



643rd Meeting of the Health Services Cost Review Commission

June 10, 2026

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

CLOSED SESSION

12:00 pm

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

PUBLIC MEETING

1:00 pm

1. Review of Minutes from the Public and Closed Meetings on May 13, 2026

Informational Session

1. Presentation: TBD

Specific Matters

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

Docket Status – Cases Closed

2689N Luminis Health Doctors Community Medical Center
2696A Johns Hopkins Health System
2697A Johns Hopkins Health System

2. Docket Status – Cases Open

2695N TidalHealth Peninsula Regional Medical Center
2670A University of Maryland Medical Center- 2nd Extension Request
2698A Johns Hopkins Health System
2699A University of Maryland Medical Center
2700A University of Maryland Medical Center

3. Final Staff Recommendation Request to Access HSCRC Confidential Data: Johns Hopkins Center for Population Health IT
4. Final Staff Recommendation Request to Access HSCRC Confidential Data: University of Maryland, Baltimore

Subjects of General Applicability

5. Report from the Executive Director
 - a. Model Monitoring
 - b. Policy Calendar Update
6. Final Recommendation: Update Factor - FY27
7. Final Recommendation: Health Outcomes Payment Effort
8. Final Recommendation: CRISP HIE Funding - FY27
9. Final Recommendation: Inpatient Length of Stay
10. Draft Recommendation: Global Budget Carve Out
11. Hearing and Meeting Schedule

As an advance notice for next month's commission meeting, the meeting originally scheduled for July 8, 2026, has been rescheduled to Wednesday, July 22, 2026.



IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
PENINSULA REGIONAL	*	DOCKET: 2026
MEDICAL CENTER	*	FOLIO: 2505
SALISBURY, MARYLAND	*	PROCEEDING: 2695N

Staff Recommendation
June 10, 2026

Introduction

On April 10, 2026, Tidal Health Inc. submitted a partial rate application to the HSCRC requesting certain outpatient infusion rates for Tidal Health Peninsula Regional (THPR) associated with services that, for purposes of the federal 340B Drug Pricing Program, are also designated as child-site services of Tidal Health Atlantic General (THA) to be effective June 15, 2026.

Tidal Health is requesting the following rates:

CDS (Costs of Drugs Sold)-340B/OID (Outpatient Infusion/Oncology)-340 Drug Rate Center - 1.5477 per RVU

Clinic Rate Center - 52.8325 per RVU

Lab Rate Center – 2.8074 per RVU

Under HSCRC law, the term “hospital services” includes hospital outpatient services of a hospital that are designated as part of another hospital under the same merged asset system to make it possible for the other hospital to participate in the 340B program.

Tidal Health requests that effective June 15, 2026, infusion clinic services provided at THA be approved to begin operations as part of the THPR oncology program. The outpatient infusion clinics located at THA will be able to operate as an off-site provider-based child-site of Tidal Health Peninsula Regional in accordance with Medicare’s rules for provider-based status. As a result of this request, the child-site at THA will be able to participate in the 340B outpatient drug discount program under THPR’s eligibility.

Additionally, Tidal Health is requesting that the revision of rates not be realigned until a full year of service.

Staff Findings

Staff found the requested outpatient infusion rates associated with services provided through THA as a 340B child site of THPR to be reasonable. As a matter of practice, staff uses the lesser between the rate requested or the statewide median rate. As these requested rates are less than the statewide median, staff will use the rates requested.

Recommendation

After reviewing the application, staff recommend that Tidal Health's request be approved because: 1) it will enable services to be provided on the campus of Tidal Health Atlantic as a child site of Tidal Health Peninsula Regional; and 2) it will produce overall Medicare savings as infusion services are weighted more heavily to Medicare.

Staff also recommend that the following rates for the infusion clinic services provided at Tidal Health Atlantic be approved and added to THPR's approved rate order and GBR effective June 15, 2026:

1. CL-340B rate of \$52.83 per RVU
2. LAB-340B rate of \$2.81 per RVU
3. CDS-340B rate of \$1.55 per RVU

In addition, Staff will collaborate with Tidal Health to implement the necessary revenue adjustments in the RY27 rate orders.



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Request For Extension of Approval

University of Maryland Medical Center

June 10, 2026

Background

On March 3, 2026, 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 University of Maryland Medical Center (UMMC) and Cigna Health Corporation. (Cigna), for solid organ and bone marrow transplants, Proceeding 2670A. The extension expires on June 30, 2026. However, UMMC and Cigna have not yet completed negotiations to extend the arrangement.

Request

UMMC requests that the Commission extend its approval for an additional three months to September 30, 2026, to complete negotiations.

Findings

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

Staff Recommendation

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



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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

June 10, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	2508
BALTIMORE, MARYLAND	*	PROCEEDING:	2698A

I. INTRODUCTION

On May 28, 2026, 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 July 1, 2026.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins Healthcare, LLC. (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the 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 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 Hospital's application for an alternative method of rate determination with self-pay patients for reproductive health services for one-year beginning July 1, 2026. 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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**Final Staff Recommendation for Access to the
HSCRC Confidential Patient Level Data Request from
Johns Hopkins Center for Population Health IT**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the June 10, 2026, Public Commission Meeting.

SUMMARY STATEMENT

Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology (CPHIT) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC). This request is intended to facilitate research aimed at identifying predictive models and factors associated with suicide. The data will support the development of new methods to identify clinical and social patterns that contribute to these outcomes. While the National Institute of Mental Health (NIMH) originally funded CPHIT to create the Maryland Suicide Data Warehouse (MSDW), NIMH has since expanded the research aims through an R01 grant to include a refresh of existing data and acquiring new data from different sources and replication of descriptive findings, develop and assess hypothesis-driven techniques to predict suicide death, explore hypothesis-generating use cases of the MSDW, and devalue the generalizability of data sources and methods.

OBJECTIVE

The project aims to identify individuals at a higher risk of suicide and subsequently provide insights on therapies and possible targeted interventions to improve care for patients exhibiting signs of suicide ideation. To achieve this, researchers have created a merged database by linking existing individual and geo-level data sources, including HSCRC's case mix data (inpatient and outpatient files), MHCC's All Payer Claims Database, the Maryland Office of the Medical Examiner (OCME) data, Vital Statistics Death data, and clinical data from Johns Hopkins Hospital, Luminis Health, and Tidal Health for individual-level information, alongside American Community Survey (ACS) and other publicly available sources aggregated at a census block group level for geo-level data. Individual data will be securely processed by CRISP using their master patient index and geocoded information to link encounters and geo-level data, followed by anonymization, ensuring only limited PHI (dates and census block group information) is shared with the research team. The resulting knowledge from this study is anticipated to provide a basis for understanding the pathways to suicide and enable earlier intervention by clinicians and individuals.

DDA received approval from the MDH Strategic Data Initiative (SDI) office on **May 22, 2026**.

(The Data will not be used to identify individual patients. The Data will be retained by Johns Hopkins School of Public Health's Center for Population Health Information Technology until project completion on December 31, 2030. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

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

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

confidentiality.

The Review Committee unanimously agreed to recommend that Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology be given access to the Data. As a condition for approval, CPHIT 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 Johns Hopkins University, Bloomberg School of Health's Center for Population Health Information Technology to the basic inpatient and outpatient confidential discharge data for Calendar Years 2019 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



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**Final Staff Recommendation for Access to the
HSCRC Confidential Patient Level Data Request from
University of Maryland, Baltimore**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the June 10, 2026, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland, Baltimore (UMB) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to support a federally-funded research study evaluating the effectiveness of the Medherent™ intervention. This request is for grouped inpatient and outpatient data for Calendar Years 2017 through 2025 and includes linkage through CRISP. The National Institute of Mental Health (NIMH)-funded project is designed to measure the impact of existing and enhanced Medherent interventions on psychiatric and medical care utilization, medication adherence, clinical outcomes, and associated healthcare costs among adults with serious and persistent mental illness (SPMI), including individuals with schizophrenia, bipolar disorder, and major depression. Access to HSCRC data will allow investigators to analyze hospitalization patterns, laboratory results available in hospital records, and other service utilization indicators necessary to evaluate the effectiveness and public health impact of the Medherent device. The study aims to assess how technology-enabled medication support may increase autonomy, improve medication adherence, and enhance care coordination within community mental health settings. These data will help determine whether Medherent contributes to reductions in healthcare utilization, improved clinical outcomes, and potential cost savings for mental health provider agencies.

BACKGROUND

The purpose of this request is to facilitate CRISP-assisted linkage of study participants to HSCRC's statewide grouped inpatient and outpatient confidential discharge datasets for Calendar Years 2017–2025. Linked case-mix data are essential to assessing:

- Hospital-based service utilization
- Emergency and inpatient encounters
- Trends in healthcare costs
- Clinical outcomes related to medication adherence
- Benefits associated with technology-enabled care coordination

The Medherent device is intended to support medication self-management, reduce the need for staff-administered dosing, improve remote care engagement, and enhance real-time monitoring of health indicators. These improvements may lead to better psychiatric and physical health outcomes for individuals with SPMI, while offering community mental health agencies opportunities to allocate staff resources more efficiently.

The public health benefit is substantial. Strengthening medication adherence and care coordination among individuals with complex behavioral health needs can reduce hospitalizations, support recovery, and alleviate pressure on Maryland's mental health and hospital systems.

Informed consent was obtained from all study participants. Risks to participants primarily relate to the possibility of a breach of confidentiality; however, UMB has implemented extensive safeguards, including secure server-based storage, VPN-restricted access, password protections, activity logging, encryption of data in motion and at rest, and adherence to institutional IT policies aligned with NIST and FedRAMP standards.

University of Maryland, Baltimore received IRB approval and MDH Strategic Data Initiative (SDI) approval on **May 22, 2026**.

(The Data will not be used to identify individual patients. Identifiers used for CRISP linkage will be destroyed immediately following linkage. De-identified HSCRC case mix data linked to Medherent study IDs will be retained only for the duration of the project. In accordance with the University of Maryland, Baltimore IRB requirements and the study protocol, all data will be stored on secure, encrypted servers with restricted access and will be destroyed at the conclusion of the study period on September 30, 2030. A Certification of Destruction will be submitted to the HSCRC confirming that all HSCRC data and any derivative files have been permanently deleted.)

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee (“the Review Committee”). The Review Committee included representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to assist HSCRC staff in making recommendations for approval to the Commission at its monthly public meeting:

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

The Review Committee voted unanimously to give the University of Maryland, Baltimore, 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 from the University of Maryland, Baltimore for access to the grouped inpatient and outpatient confidential discharge data for Calendar Years 2017 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



Final Recommendation for the Update Factors for Rate Year 2027

This represents the Final Recommendation for RY 2027 except Recommendation item (c) which is draft (outlined on page 3 and 35).

Comments on this element should be submitted to hsrc.payment@maryland.gov by June 24, 2026.

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List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design
CMS	Centers for Medicare & Medicaid Services
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
<p>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.</p>	<p>The final recommendation provides an annual update factor of 3.95 percent per capita, a revenue increase of 4.07 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.37 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.</p>	<p>The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2027. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, respiratory surge, uncompensated care, and others as deemed necessary.</p>	<p>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 AHEAD Model. 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.</p>	<p>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.</p>

Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2027. 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 a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.

(b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 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) Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.4 percent to support reinsurance and subsidies for marketplace enrollees and 0.1 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will be removed from the update factor if the final recommendation is not approved subsequently.

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

(a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

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 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.

On November 12, 2025, CMS and Maryland signed the Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model), replacing the prior AHEAD Agreement signed in 2024. The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment, and population health outcomes results in improved population health and healthier living, enhanced quality outcomes, and lowered growth of health care costs. Under the Amended and Restated AHEAD Model Maryland State Agreement, the Maryland AHEAD Implementation Period officially began on January 1, 2026. Under AHEAD, Maryland must meet Medicare FFS TCOC savings targets, all-payer TCOC growth targets, and a hospital all-payer revenue limit. HSCRC will need to closely monitor state-wide hospital revenue growth in order to meet these tests.

The approach to developing the RY 2027 annual update is outlined in this report, as well as staff's estimates on calendar year AHEAD 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 hospital's price, not volume.

This recommendation proposes Rate Year (RY) 2027 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2027, HSCRC staff is proposing an update of 3.95 percent per capita for global budget revenues and an update of 3.37 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

The publication schedule for S&P Global (Global Insights) has been revised, resulting in a one-quarter delay in the release of quarterly reports relative to prior practice. As a result, the First Quarter publication, previously used to inform staff evaluations and final recommendations, will no longer be available within the required timeframe. As a result of this publication change, staff will

transition to using the Fourth Quarter publication as the basis for Update Factor calculations going forward.

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 market basket growth estimate with a capital growth estimate using the Quarter 2 projection for 2027 from the Fourth Quarter book for 2025. For RY 2027, HSCRC Staff combined 91.20 percent market basket growth of 3.20 percent with 8.80 percent of the capital growth estimate of 2.90 percent, calculating the gross blended amount as a 3.17 percent inflation adjustment.

Update Factor Final 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 3.17 percent with an additional 0.20 percent for additional inflation support. Staff recommends suspending the productivity adjustment of 0.80 percent. The resulting proposed net update is approximately 3.37 percent.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.17%	3.17%
Productivity Adjustment	N/A	SUSPEND
Additional Inflation Support	0.20%	0.20%
Proposed Inflation Update	3.37%	3.37%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

- Meeting the requirements of the AHEAD Model, including achieving the Medicare Total Cost of Care savings targets, which increase according to a preset schedule relative to a calendar year 2023 base, beginning in CY 2026. The amount required increases throughout the agreement; for 2026, it is 0.13 percent.
- 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 AHEAD Model as well as a framework for doing so;
- Incorporating quality performance programs.
- 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 4.07 percent with a corresponding per capita growth rate of 3.95 percent. The 4.07 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 2027 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 2027				
<u>Components of Revenue Change Link to Hospital Cost Drivers /Performance</u>				
		Weighted Allowance	All Payer Revenue Increase (Millions)	Medicare Revenue Increase (Millions)
Adjustment for Inflation (this includes 3.10% for Wages and Salaries)				
- Additional Inflation Support		3.11%	\$746.5	\$246.3
- Outpatient Oncology Drugs		0.20%	\$48.1	\$15.9
		0.06%	\$15.2	\$5.0
Gross Inflation Allowance	A	3.37%	\$809.8	\$267.2
Care Coordination/Population Health				
- Reversal of One-Time Grants		-0.15%	-\$36.9	-\$12.2
- Grant Funding RY27		0.02%	\$3.7	\$1.2
- HOPE		0.21%	\$50.0	\$16.5
- CTI Transition		0.20%	\$48.7	\$16.1
Total Care Coordination/Population Health	B	0.27%	\$65.5	\$21.6
Adjustment for Volume				
- Demographic /Population Standard Policy		0.12%	\$28.8	\$9.5
- Demographic Policy Refinement - RY2026 Incremental Change		0.03%	\$7.9	\$2.6
Total Adjustment for Volume	C	0.15%	\$36.7	\$12.1
Financial Methodologies & Other Adjustments (positive and negative)				
- Set Aside for Unknown Adjustments	D	0.40%	\$96.1	\$31.7
- Low Efficiency Outliers/Revenue for Reform	E	0.00%	\$0.0	\$0.0
- Complexity & Innovation	F	0.16%	\$37.5	\$12.4
- Full Rate Application & Capital Funding	G	0.07%	\$16.2	\$5.3
- Reversal of one-time adjustments for drugs	H	-0.06%	-\$14.7	-\$4.9
- Reversal of Surge Funding (RY24-RY25 in RY26 rates)	I	-0.81%	-\$194.3	-\$64.1
- RY26 Respiratory Surge Funding Estimate (9 month)	J	0.19%	\$44.7	\$14.7
- RY25 New Volume Policies	K	0.06%	\$14.7	\$4.8
Net Other Adjustments	L = Sum of D thru K	0.00%	\$0.1	\$0.0
Quality and PAU Savings				
- PAU Redistribution	M	-0.02%	-\$5.5	-\$1.8
- Reversal of prior year quality incentives	N	0.04%	\$9.7	\$3.2
- Current Year Quality Incentives	O	-0.06%	-\$15.0	-\$5.0
Net Quality and PAU Savings	P= Sum of M thru O	-0.04%	-\$10.7	-\$3.5
Total Update First Half of Rate Year				
	Q=	Sum of A + B + C + L + P	3.75%	\$901.4
	R=	(1-Q)/(1+0.12%)	3.63%	
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>				
- Uncompensated care, net of differential	S	0.52%	\$125.0	\$41.2
- Deficit Assessment	T	-0.20%	-\$47.6	-\$15.7
	U=	Sum of S thru T	0.32%	\$77.3
Total Update First Half of Rate Year 27				
Revenue growth, net of offsets	V=	Q+U	4.07%	\$978.8
Per Capita Revenue Growth	W=	(1+V)/(1+0.12%)	3.95%	\$323.0
Adjustments in Second Half of Rate Year				
- Medicare Advantage Stabilization*		0.00%	\$0.0	\$0.0
Total Adjustments Second Half of Rate Year	X	0.00%	\$0.0	\$0.0
Total Update Full Rate Year				
	Y	V+X	4.07%	\$978.8
	Z	(1+Y)/(1+0.12%)	3.95%	\$323.0

*MA Stabilization has a revenue neutral impact on proposed increase to revenues, staff are adding this for awareness due to the adjustment being new in CY27.

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 3.17 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight’s Fourth Quarter 2025 market basket growth of 3.20 percent, with 8.80 percent of the capital growth index change of 2.90 percent. The adjustment for inflation includes 3.30 percent for wages and compensation.

In RY 2025, staff implemented a catch-up methodology incorporating a two-sided risk corridor of 1.00 percent to evaluate cumulative over- or underfunding. This methodology was subsequently refined in RY 2026, reducing the corridor to 0.25 percent. Under the revised framework, the Commission will adjust future inflation only when the variance between actual and funded inflation exceeds 0.25 percent. Variances within this range do not warrant adjustment, as such levels have historically been considered acceptable. Through RY 2025, the cumulative underfunding of inflation is 0.45 percent (as illustrated in Table 3), an amount that exceeds the 0.25 percent guardrail. The RY 2026 period has not been included in this review, as it still requires 4 more quarters of data to be deemed complete. As a result, the staff has applied the variance of 0.20 percent as an additional inflation allowance for RY 2027.

Table 3: Inflation Risk Corridor Methodology

Fiscal Year	Historical											Incomplete		Projected			
	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%	3.17%	3.17%	3.17%	3.17%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.44%	3.08%	3.17%	3.17%	3.17%	3.17%
Actual Inflation Correction as approved by Commission												1.00%	0.27%	0.20%	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%	0.80%	0.54%	0.20%	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%	-0.72%	-0.18%	0.02%	0.02%	0.02%	0.02%
Guardrail/Tolerance (A)											1.00%	1.00%	0.25%	0.25%	0.25%	0.25%	0.25%
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%	-0.45%	0.02%	0.02%	0.02%	0.02%	0.02%
Calculated Inflation Correction (C) = (A+1)/(B+1)-1										1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HSCRC Funded Inflation with Actual Inflation Correction											3.35%	4.24%	3.63%	3.37%	3.17%	3.17%	3.17%

- **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 adjustments 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 revisions 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. For the RY 2027 Update Factor, staff are using a 3 percent inflation assumption based on longer term trends of pure price. This value remains the same for both academic and non-academic hospitals. The result of this translates to approximately a 0.06 percent carve out of inflation.

- **Care Coordination / Population Health:** In RY 2026, several grant programs focused on Care Coordination and Population Health were implemented, which contributed to hospital revenues. These programs included the Behavioral Health Funding and New Paradigms in Care Delivery. The funds were allocated to hospitals on a one-time basis. As a result, Table 2 reflects a reversal of grant funding for RY 2026 at a rate of -0.15 percent. RY 2026 marked the conclusion of the Regional Partnership Grants. For RY 2027, a small carryover for New Paradigm funding will be implemented into rates.

The Healthcare Outcomes Payment Effort (HOPE) replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) staff are proposing to sunset. The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals and community partners to invest in interventions and share in savings. HOPE seeks to sustain and expand population health investments that advance Achieving Healthcare Efficiency through Accountable Design's (AHEAD) goals and drive meaningful system transformation.

HOPE is a voluntary, upside-only, shared savings, outcome payment model whereby proposals will be reviewed and approved by a committee of experts. One path to participation is for hospitals, alone or with partners, and the other path is for regional or statewide initiatives. Outcome payments will be initially anticipated to be \$50 million each year, included in the annual update factor, with the commission only able to qualify interventions with up to \$100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Hospitals and Statewide and Regional

Initiative partners receive 50 percent of measured savings, ensuring aligned incentives across participating entities. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Funding for Regional and Statewide initiatives funding are individually approved by the Commission and will not count towards the \$50 million.

HSCRC anticipates final authorization for HOPE in June 2026 as part of the RY27 update factor final recommendation. If HOPE does not pass in the June 2026 recommendation, it will be removed from the RY27 update factor.

CTI Transition funding was included as part of the final recommendation. These dollars will be provided based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year. This funding is one-time funding. An amount of \$48.7 million is included but the final payout will be based on the final reporting which is not yet available but is expected not to materially differ from the amount used in this final recommendation.

Collectively, these adjustments result in a net increase of 0.27 percent for Care Coordination and Population Health.

- **Adjustments for Volume:** The demographic adjustment policy is an annual prospective update to Maryland hospitals' global budget that accounts for age-adjusted population volume changes within a hospital's service area. Staff proposes a 0.12 percent population growth estimate for RY 2027 and a refined 0.77 percent for RY 2026, both of which incorporate specific Commission-approved adjustments.

To prevent double payment, staff exclude revenue already covered by distinct volume policies—specifically out-of-state volumes, high-cost drugs (CDS-A), and to some extent quaternary services through the complexity & Innovation policy. Additionally, a 0.1 percent national demand modifier is applied to align Maryland's growth with national per capita utilization trends. For RY 2026, these adjustments account for a 0.03 percent increase over the standard methodology, as detailed in Table 2.

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 reconciled to the cumulative population count from 2020 through the most recent year.

- **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 financial hardship,

regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.40 percent for RY 2027.

- **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.

For purposes of the Update Factor inputs, staff has earmarked a 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.

- **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 2025. 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 0.16 percent for the RY 2027 Update Factor. Staff are currently evaluating a new approach to funding this type of care via carve out and expect a final recommendation to the Commission in July 2026, should the Commission adopt this approach it may impact this funding.
- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately \$6 million through the Full Rate Application Policy and Shady Grove will get approximately \$9 million dollars in concert with the opening of their capital project, which represents 0.07 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 2027 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, 2028.

- **Surge Allocation:** The Surge Funding value for RY 2027 is 0.19 percent. This amount includes an estimate that has been determined using nine months of Case-mix and Experience data and incorporates the change in weighting to two-thirds evaluation on Case-mix and one-third evaluation on patient days as approved at the January 2026 Commission meeting. This Update Factor recommendation incorporates the reversal of the RY 2024 and RY 2025 surge funding applied in RY 2026, totaling -0.81 percent. The 9-month value will be implemented in July and will then be reconciled with a final 12-month amount in January.
- **New Volume Policies:** In RY 2026, the Commission approved new volume policies not otherwise reflected in existing market shift methodologies. These policies include Deregulation, Repatriation/Expatriation, and Out-of-State (OOS) volume Adjustments. These policies were designed to address shifts in patient utilization occurring outside of traditional in-state regulated market dynamics, including movement to unregulated settings (deregulation), cross-border utilization by Maryland residents (repatriation/expatriation, and changes in utilization at in-state regulated facilities by non-Maryland residents (OOS). For this period, hospitals received adjustments calculated using CY 2024 data. A portion of the adjustments will be implemented in RY 2027, following hospital feedback and additional staff review. These policies have an estimated impact of approximately 0.04 percent in the RY 2027 Update Factor. In addition, at the December 2025 Volume Workgroup meeting, staff introduced a policy update formalizing the treatment of Potentially Avoidable Utilization (PAU) associated with hospital conversions to Freestanding Medical Facilities (FMFs) within the Market Shift Policy. This update ensures consistent treatment of PAU-related volume and avoids overstating growth from FMF conversions. The estimated impact of this adjustment is approximately 0.02 percent. Together, these volume-related changes result in a combined impact of approximately 0.06 percent in the RY 2027 Update Factor.
- **Potentially Avoidable Utilization (PAU) Redistribution:** The PAU value for RY 2027, which represents defunding of inflation and population growth for readmissions and avoidable admissions, is -0.37 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 -0.02 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 0.04 percent.

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 2027 will be 0.02 percent. The amount in rates was 4.03 percent in RY 2026, and the proposed amount for RY 2027 is 4.05 percent, an increase of 0.02 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.

Staff considered whether federal changes to coverage policy warrants a prospective adjustment to uncompensated care. Staff do not anticipate that short-term increases for the Medicaid population are likely to be significant, because of: 1) the timeline for the new requirements (*i.e.*, six-month redeterminations and work requirements); 2) the likelihood of Medicaid eligibility determination at the time of the hospital visit (*i.e.*, due to an exemption from work requirements or procedural re-enrollment). Many individuals losing Medicaid coverage due to new immigration requirements will qualify for coverage under Emergency Medicaid Services.

In the individual market, the Maryland Health Benefit Exchange projected coverage losses of 48,000.¹ As of April 2026, the individual market had seen an eight percent decline in year-over-year enrollment, numbering approximately 18,000 individuals.²

A 48,000-beneficiary decline in the marketplace correlates to approximately \$117 million in hospital uncompensated care, assuming these enrollees have similar experience to existing uninsured individuals. In addition, working with Medicaid, the HSCRC estimates FY 2027 Medicaid losses to translate into approximately \$11 million of hospital uncompensated care.³ Based on these estimates, which contain considerable uncertainty, the UCC exposure is \$128 million or approximately 0.50 percent.

To help mitigate these coverage losses and reduce the impact on uncompensated care costs in the hospital market, Staff is proposing to provide 0.40 percent in funding to the Maryland Health Benefit Exchange Fund to provide additional reinsurance and state subsidies for marketplace enrollees and 0.10 percent to increase the reserves held in HSCRC's Uncompensated Care Fund. The Maryland Health Benefit Exchange Fund finances the operations of the Maryland insurance marketplace. Reserves in the HSCRC's Uncompensated Care Fund would be released as additional uncompensated care emerges.

This amount will be allocated across hospitals in proportion to their global budget and hospitals will collect it and remit it to the Maryland Health Benefit Exchange Fund and the HSCRC's Uncompensated Care Fund, as directed by the HSCRC. As this element is newly introduced, Staff are presenting this element as a draft recommendation with a final recommendation to follow in a subsequent Commission meeting. Staff also are considering options for providing funding to FQHCs to expand services to reduce the unnecessary use of hospital services. This is not included in this recommendation due to the complexity required but Staff are interested in comments on whether and how to direct uncompensated care funding to FQHCs, so that uninsured individuals can receive care in the most appropriate setting.

- **Deficit Assessment:** The Legislature approved a funding level of \$394,825,000 for RY 2027. The values associated with this funding level will be applied to payers and are reflected as a -0.20 percent adjustment in Table 2.

¹ Maryland Health Benefit Exchange. (Aug. 2025). Final 2026 State Subsidy and Reinsurance Parameters. Available <https://www.marylandhbe.com/wp-content/uploads/2025/08/2026-State-Subsidy-and-Reinsurance-Parameters-8-18-25.pdf>; accessed 26 May 2026.

² Maryland Health Benefit Exchange. (Apr. 2026). Data Report. Available https://www.marylandhbe.com/wp-content/uploads/2026/05/Executive-Report_-as-of-04302026.pdf; accessed 26 May 2026.

³ Medicaid estimates were derived prior to CMS' release of the Medicaid Community Engagement Requirement for Certain Individuals Interim Final Rule on June 2, 2026.

- Medicare Advantage Stabilization:** Starting in CY 2027, qualifying Medicare Advantage plans will receive rate relief through an increase in the public payer differential. Eight MA contracts, representing six parent companies and over 172,000 Marylanders, have qualified for the rate relief program in CY 2027. The increase will be offset by Medicaid and commercial payers in CY 2027 and commercial payers (only) from CY 2028 onward.

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 2027, 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 2027 permanent PAU savings reduction of -0.37 percent statewide, or -\$83,122,852. 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 2026 Total Approved Permanent Revenue	A	\$22,465,635,668
RY 2027 Inflation Factor+Demographic Adjustment	B	3.29%
CY 2025 Total Experienced PAU \$	C	\$2,554,637,322
Proposed Revenue Adjustment \$	D = B*C	-\$84,047,568
Proposed Revenue Adjustment %	E = D/A	-0.37412%
Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	-0.37000%
Adjusted Proposed Revenue Adjustment \$ * **	G = F*A	-\$83,122,852
Total PAU %	H	11.08%
Total PAU \$	I = A*H	\$2,488,773,634
Required Percent Reduction PAU	J = G/I	-3.34%

*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.

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, as well as 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. All hospitals completed these requirements and none were subject to a 0.19 percent clawback in their July rate orders.

For RY 2026, hospitals are required to submit final reporting on targets and outcomes for their High Value Care plans by June 1, 2026. All hospitals submitted a report by the deadline, as a result, no hospital will have inflation clawed back in July 2026 rate orders.

For RY 2027, 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 0.17 percent of inflation removed in the RY 2028 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. If the HOPE recommendation is adopted the reporting requirement will be replaced by the HOPE requirement of designating a senior executive responsible for the hospital's population health efforts.

Consideration of AHEAD 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 AHEAD Model agreement requirements are described in detail below.

Medicare TCOC Savings Test

This test under the AHEAD Model requires Maryland to generate 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027), respectively (these amounts are accumulated so the Year 2 target is 0.34 percent). Under current growth

trajectories and beneficiary counts, this is equivalent to Maryland growing an additional \$47 million slower than the national United States Per Capita Cost (USPCC) trend over the two years. AHEAD uses USPCC values to set the Medicare FFS TCOC savings targets, unlike the TCOC Model. USPCC projects national per capita fee-for-service (FFS) spending based on CMS' most recent Medicare FFS data, mainly for the purposes of setting MA benchmarks.⁴ As under the TCOC Model, this test ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from any savings produced in the hospital setting. Additionally, 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.

The Medicare TCOC Savings Target increases annually for the first seven years of the AHEAD Model, culminating in an annual total cost of care savings of 0.63 percent relative to the national growth rate in CY 2032, relative to a 2023 base year.

All-Payer Tests

As under the TCOC Model, the AHEAD Model maintains a 3.58 percent all-payer limit on hospital revenue in the state. However, the AHEAD Model also adds a test requiring the State to establish - and CMS to approve - annual All-Payer TCOC Growth Targets by PY2 (CY 2027). This adds a new CMS element to the HSCRC's existing state mandates related to affordability. The State is currently in the process of establishing this target via a topic-specific advisory group led by the multi-agency Regulatory Working Group, with opportunity for public input. The targets must be formally established under an executive order, legislation, or regulation. Both of these all-payer tests will further inform HSCRC's future update factor process. Additional information can be found on the [HSCRC's AHEAD Model website](#).

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

Previously, the State was held to a Medicare savings test based on national trends for that year derived from a data set provided by CMS. Staff utilized this claims data and information from CMS' Office of the Actuary to forecast future Medicare trends in order to evaluate the impact of the proposed update factor on the savings test. For the RY2027 update factor, this published estimate will be used to evaluate the update factor impact on the CY2026 savings test. Figure 1 below illustrates the State's understanding of how the Medicare FFS TCOC target will be set.

⁴ USPCC includes FFS spending on all Part A and Part B services (except hospice services and kidney acquisition costs, which are not covered by MA plans and ESRD which is assigned its own trends) as well as all shared savings and losses paid to FFS providers through the Medicare Shared Savings Program, Innovation Center models, and demonstration programs. USPCC trend information can be found here: <https://www.cms.gov/files/document/2027-announcement.pdf> See Table II-2 Current Year values

Figure 1
AHEAD Savings Target

$$\text{Target} = \text{Baseline} \times (1 + \text{Interim Years Trend}) \times (1 + \text{National MC FFS Trend} + \text{True Up}) - \text{Savings Component}$$

The **Baseline** is 2023. The **Interim Years Trend** is the adjusted observed USPCC for 2024 and 2025. The **National Medicare FFS Trend** is the product of:

1. The adjusted projected USPCC value availability at the beginning of the Performance Year (PY), or the number released by CMS in the April before the PY (“Year -1”).⁵ For 2026, this would be projected USPCC value for 2026, released in April 2025.
2. The average of the projected and observed USPCC for the prior PY⁶, and
3. The observed USPCC for the remaining previous performance years.

Instead of applying trend to the Maryland baseline dollar amount, 33 percent of the **National Medicare FFS Trend** is calculated against the equivalent national dollar amount. The **True Up** adjusts the target by 50 percent of differences between the projected and observed USPCC values beyond .50 percent, the true up only becomes relevant after the performance period when differences between the projected and observed USPCC are known. The **Savings Component** is 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027) mentioned previously.⁷ The final target is risk adjusted using HCC scores.

Before evaluating CY2026 results against the Medicare test staff must convert the recommended RY 2027 update to a calendar year growth estimate. Table 5 below shows the current revenue projections for CY 2026 to assist in estimating the impact of the recommended update factor together with the projected RY 2027 results. The overall increase from the bottom of this table is used in Tables 6a-6b.

⁵ CMMI indicated in April 2026 that they want to use Year -1 rather than Year 0 (i.e. USPCC value released in April of the performance year projected numbers to establish in-year targets for each AHEAD PY.

⁶ Projected refers to values released in Year 0 and prior and Observed to values released in Year + 1 and subsequent, where Year + 1 refers to the USPCC value released in the year following year 0 (e.g. 2026 values released in 2027).

⁷ This number increases between PY1 and PY7 under AHEAD. See Section 10.a.i of the Amended and Restarted Maryland AHEAD State Agreement.

Table 5: CY 2026 Global Budget Revenue Estimate

Estimated Position on Medicare Test (in billions)		
Actual Revenue January - June 2025		11,469,777
Actual Revenue July - December 2025		11,856,401
Actual Revenue CY 2025		23,326,178
Step 1:		
Approved GBR RY 2026		24,029,465
Actual Revenue 7/1/25-12/31/25		11,856,401
Approved Revenue 1/1/26-6/30/26		12,173,064
Projected FY25 GBR Compliance		0
Anticipated Revenue 1/1/26-6/30/26	A	12,173,064
Expected Revenue Growth 1/1/26-6/30/26		6.13%
Step 2:		
Final Approved GBR RY 2026		24,029,465
Reversal of Material Non-Repeating One-Times		-92,257
Final Adjusted GBR Base for RY 2026		23,937,208
Projected Approved GBR RY 2027		24,912,218
Permanent Update RY 2027		4.07%
Step 3:		
Estimated Revenue 7/1/26-12/31/26 (after 49.73% & seasonality)	B	12,388,846
Expected Revenue Growth 7/1/26- 12/31/26		4.49%
Step 4:		
Estimated Revenue CY 2026	A+B	24,561,910
Increase over CY 2025 Revenue		5.30%
Per Capita Increase over CY 2025		5.17%

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2025.

Step 1: The table uses global revenue for RY 2026 and actual revenue for the last six months for CY 2025 to calculate the projected revenue for the first six months of CY 2026 (i.e., the last six months of RY 2026). Hospitals currently project they will be able to charge all of RY 2026 revenue, for this reason, staff have kept the projected RY 2026 compliance line at zero.

Step 2: The final approved GBR for RY 2026 is \$24,029,464,776. This step applies the proposed update of 3.65 percent, as shown in Table 2, to the RY 2026 GBR amount to calculate the projected revenue for RY 2027. This step also makes adjustments for material non-repeating one-times that don't get included in inflation but are accounted for in RY 2026. For RY 2026, this includes one-time funding for the population health trust fund and the FY21-FY23 UCC correction.

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 2027.

Step 4: This step shows the resulting estimated revenue for CY 2026 and then calculates the increase over the actual CY 2025 Revenue. The CY 2026 increase based on this year's recommended update is 5.30 percent.

The 5.30 percent is used to estimate CY 2026 hospital spending per capita for Maryland in our savings evaluation. As explained above, the AHEAD Medicare FFS TCOC savings targets are based on USPCC trends, these trends are used in the following evaluation which illustrates two scenarios. The State is continuing to work through the details of the methodology with CMMI. A few areas of uncertainty remain. These include:

- Confirming actual claims experience under AHEAD calculation methodology, in comparison to TCOC actuals.
- Finalizing 2025 values, particularly for Non-claims based payments
- Confirming calculation of HCC scores (uses v28)
- Finalizing the appropriate USPCC values to be used

The first scenario, outlined in Table 6a below, is based on the 2026 USPCC data published by CMS in 2025.

Table 6a: AHEAD Estimate (Scenario 1, 2025 Trended forward at USPCY Year-1 Trend)

Scenario 1 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	4.0%	
Cumulative Growth (2023 to 2026)	19.6%	18.7%	-0.9%
Estimated CY 2026 Savings Run Rate			-\$88.7 M dissavings

Under this scenario, national spending would grow at 4.0 percent in 2026, reflecting the Year -1 2026 USPCY adjusted projected value. Meanwhile Maryland would grow at 5.2 percent in 2026, which reflects hospital spending driven by the CY2026 impact of the update factor of 5.30 percent and non-hospital spending which is assumed to grow at the rates set by USPCY for Part A (1.6 percent) and Part B (6.0 percent). Under this scenario the State would miss the target by \$89M.

Medicare determined that it was making duplicative payments for MA-related IME and DGME costs (one payment directly to inpatient facilities, and one payment to MA plans through higher benchmarks), so in 2024, CMS began a three-year removal of MA-related IME and DGME spending from the non-ESRD FFS USPCYs. This has resulted in lower USPCY updates over 2024, 2025, and 2026 - Maryland AHEAD's two interim years and the first PY. The State has urged CMMI to remove this technical adjustment from the USPCY for the savings test as it is not relevant for AHEAD and CMMI has conceptually agreed that an adjustment is appropriate but the nature and scope of any adjustments has not been finalized.⁸

The second scenario, outlined in Table 6b below, represents Staff's estimate of Maryland's results with the IME adjustment. While Staff believe the IME adjustment will result in a significantly improved position under the test, the State can not be sure of the impact until final notification is received from CMMI. Staff believe greater weight should be placed on Scenario 2 than Scenario 1 given the likely IME adjustment but Staff have not removed Scenario 1 as the impact of the

⁸ A summary of the decision and actions taken can be found in the following MedPac document: https://www.medpac.gov/wp-content/uploads/2025/02/02102025_MA_PD-AN-CY-2026_MedPAC_COMMENT_v2_SEC.pdf

adjustment remains uncertain and Scenario 1 therefore provides a floor for possible savings projections.

Under Scenario 2, national spending would grow at 5.3 percent for CY2026, reflecting the Year -1 2026 USCPC adjusted projected value without the IME removal. Meanwhile, Maryland would grow at the same pace as described in Scenario 1. In addition, Maryland would enter 2026 in a stronger position due to the higher trends allowed for 2024 and 2025, thus Maryland would comfortably meet its target.

Table 6b: AHEAD Estimate (Scenario 2, 2025 Trended forward at USPC Year-1 Trend with IME adjustment to 2024 to 2026 trends)

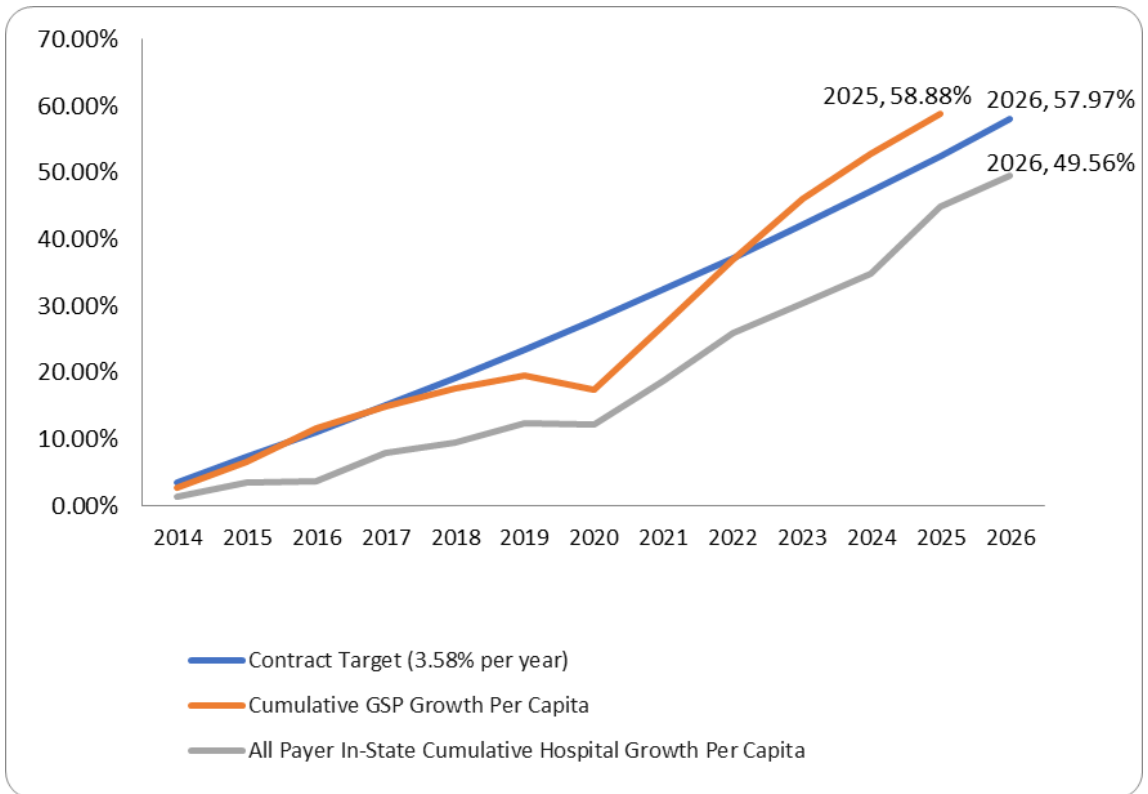
Scenario 2 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	5.3%	
Cumulative Growth (2023 to 2026)	19.6%	21.8%	+2.2%
Estimated CY 2026 Savings Run Rate			\$260.8 M savings

All-Payer Affordability

Under the AHEAD 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 2 represents the cumulative comparison since the beginning of global budgets in 2014. The blue line reflects the contract target, the orange line shows actual cumulative GSP growth through 2025, and the gray line reflects estimated cumulative in-state hospital charge growth per capita through 2026. 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 2025 due to the absence of official 2026 data, staff opted not to project GSP growth. However, even with no GSP growth in 2026, Maryland would remain under both the cumulative target and actual GSP growth. The cumulative value of this target through CY 2026 is 57.97 percent. Actual all-payer in-state hospital charge growth through CY 2025 is 44.85 percent, inflating this to 2026 using the recommended update factor on a per capita basis yields 49.56 percent. This means that Maryland is

approximately 8.8 percentage points below the contract target, which reflects system-wide savings achieved through Maryland’s total cost of care framework and carried forward under the AHEAD Model that accrue to all payers and consumers.

Figure 2
Affordability Scorecard – Cumulative GSP Test with CY 2026 Projection

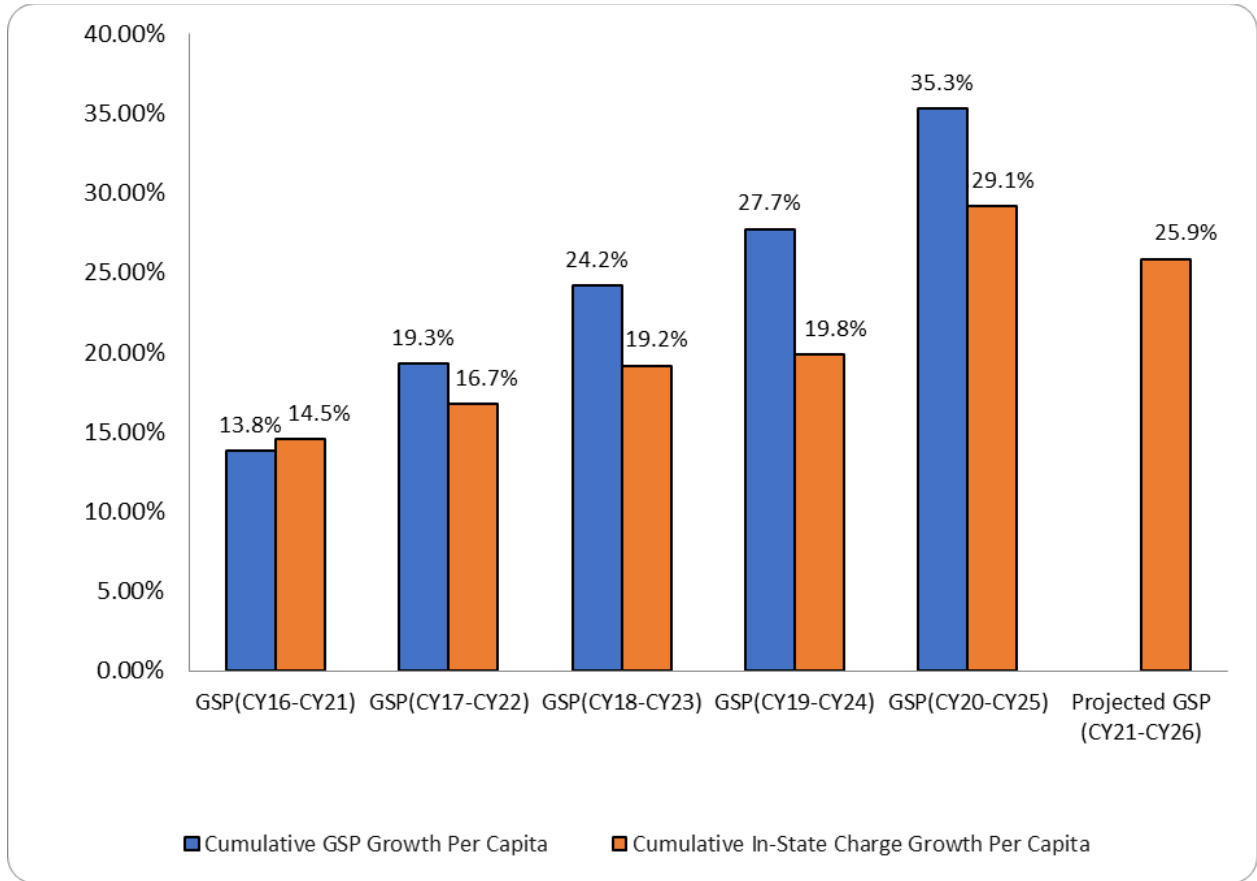


Staff also compared the all-payer in-state hospital charge growth to economic growth in Maryland, as measured by the GSP per capita, over a rolling 5-year window. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose staff believe it is not sufficient to only look at the cumulative test embedded in the AHEAD 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 3, the 5-year calculation shows a cumulative per capita growth of 37.6 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 29.1 percent. Staff

also modeled estimated hospital charge growth through CY 2026 using the proposed RY 2027 update factor. This projection results in estimated hospital charge growth of 25.9 percent.

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 3
Affordability Scorecard – Rolling 5-Year GSP Test



Medicare’s Proposed National Rate Update for FFY 2027

CMS released its proposed rule for the Inpatient Prospective Payment System’s (IPPS) payment rate on April 10, 2026. 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 2026 and will not go into effect until October 1, 2026. 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 Model Workgroup to review and provide input on the proposed RY 2027 update. Comments submitted by stakeholders primarily focused on the following areas: monitor inflation throughout the rate year, prospectively adjust the UCC provision in rates, provide additional funding to support hospital readiness for H.R. 1 an AHEAD, distribute the national demand modifier based on age-adjusted demographic growth, delay HOPE implementation pending access and latent demand concerns, limit hospital revenue growth and update factor increases, align HSCRC methodologies with AHEAD/CMMI, fund CTI rewards for RY 2025 performance, and discontinue the productivity adjustment for non-GBR hospitals.

Comment letters were received from the following entities: The Maryland Hospital Association (MHA), Adventist Healthcare, Frederick Health, Johns Hopkins Health System, MedStar Health University of Maryland Medical System, Luminis Health, Mount Washington Pediatric Hospital, J Kent McNew, Sheppard Pratt, Brook Lane Maryland Healthcare for All, Health Means Everything Alliance, and CareFirst. The comments are outlined below with staff's response in italics:

1. Monitor Inflation throughout the Rate Year

The Maryland Hospital Association (MHA) and its member hospitals expressed concern that economic volatility and current cost pressures, including rising energy and labor costs, may not be fully reflected in current forecasts. MHA requested that the Commission continue monitoring inflation throughout the rate year to ensure the inflation allowance remains adequate if actual inflation exceeds projections. Luminis Health noted that recent Producer Price Index trends for energy and supplies appear to exceed current S&P Global inflation projections. MedStar Health requested that the Commission consider suspending the inflation catch-up methodology for FY 2027 and provide the full underfunded inflation amount, which MedStar estimated would provide hospitals with an additional 0.25 percent. In contrast, CareFirst BlueCross BlueShield expressed concern regarding the calculation of the 0.20 percent inflation catch-up adjustment, stating that the most recent FY 2025 data was not incorporated into the corridor analysis. CareFirst recommended recalculating the inflation methodology using the most current available data and reiterated prior concerns regarding the selected base year for the policy.

HSCRC Response: Staff review inflation with every quarter book that S&P publishes. The catch-up methodology was specifically designed to provide additional inflation beyond the risk tolerance guardrail of 0.25 percent. Should actual inflation come in higher than what

was funded and it trips the guardrail, Staff will provide additional inflation in line with the catch-up methodology. Staff also think it is important to note that the guardrail was lowered last year from 1 percent to 0.25 percent as part of the RY 2026 Update Factor Recommendation and there were years where hospitals were overfunded, prior to the catch-up methodology being put in place, that Staff did not remove inflation.

In response to CareFirst's concerns with not using the most current year available data. Staff do not consider inflation to be complete until 7 quarters of data have passed since the funded value was put into rates. Including a year that is incomplete adds an additional reconciliation to be completed as part of the process and would add unnecessary complexity. Staff do think it is important to note that while we don't include the most current year's actual inflation in the catch-up methodology, we do include any catch-up inflation that was included in that year's calculation.

2. Prospectively Adjust the UCC Provision in Rates

MHA, Adventist Health Care, John Hopkins Health System (JHHS), MedStar Health, Luminis Health and the University of Maryland Medical System (UMMS) requested that the Commission prospectively adjust the uncompensated care (UCC) provision in rates by 0.69% for RY 2027 to reflect projected Medicaid and marketplace coverage losses resulting from federal policy changes. Additionally, they noted that under current policy, increases in UCC would not be reflected in rates until RY 2029, creating what Adventist described as an “operationally untenable” two-year lag while hospitals are already experiencing increased bad debt and charity care pressures.

HSCRC Response: Staff have proposed supporting the Maryland Health Benefit Exchange Fund and the HSCRC's Uncompensated Care Fund in order to help reduce the loss of coverage and the resulting increase in uncompensated care and provide reserves should additional uncompensated care emerge. This element of the proposal is considered draft and stakeholders have another opportunity to comment before a final recommendation is adopted.

3. Provide Additional Funding to Support Hospital Readiness for H.R.1 and AHEAD

MHA, Adventist HealthCare, JHHS, MedStar Health, Luminis Health and UMMS requested that the Commission allocate an additional 0.30% to support hospital readiness for H.R.1 and the transition to AHEAD. Commenters stated that hospitals will need to make significant investments in staffing, revenue cycle operations, Medicare cost reporting, MS-DRG implementation, clinical documentation improvement, quality reporting alignment, and technology system upgrades to operate under bifurcated payment and regulatory systems beginning in 2028. Commenters also cited the administrative burden associated with assisting patients with Medicaid eligibility, coverage retention, and

enrollment disruptions resulting from federal policy changes. MedStar Health noted that hospitals will be required to simultaneously manage differing payment, operational, and reporting requirements under both the Total Cost of Care and AHEAD frameworks, while UMMS expressed concern that monitoring, rather than proactively addressing, H.R.1-related impacts would leave hospitals responsible for bearing the financial risk associated with a broad range of potential outcomes.

HSCRC Response: Hospitals received \$25 million in one-time funding in RY2025 and \$50 million in permanent funding in RY2026 for AHEAD preparation. Permanent funding will remain in rates in perpetuity and get inflated each year moving forward. Staff do not agree that additional funding related to AHEAD preparation is warranted at this time. In addition, should HOPE get approved by the Commission, Hospitals are keeping all revenue that was at risk of a clawback as part of the high value care plans and prior to that for PAU.

4. Delay HOPE Implementation Pending Access and Latent-Demand Concerns

Adventist HealthCare requested that the Commission delay implementation of the Healthcare Outcome Payment Effort (HOPE) framework until latent-demand and access concerns are fully evaluated and coordination with CMS is established. Adventist expressed concern that the current improvement-only methodology could disadvantage already efficient, low total cost of care regions and stated that low utilization in some areas may reflect unmet need rather than efficiency. Adventist also recommended that the Commission establish a framework to assess care access before implementing policies tied to TCOC performance.

Luminis Health supports the intent of the HOPE program. However, before any funds are withheld from the update factor to support the program, additional detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what guardrails will be implemented to protect the integrity of the program.

HSCRC Response: While implementation of HOPE is being delayed with applications during FY 27 and performance periods generally starting in FY 28, Staff do not view these concerns and continued care transformation efforts as mutually exclusive. Staff believe these issues can continue to be evaluated and coordinated with CMS concurrent with ongoing HOPE development and implementation activities. Concerns with HOPE will be evaluated as the Commission reviews the HOPE recommendation.

5. Distribute the National Demand Modifier Based on Age-Adjusted Demographic Growth

Adventist HealthCare & Frederick requested that the national demand modifier be distributed proportionally based on age-adjusted demographic growth rather than evenly

across hospitals statewide. The Hospitals stated that the current methodology creates a disconnect between the purpose of the adjustment and its distribution because hospitals facing significantly different demographic pressures receive the same allocation. They emphasized that funding intended to address aging population impacts should be directed toward regions experiencing the greatest demographic growth. Luminis Health additionally expressed concern that insufficient recognition of age-adjusted population growth during the AHEAD base period could create long-term financial challenges for hospitals experiencing higher demographic growth.

HSCRC Response: Staff believe there is conceptual validity to this request. There is added complexity with adding this change after results have already been shared with the industry. In addition, the impact is relatively small. Staff agree to consider this enhancement as part of the broader policy review during the transition to split global budgets under AHEAD.

6. Limit Hospital Revenue Growth and Update Factor Increases

The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations expressed concern about the cumulative impact of consecutive hospital revenue increases on Maryland consumers and urged the Commission to limit update factor increases while protecting access to affordable, high-quality care. Both organizations stated that hospital revenue growth should not outpace broader economic and wage growth and recommended treating the draft recommendation as a cap on potential increases given ongoing affordability pressures facing Marylanders. CareFirst also emphasized the importance of balancing hospital financial stability with affordability for Maryland consumers. CareFirst noted that Maryland Medicare hospital payments per capita grew faster than the national average in 2025 and encouraged the Commission to prioritize performance under the AHEAD Model savings tests when finalizing the update factor recommendation.

HSCRC Response: Staff appreciate the comments provided by The Maryland HealthCare for All (MHCA) and Health Means Everything Consumer Alliance (HME) organizations. The Update Factor recommendation is a balance between fairness and equity for hospitals, payers, and consumers. 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 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. To ensure All-Payer affordability, Staff measures our projected update against the GSP target of 3.58% in our contract and the actual GSP since 2014. For all years measured, the All-Payer In State Hospital growth has been lower than the contract target and actual GSP.

Should the projected Hospital growth ever be expected to grow beyond the contract target or actual GSP, staff would evaluate factors within the update to ensure continued affordability.

7. Align HSCRC methodologies with AHEAD/CMMI

UMMS encouraged the Commission to focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD. Specifically, they recommended prioritizing alignment, rather than divergence, on core issues such as carve outs, volume, and quality, while focusing on methodologies that represent the “core building blocks” for Commercial and Medicaid rate setting.

HSCRC Response: Staff agree with these comments. Over the next six months of the calendar year, Staff will be working with stakeholders to align our current policies under AHEAD. There is a significant amount of consideration that will be going into this development. We appreciate the early feedback and ongoing support of stakeholders as we work to achieve alignment over the next several months.

8. Fund CTI Rewards for RY 2025 performance

MedStar Health expressed concern regarding the retrospective elimination of Care Transformation Initiative (CTI) rewards and penalties for FY 2025 performance, stating that hospitals made substantial investments in care coordination, population health, and clinical integration infrastructure based on anticipated CTI incentives. MedStar requested that the Commission consider using a portion of the CTI set-aside funds to provide bridge funding through at least FY 2028 for hospitals with established, high-performing CTI programs.

UMMS does not support ending the CTI policy without paying hospitals for their FY 2025 performance. UMMS and other commenters fully support a set aside in the update factor to fund hospitals and/or systems who have earned rewards within the CTI program.

HSCRC Response: Staff have earmarked funding to provide to hospitals based on system level earnings that would have been paid out as part of the CTI rewards in RY2027 for the RY2025 performance year.

9. Discontinue Productivity Adjustment for Non-GBR Hospitals

MHA, UMMS, JHHS, Luminis Health, Brook Lane, Mt. Washington Pediatric Hospital, Sheppard Pratt, and J. Kent McNew Family Medical Center requested that the Commission discontinue the proposed 0.80 percent productivity adjustment for non-GBR hospitals and provide specialty hospitals with the full 3.37 percent inflation allowance

included in the draft recommendation. They stated that specialty behavioral health and pediatric providers face significant labor shortages, rising operating costs, limited capacity, and low reimbursement rates while caring for clinically complex and vulnerable patient populations. The letters expressed concern that reinstating the productivity adjustment could further strain access to care, staffing, and financial stability for providers that play a critical role in Maryland's healthcare system.

HSCRC Response: Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80 percent, in line with the proposed IPPS rule for FFY 27. 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 based on 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 2025 (most recently completed fiscal year). For Mount Washington, inpatient volumes decreased by 327 cases, as measured by the Commission's casemix adjusted methodology (ECMADS). Approximately 75 percent of this reduction was due to neonatology (see Figure 4a below) and this largely aligned with statewide experience amongst general acute care facilities, with few exceptions, (see Figure 4b below), suggesting a secular decline in demand of neonatology, e.g., fewer premature births.*

Figure 4a
Mount Washington Pediatric Hospital Volume Change by Service Line

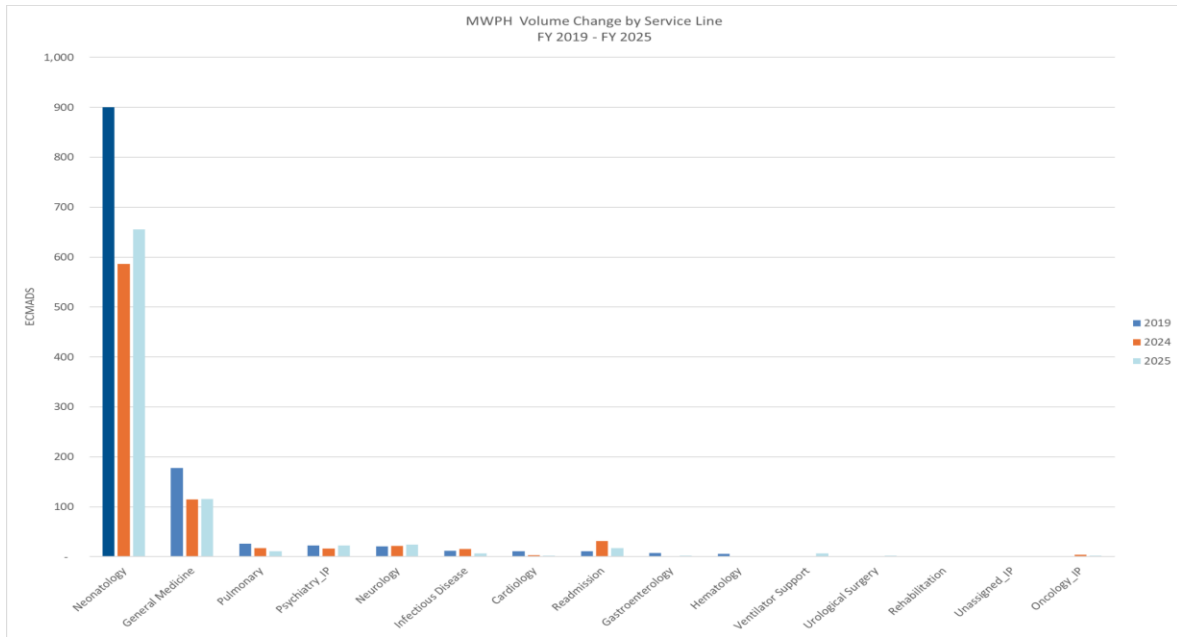
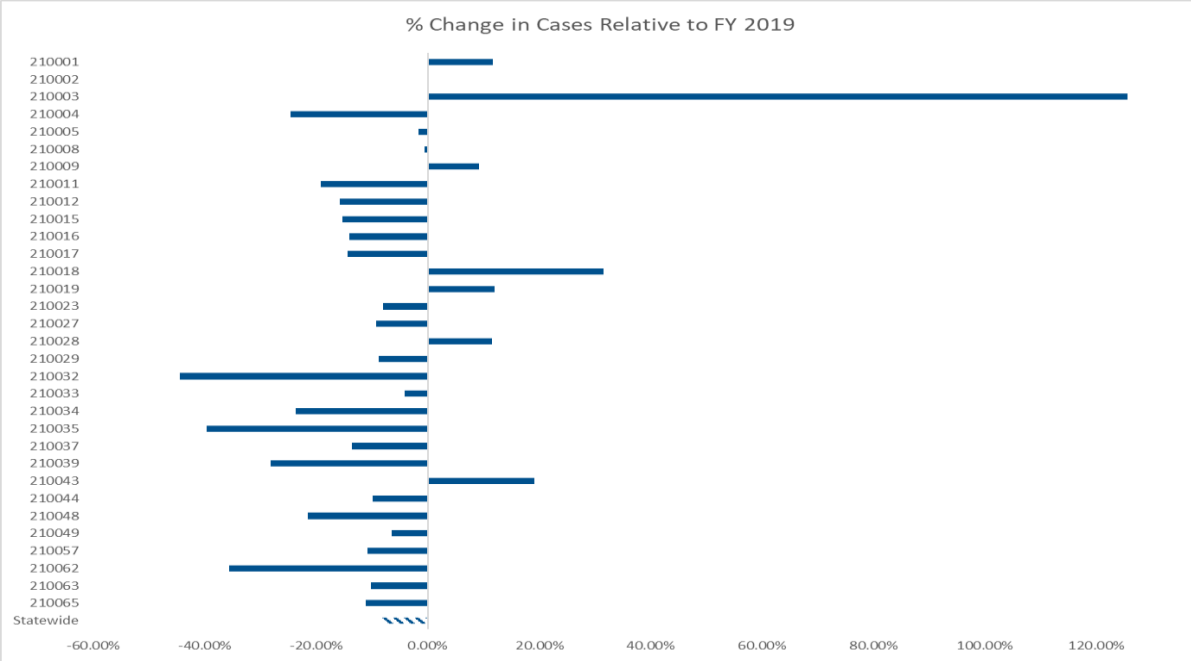
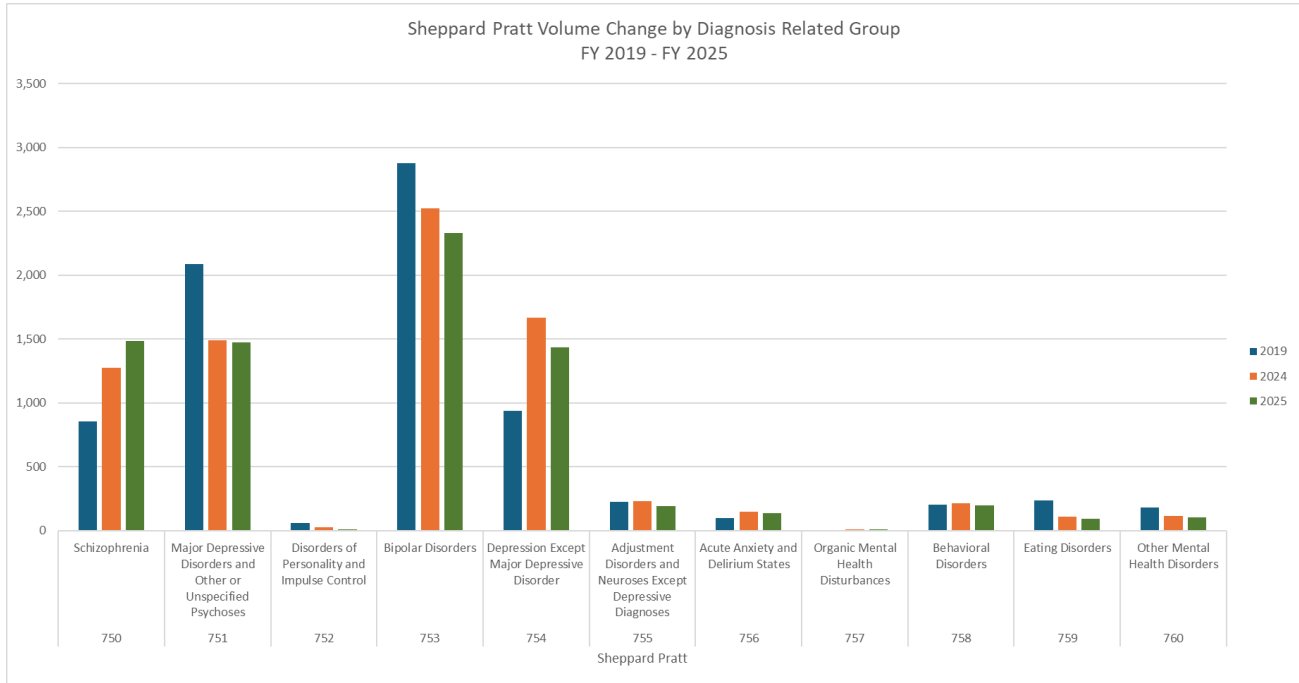


Figure 4b
Fiscal Year 2025 Percentage Change in Neonatology Cases Amongst General Acute Care Facilities



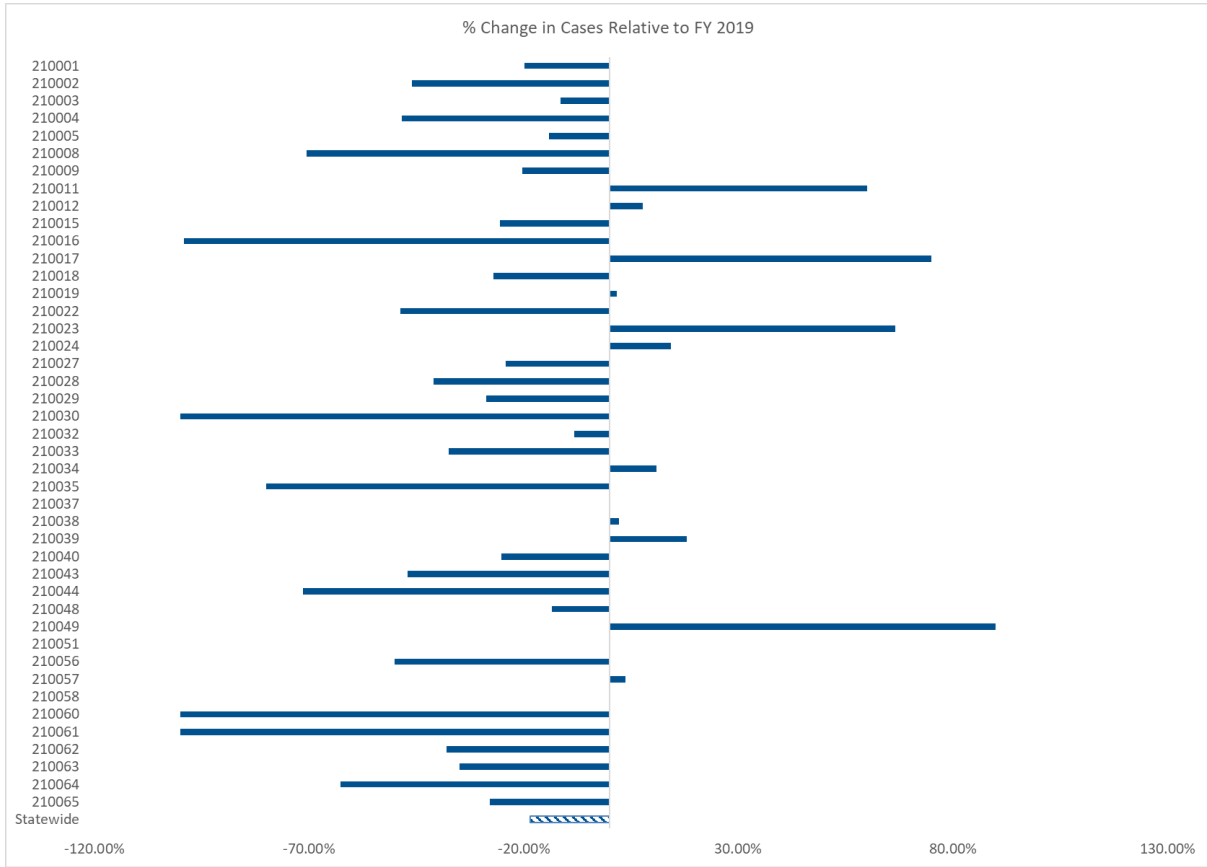
At Sheppard Pratt, inpatient volumes declined by 298 cases; however, the reduction was not localized to one service line or diagnosis related group, as various cases, e.g., schizophrenia, trended upwards, but other cases, e.g., bipolar disorders and eating disorders, saw significant reductions that entirely offset other emerging behavioral health services (see Figure 5a below).

Figure 5a
Sheppard Pratt Volume Change by Service Line



Staff noted a similar decline in behavioral health admissions among general acute care facilities (18 percent statewide), with a few notable exceptions, suggesting another potential secular decline in demand.

Figure 5b
Fiscal Year 2025 Percentage Change in Behavioral Health DRG's Amongst General Acute Care Facilities*



*Removed outliers: University of Maryland Shore Health at Easton and Doctors Community Health, who recently ramped up their Behavioral Health programs.

In light of the analyses described above, staff agree to waive the productivity adjustment for RY 2027. Staff also believe that moving forward exploration of productivity adjustment alternatives should be considered.

Recommendations

Based on the currently available data and the staff's analyses to date, HSCRC staff provides the following final recommendations for the RY 2027 update factors.

For Global Revenues:

- (a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.
- (b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 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) Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.40 percent to support reinsurance and subsidies for marketplace enrollees and 0.10 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and will be removed from the update factor if the final recommendation is not approved subsequently.

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

- (a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

Appendix I: Set Aside Reconciliation

Distribution of Set Aside for RY 2026			
RY 2026 GBR Revenue		\$24,029,464,776	
Set Aside %		0.20%	
Set Aside \$		\$48,058,930	
Hospital	Set Aside \$ Value	Set Aside %	Reason
Tidal Health - PRMC	\$11,551,709	0.05%	IE - GME Residents
Garrett	\$2,766,682	0.01%	Change in 340B eligibility to sole community provider
UCHS/Aberdeen	\$2,900,000	0.01%	Combined Surge Funding
MedStar	\$22,359,625	0.09%	IE (FS, Harbor, St. Mary's)
Frederick	\$2,000,000	0.01%	Cyberattack
PAU Redistribution for FMF Conversion	\$6,161,114	0.03%	-
Total	\$47,739,130	0.20%	
Set Aside Remaining	\$339,799	0.00%	

In RY 2026, the Commission recommended distributing approximately \$48 million in Set Aside funding. This funding allocation represents 0.20 percent of total approved GBR revenue for the

year and is targeted toward hospitals with demonstrated unforeseen circumstances that may cause financial hardship or existing commitments to Integrated Efficiency initiatives.

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 2026, approximately \$60 million was 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. Most investments approved in FY 2026 were continuations of approved FYs 2024 and 2025 investments. Staff waived penalties and safe harbor requirements associated with new FY 2026 IE results due data delays that impacted their release. Only two hospitals, Sinai Hospital and University of Maryland Shore Medical Center at Chestertown, were impacted by the FY 2026 IE results and will incorporate those results into their FY 2027 R4R applications.

Total Eligible for Safe Harbor	
<ul style="list-style-type: none"> • FY 2024 Permanent Revenue: \$23,840,552 • FY 2025 Permanent Revenue: \$39,771,749 • FY 2026 Permanent Revenue: Waived until FY27 	\$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	<ul style="list-style-type: none"> ● 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	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients ● Primary care for uninsured and underinsured patients
Lifebridge Sinai Hospital	\$21,791,363	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients ● Wraparound services/HRSN supports for patients with advanced chronic conditions and SUD ● Diabetes prevention & management and wraparound services ● Community violence intervention ● Physician Practices in HPSA/MUAs
St. Agnes Hospital	\$1,050,599	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients
Union Hospital of Cecil County	\$1,651,197	<ul style="list-style-type: none"> ● 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	<ul style="list-style-type: none"> ● Physician Practices in HPSA/MUAs
University of Maryland Medical Center Midtown Campus	\$4,688,845	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients ● Care management/transitions for patients with SUD ● Physician Practices in HPSA/MUAs
University of Maryland Shore Medical Center at Chestertown	\$1,776,248	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients
University of Maryland Shore Medical Center at Easton	\$5,779,980	<ul style="list-style-type: none"> ● Care management/transitions for high-risk and rising risk patients

University of Maryland St. Joseph Medical Center	\$2,561,803	<ul style="list-style-type: none"> ● 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	<ul style="list-style-type: none"> ● Physician Practices in HPSA/MUAs

Hospitals submit applications to secure safe harbor status for investments through two 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).

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

- Mount Washington Pediatric Hospital
- Brook Lane
- J. Kent McNew Family Medical Center
- Sheppard Pratt
- Maryland Healthcare for All (MHCA)
- Maryland Hospital Association (MHA)
- Adventist HealthCare
- Health Means Everything Consumer Alliance (HME)
- Frederick Health
- John Hopkins Health System (JHE)
- MedStar Health
- Luminis Health
- CareFirst
- University of Maryland Medical System (UMMS)



**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

April 28, 2026
Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

**RE: MWPB Comment Letter on Draft Staff Recommendation for the FY 2027
Update Factor**

Dear Mr. Kromm,

On behalf of Mt. Washington Pediatric Hospital, I am submitting comments in advance of the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027.

The HSCRC is considering 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, and that the productivity adjustment be discontinued.

As you know, MWPB admits medically fragile children who no longer need acute care services, but cannot yet go home. Referring 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. Transfers to MWPB also serve to keep higher-acuity NICU and PICU beds available for children who need them.

In addition to providing specialty medical care, Mt. Washington specializes in the family training and discharge planning that is so crucial to a safe transition for these hospitalized children, 75% of whom are covered by Medicaid.

Mt. Washington also provides outpatient rehabilitation, behavioral health and medical services to children with chronic and/or complex medical conditions. These services can be difficult to access in the community, particularly for the 50% of our outpatients covered by Medicaid, and particularly for children with complicated, time-consuming medical challenges.

Accredited by The Joint Commission
and by Commission on Accreditation
of Rehabilitation Facilities

mwph.org

Mt. Washington Pediatric Hospital
1708 West Rogers Avenue
Baltimore, Maryland 21209
410-578-8600

**Mt. Washington Pediatric Hospital
at UM Capital Region Medical Center**
901 North Harry S. Truman Drive,
8th Floor, Largo, Maryland 20774
240-677-1800 (inpatient)
240-677-1850 (outpatient)



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

Although it provides specialty, post-acute care, MWPH is subject to the same inflationary pressures as acute care hospitals, particularly for salaries. Clinicians with the specific expertise needed to treat our medically fragile children are in short supply. Salaries for pediatric nurses, psychologists and rehabilitation therapists have increased faster than inflation: the average rate MWPH has paid for these specialties have increased by 9% in the past year; by 27% over the past three years; and by 28% over the past five years. The productivity adjustment would further hinder our efforts to match market salaries, and therefore limit admissions, lengthen stays in acute care, and reduce access to care for outpatient services.

Volume growth at MWPH is already limited by payers. Insurers frequently review inpatient cases to assure that admissions are clinically appropriate and inpatient stays do not last longer than is medically necessary.

At the same time, the care of neonates has evolved over the past few years and MWPH is seeing a reduction in inpatient admissions. During this same period, outpatient demand has increased. This has exacerbated financial challenges for MWPH, as it sees reductions in its higher-margin inpatient work, and expands lower-margin but critically needed outpatient psychology, rehabilitation, primary care for medically fragile children, and other services.

The hospital is on track to lose \$10 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 specialty care for Maryland's children.

For these reasons, we request that Mt. Washington Pediatric Hospital receive the same inflation support as the global revenue hospitals, and that the HSCRC eliminate a productivity adjustment that is both unnecessary and counterproductive

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

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Cc: Joshua Sharfstein, MD, Chairman

James Elliott, MD, Vice Chairman

Nicki McCann, JD

Jonathan Blum, MPP

David N. Maine, MD

Farzaneh Sabi, MD

Ricardo R. Johnson

Allan Pack, Principal Deputy Director

Jerry Schmith, Principal Deputy Director

Noel Sousa, UMMS, CFO

Alicia Cunningham, UMMS, SVP

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BROOK LANE

Hope • Healing • Recovery

an affiliate



April 28, 2026

Maryland Health Services Cost Review Commission (HSCRC)

Re: **Productivity Adjustment – Recommendation for Continued Suspension**

Dear Commissioners:

On behalf of Brook Lane Health Services, I am writing to express concern regarding the potential reinstatement of the productivity adjustment and to respectfully request its indefinite suspension, or at a minimum, continued suspension for Rate Year (RY) 2027.

As a specialty behavioral health system, Brook Lane provides a full continuum of psychiatric care—including inpatient, partial hospitalization, residential treatment, and outpatient services—for children, adolescents, and adults with complex needs. These are individuals who cannot be safely or effectively treated in general acute care hospitals. Our services play a critical role in reducing emergency department boarding, supporting hospital throughput, and ensuring access to care for some of Maryland's most vulnerable populations.

The proposed productivity adjustment is fundamentally misaligned with the realities of behavioral healthcare delivery. Length of stay and throughput in psychiatric settings are often driven by external system constraints, including limited step-down capacity, placement challenges, and social determinants of health. These are not inefficiencies that can be resolved through internal operational changes. Applying a productivity expectation in this context risks incentivizing care decisions that could compromise patient safety and quality.

Behavioral health care is also highly labor intensive and dependent on a specialized workforce that remains in short supply. Maintaining safe staffing ratios requires licensed clinicians with specific expertise, and these roles are not easily substituted or scaled. As the workforce has not rebounded to pre-pandemic levels, Brook Lane—like many providers—has increasingly relied on contract and locum tenens professionals to meet patient demand, significantly increasing labor costs. The productivity adjustment further constrains our ability to offer competitive compensation and recruit and retain the staff necessary to sustain access to care.

Additionally, specialty hospitals operate at a structural disadvantage within Maryland's payment system. Unlike hospitals under the Global Budget Revenue (GBR) model, Brook Lane does not benefit from a fixed revenue base and remains vulnerable to fluctuations in utilization and rising costs. Years of productivity adjustments, combined with already constrained reimbursement from Medicare and Medicaid, have created a growing gap between the cost of care and reimbursement. Reinstating the adjustment in RY 2027 would exacerbate this inequity and further destabilize providers that are essential to the state's behavioral health infrastructure.



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Demand for behavioral health services—particularly for children and adolescents—continues to exceed available capacity. At Brook Lane, staffing and physical capacity already limit our ability to expand services despite clear and growing need. Policies that erode financial stability will have the unintended consequence of reducing access, increasing wait times, and placing additional strain on emergency departments and community providers.

For these reasons, we respectfully urge HSCRC to indefinitely suspend the productivity adjustment, or at a minimum, extend its suspension through RY 2027 to allow for further evaluation of its appropriateness for specialty behavioral health providers.

Thank you for your consideration and for your continued commitment to ensuring access to high-quality behavioral healthcare across Maryland.

Sincerely,

Allen L. Twigg, LCPC, FACHE
Chief Operating Officer
Brook Lane Health Services, Inc.

April 29, 2026

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 J. Kent McNew Family Medical Center to respectfully urge the Health Service Cost Review Commission to indefinitely suspend the productivity adjustment for specialty hospitals.

J. Kent McNew Family Medical Center is a standalone mental health facility providing both inpatient and outpatient services. With sixteen inpatient beds, a psychiatric hospital, and an intensive outpatient treatment program, the facility plays a vital role in caring for some of our community's most vulnerable individuals who cannot be safely or effectively treated in other settings. Facilities like McNew are essential to alleviating pressure on emergency departments, reducing avoidable hospitalizations, and supporting better long-term outcomes for patients and their families.

J. Kent McNew continues to face significant financial pressures. The need for highly specialized staff, fluctuations in patient volume, acuity of the patients, and the low reimbursement rates relative to the cost of care provided are contributing factors. Applying the productivity adjustment, substantially reduces the inflation update and further exacerbates these pressures which already threaten access to care.

In summary, the application of the productivity adjustment to specialty hospitals fails to recognize the indispensable role these facilities play in Maryland's healthcare system and support these providers play in meeting the State's priorities. Suspending the productivity adjustment for specialty hospitals is one of necessary steps needed to assist in preserving critical access to care and long-term financial stability.

Thank you for your thoughtful consideration of this matter.

Sincerely,



Kathy Talbot

VP of Revenue Strategy & Optimization

CC: Dr. Joshua Sharfstein, Chairman



2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

Dr. James Elliott, Vice Chair
Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzineh Sabi, Commissioner
William Henderson, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Cait Cooksey, Deputy Director



Sheppard Pratt

April 30, 2026

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

Dear Mr. Kromm:

Although the HSCRC has not yet proposed a RY2027 update factor for non-GBR hospitals, in prior years staff have recommended reducing the inflationary update through a productivity adjustment. From RY2021 through RY2026, the productivity adjustment was included in draft recommendations but ultimately suspended in recognition of lower volumes and the inability to generate efficiencies or margin amid significant cost pressures. Sheppard Pratt requests that the productivity adjustment be permanently eliminated, or at a minimum suspended again for RY2027, with a commitment to discuss permanent elimination before RY2028.

The productivity adjustment assumes that variable hospitals can grow volume to improve margins. In RY2026, the rationale for suspending the productivity adjustment was tied to regulated volumes remaining below pre-pandemic levels. While we appreciate the suspension, that rationale does not translate well to psychiatric services. Demand for behavioral health care remains high, and Maryland continues to face shortages in providers and capacity. Although Sheppard Pratt's regulated volumes remain below pre-pandemic levels, the decline is driven exclusively by outpatient volume that has shifted to community-based settings—where care is often more appropriate and lower cost for consumers, but reimbursement is also lower, resulting in greater provider losses. Meanwhile, inpatient demand remains stable, and Sheppard Pratt typically operates at approximately 90% capacity, leaving little opportunity to increase volume to drive margin. In RY2025, inpatient volume declined due to rising acuity and resulting staffing shortages among nurses and direct-care staff, which required us to take beds offline for one quarter to maintain safe care. Even though the beds returned to service after one quarter, that temporary reduction in capacity affected other hospitals that rely on Sheppard Pratt for inpatient psychiatric transfers.

Sheppard Pratt plays a critical role in Maryland's health care continuum, serving a complex, acute, and underserved population while supporting acute care hospitals statewide through specialized inpatient capacity. We care for some of the State's most vulnerable patients who cannot be safely or effectively treated in other settings, which requires highly specialized, labor-intensive staffing. Maryland already faces a critical behavioral health workforce shortage, and any productivity adjustment further undermines our ability to recruit and retain nurses and direct-care staff. Rising inpatient acuity has increased the need for one-to-one—and at times two-to-one—staffing to ensure the safety of patients and staff. In addition, salary and benefit costs have risen sharply since the pandemic; maintaining safe staffing levels therefore requires higher overall staffing complements on our inpatient units. One example is our adult and adolescent



Sheppard Pratt

neuropsych inpatient units, which serve patients with co-occurring neurological and psychiatric conditions resulting from brain injury or dysfunction. Patients may present with psychosis, aggression, self-injurious behavior, and/or elopement risk. Treating this population requires a comprehensive, multidisciplinary care team that understands the underlying clinical needs and can provide more specialized care than a conventional psychiatric unit.

As described in Sheppard Pratt's prior-year comment letters, the productivity adjustment applied between RY2013 and RY2020 has produced a cumulative reduction of more than 6% to base rates. This has contributed to a structural deficit driven by base rates that remain lower than reimbursement for comparable services provided in acute care settings. As a specialty psychiatric hospital, Sheppard Pratt receives Medicare and Medicaid reimbursement that is low relative to cost. In addition, because specialty hospitals are not part of the global budget model, we have less protection from utilization shifts and less ability to offset rising cost pressures—pressures that are amplified by the complexity of the population we serve.

Demand for psychiatric services has never been higher and Sheppard Pratt provides services that are unique in the market. 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. 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 permanently eliminate the productivity adjustment, or at a minimum suspend it again for RY2027, and provide non-GBR hospitals an update factor equivalent to that provided to GBR hospitals. Thank you for your consideration. Please contact me if you have any questions.

Sincerely,

Kelly Savoca
Senior Vice President and Chief Financial Officer



May 15, 2026

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

Dear Members of the Health Services Cost Review Commission (HSCRC) Payment Model Workgroup,

Thank you for the opportunity to comment on the proposed update factor. [Maryland Citizens' Health Initiative](#) (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. As you consider the update factor, we urge you to consider how to protect consumers from skyrocketing health care costs and limit increases while protecting quality. A recent poll by Kaiser Family Foundation found that 1 in 3 adults have skipped or postponed getting needed health care because of cost in the last twelve months.¹ We appreciate all you do to expand and protect access to quality, affordable health care for all Marylanders.

Best regards,

Stephanie Klapper, MSW
Deputy Director, Maryland Citizens' Health Initiative Education Fund Inc.
stephanie@healthcareforall.com

¹¹ <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>



Maryland
Hospital Association

May 20, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2027. MHA appreciates the time staff have dedicated to ensuring a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

Maryland hospitals will be operating in a rapidly changing and challenging health care landscape in rate year 2027. The current economic environment, transition to bifurcated AHEAD Model policies, and federal policy changes impacting health coverage have added complexity and uncertainty at a time when many hospitals continue to confront financial challenges. MHA identified four ways HSCRC can strengthen its update factor recommendation to preserve access to care, ensure hospitals have sufficient resources for operational readiness and necessary investment, and help facilitate a successful transition to AHEAD, described below.

- **Monitor inflation throughout the rate year.** MHA supports the staff recommendation to fully fund inflation. Additionally, as economic volatility and contemporary cost pressures, including high and rising energy prices, introduce uncertainty and potential inflationary impacts that may not be captured in current forecasts, MHA recommends staff monitor inflation throughout the year to ensure the inflation allowance is adequate.
- **Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%.** H.R.1 and other federal policy changes are expected to result in significant Medicaid and Marketplace coverage losses. However, under HSCRC's current policy, increases in UCC in RY 2027 will not be reflected in rates until RY 2029. MHA estimates UCC levels could increase to 4.73% in FY 2027 (a 0.69% increase over FY 2025), based on state-estimated coverage losses due to policies that take effect in CY 2026 alone.
- **Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD.** To support statewide efforts to mitigate Medicaid coverage losses under H.R.1, hospitals will need additional resources to identify and enroll Medicaid-eligible patients, help them maintain coverage, and navigate payment processes. Hospitals will also need to make

significant investments to successfully operate under two different sets of payment policies and regulatory systems under AHEAD.

- **Discontinue the productivity adjustment for non-GBR hospitals.** The proposed 0.80% adjustment would leave non-GBR hospitals less equipped to manage cost pressures and could unintentionally limit capacity. The provision of the full inflation allowance (3.37%) will help protect access to specialty care.

The state's favorable Medicare total cost of care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections enable HSCRC to provide the funding needed to preserve access to care and address hospital needs while preserving the state's ability to meet its commitments under AHEAD, as further described in *Appendix 1*.

Inflation

MHA supports the proposed inflation increase of 3.37% included in the draft recommendation. This includes a 3.17% core inflation allowance based on S&P Global's estimates from Q4 2025 and a 0.20% correction of historical cumulative underfunding in accordance with the revised "inflation catch-up" policy approved by the Commission last July. A sufficient inflation allowance ensures hospitals can continue to meet the care needs of their communities in an increasingly costly operating environment by helping hospital rates and global budget revenue keep pace with rising labor, supply, and operating costs that are largely outside of their control.

Economic volatility, particularly in energy markets, could place significant pressure on hospital operating costs. Increases in natural gas and electricity prices present a unique challenge for hospitals given their need to keep their doors open and lights on 24/7/365. These costs are especially burdensome for hospitals with aging infrastructure and insufficient capital to upgrade their facilities. Instability in energy markets and large price swings may also have ripple effects for the medical supply chain and transportation, which would place added cost pressure on hospital operations. Given this volatility and considering that regional energy prices have grown at a faster rate than the nation in recent years, it will be important for HSCRC to continue to closely monitor inflation throughout the upcoming year to ensure the allowance included in the update factor is adequate.

Uncompensated Care

The current uncompensated care provision in rates is historically low. While the RY 2027 provision will be updated based on RY 2025 data, the resulting level of rate support will not be aligned with the UCC burden hospitals will face in the upcoming year due to the impacts of H.R.1 and other federal policy changes. In anticipation of a large decrease in UCC due to expanded coverage under the Affordable Care Act, HSCRC modified the policy in 2014, resulting in a prospective decrease in UCC rate support for RY 2015 (see *Appendix 2*).¹ Now, as the state confronts the potential for a sizeable increase in UCC as a result of significant Medicaid and Marketplace coverage losses, HSCRC should take similar action. MHA respectfully urges

¹ As noted in HSCRC's Rate Year 2026 Uncompensated Care Report from November 2025, "In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to avoid carrying over higher UCC amounts".

HSCRC to prospectively adjust the UCC provision in rates by 0.69% in RY 2027, based on an analysis of state-estimated coverage losses due to policy changes that take effect in CY 2026. Without a prospective adjustment, any increase in UCC in RY 2027 would not be reflected in rates until RY 2029 under the current policy, which would place further financial strain on hospitals and threaten their ability to preserve access to essential acute care in the interim.

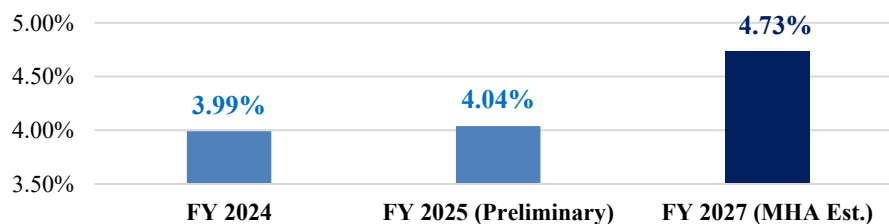
Estimated Medicaid and Marketplace Coverage Losses

Significant reductions in Medicaid enrollment are expected under H.R. 1 as new work requirements, six-month eligibility redeterminations, changes to immigrant eligibility, and other provisions take effect. As many as 130,000 Marylanders could lose Medicaid coverage due to H.R.1, according to the Maryland Department of Health (MDH). Other estimates from the Kaiser Family Foundation (KFF) and the RAND Corporation (180,000 and 230,000, respectively) project even higher coverage losses in Maryland.^{2, 3, 4} At the same time, the expiration of federal enhanced premium tax credits and changes to immigrant eligibility for tax credits for ACA Marketplace plans—two changes that took effect in January 2026—could reduce Maryland Health Connection (MHC) enrollment by 50,000, according to estimates from the Maryland Health Benefit Exchange (MHBE).¹ See *Appendix 3* for a summary of notable policy changes impacting enrollment and a comparison of associated coverage loss estimates.

Prospective Adjustment to UCC Provision in Rates

MHA’s analysis suggests the need for a 0.69% prospective UCC adjustment for RY 2027, which would raise the statewide UCC provision in rates to 4.73% (see *Figure 1*).⁵ This estimate is based on a fraction of the state projected coverage losses, specifically those tied to policy changes that take effect in CY 2026. These include changes to immigrant eligibility for Medicaid coverage and Marketplace tax credits, as well as the expiration of federal enhanced premium tax credits (ePTCs), totaling 65,000 projected coverage losses. The actual increase in UCC could exceed 0.69% if additional coverage losses result from policy changes taking effect in CY 2027 that were not captured in MHA’s analysis.

Figure 1. Statewide UCC Pool, MHA Estimate



Source: RE schedule, FY 2025 + FY 2024 for December hospitals

² Maryland Department of Health and Maryland Health Benefit Exchange January 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

³ Kaiser Family Foundation. August 20, 2025. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State: Allocating CBO’s Estimates of Additional Uninsured People Across the States. Available [here](#).

⁴ RAND. February 26, 2026. State-Level Impacts of Key Medicaid Provisions in the OBBA. Available [here](#).

⁵ MHA calculated the 0.69% projected increase in UCC by multiplying the projected coverage loss of 65,000 by the average cost per uninsured (\$2,380) based on the total amount of UCC in RY 2025 (approx. \$901 million) and the number of uninsured individuals statewide (378,600).

While Medicaid policy changes will not take effect until later this year or in 2027, questions remain about the effectiveness of the mitigation strategies outlined in the draft recommendation. The impacts of Marketplace policy changes, however, are already beginning to emerge.

Recent MHBE data show that 33,000 fewer individuals were enrolled in coverage through Maryland Health Connection (MHC) as of April 2026 compared to the start of the plan year, a 13% decrease compared to the 4% decline in enrollment as of April 2025.^{6, 7} At the same time, those who are enrolling are downgrading coverage, opting for lower-premium bronze plans with up to \$10,000 deductibles. Enrollment in bronze plans as of April 2026 was 7% higher than 2025 levels, whereas enrollment in all other standard metal tiers declined year-over-year: silver (-7%), gold (-16%), and platinum (-39%).⁶ These challenging enrollment trends have occurred despite the availability of state subsidies for plan year 2026 that have lowered monthly premiums by an average of \$95 for nearly seven in 10 MHC consumers. These trends could persist or worsen in plan year 2027 with subsidies that will likely be less generous.⁸

Hospital Readiness for H.R.1 and AHEAD

In preparation for the projected rise in uninsured patients due to H.R.1 Medicaid changes, hospitals will need to make significant operational changes to be ready to support statewide efforts to maximize enrollment in Medicaid. At the same time, hospitals will be making significant investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. MHA urges HSCRC to allocate an additional 0.20% for H.R.1 preparation and 0.10% for AHEAD Model implementation. HSCRC should consider reallocating the Healthcare Outcome Payment Effort (HOPE) funding to support these important statewide priorities.

Under the new coverage environment, hospitals will need to hire additional financial counselors to conduct more extensive Medicaid eligibility screenings, assist with Medicaid applications, assist with more frequent re-enrollment processes, and increase outreach to patients who lose coverage due to procedural or administrative barriers. In addition to expanding front-end capacity, hospitals must strengthen their revenue cycle resources to navigate the new policy changes and coverage landscape. Medicaid eligibility churn, shorter retroactive coverage periods, and more frequent procedural disenrollments are likely to increase denied claims due to coverage lapses or missing documentation. This will create additional administrative burden for hospitals that already dedicate significant resources to securing reimbursement for the care they provide to Medicaid patients.

These coverage disruptions, along with the increased volume of uninsured patients, will not be temporary. Hospitals will need to permanently expand these capabilities to manage these challenges, rather than treat them as short-term response to a policy transition.

⁶ Maryland Health Benefit Exchange. Maryland Health Connection Enrollment Data Dashboard. Available [here](#).

⁷ Enrollment declined by more than 18,000 from March to April, likely due to the expiration of grace periods for non-payment of premiums.

⁸ At MHBE's April Board meeting, the Board approved MHBE staff's preliminary proposal for the parameters for the 2027 state subsidy program. MHBE's Board will be asked to vote on the final proposed parameters in July.

The transition to AHEAD policies and programs is unprecedented and resource intensive for hospitals. For decades, Maryland's unique all-payer global budget revenue system has been built on consistent policies across payers. AHEAD represents a significant departure from that long-standing approach.

Starting in 2028, hospitals will operate under two payment policies and regulatory systems—one for Medicare and another for Medicaid and commercial payers—adding complexity to an already complicated system. As part of their efforts to effectively plan for the transition to this bifurcated system, hospitals will need to allocate significant additional resources to their finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require hospitals to hire new staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). Hospitals will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

Productivity Adjustment

In their draft recommendation, staff propose a 0.80% productivity adjustment to the inflation allowance for non-GBR hospitals. MHA recommends HSCRC discontinue the productivity adjustment and provide specialty hospitals with the full inflation allowance included in the draft recommendation (3.37%). The adjustment is intended to promote cost control and efficiency in operations at non-GBR hospitals. However, it fails to recognize the operational realities of Maryland's specialty hospitals and undermines their ability to preserve access to critical specialty services.

Specialty hospitals play a critical role in Maryland's health care continuum, serving some of the state's most vulnerable populations who cannot safely or effectively be cared for elsewhere. They provide unique inpatient and outpatient behavioral health and pediatric post-acute services to clinically complex patients. This requires specialized nurses, physicians, social workers and other caregivers, often with higher staffing ratios than general acute care hospitals. Given the complexity and highly labor intensive nature of the care they provide, these hospitals cannot be expected to make gains in efficiency without compromising care quality and patient safety.

The productivity adjustment assumes specialty hospitals can and will drive volumes. However, volumes at these hospitals either remain relatively low or are limited by provider and capacity constraints. They do not benefit from the predictability of the GBR system, making them more susceptible to financial challenges due to fluctuations in utilization or operating cost growth. Furthermore, these hospitals face the same cost pressures as their GBR counterparts, including rising energy and staffing costs. However, they are less equipped to absorb these pressures after several years of lower inflation allowances and low reimbursement rates relative to costs. Reinstating the productivity adjustment in RY 2027 would continue this payment inequity. It would also place non-GBR hospitals at a disadvantage in recruiting and retaining the specialized staff required to meet the needs of their patients at a time when they are experiencing clinical workforce shortages.

Conclusion

MHA appreciates the time and effort HSCRC staff have dedicated to the draft recommendation for the RY 2027 update and welcomes the opportunity to work with Commissioners and staff to develop the final recommendation in June. In the coming year, hospitals will need to manage rising input costs due to economic volatility, a higher number of uninsured patients due to federal policy changes, and prepare for AHEAD policies and programs—all while continuing to provide high-quality care to their communities. We ask the Commission to ensure hospitals have sufficient resources for operational readiness and necessary investment in RY 2027, while protecting their long-term financial sustainability.

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

Sincerely,



Melony G. Griffith
President & CEO

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Cait Cooksey
Jerry Schmith
William Henderson

Appendix 1. Funding Capacity

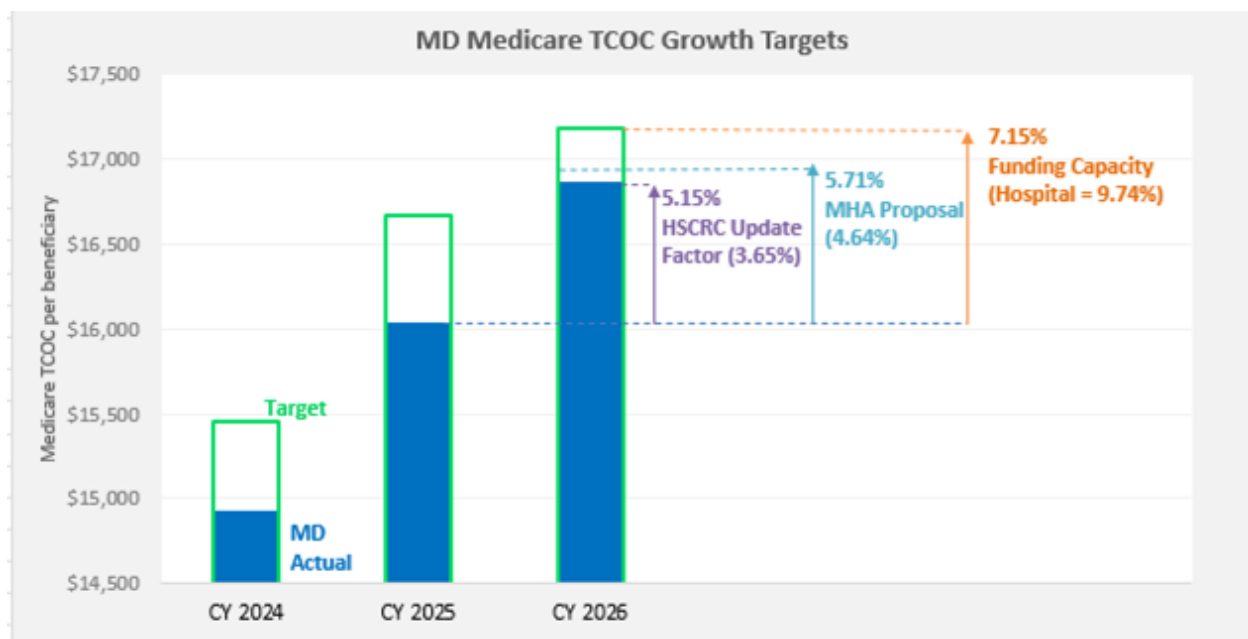
In its draft recommendation, staff present two scenarios for AHEAD target growth rates based on national USPCC trends:

- **Scenario 1:** The 2026 annual target is 4.0 percent, with cumulative growth of 19.0 percent since 2023, based on published USPCC rates.
- **Scenario 2:** Adjusts the national trend by removing duplicate CMS payment adjustments for indirect medical education (IME) and direct graduate medical education (DGME). If these corrections are made, the 2026 annual target increases to 5.3 percent, with cumulative growth of 22.2 percent.

Because AHEAD targets are intended to reflect actual Medicare fee-for-service (FFS) trends as measured by USPCC, MHA believes adjusting the trend for these IME and DGME payments is necessary to ensure a valid and fair comparison of Maryland’s performance to national trends.

Using Scenario 2 targets and incorporating Maryland’s performance in 2024 and 2025, MHA estimates that the maximum allowable total cost of care (TCOC) growth rate for 2026 is 7.15 percent. Assuming non-hospital spending grows at the national projected rate of 5.21 percent, this implies a hospital revenue per beneficiary growth capacity of approximately 9.74 percent (Figure A.1).

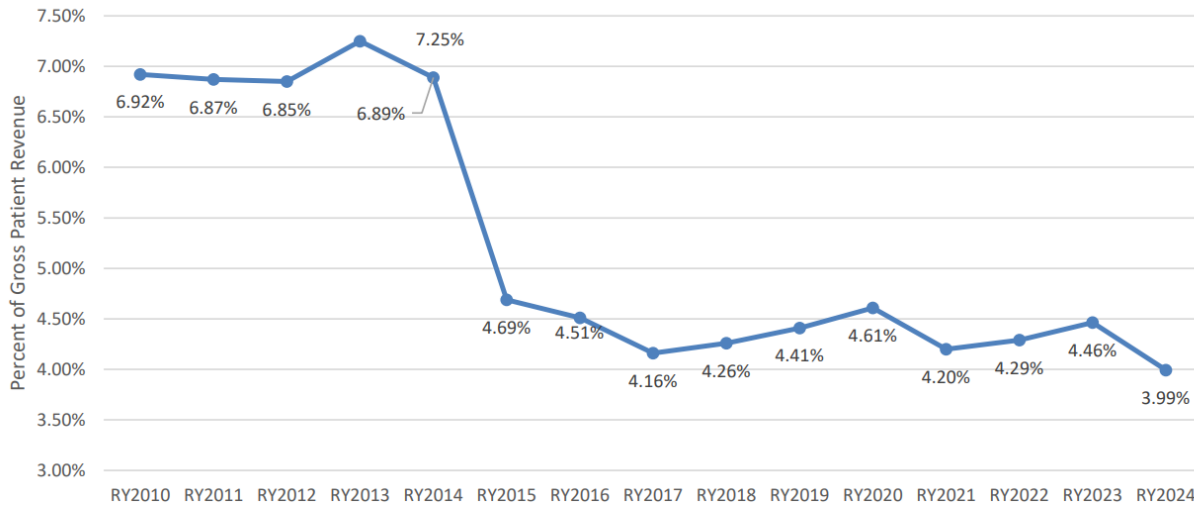
**Figure A.1. Maryland Funding Capacity, MHA Estimate
Based on HSCRC Scenario 2 Modeling Estimates**



MHA proposal (4.64%) includes draft recommendation (3.65%) + UCC (0.69%) + Hospital Readiness (0.30%)

Appendix 2. Uncompensated Care

Actual Statewide UCC in Rates (RY 2010 – RY 2024)



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

Source: HSCRC Rate Year 2026 Uncompensated Care Report, November 3, 2025

Appendix 3. H.R.1 and Other Federal Policy Changes

Table 1. Key Policy Changes, Estimated Coverage Losses, and Impact on RY27 UCC

Provision – <i>Effective Date</i>	State Estimated Coverage Loss	Included in 0.69% Prospective Adj.
<i>Marketplace Policy Changes</i>		
Immigrant Eligibility for Tax Credits – <i>Effective 1/1/26</i> Ends eligibility for Marketplace premium tax credits for lawfully present immigrants under 100% FPL.	20,000	Yes
Enhanced Premium Tax Credits (ePTCs) – <i>Effective 1/1/26</i> Ends federal Affordable Care Act enhanced premium tax credits made available via the American Rescue Plan Act.	30,000	Yes
<i>Medicaid Policy Changes</i>		
Immigrant Eligibility Changes – <i>Effective 10/1/26</i> Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.	15,000	Yes
Work Requirements – <i>Effective 1/1/27*</i> Requires certain expansion adults to complete 80 hrs. per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19-64, with limited exemptions and must be verified through ex-parte processes.	115,000	No
Six-Month Redeterminations – <i>Effective 1/1/27</i> Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver.	--	No
Retroactive Coverage – <i>Effective 1/1/27</i> Reduces retroactive coverage from three months to one month for expansion adults and two months for all other groups.	--	No

* States can request good faith effort extensions through December 31, 2028

Sources: Maryland Department of Health and Maryland Health Benefit Exchange Jan. 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

Table 2. Comparison of Medicaid and Marketplace Coverage Loss Estimates

	MDH/MHBE	KFF	RAND
Medicaid	130,000	180,000 (140,000 – 230,000)	230,000
Marketplace	50,000	30,000	--
Total	180,000	210,000 (160,000 – 260,000)	230,000

Sources: same as above (MDH/MHBE) and footnotes 2 (KFF), and 3 (RAND) on pg. 3



May 20, 2026

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

Dear Dr. Kromm:

Adventist HealthCare appreciates the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027. We are supportive of the Maryland Hospital Association's position on the update factor and would like to share several additional considerations that we believe warrant the Commission's attention. Specifically, Adventist HealthCare respectfully requests that the Commission: (1) distribute the national demand modifier proportionally based on age-adjusted demographic growth; (2) ensure the Healthcare Outcome Payment Effort (HOPE) does not disadvantage already efficient, low-total-cost-of-care regions and does not proceed before access and latent-demand issues are addressed; (3) provide the additional 0.30% hospital readiness adjustment recommended by MHA; (4) prospectively adjust the uncompensated care provision by 0.69%. We offer these comments in the spirit of partnership and in recognition of the considerable work HSCRC staff have invested in this important recommendation.

National Demand Modifier Distribution

The Commission's approach to spreading the 0.1% national demand modifier presents a significant equity concern that merits reconsideration. The current methodology distributes this adjustment evenly across all hospitals in the state, regardless of the actual concentration of aging populations or their demographic characteristics by region. This approach creates a disconnect between the purpose of the adjustment and its distribution because hospitals with materially different demographic pressures receive the same statewide allocation.

The issue is particularly acute for hospitals experiencing substantial population aging in their service areas. For example, White Oak Medical Center faces population-adjusted growth of over 11% to its aging population yet receives only 0.1% of the national demand modifier, the same as hospitals experiencing negative adjustments. This creates a fundamental misalignment between the policy's purpose and its implementation.

Since the broader HSCRC funding framework allocates the majority of population-based funding according to regional concentration of age and population growth, **we recommend that the national demand modifier be distributed proportionally using the same methodology.** Doing so would ensure that funding



targeted at the fiscal impacts of aging is directed to the areas of the state experiencing the greatest demographic pressure, thereby better serving Maryland's most vulnerable aging populations.

Healthcare Outcome Payment Effort (HOPE) Framework

Adventist HealthCare supports the intent of the HOPE framework to reduce total cost of care while maintaining and improving clinical quality outcomes. However, we have significant concerns about the current policy design that should be addressed before implementation.

First, the improvement-only methodology creates an inequitable outcome for hospitals and regions that already operate at historically low cost levels. Some areas of Maryland, including Montgomery County where two of our hospitals are located, already rank among the lowest TCOC counties in both the state and the nation. Hospitals in these regions will have limited access to HOPE funding through no fault of their own, but rather because they are already performing at high efficiency. This policy design inadvertently penalizes high-performing communities. HSCRC should include a mechanism for high-performing, low-TCOC hospitals to qualify based on maintaining efficient performance, not only improving from baseline.

Second, the Commission has not yet conducted a comprehensive assessment of latent demand or care access across the state. Low utilization rates in some areas may reflect genuine efficiency, but they may alternatively reflect unmet need for medically necessary care. Before implementing a policy that restricts funding based on TCOC performance alone, the Commission should establish an explicit framework to assess whether adequate care access exists, particularly in lower-TCOC regions. Without this assessment, the state risks restricting resources in areas that may actually have capacity or access deficiencies. Accordingly, HSCRC should not finalize HOPE until latent-demand and access issues are explicitly addressed.

Third, we respectfully recommend that HSCRC explicitly coordinate approval with the Centers for Medicare & Medicaid Services (CMMI) before finalizing the HOPE policy. The complexity of operating under parallel AHEAD payment policies, combined with the administrative burden of managing overlapping regulatory systems, requires CMMI's active participation in policy design to ensure alignment and operational feasibility.

Adventist HealthCare respectfully recommends that HOPE implementation be delayed until the above concerns, including explicit assessment of latent demand and access and CMMI coordination, are adequately addressed. The 0.21% of funding currently allocated to HOPE could instead be redeployed to address more immediate funding needs, including AHEAD readiness investments and uncompensated care increases.

Hospital Readiness Funding for AHEAD Transition

We appreciate the Commission's recognition that hospitals require additional resources to prepare for the January 2028 AHEAD transition. However, the funding provided to date is insufficient to support the operational readiness necessary for this unprecedented transition.



For Adventist HealthCare, the January 2025 AHEAD funding allocation was approximately \$2.2 million against a revenue base of approximately \$1 billion. After accounting for the cash collection cycle and accounting for differential reimbursement, denials, and bad debt, the net funding available for operations is approximately \$1.8 million. This funding has been directed primarily toward addressing structural deficits created by cumulative underfunding of demographic and inflation adjustments over several years. As of the end of 2025, Adventist accumulated a \$20 million structural deficit in compensation while attempting to maintain break-even operations.

Adventist is also already incurring costs to prepare for AHEAD, including licensing and implementation of MS-DRG grouping software, training and hiring of additional documentation specialists and coders, restructuring of quality programs to align with CMS quality metrics, and system reconfiguration for Medicare cost reporting. **We therefore respectfully urge the Commission to allocate an additional 0.30% for hospital readiness as recommended by the Maryland Hospital Association, which would provide hospitals with meaningful resources to execute their transition planning.**

Uncompensated Care and Marketplace Coverage Disruptions

We concur with HSCRC staff that the primary impacts of H.R.1's *Medicaid* provisions will not be fully realized until later in 2026 and 2027. However, we respectfully note that hospitals are experiencing significant uncompensated care pressure from current federal policy changes affecting the Marketplace, and this warrants near-term policy attention.

The most recent Maryland Health Benefit Exchange data show that enrollment in Maryland Health Connection declined by 33,000 individuals (a 13% decrease) from the start of the plan year through April 2026, compared to a 4% decline in the prior year. Concurrently, approximately 8,000 enrollees shifted from gold plans to bronze plans with deductibles as high as \$10,000, which significantly increases exposure to bad debt and charity care in the hospital setting. These trends represent immediate and measurable impacts on hospital uncompensated care that are occurring now, not in the future.

Under the current uncompensated care policy, any increase in UCC in rate year 2027 will not be reflected in rates until rate year 2029. A two-year lag is operationally untenable for hospitals managing active cash flow challenges. **We therefore support the Maryland Hospital Association's recommendation for a prospective 0.69% adjustment to the uncompensated care provision for rate year 2027, based on state-estimated coverage losses from federal policy changes taking effect in calendar year 2026.**

Conclusion

Adventist HealthCare appreciates the Commission's continued commitment to partnering with Maryland hospitals and acknowledges the significant effort HSCRC staff have invested in developing this comprehensive recommendation. We believe these targeted modifications can be made while maintaining Maryland's ability to meet its AHEAD commitments. We look forward to working collaboratively with the Commission through the June finalization process to address these important considerations. Please feel free to contact me if you would like to discuss any of these points further.



Adventist HealthCare's Recommendations

1. **Demographic:** Distribute the national demand modifier proportionally based on age-adjusted demographic growth in each region, ensuring that funding targeted at aging population impacts is directed to areas experiencing the greatest demographic pressure.
2. **HOPE:** Delay implementation of the Healthcare Outcome Payment Effort (HOPE) framework until the Commission conducts a comprehensive assessment of latent demand and care access, includes a mechanism for high-performing low-TCOC hospitals to qualify based on maintaining efficient performance, and explicitly coordinates with the Centers for Medicare & Medicaid Services (CMMI).
3. **AHEAD Readiness:** Allocate the additional 0.30% for hospital readiness as recommended by the Maryland Hospital Association, providing hospitals with meaningful capacity to execute AHEAD transition planning and manage the operational complexities of this unprecedented transition.
4. **Uncompensated Care:** Prospectively adjust the uncompensated care provision by 0.69% for rate year 2027 based on state-estimated coverage losses from federal policy changes taking effect in calendar year 2026, eliminating the operationally untenable two-year lag in current policy.

Sincerely,



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

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliott
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Cait Cooksey
Jerry Schmith
William Henderson





May 20, 2026

Dr. Jon Kromm

Executive Director

Health Services Cost Review Commission (HSCRC)

4160 Patterson Avenue Baltimore, MD 21215

Re: RY 2027 Update Factor Recommendation

Dr. Jon Kromm and HSCRC Commissioners:

Health Means Everything (HME) appreciates the opportunity to comment on the draft recommendation of the Update Factor for Rate Year (RY) 2027. While we understand this update is designed to provide hospitals with reasonable rate adjustments to address issues such as inflation and maintain operational readiness, we are concerned about the rising cost of health care and how changes to the update factor may exacerbate health care affordability challenges for consumers in the State. HME appreciates the HSCRC's consideration of the many factors that can impact the cost of delivering health care services, but we are concerned that the continuous rate increases hospitals receive year-over-year impose additional unnecessary burdens on consumers.

We worry that the continued divergence of hospital revenues and the ability of Marylanders to afford their health care is reaching a critical point. Since the year 2000, prices for hospital services in the US have increased 271.1%, outpacing other goods and services categories as well as average hourly wages (see Figure 1).¹ Consumers have had to find ways to manage increases in the price of medical services, childcare, and college tuition while hospitals have managed by increasing prices to not only cover costs, but to expand profits and build reserves. Over the past several years, hospital revenues have grown significantly. The RY 2025 update was approximately 4.8%, followed by a 5.68% revenue increase in RY 2026, and now a proposed 3.65% increase in RY 2027.² While we acknowledge that the proposed RY 2027 update is lower than last year, **the cumulative**

¹ <https://humanprogress.org/time-pricing-mark-perrys-latest-chart-of-the-century/>

² <https://www.hmecalliance.com/rising-cost-of-care>

effect of these increases compounds year over year. Marylanders are not simply absorbing one year's increase, they are absorbing the weight of many consecutive years of growth in hospital costs, which flows directly into insurance premiums, cost-sharing, and out-of-pocket expenses.

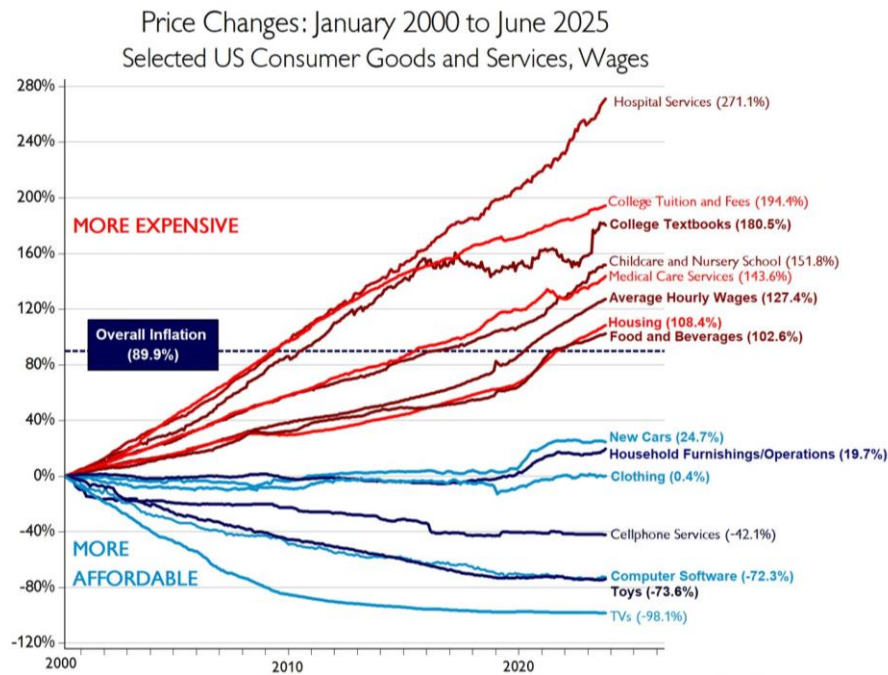


Figure 1. Trends in US Consumer Goods, Services, and Wages. Analysis by Mark J. Perry.
Data Source: Bureau of Labor Statistics

HME’s core concern is that hospital revenue growth continues to outpace what average Marylanders can afford. Wage growth in Maryland has not kept pace with the rate at which hospital revenues have grown. According to the Bureau of Labor Statistics, average weekly wages in Maryland have grown at a modest rate in recent years, especially in rural areas, while hospital revenues under the HSCRC have consistently grown.³ When the cost of health care rises faster than incomes, health insurance becomes less affordable, more Marylanders go uninsured or underinsured, and population health goals will become harder to reach.

HME notes that the foundation of Maryland's all-payer system was rooted in the fact that hospital cost growth should not outpace economic growth. In years prior, the Maryland All-Payer Model limited all-payer per capita hospital growth, including inpatient

³ https://www.bls.gov/regions/mid-atlantic/news-release/countyemploymentandwages_maryland.htm

and outpatient care, to 3.58%.⁴ While we understand that the Maryland model has undergone significant changes from the Total Cost of Care Model (TCoC) to now the AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model, the commitment to keeping health care affordable for consumers has always been, and must remain a guiding principle of Maryland's approach to care. We ask the Commission to consider the real-world impact of these increases on consumers.

HME appreciates the Commission's commitment to balancing hospital financial considerations with the affordability of health care for all Marylanders, and the degree of thought and expertise that have been put into the HSCRC's recommended approach on this issue. We believe the HSCRC's recommendation as the industry's regulator should be treated as a cap on the potential increase under consideration, and that any potential for further increase be tabled as beyond the scope of consideration given the breadth and depth of the affordability crisis Maryland residents are currently subject to.

We appreciate the opportunity to offer comment on this subject, and look forward to continued engagement on these critical issues.

Thank you for your consideration,

Ashiah Parker
Chair, Health Means Everything Consumer Alliance

⁴ <https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model>

May 20, 2026

Dr. Jon Kromm
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 Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2027. We appreciate the time staff have dedicated to ensuring a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

Frederick Health and all Maryland hospitals will be operating in a rapidly changing and challenging health care landscape in rate year 2027 with several policies refinement and development still in progress. The current economic environment, transition to bifurcated AHEAD Model policies, and federal policy changes impacting health coverage have added complexity and uncertainty at a time when many hospitals continue to confront financial challenges. Frederick Health supports the following MHA recommendations to strengthen the HSCRC update factor recommendation to preserve access to care, ensure hospitals have sufficient resources for operational readiness and necessary investment, and help facilitate a successful transition to AHEAD:

- **Monitor inflation throughout the rate year.** We support the staff recommendation to fully fund inflation of 3.37% which includes a 0.20% correction of historical cumulative underfunding in accordance with the revised “inflation catch-up” policy approved by the Commission last July. Additionally, as economic volatility and contemporary cost pressures, including high and rising energy prices, introduce uncertainty and potential inflationary impacts that may not be captured in current forecasts, we recommend staff monitor inflation throughout the year to ensure the inflation allowance is adequate.
- **Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%.** H.R. 1 and other federal policy changes are expected to result in significant Medicaid and Marketplace coverage losses. Reductions in Medicaid enrollment are expected under H.R. 1 as new work requirements, six-month eligibility redeterminations, changes to immigrant eligibility, and other provisions take effect. However, under HSCRC’s current

policy, increases in UCC in RY 2027 will not be reflected in rates until RY 2029. MHA has estimated UCC levels could increase to 4.73% in FY 2027 (a 0.69% increase over FY 2025), based on state-estimated coverage losses due to policies that take effect in CY 2026 alone. External analysis showed that Frederick could see as high as \$7M a year in reduced net reimbursement due to Medicaid disenrollment. Without a prospective adjustment, any increase in UCC in RY 2027 would not be reflected in rates until RY 2029 under the current policy, which would place further financial strain on Frederick Health and threaten our ability to preserve access to essential acute care in the interim.

- **Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD (0.20% for H.R.1 preparation and 0.10% for AHEAD Model implementation).** In preparation for the projected rise in uninsured patients due to H.R.1 Medicaid changes, we will need to make operational changes to be ready to support statewide efforts to maximize enrollment in Medicaid. Under the new coverage environment, we will need to hire additional financial counselors to conduct more extensive Medicaid eligibility screenings, assist with Medicaid applications, assist with more frequent re-enrollment processes, and increase outreach to patients who lose coverage due to procedural or administrative barriers. Medicaid eligibility churn, shorter retroactive coverage periods, and more frequent procedural disenrollments are likely to increase denied claims due to coverage lapses or missing documentation. This will create additional administrative burden for Frederick to secure reimbursement for the care provided to Medicaid patients and will delay cash payment necessary to support hospital operations.

We appreciate the Commission's recognition that hospitals require additional resources to prepare for the January 2028 AHEAD transition. However, the funding provided to date is insufficient to support the operational readiness necessary for this unprecedented transition. Frederick Health will be making significant investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. As part of our efforts to effectively plan for the transition to this bifurcated system, we will need to allocate significant additional resources to finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require us to hire new staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). We will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

- **Increase the Demographic Funding and prorate the National Demand Modifier.** In addition to MHA's recommendations, Frederick Health is requesting that the HSCRC increase the demographic funding. The current proposed FY2027 update factor includes 0.12% for volume funding related to population growth despite age adjusted growth of 8%. For Frederick the gap is even greater, age adjusted population growth is 17.7%

however Frederick Health will only receive 0.17% of demographic funding. The aging population is increasingly medically complex, with higher acuity and comorbidities. This trend results in increased demand for hospital services. Without adequate funding through the demographic adjustment increased volumes will be unfunded in the GBR.

The “national demand modifier” which was approved in January 2026 did not address the continued underfunding of volume growth due to the aging population. This underfunding comes at a time when it is critical to ensure hospitals have sufficient resources to meet growing community needs. In addition, the Commission's approach to spreading the 0.1% national demand modifier does not represent the true spread of age adjusted population growth across hospitals and gives every hospital the same 0.1%. This spread is regardless of the actual concentration of aging populations or their demographic characteristics by region. The issue is particularly acute for hospitals experiencing substantial population aging in their service areas. Frederick faces the highest population-adjusted growth of 17.7% to its aging population yet receives only 0.1% of the national demand modifier—the same 0.1% as the hospitals experiencing negative population growth. This creates a fundamental misalignment between the policy's purpose and its implementation.

We remain concerned that the current methodology does not sufficiently account for age-adjusted population growth as it caps the statewide adjustment at unadjusted population growth projections. For Frederick Health, the demographic adjustment is the only mechanism that provides additional revenue for expected utilization growth due to aging. As in prior years the gap between the age adjusted growth and the scaled adjustment provided is material for Frederick. While we agree that other factors can impact utilization it is not reasonable to assume that Frederick can absorb over 17% of expected volume growth. We request that the HSCRC increase the demographic funding in the FY2027 Update Factor to address the significant expected volume growth due to the aging of the population.

The state's favorable Medicare total cost of care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections enable HSCRC to provide the funding described above as needed to preserve access to care and address hospital needs while preserving the state's ability to meet its commitments under AHEAD.

Frederick Health appreciates the Commission's continued commitment to partnering with Maryland hospitals and acknowledges the significant effort HSCRC staff have invested in developing this comprehensive recommendation. We look forward to working collaboratively with the Commission to address these important considerations. Please feel free to contact me if you would like to discuss any of these points further.

Sincerely,



Hannah Jacobs
Senior Vice President and CFO
Frederick Health

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
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Nicki McCann
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Cait Cooksey
Jerry Schmith
William Henderson

May 20, 2026

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



Dear Dr. Kromm:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Draft Staff Recommendation for the Rate Year (RY) 2027 Payment Update.

JHHS supports the comments submitted by the Maryland Hospital Association (MHA). The recommendations outlined in MHA's letter reflect the operational and financial realities facing Maryland hospitals as they navigate a challenging and rapidly evolving environment, including sustained cost pressures, significant federal policy uncertainty, and the resource needs related to AHEAD Model transition. JHHS urges thoughtful consideration of MHA's recommendations when finalizing the RY27 update.

- 1. Monitor inflation throughout the rate year:** JHHS supports HSCRC staff's recommendation to fully fund inflation and agrees with MHA's call for ongoing monitoring throughout RY27. JHHS encourages the Commission to remain responsive to evolving cost conditions, particularly given the current market uncertainty and volatility.
- 2. Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%:** JHHS shares MHA's concern that the current uncompensated care (UCC) provision in rates will not be aligned with the burden hospitals are likely to face in the coming year. The coverage losses projected to result from H.R.1 and related federal policy changes, particularly those taking effect in CY26, are not reflected under the current policy framework. A prospective adjustment of 0.69%, consistent with MHA's analysis, is a reasonable and appropriate step to ensure hospitals are not left to absorb these costs without support in a time of transition. JHHS urges the Commission to implement this adjustment before realized impacts compound.
- 3. Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD:** The demands of both preparing for projected coverage disruptions under H.R.1 and operationalizing AHEAD Model requirements will place significant resource strain on Maryland hospitals. JHHS is actively engaged in AHEAD transition planning and can attest to the substantial estimated investments required across clinical operations, finance, technology, and other workstreams to operate under a bifurcated payment model beginning in CY28. JHHS supports MHA's recommendation that the Commission provide an additional 0.30% to support these efforts.
- 4. Discontinue the productivity adjustment for non-GBR hospitals:** JHHS also supports MHA's recommendation to discontinue the productivity adjustment for non-GBR hospitals.

Thank you for the opportunity to share comments and feedback. JHHS appreciates the HSCRC's transparent process in the development and approval of the payment update and looks forward to continued collaboration as the State prepares for significant change in the next year and beyond.

Sincerely,

Ed Beranek

Ed Beranek

Vice President, Revenue Management & Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 20, 2026

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

Dear Executive Director Kromm,

On behalf of MedStar Health and its seven Maryland hospitals, we appreciate the opportunity to comment on the Draft Recommendation for the Rate Year (RY) 2027 Update Factor. We commend HSCRC staff for their diligence during a period of exceptional complexity and uncertainty.

MedStar Health broadly supports the Maryland Hospital Association's (MHA) comments, including its requests related to fully funding the inflation allowance, prospectively adjusting the uncompensated care (UCC) provision, and providing additional resources for hospital readiness in light of H.R. 1 and the AHEAD Model transition. We write separately to underscore several concerns that are particularly acute for MedStar Health's Maryland hospitals and to advance one additional recommendation.

As a threshold matter, MedStar Health notes that Maryland's strong TCOC performance through CY 2025 and current USPCC trend projections provide meaningful fiscal capacity to support a more robust update than HSCRC staff have proposed. Using MHA's Scenario 2 modeling, which appropriately adjusts national trends for duplicate IME and DGME payment adjustments, Maryland has headroom to fund the full MHA proposal (4.64%) while preserving the state's ability to meet its AHEAD commitments. MedStar Health urges the Commission to provide this additional funding beyond the Staff's current recommendation at a moment when Maryland hospitals face simultaneous and compounding financial pressures.

I. Maryland Hospital Financial Performance Lags the Nation, and Inflation Risks Remain Understated

Maryland hospitals have underperformed national peers on key financial metrics since 2019. The cumulative effect of sustained rate pressure, below-trend inflation allowances, and pandemic-driven labor cost increases has left Maryland hospitals with limited financial resilience. MedStar Health fully supports funding the proposed 3.37% inflation allowance, but notes that this estimate is based on Q4 2025 forecasts and does not yet reflect inflationary pressures from the ongoing Middle East conflict, energy market volatility, or the potential impact of newly imposed tariffs on medical supplies and equipment. Hospitals operate around the clock; energy and supply costs are largely inelastic, and current inflation projections may prove inadequate.

Given the extraordinary volatility, MedStar Health would request consideration be given to suspend the inflation catch up methodology for one year, FY27, and provide the full underfunded inflation amount,

It's how we treat people.

providing hospitals an additional 0.25%. With the full transition to the AHEAD model looming, this additional unfunded inflation amount should be funded in FY27, or risks becoming a permanently unfunded amount.

Additionally, MedStar Health urges HSCRC to monitor inflation closely throughout RY 2027 and to make corrections if actual cost pressures exceed current forecasts. Given Maryland hospitals' already-strained financial position, there is little cushion to absorb unexpected cost increases without impacting access to care.

II. The AHEAD Transition Will Generate Substantial New Administrative Complexity and Cost

Beginning in 2028, Maryland hospitals will operate simultaneously under two payment frameworks—one for Medicare and another for Medicaid and commercial payers. This bifurcated system will require meaningful new investments in staffing, CDI, revenue cycle infrastructure, quality reporting, and technology. These are not one-time transition costs; the ongoing complexity of managing two regulatory systems with distinct performance incentives and savings requirements will create a permanent increase in administrative burden.

MedStar Health supports MHA's request for an additional allocation to support AHEAD readiness. The Commission should treat this as an infrastructure investment. The operational and clinical groundwork required to meet AHEAD's escalating Medicare savings targets must begin now, and hospitals cannot absorb those costs without adequate rate support.

III. H.R. 1 Will Drive Significant Coverage Losses and Increased Hospital Costs That Must Be Recognized Now

H.R. 1 initiated insurance coverage changes that will materially alter the patient mix at Maryland hospitals well before the end of RY 2027. HSCRC's current policy—under which increases in UCC are not reflected in rates until two years later—is inadequate to address the scale and immediacy of this disruption. Insurers in Maryland, recognizing the effects of H.R.1 on their own operations and their scale, have already filed for received approval for double digit percentage increases to premium rates in plan year 2026 & 2027 in order to pass on these costs to consumers. The HSCRC must take action to recognize the immediate impacts on hospitals in a similar manner. MedStar Health supports MHA's request for a prospective 0.69% UCC adjustment and an additional readiness allocation, and highlights the following specific impacts:

- Significant increases in uncompensated care as an estimated 130,000 to 230,000 Marylanders lose Medicaid coverage and tens of thousands more lose Marketplace coverage. MHBE enrollment data already show meaningful declines, with 33,000 fewer individuals enrolled as of April 2026 compared to the start of the plan year.
- A documented shift toward high-deductible bronze plans by approximately 8,000 former gold-plan enrollees, increasing bad debt exposure for hospitals.
- Permanent increases in administrative costs associated with Medicaid eligibility screenings, re-enrollment support, managing shorter retroactive coverage periods, and a higher volume of denied claims.

These are structural, not transitional, burdens. It should be noted that a prospective UCC adjustment is not unprecedented. HSCRC approved a prospective UCC reduction as a result of Medicaid Expansion, when hospital UCC amounts were anticipated to decrease as a result of additional Medicaid coverage. Funding this anticipated UCC increase for FY27 is a mirror image of the Medicaid Expansion issue and should be handled in a similar manner.

IV. The Retrospective Elimination of CTI Undermines Hospital Confidence in Care Transformation—HSCRC Must Act to Restore It

MedStar Health raises a concern on this final point that is distinct from MHA's submission and goes to the heart of HSCRC's ability to advance care transformation under AHEAD. At the May public meeting, the Commission voted to eliminate the rewards and penalties that the CTI program calculated based on FY25 performance due to the significant unintended consequences of the inclusion of geographic CTIs and their interaction with the net zero nature of the program.

The Care Transformation Initiative (CTI) was designed to reward hospitals that generated real, sustained savings through care redesign and clinical integration. MedStar Health's Maryland hospitals invested substantially in these programs—dedicating staff, infrastructure, and clinical leadership—and reinvested CTI rewards directly into the care coordinators, community health workers, and transitional care infrastructure. The retrospective elimination of the CTI program leaves hospitals with programs generating real savings with an abrupt funding gap with no clear transition mechanism.

The implications extend well beyond the immediate budget impact. AHEAD's success depends on hospitals' willingness to invest in care transformation—population health, care coordination, clinical integration—knowing that the financial incentives associated with those investments are reliable. If HSCRC eliminates earned rewards retroactively, it sends a signal to every Maryland hospital that care transformation investment is not worth the risk. That is precisely the wrong signal at this moment.

MedStar Health urges the Commission to use a portion of the approximately \$100 million in set-aside funds to provide bridge funding through at least FY 2028 to hospitals that: (1) had established high-performing CTI programs with consistent performance in multiple years; and (2) were projected to receive CTI rewards based on consistent savings generation.

Conclusion

MedStar Health is committed to improving the health of Marylanders and working in collaboration with the HSCRC and other stakeholders to develop and refine policies under the AHEAD Model that accomplish this goal. Maryland's strong TCOC performance provides the fiscal capacity to do more than the draft recommendation proposes—and the financial pressures confronting hospitals in RY 2027 demand it. We respectfully urge the Commission to fully fund the inflation allowance, prospectively adjust the UCC provision, provide readiness resources for H.R. 1 and AHEAD, and take corrective action on the retrospective elimination of CTI to restore the trust that effective care transformation requires.

We appreciate the Commission's consideration and welcome the opportunity to discuss any of these issues further.

Sincerely,



Susan K. Nelson

Executive Vice President and Chief Financial Officer, MedStar Health

cc: Joshua Sharfstein, MD David N. Maine, MD
James Elliott, MD Nicki McCann, JD
Jonathon Blum, MPP Farzaneh Sabi, MD
Ricardo R. Johnson

May 20, 2026

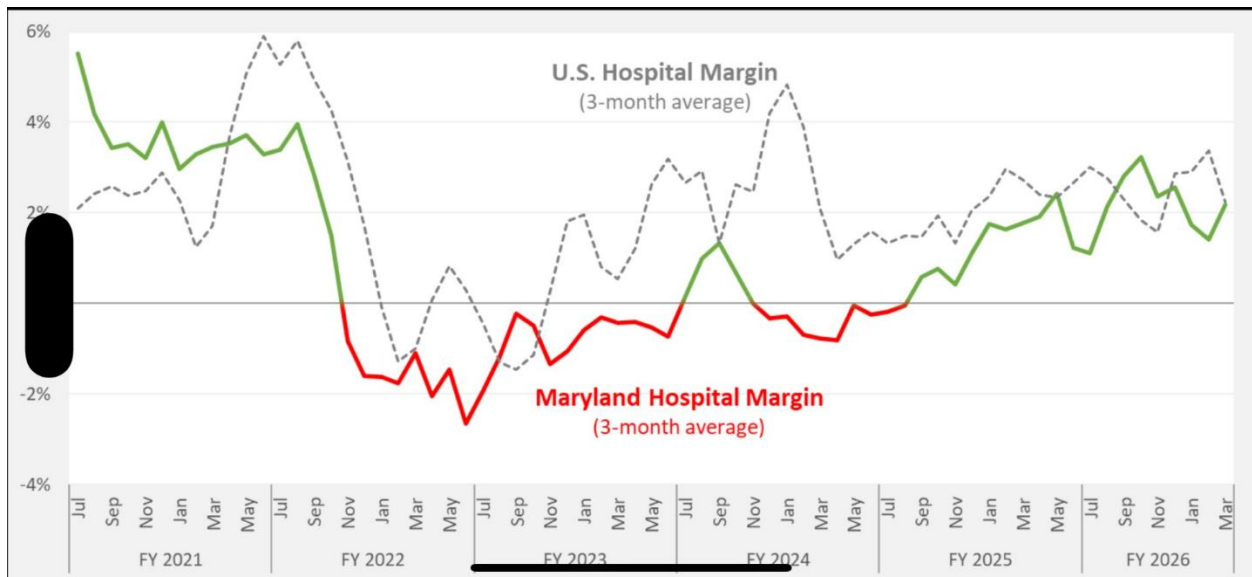
Jon Kromm, PhD Executive Director
 Health Services Cost Review Commission
 4160 Patterson Avenue
 Baltimore, MD 21215

Dear Dr. Kromm,

I am writing on behalf of Luminis Health to provide comments on the Health Services Cost Review Commission staff's ("HSCRC") draft recommendation for the annual update factor for rate year 2027.

As we are in the beginning of the AHEAD model, it is critically important we have a strong financial foundation and that the update factor recognizes not only inflation growth but recognizes and appropriately funds for federal and local changes that impact our unique global budget system.

While Maryland Hospitals are showing improvements to overall financial performance, the state health systems FY26 operating margins continue to be below the nation.



Source: Maryland Hospital Association

Furthermore, the HSCRC provided one-time money in FY26 that elevated operating performance. These adjustments related to prior year demographic and uncompensated care corrections will be removed in FY27 eroding these operating margins. While we are extremely appreciative of the corrections and the funding, the current proposed update factor will have revenue growth from FY26 well below inflation for many Maryland Hospitals, including Luminis Health, when the one-time funding is removed. The removal of these dollars we believe are not included in the update factor projections. This challenge coupled with aging population growth, implementation of H.R.1. and the transition to the AHEAD Model creates financial instability and challenges for FY27.

Luminis Health has the following enhancements to the HSCRC staff recommendation to assist in creating financial stabilization:

Support MHA’s Recommendation

(1) Inflation Funding Support with Monitoring and Permanent Removal of Specialty Hospital Productivity Adjustment

Luminis Health supports the proposed 3.37% inflation increase included in the staff recommendation based on S&P Global estimates that include an additional 0.20% catch-up adjustment intended to address prior years of underfunding. As financial pressures continue to intensify across the healthcare sector, maintaining an adequate inflation update is essential to preserving access, stability, and quality of care throughout Maryland’s health system.

In addition, consistent with the letter submitted by Luminis Health to HSCRC on April 29, we request the indefinite suspension of the productivity adjustment for specialty hospitals. A productivity adjustment of 0.8% would reduce the inflation update to only 2.5% for hospitals that are serving some of our communities’ most vulnerable populations, despite these providers facing the same financial pressures as acute care hospitals. Specialty hospitals play a critical role in Maryland’s healthcare system, supporting the State’s priorities, and limiting funding for services with historically low reimbursement could potentially undermine access to critically necessary care.

We recommend monitoring inflation throughout the year to ensure that the inflation projections are adequate. The recently updated Producer Price Index shown below demonstrates the cost growth we are experiencing in energy and supplies, which is trending above the current projections by S&P Global Insights.

12-Month Percent Change

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
202												
5	3.8	3.4	3.2	2.4	2.7	2.4	3.2	2.7	3.0	2.8	3.1	3.1

202
6 3.1(P) 3.4(P) 4.3(P) 6.0(P)

Source: Producer Price Index, Bureau of Labor Statistics

(P)=Preliminary. All months are subject to change 4 months after original publication

(2) Increase Uncompensated Care Funding for Medicaid and Marketplace Changes

With the recent passage of H.R.1, Medicaid is entering a significantly more complex and restrictive environment that will adversely affect patient coverage. New federal policies will introduce work requirements, expanded exemption verification processes, biannual renewals, and a shortened retroactive coverage period. These changes, combined with reductions in Affordable Care Act subsidy support that are expected to make Marketplace plans unaffordable for millions of individuals, will increase the number of uninsured patients.

Kaiser Family Foundation projects an estimated 210K people in Maryland may lose Medicaid coverage. In the Maryland Medicaid Expansion Group alone, 130K people may lose coverage with Anne Arundel County and Prince George's County projected to experience impacts of 7% and 16%.

ACA Marketplace enhanced premium tax credits ended on January 1, 2026, which increased premiums and reduced or eliminated subsidy levels based on income. This already has impacted participation as the most recent Maryland Health Benefit Exchange data show that enrollment in Maryland Health Connection declined by 33,000 individuals (a 13% decrease) from the start of the plan year through April 2026, compared to a 4% decline in the prior year. Concurrently, approximately 8,000 enrollees shifted from gold plans to bronze plans with deductibles as high as \$10,000, which significantly increases exposure to bad debt and charity care in the hospital setting. These trends represent immediate and measurable impacts on hospital uncompensated care that are occurring now, not in the future. These changes are also expected to increase hospitals' costs to collect. We are projecting another \$1.3m of costs related to Medicaid enrollment efforts starting January 1, 2027.

Given the magnitude and uncertainty of these anticipated changes, it is critical that the HSCRC establish an appropriate funding base in 2026 that reflects the future costs of delivering care and maintaining financial stability across Maryland hospitals. Delaying adjustments until 2028 may limit the state's ability to proactively address rising uncompensated care costs under the current reimbursement framework. Accordingly, Luminis Health supports MHA's recommendation to include an additional 0.20% to support Medicaid enrollment and retention efforts, as well as an additional 0.69% to prospectively account for expected increases in uncompensated care. We also would like the staff to continue to monitor the impact of these changes throughout the year given the substantial changes.

(3) Ahead Model Preparation

We appreciate the 0.5% funding for AHEAD that was included in Hospital Global Budgets. Hospitals will need to operate under dual systems and policies, which will require investment in people(reimbursement specialists, coders, IT professionals, consultants, etc.), significantly change

processes (for example, utilization review and coding workflows) and revise and/or deploy new technology and data infrastructure (for example, building/purchasing new data analytic tools) . We believe the current funding level does not support the investment cost needed for this new model given the significant impact in many areas of the organization. Luminis support's MHA recommendation to include an additional .10% for AHEAD Model Implementation.

Provide Adequate Demographic Adjustment based on Population Health Projections

Global Budgets need to be appropriately adjusted for age-adjusted population. We historically have seen inaccurate funding for age adjusted population growth, which is a critical component of yearly updates when hospitals are under a revenue capped system. There was significant discussion around demographic adjustment and potential changes to better reflect age adjusted population growth and an agreement to revisit the work every two years.

The proposed statewide demographic adjustment for rate year 2027 of only 0.12% does not adequately reflect the expected increase in demand for hospital services based on age adjusted population growth. We continue to believe there needs to be a better prospective adjustment given the aging population growth.

At the least, the national payment adjustor recently incorporated into the demographic adjustment should be spread based on age adjusted population growth rather than the current across the board adjustment to appropriately recognize the growth differences in the State.

With FY27 being part of the AHEAD model base period, not accurately accounting for population growth will create a starting point that will be too low and create long term financial challenges.

Health Outcome Payment Effort ("HOPE")

Luminis Health supports the intent of the HOPE program as articulated in our April 8th, 2026 letter. We believe before any dollars are withheld from the update factor to fund the HOPE program more detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what guardrails will be applied to protect the integrity of the Program.

Luminis Health appreciates the thoughtful work of the HSCRC staff in developing the draft recommendation for the annual update for rate year 2027 and looks forward to continued collaboration with Commissioners and staff as the final recommendation is considered in June. Given the states favorable Medicare Total Cost of Care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections, there is adequate room to increase the demographic and uncompensated care adjustments to account for projected changes in population growth and Medicaid and other coverage losses due to policy changes. We also request additional funding be provided for AHEAD model preparation. These adjustments are critical to support operations and long-term financial stability that will ensure continued access to high quality care for the communities we serve. Please feel free to reach out to us with any questions.

Sincerely,



Kathy Talbot
Vice President of Revenue Strategy and Optimization

CC:

Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chair
Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzineh Sabi, Commissioner

May 21, 2026

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

Dear Executive Director Kromm:

CareFirst Blue Cross Blue Shield appreciates the opportunity to comment on the Draft Annual Update Factor Recommendation for Fiscal Year 2027. We acknowledge that staff and commissioners have the responsibility every year to balance affordability for consumers against economic pressure and uncertainty. Each year, we encourage the Commission to follow its previously agreed upon formulas and policies; in this particular year, we acknowledge and appreciate that Staff adhered to its designed process.

We understand that the additional inflation support of 0.20% is based on the catch-up inflation methodology. As expressed in prior comment letters, we disagree with the chosen base year for this policy. Additionally, in arriving at the 0.20% catch-up inflation, Staff omitted from its calculation the most recently available data. If Staff included FY 2025 data, the conclusion would have been that cumulative underfunding did not surpass the threshold for an adjustment, set at 0.25%. The Commission should recalculate the corridor using the best and most timely data available.

During the May 2026 public meeting, Commission staff shared that Medicare hospital payments per capita in Maryland outpaced the nation in 2025, growing at a rate of 8.4% compared to the national growth rate of 7.5%. Particularly as we enter the AHEAD Model, the Commission should prioritize performance on model savings tests.

We remain concerned about the overall affordability of healthcare for Maryland residents, and the Commission has an important role to play. The decision on the update factor must strike the balance of both keeping pace with inflation to put hospitals in a financial position to deliver services to Marylanders and safeguarding the public from unnecessary costs.

Again, thank you to the Staff for adhering to approved policies and an inclusive stakeholder engagement process. We appreciate the opportunity to comment.

Sincerely,



Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
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Baltimore, MD 21201-6829

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May 22, 2026

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 2027 Update Factor

Dear Jon:

On behalf of the University of Maryland Medical System (“UMMS”) and its member hospitals, thank you for the opportunity to submit comments in response to the Health Services Cost Review Commission’s (“HSCRC” or “the Commission”) Draft Recommendation for the Update Factor for Rate Year 2027. UMMS understands the core inflation and catchup methodologies that drive the HSCRC’s proposed 3.37% gross inflation allowance and supports the Maryland Hospital Association’s (“MHA”) request for an additional 0.99% to provide prospective consideration for (1) the anticipated impact of House Resolution 1 (“H.R.1”) on hospital uncompensated care costs (“UCC”) and (2) readiness for the Achieving Healthcare Efficiency through Accountable Design (“AHEAD”) Model. UMMS also supports the MHA’s requests to discontinue the productivity adjustment for non-GBR hospitals and to continuously monitor both inflation and uncompensated care in what will surely be a particularly volatile year.

The Maryland Regulatory Model bears the unique burden of ensuring stability for the largest economic driver in Maryland as the healthcare industry navigates the most significant changes to federal funding in recent memory, and it must do so in the context of significant economic volatility due to the national and international landscape. The Comptroller of Maryland’s April 2026 health care industry report effectively summarized the major uncertainties that the healthcare industry faces over the next few years:

- HSCRC will lose rate-setting authority for Medicare beginning in CY2028.
- AHEAD will reduce federal hospital payments by an estimated \$870 million over CY2028-CY2032.
- H.R.1 changes beginning in FY2027 are estimated to trigger coverage loss for 130,000 Marylanders and are estimated to cut Maryland’s federal Medicaid funding by up to \$2.7 billion, representing nearly 20% of Maryland’s current Medicaid budget.
- The cost burden of Medicaid coverage and funding cuts falls hardest on hospitals’ operating budgets.
- Workforce shortages are persistent in the face of increasing demand for services as the population ages.
- Healthcare costs continue to rise, including the costs of workforce, physicians, and drugs/supplies.
- The national and international landscapes drive persistent inflationary and economic uncertainty.

As the Comptroller of Maryland's April 2026 healthcare industry report also points out, the Maryland Model plays a significant role in shaping the economic outlook of the hospital industry, which is a key driver of the healthcare sector and the State more broadly. The healthcare sector is the State's largest source of employment, responsible for 16% of all jobs in Maryland and adding more jobs than any other sector since 2015. In 2025, the healthcare sector employed 427,000 Marylanders, was one of only four sectors that added jobs vs. the prior year, added more jobs than the other three growing sectors combined, and injected \$23 billion in spending to the State economy.

As the Commission grapples with consequential issues surrounding AHEAD, H.R.1, and broader economic uncertainties, the context of our industry's outsized impact on the lives of Marylanders matters. We rely upon the Model to provide revenue stability and protection against volatility to allow us to pursue the value-based goals of reducing cost and improving health outcomes. This sentiment is reflected in our many responses to the HSCRC's call for input on positioning Maryland for success under the AHEAD Model, where we have consistently emphasized that hospitals must come from a position of financial stability to maximally engage in those transformative goals of the Model. UMMS strongly encourages the Commission to focus its efforts to stabilize the Model in three key areas of volatility that pose significant risk to broader Model goals:

- 1. Proactively, and prospectively provide funding to address the impact of H.R.1 on uncompensated care.** Hospitals cannot afford to bear the cost burden of this risk while lagged UCC funding mechanisms take years to catch up, and they should not be asked to do so. UMMS is significantly concerned that the HSCRC's approach of (1) conservatism in FY2027 estimates and (2) monitoring, rather than acting proactively, leaves the hospitals to bear the cost risk of an issue with such a broad range of potential outcomes.
- 2. Monitor FY2027 inflationary pressures throughout the year and act proactively as necessary to address economic and inflationary volatility.** The sheer number and variety of negative cost pressures in the immediate future significantly increases the likelihood that the 3.37% inflation allowance contemplated by the draft recommendation will underfund actual inflation in FY2027. To the extent that this shows in the data throughout the year, the Commission should fund it proactively, as it is not in the State's best interest to carry any known underfunded inflation forward into the future.
- 3. Focus Staff efforts on aligning core methodologies with CMMI and transitioning to AHEAD.** UMMS is increasingly concerned with the amount of methodology work required to build a non-Medicare Regulatory Model, the downside risks of not aligning HSCRC methodologies across payers on core issues such as carveouts, volume, and quality, and the timeline by which all of this needs to be accomplished. We encourage Staff to (1) prioritize alignment with, rather than divergence from, CMMI on core issues such as carveouts, volume, and quality, (2) focus energy on the methodologies that represent the core building blocks for Commercial and Medicaid rate setting, and (3) expend less time and effort on introducing new add-on methodologies such as Length of Stay.

Throughout the progressive iterations of the Total Cost of Care Model since 2014, UMMS has been committed to driving toward the Model's value-based goals. We have been a leader in utilizing facility transformations to redesign care delivery models and expand access to high-value care. We have participated fully in, and made significant investments toward, the HSCRC's Care Redesign Programs with a goal of improving outcomes in the communities we serve. 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.

To that end, UMMS does not support ending the CTI policy without paying hospitals for their FY 2025 performance. While we have previously gone on record to address the significant issues within the policy, we do not believe those issues should negate any positive rewards which were appropriately earned. We have suggested alternative approaches for dealing with the issues within the CTI policy however, the commission has since voted to cease the program. Because downside protections have diluted HSCRC's ability to pay out rewards for true, transformative savings, the Commission needs to prioritize a potential glidepath for negatively impacted hospitals to keep investment levels steady and reduce risk to critical infrastructure needed for AHEAD performance. We therefore would fully support a set aside in the update factor to fund hospitals and/or systems who have earned rewards within the CTI program.

It is worth restating that the healthcare industry, and the State more broadly, relies on the Maryland Model to provide hospitals stability to continuously and sustainably invest in the value-based goals of the Model. This is true now more than ever, as we find ourselves in incredibly uncertain times. We are unfortunately in the midst of significant disruption and volatility with the loss of Medicare rate-setting authority, the anticipated impact of H.R.1, the abrupt discontinuation of Care Redesign Programs, and broader economic realities. In its annual update factor decision, the Commission has the opportunity to provide stability by addressing multiple drivers of potential volatility. For this reason, UMMS again offers its support of the recommendations outlined in the MHA's comment letter:

- 1. Monitor inflation throughout the rate year**
- 2. Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%**
- 3. Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD**
- 4. Discontinue the productivity adjustment for non-GBR hospitals**

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. Now is the time to safeguard the Model against known sources of volatility risk, such as H.R.1, the changes in Medicare regulatory oversight, and ongoing economic uncertainty. I cannot emphasize enough that volatility of this magnitude threatens hospitals' ability achieve the transformation envisioned by the Model. UMMS looks forward to collaborating with our State partners to work toward the broader goal of improving the health of Maryland citizens.

Jon Kromm, PhD

May 22, 2026

Page 4

Sincerely,

A handwritten signature in cursive script that reads "Alicia Cunningham".

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman

James Elliott, MD, Vice Chairman

Jonathan Blum, MPP

Ricardo Johnson

David Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD



maryland
health services
cost review commission

Healthcare Outcome Payment Effort (HOPE)

Final Recommendation

June 10, 2026

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Final Recommendation

This final recommendation outlines the policy framework for the Healthcare Outcomes Payment Effort (HOPE) beginning in Fiscal Year 2027 (FY27). HOPE replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) is sunsetting on June 30, 2026. The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals and community partners to invest in interventions that improve care and health and enhance the financial sustainability of the health care system. HOPE seeks to sustain and expand population health investments that advance Achieving Healthcare Efficiency through Accountable Design's (AHEAD) goals and drive meaningful system transformation.¹

Differences from Draft Recommendation

Over the past two months, stakeholders provided extensive comments and feedback that informed the policy refinements and timeline modifications reflected in the draft recommendation. Staff carefully reviewed stakeholder input alongside lessons learned from prior and existing care transformation programs and, based on this analysis, recommend the following key updates to the original HOPE draft recommendation:

1. Shift the implementation and measurement start date from FY27 to FY28.
2. Provide reasonable flexibility in baseline and measurement periods to account for variation in initiatives and differing stages of program maturity across organizations.
3. In FY27, provide one-time infrastructure funding totaling \$25 million, distributed proportionately based on hospitals' Global Budget Revenue (GBR), as well as an additional \$25 million in seed funding for proposals that are qualified under HOPE.
4. Allow flexibility regarding eligible applicants for Regional and Statewide Initiatives (RSIs), including permitting hospitals to serve as applicants when appropriate.
5. Sunset High-Value Care Plans (HVCPs) at the conclusion of FY26 following completion of final reporting requirements.

¹ <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals, payers, and community partners to invest in interventions and share in savings. HOPE seeks to sustain and expand population health investments that advance AHEAD's goals and drive meaningful system transformation.	HOPE is a voluntary, upside-only outcome payment model that rewards hospitals and non-hospital partners for measurable reductions in inpatient and ER spending while improving population health. It creates predictable, performance-based funding pathways and positions the State as an outcome purchaser of successful projects.	Hospitals benefit from financial predictability, reduced risk, and incentives to invest in prevention and population health initiatives. The program encourages collaboration and supports infrastructure and transformation efforts.	Payers and consumers gain from improved care and health outcomes and greater financial sustainability of the health care system. The model promotes preventive care and community-based interventions that enhance patient experience and reduce unnecessary utilization.	HOPE prioritizes interventions that target defined populations and address upstream health drivers to improve outcomes and reduce disparities.

Hope Alignment with AHEAD

This proposal is designed to align closely with the AHEAD Population Health Accountability Plan (PHAP) and the broader vision advanced by stakeholders.² By reinforcing shared accountability for measurable improvements in population health, the framework supports the State's commitment to responsible cost growth, improved outcomes, and transparent performance expectations across the delivery system.

It also reflects a deliberate opportunity for prevention and restorative health that emphasizes upstream interventions, chronic disease management, and community-based supports. In addition, the framework

² <https://health.maryland.gov/mche/pages/default.aspx>

seeks to encourage cross-sector collaboration and broader care delivery models. This approach recognizes that meaningful population health gains can benefit from engagement from community providers, social service organizations, and public health partners. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.

Introduction to the HOPE Policy

The State's participation in AHEAD presents a pivotal opportunity to strengthen the alignment between payment policy and population health improvement. Building on stakeholder feedback regarding the strengths and limitations of prior initiatives including Potentially Avoidable Utilization (PAU) and CTIs, HOPE builds upon progress to date on these policies by offering clearer guidance to hospitals and partners regarding the return on investment. Described in further detail in sections below, it is a voluntary, upside only model that increases payment predictability and supports planning and investment using an annual payout structure of an initial 3 years based on validated savings. At the same time, it represents a model in which the State becomes an outcome purchaser rewarding measurable, successful interventions.

Paths to Participation

Participation can occur through one of two primary pathways: the Care Transformation Framework (CTF) or Regional & Statewide Initiatives (RSI). Both pathways aim to improve population health while reducing emergency room and inpatient expenditures and share savings with participants. They differ in who leads the effort, how approval is obtained, and the scale of intervention.

Path 2: Care Transformation Framework (CTF)

Under the CTF pathway, participation begins at the individual hospital level. A single hospital—or a group of hospitals—applies directly to implement a hospital-defined intervention. Although multiple hospitals may participate in the same intervention, the focus remains hospital specific. The hospital identifies the target population and designs interventions aimed at reducing emergency room and inpatient costs in the state of Maryland (not limited to their own emergency room and inpatient costs). Applications are reviewed by a committee for program qualification, and Commission votes for each intervention are not required. If approved, participating hospitals share in the savings generated. Outcome payments based on savings are calculated over a measurement window and paid for three years, at which time a review will be completed and consideration given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

Path 2: Regional & Statewide Initiatives (RSI)

The RSI pathway operates at a broader geographic scale. Interventions focus on defined regional populations and aim to reduce emergency room and inpatient expenditures across a broader geography. Participation is through a regional or statewide entity and must include at least one hospital partner. The entity may be technology or digital health companies, health plans, community-based organizations, etc. The entity is preferred as the applicant, rather than a hospital, and all partners involved must have a formal Memorandum of Understanding (MOU) or contractual agreement in place outlining collaboration and funds distribution. Unlike the CTF pathway, RSI proposals require both review committee qualification and a Commission vote for approval. Like CTF, participants are eligible for outcome payments over a certain measurement period. Outcome payments based on savings will be made for three years, at which time a review will be completed, and consideration will be given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

Funding and Payment Structure

Based on continued stakeholder feedback, the funding and payment structure was intentionally designed to provide clarity, predictability, and reduced financial risk. Stakeholders emphasized the importance of ensuring that participation would not affect the hospital update factor. In response, the model is not funded through the update factor, separating it from base rate updates. To further promote certainty, outcome payments will be initially anticipated to be \$50 million each year, with the commission only able to qualify interventions with up to \$100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Outcome payments for Regional and Statewide initiatives are individually approved by the Commission and will not count towards the \$50 million.

As the policy developed through the workgroup process, stakeholders expressed strong support for a model that encourages participation without exposing providers to financial risk like the CTI offset. As a result, the program is voluntary and structured as an upside-only outcome payment model, with no downside risk. The approach laid out below lowers barriers to entry and enables hospitals and initiative partners to focus on transformation efforts without the concerns of an offset or penalty. HOPE rewards sustained performance rather than short-term fluctuations. Outcome payments are therefore based on average savings achieved over a performance window. Hospitals and Statewide and Regional Initiative partners receive 50% of measured savings, ensuring aligned incentives across participating entities.

The Care Transformation Framework is designed to advance the HSCRC's central objective: balancing three critical priorities—promoting continued investment in care transformation, ensuring payment predictability for hospitals, and maintaining affordable, long-term cost growth. For the Care Transformation

Framework, the Commission proposes to establish a fixed statewide funding of \$50 million per year for FY27, FY28, and FY29. At the same time, approved initiatives collectively may not materially exceed projected annual savings of \$100 million. Each initiative seeking participation must submit projected total savings, which will be independently validated by Commission staff and reviewed by the committee to ensure methodological rigor. Interventions will be scored at actual averted hospital costs, or 125% of projected averted hospital costs, whichever is lower. If the score is less than half of the projected averted hospital costs, there will be no scored savings, i.e. minimum saving rate for projections is 50%. Payments will equal 50% of scored savings. Once established, payouts for individual initiatives will remain fixed for the subsequent three years (with continuation of the initiatives). Additionally, the statewide funding level may be increased in future years if the program demonstrates sufficient success.

Recognizing that FY27 represents a transition year and all-payer program measurement is not available, HSCRC would like to maintain support for care transformation infrastructure by providing a one-time \$25M payment distributed proportionally based on Global Budget Revenues (GBRs) to sustain transformation infrastructure across all hospitals in Maryland (if systems wish to designate this funding within their system, other than the GBR, they will be given that option). In addition, HSCRC will provide \$25M in seed funding for HOPE applicants whose proposals are approved by the review committee and whose applications justify the need for seed funding. Seed funding may be allocated to non-hospital initiatives. In FY28 the measurement period starts and potentially new seed funding may be provided to approved applicants.

Savings Measurement

Stakeholders called for a measurement methodology that is rigorous, transparent, and data driven. Payment levels will be based on statistically reliable, validated savings performance, calculated using all-payer claims data to ensure consistency and broad accountability. Statistical methodologies will incorporate risk adjustment to account for differences in patient complexity and case mix across participants. Expected spending will be adjusted using established clinical risk indicators (e.g., APR-DRG risk scores) derived from claims data to ensure that performance comparisons reflect true efficiency gains rather than underlying population differences. As outlined above, HSCRC will afford organizations and initiatives flexibility in their baseline for measuring performance. Staff will collaborate with industry and measurement experts to develop and document a transparent, statistically defensible approach. While staff will continue to prioritize reliable measurement, they may allow payouts based on varying years of certified savings performance.

All-Payer Scope

The overarching goal is for HOPE to operate effectively in an all-payer environment by FY2028. HSCRC agrees that including Medicare in the future strengthens the model and will work with CMS to pursue participation. At the same time, HSCRC is committed to moving forward with implementation even if

Medicare participation is not finalized, ensuring progress toward an all-payer structure regardless of federal timing.

A central component of this effort is ensuring access to comprehensive claims data. For FY2028, the intent is to use case-mix data to operationalize HOPE for non-Medicare payers if necessary. Initially, data and measurement will focus on inpatient and emergency department spending, providing a clear and manageable starting point. Over time, the model is expected to expand in scope as data capabilities and payer alignment evolve. HSCRC is interested in partnering with commercial payers and Medicaid, with a goal of deeper engagement beginning in FY2029 and in subsequent program years. The program's design and operational infrastructure are being developed to accommodate hospitals, Medicare, Medicaid, and commercial payers in a coordinated manner. This approach is intended to minimize administrative complexity, reduce conflicting financial incentives across payers, and maintain feasibility as Medicare global budgets transition under AHEAD in CY2028.

Review Committee and Qualifying Initiative Criteria

The review committee will be established to ensure that proposed interventions are rigorously evaluated, practically grounded, and aligned with program goals before moving forward. The goal of the committee is that it brings informed perspectives to the assessment and qualification of initiatives. The committee not only evaluates proposals against established standards but also will help the HSCRC to communicate guidance to applicants, helping to strengthen submissions and encourage high-quality, well-designed interventions over time.

Importantly, the committee is designed to leverage practical expertise. Including members with experience in care transformation ensures that recommendations are not merely theoretical, but actionable and implementable in real-world settings. This blend of public accountability and operational insight helps promote initiatives that are feasible, impactful, and positioned to deliver meaningful results.

Review Committee

Initiative proposals will be evaluated by a formal review committee, with the HSCRC Director making the final determination based on the committee's recommendation. The body serves as a review panel rather than a public decision-making entity.

The panel will consist of six members, evenly divided between governmental and non-governmental representatives. Governmental members will include one HSCRC staff member (serving as co-chair), one representative from MDH, and one representative from either MHCC or CHRC. The three non-governmental members will be experts in health care transformation or community health, with one serving as co-chair. Conflict-of-interest standards will apply. Panel experts may not be involved in any pending

applications and must recuse themselves where appropriate. The panel will also establish and apply the process by which recommendations are made.

Review Criteria

In assessing applications, the committee will ensure that submissions reflect meaningful and well-designed interventions. They will ensure that qualified initiatives are a balance of opportunities across the state given the specific challenges of each region and consider the resources already dedicated when considering how to prioritize funding. Specifically, proposals should demonstrate that they:

- Are grounded in a strong evidence base. This may be shown by citing peer-reviewed literature, prior evaluations, pilot studies, established practice standards, or technical assistance supporting the proposed intervention.
- Address a recognized State health priority. This may be shown by aligning with the state's AHEAD PHAP or the State Health Improvement Plan (SHIP) or other policies established by the Maryland Department of Health.
- Target a clearly defined population, by specifying eligibility criteria and defining characteristics of the target population, such as diagnoses, prior utilization of healthcare services, HCC score, geography, demographics, etc.
- Have a high likelihood of producing measurable impact related to the intervention. This may be shown by a clear and well-justified methodology for estimating the impact of the initiative on health and averted costs.
- Avoid adverse impacts on patient experience or total cost of care.

Program Overlaps and Transitions

The following reflects areas where this program overlaps with other existing HSCRC initiatives and policies. These intersections are important to acknowledge, as participation rules, funding, and operational requirements may interact in nuanced ways. Staff will provide more detailed guidance, as necessary, on any specific parameters of these overlaps in subsequent communications to ensure clarity and alignment.

- **New Paradigms in Care Delivery (NPCD)**
 - Funding can be used for up-front investments to support qualified programs under HOPE
- **Revenue for Reform (RfR)**
 - Generally, Revenue for Reform initiatives should not also receive funding under HOPE to avoid duplicative funding.
- **Episode Care Improvement Program (ECIP)**
 - Ends December 31, 2026, with no savings offset for 7/1/26–12/31/26.

- **Episode Quality Improvement Program (EQIP)**
 - Participation in both programs is allowed.
- **Efficiency Policy**
 - Payments should not count against hospitals under the efficiency policy.
- **Maryland Primary Care Program (MDPCP)**
 - Participation in both programs is allowed.
 - The review committee will need to consider that resources are already dedicated to primary care to prioritize other strategies.

High-Value Care Plans (HVCP)

High-Value Care Plans were established as part of the FY25 Update Factor to support the development and reporting of new and existing strategies aimed at reducing potentially avoidable utilization in priority areas identified through the VBCI tool or other approved tools. Hospitals were subject to a clawback of funds if reporting requirements were not met.

As HSCRC transitions to the next generation of care transformation through HOPE, Staff recommend sunsetting HVCPs at the conclusion of FY26, following completion of final reporting. Beginning in FY27, hospitals will retain this revenue within their GBR as long as they designate a senior executive responsible for the hospital's population health efforts.

Discussions of Comments Received

HOPE Comment Letters Summary

The Commission received 22 comment letters from a diverse group of organizations in response to the Healthcare Outcome Payment Effort (HOPE) proposal. Overall, commenters were generally supportive of the goals and direction of HOPE, while identifying areas where additional clarification, refinement, or operational flexibility may strengthen implementation. Themes raised across comments included implementation timing, funding and financial structure, scoring methodology, review committee composition, interaction with CTIs, funding caps, all-payer participation, and administrative considerations.

Implementation Timeline

Several organizations expressed concerns regarding the proposed implementation timeline. The Maryland Hospital Association (MHA) strongly urged delaying HOPE implementation until FY 2028 to allow for more deliberate development and stakeholder engagement. Similarly, the University of Maryland Medical System (UMMS) recommended delaying enrollment until FY 2028. Johns Hopkins Health System (JHHS) recommended eliminating HOPE altogether, citing concerns regarding the unpredictability of the CTI-based

methodology and potential risks to stability during the transition to the AHEAD Model. Luminis Health indicated reluctance to support HOPE without first resolving existing CTI-related issues.

HSCRC response: Staff appreciate commenters' feedback regarding the proposed implementation timeline and recognize the competing priorities facing hospitals and other stakeholders as the State continues its transition to the AHEAD Model. In response to these concerns, staff recommends delaying HOPE implementation until FY 2028, with an application period beginning in the second half of CY 2026. This revised timeline will provide additional opportunities for stakeholder engagement, program refinement, and operational planning. Staff intend to continue refining HOPE through the TCOC Workgroup during CY 2026 and CY 2027 to ensure that stakeholders have meaningful opportunities to inform implementation and that the model is appropriately aligned with broader care transformation and population health goals.

Sustainable Financial Structure and Fund Allocation

Many commenters supported the concept of HOPE as a stable funding mechanism for successful preventive care programs that often lose support when funding expires. The Abell Foundation strongly supported HOPE as a bridge to sustain effective interventions over time. CalvertHealth emphasized that base funding remains consistent for hospitals under the proposal, while Meritus Health highlighted the importance of predictable, multi-year funding to support long-term infrastructure investments. Several organizations requested additional clarity regarding funding sources and mechanics. MHA sought definitive guidance on both near- and long-term funding sources. MedStar Health supported the use of a pre-specified, fixed reward pool but requested clarification regarding any potential impact on annual update factors. MedStar also advocated reinvesting state savings generated through the program back into HOPE to accelerate future gains. Commenters also addressed the proposed funding cap and allocation methodology. JHHS supported the proposed \$50 million annual funding cap. MedStar Health recommended that FY 2027 infrastructure funding be allocated to hospitals that generated gross shared savings through CTIs and demonstrated a commitment to future HOPE participation, rather than distributing funds based on market share. UMMS recommended incorporating \$50 million in infrastructure payments proportional to the GBRs in both FY 2027 and FY 2028 to sustain existing interventions during the transition period.

HSCRC response: Staff agree with commenters that funding should be predictable and that sustainable funding is necessary for success. Staff believe that the combination of the commitment to the three-year outcome payout window and assurances regarding the handling of HOPE payments in the savings test address funding sustainability comments.

Staff note that HOPE is separate from CTIs and therefore the proposed split between Infrastructure and seed are meant to assist hospitals with continuing care transformation efforts in transition years while beginning to invest in interventions that show promise and will reduce pressure on the system as a whole. Staff recommend that in FY27 HSCRC provides \$25M for infrastructure payments and \$25M for seed funding for approved applicants. For FY28 the measurement period starts, prior to the advent of outcome payments Staff intend to continue funding via additional seed investments or other measures suggested by stakeholders.

Measurement, Scope, and Methodology

Program Scope and Focus

Several comments focused on the scope and intended focus of HOPE. Adventist HealthCare urged the HSCRC to prioritize addressing latent demand, uncompensated care, and physician reimbursement before implementing HOPE. UMMS strongly opposed narrowing program measurement to inpatient and emergency department expenditures, arguing that the Total Cost of Care (TCOC) framework should remain central. Similarly, MHA requested clarification regarding how the program would drive reductions in total cost of care if measurements are limited to inpatient and emergency department spending. CalvertHealth emphasized that program methodologies, including funding availability and distribution approaches, should be transparent, predictable, and consistently applied. The Maryland Department of Aging (MDOA) recommended prioritizing Upstream Drivers of Health, such as nutrition and transportation supports, within project review criteria.

HSCRC response: Staff agree that the policies and methodology behind HOPE should be transparent and consistent and is committed to using the TCOC workgroup for discussions and updates on the HOPE program. Staff recognize there are myriad policy concerns outside of HOPE and believe they can explore further regardless of HOPE implementation. Staff also understand commenters' concerns about the data limitations and the use of inpatient and emergency department spending in the near term however HSCRC is limited in what data can be utilized but committed to expanding data capabilities in the future. HSCRC will continue to work with CRISP to incorporate more robust data that is available to participants.

Scoring and Payouts

A number of commenters focused on the proposed scoring methodology. JHHS supported scoring interventions based on actual averted hospital costs rather than projected savings or hybrid approaches. MedStar Health supported scoring interventions at either actual averted hospital costs or 125% of projected averted hospital costs, whichever is lower, consistent with HSCRC's proposed framework. MedStar noted

that this approach appropriately rewards interventions that outperform projections. MedStar also recommended reducing the proposed minimum savings rate for projected savings from 50% to between 10 and 20%. The Primary Care Coalition opposed the use of minimum dollar thresholds for savings or performance when approving projects and similarly opposed requiring minimum performance thresholds for organizations to receive payouts.

HSCRC response: Staff agree with commenters that scoring should be tied as closely as possible to demonstrated outcomes and actual performance. Consistent with comments from MedStar Health, staff believe that scoring interventions based on actual averted hospital costs, capped at 125% of projected averted hospital costs, balances rewarding strong performance while maintaining accountability for projections. This approach recognizes interventions that outperform expectations without creating incentives for unrealistic projections.

Staff also considered comments regarding the proposed minimum savings threshold. While some commenters recommended reducing or eliminating minimum performance requirements, staff believe that a minimum threshold remains an important safeguard to ensure that scored savings reflect meaningful performance and are not driven by normal variation or small changes in utilization. At the same time, staff recognizes concerns regarding overly stringent requirements and the recommended approach seeks to balance flexibility with accountability

Program Design and Operational Clarity

General Support and Structure

Several commenters expressed general support for the structure of the program while requesting additional detail. Ascension Saint Agnes and Audacious Capital noted that the proposal remains preliminary and would benefit from additional information regarding payment distribution and total cost of care impacts. Greater Baltimore Medical Center (GBMC) requested additional detail regarding initiative approval processes, savings measurement methodologies, and any impact on the annual update factor. Meritus Health commended the voluntary, upside-only structure, citing its ability to lower barriers to participation. JHHS similarly supported the foundational design principle that HOPE operates as a voluntary, upside-only model, consistent with the structure of EQIP.

HSCRC response: Staff appreciate commenters' support for the overall structure of the HOPE model, particularly the voluntary, upside-only design. Staff agree that this approach lowers barriers to participation, encourages innovation, and allows hospitals and other participants to engage in care transformation activities without the financial risks associated with downside accountability. Consistent with comments from

Meritus Health and JHHS, staff believe that maintaining HOPE as a voluntary, upside-only model aligns with the principles of EQIP.

Staff also agree with commenters that additional operational details regarding payment distribution, intervention qualification, and the model's interaction with total cost of care goals will be important for successful implementation. Throughout model development, staff has sought to balance providing sufficient detail while maintaining flexibility to incorporate stakeholder feedback and lessons learned during implementation and maintain forward momentum. This final recommendation includes additional information regarding funding, payment methodologies, and scoring, and staff will continue to engage stakeholders as operational details are refined.

Administrative and Data Requirements

Commenters also highlighted operational and administrative considerations. Audacious Capital recommended reducing administrative burden and encouraging broader multi-payer participation. MHA requested development of a comprehensive crosswalk demonstrating how HOPE would interact with existing programs such as Revenue for Reform and the Population Health Advancement Program (PHAP) to avoid duplication and administrative complexity. UMMS opposed the proposed exclusion of Revenue for Reform initiatives and overlap with other primary care investments, including the Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, and Rural Health Transformation initiatives. MDOA expressed support for interoperability efforts, including CRISP integration, closed-loop referrals, and shared savings approaches.

HSCRC response: Staff agree with commenters that coordination with existing initiatives, payer alignment, and operational infrastructure are critical to success. Staff agree that successful implementation of HOPE requires careful integration with existing programs and resources to avoid duplication, maximize impact, and support sustainable care transformation. In response to stakeholder concerns regarding overlap with existing initiatives such as Revenue for Reform, staff included a revised overlaps crosswalk to provide greater clarity regarding how HOPE will interact with other HSCRC programs. While staff agrees that duplicative funding should be avoided, the final recommendation does not categorically exclude participation by organizations involved in other primary care or care transformation initiatives. Rather, the review committee will consider existing resources in a hospital or region and investments available to determine whether additional HOPE funding is appropriate.

Staff also agree that broad payer participation is important to maximize the effectiveness and sustainability of care transformation efforts. The Commission will continue to work with CMS to explore opportunities for Medicare participation and alignment, recognizing that multi-payer engagement can strengthen incentives

and support greater system-wide impact. Finally, staff agree that leveraging existing data and operational infrastructure will be critical to reducing administrative burden and supporting program evaluation. To that end, staff intend to continue to utilize and build upon existing CRISP capabilities.

Recommended Interventions and Focus Areas

Several organizations recommended expanding the focus on palliative care and serious illness interventions. The Maryland State Advisory Council on Serious Illness Care recommended explicitly identifying palliative care, hospice services, and advance care planning as priority HOPE initiatives. The University of Maryland School of Medicine recommended including at least one palliative care expert on the review committee and incorporating patient-reported outcome measures into program evaluation. The School of Medicine also recommended explicitly listing CAPC- and NHPCO-aligned palliative care interventions as qualifying examples in final program guidance.

Commenters broadly supported the emphasis on prevention and community-based interventions. Healthcare for All and the Maryland Citizens' Health Initiative Coalition (MCHI) highlighted HOPE's alignment with the AHEAD Model and its focus on shifting care toward prevention and community-based services. MedChi emphasized the importance of increasing physician awareness and strengthening community-based partnerships. Johns Hopkins Tele-Dizzy recommended including diagnostic excellence within the scope of HOPE-supported interventions. The organization also suggested adding "presenting symptoms" to the illustrative list of target population characteristics used in project review criteria.

HSCRC response: Staff appreciate commenters' recommendations regarding palliative care, prevention, community-based services, diagnostic excellence, and intervention evaluation. Staff agree that these areas represent important opportunities to improve outcomes and reduce avoidable utilization. The final recommendation is intended to provide flexibility for a broad range of evidence-based interventions, including those focused on serious illness care and community-based prevention. Staff will consider stakeholder feedback as implementation details are developed and believe many of these recommendations may be appropriately addressed through program guidance and the review process. Additionally, the review committee will consider intervention design, target populations, available community resources, and subject matter expertise when evaluating proposed projects.

Regional and Statewide Initiatives (RSI)

Several comments addressed the proposed Regional and Statewide Initiatives (RSI) track. JHHS recommended limiting RSI funding to between 20 and 25% of total HOPE funding, expressing concerns that regional initiatives may be less accountable and less directly patient facing. In contrast, the Primary Care Coalition argued that RSI payments should remain uncapped. UMMS expressed concern regarding the absence of an RSI funding cap and broader concerns about funding leaving the hospital. UMMS also noted potential misalignment with the Geo AHEAD Model. The Day Clinic indicated that the RSI framework is necessary to sustain and scale high-acuity, low-volume services and care settings.

Several commenters recommended expanding participation requirements and governance structures for RSI projects. MedStar Health opposed excluding hospitals from serving as anchor entities within regional collaboratives. MDOA requested formal recognition of Area Agencies on Aging (AAAs) as eligible RSI anchor entities. The Maryland Association of County Health Officers (MACHO) recommended requiring Local Health Department participation in Regional and Statewide Initiatives, strengthening the definition of community partners to explicitly include Local Health Departments, and establishing regional governance structures that incorporate public health representation.

HSCRC response: Staff appreciates the range of feedback on the proposed Regional and Statewide Initiatives (RSI) track, including comments on funding structure, accountability, governance, and eligible entities. With respect to funding levels and caps, staff notes that the Commission will vote on the RSI initiatives on an individual basis and can provide feedback on the appropriate scale and structure of funding, as part of the voting process. Staff also agree with commenters emphasizing the importance of accountability and meaningful patient-facing impact for RSI projects. While RSI is intended to support regional coordination and system-level interventions, all projects will be subject to review to ensure appropriate accountability and alignment with program objectives.

Regarding participation and governance, staff support a flexible but structured approach. Hospitals may serve as applicants or anchor entities where appropriate; however, this will be contingent on review committee determination that the proposed structure is justified and that required community partnerships are in place. RSI projects will be expected to demonstrate meaningful engagement with relevant community partners and cannot be hospital-led in isolation. Staff also agree that participation of public health entities and community organizations, including Local Health Departments and other stakeholders such as Area Agencies on Aging where appropriate, is an important component of effective regional collaboration and will be considered within the review process.

Conclusion

HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD. Through two participation pathways, the Care Transformation Framework and Regional & Statewide Initiatives, the model supports both hospital-led and cross-sector transformation efforts while maintaining standards for savings validation and performance measurement. Its voluntary, upside-only structure, capped and stable funding approach, and commitment to earned payouts are designed to reduce financial risk and encourage sustained investment in prevention and utilization reduction. By prioritizing all-payer alignment, transparent, data-driven measurement, and thoughtful coordination with existing programs, HOPE positions the State to transition toward a model in which it acts as an outcome purchaser rewarding interventions that demonstrably improve health outcomes, advance equity, control costs, and strengthen system sustainability.

April 6, 2026

Christa Speicher
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Speicher,

We write in strong support of the proposed Healthcare Outcome Payment Effort (HOPE) initiative, which would create a new outcome-based payment structure to incentivize and support hospital investments in preventive care. As Maryland-based foundations that fund health interventions, we understand the need for increased investment in preventive care, and in program models that have demonstrated success. The HOPE initiative would provide increased clarity and predictability for hospitals as they plan and budget for these interventions and enable them to sustain programs that are proven successful. We have seen too many effective health programs discontinued due to a lack of sustainable funding. By committing up front to funding effective interventions, the HOPE initiative will drive health improvements statewide, an outcome we strongly support.

We appreciate the Commission's careful review of the HOPE proposal and urge you to approve this innovative payment reform model.

Sincerely,

Abell Foundation
Jacob and Hilda Blaustein Foundation
Leonard and Helen R. Stulman Foundation
The Richman Foundation

cc: Jonathan Kromm
Joshua Sharftsein



April 8, 2026

William Henderson
Principal Deputy Director, Medical Economics and Data Analytics
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson:

Adventist HealthCare appreciates the opportunity to comment on the proposed Healthcare Outcome Payment Effort (HOPE) framework. We are supportive of the policy's intent and grateful for HSCRC's ongoing engagement with health system stakeholders. In that spirit of partnership, we respectfully share several considerations that we believe are important to address as the Commission evaluates whether and how to move the HOPE framework forward.

Prioritization of Foundational Policy Needs

We recognize the significant staff and Commission resources required to design, implement, and operationalize a new outcomes payment program. Given that context, we encourage HSCRC to weigh the opportunity cost of advancing HOPE at this time against several policy areas that may benefit from more immediate attention:

- **Latent demand and care access:** Maryland does not yet have a policy solution to latent demand, and we are hopeful that HSCRC will prioritize analysis of whether low utilization in some areas reflects genuine efficiency or unmet need for medically necessary care.
- **Uncompensated care and coverage shifts:** Federal legislative and workforce changes, including HR1, federal employment reductions affecting the Washington region, and the continued growth of high-deductible commercial health plans, are creating meaningful near-term pressure on uncompensated care that may benefit from a proactive policy response.
- **Hospital-based physician reimbursement:** Maryland physicians receive among the lowest reimbursement rates in the country, and the resulting gap is largely absorbed by hospitals representing one of the largest hospital-borne physician subsidies nationally. We believe a durable policy framework to address this structural imbalance would meaningfully strengthen Maryland's care delivery foundation.
- **AHEAD alignment and market shift policy:** Several existing HSCRC policies, including the market shift policy, will need modification to align with the evolving AHEAD framework. Resolving these foundational questions before introducing a new payment layer would help ensure HOPE is built on a stable policy footing.



Lessons from FY2025 CTI Results

The FY2025 CTI results have raised important questions about unintended policy consequences that we believe warrant careful review before the Commission proceeds. Because HOPE builds on CTI infrastructure and methodology, we would encourage HSCRC to prioritize addressing the FY2025 CTI policy results prior to finalizing the new HOPE policy.

Considerations on CTI-Based Funding Predictability

We also wish to raise a practical concern regarding the use of CTI program results as a funding source for ongoing care transformation operations. The volatility of CTI payment outcomes makes it difficult for health systems to responsibly commit to multi-year contracts, workforce investments, and care infrastructure on the basis of these returns. Funding for the infrastructure of these initiatives must come out of core operations due to the volatility of the policy results year over year. Practically, any CTI-related payments are treated as one-time rewards well suited for capital rather than a reliable operational funding stream.

Adventist HealthCare appreciates HSCRC's continued partnership and commitment to advancing population health under the evolving AHEAD framework. We share these considerations in the spirit of constructive collaboration and respectfully request that they be addressed before HOPE advances for Commission action. We welcome the opportunity to discuss any of these points further and look forward to continued dialogue.

Sincerely,

Katie Eckert

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

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

Enclosed: Adventist HealthCare February 2026 HOPE Letter





**Ascension
Saint Agnes
Hospital**

April 3, 2026

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

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes (ASA), I am writing today in response to the Health Services Cost Review Commission's (HSCRC) request for comments on the current Care Transformation Initiatives (CTI) program and the proposed Health Outcome Payment Effort (HOPE) program. ASA supports the goals of these programs to reward reductions in avoidable hospital utilization but is concerned with recent discussions at the Total Cost of Care (TCOC) Workgroup.

At the TCOC Workgroup meeting on March 25th, HSCRC staff shared concerns regarding the potential duplication or overlap of Medicare beneficiaries in community-based (geographic) CTIs. They indicated that staff would be conducting an analysis to better understand the magnitude of this overlap, with the goal being to potentially de-duplicate beneficiaries (and their associated savings) in zip codes that overlap between CTIs. ASA is concerned with this potential approach as it would be a change in the methodology after the performance year has closed and after the preliminary results are known. It also was not done in prior years despite significant savings being achieved and revenue redistributed across the state. ASA, like every other hospital in the state, submitted CTIs in advance of the performance year and with sufficient time for staff to review them and flag any concerns, including with potential overlap. If staff is concerned with this provision in the methodology, it could be addressed as part of discussions regarding the HOPE program.

Although ASA supports programs to target unnecessary utilization, the draft recommendation and information shared for the HOPE program seems preliminary and in need of greater development before it is implemented, including how much funding will be available for successful interventions, the distribution methodology, any anticipated impact to TCOC performance, and the financial impact to hospitals.

Thank you again for the opportunity to provide comments.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mitch Lomax".

Mitch Lomax
Chief Financial Officer

cc: Dr. Joshua Sharfstein, Chairman, HSCRC
Dr. James Elliott, Vice Chairman, HSCRC
Jon Blum, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. David Maine, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Dr. Farzaneh Sabi, Commissioner, HSCRC

Ascension Saint Agnes Hospital

900 S. Caton Ave
Baltimore, MD 21229
667-234-6000

Christopher Brandt
Managing Member, Audacious Capital
Interim leader, Upsurge, innovation ecosystem-focused subsidiary of the Greater Baltimore Committee.

Public Comment on the Healthcare Outcome Payment Effort (HOPE)

Chair, Commissioners, and members of the panel,
Thank you for the opportunity to comment on the Healthcare Outcome Payment Effort (HOPE).

Framing: Leadership in Health Innovation as Economic Advantage

It is important to level set what is at stake beyond healthcare delivery itself. Leadership in healthcare delivery is also economic strategy. There is a well-established link between economic strength and health outcomes, and cost of care is increasingly part of business location and growth decisions. Getting health innovation right is both a healthcare priority and an economic one.

Affordable, high-quality healthcare can be a powerful economic asset. Unaffordable healthcare is a drag on growth. In my work with the Greater Baltimore Committee and UpSurge to retain and attract growing businesses, cost of care is increasingly part of the conversation. Our region already faces a perception of business unfriendliness. We should not compound that by allowing commercial healthcare costs to rise unnecessarily to preserve legacy margin pools. Getting affordability and outcomes right is central to competitiveness.

Maryland has already demonstrated what is possible. My former company, Audacious Inquiry, grew in significant part because of Maryland's unique policy environment, including alignment, data access, and regulatory flexibility enabled by the all-payer model.

Today, Maryland's assets are even stronger. We have a nation-leading data infrastructure in CRISP and substantial new investment in artificial intelligence through initiatives such as Johns Hopkins' Data Science and AI Institute and Techstars Health AI.

If we get this model right and demonstrate measurable improvements in outcomes per dollar, Maryland can lead not only in policy but also in building companies, attracting capital, and shaping the future of healthcare delivery. If we do not, we risk ceding that leadership. HOPE is not just a program. It is a test that could materially impact Maryland's long-term economic trajectory.

Transition from CTI to HOPE

As the Care Transformation Initiatives (CTI) program approaches its sunset, HOPE represents an opportunity to build on what has worked while further strengthening Maryland's alignment of delivery incentives with measurable improvements in outcomes and total cost of care. This context leads directly to the system challenge we must address.

We have an affordability crisis in healthcare that is harming patients and families. This is not abstract. It affects access to care, financial stability, and health outcomes. Maryland's all-payer model has constrained price growth and aligned incentives in ways no other state has achieved. HOPE is the next step, and its success will depend on execution.

1. HOPE's Core Shift is Correct – and it Must Be Actionable

HOPE shifts the system from rate regulation to outcome accountability. The next decade will be won on measurable improvements in outcomes and total cost of care.

The risk is that strong concepts remain distant from day-to-day operations. Many leaders cannot see performance in near real time, attribute outcomes to interventions, or adjust quickly enough to change results. Accountability becomes retrospective.

HOPE can benefit from enabling shorter-cycle performance feedback, with more frequent interim signals, with clear attribution so leadership teams can actively manage outcomes, not simply report on them.

2. Administrative Friction Is a First-Order Problem

Administrative burden consumes resources and does not improve outcomes.

Hospitals spend significant time and capital navigating denials, prior authorizations, and payment friction, often for claims that are ultimately approved. This creates cost without value and diverts resources from care and innovation.

For HOPE, every element should be tested against a simple question: does this reduce administrative work or add to it? If it adds, it should be reconsidered.

3. The Cost Problem Is Structural and Capacity Must Follow Utilization

Cost growth is driven by volume, acuity, and input costs, not by price increases.

Maryland has reduced acute care utilization but has been slower to realign the delivery system. Licensed beds have declined and the state operates with relatively low beds per capita, while population growth, especially in the Baltimore region, has been modest.

Many hospitals still carry the fixed overhead of acute care infrastructure even as inpatient utilization has shifted downward. This creates a misalignment:

- We are paying for capacity we no longer need
- We are underinvesting in interventions that reduce total cost of care

This raises the question of whether some acute care capacity should be consolidated or closed in certain markets. The goal is to redeploy capital, management attention, and policy support toward prevention, care management, longitudinal population health, and outcome-driven programs such as HOPE.

If we do not make these tradeoffs, we will continue to fund legacy infrastructure at the expense of future outcomes.

4. Maryland's Opportunity as a National Testbed

Maryland is uniquely positioned to define the future of U.S. healthcare delivery.

No other state has multi-payer alignment, longitudinal population data, and regulatory flexibility at this scale. This creates an opportunity to be the national proving ground for value-based care and AI-enabled delivery.

Value-based care is the economic model that funds innovation. AI and advanced analytics scale when incentives reward outcomes rather than activity. HOPE should position Maryland as the place where these models are tested, proven, and shared.

5. Multi-Payer Alignment Is Non-Negotiable

HOPE will work only with strong multi-payer alignment. Fragmentation in metrics, attribution, or incentives will reduce effectiveness. This advantage should be preserved and strengthened.

6. Healthcare Is Economic Strategy

This effort is both healthcare policy and economic strategy.

Healthcare is one of Maryland's largest sectors. Improving outcomes, reducing unnecessary cost growth, and enabling innovation will lower costs for employers, improve population health, and increase competitiveness. This is central to economic development.

Convening Leaders: Inflection Point Healthcare Summit (June 4)

On June 4, Upsurge is convening the Inflection Point Healthcare Summit, bringing together leaders across health systems, payers, technology, and policy to focus on how value-based

care and emerging technologies, including AI, can translate into better outcomes per dollar. Maryland's all-payer model makes this region a natural testbed for these ideas. We would welcome continued engagement from the Commission and stakeholders as we work to align around practical steps to accelerate progress.

Conclusion

HOPE is directionally correct and necessary. To maximize its impact, the Commission should focus on:

1. Real-time, actionable feedback loops
2. Reducing administrative burden
3. Aligning risk with controllable factors
4. Strong, durable multi-payer participation
5. Realigning capacity with utilization
6. Positioning Maryland as a national innovation testbed

Maryland has already built what no other state has. The opportunity now is to connect economic leadership, system redesign, and outcome accountability into a model that delivers measurable improvements in outcomes per dollar.

If we do that, Maryland will improve care for its residents and establish a durable competitive advantage.

Thank you for your leadership and for the opportunity to comment.



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CalvertHealthMedicine.org

April 7, 2026

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

Dear Dr. Kromm,

On behalf of CalvertHealth, I am writing to provide comments regarding the current Care Transformation Initiatives (CTI) program and the proposed Health Outcome Payment Effort (HOPE) program. CalvertHealth appreciates the work of the Health Services Cost Review Commission (HSCRC) and the opportunity to provide input on these important programs.

As we offer these comments, CalvertHealth would like to emphasize several guiding principles that are critical not only to the success of these programs, but also to the long-term financial stability of Maryland hospitals:

- Programs and methodologies should be transparent, developed through a consensus-driven stakeholder process, and consistently applied across all hospitals
- Retrospective changes to policies should be limited to addressing truly unintended consequences that could not have been reasonably anticipated during policy development
- Predictability, consistency, and stability in policy application must be prioritized to support long-term financial planning, clinical program development, workforce investment, and sustainable care delivery

Maryland hospitals operate within a highly regulated environment that depends on stable and predictable policy frameworks. Consistency in program design and execution is essential to allow hospitals to make meaningful investments in population health, access, and quality. Frequent or retrospective changes—particularly those that alter financial outcomes after performance periods have concluded—undermine confidence in the system and create barriers to sustained progress.

CTI Policy

With these principles in mind, we would like to share our concerns regarding recent discussions of the Fiscal Year 2025 CTI results. CalvertHealth has participated in the CTI program since its inception and has made significant investments in care transformation initiatives. Historically, our organization has experienced financial penalties under the program, largely due to the scale advantages of larger health systems in generating savings.

Despite these challenges, CalvertHealth has remained committed to the established methodology. Rather than seeking retrospective adjustments based on financial outcomes, we have focused on improving performance through operational changes and population health investments, consistent with the approved policy framework. This approach reflects our belief that program integrity—and the broader financial stability of the system—depends on consistent application of methodologies over time.

At a recent Total Cost of Care (TCOC) Workgroup meeting, HSCRC staff indicated they are considering an analysis to deduplicate beneficiaries attributed through community CTIs and redistribute associated savings. While we understand the policy rationale behind this concept, implementing such a change retrospectively would represent a departure from the established methodology and from how it has been applied in prior years. Notably, previous applications of the methodology have resulted in significant savings and incentive payments for certain Maryland hospitals.

It is also important to recognize that CTIs are submitted in advance of the performance year, providing sufficient opportunity for prospective review and refinement. Introducing methodological changes after performance periods have concluded creates uncertainty and weakens the predictability that hospitals rely upon to guide investment decisions.

If HSCRC staff believe that methodological changes are warranted, we respectfully recommend that such changes be evaluated prospectively and, if appropriate, applied consistently across future performance periods. Additionally, any proposed changes should be reviewed transparently, including analysis of prior-year impacts, and brought forward to the full Commission for discussion and approval.

HOPE Program

The goals of the HOPE program align with those of the CTI program in promoting reduced unnecessary utilization and stronger collaboration with community partners. CalvertHealth supports these objectives and remains committed to advancing care transformation efforts within our community.

However, as this program is developed, it is essential that it reinforces—rather than disrupts—the financial stability of Maryland hospitals. Specifically, we encourage careful consideration of how HOPE funding will interact with annual payment updates, which remain foundational to hospital operations. Hospitals must be able to rely on consistent base funding to sustain services while pursuing performance-based incentives.

Additional clarity is needed regarding the total funding available, distribution methodology, interaction with TCOC performance, and the potential financial implications for hospitals. Ensuring transparency and predictability in these areas will be critical to the program's success and to maintaining confidence in Maryland's regulatory framework.

Thank you again for the opportunity to provide comments. We appreciate the Commission's continued partnership and focus on advancing policies that support both innovation and stability across Maryland's healthcare system. If you have any questions, please do not hesitate to contact me.

Sincerely,



Jeremy Bradford
President & CEO

cc: Dr. Joshua Sharfstein, Chairman, HSCRC
Dr. James Elliott, Vice Chairman, HSCRC
Jon Blum, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. David Maine, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Dr. Farzaneh Sabi, Commissioner, HSCRC

April 8, 2026

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

Dear Dr. Kromm,

On behalf of Greater Baltimore Medical Center (GBMC), I am writing today in response to a request for comments from the Health Services Cost Review Commission's (HSCRC) on the proposed Health Outcome Payment Effort (HOPE) program. Since 2011, GBMC has made significant investments in pursuit of population health interventions for its communities in Advanced Primary Care. GBMC began these initiatives prior to the implementation of hospital global budgets.

GBMC recognizes and supports the intent of the HOPE program but has concerns regarding distinct aspects of the program. GBMC would like more information on how interventions will be approved and by whom, how any savings achieved will be measured and dispersed, and the potential impact on the annual payment update and TCOC test. It is of note, that in the March TCOC Workgroup meeting the Outcome Examples listed on slide 16, only two of the scenarios presented resulted in a hospital being paid 100 cents on the dollar and that these results are dependent upon all approved initiatives, rather than hospital's specific initiative. We would encourage the HSCRC to continue working with the industry to refine the program before returning with a final recommendation.

Thank you again for the opportunity to provide comments.

Sincerely,

Robin Motter-Mast, D.O.

Dr. Robin Motter-Mast
Chief of Staff, Medical Director of Care Transformation
GBMC

cc: Dr. Joshua Sharfstein, Chairman, HSCRC
Dr. James Elliott, Vice Chairman, HSCRC
Jon Blum, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. David Maine, Commissioner, HSCRC
Nikki McCann, Commissioner, HSCRC
Dr. Farzeneh Sabi, Commissioner, HSCRC



April 8, 2026

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

Submitted to: christa.speicher@maryland.gov

Dear Members of the Health Services Cost Review Commission (HSCRC),

Thank you for the opportunity to comment on HSCRC's new [Healthcare Outcome Payment Effort \(HOPE\) draft recommendation](#). [Maryland Citizens' Health Initiative](#) (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. MCHI oversees the Maryland Health Care for All Coalition which is comprised of hundreds of faith, business, labor, community, and health care organizations across the state. We are proud to have a history of collaborating with the HSCRC, as I currently serve on the TCOC Target Technical Advisory Committee and in the past served on the Performance Measurement Workgroup and our president, Vincent DeMarco, chaired the [HSCRC Consumer Outreach Task Force](#) which helped communicate and gather feedback from communities around the state when Maryland's hospital system switched to global budgets.

We support the draft Healthcare Outcome Payment Effort (HOPE) recommendation. It is important to move HOPE forward now so that Maryland can use the framework to improve care and health equity while lowering costs. The AHEAD Model is designed to reward prevention, reduce unnecessary hospital utilization, and advance coordinated, statewide population health improvement. The model shifts care beyond hospitals toward prevention, primary care, and community-based services that address whole-person needs. The draft HOPE recommendation provides a pathway to bring these health care improvements to life. We believe HOPE will:

- **Prioritize patient-centered and population-level health outcomes**, moving away from payment measures that solely emphasize utilization or cost savings
- **Expand access to primary and preventive care** through improved coordinated care that focuses on early intervention, chronic disease management, and related services.
- **Advance health equity and reduce disparities** by integrating equity measurements directly into health outcomes assessments and promoting engagement with community health workers and social services organizations.
- **Promote health care affordability** by limiting cost growth to meet AHEAD's Total Cost of Care targets, resulting in better health outcomes at a lower cost for patients.



As you move forward, we urge you to incorporate the unique needs of beneficiaries through “[patient-first care](#)” reforms. We appreciate all you do to expand access to quality, affordable health care for all Marylanders.

Best regards,

Stephanie Klapper, MSW

Deputy Director, Maryland Citizens’ Health Initiative Education Fund Inc.

stephanie@healthcareforall.com



February 11, 2026

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

Re: Comments on the Health Outcomes from Positive Experiences (HOPE) Framework

Dear Dr. Kromm,

Thank you for giving us the chance to share our thoughts about this model. As background, The Day Clinic is a novel clinic-based alternative to hospitalization for people living with heart failure. We provide IV diuresis for acutely sick patients with longer term management of heart failure symptoms. This care management approach includes guideline directed medical therapy (GDMT), remote patient monitoring (RPM), and other advanced clinical and technology solutions. The Day Clinic's co-founders, Scott Afzal and Kapil Parakh, have been dedicated to improving the health of Marylanders through their prior work at CRISP and at Johns Hopkins, respectively.

As a recipient of a New Paradigms in Care Delivery (NPCD) grant, we are committed to supporting the development of a program that invests in safe and effective alternatives to hospital care for ambulatory sensitive conditions. We have highlighted topic areas below that we think will strengthen the approach in meaningful ways. We thought about this model from two different perspectives. First, we considered how it would fit into our Heart Failure centric work at The Day Clinic. Second, we stepped back and evaluated how it would support a broader set of regional initiatives that may be focused on other conditions. We have strong conviction in the impact we can have at The Day Clinic. Similarly, we believe deeply that this payment approach can spur innovation in the field, encouraging other entities to follow, reducing hospitalizations, lowering costs and ultimately improving the health of Marylanders.

- **All-Payer Inclusion.** The vast majority of patients suffering from heart failure are Medicare beneficiaries. Emergency department visits and inpatient hospitalization costs for heart failure are similarly heavily weighted toward Medicare. This would also be true for other ambulatory sensitive conditions (e.g. COPD; diabetes; pneumonia; dementia; falls; etc) that could be treated in novel clinic-based settings. Including Medicare in this payment model is integral to its success.
- **Regional Initiative Savings Participation.** We encourage you to explore setting the regional initiative savings participation at 50% (commensurate with hospitals). If these efforts achieve the same outcome in terms of cost / quality, we submit they should be



TheDayClinic

eligible for the same reward. Creating, scaling and sustaining these incentives outside a traditional hospital system requires significant and ongoing investment. Aligning the payment model with this reality will increase chances of success. Strong incentives to build these non-hospital approaches to avoiding hospital utilization will be powerful over time as these efforts have a very clear / clean financial motivation to avoid hospital care.

- **Start-Up Funding for Regional Initiatives.** Upfront funding for regional initiatives will be important. Absent direct hospital sponsorship, many of these efforts will lack the capital to get off the ground. Raising money from venture capital or private equity sources may be difficult without the ability to show exceptional financial returns. Given that regional initiatives will not likely show large scale financial returns from an investor perspective, the ability to offer a different source of seed capital will be valuable. Providing start-up resources could be through one-time NPCD type funding or advances of performance payments.
- **Performance Payment Timing.** If performance payments can be pulled into year two it will have a significant and beneficial impact on regional initiatives. These efforts may have limited working capital to fund operations and waiting 2 years could create operational cash flow challenges. Consider a year 2 payment based on year 1 performance that can then be reconciled as necessary based on claims run-outs or other adjustments. There are Federal and State examples of this kind of performance payment schedule in the ACO REACH program and Maryland's MDPCP initiative.

We appreciate the opportunity to participate in the development of this new and important payment approach. We believe it has the potential to motivate a new wave of innovative care delivery models throughout the state. We look forward to being a partner to you in bringing it to life and would be happy to schedule time to meet with you directly to share our perspective.

Best Regards,

The Day Clinic Team

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

April 8, 2026

Christa Speicher
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215



Dear Ms. Speicher:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the development of the Healthcare Outcome Payment Effort (HOPE). Given that the methodology builds upon that of Care Transformation Initiatives (CTIs), JHHS remains concerned about the underlying methodology of the HOPE program, particularly given the recent challenges and discrepancies with the FY25 CTI results. The methodology is unpredictable, challenging to influence through interventions, and leads to largely uncontrollable swings in data that create disproportionate impact on performance. While supportive of the intent of the HOPE program, given these methodology concerns JHHS recommends the elimination of the program at the outset of the AHEAD model. With significant changes to the payment landscape anticipated in CY2028, unpredictability and likelihood of distortions should be minimized particularly in the early years of the transition.

Though the methodology remains the primary concern, JHHS offers the following comments and recommendations on the proposed HOPE framework:

1. If the proposal advances, JHHS reiterates its strong support for the foundational design principle that HOPE function as a voluntary, upside-only program, consistent with the EQIP framework. JHHS appreciates staff's revision of CTI methodology to ensure that hospitals are not penalized based on the performance of others.
2. All-payer participation must be a prerequisite to program implementation. Launching the program without Medicare participation would create model distortions and financial inequity across payers. If Medicare does not participate, the cost of outcome payments would be borne exclusively by Medicaid and commercial payers. This construct raises affordability and policy concerns and would risk further commercial rate pressure given the other significant model changes in CY2028.
3. JHHS supports the current proposed annual funding cap of \$50 million for HOPE outcome payments. The cap provides an important guardrail against uncontrolled spending growth and preserves predictability. Any future increases in HOPE funding should require Commission approval through a formal process with stakeholder input.
4. Of the proposed payout approaches, JHHS supports the approach to score each intervention based on actual averted hospital costs, rather than on projected savings or a hybrid of the two. Payment structures that rely on projected savings as a reference point create problematic incentives, including pressure to submit inflated projections. Measurement based on actual

April 8, 2026

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

Dear Dr. Kromm,

On behalf of Luminis Health, I am writing in response to a request for comments from the Health Services Cost Review Commission (HSCRC) regarding the current Care Transformation Initiatives (CTI) program and the proposed Health Outcome Payment Effort (HOPE) program. Luminis supports the goals of these programs and has made significant investments in population health resources and interventions since the implementation of hospital global budgets. Most recently, this includes partnering with The Day Clinic through the HSCRC's New Paradigms grant program to provide ambulatory diuresis services for patients with Congestive Heart Failure.

While we remain aligned with the overarching goals, we have ongoing concerns regarding program operations and the current methodology, which has generated substantial savings alongside significant penalties, creating unpredictability and instability within the regulatory model. We are particularly concerned that the CTI program continues to carry unmitigated risk. Under the current design, hospitals that have successfully reduced total cost of care (TCOC) through meaningful clinical interventions are nonetheless subject to considerable unforeseen financial penalties. This raises serious concerns about unintended consequences of the methodology and whether the policy is equitably impacting participating hospitals across the state.

These concerns are underscored by the projected outcomes of the FY25 performance period, which will impact FY27 revenue. The rapid growth of broad-based, community geographic CTIs has driven a dramatic increase in the "statewide savings" measure from a historical average of approximately \$160 million to more than \$740 million. It is unclear whether this amount is an actual savings to TCOC or an artifact of a mathematical model. Certainly, this magnitude of change calls into question whether the results reflect true improvements in care delivery or are instead driven by methodological issues. Because the program operates as a zero-sum construct, this surge in "savings" measure significantly increases the statewide offset, resulting in disproportionate penalties that were unforeseen and unexpected. For many hospitals and health systems including Luminis Health, the penalties due to the elevated offset result in a complete elimination of our entire operating margin and, if not ameliorated, will result in dramatic challenges to ongoing care delivery and core operations, and will make it nearly impossible to continue to make significant

investments in population health strategies. This dynamic further reinforces concerns regarding fairness and the reliability of the current methodology.

Luminis acknowledges HSCRC staff's indication at the TCOC Workgroup meeting on March 25th that additional analysis is being conducted to assess potential overlap among community based CTIs. While we support efforts to improve the accuracy and integrity of reported results, this represents only one aspect of a broader set of methodological concerns that must be addressed to ensure transparency, consistency, and equity within the program.

More broadly, the uncertainty of future outcomes under the current CTI program limits hospitals' ability to plan effectively, align strategic investments, and assess how current performance will translate into future financial impacts, impacting ongoing operational and financial challenges. Given these issues, we recommend discontinuing the current CTI program at the end of the FY25 performance period.

Luminis is supportive of the intent of the HOPE program, as it aligns with our partnership with The Day Clinic; however, additional detail is needed regarding how savings will be measured, how clinical interventions will be evaluated and approved, and what impact HOPE-related savings may have on the annual payment update and the TCOC test. Furthermore, Luminis Health will be hard-pressed to support the HOPE program without having a resolution to the FY25 CTI program. The TCOC Workgroup provides an appropriate forum for these discussions prior to HSCRC staff presenting a final recommendation to the Commission.

Thank you again for the opportunity to provide comments.

Sincerely,



S. Michelle Lee
EVP and Chief Financial Officer
Luminis Health

CC: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chair
Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzineh Sabi, Commissioner

March 24, 2026

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

Via email: christa.speicher@maryland.gov, joshua.sharfstein@gmail.com

Re: Support for Healthcare Outcome Payment Effort (HOPE) and Integration of Palliative Care, Advance Care Planning, and Hospice

Dear Commissioners:

On behalf of the Maryland State Advisory Council on Serious Illness Care, we write to express our strong support for the proposed Healthcare Outcome Payment Effort (HOPE) and to urge that the program explicitly prioritize and support access to high-quality palliative care, advance care planning, and hospice for Marylanders living with serious illness and for those who matter most to them.

The Council was established to advise the General Assembly and state agencies on statutes, regulations, and policies that affect the provision of care to seriously ill individuals, including trends in care and public and professional education. In recent years, the Council has focused on ensuring that policy and payment reforms advance equitable, person-centered serious illness care, including advance care planning, palliative care across settings, and timely access to hospice.

We commend HSCRC for designing HOPE as an outcomes-focused policy framework to provide ongoing support for interventions that reduce avoidable emergency department visits and hospital admissions and that improve the health and wellbeing of Marylanders. Evidence from Maryland and nationally shows that palliative care, robust advance care planning, and hospice all contribute to better symptom control, clearer communication about goals of care, more concordant care at the end of life, and in many cases reduced avoidable utilization and total costs of care for people living with serious illness. These are precisely the outcomes that HOPE seeks to achieve.

Maryland has built a strong foundation for serious illness care, including implementation of the Maryland Medical Orders for Life-Sustaining Treatment (MOLST) program, expansion of advance care planning initiatives, and statewide work to strengthen access to hospital-based and community-based palliative care and hospice. HOPE provides an important opportunity to build on this foundation and to create a durable payment pathway for effective models that integrate palliative care, advance care planning, and hospice into serious illness care across settings and payers.

We therefore recommend that HSCRC:

1. Clearly identify palliative care, advance care planning, and hospice as priority areas for HOPE initiatives that aim to reduce avoidable emergency department visits, hospital admissions, readmissions, and other unnecessary utilization among people living with serious illness, including those with complex multimorbidity, advanced chronic illness, and serious behavioral health conditions.
2. Ensure that both hospital-based and community-based palliative care programs, hospice providers, and clinicians and organizations delivering structured advance care planning are explicitly eligible partners in HOPE applications and savings arrangements, recognizing their critical role in achieving improved outcomes and patient and family experience.
3. Encourage HOPE initiatives that embed palliative care, advance care planning, and hospice within broader population health strategies under the AHEAD Model and align with the statewide population health and equity goals, so that serious illness care is addressed as a core component of Maryland's long-term cost and quality strategy rather than as a series of isolated projects.
4. Promote equity-focused HOPE interventions that expand access to palliative care, advance care planning, and hospice for populations that have historically experienced disparities in health care, including communities of color, rural communities, individuals with disabilities, and those involved in the criminal legal system. Infrastructure and savings payments will also need to be adequate and timely to allow underserved provider organizations to participate.
5. Use the initial Medicare-only phase of HOPE and the planned all-payer expansion to test and scale interventions that integrate palliative care, advance care planning, and hospice, and to develop the data infrastructure needed to support sustainable, multi-payer coverage of these services in Maryland.

We appreciate HSCRC's leadership in developing HOPE as a voluntary, upside-only program that rewards demonstrated improvements in outcomes and supports the continuation and spread of successful interventions. By making palliative care, advance care planning, and hospice central vehicles within HOPE, Maryland can accelerate its progress toward a comprehensive, person-centered system of serious illness care that honors individual values and goals, reduces avoidable suffering, and uses resources wisely.

The Maryland State Advisory Council on Serious Illness Care stands ready to serve as a resource to HSCRC as HOPE is finalized and implemented, including providing expertise on serious illness and palliative care models, advance care planning, hospice, quality measures, and strategies to reach populations most likely to benefit from enhanced serious illness care. We would welcome

the opportunity to participate in stakeholder discussions or technical workgroups related to serious illness, palliative care, advance care planning, and hospice within HOPE.

Thank you for your consideration and for your ongoing commitment to improving care and outcomes for all Marylanders, including those living with serious illness.

Sincerely,

Dr. Marian Grant

Chair, Maryland [Advisory Council on Serious Illness Care](#)

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MEMORANDUM

TO: Joshua Sharfstein, MD, Chairman, Health Services Cost Review Commission
Members of the Commission

FROM: Maryland Association of County Health Officers

DATE: April 10, 2026

RE: **Comments: Draft Healthcare Outcomes Payment Effort (HOPE) Recommendations**

On behalf of the Maryland Association of County Health Officers (MACHO), thank you for the opportunity to provide comments on the **draft Healthcare Outcomes Payment Effort (HOPE) recommendation for FY27**. We appreciate the Commission’s continued leadership in advancing Maryland’s Total Cost of Care model and aligning with the AHEAD framework to improve population health while maintaining cost discipline. While ED and inpatient visit reduction is the stated outcome, we believe this model can have a significant up-stream impact on population health. Engaging Local Health Departments (LHDs) is a critical and necessary component that will increase the likelihood of success.

MACHO strongly supports the overarching goals of HOPE, particularly its emphasis on prevention, cross-sector collaboration, and outcome-based investment. We believe, however, that the proposal can be significantly strengthened by more explicitly incorporating and operationalizing the role of LHDs as Maryland’s “Chief Health Strategists.” As the only entities with statutory responsibility for population health, jurisdiction-wide data, and cross-sector convening, LHDs are uniquely positioned to ensure that HOPE achieves its intended impact.

We respectfully offer the following recommendations:

1. **Codify the Chief Health Strategist Role for LHDs**
The proposal should explicitly recognize LHDs as Chief Health Strategists responsible for aligning population health priorities, convening partners, and ensuring accountability for community-level outcomes. This designation should be incorporated into the Policy Overview and aligned with the AHEAD Population Health Accountability Plan.
2. **Require LHD Engagement in Regional & Statewide Initiatives (RSI)**
To ensure alignment with local population health priorities, all RSI applications should either include the LHD as a lead or co-lead entity or demonstrate formal alignment through an MOU or equivalent agreement with the relevant LHD(s).
3. **Require LHD Engagement in Care Transformation Framework (CTF)**
To ensure alignment with local population health priorities, all CTF applications should include a support process from the LHD as a partnering entity.
4. **Position LHDs as Neutral Conveners of Cross-Sector Partnerships**
The model should explicitly recognize LHDs as chief conveners responsible for bringing together hospitals, behavioral health providers, community-based organizations, and social needs agencies. This structure will promote equitable participation and reduce fragmentation.

6. Establish Dedicated Funding for Public Health Infrastructure

MACHO recommends a defined funding set-aside within HOPE to support LHD-led infrastructure, including data analytics, care coordination, and community engagement. These functions are essential to achieving savings but are not reimbursable through traditional utilization-based mechanisms. For example, using evidence based reimbursable models such as ACIS (Assistance in Community Integration Services Program) could create sustainable services that achieve the desired outcomes of HOPE.

7. Expand Measurement Beyond Hospital Utilization

While reductions in inpatient and emergency department utilization are important, the model should incorporate Total Cost of Care and intermediate outcome measures that capture upstream prevention and social drivers of health. This will better reflect the value of LHD-led interventions.

8. Strengthen Equity Implementation & Local Data Usage for Prioritization

LHDs should play a formal role in identifying and validating priority populations using local epidemiologic data and Community Health Needs Assessment findings. This will ensure that equity goals are operationalized, not just stated.

9. Include LHD Representation on the Review Committee

MACHO agrees with the review criteria and recommends the inclusion of a Local Health Officer or LHD representative on the review committee to ensure proposals are evaluated through a public health lens for community alignment, feasibility, and integration with existing public health efforts.

10. Require Regional Governance Structures with Public Health Participation

RSI proposals should demonstrate formal governance structures that include LHD participation, with clear roles in decision-making, resource allocation, and accountability.

11. Encourage Braided and Blended Funding Approaches

Proposals should be expected to leverage multiple funding streams (e.g., Medicaid, grants, local funding) with LHDs playing a coordinating role to maximize impact and sustainability.

12. Provide Upfront Investment Opportunities for LHD-Led Initiatives

Given the limitations of retrospective shared savings in building capacity, MACHO strongly encourages the continuation or expansion of funding upfront mechanisms to support LHD-led or co-led interventions.

13. Improve Data Access and Feedback Loops

Timely, actionable data is critical. LHDs should have access to regular performance reports at the local level to support ongoing convening and course correction.

14. Align with Existing Local Planning Frameworks

The model should explicitly align with Community Health Needs Assessments and Community Health Improvement Plans to avoid duplication and reinforce existing public health planning processes.

15. Clarify Accountability for Population-Level Outcomes

LHDs should have a formal role in monitoring, validating, and publicly reporting population health outcomes associated with HOPE initiatives.

16. Strengthen and Specify “Community Partner” Language

References to “community partners” should explicitly include Local Health Departments to ensure clarity in expectations and roles.

17. Consider a Public Health-Focused Pathway within RSI

MACHO recommends the creation of a distinct pathway or sub-track that allows LHDs to serve as primary applicants, with evaluation criteria tailored to prevention, equity, and upstream interventions.

18. Incorporate language to ensure that shared saving is distributed equitably to participating partners. In both pathways, participating entities should share in the success of achieving outcomes and shared savings. This should be further formalized into the application process.

19. Develop a public facing dashboard that incorporates project plans, performance metrics and outcomes. This would allow for public accountability and sharing of best practice ideas.

MACHO strongly believes that fully leveraging Local Health Departments as Chief Health Strategists will enhance the effectiveness, equity, and sustainability of the HOPE model. By formalizing the role of LHDs in governance, funding, and accountability, we can support our hospital partners so that Maryland can more fully realize the promise of AHEAD and continue to lead the nation in population health innovation.

We appreciate your consideration of these recommendations and welcome continued partnership in refining this important initiative. Our contact is Ruth Maiorana, Executive Director, MACHO, rmaiora1@jhu.edu.

April 7, 2026

Ms. Christa Speicher, Deputy Director, Payment Reform
Maryland Health Services Cost Review Commission (HSCRC)
4160 Patterson Avenue
Baltimore, MD 21215

RE: MDOA Recommendations for the Healthcare Outcomes Payment Effort (HOPE) Draft Framework

Dear Ms. Speicher,

The Maryland Department of Aging (MDOA) appreciates the opportunity to provide feedback on the Healthcare Outcomes Payment Effort (HOPE) draft recommendation. As the state moves toward implementation in FY27, we believe the Area Agency on Aging (AAA) network represents a powerful, underleveraged infrastructure capable of bridging health and social domains to ensure the success of this new payment model.

The objective of HOPE, to sustain and expand population health investments, aligns perfectly with MDOA's mission under **Longevity Ready Maryland (LRM)**. To maximize the impact of HOPE, we recommend the following strategies to integrate the aging services network into the program's design:

1. Formalize AAAs as Regional & Statewide Initiative (RSI) Partners - The RSI pathway (Path 2) is an ideal vehicle for community-based organizations to lead regional transformation. We urge the HSCRC to explicitly recognize AAAs as eligible "regional entities" that can anchor these initiatives in partnership with hospitals. AAAs are already trusted community hubs providing health-related social services and care coordination that directly impact the inpatient and ER spending targets of the HOPE model.

2. Incorporate "Upstream Drivers of Health" (UDOH) into Review Criteria - We recommend that the HOPE Review Committee prioritize proposals that address Upstream Drivers of Health (UDOH). Our network has decades of experience managing non-medical conditions, such as nutrition, transportation, and home safety, that shape health outcomes. By recognizing AAAs as auxiliary providers or contracted partners, HOPE can reward interventions that tackle the root causes of avoidable hospital utilization.

3. Scale Proven Pilot Concepts - Maryland already has successful "proof-of-concept" models that should be considered for expansion under HOPE:

- **MAP Hospital Transition Program:** This model embeds AAAs in discharge planning and has demonstrated a 55% reduction in potentially avoidable hospitalizations and a significant ROI of approximately \$20 for every \$1 spent.

- **Rural Health Hubs:** As proposed in our Rural Health Transformation Request for Information response to the Maryland Department of Health, co-locating "Health + Aging Hubs" allows AAAs to provide wraparound supports (i.e., nutrition, home safety) alongside medical partners, creating a truly integrated care plan.
- **Remote Monitoring & Coaching:** Pairing digital health devices with AAA-supported coaching helps rural older adults manage chronic diseases and addresses non-medical barriers to engagement.

4. Support Interoperability and Shared Savings - For HOPE to succeed in an all-payer environment, community partners must be integrated into the state's health information exchange (CRISP). We recommend that HOPE funding be available to support the infrastructure needed for closed-loop referrals, allowing AAAs and hospitals to track shared outcomes and validate savings with methodological rigor.

Meaningful population health gains require deep engagement from social service organizations. MDOA stands ready to collaborate with the HSCRC to design pilots and coordinate the infrastructure necessary to make the aging services network a cornerstone of the HOPE framework.

Sincerely,



Carmel Roques, Secretary
Maryland Department of Aging



Maryland
Hospital Association

April 8, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation for the Healthcare Outcome Payment Effort (HOPE) framework, including the Care Transformation Framework (CTF) and Regional and Statewide Initiatives (RSI) pathways.

MHA appreciates HSCRC's intent to establish the HOPE framework to continue key hospital interventions that were developed under the former Care Transformation Initiative (CTI) program. As a successor to CTIs, the HOPE program aims to achieve a more predictable and accountable payment structure. To succeed HOPE must enable hospitals and community partners to confidently invest in interventions, equitably share savings, and sustainably support population health initiatives aligned with the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model and broader system transformation goals.

MHA's review of the draft recommendation proposed for FY 2027 reveals significant questions about the program's design and its implications for hospitals. As HSCRC transitions from CTIs to the HOPE framework, clear and detailed guidance is needed on the funding, qualifications of initiatives, claims data sources, one-time infrastructure payment requirements, and the overlap with other HSCRC population health programs to support effective hospital planning, implementation, and optimization.

Based on feedback from our member hospitals and health systems, MHA encourages HSCRC to delay the HOPE framework timeline, including the CTF and RSI pathways, by one year. This would allow for more deliberate policy development and a balanced consideration of competing priorities and ensure stronger implementation. We respectfully offer the following comments for consideration.

Changes to TCOC Program Design

The proposed CTF design marks a significant departure from the current CTI model by moving away from a Total Cost of Care (TCOC) framework to a narrower focus on inpatient and emergency department expenditures, while also requiring hospitals to submit proposals within a

compressed timeline. While this limited scope may ease initial implementation and data collection, particularly for non-Medicare payers, it moves away from the AHEAD Model's core objectives to strengthen primary care and care coordination and achieve long-term population health improvement. Additionally, advancing the HOPE concept by FY 2027 under this structure risks prioritizing speed over multi-payer alignment, potentially limiting the program's long-term impact compared to a TCOC-based approach. Accordingly, MHA requests clear, specific clarification on:

- How will the program drive meaningful reductions in TCOC if its measurement framework is limited to inpatient and emergency department expenditures?
- What mechanisms will ensure the program is aligned with AHEAD's goals?

Source of Funding

HSCRC indicated that the CTF pathway will not be funded through the update factor, separating it from base rate updates. While earned outcome payments are projected at \$50 million annually, more clarity is needed on the sustainability and mechanics of the funding framework. MHA urges HSCRC to provide clear, definitive guidance on near- and long-term funding, including:

- How will earned outcome payments be funded in FY 2028 and subsequent fiscal years if not funded through the update factor?
- What is the source and total amount of RSI funding and how will the shared savings structure work?

Qualification of Individual Initiatives

The HOPE policy allows hospitals to submit individual CTF initiatives with projected savings validated by Commission staff. Based on a \$50-million payment cap, HSCRC indicated interventions will be qualified up to this cap in projected averted hospital costs. It remains unclear how many initiatives will be approved or whether individual proposals will face a savings threshold. Increased participation could dilute payments if many initiatives succeed, making it difficult for hospitals to assess the potential return on investment for participating in the program. MHA requests clarification on:

- Will HSCRC establish a maximum projected savings threshold per proposal? If so, how will that threshold be determined relative to the program's overall \$50 million cap?
- What specific criteria and methodology will HSCRC use to evaluate and prioritize proposals if total projected savings exceed available funding?
- How many CTF initiatives does HSCRC expect to approve for earned outcome payments?

All-Payer Scope

HSCRC indicated that HOPE is intended to be an all-payer initiative and that the goal is to work with the Center for Medicare and Medicaid Innovation (CMMI) to include Medicare under the program. The uncertainty around Medicare participation and commercial data reliability makes it difficult for hospitals to commit to participation in HOPE and investing in initiatives in the near-term when the program could change significantly in the future. MHA requests clarification on:

- What is HSCRC's contingency plan if CMMI does not participate? How will hospitals, especially those with a high volume of Medicare patients, be protected after making upfront investments based on an assumed all-payer model?
- What strategy and timeline will HSCRC use to secure, standardize, and operationalize commercial payer data to ensure it is timely, complete, and usable for performance measurement?
- What assurances can HSCRC provide that case-mix based methodologies will produce sufficiently accurate and credible all-payer insights, and how will data gaps or inconsistencies be addressed?

Savings Measurement

The HOPE policy draft recommendation indicates that FY 2026 performance data may be evaluated, as appropriate, to inform FY 2028 outcome payments since the formal measurement period begins in FY 2027 and would otherwise provide only one year of data. The recommendation then says that staff will continue to prioritize reliable measurement but will allow payouts based on a single year of performance during the transitional period. MHA requests clarity on:

- Under what circumstances does HSCRC anticipate using FY 2026 data in combination with FY 2027 data to establish a two-year measurement period for FY 2028 outcome payments, rather than relying on a single year of performance?
- How does HSCRC envision prioritizing reliable measurement if outcome payments during the transition period may be based on only one year of performance (FY 2027)?

FY 2027 Transition—Conditions for One-Time Payment

HSCRC's FY 2027 transition proposal includes a one-time, proportionally distributed payment intended to support care transformation infrastructure, contingent on hospitals designating a population health leader and submitting a written commitment to develop a HOPE proposal by a specified date. MHA recognizes the intention to support continuity of existing initiatives and to have hospitals receiving funds commit to submitting a HOPE proposal. However, the compressed timeline described by HSCRC may make it difficult for hospitals to develop and submit a successful proposal, particularly given HOPE's significantly different design features and scope of planning, internal coordination, and partnership development required. Furthermore, without assurance that submitted proposals will be approved or receive ongoing funding, hospitals risk making substantial upfront investments without a clear path to sustained support. This underscores the need for a more predictable and durable long-term funding approach to maintain care transformation infrastructure. Given this, MHA seeks clarification on:

- How will HSCRC mitigate the risks to hospitals that are asked to commit resources and make upfront investments while proposal approval and ongoing funding remain uncertain?
- What protections or contingencies will be available to hospitals that make good-faith investments in CTFs if their submitted proposals are not approved?
- Has HSCRC considered alternative approaches, such as phased implementation or pilot participation, to better align funding certainty with the upfront investments hospitals must make?

Program Overlap and Transitions

MHA appreciates HSCRC's efforts to align HOPE with existing initiatives, but the overlap with programs such as Revenue for Reform, New Paradigms in Care Delivery, and the broader population health landscape remain unclear. With multiple ongoing efforts, including the Care Redesign Program, High Value Care Plans, Population Health Inventory, Hospital Community Benefit, and the AHEAD-required Hospital Population Health Accountability Plan (PHAP), hospitals need clarity to prevent duplication, misalignment, and administrative burden. In response to HSCRC's request for thematic areas for CTF, MHA encourages the Commission to consider the AHEAD PHAP measures as foundational themes and strongly urges a comprehensive crosswalk showing how these initiatives intersect with HOPE, including whether the same interventions can be applied across programs.

The proposed HOPE timeline leaves insufficient time for thorough policy design, meaningful incorporation of lessons learned from the CTI program, or careful consideration of potential unintended consequences. Hospitals need clear guidance and predictability to develop well-designed, evidence-based proposals that align with state priorities, address key populations, and deliver measurable impact. MHA urges HSCRC to extend the planning timeline by one year and establish clear design parameters to support strategic planning, focus on high-impact interventions, and achieve meaningful, sustainable outcomes.

Thank you for the opportunity to provide input. We welcome continued dialogue on the HOPE framework and broader population health initiatives to ensure programs can be implemented effectively and achieve their intended impact.

Sincerely,



Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair HSCRC
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
William Henderson
Christa Speicher

MedChi

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Sent via email: jon.kromm@maryland.gov

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

RE: Healthcare Outcome Payment Effort (HOPE) Draft Recommendation

Dear Executive Director Kromm:

On behalf of the Maryland State Medical Society (MedChi), I am writing to express support for the HOPE Program and to recognize the outstanding work of the staff who have developed and advanced this important initiative. The level of thoughtfulness, collaboration, and commitment demonstrated by the team has been exceptional. It is clear that this work reflects not only technical expertise but also a genuine dedication to improving patient care and strengthening Maryland's health system.

Programs like HOPE do not come together by accident. They are the result of sustained effort, careful planning, and a willingness to engage stakeholders across the continuum of care, and the team behind this effort deserves significant credit. While some tweaks still may be needed we need to move forward with programs like this to foster alignment and population health improvements.

At the same time, the recent negative tone and commentary expressed by the representative of the largest health insurer in Maryland during the Total Cost of Care meetings regarding HOPE has been disappointing and counterproductive. Maryland's model has always been strongest when stakeholders work collaboratively to solve problems, not when progress is undermined by criticism that lacks constructive solutions. For example, given that CareFirst premiums increased by 6.2 percent from 2023 to 2024, while underlying medical costs rose by only 1.9 percent during the same period, there is a clear opportunity for CareFirst to focus on affordability and value. Additionally, with a Risk-Based Capital level at approximately 877 percent, more than four times the legal requirement of 200 percent, CareFirst is in a strong financial position to support innovation.

Rather than attacking or questioning the quality care redesign work led by the HSCRC, all

parties would benefit from focusing on how to build on the progress made. The HOPE Program represents exactly the kind of forward-looking, patient-centered approach that Maryland should encourage. I recognize some concerns have been raised regarding the recent CTI results and the removal of the zero-sum nature of the program. My concern is the solution cannot be to end this type of transformation programing. We have the money under the saving target to move forward as we continue to refine and develop HOPE, and we should move forward.

Looking ahead, one of the most important shared priorities should be increasing physicians' awareness of and engagement with the program. Continued outreach, education, and alignment with community physicians will be essential to long-term success. We should also work collaboratively to expand partnerships with community-based physicians and other health care practitioners to ensure that the program's benefits are broadly realized across the state. To summarize, Maryland has long been a national leader in health care innovation. The HOPE Program is another step in that direction, and it deserves strong support from all stakeholders committed to improving care, enhancing quality, and ensuring sustainability for the future.

Sincerely,

A handwritten signature in blue ink that reads "Gene M. Ransom III". The signature is written in a cursive style with a horizontal line under the "III".

Gene M. Ransom III

CEO MedChi, The Maryland State Medical Society



MedStar Health

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MedStar Franklin Square Medical Center
MedStar Good Samaritan Hospital
MedStar Harbor Hospital
MedStar Montgomery Medical Center
MedStar Southern Maryland Hospital Center
MedStar St. Mary's Hospital
MedStar Union Memorial Hospital
MedStar Georgetown University Hospital
MedStar National Rehabilitation Network
MedStar Washington Hospital Center
MedStarHealth.org

April 9, 2026

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

Dear Dr. Kromm:

On behalf of the seven (7) MedStar Health Hospitals in Maryland, we would like to thank you for your ongoing partnership in advocating for the highest quality and highest value care for Marylanders. We write to provide our support of the recently proposed "Health Outcomes Payment Effort" policy, pending further clarity on several aspects of the policy.

Support. As we stated in our previous comments, MedStar Health supports the continued inclusion of a model structure such as HOPE that provides flexible support to hospitals and health systems investing in transformational programs to reduce the total cost of care. A policy that can provide timely reward to programs proportional to their level of impact without downside risk encourages experimentation with intensive high-impact models of care that can accelerate model gains; further, we see this as complementary to the broader geographic accountabilities of the AHEAD model, where program-specific impacts can be difficult to isolate and thus invest in.

Further Clarity on Program Qualification Process. We endorse the introduction of a review process which will help to ensure reasonable expectations for impact on the target population. However, we believe we need to have more details on how that panel will be constituted in order to fully support. We feel strongly that individuals with experience in operationalizing care transformation programs will need to be involved in order for the panel to serve its intended purpose. Regarding the proposed "scoring" process, we support Option C in Step 2; this is the only option which allows reward for outperforming projections. We believe that it will be difficult for systems to accurately project impacts, and so the focus should be on actual, and not projected impacts. We would support a proposed minimum saving rate based on projection but would suggest it be much lower than the proposed 50%; 10-20% would be enough of a hedge against outlandish projections and would allow underperforming projects to still see some reward.

Comments on Financial Structure. We approve of the pre-specified, fixed reward pool in the proposed policy, however, it remains unclear to us if/how this funding will impact overall hospital annual update factors. While payments related to HOPE will be made regardless of position on any affordability test, the funding will impact those tests, potentially causing a negative adjustment to a future update factor to manage overall TCOC and affordability. MedStar feels strongly that future update factors should continue to fully fund inflation first and foremost. Additionally, we encourage the HSCRC staff to continue to consider structures that produce a positive feedback loop such that part of the savings accrued to the state are "re-invested" into larger qualifying savings amounts in the program. Reinvesting part or all of the 50% savings reserved to the state in future years would accelerate gains via this program and would produce more long-term benefit to the AHEAD model goals overall. Regarding the FY27 plan, we support the plan to fund "roll-over" CTIs and feel that the revised plan to allocate by

market share inadequately reflects the regulatory intent of the program. We believe that funds should be allocated only to those hospitals and health systems who reliably achieved gross shared savings in CTI, as well as meeting the criteria laid out by the staff to commit to future HOPE participation. Alternatively, that money could fund savings for volunteer HOPE participants in a pilot structure to test the model while awaiting clarity on all-payer considerations.

Regional Collaboratives. MedStar Health would like to reiterate that the proposed regional structure should not exclude hospitals and/or health systems from being the anchor entity in regional collaboratives. Systems are often best positioned to reach patients and provide administrative support. As a comparative example, many of the state's most successful Care Transformation Organizations in the MDPCP program are run by systems, even as they may support practices both within and outside of their parent organization. We see no reason to exclude systems from participation here. More details are clearly needed on the policy structure of regional collaboratives prior to approval.

Thank you for your consideration of our perspective. Please let us know if we can provide further clarifications and/or if you would like to discuss them with our team.

Sincerely,



Ryan Anderson, MD

Vice President, Clinical Care Transformation
MedStar Health



Michael Wood

Vice President, Rates & Reimbursement
MedStar Health



Meritus Medical Center
11116 Medical Campus Rd
Hagerstown, MD 21742
301.790.8000

March 30, 2026

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

Dear Dr. Kromm,

On behalf of Meritus Health, I am writing to express support for the proposed Healthcare Outcome Payment Effort (HOPE) framework for Fiscal Year 2027 and beyond. We appreciate the Commission's continued leadership in advancing Maryland's Total Cost of Care Model and in thoughtfully evolving policy to further align payment with population health outcomes.

The proposed HOPE framework represents a meaningful and important advancement in the State's approach to care transformation. In particular, we commend the Commission for designing a model that is upside-only and voluntary, which appropriately lowers barriers to participation and encourages broad engagement across hospitals and community partners. This structure enables providers to focus on innovation, care redesign, and prevention without the added concern of downside financial exposure—an especially important consideration given the ongoing operational and financial pressures facing health systems.

We also strongly support the model's emphasis on population health and upstream investment. By creating clear pathways for hospitals and partners to invest in interventions that reduce avoidable emergency department and inpatient utilization, HOPE reinforces the core objective of improving health outcomes rather than simply managing episodes of care. The framework appropriately recognizes that sustained improvements in cost and quality require coordinated efforts that extend beyond hospital settings.

The proposed funding approach further strengthens the model. The establishment of predictable, multi-year funding and payment structures, including the commitment to make earned payments regardless of broader affordability test performance, provides critical stability for participating organizations. This predictability is essential for long-term planning and will enable health systems to make the necessary investments in infrastructure, workforce, and partnerships to support durable transformation.

Additionally, we appreciate the inclusion of multiple pathways for participation, including both hospital-led initiatives and regional or statewide efforts. This flexibility allows for innovation at

different scales and encourages collaboration with non-hospital entities, including community-based organizations, behavioral health providers, and other partners. Such cross-sector collaboration will be essential to achieving meaningful improvements in population health and advancing health equity.

The alignment of HOPE with the AHEAD model and broader all-payer goals is also noteworthy. Emphasizing shared accountability and data-driven measurement of outcomes can help position Maryland to continue advancing value-based care. The focus on transparency and clearly defined participation criteria further supports confidence in the model's implementation.

Finally, we appreciate the recognition of FY2027 as a transition year, including the proposal for one-time infrastructure funding to help sustain care transformation efforts during this period.

In summary, we view the HOPE proposal as a thoughtful and forward-looking policy that builds on Maryland's commitment to improving population health, strengthening care coordination, and supporting sustainable cost growth. We appreciate the opportunity to provide comments and look forward to continued collaboration with the Commission as the framework is refined and implemented.

We appreciate the opportunity to provide comments and look forward to continued partnership with the Commission in implementing this important initiative.

Sincerely,

A handwritten signature in black ink that reads "Joshua Repac". The signature is written in a cursive, flowing style.

Joshua Repac
Chief Financial Officer
Meritus Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. David Maine
Jonathon Blum
Nicki McCann
Dr. Farzaneh Sabi



primary care coalition

Comments on the Healthcare Outcomes Payment Effort program

making
health care
happen

Thank you for the opportunity to comment on the proposed Healthcare Outcomes Payment Effort (HOPE) program on behalf of Primary Care Coalition. We are very excited about the opportunity to participate in collaboration with the Nexus Montgomery Regional Partnership hospitals. As the HSCRC continues to develop and refine the program, please consider the following recommendations.

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1. The program, as it is currently described, does not have a minimum dollar value for expected savings. While the size of the potential savings may certainly be considered in determining whether a program should be approved for participation, the HSCRC should not set a minimum dollar threshold for approval to participate.
2. PCC supports the staff's position that Regional and Statewide Initiative (RSI) payments should not be capped in the same way that hospital payments may be. The Commission will have more control over the number and expected value of programs because each will need to be approved by the full Commission.
3. If the HSCRC were to decide to cap the RSI payments as it is considering for hospital payments, we recommend scoring each intervention at actual averted hospital costs or 125% of projected averted hospital costs, whichever is lower. This rewards better than projected performance while allowing for some control over total spending.
4. PCC does not think there should be a minimum performance threshold for a payout.
5. PCC recognizes the HSCRC's potential concern regarding attribution of individuals to multiple projects. We recommend that the payout of savings per attributed beneficiary for each project be reduced for duplicate beneficiary attributions. For example, if one beneficiary is shared by project A and project B, and project A's expected payout per beneficiary is \$100 and project B's is \$200, the total payout for project A would be reduced by \$50 and \$100 for project B.

Thank you for the opportunity to comment on this opportunity. Please feel free to reach out to me if you have any questions.

Respectfully submitted,

Annice Cody
President and CEO

April 2, 2026

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

Re: Comments on HOPE Draft Recommendation

Dear Commissioners:

Thank you for the opportunity to comment on the draft recommendation for the Healthcare Outcome Payment Effort (HOPE) Policy. We are physicians and faculty at Johns Hopkins with expertise spanning cerebrovascular care, diagnostic excellence, patient safety, healthcare quality, and health services research. We strongly support the goals of the HOPE proposal and believe **two minor revisions** would strengthen its ability to reduce potentially avoidable utilization (PAU), lower total cost of care (TCOC), and improve patient outcomes:

1. HSCRC should add “presenting symptoms” to the list of illustrative target population characteristics in the review criteria.

The draft recommendation identifies several possible defining characteristics for target populations, including diagnoses, prior utilization of healthcare services, HCC score, geography, and demographics. HSCRC should also add **presenting symptoms** to this list. In some cases, defining a target population by **symptom** rather than **diagnosis** is the more appropriate and policy-relevant approach, particularly when the goal is to improve diagnostic efficiency and accuracy early in the care pathway and thereby reduce PAU.

For example, if the target population is defined as patients with an emergency department (ED) diagnosis of stroke, opportunities to reduce PAU through improved diagnostic performance may already be limited because the diagnosis has been established and subsequent care is often standardized. In contrast, if the target population is defined as patients presenting with the symptom of dizziness, interventions that improve the speed, accuracy, and cost-effectiveness of diagnosis would be fully captured. This approach better reflects the point at which avoidable utilization and diagnostic error often occur and allows patient outcomes to be assessed more meaningfully after implementation of diagnostic interventions.

2. HSCRC should explicitly include diagnostic excellence within the scope of HOPE-supported interventions

As drafted, the proposal emphasizes upstream interventions, chronic disease management, and community-based supports. These are important priorities. HSCRC should also explicitly identify **diagnostic excellence** as an example of an eligible intervention area under HOPE, because improving diagnostic accuracy and efficiency can reduce PAU while improving

outcomes and advancing equity. Including diagnostic excellence explicitly in HOPE would broaden the range of hospital-led interventions that can meaningfully support the program's goals.

One illustrative example is patients presenting to the emergency department with dizziness, which accounts for approximately 4–5% of ED visits. These patients often undergo unnecessary CT imaging, experience prolonged ED length of stay, and may be admitted unnecessarily, while some leave with an incorrect diagnosis. Evidence-based interventions exist that can improve diagnostic accuracy and efficiency for these patients, with the potential to reduce avoidable imaging and admissions while improving patient outcomes. However, implementation of new interventions that require changes to established clinical workflows can be difficult and may not always be viewed as an institutional investment priority. HOPE creates a unique opportunity to address this barrier by financially incentivizing hospitals and health systems to develop and deploy interventions that improve diagnostic efficiency. More broadly, diagnostic excellence is increasingly recognized as an important priority in quality measurement and healthcare value, and explicitly recognizing it within HOPE would help align HSCRC with evolving federal priorities related to quality, outcomes, and cost.

Thank you for considering these comments. The HOPE policy is a promising mechanism to encourage innovative approaches that reduce PAU and TCOC while improving outcomes. Explicitly incorporating diagnostic excellence and symptom-defined target populations would strengthen the proposal and help position HSCRC as a leader in linking diagnostic excellence, patient outcomes, and healthcare value. We would welcome the opportunity to provide additional input. These comments reflect our individual views and do not necessarily represent the official position of Johns Hopkins University or Johns Hopkins Medicine.

Sincerely,



Allen Kachalia, MD, JD
Professor of Medicine
Senior Vice President, Patient Safety
and Quality



David Newman-Toker, MD, PhD
Professor of Neurology
Director, Armstrong Institute Center for
Diagnostic Excellence
Director, Division of Neuro-Visual &
Vestibular Disorders



Elizabeth A. Fracica, MD, MPH
Assistant Professor of Clinical
Neurology
Johns Hopkins Hospital



April 3, 2026

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

Re: Comments on The Health Outcomes from Positive Experiences (HOPE) Framework

Dear Dr. Kromm,

Thank you for the opportunity to share additional thoughts regarding this important model. As background, The Day Clinic is a novel clinic-based alternative to hospitalization for people living with heart failure. We provide IV diuresis for acutely sick patients with longer term management of heart failure. This comprehensive approach includes guideline directed medical therapy (GDMT), remote patient monitoring (RPM), care coordination and other advanced clinical and technology approaches. The Day Clinic's co-founders, Scott Afzal and Kapil Parakh, have been dedicated to improving the health of Marylanders through their prior work at CRISP and at Johns Hopkins, respectively. As a recipient of a New Paradigms in Care Delivery (NPCD) grant, we are committed to supporting the development of a sustainable program that invests in safe and effective alternatives to hospital care for ambulatory sensitive conditions.

The Day Clinic will achieve substantial savings through avoided hospitalizations, reduced lengths of stay, and effective management of heart failure over time. Our intent is to rapidly scale this model of care across Maryland after we demonstrate its clinical and economic efficacy at our first site in Annapolis. **However, this is the reality:** while the clinical efficacy and cost effectiveness of ambulatory heart failure management is well-documented, it is not financially sustainable under current payment models. There is simply no current reimbursement structure that incentivizes intensive engagement in a high-acuity, low-volume setting. **Absent a framework like HOPE that allows innovative providers to share in the value and savings they create within a population, this model of care cannot be sustained—or scaled—through traditional fee-for-service reimbursement.** The HOPE framework is not just an elective option for us; it is the essential financial bridge required to provide exceptional care and safely keep patients out of the hospital setting.

At its core, The Day Clinic is premised on treating patients in a clinic setting that may require multiple hours of engagement and monitoring. We want you to imagine the following scenario:



A heart failure patient has been hospitalized twice in the past year. It took them over a month to get a follow-up visit in a cardiologist's office. They are taking some heart failure medications, but they have not been titrated to evidence-based levels. They don't really understand what the medications do or why they are taking them. They don't have a clear understanding of how nutrition impacts their disease—frankly, they don't really understand the disease itself. They are beginning to struggle with anxiety and depression as they face the significance of heart failure. They do not have any tools—such as a scale or blood pressure cuff—to monitor key markers of their condition. They haven't set any goals for how they want to live with heart failure.

These are the patients The Day Clinic will serve with dedication and compassion. But, these folks cannot be seen in a 15 minute office visit, especially after a hospitalization. Our extended timeframe allows us to engage holistically and stabilize these high-need patients before they spiral back to the emergency department. The HOPE framework is the best path to support this level of clinical intensity. Without a mechanism to capture the value of these avoided hospitalizations, the status quo of fragmented, short-duration care will continue to drive Maryland's heart failure costs.

Our team is ambitious and we are committed to the relentless pursuit of better care for heart failure patients. We draw inspiration from the most innovative programs in the world—from Singapore to Brazil to Spain—and we want to bring that level of care here to Maryland. The HOPE framework makes this level of innovation possible.

Simply stated, we will scale a model of care across Maryland that will have dramatic impacts on heart failure care and cost. But, we need a model like the HOPE framework to make it work. We believe other regional initiatives deploying innovative approaches to avoiding hospital visits will come to market once this model is available. We look forward to being a partner to you in bringing it to life and would be happy to schedule time to meet with you directly to share our perspective.

Best Regards,
The Day Clinic Team

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



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April 8th, 2026

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

RE: UMMS Comment Letter on the Healthcare Outcome Payment Effort

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS), we are writing to comment on the draft recommendation of the Healthcare Outcome Payment Effort (HOPE) policy. UMMS remains an engaged participant in the Care Transformation Initiative (CTI) policy, deploying hundreds of individual CTIs over the policy's five performance years and actively aligning population health strategy and investment alongside. Our goal is to continue leveraging population-focused incentives and contribute to the goals of the AHEAD Model through an evolved CTI policy that prioritizes return on investment and transformation of our healthcare system.

Support for the Healthcare Outcome Payment Effort (HOPE) Policy

As noted in our February letter, UMMS supports a prospective, predictable financing model that preserves CTI's core strength: defining intervention populations and measuring success through total cost reduction, thus sharing in the overall success of Maryland's Model. HOPE should continue to reward hospitals for targeted population health investments that advance AHEAD goals and the State's position on key model targets like Medicare and TCOC growth reduction, which otherwise lack direct reimbursement to hospitals.

Limitations and Opportunities of Proposed HOPE Policy

In our last comment letter, we enumerated several perceived limitations and/or opportunities with the current proposed framework:

- **Total Cost of Care should measure performance.** Hospitals will continue to be held accountable for the TCOC of Maryland Medicare beneficiaries and growth for all payers. Diverging hospital incentives to solely rewarding hospitals for inpatient and emergency department costs shifts incentives away from Model targets, and potential corrections, weakening the behavioral economics of this Model.
 - This change also narrows the scope and magnitude of potential savings significantly and overlooks the AHEAD Model's expectation placed on hospitals to deploy investments beyond their walls.
 - The HSCRC could compel payers to provide claims to support this effort, provide them with the methodology to run internally, or even use all-payer claims data sets and develop a methodology to extrapolate full state/impact estimates.

- **Maryland has an all-payer opportunity to standardize and innovate value-based payment** beyond the ACO structure available nationwide, deployed by payers heterogeneously with varying levels of success.
 - HSCRC should prioritize creating a shared-savings methodology with Medicare under AHEAD, aligned with or integrated into HOPE.
 - HOPE should be used to supplement or even replace weak and ineffective ACO model value-based contracts with commercial/Medicaid payers that are currently misaligned with AHEAD priorities, variably structured, and inconsistently negotiated across the State.
 - This approach creates a standardized, Maryland-specific framework for financing transformation tied to measurable TCOC improvement. It further supports new investment needed to succeed under AHEAD, with reduced Medicare investment and constrained revenue growth.

CTI Winddown and HOPE Implementation Timelines

The HSCRC has organized an aggressive timeline for the HOPE policy, both in development and implementation. Staff must support funding population-based interventions that Maryland hospitals have already deployed without notice that current policy may end abruptly this upcoming fiscal year. Again, this is critical given the hospital's accountability in the mission, and successes, to reduce the statewide cost of care. UMMS respectfully suggests that a more deliberate approach in timeline and policy winddown be taken:

- **Delay initial HOPE enrollment for the first measurement to FY28**, giving more time to establish the policy framework and minimizing the administrative burden on Maryland hospitals as they transition into AHEAD.
- **Incorporate \$50M of infrastructure payments proportional to GBRs in both FY27 and FY28** funding to support current interventions (previously rewarded in part by the CTI policy) during the transition.
- **Fully wind down the CTI policy and allow for some adjustment in FY28 as a result of FY26 performance**, currently underway and already invested in.
 - These CTIs were deliberately constructed and enrolled in based on current population health-based operations. To abandon FY26 CTI experience would be to retroactively punish hospitals that purposefully enrolled in the program with qualified interventions.
 - UMMS recommends HOPE enrollment and implementation prioritize supporting MD Hospital's adjustment to life under the AHEAD model and allowing them to fully prepare the policy by delaying implementation to FY28 measurement.

Interactions with Other HSCRC Policies

- **UMMS does not support the proposed exclusion of Revenue for Reform initiatives in potential HOPE-based applications.**
 - Despite Revenue for Reform methodologies shifting multiple times to account for identified flaws, Maryland hospitals are relegated to penalties in perpetuity and are never able to wipe the proverbial slate clean. HOPE then proposes that Maryland hospitals that may have historic penalties, even if now invalid due to updated methods, should have their opportunities to fund important work permanently excluded.
 - This dynamic runs the risk of stunting care transformation and disadvantaging hospitals deemed arbitrarily 'inefficient' under the Inter-Hospital Cost Comparison (ICC). As UMMS noted in prior comment, these hospitals are often those that serve Maryland's rural and socioeconomically challenged populations and that a ranking system does not allow for mobility out of penalty zones.
 - For example, UMMS' Thrive Clinic, which provides West Baltimore's population with infectious disease management and support in the community, will never be allowed evaluation under HOPE because it was

used for revenue for reform in FY24, while under new methodology the UMMC Downtown and Midtown campuses are no longer “inefficient”.

- Punitive policy should be time limited and not impede Model goals; the HSCRC must reckon with these interactions instead of simply excluding.
- **UMMS does not support allowing overlap with the Maryland Primary Care Program, Primary Care AHEAD or any other primary care investments (i.e., EQIP Primary Care, Rural health transformation).**
 - Primary care has multiple dedicated, specifically designed, incentive streams and significant Statewide Model investment already; we should not crowd out other population health funding by duplicating dollars under AHEAD.
 - Given the HSCRC is proposing to cap total savings payable through this policy, UMMS would discourage the HSCRC from duplicating investments in primary care and allowing large panel-based populations to crowd out other smaller, but meaningful, investments and savings opportunities in our system.
 - Based on the current proposal, allowing primary care to make up a portion of available savings guarantees double or even triple incentivizing a singular group/region of the state.

HOPE’s Regional Statewide Initiatives (RSI)

- **UMMS is concerned the RSI pathway does not have outlined caps on investment, redirects acute system funding to public health erroneously and will be solely at commission discretion.**
 - Maneuvering hospital funding outside of the acute care system does not enhance care if it stunts required funding to sustain support for Maryland’s most vulnerable and complex populations.
 - Additionally, there have been numerous duplicative funding streams to the public health infrastructure that are uncoordinated. E.g., the HSCRC’s Population Health Innovation Fund used hospital funding to support food insecurity, and the Maryland Department of Health also plans to apportion a significant amount of federal Rural Transformation funds to the same effort.
 - Coordination is significantly lacking in non-hospital care transformation space and runs the risk of the HSCRC spending needed hospital funds in a space with varying accountability, oversight, and ability to perform.
- **UMMS believes that there is a material overlap between the RSI pathway in HOPE and GEO AHEAD’s** intended role as a geography-based TCOC accountability vehicle UMMS would caution staff that absent clear alignment, Maryland risks creating duplicative regional accountability structures with competing attribution, savings, and financing.

HOPE Care Transformation Framework (CTF) Review Committee

UMMS believes that the funding of population-based interventions for the CTF stream needs to be deferred to community expertise and experience serving MD populations, which hospitals distinctly hold. As such, a committee tasked with the distribution of limited funds to support those interventions should be constructed as much as possible to be free of potential bias. Proportionate selection statewide, an open meeting and appeals process, and equitable investment regarding MD hospital applications is tantamount to the buy-in of this policy and its eventual success.

We thank the Commission for the opportunity to reflect and comment on these policy changes and for the commitment to retaining these important incentives in Maryland. UMMS is similarly committed to making sure that we continue to move toward a system that favors value and quality of care and rewards hospitals that are striving to deliver that to Marylanders.

Sincerely,

UMMS Healthcare Outcome Payment Effort Comment Letter

April 8th, 2026

Page 4

A handwritten signature in cursive script that reads "Alicia Cunningham".

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc:

Joshua Sharfstein, MD

James Elliot, MD

Jonathon Blum, MPP

Ricardo Johnson

David Main, MD

Nicki McCann, JD

Farzaneh Sabi, MD

Dear Ms. Speicher,

As a Geriatrician, palliative care clinician and health services researcher with over 25 years of experience in serious-illness population, I strongly support the Healthcare Outcome Payment Effort (HOPE) as a forward-thinking successor to CTIs. The voluntary, upside-only shared-savings model, \$50 million annual allocation (FY27–FY29), and one-time infrastructure payment align precisely with AHEAD’s Population Health Accountability Plan by incentivizing upstream interventions that demonstrably reduce inpatient and ED utilization while improving quality of life.

Palliative care is uniquely positioned to deliver these goals: meta-analyses consistently show 20–30 % reductions in acute-care spending for patients with advanced cancer, heart failure, and dementia, achieved through interdisciplinary symptom management, advance care planning, and community-based support—precisely the outcomes HOPE seeks to reward. The CTF and RSI pathways offer excellent vehicles for hospital-partnered programs and statewide networks, while the planned all-payer expansion by FY2028 will eliminate billing fragmentation that currently impedes hospice transitions.

To maximize clinical and fiscal impact, I respectfully recommend three targeted refinements:

1. Explicitly list palliative care interventions (CAPC- and NHPCO-aligned) as qualifying examples in final guidance to accelerate adoption.
2. Adopt a hybrid measurement approach that combines the current claims-based cost savings with patient-reported outcome measures (such as the ESAS and POS surveys) and hospice enrollment rates. This will allow HOPE to recognize the rapid symptom relief and quality-of-life improvements that palliative care delivers, which may otherwise be undervalued during the two-year measurement period.
3. Include at least one palliative care expert on the six-member review committee to ensure proposals address equity gaps in rural and minority populations without unintended undertreatment.

These modest adjustments would enhance HOPE’s return on investment, accelerate Maryland’s cost-containment objectives, and improve care for the state’s rapidly aging population. I stand ready to provide additional data or participate in the TCOC workgroup.

Thank you for the opportunity to comment.

Dr. Kheirbek

[Raya Elfadel Kheirbek, MD, MPH, FGSA](#)
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April 8, 2026

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

Submitted via email to christa.speicher@maryland.gov

Dear members of the Health Services Cost Review Commission (HSCRC),

Thank you for the opportunity to comment on HSCRC's new [Healthcare Outcome Payment Effort \(HOPE\) draft recommendation](#). We believe HOPE represents a unique opportunity for Maryland to align provider payments more closely with initiatives to improve patient and population health, health equity, and patient affordability, and we look forward to its implementation.

[United States of Care](#) (USofCare) is a multi-state, non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. In Maryland, we've worked with stakeholders and agencies, including HSCRC, to ensure the consumer perspective is heard during the development of pragmatic [patient-first care](#) solutions. In particular, we've provided technical assistance and other support to the state as Maryland builds upon the successes of Maryland's unique [Total Cost of Care \(TCOC\) Model](#) and implements the [Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#).

The AHEAD Model will provide much-needed financial certainty to health care providers while also benefiting Maryland families across the state by shifting the way in which care is delivered in order to expand access to preventive and primary care, prioritize population health, improve health outcomes, and lower health care costs in the State. The draft HOPE recommendations will better position the state to not only meet AHEAD's immediate population health goals, but also tie hospital and provider payments to patient and population health outcomes to further facilitate long-term health care delivery transformation.

HOPE was deliberately designed to align with and advance the objectives of AHEAD's Population Health Accountability Plan (PHAP) components and recognizes the need for strong cross-sector collaboration to achieve these goals to benefit patients. Using the draft framework, we believe HOPE will:

- **Improve patient and population health outcomes** by shifting payment away from measures that solely emphasize utilization or cost savings toward a more blended model that also incorporates and prioritizes better population-level and patient-centered health outcomes.
- **Promote access to primary and preventive care** by improving coordinated care that focuses on early intervention, chronic disease management, and related services.
- **Prioritize health equity and reduce health disparities** by incorporating equity measurements directly into health outcomes assessments instead of as secondary measures. We also believe HOPE will address long standing health inequities by promoting engagement with community health workers and social services organizations.

- **Promote health care affordability for people** by limiting cost growth to help meet AHEAD's Total Cost of Care targets and achieve better health outcomes at lower cost for patients.

As consumer advocates, we appreciate HSCRC's efforts to construct a draft recommendation that promotes patient-first care and prioritizes efforts to improve people's health outcomes. Moving forward, we urge the HSCRC to continue to solicit feedback from a diverse set of stakeholders, including consumer advocates, during HOPE's implementation and evaluation processes.

Thank you for the opportunity to provide comments on the HOPE draft recommendation. We appreciate all you do to expand access to quality, affordable health care for all Marylanders. Please do not hesitate to reach out if you have any questions.

Best regards,

Eric Waskowicz
Senior Policy Manager, United States of Care
ewaskowicz@usofcare.org



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**Maryland's Statewide Health
Information Exchange,
the Chesapeake Regional Information
System for our Patients: FY 2027
Funding**

Final Recommendation

June 10, 2026

This is a final recommendation for consideration by the Commission.

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List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design 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
FFY	Federal 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

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 Maryland Model and the public interest,¹ this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2027 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 (\$3,504,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, and hospital regulatory initiatives (\$7,396,000).

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling \$10,900,000 for FY 2027. As a result, the HSCRC will be funding approximately 19 percent of CRISP's Maryland funding, compared to the budgeted 26 percent in FY 2026. In FY 2026, HSCRC's share of funding for CRISP increased to address anticipated reductions in Federal matching grants. However, no changes to Federal funding occurred and prior years' match rates are anticipated to continue in federal fiscal year (FFY) 2027. HSCRC is decreasing the FY 2027 assessment given the sustained level of federal match funding.

Staff solicited public comment on the draft recommendation through May 20, 2026, but did not receive any comment letters.

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

Background – Past Funding

Over the past fifteen 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 15 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
FY 2027	\$10,900,000

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with the Maryland Health Care Commission (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. CRISP’s reimbursement from the HSCRC is 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, the Reporting and Program Administration payments are split into fixed recurring costs and a periodic true up. This funding approach allows 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. 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 11 percent of total funding for FY 2027.

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

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

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 Maryland 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 2027 for the HIE function is \$3,504,000.

Category 2: Reporting and Program Administration Related to Population Health, 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 the AHEAD 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 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.

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 AHEAD Model;
- (2) Funding for program administration related to programs under the AHEAD 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 2027 for the activities described above is \$7,396,000.

Staff Recommendation

Staff is recommending the Commission approve a total of \$10.9 million in funding through hospital rates in FY 2027 to support the HIE and continue the investments to advance the Maryland Model through both direct funding and obtaining federal MES matching funds.

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 2027 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	\$3,504,000	\$10,387,000	\$6,123,000	\$3,165,000	\$23,179,000
Reporting and Program Administration	\$7,396,000	\$10,511,000	\$0	\$3,095,000	\$21,002,000
Other non-HSCRC programs	\$0	\$11,493,000	\$0	\$2,309,000	\$13,802,000
Total Funding	\$10,900,000	\$32,391,000	\$6,123,000	\$8,569,000	\$57,983,000
% Of Total	19%	56%	11%	15%	100%



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Final Recommendation for the Inpatient Length of Stay Incentive Program for Rate Year 2028

June XX, 2026

This document contains the final recommendations for the RY 2028 Inpatient Length of Stay Incentive Program.

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List of Abbreviations

Abbreviation	Definition
AHEAD	Achieving Healthcare Efficiency through Accountable Design
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
ED	Emergency Department
FY	Fiscal Year
GBR	Global Budget Revenue
HCUP	Healthcare Cost and Utilization Project
HSCRC	Health Services Cost Review Commission
IP	Inpatient
IP LOS	Inpatient Length of Stay
LOS	Length of Stay
MHA	Maryland Hospital Association
O/E	Observed-to-Expected Ratio
PMWG	Performance Measurement Work Group
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
SNF	Skilled Nursing Facility
SOI	Severity of Illness
TCOC	Total Cost of Care

Key Methodology Concepts and Definitions

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using Solventum (formerly 3M) software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

Case-Mix Adjustment: National norms for LOS (i.e., normative value or "norm") are derived from the HCUP National Inpatient Sample by APR-DRG/SOI. Expected LOS for each hospital is derived by summing the LOS norms for each patient discharged during the measurement period.

Observed/Expected (O/E) Ratio: LOS performance is calculated by dividing the observed LOS by the expected LOS. Expected LOS is determined through case-mix adjustment using national norms.

Risk-Adjusted LOS: Observed LOS divided by Expected LOS, multiplied by the National Base Year Mean LOS.

ED Boarding: The practice of holding admitted patients in the emergency department after they have been assigned an inpatient bed, typically due to lack of available inpatient beds. ED boarding is a direct consequence of constrained inpatient capacity and prolonged inpatient length of stay.

Improvement Score: A measure of change in a hospital's risk-adjusted LOS from the base year to the performance year, expressed as a percentage.

Attainment Score: A measure of a hospital's risk-adjusted LOS relative to a fixed threshold, indicating absolute performance rather than improvement.

Recommendations

These are the final recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
 - a. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
 - b. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
 - c. Publicly report trends in IP LOS statewide and by hospital at HSCRC Commission meetings.
2. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
3. Monitor to ensure the measurement approach is valid and the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and ED revisits.

Introduction

Maryland hospitals have been and are currently funded under an all-payer global budget revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the current AHEAD model (CY 2026- CY 2035). Maryland's global budget system, which provides hospitals with annual prospective budgets, guarantees Maryland hospitals a greater source of financial stability and provides incentives to shift services to the most appropriate care setting and reduce potentially avoidable utilization. The HSCRC adjusts hospital global budgets for quality of care and patient experience through pay-for-performance policies that assess areas of national focus (e.g., hospital acquired complications, readmissions) and areas of opportunity that are unique to Maryland and global budgets. HSCRC also monitors and publicly reports measures for key areas of interest, including areas under consideration for future payment policy.

The Inpatient Length of Stay (IP LOS) Policy is being proposed to the Commission to address concerns related to significant post-pandemic growth in IP LOS at Maryland hospitals. Extended hospital stays are sometimes unavoidable. In other instances, patients remain hospitalized for longer than necessary due to ineffective initial treatment, poor discharge planning, or other hospital-specific factors. This can result in

poor patient outcomes and financially strained healthcare institutions. Prolonged inpatient LOS, and the resulting reduction in available open inpatient beds, is also a key factor in extended emergency department LOS. Currently, Maryland's emergency departments are among the most crowded in the nation, and managing IP LOS is a critical piece of managing this issue.

While the majority of Maryland hospitals are at or below the national average for IP LOS, incentives in this area are still needed. Maryland has fewer inpatient beds per capita than most states, so absent better performance on IP LOS, hospitals may experience bed capacity issues. Additionally, implementation of an IP LOS policy counterbalances the incentives of the surge policy, which provided emergency funding to support extreme patient loads during the winter respiratory illness season. Without such a counterweight, it is possible that the surge policy would result in worsening IP LOS that would place more Maryland hospitals above the national average.

Policy development for this and other State hospital incentive programs is vetted with stakeholders and approved by the Commission to ensure the programs strike a balance between driving needed changes and avoiding unanticipated consequences. For purposes of the RY 2028 IP LOS Policy, staff vetted the potential recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies. Based on stakeholder input, and given the current transition to the National quality programs, staff propose to monitor IP LOS for RY2028 and revisit payment options in RY2029 or RY2030 in conjunction with the transition to Maryland quality programs (i.e., programs impacting hospital global budgets for non-Medicare FFS patients).

Background

One of the central motivations for this policy is a paradox that has emerged in Maryland hospital utilization trends: even as the number of inpatient admissions have declined—an outcome consistent with the goals of global budgets and Total Cost of Care accountability—overall inpatient utilization, as measured by total bed-days, has increased. This divergence arises because reductions in admission volume have been more than offset by increases in the average length of each stay. The result is that hospitals are caring for fewer patients in aggregate, but those patients are occupying beds for longer periods, consuming proportionally more capacity per episode of care.

This dynamic has direct implications for the financial sustainability of the AHEAD model. Global Budget Revenue is premised on the idea that hospitals can manage both the volume and the intensity of inpatient utilization with fixed funding. When bed-days rise even as admissions fall, it signals that inpatient resources are not being freed up at the rate the model anticipates. Hospitals operating with elevated LOS face constrained physical capacity, which in turn limits their ability to respond to surges in demand, coordinate effectively with post-acute partners, and avoid the boarding of admitted patients in the emergency department. In short, declining admission volume is a necessary but not sufficient condition for model

sustainability—it must be accompanied by a proportional reduction in LOS to translate into genuine efficiency gains. The IP LOS incentive is designed to close this gap by targeting the dimension of inpatient utilization that has, to date, been moving in the wrong direction.

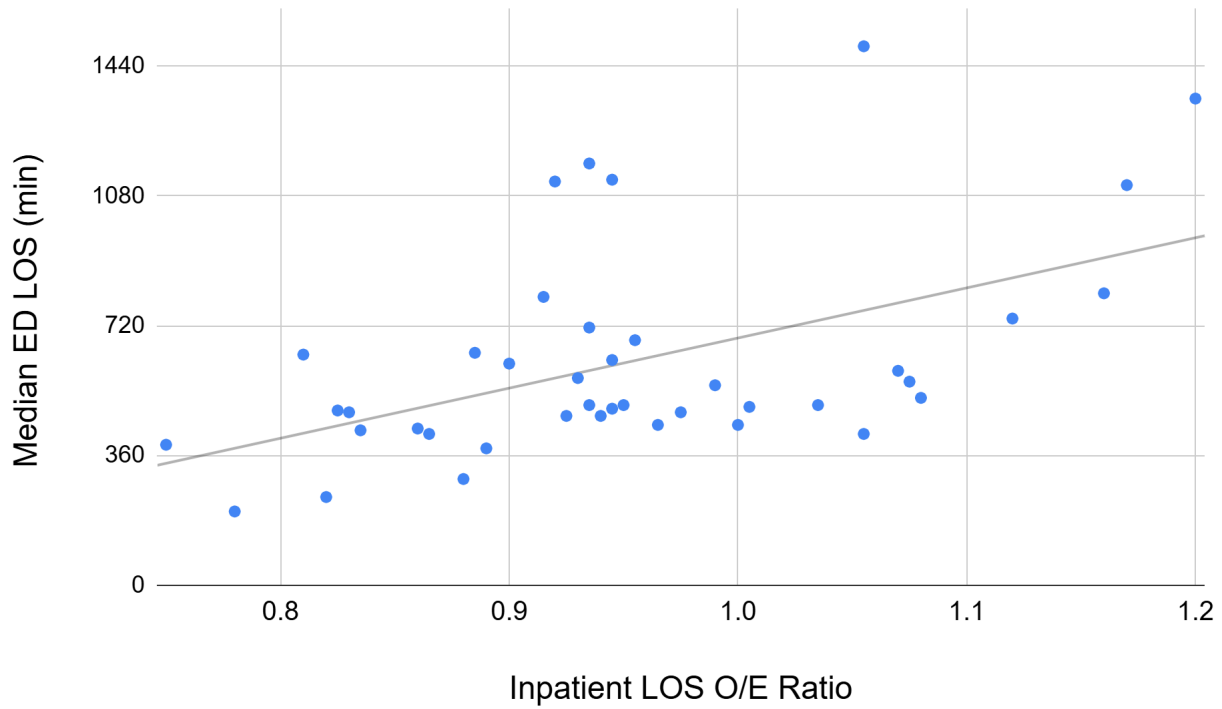
While incentives exist to improve IP LOS through global budgets and TCOC accountability, those incentives have not prevented marked growth in IP LOS. Thus, staff believe a policy focused explicitly on IP LOS, similar to RRIP for readmissions, is necessary to optimize care delivery and accelerate progress toward national norms. This is particularly true now that the recently approved surge policy provides incentives based, in part, on bed-days, which could potentially result in further increases in IP LOS.

Impact on Emergency Department Length of Stay

One of the primary rationales for implementing an IP LOS policy is its potential impact on emergency department operations. When inpatient beds are occupied by patients with prolonged stays, the hospital's capacity to admit new patients from the emergency department is constrained. This creates a "backup" effect where admitted patients must wait—or "board"—in the ED until an inpatient bed becomes available. This boarding accumulation leads to longer wait times for all ED patients, delayed treatment for new arrivals, ambulance diversion, increased patient safety risks, staff burnout and reduced quality of care.

In Maryland, the correlation between IP LOS and ED LOS at the hospital level is 0.5 (Figure 1), indicating moderate correlation. Because of this relationship, as well as the clear operational linkage between IP LOS and ED boarding, staff concluded that achieving the policy's multi-year goal of bringing IP LOS at all Maryland hospitals toward the national average could result in significant reductions in ED boarding hours, improved ED throughput, enhanced patient experience, and better clinical outcomes.

Figure 1. Inpatient and ED Length of Stay for Admitted Patients By Hospital, FY2025



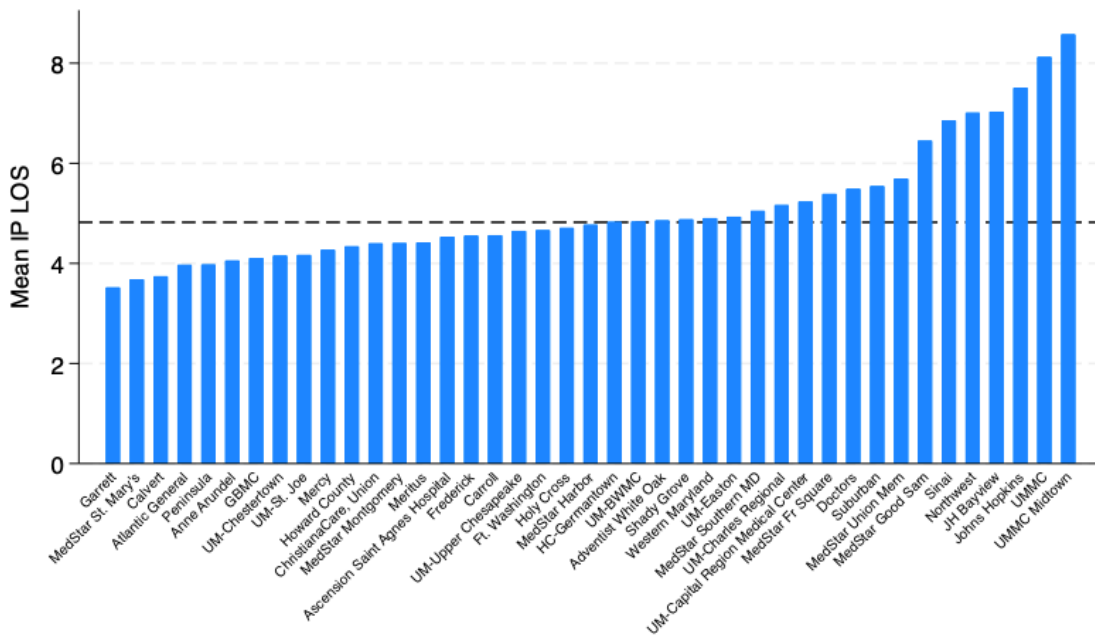
Source: FY25 IP LOS OE & HCUP 2023 norms adjusting for APR-DRG/SOI vs ED Median LOS, 2025

Maryland Hospital Performance

The following section provides an overview of Maryland hospital performance on IP LOS, evaluation of factors that may account for longer IP LOS, and addresses questions and concerns raised by stakeholders.

Staff evaluated IP LOS of Maryland hospitals against the national average using data from the Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample, a representative sample of discharge records from non-federal acute-care U.S. hospitals maintained by the federal Agency for Healthcare Quality and Research. The most recent survey data is from 2023. In FY2025, patients at 20 of the State's acute-care hospitals experienced IP LOS longer than the most recently available national average (Figure 2), with the highest mean LOS at a Maryland hospital more than 75% higher than the national average.

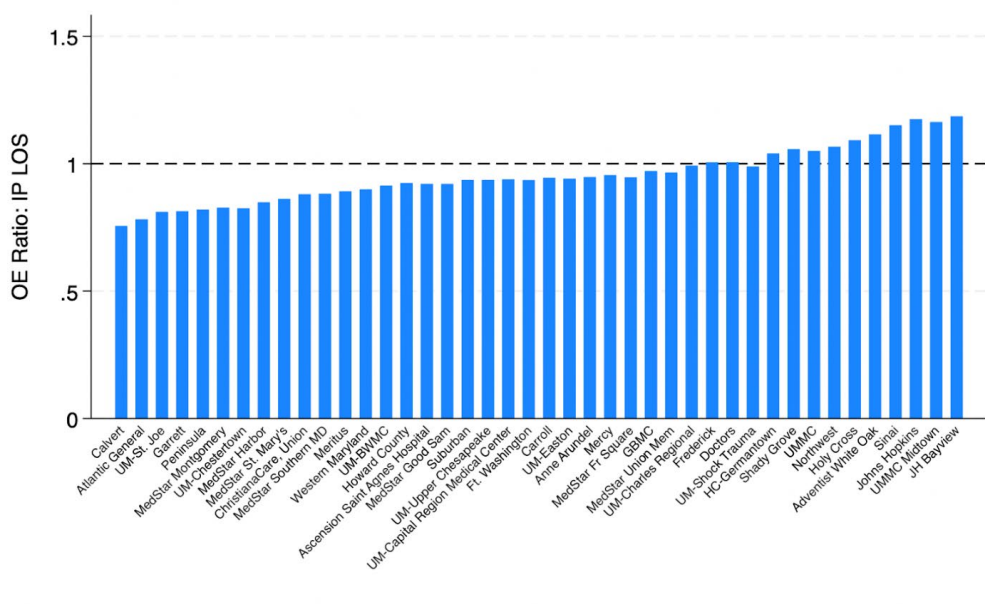
Figure 2. Mean IP LOS of Maryland Hospitals, FY2025



Source: HSCRC FY2025 Casemix

To gauge whether this comparison was impacted by differences in patient acuity between Maryland hospitals and those elsewhere, staff indirectly standardized the IP LOS of Maryland hospitals using national norms by APR-DRG, severity of illness and payer derived from the NIS. In the risk-adjusted analysis, one quarter of Maryland hospitals continued to have IP LOS higher than the national average (Figure 3). More than 38 percent of the state's hospital stays occur at facilities with IP LOS higher than the national average. Staff assessed the degree to which hospital performance was influenced by including in the analysis norms calculated on a patient group of less than 30, which can occur when there are few patients in the NIS with a particular combination of APR-DRG, severity indicator and payer. The OE ratios calculated after excluding cells with fewer than 30 patients were correlated at >0.99 with the original ratios, leading staff to conclude that small cell size was not a source of measurement error.

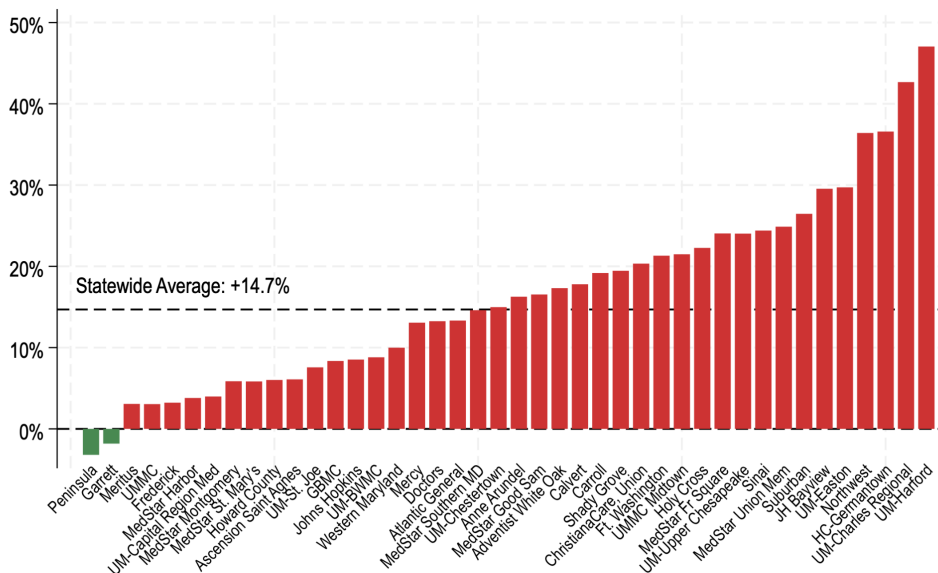
Figure 3. IP LOS Observed/Expected Ratios for Maryland Hospitals, FY2025



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

The performance of Maryland hospitals in FY2025 followed several years of increasing LOS. Between 2018 to 2024, IP LOS at most hospitals in the State increased more than 10%, while some increased more than 20%. Only two of the State's hospitals experienced decreases during the period (Figure 4).

Figure 4. Change in IP LOS for Maryland Hospitals, FY2018-2024



Source: HSCRC Casemix, FY2018-2024

Evaluation of Factors Leading to Longer IP LOS

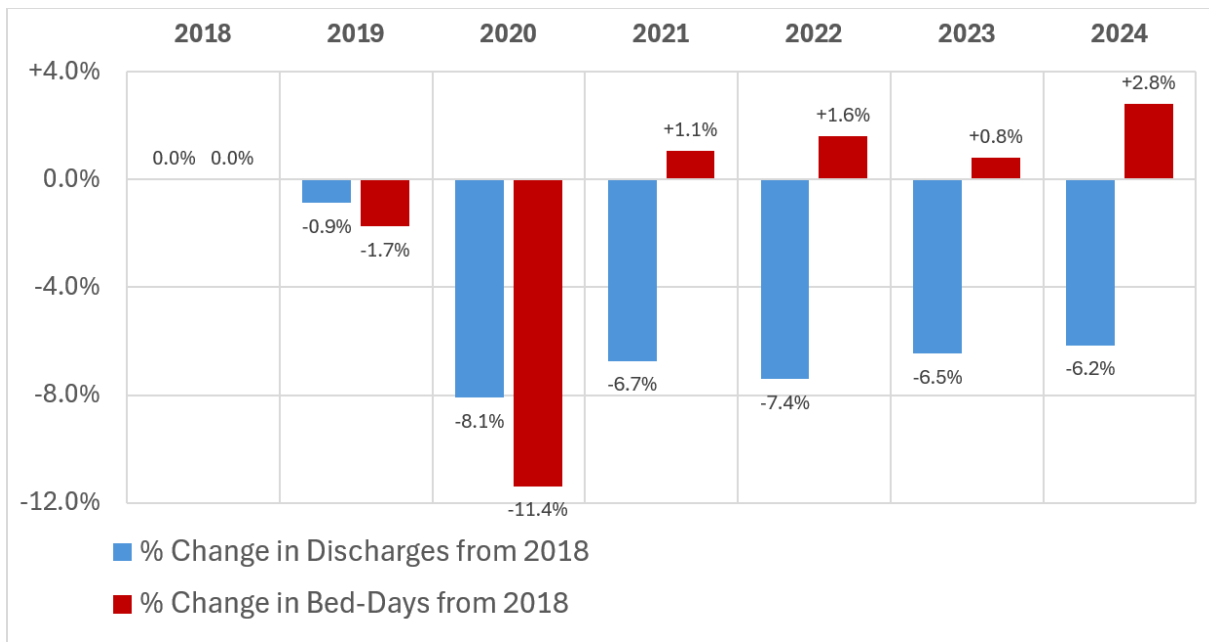
There are several potential reasons for rising IP LOS, including some related to factors largely beyond the control of hospitals. Staff evaluated these explanations empirically to ensure that the policy incentivizes an outcome that is meaningfully responsive to hospital-led interventions.

One leading explanation is that the shift in IP LOS was the result of TCOC Model dynamics, in that incentivizing a reduction in inpatient discharges directed a sizable population of low-acuity patients from inpatient services to lower-acuity settings. This would result in a longer average LOS for the remaining patients due to their higher acuity.

Staff expected that if this theory were correct, Maryland’s performance would fall in line with that of the nation after risk adjustment. However, while implementation of risk adjustment moved some Maryland hospitals in line with the national average, a significant portion of facilities remained above the national average.

To address the possibility that this risk-adjustment approach was not completely effective in controlling for patient acuity, staff evaluated the statewide change in both IP discharges and IP bed-days over time. If the IP LOS issue were driven by removal of the low-acuity population, we would expect to see discharges fall with a corresponding small decrease in bed-days. Instead, there was a net gain in statewide bed-days over time, indicating that utilization for higher-acuity patients increased (Figure 5).

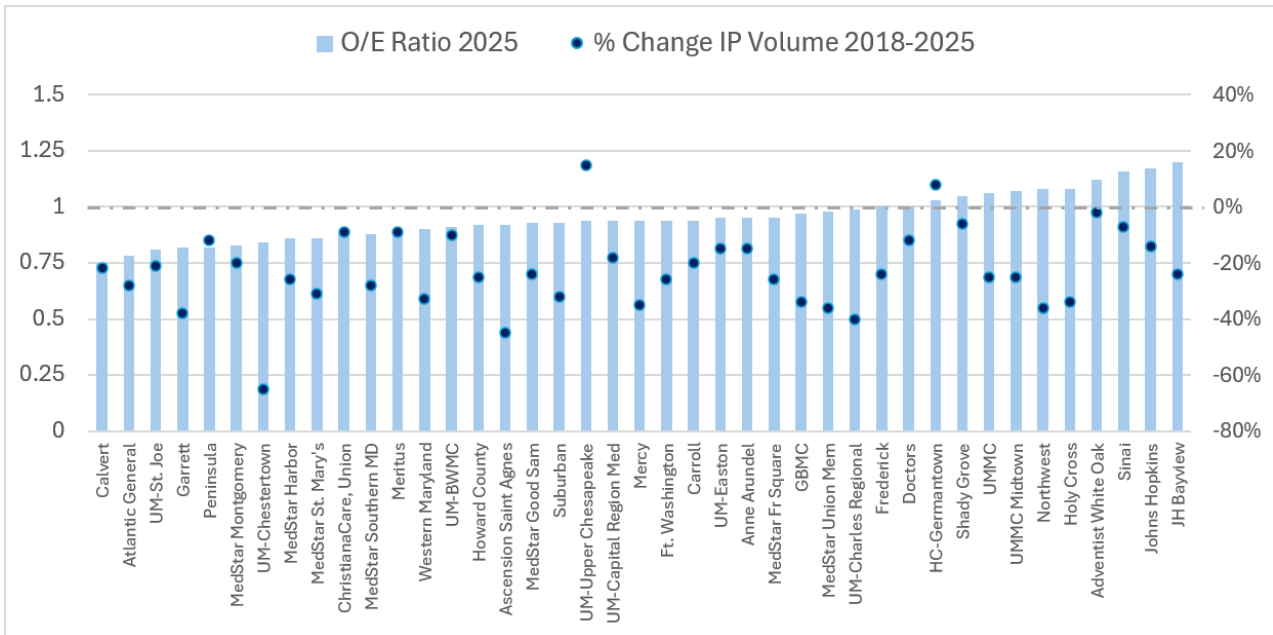
Figure 5. Patient Bed-Days vs. Observation and Inpatient Discharges, FY2018-2024



Source: HSCRC Casemix, FY2018-2024

Staff also evaluated the association between inpatient volume changes and CY2025 IP LOS performance. If the shift to lower-acuity settings was behind rising IP LOS, one would expect that the hospitals with the largest volume decreases would have the highest risk-adjusted IP LOS. However, the analysis indicated that IP LOS and volume changes are minimally correlated (Figure 6).

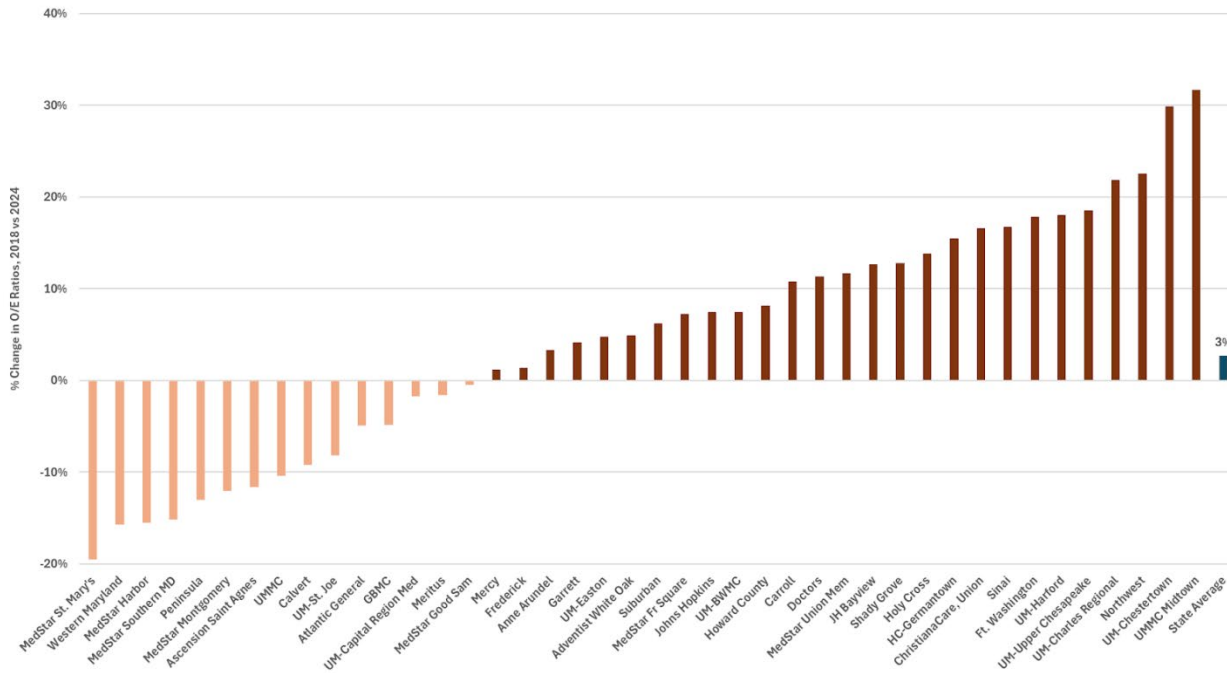
Figure 6. Association Between FY 2025 Inpatient Length of Stay and Volume Changes, 2018-2025



Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

Finally, staff identified several cohorts of patients, including those undergoing heart bypass and other major surgery, whose care has been consistently delivered on inpatient services for the duration of the TCOC Model. Staff hypothesized that if the growth in low-acuity unregulated care were responsible for rising IP LOS, these cohorts would exhibit stable LOS over time. However, significant increases in IP LOS were observed in these inpatient-only cohorts (Figure 7).

Figure 7. Change in IP LOS By Hospital for Inpatient-Only Procedures, 2018 vs 2024 FY

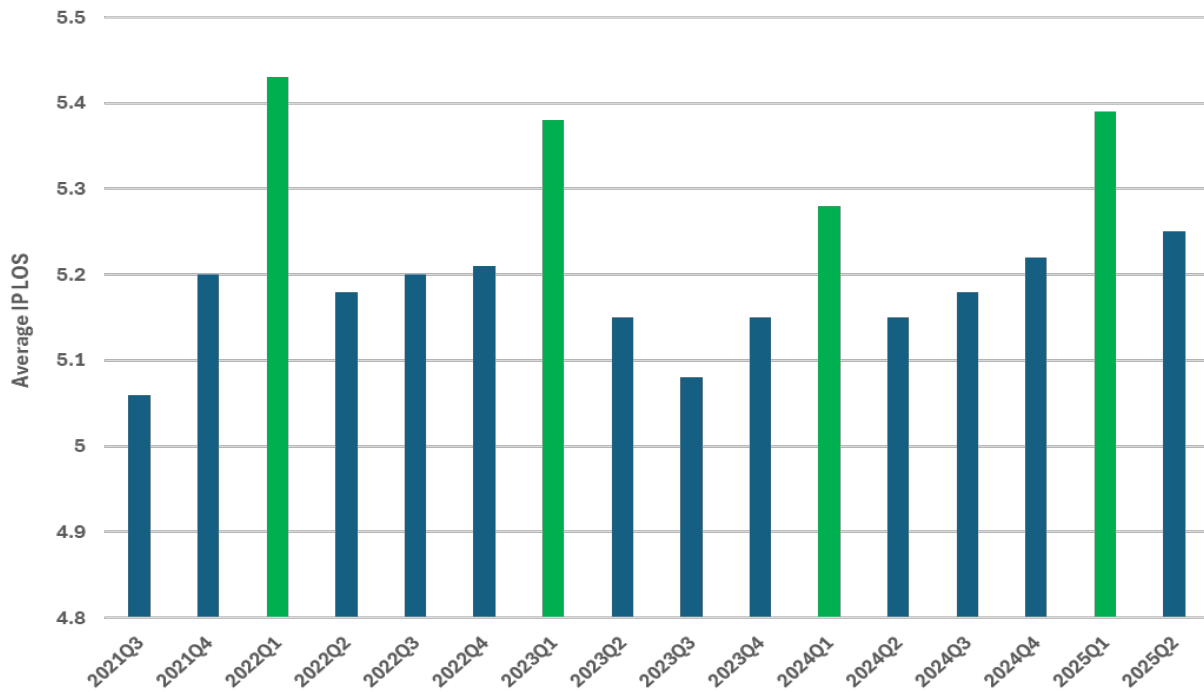


Source: HSCRC Casemix, 2018-2024 FY, risk adjusted by HCUP 2023

Another possibility is that payment practices specific to government insurance programs drive increasing IP LOS. Staff evaluated this theory by comparing hospital IP LOS performance by payer. This analysis indicated that hospitals with risk-adjusted LOS longer than the national average perform similarly regardless of payer, indicating that the issue is likely not related to payer policies.

An additional theory is that the TCOC Model created incentives for hospitals to unnecessarily lengthen LOS at the close of the fiscal year to avoid falling under global budget revenue targets. Staff evaluated this by reviewing quarterly changes in IP LOS for the past several years. This analysis (Figure 8) indicated that there is marked variation in IP LOS by quarter. However, the longest LOS regularly occurs in the first quarter of the calendar year, when respiratory illnesses peak. The second quarter, which coincides with the close of the rate year, typically sees the lowest IP LOS of the year.

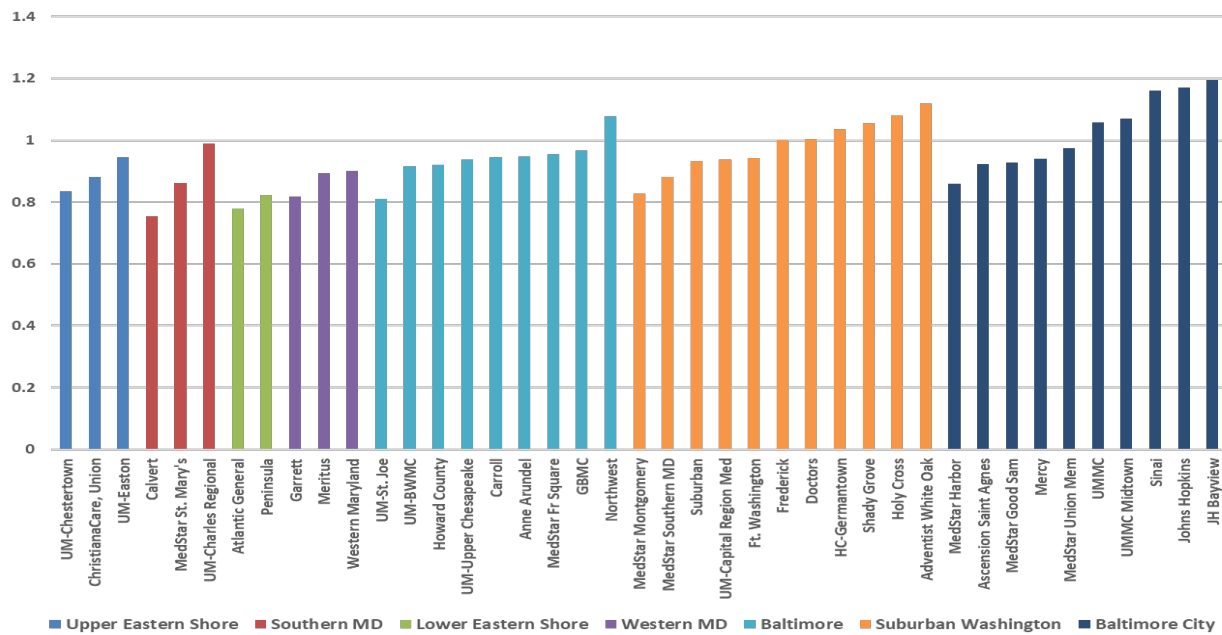
Figure 8. Variation in Inpatient Length of Stay by Calendar-Year Quarter



Source: HSCRC Casemix data, FY2022 - FY2025

Staff also investigated the possibility that IP LOS is associated with differences among patients and within hospitals operating in low-income environments. Risk-adjusted hospital IP LOS was evaluated for each of the state's seven regions. While rural areas generally had lower IP LOS, three of the state's regions, including the affluent Suburban Washington area, contained hospitals with risk-adjusted IP LOS above the national average.

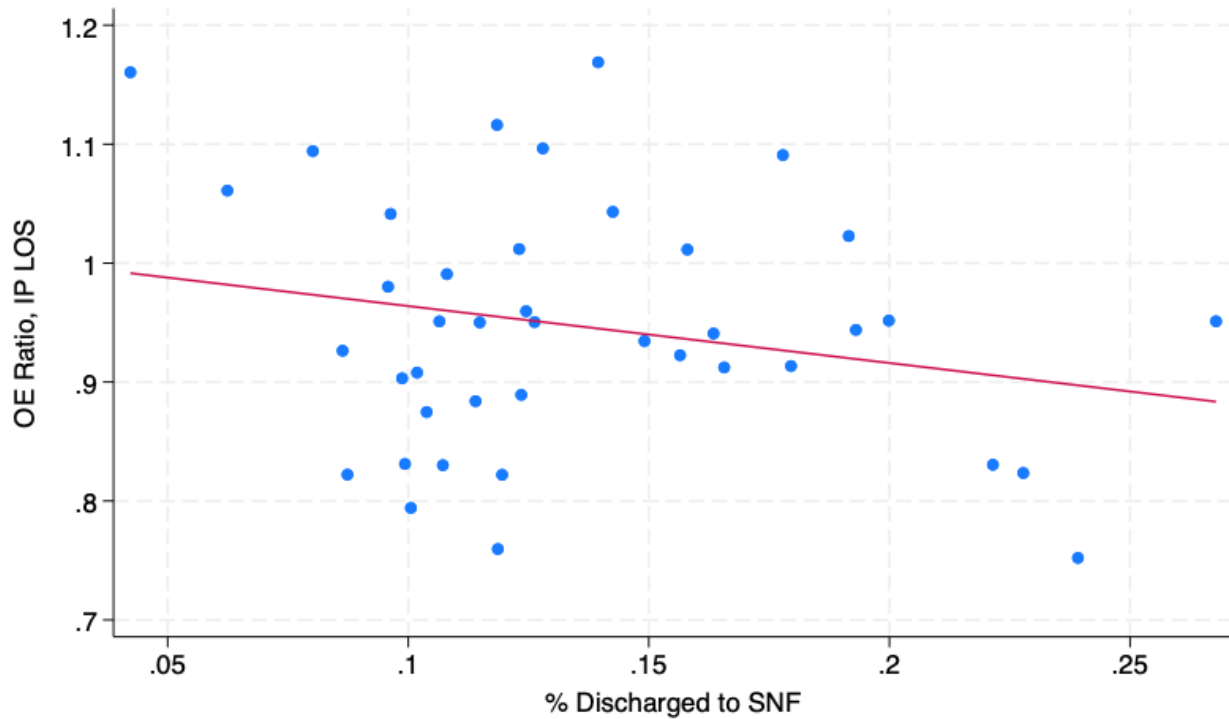
Figure 9. Risk-Adjusted Hospital IP LOS By Region, 2025



Source: 2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

Staff also considered whether post-acute care availability was responsible for elevated IP LOS. Statewide, patients discharged to post-acute care have IP LOS above the national average, while those discharged elsewhere have IP LOS below the national average. However, at the hospital level, IP LOS is minimally (and inversely) correlated with volume of post-acute discharges. This suggests that operational issues at some hospitals are lengthening LOS for patients regardless of discharge destination, and that the IP LOS policy could improve efficiency and patient experience at these facilities.

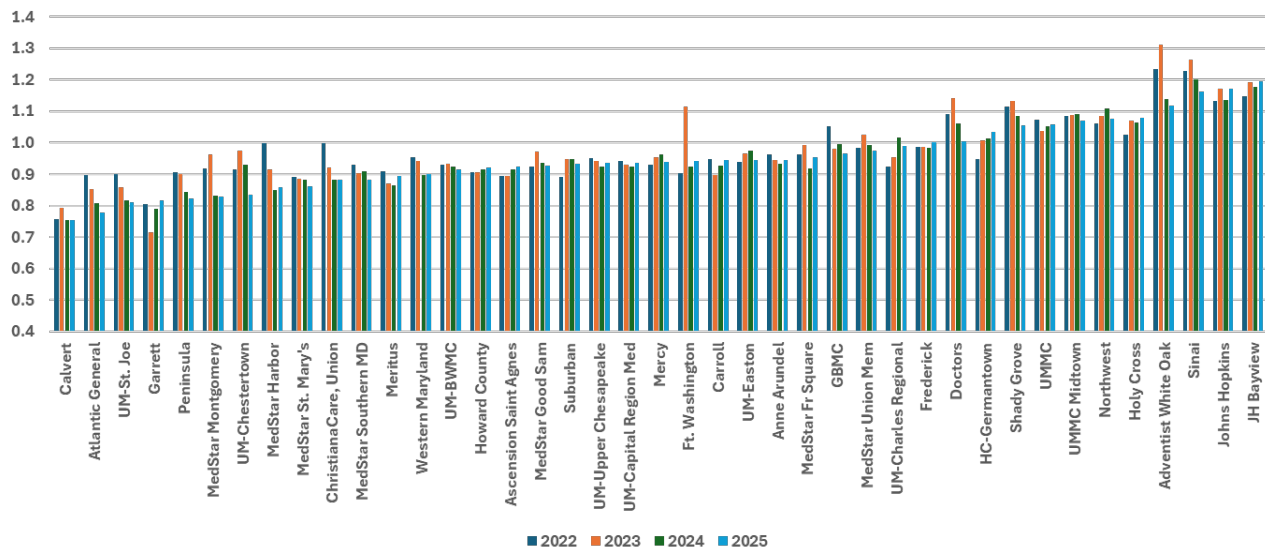
Figure 10. Risk-Adjusted Hospital IP LOS vs. Percent of Patients Discharged to SNF, 2025



Source: CY2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

A final possibility is that the performance of Maryland hospitals as compared to the nation is the result of random variation rather than differences in hospital operations. However, an analysis of risk-adjusted hospital performance over time indicated that hospitals performing below the national average in CY2025 experienced similar performance in prior years (Figure 11). Because of this, staff concluded that the factors driving elevated LOS are related to hospital operations rather than random variation.

Figure 11. Annual Variation in IP LOS, CY2022-2025



Source: 2025 HSCRC Casemix, HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

After evaluating several potential causes of rising IP LOS that are unrelated to hospital performance, as well as information on a number of successful hospital-led IP LOS interventions described in peer-reviewed literature, staff concluded that hospital operations are a significant factor in IP LOS, and that a policy incentivizing improvements in IP LOS would benefit patients, hospitals, and the State's healthcare system.

Measurement and Incentives Overview

This section provides an overview of the IP LOS performance measure. Due to the significant uncertainty around the structure and operational impact of changes to HSCRC policies under the AHEAD model, staff recommends monitoring of the measurement component of the IP LOS policy for RY2028. Additionally, staff recommends integration of IP LOS measure into the RY2029 or RY2030 quality programs, which will adjust the Maryland hospital global budgets (i.e., non-Medicare FFS global budgets set by HSCRC). Staff recommend that IP LOS be adopted as part of the portfolio of hospital quality and population health pay-for-performance incentives with the total revenue at-risk for this portfolio not to exceed the Medicare incentives. This includes consideration of this incentive under the maximum revenue guardrail policy. Additional discussion of incentive details may be found in Appendix A.

Performance Metric

Measurement

The policy will measure all-payer risk-adjusted inpatient length of stay (IP LOS) for acute-care hospitals.

Proposed Exclusions

The following discharge types are excluded from measurement:

Exclusion Category	Rationale
Discharges leaving against medical advice	Patient-driven departure, not reflective of hospital performance
Transfers out	LOS attributed to receiving hospital
Expired cases	Clinical outcomes measure, not LOS efficiency
Shock trauma and discharges from long term care beds	Unique clinical circumstances not comparable to general admissions
Unknown discharge dispositions	Data quality concern

Risk-Adjustment Methodology

Expected LOS will be calculated as the average LOS by APR-DRG, SOI, and payer (Commercial, Medicare, Medicaid, Other) from the 2023 HCUP National Inpatient Sample. Total Observed IP LOS will be calculated as the sum of the actual observed LOS (capped at 30 days) for each patient discharged during the measurement period. Total Expected IP LOS for each hospital is derived by summing the Expected LOS for the same patients. The performance metric is the total Observed IP LOS divided by the total Expected IP LOS (O/E Ratio). Hospitals that performed at the same level as the nation will have an O/E Ratio of 1. An O/E Ratio of <1 indicates better performance while a ratio > 1 indicates worse performance compared to the national benchmarks. While the O/E ratio is often multiplied by the unadjusted average from the reference population to obtain the risk-adjusted average, the pay-for-performance methodology proposed here will use the O/E ratio.

Stakeholder Feedback

Comment letters on the Draft IP LOS Policy were received from Health Means Everything Consumer Alliance (HME), the Maryland Hospital Administration (MHA), Adventist Health, Frederick Health, Johns Hopkins Health System (JHHS), Lifebridge Health, Luminis Health, MedStar Health, and the University of Maryland Medical System (UMMS). Letters expressed several concerns about the draft policy and made

suggestions for improvements. Several commenters argued that the aims of the Policy were already sufficiently incentivized by other HSCRC Policies, that the Policy did not adequately account for patient risk-profiles (particularly among academic medical centers), that the Policy would punish hospitals for structural barriers outside of their control, that the IP LOS Policy would interfere with implementation of the AHEAD model, and that the timeline of the Draft Policy was overly aggressive. Figure 16 provides an overview of the comments received and is followed by a discussion of the feedback along with staff responses.

Figure 16. Summary of Stakeholder Comment Letters

Stakeholder Comment Letters for RY 2028 IP LOS	Adventist HealthCare	Frederick Health	HME	JHHS	LifeBridge Health	Luminis Health	MedStar	MHA	UMMS
Redundant to Incentives in GBR and QBR	X			X		X	X	X	X
Misalignment with the AHEAD Model	X	X		X	X	X	X	X	X
External Factors Outside of Hospital Control	X	X		X	X	X	X	X	X
Inadequate Risk Adjustment	X			X	X	X	X	X	X
Need for Monitoring to Avoid Unintended Consequences			X	X				X	
Timing of Policy Implementation	X	X		X	X	X	X	X	X

Redundancy of the IP LOS Policy Due to Incentives Already in Place through GBR and QBR:

Adventist, JHHS, Luminis Health, MedStar, MHA, and UMMS questioned the need for an IP LOS policy given the incentives already in place under the Maryland Model. Adventist and UMMS additionally raised concerns about additional revenue-at-risk under the IP LOS policy.

Staff Response: While the current model does incentivize managing IP LOS, the rapid increase in IP LOS in recent years indicates that existing incentives have not been clear enough to prevent this growth. The IP LOS policy will be “monitoring-only” for RY 2028. If incentives are introduced in subsequent rate years, they will be included as part of the current revenue at risk for hospital quality and population health (i.e., part of the 6 percent at-risk) and be included under the maximum revenue guardrail policy.

Difficulty with Alignment to AHEAD: Adventist, Frederick, JHHS, LifeBridge, Luminis, MedStar, MHA, and UMMS argued that resources were better directed towards implementing the AHEAD model rather than creating state-specific policies.

Staff Response: While staff appreciate the difficulties of navigating the AHEAD transition, the magnitude of the State’s current issues with ED overcrowding and growth in IP LOS requires immediate action. IP LOS has increased rapidly, and if this growth continues, it would likely threaten the financial viability of the AHEAD model.

Influence of Systematic Issues Beyond Hospital Control and Outliers: Adventist, Frederick, JHHS, Luminis Health, MedStar, MHA, and UMMS argued that deficits in post-acute bed capacity, payer authorization delays, and patient social factors contribute to prolonged LOS and are outside of the hospital's control. Adventist, Frederick, and UMMS additionally recommended that the IP LOS policy focus only on patients discharged to their homes.

Staff Response: Staff acknowledge that patients who are discharged to post-acute care have longer IP LOS than patients discharged home. However, we also found that hospitals with a higher percentage of post-acute discharges also tended to have better performance on the IP LOS measure, suggesting it is possible to develop efficient discharge workflows under current capacity. We found that hospitals with prolonged LOS on patients discharged to post-acute settings also tended to have prolonged LOS on patients discharged home, pointing to hospital-level factors driving IP LOS performance rather than external factors. Additionally, excluding patients discharged to post-acute settings would have negative policy implications and remove an opportunity for hospitals to improve quality of care for all of their patients. We will stratify IP LOS reporting by discharge destination and staff will monitor for unintended consequences and propose policy changes as necessary.

Methodology for Risk Adjustment: Adventist, JHHS, LifeBridge, Luminis, MedStar, MHA, and UMMS raised concerns about the proposed risk-adjustment methodology, including the use of HCUP data to establish national benchmarks, and lack of adjustment for social and legal factors that may contribute to prolonged LOS. JHHS and UMMS additionally argued that the proposed methodology did not adequately account for the patient complexity at AMCs.

Staff Response: The proposed risk-adjustment methodology is similar to the approaches used in the Commission-approved RRIP, MHAC, and QBR policies. The APR-DRG system and SOI were specifically designed to address differences in utilization outcomes like LOS across hospitalizations. The HCUP survey is also designed to be representative of discharges from all non-federal acute-care hospitals in the US, and includes data from AMCs as well as behavioral health and complex medical cases. We have also amended the policy to cap each individual patient's stay at 30 days for the purposes of calculating a hospital's average LOS to minimize the effect of these outlier cases..

Need for Monitoring to Avoid Unforeseen Consequences: HME, JHHS, and MHA raised concerns about potential unintended consequences of the draft IP LOS policy; HME recommended (1) monitoring for premature discharge, particularly for elderly patients and those with complex medical or behavioral health needs; (2) working with insurers and providers to ensure safe discharges, and (3) publicly reporting on program performance to allow consumers to make informed healthcare decisions.

Staff Response: Staff agrees that managing IP LOS could result in premature discharges. However, existing quality programs, including RRIP and QBR, will likely detect any of these unintended

consequences. Staff set the revenue-at-risk for the IP LOS policy to be lower than revenue-at-risk for RRIP specifically to avoid this issue.

Timing of Policy Implementation: All of the hospital systems raised concerns about the timing of the policy implication; the draft policy designated 2026 as the performance period for RY 2028, but the policy would not be finalized until June of 2026, half way through the performance period.

Staff Response: Staff have recommended changing the policy to monitoring-only for RY 2028 and introducing financial penalties and rewards starting in RY 2029 or RY 2030. We will also monitor the policy to ensure the intended result (lowering of ED LOS and IP LOS) is achieved and to surveil for unintended consequences, including increased readmissions and ED revisits.

Recommendations

These are the final recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement a monitoring program for all-payer inpatient length of stay (IP LOS) for acute-care hospitals.
 - a. Assess the risk-adjusted, mean IP LOS for acute admissions, with clinical exclusions and winsorization to minimize the effect of extreme outlier cases.
 - b. Provide summary level reports and patient level files that allow hospitals to track IP LOS and stratify by patient characteristics (i.e., primary diagnosis, patient disposition) or other factors to identify areas of opportunity.
 - c. Publicly report trends in IP LOS statewide and by hospital at HSCRC Commission meetings.
2. Propose inclusion of IP LOS for payment in RY2029 or RY2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global budgets).
3. Monitor to ensure the measurement approach is valid and the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and ED revisits.

Appendix A: Potential Structure of Incentive Program

This section presents details on how financial incentives for IP LOS performance could be structured for inclusion in RY 2029 or RY 2030 payment policy.

Performance Targets

Performance targets are modeled similarly to how the targets for the Readmission Reduction Incentive Program were established. Specifically, hospitals will be assessed on both improvement in IP LOS from a fixed base period and actual performance (i.e., attainment) relative to the nation during each performance year. Below are the improvement and attainment targets established based on modeling of opportunity and stakeholder feedback.

Improvement Targets

Figure 12 provides a range of improvement scenarios that were considered and the proposed improvement goal for CY2023 through CY2028. Given this is a new policy, staff believes the improvement goal should both consider what is required to have all hospitals reach the national average, as well as historical performance over time to avoid setting an overly aggressive goal that could lead to unintended consequences. Based on stakeholder feedback, a set base period of CY2023 will be used for measuring improvement in CY 2026. Staff propose a cumulative improvement of 5 percent over 5-years (CY2023-CY2028) based on historical trends and the goals set forth in this policy.

Figure 12. Improvement Scenario Options

#	Estimating Method	Percent Improvement	Annualized Improvement	CY2026 Improvement Threshold
1	Statewide improvement, CY2023-CY2025	-1.05%	-0.21%	-0.63%
2	Mean hospital improvement, CY2023-CY2025	-1.26%	-0.25%	-0.76%
3	Mean hospital improvement among hospitals with reductions, CY2023-CY2025	-3.72%	-0.75%	-2.25%
4	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to 1 in CY 2023	-4.35%	-0.89%	-2.63%
5	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to statewide median in CY2023	-6.56%	-1.35%	-3.99%
6	Improvement from the mean O/E ratio of those greater than 1 in CY2023 to 1	-8.77%	-1.82%	-5.36%
Proposed Improvement Goal		-5.00%	-1.02%	-3.03%

Using the 5 percent improvement goal, Figure 13 shows the proposed improvement scale for scaling revenue adjustments based on CY2023 to CY2026 performance. The threshold of -3.03 percent is the improvement needed to avoid being penalized. The maximum penalty was set at the mean improvement for the worst decile of improvement from CY 2023 to CY 2025. The maximum reward was linearly extrapolated from the threshold and the maximum penalty.

Figure 13. Improvement Scale

LOS % IP Revenue Payment Adjustment		LOS % IP Revenue Payment Adjustment
Improving	-10.22%	0.50%
	-9.50%	0.45%
	-8.78%	0.40%
	-8.06%	0.35%
	-7.34%	0.30%
	-6.63%	0.25%
	-5.91%	0.20%
	-5.19%	0.15%
	-4.47%	0.10%
	-3.75%	0.05%
Threshold	-3.03%	0.00%
	-2.31%	-0.05%
	-1.59%	-0.10%
	-0.87%	-0.15%
	-0.15%	-0.20%
	0.56%	-0.25%
	1.28%	-0.30%
	2.00%	-0.35%
	2.72%	-0.40%
	3.44%	-0.45%
Worsening	4.16%	-0.50%

Attainment Targets

Figure 14 provides the proposed attainment scaling. The attainment threshold is set at O/E Ratio of 1 from CY 2023, adjusted for the improvement threshold determined above. While the attainment threshold could be set at the O/E ratio of 1.0, staff have historically included the improvement goal into the attainment standards for readmissions to further emphasize improvement. The attainment benchmark (i.e., O/E ratio where hospitals could receive full reward) was set at the average of the top performing decile of hospitals in CY2023 plus the improvement target.

Figure 14. Attainment Scale

LOS % IP Revenue Payment Adjustment	LOS % IP Revenue Payment Adjustment
Improving	0.50%
	0.45%
	0.40%
	0.35%
	0.30%
	0.25%
	0.20%
	0.15%
	0.10%
	0.05%
Threshold	0.00%
	-0.05%
	-0.10%
	-0.15%
	-0.20%
	-0.25%
	-0.30%
	-0.35%
	-0.40%
	-0.45%
Worsening	-0.50%

Revenue Adjustment Modeling

Figure 15 provides statewide revenue adjustments using the parameters set above and CY2025 data as a proxy for CY2026 performance. Given that the majority of hospitals perform better than the national average, the net statewide adjustments are +0.3 percent (estimated at +\$3.6 million). Of the 40 hospitals included in the policy, 11 would be penalized a total of 0.08 percent due to increases in IP LOS or improvements less than the improvement threshold and O/E ratios greater than attainment threshold (estimated at -\$9.4 million). By hospitals modeling is provided in Appendix B and an excel modeling workbook has been provided to stakeholders and can be provided upon request.

Figure 15. Statewide Revenue Adjustment, Base 2023 vs CY 2026 (CY 2025 used as proxy)

Summary			
Statewide Revenue		\$12,379,325,935	
\$ Better of Attainment/ Improvement	Rewards (29 Hosp.)	\$13,017,011	Statewide Percent: 0.11%
	Penalties (11 Hosp.)	(\$9,392,283)	Statewide Percent: -0.08%
Net Revenue Adjustment		\$3,624,728	Statewide Percent: 0.03%

AHEAD Model Considerations

Staff will discuss inclusion of the IP LOS revenue adjustment in the CMS HGBs. If this is not possible, staff will update the policy so that all-payer performance is used to adjust revenue for State HGBs for non-Medicare revenue.

Appendix B: By Hospital Modeling

Modeling of Revenue Adjustments by Hospital (05/26/2026)					Improvement Scaling			Attainment Scaling			Final Adjustment				
HO SPITAL ID	HO SPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	Base 2023	CY 2026 (CY 2025 used as proxy)	Percent change	Target	% Revenue Adjustment	\$ Revenue Adjustment	CY 2026 (CY 2025 used as proxy)	Target (national average + improvement)	% Revenue Adjustment	\$ Revenue Adjustment	\$ Better of Attainment or Improvement	FY 25 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	\$307,533,751	0.8568	0.8921	3.91%	-3.03%	-0.48%	-\$1,476,162	0.8921	0.9697	0.21%	\$645,821	\$645,821	0.21%	Att
210002	UMMC	\$1,667,872,778	1.0388	1.0605	2.11%	-3.03%	-0.36%	-\$6,004,342	1.0605	0.9697	-0.25%	-\$4,169,682	-\$4,169,682	-0.25%	Att
210003	UM-Capital Region Med	\$334,294,899	0.9446	0.9792	3.67%	-3.03%	-0.47%	-\$1,571,186	0.9792	0.9697	-0.03%	-\$100,288	-\$100,288	-0.03%	Att
210004	Holy Cross	\$402,793,216	1.0808	1.1022	1.98%	-3.03%	-0.35%	-\$1,409,776	1.1022	0.9697	-0.36%	-\$1,450,056	-\$1,409,776	-0.35%	Imp
210005	Frederick	\$288,140,344	1.0140	1.0204	0.64%	-3.03%	-0.28%	-\$743,965	1.0204	0.9697	-0.14%	-\$400,596	-\$400,596	-0.14%	Att
210008	Mercy	\$249,515,476	0.9586	0.9373	-2.22%	-3.03%	-0.06%	-\$149,709	0.9373	0.9697	0.09%	\$224,564	\$224,564	0.09%	Att
210009	Johns Hopkins	\$1,984,717,053	1.1240	1.1016	-1.99%	-3.03%	-0.07%	-\$1,389,302	1.1016	0.9697	-0.36%	-\$7,144,981	-\$1,389,302	-0.07%	Imp
210011	Ascension Saint Agnes	\$269,943,037	0.9047	0.9241	2.15%	-3.03%	-0.36%	-\$971,795	0.9241	0.9697	0.12%	\$323,932	\$323,932	0.12%	Att
210012	Sinai	\$578,915,177	1.1877	1.1061	-6.87%	-3.03%	0.27%	\$1,557,671	1.1061	0.9697	-0.37%	-\$2,134,586	\$1,557,671	0.27%	Imp
210015	MedStar Fr Square	\$437,038,002	0.9259	0.9571	3.36%	-3.03%	-0.44%	-\$1,922,967	0.9571	0.9697	0.03%	\$131,111	\$131,111	0.03%	Att
210016	Adventist White Oak	\$306,648,357	1.1923	1.1183	-6.21%	-3.03%	0.22%	\$674,626	1.1183	0.9697	-0.40%	-\$1,226,593	\$674,626	0.22%	Imp
210017	Garrett	\$30,285,668	0.7778	0.7708	-0.91%	-3.03%	-0.15%	-\$45,429	0.7708	0.9697	0.50%	\$151,428	\$151,428	0.50%	Att
210018	MedStar Montgomery	\$110,817,149	0.8793	0.8266	-5.98%	-3.03%	0.21%	\$232,716	0.8266	0.9697	0.39%	\$432,187	\$432,187	0.39%	Att
210019	Peninsula	\$394,776,979	0.8907	0.8415	-5.53%	-3.03%	0.17%	\$671,121	0.8415	0.9697	0.35%	\$1,381,719	\$1,381,719	0.35%	Att
210022	Suburban	\$275,339,890	0.9379	0.9059	-3.40%	-3.03%	0.03%	\$82,602	0.9059	0.9697	0.17%	\$488,078	\$488,078	0.17%	Att
210023	Anne Arundel	\$461,250,402	0.9498	0.9625	1.34%	-3.03%	-0.30%	-\$1,383,751	0.9625	0.9697	0.02%	\$92,250	\$92,250	0.02%	Att
210024	MedStar UnionMem	\$316,870,786	1.0143	0.9461	-6.72%	-3.03%	0.26%	\$823,864	0.9461	0.9697	0.06%	\$190,122	\$823,864	0.26%	Imp
210027	Western Maryland	\$202,494,635	0.9413	0.9838	4.51%	-3.03%	-0.50%	-\$1,012,473	0.9838	0.9697	-0.04%	-\$80,998	-\$80,998	-0.04%	Att
210028	MedStar St. Mary's	\$98,519,520	0.8929	0.8843	-0.96%	-3.03%	-0.14%	-\$137,927	0.8843	0.9697	0.23%	\$226,595	\$226,595	0.23%	Att
210029	JH Bayview	\$522,055,692	1.1503	1.1403	-0.87%	-3.03%	-0.15%	-\$783,083	1.1403	0.9697	-0.46%	-\$2,401,466	-\$783,083	-0.15%	Imp
210032	ChristianaCare, Union	\$114,302,009	0.8950	0.8949	0.00%	-3.03%	-0.21%	-\$240,034	0.8949	0.9697	0.20%	\$228,604	\$228,604	0.20%	Att
210033	Carroll	\$178,074,349	0.9155	0.9398	2.65%	-3.03%	-0.40%	-\$712,297	0.9398	0.9697	0.08%	\$142,459	\$142,459	0.08%	Att
210034	MedStar Harbor	\$147,837,218	0.8967	0.8596	-4.14%	-3.03%	0.08%	\$118,270	0.8596	0.9697	0.30%	\$443,512	\$443,512	0.30%	Att
210035	UM-Charles Regional	\$109,649,404	0.9984	0.9562	-4.23%	-3.03%	0.08%	\$87,720	0.9562	0.9697	0.04%	\$43,860	\$87,720	0.08%	Imp
210037	UM-Easton	\$162,954,562	0.9575	0.9659	0.87%	-3.03%	-0.27%	-\$439,977	0.9659	0.9697	0.01%	\$16,295	\$16,295	0.01%	Att
210038	UMMC Midtown	\$155,503,757	1.0610	1.1092	4.54%	-3.03%	-0.50%	-\$777,519	1.1092	0.9697	-0.38%	-\$590,914	-\$590,914	-0.38%	Att
210039	Calvert	\$89,452,152	0.7856	0.7827	-0.38%	-3.03%	-0.18%	-\$161,014	0.7827	0.9697	0.50%	\$447,261	\$447,261	0.50%	Att
210040	Northwest	\$185,021,826	1.0818	1.0387	-3.98%	-3.03%	0.07%	\$129,515	1.0387	0.9697	-0.19%	-\$351,541	\$129,515	0.07%	Imp
210043	UM-BWMC	\$337,061,709	0.9319	0.9103	-2.32%	-3.03%	-0.05%	-\$168,531	0.9103	0.9697	0.16%	\$539,299	\$539,299	0.16%	Att
210044	GBMC	\$285,831,225	0.9758	0.9924	1.70%	-3.03%	-0.33%	-\$943,243	0.9924	0.9697	-0.06%	-\$171,499	-\$171,499	-0.06%	Att
210048	Howard County	\$260,887,192	0.9281	0.9103	-1.92%	-3.03%	-0.08%	-\$208,710	0.9103	0.9697	0.16%	\$417,420	\$417,420	0.16%	Att
210049	UM-Upper Chesapeake	\$279,739,543	0.9665	0.9377	-1.97%	-3.03%	-0.07%	-\$195,818	0.9377	0.9697	0.09%	\$251,766	\$251,766	0.09%	Att
210051	Doctors	\$187,925,562	1.0789	0.9972	-7.58%	-3.03%	0.32%	\$601,362	0.9972	0.9697	-0.07%	-\$131,548	\$601,362	0.32%	Imp
210056	MedStar Good Sam	\$196,413,974	0.9834	0.9732	1.02%	-3.03%	-0.28%	-\$549,959	0.9732	0.9697	-0.01%	-\$19,641	-\$19,641	-0.01%	Att
210057	Shady Grove	\$364,335,482	1.1382	1.0777	-5.31%	-3.03%	0.16%	\$682,937	1.0777	0.9697	-0.29%	-\$1,066,573	\$682,937	0.16%	Imp
210060	Ft. Washington	\$39,131,159	1.0396	0.9705	-6.64%	-3.03%	0.25%	\$97,828	0.9705	0.9697	0.00%	\$0	\$97,828	0.25%	Imp
210061	Atlantic General	\$49,382,101	0.8298	0.8091	-2.49%	-3.03%	-0.04%	-\$19,753	0.8091	0.9697	0.44%	\$217,281	\$217,281	0.44%	Att
210062	MedStar Southern MD	\$204,927,843	0.9011	0.8421	-6.54%	-3.03%	0.24%	\$491,827	0.8421	0.9697	0.35%	\$717,247	\$717,247	0.35%	Att
210063	UM-St. Joe	\$310,535,107	0.8487	0.8660	0.86%	-3.03%	-0.27%	-\$838,445	0.8660	0.9697	0.31%	\$962,659	\$962,659	0.31%	Att
210065	HC-Germantown	\$108,347,654	1.0263	1.0635	3.62%	-3.03%	-0.46%	-\$489,199	1.0635	0.9697	-0.26%	-\$276,504	-\$276,504	-0.26%	Att
STATEWIDE		\$12,379,325,935						-\$18,594,307				-\$13,011,986	\$3,624,728	0.03%	
Penalty								-\$24,746,366				-\$21,707,456	-\$9,392,283	-0.08%	
Reward								\$6,152,059				\$8,695,470	\$13,017,011	0.11%	



April 24, 2026

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

Re: Inpatient Length of Stay Incentive Program

Dear Dr. Kromm and HSCRC Commissioners:

Health Means Everything (HME) appreciates the opportunity to comment on the draft recommendations for the Inpatient Length of Stay (IP LOS) Incentive Program.

We welcome the Commission's recognition that IP LOS is an important quality and efficiency measure. Shorter hospital stays supported by proper discharge planning and community resources generally create a more positive experience for patients. As a consumer-focused coalition representing Maryland patients and families, we are broadly supportive of efforts to reduce unnecessary hospital stays. We are especially pleased to see that the draft recommendation utilizes risk adjustment and includes explicit monitoring for unintended consequences.

We recommend that as the HSCRC continues developing the IP LOS program draft recommendations and ultimately implements the program, the following considerations are taken into account:

1. Premature discharge is a real patient safety risk. Despite the risk-adjustment guardrail, our most fundamental concern is whether financial pressure to shorten stays could incentivize hospitals to discharge patients before they are clinically ready. This is especially dangerous for elderly patients, those with complex chronic conditions, and patients with behavioral health needs. This danger extends to the caregivers who may need to care for the individual after discharge and may need to do so without receiving the appropriate training and resources from hospital staff. We appreciate that the HSCRC's IP LOS draft recommendations include a guardrail to monitor the policy to



LIFEBRIDGE HEALTH.
CARE BRAVELY

April 24, 2026

Jon Kromm, Executive Director
Health Services Cost Review Commission

Dear Jon,

LifeBridge Health appreciates the Health Services Cost Review Commission's (HSCRC) efforts to refine the proposed Inpatient Length of Stay Policy. However, we continue to have significant concerns regarding the adequacy of the risk adjustment methodology and the proposed implementation timeline. Accordingly, we cannot support the policy in its current form and respectfully recommend that the Commission defer any vote on the proposal.

HSCRC staff's draft recommendation indicates that most Maryland hospitals have lower inpatient length of stay than national benchmarks, with additional analyses showing lower length of stay in rural areas of the State relative to urban areas. Based on these findings, staff conclude that differences in length of stay are primarily attributable to hospital operational challenges rather than factors related to discharge destination.

LifeBridge respectfully disagrees with that conclusion. Discharges to post-acute settings are dependent on external factors beyond hospitals' control, such as patient choice, prior authorization, and adequate staffing. These findings suggest that discharge destination and payer mix are important drivers of inpatient length of stay and should be more fully considered in the policy design. If HSCRC elects to implement a length of stay policy, corresponding action should also be taken with commercial payers. Hospitals increasingly experience delays associated with commercial payer prior authorization requirements, denials, and delays in approving post-acute placement or continued stay.

Moreover, if the risk adjustment methodology were sufficiently robust, the regional variation observed in the current analyses would likely be less pronounced. To date, the Commission has not comprehensively evaluated the impact of factors such as academic teaching status, urbanicity, and trauma center designation, each of which may materially influence length of stay for certain hospitals.

An additional consideration is inpatient length of stay has increased nationally as a growing number of procedures have shifted to outpatient settings, a pattern that is particularly pronounced among Medicare patients. As shorter-stay cases migrate out of the inpatient setting, the remaining inpatient population is increasingly comprised of higher-acuity patients with inherently longer lengths of stay.

At the same time, the Maryland Health Care Commission (MHCC) has been directed by the Governor's Multi-Agency Working Group to issue a final report by June regarding the factors affecting quality, access, and cost in the post-acute care setting. Because many of the underlying drivers of inpatient length of stay depend upon partnerships and capacity outside of the acute care setting, this report is likely to provide important insight into both the causes of extended stays and

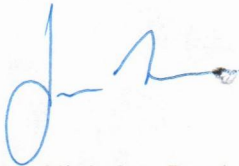
potential policy solutions. Advancing the policy before the report is issued is premature and would not allow sufficient opportunity to incorporate its findings into the final design.

We are also concerned that the proposed performance period would include the remainder of calendar year 2026, which is already underway. This would represent a significant departure from longstanding HSCRC practice, under which hospitals are provided sufficient lead time to understand new requirements, make operational changes, and meaningfully influence performance. In addition, the policy would begin affecting hospital revenue in Rate Year 2028, concurrent with implementation of the AHEAD Model transition under which responsibility for Medicare hospital global budgets shifts to CMS while HSCRC retains authority over Medicaid and commercial budgets. During the March 31 webinar, staff acknowledged that this transition has not yet been reflected in the proposed policy design.

Finally, HSCRC is advancing the Inpatient Length of Stay Policy while several higher-priority policies necessary to implement the AHEAD transition have not yet been updated to reflect the Rate Year 2028 framework. To date, there has been no written direction or public discussion indicating that this policy should take precedence over those efforts.

For these reasons, we respectfully recommend that HSCRC suspend further consideration of the Inpatient Length of Stay Policy and instead prioritize the AHEAD-related policy changes that have already been identified and approved by the Commission.

Sincerely,



Jen Nickoles, President & CEO
LifeBridge Health



David, Krajewski, EVP and CFO
LifeBridge Health

ensure there are no adverse unintended consequences like readmissions and ED visits. We strongly urge the Commission to ensure that monitoring unintended consequences is not a minimal commitment. Monitoring should be robust, conducted regularly, publicly reported, and trigger meaningful corrective action if rates worsen.

2. Discharge must lead somewhere safe. A shorter hospital stay is only a positive outcome if patients are discharged to the appropriate care setting. Maryland has well-documented challenges with post-acute care capacity, including delays related to insufficient nursing home capacity, home health service placement, and prior authorization. The Commission should monitor whether IP LOS reductions are accompanied by adequate discharge planning resources. We urge the Commission to coordinate with insurers and post-acute providers to develop strategies that highlight safe and practical discharge practices and implement strategies to mitigate potential barriers to safe and effective hospital discharges and transition to new care settings.

3. Consumer transparency. As the policy is monitored to ensure it is achieving its intended result, we ask that reporting is made publicly available so patients and community members can understand how their local hospitals are performing and what steps hospitals are taking to improve care. We also ask that any reporting includes language that is easily digestible for the average consumer and is developed in a way that allows consumers to make informed decisions about their care.

We appreciate your thoughtful approach to this issue, and are happy to provide further input should it be of use in your deliberations.

Thank you for your consideration,

Ashiah Parker,
Chair, Health Means Everything Consumer Alliance





April 24, 2026

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

Geoff Dougherty,

Adventist HealthCare (AHC) appreciates the opportunity to provide comments on the draft recommendation for the Rate Year (RY) 2028 Inpatient Length of Stay (IP LOS) Policy.

The HSCRC began discussions on an IP LOS reduction policy in the fall 2025 during Performance Measurement Workgroup (PMWG). However, details of the policy were just shared at the end of March 2026. The policy aims to improve patient outcomes, promote post-acute care coordination, and reduce emergency department boarding. AHC fully supports these objectives and has invested significantly in improving hospital throughput as evidenced by our substantial reduction in ED Wait Time over the past year. However, we have methodological concerns with the policy and believe the accelerated timeline for finalization does not allow for adequate field validation prior to implementation. Additionally, when HSCRC shared preliminary IP LOS results, approximately 75% of Maryland hospitals were at or below the O/E threshold of 1.0, indicating performance that fairs favorably against national benchmarks. This raises the question of whether a meaningful statewide LOS issue exists in Maryland.

Risk Adjustment Methodology

Health Care and Utilization Project (HCUP) Norms

HSCRC's use of the HCUP National Inpatient Sample (NIS) to establish expected values may not provide adequate risk adjustment for hospitals that treat more complex patients and offer specialized services. The NIS is a sample of discharges from community hospitals nationwide and may not fully reflect the case mix or service intensity of all Maryland hospitals. Data shared by HSCRC indicates that hospitals performing above the national average tend to have a higher revenue base and broader service offerings, suggesting potential limitations in the comparability of the benchmark. We recommend further evaluation of the hospital types and case characteristics represented in the HCUP NIS data to ensure risk adjustment is appropriate and equitable across Maryland hospitals.

Post Acute Adjustment

The policy includes risk adjustment for diagnosis, severity of illness, and payer, but does not account for discharge disposition to post-acute settings, a significant driver of inpatient length of stay.

Discharges to post-acute settings are often more challenging for Medicaid patients due to limited provider participation and capacity constraints in post-acute facilities. This is frequently compounded by



administrative and authorization barriers. Post-acute availability is largely outside a hospital's control, yet hospitals bear full financial accountability when LOS targets are not met.

As outlined in the Maryland ED Wait Time Reduction Commission report presented at the November 2025 meeting, shortages in long-term care hospitals (LTCHs) and skilled nursing facilities (SNFs) are a major cause of delayed discharges. Maryland ranks 30th nationally in post-acute bed capacity, requiring an estimated 1,668 additional LTCH and SNF beds to reach the national average. Patients requiring LTCH placement experience inpatient stays that are, on average, 11 days longer, while stays are six days longer for those awaiting SNF placement. These delays are attributed to factors beyond hospital control, including prior authorization requirements and regional shortages of post-acute beds and trained staff.

We concur with the ED Wait Time Report's conclusion that hospitals have primary accountability for patients discharged to home, while effective transitions to post-acute care require coordinated action across multiple stakeholders. Accordingly, we recommend that the inpatient policy either focus exclusively on patients discharged to home or incorporate appropriate risk adjustment to account for post-acute care availability and payer type.

Outliers

The policy does not account for outlier cases. Extended lengths of stay are often driven by patient acuity, clinical complications, discharge barriers, and system-level constraints. While some may present opportunities for improvement, many are clinically appropriate and reflect the realities of caring for medically and socially complex patients. Notably, several HSCRC programs already incorporate methodological adjustments for outliers—for example, QBR uses median ED LOS, MHAC excludes cases with more than 6 PPCs, and CMS applies geomean LOS calculations. Consistent with these approaches, we recommend winsorization or trimming to appropriately account for outlier cases.

CY 2026 Performance Period

The draft proposal designates 2026 as the performance period for the RY28 policy. However, by the time the policy is finalized in June, more than half of the performance year will have elapsed. Establishing targets mid-year is inconsistent with prospective rate setting principles, which are intended to provide hospitals with clear, forward-looking incentives. Historically, new metrics have been introduced as monitoring only for at least one year prior to incorporation into payment policy to validate measure performance and avoid unintended consequences. Accordingly, we recommend applying monitoring only status in 2026 and reassessing the policy after outcomes have been evaluated.

Revenue at Risk

The draft policy proposes placing 0.5% of revenue at risk in RY2028, increasing by 0.25% annually to 1% in RY2030. Maryland hospitals already operate under significantly greater financial accountability than hospitals nationwide. While hospitals in other states face up to 6% of Medicare revenue at risk, Maryland hospitals face 6% of all-payer revenue, in addition to the Maryland Performance Adjustment



(MPA), including Care Transformation Initiative (CTIs), effectively subjecting Maryland hospitals to substantially higher overall revenue risk.

Introducing an additional 1% of all-payer revenue at risk further compounds this burden in a state that is already a national leader in accountability. As new policies are considered, HSCRC should ensure that total revenue at risk remains balanced and aligned with national benchmarks. It is also critical that IP LOS revenue at risk does not diminish incentive opportunities within other HSCRC programs. Accordingly, we recommend a comprehensive assessment of cumulative revenue at risk across HSCRC policies and closer alignment of the IP LOS policy with the ED LOS revenue at risk under the QBR program, which is approximately 0.20% of revenue.

AHEAD Alignment

AHC has consistently advocated for alignment of HSCRC policies with the AHEAD framework. The draft policy does not address this alignment, creating additional strain on hospitals as they prepare for the AHEAD transition amid ongoing regulatory change in Maryland. To support effective implementation and focused resource allocation, we recommend HSCRC prioritize AHEAD alignment before advancing new policies or modifying existing ones.

Recommendations

Adventist HealthCare recommends the following actions for the RY28 IP LOS Draft Recommendation:

- Evaluate hospital types and case characteristics represented in the HCUP NIS data to ensure appropriate and equitable risk adjustment
- Focus policy on patients discharged home only or incorporate appropriate risk adjustment to account for post-acute care availability and payer type.
- Incorporate winsorization or trimming into the methodology to appropriately account for outlier cases.
- Apply monitoring only status in 2026 and reassess after outcomes have been evaluated.
- Assess cumulative revenue at risk across HSCRC policies and align IP LOS revenue at risk with the ED LOS revenue at risk under the QBR program.
- Prioritize AHEAD alignment before advancing new policies or modifying existing ones.

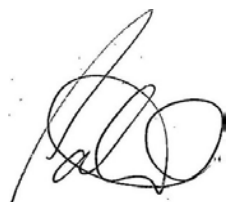
Conclusion

Adventist HealthCare supports the goals of the proposed RY28 IP LOS policy and shares HSCRC's commitment to improving patient outcomes, care coordination, and system efficiency. However, as outlined above, meaningful methodological concerns, particularly related to risk adjustment, post-acute care constraints, treatment of outliers, timing, revenue at risk, and alignment with the AHEAD framework, must be addressed to ensure the policy is fair, effective, and operationally feasible. We urge HSCRC to adopt a measured approach that prioritizes monitoring, validation, and alignment before implementation. Doing so will reduce unintended consequences, promote equity across



hospitals, and allow providers to focus resources on high impact improvements that advance the shared goal of delivering high quality care to all Marylanders.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. McNeil', with a stylized flourish at the end.

Patsy M. McNeil, M.D., MBA, FACEP
Adventist HealthCare
Executive Vice President and System Chief Medical Officer

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



April 24, 2026

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

Dear Mr. Daugherty,

Frederick Health appreciates the opportunity to comment on the draft recommendation for the Rate Year 2028 Inpatient Length of Stay (IP LOS) Policy. While we support the policy's goals of improving outcomes, enhancing care coordination, and reducing emergency department boarding, we have concerns regarding methodology and the accelerated timeline for implementation.

Post-Acute Adjustment Considerations

The proposed policy does not account for discharge to post-acute settings, a key driver of length of stay that is largely outside hospital control. Given ongoing work by the Maryland Health Care Commission Post-Acute Care Workgroup and unresolved barriers to placement, we strongly encourage focusing the policy on home discharges until these issues are addressed. At present, the opportunities identified by the Workgroup result in significant barriers for hospitals' ability to discharge patients to appropriate post-acute care settings. Given the final report will not be submitted until the Fall of 2026, with no clear indication as to when, or if any action will be taken to address the opportunities/barriers, we strongly encourage the Commission to limit the IP LOS policy to discharges to home.

CY 2026 Performance Period

Designating 2026 as the performance period is inconsistent with prospective rate-setting, as the policy will be finalized mid-year. Historically, new measures undergo a monitoring period prior to financial application. We recommend assigning monitoring-only status for 2026 and reassessing after evaluating outcomes.

AHEAD Alignment

The draft does not address alignment with the AHEAD framework, creating additional strain during a period of significant regulatory transition. We recommend prioritizing AHEAD alignment before implementing new or modified policies.

Recommendations

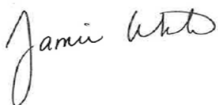
Frederick Health recommends:

- Limiting the policy to patients discharged home
- Applying monitoring-only status in 2026
- Prioritizing AHEAD alignment before advancing changes

Conclusion

Frederick Health supports the intent of the proposed policy but urges a measured approach that addresses methodological concerns, timing, and alignment. Prioritizing validation and alignment will help avoid unintended consequences and support equitable, effective implementation.

Sincerely,



Jamie White, PhD, RN
Vice President, Chief Nursing Officer
Frederick Health

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman

April 24, 2026



Mr. Geoff Dougherty
Director, Performance Measurement
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Dougherty,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide feedback on the draft recommendation for an Inpatient Length of Stay (IP LOS) policy. While JHHS acknowledges the Commission's interest in addressing post-pandemic growth in IP LOS at some hospitals, JHHS does not support the adoption of this policy as currently drafted and recommends a pause on any further development of this policy.

The draft recommendation states that "Maryland has fewer inpatient beds per capita than most states, so absent better performance on LOS, hospitals may experience bed capacity issues." As JHHS has previously noted, distortions created by the model have led to Emergency Department (ED) and capacity issues, and these distortions cannot be resolved through an LOS measure. To create meaningful improvement, the State must resolve these distortions through a comprehensive rebasing process, and must redirect funding towards addressing capacity where needed.

Further, JHHS questions if data supports the conclusion that Maryland has a meaningful statewide IP LOS issue. Current statewide O/E LOS performance is below 1.0, with ~75% of Maryland hospitals performing at or below the 1.0 threshold. This profile compares favorably with national benchmarks. Additionally, the model encourages the shift of lower-acuity volume to outpatient and lower-cost settings; as these shifts continue, average LOS for remaining inpatient admissions will naturally increase to reflect a higher-acuity case mix. If admissions, patient days, and Total Cost of Care per capita are performing well, an O/E LOS ratio at or near 1.0 should not be treated as evidence of a problem warranting financial penalty.

JHHS's concerns are outlined in further detail below.

AHEAD Model Readiness and Alignment Must Take Precedence Over New Policy Development

Most importantly, as the State prepares for a critical transition to the AHEAD model in CY2028, JHHS urges the State to mitigate any additional risks or threats to healthcare market stability in light of impending substantial model changes. With critical policy development, operational infrastructure, and stakeholder alignment work still required before Maryland's CY2028 AHEAD model transition, JHHS urges the Commission to carefully sequence priorities, ensuring that foundational model readiness workstreams are sufficiently advanced before directing significant attention and resources to the design of new measures such as an IP LOS policy.

Implementation of an IP LOS policy would further expand the inventory of state-specific policies that are not yet aligned with the CMS AHEAD Hospital Global Budget methodology specifications. Alignment

between State-administered and federally-administered global budgets is essential to the sustainability and long-term viability of the model. The introduction of additional State-specific payment mechanisms runs counter to this goal, increasing methodological complexity when alignment should be the collective priority. Foundational AHEAD policy development and alignment with CMS methodologies must be the State and industry's primary focus over the next year, and JHHS looks forward to further collaboration on this process.

Root Cause Investigation Must Precede Policy

JHHS is concerned that the draft recommendation moves directly to financial penalties without first establishing a clear, evidence-based understanding of the drivers of IP LOS variation across Maryland hospitals. A new financial metric does not solve an operational problem; meaningful and sustainable improvement in IP LOS requires targeted, root-cause-driven interventions. JHHS recommends a structured, collaborative process that directly engages hospitals demonstrating strong LOS performance alongside those identified as outliers. That process should involve discharge planners, care coordination leads, frontline clinical staff, and post-acute partners to develop an understanding of where the opportunity lies and where interventions have proven effective. Implementing a penalty program without this foundation risks penalizing hospitals for factors that are not within their operational control, and does not equip institutions with the tools needed to meaningfully improve.

Existing Policy Mechanisms Contain Incentives and Penalties for IP LOS

Maryland's all-payer global budget structure already creates incentives for hospitals to reduce inpatient utilization and length of stay. The global budget revenue framework, by design, aims to reward efficiency; hospitals that reduce avoidable admissions, limit unnecessary bed days, and transition care to appropriate post-acute settings benefit financially from a fixed revenue budget. These incentives are reinforced by quality programs generally and the Quality Based Reimbursement policy, which includes the Emergency Department LOS metric for admitted patients as an explicit measure of throughput performance. Adding a standalone IP LOS incentive program to this existing framework risks introducing redundancy and administrative complexity without meaningfully advancing outcomes.

Benchmarking Methodology Must Utilize Peer Groups

Benchmarking IP LOS performance against a national average derived from the HCUP National Inpatient Sample, which includes community, rural, and general acute-care hospitals, raises additional methodological concerns. Large, urban teaching hospitals, safety-net institutions, and other hospital types must be compared to similar peers. JHHS recommends that the Commission establish hospital cohorts for benchmarking purposes, grouping institutions by academic medical center designation, case complexity, and safety-net characteristics, to ensure performance is assessed against an appropriate peer group. If peer groups are not utilized, the policy risks producing misleading comparisons that penalize institutions for the characteristics that make them essential providers for Maryland patients.

If Implemented, IP LOS Policy Should Be Monitoring-Only at Outset

If the IP LOS policy is developed further, JHHS strongly recommends that any initial implementation be structured as a monitoring-only program for the first performance year and in the early years of the AHEAD model transition. This approach is consistent with the Commission's historical introduction of new quality and utilization measures.

A monitoring period would allow hospitals to assess the adequacy of the risk-adjustment methodology, understand performance relative to benchmarks, validate the accuracy of data, and begin identifying the internal operational drivers of LOS variation. It would also give the Commission the opportunity to evaluate the measure before attaching financial consequences. Given the unresolved questions around AHEAD alignment, peer group comparability, and root cause attribution, proceeding directly to a penalty structure is premature.

AHEAD Carve-out Services Should Be Excluded from IP LOS measure

Services excluded from AHEAD global budgets, including certain high-acuity procedures concentrated at academic medical centers, are services likely to carry longer inpatient stays given their clinical complexity, procedural intensity, and the patient populations served. Including these services in an IP LOS incentive program designed for the general acute-care population would introduce bias against institutions providing high-complexity care. JHHS recommends that AHEAD carve-out services be excluded from any IP LOS policy. If not excluded, this policy would disproportionately penalize the facilities that provide access to high-acuity services for Marylanders.

JHHS remains deeply committed to the advancement of high-quality, accessible care for all Marylanders. As the State enters this critical period of transition to the AHEAD model, JHHS looks forward to continued partnership with the State and industry stakeholders to ensure the AHEAD model's policy foundation is sustainable, operationally viable, and aligned with the best interests of patients and providers.

Sincerely,



Peter M Hill, MD, MS, FACEP
Senior Vice President of Medical Affairs and Chief Medical Officer
Johns Hopkins Health System

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

April 20, 2026

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

Dear Dr. Kromm,

On behalf of Luminis Health, I am writing in response to the Health Services Cost Review Commission's (HSCRC) request for comments regarding the draft recommendation for the Inpatient Length of Stay (IP LOS) Policy.

We appreciate the Commission's focus on improving patient outcomes, enhancing care coordination across the continuum, and addressing capacity constraints impacting emergency department boarding. However, we have several concerns regarding the technical components, necessity, and timing of introducing a new IP LOS-focused quality policy, particularly as the system transitions to the AHEAD model.

We are gravely concerned by the introduction of an additional quality metric that is not clearly aligned with federal program priorities. At present, there has been no indication from the Center for Medicare & Medicaid Innovation (CMMI) that inpatient length of stay will be included as a measured metric for the Medicare population under the AHEAD model. As the industry has consistently emphasized, alignment across policies where possible is essential to ensure clarity, reduce burden, and support successful implementation.

Beyond alignment concerns, it is important to recognize that meaningful incentives to appropriately manage length of stay already exist within the Global Budget Revenue (GBR) framework. Hospitals operate under strong financial and clinical pressures to avoid unnecessary inpatient days. Days that are not medically necessary are routinely subject to payer scrutiny and denials, meaning that hospitals bear the financial risk of extended stays that cannot be clinically justified. The assumption that hospitals can rely on GBR to offset operational inefficiencies does not fully reflect the realities of reimbursement, where payment is contingent upon demonstrating medical necessity. Once a patient is clinically appropriate for discharge, additional days are unlikely to be reimbursed. In a system where revenue is capped, hospitals are already highly motivated to optimize throughput while maintaining safe and appropriate discharge practices.

In addition, the data presented by the HSCRC suggests that performance across the state is largely in line with, or better than, national benchmarks. With only 10 of 42 hospitals exhibiting a risk adjusted IP LOS above the national average, the majority of Maryland hospitals appear to be effectively managing length of stay. This raises important questions about whether a broad, statewide policy is the most appropriate approach. A more targeted strategy, focused on supporting the subset of hospitals with higher than

expected LOS, may yield more meaningful improvements without introducing unnecessary burden across the entire system.

From a technical standpoint, we have concerns regarding the timing of the first measurement period as well as data considerations that are critical to the methodology. The proposed policy would introduce scaled penalties and rewards using calendar year 2026 as the first performance year. We disagree with approving and implementing a policy that uses a performance year that is already underway. Hospitals require sufficient lead time to understand new policy requirements and adjust operational strategies accordingly. Implementing a performance based policy in the middle of a measurement period undermines that ability. Additionally, it is unclear whether the methodology adequately accounts for structural and operational difference across hospitals that influence length of stay, such as teaching status or specialized service lines such as psychiatric care.

While we support the concept and outcomes associated with the reduction of length of stay, we believe this must be pursued in a manner that is data-driven, targeted, and aligned with existing incentives and program structures. The introduction of a new policy at this juncture, without clear alignment or demonstrated statewide need, risks adding complexity without proportionate benefit. More importantly, the introduction of a new quality metric that is not consistent with CMMI at this point in AHEAD model planning creates additional and ill-timed instability as all hospitals are working through the transition to the AHEAD model.

For these reasons, we respectfully urge HSCRC to carefully reconsider the necessity of implementing the proposed IP LOS policy at this time.

Thank you for the opportunity to provide feedback.

Sincerely,



Michelle Lee
EVP and Chief Financial Officer
Luminis Health

CC: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chair
Jon Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzineh Sabi, Commissioner



MedStar Health

8094 Sandpiper Circle
Suite O
Nottingham, MD 21236

MedStarHealth.org

April 24, 2026

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

Dear Executive Director Kromm,

On behalf of MedStar Health, Inc. (MedStar) and its seven Maryland hospitals, thank you for the opportunity to provide comments on the Inpatient Length of Stay Incentive Program (IP LOS) Draft Recommendation presented at the April 15, 2026, Health Services Cost Review Commission (HSCRC) public session. MedStar agrees with HSCRC staff that the management of length of stay is critical to both success in improving patient care quality and achieving the financial savings targets of the Maryland Model and we appreciate the recent modifications to the policy which greatly improved the improvement vs. attainment calculations. However, MedStar does not support the adoption of the IP LOS policy as drafted. MedStar is in alignment with the comments provided by the Maryland Hospital Association and offers the following:

The creation of a stand-alone IP LOS policy is duplicative with the fundamental incentives of Global Budgets for hospitals and managing Total Cost of Care in Maryland

Incentives to manage patient length of stay already exist through the global budget framework and pay for performance incentives layered into the TCOC model. In fact, Hospitals in Maryland have been incentivized to manage length of stay since even before the GBR system was put in place as inpatient reimbursement was previously based on a charge per case and/or charge per episode. Reducing length of stay saves hospital costs and doesn't impact revenue. Those fundamentals have been in place in Maryland for far more than a decade. MedStar believes the adoption of this policy as a stand-alone incentive for managing patient length of stay is duplicative and unnecessary and has the potential to hold hospitals financially accountable for addressing issues beyond their control, including an inadequate post-acute care infrastructure, Medicaid eligibility issues and general availability of staffing to maintain bed capacities. With the incentives already in place, hospitals are always looking for opportunities to reduce length of stay. Unfortunately, with so many issues beyond a hospital's control, managing length of stay is an incredibly difficult task. As such, MedStar believes creating specific rewards and penalties related to length of stay is unnecessary and unfair.

It's how we treat people.

There are numerous technical concerns with the policy that need to be addressed through a transparent and collaborative policy development forum before financially penalizing or rewarding hospitals in Maryland

The policy development process of the IP LOS policy has been lacking in data transparency and numerous technical concerns remain, including:

1. Accounting for the effects of the Maryland TCOC model on Maryland hospital LOS
2. The impact of outpatient observation in MD vs. the nation
3. The impact of IME on hospital utilization
4. Risk factors beyond DRG/Severity that contribute to hospital LOS disparities

MedStar believes additional consideration of these and potentially other factors should be considered before Maryland hospitals can be held accountable and rewarded/penalized for LOS variances.

HSCRC time and effort needs to be directed towards adapting core reimbursement methodologies in preparation for the transformative impacts of AHEAD

The AHEAD Model officially began for Maryland on 1/1/2026 and on 1/1/2028, transformative changes to how hospitals in the state are reimbursed will occur. Despite this short timeframe, there has been little movement on core HSCRC reimbursement methodologies (Market shift, Efficiency, Demographic, UCC) that will allow hospitals to understand how non-Medicare hospital global budgets will be calculated. MedStar believes the limited resources of the HSCRC, and stakeholders, should be focused on the fundamental backbone of the MD GBR system at this critical time. While 1/1/2028 is more than 18 months away, Maryland hospitals will be completing their FY2028 Budgets in less than a year and this information will be a critical input for management and Boards to understand. Also, technology updates to prepare IT systems to support Maryland and CMMI Medicare, new methodologies will also likely require significant lead time, further adding to the need for these fundamental policies to be understood.

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

Sincerely,

Michael Wood

Michael Wood
VP – Revenue Management & Reimbursement
MedStar Health

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
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Maryland
Hospital Association

April 24, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation for the Inpatient Length of Stay Incentive Program (IPLOS) Policy. Hospitals share HSCRC's goal to improve patient flow, reduce emergency department (ED) boarding, and strengthen the sustainability of the AHEAD Model.

The hospital field agrees that addressing prolonged inpatient stays is essential to improve throughput and patient experience. However, hospitals have significant concerns about the draft policy, its underlying assumptions, and lack of alignment with Maryland's other efforts to improve ED and inpatient throughput. Additionally, the hospital field has not received clarity about Medicare participation as the state moves forward with the AHEAD Model. As outlined below, MHA recommends an alternative, targeted approach that emphasizes direct hospital engagement, monitoring, and reporting, rather than financial incentives or penalties.

We encourage HSCRC to withdraw the proposed IPLOS policy and instead advance the following steps:

1. **Engage Hospitals Directly:** For hospitals that are inpatient length of stay outliers, engage directly to determine root causes and the need for a targeted monitoring and reporting approach
2. **Account for Maryland's Unique Environment:** Conduct a more thorough multi-factor inpatient length of stay analysis to more appropriately compare Maryland hospital performance to national benchmarks
3. **Consider the Impact of Outlier Cases & Structural Barriers:** Exclude outlier cases from the inpatient length of stay analysis and account for other health care system structural issues that are out of hospitals' control

This alternative approach to address inpatient length of stay concerns would support improvement and transparency without creating unintended consequences or misaligned accountability.

MHA Proposal for an Alternative Design Approach: Hospital Direct Engagement

The proposed methodology evaluates performance based on the better of attainment or improvement, with an attainment target set above the national average observed to expected (O/E) ratio and modified by an improvement threshold. As designed, hospitals performing at or better than the national normative values (norm) could still fail to meet the attainment standard and incur penalties, creating expectations that do not reflect current system realities.

Similarly, the improvement framework requires all hospitals, including those with strong baseline performance, to converge toward an O/E of 1.0 over a five-year period. Together, these targets do not sufficiently account for structural constraints, including post-acute care capacity and discharge barriers, which are largely outside of hospitals' control.

Because of these concerns, MHA respectfully recommends that HSCRC first directly engage outlier hospitals to determine root causes and barriers affecting inpatient length of stay. If these are within hospital control, HSCRC could adopt a targeted monitoring and reporting approach with a focus on addressing these factors. This alternative design could focus efforts on hospitals with inpatient length of stay O/E ratios above the national average, promote transparency, more narrowly target analysis, and foster improvement over time without broad punitive application. Additionally, this approach would support policy goals while allowing HSCRC to better assess trends, identify root causes, and consider appropriate future interventions needed to improve inpatient length of stay.

Maryland's Unique Payment Environment

Maryland's all-payer global budget system differs fundamentally from the national fee-for-service (FFS) environment that underpins Healthcare Cost and Utilization Project (HCUP) norms. Evidence from Maryland's global budget experience shows that implementation was associated with reduced hospital admissions, particularly for potentially avoidable conditions.¹

Additionally, recent HSCRC analyses show a decline in hospital admissions alongside an increase in inpatient length of stay. This finding is consistent with the literature showing that global budgets encourage reduction in unnecessary utilization, which in turn concentrates inpatient care among patients with higher acuity and more complex discharge needs.² As a result, length of stay trends in Maryland reflect hospital operations and the expected structural effects of the payment model itself, which should be considered when applying national length of stay norms and setting performance expectations. For example, including outpatient observation stays lasting longer than 24 hours reduced the state average inpatient length of stay by 1.9% in CY 2024.

¹ Roberts, Eric T., et al. "Changes in Hospital Utilization Three Years Into Maryland's Global Budget Program." *Health Affairs* 37, no. 4 (2018): 644–653. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5993431/>

² Ibid

Peer-reviewed research conducted at large academic medical centers have found that increases in average length of stay were driven significantly by highly complex patients with prolonged hospitalizations. The literature demonstrated that when extreme cases were excluded, baseline length of stay continued to rise, underscoring that shifts in patient complexity and discharge barriers influence length of stay independent of hospital efficiency.³

Furthermore, Maryland hospitals report elevated medical and social complexity among inpatients, including behavioral health needs, chronic disease burden, and social risk factors that extend length of stay independent of hospital performance.⁴ Behavioral health boarding contributes to prolonged stays and ED throughput challenges as psychiatric patients experience significantly longer boarding times than medical patients.⁵ Post-acute constraints such as Skilled Nursing Facility (SNF) staffing shortages, limited bed availability, and regional variation in post-acute capacity, also delay discharge for medically complex patients.⁶ These factors are not fully captured in national length of stay norms derived from the FFS healthcare environment. Given these structural differences, national benchmarks alone may not accurately reflect Maryland's operating context. MHA therefore recommends that HSCRC adopt an analytical approach that utilizes peer-grouping and Maryland-specific adjustments to complement HCUP norms and support fair, context-appropriate performance assessment.

Factors Outside Hospitals' Control

Maryland hospitals continue to experience structural barriers that extend inpatient length of stay independent of hospital performance. These factors differentiate Maryland from the national fee for service environment underlying HCUP benchmarks and are not fully addressed in the current exclusions' framework. Any IPLOS policy must consider these inputs to ensure fair and accurate performance assessment.

Misalignment With Ongoing State Efforts on Post-Acute Care Capacity

Significant post-acute care access challenges, such as limited availability of specialized placements (including ventilator capable facilities), denied and delayed Medicaid eligibility determinations and authorizations, workforce shortages, constrained bed capacity, and regional variation in post-acute infrastructure, are key drivers of prolonged length of stay and ED throughput challenges. These issues have been identified by both the Emergency Department Wait Time Reduction (ED WTR) Commission and the Maryland Health Care Commission (MHCC) led Regulatory Working Group on Post Acute Care, which are actively developing recommendations to address these system level constraints.

³ Andrew H. Hughes, David Horrocks Jr., Curtis Leung, Melissa B. Richardson, and Ann M. Sheehy, "The Increasing Impact of Length of Stay 'Outliers' on Length of Stay at an Urban Academic Hospital," *BMC Health Services Research* 21, no. 1 (2021): 940, <https://doi.org/10.1186/s12913-021-06972-6>.

⁴ Ryan, Andrew M., et al. "Changes in Patient Characteristics and Hospital Utilization After Implementation of Maryland's Global Budget Program." *JAMA Internal Medicine* 179, no. 11 (2019): 1423–1429.

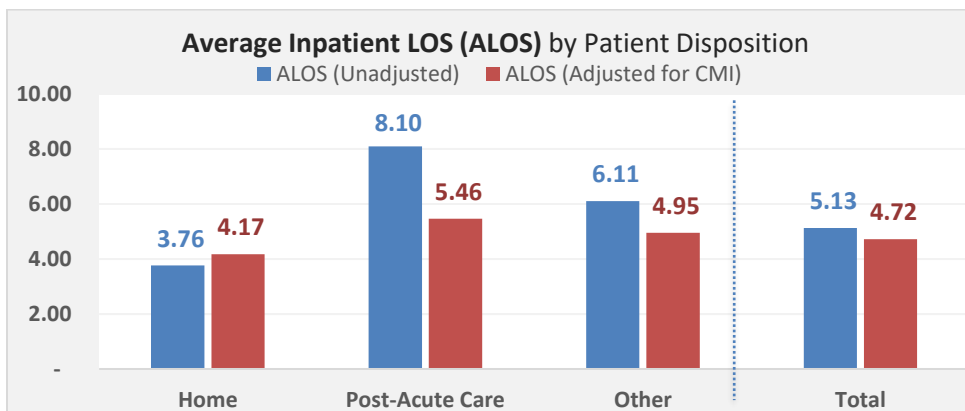
⁵ Nicks, Bret A., and David M. Manthey. "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International* (2012). <https://onlinelibrary.wiley.com/doi/10.1155/2012/360308>

⁶ Medicare Payment Advisory Commission (MedPAC). Skilled Nursing Facility Services Payment System. Chapter 7. March 2023. <https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/>

In 2025, the ED WTR Commission reported that Maryland faces a shortage of post-acute beds compared to peer states, contributing to discharge delays for patients no longer requiring acute care and creating inpatient and ED bottlenecks.⁷ The report identified multiple drivers of post-acute delays, including prior authorization barriers, limited weekend admissions, regional workforce and bed shortages, and operational opportunities for improvement across both acute and post-acute settings. Importantly, the Commission emphasized the need for coordinated, statewide solutions and recommended development of a formal proposal to improve post-acute access and capacity, with particular focus on regional needs and complex patient populations.

The proposed IPLOS policy, however, is misaligned with this body of work by introducing a pay-for-performance framework that holds hospitals financially accountable for length of stay drivers that are largely outside their control and remain the subject of ongoing statewide policy development. The analysis underlying the proposed policy also does not sufficiently consider regional dynamics contributing to inpatient length of stay. While the HSCRC analysis finds that inpatient length of stay, at the hospital level, is minimally correlated with the volume of post-acute discharges, it analyzes regional groupings at a level of imprecision that risks not capturing more granular regional access challenges for patients in need of post-acute facility or home health services. Moreover, regression analyses confirm that patient disposition has a statistically significant correlation with IPLOS. If left as the only independent variable, patient disposition explains 50.9% of IPLOS (Figure 1).

Figure 1: Average Inpatient Length of Stay by Patient Discharge Disposition



Source: MHA’s analysis of CY 2024 Case-mix data. Analysis excluded IPLOS >18 days, left against medical advice, expired patients.

As noted above, hospitals frequently encounter barriers when discharging patients due to limited in-network post-acute placement options and other authorization delays. More detailed analysis is needed on the extent to which specific payer practices are driving inpatient length of stay. If these structural constraints and analytical limitations are not resolved, a policy that penalizes hospitals for prolonged inpatient lengths of stay would misplace accountability, undermining

⁷ HSCRC. “The Emergency Department Wait Times Reduction Commission Activities and Findings” November 2025.
<https://hscrc.maryland.gov/Documents/Work%20Group%20Uploads/ED%20WTR%20Commission/Emergency%20Department%20Wait%20Times%20Reduction%20Commission%20Interim%20Report%202025%20HSCRC.pdf>

policy effectiveness, and introduce unmanageable financial risk for hospitals rather than advancing meaningful system improvement.

Outlier Patient Cases

In addition to system-wide post-acute capacity constraints, inpatient length-of-stay measurement should account for challenging patient cases that materially extend stays but fall outside hospitals' ability to control. These cases include behavioral health boarding, patients with high social needs, guardianship related delays, and pediatric overstays. Behavioral health patients continue to experience substantially longer boarding times in emergency departments and inpatient units due to limited psychiatric bed availability and insufficient community-based crisis stabilization capacity.⁸ These challenges persist independent of hospital performance and disproportionately affect inpatient throughput.

Hospitals are also increasingly caring for patients who are medically ready for discharge but cannot safely transition due to social complexity, housing instability, or the absence of a legally authorized decision-maker. For patients requiring guardianship authorization, Maryland's multi-step legal process, encompassing petitions, evaluations, and court proceedings, cannot be expedited by hospitals and frequently extends well beyond the point of medical readiness.⁹ Federal oversight findings similarly document that guardianship delays result in prolonged institutional stays unrelated to clinical need.¹⁰ Pediatric overstays represent an additional outlier case. Children who are medically ready for discharge may remain inpatient due to limited foster care or family placement delays or behavioral health service gaps. These circumstances are highly individualized, structurally driven, and not reflective of hospital operational performance.

Collectively, these outlier cases represent structural barriers that are outside hospital control and are not adequately captured by standard length-of-stay measurement approaches. Absent appropriate exclusions or adjustments, inclusion of these cases risks distorting performance assessment and undermining policy equity.

Unintended Consequences

The proposed IPLOS policy may create unintended operational pressures, including incentives to accelerate discharges before safe placements are secured. The Centers for Medicare and Medicaid Services' discharge planning requirements emphasize that hospitals must ensure safe transitions of care and recognize that discharge may appropriately be delayed when the necessary services or supports are unavailable.¹¹ Without careful design, monitoring, and coordination, this state-based IPLOS policy risks unintended impacts on care quality and patient safety.

⁸ Nicks, Bret A., and David M. Manthey. "[The Impact of Psychiatric Patient Boarding in Emergency Departments.](https://www.hindawi.com/journals/eml/2012/360308/)" *Emergency Medicine International* (2012). <https://www.hindawi.com/journals/eml/2012/360308/>

⁹ Maryland Judiciary. "Court Appointed Guardians." <https://www.mdcourts.gov/family/guardianship/courtappointedguardians>.

¹⁰ U.S. Government Accountability Office (GAO). Highlights of GAO 11 678. <https://www.gao.gov/assets/gao-11-678-highlights.pdf>.

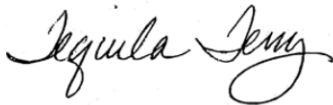
¹¹ Federal Register. "[Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care.](#)"

Addressing hospital inpatient length of stay requires a coordinated, cross-sector strategy involving payers, post-acute providers, and state agencies to address the systemic drivers and make meaningful progress. Hospital inpatient length of stay trends in Maryland are shaped by the state's unique payment model, post-acute care capacity constraints, behavioral health boarding, guardianship delays, pediatric overstays, and other structural factors beyond hospitals' control. These issues are being examined by the MHCC Post Acute Care Workgroup and the ED WTR Commission, with recommendations forthcoming.

Given these considerations, MHA respectfully urges HSCRC to withdraw the IPLOS draft policy and instead work directly with outlier hospitals to identify barriers and solutions. This approach would provide more visibility into drivers of inpatient length of stay and support improvement, while allowing sufficient time to assess policy impacts, avoid unintended consequences, and align future action with broader statewide efforts to strengthen post-acute capacity and care transitions.

Thank you for the opportunity to provide input. MHA looks forward to continued collaboration with HSCRC to ensure quality programs remain equitable, transparent, and aligned with our shared goal of improving patient care and system performance statewide.

Sincerely,



Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
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CORPORATE OFFICE

April 24th, 2026

Geoff Dougherty, PhD, MPH
Deputy Director, Population-Based Methodologies, Analytics, and Modeling
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Dougherty:

On behalf of the University of Maryland Medical System (UMMS), thank you for the opportunity to comment on the proposed Inpatient Length of Stay Incentive Program (IP LOS). We appreciate the Commission's ongoing collaboration with hospitals and its efforts to position Maryland for success under the forthcoming AHEAD Model.

While UMMS strongly supports the Commission's goals of improving Emergency Department throughput and reducing avoidable inpatient days, UMMS does not support incorporating IP LOS into an incentive framework.

We respectfully offer several considerations that we believe are important to both effective and appropriate policy alignment with the primary drivers of Emergency Department (ED) wait times.

Existing Mechanisms Already in Place

There are several mechanisms already in place under the Maryland model, such as:

- Under the Global Budget Revenue (GBR) structure hospitals are incentivized to reduce LOS.
- The Quality-Based Reimbursement (QBR) program already includes a hospital throughput measure (Time from Arrival to Departure for the ED for Admitted Patients: ED-1b) that places

revenue at risk based on performance. ED-1b performance improvement is highly correlated with LOS reductions. Including a separate at-risk measure for IP LOS is redundant.

- Hospitals are actively implementing the ED Hospital Throughput Best Practices Policy, which requires structured operational improvements such as interdisciplinary discharge planning, escalation pathways, standardized throughput huddles, and patient flow governance infrastructure.
- Strategies to improve ED wait times are already working. This is demonstrated by state-wide improvements in Arrival to Departure for Discharged Patients (OP-18b) and reduced Left Without Being Seen (LWBS) times.

For these reasons, we do not support additional at-risk revenue above the 6% already in place for Maryland quality incentive programs consistent with nation.

Post-Acute Care Access

The Emergency Department Wait Times Reduction Commission's interim report highlights that post-acute care access and care transitions are among the most significant contributors to prolonged inpatient LOS, particularly for patients requiring placement in skilled nursing facilities (SNFs) or Long Term Acute Care (LTAC) facilities. **These transitions extend inpatient stays by an average of approximately 6–6.4 days for SNF placement and 11–12 days for LTAC placement: factors that are often outside the direct control of hospitals.**

Available performance data demonstrates that hospitals are already making progress in areas where they have the greatest operational control. For example, across UMMS, **the observed-to-expected (O/E) LOS ratio for patients discharged home remains below 1.0**, reflecting strong performance relative to expected benchmarks. In contrast, extended LOS is more frequently associated with patients requiring post-acute placement, consistent with statewide findings regarding capacity limitations and authorization-related delays in these settings.

Additionally, we conducted analysis running normative expected values including post-acute discharges and excluding post-acute discharges. Under this sensitivity, state-wide rewards increased by \$2.97M by excluding post-acute discharges, including a \$3.02M improvement for UMMS. This demonstrates a significant impact of post-acute discharges on LOS.

Finally, we conducted an analysis correlating LOS O/E to SNF beds per 1000 discharges by Maryland County and by Maryland City. Under both analysis, there was a negative correlation, where hospital LOS O/E decreases with increases in SNF beds per 1000 discharges in both counties and cities. **This indicates areas with greater availability of SNF beds have shorter hospital stays.**

We offer two considerations for the Maryland model to address the Post-Acute Care Access constraints:

1. Remove “Chronic” from rate regulation and allow LTAC operators to enter Maryland
2. Expansion of a PDPM-aligned payment structure to improve financial sustainability for SNFs accepting medically complex discharges thus reducing placement delays that extend inpatient LOS.”
3. Expansion of the post-acute capacity in Maryland to align with national benchmarks by strategically improving the current Certificate of Need (CON) processes in the state. Foster a CON environment in which operators of SNF, home health, hospice, inpatient rehab facilities (IRF) and LTAC can actively expand to address significant post-acute capacity deficits in the state, with regulatory oversight and due diligence.
4. Improved guardianship policy for patients that do not have capacity or medical decision-making ability to allow for hospitals to achieve timely discharges.

Considerations for Academic Medical Centers (AMCs)

If the IP LOS policy is approved, we request consideration for adjustments for AMCs. Staff modelling clearly shows that highly complex hospitals, such as the University of Maryland Medical Center (UMMC), have higher LOS O/E compared to community hospitals across the state. Due to the complexities of these hospitals, there is bias in the policy that does not allow AMCs to achieve the attainment targets.

We have analyzed LOS opportunity using Vizient, the nation’s largest provider-driven healthcare improvement company. Their Clinical Database (CDB) utilizes data from over 1300 hospitals across the country.

In this analysis, we found:

- **UMMC has a comparable and favorable LOS O/E compared to other AMCs (0.96 vs 0.97) but is worse in a state of Maryland comparison (0.88)**
- However, UMMC has higher expected LOS (8.48) than other AMCs (6.32) and Maryland hospitals (6.15)
- These differences are due to significantly higher clinical complexity compared to other statewide hospitals and AMC peers:
 - Overall ICU utilization: UMMC: 25.4%; AMCs: 17.9%; Maryland hospitals: 12.36%
 - Surgical ICU utilization: UMMC: 35.96%; AMCs: 26.47%; Maryland hospitals: 21.17%
 - Transfer volume: UMMC: 20.8%; AMCs: 13.5%; Maryland hospitals: 6.74%
 - ICU utilization for transfers: UMMC: 50%; AMCs: 36%; Maryland hospitals: 21%

For these reasons, the proposed IP LOS policy disproportionately disadvantages AMCs like UMMC. With the combined Post-Acute constraints and unique AMC attributes, the statewide attainment goal is unobtainable for UMMC and given UMMC is favorable compared to their peers in LOS O/E, additional improvement opportunities are limited.

Therefore, if the policy is approved, we recommend “monitoring only” until a cohort methodology can be constructed that accounts for different hospital acuities across the state, especially for AMCs.

Conclusion

We appreciate the HSCRC’s efforts to improve hospital throughput and capacity. Continued coordination with the Emergency Department Wait Times Reduction Commission’s ongoing work on post-acute capacity, care transitions, and statewide throughput strategies will help ensure the policy achieves its intended impact on ED wait times.

Sincerely,



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Senior Vice President and Chief Clinical Officer
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maryland
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Draft Recommendation for Global Budget Carve-outs Under AHEAD

June 10, 2026

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This document contains the draft staff recommendations for Global Budget Carve-outs under AHEAD. Please submit comments on this draft to the Commission by Friday, June 19, 2026, via email to william.henderson@maryland.gov and prudence.akindo@maryland.gov

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Executive Overview

This draft policy presents a list of services determined by staff as highly specialized care, eligible for carve-out from population-based methodologies per Achieving Healthcare Efficiency through Accountable Design (AHEAD) specifications. This document outlines the staff methodology for determining the list of services based on a five-part criteria which prioritizes quaternary and tertiary care performed at the states' academic medical centers and tertiary services performed at other service specialty designated hospitals in the state. Carve-out volumes will be based on calendar year 2025 (CY 2025) performance inflated to fiscal year 2027 (FY 2027) and removed from the hospital's global budget. Going forward, carved-out volumes will be charged at 100 percent of the current applicable rates (i.e. 100 percent variable cost factor) with hospitals being held 100 percent liable for volume volatility.

Introduction

In 2014, Maryland transitioned all its acute care hospitals to an All-Payer Global Budget Revenue (GBR) model. Under this model, hospitals operate under fixed revenue caps as opposed to traditional fee-for-service payments. The Maryland All-Payer model focused on improving quality, enhancing health outcomes, and controlling Medicare spending for hospital inpatient and outpatient services. Between 2014 and 2018, hospitals successfully reduced unnecessary readmissions and hospital-acquired conditions while slowing growth in hospital costs per capita. However, the All-Payer Model primarily targeted hospitals and did not fully support coordinated care across the broader health care system.

In 2019, Maryland transitioned to the Total Cost of Care (TCOC) Model. Under the TCOC Model, Maryland was expected to transform care delivery across the health system, improve health and quality of care, and maintain Medicare spending growth below the national rate. The TCOC Model gave Maryland the flexibility to tailor initiatives to the state's unique health care environment and encouraged innovation among providers. It supported investments in population health improvement, care redesign and provided new tools and resources for primary care providers to better manage complex and chronic conditions, helping Marylanders achieve better health. The State achieved significant savings, quality improvements, and care transformation progress under the TCOC Model.

As of January 1, 2026, Maryland transitioned from the Maryland TCOC Model to the national Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model; a voluntary, state-based total cost of care model that allows Maryland to manage healthcare costs and quality and improve the overall health of the state through expanding primary care and strengthening population health.

This policy recommendation will detail the work staff have done with the Volume Workgroup and the methods by which staff and stakeholders concluded on a carve-out list that prioritizes quaternary and tertiary cases performed at academic centers and tertiary services also performed at non-academic hospitals.

Background

Majority of Maryland hospitals have seen a growth in inpatient case-mix acuity despite declines or stable volumes between fiscal year 2023 (FY 2023) and 2025 (FY 2025). This is an indicator that Maryland has successfully shifted low acuity cases out of the inpatient setting and volumes that tend to remain are appropriate for that setting of care as the patients tend to be sicker and in certain instances require care that is complex and highly specialized.

Given the focus on growth in high acuity and highly specialized care, staff recognize that shielding that care from global budget limitations may be appropriate. While the AHEAD Model includes a requirement that at least 85 percent of in-state, acute care hospital revenue remain under population-based

methodologies that is down from 95% under the Total Cost of Care Model, leaving an opportunity to implement an alternative financing mechanism.

In addition to revising the amount available for exclusion under existing global budgets, Maryland can also propose additional exclusions under the Medicare Hospital Global Budgets that are effective January 1, 2028. As stipulated in section 12(a)(iii) of the State Agreement, “the State may propose additional services to be added to the list of exclusions in the financial specifications for the CMS-Designed Hospital Global Budget Methodology for Medicare FFS. This proposal must include:

1. A definition of additional services to be excluded from the CMS-Designed Hospital Global Budget Methodology for Medicare FFS, as described in this Section 12;
2. A policy explanation for each set of excluded services, which considers various factors such as:
 - . Disproportionate cost growth for certain services driven by factors outside of the control of hospitals;
 - . The innovative nature of certain areas of care, such as high-intensity quaternary and tertiary care;
 - . The statistical reliability of the volume of services provided in a year”¹

The HSCRC identified (1) revenue associated with high-cost drugs, (2) complex tertiary/quaternary care, and (3) certain low volume surgeries as volumes potentially appropriate for carve-out under AHEAD, given that these services are often unpredictable and often characterized by high volume variability and high-cost. While this recommendation is focused on Maryland’s global budget, the State plans to use the approach developed as a starting point for discussions with CMS.

High-cost outpatient physician-administered drugs were prioritized under the TCOC Model 5 percent carve-out allotment given the volume volatility and high-cost nature of these therapies. The Commission approved use of a quantitative evaluation to identify eligible drugs which are funded at 100 percent of drug costs through the CDS-A policy.² Based on this approach, 2.1 percent of total hospital in-state revenue is carved out of hospital GBRs. Not using the entire 5 percent in one year provided enough cushion in the model for growth and future additions of new emerging innovative therapies.

Staff and stakeholders generally support the continuation of high-cost outpatient drug carve-outs identified in the CDS-A Policy under AHEAD albeit with refinements to align with Center for Medicare and Medicaid Innovation’s (CMMI) drug carve-out list. As there is already a carve-out for these drugs that was revised relatively recently, Staff felt that revisions to this policy could wait to be implemented co-incident with the shift to separate Medicare Hospital Global Budgets. However, complex tertiary/quaternary care, some of which was handled under the Complexity and Innovation Policy as well as certain low volume surgeries were flagged by staff and stakeholders as potential areas of opportunity which necessitate new policy development and/or refinements.

Low volume Surgical Service Lines

Through various statistical analyses done in 2025 to assess the reliability of service lines included in the State’s Market Shift Adjustment policy, staff identified and recommended seven surgical service lines for possible exclusion due to their low volumes.³ These service lines make up approximately 2.5 percent of

¹Amended and Restated AHEAD Model Maryland State Agreement

https://hscrc.maryland.gov/Documents/AHEAD/Amended%20and%20Restated%20AHEAD%20Model%20Maryland%20State%20Agreement_vFinal_State%20signed_CMMI%20Signed_vPublic.pdf

² Proposed Revisions to Outpatient High-Cost Drug Funding Policy

<https://docs.google.com/document/d/1VZOCwRnIaaPvRQsjJ39rGEpwTffh9wgX/edit>

³ Final Recommendation for Market Shift Refinement

<https://docs.google.com/document/d/1k8PbDWNNoE594AGLeBfVbLAIMtMXnB6ch/edit>

all in-state revenue and include Endocrinology Surgery, Ear Nose and Throat (ENT) Surgery, Gynecological Surgery, Ophthalmologic Surgery, Thoracic Surgery, Urological Surgery, and Ventilator Support.

While stakeholders generally acknowledged that excluding low-volume surgical service lines could improve market shift reliability, concerns regarding impact on reimbursement, TCOC savings target and access implications led to further evaluations by staff on whether or not to completely carve-out these service lines. Analyses conducted by staff revealed that while these service lines were characterized by low or declining volumes, they also experienced the most growth in acuity levels, hence, fewer but sicker patients seeking care in the most appropriate setting. Hospital-specific evaluations on volume variability for these service lines between FY 2023 and FY 2025 also showed relative stability and as such staff ruled out the decision to carve out these service lines entirely. However, some cases contained within these service lines could be eligible for carve-outs under AHEAD should they meet the expanded quaternary and tertiary care definitions/criteria.⁴

Figure 1. FY 2023 – 2025 Top Service line Volume and Acuity Growth

Site	Product Line	FY 23 CMI	FY24 CMI	FY25 CMI	FY23-FY25	FY23-FY25
					CMI Growth	ECMAD Growth
IP	Transplant Surgery	7.33	7.97	8.14	11%	11%
	Ophthalmologic Surg	1.48	1.34	1.54	5%	38%
	Urological Surgery	1.57	1.61	1.64	5%	-3%
	Endocrinology Surgery	1.22	1.23	1.27	4%	-53%
	Gynecological Surg	1.14	1.16	1.18	4%	-11%
	Spinal Surgery	2.31	2.40	2.38	3%	1%
	Vascular Surgery	2.70	2.76	2.78	3%	0%
	Infectious Disease	1.14	1.16	1.17	3%	16%

Restricted to product lines with Case Mix Growth (CMI) growth rates \geq the average growth rate of 3% and CMI \geq 1.00 between FY23 and FY24

Complex Tertiary and Quaternary Care Services

In CY 2020, Staff developed and the Commission approved the Complexity and Innovation Policy, which determined prospectively through a case-mix acuity and cell dominance approach, highly specialized care. Highly specialized care as defined by the policy includes unique and costly tertiary and/or quaternary services, such as organ transplants, that are typically performed at academic medical centers. To qualify for the policy, hospitals must exhibit a 95 percent cell dominance for procedures related to that service and the case must have a case-mix index of 1.5 or greater.⁵ Currently, about 2.7 percent of Maryland in-state, all-payer revenue is funded through the Complexity and Innovation Policy but funding is limited to the States Academic Medical Centers (AMCs).

Staff and Stakeholders believe that with the expanded maximum GBR carve-outs from 5 percent under TCOC to 15 percent under AHEAD, there is opportunity to revise the definitions of “highly specialized care” to capture more services previously defined as population-based though not well suited to fixed global budgets given their high cost, innovation-driven and volume variable nature. The Carve-out Policy will replace the current Complexity and Innovation policy and staff intention is to develop an approach that prioritizes highly complex, innovative quaternary and tertiary care typically occurring at academic medical

⁴ See figure 3 on definitions and criteria for identifying tertiary and quaternary care and Appendix 6 with the details

⁵ Final Recommendation for a Complexity and Innovation Policy <https://hsrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Innovation%20Policy%20v3%20%28002%29.pdf>

centers while recognizing that other complex care non-academic hospitals may provide services that are unique and costly and therefore expand the highly specialized care definition to include those hospitals.

Procedure Code Based Approach

Staff initially sought to leverage the Current Complexity and Innovation Policy framework to define highly specialized care meriting carve-out from population-based methodologies albeit without the nuances associated with the methodology such as cell dominance scenarios, and cost to charge conversions for supplies and drugs. Using the International Classification of Disease (ICD) procedure codes identified under the Current Complexity and Innovation Policy at 95 percent cell dominance and 1.5 CMI thresholds at AMCs, staff isolated procedure codes that meet this criteria statewide to identify eligible cases and carve-out magnitude. Then the cell dominance thresholds were lowered in decrements of 5 percent, stopping at 70 percent while CMI was increased by 0.1 stopping at 2.0 in each scenario, with the goal of increasing carve-out eligible volume statewide to a level that was reasonable while still prioritizing tertiary and quaternary care at the AMCs.⁶

Figure 2. FY 2025 Statewide Total Charges based on Adjusted Procedure Cell Dominance and CMI Thresholds

Total charges (in millions \$) (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	\$677	\$670	\$667	\$662	\$656	\$648	\$638
	90%	828	819	815	810	802	793	778
	85%	917	906	903	896	887	874	858
	80%	1,141	1,128	1,123	1,113	1,097	1,078	1,054
	75%	1,308	1,293	1,287	1,274	1,252	1,226	1,199
	70%	1,513	1,495	1,488	1,470	1,443	1,411	1,382

Charges as a % of total in-state revenue (AMC & Non-AMC)	CMI	1.4	1.5	1.6	1.7	1.8	1.9	2.0
Cell Dominance Threshold	95%	3.2%	3.2%	3.1%	3.1%	3.1%	3.1%	3.0%
	90%	3.9%	3.9%	3.8%	3.8%	3.8%	3.7%	3.7%
	85%	4.3%	4.3%	4.2%	4.2%	4.2%	4.1%	4.0%
	80%	5.4%	5.3%	5.3%	5.2%	5.2%	5.1%	5.0%
	75%	6.2%	6.1%	6.1%	6.0%	5.9%	5.8%	5.6%
	70%	7.1%	7.0%	7.0%	6.9%	6.8%	6.6%	6.5%

Staff believes that procedure codes are generally objective and do a better job at isolating specific, highly intensive services; however, they are more frequently subjected to changes making them unstable. Stakeholders argued that the ever-changing nature of procedure codes further complicated the current Complexity and Innovation policy subjecting it to more frequent updates and making it hard for hospitals to predict volumes and therefore they generally expressed a desire to move away from a procedure-based approach in favor of one using Diagnosis Related Groups (DRGs).

Medicare Severity Diagnosis Related Group (MS-DRG) Based Approach

Stakeholders expressed support for a simpler carve-out approach that has stable, clear definitions and enables modeling. Several recommended using a DRG based approach such as the Sg2's tertiary and quaternary DRG list to define eligible services. CMMI, while indicating a strong preference for using a transparent, non-proprietary approach, also indicated a strong preference towards an MS-DRG based approach for defining carve-out eligible services for reasons of payment simplicity.⁷ CMMI also stated that alignment on a list of carve-out services and not a methodology to arrive at an annual carve-out list

⁶ See appendix 1: Complex cases at AMC versus Non-AMCs using high end and low-end Procedure-based dominance thresholds

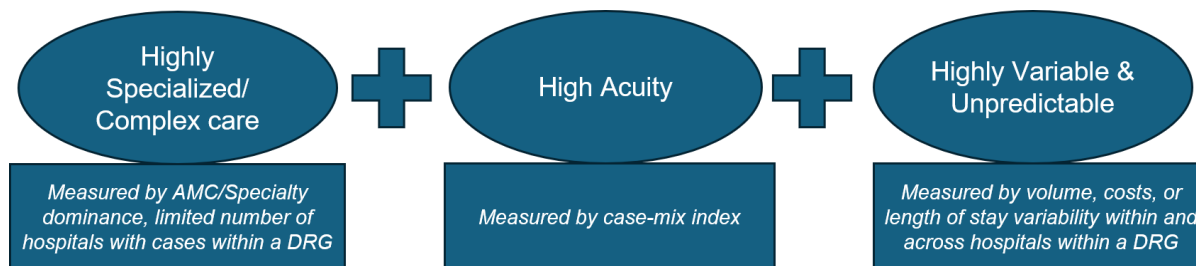
⁷ Due to the desire to align with CMMI this policy uses MS-DRGs and not APR-DRGs, that are used in most HSCRC policies. All references to DRGs should be assumed to reference MS-DRGs

was preferable. While staff believe that using DRGs erodes procedure specificity, for purposes of alignment, simplification and transparency, staff have pivoted to an MS-DRG based approach for defining eligible carve-out services.

Establishing a Definition of Highly specialized care for carve-out consideration

Highly specialized and complex care refers to advanced tertiary and quaternary services for rare or life-threatening conditions delivered at the highest levels of care, for this purpose, Staff have defined that specifically as tertiary and quaternary care at AMCs⁸ and tertiary care at Maryland Institute for Emergency Medical Services Systems (MIEMSS) and National Cancer Institute (NCI)-designated specialty centers.⁹

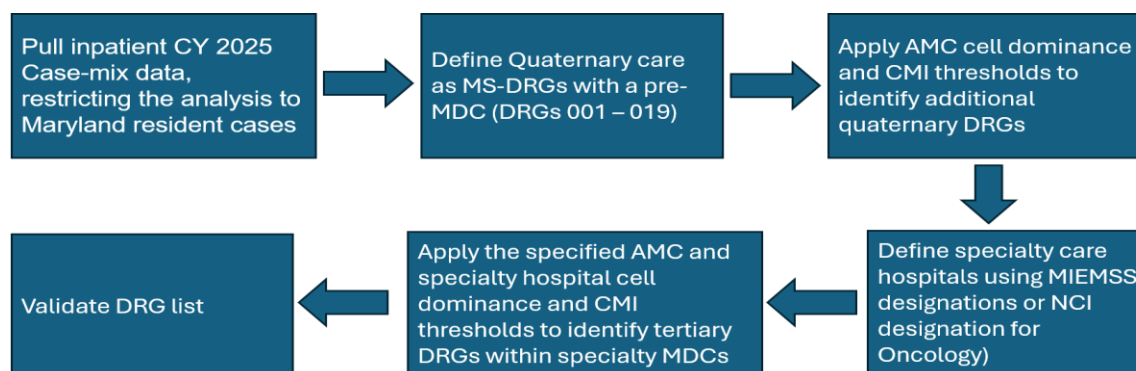
Cases considered for carve-out under this policy must meet all three of the following criteria:



It is important to note that high acuity does not necessarily always equate to highly specialized care. Highly acute and specialized care includes services often delivered at a limited number of specialty designated hospitals such as burn care, NICU and Trauma services. These services will be eligible for carveouts. On the other hand, highly acute but not specialized care includes cases with a high CMI but for which services have greater volume dispersion, such as cardiac services. While cardiac services are also highly acute there are 24 cardiac centers in the state and volumes are broadly distributed across all hospitals, indicating that they are relatively accessible rather than highly specialized. As such some of these services are less obviously suitable for carve-outs. Services prioritized for the carve-out should also be unpredictable or inconsistent in terms of cost, volume, length of stay, or care pathway. These types of cases are not ideal for a population-based methodology due to their variable nature and therefore would be identified as carve-out eligible.

Staff developed a formulaic approach, which is described in Figure 3, to identify potential carveouts and modeled two scenarios. Appendix 6 of this draft recommendation outlines the methodology in detail.

Figure 3. Formulaic DRG-Based Approach to Identify Highly Specialized Care¹⁰



⁸ A limited number of hospitals with advanced resources for treating highly complex cases

⁹ A limited number of hospitals with specialized programs and resources for treating highly complex cases within a given specialty such as trauma, NICU, cardiac specialty designations

¹⁰ Process relies on DRG and Major Diagnostic Categories (MDC) for analysis.

Scenario 1 - More restrictive

Included all “pre-MDC” categories (DRGs 1-19), quaternary and tertiary services at AMCs with a cell dominance of 50 percent and CMI of 2.5, Burn cases at a 90 percent cell dominance threshold and 1.5 CMI, Trauma at 50 percent cell dominance and a 2.5 CMI and NICU cases with a 60 percent cell dominance and 1.5 CMI. The pre-MDC DRGs were included because, by definition, they represent a set of highly specialized services. For the remaining categories thresholds were set based on the observed distribution of cases in that category in order to balance inclusion of high acuity services with the relative level of dispersion in that service area. In this model only the Burn, Neonatal Intensive Care Unit (NICU) and Trauma specialties were included as they are the only categories with MIEMSS designation which represent services delivered by only a few select hospitals. Using FY 2025 case-mix data this scenario rendered 48 DRGs amounting to 1.4 billion in total charges, the equivalent of 6.8 percent of in-state revenue of which 63% was delivered at AMCs (See Figure 4).

Figure 4. More Restrictive Scenario Results

Total carve out charges		% of In-state revenue*		Number of DRGs			
\$ 1.4B		6.8%		48			
% AMC Contribution to Carve out charges		% Specialty Hosp Contribution to Carve out charges		% Other Hosp Contribution to Carve out charges			
63%		17%		20%			

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	-	90%	90%	50%	60%	-
CMI	-	2.5	-	1.5	1.5	2.5	1.5	-
Charges in \$M	\$654.5	\$190.2	-	-	\$15.4	\$ 331.1	\$240.5	-

Scenario 2 - Less Restrictive with Clinical Edits

Realizing that there are some areas of highly specialized care are not captured by the more restrictive scenario, staff revised scenario 1 to incorporate cardiology cases at 90 percent cell dominance and 2.5 CMI and oncology cases at 60 percent cell dominance with 1.5 CMI. Using FY 2025 case-mix data, this scenario renders an additional 18 DRGs bringing the total DRGs eligible for carve-outs to 78. This scenario expands and provides more comprehensive coverage of specialized clinical areas statewide while still prioritizing services performed at AMCs resulting in only a slight decrease in concentration when compared to scenario 1. Therefore, Staff used the list generated by Scenario 2 as a starting point for further clinical review and refinement.

Initial clinical evaluations flagged DRGs related to cardiac valves for removal from the carve-out lists given the high level of dispersion across hospitals. However, hospital stakeholders have argued for their re-statement given that high clinical acuity and specialization. Staff have re-instated the DRGs related to cardiac valves identified by the methodology to the carve-out list but will monitor on an annual basis as potential advances in technology and dispersion could warrant removal in the future.

Spinal fusion DRGs, cardiac defibrillator DRGs, AICD and certain cardiac device implant DRGs that made the list based on the methodology were later determined based on clinical review as not carve-out eligible. These DRGs were deemed as “standard of care” and not highly specialized given the level of dispersion across hospitals despite their high levels of acuity.¹¹ These DRGs were subsequently manually removed from the staff proposed carve-out list, reducing the list to 66 DRGs. These 66 DRGs that constitute the proposed carve-out list are shown in Appendix 2.

Statewide, cases attributed to these 66 DRGs equal about \$1.9 billion in total charges, equivalent to 9.4 percent of total in-state revenue. This list prioritizes highly specialized care performed at AMCs (58 percent of total charges), tertiary services performed at specialty hospitals (28 percent of total charges) and tertiary services at other community hospitals (14 percent of total charges) (See Figure 5)

Staff remains open to further assessments and discussion on specific DRGs, especially NICU DRGs, tracheostomy DRGs and a handful of DRGs that meet the trauma inclusion criteria but might not reflect highly specialized care due to relatively wide dispersion. NICU also presents a challenge due to the relatively crude categorization available in MD-DRGs.¹²

Figure 5. Less Restrictive Scenario Results with Clinical Edits

Total carve out charges		% of In-state revenue*		Number of DRGs			
\$ 1.9B		9.4%		66			
% AMC Contribution to Carve out charges		% Specialty Hosp Contribution to Carve out charges		% Other Hosp Contribution to Carve out charges			
58%		28%		14%			

Categories	Quaternary		Tertiary					
	Pre-MDC (DRGs 1-19)	AMC Dominance	Cardiac	Stroke	Burn	Trauma	NICU	Oncology
Cell Dominance	-	50%	90%	90%	90%	50%	60%	60%
CMI	-	2.5	2.5	1.5	1.5	2.5	1.5	1.5
Charges in \$M	\$654.5	\$96.5	\$568.1	-	\$15.4	\$319.3	\$240.5	\$66.5

The staff methodology did not include specific specialty designations for other service lines such as orthopedics or neurology, as Maryland does not issue standalone specialty hospital licenses for those services. Hospitals specialty status for these programs is typically designated through hospital accreditation, clinical ratings and the presence of a state-sanctioned Trauma Center. The staff methodology includes MIEMSS designated Trauma Centers which captures DRGs that are highly specialized pertaining to these service lines.

Funding and Implementation

Staff recommend that all in-state cases with DRG assignments on the DRG Carve-out list, regardless of whether they are seen at an AMC, specialty or community hospital, be removed from all eligible volume

¹¹ See Appendix 4: DRGs that Made Carve-out List but were Removed Upon Clinical Review

¹² See Appendix 5: DRGs on Carve-outs List but are flagged for Further Investigation

methodologies and instead be funded at a 100 percent variable cost factor (VCF) to prevent any duplicate funding.¹³ As such, hospitals will be held 100 percent liable for changing volumes associated with these cases. Funding for all other cases, not eligible for carve-outs, will maintain the respective inpatient medical and surgical service line VCFs. The Carve-out Policy will replace the current Complexity and Innovation Policy therefore, any prospective adjustments relevant to that policy will be reversed once the carve-out policy is approved and in effect; retrospective adjustments for FY 2025 and 2026 will be made. Staff will continue to include carve-out eligible volumes in the various quality pay for performance programs and the PAU Redistribution Policy.

Effective July 1, 2026, the Commission will begin using the Carve-out service DRG list to remove from Maryland FY 2027 Global Budgets all cases with DRGs identified on the list. Hospital baselines will be set using Calendar Year (CY) 2025 performance inflated to FY 2027. However, due to the volatile nature of highly specialized and complex services, hospitals with small volumes will have their baseline assessed using a three-year average. At such a time when CMMI has a final carve-out list, staff will seek to align its list with the CMMI list no later than January 1, 2028. Staff have reviewed a preliminary list from CMMI and believe Maryland is aligned generally, although the specific list will still require reconciliation.

Additional Considerations

Hospital-level data

Staff are working to quantify the magnitude of volumes eligible for carve-outs at the hospital-specific level. Staff are aware that volumes eligible for carve-out will vary across hospital types, so it is important to set base line volumes at the hospital specific level that are appropriate and reflect true hospital activity. Year over year hospital performance will be measured against the baseline to determine hospital carve-out growth or decline. For hospitals with significantly low volumes in the CY 2025 base year, Staff recommends using a blended CY 2023 – CY 2025 average to establish the base. The threshold for volumes deemed as “significantly low” will be determined by the amount of hospital-specific volume dispersion from the statewide average. Staff plans to distribute hospital-specific carve-out volume details to hospitals shortly after the release of this draft recommendation.

Outpatient Cosmetic Surgery Exemption

HSCRC has long permitted hospitals, who meet the requirements of the program, to provide discounts below approved rates for some cosmetic surgeries. For the most recently reported four quarters statewide charges under this program were \$1.3 million or approximately 0.01% of statewide regulated revenue across 5 hospitals (payments were significantly less since discounts are provided). In response to stakeholder advocacy and to allow greater flexibility, Staff recommend revenues charged in compliance with this program also be carved out of the global budget. Given the minimal revenue involved, no global budget adjustments will be made for this carve out, however, staff agree that these revenues will no longer impact year end GBR compliance.

Monitoring and Updating of Carved Out Services

The list proposed in this recommendation will be used for carve-outs in FY 2027 and may be modified for future periods as follows:

¹³ Volume methodologies including but not limited to Market Shift Adjustment, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation

1. **CMMI List:** Staff will work with CMMI on the carve out list under their Hospital Global Budgets and where possible update the Maryland list to match the final CMMI list in CY 2028.
2. **Adding DRGs:** Staff will annually review DRG updates to consider if new DRGs should be added to the carve out list
3. **Removing DRGs:** Staff will annually review utilization of DRGs on the carve-out lists and consider removing DRGs which have diffused across a majority of hospitals and that may no longer qualify as specialized. At the time the changes are made, charges will be added back to the global budget for dropped DRGs based on recent utilization levels. Such adjustment will only be made once diffusion is believed to be complete to avoid locking into the global budget utilization patterns that do not reflect the end state of diffusion.
4. **Program Monitoring:** Staff will monitor utilization across carved out DRGs to ensure there are not unintended consequences opposed to the goals of the carve out, the HSCRCs regulatory mandate or the AHEAD model and make changes should unintended consequences be noted.
5. **AHEAD Carve-out Limit:** Staff will monitor overall utilization to ensure compliance with the carve-out limit under the AHEAD model and consider changes to ensure the most appropriate use of the carve out should the State be close to the 15 percent cap.

Any changes contemplated under the bullets above will be shared with the relevant HSCRC workgroups. Material changes under any of these provisions will be subject to Commission approval.

Recommendations

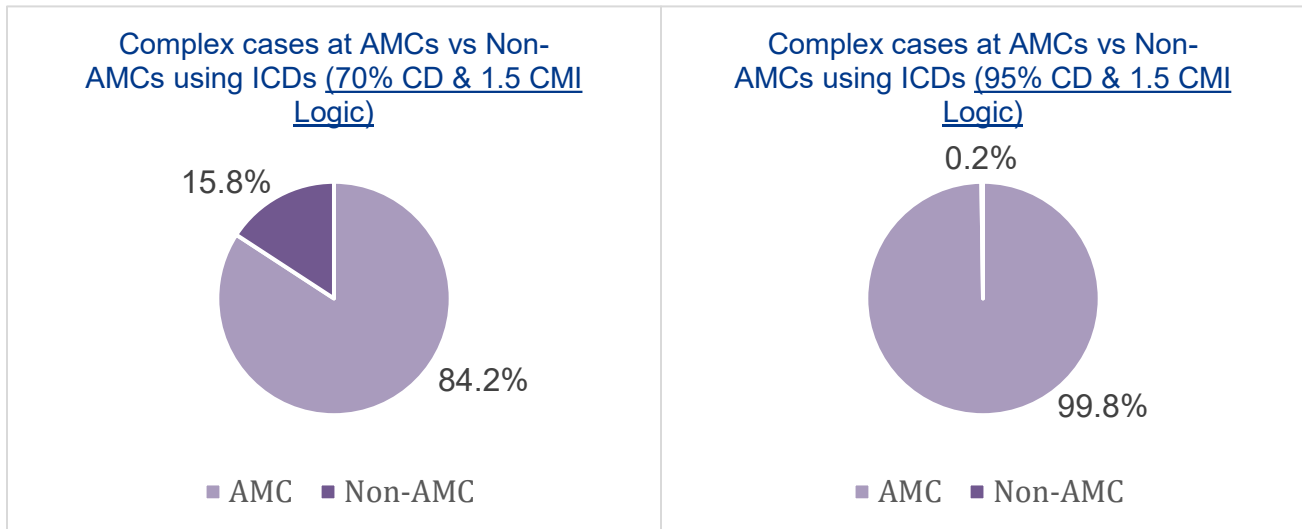
Based upon the analyses and validations performed by staff, staff is proposing the following recommendations

1. Staff propose the adoption of the less restrictive list effective July 1, 2026, which carves out approximately 9.4 percent of statewide revenue associated with highly specialized care from population-based methodologies
 - Proposed carve-out list prioritizes highly specialized tertiary and quaternary care performed at AMCs (58 percent), with expansions to include certain tertiary services also performed at non-AMCs (41 percent)
 - The list could be updated effective January 1, 2028, based on desired alignment with a final CMMI list
2. Staff propose the use of CY 2025 charges, inflated to FY 2027, as the baseline for carve-out eligible volume which would be removed from global budgets. The baseline for lower volume hospitals should be based on a three-year average
3. Staff propose that all volumes eligible for carve-outs under this policy are funded at 100 percent variable costs and hospitals are held 100 percent liable for volatility
4. All prospective adjustments in FY 2027 rates relevant to the current Complexity and Innovation Policy will be reversed upon a Carve-out Policy approval, retrospective adjustments for FY 2025 and FY 2026 will be made
5. Staff propose the removal of all carve-out cases from all other volume methodologies including the Market Shift, Demographic Adjustment, Surge Funding, Deregulation, and Repatriation/Expatriation.

- a. Continue including carve-out eligible cases in the quality pay-for-performance and PAU Redistribution assessments
6. Staff propose to review the list annually (1) for potential additions and subtractions and (2) to understand the impact of the policy. Material changes will be brought to the Commission for approval
7. Volumes eligible under the existing Outpatient Cosmetic Surgery program will also be carved out effective July 1, 2027

Appendices

Appendix 1: Complex Cases at AMC versus Non-AMCs Using High End and Low-End Procedure-Based Dominance Thresholds



Appendix 2: Staff Proposed DRG Carve-outs List

HSCRC Proposed Carveouts list	
MSDRG	Description
1	Heart Transplant or Implant of Heart Assist System with MCC
2	Heart Transplant or Implant of Heart Assist System without MCC
3	ECMO or Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
5	Liver Transplant with MCC or Intestinal Transplant
6	Liver Transplant without MCC
7	Lung Transplant
8	Simultaneous Pancreas and Kidney Transplant
10	Pancreas Transplant
11	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with MCC
12	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy with CC
13	Tracheostomy for Face, Mouth and Neck Diagnoses or Laryngectomy without CC/MCC
14	Allogeneic Bone Marrow Transplant
16	Autologous Bone Marrow Transplant with CC/MCC
17	Autologous Bone Marrow Transplant without CC/MCC
18	Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies
19	Simultaneous Pancreas and Kidney Transplant with Hemodialysis
20	Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC
23	Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator
25	Craniotomy and Endovascular Intracranial Procedures with MCC
28	Spinal Procedures with MCC
29	Spinal Procedures with CC or Spinal Neurostimulators
31	Ventricular Shunt Procedures with MCC
140	Major Head and Neck Procedures with MCC
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC
212	Concomitant Aortic and Mitral Valve Procedures
215	Other Heart Assist System Implant
216	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC
217	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with CC
218	Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization without CC/MCC
219	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC

220	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with CC
221	Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization without CC/MCC
228	Other Cardiothoracic Procedures with MCC
231	Coronary Bypass with PTCA with MCC
232	Coronary Bypass with PTCA without MCC
233	Coronary Bypass with Cardiac Catheterization or Open Ablation with MCC
234	Coronary Bypass with Cardiac Catheterization or Open Ablation without MCC
235	Coronary Bypass without Cardiac Catheterization with MCC
236	Coronary Bypass without Cardiac Catheterization without MCC
266	Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC
267	Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC
268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
270	Other Major Cardiovascular Procedures with MCC
319	Other Endovascular Cardiac Valve Procedures with MCC
405	Pancreas, Liver and Shunt Procedures with MCC
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
650	Kidney Transplant with Hemodialysis with MCC
651	Kidney Transplant with Hemodialysis without MCC
652	Kidney Transplant
653	Major Bladder Procedures with MCC
789	Neonates, Died or Transferred to Another Acute Care Facility
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate
829	Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with CC/MCC
834	Acute Leukemia with MCC
837	Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC
838	Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent
846	Chemotherapy without Acute Leukemia as Secondary Diagnosis with MCC
927	Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft
928	Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
955	Craniotomy for Multiple Significant Trauma
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC

Appendix 3: Specialty Hospital Designations

HOSPID	Hospital Name	Cardiac	Stroke	NICU	Burns	Trauma
210029	Bayview Medical Center (JHM)	Y	Y	Y	Y	Y
210003	Capital Region Medical Center (UM)	Y		Y		Y
210012	Sinai Hospital of Baltimore (LifeBridge)	Y	Y	Y		Y
210022	Suburban Hospital (JHM)	Y	Y			Y
210001	Meritus Medical Center	Y				Y
210019	Peninsula Regional Medical Center (TidalHealth)	Y				Y
210027	Western Maryland (UPMC)	Y				Y
210024	Union Memorial Hospital (MedStar)	Y				
210023	Anne Arundel Medical Center (Luminis)	Y		Y		
210005	Frederick Health Hospital	Y		Y		
210044	Greater Baltimore Medical Center			Y		
210004	Holy Cross Hospital - Silver Spring	Y		Y		
210048	Howard County Medical Center (JHM)	Y		Y		
210008	Mercy Medical Center			Y		
210011	Saint Agnes Health (Ascension)	Y		Y		
210063	Saint Joseph Medical Center (UM)	Y		Y		
210057	Shady Grove Medical Center (Adventist HealthCare)	Y	Y	Y		
210015	Franklin Square Medical Center (MedStar)	Y	Y	Y		
210043	Baltimore Washington Medical Center (UM)	Y				
210033	Carroll Hospital (LifeBridge)	Y				
210037	Shore Medical Center at Easton (UM)	Y				
210062	Southern Maryland Medical Center (MedStar)	Y				
210049	Upper Chesapeake Medical Center (UM)	Y				
210016	White Oak Medical Center (Adventist HealthCare)	Y				

Note: Stroke only looked considered Thrombectomy and Comprehensive stroke centers

Appendix 4: DRGs that Made Carve-out List but were Removed Upon Clinical Review

MS-DRG	Description
226	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC
227	Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
245	AICD Generator Procedures
258	Cardiac Pacemaker Device Replacement with MCC
275	Cardiac Defibrillator Implant with Cardiac Catheterization and MCC
276	Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator
277	Cardiac Defibrillator Implant without MCC
456	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with MCC
457	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions with CC
458	Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, Infection or Extensive Fusions without CC/MCC
459	Spinal Fusion Except Cervical with MCC
471	Cervical Spinal Fusion with MCC

Appendix 5: DRGs on Carve-outs List but are flagged for Further Investigation

MS-DRG	Description
4	Tracheostomy with MV >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R. Procedures
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC
653	Major Bladder Procedures with MCC
789	Neonates, Died or Transferred to Another Acute Care Facility
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate

Appendix 6: Methodology

Using FY 2025 Case-mix data, staff methodology to quantify highly specialized care eligible for carve-outs include a 5-step process

1. Define Quaternary care as MS-DRGs with a pre-Major Diagnostic Category (MDC) (DRGs 1 – 19)

Pre-MDC DRGs are specialized procedure-driven hospital cases that are categorized strictly by high-cost, high-resource surgical procedures regardless of the principal diagnosis, such as organ transplants or tracheostomies. The pre-MDC category typically includes DRGs 001 through 019 and because they require the highest level of specialization, are typically handled by major academic medical centers.

2. Apply AMC cell dominance and CMI thresholds to identify additional quaternary DRGs

After scoring DRGs 1-19 as quaternary, staff further quantifies quaternary services at AMCs by isolating cases where AMC volumes combined make up the larger share of statewide activity, greater than 50 percent of statewide volumes, and with a case-mix index of 2.5 or greater.

3. Define specialty care using Maryland Institute for Emergency Management Services Systems (MIEMSS) designations (National Cancer Institute (NCI) designation for Oncology)

To define tertiary services eligible for carve-outs, staff used MIEMSS trauma and specialty center designations to identify Maryland hospitals that are officially verified and equipped to handle specific, life-threatening medical emergencies. The MIEMSS specialty and referral center designations used in the staff approach include adult and pediatric trauma centers, comprehensive stroke and thrombectomy centers only, cardiac interventional centers, adult and pediatric burn centers and Level III and IV perinatal and neonatal intensive care units.¹⁴¹⁵ Staff used NCI designations to identify tertiary oncology services.¹⁶

4. Apply AMC and specialty hospital cell dominance and CMI thresholds to identify tertiary DRGs within specialty MDCs

After defining tertiary hospitals, staff determined specialty DRGs by way of MDCs assigned to the specific service. Staff quantified tertiary services at AMCs and specialty hospitals by isolating cases where AMC and specialty volumes combined made up a larger share of statewide activity within the MDC's DRG listing. Recognizing that DRG distributions and associated costs and technology vary within services, staff varied the cell dominance and CMI thresholds for the various specialty services.¹⁷

5. Validate DRG list

The final step involved performing various validations to further refine the staff list. These include:

- a) **Threshold calibration:** Staff recognized that the cell dominance and CMI thresholds will need to vary across specialty services based on DRG volume distributions and level of specialty service dispersion. For example, in Maryland, cardiology has 24 specialty designated hospitals while oncology only has two. Also, DRGs assigned to the cardiology

¹⁴ Maryland Institute for Emergency Medical Services Systems (MIEMSS) <https://www.miemss.org/home/hospitals/specialty-referral-centers>

¹⁵ See appendix 3: Specialty Hospital Designations

¹⁶ National Cancer Institute (NCI) <https://www.cancer.gov/research/infrastructure/cancer-centers/find>

¹⁷ See Figure 6: Less Restrictive scenario results with Clinical edits. For the various cell dominance and CMI thresholds per specialty

MDC in FY 2025 make up about 58,000 statewide volumes while oncology equates to about 3,700.

- b) **Severity hierarchy validations:** Staff reviewed “With Complication or Comorbidity” DRGs (CC) and “With Major Complication or Comorbidity” (MCC) DRG hierarchies to ensure consistent application within DRG families. When a CC DRG met the carve-out thresholds for highly specialized and complex services while the corresponding MCC DRG did not, the corresponding MCC variants were manually included in the carve-out list to maintain alignment across the DRG family. However, in instances where the MCC made the carve-out list while the CC did not, no change was made. We assume in such an instance that the methodology appropriately isolates the more highly specialized and acute service for carve-out. This is a change from the previous approach to remove from the list DRG families in instances where a lesser complication DRG made the list while a more complicated one did not.
- c) **Exclusion review:** Staff also reviewed and excluded from its list, few select medical DRGs pertaining to rehabilitation and psychiatry that met the various cell dominance and CMI threshold criteria to classify as highly specialized care.
- d) **Clinical Validation:** Staff had the list of identified DRGs reviewed by clinical experts who found the Staff approach to be directionally sound and analytically rigorous. Various DRGs were flagged for removal from the carve-out lists, while a few others were flagged for further review.¹⁸
- e) **Year over Year validation:** Staff performed longitudinal analyses to validate consistency of the DRG list over time. The majority of DRGs identified as highly specialized remained relatively consistent between FY 2023 and FY 2025 with fewer than 10 DRGs newly classified as highly specialized under the same criteria.
- f) **Comparisons to other stakeholder developed carve-out lists:** The staff list was compared against other stakeholder-developed lists including Sg2 and another developed by a hospital system to which there was significant overlap. The staff list also includes NICU DRGs which the other lists do not include.

¹⁸ See Appendix 4 and 5



TO: HSCRC Commissioners

FROM: HSCRC Staff
DATE: June 10, 2026
RE: Hearing and Meeting Schedule

Joshua Sharfstein, MD
Chairman

James N. Elliott, MD
Vice-Chairman

Jonathan Blum, MPP

Ricardo R. Johnson

David N. Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD

July 22, 2026 UPDATE: The meeting originally scheduled for July 8, 2026 is rescheduled to Wednesday, July 22, 2026.

In person at HSCRC office and Zoom webinar

August 2026 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.

Jonathan Kromm, PhD
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity