in the fourth quartile that are also identified as ICC outliers and supported the use of a historical standard deviation. Medstar also encouraged convening a stakeholder workgroup to collaborate on additional revisions to the policy and related methodologies. LifeBridge Health requested the suspension of Integrated Efficiency policy penalties in RY 2026, citing uncertainty of Maryland's Medicare Waiver and projected statewide savings targets.

HSCRC Response: Staff appreciate the broad support provided by stakeholders to limit the downside risk of the Integrated Efficiency policy to hospitals in the fourth quartile that also are worse than one standard deviation from average performance in the ICC.

Staff generally agree with Medstar that the Commission should every 3-5 years review existing policies to assess their efficacy and amend them if necessary. Staff would note though the Integrated Efficiency policy has gone through revisions approximately every two years since its original inception in 2020 (implementation in 2022), and there are also several other policies that stakeholders would like staff to review/amend, most notably the marketshift policy and the demographic adjustment policy.

Staff do not agree with Lifebridge Health's request to suspend the implementation of the Integrated Efficiency policy, as the proposed modification further ensures that the policy only identifies outliers. Additionally, the federal government has noted in its AHEAD methodology specifications that it aims to use global budgets to make greater investments in population health, and uncertainty regarding the future of the Maryland Model does not eliminate the Commission's obligation to ensure that hospital costs are reasonable and hospital costs are reasonably related to charges, both of are accomplished by the ongoing application of the Integrated Efficiency policy.

7. RY 2026 Suspend Productivity Adjustment for non-GBR Hospitals

- The Maryland Hospital Association and its member hospitals are requesting the suspension of the productivity adjustments for non- GBR hospitals. The proposed -0.80% would lower the non-GBR hospitals with an update of 2.56%
- The Maryland Hospital Association states that non-GBR hospitals are confronting challenges with recruitment, retention, and increased compensation of physicians and other staff, which may impact their ability to meet the demand for the specialty services they provide. Applying a lower inflation factor to non-GBR hospitals at this time could create unnecessary financial strain.

7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals

Draft Recommendation Inflation Breakdown: Specialty Hospitals	
Inflation	**3.36%**
Productivity Adjustment	**SUSPENDED**
Additional Inflation Support	**0.00%**
Gross Inflation Allowance	**3.36%**

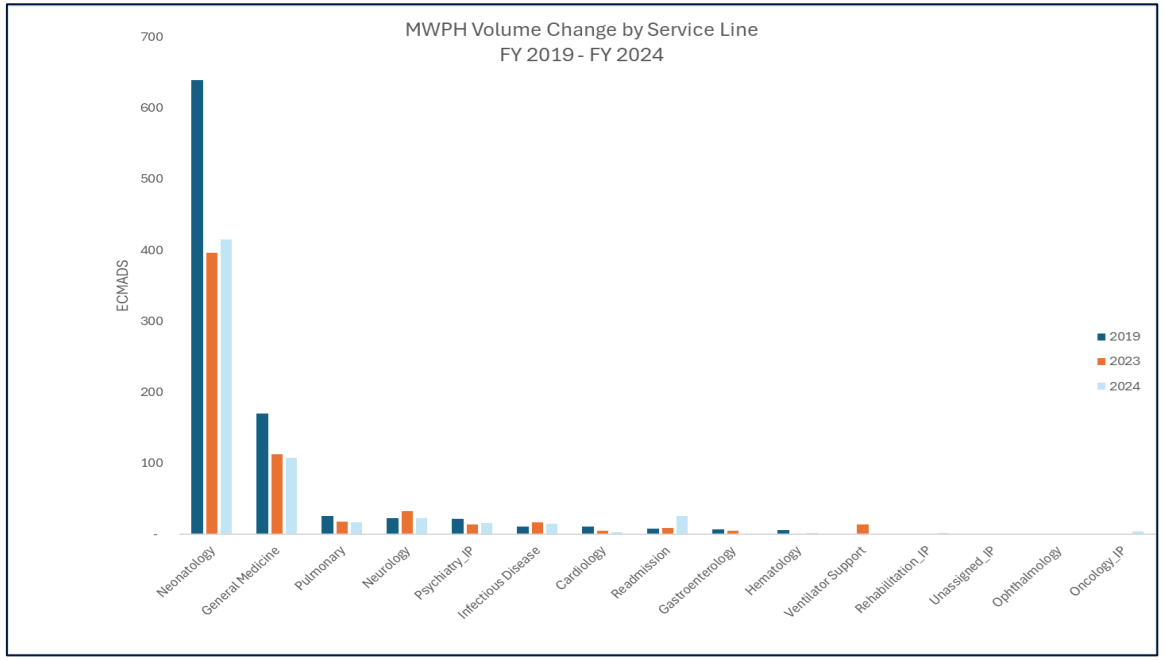
HSCRC Response: Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80% in line with the proposed IPPS rule for FFY 26. The productivity adjustment is a tool that aligns Medicare payment updates with broader economic productivity trends, promoting cost control and efficiency in hospital operations. A productivity adjustment is applied to hospitals under both IPPS and IPF PPS. HSCRC staff do not set Medicare rates for non-GBR hospitals. The proposed update is included for non-governmental payers. HSCRC staff understand that non-GBR hospitals are facing similar cost pressures to GBR hospitals. Volumes at these hospitals are still down relative to a 2019 base and as these volumes declined they were removed at a 100 percent variable cost factor. These hospitals are a valuable resource in the Maryland healthcare ecosystem. It is important that they have the ability to respond to the needs of the community and be available as a statewide resource in specialty hospital care for pediatrics and psychiatric services.

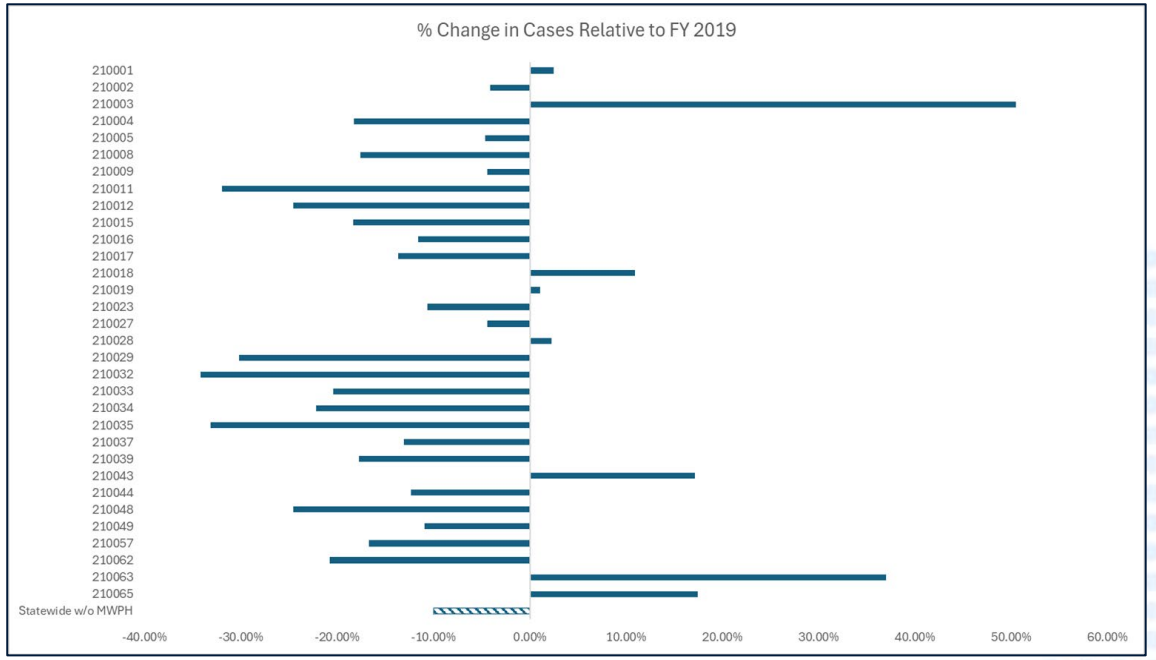
7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals

HSCRC Response: Staff reviewed additional analyses, described below, to better understand the volume declines at these hospitals. For purposes of our analytics, we focused on the two specialty hospitals with the largest revenue bases - Sheppard Pratt & Mount Washington Pediatric Hospital.

a. *Staff reviewed trends in hospital abstract volume at Mount Washington Pediatric Hospital and Sheppard Pratt from Fiscal Year 2019 (pre-pandemic) to Fiscal Year 2024 (most recently completed fiscal year). For Mount Washington, inpatient volumes decreased by 293 cases, as measured by the Commission's casemix adjusted methodology (ECMADS). Approximately 76 percent of this reduction was due to neonatology (see Figure 6a) and this largely aligned with statewide experience amongst general acute care facilities, with few exceptions, (see Figure 6b), suggesting a secular decline in demand of neonatology, e.g., fewer premature births.*
b. *At Sheppard Pratt, inpatient volumes declined by 3,743 cases; however, the reduction was not localized to one service line or diagnosis related group, as various cases, e.g., schizophrenia, trended upwards, but other cases, e.g., bipolar disorders and eating disorders, saw significant reductions that entirely offset other emerging behavioral health services (see Figure 7a).*
c. *Staff noted a similar decline in behavioral health admissions among general acute care facilities (15 percent statewide), with a few notable exceptions, suggesting another potential secular decline in demand.*

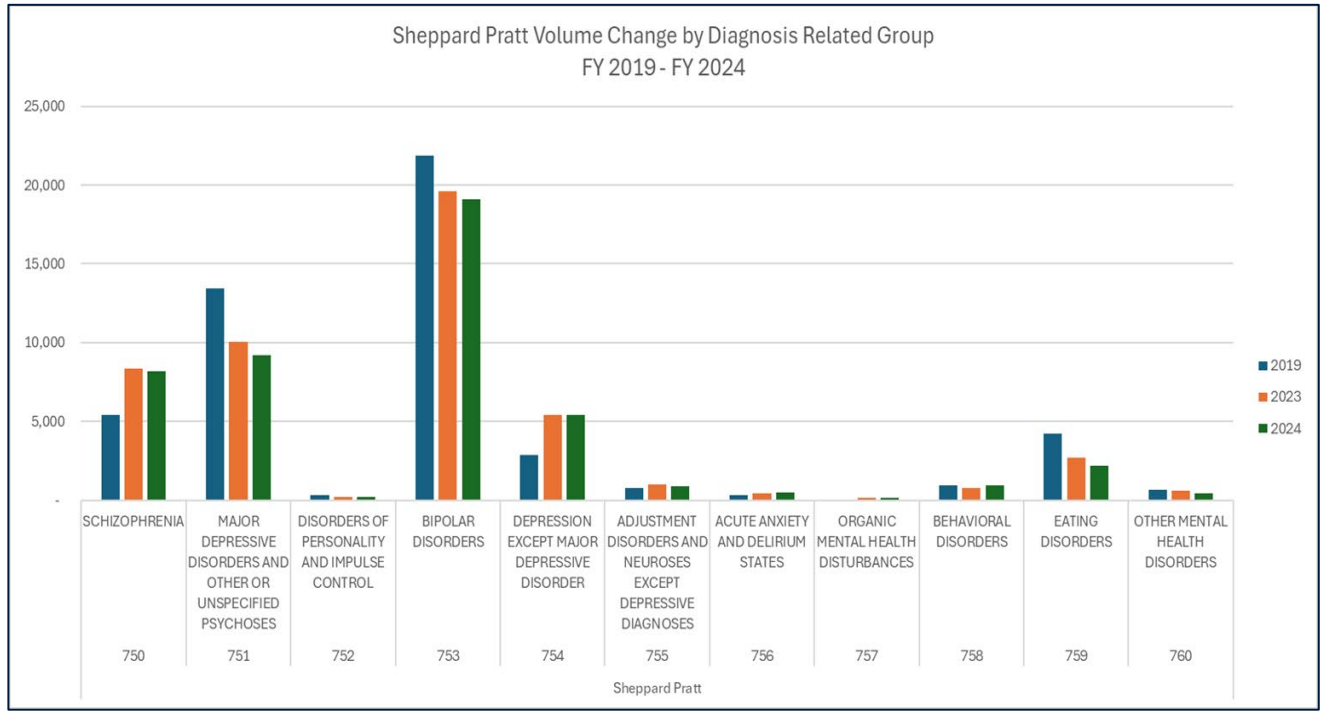
7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals

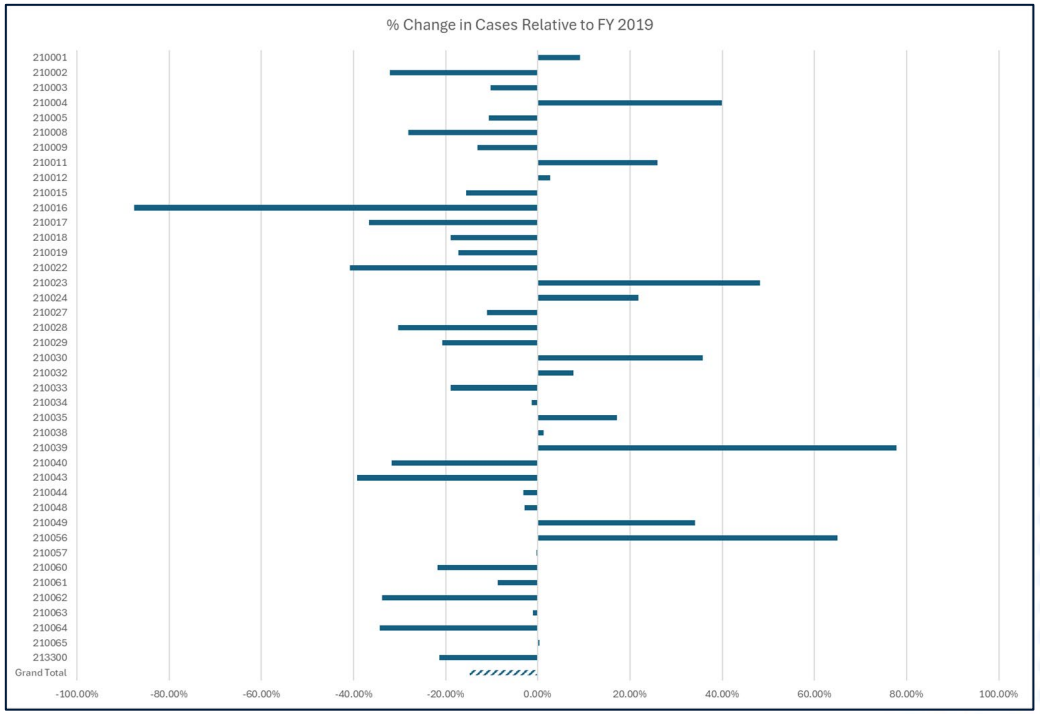




- Mount Washington cases went down by 293 from 2019 to 2024
- 76% of the reduction was due to neonatology cases
- Similar declines for neonatology cases were seen across general acute care facilities, with few exceptions

7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals





- Sheppard Pratt cases declined by 3,743 from 2019
- Similar if not larger declines for behavioral health DRG's were seen across general acute facilities, with few exceptions

7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals

- *Staff were potentially concerned that an analysis of service lines and/or diagnosis groupings may be flawed if behavioral health cases, especially post-COVID, were not mapping to behavioral health DRG's*
- *As such, staff also reviewed all admissions with a behavioral health diagnosis, either as primary or secondary (or not primary), and noted that the decline in behavioral health cases was systemic across both classifications:*

Primary vs. Secondary Diagnosis Behavioral Health Admissions (FY19 - FY23)

Primary vs Secondary BH	FY19	FY20	FY21	FY22	FY23
Primary Diagnosis as "PrinDiag"	45,019	41,414	38,601	34,861	32,995
Secondary Diagnois as "Diag 1"	14,001	11,023	10,364	11,320	10,453

Source: AHRQ

In light of the analyses described above, staff are recommending to suspend the productivity adjustment in RY 2026.

8. Payer and Other Stakeholder Comments

- Carefirst opposed the draft recommendation, stating that hospitals have already received more than $541 million in additional funding through recent Commission actions, including RSV surge support, margin enhancements, and inflation catch-up adjustments. They argued that these increases have prioritized hospital revenue over consumer affordability and warned that such an approach is not sustainable.
- CareFirst further noted that all modeled update scenarios exceeded Medicare guardrail thresholds and expressed concern that this continued trend could put the State's Model at risk.

HSCRC Response: Staff appreciate CareFirst's concern and commitment to protecting consumers and patients in Maryland. Staff are committed to ensuring that the recommended balance update considers hospitals, payers, and patients that receive care in the State of Maryland. For this reason, staff do not recommend revising the draft policy to amend for any of the concerns outlined in other stakeholder comment letters. We understand the importance of considering both savings and guardrail positions related to our Model performance.

Update Factor Discussion

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.74%	$166.0	$54.8
- RY2026 Revision to Prior Year Estimates			0.76%	$170.5	$56.3
Total Adjustment for Volume	**C**		**1.50%**	**$336.5**	**$111.1**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.20%	$44.9	$14.8
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.20%	$44.9	$14.8
- Reversal of one-time adjustments for drugs	G		-0.05%	-$11.2	-$3.7
- Capital Funding & Estimated Increase for Full Rate Applications	H		0.13%	$28.6	$9.4
- UCC Fund Revision	I		0.30%	$67.2	$22.2
Net Other Adjustments	**J =**	**Sum of D thru I**	**0.78%**	**$174.3**	**$35.3**
Quality and PAU Savings					
- PAU Redistribution	K		-0.03%	-$6.73	-$2.2
- Reversal of prior year quality incentives -QBR, MHAC, Readmissions	L		-0.16%	-$34.9	-$11.5
- Current Year Quality Incentives	M =		-0.06%	-$13.8	-$4.5
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.4**	**-$18.3**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.42%**	**$1,185.1**	**$368.9**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.64%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	Q		-0.44%	-$98.7	-$32.6
- Deficit Assessment	R =		0.70%	$158.0	$52.1
Net decreases	**S =**	Q + R	**0.26%**	**$59.2**	**$19.5**
Total Update First Half of Rate Year 26					
Revenue growth, net of offsets	**T =**	O + S	**5.68%**	**$1,274.4**	**$388.5**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.90%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**V =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**W =**	T + V	**5.68%**	**$1,274.4**	**$420.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.90%**		

Revenue Scenarios

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2024		10,772,404,416
Actual Revenue July - December 2024		11,019,304,349
Actual Revenue CY 2024		21,791,708,765
Step 1:		
Approved GBR RY 2025		22,436,402,668
Actual Revenue 7/1/24-12/31/24		11,019,304,349
Approved Revenue 1/1/25-6/30/25		11,417,098,319
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/25-6/30/25	**A**	**11,417,098,319**
Expected Revenue Growth 1/1/25-6/30/25		**5.98%**
Step 2:		
Final Approved GBR RY 2025		22,436,402,668
Reversal of Extraordinary One-Times		-181,511,599
Final Adjusted GBR Base for RY 2025		22,254,891,069
Projected Approved GBR RY 2026		23,518,962,716
Permanent Update RY 2026		5.68%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,607,440,332
Projected RY26 Increase over RY25		6.08%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,764,845,077**
Expected Revenue Growth 7/1/25- 12/31/25		**6.77%**
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,181,943,396**
Increase over CY 2024 Revenue		**6.38%**
Per Capita Increase over CY 2024		**5.60%**

CY 25 Guardrail Scenarios

Scenario 1: 2024 Trended forward at 2017 - 2019 Trend
Table 6a: TCOC Estimate (Scenario 1, 2017 to 2019 Base)

Scenario 1 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,421	$13,886	Predicted Variance
YOY Growth	5.3%	3.9%	1.4% Over
Estimated CY 2025 Savings Run Rate			$641.9 M

Scenario 2: 2024 Trended forward at 2015 - 2019 Trend
Table 6b: TCOC Estimate (Scenario 2, 2015 to 2019 Base)

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,343	$13,746	Predicted Variance
YOY Growth	4.8%	2.9%	1.9% Over
Estimated CY 2025 Savings Run Rate			$569.0 M

Scenario 3: 2024 Trended forward at 2022 - 2024 Trend
Table 6c: TCOC Estimate (Scenario 3, 2022 to 2024 Base)

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,508	$14,141	Predicted Variance
YOY Growth	5.9%	5.8%	0.1% Over
Estimated CY 2025 Savings Run Rate			$814.2 M

Scenario 4: 2024 Trended forward using USPCC projections
Table 6d: TCOC Estimate (Scenario 4, USPCC Base)

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,500	$14,033	Predicted Variance
YOY Growth	5.8%	5.0%	0.8% Over
Estimated CY 2025 Savings Run Rate			$722.2M

Scenario 4 is based on the United States Per Capita Cost (USPCC) data published by CMS.
USPCC trend information can be found here: https://www.cms.gov/files/document/2026-announcement.pdf

Final Recommendations

For Global Revenues:

- Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.
- Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.
- Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than annual percentage growth rates, thus improving the accuracy and better reflecting actual population changes.
- To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.
- Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.
- Transition to a percentage-based allocation model for the Deficit Assessment Allocation (14.5 percent for hospitals & 85.5 percent for payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.36 percent for inflation and suspend the productivity offset of 0.80 percent.

Appendix

8. Payer and Other Stakeholder Comments

HSCRC staff received comment relating to “systemic and complex policy errors that have led to multi-year underfunding. We are deeply concerned that the continued layering of increasingly complex methodologies—without the ability to consistently execute them in a timely and accurate manner—risks the long-term viability of the Model. We encourage the Commission to prioritize simplification and external, independent replication of policy results to ensure the Model’s long-term sustainability.”

HSCRC Response: Staff would like to emphasize our commitment to a thorough and inclusive stakeholder engagement process. This approach ensures adequate time for making substantive changes and improvements that meaningfully inform decision-making. Such processes often span several months and involve extensive data sharing and dialogue with Maryland hospitals and other stakeholders.

To support this collaborative effort, it is imperative that the HSCRC receives timely and accurate hospital data. This data is essential for informing the work and analyses under review, enabling the development of policies that reflect the collective input and needs of all parties involved. Requests for data resubmission, data submission errors, and other data corrections that need to be made hinder the integrity of results. To date in FY 2025, staff have approved approximately 15 requests for extensions or data resubmissions. Oftentimes, this results in staff’s inability to run timely or correct methodologies that informs policy making on a statewide basis.

8. Other Stakeholder Comments

One comment received related to the reconciliation of the set aside funding. The Commission approved $31.7 million of permanent hospital funding in the RY 2025 update factor through the set-aside, only $10.8 million of this was distributed to hospitals permanently per the reconciliation in Appendix I. MedStar seeks clarification around this $20.9 million difference and how staff are accounting for this in the RY 2026 update factor.

HSCRC Response: While the historical distribution of set aside funding has been concentrated on permanent funding, the allotment has always been a mix of both permanent and one-time funding, i.e., there is no guarantee that the funding will be permanent or one-time. In RY 2025, due to the process by which set aside funding was distributed, a large portion was provided as one-time funding for financial hardship, as seen in Appendix I. HSCRC removed the permanent portion of this funding from the total set aside allotment and the remainder was included in the removal of extraordinary one-time adjustments as described in Table 5 of the recommendation. Based on MedStar's commentary, staff have revised the extent of one-time set aside funding that will be reversed in RY 2026. This small correction is reflected in the final recommendation.

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Final Recommendation for the Update Factors for Rate Year 2026

Table of Contents

List of Abbreviations

ADI	Area Deprivation Index
AHEAD	Advancing All-Payer Health Equity Approaches and Development
CARES	Coronavirus Aid, Relief, and Economic Security
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
ICC	Interhospital Cost Comparison
MHAC	Maryland Hospital Acquired Conditions
PAU	Potentially avoidable utilization
QBR	Quality-Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care
USPCC	United States Per Capita Cost

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 4.90 percent per capita, a revenue increase of 5.68 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.36 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2026. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2026. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability for consumers and purchasers of hospital services, as well as meeting all of the State's contractual obligations with the federal government.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

(a) Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.

(b) Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(c) Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.

(d) Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than annual percentage growth rates, thus improving the accuracy and better reflecting actual population changes.

(e) To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.

(f) Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.

(g) Transition to a percentage-based allocation model for the Deficit Assessment Allocation (14.5 percent for hospitals & 85.5 percent for payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

For Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.36 percent for inflation and suspend the productivity offset of 0.80 percent.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year in the development of the update factor, the HSCRC is considering the impact recent inflationary trends have had on the healthcare industry. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In November 2024 the State signed a new agreement with CMS that runs through 2034, the AHEAD agreement (AHEAD). The AHEAD Model is a state-based total cost of care model, designed to curb healthcare cost growth, improve population health, and promote healthier living. Under AHEAD the State must increase Medicare total cost of care savings by 0.128% each year, when compared to a calendar year 2023 base, starting in calendar year 2026. The HSCRC estimates the resulting 2026 target will be approximately $525 million. In 2025 the State remains under the Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. The TCOC Model requires that the State reach an annual total cost of care savings of $372 million relative to the national growth rate in 2025, relative to a 2013 base year.

To meet the ongoing requirements of the TCOC Model, and future commitments under AHEAD, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to developing the RY 2026 annual update is outlined in this report, as well as staff's estimates on calendar year TCOC Model tests. There are two categories of hospital revenue types included in this recommendation:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland,

and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals only affects the hospitals price, not volume.

This recommendation proposes Rate Year (RY) 2026 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2026 HSCRC staff is proposing an update of 4.90 percent per capita for global budget revenues and an update of 3.36 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's First Quarter 2025 market basket growth estimate with a capital growth estimate. For RY 2026, HSCRC Staff combined 91.20 percent of Global Insight's First Quarter 2025 market basket growth of 3.40 percent with 8.80 percent of the capital growth estimate of 2.90 percent, calculating the gross blended amount as a 3.36 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.36 percent. Furthermore, the staff recommends suspending the productivity adjustment of 0.80 percent.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.36%	3.36%
Productivity Adjustment	N/A	SUSPENDED
Additional Inflation Support	0.00%	0.00%
Proposed Inflation Update	3.36%	3.36%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the TCOC Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the TCOC Model agreement, including achieving $372 million in annual Medicare savings by the end of CY 2025 and achieving approximately $525 million annual savings under the first year of the AHEAD (CY 2026);
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the TCOC Model as well as framework for doing so;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates revenue growth for the full rate year to be 5.68 percent with a corresponding per capita growth rate of 4.90 percent. The 5.68 percent revenue growth will be used to measure the proposed update against financial tests, which are performed on Calendar Year results; staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2026 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC Staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.74%	$166.0	$54.8
- RY2026 Revision to Prior Year Estimates			0.76%	$170.5	$56.3
Total Adjustment for Volume	**C**		**1.50%**	**$336.5**	**$111.1**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.20%	$44.9	$14.8
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.20%	$44.9	$14.8
- Reversal of one-time adjustments for drugs	G		-0.05%	-$11.2	-$3.7
- Capital Funding & Estimated Increase for Full Rate Applications	H		0.13%	$28.6	$9.4
- UCC Fund Revision	I		0.30%	$67.2	$22.2
Net Other Adjustments	**J =**	**Sum of D thru I**	**0.78%**	**$174.3**	**$35.3**
Quality and PAU Savings					
- PAU Redistribution	K		-0.03%	-$6.73	-$2.2
- Reversal of prior year quality incentives	L		-0.16%	-$34.9	-$11.5
-QBR, MHAC, Readmissions					
- Current Year Quality Incentives	M =		-0.06%	-$13.8	-$4.5
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.4**	**-$18.3**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.42%**	**$1,185.1**	**$368.9**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.64%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	Q		-0.44%	-$98.7	-$32.6
- Deficit Assessment	R =		0.70%	$158.0	$52.1
Net decreases	**S =**	Q + R	**0.26%**	**$59.2**	**$19.5**
Total Update First Half of Rate Year 26					
Revenue growth, net of offsets	**T =**	O + S	**5.68%**	**$1,274.4**	**$388.5**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.90%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**V =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**W =**	T + V	**5.68%**	**$1,274.4**	**$420.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.90%**		

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.36 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2025 market basket growth of 3.40 percent, with 8.80 percent of the capital growth index change of 2.90 percent. The adjustment for inflation includes 3.70 percent for wages and compensation.

  In RY 2025, the staff adopted a catch-up methodology that includes a two-sided risk corridor of 1.00 percent for all future evaluations of cumulative over- or underfunding. This means that the Commission will adjust future inflation if the difference between actual inflation and funded inflation exceeds 1.00 percent. Conversely, if the difference is within 1.00 percent, this methodology does not recommend any adjustments, as this level of variance has been "tolerated" in previous years.

  As shown in Table 3 below, the current cumulative underfunding of inflation is -0.52 percent, which does not meet the 1 percent threshold to fund a variance between actual and funded inflation.

Table 3: Inflation Risk Corridor Methodology

Inflation Catch-Up Methodology

Max Tolerance =	**1.00%**					**1.00%**											
HSCRC Scenario/Table 1 - Inflation	**Historical**											**Projected**					
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.35%	3.24%	3.36%	3.36%	3.36%	3.36%	3.36%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.24%	3.36%	3.36%	3.36%	3.36%	3.36%
Actual Inflation Correction												1.00%	0.00%	0.00%	0.00%	0.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	-0.35%	1.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.51%)	-0.52%	-0.52%	(0.52%)	(0.52%)	(0.52%)	(0.52%)
Guardrail/Tolerance **(A)**											1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.52%)	(0.52%)	**(0.52%)**	(0.52%)	(0.52%)	(0.52%)	(0.52%)
Calculated Inflation Correction (C) =								**1% for stub period**		1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.35%	4.24%	3.36%	3.36%	3.36%	3.36%	3.36%

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs.

  At the January 8, 2025 Commission meeting, the Commission voted to approve revision to the outpatient high-cost drug funding policy or CDS-A policy. The approved revision included providing funding based on 100 percent reimbursement of changes in drug cost. As a result of this policy revision, inflation is only needed for pure price which is the price

change of each drug at its base year volume. In the RY 2026 Update Factor, staff are using a 1 percent inflation based on longer term trends of pure price. This value is the same for both academic and non-academic hospitals. The result of this translates to 0.02 percent carve out of inflation.

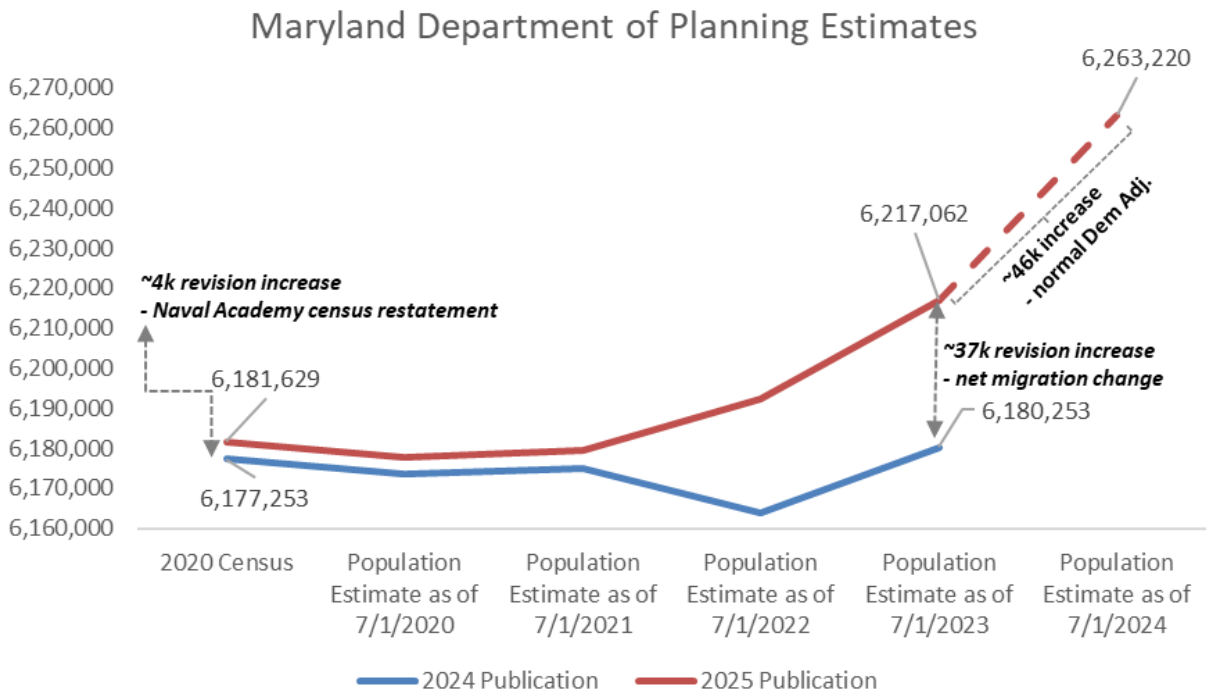
- **Care Coordination / Population Health:** In RY 2025, several grant programs focused on Care Coordination and Population Health were implemented, which contributed to hospital revenues. These programs included the Behavioral Health and Maternal and Child Health Improvement Fund Assessment. The funds were allocated to hospitals on a one-time basis. As a result, you will see a line in Table 2 reflecting a reversal of grant funding for RY 2025 at a rate of -0.15 percent. Funding for RY 2026 is expected to be approximately 0.04 percent and will continue to support Behavioral Health initiatives.

  One of the paths to success under global budgets is to find innovative solutions that avert the need for traditional hospitalization. While significant progress has been made in averting these admissions, staff believe there is an opportunity to accelerate these efforts through targeted investment in transformative solutions that may be too expensive or speculative to be funded in the normal course of business. For example, hospital-at-home approaches in rural areas could reduce cost, while also eliminating the travel burden on patients, but can't be tested at scale and therefore require extra investment to develop a proof of concept. In a continuation of a program approved last year, the Transformation Fund will provide approximately $30M to match investments committed by hospitals (roughly $15M) or other entities to pursue these transformative ideas. Staff anticipate that additional funding may be needed in subsequent years.The funding shall be awarded based on a competitive process administered by HSCRC staff as an extension of the Care Transformation Initiative program; both Maryland hospitals and other entities, in partnership with a Maryland hospital, will be eligible. Staff initiated this process in RY 2025 under the name "New Paradigms in Care Delivery" and received 16 proposals from hospitals and payers across the state. The proposals included a wide range of initiatives related to palliative care, congestive heart failure, maternal health, behavioral health, and access to primary and urgent care. Staff will select roughly 10 proposals based on documented criteria that will include but not be limited to (1) degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding), (2) speed of implementation, (3) the share of funding provided by the applicant versus requested from the State, (4) likelihood of scalability and (5) estimated long-term impact on lowering total cost of care and/or increasing quality. HSCRC will send award notifications at the end of May/early June 2025. The impact of Care Transformation in RY 2026 is approximately 0.13 percent, bringing the total Care Coordination/Population Health adjustment in this recommendation to 0.03 percent.

- **Adjustments for Volume:** Staff are proposing a population growth estimate of 0.74 percent for RY 2026 (~46 thousand lives) in line with the historical methodology of increasing global budgets by the most recent year-over-year population growth estimate from the Maryland Department of Planning. In addition to applying the standard

methodology, staff are also proposing to reflect revised historical data from the Maryland Department of Planning. These revisions were significant and included a census restatement that added 4,405 lives, as well as a 2023 base year restatement for net migration, which added 36,809 lives (see Figure 1 below).

Figure 1: Maryland Department of Planning Revisions to Population Estimates



Historically, the Demographic Adjustment reconciled to the percentage growth statistic reported by the Department of Planning, rather than the actual population count. Because hospitals vary in size, this approach resulted in allocations that did not align precisely with the actual population change. To address both the revised Planning estimates and the limitations of reconciling to a percentage growth rate, staff are proposing that the RY 2026 Demographic Adjustment, and those in future years, be reconciled to the cumulative population count from 2020 through the most recent year.

These methodological improvements will add an additional 0.76 percent to the volume estimate, bringing the total volume adjustment in this recommendation to 1.50 percent.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining relatively inefficient hospitals in the TCOC Model. The policy utilizes the Inter-Hospital Cost Comparison (ICC) methodology to compare relative cost-per-case efficiency and Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State.

The above evaluations are then used in an ordinal ranking scoring matrix to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. In prior years, the Integrated Efficiency policy has redirected funding from hospitals if they were in the bottom quartile of the scoring matrix; however, a methodology that relies on ordinal ranking to determine outliers AND continually scales hospitals accordingly may eventually penalize hospitals closer to average performance, i.e., the cliff effect. Additionally, staff have discussed with the Payment Model Workgroup that there is a clear tightening of performance in the ICC and generally in hospital charge per case, suggesting the policy is working but the current ongoing application may be inappropriate (see Figures 2a and 2b below):

Figure 2a: Interhospital Cost Comparison Distribution in Integrated Efficiency Policy

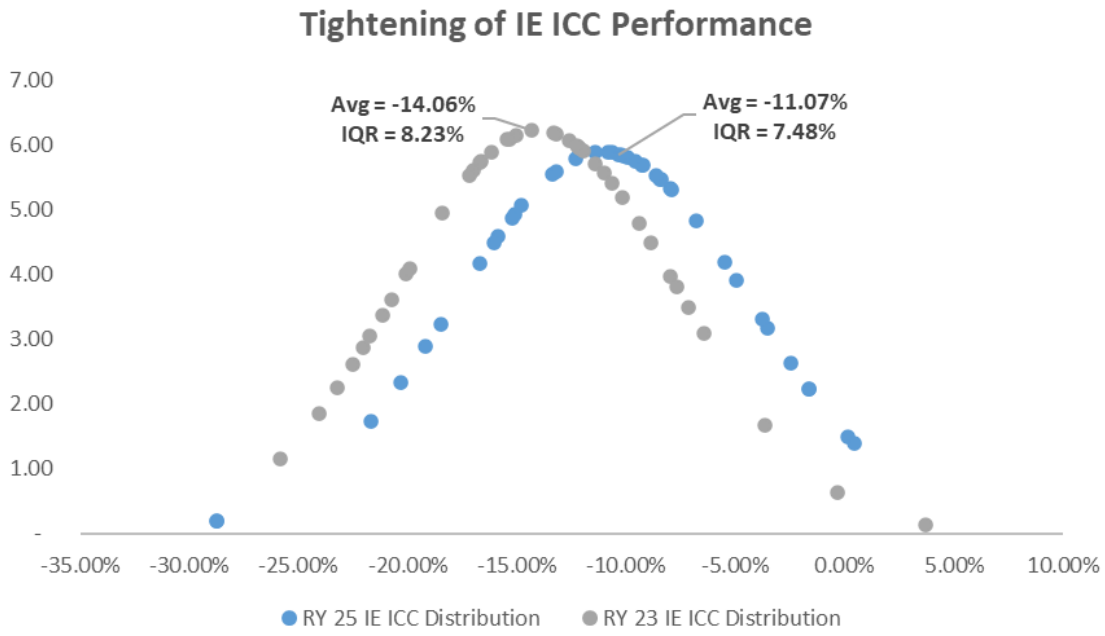
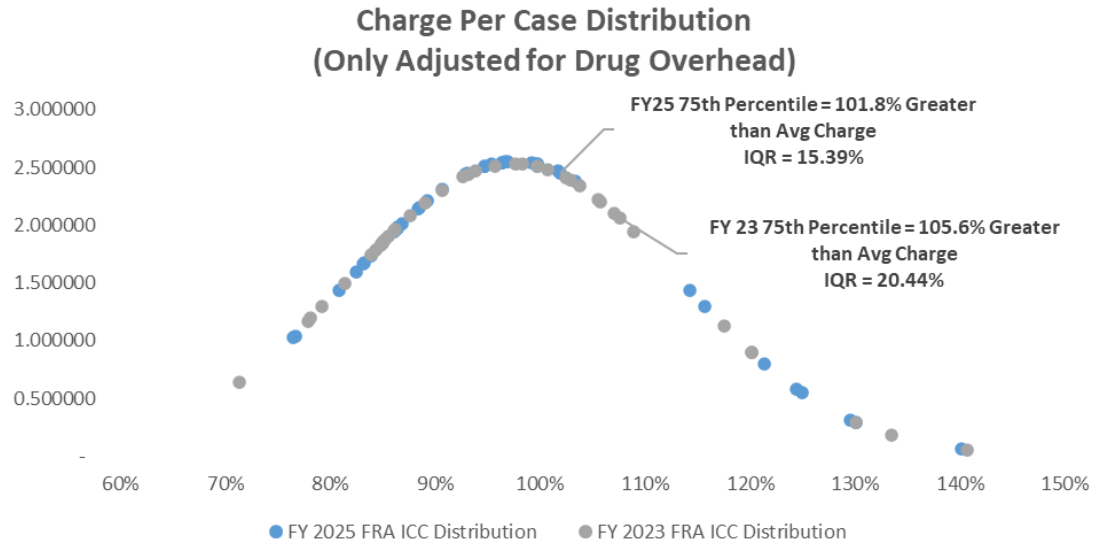


Figure 2b: Hospital Charge Per Case Distribution



In light of the tightening of hospital's efficiency performance, staff are recommending a threshold by which hospitals will not be penalized in Integrated Efficiency:

- 3rd quartile or better OR
- NEW! Better than one historical standard deviation (6.41 percent) from Average ICC Performance

This approach aligns with the current approach for recognizing efficient hospitals, i.e., hospitals in the best quartile and better than one standard deviation from average performance, thereby creating symmetry in the policy, and it aligns with the historical Commission efficiency scaling methodologies, e.g., Screens that utilized ordinal ranking but created a predictable threshold by which hospitals were no longer penalized, thereby recognizing the inherent flaw in using ordinal ranking in perpetuity as performance narrows.

For purposes of the Update Factor inputs, staff has earmarked 0 percent reduction for low efficiency outliers, because relatively inefficient hospitals are encouraged to buyout of their reductions through investments in Revenue for Reform and if buyouts do not occur, relatively efficient hospitals can petition the Commission for funding that is withheld from relatively inefficient hospitals.

- **Set-Aside:** The intention of the set-aside is to use these funds for 1) Global Budget Revenue enhancements for relatively efficient hospitals that qualify under the Integrated Efficiency policy and 2) unforeseen events that occur at hospitals with a financial hardship,

regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.20 percent for RY 2026.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, HSCRC staff developed an approach to provide a higher variable cost factor (100 percent for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2024. Based on this analysis, staff concluded that the historical average growth rate was approximately 0.39 percent, which equates to a combined State impact of 0.20 percent for the RY 2026 Update Factor.

- **UCC Fund Revision:** The Uncompensated Care (UCC) fund calculation uses a 50/50 blend of actual UCC data and predicted UCC derived from a logistic regression model. This model estimates the probability of UCC based on payer type, Area Deprivation Index (ADI), and site of service at the patient level. When ADI data is missing, hospital-level average ADI values are used. In the RY 2023 to RY 2025 UCC funding determinations, a data issue caused the ADI variable to be improperly captured, resulting in the universal use of hospital average ADI values as opposed to patient specific ADI values. This resulted in incorrect UCC coefficients, which, when applied, impacted the UCC probabilities and subsequently predicted UCC calculations. The error disproportionately impacted hospitals with lower-than-average ADI scores—typically those serving more affluent populations. Importantly, the statewide UCC pool was not affected, as the policy is redistributive by design, i.e., statewide net funding was accurate. Staff are recommending that all hospitals and/or hospital systems that were disadvantaged by this error be compensated by correcting for prior year errors in RY 2026. To mitigate rate impact, staff propose assessing adverse impact on a per system basis, similar to what occurred during the reconciliation of CARES funding, i.e., funding owed to hospitals would first be netted by funding that was overpaid to hospitals in the same health system. To minimize disruption, the recommended approach is to hold hospitals, which benefited from this data error, harmless, because a clawback could be destabilizing and the hospitals tended to be rural and safety net hospitals. Staff recommends that the settlement occur over one year to reduce complexity; however, if staff's proposal to hold hospitals harmless is not accepted, staff recommend extending the correction period to three years to alleviate hospital budgetary impact The proposed statewide impact is $67.2 million or 0.30 percent

which will be funded through the UCC fund balance first and then a statewide UCC markup in rates.

- **Potentially Avoidable Utilization (PAU) Redistribution:** The PAU value for RY 2026, which represents defunding of inflation and population growth for readmissions and avoidable admissions, is -0.53 percent. This policy was refined in RY 2025 to be revenue-neutral across the State; however, there were concerns that the policy may reward hospitals that have not improved PAU performance under the TCOC Model. As a result of this concern, rewards for individual hospitals are capped at 0.0 percent, and minor negative scaling is still applied to hospitals that have worse PAU performance than the statewide average. The net result of the PAU Redistribution policy, as represented on Table 2, is -0.03 percent.
- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The current revenue adjustments across the three programs is -0.06 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of -0.16 percent.
- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately $28.6 million through the Full Rate Application Policy, which represents 0.13 percent of the recommendation. This value is subject to change based on quality assurance reviews of the Inter-hospital Cost Comparison (ICC) methodology and review of commercial TCOC benchmarks. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2026 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology (no additional methodological considerations will be contemplated); and the hospital will not file any subsequent rate request until July 1, 2027.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2026 will be -0.44 percent. The amount in rates was 4.46 percent in RY 2025, and the proposed amount for RY 2026 is 4.02 percent, a decrease of -0.44 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.

- **Deficit Assessment:** The Legislature approved a funding increase of $150,000 from RY 2025 which increases the total assessment to $444,825,000 in RY 2026. The value associated with this increase that will be applied to payers is represented by 0.70 percent in Table 2.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Redistribution - Updated Methodology

The PAU Savings Policy historically reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation.

For RY 2026, the incremental amount of statewide PAU Savings reductions was determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This would result in a RY 2026 permanent PAU savings reduction of -0.53 percent statewide, or -$113,774,837. Hospital performance on avoidable admissions per capita and 30-day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4: PAU Shared Savings Adjustment

Statewide PAU Reduction	Formula	Value
RY 2025 Total ApprovedPermanent Revenue	A	$21,466,950,321
RY 2026 Inflation Factor+Demographic Adjustment	B	4.87%
CY 2024 Total Experienced PAU $	C	$2,315,704,799
Proposed Revenue Adjustment $	D = B*C	-$112,774,824
Proposed Revenue Adjustment %	E = D/A	-0.52534%
Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.530000%**
Adjusted Proposed Revenue Adjustment $ * **	G = F*A	**-$113,774,837**
Total PAU %	H	10.81%
Total PAU $	I = A*H	$2,320,752,199
Required Percent Reduction PAU	J = G/I	-4.90%

*Does not include revenue from McCready, or freestanding EDs.
** Inflation factor is subject to revisions related to updated data and Commission approval

However, as previously noted, staff are proposing to maintain the amendment to the PAU Shared Savings policy such that it is a PAU Redistribution policy, whereby the PAU measurement is utilized in order to recognize differential opportunities among hospitals in a fixed revenue model but does not generate TCOC Model savings. The reasons for this change, which was adopted in

RY 2025, are as follows: the policy already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management, future ongoing reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions, and the additional funding allows hospitals to make greater investments in population health that overtime will make global budgets more sustainable than annual PAU reductions to hospitals that do not allow for system reinvestment.

For example, the RY 2025 Update Factor recommendation included a requirement for hospitals to submit population health management plans as part of efforts to reduce statewide potentially avoidable utilization. For the first portion of this requirement, hospitals were required to submit Population Health Inventories. All hospitals completed this requirement. For the second portion of this requirement, hospitals were required to submit high value care plans that described new and existing strategies and initiatives aimed at addressing priority areas of focus identified by the Value-Based Care Insights tool provided by CRISP or an alternate tool. Hospitals were required to include improvement targets and outcomes for the identified area of focus. Hospitals that did not submit plans or submit plans that did not meet passing criteria would have been subject to a 0.19 percent clawback in their July rate orders; however all hospitals met the passing criteria.

For RY 2026, hospitals will be required to report on their improvement targets and outcomes as part of their high value care plans. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders. Staff anticipate that with this ongoing focus on high value care plans, hospitals will continue to make the reinvestments necessary to improve the health of the population and by extension the financial sustainability of the Model.

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the TCOC Model to generate $372 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by the end of CY 2025. The TCOC Model Medicare savings requirement is different from the previous All-Payer Model Medicare Savings. Maryland's TCOC Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the previous model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from TCOC Model implementation. Additionally, the change to the total cost of care focuses hospital

efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care. AHEAD continues this focus.

The TCOC Model requires that the State reach an annual total cost of care savings of $372 million relative to the national growth rate in CY 2025, relative to a 2013 base year. AHEAD requires continued savings beyond 2025, as described above, with an estimated annual target in CY 2026 of $525 million. Thus, there must be continued improved performance overtime to meet future Medicare Savings Requirements.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff obtained calendar year growth estimates for Medicare Fee-for-Service growth from the Office of the Actuary. Staff then converted these estimates to an All-Payer value by calculating a difference statistic, to estimate that TCOC Model savings and guardrails were being met. Prior to the pandemic staff established an approach, whereby the prior year national trend was used as the stand-in to estimate national trends. However, due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails for RY 2023. For RY 2026 staff are using a combination of these approaches. In addition, staff have introduced a fourth scenario based on the requirements under the AHEAD agreement.

Actual revenue resulting from RY 2026 updates affects the CY 2025 results. As a result, staff must convert the recommended RY 2026 update to a calendar year growth estimate. Table 5 below shows the current revenue projections for CY 2025 to assist in estimating the impact of the recommended update factor together with the projected RY 2026 results. The overall increase from the bottom of this table is used in Tables 6a-6d.

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2024		10,772,404,416
Actual Revenue July - December 2024		11,019,304,349
Actual Revenue CY 2024		21,791,708,765
Step 1:		
Approved GBR RY 2025		22,436,402,668
Actual Revenue 7/1/24-12/31/24		11,019,304,349
Approved Revenue 1/1/25-6/30/25		11,417,098,319
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/25-6/30/25	**A**	**11,417,098,319**
Expected Revenue Growth 1/1/25-6/30/25		**5.98%**
Step 2:		
Final Approved GBR RY 2025		22,436,402,668
Reversal of Extraordinary One-Times		-181,511,599
Final Adjusted GBR Base for RY 2025		22,254,891,069
Projected Approved GBR RY 2026		23,518,962,716
Permanent Update RY 2026		5.68%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,607,440,332
Projected RY26 Increase over RY25		6.08%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,764,845,077**
Expected Revenue Growth 7/1/25- 12/31/25		**6.77%**
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,181,943,396**
Increase over CY 2024 Revenue		**6.38%**
Per Capita Increase over CY 2024		**5.60%**

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2024.

Step 1: The table uses global revenue for RY 2025 and actual revenue for the last six months for CY 2024 to calculate the projected revenue for the first six months of CY 2025 (i.e., the last six months of RY 2025). Hospitals currently project they will be able to charge all of RY 2024 revenue, for this reason, staff have kept the projected RY 2025 compliance line at zero.

Step 2: The final approved GBR for RY 2025 is $22,436,402,668. This step applies the proposed update of 5.68 percent, as shown in Table 2, to the RY 2025 GBR amount to calculate the projected revenue for RY 2026. This step also makes adjustments for

miscellaneous/extraordinary one-times that don't get included in inflation but are accounted for in RY 2025 and RY 2026. For RY 2025, this includes one-time funding AHEAD preparation, surge funding, and set aside above the approved value in RY 2025. The RY 2026 miscellaneous inputs include the remaining surge funding and population health trust funding.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2026 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2026. Staff also included the permanent AHEAD preparation funding that will be applied to revenues in RY 2026 to this step.

Step 4: This step shows the resulting estimated revenue for CY 2025 and then calculates the increase over the actual CY 2024 Revenue. The CY 2025 increase based on this year's recommended update is 6.38 percent. The 6.38 percent is used to estimate CY 2025 hospital spending per capita for Maryland in our guardrail and savings policy, which is explained in the next section.

Staff modeled four different scenarios to project the CY 2025 guardrail position. Scenarios 1 through 3 models 2025 trends based on a historic time window, as described in more detail below. Consistent with last year, staff used two scenarios that reference the pre-pandemic trends (i.e. 2019 and prior, scenarios 1 and 2) and one scenario using post-pandemic trends (i.e. 2022 and later, scenario 3). Last year the only post-pandemic period available was 2023 over 2022. Staff decided to update this scenario to 2024 over 2022 to obtain a longer window for reference. Staff elected not to move it forward and use 2024 over 2023 as Maryland non-hospital trends were abnormally low in 2024. Maryland was 2.3 percentage points below the nation in 2024 having been above the nation in every other non-pandemic year since 2015. These low 2024 trends are factored into Scenario 3 but are blended with the more typical trends seen in 2023 to reduce their weight.

In addition to the three scenarios based on historic trends, Staff added a 4th scenario this year. Scenario 4 is based on the United States Per Capita Cost (USPCC) data published by CMS[1]. Staff added this scenario as USPCC is used in target setting in the future under the AHEAD model. At this time staff have not confirmed with CMS the exact approach to be used to apply USPCC data for CY 2026, therefore Scenario 4 should be seen as an approximation of the target setting that might occur with AHEAD, rather than an exact representation.
The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2025 growth of 6.38 percent, shown in Table 5 to Maryland hospital spending per capita from 2024. These analyses assume that Medicare growth equals All-Payer growth.

[1] USPCC trend information can be found here: https://www.cms.gov/files/document/2026-announcement.pdf

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B), which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2024 as the base.

Scenario 1 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,421	$13,886	Predicted Variance
YOY Growth	5.3%	3.9%	1.4% Over
Estimated CY 2025 Savings Run Rate			$641.9 M

Table 6a: TCOC Estimate (Scenario 1, 2017 to 2019 Base)

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 to 2019 and trends the data forward using 2024 as the base. This is the most conservative estimate of the four scenarios as average national trends for that period were low. Utilizing this longer period to establish the “typical” trend results in a lower trend estimate, as the shorter 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b: TCOC Estimate (Scenario 2, 2015 to 2019 Base)

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,343	$13,746	Predicted Variance
YOY Growth	4.8%	2.9%	1.9% Over
Estimated CY 2025 Savings Run Rate			$569.0 M

Scenario 3, shown in Table 6c, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and

non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 3 takes the trend from the prior period (2022 to 2024) and trends the data forward using 2024 as the base. This approach results in a higher estimate of national trends and larger projected savings than Scenario 2. Previously staff have included a scenario that only uses the most recent year, this was not included this year as discussed in the introduction to this section.

Table 6c: TCOC Estimate (Scenario 3, 2022 to 2024 Base)

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,508	$14,141	Predicted Variance
YOY Growth	5.9%	5.8%	0.1% Over
Estimated CY 2025 Savings Run Rate			$814.2 M

Scenario 4, shown in Table 6d, utilizes USPCC projected per capita data broken out into two buckets (part A and part B) which are then added together to calculate a total per capita estimate. Unlike scenarios 1 through 3 both Maryland and the Nation will use the exact same values for non-hospital, while the above scenarios use the same reference periods but not the same values. This approach results in a higher estimate of national trends and larger projected savings than Scenario 2 but lower national trend and savings than Scenario 3.

Table 6d: TCOC Estimate (Scenario 4, USPCC Base)

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,500	$14,033	Predicted Variance
YOY Growth	5.8%	5.0%	0.8% Over
Estimated CY 2025 Savings Run Rate			$722.2 M

In addition to modeling the CY 2025 guardrail position, staff also modeled estimated savings under each scenario; these are shown in each table above. The guardrail can not be above the

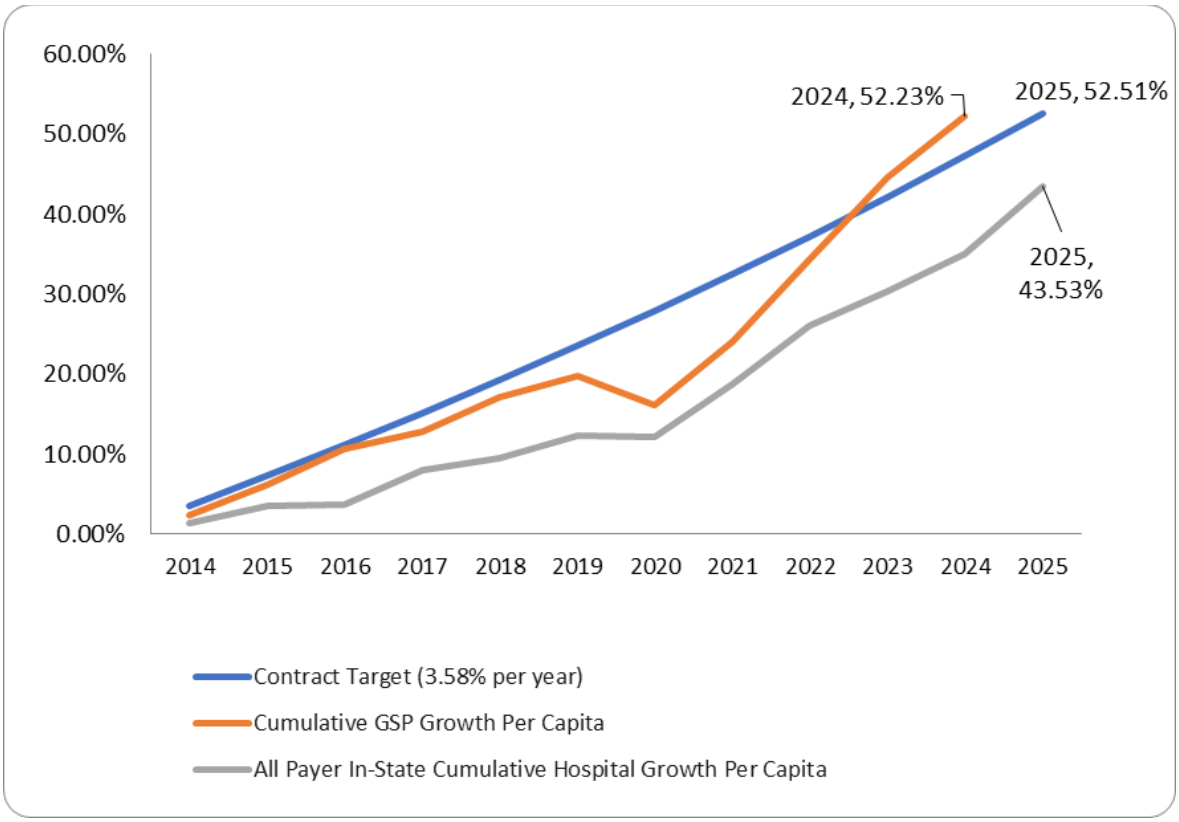
Nation by 1 percent in any year or above the Nation by any percent in two consecutive years. The guardrail position in CY 2024 was below the Nation, so Maryland will only trigger the guardrail if growth is more than 1 percent above the Nation. In addition, the estimated savings for CY 2024 is projected to be $795 million, although this amount won't be final until it is confirmed by CMS. The TCOC Model savings target for CY 2025 is $372 million but under the AHEAD model CY 2026 savings must be approximately $525 million.

In all the above scenarios, Maryland is set to achieve the savings target for CY 2025 with varying degrees of cushion. In the most conservative scenario, shown in Table 6b, estimated savings is projected to be $569 million, which is above both the CY 2025 TCOC Model target ($372 Million) and the CY 2026 AHEAD target (estimated to be $525 Million). However, this scenario does result in a guardrail violation as Maryland would be anticipated to exceed national growth by more than 1 percent. However, under Scenarios 3 and 4, which reflect more recent national trend experience, Maryland would not trip the guardrail while also producing significant savings above target.

All-Payer Affordability

Under the Total Cost of Care Contract all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). Figure 3 represents the cumulative comparison since the beginning of global budgets in 2014. The blue line reflects the contract target, the orange line shows actual GSP growth through 2024, and the gray line reflects estimated cumulative in-state hospital charge growth per capita through 2025. Staff emphasize that this analysis includes hospital spending only and does not incorporate non-hospital components of total cost of care. The GSP line ends in 2024 due to the absence of official 2025 data, staff opted not to project GSP growth. However, even with no growth in 2025, Maryland would remain under both the cumulative target and actual GSP growth. The cumulative value of this target through CY 2025 is 52.51 percent. Actual all-payer in-state hospital charge growth through CY 2024 is 35.06 percent, inflating this to 2025 using the recommended update factor on a per capita basis yields 43.53 percent. This means that Maryland is approximately 9 percentage points below the contract target, which is an indication of savings generated by the TCOC Model that accrue to all payers and consumers.

Figure 3
Affordability Scorecard – Cumulative GSP Test with CY 2025 Projection

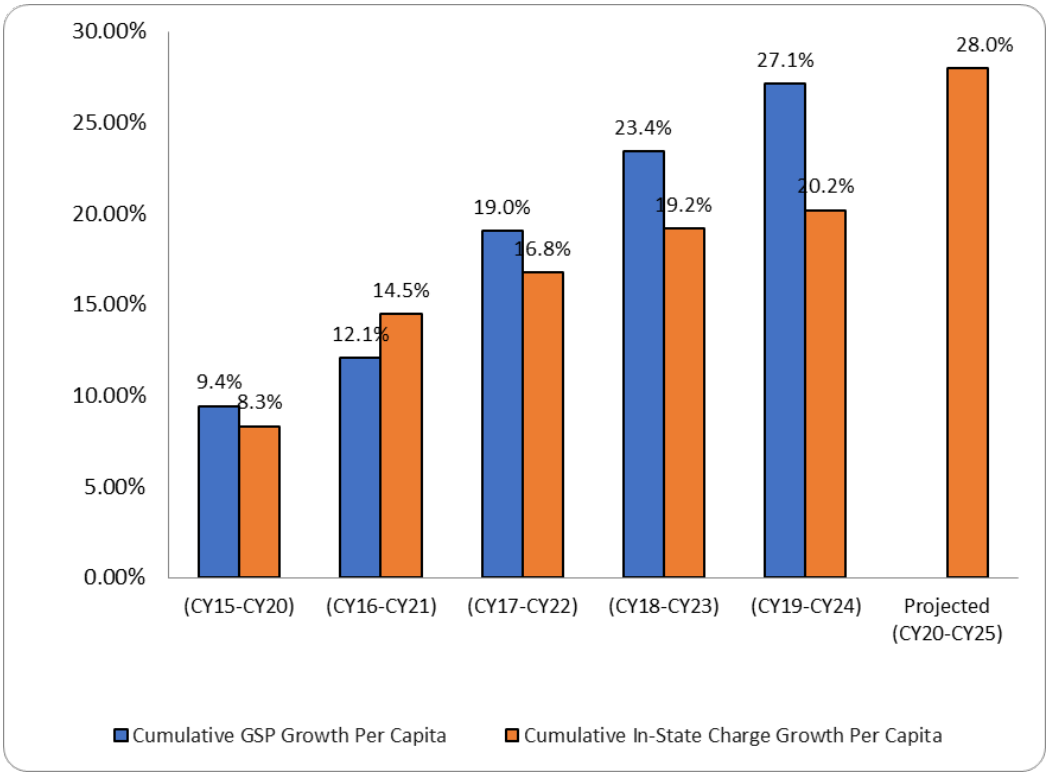


Staff also compared the all-payer in-state hospital charge growth to economic growth in Maryland, as measured by the GSP per capita, over a rolling 5-year window. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose staff believe it is not sufficient to only look at the cumulative test embedded in the Total Cost of Care Contract. Therefore, staff calculated the cumulative per capita growth for the five-year period using the most updated State GSP numbers available. As shown in Figure 4, the 5-year calculation shows a cumulative per capita growth of 27.1 percent. Staff then compared that number to the 5-year cumulative in-state acute hospital charge growth over the same five-year window, which equals 20.2 percent. Staff also modeled estimated hospital charge growth through CY 2025 using the proposed RY 2025 update factor. This projection results in estimated hospital charge growth of 28.0 percent. Without GSP for 2025 staff can not compare this value to GSP; however, GSP growth for the first 4 years of this window was 31.14 percent meaning that as long as GSP growth for CY 2025 is greater than -2.4 percent Maryland will still be below GSP on a 5-year rolling basis.

This rolling five-year test provides a complementary view to the cumulative analysis. While the margin between hospital charge growth and GSP is smaller under this test, the results still

indicate that hospital spending growth remains below the State's economic growth, reinforcing the affordability goals of the Model.

Figure 4
Affordability Scorecard – Rolling 5-Year GSP Test



All-Payer Test with Medicare FFS & Non-Medicare FFS

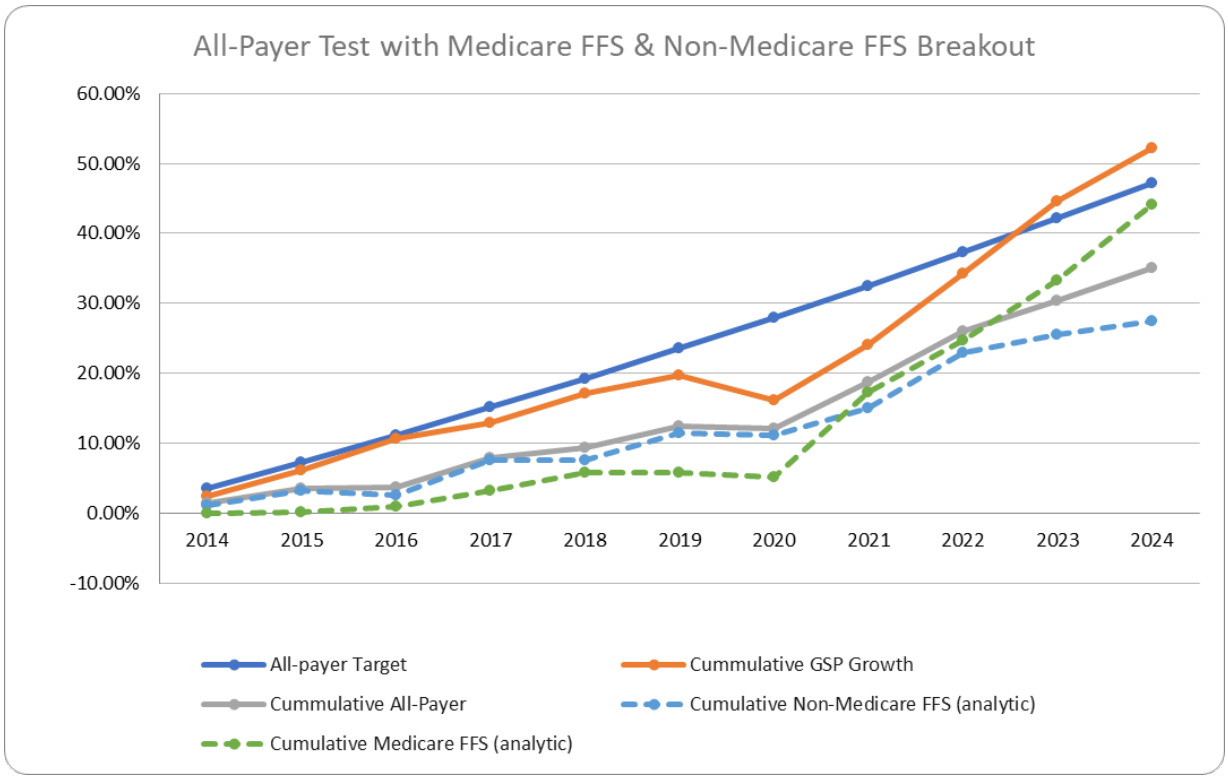
Staff also reviewed cumulative growth by payer category, separating Medicare fee-for-service (FFS) from Non-Medicare fee-for-service populations. This analysis was conducted to assess whether all-payer aggregate results might be masking differing trends across payer types. While staff initially explored breaking out commercial, Medicaid, and Medicare Advantage separately, data limitations, particularly around accurate beneficiary counts, prevented a clean and meaningful split. Instead, staff defined non-Medicare FFS as the residual population after subtracting Medicare FFS counts from total state population estimates. This grouping includes commercial, Medicare, and Medicare Advantage enrollees.

As shown in Figure 5, cumulative Medicare FFS and non-Medicare FFS charge growth tracked closely for much of the model period. However, by CY 2024, Medicare FFS growth modestly outpaced non-Medicare FFS growth, resulting in a divergence between the two trends. Despite this difference, the results reinforce that overall savings have not been achieved by shifting costs from one payer group to another. In fact, the consistency between these two trajectories

throughout most of the model period suggest that cost containment has been broadly shared across the payer mix.

Staff notes that population estimates for CY 2024 are provisional and may shift slightly once final data becomes available, though this is not expected to materially affect the conclusions. Taken together, these results reaffirm that all-payer hospital charge growth remains under control and that Medicare FFS growth trends should continue to be monitored as Maryland prepares for a broader total cost of care test in future years.

Figure 5
All-Payer Test with Medicare FFS & Non-Medicare FFS Breakout



Medicare's Proposed National Rate Update for FFY 2026

CMS released its proposed rule for the Inpatient Prospective Payment System's (IPPS) payment rate on April 11, 2025. In the proposed rule, CMS would increase rates by approximately 2.40 percent, which includes a market basket increase of 3.20 percent and a productivity reduction of -0.80 percent. This proposed increase will not be finalized until August 2025 and will not go into effect until October 1, 2025. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments, as well as potential reductions for

additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Stakeholder Comments

Staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2026 update. Comments submitted by stakeholders primarily focused on the following areas: provide additional inflation, fully fund age-adjusted demographic growth, pass on medicaid deficit assessment to payers, UCC fund revision, reinvestment of excess medicare savings, integrated efficiency policy modification, and suspending the productivity adjustment for non-GBR hospitals.

The Maryland Hospital Association (MHA) submitted a proposal requesting an increase to support its member hospitals. CareFirst opposed the draft recommendation, raising concerns about recent increases in hospital funding and potential violations of the TCOC guardrail. In addition to MHA and CareFirst, comments were submitted by the University of Maryland Medical System, Johns Hopkins Health System, MedStar Health, LifeBridge Health, Frederick Health, Adventist HealthCare, Luminis Health, Mount Washington Pediatric Hospital, and Sheppard Pratt. The request and comments outlined by MHA, CareFirst, and Maryland hospitals are outlined below with staff's response in italics:

1. **Address Inflation Pressures:**
    a. The Maryland Hospital Association and its member hospitals requested that the Commission consider funding additional inflation funding. Hospitals suggested that the 3.36% outlook for Q1 provided through S&P was likely to be conservative and the actual inflation value would come in higher. Hospitals requested an additional 0.67%, which was calculated by the average relative difference of funded versus actual inflation for RY23 and RY24. One hospital system requested the 0.52% that is the current calculated underfunding as calculated through the inflation catch up methodology.

HSCRC Response: As part of the RY 2025 Approved Update Factor Recommendation an inflation catch-up methodology was adopted. This methodology aims to:

- *Consider historical overfunding allowances*
- *Allow for two-sided risk*
- *Utilize multi-year solutions to ensure savings tests are met*
- *Establish formulaic methods that are predictable to hospitals and payers*
- *All additional inflation values still need to be considered against required savings*

The current calculation of the catch-up methodology indicates an 'unfunded' inflation rate of -0.52%. This figure does not activate the 1% guardrail threshold, meaning no additional inflation

funding is provided for Maryland hospitals at this time, per policy. Should actual inflation exceed the funded inflation for Rate Year 2026 (RY26), the catch-up methodology will automatically adjust to account for any variance, triggering additional inflation support if the 1% guardrail is breached.
It's important to note that the 1% guardrail was established as an acceptable tolerance level, reflecting historical inflation funding patterns since 2013. Additionally, hospitals have not provided supporting evidence suggesting a significant deviation between actual and funded inflation rates.

2. **Fully Fund Age Adjusted Demographic Growth**
    a. The Maryland Hospital Association and its member hospitals requested that the Commission go beyond the proposed 0.76% correction and fully fund age-adjusted demographic growth. They stated that the current adjustment does not reflect the true cost of serving an aging population. MHA estimated that 2.6% in age-adjusted growth from 2020 to 2024, or roughly 0.65% per year, remains unfunded and recommended including this amount in the update.

HSCRC Response: Staff propose moving forward with recommending an additional 0.76 percent to reflect revised historical data from the Maryland Department of Planning. Staff also propose that RY 2026 and future demographic adjustments be reconciled to cumulative population count from 2020 through the most recent year.

In addition to the aforementioned policy correction, hospitals have requested additional funding related to a proposed revision of the demographic policy, specifically concerning updates to age and risk adjustment calculations. Staff are committed to continued collaboration with hospitals and other stakeholders to revise this policy and will work over the coming months to review and align it with the implementation of the AHEAD Model. It is important to note that this process involves a fundamental change to the underlying methodology, not merely a revision related to source data or calculation errors. Therefore, it is essential that this process is conducted through a thorough stakeholder engagement process.

3. **Pass on Medicaid Deficit Assessment Increase to Payers**
    a. The Maryland Hospital Association and its member hospitals requested that hospitals not be required to directly remit any portion of the $150-million increase to the Medicaid Deficit Assessment, citing financial vulnerability.

HSCRC Response: The Maryland Legislature has approved a $150 million increase to the Medicaid Deficit Assessment, bringing the total amount to be collected in Rate Year (RY) 2026 to approximately $444 million. Given the magnitude of this increase, staff believe it would be inequitable to pass the entire burden onto payers and patients.

Staff propose a hospital-payer split consistent with the historical allocation used in RY 2015, which was 14.5% for hospitals and 85.5% for payers. Applying this split would result in an additional $8 million in hospital costs statewide, representing 0.04% of revenue. Staff propose

transitioning to a percentage-based allocation model (14.5% hospitals & 85.5% payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

4. **UCC Fund Revision**
    a. The Maryland Hospital Association and all member hospitals supported the proposed correction to the uncompensated care (UCC) fund calculations for RY2023 to RY2025. They agreed with providing additional funding to hospitals and health systems that were underfunded, while holding harmless those that were overfunded. MedStar requested clarification on how the UCC correction will be implemented, specifically whether it will be applied as a one-time rate adjustment in RY2026.

HSCRC Response: Staff appreciates the hospital support and understanding regarding the need for policy corrections when errors occur. In an effort to ensure that undue burden is not placed on hospitals when corrections need to be made, staff is proposing holding hospitals harmless who were overfunded based on this policy correction. If approved by the Commission, HSCRC staff will implement this policy correction as a one-time adjustment in RY 2026, not as an increase to mark up.

5. **RY 2026 Reinvestment of Excess Medicare Savings**
    a. The Maryland Hospital Association, along with several hospitals including UMMS, LifeBridge, and MedStar, noted the state's estimated $795 million in CY 2024 Medicare Total Cost of Care savings and identified it as an opportunity to support hospital funding. LifeBridge and MedStar more directly urged the Commission to reinvest a portion of the surplus and cited the role hospitals played in generating the savings and the need to stabilize operations in preparation for the AHEAD model. The MHA cited several hospital cost pressures in their comment letter. These cost pressures included:
        i. Expected Impact on Tariffs
        ii. Potential Funding Cuts to Medicaid
        iii. Increase in Payer Denials
        iv. Rising Physician & Other Staffing Costs
        v. Medical Liability Costs
        vi. Cybersecurity and Campus Security

HSCRC Response: Staff modeled four different scenarios to project the CY 2025 guardrail position. In all four modeled scenarios, Maryland is expected to achieve the savings target for CY 2025 with varying degrees of cushion. However, it is important to note that the guardrail can not be above the nation by 1 percent in any year or above the nation by any percent in two consecutive years. The guardrail position in CY 2024 was below the nation, so Maryland will only trigger the guardrail if growth is more than 1 percent above the Nation. In two of the scenarios

modeled, Maryland exceeds the guardrail by more than 1 percent. In another scenario, the estimated guardrail is 0.8 percent above the nation, 0.2 percent away from tripping the guardrail.

The HSCRC received a large number of comments regarding potential rate increases above the formulaic update factor methodology. At this time, Staff are not making recommendations related to reinvestment of savings above target and above the formulaic adjustments outlined in this presentation.

6. **RY 2026 Integrated Efficiency Policy Modification**
    a. The Maryland Hospital Association, along with JHHS and MedStar, specifically supported the recommended modification to the Integrated Efficiency Policy. They agreed with limiting penalties to hospitals in the fourth quartile that are also identified as ICC outliers and supported the use of a historical standard deviation. Medstar also encouraged convening a stakeholder workgroup to collaborate on additional revisions to the policy and related methodologies. LifeBridge Health requested the suspension of Integrated Efficiency policy penalties in RY 2026, citing uncertainty of Maryland's Medicare Waiver and projected statewide savings targets.

HSCRC Response: Staff appreciate the broad support provided by stakeholders to limit the downside risk of the Integrated Efficiency policy to hospitals in the fourth quartile that also are worse than one standard deviation from average performance in the ICC.

Staff generally agree with Medstar that the Commission should every 3-5 years review existing policies to assess their efficacy and amend them if necessary. Staff would note though the Integrated Efficiency policy has gone through revisions approximately every two years since its original inception in 2020 (implementation in 2022), and there are also several other policies that stakeholders would like staff to review/amend, most notably the marketshift policy and the demographic adjustment policy.

Staff do not agree with Lifebridge Health's request to suspend the implementation of the Integrated Efficiency policy, as the proposed modification further ensures that the policy only identifies outliers. Additionally, the federal government has noted in its AHEAD methodology specifications that it aims to use global budgets to make greater investments in population health, and uncertainty regarding the future of the Maryland Model does not eliminate the Commission's obligation to ensure that hospital costs are reasonable and hospital costs are reasonably related to charges, both of which are accomplished by the ongoing application of the Integrated Efficiency policy.

7. **RY 2026 Suspend Productivity Adjustment for non-GBR hospitals**
    a. The Maryland Hospital Association and its member hospitals are requesting the suspension of the productivity adjustments for non- GBR hospitals. The proposed -0.80% would lower the non-GBR hospitals with an update of 2.56%

b. The Maryland Hospital Association states that non-GBR hospitals are confronting challenges with recruitment, retention, and increased compensation of physicians and other staff, which may impact their ability to meet the demand for the specialty services they provide. Applying a lower inflation factor to non-GBR hospitals at this time could create unnecessary financial strain.

HSCRC Response: Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80% is in line with the proposed IPPS rule for FFY 26. The productivity adjustment is a tool that aligns Medicare payment updates with broader economic productivity trends, promoting cost control and efficiency in hospital operations. A productivity adjustment is applied to hospitals under both IPPS and IPF PPS. HSCRC staff do not set Medicare rates for non-GBR hospitals. The proposed update is included for non-governmental payers. HSCRC staff understand that non-GBR hospitals are facing similar cost pressures to GBR hospitals. Volumes at these hospitals are still down relative to a 2019 base and as these volumes declined they were removed at a 100 percent variable cost factor. These hospitals are a valuable resource in the Maryland healthcare ecosystem. It is important that they have the ability to respond to the needs of the community and be available as a statewide resource in specialty hospital care for pediatrics and psychiatric services. Staff reviewed additional analyses, described below, to better understand the volume declines at these hospitals. For purposes of our analytics, we focused on the two specialty hospitals with the largest revenue bases - Sheppard Pratt & Mount Washington Pediatric Hospital.

a. Staff reviewed trends in hospital abstract volume at Mount Washington Pediatric Hospital and Sheppard Pratt from Fiscal Year 2019 (pre-pandemic) to Fiscal Year 2024 (most recently completed fiscal year). For Mount Washington, inpatient volumes decreased by 293 cases, as measured by the Commission's casemix adjusted methodology (ECMADS). Approximately 76 percent of this reduction was due to neonatology (see Figure 6a below) and this largely aligned with statewide experience amongst general acute care facilities, with few exceptions, (see Figure 6b below), suggesting a secular decline in demand of neonatology, e.g., fewer premature births.

Figure 6a
Mount Washington Pediatric Hospital Volume Change by Service Line

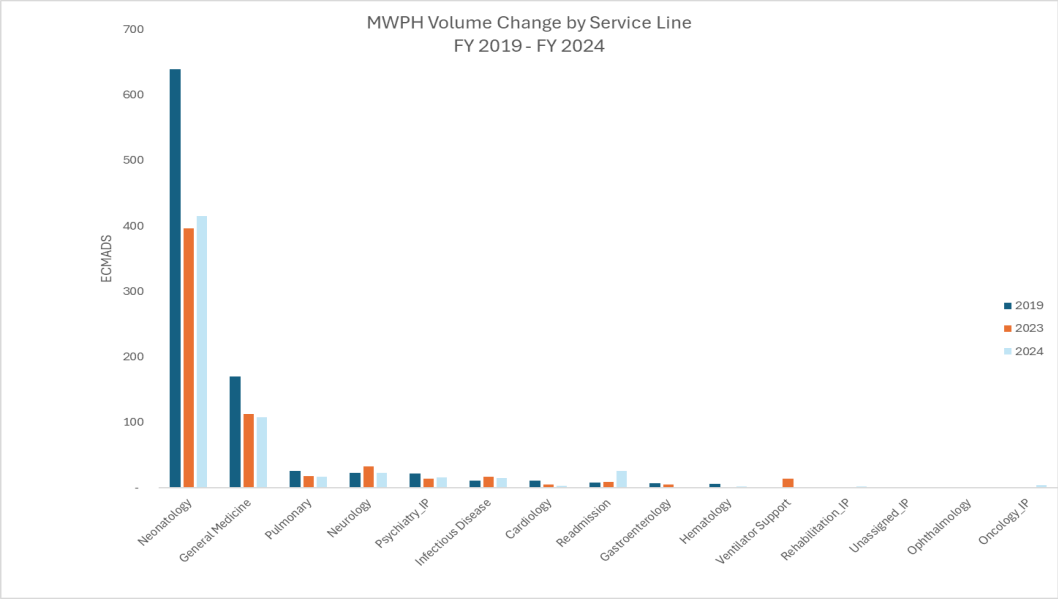
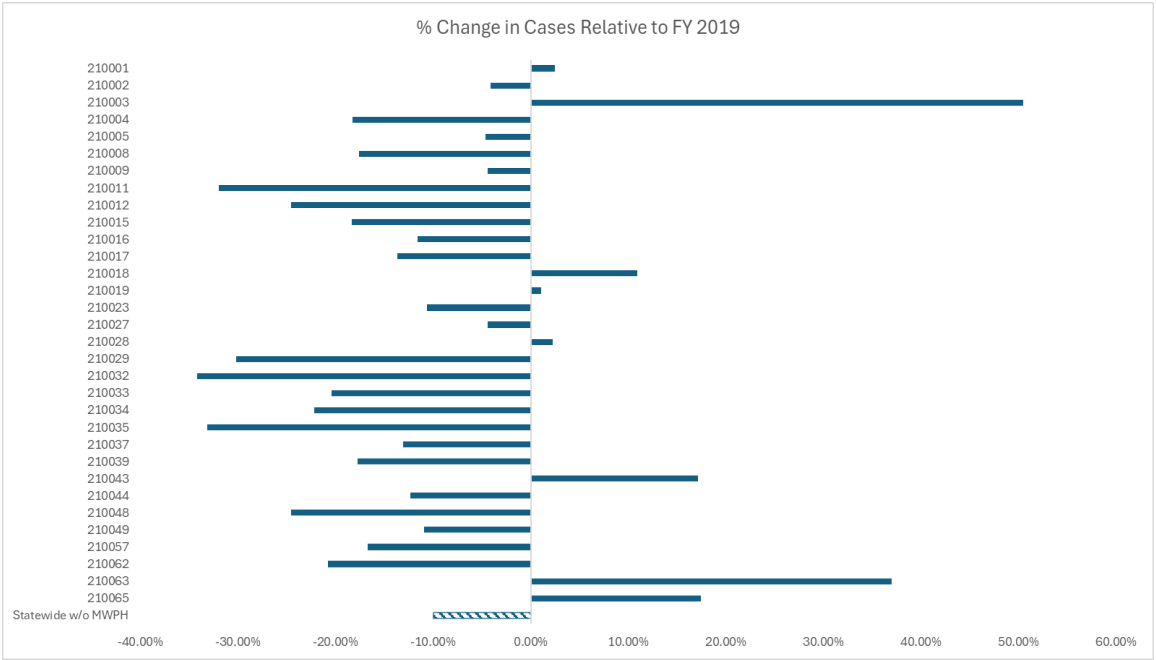
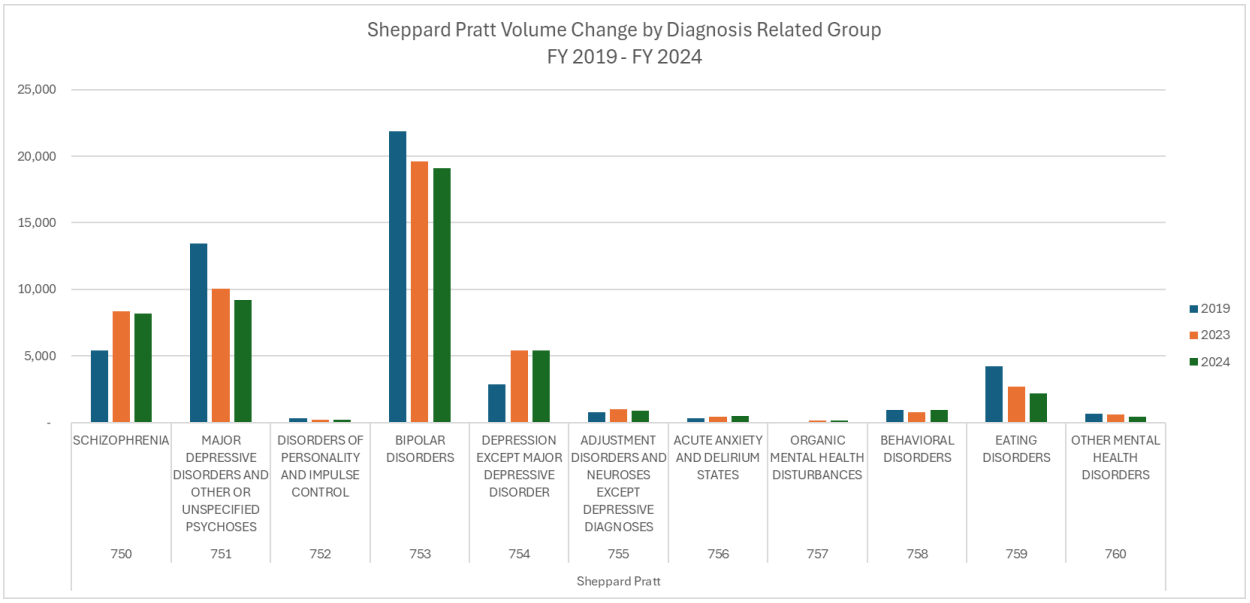


Figure 6b
Fiscal Year 2024 Percentage Change in Neonatology Cases Amongst General Acute Care Facilities



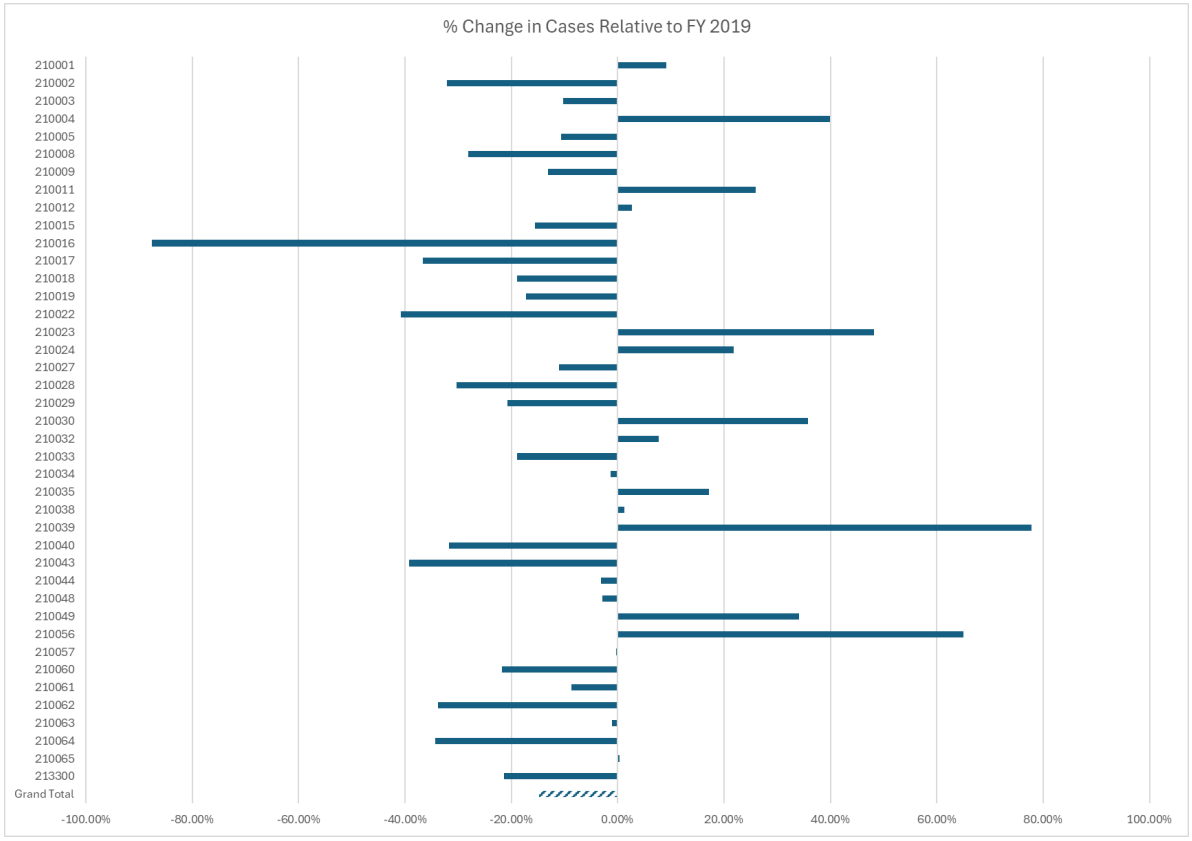
At Sheppard Pratt, inpatient volumes declined by 3,743 cases; however, the reduction was not localized to one service line or diagnosis related group, as various cases, e.g., schizophrenia, trended upwards, but other cases, e.g., bipolar disorders and eating disorders, saw significant reductions that entirely offset other emerging behavioral health services (see Figure 7a below).

Figure 7a
Sheppard Pratt Volume Change by Service Line



Staff noted a similar decline in behavioral health admissions among general acute care facilities (15 percent statewide), with a few notable exceptions, suggesting another potential secular decline in demand.

Figure 7b
Fiscal Year 2024 Percentage Change in Behavioral Health DRG's Amongst General Acute Care Facilities*



Finally, staff were potentially concerned that an analysis of service lines and/or diagnosis groupings may be flawed if behavioral health cases, especially post-COVID, were not mapping to behavioral health DRG's because other comorbidities were more indicative of the reason for the hospital visit, e.g., respiratory syncytial virus with a co-occurrence of a behavioral health diagnosis. As such, staff also reviewed all admissions with a behavioral health diagnosis, either as primary or secondary (or not primary), and noted that the decline in behavioral health cases was systemic across both classifications:

Figure 8c
Behavioral Health Diagnoses Fiscal Year 2019- Fiscal Year 2024

Primary vs. Secondary Diagnosis Behavioral Health Admissions (FY19 - FY23)

Primary vs Secondary BH	FY19	FY20	FY21	FY22	FY23
Primary Diagnosis as "PrinDiag"	45,019	41,414	38,601	34,861	32,995
Secondary Diagnois as "Diag 1"	14,001	11,023	10,364	11,320	10,453

Source: AHRQ

In light of the analyses described above, staff are recommending to suspend the productivity adjustment in RY 2026. The recommendations outlined in this final recommendation reflect this position.

8. **Other Stakeholder Comments**
    a. Carefirst opposed the draft recommendation, stating that hospitals have already received more than $541 million in additional funding through recent Commission actions, including RSV surge support, margin enhancements, and inflation catch-up adjustments. They argued that these increases have prioritized hospital revenue over consumer affordability and warned that such an approach is not sustainable.
    b. CareFirst further noted that all modeled update scenarios exceeded Medicare guardrail thresholds and expressed concern that this continued trend could put the State's Model at risk.

HSCRC Response: Staff appreciate CareFirst's concern and commitment to protecting consumers and patients in Maryland. Staff are committed to ensuring that the recommended balance update considers hospitals, payers, and patients that receive care in the State of Maryland. For this reason, staff do not recommend revising the draft policy to amend for any of the concerns outlined in other stakeholder comment letters. We understand the importance of considering both savings and guardrail positions related to our Model performance.

    c. HSCRC staff received a comment relating to "systemic and complex policy errors that have led to multi-year underfunding. We are deeply concerned that the continued layering of increasingly complex methodologies—without the ability to consistently execute them in a timely and accurate manner—risks the long-term viability of the Model. We encourage the Commission to prioritize simplification and external, independent replication of policy results to ensure the Model's long-term sustainability."

HSCRC Response: Staff would like to emphasize our commitment to a thorough and inclusive stakeholder engagement process. This approach ensures adequate time for making substantive

changes and improvements that meaningfully inform decision-making. Such processes often span several months and involve extensive data sharing and dialogue with Maryland hospitals and other stakeholders.

To support this collaborative effort, it is imperative that the HSCRC receives timely and accurate hospital data. This data is essential for informing the work and analyses under review, enabling the development of policies that reflect the collective input and needs of all parties involved. Requests for data resubmission, data submission errors, and other data corrections that need to be made hinder the integrity of results. To date in FY 2025, staff have approved approximately 15 requests for extensions or data resubmissions. Oftentimes, this results in staff's inability to run timely or correct methodologies that informs policy making on a statewide basis.

d. One comment received related to the reconciliation of the set aside funding. The Commission approved $31.7 million of permanent hospital funding in the RY 2025 update factor through the set-aside, only $10.8 million of this was distributed to hospitals permanently per the reconciliation in Appendix I. MedStar seeks clarification around this $20.9 million difference and how staff are accounting for this in the RY 2026 update factor.

HSCRC Response: While the historical distribution of set aside funding has been concentrated on permanent funding, the allotment has always been a mix of both permanent and one-time funding, i.e., there is no guarantee that the funding will be permanent or one-time. In RY 2025, due to the process by which set aside funding was distributed, a large portion was provided as one-time funding for financial hardship, as seen in Appendix I. HSCRC removed the permanent portion of this funding from the total set aside allotment and the remainder was included in the removal of extraordinary one-time adjustments as described in Table 5 of the recommendation. Based on MedStar's commentary, staff have revised the extent of one-time set aside funding that will be reversed in RY 2026. This small correction is reflected in the following tables.

Recommendations

Based on the currently available data and the staff's analyses to date, HSCRC staff provides the following final recommendations for the RY 2026 update factors.

For Global Revenues:

(a) Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.

(b) Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as

shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(c) Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.

(d) Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than annual percentage growth rates, thus improving the accuracy and better reflecting actual population changes.

(e) To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.

(f) Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.

(g) Transition to a percentage-based allocation model for the Deficit Assessment Allocation (14.5 percent for hospitals & 85.5 percent for payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

For Non-Global Revenues, including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.36 percent for inflation and suspend the productivity offset of 0.80 percent.

Appendix I: Set Aside Reconciliation

Distribution of Set Aside for RY 2025			
RY 2025 GBR Revenue		$22,436,402,668	
Set Aside %		0.36%	
Set Aside $		$80,448,745	
Hospital	Set Aside $ Value	Set Aside %	Reason
Tidal Health	$9,902,458	12%	IE - Permanent
UM Charles Regional	$981,567	1%	IE - Permanent
Adventist Health	$18,500,000	23%	Financial Hardship
UM Shore Medical Center at Easton	$15,100,000	19%	Financial Hardship
Frederick	$10,464,720	13%	Financial Hardship
MedStar Southern Maryland	$7,300,000	9%	Financial Hardship
MedStar Harbor Hospital	$4,500,000	6%	Financial Hardship
Luminis Health - Doctors Community Hospital	$4,000,000	5%	Financial Hardship
MedStar St. Mary's	$3,500,000	4%	Financial Hardship
Calvert Health	$3,200,000	4%	Financial Hardship

MedStar Montgomery	$3,000,000	4%	Financial Hardship
Total	$80,448,745	100%	

In RY 2025, the Commission recommended distributing approximately $80.4 million in Set Aside funding. This funding allocation represents 0.36 percent of total approved GBR revenue for the year and is targeted toward hospitals with demonstrated financial vulnerability or existing commitments to Integrated Efficiency initiatives. The set aside allocation approved in the RY 2025 update factor was 0.15 percent or $31.7 million. This value was later increased to the amounts listed above based on Commission approval.

A significant portion of the funding, approximately $69 million, supports hospitals that have experienced sustained financial challenges and serve as critical access points within their communities. These hospitals, including Adventist Health, UM Shore Medical Center at Easton, and Frederick Health, will receive funds to help stabilize operations and preserve essential services.

The remaining funds, approximately $11 million, are allocated to hospitals for approved Integrated Efficiency investments, including Tidal Health and UM Charles Regional. These resources are intended to ensure the continuity of care delivery redesign efforts aimed at improving quality and reducing avoidable utilization.

All distributions were based on submitted financial documentation and system-level performance considerations. HSCRC staff reviewed requests individually and determined funding amounts consistent with the total available set aside and the scale of demonstrated need.

Appendix II: Revenue for Reform

Revenue for Reform is intended to safe harbor population health investments from the HSCRC Integrated Efficiency Policy, which would otherwise withhold dollars from hospitals with excess retained revenue relative to their peers. This policy ensures that hospital-retained revenue which is directed toward meaningful community-based population health initiatives is not reclaimed as "inefficient".

The primary objectives of the Revenue for Reform policy are to:

- Direct hospital-retained revenue into community-based population health investments, fostering overall health improvement.
- Support projects aligned with the TCOC Model's goals to improve population health and reduce total cost of care.
- Establish a self-sustaining cycle in which reduced hospital service demand leads to increased hospital investment in community health.

Under this policy, hospitals are required to invest in approved community health activities or return funds to payers. Hospitals authorized to make population health investments are required to maintain annual spending on population health initiatives, ensuring that the funding is utilized for sustainable health investments.

In FY 2025, approximately $60 million will be directed to community health and expanding/maintaining access to primary care and behavioral health providers in Baltimore City, Carroll County, the Eastern Shore, and the DC Metro region. Many investments approved in FY 2025 were continuations of approved FY 2024 investments

Total Eligible for Safe Harbor ● FY 2024 Permanent Revenue: $23,840,552 ● FY 2025 Permanent Revenue: $39,771,749	$63,612,301
Approved for Safe Harbor	$60,070,024
Permanent Savings to Payers	$3,542,277

Hospital	**Investments in Pop Health & Provider Access**	**Approved Program/Interventions**
Johns Hopkins Bayview Medical Center	$14,021,944	● Care management/transitions for high-risk and rising risk patients ● Primary, specialty, and post-acute care for uninsured and undocumented populations ● Pediatric and OBGYN – FQHC support ● HRSN screening and referrals ● Behavioral healthcare expansion

Lifebridge Carroll Hospital Center	$2,484,359	● Care management/transitions for high-risk and rising risk patients ● Primary care for uninsured and underinsured patients
Lifebridge Sinai Hospital	$21,791,363	● Care management/transitions for high-risk and rising risk patients ● Wraparound services/HRSN supports for patients with advanced chronic conditions ● Diabetes prevention & management and wraparound services ● Respite Housing ● Physician Practices in HPSA/MUAs
St. Agnes Hospital	$1,050,599	● Care management/transitions for high-risk and rising risk patients
Union Hospital of Cecil County	$1,651,197	● Care management/transitions for high-risk and rising risk patients ● HRSN screening and referrals ● Physician Practices in HPSA/MUAs
University of Maryland Capital Region Medical Center	$3,207,995	● Physician Practices in HPSA/MUAs
University of Maryland Medical Center Midtown Campus	$4,688,845	● Addiction medicine and behavioral healthcare for patients living with HIV and infectious diseases
University of Maryland Shore Medical Center at Chestertown	$1,776,248	● Care management/transitions for high-risk and rising risk patients
University of Maryland Shore Medical Center at Easton	$5,779,980	● Care management/transitions for high-risk and rising risk patients
University of Maryland St. Joseph Medical Center	$2,561,803	● Care management/transitions for high-risk and rising risk patients ● Primary care and behavioral health services for uninsured and undocumented populations
Washington Adventist Hospital	$1,055,691	● Physician Practices in HPSA/MUAs

Hospitals submit applications to secure safe harbor status for investments through three tracks.

1. Track 1: Community Health Investments
    - Track 1A: Multidisciplinary Care Transitions and Care Management Programs
        - Directs spending to address leading conditions driving avoidable hospital utilization, readmissions, and healthcare costs.
        - Implements tailored, multidisciplinary care transitions and care management programs.
    - Track 1B: Evidence-Based Community Health Improvement Programs

        - Supports the implementation of new or existing evidence-based community health improvement programs within a hospital's primary service area.
2. Track 2: Physician Spending
    - Facilitates investment in primary care, mental health providers, and dental providers in designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA).
3. Track 3: State Pre-Approved Projects
    - Hospitals could support projects pre-cleared by the Maryland Department of Health (MDH) and HSCRC as high-value community health initiatives supporting the TCOC Model or propose projects of comparable scope and value to those pre-approved by the state. There was limited uptake of this option.

Applications are reviewed by a cross-functional team from the HSCRC and Maryland Department of Health against track-specific evaluation criteria. Staff approve, deny, or request revisions to submitted applications.

Appendix III: Comment Letters

Letters were received from:

- Maryland Hospital Association (MHA)
- University of Maryland Medical Systems
- LifeBridge Health
- Luminis Health
- Frederick Health
- Sheppard Pratt
- Mount Washington Pediatric Hospital
- MedStar Health
- CareFirst
- Adventist Healthcare
- Johns Hopkins Health System

Maryland
Hospital Association

May 21, 2025

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

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2026. MHA appreciates the time your dedicated staff took to ensure a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

After reviewing staff's draft recommendation, MHA respectfully requests consideration of an additional 1.32% revenue growth (0.65% for age-adjusted demographic growth and 0.67% for a prospective inflationary increase), a full pass through of the increase in the Medicaid Deficit Assessment to payers, and suspension of the productivity adjustment for non-GBR hospitals, as described in greater detail below.

Maryland hospitals and health systems are navigating uncharted waters. Challenging financial conditions and unprecedented cost pressures related to tariffs, potential cuts to Medicaid funding, rising insurer denials, and increasing physician costs challenge their stability at a time when they can least afford it. Ensuring hospitals and health systems have sufficient resources for operational readiness and necessary investment in care transformation is more important than ever and will support the state's transition to the new phase of the Maryland Model.

MHA and its members appreciate HSCRC's actions to address hospital needs in RY 2025 through additional funding for underfunded inflation, one-time set-aside, and respiratory surge funding. Even with these efforts, Maryland hospitals are facing serious financial pressures, with many of them operating in the red. This is not sustainable, and additional support is needed.

Recognizing the update proposed under the draft recommendation is relatively high, a significant portion (0.70%) is attributable to the legislatively-mandated $150-million increase to the Medicaid Deficit Assessment, from which hospitals and health systems do not directly financially benefit. In addition, 1.06% of the update represents technical corrections to the demographic adjustment and uncompensated care calculations from prior rate years. As a result, the proposed update (5.68% revenue growth over RY 2025) overstates the level of financial benefit to hosptials and health systems to address contemporary funding needs in RY 2026.

MHA believes the substantial excess Medicare Total Cost of Care (TCOC) savings generated currently and over the course of the Model offers an opportunity—and existing levers within the global budget methodology including the demographic adjustment and inflation update, a vehicle—to provide hospitals and health systems with the additional, immediate funding relief needed to address the contemporary cost pressures they face and ensure their stability during the Model transition.

MHA Request for an Adjusted Annual Payment Update

We offer the following proposals for the final recommendation in June:

- **Provide an adjustment to address unprecedented inflationary cost pressures**. S&P Global Insights' Q1 2025 cost tables estimate inflation of 3.36% for RY 2026. However, forecasts have been consistently conservative in the post-COVID era. The average relative difference between forecasts and actuals for RY 2023 and RY 2024 was 0.67%.
- **Fully fund age-adjusted demographic growth**. Over the last four years (2020-2024) and after accounting for a proposed correction in the staff recommendation, HSCRC will have funded 1.39% of overall population growth, with 2.6% of age-adjusted population growth over the same period having gone unfunded (average of 0.65% per year).
- **Pass through the increase in the Medicaid Deficit Assessment to payers**. Given hospitals' financial vulnerability, MHA asks that hospitals not be required to directly remit any portion of the $150-million increase to the Medicaid Deficit Assessment.
- **Suspend implementation of the productivity adjustment for non-GBR hospitals**. The proposed 0.80% productivity adjustment would significantly reduce the inflation update for non-GBR hospitals. However, specialty hospitals face the same inflationary cost pressures as acute care hospitals and continue to experience low volumes.

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Financial Conditions of Maryland Hospitals

Maryland hospitals and health systems continue to confront significant financial challenges. Data show Maryland hospitals and systems fare poorly on key measures of financial stability:

- **Operating margins**: The average operating margin across Maryland systems as of the end of Q3 of 2024 (the most recent quarter for which national data is available) was 0.3%, well below the average among a Bank of America sample of 150 nonprofit systems nationwide of 1.5% and even further below the industry benchmark for sustainable positive operating margins of 3%. Six Maryland systems had negative operating margins in CY 2024, twice as many as at the start of the Total Cost of Care Model and three times as many as at the start of the All-Payer Model.
- **Debt and capital adequacy**: Maryland hospitals and health systems lag behind the nation on key measures of debt and capital adequacy (debt to capital, capital expenses as a percentage of depreciation, and average age of plant). Many hospitals and health

systems also have deferred capital investments, which can impact patient care, due to resource constraints and financial uncertainty at a time when capital needs are growing.

- **Cash reserves**: While liquidity levels are sound overall, several Maryland systems have fewer than 150 days cash on hand, and cash reserves are well below national benchmarks when comparing cash reserves to debt—an important credit metric. If health care systems are forced to draw down on these limited cash reserves to cover their operating losses, their ratings may continue to be downgraded, and hospitals may lose their ability to invest in needed capital.

- **System ratings**: Staff noted at the April Commission meeting that, in their estimation, "no hospitals are facing immediate solvency questions." Solvency is a low bar for measuring financial sustainability, and rating outlooks for Maryland systems are stable at best. As of the date of this letter, three systems have negative rating outlooks, and no systems have positive rating outlooks.

When hospitals face financial challenges, they cannot reinvest in clinical care, attract and keep skilled staff, or improve the patient experience. These limitations directly affect care quality and threaten the ability to provide round-the-clock acute care statewide. Furthermore, these challenges threaten the financial stability of hospitals at a time when they can least afford it given the unprecedented cost pressures they face.

Significant Cost Pressures Maryland Hospitals Face

Maryland hospitals are navigating an unprecedented combination of cost pressures and unfunded mandates that are not fully accounted for in the state's current rate-setting methodologies. From inflation and potential tariff-driven supply cost increases to rising uncompensated care and new population health mandates, these challenges are creating sustained financial strain across the field. Despite clear evidence of growing operating expenses, recent annual updates have fallen short of addressing the financial realities hospitals face every day.

As a result, hospitals are increasingly forced to absorb the costs of inflation and comply with new regulatory and care delivery mandates without corresponding rate support. This growing disconnect between actual costs and available funding is eroding already-thin margins, forcing delays in needed investments, and threatening hospitals' ability to deliver high-quality, accessible care. Without timely and adequate relief, these pressures risk undermining the very foundation of Maryland's hospital infrastructure.

Given the scope and severity of these issues, a meaningful and appropriately scaled Rate Year 2026 annual payment update is essential. The Commission has the opportunity to take decisive action to preserve hospital financial stability, protect access to care, and enable hospitals to meet the state's evolving health system goals.

Impact of Expanded Tariffs on Hospitals

Recent federal trade policy changes, including expanded tariffs on medical devices, pharmaceuticals, and supplies, have introduced external inflationary pressures that will likely

further burden hospitals. Tariffs on these critical goods could further disrupt patient care and increase hospital expenses. Hospitals rely heavily on a global supply chain, and tariffs on goods could potentially crowd out funds for other needs.

As of March 2025, the United States faced over 270 active drug shortages, and nearly 70% of medical devices were sourced exclusively from overseas manufacturers. Tariffs applied to these products could increase procurement costs, disrupt supply chains, and create volatility in budgeting for essential clinical resources. These costs, which are entirely outside of hospital control, could contribute to inflation above historic annual updates. Ongoing federal tariff activity is an exogenous cost driver that could further strain hospital finances and must be considered as part of the RY 2026 inflation adjustment.

Potential Funding Cuts to Medicaid

Hospitals remain vulnerable to potential changes in federal Medicaid funding. Any reduction in federal support would shift a significant financial burden onto states and providers and erode hospital revenue. Hospitals cannot trim expenses to offset such a loss. Given that 1.6 million Marylanders rely on Medicaid, hospitals would be required to absorb an increase in uncompensated care, particularly in emergency and inpatient settings.

The state's all-payer system could provide some mitigation, but that alone is insufficient to address the magnitude of the risk. As such, the Commission should account for the possibility of federal funding changes when evaluating upcoming financial needs.

Increase in Payer Denials

Hospitals are experiencing a sharp and unsustainable rise in claims denials from insurers, which reduces payment for care already delivered and places increasing strain on revenue cycles and operational resources. Between FY 2013 and FY 2024, denied hospital claims in Maryland more than tripled to $1.39 billion. Many of these denials stem from administrative policy changes or automated algorithms, rather than clinical judgment, resulting in delayed reimbursements, lost revenue, and heightened administrative burden. This trend directly erodes hospital revenue, and we urge the Commission to recognize payer denials as a growing systemic risk and factor in their financial impact.

Rising Physician and Other Staffing Costs

Labor expenses, making up approximately 56% of total hospital costs, have surged in recent years due to persistent workforce shortages and the need to offer competitive wages to attract and retain staff. This adds significantly to the financial pressures hospitals face. One of the most critical and growing drivers of labor cost is physician coverage. To ensure continuous access to critical services such as emergency care, anesthesia, and intensive care, hospitals continue to absorb substantial physician-related expenses.

Unlike many states, Maryland hospitals operate under global budgets that generally exclude physician professional fees from hospital rate payments. As a result, hospitals remain financially responsible for securing and subsidizing this essential coverage, especially in high-demand

specialties where staffing is limited and costs are escalating. Rising physician compensation, market competition, and recruitment challenges have embedded these expenditures into hospital operating budgets without a clear path for rate recovery. Because hospitals cannot simply increase charges under a global budget, physician deficits directly erode regulated margins, diverting resources away from core operations.

Currently, there is no mechanism to fully account for these mounting structural costs. As physician costs continue to climb, the ability of hospitals to maintain 24/7 access to critical services is increasingly at risk. Essential physician coverage is a foundational cost of care delivery, and the Rate Year 2026 update should reflect the reality of this financial burden.

Medical Professional Liability Costs

Medical professional liability insurance premiums continue to rise. National trends in litigation, jury awards, and insurance market volatility are driving higher premiums. The cost per malpractice claim in Maryland is significantly higher than in most other states and has been steadily rising in recent years. The increasing frequency of large claims in Maryland has reduced access to commercial insruance protection, as several insurance providers have left the market while the rest have reduced participation, leaving Maryland healthcare systems to bear the cost. Liability costs are largely fixed and unavoidable, yet they reduce available operating funds. According to a Willis Towers Watson analysis of claims as of March 2025, liability claims have cost Maryland healthcare organizations an estimated $4.5 billion over the past decade. As financial margins tighten, hospitals will have limited capacity to absorb additional liability expenses without adjustments to their base rates.

Cybersecurity and Campus Security

Physical and digital security has become an operational imperative for Maryland hospitals. Maryland hospitals today must invest heavily in security measures, both cyber and physical, to safeguard patients, data, and staff. These investments have become indispensable in response to rising threats, but they impose significant costs that are not directly reimbursed within global budgets.

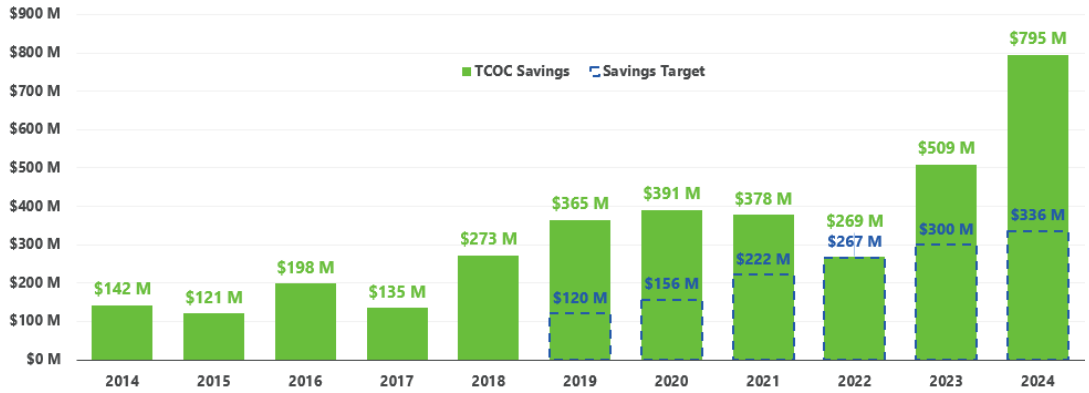
Cyberattacks targeting hospitals are growing in frequency and severity, with substantial consequences ranging from operational shutdowns to legal settlements. At the same time, rising threats of violence on hospital campuses have prompted increased investment in physical security infrastructure, such as surveillance systems, panic alerts, and trained security personnel. These measures are crucial for protecting health care workers and patients, but carry a financial cost, often substantial capital investments up front and higher operating costs for staffing and technology maintenance.

For Maryland’s rate-regulated hospitals, the rising spend on security is largely unrecovered through current payment structures. The Commission should acknowledge cybersecurity and violence prevention as essential health care investments in today’s environment. Ensuring hospitals have the funding to keep up with these investments is an important part of maintaining overall hospital viability.

Excess Medicare Total Cost of Care Savings

According to HSCRC, the state is on track to generate an estimated $795 million in cumulative Medicare TCOC savings through CY 2024, $460 million more than the year-end target of $336 million (Figure 1). Over the course of the Model, savings have been driven by significant reductions in hospital expenditures—between the start of the All-Payer Model (2014) and 2024, the state generated $1.02 billion in cumulative hospital savings and $354 million in non-hospital dissavings—yet they have accrued to the benefit of payers, not hospitals and health systems.

Figure 1. Medicare Total Cost of Care Savings (2014-2024)



HSCRC staff modeled three scenarios based on historic spending trends to project the CY 2025 savings and guardrail position using the recommended update factor: two that rely on pre-COVID trends (2015 to 2019 and 2017 to 2019) and one on a more contemporary trend (2022 to 2024). The third scenario, which is based on more recent national trend experience (2022 to 2024) and is a better predictor of future performance supports a robust update for RY 2026. In fact, the estimated savings run rate for this scenario is $810 million, more than twice the CY 2025 savings target of $372 million. Furthermore, MHA's analysis suggests that even after accounting for full funding of age-adjusted demographic growth (with an inclusion of an estimated additional 0.65%) and an additional 0.67% adjustment for inflation, the third scenario would still generate savings ($731 million) well above the CY 2025 target and year-over-year Medicare TCOC growth less than 1% above the nation (Table 1).

Table 1. TCOC Estimate (Scenario 3, 2022 to 2024 Base) *with MHA's Requests*

Scenario 3 Guardrail Projections			
	Maryland	U.S.	
2024	$14,647	$13,365	
2025	$15,603	$14,141	Predicted Variance
YOY Growth	6.5%	5.8%	0.7% Over
Estimated CY 2025 Savings Run Rate			$731 M

Staff also modeled a fourth scenario using the United States Per Capita Cost (USPCC) trend to project the CY 2025 savings and guardrail position. MHA encourages HSCRC to not draw any conclusions about the amount of room for additional hospital revenue growth (or lack thereof) from the USPCC trend given it is not yet clear how USPCC data will be used in the CY 2026 target setting under the AHEAD Model, which staff acknowledged in the draft recommendation.

Finally, MHA recognizes that only the first half of RY 2026 falls within CY 2025. Therefore, HSCRC must also consider CY 2026 savings requirements under the AHEAD Model when determining the update factor. Importantly, as staff noted, all four of the aforementioned scenarios are expected to generate savings in excess of the estimated CY 2026 AHEAD target.

Prospective Adjustment for Inflation

MHA and our member hospitals and health systems are concerned that the proposed inflation update in the draft recommendation of 3.36% will not sufficiently address the exceptional cost pressures hospitals and health systems are facing. We respectfully urge HSCRC to consider providing a 0.67% prospective adjustment to inflation to account for anticipated economic volatility.

S&P Global Insights' inflation forecasts have been consistently conservative in recent years (Table 2). The average relative difference between inflation forecasts and actuals for RY 2023 and RY 2024 was 0.67%. When including RY 2022, the average relative difference over the prior three rate years (2022-2024) is even greater: 1.15%. Though the accuracy of the forecast has improved from year to year, an imprecise forecast for RY 2026 is likely given the high degree of uncertainty in the health care and economic landscapes.

Table 2. Inflation Forecasts vs. Actuals (2022-2024)

	Forecast (HSCRC Funded)	Actual Inflation	Relative Difference
RY 2022	2.57%	4.79%	2.12%
RY 2023	4.06%	5.09%	0.98%
RY 2024	3.35%	3.71%	0.35%
Average Relative Difference (RY 2022, RY 2023, and RY 2024)			1.15%
Average Relative Difference (RY 2023, RY 2024)			**0.67%**

It is important to note that the S&P Global Insights Q1 2025 forecast, the basis for the proposed update, relies on assumptions that may not fully account for the impact of federal policies and tariffs. MHA requests that HSCRC include in its final recommendation the most recent inflation forecasts available at that time and include an additional prospective adjustment to address the economic volatilty and associated cost pressures not accounted for due to conservative forescasting.

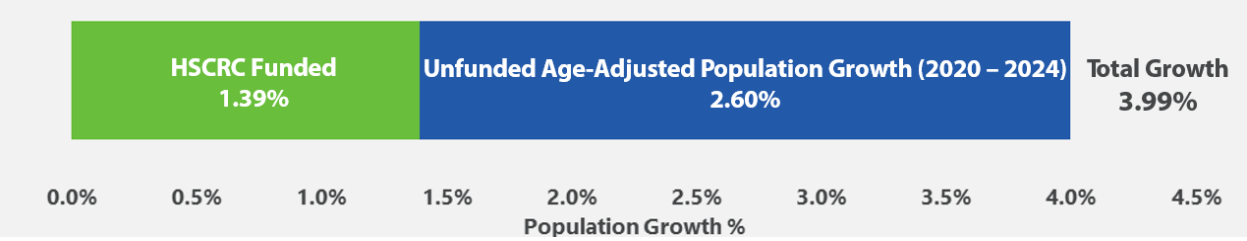
Recognizing the Commission adopted a policy last year that provides a mechanism to address historic over- and underfunding of inflation, hospitals and health systems cannot afford to wait until next July or later for a retrospective adjustment. An adjustment now—rather than relying on a conservative forecast—would better reflect the extraordinary challenges hospitals are facing.

Age-Adjusted Demographic Growth Funding

The draft recommendation includes a proposed 0.76% adjustment for volume to account for revised historical data and population growth estimates from the Maryland Department of Planning. This is a welcomed and important adjustment. It should be noted, however, that this adjustment represents a correction of historic underfunding for demographic growth and is funding that should have been incorporated in prior updates. This correction does not address the underlying underfunding of age-adjusted demographic growth.

The demographic adjustment policy is intended to provide funding increases or decreases to account for anticipated changes in hospital volumes associated with age-adjusted population changes. However, according to data shared by staff at the April 29 Payment Models Workgroup Meeting, an estimated 2.60% in age-adjusted population growth has gone unfunded over the last four years (2020 to 2024), or an average of 0.65% per year (Figure 2). ***This estimate of unfunded age-adjusted demographic growth accounts for the proposed correction. When excluding this proposed correction, the level of underfunding is even higher at 3.63% over the four-year period, an average underfunding of 0.91% each year.***

Figure 2. Unfunded Age-Adjusted Population Growth (2020-2024)



Maryland's population has aged in recent years and is expected to continue aging between now and 2030. The correlation between this aging population and increased utilization of hospital services is clear. Case mix data from 2020 to 2023 shows that there were more inpatient admissions and outpatient visits among the 60 to 64 age cohort and older age cohorts (65 and older) than any younger age cohorts. Generally, the older the patient, the more likely they are to have been admitted to a hospital or visited an outpatient department (Figure 3 and Figure 4).

Additionally, MHA analyzed population growth by age cohort and unrecognized growth in Equivalent Case-Mix Adjusted Discharges (ECMADs) not attributable to market shifts between 2022 and 2023 using Department of Planning and case mix data (Figure 5). The data show that, generally, counties that experienced the largest growth in age cohorts 60 to 79 and 80 and older tend to have the highest amount of unrecognized ECMAD growth.

Figure 3. Maryland Inpatient Admissions per 1,000 by Age Category (2020-2023)

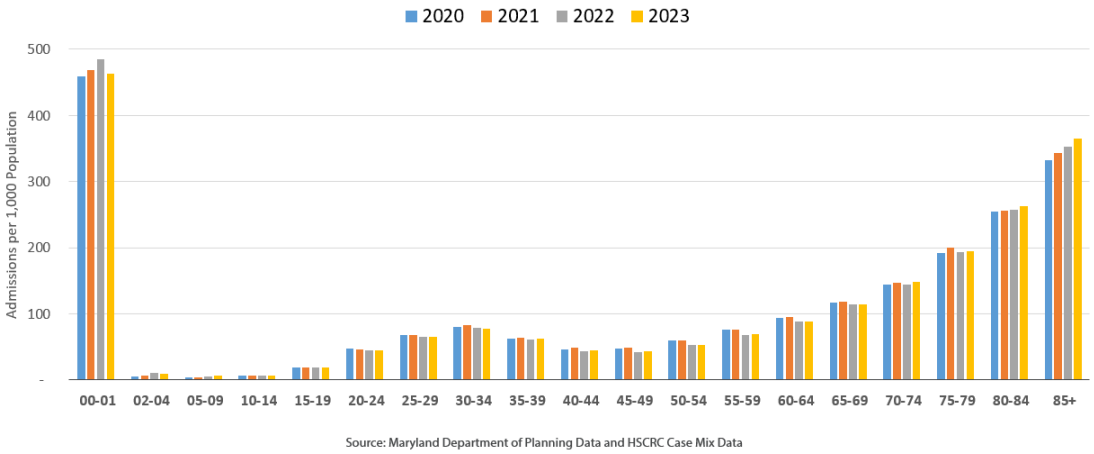


Figure 4. Maryland Outpatient Visits per 1,000 by Age Category (2020-2023)

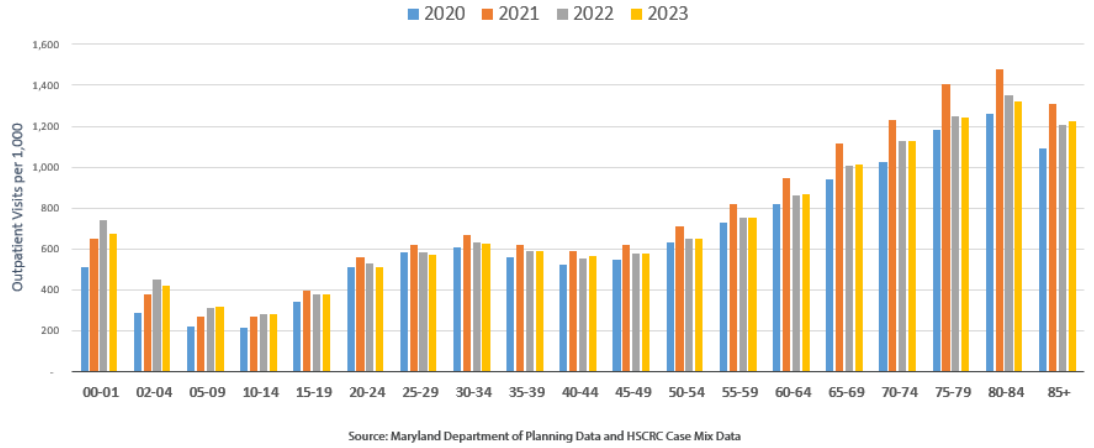
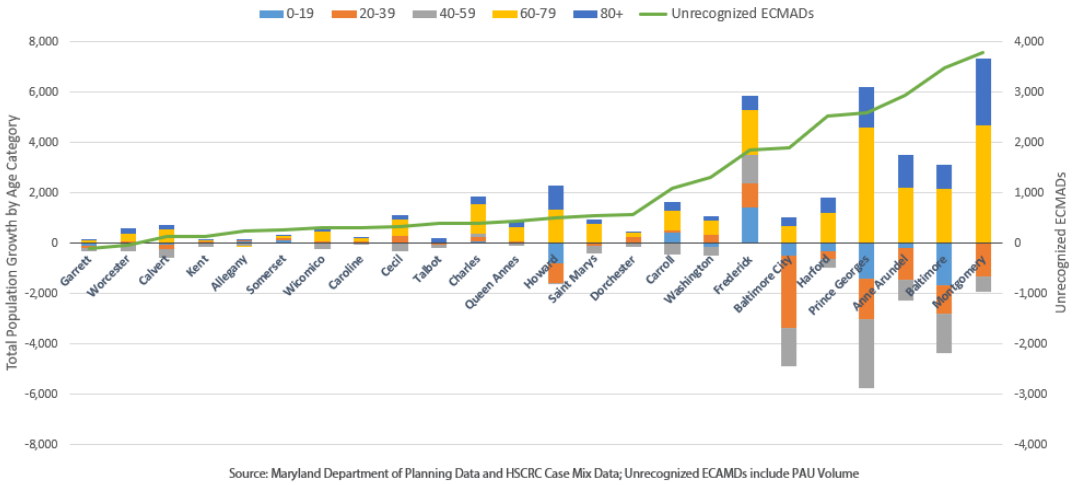


Figure 5. YOY Population Change vs. Unrecognized ECMAD Growth (2023 v 2022)



We ask that HSCRC provide full funding for estimated age-adjusted demographic growth, in addition to funding for overall population growth, this year and going forward. HSCRC should include in the update an additonal 0.65%, which represents the average annual amount of unfunded age-adjusted population growth over the measurement period. This request is consistent with the intent of the demographic adjustment policy.

MHA appreciates HSCRC's interest in collaborating with the field to identify potential refinements to its volume policies, including the demographic adjustment. While we understand the desire to conduct a more comprehensive assessment of the volume policies, hospitals cannot afford to wait for long-term refinements. 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.

Medicaid Deficit Assessment

The Maryland General Assembly approved a $150-million increase to the Medicaid Deficit Assessment for FY 2026 as part of the Budget Reconciliation and Financing Act (BRFA) of 2025 to help cover the increasing cost of the Medicaid program. In light of the financial vulnerability of hospitals and health systems, we respectfully ask that HSCRC pass through the full amount of the increase to the Medicaid Deficit Assessment to payers.

Productivity Adjustment

MHA urges the Commission to continue suspension of the productivity adjustment for non-GBR hospitals in Rate Year 2026. The proposed -0.80% adjustment would lower the inflation update for these hospitals to 2.56%, despite the fact that they are experiencing the same inflationary pressures and contemporary cost drivers as their GBR counterparts. In particular, non-GBR hospitals are confronting challenges with recruitment, retention, and increased compensation of physicians and other staff, which may impact their ability to meet the demand for the specialty services they provide. Moreover, the size of this downward adjustment is at the upper range of productivity adjustments that have been applied in previous years. Applying a lower inflation factor to non-GBR hospitals at this time could create unnecessary financial strain and limit their ability to meet rising costs while maintaining access to high-quality care. Considering the significant and shared challenges across all hospitals, we believe it is important that the annual update be applied equitably and in a manner that supports stability across the full hospital field.

Integrated Efficiency Policy Proposal

MHA supports the recommended modification to the integrated efficiency policy. As staff noted, all hospitals in the fourth quartile of overall efficiency ranking are subject to negative scaling of the update factor or participation in the revenue for reform program under the current policy, regardless of their performance variance from hospitals in the third quartile. The proposed policy modification ensures that hospitals in the fourth quartile are only subject to penalties if they have outlier Inter-Hospital Cost Comparison (ICC) performance. MHA also supports the proposal to use a historical standard deviation, as opposed to a standard deviation that changes over time as the distribution of hospital performance narrows, to identify outlier hospitals.

UCC Fund Revision

MHA supports the proposed correction to the uncompensated care (UCC) fund calculations for RY 2023 to RY 2025. In particular, MHA supports the recommendation to allocate additional funding to hospitals and health systems that were underfunded for UCC and to hold harmless those that were overfunded. As staff note, many of the hospitals that were overfunded are rural and safety net hospitals, and it's important to protect these hospitals from any negative policy adjustment that may jeopardize their ability to care for the vulnerable populations they serve.

Conclusion

MHA sincerely appreciates the time and effort staff have dedicated to the draft recommendation for the RY 2026 update and welcomes the opportunity to work with Commissioners and staff to develop the final recommendation in June. Rate Year 2026 will bring an extraordinary amount of change to Maryland's health care system due to volatility stemming from federal policies coupled with the implementation of a new phase of the Maryland Model. Given these unprecedented circumstances, the Commission has the opportunity to stabalize Maryland's acute care infrastructure to ensure hospitals and health systems can maintain their important mission. We urge the Commission to support both the near-term and long-term financial stability of Maryland hospitals.

Thank you for the opportunity to comment on this crtitical issue. 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
Nicki McCann
Dr. Farzaneh Sabi

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CORPORATE OFFICE

May 21, 2025

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2026 Update Factor

Dear Jon:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I am submitting comments in response to the Health Services Cost Review Commission's ("HSCRC") Draft Recommendation for the Update Factor for Rate Year 2026. We appreciate the time spent by Commission Staff developing the recommendations with the industry.

This year's 5.68% update factor recommendation includes large adjustments that are unrelated to base inflation including demographic volume changes (1.5%), UCC fund revisions (0.3%), and the state-mandated increase in the Deficit Assessment (0.7%). We support the Staff's recommended policy solutions to address revisions to state population estimates and correct historical Uncompensated Care ("UCC") funding errors, however it is important to hold those necessary adjustments aside and focus on the current recommendation of providing a 3.36% inflationary update based on S&P Global Insights forecasts. As I will discuss further in this letter, UMMS supports the Maryland Hospital Association's ("MHA") request for consideration of an additional 1.32% as well as the requests to ensure the increase to the Medicaid Deficit Assessment is neutral to hospitals and to suspend the proposed -0.8% productivity adjustment for non-GBR hospitals.

UMMS is committed to driving the AHEAD Model's goals of expanding access to high-value care and improving outcomes in the communities we serve. Throughout our time on the Total Cost of Care Model, we have committed to being a leader in implementing valid, data-driven efforts to identify health needs and working in partnership within our communities to address them. In our responses to the HSCRC's call for input on positioning Maryland for success under the AHEAD Model in February 2025, we emphasized that hospitals must come from a position of financial stability to maximally engage in those transformative goals of the Model. Providing appropriate resources to ensure access to medically necessary services, to address workforce shortages and inflationary pressures, and to address capital needs are core enabling factors to achieve Model goals, and the Commission, in its annual update factor decision, should prioritize providing sufficient resources to address these needs.

This is true now more than ever, as we find ourselves in incredibly uncertain times. The hospital industry, after absorbing years of depressed operating performance, is well behind in terms of investing in critical facility needs, program improvements, innovative technology and population health strategies. New uncertainties around federal policy and funding decisions compound the problem. Now is the time to infuse resources to address the persistent financial pressures that we continue to bear as a hospital industry. The prolonged inability to make needed investments absolutely puts us behind in AHEAD preparedness and produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services.

At the same time, the Maryland Model is generating unprecedented excess savings to Medicare, generating nearly $800 million savings in CY2024, an annual run rate that is nearly $300 million beyond what is required for CY2026, year 1 of the AHEAD Model. We agree with MHA's analysis showing that even after funding an additional 1.32% Maryland will still have significant excess savings. I cannot emphasize enough that resource-starved hospitals will not achieve the transformation envisioned by AHEAD. These savings levels represent lost resources that could otherwise have provided the stabilizing force necessary for success, and it is appropriate for at least a portion of this excess savings to be redirected into the continuous transformation of the Model. This truly is a critical period in terms of setting the foundational framework for the next ten years of our Model, and the strength of our Model is we can address this in a way that is unachievable under payment models in other States.

UMMS again offers its support of the recommendations outlined in the MHA's comment letter and appreciates the opportunity to offer the following specific commentary on the HSCRC's Draft Recommendation for the FY2026 Update Factor:

The Maryland Model must proactively keep pace with inflation pressures

UMMS agrees with the MHA's recommendation to consider a prospective inflationary adjustment to address known cost pressures that are on the horizon that are likely underrepresented by the current S&P Global Insights market basket growth forecast of 3.36%. Rising physician and staff costs, medical staff liability costs, cybersecurity costs, the impact of tariffs, and the many threats of reduced federal funding are several examples of the immediate challenges that hospitals face. The sheer number and variety of negative cost pressures in the immediate future significantly increases the likelihood that the 3.36% inflation allowance contemplated by the draft recommendation is likely conservative and warrants a prospective adjustment. For the same reasons, considering the known cost pressures and the uncertainty of the federal funding environment, it is not in the State's best interest to carry any known underfunded inflation forward into the future. The Commission should consider MHA's request or alternatively waive the 1% threshold for addressing cumulative underfunding and release the remaining 0.52% cumulative difference from the 2014 base.

The annual demographic adjustment methodology should be risk-adjusted

UMMS believes that appropriately accounting for the impact of demographics on hospital global budgets must appropriately account for the risks associated with an aging population, which the current Demographic Adjustment methodology fails to do. While UMMS continues to believe the Staff should engage the industry in a comprehensive volume policy evaluation, we agree with the MHA's recommendation to fund age-adjusted growth as an appropriate step in the FY2026 Demographic Adjustment.

UMMS supports the recommended changes to the Integrated Efficiency policy, but a more comprehensive evaluation is needed

UMMS has been consistent in its AHEAD policy commentary that we must comprehensively rethink hospital efficiency policies based on the driving characteristics of an effective hospital in the context of the AHEAD Model. The goals of high-value care, fairness in access to care, and better outcomes require significant, differential investment in our highest need communities, and this need for differential investment funds cannot be labelled as inefficiency. Until a more comprehensive process to define an "effective" hospital in the context of AHEAD goals and a rethinking of policy with an intention to hold hospitals directly accountable to that definition is undertaken, UMMS supports the Draft Recommendation's proposed changes to the Integrated Efficiency methodology.

Do not apply a 0.8% productivity adjustment for non-GBR hospitals

The proposed 0.8% productivity adjustment, which represents a nearly 24% reduction in overall inflation allowance for non-GBR hospitals, would be financially crippling for specialty hospitals that provide needed services, such as psychiatric care, neonatal care, and acute rehabilitation, for typically safety net populations. Many of the specialty facilities have endured multiple years of financial hardship as they absorbed the significant disruptions of the COVID-19 pandemic without the benefit and stability of a fixed revenue base. For example, UM Mount Washington Pediatric Hospital ("UM MWPH"), which provides step-down neonatal services for a population that is 80% Medicaid and Self Pay, has experienced negative operating margins in every year since FY2022. We acknowledge and appreciate that HSCRC Staff has worked with hospitals like UM MWPH through the pandemic to provide temporary financial relief, and we continue to discuss with Staff the drivers of ongoing hardship. The most immediate positive action to protect this safety net care is to eliminate 0.8% productivity adjustment contemplated in the draft recommendation.

Because we serve so many communities in so many ways, UMMS is deeply invested in the success of the Maryland Model, and we believe strongly that the Commission must act proactively in the face of such uncertainty to provide hospitals with the appropriate resources to ensure access for Maryland and achieve the Model's value-based goals. This truly is a critical period in terms of setting the foundational framework for the next ten years of our Model. UMMS looks forward to collaborating with our State partners to work toward the broader goal of improving the health of Maryland citizens.

Sincerely,

Mohan Suntha, MD, MBA
President and Chief Executive Officer
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Maulik Joshi, DrPH
Ricardo Johnson
Nicki McCann, JD
Farzaneh Sabi, MD
Jerry Schmith, Principal Deputy Director
Allan Pack, Principal Deputy Director

LIFEBRIDGE HEALTH®

CARE BRAVELY

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

May 21, 2025

Dear Jon,

LifeBridge Health appreciates the opportunity to comment on the Staff recommendation for the Rate Year (RY) 2026 Annual Payment Update. We are supportive of the Maryland Hospital Association and field position that requests additional funding, recognizing that large portions of the current update factor revenue increase do not directly benefit all hospitals, most notably the deficit assessment increase. We are also supportive of the recommendation to correct the demographic adjustment but continue to advocate for an improved mechanism to risk adjust patient populations (noted in our April 24th comment letter to Mr. Pack).

Additionally, in light of information shared by the Centers for Medicare & Medicaid Innovation (CMMI) suggesting the uncertainty of Maryland's Medicare Waiver; projected performance on the statewide savings target, as well as our previously mentioned concerns over methodology, we request consideration of suspending any Integrated Efficiency Policy penalties planned for Rate Year 2026.

While we appreciate Staff's collaboration in evaluating and correcting the demographic and uncompensated care policies, instituting further rate reductions related to an efficiency standard on hospitals at a time when Medicare savings have been acknowledged by HSCRC to be $800M – almost $300M more than the base year savings required for Maryland's transition to the States Advancing All-Payer Health Equity and Development Model (AHEAD) —is unnecessary and removes critical revenue that needs to be directed to operational changes that will be necessary under either an AHEAD model construct or Prospective Payment System.

Please do not hesitate to reach out if you would like to discuss any of our recommendations.

Sincerely,

David Krajewski
EVP & CFO, LifeBridge Health

cc: Joshua Sharfstein, M.D., Chairman
Allan Pack, Principal Deputy Director, Quality and Population Based Methodologies
Jerry Schmith, Principal Deputy Director

Luminis Health

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May 21, 2025

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

Dear Dr. Kromm,

I am writing on behalf of Luminis Health (LH) to provide comments on the Health Services Cost Review Commission (HSCRC) staff's draft recommendation for the annual update factor for rate year 2026. We appreciate the time, analysis, and effort that informed this proposal. However, LH remains concerned that the recommended updates are too conservative considering historical underfunding, excess savings, and the current economic and political volatility.

It is important to recognize that, although the proposed update factor appears relatively high compared to prior years, much of the increase is attributable to the rise in the Medicaid Deficit Assessment, which offers no financial benefit to hospitals, as well as corrections to demographic and uncompensated care calculations from previous rate years. Per the HSCRC, the state is on track to generate $795M in cumulative Medicare TCOC savings through CY24, which is $460M in excess savings. Given the excess savings generated under the model to date, we believe there is an opportunity to offer hospitals meaningful rate relief to help address ongoing cost pressures and support stability in Maryland healthcare.

Inflation Funding

Recent trends show that inflation estimates from S&P Global Insights, used by the HSCRC, have regularly fallen short of actual inflation rates. According to the Maryland Hospital Association's review, the discrepancy for Rate Years 2023 and 2024 averaged 0.67%, and increased further when including Rate Year 2022. This pattern suggests that relying solely on forecasted figures risks underfunding hospitals yet again.

Healthcare providers, including Luminis Health, continue to operate in a challenging financial environment marked by rapidly rising labor costs, supply chain issues, and broader economic pressures. These conditions are expected to persist. Meanwhile, the current inflation forecast used in the draft update may not fully reflect the potential effects of federal policy changes, trade shifts, or other emerging economic dynamics.

While we recognize the Commission's efforts to reconcile past inflation shortfalls through retrospective adjustments, hospitals cannot wait until future rate years for relief. A modest prospective adjustment now would help ensure hospitals have the financial resources they need to maintain access to care and meet community needs during this period of economic uncertainty.

Luminis Health

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Luminis Health, along with the Maryland Hospital Association and other health systems, is concerned that the proposed 3.36% inflation update for FY 2026 does not go far enough to address the real and growing cost pressures hospitals are facing. We recommend that the Health Services Cost Review Commission (HSCRC) incorporate a 0.67% prospective adjustment, noted above, to account for ongoing economic uncertainty and the limitations of inflation forecasting models.

Demographic Adjustment

Luminis Health appreciates and supports the inclusion of the HSCRC staff's proposed 0.76% demographic correction related to revised historical population growth estimates from the Maryland Department of Planning. It's important to recognize this adjustment as a correction of prior underfunding that should have been received in prior rate years and should not be viewed as relief for ongoing financial challenges when considering the overall Annual Update recommendation.

Unfunded age-adjusted population growth remains a key issue facing Maryland hospitals. Luminis Health supports the MHA recommendation to provide an additional 0.65% demographic adjustment derived from taking the average unfunded growth from 2020 to 2024 from HSCRC data shared in the Payment Models Workgroup. We request that full funding for age-adjusted demographic changes be built into policy moving forward.

At Luminis Health, we are directly experiencing the impact of these demographic trends. We have seen measurable increases in inpatient admissions and outpatient visits among older age cohorts, particularly those aged 60 and above. This trend is consistent with state-level case mix data showing that hospital utilization increases significantly with age. The reality is clear: as our communities age, the need for hospital services rises—and so must the funding to support it.

UCC Fund Correction

Luminis Health supports the proposed correction to the Uncompensated Care (UCC) calculation used to determine funding for Rate Years 2023 through 2025. We commend the approach of allocating additional funding to hospitals that were underfunded, while holding harmless those that received excess funding.

Productivity Adjustment

Luminis Health strongly encourages the HSCRC to continue suspending the productivity adjustment for non-GBR hospitals in Rate Year 2026. This adjustment would directly affect our specialty hospital, J. Kent McNew Family Medical Center, which delivers essential behavioral health services aligned with the state's population health goals and priorities.

J. Kent McNew Family Medical Center, like acute care hospitals, is contending with significant financial pressures, yet receives lower reimbursement for behavioral health services—services that are critically needed by some of the state's most vulnerable populations. Applying the proposed –0.8% productivity adjustment would reduce the inflation update for these hospitals to 2.56%, further intensifying financial challenges and potentially undermining access to vital care.

Luminis Health

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Medicaid Deficit Assessment

In line with the MHA recommendation, Luminis Health requests the entirety of the $150 million increase to the Medicaid Deficit Assessment be funded in GBR and therefore passed through to payers. Before additional assessments are imposed on hospitals, the state must evaluate the Medical Loss Ratios (MLRs) and profit collars for Medicaid Managed Care Organizations (MCOs).

Rising denial trends from MCOs in recent years are another area of concern. Several MCOs have increased their denial rates to improve their margins and pass expenses on to hospitals. Luminis Health collected an average of 81% of charges on FY24 discharges from MCOs despite the HSCRC-mandated rate of 92.3%. This shortfall of $14 million, paid by taxpayers intended for patient care, should be explored statewide before increases in the hospital portion of the Deficit Assessment are considered.

To address the structural issues within the Maryland Medicaid program and ensure long-term sustainability, Luminis Health recommends the following reforms:

- Implement oversight of MCO financial performance beyond existing MLR penalties, including the potential adoption of profit collars that return excess margins above a defined threshold to the Medicaid program.
- Re-evaluate the integrity and enforcement of Medical Loss Ratio reporting and threshold compliance.
- Establish a recurring MCO procurement process (every 3–5 years) with a limit of no more than three participating plans to reduce administrative burden on providers and promote greater accountability in claims and denial management.
- Consider enacting an "Any Willing Provider" law to minimize out-of-network barriers, prevent care disruptions, and reduce avoidable payment denials.

In summary, Luminis Health respectfully requests that the HSCRC take the following actions in its final FY 2026 update factor recommendation:

- Include a 0.67% prospective inflation adjustment to account for persistent economic volatility and the historical underestimation of inflation.
- Provide funding for age-adjusted demographic growth of 0.65% to address the average annual underfunding from 2020 to 2024.
- Sustain the staff recommendation for corrections to uncompensated care funding.
- Continue suspension of the productivity adjustment for non-GBR hospitals, to ensure stability for specialty providers like the J. Kent McNew Family Medical Center.
- And pass the full $150 million Medicaid Deficit Assessment increase through to payers.

We are grateful for HSCRC's thoughtful and transparent approach to policymaking and for the opportunity to offer feedback on the draft recommendation. We also thank the HSCRC staff for their time, data analysis, and engagement with stakeholders throughout this process.

Thank you again for the opportunity to comment and for the continued efforts to support a fair, sustainable, and equitable rate-setting system for all Marylanders.

Luminis Health

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

Sincerely,

Stephanie Schnittger
Chief Financial Officer

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

Frederick Health

400 West 7th Street
Frederick, MD 21701

240-566-3300

May 21, 2025

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

Dear Dr. Kromm,

On behalf of Frederick Health, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Rate Year 2026 Annual Payment Update. We appreciate the Commission staff's efforts to engage stakeholders throughout this process and to propose an update that recognizes the financial pressures Maryland hospitals continue to face.

As a sole community provider in a rapidly growing county, we are experiencing sustained challenges related to inflation, demographic changes, and contemporary cost drivers, specifically hospital based provider coverage subsidies. These challenges continue to place significant strain on our ability to meet patient needs, invest in care improvements, attract and retain skilled staff, and maintain financial stability.

We support the comments submitted by the Maryland Hospital Association and offer the following specific feedback and local context from our organization:

Support for a Meaningful Update Factor

We urge the Commission to provide a robust update factor that fully accounts for the following:

- **Unfunded Age-Adjusted Demographic Growth**: Our hospital has seen 14.03% Age and PAU adjusted growth between 2020 and 2025, nearly three times the statewide average. The current methodology scaled the 14.03% down to 4.17%, which while higher than in previous years, is still 10% lower and does not reflect the increased costs to care for growth in the older age categories. While we understand the desire to conduct a more comprehensive assessment of the volume policies, Frederick has faced significant financial hardship over the past four years that could have been mitigated by bridging the gap between the age adjusted growth and the final scaled demographic update.

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.

- **Inflationary Pressures**: Frederick has experienced inflation well above the current projection. The MHA comment letter demonstrates that the three prior years estimates were conservative. Frederick agrees with MHA's recommendation that HSCRC should include in its final recommendation the most recent inflation forecasts available at that time and include an additional prospective adjustment to address the economic volatility and associated cost pressures, including the impact of federal policies and tariffs, not accounted for due to conservative forecasting.

- **Medicaid Deficit Assessment Pass-Through**: We ask that HSCRC ensure the $158 million increase is covered by payers and does not result in a direct financial hit to hospitals.

Our Hospital's Financial Context

Frederick Health has been working to stabilize its financial footing in the face of mounting pressures:

- Incorporated $14M of operational improvements into the FY25 budget in addition to funds awarded through the set-aside adjustment
- Deferred capital projects due to constrained days cash on hand, on both main campus and ambulatory settings that would improve access and quality. Frederick is projecting to have 132 days cash on hand for FY25 which is below national benchmarks.
- Fitch rating agency downgraded Frederick Health in February 2025 from BBB+ to BBB which will have future impact on cost of capital

Key Cost Drivers Impacting Our Hospital

We would also like to highlight the following cost drivers affecting our operations:

- **Rising Physician and Other Staffing Costs**: MHA noted that one of the most critical and growing drivers of labor cost is physician coverage. As shared previously, Frederick Health hospital based provider costs net of provider billings has doubled from $9M pre-COVID to greater than $18M in FY25. Frederick continues to be willing to work with staff on a policy driven approach to properly account for these costs within the regulated setting. In the meantime, waiting 2.5 years for such a policy puts our financial condition and ability to maintain 24/7 access to critical services for Frederick residents at risk.

- **Rising Denials**: Some common issues Frederick Health is experiencing are leading to denials and delays in payments:
    - Automatic downcoding of ED services across commercial and Medicaid MCOs
    - Delayed discharge of inpatient and observation patients due to lack of space at SNFs and other community resources
    - Delayed authorizations and workflow interruptions due to the transition from Optum to Carelon for Medicaid Behavioral Health carveout services
    - Denial of payments due to lack of coordination between Medicaid MCOs and Behavioral Health on payment for covered services
    - Medicaid takebacks for third-party liability claims years after services were provided
    - Automatic denial of ancillary charges for denied inpatient days by Medicaid MCOs without a medical necessity review
    - Increased medical necessity denials from Medicare Advantage payers, ignoring the Medicare 2-midnight rule

    These issues, coupled with various other denial reasons, are leaving Frederick Health underpaid for medically necessary care we are providing to our patients and community. In addition, the administrative burden of response to denials has forced the need for increased external contracted services.

- **Cybersecurity**: Frederick Health has been impacted by two cyber attacks within the past two years. While cyber insurance covers certain costs, the significant and delayed impact to the revenue cycle and collectability of patient claims is uncertain. The costs to increase cyber security through resources and technology will push annual spend in excess of $3M in FY26 and beyond. These are real and growing expenses that are not adequately covered under the current system and must be factored into the RY 2026 update.

Conclusion

We ask the Commission to recognize the financial realities hospitals are facing and to finalize an annual update that reflects actual cost growth, funds age adjusted demographic changes, and protects hospitals' ability to care for their communities. We thank the Commission for its continued leadership and stand ready to provide any additional data or context to support this process.

Sincerely,

Hannah Jacobs
Sr VP / CFO
Frederick Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Thomas Kleinhanzl, President & CEO, Frederick Health
Dr. Cheryl Cioffi, Executive Vice President, Chief Administrative Officer

Sheppard Pratt

May 16, 2025

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

Dear Mr. Kromm:

In its draft recommendation for the proposed update factor for RY2026, the HSCRC staff has recommended an update factor for the Global Budget Revenue (GBR) hospitals along with a different, lower update factor for the non-GBR hospitals in the State. For RY 2026, HSCRC staff is proposing an update of 2.56% per capita for non-global revenues without additional inflation support and inclusive of a productivity adjustment of -.8%. This letter, written on behalf of Sheppard Pratt, requests that the HSCRC provide an update factor to the non-Global Budget Hospitals equivalent to the GBR hospitals or 3.36% without the productivity adjustment. Sheppard Pratt also requests the same funding that the GBR hospitals get with respect to additional inflation support.

Hospitals under Global Budget Revenues are under the HSCRC's full rate-setting authority, and the Commission sets rates for all payers. For specialty hospitals not covered under the waiver, the HSCRC sets the rates paid by non-governmental payers and purchasers. Where CMS has not waived Medicare's rate-setting authority to Maryland, Medicare does not pay based on those rates. Medicaid also does not pay regulated rates. Hospitals falling in this category include freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

In the staff recommendation for the non-GBR hospital update factor, the HSCRC staff proposes suspending the productivity adjustment to the inflation update but does not include additional inflation support. The proposal is summarized in the table below, from the staff proposal.

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.36%	3.36%
Productivity Adjustment	N/A	-0.80%
Additional Inflation Support	0.00%	0.00%

Proposed Inflation Update	3.36%	2.56%

The Commission began providing lower update factors to the non-waiver hospitals with the FY2013 update factor. At that time, the Commission decided to reduce the update factor with a productivity adjustment of 0.5 percentage points below the market basket of 2.59%, leaving an update of 2.09%. While there was no stated justification beyond the imposition of a productivity factor, the apparent implication was that the non-waiver hospitals were not constrained by the terms of the waiver and in later years by the incentives of the Global Budget Revenue model.

These negative adjustments continued through FY2020, and the cumulative effect of these diminished updates are substantial. From FY2013 through FY2020, the cumulative effect of these reductions is >6% of the revenue base, based on the quantity of services provided in FY2013 as the base year. The productivity factor is put into place with the presumption that providers will drive volume growth to improve margins. HSCRC has recognized in recent years that this limits providers ability to maintain access to services and has suspended the productivity adjustments which has allowed Sheppard Pratt to not lose additional ground on reimbursement.

In rate year FY26, the exclusion of the specialty hospitals from the underfunded inflation adjustment is especially concerning. Demand for psychiatric services has never been higher and Sheppard Pratt provides services that are unique in the market to an underserved, chronically acute population. Sheppard Pratt has experienced rising cost pressures over the past several years like the other Maryland hospitals and health systems. In many ways, Sheppard Pratt is less equipped than other health systems to manage the same cost pressures due to lower reimbursement for behavioral health services and receiving reduced reimbursement from our largest payers, Medicaid and Medicare. Labor and benefit costs drive the greatest expense increases, and the broader workforce environment leaves Sheppard Pratt with higher position vacancies and dependent on higher levels of agency staffing than ever before. This has limited capacity of services in recent years. Sheppard Pratt remains focused on maintaining services and staffing levels that support the broader community, including the acute care hospital systems in Maryland. Providing rate updates to Sheppard Pratt that are below the GBR hospitals creates a reimbursement parity issue that will be compounded over time, and which is not in alignment with the state's focus on creating access to behavioral health services.

We respectfully request that the Commission provide the non-GBR hospitals an update factor equivalent to the GBR hospitals. We appreciate your consideration of our request. Please contact me if you have any questions.

Sincerely,

Sheppard Pratt

Kelly Savoca
Senior Vice President and Chief Financial Officer

Mt. Washington
Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

May 21, 2025
Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: MWPH Comment Letter on Draft Staff Recommendation for the FY 2026 Update Factor

Dear Mr. Kromm,

On behalf of Mt. Washington Pediatric Hospital, I am submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2026.

The current HSCRC recommendation includes a productivity adjustment of -0.80% for Mt. Washington Pediatric and the other non-global budget hospitals.

I am writing to ask that Mt. Washington be provided the full update factor provided to the global budget hospitals, currently projected at 3.36%.

As you know, MWPH admits medically fragile children who no longer need acute care services, but cannot yet go home. The acute care hospitals depend on MWPH to admit these children so that they keep beds available for patients who need NICU and PICU care. Transfers to MWPH reduce overall costs, as it is less expensive to treat children here than in these acute care settings.

However, MWPH is subject to the same inflationary pressures as acute care hospitals, particularly for salaries. Nursing shortages, and the challenge of keeping up with market salary rates, have slowed the hospital's return to pre-covid inpatient volumes. The productivity adjustment will further hinder our efforts to match market salaries, and therefore limit admissions.

Referrals decreased in the past few years partly because wait times for admission grew as MWPH struggled to staff nurses. As MWPH has been able to hire more nurses, wait times have decreased and inpatient days have increased. Also, MWPH continues to work with acute care hospitals to target additional populations for its care. Even as low birthweight births have declined, admissions to MWPH of infants born at less than 25 weeks gestation have significantly increased. For these and other vulnerable pediatric populations, the acute care hospitals look to Mt. Washington as a crucial partner in their efforts to reduce unnecessary volume and cost, by assuring that services are provided in the appropriate, lowest-cost setting.

Mt. Washington
Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

The productivity adjustment is designed to serve as an incentive to move care from inpatient to outpatient or other settings, however the medically complex children that MWPH admits as inpatients are a particularly vulnerable population. The hospital's work is already overseen by insurers, who typically review inpatient cases to assure that admissions are clinically appropriate and inpatient stays do not last longer than is medically necessary. The -0.80% productivity adjustment would not serve to limit length of stay or readmissions, instead, it would hinder our ability to retain and recruit clinical staff in a competitive market thus making it difficult to accept patients. Ultimately, this drives up Medicaid costs and hospital costs.

The hospital lost $4.4 million on operations in FY 2024, is on track to lose $2.0 million on operations in FY 2025, and is projecting a loss of $1.5 million on operations in FY 2026. A rate increase at less than the inflation factor would further threaten the hospital's ability to provide access to this specialty care.

For these reasons, we request that Mt. Washington Pediatric Hospital receive the same inflation support as the global revenue hospitals.

I appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Scott Klein, MD, President and CEO
Mt. Washington Pediatric Hospital
Cc: Joshua Sharfstein, MD, Chairman

James Elliott, MD, Vice Chairman
Nicki McCann, JD
Maulik Joshi, DrPH
Farzaneh Sabi, MD
Ricardo R. Johnson
Adam Kane
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Joe Hoffman, UMMS, Interim CFO
Alicia Cunningham, UMMS, SVP

MedStar Health

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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 21, 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 to comment on the Health Services Cost Review Commission (HSCRC) staff recommendation regarding the annual update factor for hospital Rate Year 2026 presented during May 14, 2025, public Commission meeting. MedStar appreciates the opportunity to comment on this critical topic and is committed to working in collaboration with Commissioners, staff, and other stakeholders to develop the final recommendation.

Maryland hospitals continue to confront challenging financial conditions and unprecedented cost pressures. As a result, Maryland hospital and health system financial health has eroded and underperformed across key financial metrics when compared to national peers and widely accepted industry benchmarks as outlined in the Maryland Hospital Association's comment letter. The erosion of Maryland hospitals and health systems financial health has occurred while the Rate Setting Model generated hundreds of millions of dollars in excess savings. In 2023, Maryland generated $509 million of Medicare Total Cost of Care (TCOC) savings, $209 million above target. In 2024, the HSCRC reports $795 million of estimated Medicare TCOC savings, approximately $460 million above target. These excess savings were generated largely on the backs of hospitals and health systems by constraining patient care revenues and generating financial benefits to payors. **With the expected transition to a New Model in 2026, now is the time to address the inadequacy of hospital global budgets and the under resourcing of Maryland's hospitals. We strongly urge the Commission to take meaningful and permanent action to stabilize the financial health of Maryland's hospitals and ensure continued health care access for Marylanders.**

MedStar supports Maryland Hospital Association's request for an additional 1.32% above the staff's RY 2026 annual update factor recommendation.

- Provide a prospective inflation adjustment of 0.67% in addition to the S&P Global Insights' Q1 2025 estimated inflation of 3.36% for RY 2026.

- Provide additional funding for demographic changes and age-adjusted population changes which have been underfunded by 2.6% over the last four years and increase the demographic adjustment for RY 2026 by at least 0.65% above staff's draft recommendation.
- In recognition of hospital and health system financial vulnerability, pass through the full responsibility for the $150 million increase to the Medicaid Deficit Assessment in RY 2026 to the payors who have benefitted from the excess savings under the Maryland Model.

We appreciate the policy actions taken in RY 2025 by the staff and Commission in recognition of the cost pressures faced by hospitals relating to high-cost outpatient drug growth, the respiratory patient volume surges, and the set-aside funding for hospitals with demonstrated financial hardship. However, the majority of the additional funding made available to hospitals was one-time in nature and will reverse out of hospital rates in RY 2026 leaving hospitals once again under resourced. The draft recommendation brought forward by staff for the RY 2026 payment update includes adjustments made in good faith to address some demographic underfunding caused by census data errors; however, the HSCRC staff's proposal is largely consistent with the historical conservative approach. Given the magnitude of TCOC savings being generated, the financial health of Maryland's hospitals, and the need to provide stability in anticipation of the transition to the new demonstration model, a conservative approach to the RY 2026 update factor is unwarranted. At this moment, the Commission should prioritize its commitment to fully funding inflation and demographic change, two key pillars of the model and the Global Budget Revenue system.

The proposed revision to the Integrated Efficiency Policy included as part of the RY 2026 update factor recommendation is a welcome change brought forward by staff and creating symmetry in the policy is appropriate.

MedStar supports the staff recommendation to modify the current Integrated Efficiency Policy so that only hospitals who are both in the fourth quartile and are identified as an inefficient outlier based on Inter-Hospital Cost Comparison (ICC) performance are subject to revenue reductions or safe-harboring revenue through the Revenue for Reform policy. This revision creates symmetry in the policy in the application of revenue adjustments for both high performing and low performing hospitals.

In addition, MedStar encourages staff to convene a workgroup to collaborate with industry stakeholders on further revisions to the efficiency policy and underlying methodologies. Additional topics should include the accuracy of the labor market adjustment, regulated profit strip, and direct expense adjustment as it pertains to the additional costs of trauma programs.

MedStar supports HSCRC staff's proposed correction to the uncompensated care fund calculations for RY 2023, RY 2024, and RY 2025 and holding harmless those hospitals and health systems that were overfunded during the period.

MedStar appreciates staff's acknowledgement that hospitals and health systems developed operating budgets in 2023, 2024, and 2025 based on information provided by the HSCRC calculating hospital UCC payments/receipts and implementing a revenue reduction to hospitals who were overfunded in this period would penalize them for relying on HSCRC information. Additionally, MedStar agrees with HSCRC staff's reasoning that many of the hospitals that were overfunded during the period were rural and safety net hospitals who should be protected against unanticipated revenue reductions which may jeopardize their ability to care for vulnerable patient

populations. Given Maryland's TCOC savings position in 2024 and projected savings in 2025, allocating additional funding to hospitals to rectify UCC underfunding from 2023-2025 is the most appropriate avenue to pursue. MedStar seeks clarification on the mechanics of this funding allocation, specifically whether it will flow through hospital rates as a one-time adjustment in RY 2026.

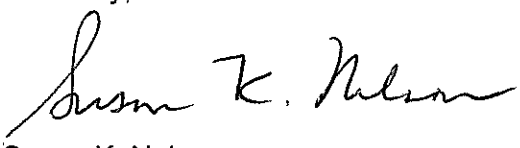
MedStar seeks clarification on the FY 2025 set-aside reconciliation presented in Appendix I of the RY 2026 update factor draft recommendation.

HSCRC staff provided a reconciliation showing the distribution of the FY 2025 set-aside, originally approved to be $31.7 million, totaling $80.4 million as part of the RY 2026 update factor draft recommendation. This funding distribution is reported to be split with $10.9 million of set-aside funding distributed permanently to hospitals who qualify based on Integrated Efficiency and $69.6 million distributed to hospitals based on financial hardship as one-time funding, to be reversed out of rates in RY 2026. While the Commission approved $31.7 million of permanent hospital funding in the RY 2025 update factor through the set-aside, only $10.8 million of this was distributed to hospitals permanently per the reconciliation in Appendix I. MedStar seeks clarification around this $20.9 million difference and how staff are accounting for this in the RY 2026 update factor.

Summary & Conclusion

MedStar appreciates staff's efforts and the time they have dedicated to the RY 2026 update and their collaborative approach in working with the industry in its development. MedStar welcomes the opportunity to continue working with Commissioners and staff to develop the final recommendation for Rate Year 2026, a year in which an extraordinary amount of change to Maryland's healthcare landscape is anticipated. MedStar urges the commission to act now to stabilize Maryland's acute healthcare infrastructure and ensure the financial health of the state's hospitals both in the short-term and long-term. The health of Marylander's and their ability to access needed care depends on it. Again, thank you for the opportunity to provide comment on this issue. If you have any questions or wish to discuss any of the above further, please do not hesitate to reach out.

Sincerely,



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

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

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

May 21, 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) staff's presentation on the draft update factor for fiscal year 2026.

The purpose of the Medicare guardrail test in the Total Cost of Care (TCOC) model is to protect consumers from exorbitant price increases on a year-over-year basis. It was clear in the contract that cumulative savings are important, but year-over-year spikes would not be tolerated. The Commission's actions over the last 12 months reflect a disturbing tendency to forego traditional practice and prioritize hospital financials over consumers. As shown in the table below, the Commission has authorized more than half a billion dollars in extra funding to hospitals over the past year.

Month	**$ Amount**	**Description**
June 2024	~$200M	"Catch-up" inflation (a retrospective adjustment in a prospective payment system)
Nov 2024	~$51M	Increase to "set-aside" funding
Dec 2024	~$50M	Permanent adjustment to support staffing needs through increases to regulated margins
Dec 2024	~$100M	Adopted new materiality thresholds on volume policies that diminished impact
Mar 2025	~$140M	RSV surge funding that did not follow typical stakeholder engagement process
Total	**$541M**	**Roughly 2.7% in incremental funding**

The Commission has made these accommodations for hospitals without adequately considering their impact on consumers. While we recognize hospitals have struggled with cost pressure, and thus have experienced depressed margins, Marylanders have experienced the same – pandemic related disruptions, inflation, and now job-loss and economic uncertainty. The state and CMMI committed to guardrails to ensure the Commission gets the balance right.

In Tables 6a through 6d in the recommendation, the staff shows Maryland's estimated performance on the guardrail under four different scenarios. The proposed update factor fails in all four. On average, it fails by more than 1%, which would be a triggering condition for the TCOC model. Rather than leveraging these tests to adjust the recommendation and strike the right balance between affordability for consumers

and appropriate funding for hospitals, the staff disregards the results. The Commission should not be selective about following its methodologies.

We oppose the staff's recommendation for the reasons described above and we urge the Commission to stick to its methodologies and work intentionally to center Marylanders in policymaking. 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

Adventist HealthCare

May 21, 2025

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

Dear Dr. Kromm

Thank you for the opportunity to comment on the HSCRC's Draft Recommendation for the Rate Year 2026 Annual Update Factor. We appreciate the extensive work by Commission staff and your openness to stakeholder input throughout the rate development process. **We write to express our appreciation for the overdue technical corrections included in the draft update, while also voicing concern about the implications of delayed policy corrections and structural complexity for the long-term sustainability of Maryland's hospital financing model.**

Appreciation for Corrections and Concern About Systemic Underfunding and Policy Complexity

We are sincerely grateful for the proposed adjustments to the demographic and uncompensated care (UCC) calculations. These corrections address important historical inaccuracies that have materially underfunded hospitals across the state, including AHC, over multiple years.

At the same time, these fixes reflect systemic issues— complex policy errors that have led to multi-year underfunding. We are deeply concerned that the continued layering of increasingly complex methodologies—without the ability to consistently execute them in a timely and accurate manner—risks the long-term viability of the Model. We encourage the Commission to prioritize simplification and external, independent replication of policy results to ensure the Model's long-term sustainability.

Correct Underfunding Before AHEAD Transition

We also urge the Commission to correct the uncompensated care and demographic underfunding before the transition to AHEAD, so hospitals do not carry forward past underfunding into a more demanding federal framework.

Support for MHA's Recommendations

We strongly support the Maryland Hospital Association's recommendation to increase the update by an additional 1.32% (0.65% for age-adjusted demographic growth and 0.67% for prospective inflation), fully pass through the Medicaid Deficit Assessment increase, and suspend the productivity cut for non-

GBR hospitals. This funding is critical to ensure access to medically necessary care in our communities. It will stabilize the financial condition of Maryland hospitals and absorb unprecedented cost pressures stemming from labor shortages, federal tariff impacts, rising payer denials, and significant uncertainty in Medicaid funding.

Maryland has achieved $795 million in cumulative Medicare savings for calendar year 2024—far exceeding the required target by $450 million. Most of these savings have come from hospitals, yet the financial benefit has accrued to payers. Current projections show that even with MHA's recommended adjustments, Maryland would still exceed its Medicare savings target by a wide margin. We believe this creates space for a more meaningful update to stabilize hospital finances without jeopardizing the Model's success.

In Conclusion

For over 115 years, Adventist healthcare has served our local community with the mission to extend God's care through the ministry of physical, mental, and spiritual healing. We consistently provide high-quality, low-cost healthcare to marginalized and disadvantaged patients in Maryland. AHC remains committed to being a constructive and collaborative partner and appreciates Staff's proposed corrections. **However, given the extraordinary excess savings coupled with historic financial pressure on hospitals, AHC recommends an incremental 1.32% as well as correction for the underfunding prior to an AHEAD transition to ensure access to medically necessary care for Marylanders.**

Sincerely,

Katie Eckert

Katie Eckert, CPA

Senior Vice President, Strategic Operations
Adventist HealthCare

cc: Joshua Sharfstein, MD
Maulik Joshi, DrPH
Adam Kane, Esq
James N. Elliott, MD
Nicki McCann, JD
Ricardo R. Johnson
Dr. Farzaneh Sabi

May 21, 2025

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

Dear Mr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Draft Staff Recommendation for the Fiscal Year (FY) 2026 Payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Base Inflation Update

JHHS is appreciative of the inclusion of the 3.36% inflation increase in FY 2026. factor. However, given the uncertainty around the various proposed tariffs, JHHS would encourage the HSCRC to consider providing hospitals with additional funding beyond the staff recommendation.

Demographic Funding

JHHS appreciates the staff proposal to that adjusts the demographic to include a proposed 0.76% adjustment for volume to account for revised historical data and population growth estimates from the Maryland Department of Planning. This is a welcomed and important adjustment that represents a correction of historic underfunding for demographic growth that should have been incorporated in prior updates. The demographic policy is intended to provide funding increases or decreases to account for anticipated changes in hospital volumes associated with age-adjusted population changes. 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.

Uncompensated Care Funding

JHHS supports the proposed correction to the uncompensated care (UCC) fund calculations for

RY 2023 to RY 2025. We support the recommendation to allocate additional funding to hospitals and health systems that were underfunded for UCC and to hold harmless those that were overfunded.

Efficiency Methodology

JHHS supports the recommended modification to the integrated efficiency policy. The proposed policy modification ensures that hospitals in the fourth quartile are only subject to penalties if they have outlier performance under the Inter-Hospital Cost Comparison (ICC). JHHS also supports the proposal to use a historical standard deviation, as opposed to a standard deviation that changes over time as the distribution of hospital performance narrows, to identify outlier hospitals. This is consistent with historical HSCRC regulations.

Medicaid Deficit Assessment

The Maryland General Assembly approved a $150 million increase to the Medicaid Deficit Assessment for FY 2026 as part of the Budget Reconciliation and Financing Act (BRFA) of 2025 to help cover the increasing cost of the Medicaid program. In light of the financial vulnerability of hospitals and health systems, we respectfully ask that HSCRC pass through the full amount of the increase to the Medicaid Deficit Assessment to payers.

Recommendations

Given the uncertain economic climate and the challenges currently faced by the healthcare industry and given the significant savings that the state is generating in excess of the contractual target, there are ample funds available to properly fund hospitals for the underfunded demographic and UCC from prior years.

Given these considerations, JHHS is supportive of the additional increases for demographic and prospective inflation as proposed by the MHA. Thank you for the opportunity to share comments and feedback. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,

Ed Beranek

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

cc: Joshua Sharfstein, M.D.
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane

Nicki McCann
Dr. Farzaneh Sabi

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
June 11, 2025

RE:
Hearing and Meeting Schedule

July 30, 2025 In person at HSCRC office and Zoom webinar

August 2025 No Meeting

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.