



640th Meeting of the Health Services Cost Review Commission

March 11, 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 February, 2025

Informational Session

1. Tools for identifying and addressing preventable illness and utilization in Maryland

Specific Matters

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

Docket Status – Cases Closed

2687A Johns Hopkins Health System

2688A Johns Hopkins Health System

2. **Docket Status – Cases Open**

2689N Luminis Health Doctors Community Medical Center

2690A Johns Hopkins Health System

2691A Johns Hopkins Health System

2692A Johns Hopkins Health System

2693A Johns Hopkins Health System

2694A Johns Hopkins Health System

2666A University of Maryland Medical Center- Second Extension Request

2667A University of Maryland Medical Center- Second Extension Request

3. Adventist HealthCare Germantown Emergency Center Action

Subjects of General Applicability

4. Report from the Executive Director
 - a. Model Monitoring
 - b. Policy Calendar Update
 - c. Health System Transformation Update
 - d. Legislative Report
5. Presentation: FY 2025 Clinician Cost Schedule Results
6. Draft Recommendation: Healthcare Outcome Payment Effort
7. Final Recommendation: Readmissions Reduction Incentive Program (RRIP) - FY 2028 Policy
8. Final Recommendation: Medicare Performance Adjustment (MPA)
9. *Materials Only* - Hospital Community Benefit Activities - FY 2024 Report
10. Hearing and Meeting Schedule

**MINUTES OF THE
639th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
FEBRUARY 11, 2026**

Chairman Joshua Sharfstein, M.D. called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Vice Chairman James Elliott, M.D., Jon Blum, M.P.P., David Maine, M.D., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner McCann and seconded by Commissioner Blum, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:05 p.m.

REPORT OF FEBRUARY 11, 2026, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the February 11, 2026, Closed Session.

**ITEM I
REVIEW OF THE MINUTES FROM JANUARY 14, 2026, PUBLIC
MEETING AND CLOSED SESSION**

Commissioner McCann moved to amend the January minutes to clarify that she and Commissioner Maine recused themselves from the January discussion and vote regarding the Medicare Advantage portion only of the Governor's December 2025 Directive. Commissioner McCann noted that both she and Commissioner Maine participated in the discussion on the commercial payer reimbursement portion of the Directive. Commissioner McCann's motion to amend the January minutes accordingly was approved unanimously.

Subsequently, upon motion made by Commissioner Johnson and seconded by Commissioner McCann, the Commission voted unanimously to approve the January 14, 2026, Public and Closed Session minutes (as amended) and to unseal the Closed Session minutes.

**ITEM II
CLOSED CASES**

- 2685A Johns Hopkins Health System
- 2686A Johns Hopkins Health System-WITHDRAWN

**ITEM III
OPEN CASE**

- 2687A Johns Hopkins Health System
- 2688A Johns Hopkins Health System
- 2689N Luminis Health Doctors Community Medical Center

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

Jonathan Kromm, PhD
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

2690A Johns Hopkins Health System
2691A Johns Hopkins Health System
2682A Johns Hopkins Health System
2693A Johns Hopkins Health System

ITEM IV
PRESENTATION: COMMUNITY HEALTH RESOURCES COMMISSION (CHRC)

Dr. Destiny-Simone Ramjoh, Chair, Community Health Resources Commission (CHRC), Mr. Mark Luckner, Executive Director, CHRC; Mr. Martin Raffell, Director of Continuing Care Services, Data, and Analytics, Greater Baltimore Medical Center (GBMC); Ms. Karen Thompkins, Director of Community Partnerships, GBMC; Mr. David Lehr, Commissioner, CHRC; Mr. Paari Gopalakrishnan, President and CEO, GBMC; and Catherine Hamel, President, Gilchrist, presented *A Statewide Approach to Community Health & Cost Control: The Power of Partnerships* (see “A Statewide Approach to Community Health & Cost Control: The Power of Partnerships” available on the HSCRC website).

Dr. Ramjohn acknowledged the historical context of the Commission that dates back to the Community Health Care Access and Safety Net Act of 2005. Dr. Ramjohn explained that while the initial charge of expanding access in underserved areas and reducing avoidable ER visits was bold for its time, it has since blossomed into a sophisticated, statewide public investment infrastructure. She highlighted the unique operational characteristics and the extensive reach of the Commission. The CHRC functions as a performance-based platform, utilizing milestone disbursements and structured monitoring to ensure accountability and successful outcomes. By fostering collaboration between hospitals, community organizations, and local health departments, the Commission has successfully established a presence in every Maryland jurisdiction. Notably, its impact is felt deeply in the education system, reaching 86 percent of Maryland schools and serving over 136,000 young people through school-based health centers.

Mr. Luckner emphasized the system-level impact of the Commission’s grant-making strategy, highlighting a remarkable 75 percent sustainability rate for awarded projects. Additionally, the Commission has been able to leverage public funding to secure additional investment, obtaining \$60 million in supplemental funding, primarily from private and local sources. He views this as a testament to the credibility and trust the Commission has built with its partners. By holding grantees accountable for these financial milestones, the Commission ensures that public dollars act as a catalyst for broader community investment and long-term financial viability.

Mr. Luckner highlighted the success of the Maryland Health Equity Resource Act, a seven-year, \$60 million initiative. Supported by rigorous data analytics, the program’s first two years saw over 11,000 patients served and significant reductions in hospital utilization: a 20 percent drop in inpatient visits, a 14 percent decrease in emergency department visits, and a 26 percent reduction in readmissions. As the program enters its second phase, he remains confident that this momentum will continue to drive down avoidable hospital usage and improve health outcomes across the state’s 12 designated zones.

Ms. Thompkins shared the story of the success of GBMC's partnership with the CHRC, specifically highlighting the transition from a two-year Pathways Grant that concluded in 2024 to their current status as a Health Equity Resource Community (HERC) grantee. Under the initial grant, the program successfully enrolled 1,500 people into primary care services. Based out of the Jonestown practice in Baltimore City, the initiative also includes a specialized in-home component managed by Gilchrist Geriatric Medical Care, designed specifically to support frail seniors who may otherwise struggle to access traditional clinical settings. Ms. Thompkins notes that 57 percent of their patients have at least one identified social driver of health need, and are also managing chronic conditions such as diabetes, hypertension, and obesity. A critical element of this success is the collaboration with funded community partners, such as the BIT Center, which provides fresh produce, food education, and cooking demonstrations for food-insecure patients. These partners serve as trusted advisors and are essential for community outreach and engagement. By organizing local events and addressing immediate social needs like nutrition, these partners create the necessary trust and infrastructure to bridge the gap between residents in need and the primary care system.

Mr. Martin Raffel noted that electronic medical record (EMR) data and data from CRISP (the state's health information exchange) has been instrumental in tracking the success of the organization's initiatives on chronic condition outcomes. Through both the Pathways and HERC grants, the program has documented significant increases in the number of patients successfully controlling hypertension and diabetes. Mr. Raffel reported that the organization also achieved significant reductions in inpatient admissions, emergency department utilization, and total healthcare costs. Additionally, the program's community engagement has been extensive, with the team leading or participating in 98 events that reached over 4,300 participants, consistently exceeding their initial outreach goals. These metrics provide a clear indication that the program is successfully shifting care away from expensive hospital settings and toward more sustainable community-based primary care.

Commissioner Blum asked for an assessment of how effectively Maryland's various governing bodies are coordinated toward a single focus and how well the Commission's current initiatives align with the work being done in other parts of the state government. Commissioner Lehr explained that most CHRC grants target non-hospital entities like Federally Qualified Health Centers (FQHCs) and community organizations to address social determinants of health and school-based mental health. While these grants focus outside the traditional medical profession, the Commission coordinates with health systems by funding innovative pilots that serve as statewide models. A core requirement for these projects is a long-term sustainability plan to ensure they continue after the grant funding ends. Ultimately, the commission's goal is to seed self-sustaining programs that can be scaled across the state.

Chairman Sharfstein asked whether current reimbursement levels are sufficient to make successful, results-driven grants fully sustainable in the long term and how the Commission can partner with these programs to ensure they continue once initial funding ends. Dr. Gopalakrishnan explained that while the Jonestown practice has successfully reduced inpatient and emergency room utilization, the program would have been nearly impossible to implement

without the initial grant. He admitted that once the grant ends, the practice will struggle to sustain these operations without additional funding, as the current reimbursement structure does not fully cover the costs of these community-based improvements. Chairman Sharfstein acknowledged this reality, noting that the goal of the discussion is to find ways to make such promising innovations truly sustainable within the state's financial model.

No action was taken on these agenda items.

ITEM V

FINAL RECOMMENDATION: REQUEST TO ACCESS HSCRC CONFIDENTIAL PATIENT LEVEL DATA FROM JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Ms. Hannah Thurner, Analyst, Healthcare Data Management and Integrity, presented the staff's Final Recommendation: Request to Access HSCRC Confidential Patient Level Data from John's Hopkins Bloomberg School of Public Health (see "Final Recommendation: Request to Access HSCRC Confidential Patient Level Data from John's Hopkins Bloomberg School of Public Health" available on the HSCRC website).

Chairman Sharfstein recused himself from the discussion and subsequent vote; Vice Chairman Elliott presided over this portion of the meeting.

Ms. Hannah Thurner presented the staff's Final Recommendation regarding a confidential data request from the Johns Hopkins University Bloomberg School of Public Health (JHU). The university is seeking access to statewide inpatient and outpatient hospital discharge data to evaluate the Baltimore Young Family Success Fund. By linking this data with the Maryland Medical Care Database, researchers intend to determine if guaranteed income programs effectively improve health equity, specifically concerning adolescent health, addiction, and violence.

The study aims to track several key indicators among consenting participants, including mental and behavioral health service utilization, insurance stability, and medication access. To ensure ethical compliance and data security, the project has already secured approval from the Maryland Department of Health Institutional Review Board and the Strategic Initiative Office. The HSCRC Confidential Data Review Committee has also reviewed the request and recommends approval, provided the research team adheres to strict confidentiality protocols and uses de-identified data sets managed in collaboration with CRISP.

As a condition of this approval, Johns Hopkins must provide annual progress reports and submit a final report to the HSCRC for review prior to any public release. The university is prohibited from identifying individual patients and must destroy the data by September 30, 2026, submitting a formal certification of destruction to the Commission at that time.

Ms. Thurner presented the staff's Final Recommendation for the request to access HSCRC confidential data from JHU as follows:

1. The request by Johns Hopkins Bloomberg School of Public Health for the aforementioned data related to Calendar Year 2022 be approved.
2. Access will include limited confidential information for subjects meeting the criteria for the research.

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

ITEM VI **REPORT FROM THE EXECUTIVE DIRECTOR**

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through October 2025 (for claims paid through December 2025). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is .82 percent above the nation through October 2025, and that Maryland Medicare hospital and non-hospital growth through October resulted in savings of \$87 million.

Policy Calendar Update

Dr. Jon Kromm, Executive Director, provided an update on the HSCRC policy calendar, noting that while several items have been completed, the upcoming months will be particularly intensive with a high volume of draft recommendations and workgroup engagements. He confirmed that the current schedule is on track, following some strategic adjustments made in the previous month to shift certain timelines. A major upcoming milestone is the Care Innovation Draft Recommendation, scheduled for March, which aligns with the Commission's ongoing focus on transformative care models.

A significant portion of the update focused on the Update Factor workstream, which is now kicking off and will incorporate critical analysis regarding Uncompensated Care. In collaboration with Medicaid, the staff is currently conducting an eligibility-group analysis to understand potential impacts. This comprehensive financial and policy review will serve as the primary vehicle for future proposals and ideas related to hospital payment adjustments.

Dr. Kromm touched on the multi-agency efforts and the implementation of the AHEAD model. He reported that work on the All-Payer Total Cost of Care Growth and Primary Care Investment

Targets is currently on track, with a significant amount of work slated before the end of the year. Other long-term requirements, such as those regarding the Choice and Competition Policy, have not yet begun in earnest as the state has sufficient time to address those selections. Overall, the Commission remains positioned to meet its priority deadlines despite the heavy workload ahead.

Inpatient Length of Stay (LOS)

Dr. Kromm addressed the growing challenge of inpatient length of stay (LOS), explaining that while admission volumes in Maryland have decreased, increasing LOS is eroding those gains and straining the state's functional inpatient capacity. He noted that unlike the national DRG model, which provides a singular focus on reducing LOS, Maryland's global budget system offers a more generalized incentive that varies based on a hospital's specific volume status. This lack of a singular focus has led to a situation where stagnant or rising LOS is making global budgets less financially sustainable and directly contributing to emergency department (ED) boarding, which consequently creates bottlenecks across the entire care system.

A critical finding in the staff's analytic work is the persistent variance in performance across different hospitals. Dr. Kromm acknowledged that while structural barriers such as the difficulty of discharging patients to post-acute care settings are a significant statewide issue, they do not explain the full scope of the disparities. Even when controlling for geography, payer mix, and clinical acuity, significant hospital-level variance remains. This suggests that internal hospital processes and efficiencies, rather than external factors alone, play a major role in how long a patient remains in an inpatient bed.

Moving forward, the staff aims to develop a targeted policy to incentivize LOS reductions, thereby separating this work from previous surge policies. Dr. Kromm noted that while breaking data down to specific procedure codes might introduce statistical noise, looking at the observed versus expected outcomes reveals systemic hospital-level differences. The goal of this early-stage policy development is to identify the most effective leverage points to improve throughput, reduce ED wait times, and ensure the long-term stability of the Maryland healthcare model.

Mr. Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling, clarified the technical methodology behind the Commission's LOS analysis, noting that most adjustments utilize the Solventum™ All Patient Refined Diagnosis Related Groups (APR DRG) System. This framework allows the team to account for complexity by combining data on diagnoses, procedures, and the severity of illness. His findings indicate a notable expansion in inpatient length of stay even within specific inpatient-only procedure groups over time. While the team has not yet teased out this specific data on a hospital-by-hospital basis, Mr. Dougherty expressed confidence that the general upward trend in LOS would be consistent across most facilities.

Mr. Dougherty addressed the possibility of seasonality and acknowledged that the team has not yet specifically analyzed whether LOS fluctuates from quarter to quarter or spikes toward the end of the fiscal year. However, he committed to investigating these time-based variables as

part of the ongoing analytic work to determine if external calendar factors or fiscal cycles influence hospital discharge behavior.

Dr. Kromm illustrated that the increase in inpatient LOS is not a localized issue but a systemic trend. He presented data showing that while the state has successfully reduced preventable admissions, the time patients spend in the hospital once admitted has climbed steadily. This length of stay creep effectively neutralizes the financial and capacity benefits of having fewer admissions. He warned that if this trend continues, the physical capacity of Maryland hospitals will remain artificially constrained, leading to continued bottlenecks in emergency departments and higher overhead costs that threaten the stability of global budgets.

He delved into the observed versus expected (O/E) ratios for length of stay across various institutions. He noted that even after adjusting for patient acuity and risk, some hospitals consistently exceed their expected stay durations while others remain efficient. This discrepancy suggests that internal hospital management such as the timing of rounds, the speed of diagnostic testing, and discharge planning efficiency is a significant variable. He emphasized that identifying these internal best practices is essential for developing a policy that rewards hospitals for proactive management without penalizing them for treating more complex patients.

Dr. Kromm emphasized the inter-agency collaboration required to solve structural barriers, such as the shortage of post-acute care beds. He noted that the Commission is working with other state agencies to streamline the transition from acute hospital care to skilled nursing facilities (SNF) or home health. However, he maintained that hospitals cannot wait for these external fixes alone; they must focus on the leverage points within their control.

Dr. Kromm reiterated that the Maryland model's existing incentives have not uniformly reduced excess LOS, making a targeted policy intervention necessary. He emphasized that managing LOS is critical for optimizing statewide hospital capacity, ensuring the financial sustainability of global budgets, and improving affordability for both patients and purchasers. Most significantly, he identifies hospital throughput as the primary mover for solving ED boarding challenges, noting that the current inability to move patients efficiently through the system creates a bottleneck that degrades care quality across the board.

Dr. Kromm acknowledged that the data clearly reflects the difficulties hospitals face when discharging patients to these external facilities, which often results in unintended LOS trade-offs. While the Commission primarily focuses on regulatory levers within its control, Dr. Kromm agrees that the hospital must remain mindful of these structural, macro changes in the health system. He suggests that the Commission should stay briefed on parallel multi-agency work and frontline feedback to ensure their policies don't operate in a vacuum.

Health System Transformation Policy

Dr. Kromm introduced the Health System Transformation Policy, framed within the context of the new AHEAD model. The primary objective is to evaluate how the state can strategically address and reduce excess hospital capacity. This transformation is not merely about downsizing; it aims to realign resources to improve health access, redeploy funds into

community settings to drive better outcomes, and achieve significant statewide Total Cost of Care savings. To begin this process, the HSCRC is initiating a public comment period to gather feedback on several core policy questions.

A major focus of the proposal is the identification of specific geographic areas and hospitals that are best positioned for transition. Dr. Kromm noted that excess capacity is often concentrated in certain regions, necessitating a clear set of metrics to pinpoint where resources are underutilized. Rather than solely waiting for hospitals to propose their own facility changes, the Commission is exploring whether it should establish a proactive process to identify focus hospitals within health systems that could transition from acute care to alternative models of service delivery.

The policy also addresses the replacement of services and its impact on the broader healthcare ecosystem. If an acute care hospital closes or transitions, the Commission must determine how to assess the type and quantity of new services required to meet the community's needs. Dr. Kromm specifically highlighted Emergency Department (ED) wait times, noting that excess capacity in some areas may actually be a barrier to solving throughput challenges. Exploring how facility transitions can alleviate ED boarding and wait times is a top priority for this exploratory phase.

Dr. Kromm raised the critical question of how to manage the financial savings generated by these transitions. The staff is seeking input on how to balance the distribution of saved funds between returning value to healthcare purchasers, redirecting resources into the local community, and supporting other health systems. He noted establishing a transparent framework for these savings expectations is essential to ensure that the policy supports both fiscal stewardship and the long-term health equity goals of the state.

Legislative Report

Ms. Janice Lepore, Chief, Policy and Government Affairs, provided an update on the 2026 Maryland General Assembly session. She noted that the 90-day session, which runs from January 14 to April 13, is currently about one-third of the way complete. With over 2,000 bills already introduced, the HSCRC staff is actively tracking a wide range of legislation to ensure the Commission remains informed of any activity that could impact on its mission or the broader healthcare landscape.

The staff's primary focus is given to budget-related bills, such as the Budget Reconciliation and Financing Act (BRFA) of 2026, and legislation that directly mentions the HSCRC. Specifically, Ms. Lepore highlighted SB 246, which addresses the tenure of Commissioners serving after their terms end, and another bill set for a hearing that reviews the Commission's jurisdiction and rate-setting authorities. When asked by Commissioner Johnson about the Commission's role in these proceedings, Dr. Kromm clarified that staff primarily provides impact estimates and technical analysis rather than taking formal political positions.

Ms. Lepore discussed broader healthcare and insurance-related bills that could influence hospital functions or the Maryland model. These include HB 599, which would require hospitals

to qualify as nonprofit organizations for licensure, and legislation regarding primary care investment targets. She also noted that the staff is keeping an eye on emerging trends in the legislature, such as HB 795, which addresses the use of artificial intelligence, a major focal point of the current session.

No action was taken on these agenda items.

ITEM VII
FINAL RECOMMENDATION: MARYLAND HOSPITAL ACQUIRED CONDITION (MHAC) POLICY

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

Dr. Schuster presented the staff's Final Recommendation for the Maryland Hospital Acquired Conditions (MHAC) Policy for Rate Year (RY) 2028. This policy is part of a broader quality framework that includes the Quality-Based Reimbursement (QBR) and readmission policies. The central feature of the MHAC policy is its all-payer focus, which holds 2 percent of inpatient hospital revenue at risk based on performance. The primary objective is to incentivize hospitals to reduce complications occurring during stays such as respiratory failure or surgical-site infections that result from treatment rather than the progression of the patient's underlying disease.

The staff's final recommendation maintains a multi-measure approach to ensure a comprehensive assessment of patient safety. She proposed continuing the use of the Solventum™ Potentially Preventable Complications (PPCs), a set of 16 measures tailored to the Maryland model while adding the All-Payer AHRQ Patient Safety Index (PSI) composite. This addition aligns Maryland more closely with the national CMS Complication Program. She stated that these two measure sets are complementary, noting that 60 percent of complications are identified solely by the PPC grouper, highlighting its unique value in tracking conditions like maternal complications that are vital to Medicaid and commercial payers.

Addressing stakeholder feedback, Dr. Schuster acknowledged concerns from hospital groups regarding the transition to the AHEAD model and the complexity of using proprietary groupers like Solventum™. While some hospitals suggested discontinuing the use of PPCs to reduce administrative burden, she argued that it is premature to do so before a full review of clinical value. To address this, she stated that the staff will convene a subgroup to assess complication measures and determine where it is beneficial for Maryland to deviate from national Medicare benchmarks to better serve its unique all-payer population.

A key point of departure from the national CMS program is Maryland's use of a scaled rewards and penalties system. While the national program is penalty-only for the bottom quartile of performers, Maryland's policy allows for revenue adjustments of up to 2 percent in either

direction. This methodology is intended to reward high-performing hospitals, providing them with capital to reinvest in future quality improvements. Consumer advocates voiced support for this approach, viewing it as a necessary guardrail against potential efficiencies under global budgets that could inadvertently compromise patient safety.

Commissioner Blum requested clarification on the process for resolving technical conflicts when state and CMS measures share the same goal but use different definitions, and whether these discrepancies are settled through staff-level decisions or require a formal Commission vote. Dr. Schuster stated that staff plans to reconvene the Clinical Adverse Events Measures Subgroup to develop specific criteria for selecting and defining these measures. This group will provide staff with the technical basis to present the Commission with formal recommendations that weigh stakeholder concerns and the "pros and cons" of each option. Ultimately, while staff will provide a recommended path, the Commission retains the final authority to vote on and approve or reject any specific measure.

Testimonies:

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance, Maryland Hospital Association (MHA), reaffirmed the industry's commitment to patient safety and high-quality care, noting that these goals guide their perspective on the MHAC program. She expressed gratitude for the collaborative efforts of the HSCRC Quality team, highlighting the importance of their partnership with hospitals as the state transitions toward the AHEAD model.

Regarding specific policy recommendations, she voiced support for the RY 2028 MHAC policy and the move toward closer alignment with the CMS Hospital Acquired Conditions Reduction Program. Specifically, she praised the inclusion of the All-Payer PSI 90 measure as a vital step for multi-payer simplification. She also endorsed the plan to restart the Clinical Events Adverse Measures Subgroup, which she believes is essential for ensuring that future complication measures remain both clinically meaningful and operationally feasible.

Ms. Terry welcomed the one-year extension of the PPC composite measure. She noted that this extension provides hospitals with the necessary time to manage an orderly exit from the current system with Solventum. She noted that the staff's RY 2028 recommendations successfully align hospital goals with meaningful incentives to reduce hospital-acquired conditions.

Amanda Wright, Director of Quality and Clinical Care, MHA, recommended transitioning away from the Potentially Preventable Complications (PPC) methodology by RY 2029. She argued that the current proprietary system imposes a significant administrative and financial burden, requiring hospitals to maintain specialized software and parallel reporting routines. This overhead, she noted, diverts critical resources away from preparing for new federal applications and DRG-based coding transitions required under the AHEAD model.

She further emphasized that maintaining PPCs alongside the new PSI 90 measure would be duplicative and unnecessarily complex. Continuing both frameworks would increase the

reporting burden without actually improving provider accountability because overlapping complications use different definitions and attribution rules. Instead, the hospital field urges the Commission to align with CMS standards by replacing the PPC composite with National Healthcare Safety Network (NHSN) measures, which offer a nationally recognized, evidence-based, and audited framework.

Ms. Wright called for early communication regarding reward and penalty structures for non-Medicare payers and requested ongoing monitoring of the PSI 90's cumulative impact. She noted that the AHEAD transition is a prime opportunity to modernize the MHAC program by reducing complexity and strengthening the alignment between state and federal quality initiatives. She reaffirmed the hospitals' commitment to patient safety and their desire for continued collaboration with the HSCRC.

Chairman Sharfstein asked how the Commission will address maternal complications, which are included in the PPC methodology but excluded from the Medicare PSI 90 measure. He questioned whether these complications would still be measured in the future or if they are already being tracked through other programs. Ms. Terry proposed addressing maternal health and other state-specific priorities through a separate, parallel state-based program rather than embedding them into the CMS-aligned framework. She emphasized that while hospitals support monitoring these key initiatives, core quality programs should remain strictly aligned with federal standards to ensure technical integrity and simplicity. This carve-out approach allows Maryland to pursue its unique clinical priorities without creating conflicts within the primary CMS measures.

Chairman Sharfstein asked for clarification on whether these state-specific parallel measures should be used strictly for monitoring or if they should also carry financial incentives. Ms. Terry stated that the hospital field is open to discussing financial incentives for state-specific measures, noting that the decision to apply rewards or penalties would depend on the specific measure selected. She expressed confidence in the staff's ability to design these structures effectively and indicated a willingness to collaborate on determining which unique state priorities warrant financial risk.

Commissioner Blum asked for a more precise definition of administrative burden when hospitals are forced to manage two separate measurement systems. He questioned whether the primary burden lies in the technical calculation and data processing, or if it stems from the clinical workflow and team coordination required to respond to conflicting measures. Ms. Terry clarified that the primary burden stems from hospitals having to develop unique operational procedures to address state-specific measures. She argued that since federal models already exist for areas like complications and readmissions, Maryland should align with those established systems to streamline hospital workflows. However, she reaffirmed that the state can still pursue unique clinical priorities by developing separate, appropriate strategies for those specific goals.

Commissioner Sabi requested a clear comparison between the two sepsis measures to understand the advantages and disadvantages of maintaining both. She asked what is gained or lost by keeping dual definitions and sought to understand the associated administrative

burden. Dr. Schuster explained that the PSI 90 measure is limited to postoperative surgical sepsis, while the state's PPC methodology is broader, capturing both medical and surgical cases. She recommended reconvening the expert subgroup to conduct a deeper technical analysis before making a final recommendation.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation for the MHAC Policy for RY 2028. Commissioner Sabi moved to approve the staff's Final Recommendation, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's Final Recommendation.**

ANNOUNCEMENT: STAFF DEPARTURES

Dr. Kromm shared a heartfelt tribute to Ms. Deb Rivkin, who recently concluded her service with the HSCRC. He praised her as an incredible contributor and a voice of reason whose strong moral compass and mission-driven approach were vital to the agency's success. He expressed profound gratitude for her friendship and deep commitment to the state, noting that while she has officially left her role, her impact on the team remains significant.

Dr. Kromm also announced the departure of Mr. Alan Pack, describing him as a tremendous contributor whose tireless work ethic and analytical mastery were essential to the agency's success. He highlighted Pack's unique ability to tackle the most difficult financial problems while simultaneously serving as a dedicated mentor to junior staff.

Reflecting on their shared history, Dr. Kromm credited Mr. Pack as the indispensable force behind the successful turnaround of the Maryland Health Benefit Exchange during its early crisis. Dr. Kromm presented him with an honorary plaque, officially welcoming him as a distinguished alumnus of the HSCRC.

Chairman Sharfstein and the Commissioners expressed their deep gratitude for Mr. Pack's 16 years of distinguished service to the State of Maryland, honoring his many accomplishments and wishing him continued success in his future endeavors.

In his farewell remarks, Mr. Pack reflected on his career in public service, describing his nine-year tenure as the HSCRC's Director of Methodologies as the most rewarding role of his life. He traced his journey from a Medicaid budget analyst during the Great Recession to serving as CFO of both the Health Benefit Exchange and the Maryland Department of Health, emphasizing that the Commission's greatest strength is the thoughtful and passionate people who drive its mission.

ITEM VIII
HEARING AND MEETING SCHEDULE

March 11, 2026,

Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned.

**Closed Session Minutes
of the
Health Services Cost Review Commission
February 11, 2026**

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103, §3-104 and §3-305 for the purpose of discussing the administration of the Model, updating the Commission on the current staff investigation, and receiving legal advice from Counsel.

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

The administrative session was called to order by motion at 12.05 p.m.

In addition to Chairman Sharfstein, Commissioners Blum, Elliott, Johnson, Maine, McCann and Sabi were in attendance.

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

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

Item I

Ms. Erin Schurmann, Associate Director, Strategic Initiatives, updated the Commission on the Regional Partnership performance.

Item II

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

Item III

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

Item IV

Mr. Henderson also updated the Commission, and the Commission discussed the FY26 Hospital Financial Condition through December 2025.

Item V

Mr. Stan Lustman, Commission Counsel, provided legal advice to the Commissioners.

The Closed Session was adjourned at 12:40p.m.



CRISP Tools to Support the Identification and Reduction of Potentially Avoidable Utilization

Overview of Existing and Future Offerings
HSCRC Commission Meeting
March 11, 2026

● Available Now in CRISP

- Potentially Avoidable Utilization (PAU)
- Value-Based Care Insights (VBCI)
- Other reports: Pre/Post, Public Health Dashboard
- Alerts and other clinical tools
- Clinical data reports and Data Extracts
- Hilltop's Pre-AH Prediction Scores – MDPCP & MPR Suites

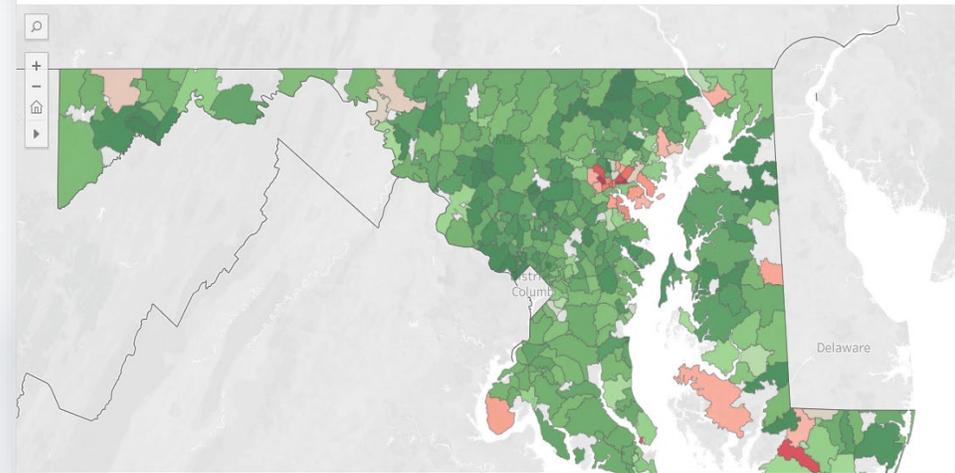
● HSCRC PAU Reports

- The PAU reports give hospitals performance insights for key components of the HSCRC PAU Policy, using the HSCRC Case Mix data.
- Includes metrics for each hospital's MPA-attributed beneficiaries to identify PAU:
 - Readmission (IP + OBS>23)
 - Prevention Quality Indicators
 - Pediatric Quality Indicators

Potentially Avoidable Utilization (PAU)

- ▶ ❤ Attributed PQI PDI Report
- ❤ MPA PQI Summary
- ❤ RY27 Avoidable Admission Report
- ▶ ❤ RY27 PAU Details
- ❤ RY27 PAU Savings - Performance
- ❤ RY27 PAU Summary - Reference

Avoidable Admissions Report PQI per 1000 by Zip Code - Diabetes Composite



● Value Based Care Insights (VBCI)

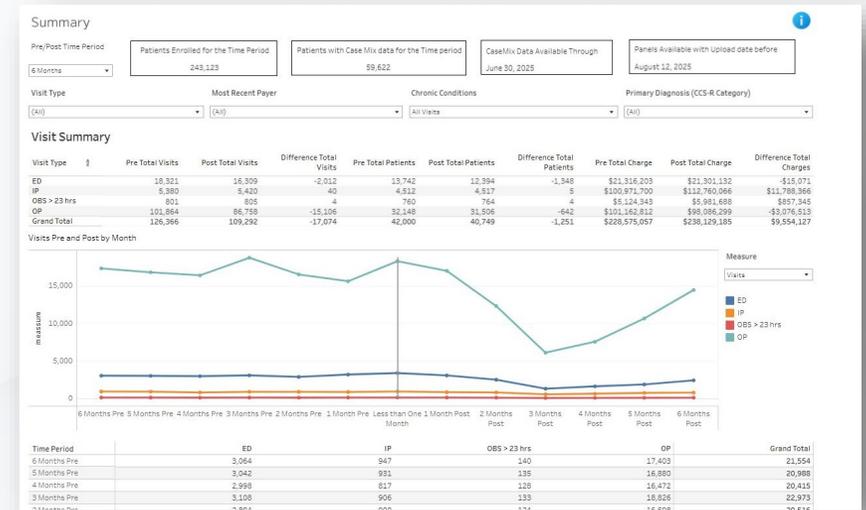
- VBCI enables users to assess hospital utilization and costs over time against relevant benchmarks with drill-through to patient-level details for their attributed Medicare FFS beneficiaries.
- VBCI reports show potentially avoidable admissions for IP and ED visits, broken down by hospital and DRG.

Hospital Detail
Select a hospital to filter the provider and beneficiary panel tables

Hospital Name	Hospital CCN	IN	Volume Medical Admits	% of Total Medical Admits	% Potentially Avoidable Admits
<input type="checkbox"/> LUMINIS HEALTH ANNE ARUNDEL MEDICAL CENTER, INC	210023				
<input type="checkbox"/> UNIVERSITY OF MD UPPER CHESAPEAKE MEDICAL CENTER	210049				
<input type="checkbox"/> FREDERICK HEALTH HOSPITAL	210005				
<input type="checkbox"/> MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	210015				

Other CRS Reports

- Public Health Dashboard is a summary report that shows hospital utilization for Maryland residents based on the HSCRC Case Mix data; includes filters for Prevention Quality Indicators (PQIs)
- Pre/Post allows users to analyze hospital utilization before and after enrollment in an intervention.
- PaTH provides a view of patient hospital utilization regardless of enrollment date, offering insight into overall hospital usage.



Alerts and other clinical tools

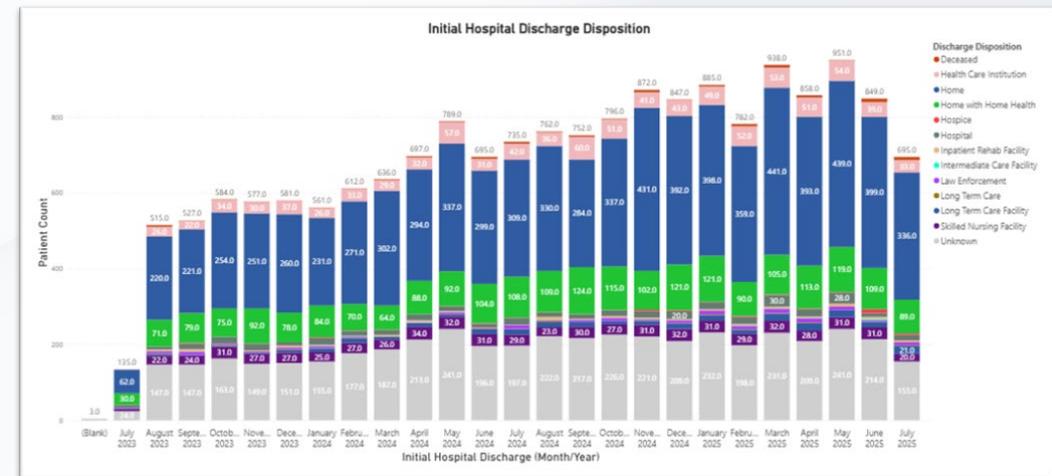
- CEND - real-time hospital encounters & other customizable alerts
- Examples – Breast & Colorectal Screenings; Readmission Alerts, Non-Fatal Overdose Alerts, Diabetes Care
- Delivery Methods – Data Integration (Epic In Basket & HL7 Messages), MFT File Transfer, Web Based Interface through CRISP portal (Population Explorer)

The screenshot displays the 'Population Explorer' tool interface. The top navigation bar includes 'View Panel', 'DC Demo Panel 2 (DC_C)', 'Export', and 'Configure Advanced Filter'. The main content area is divided into a 'DETAIL' view and a 'TABLE' view. The 'DETAIL' view shows patient information for four individuals: STEIN_DEMO, BARBARA (DOB: 1941-06-01, Admit Date: 2024-02-02 04:31 PM, Female, Facility: NATIONAL REHABILITATION HOSPITAL I); PAYNE_DEMO, SASHA (DOB: 1983-06-01, Admit Date: 2024-02-02 08:24 AM, Female, Facility: Sibley Memorial Hospital); MOORE_DEMO, MICHAEL (DOB: 1984-06-01, Admit Date: 2024-02-01 08:40 PM, Male, Facility: Medstar Georgetown University Hospital); and JONES_DEMO, OLIVIA (DOB: 2024-06-01, Admit Date: 2024-01-31 06:48 PM, Female). The 'Follow-Up Status' section shows 'Not Started' for the selected patient. The 'Patient Demographics' section displays: First Name: SASHA, Middle Name: (blank), Last Name: PAYNE_DEMO, Gender: Female, Address: PO BOX 99887, BETHESDA, MD, 20814, Home Phone: (blank), Work Phone: (blank), Date of Birth: 1983-06-01. The right sidebar contains a 'Quick Filter' section with 'Encounter Type' set to 'Inpatient' and an 'APPLY' button. Below the filter is a 'Saved Filters' section with a 'Load' button and 'Clear Filters' and 'Save Current Filter' buttons.

^Population Explorer Tool

Clinical Data Reports

- CRISP is currently piloting dynamic, population health reports using CRISP clinical data (ADTs, Labs, etc)
- Reports allow for earlier identification of trends in utilization and a more robust clinical picture of the population
- Clinical data extracts in support of treatment, care coordination and quality improvement are available upon request



Patient discharge disposition by month, from Hospital Revisit Report.

● New Opportunities and Tools

- Analysis and reporting on newly added non-CDS dispensed medications
 - Example use cases- understanding dispensed meds in conditions such as asthma, heart failure, diabetes
- Analysis and reporting on social determinants through CRISP SDoH screening, z-codes, and referrals (*coming late 2026*)
- Clinical data to support gaps in claims
- Reporting to support AHEAD model monitoring

Hilltop's Prediction Scores in MDPCP and Multipayer Reporting Suites

- The Pre-Avoidable Hospitalization (Pre-AH) score estimates the probability that a beneficiary will have an avoidable hospital event (IP or ED) within the next 30 days.
- Pre-AH reports are available in the MDPCP (Medicare FFS only) and Multi-Payer Reporting Suites (Medicare FFS & Medicaid)
 - These reports display prediction scores by beneficiary.
 - Users can create a patient roster and view those individuals in other reports within the suites.

Prediction Tool

Beneficiary Name: (All) Prediction Score Key: (All)

Prediction Score Key

- Top 1st Percentile
- Between 2nd and 5th Percentile
- Between 6th and 10th Percentile
- Between 11th and 20th Percentile
- Between 21st and 100th Percentile

Beneficiary Name	Medicare ID	Medicaid ID	Sex	DOB	Dual Status	Age	Race	Ethnicity	County Name	ADI	HEART	PQI - Like Events	≥4 ED Visits Super Utilizer	Prediction Score
														99.94%
														99.87%
														99.87%
														99.01%
														96.00%



The Hilltop Institute

Hilltop's Prediction Tools

Morgan Henderson, PhD
Director, Analytics & Research
March 11, 2026



UMBC

Prediction tools updated monthly for 2 million Marylanders

MDPCP

350,000 Medicare FFS Beneficiaries

HealthChoice

1.2 Million Medicaid Managed Care Beneficiaries

Multipayer Dashboard

All MD Full-Benefit Medicare FFS + Medicaid Beneficiaries



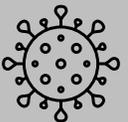
Pre-AH
Avoidable Hospital Events
All Medicare + All Medicaid



Pre-DC
Severe Diabetes Complications
All Medicare + All Medicaid

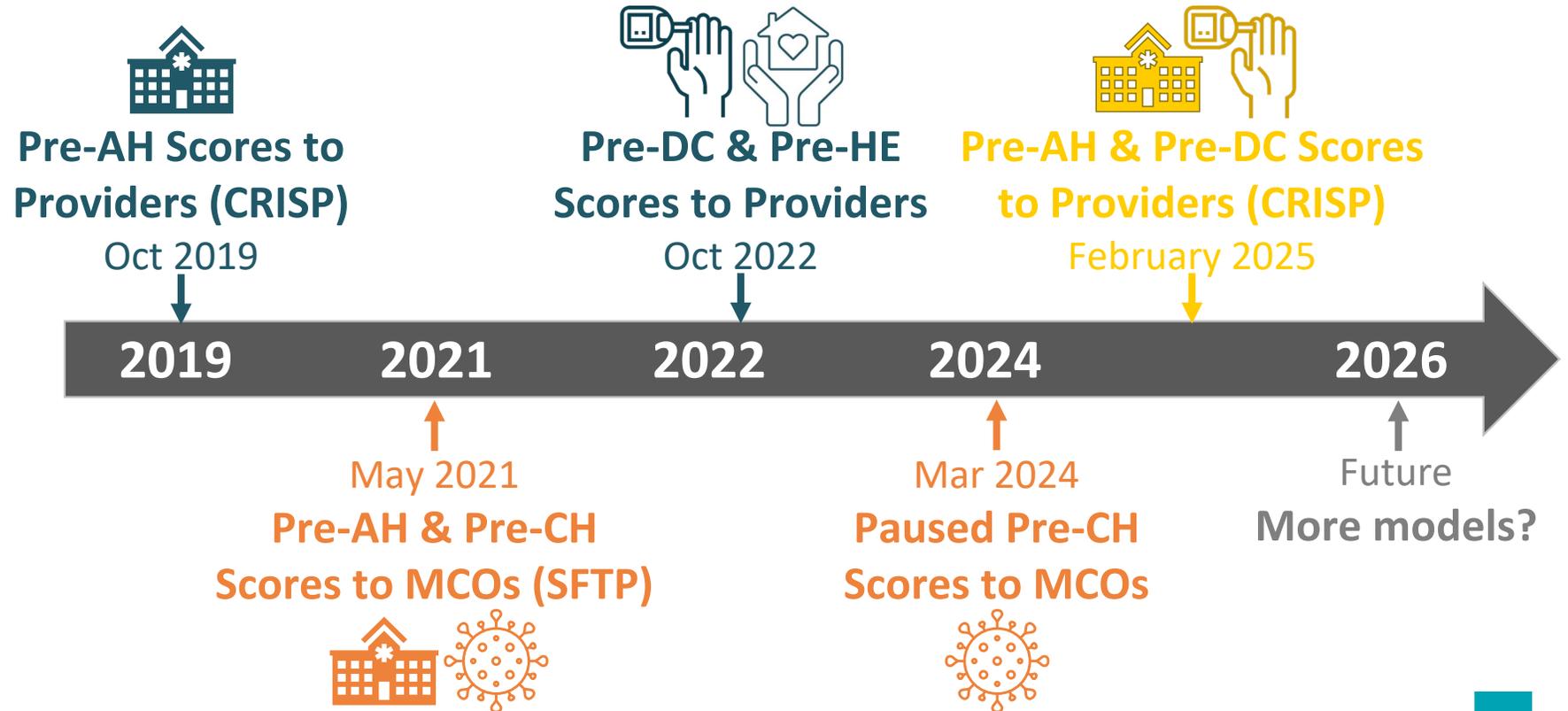


Pre-HE
Hospice Eligibility/Mortality
AHEAD MDPCP Medicare only



Pre-CH
COVID-19 Hospital Events
Medicaid HealthChoice only

Decommissioned in 2024



Strengths of Hilltop's prediction tools

Focused Outcome:

Optimized for a
Specific Event



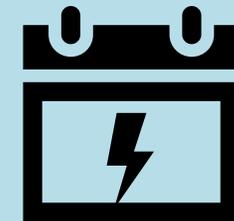
Tested & Trusted:

Record of Quality
Performance



Timely:

Recent Claims History
& Updated Monthly



Global Relevance:

Associated with
Broader Risk



Apples to Apples:

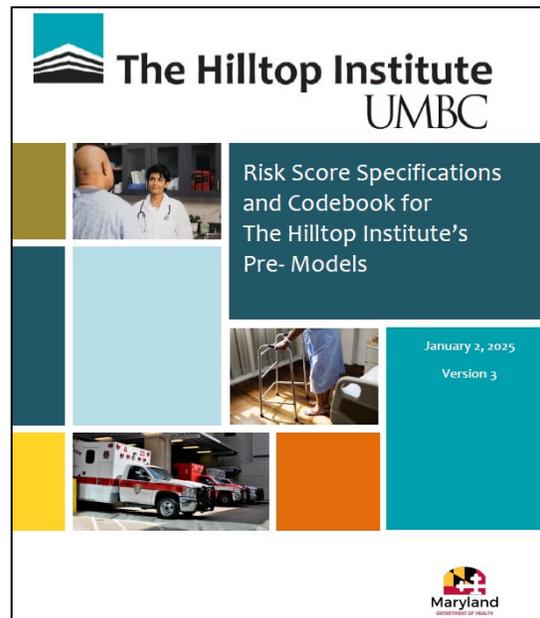
Compare across
Practices, Populations



High ← **Event Risk** → Low

Where to go
for more
information

More information on these tools, including a full list of risk factors, is available on the **Hilltop website** and is **embedded in the CRISP reporting suites**.



Hilltop's Pre- Models
Specifications
and Codebook



Contact

Morgan Henderson, PhD

Director, Analytics & Research

The Hilltop Institute



mhenderson@hilltop.umbc.edu

Questions or Suggestions?

CRISP wants your feedback and suggestions. Reach out to your CRISP Account Representative or the following emails to suggest ways we can improve data for managing PAU.

For reporting questions and suggestions: kate.talbert@crisphealth.org

For CRISP access: support@crisphealth.org



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Alternative Method of Rate Determination

University of Maryland Medical Center

Request for Extension

March 11, 2026

University of Maryland Medical Center- Request for Extension

- On October 21, 2025, in accordance with authority granted by the Commission, Staff approved a 3-month extension of the alternative rate arrangement between University of Maryland Medical Center(UMMC) and Aetna Health Inc. (Aetna), Proceeding 2666A. This extension expires on March 31, 2026.
- On February 26, 2026 UMMC requested the Commission extend the rate arrangement an additional three months to complete contract negotiations with Aetna.
- Staff's review of historical data has shown the rate agreement has been unfavorable.
- Staff recommends the 3-month extension be granted contingent upon completion of negotiations by June 30, 2026. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.



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Request For Extension of Approval

University of Maryland Medical Center

March 11, 2026

Background

On October 21, 2025, in accordance with the authority granted to it by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the University of Maryland Medical Center (UMMC) and Aetna Health, Inc. (Aetna), for solid organ and bone marrow transplants, Proceeding 2666A. The extension expires on March 31, 2026. However, UMMC and Aetna have not yet completed negotiations to extend the arrangement.

Request

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

Findings

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

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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Alternative Method of Rate Determination

University of Maryland Medical Center

Request for Extension

March 11, 2026

University of Maryland Medical Center- Request for Extension

- On October 21, 2025, in accordance with authority granted by the Commission, Staff approved a 3-month extension of the alternative rate arrangement between University of Maryland Medical Center(UMMC) and Optum HealthCare Solutions (Optum), Proceeding 2667A. This extension expires on March 31, 2026.
- On February 26, 2026 UMMC requested the Commission extend the rate arrangement an additional three months to complete contract negotiations with Optum.
- Staff's review of historical data has shown the rate agreement has been unfavorable.
- Staff recommends the 3-month extension be granted contingent upon completion of negotiations by June 30, 2026. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.



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Request For Extension of Approval

University of Maryland Medical Center

March 11, 2026

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

March 11, 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: 2500
BALTIMORE, MARYLAND	*	PROCEEDING: 2690A

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on January 29, 2026, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County General Hospital, and Suburban Hospital (“the Hospitals”). The application was filed also on behalf of Johns Hopkins , LLC (JHHC) to add additional joint procedures at Johns Hopkins Howard County General Hospital to the current global rate arrangement with Assured Partners, Proceeding 2685A, approved at the HSCRC’S October 8, 2025 public meeting. The effective date for the approval for the additional procedures is March 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add additional joint procedures at Johns Hopkins Howard County General Hospital to the currently approved arrangement with an effective date of March 1, 2026. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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



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cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

March 11, 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: 2501
BALTIMORE, MARYLAND	*	PROCEEDING: 2691A

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on January 29, 2026, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County General Hospital, and Suburban Hospital (“the Hospitals”). The application was filed also on behalf of Johns Hopkins HealthCare, LLC (JHHC) to add additional joint procedures at Johns Hopkins Howard County General Hospital to the current global rate arrangement with Accarent Health, Proceeding 2677A, approved at the HSCRC’S July 30, 2025 public meeting. The effective date for the approval the additional procedures is March 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

March 11, 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: 2502
BALTIMORE, MARYLAND	*	PROCEEDING: 2692A

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on January 29, 2026, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, (“the Hospitals”) and on behalf of Johns Hopkins HealthCare, LLC (JHHC). The Hospitals seek to add additional joint procedures at Johns Hopkins Howard County General Hospital to the current global rate arrangement with Carrum Health, Inc., Proceeding 2665A, approved at the HSCRC’s December 11, 2024 public meeting. The effective date for the approval for the additional procedures is March 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add additional joint procedures at Johns Hopkins Howard County General Hospital to the currently approved arrangement with an effective date of March 1, 2026. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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



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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

March 11, 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: 2503
BALTIMORE, MARYLAND	*	PROCEEDING: 2693A

I. INTRODUCTION

On January 30, 2026, Johns Hopkins Health System (“System”) filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County Medical Center and Suburban Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Employer Direct Healthcare for cardiovascular services, bariatric surgery, orthopedic services (shoulder, hip, knee, and spine), gallbladder, thyroid/parathyroid, oncology diagnosis and prostate services. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination with Employer Direct Healthcare for cardiovascular services, bariatric surgery, orthopedic services (shoulder, hip, knee, and spine), gallbladder, thyroid/parathyroid, oncology diagnosis and prostate services for the period beginning March 1, 2026. The Hospitals 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 Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.



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Adventist Healthcare Germantown Emergency Center Action

GEC Closure

- In February 2026 Adventist Healthcare (Adventist) submitted a request to the Health Service Cost Review Commission (HSCRC) to move global budget revenue from the Shady Grove Germantown Emergency Center (GEC) to Shady Grove Medical Center (SGMC) in conjunction with the planned closure of the GEC expected on June 30, 2026.
- The proposal effectively relocates emergency care access to the Shady Grove campus, 15 minutes from the existing GEC campus. Adventist received a Determination of Coverage from the Maryland HealthCare Commission confirming that no certificate of need is required for the closure of GEC, simply 90 days' notice to MHCC.

Staff reviewed Adventist's proposed approach and prior facility terminations to determine an appropriate approach to adjusting global budgets considering the facility closure. Proposed approach is shown in Table 1.

Table 1: Proposed Redistribution of GEC Global Budget

Description	Amount	Share
Current GEC Global Budget (A)	\$19.5 M	100%
Estimated Funding to SGMC for shifted services (B)	\$8.5M	44%
Estimated Funding to HCG for shifted services (C)	\$1.5M	8%
Gross Savings (D=A-(B+C))	\$9.5 M	48%
Savings Retained by SGMC (50% of savings) (E)	\$4.75 M	24%
Savings Retained by SGMC for direction to Montgomery Cty. (F)	\$2.0 M	10%
Net Savings to Payers (G=D-(E+F))	\$2.75M	14%
Total Value to the System (G+F)	\$4.75 M	24%

GEC Closure

The HSCRC staff makes the following preliminary recommendations:

- For FY2027, the global budget of GEC will be eliminated, and \$15.25 M of permanent revenue will be transferred to SGMC. Of this:
- \$8.5 M is the prospective market shift estimate which is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A.
- \$2.0 M annually, for 10 years, will be directed to Montgomery County for investment in the health needs of the community under terms agreeable to all parties.
- \$4.75 M will be retained by SGMC for investments at Adventist's discretion to address other health needs of the community, such as the expansion of access to other hospital services.
- For FY2027, the global budget of HCG will be increased by \$1.5 M. This is the prospective market shift estimate and is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A.



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Germantown Emergency Room Closure

Final Recommendation

March 11, 2026

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Overview and Hospital Request

In February 2026 Adventist Healthcare (Adventist) submitted a request to the Health Service Cost Review Commission (HSCRC) to move global budget revenue from the Shady Grove Germantown Emergency Center (GEC) to Shady Grove Medical Center (SGMC) in conjunction with the planned closure of the GEC on expected June 30, 2026.

Adventist believes shifting the funding for the services to SGMC and other local full-service hospitals will enable the provision of the same services at a lower average cost without any erosion in the quality of services available to the community. The proposal effectively relocates emergency care access to the Shady Grove campus, 15 minutes from the existing GEC campus. Adventist received a Determination of Coverage from the Maryland HealthCare Commission confirming that no certificate of need is required for the closure of GEC, simply 90 days' notice to MHCC.

Savings from this closure will accrue from 3 sources (1) elimination of fixed costs associated with GEC, (2) more efficient care delivery at the receiving hospitals and (3) the shift of low acuity services to lower cost non-acute settings.

Staff worked with Adventist to develop an approach consistent with prior Commission precedent for closing facilities which returns savings to payers while also allowing the hospital to reinvest some of the savings in other initiatives. In addition, also consistent with prior closures, Staff are proposing to redirect some of the payer savings to investments in the local community, in this case through a partnership with Montgomery County.

Staff recommends that starting in Fiscal Year 2027, the Commission should approve the plan detailed below which generates a 14 percent or \$2.75 M savings to payers on the current permanent global budget of approximately \$19.5M; generates a \$2.0 M investment in local health services to be coordinated with Montgomery County each year for 10 years; and allows SGMC to retain \$4.8M for re-investment, at its discretion, to address other health needs of the community such as the expansion of access to other hospital services.

Background

GEC is a freestanding emergency center that in the year ended June 30, 2025 (FY2025) provided about 23,000 emergency visits under a global budget that included \$19.5 M in permanent revenue. Of those visits

approximately 4,500 were Level 1 and 2¹, indicating they were for minor injuries and events of low complexity. It is assumed that many of these visits could be treated at an urgent care or primary care location. The remainder of the FY2025 visits were spread across Levels 3 to 5 with the bulk of them, about half the total being Level 3. It is assumed these visits will shift to local hospitals.

Adventist analyzed the residential distribution of the visits at GEC and concluded that about 85 percent would shift to SGMC due to the concentration of GEC's highest-volume zip codes south of GEC making SGMC the closer and likelier destination and the remainder to Holy Cross Germantown (HCG). The relocation of services is timed to coincide with SGMC's new tower and emergency room opening.

Analyses

Staff reviewed Adventist's proposed approach and prior facility terminations to determine an appropriate approach to adjusting global budgets considering the facility closure. Table 1 shows the proposed redistribution of the current global budget. (All amounts in this recommendation are rounded for simplicity; final amounts will be determined by Staff as the adjustments are implemented but should not differ materially).

Table 1: Proposed Redistribution of GEC Global Budget

Description	Amount	Share
Current GEC Global Budget (A)	\$19.5 M	100%
Estimated Funding to SGMC for shifted services (B)	\$8.5M	44%
Estimated Funding to HCG for shifted services (C)	<u>\$1.5M</u>	<u>8%</u>
Gross Savings (D=A-(B+C))	<u>\$9.5 M</u>	48%
Savings Retained by SGMC (50% of savings) (E)	\$4.75 M	24%
Savings Retained by SGMC for direction to Montgomery Cty (F)	\$2.0 M	10%
Net Savings to Payers (G=D-(E+F))	<u>\$2.75M</u>	14%
Total Value to the System (G+F)	<u>\$4.75 M</u>	24%

¹ Level 1 and 2 visits reflect CPT codes 99281 and 99282 or G0380 and G0381.

The amounts in table 1 are based on the following assumptions:

- Only permanent revenue is included in the shift; all non-permanent amounts will lapse.
- 85 percent of Level 1 and Level 2 services and 100 percent of Level 3 through 5 services are assumed to shift from GEC to SGMC and HCG. The assumption of the dissipation of 15 percent of Level 1 and Level 2 services to non-hospital settings is consistent with assumptions in prior closure adjustments. Typically, 5 percent overall dissipation is assumed. For this purpose, Staff are assuming that dissipation is concentrated in Level 1 and Level 2. There is a small cost associated with the provisions of the dissipated services in non-hospital settings. This analysis only focuses on the hospital setting and that cost is not factored into this analysis. Of the shifted services 85 percent is assumed to move to SGMC with the remainder to HCG. This split is subject to further review and will true up on a retrospective basis during the normal market shift process. See further discussion in the contingency section.
- Shifted services are funded at the variable portion of the cost per ECMAD at the receiving hospital, consistent with the normal market shift approach. The variable cost factor applicable to these services is 54 percent.
- Savings are split 50:50 between the closing system (Adventist) and payers, consistent with prior Commission approaches. Adventist has discretion on the use of these funds, but it is the expectation of the Commission that they be used to meet other health needs of the community such as the expansion of access to other hospital services and Staff may request, at a future date, reporting from Adventist on the use of these funds and on the impact of the closure on relevant emergency department performance metrics (e.g. diversion rates).
- Staff are recommending the redirection of \$2.0 M annually of payer savings to Montgomery County for the provision of services that meet the health needs of the community and the historic users of GEC for the first 10 years after the closure. This redirection to community investment is consistent with the arrangements of prior closures. See further discussions in the contingencies section.

Contingencies

The final implementation of this recommendation is subject to the following contingencies:

- Staff are in the process of reviewing with HCG representatives the assumptions behind the prospective split of shifted volume of 85:15 between SGMC and HCG. This split may be revised if, in the judgement of Staff, HCG raises issues that point to a different prospective split being more appropriate.

- Regardless of the final prospective split, the shifted amounts will be adjusted retrospectively under the market shift, as described in Appendix A of this recommendation. Such retrospective adjustments may result in funding being shifted to hospitals other than SGMC or HCG.
- While initial discussions have been held regarding the disposition of funds to Montgomery County, final terms have not been agreed upon. Staff will work with Adventist and the representatives of Montgomery County to develop terms that are agreeable to Adventist, the HSCRC, and Montgomery County. Should such an agreement not be reached, Staff will return to the Commission with an amended recommendation.

Recommendations

The HSCRC staff makes the following recommendations:

1. For FY2027, the global budget of GEC will be eliminated, and \$15.25 M of permanent revenue will be transferred to SGMC. Of this:
 - a. \$8.5 M is the prospective market shift estimate which is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A.
 - b. \$2.0 M annually, for 10 years, will be directed to Montgomery County for investment in the health needs of the community under terms agreeable to all parties.
 - c. \$4.75 M will be retained by SGMC for investments at Adventist's discretion to address other health needs of the community, such as the expansion of access to other hospital services.
2. For FY2027, the global budget of HCG will be increased by \$1.5 M. This is the prospective market shift estimate and is subject to final review with HCG and retrospective adjustment under market shift methodology as described in Appendix A.

Appendix A: Retrospective Market Shift Reconciliation Process

In the year of closure, Staff will treat SGMC and GEC as one facility and run a market shift that combines them into one hospital. This ensures that intra-system shifts are not inappropriately captured in the market shift and all shifts from Adventist to other non-Adventist facilities are appropriately captured. Upon completion:

- Holy Cross Adjustment = Market Shift Outcome – Prospective Adjustment
- Shady Grove = Combined Shady Grove/GEC Market Shift Outcome – Prospective Adjustment (including prospective shift out of GEC)
- All Other Hospitals = Market Shift Outcome

Assuming a 7/1/2026 implementation this adjustment will impact both the CY26/CY25 Market Shift as of July 1, 2027, and the CY27/CY26 Market Shift as of January 1, 2028.

MONTGOMERY COUNTY DHHS COMMUNITY HEALTH TRANSFORMATION INITIATIVE

March 11, 2025

HSCRC Public Meeting

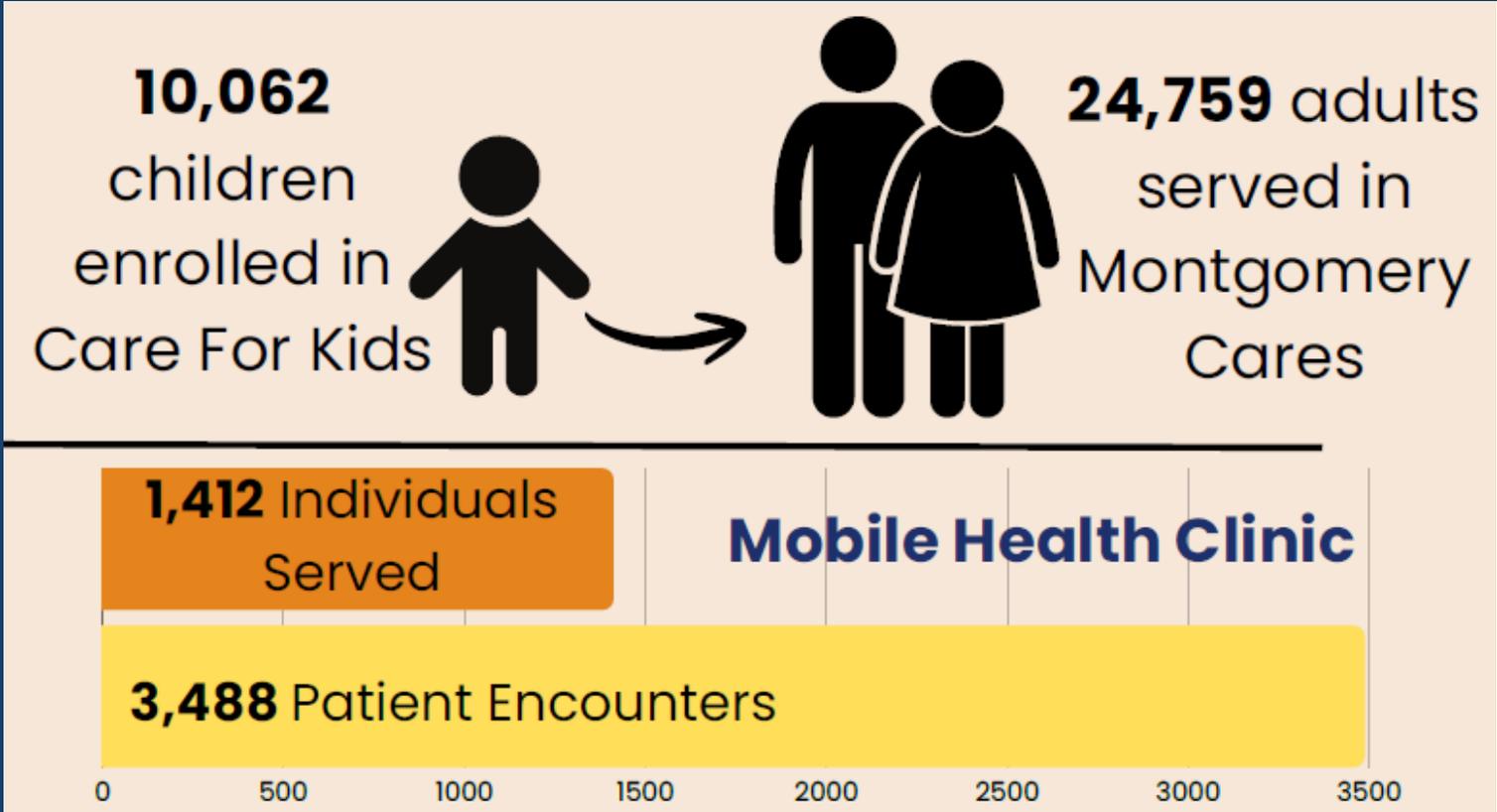
Nina Ashford, DrPH, MPH

Chief - Public Health Services



MONTGOMERY COUNTY'S INVESTMENT IN THE SAFETY NET

FY25
Investment
\$19,344, 177



Healthcare for Uninsured Populations in Montgomery County, MD



Montgomery Cares Ages 18+



Care for Kids Ages 0 - 18



Primary Care



Behavioral Health



Specialty Care



Medicine Access
Brand Name &
Formulary



Primary Care



Behavioral Health



Specialty Care



Dental Care



Cancer Screenings



Dental Care



Vision Care

EVEN WITH THESE INVESTMENTS, THERE ARE STILL GAPS TO CARE

Montgomery Cares and Care for Kids are strong primary care safety-net programs, but they are **not insurance** and do not include urgent care services

Patients who need urgent care outside of clinic hours go to **Emergency Departments**

After hours and weekend care is **limited**

GOAL OF INCREASED INVESTMENTS



Tighten connection to
primary care



Telehealth Urgent Care-Lite,
In-person Urgent Care-Lite,
Expand same-day/next-day
primary care appointments,
Care navigation



Reduce dependence on
emergency rooms for
low-acuity visits

APPENDIX

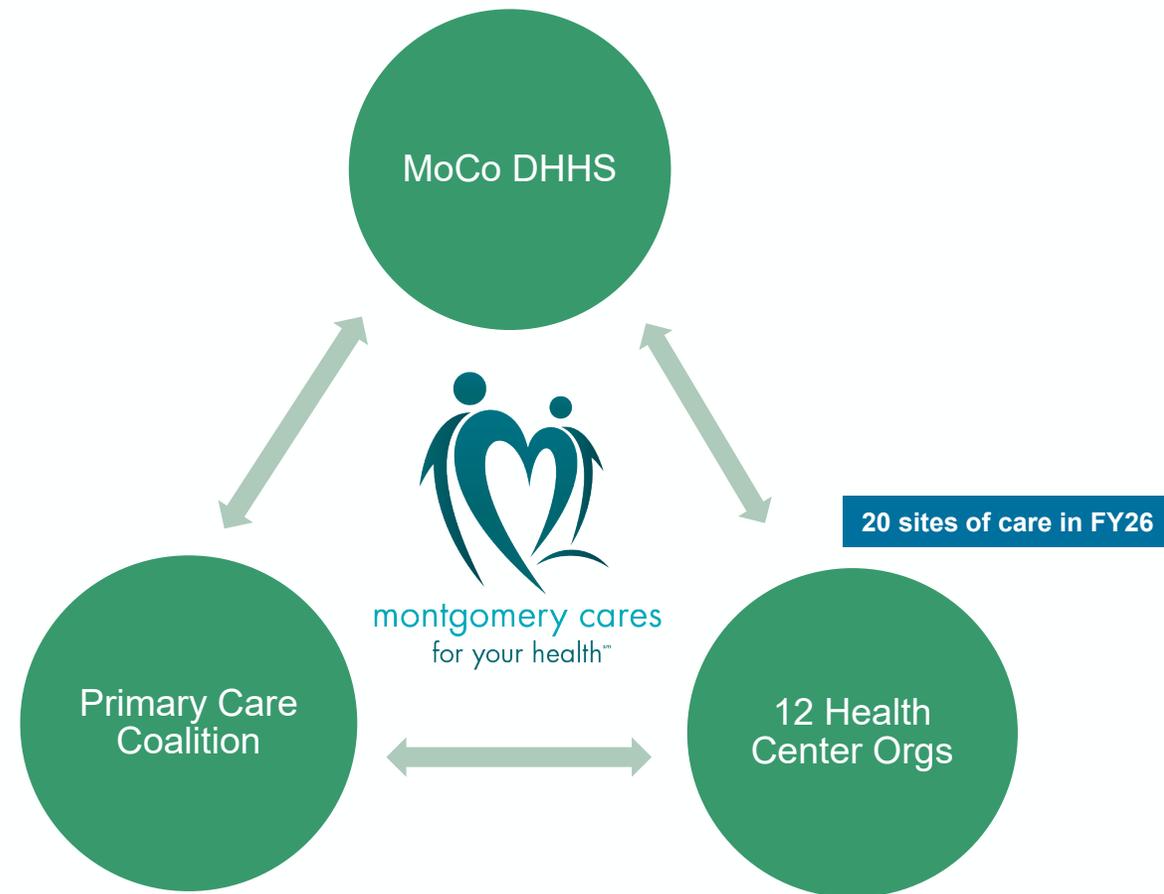
Montgomery Cares

A Public-Private Partnership

The Montgomery Cares program is a **public-private partnership** between the Montgomery County Department of Health and Human Services (MoCo DHHS), Primary Care Coalition (PCC), 12 independent community-based health care organizations – which provides health care services to **low-income, uninsured Montgomery County adults 18+ years old.**

Services Available:

- Primary Care
- Medication Access
- Specialty Care
- Cancer Prevention & Detection
- Behavioral Health
- Dental Care



PCC is the network hub, integrating the health centers into a **connected system**, offering foundational support, including:

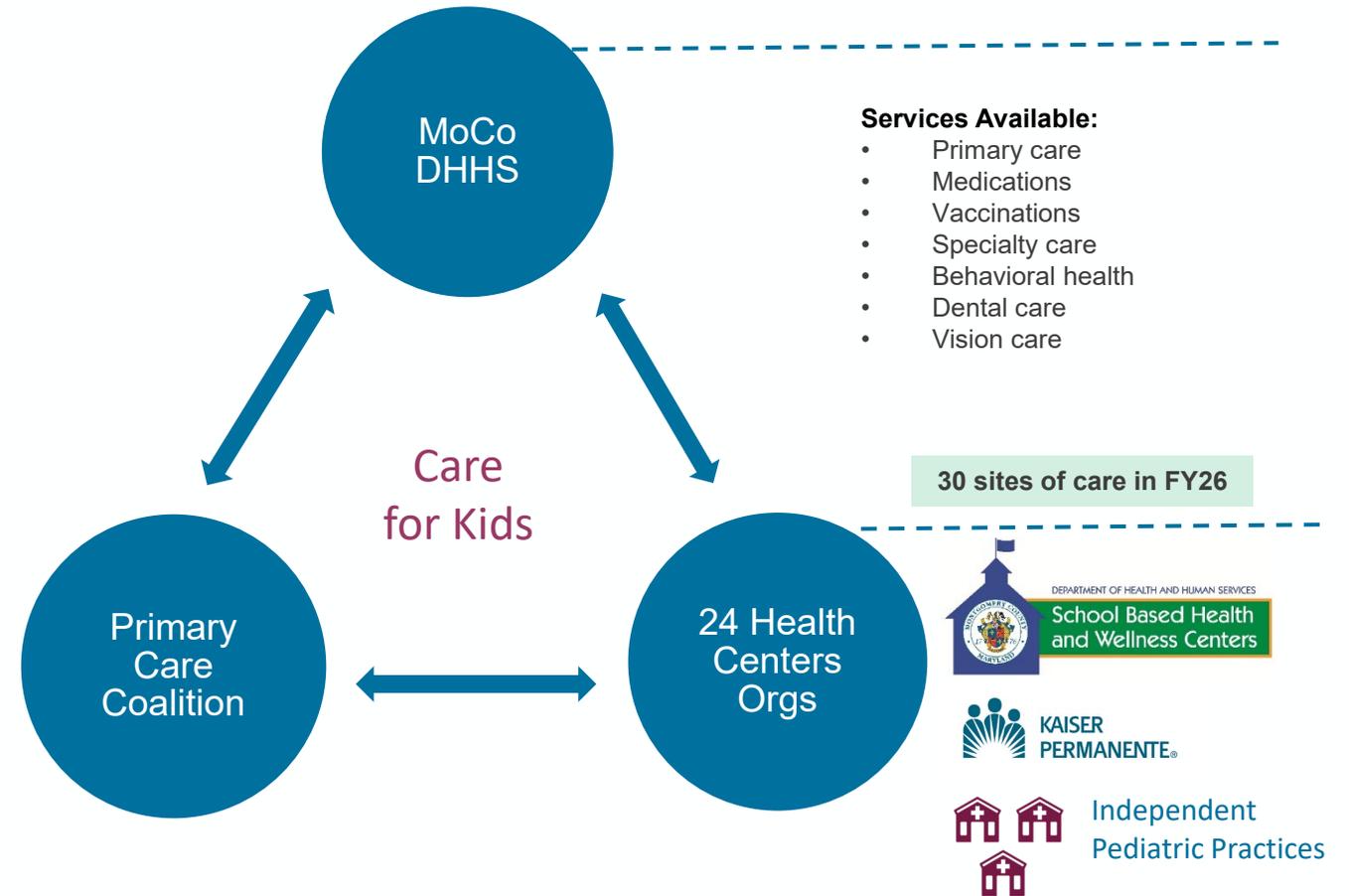
Oversight and administration, the technical infrastructure, data analytics, service delivery design, training and quality assurance, quality and process improvement, reimbursement, & technical assistance.

PCC also provides patient navigation, case management & direct patient care for programs that augment care at the sites.

Care for Kids

A Public-Private Partnership

The Care for Kids program is a public-private partnership between the Department of Health and Human Services (MoCo DHHS), Primary Care Coalition, and 24 Health Centers Orgs. The program provides health care services to years old.



PCC manages and oversees the program to make sure it runs smoothly, supporting child and family engagement. This includes assigning youth to a medical home, coordinating care beyond primary care, and conducting enrollment and program renewal outreach. Children who need dental, vision, behavioral health, specialty care or social services are connected to care providers in the community. The program also covers costs for approved care through reimbursement.

PCCs partnerships helps meet each child's unique needs and ensure they get the full range of care they require.



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Update on Medicare FFS Data & Analysis

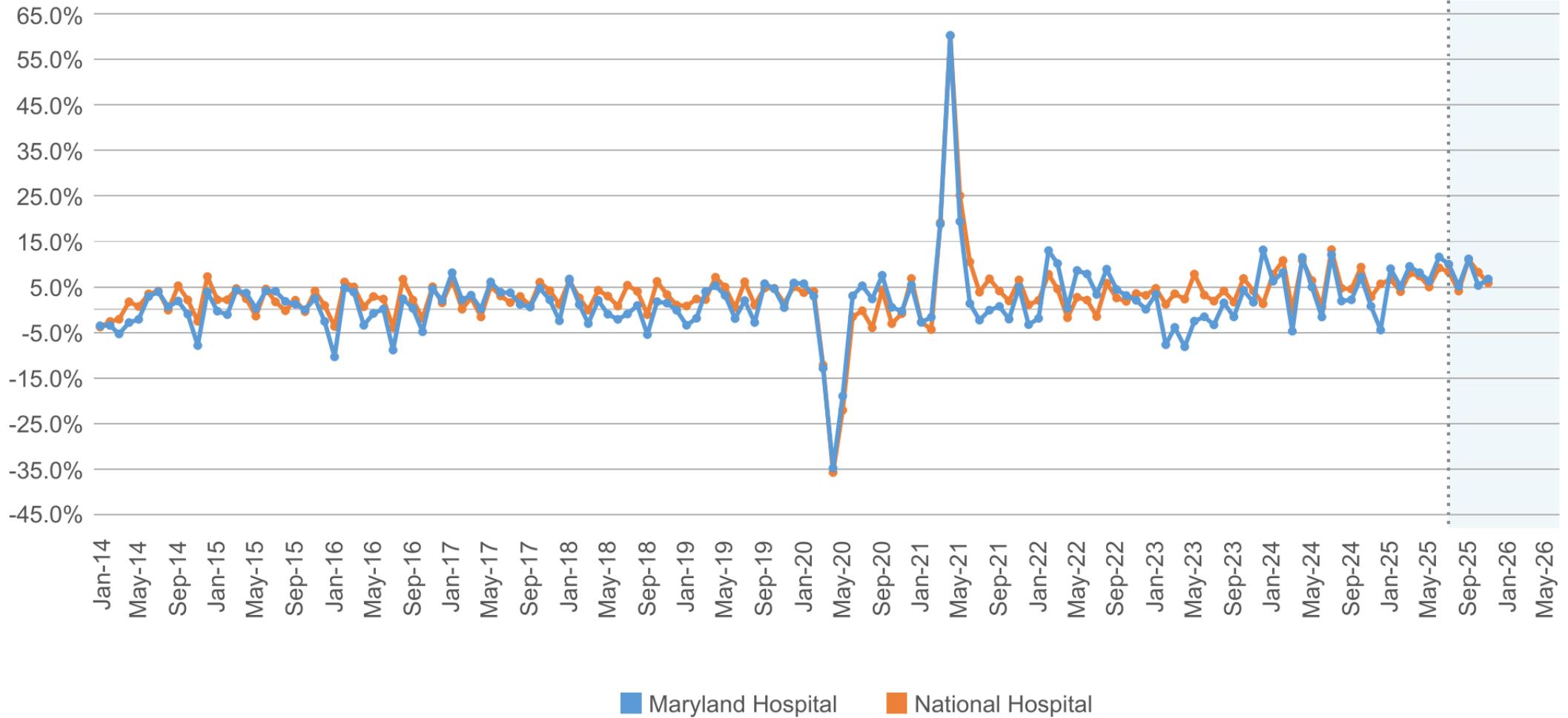
March 2026 Update

Data through November 2025, Claims paid through January 2026

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

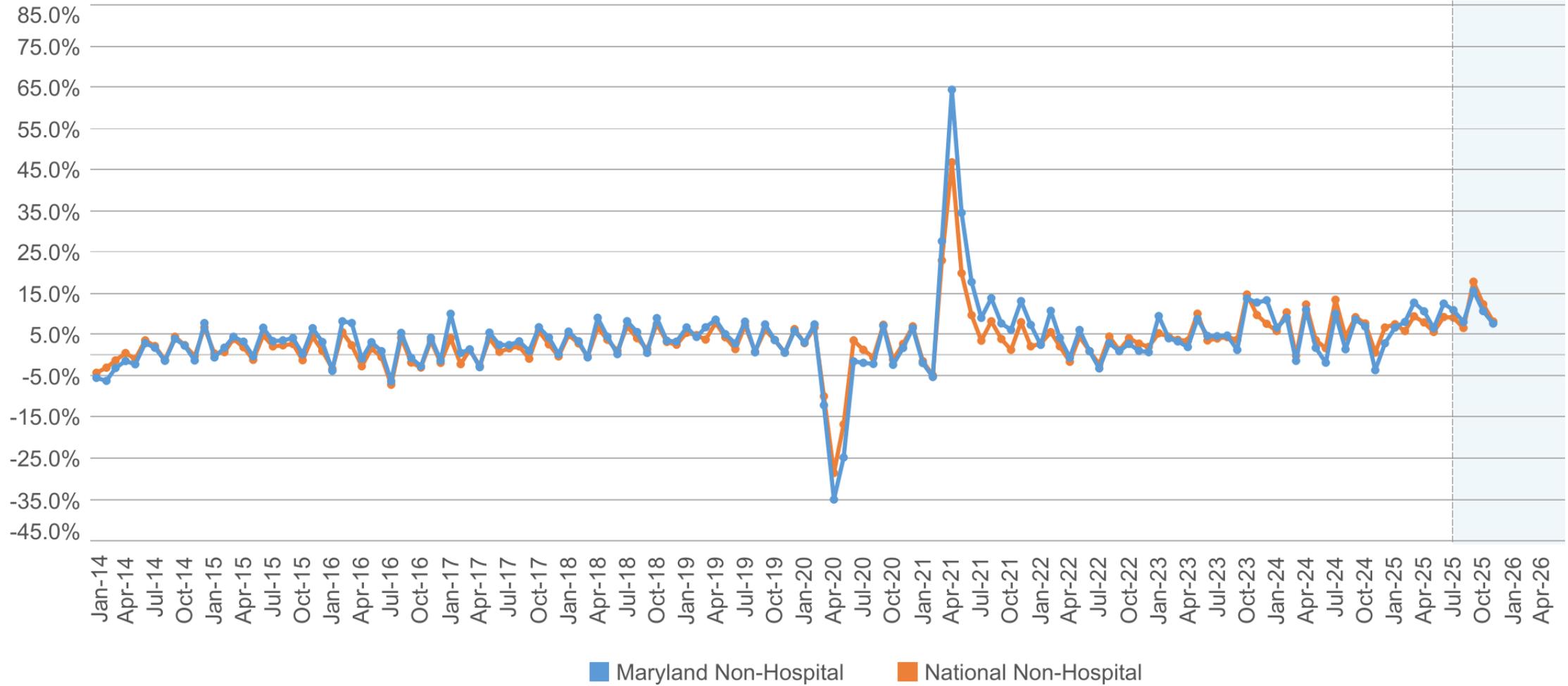
Medicare Hospital Spending per Capita

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



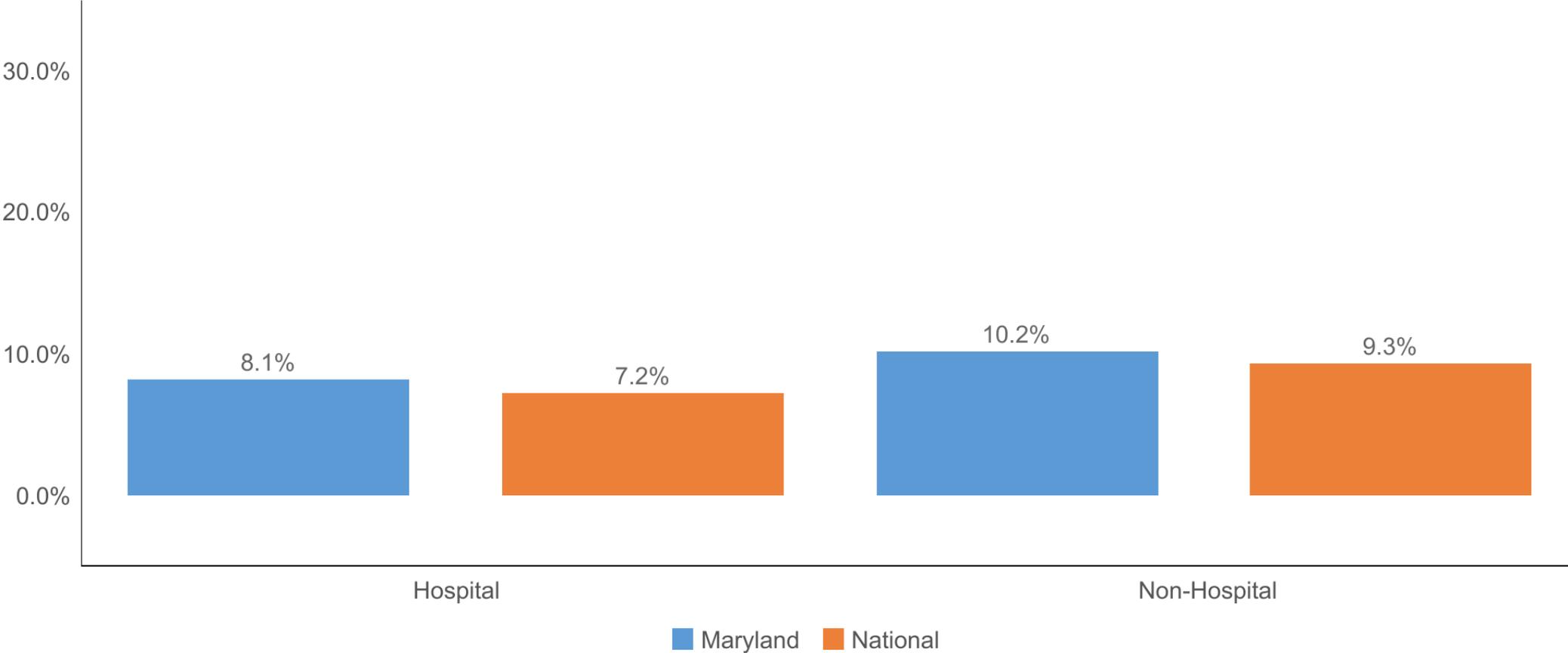
Medicare Non-Hospital Spending per Capita

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



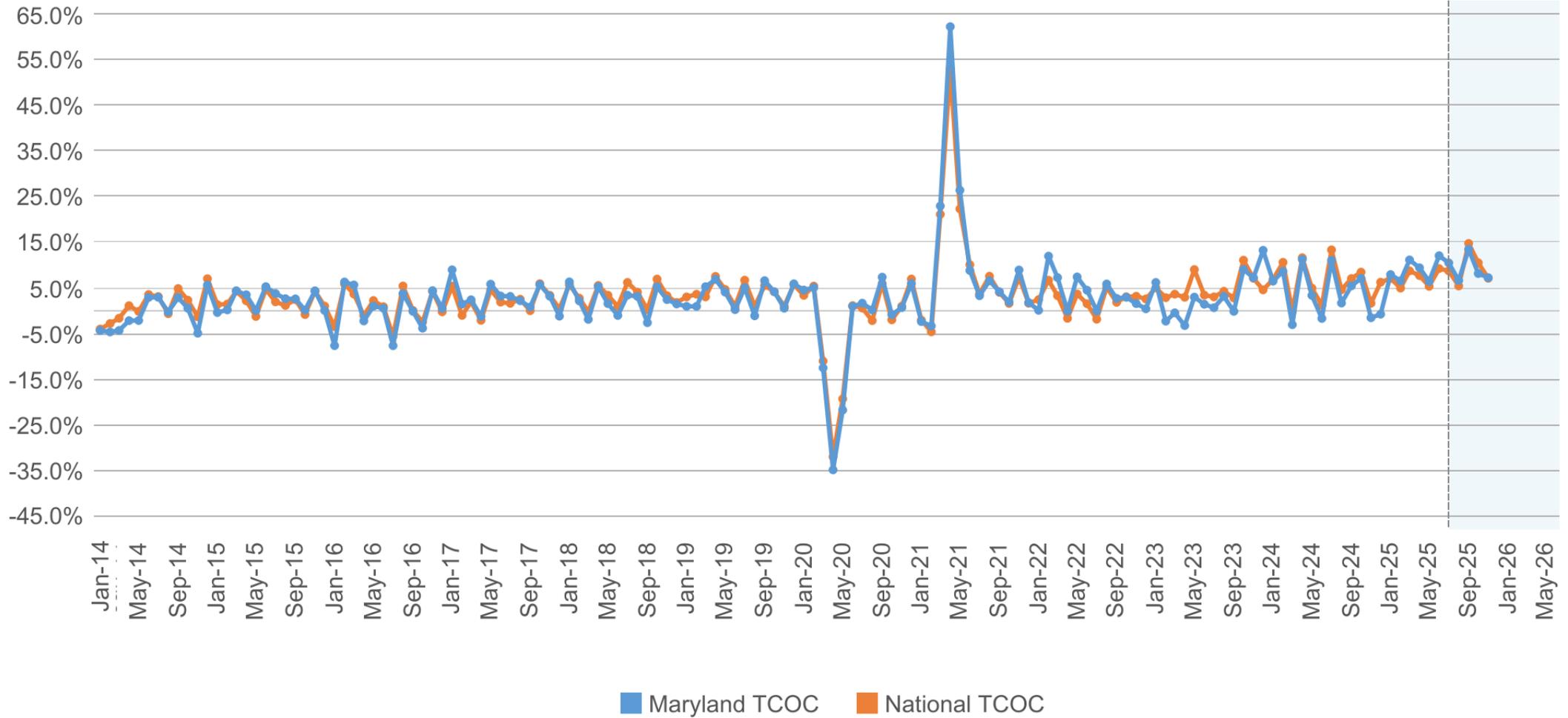
Medicare Hospital and Non-Hospital Payments per Capita

Year to Date Growth
January-November 2024 vs January-November 2025

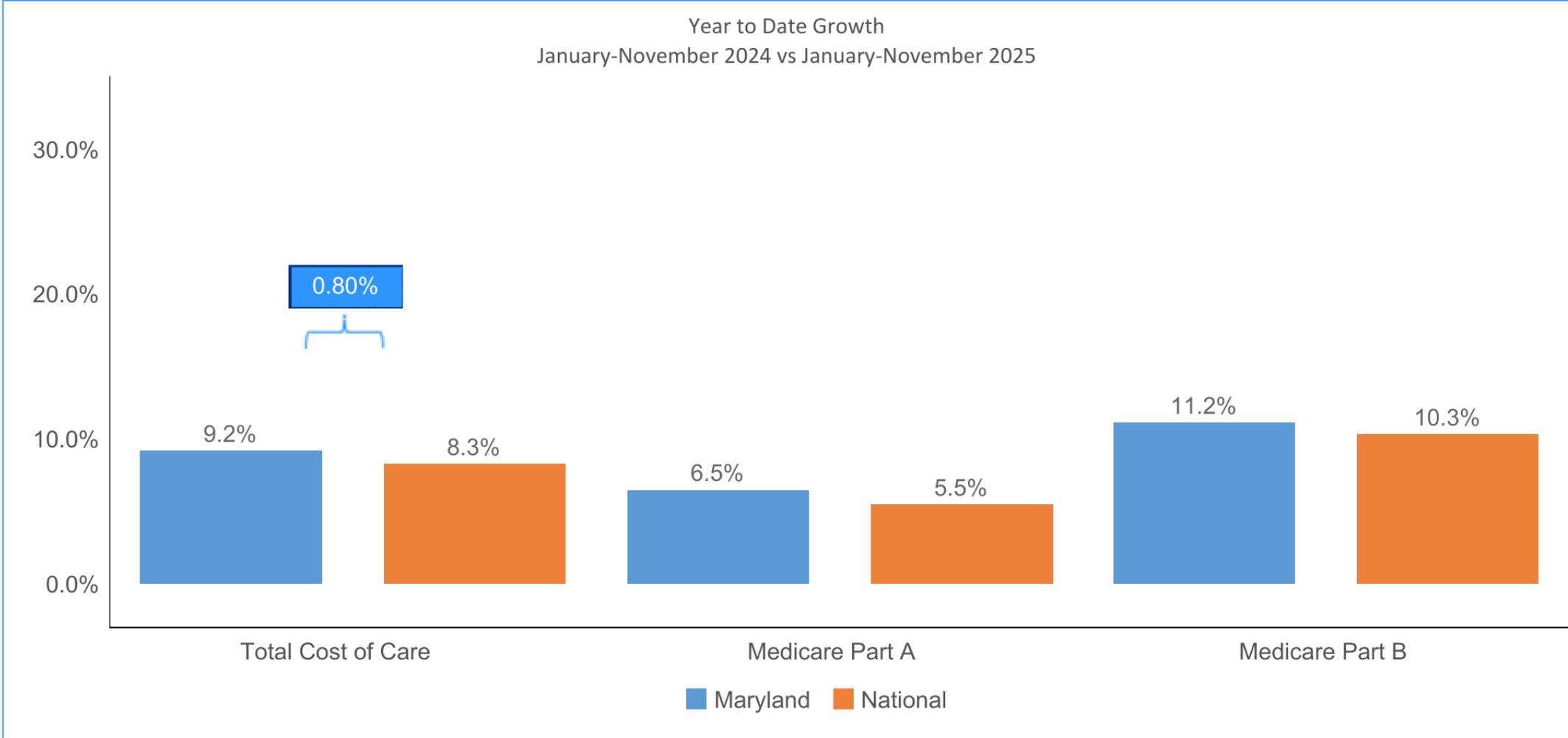


Medicare Total Cost of Care Spending per Capita

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

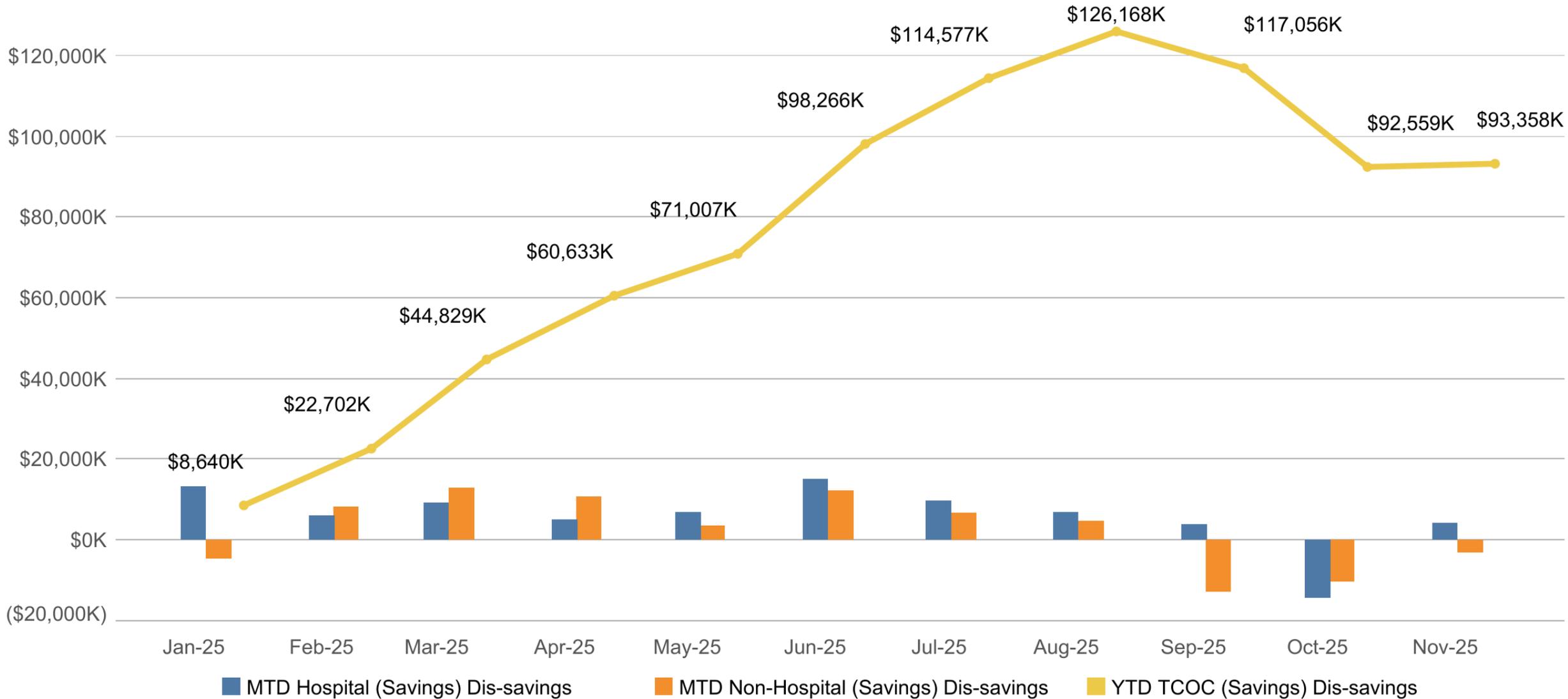


Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Savings

CYTD through November 2025





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HSCRC AHEAD Model Policy Timeline

Commission Update

March 2026

HSCRC AHEAD Model Policy Timeline

Policy Updates Already Planned

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

Required Changes for AHEAD Implementation

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

AHEAD-Related Policy Changes

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

Policy Changes Involving Multiple Agencies

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

** Coordinated by Regulatory Working Group*

Key to Timeline Descriptions

S: Staff

HSCRC staff are working on policy development and implementation.

W: Workgroup

The policy topic will be discussed by an HSCRC workgroup.

C: Call for Public Input

The HSCRC will request public comment for policy topics, *i.e.*, that will not ultimately require a Commission vote.

T: Topic discussed at Commission Meeting

The Commission will discuss ideas for policy topics as generated by a call for public input.

D: Draft Recommendation

HSCRC staff present a draft recommendation at the Commission meeting.

P: Public Comment for Recommendation

Stakeholders submit comments in response to a draft recommendation.

F: Final Vote

HSCRC staff present a final recommendation for Commission discussion and vote.

Italics indicate that timeline is contingent upon CMMI action.

Required Changes for AHEAD Implementation

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

- Today's Agenda
 - Care Innovation (HOPE): Draft Recommendation
Final draft shifted from April to May, to allow for public comment.
- April Agenda
 - N/A

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

AHEAD-Related HSCRC Policy Changes

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
C. AHEAD-Related HSCRC Policy Changes									
Physician Costs			C	T					
<i>Efficiency Policy (shifted to November)</i>									
Preventable Utilization - Length of Stay	S	W	S	S	T	S	D	P	F
Health System Transformation Policy				S	C	T	S	S	S

- Today's Agenda
 - Health System Transformation: Discussion
- April Agenda
 - Length of Stay Policy: Draft Recommendation
Draft recommendation shifted from March agenda.
 - Efficiency Policy: *Shifted from April to November, in conjunction with CMMI timeframes for Medicare global budget development*

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

Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI
Graduate Medical Education and Workforce*	Preliminary information-gathering in progress; hosting focus groups in March; draft report anticipated for June
Denials	Next meeting of the Adverse Decisions Workgroup scheduled for March 30th; report due December 2026
Medicare Advantage Market Stabilization*	Qualified plans notified in February; differential for CY 2027 under development; metrics under development.
Post-Acute Strategy*	Preliminary information-gathering in progress; hosting focus groups in March; draft report anticipated for June
Cost-Shifting*	Will be part of FY 2028 update factor; metrics under development.
All-Payer Total Cost of Care Growth and Primary Care Investment Targets*	Two meetings for all-payer growth held in February; public comment period open until March 20th - listening session scheduled April 10th
Choice and Competition*	Preliminary information-gathering in progress; hosting focus groups in March; draft report anticipated for June
ED Wait Times Commission	Commission meeting held March 4th; Data Subgroup meeting March 13th; Access and Capacity Subgroup March 26th

*Coordinated by Regulatory Working Group

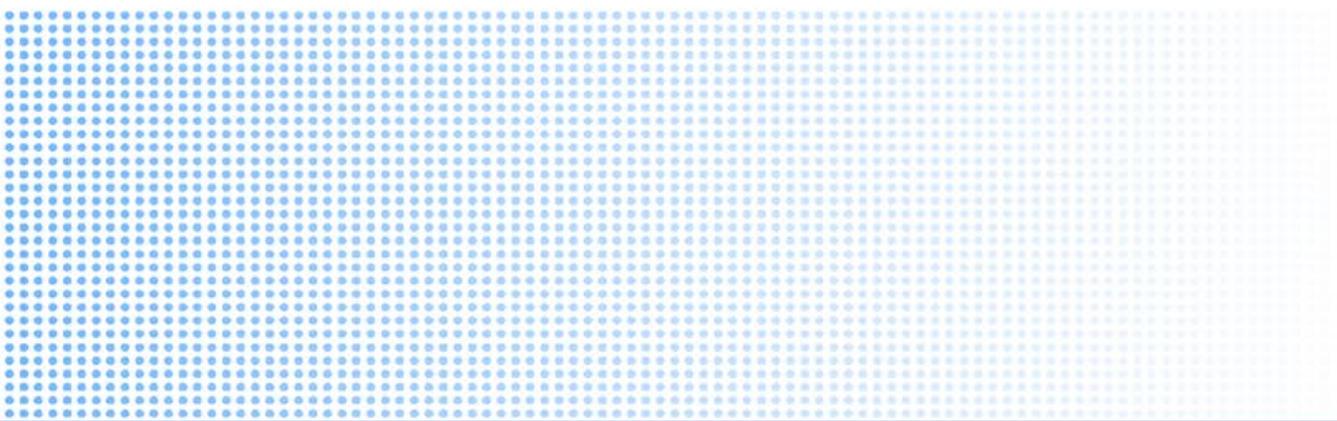
Discussion: Health System Transformation

Discussion: Health System Transformation

To support Maryland's success under AHEAD, the state may be able to reduce excess capacity where it exists to create or realign resources for health access, improved health outcomes and achieve statewide TCOC savings.

Areas for comment:

- Focus geographic areas
- Focus hospitals
- Additional services
- Emergency department wait times
- Savings expectations
- Other considerations



Legislative Update

2026 Legislative Session: Key Dates

	January	February	March	April
Key Dates	<ul style="list-style-type: none"> Session Starts: January 14 	<ul style="list-style-type: none"> Senate Introduction Deadline: February 9 House Introduction Deadline: February 13 	<ul style="list-style-type: none"> Crossover Date: March 23 	<ul style="list-style-type: none"> Last Day of Session (Sine Die): April 13
What to Expect	<ul style="list-style-type: none"> Briefings to Legislative Committees on Key Topics Bill Hearings in House of Origin 	<ul style="list-style-type: none"> Bill Hearings Amendments to Bills Votes on Bills in the House of Origin Agency / Department Budget Hearings 	<ul style="list-style-type: none"> Amendments to Bills Votes on Bills in the House of Origin Bill Hearings in Opposite Chamber Votes on Bills in Opposite Chamber 	<ul style="list-style-type: none"> Votes on Bills in Opposite Chamber Conference Committees Final Votes on Bills in Original Chamber

Sample of Bills Currently Being Monitored

HB 390 SB 282	Budget Bill FY 2027	Hearing Status:
Governor's proposed appropriations for FY 2027.		Appropriations Budget and Taxation
HB 392 SB 284	Budget Bill FY 2027	Hearing Status:
Budget Reconciliation and Financing Act of 2026		Appropriations 3/5/2026 Budget and Taxation 3/4/2026

Sample of Bills Currently Being Monitored

SB 246	Health Services Cost Review Commission – Term of Office of Members	Hearing Status:
Authorizes members to continue to serve for 6 months after the end of their term, rather than until a successor is appointed and qualifies.		Finance 1/27
HB 616 SB 515	Health Services Cost Review Commission – Health Facilities – Jurisdiction and Rate Setting	Hearing Status:
Expands the jurisdiction of HSCRC to include the costs for a facility associated with employing or contracting with physicians or other professional providers for which the facility does not receive corresponding offsetting professional revenue, requiring HSCRC to take this information into account when assessing facility resources to meet its financial requirements.		Finance 2/24

Sample of Bills Currently Being Monitored

HB 494	Health Insurance – Primary Care Investment Targets – Reimbursement and Reporting	Hearing Status:
Requires certain entities to provide reimbursement to health care providers in a manner that meets the annual primary care investment targets, and to provide a description of the entity’s progress in meeting the targets when filing a premium rate or rate change with the Commissioner.		Health 2/12 Passed Finance
HB 599	Health – Licensure of Hospitals – Ownership Requirements	Hearing Status:
Requires hospitals to qualify as a nonprofit organization under federal law and to be registered as a nonprofit organization in the State as a condition of licensure, limits transfer of ownership of a licensed hospital to nonprofit organizations.		Health 2/11 Passed Finance

Sample of Bills Currently Being Monitored

<p>HB 372 SB 169</p>	<p>Hospitals – Emergency Pregnancy-Related Medical Conditions – Procedures</p>	<p>Hearing Status:</p>
<p>Requires hospitals to conduct screening on a patient presenting at an emergency department to determine whether the patient has an emergency pregnancy-related medical condition, and establishing requirements and prohibitions related to the treatment and transfer of a patient who has an emergency pregnancy-related medical condition.</p>		<p>Finance 1/21 Passed</p> <p>Health 2/11 Passed</p>
<p>HB 1563</p>	<p>Emergency Room Services and Post Acute Care - Coverage and Studies</p>	<p>Hearing Status:</p>
<p>Prohibits denial of insurance coverage for emergency room services under certain circumstances; requires the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, to conduct studies quantifying bed capacity in hospitals and post-acute settings, as well as clinically appropriate transitions between acute and post acute care.</p>		<p>Health 3/4</p>

Questions?

Janice Lepore

Chief of Policy and Government Affairs

Janice.Lepore1@maryland.gov



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Annual Filing Modernization

Clinician Cost Schedule Update to Commissioners

March 11, 2026

Agenda

- Definitions
- Data Variability / Reliability
- Overall Metrics Reported
- Clinician Cost Financial Results (FY 2025)
- Selected Call Outs
- Possible Improvements for 2026 and Beyond

Objectives

1. Update Commission and the public on the work to gather information on clinician costs
2. Share examples of the challenges in collecting and standardizing this data
3. Provide a high-level summary of fiscal year 2025 results
4. Provide examples of drill down analytics that might be relevant in the future

Definitions

Definitions used throughout this report include...

Clinician



Any provider that may bill separately for services. Includes physicians and APPs.

Physician



Individuals identified as a Doctor.

***Other FTE
Related
Compensation***



Remuneration to non-employee clinicians, such as independent contractors

***Support
Costs***



Costs used to provide support services to a clinician.

Key Reporting Enhancements in 2025 Clinician Cost Schedule

1

Information
collected on
Support Costs

2

Regulated
and
Unregulated

3

Collecting
data by
Physician,
APP, and
Total Clinician

Data Variability

Data submitted by hospitals continues to have anomalies and/or variations of data definitions:

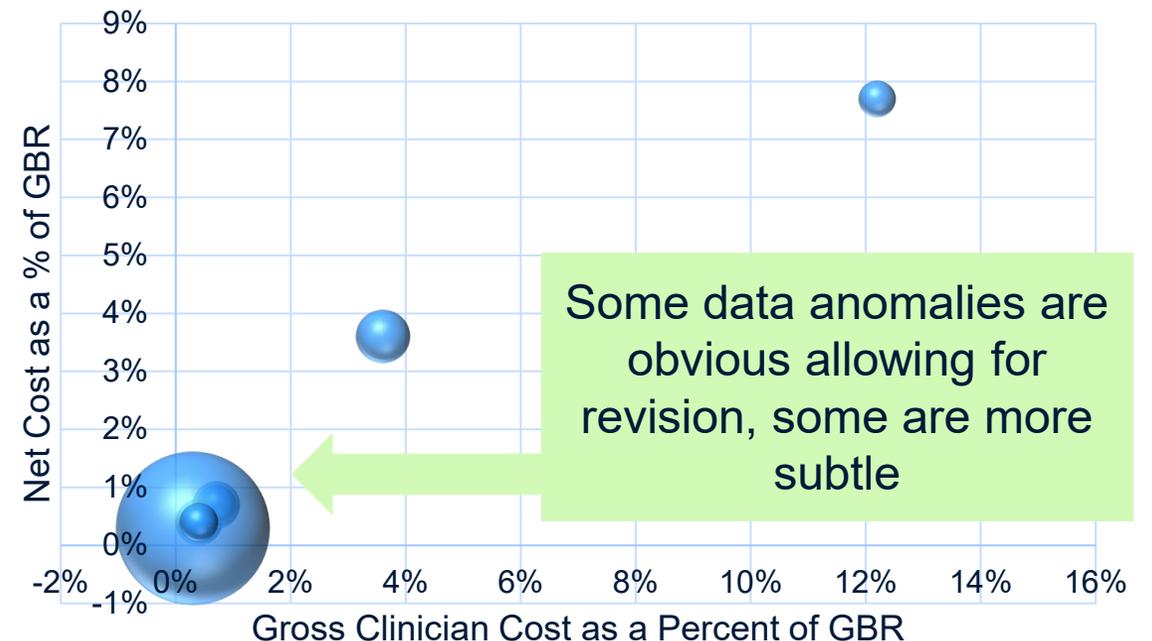
- Varying principles for identifying specialties
- Other FTE costs can vary in definition to include combining cost and professional fees in reported values
- Submission of solely summarized data clouds the differentiation between gross and net values, only allowing those values to be included at a summary level

As the data matures, more reporting anomalies will be identified and addressed.

EXAMPLE

Mid-Sized Rural hospitals. **Regulated Clinician Revenue**

Bubbles: Clinician Cost per FTE (no On-Call)



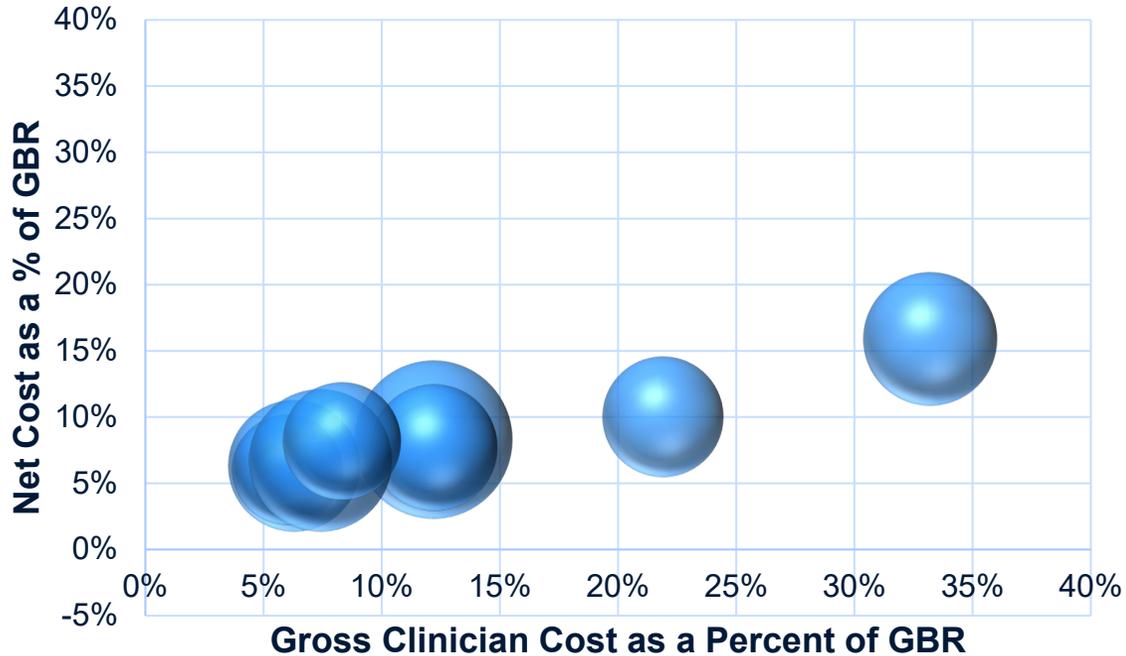
Data Variability Among Similar Facilities

Some differences will reflect real outcome difference while others are a function of reporting. As the data is refined and used the real differences will emerge.

EXAMPLE

Mid-Sized Rural hospitals. **Total clinician revenue**

Bubbles: Net Clinician Cost per FTE (no On-Call)

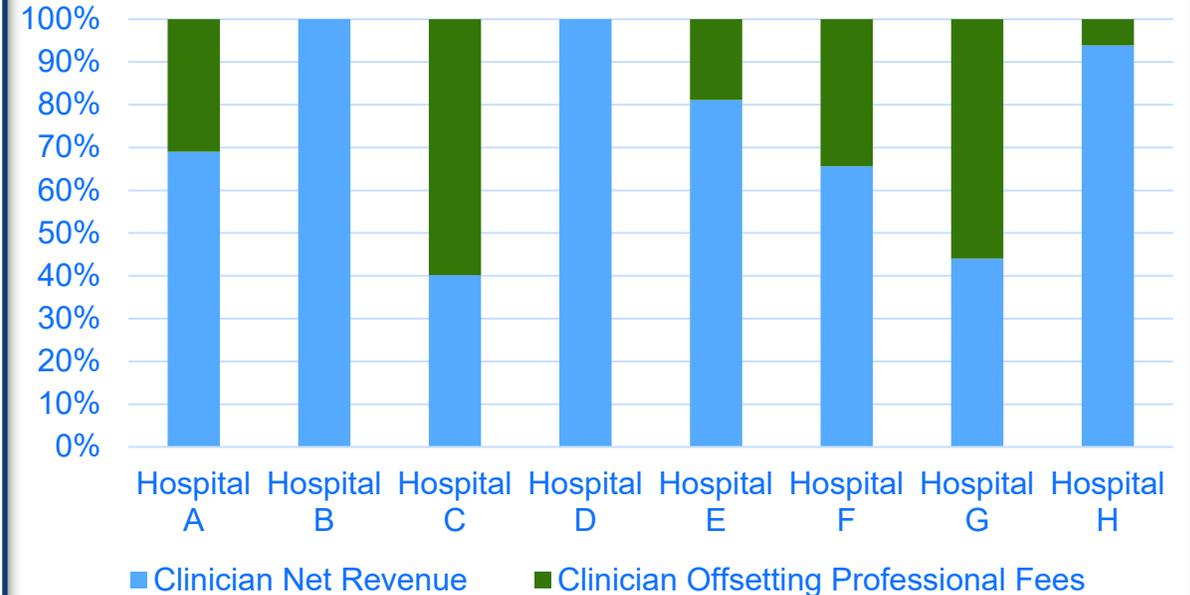


This hospital appears to be much more invested in physicians.

EXAMPLE

Mid-Sized Rural hospitals. **Primary Care (Total Revenue)**

Clinician Net Revenue & Offsetting Professional Fees as a % of Gross Clinician Cost



Some hospitals can only report net revenue.

Overall Metrics Reported – Regulated and Unregulated

5,562

Number of
Clinician FTEs

47k

On-Call Hours
per year

\$2.3b

Gross Clinician
Cost

\$838m

Offsetting
Revenues

\$1.5b

Net Clinician
Cost

Key Points:

1

38 acute care hospitals submitted responses

Cost and Revenues include both regulated and unregulated amounts

2

Submitted results from 34 of 38 acute hospitals were deemed acceptable for evaluating the tool and Clinician cost results. Amounts in this presentation are based on the 34 hospitals included in the data set.

Note:

- 5 Calendar Year hospitals will submit data at a future time.
- Gross Clinician costs increase to \$2.8b include data for 4 hospitals who were otherwise unable to be included

FY 2025 Overall Financial Results*



		Total Clinician Costs	Average Cost per Hospital	% of Regulated Revenue
(data in millions)				
Wages, Benefits & Subsidies	Wages, Salaries & Benefits	\$558	\$16	
	Support Costs	\$479	\$14	
	On-Call Fees	\$125	\$4	
	Other FTE Related Compensation	\$1,152	\$34	
	TOTAL COST OF CLINICIAN SERVICES	\$2,313	\$68	14.9%
Offsetting Revenues	Offsetting Revenue	(\$838)	(\$25)	-5.4%
TOTAL	Clinician Net Cost	\$1,475	\$43	9.5%
	Clinician Net Cost – Unregulated	\$1,017	\$30	6.5%

Notes:

- Amounts based on the 34 hospitals included in database.
- Includes regulated and unregulated data.
- Revenue data excludes specialty hospitals.

Breakdown of Costs – Regulated v. Unregulated

Cost Category (in millions):	TOTAL			% of Total Costs
	Physicians	APPs	Total Clinicians	
Wages, Salaries & Benefits	\$401	\$156	\$558	24%
Support Costs	\$452	\$27	\$479	21%
On-Call Fees	\$114	\$11	\$125	5%
Other FTE Related Compensation	\$1,004	\$149	\$1,152	50%
TOTAL COSTS	\$1,971	\$342	\$2,313	100%
Offsetting Revenue:	(\$755)	(\$83)	(\$838)	36%
Clinician Net Cost	\$1,216	\$259	\$1,475	64%
% of Total	82%	18%	100%	

Physicians	APPs	Total Regulated Clinicians	% of Total Costs
\$78	\$56	\$134	28%
\$40	\$	\$40	8%
\$19	\$	\$19	4%
\$282	\$4	\$286	60%
\$420	\$59	\$479	100%
(\$16)	(\$5)	(\$21)	4%
\$404	\$54	\$458	96%
88%	12%	31%	

Physicians	APPs	Total Unreg Clinicians	% of Total Costs
\$323	\$101	\$424	23%
\$412	\$27	\$438	24%
\$95	\$11	\$106	6%
\$721	\$145	\$866	47%
\$1,551	\$283	\$1,834	100%
(\$739)	(\$78)	(\$817)	45%
\$812	\$205	\$1,017	55%
80%	20%	69%	

82%

of net costs are Physicians

50%

of net costs are driven through related party entities

69%

of all net costs are unregulated

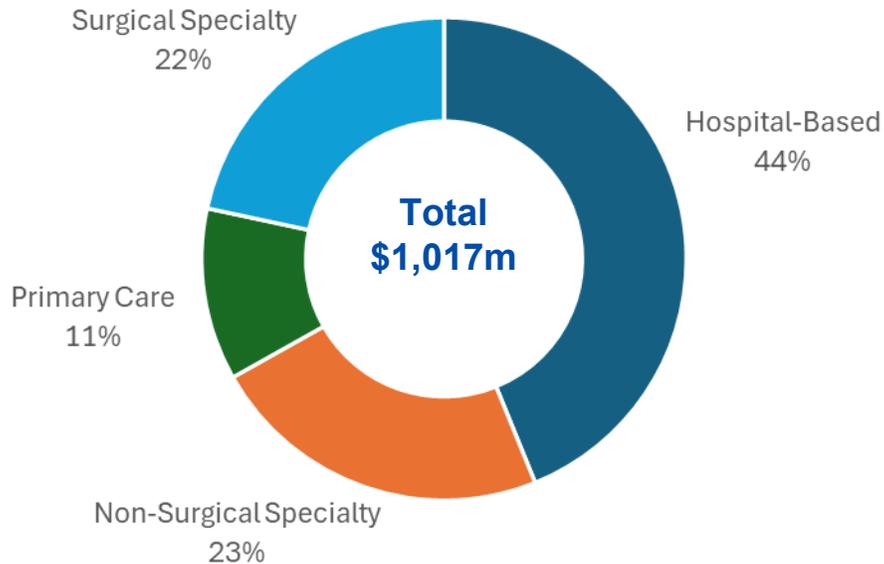
Top 10 Specialties by Net Cost of Clinician Services by Type*

UNREGULATED Only

FY 2025

Total Net Clinician Cost - Unregulated

(in millions)



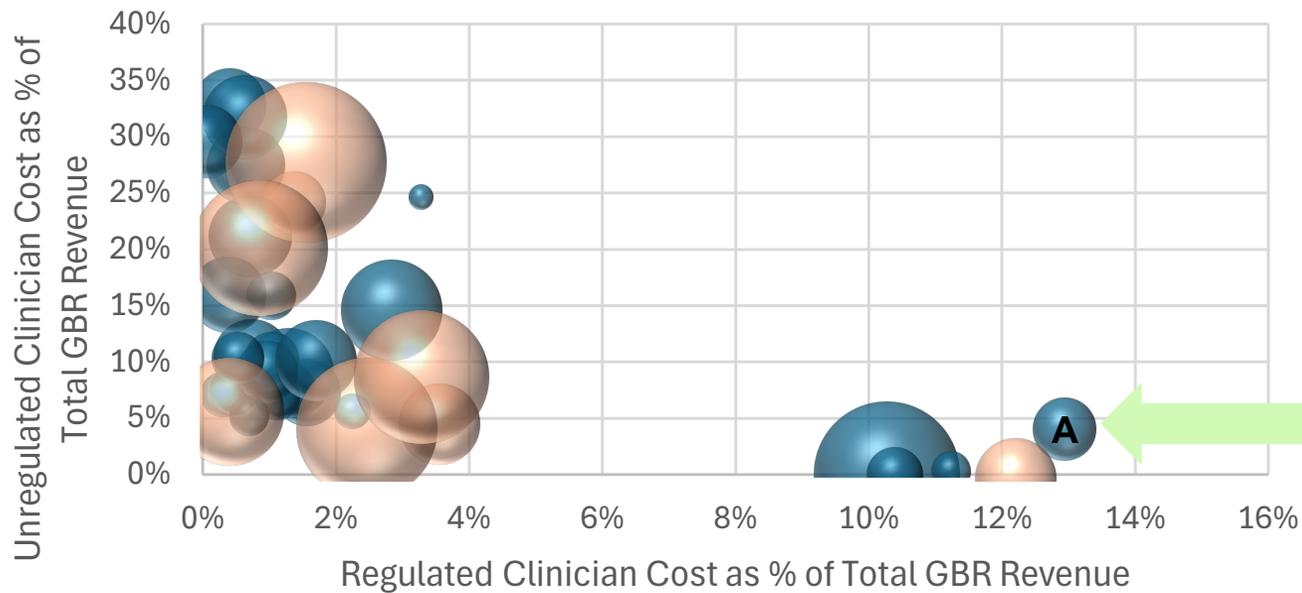
Grouping / Speciality	Gross Clinician Cost (in millions)	% of Total Gross Clinician Cost	Offsetting Revenue as % of Gross Costs
Hospital-Based	\$635	34.6%	28.9%
Anesthesiology	\$215	11.7%	21.8%
Hospitalist: Internal Medicine	\$151	8.2%	33.5%
Emergency Medicine	\$74	4.0%	30.4%
Critical Care: Intensivist	\$61	3.3%	30.2%
Radiology: Diagnostic	\$56	3.1%	31.0%
Hospitalist: Family Medicine	\$22	1.2%	23.0%
Pediatrics: Hospitalist-Int.Med & Gen	\$28	1.5%	48.9%
Hospitalist: OB/GYN	\$12	0.7%	27.2%
Radiology: Interventional	\$6	0.3%	21.1%
Pathology: Anatomic and Clinical	\$4	0.2%	37.9%
All Other Hospital-Based	\$6	0.3%	45.3%
Primary Care	\$292	15.9%	60.3%
Obstetrics/Gynecology: General	\$73	4.0%	46.0%
Internal Medicine: General	\$51	2.8%	47.5%
Internal Medicine: Ambulatory Only (No IP)	\$65	3.6%	70.6%
OB/GYN: Gynecology (Only)	\$13	0.7%	37.6%
Hospice/Palliative Care	\$11	0.6%	33.1%
Family Medicine: Ambulatory Only (No IP)	\$44	2.4%	88.9%
Geriatrics	\$5	0.3%	32.5%
Family Medicine: Sports Medicine	\$2	0.1%	0.0%
Pediatrics: Adolescent Medicine	\$10	0.6%	79.9%
Family Medicine: Urgent Care	\$2	0.1%	17.8%
All Other Primary Care Specialties	\$16	0.9%	93.0%

Grouping / Speciality	Gross Clinician Cost (in millions)	% of Total Gross Clinician Cost	Offsetting Revenue as % of Gross Costs
Non-Surgical Specialty	\$515	28.1%	55.1%
Cardiology: Noninvasive	\$81	4.4%	60.2%
Psychiatry: General	\$34	1.9%	19.2%
Hematology/Oncology	\$110	6.0%	77.7%
Gastroenterology	\$38	2.1%	37.7%
Neurology	\$31	1.7%	44.0%
Pulmonary Medicine: General	\$33	1.8%	54.6%
OB/GYN: Maternal and Fetal Med	\$22	1.2%	56.9%
Pulmonary Medicine: Critical Care	\$11	0.6%	14.4%
Cardiology: Invasive-Interventional	\$23	1.3%	64.5%
Pediatrics: Neonatal Medicine	\$12	0.7%	38.3%
All Other Non-Surgical Specialties	\$119	6.5%	53.2%
Surgical Specialty	\$391	21.3%	44.4%
Surgery: General	\$76	4.1%	32.5%
Orthopedic Surgery: General	\$92	5.0%	66.4%
Surgery: Neurological	\$33	1.8%	30.8%
Surgery: Cardiovascular	\$20	1.1%	34.4%
Surgery: Breast	\$19	1.0%	40.2%
Anesthesiology: Pain Management	\$18	1.0%	53.0%
Urology	\$14	0.8%	42.5%
Surgery: Vascular (Primary)	\$14	0.8%	42.7%
Orthopedic Surgery: Spine	\$13	0.7%	44.9%
Orthopedic Surgery: Hip and Joint	\$10	0.5%	31.8%
All Other Surgical Specialties	\$83	4.5%	39.5%

* Amounts based on the 34 hospitals included in final database, see appendix for amounts including regulated and by gross cost.

Independent v. System Hospitals

Net Cost in Relation to Regulated and Unregulated
% of Total GBR Revenue for all 34 Hospitals



● System hospitals ● Independent hospitals

Comments

- Graph shows how individual hospital Regulated and Unregulated Costs compare to GBR Revenue.
- Graph indicates that some hospitals vary significantly in where they have invested clinician dollars.
- Bubble size is determined by Net Clinician Cost

EXAMPLE

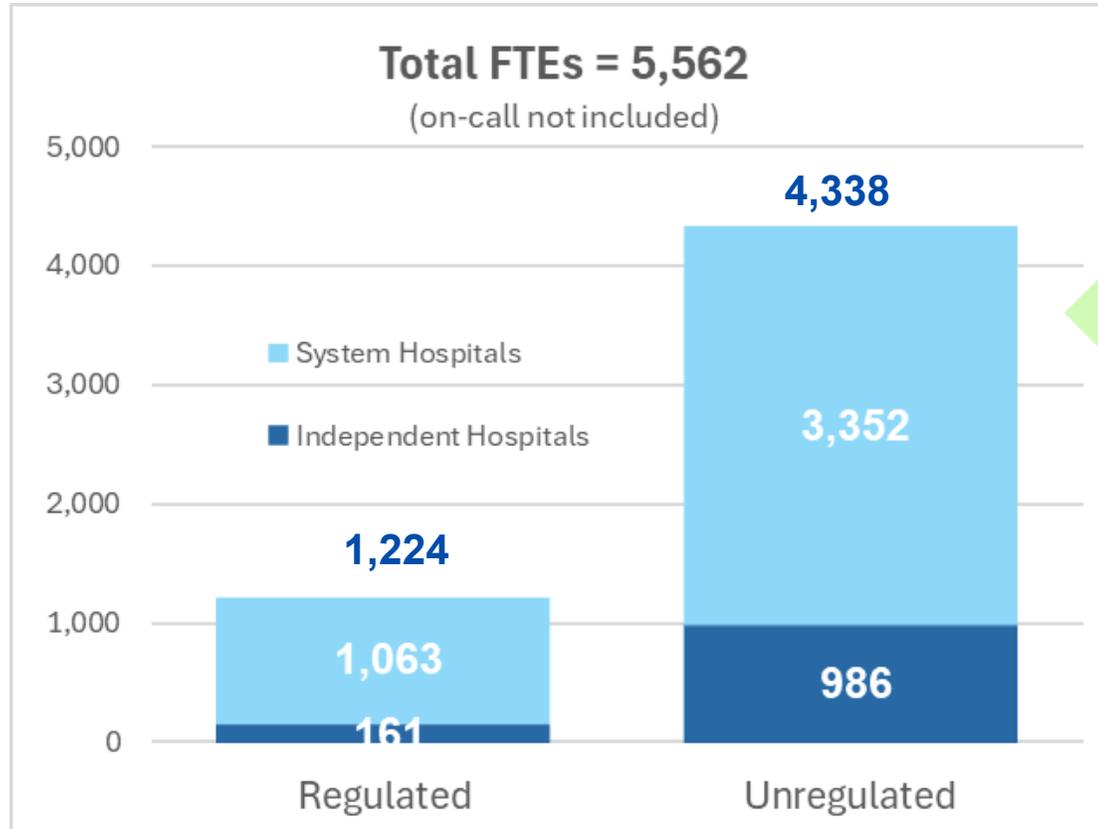
Hospital A Unregulated Clinician Costs are <5% of Total GBR.

Hospital A Regulated Clinician Costs are roughly 13% of Total GBR.

Notes:

- Independent hospitals include those institutions that were not a part of a larger, Maryland-based health system in FY25.

Total FTEs and Net Cost per FTE (excludes on-call)



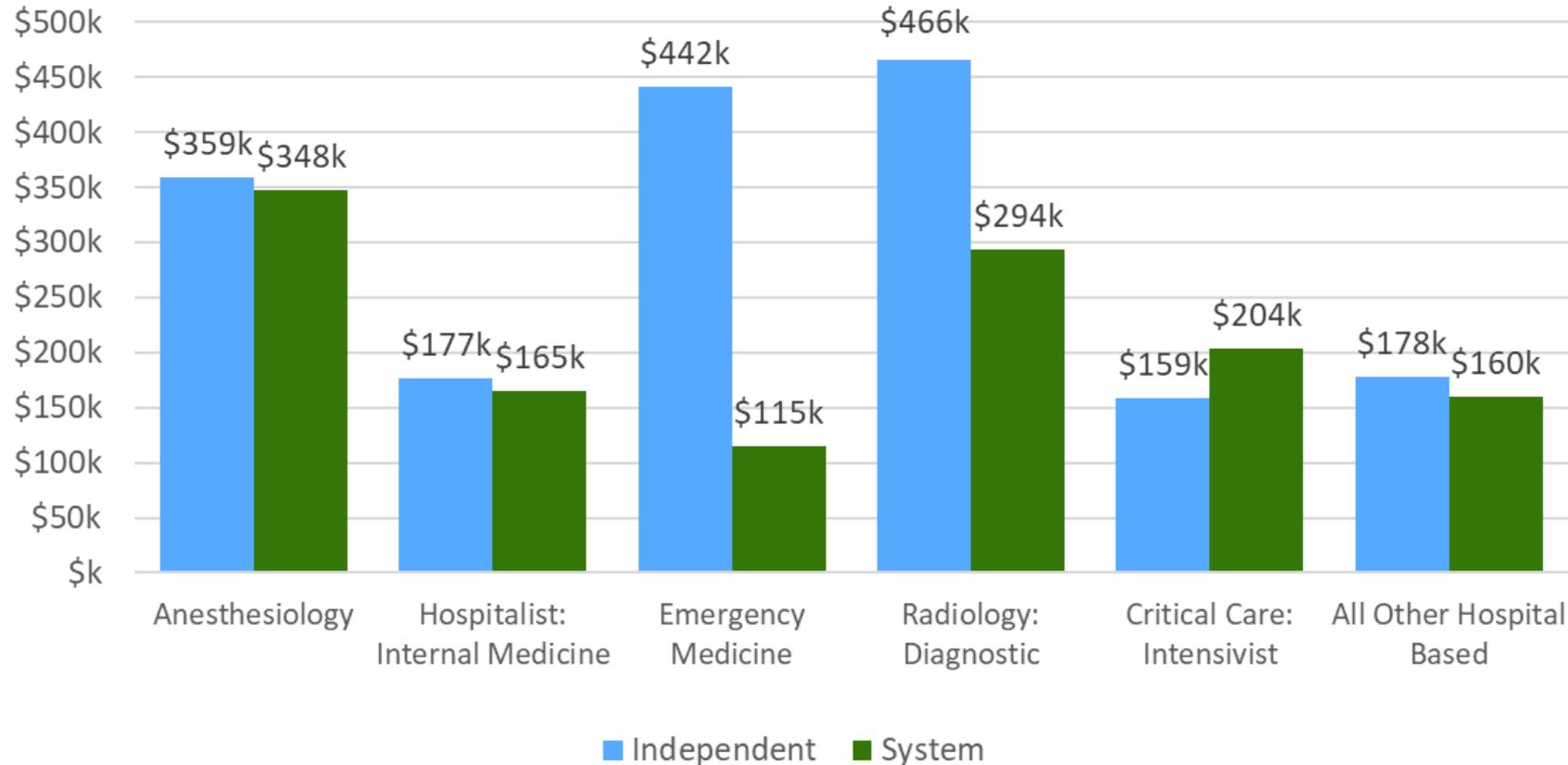
The majority of FTE volumes are in the system hospitals and provide unregulated services.

Net FTE Costs (in millions)	\$438,861k	\$910,939k
Net Cost / FTE	\$359k	\$210k
System Net Cost/FTE	\$351k	\$218k
Independent Net Cost/FTE	\$411k	\$182k

Mix of specialties could provide some explanation for the variance between system and independent.

Top 5 Hospital-Based Specialties Unregulated Net Cost per FTE

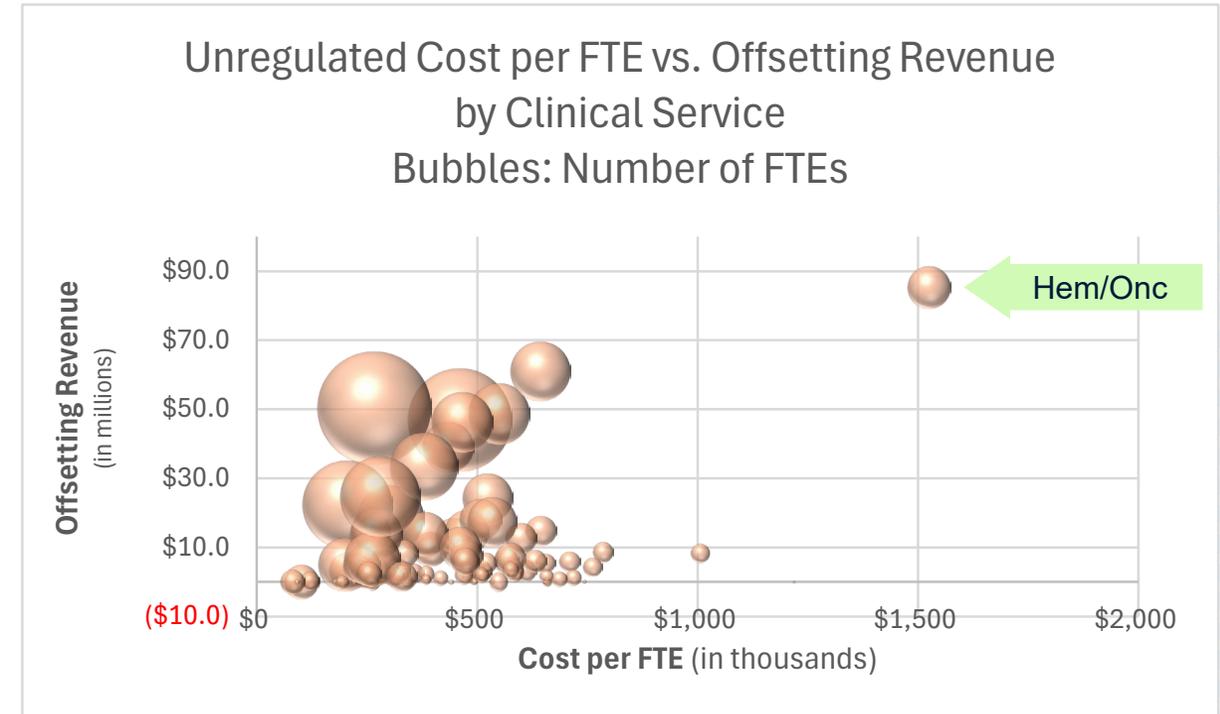
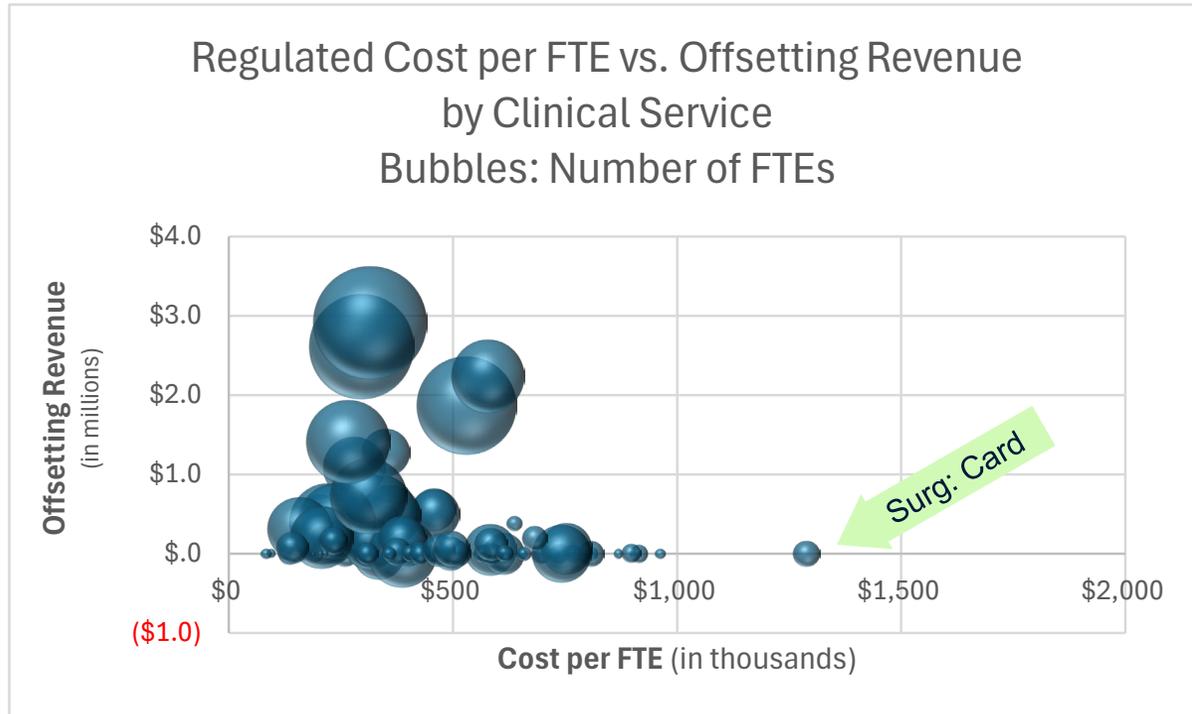
Total Cost per FTE for Top 5 Hospital-Based Specialties



- At a specialty level independent hospitals generally pay more but the gap varies widely.
- Emergency Medicine gap is very large and suggests a potential data issue.

Gross Cost Per FTE – All Hospitals Analysis

Gross Cost per FTE (Not including On-Call)



Total On-Call Costs

On-Call Hours by Category	On-Call Hours			Average On-Call Fee Per Hour	Total Average Fees Per Day	% of Total Fees per Day	
	Physician	APP	All Clinician				
Regulated	20,019	100	20,119	\$19,157,175	\$952	\$52,485	15.3%
Hospital-Based	1,645	-	1,645	\$2,734,087	\$1,662	\$7,491	2.2%
Non-Surgical	9,026	100	9,126	\$6,341,039	\$695	\$17,373	5.1%
Primary Care	707	-	707	\$0	\$0	\$0	0.0%
Surgical	8,641	-	8,641	\$10,082,049	\$1,167	\$27,622	8.1%
Unregulated	23,912	2,520	26,433	\$105,988,693	\$4,010	\$290,380	84.7%
Hospital-Based	10,750	1,145	11,895	\$63,652,571	\$5,351	\$174,391	50.9%
Non-Surgical	4,688	526	5,215	\$11,965,206	\$2,295	\$32,781	9.6%
Primary Care	1,430	294	1,724	\$10,052,010	\$5,831	\$27,540	8.0%
Surgical	7,044	556	7,599	\$20,318,905	\$2,674	\$55,668	16.2%
Total	43,931	2,620	46,551	\$125,145,868	\$2,688	\$342,865	100.0%

On-Call costs include both the hourly on-call amount paid and amount paid to providers when called in for service.

Just over half of on-call hours are unregulated (26k out of 47k)

Total amount paid for all hospitals across Maryland for on-call services per day

Next Steps

These actions are scheduled to occur over the next 6 months

SHARE FY25 DATA

Present data to Hospitals and Commissioners, noting any new trends or anomalies



RELEASE AGGREGATED FY25 DATA

Share aggregated data that is meaningful to Hospitals and Stakeholders



REVIEW SPECIFIC HOSPITAL DATA

Connect with Hospitals to understand some anomalies and create a plan



INCORPORATE INTO eF2

Incorporate CCS data collection into eF2 online submission process



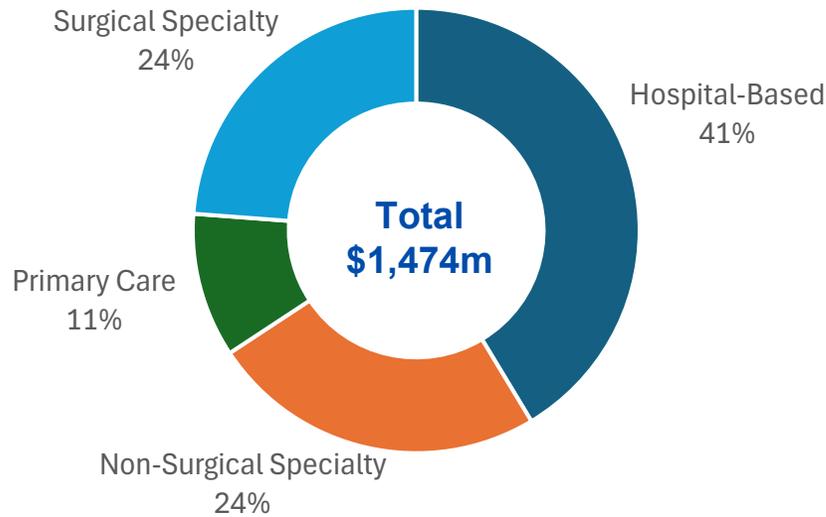
Questions, Comments & Other Suggestions?

Top 10 Specialties by Net Cost of Clinician Services by Type*

FY 2025

Total Net Clinician Cost

(in millions)



Grouping / Specialty	Net Clinician Cost (in millions)	% of Total Net Clinician Cost	Offsetting Revenue as % of Gross Costs
Hospital-Based	\$610	41.4%	24.1%
Anesthesiology	\$210	14.3%	18.9%
Hospitalist: Internal Medicine	\$130	8.8%	29.1%
Emergency Medicine	\$75	5.1%	25.0%
Radiology: Diagnostic	\$62	4.2%	24.0%
Critical Care: Intensivist	\$55	3.7%	25.2%
Peds: Hospitalist-Int.Med & Gen	\$29	2.0%	32.3%
Hospitalist: Family Medicine	\$18	1.2%	22.0%
Hospitalist: OB/GYN	\$9	0.6%	27.9%
Pathology: Anatomic and Clinical	\$9	0.6%	16.0%
Radiology: Interventional	\$7	0.5%	14.9%
All Other Hospital-Based	\$5	0.4%	34.5%
Primary Care	\$155	10.5%	53.5%
Obstetrics/Gynecology: General	\$48	3.2%	41.5%
Internal Medicine: General	\$44	3.0%	36.1%
Internal Medicine: Amb Only (No IP)	\$21	1.4%	68.6%
Hospice/Palliative Care	\$9	0.6%	28.4%
OB/GYN: Gynecology (Only)	\$9	0.6%	36.4%
Pediatrics: Adolescent Medicine	\$7	0.5%	54.9%
Family Medicine: Amb Only (No IP)	\$6	0.4%	86.1%
Geriatrics	\$4	0.3%	28.7%
Family Medicine: Sports Medicine	\$3	0.2%	0.0%
Family Medicine (without OB)	\$2	0.1%	87.9%
All Other Primary Care Specialties	\$2	0.1%	16.3%

Grouping / Specialty	Net Clinician Cost (in millions)	% of Total Net Clinician Cost	Offsetting Revenue as % of Gross Costs
Non-Surgical Specialty	\$359	24.3%	44.6%
Psychiatry: General	\$42	2.9%	14.8%
Cardiology: Noninvasive	\$40	2.7%	55.6%
Hematology/Oncology	\$35	2.4%	70.8%
Gastroenterology	\$31	2.1%	32.4%
Neurology	\$25	1.7%	36.3%
Pulmonary Medicine: General	\$22	1.5%	45.0%
OB/GYN: Maternal and Fetal Med	\$19	1.3%	40.4%
Pediatrics: Neonatal Medicine	\$14	0.9%	26.3%
Cardiology: Invasive	\$12	0.8%	5.0%
Cardiology: Invasive-Interv	\$12	0.8%	56.4%
All Other Non-Surgical Specialties	\$108	7.3%	38.2%
Surgical Specialty	\$351	23.8%	33.5%
Surgery: General	\$67	4.5%	28.2%
Orthopedic Surgery: General	\$43	2.9%	59.0%
Surgery: Neurological	\$40	2.7%	20.2%
Surgery: Trauma	\$25	1.7%	8.4%
Surgery: Cardiovascular	\$20	1.4%	25.7%
Orthopedic Surgery: Trauma	\$16	1.1%	19.5%
Surgery: Vascular (Primary)	\$13	0.9%	30.8%
Surgery: Breast	\$13	0.9%	37.5%
Urology	\$12	0.8%	33.9%
Anesthesiology: Pain Mgmt	\$11	0.8%	47.2%
All Other Surgical Specialties	\$91	6.2%	28.4%

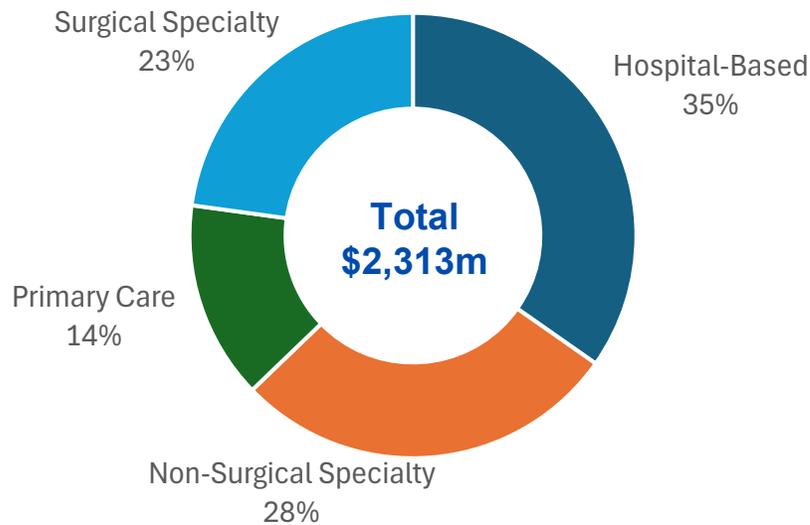
* Amounts based on the 34 hospitals included in final database

Top 10 Specialties by Gross Cost of Clinician Services by Type*

FY 2025

Total Gross Clinician Cost

(in millions)



Grouping / Speciality	Gross Clinician Cost (in millions)	% of Total Gross Clinician Cost	Offsetting Revenue as % of Gross Costs
Hospital-Based	\$804	34.8%	24.1%
Anesthesiology	\$259	11.2%	18.9%
Hospitalist: Internal Medicine	\$183	7.9%	29.1%
Emergency Medicine	\$100	4.3%	25.0%
Radiology: Diagnostic	\$82	3.5%	24.0%
Critical Care: Intensivist	\$73	3.2%	25.2%
Peds: Hospitalist-Int.Med & Gen	\$43	1.9%	32.3%
Hospitalist: Family Medicine	\$23	1.0%	22.0%
Hospitalist: OB/GYN	\$13	0.6%	27.9%
Pathology: Anatomic and Clinical	\$11	0.5%	16.0%
Radiology: Interventional	\$9	0.4%	14.9%
All Other Hospital-Based	\$8	0.3%	34.5%
Primary Care	\$333	14.4%	53.5%
Obstetrics/Gynecology: General	\$82	3.5%	41.5%
Internal Medicine: General	\$69	3.0%	36.1%
Internal Medicine: Amb Only (No IP)	\$67	2.9%	68.6%
Family Medicine: Amb Only (No IP)	\$45	2.0%	8.1%
Family Medicine (without OB)	\$17	0.7%	29.2%
Pediatrics: Adolescent Medicine	\$16	0.7%	54.9%
OB/GYN: Gynecology (Only)	\$14	0.6%	284.2%
Hospice/Palliative Care	\$13	0.6%	12.0%
Geriatrics	\$5	0.2%	0.0%
Family Medicine: Sports Medicine	\$3	0.1%	576.9%
All Other Primary Care Specialties	\$2	0.1%	16.3%

Grouping / Speciality	Gross Clinician Cost (in millions)	% of Total Gross Clinician Cost	Offsetting Revenue as % of Gross Costs
Non-Surgical Specialty	\$649	28.0%	44.6%
Hematology/Oncology	\$121	5.2%	6.1%
Cardiology: Noninvasive	\$89	3.9%	55.6%
Psychiatry: General	\$50	2.1%	172.7%
Gastroenterology	\$46	2.0%	32.4%
Pulmonary Medicine: General	\$41	1.8%	34.6%
Neurology	\$39	1.7%	47.2%
OB/GYN: Maternal and Fetal Med	\$31	1.3%	40.4%
Cardiology: Invasive-Interv	\$26	1.1%	18.7%
Pediatrics: Neonatal Medicine	\$19	0.8%	3.4%
Cardiology: Invasive	\$13	0.5%	119.1%
All Other Non-Surgical Specialties	\$174	7.5%	38.2%
Surgical Specialty	\$528	22.8%	33.5%
Orthopedic Surgery: General	\$104	4.5%	25.0%
Surgery: General	\$93	4.0%	66.5%
Surgery: Neurological	\$50	2.2%	20.2%
Surgery: Trauma	\$28	1.2%	8.4%
Surgery: Cardiovascular	\$27	1.2%	25.7%
Anesthesiology: Pain Mgmt	\$21	0.9%	17.8%
Surgery: Breast	\$20	0.9%	29.2%
Surgery: Vascular (Primary)	\$19	0.8%	39.5%
Orthopedic Surgery: Trauma	\$19	0.8%	32.5%
Urology	\$19	0.8%	54.0%
All Other Surgical Specialties	\$128	5.5%	28.4%

* Amounts based on the 34 hospitals included in final database

Breakdown of Clinician Costs – By Specialty Group, Regulated v. Unregulated

Cost Category (in millions)	TOTAL					Regulated					Unregulated				
	Hospital Based	Non-Surgical	Primary Care	Surgical	Total	Hospital Based	Non-Surgical	Primary Care	Surgical	Total	Hospital Based	Non-Surgical	Primary Care	Surgical	Total
Wages, Salaries & Benefits	\$174	\$159	\$89	\$135	\$558	\$27	\$49	\$24	\$33	\$134	\$148	\$110	\$65	\$102	\$424
Support Costs	\$57	\$203	\$103	\$115	\$479	\$14	\$11	\$1	\$15	\$40	\$43	\$193	\$102	\$101	\$438
On-Call Fees	\$66	\$18	\$10	\$30	\$125	\$3	\$6	\$	\$10	\$19	\$64	\$12	\$10	\$20	\$106
Other FTE Related Comp	\$506	\$268	\$131	\$247	\$1152	\$125	\$67	\$15	\$78	\$286	\$380	\$201	\$116	\$169	\$866
TOTAL COSTS	\$804	\$649	\$333	\$528	\$2,313	\$169	\$133	\$41	\$137	\$479	\$635	\$515	\$292	\$391	\$1,834
Offsetting Revenue:	(\$194)	(\$290)	(\$178)	(\$177)	(\$838)	(\$10)	(\$6)	(\$2)	(\$3)	(\$21)	(\$183)	(\$284)	(\$176)	(\$174)	(\$817)
<i>Offsetting Revenue as % of Total Cost</i>					36%					1%					35%
Physician Net Cost	\$610	\$359	\$155	\$351	\$1,475	\$158	\$128	\$39	\$133	\$458	\$452	\$231	\$116	\$218	\$1,017
<i>% of Total Net Cost</i>	41%	24%	10%	24%	100%	11%	9%	3%	9%	31%	31%	16%	8%	15%	69%

41%

of net costs are Hospital-Based

36%

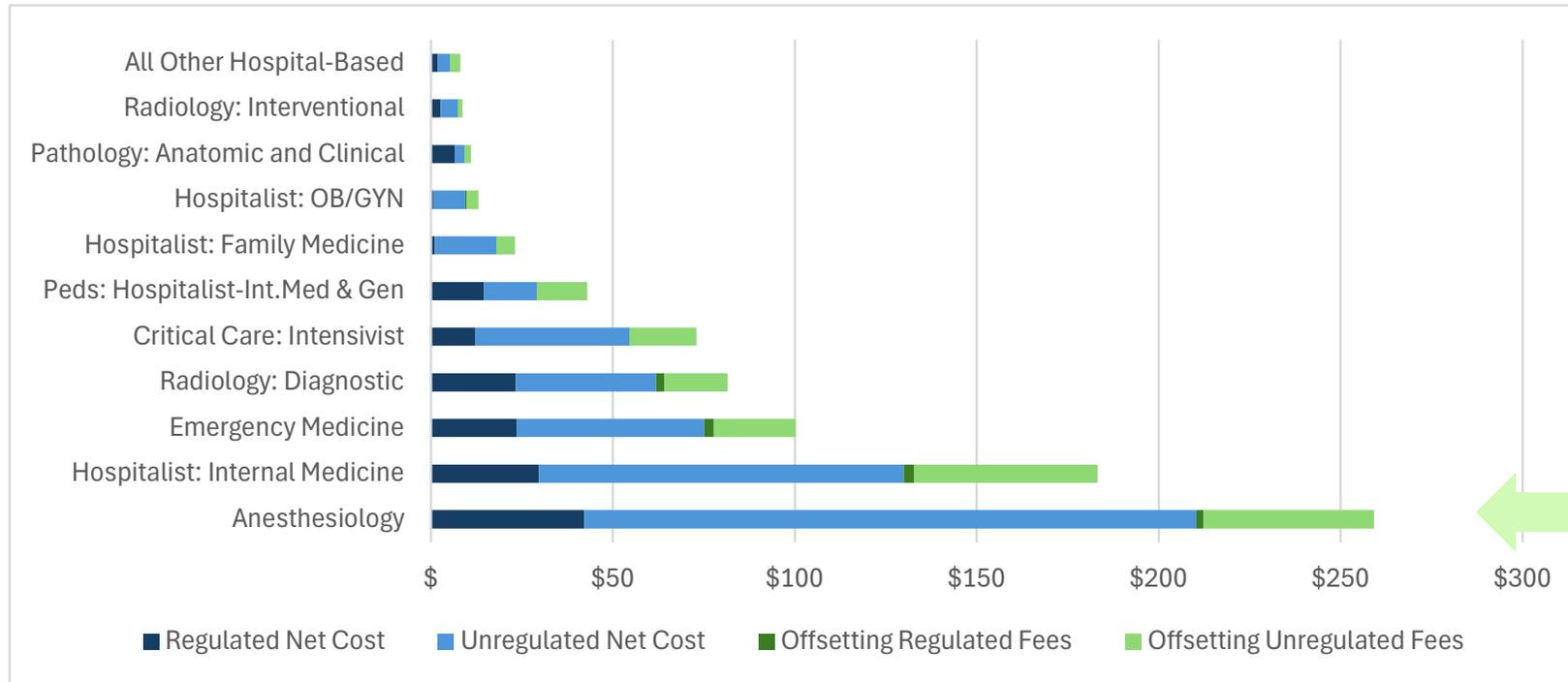
of total costs are offset by billed revenue

1%

of total regulated costs are offset by billed revenue

Top 10 Specialties by Net Direct Cost of Clinician Services – Hospital-Based Breakout

FY2025
Top 10 Hospital-Based Regulated & Unregulated Clinician Costs & Offsetting Revenue
 (in millions)



\$210m
 of net Hospital-Based costs are in Anesthesiology

* Amounts based on the 34 hospitals included in final database



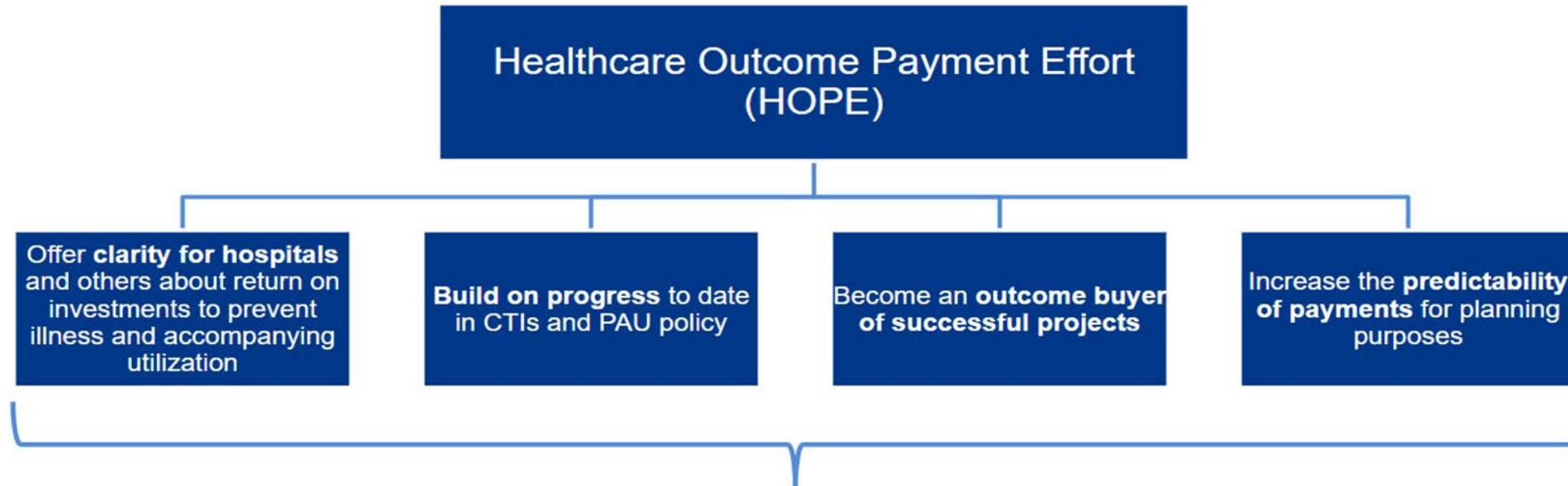
maryland
health services
cost review commission

Healthcare Outcome Payment Effort
Draft Recommendation
March 2026

Christa Speicher

HOPE FRAMEWORK

Care Transformation Initiatives (CTI) are ending June 30, 2026 and this program is the replacement, aligned with AHEAD, to further the goals of the Model.



Achieving Healthcare Efficiency through Accountable Design (AHEAD)

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. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.

Timeline

- **March 2026**
 - Comment letters received during the workgroup process and reviewed with the TCOC workgroup.
 - Written summary of the comments is attached to written recommendation
 - Draft Commission recommendation
 - Discuss program operationalization at TCOC workgroup meeting
- **April 2026**
 - Review Commission comment letters and discuss any revisions for final recommendation with TCOC workgroup
- **May 2026**
 - Final commission vote
- **April - June 2026**
 - Program buildout
- **July 2026**
 - Measurement period start July 1,2026
- **Q2 FY2027**
 - Reporting available

Two Paths to Participation

Care Transformation Framework (CTF)

- *Maryland Acute Hospitals*

Regional and Statewide Initiatives (RSI)

- *Coordinated by non-hospital organization*
- *Partner with one or more Maryland hospitals*
- *Must have regional scope*

Two Paths to Participation Detail

	Care Transformation Framework (CTF)	Regional and Statewide Initiatives (RSI)
Who Participates	Individual hospitals	Regional or statewide initiative with a hospital partner. The initiative which may include provider-led organizations, technology/digital health companies, health plans, community organization, etc. Regional and statewide Initiative partners must have an MOU or contractual agreement in place that outlines how they will work together and funds will be distributed.
Who Applies	Individual hospital or a group of hospitals	Preference is for the non-hospital entity to apply
Level of Intervention	Hospital-level, multiple hospitals could participate in the same intervention.	Regional or statewide – defined regional geography
Approval Process	Program qualification by review committee; no Commission vote required	Program qualification by review committee; Commission vote required
Focus of Work	Hospital-defined populations and interventions focused on reduced ER and inpatient expenditures.	Defined populations and interventions focused on reduced ER and inpatient expenditures.
Savings Model	Base share of savings is 50%	Base share of savings is 50%
Payout Approach	Average savings achieved over 2-year measurement window are paid out annually over a 3-year payment window.	Average savings achieved over 2-year measurement window are paid out annually over a 3-year payment window.
Payer scope	All-payer beginning FY28, Medicare participation is a goal but TBD	All-payer beginning FY28, Medicare Participation is a goal but TBD

Funding Approach - Care Transformation Framework*

- **Commission will establish a funding level for FY27, FY28 and FY29 of \$50M per year.**
 - FY27 - one-time payment into GBRs for infrastructure
 - FY28 - earned outcome payments are paid once for FY28 based on FY27 data
 - FY29 - earned outcome payments are paid annually for 3 years based on FY27 and FY28 data.
- **Commission commits to making earned payouts regardless of position on the relevant savings and affordability tests.**
- **Starting with FY29, payouts for initiatives are fixed for the following three years.**
- **Statewide funding level could be increased in subsequent years based on level of success.**

*Regional and Statewide Initiatives funding will be explicitly approved by the Commission.

Payout and Measurement Schedule

FY27 FY28 FY29 FY30 FY31 FY32 FY33 FY34

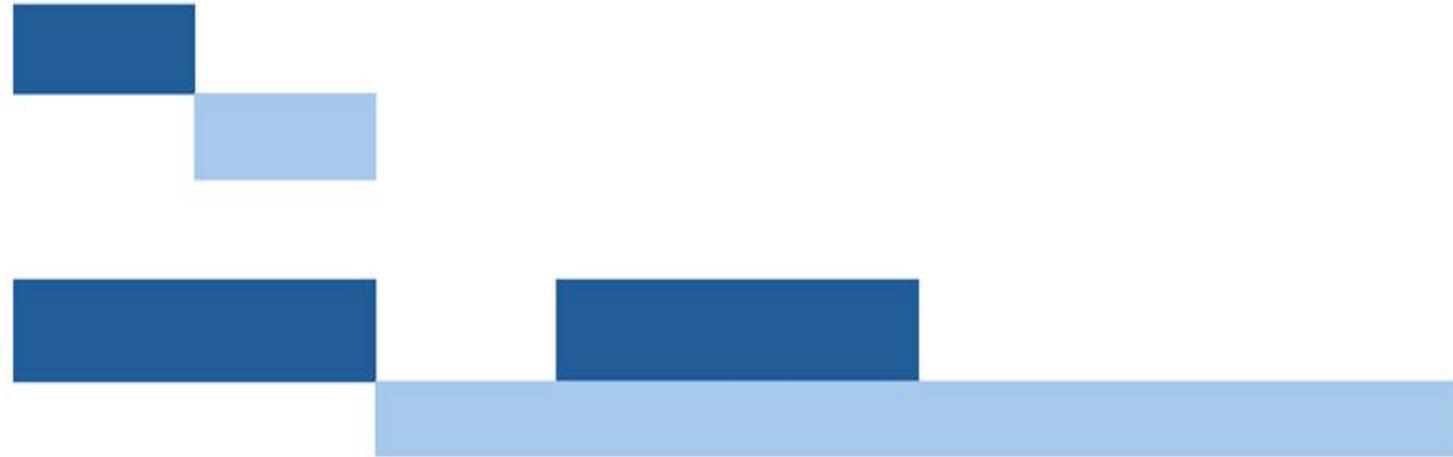
Year 1 Applicant

Initial Measurement Window

Payout Window

Permanent Measurement Window

Payout Window



FY27 Transition Year

- **FY27 represents a transition year and all-payer program measurement is not available, HSCRC would like to maintain support for care transformation infrastructure.**
- **Recommendation to provide a one-time payment distributed proportionally based on GBRs to sustain transformation infrastructure across hospitals. As a condition of receiving the infrastructure payment, hospitals must:**
 - designate a population health leader within their organization and
 - submit a written commitment to develop and submit a HOPE proposal by a specified date.

Methodology for Calculating Outcome Payments

- **Care Transformation Framework Outcome Payment Steps:**
 - **Step 1 - During review process, qualify proposals up to a certain total of projected savings.**
 - **Step 2 - Upon performance period completion, score each intervention in terms of actual savings.**
 - Minimum savings rate and maximum savings rate will be established and impact the actual amount of savings score (likely based on the projected savings amount in Step 1).
 - Base outcome payments will be 50% of scored actual savings.
 - **Step 3 - Adjust the base outcome payment amount, if needed, to fit the total outcome payments within the \$50M annual budget.**
- **Staff will work with TCOC workgroup to refine Steps 2 and 3 and incorporate in the final recommendation.**
- **Regional and Statewide Initiatives will be explicitly approved by the Commission.**

All-Payer Scope & Medicare Inclusion

- **Launch HOPE as an all-payer model by FY2028**
- **Medicare participation is a priority, but implementation will proceed regardless of CMS timing**
- **Use case-mix data in FY2028**
- **Initial focus on inpatient and ED spending**
- **Engage Medicaid and commercial payers more deeply beginning FY2029**
- **Supports transition of Medicare global budgets under AHEAD (CY2028)**

Review Committee

Committee Members

- Public-private review committee assesses and qualifies interventions and communicates guidance to encourage high-quality submissions.
- Leverage practical expertise by including panel members with hands-on care transformation experience to ensure recommendations are actionable.

Governmental

- 1 HSCRC staff (co-chair)
- 1 MDH staff
- 1 staff from MHCC or CHRC

Non-governmental

- 3 experts in health care transformation or community health
- 1 appointed co-chair

Review Criteria

- **In assessing applications, the committee will ensure that:**
 - Submissions reflect meaningful and well-designed interventions
 - 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
 - Total projected savings does not exceed payout cap
- **HSCRC Executive Director makes the final decision on the recommendation of the review committee.**

Review Criteria

- **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.**
 - Specify 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.**
 - 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.**

Interactions with other HSCRC Programs and Policies

- **New Paradigms in Care Delivery (NPCD)**
 - Funding can be used for up-front investments to support innovative care delivery initiatives.
- **Revenue for Reform (RfR)**
 - Cannot utilize the same initiative across RfR and this program.
- **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 is allowed.
- **Efficiency policy**
 - Payments should not count against hospitals in the efficiency policy.
- **Maryland Primary Care Program (MDPCP)**
 - Participation in both is allowed.
 - The review committee will need to consider that resources are already dedicated to prioritize other strategies.

Staff Recommendation

- HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD and creates a glidepath for CTIs ending in June of 2026. 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.

Comment letters are due by March 25, 2026 and can be sent to Christa.speicher@maryland.gov



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Healthcare Outcome Payment Effort

Draft Recommendation

March 11, 2026

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This is a draft recommendation for consideration by the Commission. Public comments must be received by March 25, 2026, to christa.speicher@maryland.gov.

Recommendations for FY27 Policy

This recommendation outlines the proposed policy framework for the Healthcare Outcomes Payment Effort (HOPE) to be implemented beginning in Fiscal Year 2027 (FY27). HOPE replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) staff are proposing to sunset 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 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.¹ With stakeholder feedback, HSCRC staff continue to refine the program and create a glidepath for sunsetting CTIs on an accelerated timeline. Staff is proposing the following timeline to implementation:

March 2026

- Draft Commission recommendation
- Discuss program operationalization at Total Cost of Care (TCOC) workgroup meeting
- Commission comment letters due on March 25, 2026

April 2026

- Review Commission comment letters and discuss any revisions for final recommendation with TCOC workgroup

May 2026

- Final commission vote

April - June 2026

- Program buildout

July 2026

- Implementation - Standard measurement period start July 1, 2026

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 shared savings 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 lower overall health costs, improved care coordination, and more transparent, outcome-driven accountability. 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.

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

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 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 a three-year annual payout structure based on the prior two years of validated savings. At the same time, it moves toward 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 1: 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. 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 two-year 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 following measurement over two years. 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

Based on 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. Funding for Regional and Statewide initiatives funding are individually approved by the Commission will not count towards the \$50 million.

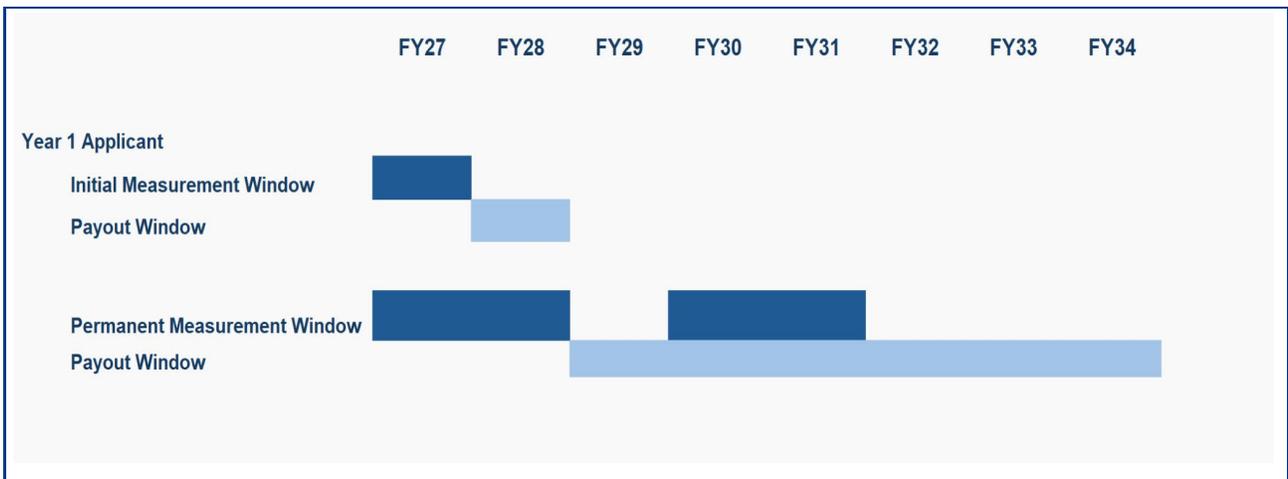
Stakeholders also strongly supported a model that encourages participation without exposing providers to financial risk like the CTI offset. As a result, the program is voluntary and structured as an upside-only shared savings model, with no downside risk. The approach laid out below lowers barriers to entry and enables hospitals and initiative partners to focus on transformation efforts without the concerns of an offset or penalty. In terms of distribution, stakeholders favored a model that rewards sustained performance rather than short-term fluctuations. Shared savings are therefore based on average savings achieved over a two-year 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 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 to ensure methodological rigor. For the first year of the program, all initiatives will use calendar year 2025 as the baseline for measuring performance.

Payments will equal 50% of measured savings unless the total outcome payments due exceed the available funding in which case payments will be scaled based on projected savings or other mechanisms, to be determined. Importantly, the Commission commits to making earned payouts regardless of performance on relevant savings and affordability tests. Once established, payouts for individual initiatives will remain fixed for the subsequent three years. Additionally, the statewide funding level may be increased in future years if the program demonstrates sufficient success. See **Figure 1**.

Figure 1. Payout and Measurement Schedule



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 payment distributed proportionally based on Global Budget Revenues (GBRs) to sustain transformation infrastructure across hospitals. As a condition of receiving the infrastructure payment, hospitals must designate a population health leader within their organization and submit a written commitment to develop and submit a HOPE proposal by a specified date.

Savings Measurement

Stakeholders called for a measurement methodology that is rigorous, transparent, and data-driven. Payment levels will be based on two years of statistically reliable, validated savings performance, calculated using all-payer claims data to ensure consistency and broad accountability. For the first year of the program, all initiatives will use calendar year 2025 as the baseline for measuring performance. Staff will collaborate with industry and measurement experts to develop and document a transparent, statistically defensible approach.

As shown in **Figure 1**, the initial measurement window begins in FY27; however, staff will also evaluate FY26 performance, as appropriate, given that there is only one year of data available for FY2028 payouts. While staff will continue to prioritize reliable measurement, they may allow payouts based on a single year of performance during this transitional period. As reflected in **Figure 1**, FY29 savings will be recertified once two full years of data are available.

All-Payer Scope

The overarching goal is for HOPE to operate effectively in an all-payer environment by FY2028. Achieving this requires deliberate alignment across Medicare, Medicaid, commercial payers, and hospitals to ensure the model is sustainable and operationally feasible over time. Medicare participation is viewed as critically important to long-term success. 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 balanced 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. 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 innovative care delivery initiatives.
- **Revenue for Reform (RfR)**
 - The same initiative cannot be utilized across RfR and this program.
- **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.

Conclusion

HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD and create a glidepath for CTIs ending in June of 2026. 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.

Appendix - Comment Letters

Staff received a first round of comment letters via the Total Cost of Care Workgroup on February 13th that offered insight and feedback on the initial HOPE design proposal. Comments from thirteen organizations are summarized below.

1. Adventist HealthCare:

- a. Program Design and Funding: Requests input on how HSCRC will ensure the update factor continues to fulfil its core purpose of supporting inflation and demographic change if outcome payments are funded through the update factor. Requests input if funding from an all-payer update mechanism creates cross-subsidization concerns. Requests input on hospitals savings contribution scoring separately from broader system savings to ensure aligning between update factor funding and policy.
- b. Incentive Structure and Equity: Requests more info behind improvement-only without attainment structure, rollover eligibility for newer interventions, and risk of reinforcing low utilization driven by medically necessary care access constraints.
- c. Scope Alignment with Federal Frameworks: Requests more information on the all-payer structure, alignment with Geo AHEAD and federal methodologies, and considerations for sunseting legacy CTI structures.
- d. Governance, Process, and Transparency: Requests more information on technical review panel, formal draft policy for public comment prior to Commission action, and transparency standards.
- e. Regional and Statewide Initiative Structure: Requests more information on HSCRC assessment of projected impact, upfront investment costs, savings distribution methodology, applications leads, and savings measurements reflecting intent-to-treat populations.

2. Audacious Capital

- a. Program Design and Funding:
 - i. States continued innovation under HOPE positions the state to align with evolving federal models while exporting successful approaches beyond its borders.
 - ii. States Maryland can scale what already works, including the following opportunity areas meriting continued focus:
 1. Leveraging statewide encounter data and post-acute performance tools to strengthen transitions of care, reduce avoidable readmissions, and lower emergency department utilization.

2. Scaling high-performing care management programs for patients with complex chronic conditions and frequent hospital utilization.
 3. Expanding behavioral health crisis response and community-based alternatives to emergency department utilization through coordinated regional approaches.
 - iii. States clear measurement frameworks, rigorous risk adjustment, and transparent savings methodologies will support participation and investment while ensuring fairness across systems serving diverse populations.
 - iv. States rapid scaling of successful pilots will allow benefits to be realized statewide more quickly.
 - v. Proposes shortened performance feedback loops. Prior HSCRC programs relied on long measurement cycles that are difficult for health system leadership to actively manage toward targets.
 - vi. Proposes more frequent reporting and interim performance signals.
3. Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE)
 - a. Start-Up Funding: Proposes the commission to continue to provide such funds for community-initiated programs through programs such as New Paradigms in Care Delivery. All-Payer Approach: States limiting the payer base for the purposes of calculating shared savings will greatly underestimate the true health economic impact of programs targeted at managing and mitigating chronic disease.
 - b. Alignment with Community and Hospital Initiatives: States misaligned incentives, or a diminishment of the rewards available to particular components of the system, threaten the landscape for innovation.
4. The Day Clinic
 - a. All-Payer Inclusion: Proposes including Medicare in the payment model is integral to success.
 - b. Regional Initiative Savings Participation: Encourages exploring setting the savings participation at 50% as aligning the payment model with investment will increase changes of success.
 - c. Start-Up Funding: States upfront funding for regional initiatives will be important to get initiatives off the ground, similar to New Paradigms in Care Delivery funding.
 - d. Performance Payment Timing: Proposes considering a year 2 payment based on year 1 performance that can then be reconciled as necessary based on claims run-outs or other adjustments, as these efforts may have limited working capital to fund operations and waiting 2 years could create operational cash flow challenges.
5. Greater Baltimore Medical Center

- a. CTI Rollover Criteria: States proposed CTI rollover criteria may be overly stringent as transformation work of this scale often requires a multi-year runway before savings stabilize and become statistically visible. Requests consideration of more recent, performance-optimized CTIs for rollover to preserve program momentum and protect prior infrastructure investments.
 - b. NPI Stability and Minimal Savings Rate Risk: States concerns regarding the loss of attributed NPIs if older-year CTIs are prioritized. Provider composition shifts annually and a structure that inadvertently reduces stability may unintentionally penalize otherwise effective clinical transformation efforts.
 - c. ECIP Transition and Preserving Savings: Proposes consideration of a structured transition pathway for high-performing ECIP initiatives so that successful care redesign efforts are not discontinued due to programmatic restructuring.
 - d. Program Development Timeline: States concern of proposed timeline for finalizing and operationalizing the new program. Requests that program clarity and structural stability be prioritized over speed of implementation. States appreciation for pursuing an upside-only model and the decision not to include a 2% offset in FY2027.
6. Johns Hopkins Health System
- a. Program Design and Funding:
 - i. Supports the voluntary and upside-only approach: Encourages the HSCRC to preserve it as the framework is finalized.
 - ii. Concerned about the proposed treatment of the outcome payments in the context of the annual update factor. States incorporating the outcome payments into the model should not take dollars away from some hospitals in order to reward others through any mechanism.
 - iii. Supports the intent of the program and looks forward to further detail around savings and measurement methodology.
 - b. All-Payer Inclusion: Looks forward to further detail about implementation into an all-payer environment: States limiting only to inpatient and emergency department data will narrow the scope and potential to measure the impact of meaningful efforts across the care continuum.
7. Johns Hopkins School of Nursing
- a. Program Timeline: States calculating savings using two years as the measurement period for savings will capture short term impact on utilization but will not reflect prevention strategies that support health and well-being over the medium to long term. Proposes HSCRC to consider how it could evolve the program, particularly for new participants in later years, to incentivize approaches that shift the system toward prevention and

restorative health so that hospitals can focus on appropriate utilization. Also, encourages consideration of layering outcome measures on the savings targets to determine payouts.

- b. Outcome Measurements: States supporting localized interventions that offer longer term gains will also require measurable population-level outcomes at meaningfully smaller spatial scales than are currently available to program evaluators.

8. LifeBridge Health

a. Program Recommendation:

- i. Recommends sunseting the CTI program after FY 2027 and not implementing the healthcare outcome payment effort program due to the growing operations complexities that will emerge once Medicare global budgets transition out of HSCRC authority. Supports establishing a final payout model that allocates a defined share of positive savings while considering Medicare TCOC requirements under the AHEAD model.
- ii. Proposes implementing the final CTI payout for FY 2027 through a defined percentage of upside-only payments.
- iii. States HSCRC payment programs should align with Medicare methods and requirements instead of creating duplicative work and administrative burden.
- iv. States concern over program limiting eligibility to CTIs with multi-year consistent savings – penalizing hospitals investing in innovative care-management strategies.

9. Maryland Citizens' Health Initiative and United States of Care

- a. Stakeholder Process: Encourages incorporating the unique needs of beneficiaries through “patient-first care” during program design.

10. Maryland Hospital Association

- a. Source of Funding: Requests clarification on how program will be funded in the near term and long term including: impact on annual payment update; impact on hospitals that do not have qualifying rollover CTIs; capping of rewards; funding structure operationalize with CMS Medicare hospital global budgets; and funding for non-Medicare payers through HSCRC-administered hospital global budgets.
- b. New Care Transformation Framework: Requests clarification on rationale for selecting the proposed rollover CTI criteria and how the criteria considers new initiatives that show promise but are yet to demonstrate savings.
- c. Regional and Statewide Initiatives: MHA seeks further detail on: assessing potential impact of new interventions; upfront investment costs; savings distributions; application lead; eligibility of nonhospital organizations; and savings measurement.
- d. Technical Panel: Requests further information on technical panel eligibility, criteria, and HSCRC processes to ensure transparency in panel decisions.

- e. All-Payer Evaluation Data: Requests details on HSCRC's plan to obtain commercial claims information to support the all-payer approach being contemplated.
- f. Comprehensive Population Health Strategy: Urges a review of all HSCRC-led hospital population health programs to identify needed changes and alignment with AHEAD statewide Population Health Accountability Plan.

11. MedStar Health

- a. Program Governance: Requests more information on technical review panel and states need for individuals with experience in operationalize care transformation programs to be involved.
- b. Financial Structure: Supports fixed payments for earned savings. Requests transparent allocation of funds for payments and recommends payments for savings be guaranteed as a share of a prespecified available funding amount that is transparently developed.
- c. Rollover CTIs: Supports current plan.
- d. Regional Collaboratives: States proposed regional structure should not exclude hospitals and/or health systems from being the anchor entity. Also, strongly opposes to the funding of shared savings via update factor as funding in an uncapped fashion would be destabilizing.

12. Primary Care Coalition

- a. Program Design and Funding:
 - i. Suggests setting the statewide and regional initiatives to 50% of measured savings as well.
 - ii. Encourages allowing multiple hospitals to participate in a single new care transformation framework to offer the efficiency of shared initiatives while measuring individual hospital performance.
 - iii. Requests clarification on Medicare only limitations for statewide and regional initiatives in FY 2027. Suggests additional inclusion of Medicaid and Self-Pay.

13. University of Maryland Medical System

- a. Program Design and Funding
 - i. Suggests continuing to define intent-to-treat populations and measure TCOC.
 - ii. Suggests shared savings structure should build from a recognition of TCOC growth and lower hospital charge benefits currently provided to payers.
 - iii. Suggests required all-payer engagement to fill ACOS and commercial value-based gaps in MD.
 - iv. Suggests financing through hospital rate controls and identifying max annual pool with room for growth.

- v. Encourages HSCRC to commit to a ceiling or pool of investment developed with the industry to transform under AHEAD and sustain hospital transformation.
- vi. States moving from TCOC to only potentially avoidable utilization in the hospital setting will regress from Model's progress.
- vii. Discourages HSCRC from duplicating investments in primary care.
- viii. Concerns regarding proposed rollover methodology for FY2027.
- ix. Urges HSCRC to extend ECIP through December 31, 2026.



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RY 2028 Readmissions Reduction Incentive Program Final Policy

March 11, 2026

HSCRC Quality Team

RY 2028 Final Recommendations for Commissioner Vote

1. Maintain the 30-day, all-payer, all-cause, all-condition readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 compared to two-year base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
 - a. Adjust case-mix readmission rate by the Out of State (OOS) Utilization Adjustment to account for OOS readmissions and transfers for RY 2027 beyond.
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide regular updates on by-hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Stakeholder Feedback

Comment Letters

Staff received comment letters from:

- Health Means Everything (HME) Consumer Alliance
- Maryland Hospital Association (MHA)
- Maryland Department of Health (MDH)
- Adventist Health
- Luminis Health
- Garrett Regional Medical Center

In general, comments were supportive of the RY 2028 recommendations with the suggestion of applying the newly proposed OOS adjustment retrospectively to RY 2026 and prior RYs. Commenters also gave recommendations on which measure to align with under AHEAD.

Summary of Stakeholder Feedback

Stakeholder Comment Letters for RY 2028 RRIP	Adventist	MHA	Luminis Health	Garrett	MDH	HME
Fully align with HRRP but maintain the reward incentive	X					
Align with PHAP goal (NCQA PCR measure)					X	X
Transparency on OOS ratio revision and financial impacts	X					
Apply OOS revision retrospectively (# of years varies by letters)	X	X	X	X		
Model revenue adjustment using HRRP, NCQA PCR, and HWR measures		X				

Overall Support for RY 2028 RRIP Policy

- Stakeholder feedback
 - HME and MHA expressed support for maintaining the current RRIP policy for at least RY2028.
 - Adventist supported current RRIP policy if full alignment with HRRP is infeasible.
- Staff's response:
 - Staff appreciates stakeholder's support for maintaining the program in RY 2028, including the previously established improvement and attainment goals and revenue adjustment methodology.

Alignment of RRIP Under the AHEAD Model

- Stakeholder feedback:
 - HME and MDH supported aligning the RRIP measure with the NCQA PCR measure included in Maryland's PHAP for the AHEAD model.
 - Adventist supported aligning the future RRIP measure with HRRP's condition-specific measures but with maintenance of rewards.
 - MHA didn't specify support for a specific alignment option but requested that the HSCRC provide comparative by-hospital modeling on hospitals' performance on the HRRP, NCQA PCR, and HWR measures.
- Staff response
 - Staff believes that alignment with the PHAP goal is warranted to ensure achievement of the statewide biannual goals required under AHEAD and would like Commissioner feedback on what options to prioritize.
 - Staff will work with contractors to evaluate the feasibility of potential alignment options and work with PMWG, Commissioners, and other stakeholders on HRRP transition timeline and RY 2029 policy.

Attainment Methodology: Out of State Adjustment

- To fairly assess relative performance across hospitals (i.e., attainment), the case-mix adjusted readmission rate is adjusted for out of state readmissions.
 - Prior to RY 2018, readmission performance assessed on improvement only
 - Due to concerns about hospital with low readmission rates having less opportunity for improvement, the attainment goal was added in RY 2018
 - Adjustment of OOS readmissions to fairly compare hospitals as some hospitals may have higher OOS readmissions (e.g., border hospitals, systems with OOS hospitals)
 - Adjustment based on CMMI Medicare report that provides count of out of state readmissions
 - Staff validated the reported readmission count using Medicare CCW data in order to assess concerns from hospitals regarding the accuracy of the adjustment
 - Two issues were discovered during this validation:
 - Double counting of out of state readmissions when followed by third admission or transfer back to MD
 - Transfers out of state that are then transferred back to Maryland flag a readmission

OOS Utilization Adjustment

- Working with stakeholders, staff were able to identify an effective approach to adjusting readmission rates to account for OOS readmissions and transfers
 - **OOS Utilization Adjustment**= $\text{CCW Readmission Rate} / \text{CCW- MD Readmission Rate}$
 - This will account for any OOS differences seen between CCW and Case-Mix
 - Validated this adjustment method by applying OOS readmission adjustment and OOS transfer adjustment
- Staff are recommending to apply this adjustment to RY 2027 and beyond

OOS Transfers

- Stakeholder feedback:
 - MHA expressed concern regarding the identification of OOS transfers across payers and encouraged staff to pursue a multi-payer approach to improve the accuracy and fairness of the OOS transfer calculation.
- Staff response:
 - The proposed OOS Utilization Adjustment using *Medicare* FFS data is an initial step in addressing OOS utilization for both transfers and readmissions.
 - Staff will continue to work with stakeholders to explore opportunities to incorporate other payers' data sources and refine the methodology.

OOS Readmissions

- Stakeholder feedback
 - MHA, Garrett, Luminis Health, and Adventist supported addressing the double counting of readmissions in the OOS ratio.
 - Adventist supported correcting the issue in RY 2027, but requested additional transparency.
 - Garrett and Luminis Health requested the corrections be applied for RY 2026 and prior rate years retrospectively.
 - MHA recommended applying the correction to multiple rate years, citing precedent for retrospectively correcting errors.
- Staff response:
 - Staff recommend modifying the attainment adjustment methodology to use the OOS Utilization Adjustment which addresses the double counting of readmissions as well as the OOS transfer issue
 - The identified issue reflects a methodological limitation, not an implementation or staff error, thus staff do not think this should be applied retrospectively.
 - However, a one-time staff error was also identified in RY 2026. Staff recommends updating revenue adjustments only for those hospitals that would have received additional revenue (i.e., lower penalty or higher reward without the error).

RY 2028 Final Recommendations for Commissioner Vote

1. Maintain the 30-day, all-payer, all-cause, all-condition readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 compared to two-year base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
 - a. Adjust case-mix readmission rate by the Out of State (OOS) Utilization Adjustment to account for OOS readmissions and transfers for RY 2027 beyond.
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide regular updates on by-hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Appendix

Options for Addressing Staff Error in RY 2026

1. Maintain the current RY 2026 results and not correct the staff implementation error.
2. Correct the error using the originally intended OOS readmission ratio.
3. Implement the newly proposed OOS Utilization Adjustment.

Staff recommend Option #2 which is consistent with precedent on how errors and methodology changes are normally handled.

- Due to this being a retrospective revenue adjustment that is relatively small statewide, Staff recommend updating revenue adjustments for only those hospitals that would have received additional revenue (i.e., lower penalty or higher reward).

Summary of Impact of Change in OOS Adjustment

RY 2026 Revenue Adjustments by Option		Option 1: Maintain what went into rates and do not fix staff error		Option 2: Correct error but do not update OOS methodology				Option 3: Update RY 2026 using the new OOS utilization adjustment				
		Revenue Adjustment		Revenue Adjustment		Difference from Rates		Revenue Adjustment		Difference from Rates		
HOSPITAL ID	HOSPITAL NAME	\$	%	\$	%	\$	%	\$	%	\$	%	
210017	Garrett	-\$22,236	-0.07%	-\$181,061	-0.57%	-\$158,825	-0.50%	\$508,240	1.60%	\$530,476	1.67%	
210035	UMMS- Charles	-\$84,173	-0.08%	\$147,303	0.14%	\$231,476	0.22%	\$778,604	0.74%	\$862,777	0.82%	
210039	Calvert	-\$679,575	-0.80%	-\$450,219	-0.53%	\$229,356	0.27%	-\$433,229	-0.51%	\$246,346	0.29%	
210051	Luminis- Doctors	\$585,123	0.30%	\$585,123	0.30%	\$0	0.00%	\$780,163	0.40%	\$195,040	0.10%	
210049	UMMS-Upper Chesapeake	-\$2,993,814	-1.15%	-\$2,655,383	-1.02%	\$338,431	0.13%	-\$2,759,515	-1.06%	\$234,299	0.09%	
210044	GBMC	\$1,402,356	0.51%	\$1,484,848	0.54%	\$82,492	0.03%	\$1,484,848	0.54%	\$82,492	0.03%	
210030	UMMS- Chestertown	\$216,606	2.00%	\$203,610	1.88%	-\$12,996	-0.12%	\$216,606	2.00%	\$0	0.00%	
210018	MedStar- Montgomery	-\$482,409	-0.45%	-\$557,451	-0.52%	-\$75,042	-0.07%	-\$482,409	-0.45%	\$0	0.00%	
210058	UMMS- UMROI	-\$202,066	-0.23%	-\$202,066	-0.23%	\$0	0.00%	-\$224,517	-0.25%	-\$22,452	-0.03%	
210057	Adventist- Shady Grove	-\$2,022,306	-0.56%	-\$2,166,756	-0.60%	-\$144,450	-0.04%	-\$2,311,207	-0.64%	-\$288,901	-0.08%	
210002	UMMS- UMMC	-\$9,277,409	-0.59%	-\$9,434,653	-0.60%	-\$157,244	-0.01%	-\$11,950,561	-0.76%	-\$2,673,152	-0.17%	
210037	UMMS- Easton	\$2,324,864	1.68%	\$1,923,548	1.39%	-\$401,316	-0.29%	\$2,075,771	1.50%	-\$249,093	-0.18%	
210003	UMMS- Capital Region	\$1,073,652	0.33%	\$422,954	0.13%	-\$650,698	-0.20%	-\$97,605	-0.03%	-\$1,171,257	-0.36%	
210061	Atlantic General	\$4,984	0.01%	-\$134,567	-0.27%	-\$139,551	-0.28%	-\$284,085	-0.57%	-\$289,069	-0.58%	
Statewide Impact												
STATEWIDE	\$	12,634,054,157	-\$27,938,378	-0.22%	-\$28,796,745	-0.23%	-\$858,367	-0.01%	-\$30,480,871	-0.24%	-\$2,542,494	-0.02%
Penalty			-\$45,138,690	-0.36%	-\$45,156,858	-0.36%	-\$18,168	0.00%	-\$47,917,830	-0.38%	-\$2,779,141	-0.02%
Reward			\$17,200,312	0.14%	\$16,360,113	0.13%	-\$840,199	-0.01%	\$17,436,959	0.14%	\$236,647	0.00%
Statewide Impact if Negatively Impacted Hospitals Held Harmless												
STATEWIDE	\$	12,634,054,157	-\$27,938,378	-0.22%	-\$27,056,623	-0.21%	\$881,755	0.01%	-\$25,786,948	-0.20%	\$2,151,430	0.02%
Penalty			-\$45,138,690	-0.36%	-\$44,486,730	-0.35%	\$651,960	0.01%	-\$44,551,636	-0.35%	\$587,054	0.00%
Reward			\$17,200,312	0.14%	\$17,430,107	0.14%	\$229,795	0.00%	\$18,764,688	0.15%	\$1,564,376	0.01%



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Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2028

March 11, 2026

This document contains the final recommendations for the RY 2028 Readmissions Reduction Incentive Program.

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List of Abbreviations

ADI	Area Deprivation Index
AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-For-Service
FFY	Federal Fiscal Year
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
PY	Performance Year
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

Key Methodology Concepts and Definitions

AHEAD Model: The Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model is a multi-state framework initiated by CMS that aims to drive health care transformation and multi-payer alignment to improve the total health of Maryland's population while lowering costs.

HRRP: The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with higher-than-expected 30-day readmissions for six specific conditions.

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

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

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

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

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

Recommendations

These are the final recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-payer, all-cause, all-condition readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 compared to two-year base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
 - a. Adjust case-mix readmission rate by the Out of State (OOS) Utilization Adjustment to account for OOS readmissions and transfers for RY 2027 beyond.
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide regular updates on by-hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Introduction

Maryland hospitals have been and are currently funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the current Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the upcoming AHEAD model (CY 2026- CY 2035). Under the new AHEAD Model, the State will transition in CY 2028 (Performance Year (PY) 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain

quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA), state leaders, other health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup (PMWG) to develop a transition plan that increases alignment between the state's performance based programs and the CMS national programs over the initial years of the AHEAD model.

Under global budget systems, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under the Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reductions in unplanned readmissions, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. Under global budgets, it is important to ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs to date have rewarded quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets all-payer unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially strained healthcare institutions.¹ The RRIP currently holds up to two percent of hospital inpatient revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates.

¹ Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. *Cureus* 15(5): e39022. doi:10.7759/cureus.39022

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2028 RRIP Draft Policy, staff vetted the updated proposed recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Transitioning to the AHEAD Model

The AHEAD model, which will begin in January 2026, includes a two year transition period where the state will maintain its all-payer rate setting system. The new CMS Medicare FFS hospital global budgets will begin in CY 2028 and at that time, the hospitals will transition to the CMS quality programs for Medicare FFS and the state will administer hospital global budgets and quality programs for all other payers. For RY 2028, which will assess CY 2026 performance, staff is working to assess all of the quality programs to determine opportunities for better alignment with the CMS programs. The initial focus of the state's transition work has been aligning the Quality Based Reimbursement (QBR) program with the Hospital Value-Based Purchasing (HVBP) program. During CY 2026, staff proposes to engage stakeholders to assess opportunities for further alignment with the AHEAD Model.

Under the AHEAD Model, hospital global budgets will be adjusted for readmissions through multiple mechanisms. First, beginning in calendar year (CY) 2028, the AHEAD Hospital Global Budget (HGB) for Medicare FFS will incorporate adjustments based on a hospital's performance under the Hospital Readmission Reduction Program (HRRP). Second, as part of the AHEAD Model, the State submitted a Population Health and Accountability Plan (PHAP) that includes the CMMI-recommended National Committee for Quality Assurance (NCQA) Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide readmissions performance over the nine-year model period. In addition, the Medicare HGB methodology includes a Community Improvement Bonus (CIB) and an Effectiveness Adjustment (EA). The CIB will assess performance on two measures: the digital Hybrid Hospital Wide Readmission (Hybrid eHWR) measure and Prevention Quality Indicators (PQI-90). The EA, as staff understands it, applies a downward adjustment based on a hospital's Medicare fee-for-service (FFS)

performance relative to other statewide hospitals on the revenue associated with unplanned readmissions, avoidable admissions, and ED utilization out of total revenue. Readmissions are determined using the planned readmission algorithm from CMS' Hospital-Wide All-Cause Unplanned Readmission (HWR) measure, Avoidable admissions are defined by AHRQ's PQI-90 measure, and ED Utilization is measured using the NCQA Emergency Department Utilization (EDU) measure. Last, Maryland may continue to adjust non-Medicare HGB based on readmission performance.

For the RY 2028 RRIP policy, staff proposes to maintain the 4-year improvement target of -5.0 percent through CY 2026 compared to the two year base period of CY 2022 and CY 2023. This will finish out the goal set under the TCOC model and give staff time to engage stakeholders to assess opportunities to align the RRIP with the AHEAD model's readmission evaluation. Specifically, alignment entails consideration of measures, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Background

Brief History of RRIP Program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.² In order to meet the All-Payer Model Medicare requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system. In addition to the Medicare FFS targets for the State, CMMI historically required the RRIP to address all-payer readmissions. As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more

² Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it uses an all-cause, all-condition measure and assesses both improvement and attainment, whereas, HRRP uses Medicare-only condition specific readmission measures to assess attainment.³ Figure 1 below compares the RRIP to the HRRP.

Figure 1. RRIP Compared to HRRP

Feature	Maryland RRIP	National HRRP
Population	All patients, all payers	Medicare Fee-for-Service beneficiaries only
Conditions Measured	All-conditions, including psychiatric and adult oncology	Six specific conditions (i.e., AMI, COPD, HF, Pneumonia, CABG, THA/TKA)
Readmission Definition	30-day, all-cause, unplanned admissions	30-day, all-cause, unplanned admissions
Performance Measures	Both improvement (relative change) and attainment (absolute performance, adjusted for out-of-state readmissions)	Attainment only, stratified by percent duals
Incentives	Scaled rewards and penalties , capped at $\pm 2\%$ of inpatient revenue	Scaled penalties only , capped at 3% of Medicare payments
Data Source	State-based case-mix data (with unique patient identifiers across hospitals)	CMS Medicare claims data

With the onset of the Total Cost of Care Model (TCOC) Agreement, each program was overhauled to ensure the policy supported the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target of -7.5 percent, adjustment of the attainment target based on national Medicare and commercial benchmarks, and the addition of an incentive to reduce within hospital disparities in readmissions. Subsequently, during CY2023, staff reassessed Maryland's performance on readmissions and developed a four-year (2022-2026) improvement target of 5 percent that was approved in the RY2026 policy. This improvement target was set using a range

³ For more information on the HRRP, please see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>

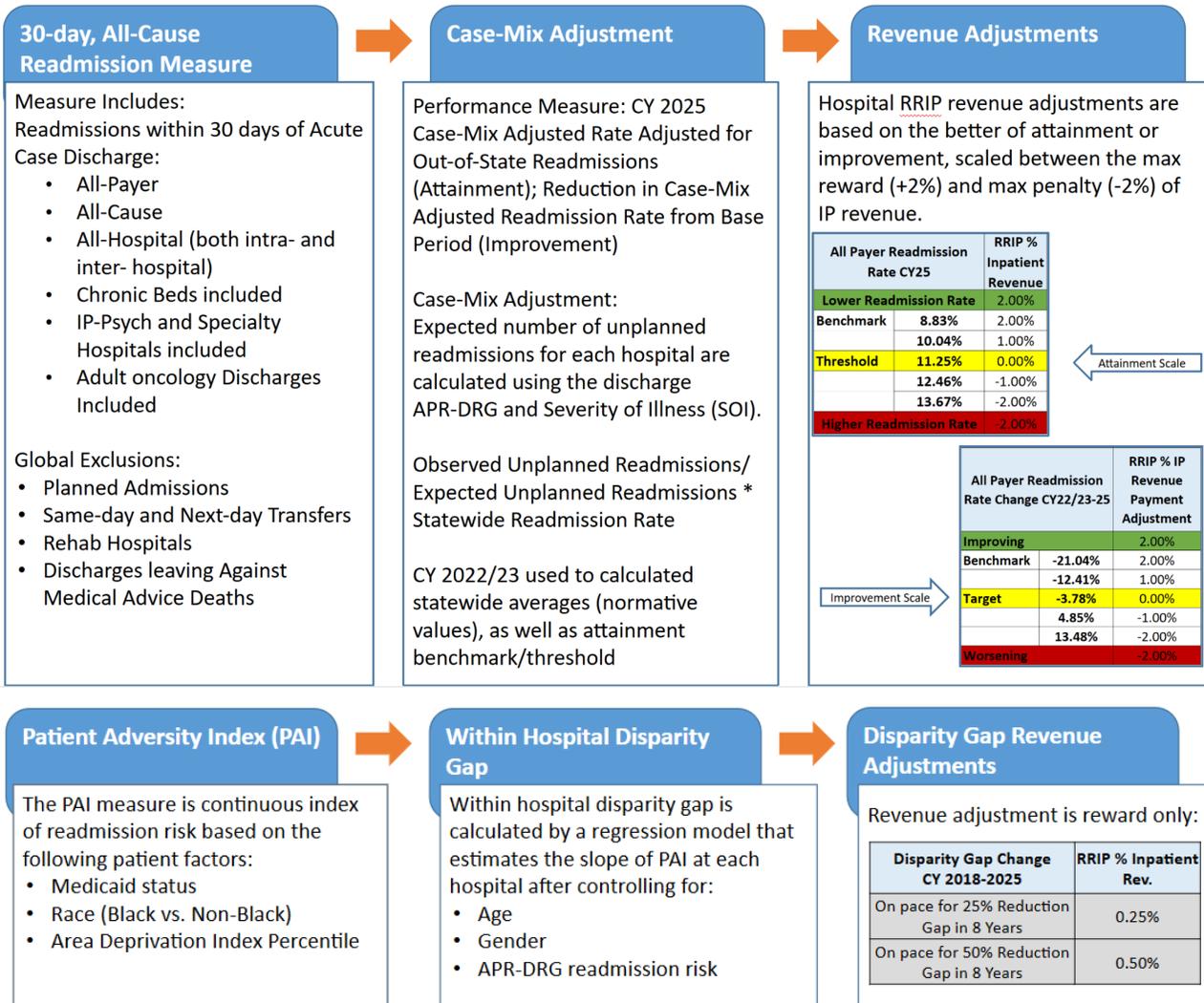
of potential improvement scenarios (e.g., historical improvements trended forward) and updated benchmarking for Medicare and Commercial payers nationally.

RRIP Methodology

Figure 2 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (e.g., pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.⁴ The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

⁴ See Appendix I for details on the current RRIP methodology.

Figure 2. RRIP Methodology RY2027



Assessment

For RY 2028, there are no proposed changes to the readmission measure, however, staff is recommending that additional analytics continue to be conducted over the coming year to assess impact of observation stays, which staff believe will complement some of the other workstreams the Commission currently is engaging in to improve emergency department length of stay and align with the AHEAD Model's Population Health Accountability Plan (PHAP) readmission

measure. Also, staff is recommending a modification to the calculation of Out-Of-State Ratios used to adjust the readmission measure for attainment.

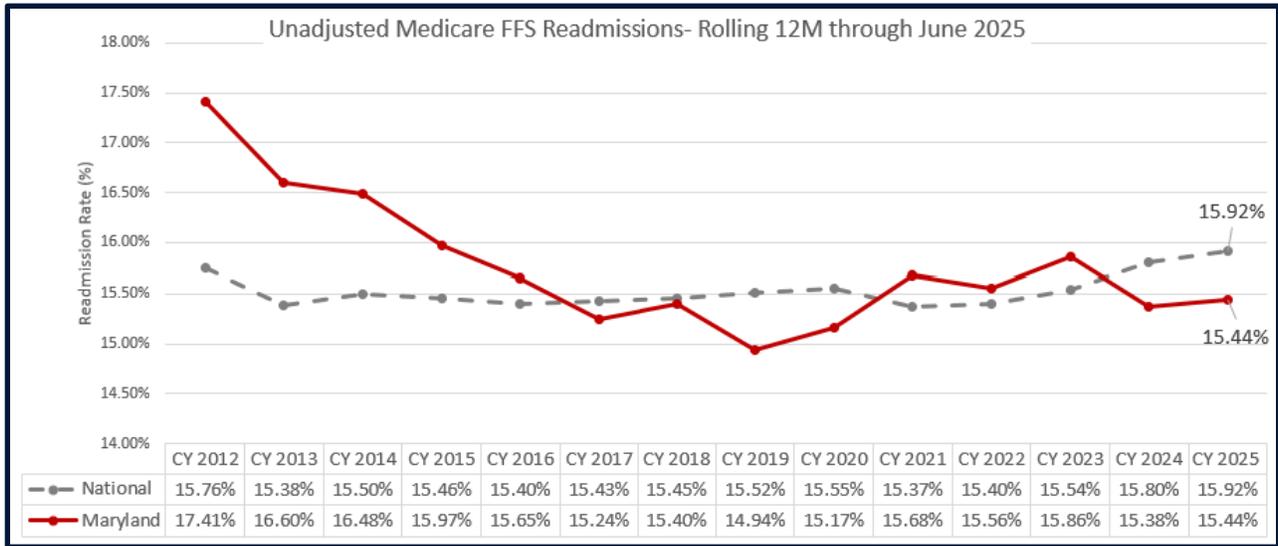
Current Statewide Year To Date Performance

Readmission performance is assessed in several ways using different measure specifications. First, we present data on the unadjusted, all-cause Medicare readmission rate (the original “Waiver Test”), which shows that Maryland currently has a slightly lower unadjusted readmission rate than the nation. Second, we present Maryland and national performance on the CMMI-adapted Hospital-Wide Readmission (HWR) measure for Maryland (the revised “Waiver Test”). Third, we present the all-payer, case-mix–adjusted readmission results used for the Readmissions Reduction Incentive Program (RRIP). Fourth, we present the condition-specific readmission results used for the Hospital Readmission Reduction Program (HRRP). Finally, we present performance on the NCQA Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide performance under the AHEAD Model. Also, please refer to the RY 2028 Quality Based Reimbursement policy for discussion of the state’s collection of digital quality measures in alignment with the CMS. Specifically, the state is requiring submission of the Core Clinical Data Elements (CCDE) used for the digital Hybrid HWR measure and could consider augmenting the RRIP all-payer measure with EHR data elements in the future. Below we present the currently available data using the measures from CMMI, CMS, and HSCRC.

Medicare FFS Performance

At the end of 2018, Maryland had an unadjusted Medicare FFS readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This was the measure that CMMI used to assess Maryland’s successful performance on readmissions under the All-Payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. While the unadjusted Maryland Medicare rate was higher than the nation starting in 2021, the CY2025 rolling 12 months readmission data, which is presented in Figure 3, shows Maryland’s readmission rate at 15.44 percent, which is lower than the Nation’s performance at 15.92 percent.

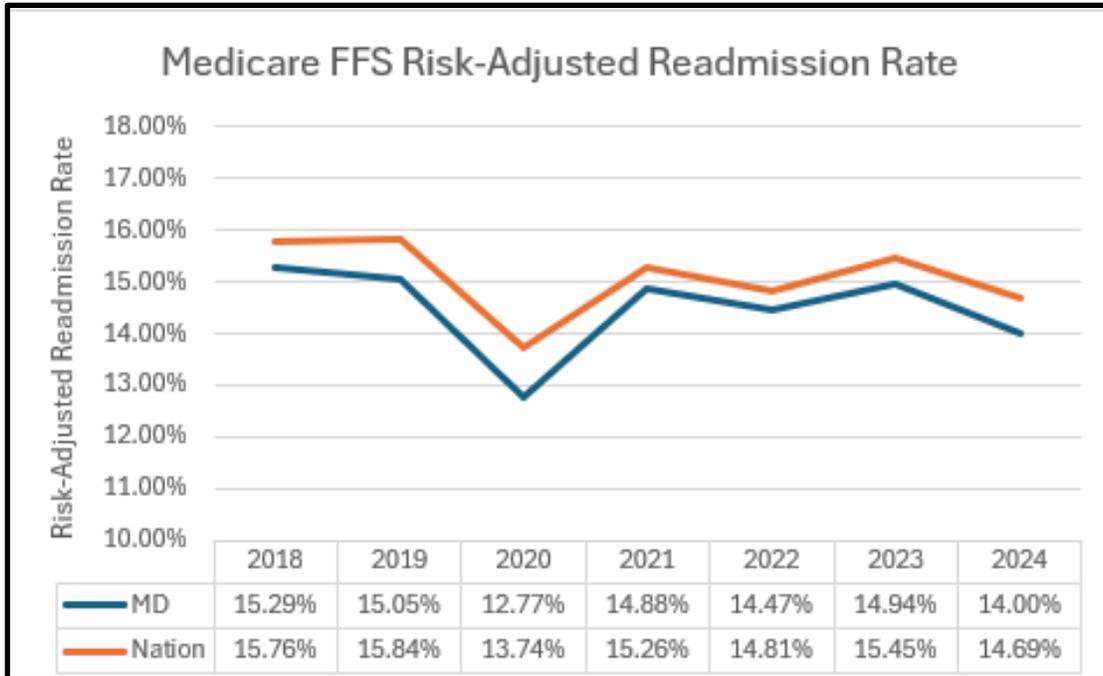
Figure 3. Maryland and National Medicare FFS Unadjusted Readmission Rates



Hospital Wide Readmission Measure Performance

Because of concerns about changes in patient acuity, CMMI agreed to switch to a risk-adjusted readmission measure to compare Medicare FFS performance in Maryland compared to the Nation. Beginning with CY 2023 performance, CMMI calculated a risk-adjusted hospital wide readmission (HWR) measure modified to include Medicare FFS beneficiaries under the age of 65 and a few other adjustments. Figure 4 provides the Maryland and National results on readmissions for CY 2018 and CY 2024 from CMMI using this modified HWR measure. Based on this data, the State has met its contractual goal of performing better in CY 2024 than in CY 2018 and performing better than the nation in CY 2024. Since 2018, Maryland has reduced Medicare readmissions by 8.44 percent, while the nation has reduced readmissions by 6.79 percent. While the contractual test does not require Maryland to be statistically better than the nation, the analysis by CMMI found that Maryland was statistically better than the nation in CY 2024. Currently staff are awaiting the final report for CY 2025 performance, however, 12-month data through August 2025 indicates Maryland continues to outperform the nation on this risk-adjusted readmission measure.

Figure 4. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance

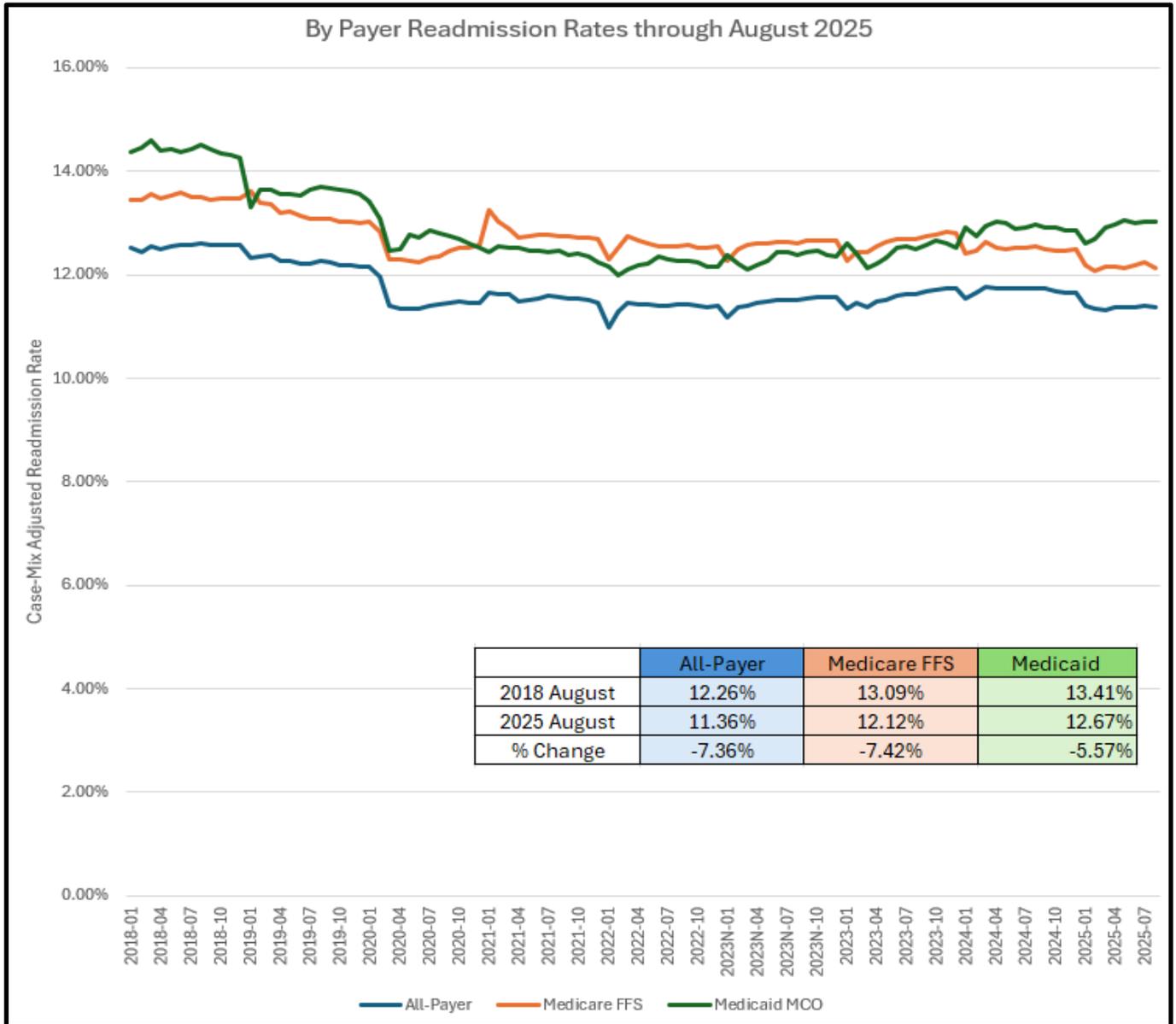


<https://hsrc.maryland.gov/pages/default.aspx>

All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 5. Through August of 2025 compared to August of 2018, All-Payers, Medicare FFS, and Medicaid beneficiaries saw a reduction in readmissions of 7.36 percent, 7.42 percent, and 5.57 percent, respectively.

Figure 5. Statewide Change in Case-Mix Adjusted Readmission Rates by Payer, 2018 through August 2025



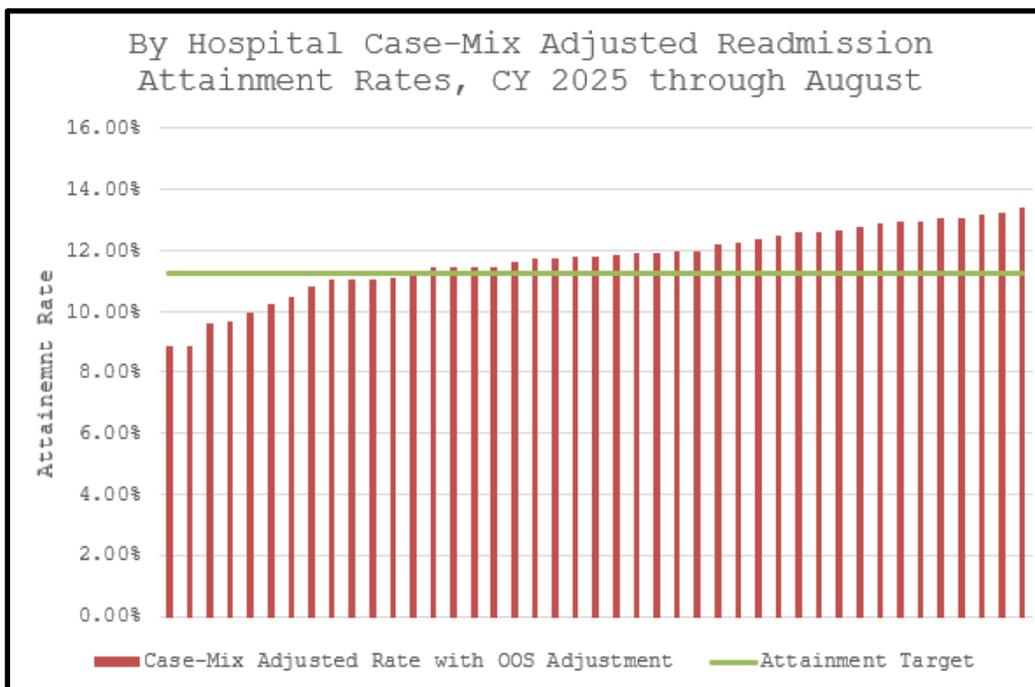
The RY 2027 RRIP program assesses improvement from a two-year base period of CYs 2022 and 2023 to CY 2025, and attainment performance in CY 2025 based on historical standards. Statewide there has been a 1.56 percent improvement in 2025 YTD compared to the

CY2022/2023 base period. As illustrated in Figure 6 below, 22 hospitals are on target to reach the improvement goal of a 3.78 percent reduction, and as shown in Figure 7, 12 hospitals are on target to have a readmission rate below the attainment threshold of 11.25 percent. Hospitals performing well on either improvement or attainment will receive a revenue adjustment equal to the better of these evaluations, in line with the policy aim of simultaneously incentivizing excellent performance and constant improvement. Overall there are 24 unique hospitals on track to receive a scaled reward for CY 2025 performance. The most recent data through November shows that the statewide readmission rate has only decreased by 0.43% from the two-year base period of CY 2022-CY2023. During this time, there has been a 22.37% decrease in readmissions for the Medicare FFS population, however, the Medicaid (FFS and MCO) population has seen an increase in readmissions by 23.14%. Staff are analyzing the case-mix dataset to understand what’s driving the increase in Medicaid utilization.

Figure 6. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2022/2023- 2025 YTD Through August



Figure 7. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2025

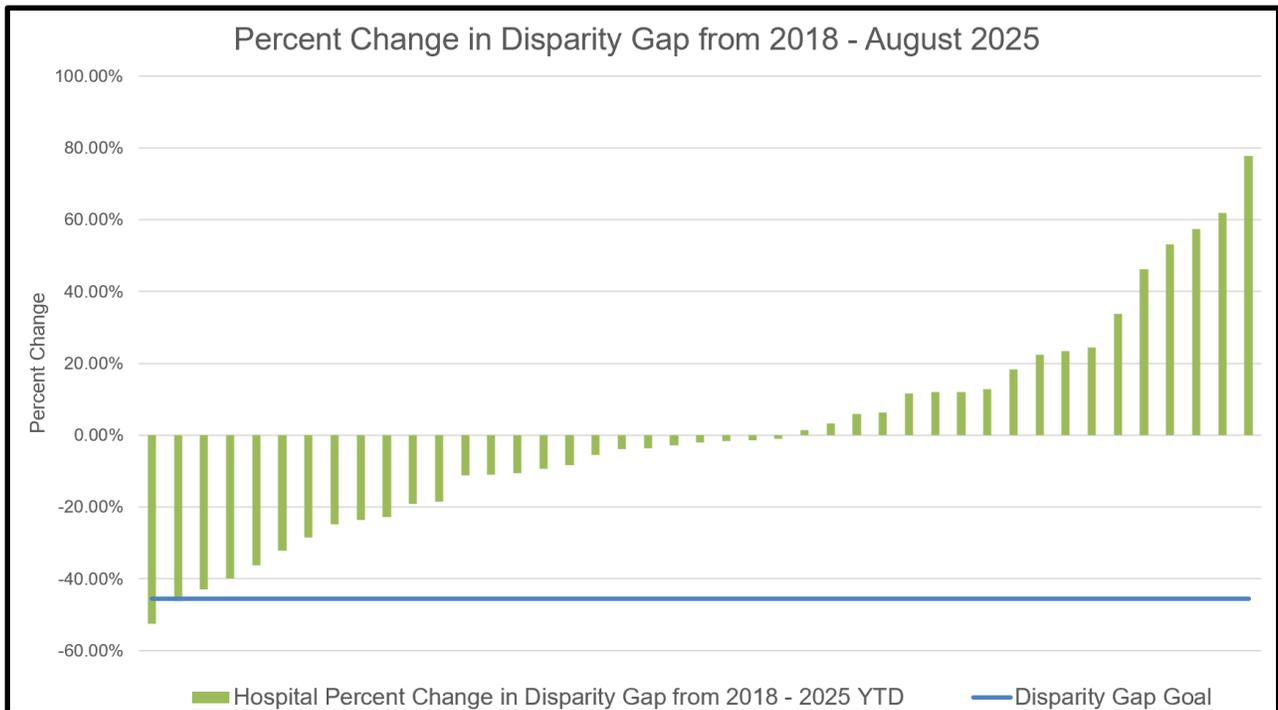


Disparities in Readmissions

Beginning in RY 2021, Maryland hospitals could be rewarded for reducing disparities in readmissions using HSCRC developed methodology. The reduction in readmission disparities was included as a Statewide Integrated Health Improvement Strategy (SIHIS) goal under the TCOC model. Specifically, the goal was to have at least half of Maryland hospitals achieve at least a 50 percent reduction from CY 2018 to CY 2026. For RY 2027, through August of 2025, 25 hospitals have reduced readmission disparities by an average of -18.40 percent, with a range of reductions from -1.01 percent to -52.50 percent. Via the disparity gap component of the RRIP, two hospitals are on track for receiving rewards for reducing their disparities in readmissions by at

least -45.47 percent in CY 2025 compared to CY 2018, as seen below in Figure 8. For RY 2028, to better align with the National readmissions program, the RRIP draft recommendation is to monitor reductions in readmissions disparities in readmissions by reporting performance quarterly at Commission meetings. For details on the measure used to assess disparities in readmissions, see Appendix V.

Figure 8. By-Hospital Changes in Readmission Disparities, CY 2025 through August compared to CY 2018



Hospital Readmission Reduction Program Performance

The CMS Hospital Readmission Reduction Program (HRRP) assesses readmissions for Medicare using six condition specific, all-cause readmissions measures and comparing performance of hospitals within peer groups based on proportion of dually eligible Medicare beneficiaries. For FFY 2025, CMMI provided proxy payment adjustment factors to estimate how Maryland hospitals would have performed under the HRRP program. The Maryland data from CMMI was compared with national HRRP data found on Care Compare (Figure 9). The Maryland data indicates that 84

percent of hospitals in the state would receive a penalty, with the median penalty among those that would have been penalized of 0.20 percent (minimum penalty 0.01 percent and maximum penalty 1.07 percent). While the national data indicates that a lower percentage of hospitals would receive a penalty (79 percent), the median penalty among those that were penalized is higher at 0.27 percent (minimum penalty 0.01 percent and maximum penalty 3 percent). Furthermore, the average penalty for Maryland hospitals was lower than the nation for each of the five dual eligible peer groups. Thus despite the higher proportion of hospitals in Maryland that would be penalized for excess readmissions, on average Maryland hospitals have lower excess readmissions as shown by the lower penalties that Maryland hospitals would receive. Given these condition specific measures use multiple years of data through the June of 2023, these results are not surprising since the unadjusted Medicare test also showed favorable results over the same time period.

Figure 9. FFY 2025 HRRP Performance, Maryland vs Nation

FY 2025 (July 1, 2020 - June 30, 2023)	Maryland	Nation
Percent of Hospitals with Penalty	83.72%	78.59%
Median Penalty*	0.20%	0.27%
Average Penalty*	0.30%	0.41%
Average Penalty by Dual Peer Group		
Low Proportion	1 0.23%	0.32%
	2 0.26%	0.35%
	3 0.28%	0.32%
	4 0.16%	0.31%
High Proportion	5 0.05%	0.31%
*Calculated among those penalized only.		

National Committee for Quality Assurance Plan All-Cause Readmission Measure

As mentioned above in the “Transitioning to AHEAD” section, the Population Health Accountability Plan (PHAP) will assess statewide readmission performance using the National Committee for Quality Assurance Plan All-Cause Readmission (NCQA PCR) measure based on CMMIs directive. Furthermore, CMMI also required that the Statewide goal be all-payer rather than Medicare specific. The NCQA readmission measure was originally designed as a health plan

measure (i.e., HEDIS). Figure 10 provides a comparison of the RRIP and NCQA readmission measure, both of which look at all-cause unplanned readmissions for all eligible patients (i.e., not condition specific). The biggest differences between the measures is that the NCQA readmission measure includes both inpatient and observation visits as both index and readmissions, and the by-payer risk adjustment method used for the NCQA measure. HSCRC worked with contractors to adapt this health plan measure to calculate a Maryland statewide observed to expected ratio using claims data for Medicare FFS, Medicare MA, Medicaid, and Commercial.

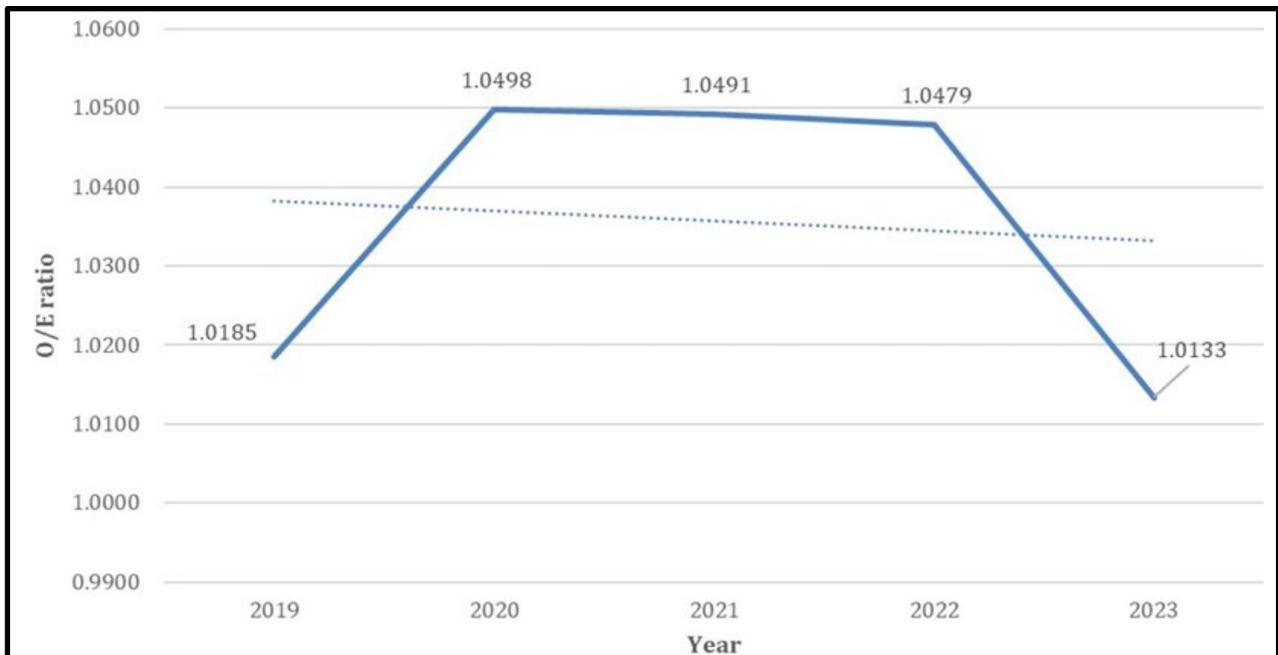
Figure 10. Comparison of the NCQA PCR and RRIP Readmission Measures

Feature	Maryland RRIP	NCQA PCR
Readmission Type	All-cause, unplanned inpatient readmissions	All-cause, unplanned inpatient and observation readmissions
Numerator	Number of observed unplanned readmissions	The observed numerator is all unplanned eligible observation stays and readmissions within 30 days of an eligible discharge. The expected numerator is weighted based on measure specifications
Denominator	Number of expected unplanned readmissions based on discharge APR-DRG and SOI	Any acute inpatient or observation stay discharge occurring during the measurement year; patients must be 18 or older during the month of discharge date and have 365 days on continuous enrollment before index admission and 30 days after index.
Exclusions	CMS Planned Readmission Logic, Bone marrow transplants and liquid tumor patients, Left AMA, transfers, newborn DRGs	Hospice and/or death at any time during the measurement year; perinatal admissions, potentially planned procedures, organ transplant, chemotherapy, and psychiatric/rehab facilities and transfer/IP admission. Patients with 4+ inpatient admissions in a year.
Risk-Adjustment	Case-mix and APR DRG SOI level	Risk-adjusted by IP vs. observation status, discharge condition, age, gender, surgical procedure, and SNF and dual eligibility status based on predetermined weights by payer

Figure 11 below presents Maryland’s all-payer observed to expected ratio, which shows that from 2019 to 2023, Maryland saw a 0.51 percent decrease in readmissions. However, given the increase in readmissions during COVID, this trend should be interpreted with caution. Thus, staff

also utilized NCQA and other readmission benchmarks calculated by the HSCRC to propose targets for improvement to the [insert MCHC reference and that they were body to review]. Based on staff analyses, historical improvements in readmissions (i.e., gains the state has already made since 2013), and stakeholder input, a readmission goal of a 3.07 percent reduction in the O/E ratio between 2023 and 2024 was submitted to CMMI in the PHAP proposal. This is currently under review by CMMI. Staff believes that the Commission should consider whether the non-Medicare global budget adjustments for readmissions should align with the final PHAP goal or the HRRP program. Staff is currently working with contractors to adapt the NCQA readmission measure to the case-mix dataset to see if it can be used for RRIP in the future.

Figure 11. Maryland Performance on NCQA PCR measure, CY 2019- CY 2023



Out of State Adjustment Concerns

The RRIP policy assesses attainment by adjusting the all-payer readmission rate to account for out-of-state (OOS) readmissions which is defined as “Total number of Medicare FFS Readmissions/ Number of in-state readmissions”. The RRIP methodology uses Medicare FFS

OOS ratios calculated via the Chronic Conditions Warehouse (CCW) dataset, which are used as a proxy for all-payer OOS readmission patterns. Without an OOS readmission adjustment, hospitals across the State could not be compared fairly as some hospitals may have higher OOS readmissions (e.g., border hospitals, systems with OOS hospitals). Hospitals have raised concerns about the accuracy and use of the OOS readmission ratio within the RRIP.

Staff investigated the issues brought by hospitals regarding the accuracy and use of the OOS readmission ratios and uncovered that there are two issues that need to be addressed. First, readmission cases are being captured as a readmission in both the in-state case-mix dataset as well as in the CCW's OOS ratio (i.e., are being double counted). Second, as hospitals suggested, transfers out of state that are then transferred back to Maryland flag a readmission in the Case-Mix dataset, even though they represent a continuation of care rather than a true unplanned readmission event. Furthermore, transfers into Maryland also present the concern of being treated as eligible for a readmission although they should not be eligible as the transfer represents a continuation of care rather than a true admission that is eligible for a readmission (i.e., transferring hospital has an inflated denominator). Appendix II provides examples of cases that are double counted and Appendix III provides an example of how OOS transfers that are then transferred back to Maryland are flagged for a readmission in the Case-Mix dataset.

In collaboration with stakeholders, Staff was able to identify an approach to adjusting readmissions that addresses both the OOS readmissions and the OOS transfer issue. Staff has coined this approach as the "OOS Utilization Adjustment". Details on the OOS Utilization Adjustment Methodology are provided in Appendix IV. To appropriately account for OOS readmissions and transfers, staff recommends adjusting the case-mix readmission rate by the OOS Utilization Adjustment, for RY 2027 and beyond. Applying the Utilization Adjustment to the RY 2026 results (most recent full year of data that is available for modeling) yields a statewide net adjustment of ~\$30.5M, consisting of ~\$47.9M in net penalties and ~\$17.4M in net rewards. Revenue adjustment comparisons of the Utilization Adjustment to the revenue adjustments that were put into rates (i.e., incorrect OOS ratios) and the updated OOS ratios are included in Appendix IX. Additional discussion of the OOS readmission and transfer impact and whether RY 2026 should be adjusted is discussed in the stakeholder feedback section with options for Commissioner consideration

Hospital Scores and Revenue Adjustments

This section provides an overview of the RRIP and HRRP revenue adjustment methodology and then presents modeling of hospital scores and revenue adjustments for the RY 2027 program and the final RY 2025 RRIP and estimated FFY 2025 HRRP results for Maryland hospitals.

Comparison of RRIP and HRRP Scoring and Revenue Adjustment Methodology

Under the RRIP, hospitals are scored based on their performance on the case-mix adjusted readmission measure that compares each hospital's observed readmissions to expected readmissions for all-payers. Hospital revenue adjustments are based on the better of improvement in readmission rate or attainment of relatively low readmission rate. Improvement in the readmission rate is determined by calculating the percentage change in the readmission rate in the performance period compared to the readmission rate in the base period; the attainment rate is calculated as the case-mix adjusted rate in the performance period further adjusted by the Medicare OOS ratio. The improvement and attainment rates are compared to predetermined improvement and attainment targets. The 65th percentile of best performers in the base period is the threshold to begin receiving rewards for attainment, which allows hospitals in the top-third of Maryland performance to earn financial rewards. The improvement target is set based on the modeling of various improvement scenarios (e.g., historical trends, commercial and Medicare benchmarking). Comparing a hospital's performance to the targets, the policy determines a hospital's final revenue adjustment as the better of revenue adjustments for improvement or attainment, with scaled rewards and penalties up to two percent of a hospital's inpatient revenue.

In contrast, the HRRP uses six condition specific readmission measures and calculates excess readmissions by hospital for each condition for Medicare beneficiaries.⁵ For each HRRP condition, CMS applies a hierarchical logistic regression model that adjusts for patient's age and sex, diagnoses and comorbidities from claims, and a hospital-specific random effect to generate

⁵ The six condition specific measures are 1. Acute Myocardial Infarction (AMI) 2. Coronary Artery Bypass Grafting (CABG) 3. Coronary Obstructive Pulmonary Disease (COPD) 4. Heart Failure (HF) 5. Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) 6. Pneumonia (PN)

both observed readmissions and expected readmissions. The performance metric is the Excess Readmission Ratio (ERR) which is the ratio of observed to expected readmissions; values greater than 1.0 indicate worse-than-expected performance. For each HRRP condition, the program then compares hospitals' ERRs to those with similar proportions of dual eligibles (i.e., peer groups) and penalizes those with excess readmissions up to three percent of base operating DRG payments for all Medicare inpatient discharges. HRRP assesses readmissions based on peer groups to improve adjustment for social risk given that differences in hospitals' patient populations are not fully captured by claims-based risk adjustment. The actual penalty received is proportional to the excess readmission for each condition (i.e., higher penalties mean greater excess readmissions compared to others in peer group).

Maryland's RRIP and Estimated HRRP Revenue Adjustments

In the Assessment Section, readmission performance in the RY 2027 program is presented. In Figure 12 below, the RY 2027 year-to-date (YTD) revenue adjustments are estimated using performance through August. Statewide the net revenue adjustment is a reduction of approximately \$18 million or -0.14 percent of inpatient revenue. Specifically, 19 out of 44 hospitals would receive a penalty with the average penalty being -0.57 percent of inpatient revenue (penalties range from -1.34 percent to -0.10 percent), the other 25 hospitals would receive a reward with the average reward being 0.78 percent (rewards range from 0.04 percent to 2 percent). By-hospital results are presented in Appendix VI.

Figure 12. Summary of Statewide Estimated RRIP RY 2027 YTD through August Revenue Adjustments⁶

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-\$33,119,595.00	-0.26%	-\$82,476,354.24	-0.65%	-\$17,879,167.24	-0.14%
Penalty	-\$53,891,691.00	-0.43%	-\$91,995,937.24	-0.73%	-\$42,882,684.24	-0.34%
Reward	\$20,772,096.00	0.16%	\$9,519,583.00	0.08%	\$25,003,517.00	0.20%

Revenue adjustments for RY 2026 RRIP performance is shown in Figure 13, however, an error was identified in the OOS ratios used to calculate the attainment rates. Figure 14 provides a statewide summary of Final RY 2026 RRIP performance using the originally intended OOS

⁶ These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.

readmission ratios which staff will implement in the RY 2027 (i.e., starting in July 2026). By-hospital comparisons of revenue adjustments with incorrect and updated OOS readmission ratios are in Appendix VII. Further discussion of the correction of this error and the change to the OOS utilization methodology is included in the Stakeholder Feedback section. As with RY 2027 YTD estimates, there was a net negative revenue adjustment statewide. Prior to RY 2026, which updated the base period to be post-COVID (i.e., CY 2022-2023) and provided a new readmission improvement goal, the statewide net revenue adjustments had been positive for all years of the RRIP program.

Figure 13. Summary of Final Statewide RY 2026 Revenue Adjustments in Rates^{7, 8}

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-\$45,899,899	-0.36%	-\$100,545,103	-0.80%	-\$27,938,378	-0.22%
Penalty	-\$57,893,582	-0.46%	-\$110,027,989	-0.87%	-\$45,138,690	-0.36%
Reward	\$11,993,683	0.09%	\$9,482,886	0.08%	\$17,200,312	0.14%

Figure 14. Summary of Final Statewide RY 2026 Revenue Adjustments^{9, 10}

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-\$45,899,899	-0.36%	-\$100,934,927	-0.80%	-\$28,796,745	-0.23%
Penalty	-\$57,893,582	-0.46%	-\$109,019,144	-0.86%	-\$45,156,858	-0.36%
Reward	\$11,993,683	0.09%	\$8,084,217	0.06%	\$16,360,113	0.13%

CMMI has provided proxy payment adjustment factors that estimate how Maryland hospitals would perform under the HRRP. However, the most recent data available is FFY 2025. The Maryland data indicates that 84 percent of hospitals in the state would receive a penalty, with the median penalty of 0.20 percent among those that would have been penalized (minimum penalty 0.1 percent and maximum penalty 1.07 percent); HRRP does not provide rewards.

To allow for comparison to the most recent HRRP performance, the RY 2025 RRIP performance is presented rather than the RY 2026 or RY 2027 YTD results presented above. In RY 2025,

⁷ These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.

⁸ These results are incorrect due to the use of the incorrect OOS ratios.

⁹ These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.

¹⁰ These results reflect the updated OOS readmission ratios (i.e., addresses Staff's error).

Maryland hospitals received revenue adjustments to their global budgets for their CY 2023 readmissions performance compared to the improvement target of 7.50 percent and attainment target of 11.32 percent. Statewide, the total net adjustments was approximately \$14M, with penalties of approximately \$28M and rewards of approximately \$42M. Specifically, about 55 percent of the hospitals received a scaled penalty and the remaining 45 percent received a scaled reward; the average penalty was -0.64 percent (penalties ranged from -1.52 percent to -0.15 percent) and the average reward was 0.53 percent (rewards ranged from 0.03 percent to 1.24 percent). Figure 14 below shows a comparison of estimated FFY 2025 HRRP and final RY 2025 RRIP revenue adjustments, which both assessed readmission performance in CY 2023; by hospital results are in Appendix VIII.

Figure 14. Comparison of Final RY 2025 RRIP and Estimated FFY 2025 HRRP Revenue Adjustments

Program	Statewide Net Total	%	Penalties	%	Rewards	%
RRIP	\$ 14,102,128.30	0.12%	\$(28,215,336.00)	-0.24%	\$ 42,317,464.30	0.36%
HRRP	\$ (23,305,042.30)	-0.20%	\$(23,305,042.30)	-0.20%	0	-

Estimates for MD hospitals' performance in National programs are applied to All-Payer revenue for comparison; CMS would apply adjustments to Medicare FFS revenue.

Overall, given the changes to the RRIP program starting in RY 2026 and the lack of CMS data past FFY 2025, it is difficult to compare the current program with the CMS HRRP. However, staff supports the continued inclusion of rewards in the RRIP program and will analyze the RY 2026 RRIP and FFY 2026 HRRP when available.

Stakeholder Feedback

Comment letters to the Draft RRIP Policy were received from Health Means Everything Consumer Alliance (HME), the Maryland Hospital Association (MHA), the Maryland Department of Health (MDH), Adventist Health, Luminis Health, and Garrett Regional Medical Center. Overall, commenters expressed broad support for maintaining the RRIP framework for RY 2028. Several commenters supported the OOS revision that addressed the double counting issue; Hospitals and MHA requested retrospective application of the correction prior to RY 2027. Commenters also provided recommendations regarding future alignment of RRIP with either the NCQA Plan All-Cause Readmission (PCR) measure or the Medicare Hospital

Readmissions Reduction Program’s measures under the AHEAD model. Figure 15 provides an overview of the comments received and is followed by a discussion of the feedback along with staff’s responses.

Figure 15. Summary of Stakeholder Comment Letters

Stakeholder Comment Letters for RY 2028 RRIP	Adventist	MHA	Luminis Health	Garrett	MDH	HME
Fully align with HRRP but maintain the reward incentive	X					
Align with PHAP goal (NCQA PCR measure)					X	X
Transparency on OOS ratio revision and financial impacts	X					
Apply OOS revision retrospectively (# of years varies by letters)	X	X	X	X		
Model revenue adjustment using HRRP, NCQA PCR, and HWR measures		X				

Overall Support for RY 2028 RRIP Framework: HME and MHA expressed support for maintaining the current RRIP core structure for RY 2028; Adventist supported the current RRIP core structure for RY 2028 only if full alignment with HRRP is infeasible. Commenters noted that RRIP has been associated with sustained reductions in readmissions and emphasized the importance of maintaining the incentive during the transition period to the AHEAD model’s quality programs for Medicare beneficiaries. Adventist supported maintaining the current revenue at risk structure for RY 2028 and encouraged preserving upside reward potential in future years to sustain incentives for quality improvement.

Staff Response: Staff appreciates stakeholders’ support for maintaining the program in RY 2028.

OOS Readmission Double Counting Correction: MHA, Garrett, Luminis Health, and Adventist supported addressing the identified double counting of readmissions in the OOS Readmission Ratio. Commenters stated that the issue has disproportionately affected border hospitals and resulted in overstated readmission rates and financial penalties.

Adventist supported correcting the issue beginning in RY 2027, but requested additional transparency regarding revised calculations and financial impacts before finalizing policy decisions.

Garrett and Luminis Health specifically requested that the corrections be applied for RY 2026 and prior rate years retrospectively. MHA similarly recommended applying the correction to multiple prior years, citing precedent for retrospectively correcting errors.

Staff Response: Staff acknowledges that border hospitals may have experienced disproportionate negative impacts under the prior OOS readmission ratio methodology. The identified issue, however, reflects a methodological limitation in how OOS readmissions were incorporated into the calculation, rather than an implementation or calculation error by staff.

The OOS ratio was developed using the best available data at the time. Upon further analysis due to concerns raised by hospitals, staff identified an opportunity to refine the methodology to better account for the double counting of readmissions and also identified the OOS transfer concern. The proposed OOS Utilization Adjustment, which is a refinement to the methodology, is intended to address these limitations and improve the accuracy and fairness of the assessment of hospital performance moving forward. Additional discussion of the OOS utilization ratio is included in the Assessment section above.

There is precedent for the HSCRC to apply retrospective adjustments when correcting staff errors, while methodological refinements are generally applied prospectively. For example, in the Annual Payment Update for RY 2026, HSCRC implemented a retrospective revision to remedy a data issue impacting Uncompensated Care funding determinations for RY 2023 through RY 2025. The retrospective revision was made because staff used the average Area Deprivation Index (ADI) for each zip code for all patients and not just those with a missing ADI value, as intended by the approved policy. Again this was a retrospective change to correct an error, and not a change to the methodology, and only hospitals that needed to contribute less or who earned more were retrospectively changed (i.e., those hospitals with a negative impact were not changed). An example of a methodological refinement that was made prospectively would be the update made to the Variable Cost Factor (VCF). Staff worked with the industry to address concerns raised about the VCF and determined that the single VCF of 50% was not covering variable costs. Thus staff developed updated VCFs for different types of services. Because this was a methodological refinement and not a staff or implementation error, the refinement was only applied prospectively.

This distinction between correcting errors versus refining methodology guides staff's recommendation to apply the OOS Utilization Adjustment to RY 2028 and beyond. Being that the RY 2027 results have not been finalized, staff compromised on making the adjustment to RY 2027 given the disproportionate impacts to border hospitals. This is consistent with other quality policies as well.

While staff recommend only applying the OOS Utilization Adjustment beginning in RY 2027, staff presents three options for Commissioners' consideration pertaining to RY 2026. Given the implementation error, RY 2026 results need to be corrected, thus Commissioners' could decide to apply the new OOS Utilization Adjustment retrospectively since it better captures impacts of both OOS readmissions and transfers. The three options for RY 2026 are as follows:

1. Maintain the current RY 2026 results and not correct the staff implementation error (not recommended by staff).
2. Correct the error using the originally intended OOS readmission ratio (i.e., recalculating the attainment rates using the OOS ratios that would have been implemented absent the error).
3. Implement the newly proposed OOS Utilization Adjustment.

Figure 16 summarizes the impacts of each of the Options for the affected hospitals only (i.e., other hospitals would not have any revenue adjustment changes). If Option 2 or Option 3 are chosen, Commissioners also need to decide on whether to retrospectively remove additional revenue for hospitals with higher penalties or lower rewards. Staff recommend updating revenue adjustments for only those hospitals whose performance improves with the application of either the originally intended OOS readmission ratios or the newly proposed OOS Utilization Adjustment (i.e., only implement changes for hospitals receiving a higher reward or lesser penalty). Staff believes this approach is consistent with the precedent of how staff errors have been handled previously and note that the overall percentage adjustment is relatively small. Furthermore, RY 2026 revenue adjustments have already been incorporated into budgeting and operational planning and applying either the originally intended OOS ratios or OOS Utilization Adjustment for hospitals that will have worsened performance may cause financial instability and operational disruption at this stage.

Staff notes that Garrett has the largest percentage impact under the newly proposed OOS utilization adjustment. While Garrett requested that the adjustment be applied retrospectively for additional rate years, staff do not have readily available data to estimate the impacts prior to RY 2026. Notably, however, in two of the three rate years preceding RY 2026, Garrett received the full two percent reward and thus application of the OOS Utilization Adjustment in those years would not change the revenue adjustments. Also, note that if Option 2 is chosen and negatively impacted hospitals are included, Garrett would be the only hospital negatively impacted that would otherwise receive a larger reward under the OOS utilization adjustment. This presents a concern for Staff and may warrant special consideration.

Figure 16. Summary of Impacts for the Hospitals Affected by Change in OOS Adjustment

RY 2026 Revenue Adjustments by Option		Option 1: Maintain what went into rates and do not fix staff error		Option 2: Correct error but do not update OOS methodology				Option 3: Update RY 2026 using the new OOS utilization adjustment				
		Revenue Adjustment		Revenue Adjustment		Difference from Rates		Revenue Adjustment		Difference from Rates		
HOSPITAL ID	HOSPITAL NAME	\$	%	\$	%	\$	%	\$	%	\$	%	
210017	Garrett	-\$22,236	-0.07%	-\$181,061	-0.57%	-\$158,825	-0.50%	\$508,240	1.60%	\$530,476	1.67%	
210035	UMMS- Charles	-\$84,173	-0.08%	\$147,303	0.14%	\$231,476	0.22%	\$778,604	0.74%	\$862,777	0.82%	
210039	Calvert	-\$679,575	-0.80%	-\$450,219	-0.53%	\$229,356	0.27%	-\$433,229	-0.51%	\$246,346	0.29%	
210051	Luminis- Doctors	\$585,123	0.30%	\$585,123	0.30%	\$0	0.00%	\$780,163	0.40%	\$195,040	0.10%	
210049	UMMS-Upper Chesapeake	-\$2,993,814	-1.15%	-\$2,655,383	-1.02%	\$338,431	0.13%	-\$2,759,515	-1.06%	\$234,299	0.09%	
210044	GBMC	\$1,402,356	0.51%	\$1,484,848	0.54%	\$82,492	0.03%	\$1,484,848	0.54%	\$82,492	0.03%	
210030	UMMS- Chestertown	\$216,606	2.00%	\$203,610	1.88%	-\$12,996	-0.12%	\$216,606	2.00%	\$0	0.00%	
210018	MedStar- Montgomery	-\$482,409	-0.45%	-\$557,451	-0.52%	-\$75,042	-0.07%	-\$482,409	-0.45%	\$0	0.00%	
210058	UMMS- UMROI	-\$202,066	-0.23%	-\$202,066	-0.23%	\$0	0.00%	-\$224,517	-0.25%	-\$22,452	-0.03%	
210057	Adventist- Shady Grove	-\$2,022,306	-0.56%	-\$2,166,756	-0.60%	-\$144,450	-0.04%	-\$2,311,207	-0.64%	-\$288,901	-0.08%	
210002	UMMS- UMMC	-\$9,277,409	-0.59%	-\$9,434,653	-0.60%	-\$157,244	-0.01%	-\$11,950,561	-0.76%	-\$2,673,152	-0.17%	
210037	UMMS- Easton	\$2,324,864	1.68%	\$1,923,548	1.39%	-\$401,316	-0.29%	\$2,075,771	1.50%	-\$249,093	-0.18%	
210003	UMMS- Capital Region	\$1,073,652	0.33%	\$422,954	0.13%	-\$650,698	-0.20%	-\$97,605	-0.03%	-\$1,171,257	-0.36%	
210061	Atlantic General	\$4,984	0.01%	-\$134,567	-0.27%	-\$139,551	-0.28%	-\$284,085	-0.57%	-\$289,069	-0.58%	
Statewide Impact												
STATEWIDE	\$	12,634,054,157	-\$27,938,378	-0.22%	-\$28,796,745	-0.23%	-\$858,367	-0.01%	-\$30,480,871	-0.24%	-\$2,542,494	-0.02%
Penalty		-\$45,138,690	-0.36%	-\$45,156,858	-0.36%	-\$18,168	0.00%	-\$47,917,830	-0.38%	-\$2,779,141	-0.02%	
Reward		\$17,200,312	0.14%	\$16,360,113	0.13%	-\$840,199	-0.01%	\$17,436,959	0.14%	\$236,647	0.00%	
Statewide Impact if Negatively Impacted Hospitals Held Harmless												
STATEWIDE	\$	12,634,054,157	-\$27,938,378	-0.22%	-\$27,056,623	-0.21%	\$881,755	0.01%	-\$25,786,948	-0.20%	\$2,151,430	0.02%
Penalty		-\$45,138,690	-0.36%	-\$44,486,730	-0.35%	\$651,960	0.01%	-\$44,551,636	-0.35%	\$587,054	0.00%	
Reward		\$17,200,312	0.14%	\$17,430,107	0.14%	\$229,795	0.00%	\$18,764,688	0.15%	\$1,564,376	0.01%	

OOS Transfers: MHA expressed concern regarding the identification of OOS transfers across payers, noting that inconsistencies may exist for Medicare Advantage, Medicaid, and commercial populations. MHA encouraged staff to pursue a comprehensive, multi-payer approach to improve the accuracy and fairness of the OOS transfer calculation.

Staff Response: Staff recognizes the importance of accurately capturing both OOS readmissions and transfers across payer types. The proposed OOS Utilization Adjustment is an initial step in addressing OOS utilization that cannot be captured in the Case-Mix data using Medicare FFS data. Staff will continue to work with stakeholders to explore opportunities to incorporate other payers' data sources and refine the methodology as access to additional data sources becomes available. However, as with the currently proposed methodological refinement, changes based on inclusion of additional payers should not be applied retrospectively.

Alignment Under the AHEAD Model: HME and MDH supported aligning the RRIP readmissions measure with the NCQA PCR measure included in Maryland's PHAP. Commenters emphasized that the AHEAD model establishes statewide population health and utilization targets that apply across payers, including commercial and Medicaid populations. Commenters stated that aligning RRIP with the PCR measure and statewide goal would directly support the State's commitment under AHEAD by tying hospital financial incentives to the same all-payer, all-condition, and all-cause measure used to assess statewide performance. Additionally, commenters expressed concern that aligning RRIP with HRRP's condition specific measures could narrow the scope of accountability to select Medicare diagnoses and potentially create competing or fragmented incentives.

Adventist expressed a preference for aligning the future RRIP measure with the HRRP condition-specific measures. Adventist noted that greater alignment between state and federal programs could reduce administrative complexity and simplify reporting and tracking for hospitals.

MHA didn't specify support for a specific alignment option but requested that HSCRC provide comparative by-hospital modeling of Maryland hospitals' performance on the HRRP, NCQA PCR, and HWR measures before making future policy decisions. MHA emphasized that comparative modeling will help hospitals understand the implications of the potential alignment pathways and prepare for future rate year policy decisions.

Staff Response: Staff appreciates the feedback regarding alignment options and will continue to engage stakeholders in discussions to assess measure design, financial implications, and consistency with AHEAD Model requirement prior to recommending changes for future rate years. In general, staff believes that alignment with the all-payer PHAP goal is warranted to ensure achievement of the statewide biannual goals required under AHEAD. Staff are exploring what elements of the NCQA measure can and should be applied to RRIP. For example, alignment with the NCQA PCR measure could involve adding in observation stay data but maintaining current RRIP risk-adjustment, or could involve adding observation and the NCQA PCR risk-adjustment. Furthermore, staff support the alignment with PHAP measure because of concerns about applying the Medicare condition specific readmission measure to other payer populations, as opposed to an all-condition measure.

During CY 2026, staff will work with contractors to further evaluate feasibility of potential alignment with options including:

1. Assess adaptation of the NCQA PCR measure specifications for use with Case-Mix data rather than claims data.
2. Evaluate whether the HWR measure and the HRRP condition-specific measures could be adapted for application to all-payer or non-Medicare populations using case-mix data.
3. Determine all-payer or non-Medicare FFS performance goals for Maryland hospitals (i.e., improvement and/or attainment goals) and the revenue adjustment methodology for non-Medicare HGBs.

Staff will provide updates as they become available on the progress for determining the policy for RY 2029.

Recommendations

These are the final recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-payer, all-cause, all-condition readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 compared to two-year base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
 - a. Adjust case-mix readmission rate by the Out of State (OOS) Utilization Adjustment to account for OOS readmissions and transfers for RY 2027 beyond.

4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide regular updates on by-hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
 - Case-mix adjustment acknowledges increased severity of illness over time
 - Standard Deviation analysis of Eligible Discharges suggests that further reduction in readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
 - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
 - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
 - Include Oncology Discharges with more nuanced exclusion logic
 - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
 - 7.5 percent Improvement over 5 years (2018-2023)
 - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
 - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
 - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
 - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
 - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Methodology Steps

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.¹¹ Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.¹² Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.¹³
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.¹⁴
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.

¹¹ Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].

¹² **Rehab DRGs:** 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

¹³ **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

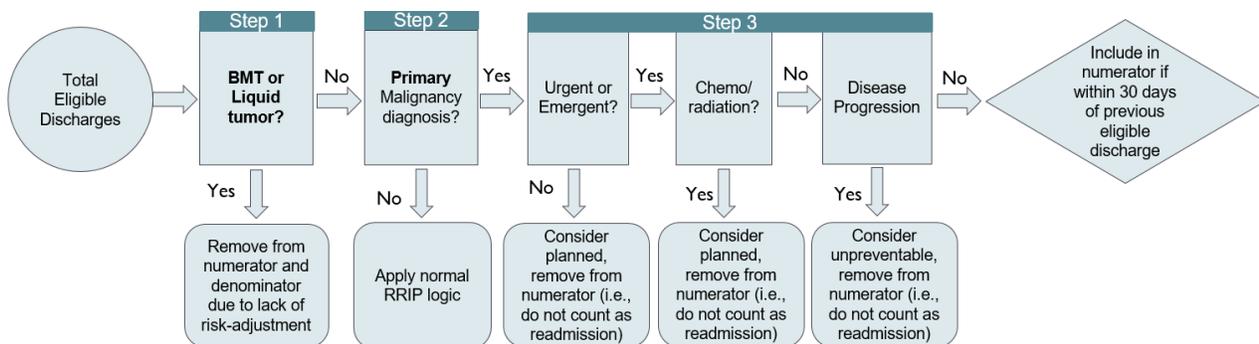
¹⁴ **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
 - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
 - Duplicates are removed.
 - Negative interval days are removed.

HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure which risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff thinks we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

- a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
- b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
- c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2023 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2022 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below.

Please note that, the base year readmission rates are not “locked in”, and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 42 for CY 2018-CY 2025.

Calculation:

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions) Readmission Rate}}{\text{Readmission Rate (Expected Readmissions)}} * \text{Statewide Base Year}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- o Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital’s case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital’s case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals,

given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm

P = Number of discharges with a readmission

D = Number of eligible discharges

i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital's DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

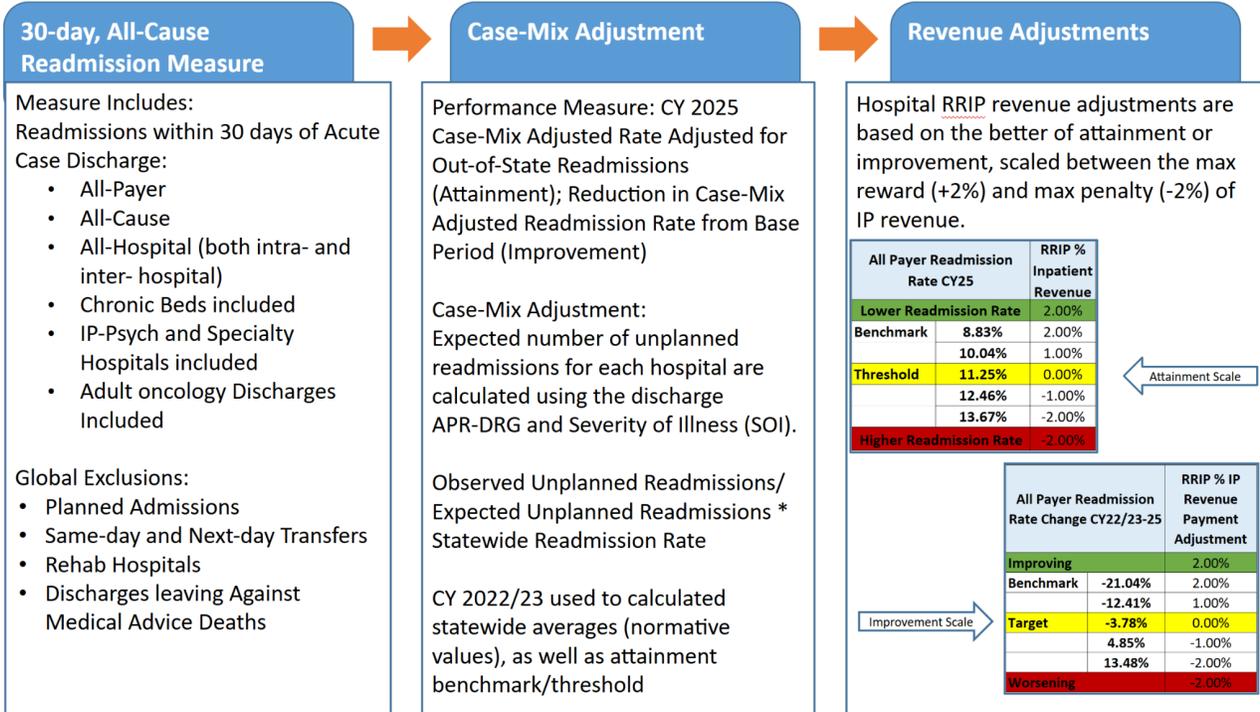
A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	500	45	.09		56.5

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., $0.09 = 45/500$. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E). The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

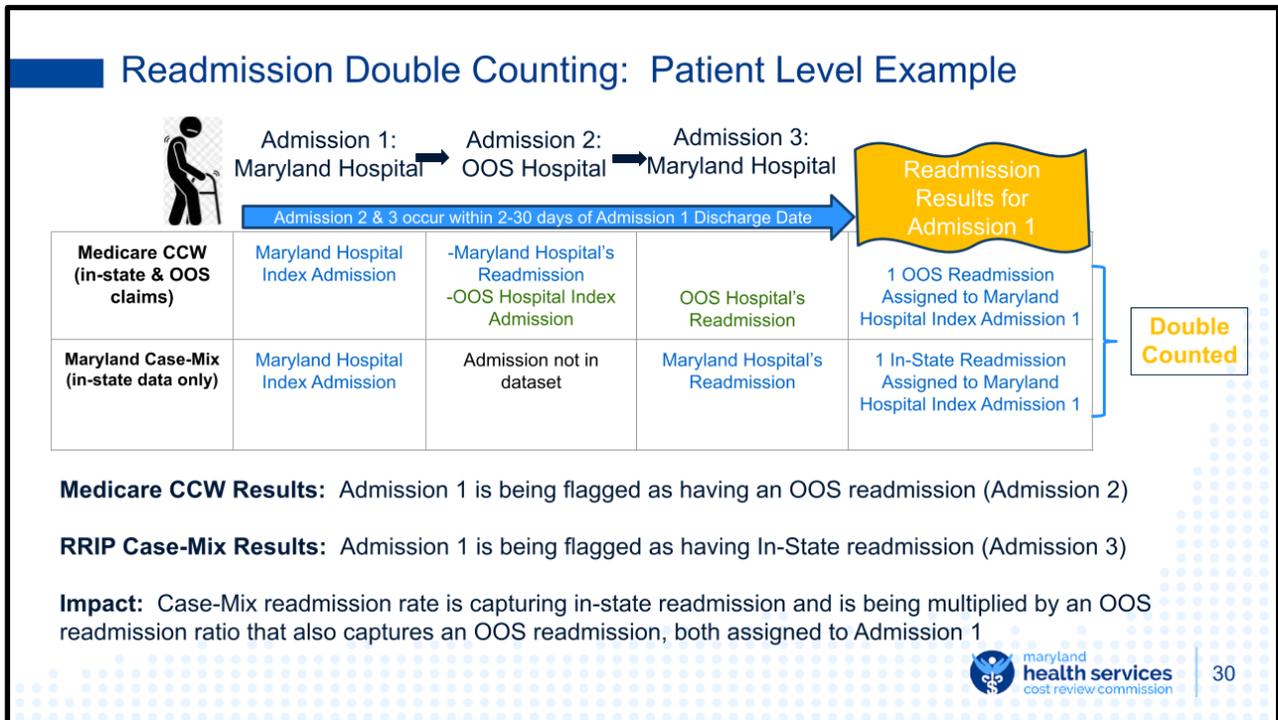
In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2027 RRIP methodology for reference.



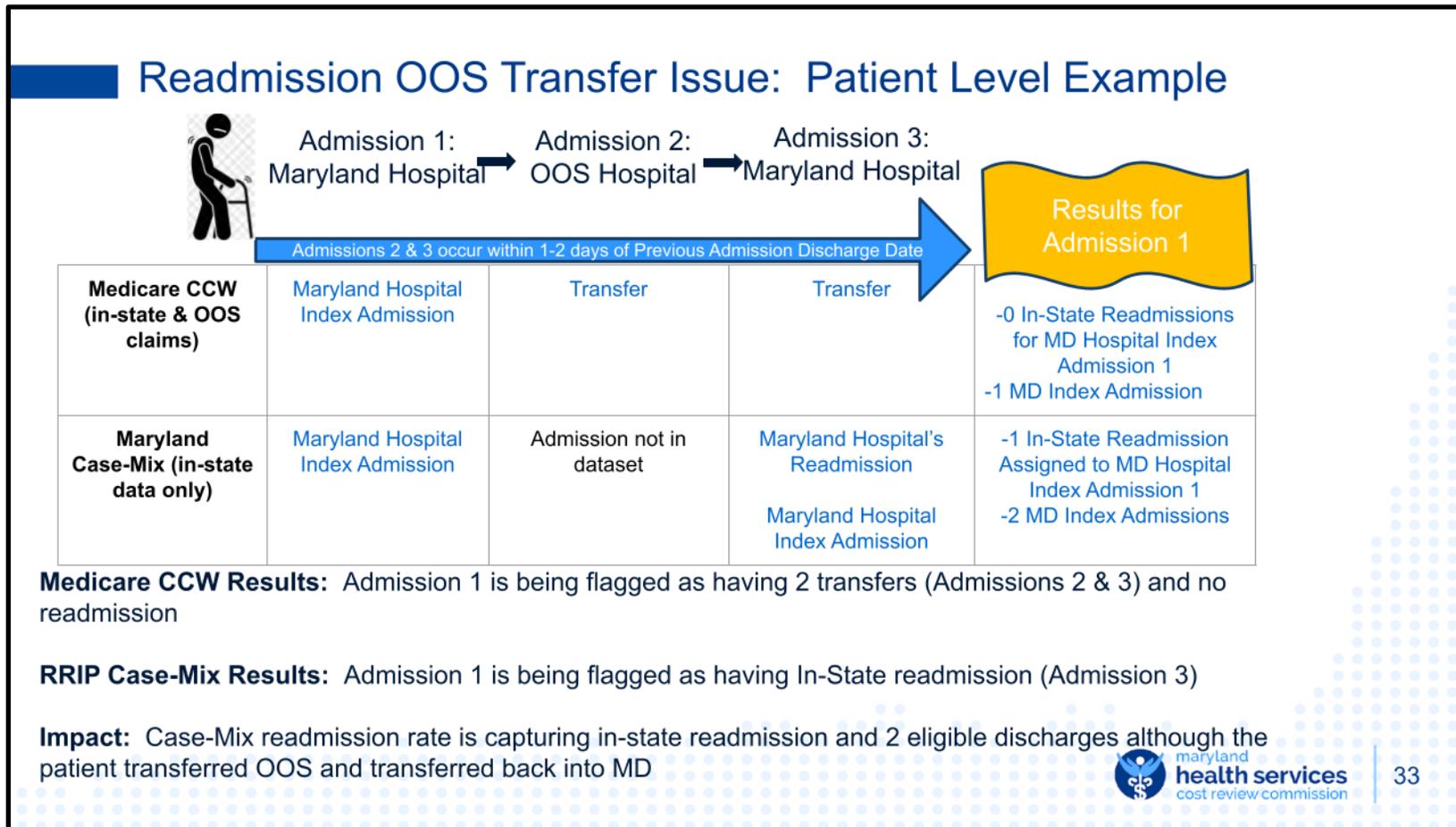
Appendix II. Example of Double Counting Issue



OOS Ratio Works when only two Admits				OOS Ratio Issue when three or more Admits				
Data Source	Admission 1	Admission 2	Readmission Results for Admission 1	Data Source	Admission 1	Admission 2	Admission 3	Readmission Results for MD Hospital
Medicare CCW (in-state & OOS claims)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	20 Total Readmissions / 100 Index Admissions = 20%	Medicare CCW (in-state & OOS claims)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	10 MD Hospital Readmissions Assigned to OOS Hospital	10 In-State + 10 OOS Readmissions / 100 Index = 20%
Maryland Case-Mix (in-state data only)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	10 In-State Readmissions / 100 Index Admissions = 10%	Maryland Case-Mix (in-state data only)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	10 Maryland Hospital Readmission	20 In-State Readmissions / 100 Index Admissions = 20%
OOS Adjustment Calculation	OOS Ratio from CCW: 20 Total / 10 In-State Readmission = 2 Attainment Rate: 10% Case-Mix Rate * 2 OOS Ratio = 20% ✓			OOS Adjustment Calculation	OOS Ratio from CCW: 20 Total / 10 In-State Readmission = 2 Attainment Rate: 20% Case-Mix Rate * 2 OOS Ratio = 40% ✗			

The readmission adjustment ratio accounts for this issue by multiplying the case-mix adjusted readmission rate by the ratio of readmissions observed in the CCW with MD only claims (which has been validated as a proxy for the case-mix dataset) and the CCW with all claims. This ratio adjusts the case-mix adjusted rate to reflect the additional readmission utilization attributable to OOS activity that is not already captured in the MD case-mix data.

Appendix III. Example of OOS Transfer Issue



OOS Transfer Issue Example- Hospital Level

Data Source	Index Admits	MD Readmits	Readmit Rate
CCW: 800 index admits, 80 readmits, 400 transfers,	800	80	10%
Case-Mix: 800 index admits, 80 readmits, 400 transfers	1200	80	6.67%
CCW: 800 index admits, 80 readmits 100 transfers,	800	80	10%
Case-Mix: 800 index admits, 80 readmits, 100 transfers	900	80	8.89%
CCW: 800 index admits, 80 readmits, 100 transfers, 50 readmits for transfers	800	130	16.25%
Case-Mix: 800 index admits, 80 readmits, 100 transfers, 50 readmits for transfers	900	130	14.44%

Impact: Readmission rate is impacted by OOS transfer rate and OOS transfer with a readmission rate

The transfer adjustment ratio accounts for this issue by multiplying the case-mix adjusted readmission rate by the ratio of admissions between the CCW with all claims and the CCW with MD only claims (which has been validated as a proxy for the case-mix dataset). This ratio proportionally corrects denominator inflation due to misclassified transfers.

Appendix IV. Out of State (OOS) Utilization Adjustment Methodology

I. Purpose

The purpose of the OOS Utilization Adjustment is to account for OOS utilization that cannot be captured in the Case-Mix dataset. Without an OOS utilization adjustment, hospitals across the State could not be compared fairly being that some hospitals may have higher OOS utilization (e.g., border hospitals, systems with OOS hospitals).

Because the HSCRC does not have access to comprehensive all-payer OOS claims data, this methodology uses Medicare Chronic Conditions Warehouse (CCW) claims data as a proxy to estimate the impact of OOS utilization on readmission rates.

II. Data Sources

Staff uses Medicare fee-for-service claims data obtained through CMMI from the Chronic Conditions Warehouse (CCW). Data availability is as follows:

- Quarterly preliminary files include:
 - 100% of Maryland claims
 - 100% of border state claims
 - 5% sample of national claims
- Annual final files include (expected each April):
 - 100% of national Medicare claims for the prior calendar year

Due to the 30-day readmission run-out requirement, staff applies readmission logic to December–November CCW claims data to ensure complete capture of 30-day readmissions.

For example, in April 2026, staff expects to receive 100% of national claims for January–December 2025. Readmission logic will be applied to December 2024–November 2025 claims to allow for full 30-day follow-up.

III. Definitions

For purposes of this adjustment:

- **CCW All Claims Readmission Rate:**
The Medicare readmission rate calculated using all available national claims (Maryland,

border states, and national claims).

- **CCW MD Only Claims Readmission Rate:**
The Medicare readmission rate calculated using only Maryland claims.
- **Readmission Logic:**
The code is from GDIT based on the V6 report. The HSCRC has maintained the logic consistently since 2018.
- **OOS Readmission Adjustment Ratio:** $\frac{\# \text{ of CCW All Claims Readmissions}}{\# \text{ of CCW-MD Only Readmissions}}$ This ratio corrects for the inflation of the # of readmissions
- **OOS Transfer Adjustment Ratio:** $\frac{\# \text{ of CCW-MD Only Admissions}}{\# \text{ of CCW All Claims Readmissions}}$ This ratio corrects for the inflation of the # of eligible discharges

IV. OOS Utilization Adjustment Formula

The OOS Utilization Adjustment is calculated as: $\frac{CCW \text{ All Claims Readmission Rate}}{CCW \text{ MD Only Claims Readmission Rate}}$

The OOS Utilization Adjustment reflects the combined effect of the OOS Readmission Adjustment Ratio and the OOS Transfer Adjustment Ratio. The OOS Utilization Adjustment ratio estimates the relative impact of out-of-state utilization (transfers and readmissions) on readmission rates using Medicare as a proxy for all-payer patterns.

V. Application to Case-Mix Readmission Rates

The OOS Utilization Adjustment is applied by being multiplied by the Case-Mix Adjusted Readmission Rate to calculate the attainment rate.

Attainment Rate=Case-Mix Adjusted Readmission Rate x OOS Utilization Adjustment

Appendix V. Reducing Disparities in Readmissions

Racial and socioeconomic differences in readmission rates are well documented^{15, 16} and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for Blacks was 2.6 percentage points higher than for whites, and the rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 *Annals of Internal Medicine* paper co-authored by HSCRC staff¹⁷ reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, historically identified reductions in disparities as a key priority. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 10, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.¹⁸

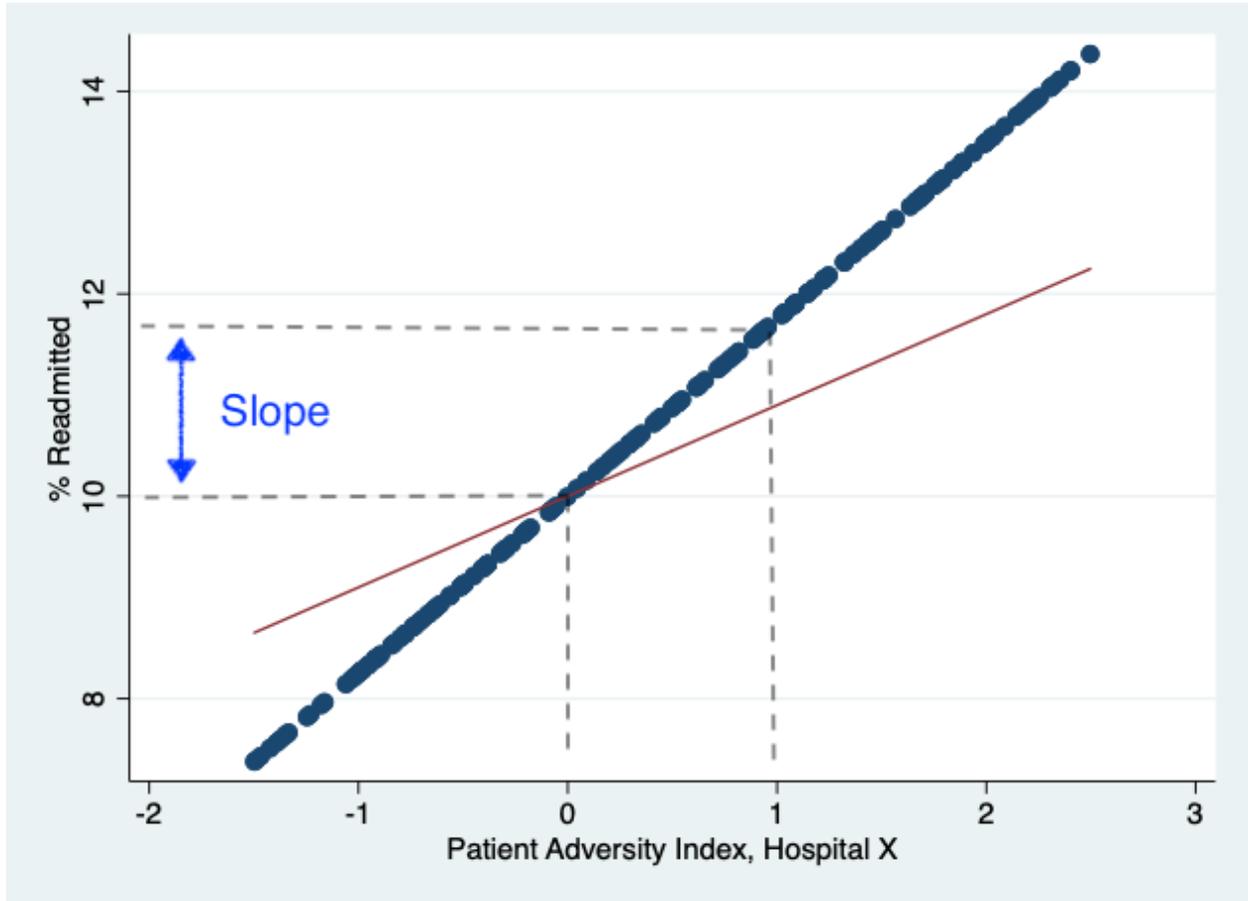
¹⁵ Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;

¹⁶ Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.

¹⁷ Jencks, Stephen F., et al. "Safety-Net hospitals, neighborhood disadvantage, and readmissions under Maryland's all-payer program: an observational study." *Annals of internal medicine* 171.2 (2019): 91-98.

¹⁸ [RY 2021 RRIP Policy](#)

Figure 10. Hypothetical Example of Relationship between PAI and Readmission Rates



Appendix VI. RY 2027 Preliminary Revenue Adjustments, CY 2025 YTD through August

HOSPITAL ID	HOSPITAL NAME	FY 25 Estimated Permanent Inpatient Revenue	Improvement Scaling				Attainment Scaling				Final Adjustment		
			CY22/23-CY25% Change in Case Mix Adjusted Rate	Target	% Revenue Adjustment	\$ Revenue Adjustment	CY 2025 Case Mix Adjusted Rate with Out-of-State Adjustment	Target (top 25th %)	% Revenue Adjustment	\$ Revenue Adjustment*	\$ Better of Attainment or Improvement	FY 27 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	\$269,729,949	-4.15%	-3.78%	0.04%	\$107,892	12.65%	11.25%	-1.16%	-\$3,128,867	\$107,892	0.04%	Imp
210002	UMMS- UMMC	\$1,572,442,188	-0.99%	-3.78%	-0.32%	-\$5,031,815	11.47%	11.25%	-0.18%	-\$2,830,396	-\$2,830,396	-0.18%	Att
210003	UMMS- Capital Region	\$325,349,234	-2.20%	-3.78%	-0.18%	-\$585,629	11.09%	11.25%	0.13%	\$422,954	\$422,954	0.13%	Att
210004	Trinity - Holy Cross	\$440,757,012	-4.65%	-3.78%	0.10%	\$440,757	12.00%	11.25%	-0.62%	-\$2,732,693	\$440,757	0.10%	Imp
210005	Frederick	\$255,860,248	5.04%	-3.78%	-1.02%	-\$2,609,775	12.39%	11.25%	-0.94%	-\$2,405,086	-\$2,405,086	-0.94%	Att
210008	Mercy	\$244,094,359	-13.42%	-3.78%	1.12%	\$2,733,857	11.94%	11.25%	-0.57%	-\$1,391,338	\$2,733,857	1.12%	Imp
210009	JHH- Johns Hopkins	\$1,915,323,836	0.59%	-3.78%	-0.51%	-\$9,768,152	12.88%	11.25%	-1.35%	-\$25,856,872	-\$9,768,152	-0.51%	Imp
210011	St. Agnes	\$280,211,776	-10.07%	-3.78%	0.73%	\$2,045,546	11.06%	11.25%	0.16%	\$448,339	\$2,045,546	0.73%	Imp
210012	Lifebridge- Sinai	\$527,147,859	0.00%	-3.78%	-0.44%	-\$2,319,451	11.83%	11.25%	-0.48%	-\$2,530,310	-\$2,319,451	-0.44%	Imp
210015	MedStar- Franklin Square	\$407,544,466	7.76%	-3.78%	-1.34%	-\$5,461,096	12.96%	11.25%	-1.41%	-\$5,746,377	-\$5,461,096	-1.34%	Imp
210016	Adventist- White Oak	\$269,335,289	1.55%	-3.78%	-0.62%	-\$1,669,879	12.81%	11.25%	-1.29%	-\$3,474,425	-\$1,669,879	-0.62%	Imp
210017	Garrett	\$31,765,005	-4.98%	-3.78%	0.14%	\$44,471	10.00%	11.25%	1.03%	\$327,180	\$327,180	1.03%	Att
210018	MedStar- Montgomery	\$107,202,092	0.85%	-3.78%	-0.54%	-\$578,891	11.50%	11.25%	-0.21%	-\$225,124	-\$225,124	-0.21%	Att
210019	Tidal- Peninsula	\$356,375,986	-5.31%	-3.78%	0.18%	\$641,477	11.05%	11.25%	0.16%	\$570,202	\$641,477	0.18%	Imp
210022	JHH- Suburban	\$276,688,736	-5.21%	-3.78%	0.17%	\$470,371	11.64%	11.25%	-0.32%	-\$885,404	\$470,371	0.17%	Imp
210023	Luminis- Anne Arundel	\$419,860,154	6.17%	-3.78%	-1.15%	-\$4,828,392	13.22%	11.25%	-1.63%	-\$6,843,721	-\$4,828,392	-1.15%	Imp
210024	MedStar- Union Mem	\$306,565,594	0.47%	-3.78%	-0.49%	-\$1,502,171	13.06%	11.25%	-1.50%	-\$4,598,484	-\$1,502,171	-0.49%	Imp
210027	Western Maryland	\$206,549,734	-4.19%	-3.78%	0.05%	\$103,275	11.85%	11.25%	-0.49%	-\$1,012,094	\$103,275	0.05%	Imp
210028	MedStar- St. Mary's	\$99,664,006	-0.27%	-3.78%	-0.41%	-\$408,622	13.07%	11.25%	-1.51%	-\$1,504,926	-\$408,622	-0.41%	Imp
210029	JHH- Bayview	\$505,597,983	5.54%	-3.78%	-1.08%	-\$5,460,458	13.41%	11.25%	-1.79%	-\$9,050,204	-\$5,460,458	-1.08%	Imp
210030	UMMS- Chestertown	\$10,830,306	3.75%	-3.78%	-0.87%	-\$94,224	8.88%	11.25%	1.96%	\$212,274	\$212,274	1.96%	Att
210032	ChristianaCare, Union	\$111,158,432	-10.69%	-3.78%	0.80%	\$889,267	12.96%	11.25%	-1.42%	-\$1,578,450	\$889,267	0.80%	Imp
210033	Lifebridge- Carroll	\$166,721,865	-6.95%	-3.78%	0.37%	\$616,871	11.75%	11.25%	-0.42%	-\$700,232	\$616,871	0.37%	Imp
210034	MedStar- Harbor	\$137,076,633	-8.10%	-3.78%	0.50%	\$685,383	12.26%	11.25%	-0.84%	-\$1,151,444	\$685,383	0.50%	Imp
210035	UMMS- Charles	\$105,216,708	-7.35%	-3.78%	0.41%	\$431,389	10.51%	11.25%	0.61%	\$641,822	\$641,822	0.61%	Att
210037	UMMS- Easton	\$138,384,760	-11.32%	-3.78%	0.87%	\$1,203,947	8.91%	11.25%	1.94%	\$2,684,664	\$2,684,664	1.94%	Att
210038	UMMS- Midtown	\$140,973,899	0.73%	-3.78%	-0.52%	-\$733,064	12.59%	11.25%	-1.11%	-\$1,564,810	-\$733,064	-0.52%	Imp
210039	Calvert	\$84,946,923	3.21%	-3.78%	-0.81%	-\$688,070	11.75%	11.25%	-0.42%	-\$356,777	-\$356,777	-0.42%	Att
210040	Lifebridge- Northwest	\$173,564,819	2.78%	-3.78%	-0.76%	-\$1,319,093	13.16%	11.25%	-1.58%	-\$2,742,324	-\$1,319,093	-0.76%	Imp
210043	UMMS- BWMC	\$329,675,757	-5.53%	-3.78%	0.20%	\$659,352	11.47%	11.25%	-0.18%	-\$593,416	\$659,352	0.20%	Imp
210044	GBMC	\$274,971,840	-5.86%	-3.78%	0.24%	\$659,932	10.25%	11.25%	0.83%	\$2,282,266	\$2,282,266	0.83%	Att
210048	JHH- Howard County	\$256,140,273	-5.49%	-3.78%	0.20%	\$512,281	12.60%	11.25%	-1.12%	-\$2,868,771	\$512,281	0.20%	Imp
210049	UMMS-Upper Chesapeake	\$260,331,648	2.37%	-3.78%	-0.71%	-\$1,848,355	11.87%	11.25%	-0.51%	-\$1,327,691	-\$1,327,691	-0.51%	Att
210051	Luminis- Doctors	\$195,040,841	11.32%	-3.78%	-1.75%	-\$3,413,215	11.98%	11.25%	-0.60%	-\$1,170,245	-\$1,170,245	-0.60%	Att
210056	MedStar- Good Sam	\$199,681,457	-11.16%	-3.78%	0.86%	\$1,717,261	12.49%	11.25%	-1.02%	-\$2,036,751	\$1,717,261	0.86%	Imp
210057	Adventist- Shady Grove	\$361,126,072	4.36%	-3.78%	-0.94%	-\$3,394,585	11.46%	11.25%	-0.17%	-\$613,914	-\$613,914	-0.17%	Att
210058	UMMS- UMROI	\$89,094,194	44.14%	-3.78%	-2.00%	-\$1,781,884	11.92%	11.25%	-0.55%	-\$88,203	-\$88,203	-0.10%	Att
210060	Adventist-Ft. Washington	\$37,325,252	-15.78%	-3.78%	1.39%	\$518,821	10.87%	11.25%	0.32%	\$119,441	\$518,821	1.39%	Imp
210061	Atlantic General	\$49,839,515	-22.98%	-3.78%	2.00%	\$996,790	9.68%	11.25%	1.30%	\$647,914	\$996,790	2.00%	Imp
210062	MedStar- Southern MD	\$210,782,871	-15.62%	-3.78%	1.37%	\$2,887,723	11.13%	11.25%	0.10%	\$210,783	\$2,887,723	1.37%	Imp
210063	UMMS- St. Joe	\$305,357,564	-7.16%	-3.78%	0.39%	\$1,190,895	11.30%	11.25%	-0.04%	-\$122,143	\$1,190,895	0.39%	Imp
210064	Lifebridge- Levindale	\$71,025,639	-18.58%	-3.78%	1.71%	\$1,214,538	9.63%	11.25%	1.34%	\$951,744	\$1,214,538	1.71%	Imp
210065	Trinity - Holy Cross Germantown	\$106,721,583	-0.59%	-3.78%	-0.37%	-\$394,870	12.23%	11.25%	-0.81%	-\$864,445	-\$394,870	-0.37%	Imp

Appendix VII. By Hospital Comparison of RY 2026 Revenue Adjustments with Incorrect vs Updated OOS Ratios

HOSPITAL ID	HOSPITAL NAME	INCORRECT OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY (WHAT'S IN RATES)			UPDATED OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY			Performance compared to what's in rates (\$)	Performance compared to what's in rates (%)
		Final Adjustment			Final Adjustment				
		\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment		
210001	Meritus	-\$2,346,651	-0.87%	Imp	-\$2,346,651	-0.87%	Imp	\$0	0.00%
210002	UMMS- UMMC	-\$9,277,409	-0.59%	Att	-\$9,434,653	-0.60%	Att	-\$157,244	-0.01%
210003	UMMS- Capital Region	\$1,073,652	0.33%	Att	\$422,954	0.13%	Att	-\$650,698	-0.20%
210004	Trinity - Holy Cross	-\$2,732,693	-0.62%	Imp	-\$2,732,693	-0.62%	Imp	\$0	0.00%
210005	Frederick	\$281,446	0.11%	Imp	\$281,446	0.11%	Imp	\$0	0.00%
210008	Mercy	\$48,819	0.02%	Imp	\$48,819	0.02%	Imp	\$0	0.00%
210009	JHH- Johns Hopkins	-\$574,597	-0.03%	Imp	-\$574,597	-0.03%	Imp	\$0	0.00%
210011	St. Agnes	\$1,457,101	0.52%	Imp	\$1,457,101	0.52%	Imp	\$0	0.00%
210012	Lifebridge- Sinai	-\$4,111,753	-0.78%	Imp	-\$4,111,753	-0.78%	Imp	\$0	0.00%
210015	MedStar- Franklin Square	-\$4,482,989	-1.10%	Imp	-\$4,482,989	-1.10%	Imp	\$0	0.00%
210016	Adventist- White Oak	-\$26,934	-0.01%	Imp	-\$26,934	-0.01%	Imp	\$0	0.00%
210017	Garrett	-\$22,236	-0.07%	Att	-\$181,061	-0.57%	Att	-\$158,825	-0.50%
210018	MedStar- Montgomery	-\$482,409	-0.45%	Att	-\$557,451	-0.52%	Att	-\$75,042	-0.07%
210019	Tidal- Peninsula	\$2,744,095	0.77%	Imp	\$2,744,095	0.77%	Imp	\$0	0.00%
210022	JHH- Suburban	\$968,411	0.35%	Imp	\$968,411	0.35%	Imp	\$0	0.00%
210023	Luminis- Anne Arundel	-\$3,190,937	-0.76%	Imp	-\$3,190,937	-0.76%	Imp	\$0	0.00%
210024	MedStar- Union Mem	-\$1,931,363	-0.63%	Imp	-\$1,931,363	-0.63%	Imp	\$0	0.00%
210027	Western Maryland	\$185,895	0.09%	Imp	\$185,895	0.09%	Imp	\$0	0.00%
210028	MedStar- St. Mary's	\$1,295,632	1.30%	Imp	\$1,295,632	1.30%	Imp	\$0	0.00%
210029	JHH- Bayview	-\$3,791,985	-0.75%	Imp	-\$3,791,985	-0.75%	Imp	\$0	0.00%
210030	UMMS- Chestertown	\$216,606	2.00%	Att	\$203,610	1.88%	Att	-\$12,996	-0.12%
210032	ChristianaCare, Union	\$400,170	0.36%	Imp	\$400,170	0.36%	Imp	\$0	0.00%
210033	Lifebridge- Carroll	\$0	0.00%	Imp	\$0	0.00%	Imp	\$0	0.00%
210034	MedStar- Harbor	-\$726,506	-0.53%	Imp	-\$726,506	-0.53%	Imp	\$0	0.00%
210035	UMMS- Charles	-\$84,173	-0.08%	Imp	\$147,303	0.14%	Imp	\$231,476	0.22%
210037	UMMS- Easton	\$2,324,864	1.68%	Att	\$1,923,548	1.39%	Att	-\$401,316	-0.29%
210038	UMMS- Midtown	-\$437,019	-0.31%	Imp	-\$437,019	-0.31%	Imp	\$0	0.00%
210039	Calvert	-\$679,575	-0.80%	Att	-\$450,219	-0.53%	Att	\$229,356	0.27%
210040	Lifebridge- Northwest	-\$1,145,528	-0.66%	Imp	-\$1,145,528	-0.66%	Imp	\$0	0.00%
210043	UMMS- BWMC	-\$2,406,633	-0.73%	Imp	-\$2,406,633	-0.73%	Imp	\$0	0.00%
210044	GBMC	\$1,402,356	0.51%	Att	\$1,484,848	0.54%	Att	\$82,492	0.03%
210048	JHH- Howard County	\$153,684	0.06%	Imp	\$153,684	0.06%	Imp	\$0	0.00%
210049	UMMS-Upper Chesapeake	-\$2,993,814	-1.15%	Att	-\$2,655,383	-1.02%	Att	\$338,431	0.13%
210051	Luminis- Doctors	\$585,123	0.30%	Att	\$585,123	0.30%	Att	\$0	0.00%
210056	MedStar- Good Sam	\$1,098,248	0.55%	Imp	\$1,098,248	0.55%	Imp	\$0	0.00%
210057	Adventist- Shady Grove	-\$2,022,306	-0.56%	Att	-\$2,166,756	-0.60%	Att	-\$144,450	-0.04%
210058	UMMS- UMR01	-\$202,066	-0.23%	Att	-\$202,066	-0.23%	Att	\$0	0.00%
210060	Adventist-Ft. Washington	-\$22,395	-0.06%	Imp	-\$22,395	-0.06%	Imp	\$0	0.00%
210061	Atlantic General	\$4,984	0.01%	Att	-\$134,567	-0.27%	Att	-\$139,551	-0.28%
210062	MedStar- Southern MD	\$1,538,713	0.73%	Imp	\$1,538,713	0.73%	Imp	\$0	0.00%
210063	UMMS- St. Joe	-\$977,144	-0.32%	Imp	-\$977,144	-0.32%	Imp	\$0	0.00%
210064	Lifebridge- Levindale	\$1,420,513	2.00%	Att	\$1,420,513	2.00%	Att	\$0	0.00%
210065	Trinity - Holy Cross Germantown	-\$469,575	-0.44%	Imp	-\$469,575	-0.44%	Imp	\$0	0.00%
STATEWIDE	\$ 12,634,054,157.03	-\$27,938,378	-0.22%		-\$28,796,745	-0.23%		-\$858,367	-0.01%
Penalty		-\$45,138,690	-0.36%		-\$45,156,858	-0.36%		-\$18,168	0.00%
Reward		\$17,200,312	0.14%		\$16,360,113	0.13%		-\$840,199	-0.01%

Appendix VIII. By Hospital FFY 2025 Estimated HRRP and RY 2025 Final RRIP Revenue Adjustments

Hospital ID	Hospital Name	FFY 2025 HRRP Revenue Adjustment (\$)	FFY 2025 HRRP Revenue Adjustment (%)	RY 2025 RRIP Revenue Adjustment (\$)	RY 2025 RRIP Revenue Adjustment (%)
210001	Meritus	\$ (2,444,359.12)	-0.97%	\$ (2,217,563.00)	-0.88%
210002	UMMS- UMMC	\$ (736,536.06)	-0.05%	\$ 18,266,094.00	1.24%
210003	UMMS- Capital Region	\$ (959,427.78)	-0.31%	\$ 3,342,523.00	1.08%
210004	Trinity - Holy Cross	\$ (413,940.59)	-0.10%	\$ (413,941.00)	-0.10%
210005	Frederick	\$ (152,737.52)	-0.06%	\$ (534,581.00)	-0.21%
210008	Mercy	\$ (176,531.62)	-0.08%	\$ (3,354,101.00)	-1.52%
210009	JHH- Johns Hopkins	\$ (181,890.34)	-0.01%	\$ 6,911,833.00	0.38%
210011	St. Agnes	\$ (636,911.21)	-0.25%	\$ (382,147.00)	-0.15%
210012	Lifebridge- Sinai	\$ (467,111.59)	-0.09%	\$ (1,972,249.00)	-0.38%
210015	MedStar- Franklin Square	\$ -	-0.02%	\$ 2,008,056.00	0.54%
210016	Adventist- White Oak	\$ (2,598,932.33)	-1.07%	\$ (2,161,729.00)	-0.89%
210017	Garrett	\$ (11,595.28)	-0.04%	\$ (43,482.00)	-0.15%
210018	MedStar- Montgomery	\$ -	0.00%	\$ 1,037,362.00	1.08%
210019	Tidal- Peninsula	\$ -	0.00%	\$ 140,150.00	0.04%
210022	JHH- Suburban	\$ (399,174.46)	-0.16%	\$ (249,484.00)	-0.10%
210023	Luminis- Anne Arundel	\$ (1,802,859.22)	-0.49%	\$ (2,649,099.00)	-0.72%
210024	MedStar- Union Mem	\$ (53,583.46)	-0.02%	\$ (1,232,420.00)	-0.46%
210027	Western Maryland	\$ -	-0.01%	\$ (825,209.00)	-0.45%
210028	MedStar- St. Mary's	\$ (582,781.01)	-0.58%	\$ 813,884.00	0.81%
210029	JHH- Bayview	\$ (660,500.70)	-0.14%	\$ 3,632,754.00	0.77%
210030	UMMS- Chestertown	\$ -	0.00%	\$ 36,299.00	0.48%
210032	ChristianaCare, Union	\$ (356,172.27)	-0.42%	\$ (636,022.00)	-0.75%
210033	Lifebridge- Carroll	\$ -	0.00%	\$ (618,811.00)	-0.38%
210034	MedStar- Harbor	\$ (12,823.45)	-0.01%	\$ 256,469.00	0.20%
210035	UMMS- Charles	\$ (214,689.70)	-0.22%	\$ 614,793.00	0.63%
210037	UMMS- Easton	\$ (49,446.98)	-0.04%	\$ 988,940.00	0.80%
210038	UMMS- Midtown	\$ (70,209.33)	-0.05%	\$ 1,109,307.00	0.79%
210039	Calvert	\$ (412,717.83)	-0.51%	\$ 129,480.00	0.16%
210040	Lifebridge- Northwest	\$ (482,584.16)	-0.30%	\$ (1,769,475.00)	-1.10%
210043	UMMS- BWMC	\$ -	0.00%	\$ (2,018,621.00)	-0.62%
210044	GBMC	\$ (685,814.10)	-0.26%	\$ 1,081,476.00	0.41%
210048	JHH- Howard County	\$ (1,630,127.96)	-0.74%	\$ (2,467,221.00)	-1.12%
210049	UMMS- Upper Chesapeake	\$ (757,960.20)	-0.32%	\$ (1,586,979.00)	-0.67%
210051	Luminis- Doctors	\$ (486,803.48)	-0.26%	\$ 917,437.00	0.49%
210056	MedStar- Good Sam	\$ (130,639.87)	-0.07%	\$ 391,920.00	0.21%
210057	Adventist- Shady Grove	\$ (1,803,454.74)	-0.54%	\$ 367,370.00	0.11%
210058	UMMS- UMROI	\$ -	0.00%	\$ 242,904.30	0.30%
210060	Adventist- Ft. Washington	\$ (238,032.71)	-0.63%	\$ (358,938.00)	-0.95%
210061	Atlantic General	\$ (85,381.21)	-0.18%	\$ (237,170.00)	-0.50%
210062	MedStar- Southern MD	\$ (210,921.41)	-0.10%	\$ (1,244,436.00)	-0.59%
210063	UMMS- St. Joe	\$ (2,896,423.64)	-0.99%	\$ (409,595.00)	-0.14%
210064	Lifebridge- Levindale	\$ -	0.00%	\$ (517,924.00)	-0.76%
210065	Trinity - Holy Cross Germantown	\$ (501,966.96)	-0.53%	\$ 28,413.00	0.03%

Appendix IX. By Hospital Comparison of Utilization Adjustment vs Incorrect OOS Ratios using Original Methodology and Updated OOS Ratios using Original Methodology

HOSPITAL ID	HOSPITAL NAME	INCORRECT OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY (WHAT'S IN RATES)			UPDATED OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY			OOS READMISSION AND TRANSFER ADJUSTMENTS = OOS UTILIZATION ADJUSTMENT (Staff Recommendation)		
		Final Adjustment			Final Adjustment			Final Adjustment		
		\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	-\$2,346,651	-0.87%	Imp	-\$2,346,651	-0.87%	Imp	-\$2,346,651	-0.87%	Imp
210002	UMMS-UMMC	-\$9,277,409	-0.59%	Att	-\$9,434,653	-0.60%	Att	-\$11,950,561	-0.76%	Att
210003	UMMS- Capital Region	\$1,073,652	0.33%	Att	\$422,954	0.13%	Att	-\$97,605	-0.03%	Att
210004	Trinity - Holy Cross	-\$2,732,693	-0.62%	Imp	-\$2,732,693	-0.62%	Imp	-\$2,732,693	-0.62%	Imp
210005	Frederick	\$281,446	0.11%	Imp	\$281,446	0.11%	Imp	\$281,446	0.11%	Imp
210006	Mercy	\$48,819	0.02%	Imp	\$48,819	0.02%	Imp	\$48,819	0.02%	Imp
210009	JHH- Johns Hopkins	-\$574,597	-0.03%	Imp	-\$574,597	-0.03%	Imp	-\$574,597	-0.03%	Imp
210011	St. Agnes	\$1,457,101	0.52%	Imp	\$1,457,101	0.52%	Imp	\$1,457,101	0.52%	Imp
210012	Lifefridge- Sinai	-\$4,111,753	-0.78%	Imp	-\$4,111,753	-0.78%	Imp	-\$4,111,753	-0.78%	Imp
210015	MedStar- Franklin Square	-\$4,482,989	-1.10%	Imp	-\$4,482,989	-1.10%	Imp	-\$4,482,989	-1.10%	Imp
210016	Adventist- White Oak	-\$26,934	-0.01%	Imp	-\$26,934	-0.01%	Imp	-\$26,934	-0.01%	Imp
210017	Garrett	-\$22,236	-0.07%	Att	-\$181,061	-0.57%	Att	\$508,240	1.60%	Att
210018	MedStar- Montgomery	-\$482,409	-0.45%	Att	-\$557,451	-0.52%	Att	-\$482,409	-0.45%	Att
210019	Tidal- Peninsula	\$2,744,095	0.77%	Imp	\$2,744,095	0.77%	Imp	\$2,744,095	0.77%	Imp
210022	JHH- Suburban	\$968,411	0.35%	Imp	\$968,411	0.35%	Imp	\$968,411	0.35%	Imp
210023	Luminis- Anne Arundel	-\$3,190,937	-0.76%	Imp	-\$3,190,937	-0.76%	Imp	-\$3,190,937	-0.76%	Imp
210024	MedStar- Union Mem	-\$1,931,363	-0.63%	Imp	-\$1,931,363	-0.63%	Imp	-\$1,931,363	-0.63%	Imp
210027	Western Maryland	\$185,895	0.09%	Imp	\$185,895	0.09%	Imp	\$185,895	0.09%	Imp
210028	MedStar- St. Mary's	\$1,295,632	1.30%	Imp	\$1,295,632	1.30%	Imp	\$1,295,632	1.30%	Imp
210029	JHH- Bayview	-\$3,791,985	-0.75%	Imp	-\$3,791,985	-0.75%	Imp	-\$3,791,985	-0.75%	Imp
210030	UMMS- Chestertown	\$216,606	2.00%	Att	\$203,610	1.88%	Att	\$216,606	2.00%	Att
210032	ChristianaCare, Union	\$400,170	0.36%	Imp	\$400,170	0.36%	Imp	\$400,170	0.36%	Imp
210033	Lifefridge- Carroll	\$0	0.00%	Imp	\$0	0.00%	Imp	\$0	0.00%	Imp
210034	MedStar- Harbor	-\$726,506	-0.53%	Imp	-\$726,506	-0.53%	Imp	-\$726,506	-0.53%	Imp
210035	UMMS- Charles	-\$84,173	-0.08%	Imp	\$147,303	0.14%	Imp	\$778,604	0.74%	Att
210037	UMMS- Easton	\$2,324,864	1.68%	Att	\$1,923,548	1.39%	Att	\$2,075,771	1.50%	Att
210038	UMMS- Midtown	-\$437,019	-0.31%	Imp	-\$437,019	-0.31%	Imp	-\$437,019	-0.31%	Imp
210039	Calvert	-\$679,575	-0.80%	Att	-\$450,219	-0.53%	Att	-\$433,229	-0.51%	Att
210040	Lifefridge- Northwest	-\$1,145,528	-0.66%	Imp	-\$1,145,528	-0.66%	Imp	-\$1,145,528	-0.66%	Imp
210043	UMMS- BlwMC	-\$2,406,633	-0.73%	Imp	-\$2,406,633	-0.73%	Imp	-\$2,406,633	-0.73%	Imp
210044	GBMC	\$1,402,356	0.51%	Att	\$1,484,848	0.54%	Att	\$1,484,848	0.54%	Att
210048	JHH- Howard County	\$153,684	0.06%	Imp	\$153,684	0.06%	Imp	\$153,684	0.06%	Imp
210049	UMMS- Upper Chesapeake	-\$2,993,814	-1.15%	Att	-\$2,655,383	-1.02%	Att	-\$2,759,515	-1.06%	Att
210051	Luminis- Doctors	\$585,123	0.30%	Att	\$585,123	0.30%	Att	\$780,163	0.40%	Att
210056	MedStar- Good Sam	\$1,098,248	0.55%	Imp	\$1,098,248	0.55%	Imp	\$1,098,248	0.55%	Imp
210057	Adventist- Shady Grove	-\$2,022,306	-0.56%	Att	-\$2,166,756	-0.60%	Att	-\$2,311,207	-0.64%	Att
210058	UMMS- UMPQI	-\$202,066	-0.23%	Att	-\$202,066	-0.23%	Att	-\$224,517	-0.25%	Att
210060	Adventist- Ft. Washington	-\$22,395	-0.06%	Imp	-\$22,395	-0.06%	Imp	-\$22,395	-0.06%	Imp
210061	Atlantic General	\$4,984	0.01%	Att	-\$134,567	-0.27%	Att	-\$284,085	-0.57%	Imp
210062	MedStar- Southern MD	\$1,538,713	0.73%	Imp	\$1,538,713	0.73%	Imp	\$1,538,713	0.73%	Imp
210063	UMMS- St. Joe	-\$977,144	-0.32%	Imp	-\$977,144	-0.32%	Imp	-\$977,144	-0.32%	Imp
210064	Lifefridge- Levindale	\$1,420,513	2.00%	Att	\$1,420,513	2.00%	Att	\$1,420,513	2.00%	Att
210065	Trinity - Holy Cross Germantown	-\$469,575	-0.44%	Imp	-\$469,575	-0.44%	Imp	-\$469,575	-0.44%	Imp



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

January 28, 2026

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

RE: RY 2028 Readmissions Reduction Incentive Program (RRIP)

Dear Dr. Kromm:

On behalf of the Maryland Department of Health, I am writing in response to the Health Services Cost Review Commission's (HSCRC) request for feedback on whether the Readmissions Reduction Incentive Program (RRIP) should align its readmissions measure with either 1) the NCQA Plan All-Cause Readmissions (PCR) measure included in the statewide Population Health and Accountability Plan (PHAP) or 2) the six Medicare condition-specific readmission measures included in the Hospital Readmissions Reduction Program (HRRP). The Department encourages alignment with the NCQA PCR measure.

Under the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, the State was required to submit a PHAP that establishes Statewide Quality and Population Health Targets across six domains, including utilization. For the utilization domain, CMS recommended the use of the NCQA PCR measure. Accordingly, the State adopted a statewide target to reduce all-payer, all-cause, all-condition 30-day readmissions by 3.07 percent from 2023 to 2034.

Aligning the RRIP readmissions measure with the NCQA PCR measure used in PHAP would directly support achievement of the State's utilization target by ensuring that hospital financial incentives are tied to the same all-payer population the State has committed to improving. RRIP is one of the State's primary levers for influencing hospital priorities, and alignment with the NCQA PCR measure would allow RRIP to function as a complementary mechanism to PHAP by linking statewide population health goals to actionable and aligned hospital-level incentives.

Given that under the AHEAD model the State's quality programs will only impact commercial and Medicaid hospital global budgets, RRIP measure alignment with the HRRP's measure would be less suited to advancing the State's goal under the AHEAD model. The HRRP measures are limited to six conditions which were designed for the Medicare population; RRIP alignment would narrow the scope of accountability and does not reflect Maryland's all-payer, population-based approach to care transformation. Reliance on condition-specific measures may also create competing incentives by focusing hospital efforts on select diagnoses rather than encouraging system-wide initiatives that reduce avoidable readmissions across all patient populations.

For these reasons, the Maryland Department of Health encourages the HSCRC to align the RRIP readmissions measure with the NCQA PCR measure used in PHAP. This alignment would promote consistency across State initiatives and reinforce Maryland's commitment to an all-payer, population-based approach to reducing avoidable readmissions under the AHEAD Model. The Department appreciates the opportunity to provide feedback and looks forward to continued collaboration with the HSCRC.

My Best,

A handwritten signature in blue ink, appearing to read 'Meena Seshamani', with a stylized flourish at the end.

Meena Seshamani, MD, PhD

Secretary of Health



February 2, 2026

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

Dear Alyson Schuster,

Adventist HealthCare (AHC) appreciates the opportunity to provide comments on the draft recommendation for the Rate Year (RY) 2028 Readmission Reduction Incentive Program (RRIP).

The HSCRC has been working collaboratively with hospitals to redesign the Maryland quality programs to more closely align with the CMS quality programs. While alignment of the Quality-Based Reimbursement (QBR) program and the CMS Hospital Value-Based Purchasing (HVBP) program has been much of the focus for HSCRC staff, we still actively encourage maximizing alignment between the other programs as well. Our preference is full alignment between the RRIP Program and the CMS Hospital Readmission Reduction Program (HRRP). However, if full alignment can't be achieved, we support keeping the program the same for RY28 with recommended modifications pending more clarification on the impacts of the OOS ratio correction. Regardless, we highly encourage maximum alignment between RRIP and HRRP by Year 2.

Continue RY27 Program for RY28 if Full HRRP Alignment Can't Be Achieved

As recommended with both the QBR and MHAC programs, AHC is in support of maximizing alignment between the RRIP and HRRP program to focus on condition specific readmissions. Narrowing the program to only those conditions included in the HRRP program would simplify reporting and tracking of performance while still having an impact on overall all-cause readmission rates. However, since alignment in Year 1 is unlikely, we support keeping the program the same for RY28 with recommended modifications pending more clarification on the impacts of the OOS ratio correction.

Out of State (OOS) Ratio Correction

The draft policy proposes a correction to the OOS ratio methodology, which currently double-counts readmissions as both in-state and out-of-state. This technical error affects the attainment calculation and has produced unintended financial impacts. In theory, AHC supports HSCRC staff's recommendation to apply this correction beginning in RY27.

However, we have also recently become aware of a second technical issue in the RY26 results that staff intend to address, though the underlying calculations and specific impacts have not yet been provided. We respectfully request the opportunity to fully understand these proposed technical corrections and their associated financial effects before offering final comment or recommending a policy solution.



Accordingly, we ask that staff share the revised RY27 calculations for both corrections and estimated impacts prior to finalizing the policy decision.

Maintain Upside Reward Potential in RY28 and Beyond

While AHC is in full support of aligning with the CMS quality programs, we encourage keeping the upside reward potential available in the RRIP program both in Year 1 and in future years. Maintaining upside reward potential incentivizes hospitals to invest in quality improvement initiatives, which aligns with the program's overarching goals. Flexibility in the revenue at risk keeps the infrastructure and scoring of the programs consistent but allows hospitals to reinvest rewards in areas of opportunity. Therefore, we agree with the draft proposal maintaining the revenue at risk at a maximum penalty at 2 percent and maximum reward at 2 percent for RY28. We also encourage this to continue as more full alignment is achieved with HRRP in future years.

Recommendations

Adventist HealthCare recommends the following actions for the RY28 RRIP Draft Recommendation:

- AHC prefers full alignment between RRIP and HRRP. However, if full alignment can't be achieved in Year 1, we support keeping the program the same for RY28 with recommended modifications. This is pending more clarification on the impacts of the OOS ratio correction.
- Share revised RY27 OOS calculations for both identified errors as well as the estimated financial impacts prior to finalizing the policy decision.
- Keep the revenue at risk at a maximum penalty at 2 percent and maximum reward at 2 percent for RY28 and consider continuing this in future years even as RRIP and HRRP are more closely aligned.

Conclusion

We value HSCRC's partnership and collaborative efforts to align the Maryland quality programs with the CMS quality programs. We are still in full support of aligning RRIP with HRRP by Year 2. However, we believe maintaining the current RRIP structure for RY28 pending more clarification on the OOS correction is the most practical approach for Year 1. We look forward to working closely with HSCRC staff to achieve full alignment by next year and to advance shared goals of quality care, program consistency, and improved outcomes across Maryland.

Sincerely,



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



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





Maryland
Hospital Association

February 2, 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 provide comment on the Health Services Cost Review Commission (HSCRC) recommendation for the Rate Year (RY) 2028 Readmissions Reduction Incentive Program (RRIP). We commend HSCRC for its continued commitment to advancing quality improvement through stable, incentive-based approaches.

MHA supports the RY 2028 RRIP recommendation. We appreciate staff's effort to maintain a familiar and predictable policy framework and minimize disruption for hospitals as Maryland transitions to the AHEAD Model. Preserving the core elements of RRIP during this period of significant change will enable hospitals to remain focused on performance improvement while contributing to broader discussions about multi-payer alignment under AHEAD's readmission quality requirements.

HSCRC is planning to reconvene the Clinical Adverse Events Measures Subgroup to discuss opportunities to improve its complication measurement approach and to identify strategies to align Maryland quality program measures with Centers for Medicare & Medicaid Services (CMS) quality program measures. As Maryland transitions to the AHEAD Model, a structured, collaborative venue that brings together the hospital field and policymakers will be essential to assess measures design, performance periods, and revenue adjustments and maintain consistency across state and federal programs.

MHA recommends the following policy refinements that can strengthen the RRIP design and help prepare for the AHEAD Model transition.

Out-of-State (OOS) Readmission Ratio Methodology Refinement

MHA appreciates HSCRC staff's responsiveness to members' concerns regarding OOS readmission ratio calculations and supports the proposed technical correction to address double counting of in-state and out-of-state (OOS) readmissions that was discovered when analyzing the use of the OOS readmission ratio that is derived from data in the Chronic Conditions Data Warehouse. Resolving this issue is essential to ensure accurate attribution and fair assessment of

hospital performance. The OOS calculation error has spanned multiple years and has disproportionately affected hospitals near state lines. Because of this, we recommend that the Commission apply the correction not only to RY 2027 but also to earlier rate years to ensure an accurate assessment for all prior year performance years. The Commission has previously implemented adjustments to retrospectively remedy issues adversely impacting hospitals across multiple years. In the annual payment update for RY 2026, HSCRC applied a revision to remedy a data issue impacting uncompensated care (UCC) funding determinations for RY 2023 through 2025. The Commission should follow this precedent for RRIP and implement a multi-year solution. We also encourage HSCRC to continue monitoring the OOS ratio following implementation of the correction, as additional refinement needs may emerge.

OOS Transfers

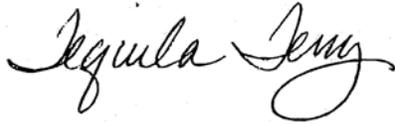
While HSCRC proposed a solution to address double counting of OOS transfers observed in Medicare data, the hospital field is concerned about inaccuracies in calculating readmissions across all payers due to OOS transfers. Hospitals identified inconsistencies in how OOS transfers are captured for patients enrolled in Medicare Advantage, Medicaid, or commercial coverage. These inconsistencies may influence performance results in ways not reflected in the limited analysis of Medicare OOS transfer data. A comprehensive, multi-payer approach is essential to improve the accuracy and fairness of the OOS transfer calculations and to strengthen insight into cross-border patient movement. MHA supports HSCRC's plan to incorporate broader data sources into future refinements and looks forward to the findings.

Planning for Future Alignment with the AHEAD Model

RY 2028 will assess CY 2026 performance, which is the first year of the AHEAD quality transition period. Given this, MHA supports HSCRC's intent to begin evaluating opportunities to align RRIP measures, targets, and revenue adjustments with AHEAD's readmission quality requirements. Early planning and transparent communication will be essential to ensure a smooth transition for hospitals. To support this work, MHA requests that HSCRC provide estimated impact modeling for the AHEAD readmission measurement options being considered, including the Hospital Readmission Reduction Program condition specific measures, the NCQA Plan All-Cause Readmission measure, and the CMS Hospital-Wide Readmission measure used in the AHEAD 3.0 Quality Hospital Global Budget methodology. Comparative modeling will help hospitals understand the implications of the potential alignment pathways and prepare for future rate year policy decisions.

The hospital field values HSCRC's commitment to collaborative, data-driven policymaking. As Maryland moves into the AHEAD Model, the transition will shape the state's quality programs for the next decade. This presents an important opportunity to better align state and federal programs, reduce administrative burden, and ensure policies remain fair, transparent, and actionable. Hospitals and health systems remain committed to improving patient outcomes and look forward to continued collaboration with HSCRC.

Sincerely,



Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Alyson Schuster
Princess Collins Taylor

February 2, 2026

Alyson Schuster, Ph.D.
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Alyson,

WVU Medicine Garrett Regional Medical Center “GRMC” appreciates the opportunity to comment on the draft staff recommendation on the Readmission Reduction Incentive Program (RRIP) for Rate Year 2028, dated January 14, 2026. GRMC appreciates the opportunity to provide feedback on this important policy. In evaluating HSCRC methodologies it is critical to ensure that the policies are fair and balanced and align with the goals of the Maryland Demonstration Model.

GRMC comments are focused on Out of State (OOS) readmission adjustment which is used to adjust readmission performance for out of state readmissions. Based on concerns from the industry related to the accuracy of the OOS readmission adjustment, Staff investigated the calculation and noted that the calculation is double counting readmissions in both the in-state and out-of-state readmissions and also counting interstate transfers as readmissions in the RRIP calculations. As a result the readmission rate for border hospitals is overstated which results in understating RRIP reward or overstating RRIP penalties. Based on CMS claims data, the impact of this error is six hospitals are penalized by more than \$3M. Due to our location, GRMC has one of the highest out of state adjustment factors of over 20% vs. a Statewide average of 4%. GRMC is being penalized by \$333K or 0.3% of GBR due to overstating readmission rates in the current RY2026 RRIP adjustment.

The HSCRC staff has quantified the impact of the double counting however is recommending to delay correcting the RRIP calculation until RY2027. As a result, GRMC’s RY2026 GBR will continue to be reduced despite identifying and quantifying the impact the OOS readmission overstatement in the RRIP calculation. GRMC is requesting that the RRIP calculation be corrected for RY2026 and the impact for the previous three rate years be quantified and reflected in the January 2026 rate order

GRMC appreciates the work of staff to continue to evaluate policies and requests that the Staff address the overstatement of readmission to ensure border hospitals are not inappropriately penalized for a calculation error. Thank you for your consideration of this matter.

With best regards,



Mark Boucot, MBA, FACHE
President/CEO
WVU Medicine Garrett Regional Medical Center

cc:

Jon Kromm, Executive Director

Allan Pack, Principal Deputy Director, Quality and Population-based Methodologies

Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations



January 26, 2026

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

RE: DRAFT RECOMMENDATIONS ON READMISSION REDUCTION INCENTIVE PROGRAM

Dear Dr. Kromm and HSCRC Commissioners:

Health Means Everything (HME) is supportive of the HSCRC's efforts to update the Readmission Reduction Incentive Program (RRIP), which provides important incentives for hospitals to provide high-quality care and prevent hospital readmissions. This program serves as an important guardrail to ensure that hospital readmissions do not increase and cause safety risks or lower quality of care for Marylanders.

HME appreciates that the HSCRC's RY2028 draft recommendations propose to maintain the Readmission Reduction Incentives Program with its current core structure, including the 4-year improvement target of -5.0% through CY 2026. Maryland's RRIP has been associated with meaningful reductions in statewide readmissions, including continued lower Medicare FFS compared to the rest of the nation, and continued improvement on all-payer case-mix adjusted readmissions. These results demonstrate sustained performance under the existing framework. **As such, HME supports the HSCRC's draft RRIP recommendation for RY 2028.** The limited changes proposed prior to RY2028 appropriately focus on technical refinement, such as correcting out-of-state readmission ratios and increasing transparency on hospital disparities, which are meaningful and targeted improvements that refine the program without introducing structural disruptions. This recommendation would maintain stability during this period of system transition.



HEALTH MEANS EVERYTHING

CONSUMER ALLIANCE

Looking beyond RY 2028, the HSCRC seeks feedback on whether it should align RRIP policy with the NCQA Plan All Cause Readmission (PCR) measure included in the Population Health and Accountability Plan (PHAP) or the Medicare-specific Hospital Readmissions Reduction Program (HRRP). **HME believes that revising RRIP towards the NCQA's PCR, as was included in the PHAP, better aligns with Maryland's long-standing goal of improving the delivery of health care for all consumers – not just those on Medicare. As a result, we recommend continued alignment with the PCR/PHAP measures.** Further, as the HSCRC rightfully points out, the HRRP is an element of the AHEAD model's quality adjustment measures and will be used in the calculation of the annual payment adjustment for hospitals. Thus, even if RRIP does not directly align with HRRP, hospitals will remain incentivized to adhere to it. As a consequence, adherence to the more inclusive measure considered under the PHAP does not have to come at the expense of the impact that the HRRP will have on the AHEAD model's Medicare-specific payment calculations.

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

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

Sincerely,

Ashiah Parker
Chair, Health Means Everything



January 21, 2026

Alyson Schuster, Ph.D.
 Deputy Director, Quality Methodologies
 Health Services Cost Review Commission
 4160 Patterson Avenue
 Baltimore, Maryland 21215

Dear Alyson,

On behalf of Luminis Health and its member hospital, Doctors Community Medical Center (LHDCMC), I am writing in response to the draft staff recommendation on the Readmission Reduction Incentive Program (RRIP) for Rate Year (RY) 2028, dated January 14, 2026. Luminis appreciates the opportunity to provide feedback on this important policy.

Specifically, Luminis would like to address the impact of the double counting of readmissions in both the in-state and out-of-state readmissions. This error was acknowledged by the Health Services Cost Review Commission (HSCRC) staff in the RRIP draft recommendation at the January 14, 2025 Commission meeting. As outlined in the staff recommendation, 12 border hospitals are penalized by \$4.7M in Fiscal Year (FY) 2026 due to the overstatement of readmissions related to the double counting of readmissions. The impact of the overstatement to the 12 hospitals ranges from \$3,000 to \$1.2M. The impact to LHDCMC specifically is \$600K, or 0.2% of LHDCMC's FY 2026 Global Budget Revenue (GBR).

Table 1

Prov Num	Hospital Name	RY2026 RRIP Adjustment in Rates	Adjustment with Correction for OOS Double Counting	Impact of Correction	FY2026 Approved Target (July)	Impact as a % of Approved GBR
210035	UM Charles Regional Medical Center	(\$84,173)	\$810,169	\$894,342	\$203,860,066	0.44%
210017	Garrett Regional Medical Center	(22,236)	273,179	295,415	101,914,707	0.29%
210057	Adventist HealthCare Shady Grove Medical Center	(2,022,306)	(830,590)	1,191,716	590,987,553	0.20%
210051	Luminis Health Doctors Community Medical Center	585,123	1,189,749	604,626	340,304,768	0.18%
210039	CalvertHealth Medical Center	(679,575)	(356,777)	322,798	207,221,799	0.16%
210003	UM Capital Region Medical Center	1,073,652	1,854,491	780,839	510,040,594	0.15%
210027	UPMC Western Maryland	185,895	433,754	247,859	418,403,892	0.06%
210049	UMMS Upper Chesapeake	(2,993,814)	(2,837,615)	156,199	485,037,045	0.03%
210018	MedStar - Montgomery	(482,409)	(428,808)	53,601	248,028,050	0.02%
210037	MedStar - Montgomery	2,324,864	2,394,056	69,192	318,643,997	0.02%
210015	MedStar - Franklin Square	(4,482,989)	(4,360,726)	122,263	760,365,997	0.02%
210058	UMMS - UMROI	(202,066)	(198,858)	3,208	163,389,020	0.00%
	Sub-total	(6,800,034)	(2,057,976)	4,742,058	4,348,197,488	0.11%
	8 other hospitals with impact < \$200k + 28 hospitals no impac	(21,138,344)	(21,448,026)	(309,682)	20,887,070,466	0.00%
	Statewide (for acute hospitals in RRIP calculation)	(\$27,938,378)	(\$23,506,002)	\$4,432,376	\$23,259,803,845	0.02%

Source: RRIP amounts from HSCRC Staff Recommendation, dated 1/14/2026

Approved GBR FY2026 amounts from HSCRC website (July rate order amounts)

Discharges from Maryland non-confidential dataset for FY25 for 43 hospitals in RRIP program where case is flagged as 1 in DEN field (case eligible as initial admission)

The HSCRC staff acknowledges the overstatement of readmissions, however recommends that the correction of the calculation not occur until RY 2027. As the miscalculation has been identified and quantified, it is not appropriate to continue to penalize border hospitals based on a known error in the calculation. The HSCRC already has a process in place to issue January rate orders related to Quality Based Reimbursement (QBR) and various volume policies (deregulation, repatriation, out of state volume adjustment and market shift). The inclusion of the RRIP correction should be incorporated as well.

Luminis appreciates the staff diligence in investigating the out of state readmission adjustment and requests that the staff reconsider any further delay in correcting the calculation. We thank you again for your transparency and effort in working with Maryland hospitals to provide fair and balanced methodologies.

With best regards,



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

cc: 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
Jon Kromm, Executive Director
Allan Pack, Principal Deputy Director, Quality and Population-based Methodologies
Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations
Prudence Akindo, Associate Director- Financial Methodologies, HSCRC



maryland
health services
cost review commission

FINAL 2026 MPA Recommendation
Commission Meeting
March 2026

Christa Speicher

MPA Recommendation and Next Steps

- No changes from CY 2025 Final MPA Recommendation to CY 2026.
 - No comments received.
 - CMS approved the proposal from December 2025 which maintains the current approach as the MPA is sunseting when Medicare fee-for-service global budgets are implemented in 2028.
 - HSCRC staff will continue ongoing discussions with stakeholders on the future of care redesign programs throughout 2026 workgroups.
- Next Steps
 - Proposing to CMMI to end the Traditional MPA in 2026.



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Medicare Performance Adjustment Calendar Year 2026

Final Recommendation

March 2026

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Recommendations for CY 2026 MPA Policy

This recommendation does not introduce any changes from the approved Medicare Performance Adjustment (MPA) policy from calendar year 2025 (CY 2025). The relevant policies will remain unchanged from the prior year. Staff recommend maintaining the current approach as the MPA is sunsetting when Medicare fee-for-service global budgets are implemented in 2028.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation maintains the current policy and related MPA Framework without modification.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers other than Medicare Fee-for-service. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2026 (also known as MPA Year 8). The Efficiency and Savings Component are governed via the MPA Framework adopted by the Commission in October 2019¹ (as amended in the MPA Year 6 recommendation adopted in 2024). These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount or inflator to the amount that Medicare pays on each claim submitted by the hospital.

MPA Traditional Component

Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2024, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022, 2023, 2024 and 2025 MPA policies, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are

¹ Available, starting on page 10, here: [MPA Framework](#)

calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a case-mix index (CMI) greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes, or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1 st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2 nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3 rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4 th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5 th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C

in Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

Table 2: Calculation of the MPA Targets

Variable	Source				
A = 2019 TCOC	Calculation from attributed beneficiaries				
B = 2020 National TCOC Growth	Input from national data				
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)				
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)				
E = MPA TCOC Target	$A \times (1 + B) \times (1 + C - D) = E$				
Example Calculation of MPA Targets					
Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	$3\% - 0.00\% = 3.00\%$	\$11,650	\$12,000	\$12,359
Hospital B	2	$3\% - 0.25\% = 2.75\%$	\$11,193	\$11,529	\$11,846
Hospital C	3	$3\% - 0.50\% = 2.50\%$	\$11,169	\$11,504	\$11,792
Hospital D	4	$3\% - 0.75\% = 2.25\%$	\$11,204	\$11,540	\$11,800
Hospital E	5	$3\% - 1.00\% = 2.00\%$	\$10,750	\$11,073	\$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Starting last year, as described below, the rewards and penalties were scaled such that the maximum reward or penalty was 2%, which will be achieved at a 6% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input			
E = MPA Target	See previous section			
F = 2021 MPA Performance	Calculation			
G = Percent Difference from Target	$(E - F) / E$			
H = MPA Reward or Penalty	$(G / 3\%) \times 1\%$			
I = Revenue at Risk Cap	Greater / lesser of H and $\pm 2\%$			
Example MPA Performance Calculations				
Hospital	MPA Target	MPA Performance	% Difference	Reward (Penalty)
Hospital A	\$12,359	\$12,235	-1.00%	0.33%
Hospital B	\$11,846	\$11,941	0.80%	-0.27%
Hospital C	\$11,792	\$11,556	-2.00%	0.67%
Hospital D	\$11,800	\$11,033	-6.50%	2.00%
Hospital E	\$11,294	\$11,859	5.00%	-1.67%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program.

In the MPA Year 6 final recommendation, the Commission approved two changes to MPA policy beginning in 2024. MPA policy was revised to include an increase in the maximum revenue-at-risk as well as the addition of a population health measure to the quality adjustment included in the Traditional MPA. The amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA increased from 1% to $\pm 2\%$. Increasing the revenue at risk under the MPA had been a stated goal of the Center for Medicare and Medicaid Services (CMS) for several years. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at $\pm 6\%$.

In addition to increasing the revenue-at-risk, MPA policy was revised to add a population health metric to the quality adjustment included in the Traditional MPA and include it in the Calendar Year 2024 and future MPA adjustments according to the formula below (adjusted for 2% revenue-at-risk):

TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

In the MPA Year 7 final recommendation, the Commission approved a retroactive adjustment to correct the MPA savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments (NCBPs) resulting in a one-time increase to hospital rewards estimated at approximately \$22.0 M from Medicare only, through Calendar Year 2023. The corrected 2024 targets were used in setting payments for that year which began July 1 of 2025. This adjustment in the MPA savings target is replicated on a go-forward basis beginning in Calendar Year 2025.

MPA Framework Reconciliation Component

Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being penalized for their non-participation. Additionally, the Offset incentivizes participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers. In December of 2023 (MPA Year 6 recommendation), the Framework was amended to include a cap on the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

In the MPA year 7 recommendation, HSCRC revisited the CTI offset to incorporate an attainment aspect. The Commission approved tiering the stop loss applied during the offset in a way that mirrors the Traditional MPA Scaled Growth Adjustment. This will provide greater protection for hospitals with less opportunity without eliminating the incentive for all hospitals to drive savings. Table 4 shows the tiers.

Table 4: Scaled Stop Loss Tiers

Hospital Performance vs. Benchmark	Stop Loss
1 st Quintile (-15% to + 1% Relative to Benchmark)	1.250%
2 nd Quintile (+1% to +10% Relative to Benchmark)	1.875%
3 rd Quintile (+10% to +15% Relative to Benchmark)	2.500%
4 th Quintile (+15% to +21% Relative to Benchmark)	3.125%
5 th Quintile (+21% to +28% Relative to Benchmark)	3.750%

Modeling using Year 2 CTI adjustments showed this change would have had the impact of shifting approximately \$5 million from the highest cost quintiles to the lowest cost quintiles. Although as the portfolio of CTIs implemented changes each year the actual future impact could be less or more. However, consistent with stakeholder feedback that changes should not be applied to periods that have already been implemented, Staff implemented this change for CTIs starting July 1, 2025.

Future Areas of Focus

With no changes proposed for the Calendar Year 2026 MPA Recommendation, HSCRC staff will continue ongoing discussions with stakeholders and subject matter experts on the future of care redesign programs. Stakeholders will continue to participate in HSCRC-led workgroups throughout 2026 to provide feedback and engage in comprehensive discussions.



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Maryland Hospital Community Benefit Report: FY 2024

January 8, 2026

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List of Abbreviations

ACA	Affordable Care Act
AHEAD	Achieving Healthcare Efficiency through Accountable Design
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
CY	Calendar Year
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
GME	Graduate Medical Education
HCB	Hospital Community Benefit
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
NSP	Nurse Support Program
PSA	Primary Service Area
TCOC	Total Cost of Care

Executive Summary

Tax-exempt hospitals are required to provide “community benefit” as a condition of their federal tax-exemption. The term “community benefit” refers to initiatives, activities, and investments undertaken by hospitals to improve the health of the communities they serve. Hospitals submit information on their community benefit activities to the federal government each year. In addition, Maryland law¹ requires Maryland’s nonprofit hospitals to report annual community benefit information to the Health Services Cost Review Commission (HSCRC). Maryland law builds on the federal requirements, providing the State with more information than is available through the federal reports.

In this report, the HSCRC summarizes fiscal year (FY) 2024 information submitted by hospitals, representing the HSCRC’s 21st year reporting on Maryland hospital community benefit (HCB) data. The report describes how the State’s reporting requirements differ from federal requirements, provides an overview of recent updates made to the reporting instructions, and highlights HSCRC programs that impact hospitals’ community benefit spending.

Key Highlights

- **Reporting Compliance:** All 49 nonprofit Maryland hospitals submitted their required FY 2024 community benefit reports.²
- **Community Benefit Expenditures:** Maryland hospitals reported \$2.35 billion in total community benefit in FY 2024, an increase of around 3% from FY 2023.
 - **Rate Support for Hospital Community Benefits:** About 42% of the total HCB expenses are built into hospital rates, which are reimbursed by health care payers, including Medicare, Medicaid, commercial insurance, and patients. Roughly 58% (\$1.37 billion) of total hospital HCB spending comes directly from the hospitals without any rate support.
 - **Indirect Costs:** Hospital community benefit spending includes both direct and indirect costs (i.e., overhead costs). There is significant variation between hospitals in the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 28% to 137% for hospital-based community benefit activities.
- **Community Health Needs Assessments (CHNAs):** Under federal law, hospitals are required to conduct CHNAs every three years. CHNAs identify priority health needs and include implementation strategies to address them. All Maryland hospitals reported complying with this

¹ MD. CODE. ANN., Health-Gen. § 19-303.

² There are 49 hospitals but only 47 narrative reports (45 reports from single hospitals and 2 reports that each cover 2 hospitals).

requirement. Hospitals reported spending 42.5% of their net community benefit on CHNA-related activities. Hospitals identified “Settings and Systems - Community” as the most frequently addressed CHNA priority area. Hospitals continued to show wide variation in the percentage of net community benefit spent on CHNA-related activities.

Introduction

This report presents the results of an annual assessment of community benefit investments and activities of Maryland's nonprofit hospitals. Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit this report annually,³ based on hospital community benefit (HCB) data submitted by each hospital. The reports submitted by individual hospitals are also posted on the HSCRC's website.⁴

This report explains the HCB reporting requirements and provides a summary of the fiscal year (FY) 2024 data that hospitals submitted to the HSCRC. It also describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to Maryland's reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending.

Federal and State Authority over Community Benefits

Federal Tax Exemption and Reporting Requirements

Maryland's hospitals are nonprofit tax-exempt organizations. The federal Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.⁵ In order to maintain federal tax-exempt status, a hospital must provide "community benefits"⁶ and report their community benefit activities to the Internal Revenue Service (IRS) annually. The IRS has no requirement for the minimum amount of community benefit that a hospital must provide to qualify for federal tax-exempt status.⁷ In addition, every tax-exempt hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years.⁸ CHNAs are discussed in more detail later in this report. Hospitals must also report information about their CHNAs to the IRS.

³ MD. CODE. ANN., Health-Gen. § 19-303.

⁴ https://hscrc.maryland.gov/Pages/init_cb.aspx

⁵ 26 U.S.C. § 501(c)(3). Nonprofit hospitals have been required to demonstrate community benefit to qualify for federal tax-exemption since 1969. The IRS specifies categories of activities that qualify as community benefits in Schedule H of form 990. Federal tax law requires hospitals to conduct a CHNA, including an implementation strategy; have a written financial assistance policy for medically necessary and emergency care; limit hospital charges for those eligible for financial assistance; and comply with billing and collections requirements. Source: James, J. (2016, February 25). Nonprofit hospitals' community benefit requirements, Health Affairs Health Policy Brief. DOI: 10.1377/hpb20160225.954803. Maryland law requires additional reporting of community benefit information. MD. CODE. ANN., Health-Gen. § 19-303. Maryland law adds requirements that exceed the federal requirements related to financial assistance and medical debt collection. MD. CODE. ANN., Health-Gen. §§ 19-214.1 and 19-214.2.

⁶ A hospital must report community benefits to demonstrate to the IRS that they are a "charitable" organization, and thus eligible for tax exempt status. Historically, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so. Ruling 56-185, 1956-1 C.B. 202. However, in 1969, the IRS modified the "charitable" standard to focus on "community benefits" rather than "charity care." Rev. Ruling 69-545, 1969-2 C.B. 117. "Charity care," now referred to as "financial assistance," is a category of community benefit.

⁷ Congressional Research Service. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals, page 4. <https://crsreports.congress.gov/product/pdf/R/R48027>

⁸ Hospitals that do not conduct a CHNA every three years are subject to an annual penalty of up to \$50,000 and loss of their tax-exempt status. 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959. Tax-exempt hospitals must report information on their CHNA on Schedule H of IRS Form 990. This reporting requirement was added by the Affordable Care Act.

Tax-exempt hospitals (also referred to as nonprofit hospitals) are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing. Table 1 shows the number of Maryland hospitals that reported claiming each type of tax exemption in their FY 2024 community benefit report (CBR).

Table 1. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	44
Local property tax (real and personal)	42
Other	5

Four of the hospitals that selected “Other” indicated that they also claimed an exemption from the federal unemployment insurance tax, while one hospital reported claiming exemptions from some property taxes—depending on usage—but not from all local property taxes. The HSCRC conducted a tax benefit assessment of Maryland hospitals in 2020 to estimate the value of hospitals’ tax exemptions statewide, calculating an overall net tax benefit of about \$704 million for the year ending June 30, 2019.⁹

Overview of Maryland Reporting Requirements

Maryland law requires hospitals to report their HCB activities to the HSCRC annually, and the HSCRC is required to submit an annual statewide summary report to the General Assembly. This report contains the community benefit data for FY 2024,¹⁰ marking the HSCRC’s 21st year reporting on Maryland HCB.

Maryland’s HCB reporting requirements are more extensive than the federal requirements. Maryland law defines “community benefit” as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.¹¹ Hospitals must report their community benefit activities in categories that are specified by the HSCRC, including community health services; health professions education; research; financial contributions to other organizations; community-building

⁹ The HSCRC study is available here:

https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/HSCRC%20Hospital%20Tax%20Benefit%20Report%20July%202020.pdf. Other researchers have published articles and reports on the national scale of the benefit of hospital tax exempt status. “There is debate in the literature regarding the calculation of tax exemption value, particularly concerning federal and state corporate income taxes.” Zare, H. & Anderson, G. (2024). Beyond the bottom line: Assessing charity care, community benefits, and tax exemptions in nonprofit hospitals. *Journal of Healthcare Management* 69(6), 439-454. DOI: 10.1097/JHM-D-24-00080. This results in different estimates by different researchers.

¹⁰ The reporting period for these financial data is July 1, 2023, through June 30, 2024. Several hospitals are on a calendar financial year and report their most recent calendar year’s data instead.

¹¹ MD. CODE. ANN., Health-Gen. § 19-303(a)(3); COMAR 10.37.01.03.

activities, including partnerships with community-based organizations; financial assistance (i.e., free and reduced cost care); and mission-driven health services.¹² These categories are generally aligned with federal reporting categories (see Appendix A for a comparison of the federal and state reporting categories). The HSCRC also requires hospitals to report on health disparities and the types of tax exemptions claimed by the hospital in the preceding year.

Hospitals are also required to report information about their CHNA, including the amount of community benefit activities that are connected to community needs identified in the hospital's CHNA. The CHNA should influence the hospital's community benefit activities so that the hospital is serving identified community needs.

Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the health needs of the hospital's community
- A description of efforts to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A description of the process the hospital used to develop their CHNA
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the preceding taxable year¹³

Hospitals submit a narrative report that contains descriptive information on their community benefit activities and a financial report on community benefit expenditures. The financial reports collect information about direct and indirect costs of community benefits, categorized by type of community benefit activity. Hospitals should use data from audited financial statements to calculate the cost of each community benefit category contained in the financial reports and to limit reporting to only those hospital services reported on the IRS Form 990 Schedule H. Hospitals also submit their financial assistance policies. Each hospital's narrative and financial reports and financial assistance policies are posted on the HSCRC's website.¹⁴

¹² The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*, available here:

<https://hsrc.maryland.gov/Documents/CommBen/FY%202024%20Data%20Collection/FINAL%20FY%202024%20Community%20Benefit%20Guidelines%20and%20Definitions.pdf>.

These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. <https://www.irs.gov/pub/irs-pdf/f990sh.pdf>.

¹³ MD. CODE. ANN., Health-Gen. § 19-303(c)(4). Each hospital also reports to the HSCRC on the geographic region where the hospital offers its community benefit programs. This is referred to as the hospital's community benefit service area (CBSA). More information on how hospitals determined their CBSAs is in Appendix G.

¹⁴ https://hsrc.maryland.gov/Pages/init_cb.aspx; <https://hsrc.maryland.gov/Pages/hsp-fap.aspx>.

Updates to Maryland's Reporting Instructions

In response to legislation, the HSCRC updated the reporting instructions in FY 2022, requiring hospitals to:

1. Report on initiatives that directly address needs identified in the CHNA
2. Within the financial report, itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

After reviewing the results of the FY 2022 HCB reports, the HSCRC identified potential reporting issues with data related to indirect costs and CHNA-aligned spending. The HSCRC's Commissioners directed staff to convene a short-term technical workgroup¹⁵ to review the reporting instructions. As a result of workgroup deliberations, staff made technical corrections to the reporting instructions for the FY 2024 reports, including adjustments to directions for reporting physician subsidies, CHNA-identified community needs, and justifications for certain indirect costs.

State Authority over Hospital Community Investments

State law requires hospitals to submit community benefit data to the HSCRC. The HSCRC has the authority to fine hospitals for failing to report accurate and timely information in their annual CBRs. All hospitals were compliant with the State community benefit reporting requirement for FY 2024.¹⁶ Appendix B lists the hospitals submitting CBRs by hospital system. Maryland law does not provide regulatory authority over the quantity or quality of the community benefit activities or the CHNA. Maryland's HCB reporting requirements have no bearing on a nonprofit hospital's exemption from state income taxes; state tax exemption is based on the federal determination of the hospital's tax-exempt status.

Hospital Investments in Community Health and Rate Setting

Maryland has a unique statewide all-payer hospital rate-setting system. In contrast to the HSCRC's limited authority over community benefit, Maryland's hospital rate-setting system is a powerful tool for directing hospital investment in community health. The HSCRC uses the rate-setting system to direct hospital investment in activities that align with state and community priorities. The following are current HSCRC programs that use the hospital rate-setting system to direct hospital spending on community health.

- **Revenue for Reform:** Hospitals the HSCRC identifies as inefficient (having excess costs relative to their peers) are required to invest in community health activities or return funds to payers. These

¹⁵ <https://hscrc.maryland.gov/Pages/Community-Benefit-Workgroup.aspx>.

¹⁶ The HSCRC received 49 financial reports and 47 narrative reports. The University of Maryland Medical System submits one narrative report for its two hospitals on the Eastern Shore and another report for its two hospitals in Harford County.

hospitals may only use the funds for community health activities that are approved by the HSCRC and the Maryland Department of Health (the Department). This funding remains in a hospital's global budget revenue (GBR) year after year, creating sustainable long-term funding for population health activities.

- **Behavioral Health Regional Partnership Catalyst Program:** The HSCRC approved \$79.1 million in cumulative funding over a five-year period—calendar years (CYs) 2021-2025—for three behavioral health programs that are focused on expanding access to crisis services. Hospitals applied for this funding and had to demonstrate that they developed meaningful community partnerships and would maintain those partnerships throughout the program. This program has funded new behavioral health crisis centers, mobile response teams, and other crisis services on the Eastern Shore, in Prince George's County, and in the greater Baltimore metropolitan region.
- **Maternal and Child Health Initiative:** The HSCRC assessed \$40 million in funding over four years (FY 2022–FY 2025) to support maternal and child health interventions led by Medicaid managed care organizations and the Department's Prevention and Health Promotion Administration. This funding supports new services not previously offered to Medicaid participants and continued efforts to reduce health care disparities. The Department has until the end of CY 2027 to spend the available funds.
- **Nurse Support Programs (NSP):** The HSCRC maintains two programs to develop and maintain the nursing workforce in Maryland. All Maryland hospitals receive funding through NSP I to support recruitment and retention of clinical nurses. In FY 2024, \$19.5 million was included in hospital rates for NSP I activities. NSP II is funded through a \$19.2 million hospital assessment aimed at expanding faculty and educational capacity at Maryland nursing schools. The Maryland Higher Education Commission administers NSP II on behalf of the HSCRC. Both programs have been implemented for over 21 years.

The HSCRC plans to continue to work with the Department in future years to develop programs that invest in the health of Maryland communities. Currently, the HSCRC increases hospital rates to fund these programs (or, in the case of Revenue for Reform, does not lower rates). Health care payers (including Medicare, Medicaid, private insurers, and patients) fund these activities through their payment of hospital claims. Maryland transitioned from the Total Cost of Care (TCOC) Model to the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model on January 1, 2026. In 2028, Maryland's hospital rate-setting structure under AHEAD will change as the Centers for Medicare & Medicaid Services begin to administer Medicare fee-for-service global budgets, which will likely affect how the rate-setting system can be used to support community health investments. To the extent these hospital investments fit the definition of "community benefit," hospitals may include them in their CBRs. Hospitals identify expenditures on these

and other programs that the HSCRC includes in the annual calculation of each hospital's rates so that the HSCRC can determine the percentage of each hospital's community benefit that is funded through rates. These data are discussed later in this report.

Alignment of Hospital Community Benefit Activities with State/Federal Models

Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) have entered several agreements since 2014 that support Maryland's all-payer hospital rate setting system, enhanced primary care, population health investments, and other aspects of the health care delivery system. Under the current TCOC agreement (CY 2019 – CY 2025), Maryland agreed to four population health goals: 1) reducing the mean body mass index (BMI) for Maryland residents as it pertains to diabetes; 2) improving opioid overdose mortality; 3) decreasing asthma-related emergency department (ED) visits for children; and 4) reducing the severe maternal morbidity rate. The CBR asks hospitals about community benefit initiatives targeting these goals. All 46 hospitals that responded to this question reported that their community benefit activities addressed at least one of these goals, and most hospitals addressed more than one goal. Reducing the mean BMI was the goal most frequently addressed by community benefit activities (Table 2). Please note that hospitals may have other initiatives addressing these goals that do not count as community benefit.

Table 2. Number of Hospitals with Community Benefit Activities Addressing Population Health Goals under the Total Cost of Care Model, FY 2024

Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	36
Maternal and Child Health – Reduce severe maternal morbidity rate	28
Maternal and Child Health – Decrease asthma-related ED visit rates for children aged 2-17	12

The State is working with stakeholders and CMMI to finalize the population health goals that will be used under the AHEAD Model which began on January 1, 2026. The HSCRC will adjust the hospital community benefit reporting instructions to collect information on the alignment between hospital community benefit investments and the AHEAD Model population health goals after those goals are established.

Spending on Community Benefits

Maryland hospitals provided approximately **\$2.35 billion in total community benefit activities in FY 2024.**¹⁷ This is an increase of **3.2% over FY 2023.** In inflation-adjusted (real) dollars, Maryland community benefit expenditures were \$971.3 million in FY 2004 (6.9% of operating expenses),¹⁸ which is a significant increase in community benefit investment over the past 20 years.

Rate Support for Community Benefit Activities

As described earlier in this report, the HSCRC ensures that hospitals have funding for community benefit activities that are State priorities. The HSCRC increases hospital GBRs (and, relatedly, hospital rates) to fund these activities.¹⁹ **Approximately \$989 million of the \$2.35 billion in community benefit reported in FY 2024, or 42% of HCB activities, was funded by health care payers through hospital rates. Approximately \$1.37 billion of HCB activities was not funded through rates.** This equates to 6.5% of total hospital operating expenses. This is similar to the \$1.34 billion in community benefit that was not rate-supported in FY 2023 (approximately 6.6% of operating expenses). Figures 1 and 2 show the trend of community benefit expenses with and without rate support. Appendix C details the amounts that were included in rates and funded by all payers for FY 2024.

Appendix D presents the total amount of community benefit reported and the amount of community benefit recovered through HSCRC-approved rate support.²⁰ Hospitals differ in their amount of community benefit not supported by rates compared to their total operating expenses. The total amount of community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.1% to 24.7%, with an average of 7.4%. This is similar to the average of 7.6% in FY 2023. Nine hospitals reported providing community benefit that exceeded 10% of their operating expenses, the same number as in FY 2021 through FY 2023.

¹⁷ This amount excludes expenditures on community benefit activities that are offset by revenue.

¹⁸ FY 2004 community benefit expenses were \$586.5 million. Inflated by CPI to FY 2024, this equals \$971.3 million.

¹⁹ The HSCRC sets the rates that most hospitals can charge payers for hospital services. For general acute care and chronic care hospitals, these rates are paid by Medicare, Medicaid, commercial insurance, and individuals who pay all or a portion of their hospital bill out of their own pocket. For pediatric and psychiatric hospitals, the HSCRC only sets rates for commercial insurers.

²⁰ Some hospital community benefits activities, such as clinics, generate revenue that offsets the amount of community benefit. Hospitals report the full amount of community benefit that they provide and any offsetting revenue that is not funded through rates. The HSCRC calculates the amount of hospital community benefit from rates using data that is separate from the hospital CBRs. This is intended to align HSCRC reporting with hospital reporting on the IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting.

**Figure 1. FY 2014–FY 2024 Community Benefit Expenses with and without Rate Support
 (in Millions, Inflation Adjusted)**

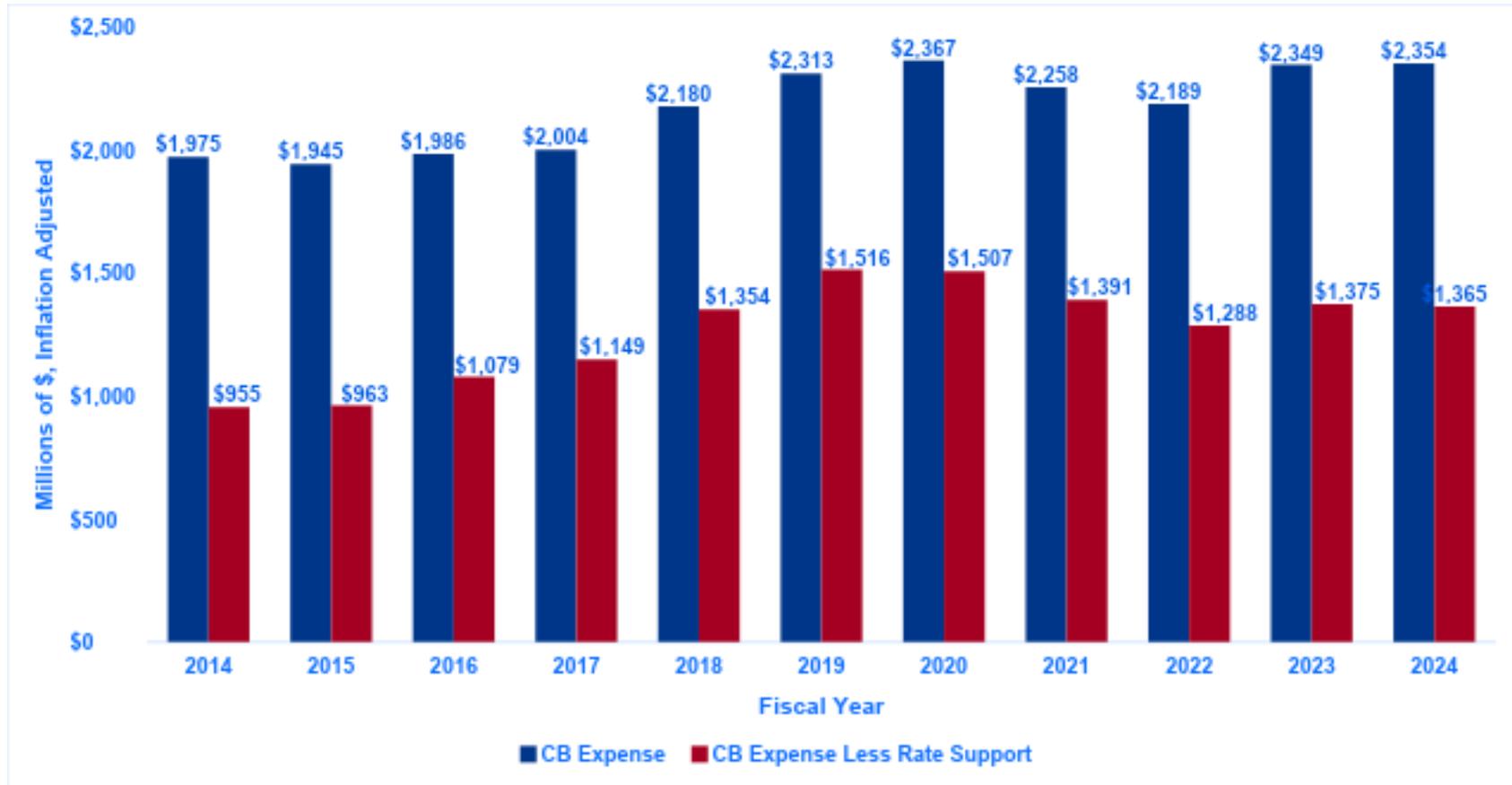


Figure 2. FY 2014–FY 2024 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support

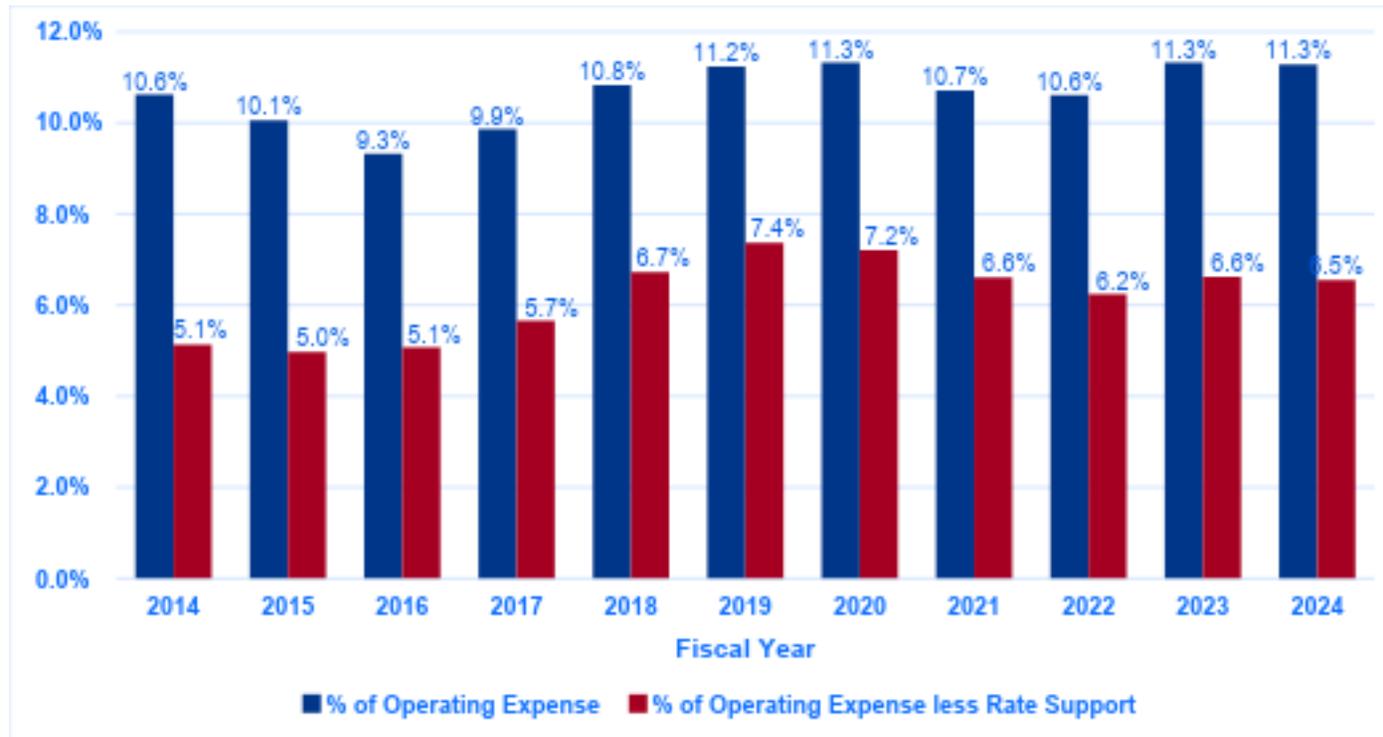
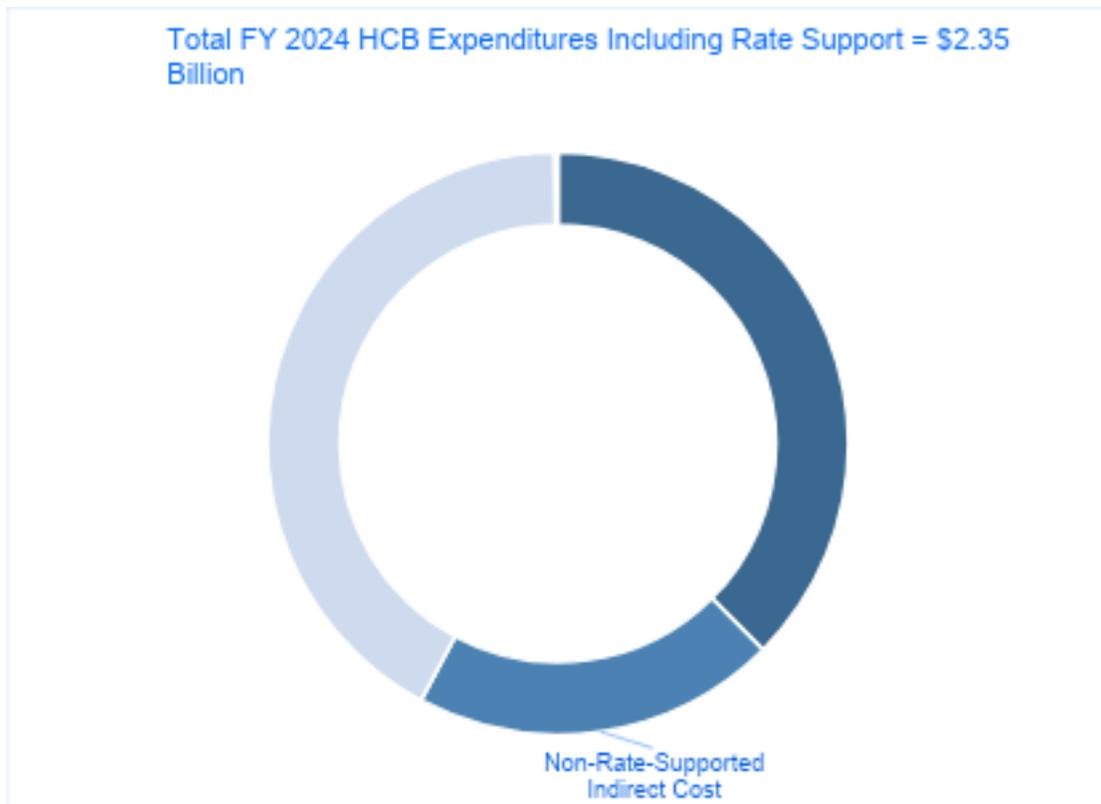


Figure 3 shows hospitals' total rate-supported and non-rate-supported direct and indirect costs in FY 2024 as a percentage of total HCB expenditures. Rate-supported direct and indirect costs accounted for roughly 42% of total expenditures.

Figure 3. Total Direct and Indirect Costs by Rate Support Status for All Hospitals, FY 2024



Examples of the community benefit costs that the HSCRC builds into hospital rates include the following:

- Financial assistance for low-income patients (free and reduced cost care, also known as charity care)
- Graduate medical education (GME)
- The HSCRC's Nurse Support Programs, which support nursing education, recruitment, and retention programs in the State
- The Regional Partnership Catalyst Program for behavioral health crisis services

- The Revenue for Reform Program, which incorporates community health spending deployed outside the hospital directly into the hospital's global budgets

The following sections provide additional information on financial assistance, GME, and nurse support programs.

Financial Assistance

Maryland law requires general acute care and chronic care hospitals to provide financial assistance to patients with low income.²¹ This is the third largest category of HCB spending, representing approximately 19% of total HCB spending (\$438 million) in FY 2024. All of this spending is accounted for in rates.

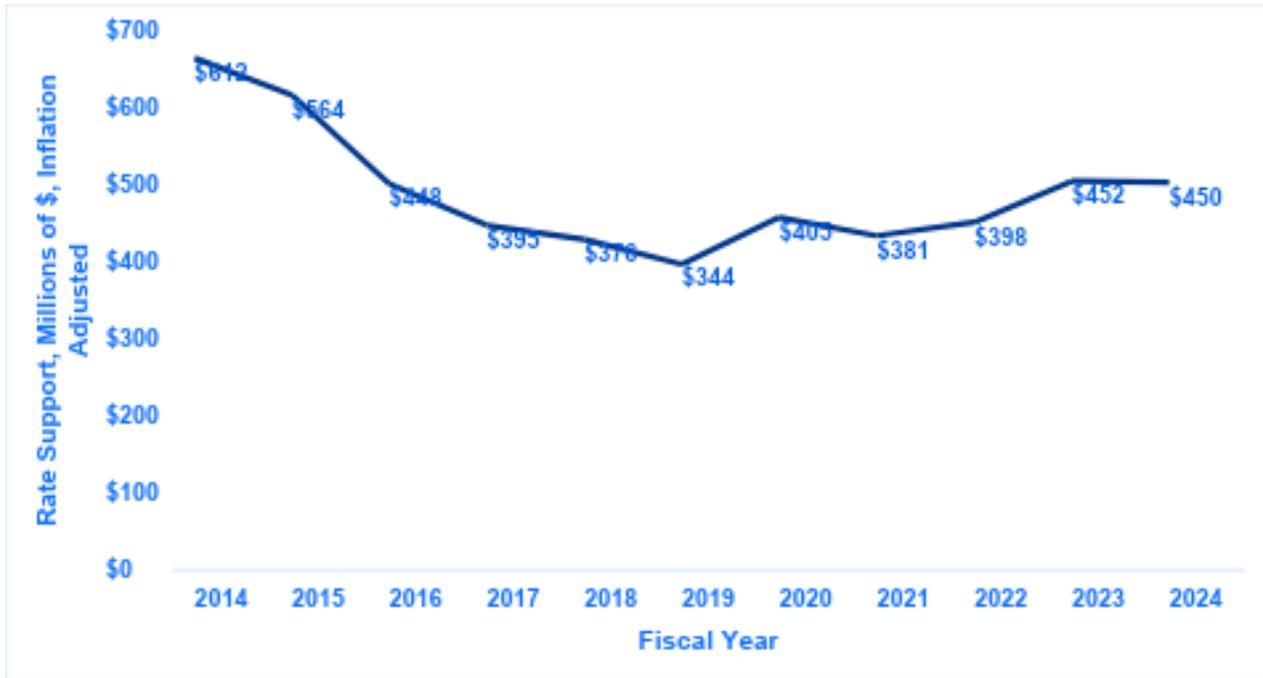
Figure 4 shows the amount built into hospital rates for financial assistance from FY 2014 through FY 2024, in real 2024 dollars. The amounts built into hospital rates for financial assistance are based on the amount of financial assistance that the hospitals provided to patients two years prior to the fiscal year. For example, the amount of rate support provided to hospitals for financial assistance in FY 2024 is based on the amount of financial assistance the hospitals provided to patients in FY 2022.²² Because this rate support is set prospectively, the actual amount is not expected to align exactly. However, given the most recently completed fiscal year is the best available projection of uncompensated care, the rate support should be very indicative of expected uncompensated care. Additionally, because the policy updates each year, any discrepancies caused by using prior year experience to project future uncompensated care will be automatically accounted for in future rate support.

As insurance coverage expanded under the Affordable Care Act (ACA) in 2014 and subsequent years, hospital patients needed less financial assistance. However, the need for financial assistance has increased since FY 2019, resulting in larger amounts of funding being included in hospital rates for financial assistance. Rate support for financial assistance decreased slightly in FY 2024. See Appendix E for more details on the financial assistance methodology.

²¹ MD. CODE. ANN., Health-Gen. § 19-214.1 and COMAR 10.37.10.26(A-2).

²² The HSCRC calculates this amount as a percentage of total statewide hospital revenue, adjusted for inflation.

Figure 4. Rate Support for Financial Assistance (in Millions, Inflation-Adjusted), FY 2014–FY 2024



Maryland law sets minimum eligibility standards for patient income based on family income. In FY 2024, hospitals were required to provide free care to patients under 200% of the federal poverty level (FPL), reduced cost care to patients under 300% of the FPL, and reduced cost care to patients under 500% of the FPL with medical debt that exceeds 25% of their annual income.²³ Hospitals may provide financial assistance to other patients. If a hospital is more generous in either the eligibility criteria in their financial assistance policy or in the amount of assistance they provide to patients who qualify, that could increase their spending on financial assistance. Legislation passed in 2025²⁴ changed some of these financial assistance requirements effective October 2025; future community benefit reports will be updated accordingly.

Staff reviewed hospital financial assistance policies and compared the income thresholds for patient eligibility for free and reduced cost care in the policies with the eligibility requirements in law (Table 3). As with prior years, staff noted variation in the content and format of the financial assistance policy documents.

²³ MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a) and COMAR 10.37.10.26(A-2)(3).

²⁴ 2025 MD Laws Ch. 693 (to be codified at MD. CODE. ANN., Health-Gen. § 19-201; 19-214.1; 19-214.2; 19-301).

Table 3. Number of Hospitals with Expanded Financial Assistance Eligibility Criteria

Type of Financial Assistance	Statutory Eligibility Criteria	# of Hospitals That Provide Financial Assistance to a Higher Income Level
Free Care	Family income at or below 200% FPL	23
Reduced Cost Care	Family income between 201% and 300% FPL ²⁵	42
Reduced Cost Care due to Financial Hardship	Family income between 301% and 500% FPL, and the medical debt incurred by the family over a 12-month period exceeds 25% of the family's income ²⁶	19

Workforce: Graduate Medical Education and Nurse Support Programs

The HSCRC builds the cost of GME into hospital rates, as well as the cost of nursing workforce education and retention programs. GME is the cost of educating physician residents and interns. GME costs include the direct costs (i.e., direct medical education, or DME) of wages and benefits for residents and interns, faculty supervisory expenses, and allocated overhead. In FY 2024, DME costs in Maryland totaled \$443 million.²⁷

The HSCRC's NSP I and II programs are aimed at addressing the short- and long-term nursing shortages affecting Maryland hospitals. In FY 2024, the HSCRC provided over \$19 million each in hospital rate adjustments for NSP I and NSP II. See Appendix C for detailed information about the funding provided to specific hospitals through these programs.

Table 4 presents HCB expenditures for health professions education by activity. As with prior years, the education of physicians and medical students (including the DME expenses described above) made up most expenses in this category. The second highest category was the education of nurses and nursing students, totaling \$45 million, including the NSP expenses described above.

²⁵ COMAR 10.37.10.26(A-2)(2)(a)(ii).

²⁶ MD. CODE. ANN., Health-Gen. § 19-214.1

²⁷ The HSCRC's annual cost report.

Table 4. Health Professions Education Activities and Costs, FY 2024

Health Professions Education	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Physicians and Medical Students	\$617,888,302	\$411,942,709
Nurses and Nursing Students	\$45,443,893	\$28,211,888
Other Health Professionals	\$31,963,446	\$21,947,184
Scholarships and Funding for Professional Education	\$5,099,845	\$3,422,830
Other	\$2,454,147	\$1,056,385
Total	\$702,849,634	\$466,580,996

Categories of Community Benefit Activities

Hospitals must report on their community benefit activities in the following categories²⁸ defined by the HSCRC:

- **Medicaid Costs:** The cost of the Medicaid Deficit Assessment.
- **Community Health Improvement Services:** Activities that are carried out to improve community health (such as community health education, health screenings, and clinics for uninsured people).
- **Health Professionals Education:** Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification by a professional board.
- **Mission-Driven/Subsidized Health Services:** Services provided to the community that were never expected to result in cash inflows that the hospital undertakes as a direct result of its community or mission-driven initiatives—or which would otherwise not be provided in the community if the hospital did not perform these services, including physician subsidies that address gaps in physician availability.
- **Research:** Clinical research and community and health services research.
- **Cash Donations and In-Kind Contributions:** Resources donated by the hospital to organizations outside the hospital.
- **Community-Building Activities:** Activities that address the underlying causes of health problems and improve health status and quality of life services.
- **Community Benefit Operations:** Costs associated with staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

²⁸ The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here:

<https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf>. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. <https://www.irs.gov/pub/irs-pdf/f990sh.pdf>

See Appendix F for a detailed combined spreadsheet showing all hospitals' costs, rate support, and offsetting revenue across all categories.

As in previous years, hospitals spent the highest amount of their community benefit investments on mission-driven health services, health professions education, and financial assistance. The rate support hospitals received for financial assistance was greater than their financial assistance spending due to the prospective methodology for building uncompensated care into hospital rates (Table 5).

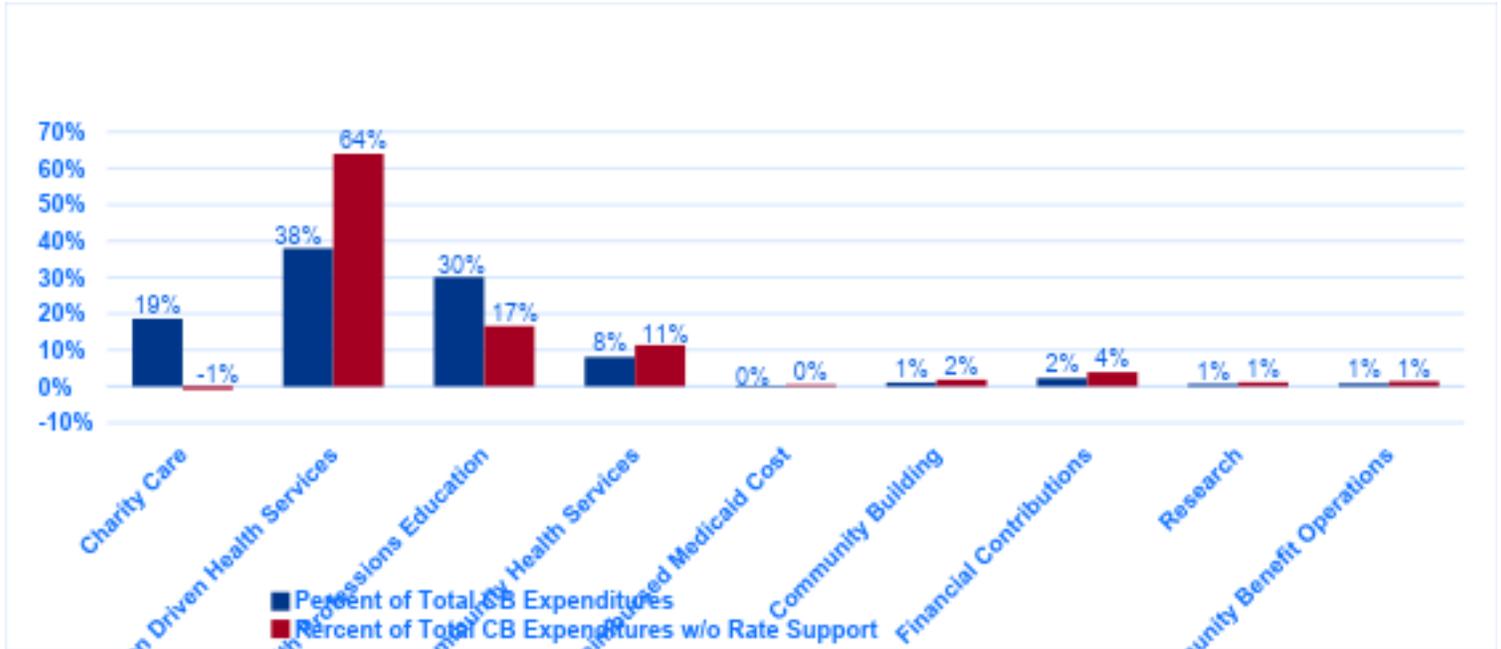
Table 5. Total Community Benefit Expenditures, FY 2024

Community Benefit Category	Net Community Benefit Expense ²⁹	Percent of Total CB Expenditures	Net Community Benefit Expense Less Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	\$6,623,580	0.28%	\$6,623,580	0.49%
Community Health Services	\$190,052,954	8.08%	\$155,971,965	11.43%
Health Professions Education	\$708,301,854	30.10%	\$226,215,615	16.58%
Mission Driven Health Services	\$894,975,693	38.03%	\$872,190,832	63.91%
Research	\$15,433,883	0.66%	\$15,433,883	1.13%
Financial Contributions	\$53,337,456	2.27%	\$53,337,456	3.91%
Community Building	\$25,042,044	1.06%	\$25,042,044	1.83%
Community Benefit Operations	\$18,730,333	0.80%	\$18,730,333	1.37%
Foundation	\$3,280,813	0.14%	\$3,280,813	0.24%
Financial Assistance	\$437,764,179	18.60%	-\$12,083,201	-0.89%
Total	\$2,353,542,789	100%	\$1,364,743,320	100%

Accounting for rate support significantly affects the distribution of expenses by category. Figure 5 shows expenditures for each community benefit reporting category as a percentage of total community benefit expenditures in FY 2024. Figure 5 also shows the percentage of expenditures by category for FY 2024 less the amount supported through rates.

²⁹ This amount excludes expenditures on community benefit activities that are offset by revenue.

Figure 5. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2024



Direct and Indirect Costs

Total hospital community benefit spending includes both the direct cost of the activity provided in the community and indirect costs. Indirect costs represent the proportion of total community benefit costs that are not attributed to products and/or services but are necessary for general operations, including salaries for human resources and finance departments, insurance, and overhead expenses.³⁰ The HSCRC's reporting instructions allow hospitals to report two indirect cost ratios: one for hospital/facility-based activities and one for activities in the community.³¹ The "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. Table 6 presents the indirect cost ratios reported by each hospital for each community benefit category.

There is significant variation between hospitals regarding the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 28 to 137% for hospital-based community benefit activities. Four hospitals reported that indirect costs of hospital-based community benefit activities exceeded direct costs (see the

³⁰ The HSCRC specifies the methodology for calculating the indirect cost ratio. The cost ratio that hospitals report for community benefit should align with the cost ratio that they report on Schedule M of their annual cost report to the HSCRC. Staff followed up with hospitals whose indirect costs did not align with Schedule M. Many hospitals reported manually reducing their indirect cost ratio for community benefits, as they felt the ratio derived from their Schedule M was inappropriately high for community benefits activities.

³¹ Some indirect costs are reported as a fixed dollar amount while others are a calculated percentage of the hospital's reported direct costs.

“Hospital-Based CB Activities” column in Table 6). There is less variation between hospitals in their reported indirect cost ratios for community-based services, but there are a few outliers. Three hospitals report indirect cost ratios greater than 25% for community-based services.

**Table 6. Hospital-Reported Indirect Cost Ratios, FY 2024
(Indirect Costs as a Percentage of Direct Costs)**

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
UM Shore Medical Center at Chestertown	136.90%	18.70%
Sheppard Pratt	119.78%	
Adventist HealthCare Rehabilitation	118.72%	15.00%
MedStar Harbor Hospital	100.48%	
UM Shore Medical Center at Easton	95.00%	10.30%
UM Charles Regional Medical Center	92.41%	15.79%
Saint Agnes Healthcare, Inc.	85.76%	10.00%
MedStar Southern Maryland Hospital Center	82.45%	
Mercy Medical Center	82.09%	10.00%
UM Harford Memorial Hospital	81.90%	12.30%
MedStar Montgomery Medical Center	81.89%	
UM Baltimore Washington Medical Center	80.00%	13.30%
MedStar Good Samaritan Hospital	79.89%	
Frederick Health Hospital	79.46%	79.46%
CalvertHealth Medical Center	76.70%	32.20%
Greater Baltimore Medical Center	76.37%	
MedStar St. Mary's Hospital	74.90%	
Adventist HealthCare White Oak Medical Center	74.55%	15.00%
UMMC Midtown Campus	73.68%	13.12%
Adventist HealthCare Fort Washington Medical Center	73.03%	15.00%
UM Capital Region Health	71.93%	10.70%
UM Upper Chesapeake Health	71.30%	8.10%
MedStar Franklin Square Medical Center	70.55%	
Adventist HealthCare Shady Grove Medical Center	70.01%	15.00%
UPMC Western Maryland	69.17%	35.82%
Mt. Washington Pediatric Hospital	68.30%	11.82%
Meritus Medical Center	68.23%	15.00%
UM Rehabilitation & Orthopaedic Institute	66.60%	10.60%
UM St. Joseph Medical Center	66.55%	

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
MedStar Union Memorial Hospital	65.10%	
Luminis Health Doctors Community Medical Center	64.39%	
Suburban Hospital	62.53%	24.59%
TidalHealth McCready Pavillion	62.23%	
Johns Hopkins Howard County Medical Center	61.26%	17.72%
Sinai Hospital of Baltimore, Inc.	60.00%	12.00%
Carroll Hospital Center	60.00%	12.00%
Northwest Hospital Center, Inc.	60.00%	12.00%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	60.00%	
GRMC, Inc. DBA Garrett Regional Medical Center	58.28%	
Luminis Health Anne Arundel Medical Center	57.93%	
University of Maryland Medical Center	56.37%	
TidalHealth Peninsula Regional	53.30%	
Johns Hopkins Bayview Medical Center	51.60%	16.80%
Johns Hopkins Hospital	41.10%	15.08%
Luminis Health McNew Family Health Center	40.90%	
Atlantic General Hospital Corporation	40.09%	25.00%
ChristianaCare, Union Hospital	34.00%	
Holy Cross Hospital	33.60%	10.00%
Holy Cross Germantown Hospital	28.40%	10.00%

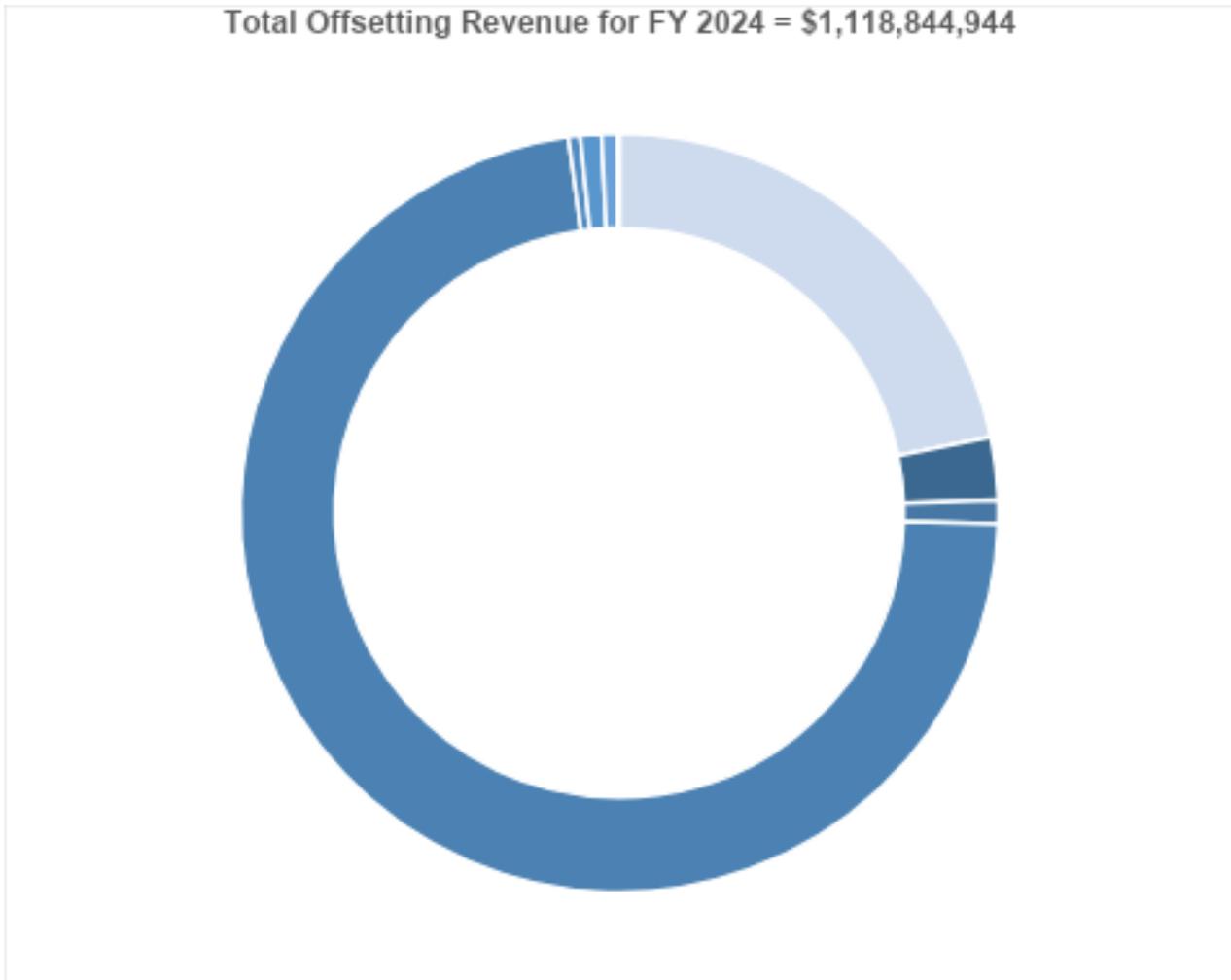
Offsetting Revenue and Mission-Driven Health Services

This report removes offsetting revenue from reported total community benefits. Offsetting revenue is defined as any revenue generated by the activity or program. For example, any payment by patients for services provided to those patients in a sliding-scale clinic would offset the total community benefit expenditures reported by the hospital for that clinic. Other examples include restricted grants or contributions to the hospital that are used to fund a portion of the hospital's community benefit. Hospitals report offsetting revenue to the HSCRC in their annual community benefit reports.

Hospitals reported over \$1.1 billion in offsetting revenue for community benefit activities—the majority for mission-driven health services, which are, by definition, intended to be services

provided to the community that are not expected to result in revenue. Figure 6 presents the total FY 2024 offsetting revenue by community benefit category.

Figure 6. Offsetting Revenue by Category of Community Benefit Activity for Maryland Hospitals, FY 2024



Offsetting revenue is different from rate-supported activities (described above). In general, hospitals do not report rate support as offsetting revenue. The Medicaid deficit assessment is the exception. The Medicaid deficit assessment (shown as “Medicaid assessments” in Figure 6, above) is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue.

Table 7 presents offsetting revenue for mission-driven health services by hospital. As noted above, mission-driven health services is the community benefit category that generates the most offsetting revenue. However, mission-driven health services are not intended to create revenue. Instead, mission-driven health services are intended to be services that hospitals undertake as a direct result of their community or mission-driven initiatives, or because the services would otherwise not be provided in the community. The hospitals are sorted by the proportion of total expenditures for mission-driven health services that are offset by revenue. Nine hospitals did not report any offsetting revenue from mission-driven health services. Sixteen hospitals reported offsetting revenue for 50% or more of their mission-driven expenditures. After removing offsetting revenue, mission-driven health services remain the largest category of community benefit activities, as shown in Table 5, above.

Table 7. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2024

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
UM Shore Medical Center at Easton	\$147,579,540	\$117,180,556	79.4%	\$30,398,984
MedStar Southern Maryland Hospital Center	\$38,097,777	\$27,846,024	73.1%	\$10,251,753
UM Shore Medical Center at Chestertown	\$32,188,679	\$23,441,736	72.8%	\$8,746,943
Greater Baltimore Medical Center	\$175,882,706	\$122,271,455	69.5%	\$53,611,251
MedStar Franklin Square Medical Center	\$60,792,591	\$41,396,485	68.1%	\$19,396,106
Adventist HealthCare White Oak Medical Center	\$58,752,030	\$39,587,768	67.4%	\$19,164,262
MedStar Good Samaritan Hospital	\$22,265,666	\$14,733,788	66.2%	\$7,531,878
MedStar Montgomery Medical Center	\$25,069,704	\$16,298,954	65.0%	\$8,770,750
Adventist HealthCare Rehabilitation	\$4,962,486	\$3,224,869	65.0%	\$1,737,617
Meritus Medical Center	\$167,099,463	\$105,451,957	63.1%	\$61,647,506
Atlantic General Hospital Corporation	\$15,074,686	\$9,485,735	62.9%	\$5,588,951
UM Baltimore Washington Medical Center	\$48,798,577	\$29,981,209	61.4%	\$18,817,369
MedStar Union Memorial Hospital	\$24,824,499	\$15,045,694	60.6%	\$9,778,805
MedStar Harbor Hospital	\$23,675,218	\$13,205,872	55.8%	\$10,469,346
MedStar St. Mary's Hospital	\$18,511,982	\$10,232,869	55.3%	\$8,279,113
UPMC Western Maryland	\$97,418,685	\$51,743,952	53.1%	\$45,674,733
Saint Agnes Healthcare, Inc.	\$47,623,359	\$21,867,432	45.9%	\$25,755,927
University of Maryland Medical Center	\$27,849,468	\$11,610,337	41.7%	\$16,239,131

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Northwest Hospital Center, Inc.	\$16,505,532	\$6,846,279	41.5%	\$9,659,253
TidalHealth Peninsula Regional	\$74,153,143	\$30,350,465	40.9%	\$43,802,678
Sinai Hospital of Baltimore, Inc.	\$78,413,720	\$30,633,329	39.1%	\$47,780,391
Mt. Washington Pediatric Hospital	\$682,802	\$266,554	39.0%	\$416,249
ChristianaCare, Union Hospital	\$31,145,545	\$10,812,078	34.7%	\$20,333,467
UM Charles Regional Medical Center	\$15,071,614	\$4,964,278	32.9%	\$10,107,335
Adventist HealthCare Shady Grove Medical Center	\$31,465,578	\$10,347,669	32.9%	\$21,117,908
UM Capital Region Health	\$38,876,169	\$12,556,436	32.3%	\$26,319,733
Adventist HealthCare Fort Washington Medical Center	\$8,823,136	\$2,515,600	28.5%	\$6,307,535
GRMC, Inc. DBA Garrett Regional Medical Center	\$15,087,506	\$3,923,696	26.0%	\$11,163,810
UM Rehabilitation & Orthopaedic Institute	\$3,500,757	\$788,907	22.5%	\$2,711,850
Johns Hopkins Bayview Medical Center	\$11,215,679	\$2,151,872	19.2%	\$9,063,807
UMMC Midtown Campus	\$25,113,345	\$4,418,806	17.6%	\$20,694,538
Carroll Hospital Center	\$14,710,197	\$2,011,275	13.7%	\$12,698,922
Suburban Hospital	\$17,132,240	\$2,256,356	13.2%	\$14,875,884
Holy Cross Hospital	\$10,675,346	\$1,381,106	12.9%	\$9,294,240
Luminis Health Anne Arundel Medical Center	\$56,824,905	\$5,927,620	10.4%	\$50,897,285
CalvertHealth Medical Center	\$1,208,712	\$104,261	8.6%	\$1,104,451
Johns Hopkins Hospital	\$19,863,188	\$1,234,254	6.2%	\$18,628,934
Sheppard Pratt	\$23,100,771	\$987,242	4.3%	\$22,113,528
Mercy Medical Center	\$21,947,729	\$754,447	3.4%	\$21,193,283
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	\$1,172,763	\$18,027	1.5%	\$1,154,736
Frederick Health Hospital	\$45,934,082	\$0	0.0%	\$45,934,082
UM Harford Memorial Hospital	\$1,675,918	\$0	0.0%	\$1,675,918
TidalHealth McCready Pavillion	\$0	\$0	0.0%	\$0
Johns Hopkins Howard County Medical Center	\$16,595,759	\$0	0.0%	\$16,595,759
UM Upper Chesapeake Health	\$20,440,085	\$0	0.0%	\$20,440,085
Luminis Health Doctors Community Medical Center	\$17,876,521	\$0	0.0%	\$17,876,521
UM St. Joseph Medical Center	\$44,091,857	\$0	0.0%	\$44,091,857
Holy Cross Germantown Hospital	\$3,730,952	\$0	0.0%	\$3,730,952
Luminis Health McNew Family Health Center	\$1,252,666	\$0	0.0%	\$1,252,666
Total	\$1,704,755,334	\$809,857,251	47.5%	\$894,898,083

Mission-Driven Health Services: Physician Gaps in Availability

As noted above, the mission-driven health services category is the largest category of community benefit reported by Maryland hospitals. The mission-driven health services category includes subsidies that hospitals provide to physicians to address gaps in physician availability to serve the hospital's uninsured population. Maryland law requires hospitals to justify the reporting of spending on physician subsidies as a community benefit.³² Hospitals must provide a written description of gaps in the availability of providers to serve their uninsured populations by specialty. Since FY 2021, hospitals have been required to separately itemize all physician subsidies claimed by type and specialty. The most frequently reported gaps in FY 2024 were specialties other than those listed (reported by 37 hospitals), followed by obstetrics and gynecology and psychiatry, then general surgery. Six hospitals reported no gaps in the availability of physicians to serve their uninsured population. See Table 8.

Table 8. Number of Hospitals Reporting Gaps in Physician Availability by Specialty

Gap in Physician Availability, by Specialty	Number of Hospitals
No gaps reported	6
Other	37
Obstetrics & Gynecology	25
Psychiatry	25
Surgery	21
Pediatrics	19
Neurology	17
Emergency Medicine	16
Cardiology	15
Anesthesiology	12
Endocrinology, Diabetes & Metabolism	12
Oncology-Cancer	12
Radiology	10
Urology	10
Ophthalmology	8
Neurological Surgery	7
Orthopedics	7
Internal Medicine	6

³² MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

Gap in Physician Availability, by Specialty	Number of Hospitals
Otolaryngology	5
Physical Medicine & Rehabilitation	5
Plastic Surgery	4
Family Practice/General Practice	3
Geriatrics	2
Pathology	2
Medical Genetics	1
Preventive Medicine	1

Community Health Needs Assessments

Federal law requires hospitals to conduct a CHNA every three years and develop an implementation plan for addressing the community needs identified in the CHNA.³³ The CHNA evaluates the health needs of the community the hospital serves and identifies needs, gaps, assets, and resources as they relate to the health of the community. CHNAs are supposed to be developed with robust community input. CHNAs help the hospital set priorities for community benefits expenditures.

Appendix G shows maps indicating the coverage of hospitals' primary service areas and community benefit service areas (CBSAs), two ways of defining the community each hospital serves, as well as describing the ways hospitals reported identifying their CBSAs. Hospitals report details about these communities, which help inform decisions about HCB activities. Appendix H contains demographic statistics on each Maryland county, similar to the measures hospitals may use. See Appendix I for a list of the data sources hospitals reported on their FY 2024 narrative survey that they use in their HCB efforts. Appendix J provides links to the most recent CHNA each hospital reported conducting.

Maryland requires hospitals to include information about their CHNA in their annual CBRs. The goal of this reporting is to provide transparency about 1) the extent to which the hospital's community benefit activities are aligned with their CHNA and 2) the level of community involvement in the development of the CHNA.

³³ Loyola University Chicago. (2024). *Background on community health needs assessment*. <https://hsd.luc.edu/ipath/communityhealthneedsassessment/backgroundoncommunityhealthneedsassessment/#:~:text=The%20CHNA%20process%20helps%20not,the%20basis%20of%20tax%20exemption>

Spending on CHNA-Related Activities

Hospitals reported spending 42.5% of their net community benefit spending on CHNA-related activities, an increase over the 37.2% of net community benefit spending that was for CHNA-related activities in FY 2023. Note that not all community benefit activities are expected to align with the CHNA. While CHNAs help identify community health needs and priorities, some community benefit activities may address broader community well-being, even if they do not directly relate to those specific identified needs. Further, because CHNAs are conducted every three years, community benefit activities may address emerging community health needs, e.g., the COVID-19 pandemic.

There was wide variation between individual hospitals, ranging from 0% to 97.4% of total community benefit spent on CHNA-related activities. This wide variation was similar to what was reported in FY 2023. Table 9 presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities, along with the corresponding percentage each hospital reported in FY 2023.

Table 9. CHNA Spending³⁴ as a Percentage of Net Community Benefit, FY 2024

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB	
			FY 24	FY 23
Johns Hopkins Bayview Medical Center	\$101,093,781	\$103,796,475	97.4%	67.0%
Johns Hopkins Hospital	\$352,476,842	\$390,471,661	90.3%	80.3%
Suburban Hospital	\$34,284,753	\$38,720,190	88.5%	65.8%
GRMC, Inc. DBA Garrett Regional Medical Center	\$11,830,775	\$14,605,360	81.0%	66.9%
Johns Hopkins Howard County Medical Center	\$28,106,962	\$37,264,233	75.4%	69.8%
MedStar Union Memorial Hospital	\$33,759,406	\$45,615,482	74.0%	73.8%
UPMC Western Maryland	\$43,411,985	\$64,224,306	67.6%	72.3%
MedStar Franklin Square Medical Center	\$43,396,256	\$64,469,462	67.3%	70.5%
MedStar St. Mary's Hospital	\$11,090,108	\$17,625,053	62.9%	68.2%
MedStar Harbor Hospital Center	\$18,740,153	\$30,180,512	62.1%	65.3%
MedStar Montgomery Medical Center	\$10,766,929	\$18,225,215	59.1%	55.2%
MedStar Good Samaritan Hospital	\$15,897,877	\$27,101,362	58.7%	58.4%
Meritus Medical Center	\$46,281,069	\$83,633,973	55.3%	47.3%
Mercy Medical Center	\$43,242,987	\$79,078,035	54.7%	56.2%
UMMC Midtown Campus	\$20,648,523	\$38,182,438	54.1%	2.0%
MedStar Southern Maryland Hospital Center	\$13,199,557	\$24,868,619	53.1%	62.2%

³⁴ Offsetting revenue has been removed.

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB	
			FY 24	FY 23
Northwest Hospital Center, Inc.	\$12,071,204	\$23,315,792	51.8%	17.6%
Holy Cross Germantown Hospital	\$3,880,156	\$8,328,443	46.6%	48.0%
TidalHealth McCreedy Pavillion	\$152,268	\$329,768	46.2%	81.2%
TidalHealth Peninsula Regional	\$28,663,373	\$70,519,865	40.6%	34.7%
Carroll Hospital Center	\$9,908,949	\$24,730,815	40.1%	25.2%
Univ. of Maryland Harford Memorial Hospital	\$1,376,397	\$3,798,355	36.2%	16.7%
UM Rehabilitation & Orthopaedic Institute	\$3,585,766	\$10,118,263	35.4%	1.5%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	\$1,418,790	\$4,849,356	29.3%	31.3%
Holy Cross Hospital	\$12,403,257	\$43,108,854	28.8%	27.8%
Luminis Health Doctors Community Medical Center	\$20,140,077	\$82,674,645	24.4%	15.5%
UM Upper Chesapeake Health	\$7,325,864	\$31,477,002	23.3%	20.7%
Sheppard Pratt	\$7,832,546	\$37,139,797	21.1%	15.3%
Luminis Health McNew Family Health Center	\$356,736	\$2,118,665	16.8%	13.1%
University of Maryland Medical Center	\$42,110,500	\$280,281,771	15.0%	0.5%
UM Baltimore Washington Medical Center	\$3,819,466	\$29,170,817	13.1%	11.5%
CalvertHealth Medical Center	\$566,662	\$5,380,493	10.5%	1.9%
Luminis Health Doctors Community Medical Center	\$3,792,765	\$39,554,853	9.6%	32.8%
UM St. Joseph Medical Center	\$4,532,600	\$54,313,276	8.3%	8.3%
UM Shore Medical Center at Chestertown	\$549,608	\$9,994,510	5.5%	6.3%
UM Capital Region Health	\$2,127,351	\$41,464,774	5.1%	2.6%
Frederick Health Hospital	\$2,404,662	\$57,152,706	4.2%	4.4%
Adventist HealthCare Fort Washington Medical Center	\$336,417	\$9,971,145	3.4%	2.8%
UM Shore Medical Center at Easton	\$1,003,759	\$38,199,045	2.6%	3.6%
Mt. Washington Pediatric Hospital	\$31,898	\$1,896,030	1.7%	29.7%
ChristianaCare, Union Hospital	\$381,132	\$23,149,242	1.6%	0.5%
Saint Agnes Healthcare, Inc.	\$770,619	\$55,313,223	1.4%	3.8%
Sinai Hospital of Baltimore, Inc.	\$1,064,425	\$113,077,839	0.9%	30.2%
Atlantic General Hospital Corporation	\$65,780	\$7,711,731	0.9%	0.8%
UM Charles Regional Medical Center	\$92,715	\$14,921,744	0.6%	8.8%
Adventist HealthCare Rehabilitation	\$11,332	\$2,586,379	0.4%	23.9%
Adventist HealthCare White Oak Medical Center	\$15,936	\$36,745,335	0.0%	4.5%
Adventist HealthCare Shady Grove Medical Center	\$8,440	\$44,519,875	0.0%	9.0%

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB	
			FY 24	FY 23
Greater Baltimore Medical Center	\$10,000	\$67,402,836	0.0%	-0.3%
Total	\$1,001,039,413	\$2,353,379,619	42.5%	37.2%

Average:	33.2%	30.9%
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Hospitals also described the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the CHNA priority area categories most commonly addressed by hospital initiatives in FY 2024. Appendix K shows the number of hospitals reporting initiatives to address each of the full list of CHNA-identified community health needs.

Table 10. Top 5 CHNA Priority Area Categories Addressed by Hospitals

CHNA Priority Area	Number of Hospitals
Settings and Systems - Community	37
Social Determinants of Health - Health Care Access and Quality	36
Health Behaviors - Preventive Care	31
Health Conditions - Mental Health and Mental Disorders	29
Health Conditions - Diabetes	27

CHNA Development Process

All Maryland nonprofit hospitals reported conducting CHNAs within the past three fiscal years, as required by federal law. See Appendix L for the dates on which hospitals completed their last CHNAs.

Federal law requires hospitals to use input from individuals who represent the broad interests of the community served by the hospital in their CHNA. Each hospital records the process for assessing community needs and the findings from that process in a CHNA document that is made available to the public. Hospitals also produce a plan for implementing activities to address the identified community needs,³⁵ which some include directly in the CHNA document and others provide separately. All Maryland nonprofit hospitals reported adopting an implementation strategy. The CHNA document must also note any community needs that were identified in prior CHNAs that have not been met and explain why they were not addressed.

³⁵ 26 U.S.C. § 501(r)(3)(A)-(B).

The CHNA document includes descriptions of the people and organizations with whom the hospital collaborated on the assessment of community health needs. Hospitals reported collaborating with a broad set of community organizations when developing their CHNAs. Table 11 shows the number of hospitals that reported collaborating with various types of external organizations. See Appendices M and N for more detail on these external participants.

Table 11. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2024

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	20	43%
Local Health Departments	46	98%
Local Health Improvement Coalitions	44	94%
Other Hospitals	39	83%
Behavioral Health Organizations	42	89%

Community Benefit Administration

Hospitals report information on how they staff CHNA and HCB activities, whether they audit their community benefit data, the role of the hospital board in their community benefit report, and whether community benefit is included in the hospital's strategic planning process.

Conducting CHNAs, developing implementation plans, and reporting HCB takes time and resources. Hospitals have different approaches to staffing the administration of their community benefit activities and reporting responsibilities. Most hospitals have invested in staff who are dedicated to community benefit and/or population health. These staff play a key role in hospital CHNAs and community benefit activities, as shown in Table 12.

Table 12. Number of Hospitals Reporting Staff in the Following Categories Contributing to CB or CHNA Operations

Staff Category	Number of Hospitals	Percentage of Hospitals
Population Health Staff	46	98%
Community Benefit Staff	43	91%
Community Benefit/Pop Health Director	45	96%

Appendix O details the types of staff involved in hospital CHNAs. Appendix P details the types of staff involved in HCB activities.

All hospitals conducted some form of audit on the financial data they submitted to the HSCRC (Table 13). These audits were mostly performed by hospital or hospital system staff, but 12 hospitals used third-party auditors.

Table 13. Hospital Audits of CBR Financial Spreadsheet

Staff or Entity Conducting Audit	Number of Hospitals Completing Audit	
	Yes	No
Hospital Staff	42	5
System Staff	38	9
Third-Party	12	35
No Audit	0	47
Two or More Audit Types	37	10
Three or More Audit Types	8	39

Each nonprofit hospital is governed by a board. The majority (36) of the CBRs were reviewed by the hospital boards (Table 14). Of the 11 CBRs that were not reviewed by the board, common reasons were timing or because the board had delegated this authority to executive or financial staff or an external firm. For example, several hospitals reported that their board meeting schedules were such that they did not have the opportunity to review before the report deadline. These responses were similar to what was reported in FY 2023.

Table 14. Hospital Board Review of the CBR

Board Review/Approval	Number of Hospitals	
	Yes	No
Financial Report (Spreadsheet)	36	11
Narrative Report	36	11

Conclusion

Maryland’s community benefit reporting requirements are more extensive than the federal requirements. All 49 nonprofit hospitals in Maryland submitted the required information for FY 2024. Maryland hospitals’ FY 2024 community benefit expenditures totaled over \$2.35 billion, or \$1.37 billion after accounting for activities that are funded through hospital rates set by the HSCRC. Total community benefit expenditures as a percentage of hospital operating expenses remained constant at 11.3% between FY 2023 and FY 2024. When the rate-supported activities are removed, community benefit expenses fell slightly from 6.6% to 6.5% of operating expenses over the same period. All hospitals reported claiming exemption from federal and state income taxes.

All hospitals submitted a CHNA and CHNA implementation strategy. Most hospitals reported collaborating with local health departments and health improvement coalitions, other hospitals, and behavioral health organizations on their CHNAs. Most hospitals have dedicated staff for community benefit and/or population health. Most reported that both hospital and system staff audit community benefit financial report data and that the hospital board reviews the financial spreadsheet and the narrative report.

Staff identified the wide variation that remains in both the percentage of net community benefit hospitals reported spending on CHNA-related activities and their indirect cost ratios as areas for continued review. Future reporting instructions will also be updated to reflect 2025 legislative changes for financial assistance, as well as for population health goals under the AHEAD Model once finalized.

Appendix A. Comparison of Federal and State Community Benefit Categories

Activities the Federal Government Defines as HCB (Schedule H)	Activities Maryland Includes as HCB (this list is not exclusive)
Net, unreimbursed costs of financial assistance (free or reduced cost care)**	Financial assistance
Participation in means-tested government programs, such as Medicaid**	Hospital contribution to the Medicaid Deficit Assessment
Health professions education	Health professions education
Health services research	Research
Subsidized health services	Mission-driven health service
Community health improvement activities	<p>A community health service</p> <p>An operation related to a planned, organized, and measured activity that is intended to meet identified community health needs within a service area</p> <p>A planned, organized, and measured activity that is intended to meet identified community health needs within a service area is funded by a foundation</p>
Cash or in-kind contributions to other community groups.	<p>A financial contribution</p> <p>Financial or in-kind support of the Maryland Behavioral Health Crisis Response System.</p>
Community-building activities. Example: Investments in housing	A community-building activity, including partnerships with community-based organizations

Appendix B. Hospitals Submitting Community Benefit Reports

Maryland Hospitals that Submitted CBRs in FY 2024, by System

Adventist HealthCare	Luminis Health
Adventist HealthCare Fort Washington Medical Center	Luminis Health Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Luminis Health Doctors Community Medical Center
Adventist HealthCare Shady Grove Medical Center	Luminis Health McNew Family Health Center
Adventist HealthCare White Oak Medical Center	MedStar Health
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital Corporation	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	TidalHealth
Greater Baltimore Medical Center	TidalHealth McCready Pavilion ³⁶
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	Trinity Health
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Johns Hopkins Howard County Medical Center	University of Maryland Medical System
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital ³⁷	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	UMMC Midtown Campus
Northwest Hospital Center, Inc.	University of Maryland Medical Center
Sinai Hospital of Baltimore, Inc.	UPMC
	UPMC Western Maryland
	West Virginia University Health System
	GRMC, Inc. DBA Garrett Regional Medical Center

³⁶ The TidalHealth McCready Pavilion is a Freestanding Medical Facility associated with Peninsula Regional.

³⁷ Jointly owned by the University of Maryland Medical System and Johns Hopkins.

Appendix C. FY 2024 Funding through Rates for HCB Activities

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Adventist HealthCare Fort Washington Medical Center	\$0	\$74,116	\$74,112	\$443,438	\$2,483,775	\$0	\$3,075,440
Adventist HealthCare Rehabilitation	\$0	\$53,787	\$0	\$0	\$0	\$0	\$53,787
Adventist HealthCare Shady Grove Medical Center	\$0	\$507,181	\$507,180	\$732,276	\$12,104,066	\$0	\$13,850,703
Adventist HealthCare White Oak Medical Center	\$0	\$352,794	\$352,788	\$0	\$7,357,468	\$0	\$8,063,049
Atlantic General Hospital Corporation	\$0	\$124,941	\$124,944	\$545,476	\$871,531	\$0	\$1,666,891
CalvertHealth Medical Center	\$0	\$170,684	\$170,688	\$0	\$3,148,670	\$0	\$3,490,042
Carroll Hospital Center	\$0	\$258,148	\$258,144	\$268,909	\$3,256,037	\$0	\$4,041,239
ChristianaCare, Union Hospital	\$0	\$181,753	\$181,752	\$0	\$2,318,500	\$1,005,692	\$3,687,697
Frederick Health Hospital	\$0	\$400,842	\$400,848	\$797,961	\$5,490,100	\$0	\$7,089,751
Greater Baltimore Medical Center	\$7,811,271	\$495,095	\$495,096	\$550,297	\$3,403,027	\$0	\$12,754,786
GRMC, Inc. DBA Garrett Regional Medical Center	\$0	\$71,160	\$71,160	\$0	\$4,078,070	\$0	\$4,220,390
Holy Cross Germantown Hospital	\$0	\$141,904	\$141,900	\$0	\$6,240,517	\$0	\$6,524,321
Holy Cross Hospital	\$2,442,700	\$573,097	\$573,096	\$0	\$34,068,242	\$0	\$37,657,135
Johns Hopkins Bayview Medical Center	\$29,452,247	\$778,281	\$778,284	\$1,808,886	\$24,377,000	\$6,737,729	\$63,932,427
Johns Hopkins Hospital	\$141,550,749	\$2,832,180	\$2,832,180	\$6,298,293	\$58,936,200	\$0	\$212,449,602

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Johns Hopkins Howard County Medical Center	\$0	\$344,977	\$344,976	\$959,818	\$8,132,000	\$0	\$9,781,771
Lifefridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	\$0	\$74,238	\$74,232	\$0	\$2,070,826	\$0	\$2,219,296
Luminis Health Anne Arundel Medical Center	\$8,116,363	\$724,139	\$724,140	\$0	\$4,392,499	\$0	\$13,957,140
Luminis Health Doctors Community Medical Center	\$0	\$263,081	\$263,076	\$372,138	\$15,410,046	\$0	\$16,308,341
Luminis Health McNew Family Health Center	\$0	\$9,169	\$0	\$0	\$88,700	\$0	\$97,869
MedStar Franklin Square Medical Center	\$10,241,155	\$609,275	\$609,276	\$644,337	\$18,457,288	\$0	\$30,561,331
MedStar Good Samaritan Hospital	\$2,413,642	\$290,129	\$290,124	\$307,323	\$9,833,762	\$0	\$13,134,980
MedStar Harbor Hospital	\$1,170,377	\$201,748	\$201,744	\$212,964	\$9,906,517	\$0	\$11,693,350
MedStar Montgomery Medical Center	\$0	\$192,884	\$192,888	\$0	\$6,420,791	\$0	\$6,806,563
MedStar Southern Maryland Hospital Center	\$0	\$299,186	\$299,184	\$2,356,962	\$10,205,336	\$0	\$13,160,667
MedStar St. Mary's Hospital	\$0	\$204,364	\$204,360	\$271,051	\$5,530,383	\$0	\$6,210,159
MedStar Union Memorial Hospital	\$10,424,151	\$442,853	\$442,848	\$484,129	\$10,323,673	\$0	\$22,117,653
Mercy Medical Center	\$4,963,684	\$628,565	\$628,560	\$631,651	\$25,572,579	\$0	\$32,425,039
Meritus Medical Center	\$5,059,512	\$430,476	\$430,476	\$1,196,458	\$17,571,700	\$0	\$24,688,622
Mt. Washington Pediatric Hospital	\$0	\$60,326	\$0	\$0	\$107,673	\$0	\$167,999
Northwest Hospital Center, Inc.	\$0	\$301,665	\$301,668	\$309,396	\$4,652,036	\$0	\$5,564,764
Saint Agnes Healthcare, Inc.	\$6,889,024	\$472,143	\$472,140	\$1,003,671	\$15,110,119	\$0	\$23,947,097

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Revenue for Reform	Total Rate Support
Sheppard Pratt	\$2,391,274	\$166,178	\$0	\$0	\$7,956,433	\$0	\$10,513,885
Sinai Hospital of Baltimore, Inc.	\$19,852,029	\$968,801	\$968,796	\$1,785,128	\$14,180,752	\$7,344,479	\$45,099,985
Suburban Hospital	\$479,542	\$392,502	\$392,496	\$0	\$8,728,792	\$0	\$9,993,331
TidalHealth McCready Pavillion	\$0	\$5,788	\$5,784	\$0	\$177,500	\$0	\$189,072
TidalHealth Peninsula Regional	\$10,875,500	\$525,052	\$519,264	\$1,636,427	\$13,170,300	\$0	\$26,726,543
UM Baltimore Washington Medical Center	\$589,257	\$514,054	\$514,056	\$0	\$6,370,000	\$0	\$7,987,367
UM Capital Region Health	\$4,424,928	\$386,755	\$386,760	\$3,149,044	\$7,867,489	\$2,377,394	\$18,592,370
UM Charles Regional Medical Center	\$0	\$175,776	\$175,776	\$403,995	\$2,754,000	\$0	\$3,509,547
UM Rehabilitation & Orthopaedic Institute	\$1,580,466	\$135,128	\$135,132	\$0	\$1,357,000	\$0	\$3,207,726
UM Shore Medical Center at Chestertown	\$0	\$43,464	\$54,348	\$0	\$605,000	\$0	\$702,812
UM Shore Medical Center at Easton	\$150,588	\$285,433	\$285,432	\$0	\$4,626,000	\$2,510,462	\$7,857,915
UM St. Joseph Medical Center	\$0	\$431,503	\$431,508	\$446,826	\$5,012,785	\$0	\$6,322,622
UM Upper Chesapeake Health	\$0	\$366,389	\$366,384	\$0	\$3,188,000	\$0	\$3,920,773
UMMC Midtown Campus	\$3,631,984	\$245,010	\$245,016	\$1,881,709	\$4,181,000	\$2,809,105	\$12,993,825
Univ. of Maryland Harford Memorial Hospital	\$0	\$119,935	\$119,940	\$0	\$638,000	\$0	\$877,875
University of Maryland Medical Center	\$168,856,004	\$1,807,462	\$1,807,464	\$3,457,008	\$22,233,000	\$0	\$198,160,938
UPMC Western Maryland	\$0	\$367,682	\$367,680	\$1,125,420	\$14,882,200	\$0	\$16,742,981
Total	\$443,366,447	\$19,502,092	\$19,217,700	\$34,080,989	\$449,847,380	\$22,784,861	\$988,799,469

Appendix D. FY 2024 Community Benefit Analysis

Table D1. Hospital Operating Expenses and Community Benefit Expenses

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
Adventist HealthCare Fort Washington Medical Center	\$63,085,411	\$9,971,145	15.81%
Adventist HealthCare Rehabilitation	\$68,580,685	\$2,586,379	3.77%
Adventist HealthCare Shady Grove Medical Center	\$441,086,230	\$44,519,875	10.09%
Adventist HealthCare White Oak Medical Center	\$317,242,531	\$36,745,335	11.58%
Atlantic General Hospital Corporation	\$169,587,689	\$7,711,731	4.55%
CalvertHealth Medical Center	\$164,446,825	\$5,380,493	3.27%
Carroll Hospital Center	\$289,841,728	\$24,730,815	8.53%
ChristianaCare, Union Hospital	\$193,170,384	\$23,149,242	11.98%
Frederick Health Hospital	\$422,677,000	\$57,152,706	13.52%
Greater Baltimore Medical Center	\$631,175,350	\$67,402,836	10.68%
GRMC, Inc. DBA Garrett Regional Medical Center	\$57,842,000	\$14,605,360	25.25%
Holy Cross Germantown Hospital	\$148,956,973	\$8,328,443	5.59%
Holy Cross Hospital	\$518,718,021	\$43,108,854	8.31%
Johns Hopkins Bayview Medical Center	\$783,511,000	\$103,796,475	13.25%
Johns Hopkins Hospital	\$3,267,971,000	\$390,471,661	11.95%
Johns Hopkins Howard County Medical Center	\$331,189,000	\$37,264,233	11.25%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	\$77,262,706	\$4,849,356	6.28%
Luminis Health Anne Arundel Medical Center	\$639,587,000	\$82,674,645	12.93%
Luminis Health Doctors Community Medical Center	\$259,599,000	\$39,554,853	15.24%
Luminis Health McNew Family Health Center	\$8,167,000	\$2,118,665	25.94%
MedStar Franklin Square Medical Center	\$718,629,103	\$64,469,462	8.97%

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
MedStar Good Samaritan Hospital	\$318,459,961	\$27,101,362	8.51%
MedStar Harbor Hospital	\$244,442,802	\$30,180,512	12.35%
MedStar Montgomery Medical Center	\$240,355,994	\$18,225,215	7.58%
MedStar Southern Maryland Hospital Center	\$372,032,962	\$24,868,619	6.68%
MedStar St. Mary's Hospital	\$230,038,405	\$17,625,053	7.66%
MedStar Union Memorial Hospital	\$532,389,932	\$45,615,482	8.57%
Mercy Medical Center	\$605,639,730	\$79,078,035	13.06%
Meritus Medical Center	\$591,199,119	\$83,633,973	14.15%
Mt. Washington Pediatric Hospital	\$70,797,599	\$1,896,030	2.68%
Northwest Hospital Center, Inc.	\$302,110,467	\$23,315,792	7.72%
Saint Agnes Healthcare, Inc.	\$545,834,000	\$55,313,223	10.13%
Sheppard Pratt	\$288,145,200	\$37,139,797	12.89%
Sinai Hospital of Baltimore, Inc.	\$945,794,581	\$113,077,839	11.96%
Suburban Hospital	\$390,538,000	\$38,720,190	9.91%
TidalHealth McCready Pavillion	\$7,264,200	\$329,768	4.54%
TidalHealth Peninsula Regional	\$477,491,000	\$70,519,865	14.77%
UM Baltimore Washington Medical Center	\$474,520,000	\$29,170,817	6.15%
UM Capital Region Health	\$398,366,000	\$41,464,774	10.41%
UM Charles Regional Medical Center	\$158,383,973	\$14,921,744	9.42%
UM Harford Memorial Hospital	\$56,289,000	\$3,798,355	6.75%
UM Rehabilitation & Orthopaedic Institute	\$129,865,000	\$10,118,263	7.79%
UM Shore Medical Center at Chestertown	\$46,472,000	\$9,994,510	21.51%
UM Shore Medical Center at Easton	\$311,528,000	\$38,199,045	12.26%
UM St. Joseph Medical Center	\$424,403,000	\$54,313,276	12.80%
UM Upper Chesapeake Health	\$350,247,000	\$31,477,002	8.99%
UMMC Midtown Campus	\$279,537,000	\$38,182,438	13.66%

Hospital Name	Total Hospital Operating Expense	Total Net Community Benefit Expense	Total CB as % of Total Operating Expense
University of Maryland Medical Center	\$2,117,678,000	\$280,281,771	13.24%
UPMC Western Maryland	\$378,032,957	\$64,224,306	16.99%
Total, All Hospitals	\$20,860,182,517	\$2,353,379,619	11.28%

Table D2. Rate-Supported Community Benefit, Including Financial Assistance

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense ³⁸	Amount of Community Benefit Amount included in Rates ³⁹	Total CB not included in hospital rates ⁴⁰	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
	A	B	C	D=B-C	E=D/A	F	G=F/A
Adventist HealthCare Fort Washington Medical Center	\$63,085,411	\$9,971,145	\$3,075,440	\$6,895,704	10.93%	\$2,245,578	3.56%
Adventist HealthCare Rehabilitation	\$68,580,685	\$2,586,379	\$53,787	\$2,532,592	3.69%	\$212,231	0.31%
Adventist HealthCare Shady Grove Medical Center	\$441,086,230	\$44,519,875	\$13,850,703	\$30,669,172	6.95%	\$14,854,649	3.37%
Adventist HealthCare White Oak Medical Center	\$317,242,531	\$36,745,335	\$8,063,049	\$28,682,286	9.04%	\$10,673,174	3.36%
Atlantic General Hospital Corporation	\$169,587,689	\$7,711,731	\$1,666,891	\$6,044,839	3.56%	\$871,531	0.51%
CalvertHealth Medical Center	\$164,446,825	\$5,380,493	\$3,490,042	\$1,890,451	1.15%	\$3,149,123	1.91%
Carroll Hospital Center	\$289,841,728	\$24,730,815	\$4,041,239	\$20,689,576	7.14%	\$3,256,034	1.12%
ChristianaCare, Union Hospital	\$193,170,384	\$23,149,242	\$3,687,697	\$19,461,545	10.07%	\$1,822,210	0.94%
Frederick Health Hospital	\$422,677,000	\$57,152,706	\$7,089,751	\$50,062,955	11.84%	\$992,479	0.23%

³⁸ Excludes expenditures on community benefit activities that are offset by revenue.

³⁹ Includes funding for financial assistance, DME, NSPI, NSPII, Regional Partnership Catalyst Grant, and Revenue for Reform.

⁴⁰ The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, Regional Partnership Catalyst, and Revenue for Reform funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from the total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense ³⁸	Amount of Community Benefit Amount included in Rates ³⁹	Total CB not included in hospital rates ⁴⁰	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Greater Baltimore Medical Center	\$631,175,350	\$67,402,836	\$12,754,786	\$54,648,050	8.66%	\$3,403,027	0.54%
GRMC, Inc. DBA Garrett Regional Medical Center	\$57,842,000	\$14,605,360	\$4,220,390	\$10,384,970	17.95%	\$2,737,066	4.73%
Holy Cross Germantown Hospital	\$148,956,973	\$8,328,443	\$6,524,321	\$1,804,122	1.21%	\$4,352,584	2.92%
Holy Cross Hospital	\$518,718,021	\$43,108,854	\$37,657,135	\$5,451,719	1.05%	\$23,544,800	4.54%
Johns Hopkins Bayview Medical Center	\$783,511,000	\$103,796,475	\$63,932,427	\$39,864,048	5.09%	\$24,377,000	3.11%
Johns Hopkins Hospital	\$3,267,971,000	\$390,471,661	\$212,449,602	\$178,022,058	5.45%	\$58,936,000	1.80%
Johns Hopkins Howard County Medical Center	\$331,189,000	\$37,264,233	\$9,781,771	\$27,482,462	8.30%	\$8,132,232	2.46%
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	\$77,262,706	\$4,849,356	\$2,219,296	\$2,630,060	3.40%	\$2,070,826	2.68%
Luminis Health Anne Arundel Medical Center	\$639,587,000	\$82,674,645	\$13,957,140	\$68,717,505	10.74%	\$4,392,499	0.69%
Luminis Health Doctors Community Medical Center	\$259,599,000	\$39,554,853	\$16,308,341	\$23,246,512	8.95%	\$15,410,046	5.94%
Luminis Health McNew Family Health Center	\$8,167,000	\$2,118,665	\$97,869	\$2,020,796	24.74%	\$88,700	1.09%
MedStar Franklin Square Medical Center	\$718,629,103	\$64,469,462	\$30,561,331	\$33,908,131	4.72%	\$20,861,542	2.90%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense ³⁸	Amount of Community Benefit Amount included in Rates ³⁹	Total CB not included in hospital rates ⁴⁰	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
MedStar Good Samaritan Hospital	\$318,459,961	\$27,101,362	\$13,134,980	\$13,966,382	4.39%	\$11,104,975	3.49%
MedStar Harbor Hospital	\$244,442,802	\$30,180,512	\$11,693,350	\$18,487,162	7.56%	\$11,371,834	4.65%
MedStar Montgomery Medical Center	\$240,355,994	\$18,225,215	\$6,806,563	\$11,418,652	4.75%	\$7,390,557	3.07%
MedStar Southern Maryland Hospital Center	\$372,032,962	\$24,868,619	\$13,160,667	\$11,707,951	3.15%	\$11,566,697	3.11%
MedStar St. Mary's Hospital	\$230,038,405	\$17,625,053	\$6,210,159	\$11,414,894	4.96%	\$6,380,009	2.77%
MedStar Union Memorial Hospital	\$532,389,932	\$45,615,482	\$22,117,653	\$23,497,828	4.41%	\$11,692,906	2.20%
Mercy Medical Center	\$605,639,730	\$79,078,035	\$32,425,039	\$46,652,996	7.70%	\$25,572,579	4.22%
Meritus Medical Center	\$591,199,119	\$83,633,973	\$24,688,622	\$58,945,351	9.97%	\$18,196,186	3.08%
Mt. Washington Pediatric Hospital	\$70,797,599	\$1,896,030	\$167,999	\$1,728,031	2.44%	\$107,673	0.15%
Northwest Hospital Center, Inc.	\$302,110,467	\$23,315,792	\$5,564,764	\$17,751,028	5.88%	\$4,652,036	1.54%
Saint Agnes Healthcare, Inc.	\$545,834,000	\$55,313,223	\$23,947,097	\$31,366,126	5.75%	\$16,832,991	3.08%
Sheppard Pratt	\$288,145,200	\$37,139,797	\$10,513,885	\$26,625,912	9.24%	\$7,956,400	2.76%
Sinai Hospital of Baltimore, Inc.	\$945,794,581	\$113,077,839	\$45,099,985	\$67,977,853	7.19%	\$14,180,752	1.50%
Suburban Hospital	\$390,538,000	\$38,720,190	\$9,993,331	\$28,726,859	7.36%	\$8,729,000	2.24%
TidalHealth McCreedy Pavillion	\$7,264,200	\$329,768	\$189,072	\$140,696	1.94%	\$177,500	2.44%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense ³⁸	Amount of Community Benefit Amount included in Rates ³⁹	Total CB not included in hospital rates ⁴⁰	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
TidalHealth Peninsula Regional	\$477,491,000	\$70,519,865	\$26,726,543	\$43,793,322	9.17%	\$1,966,890	0.41%
UM Baltimore Washington Medical Center	\$474,520,000	\$29,170,817	\$7,987,367	\$21,183,449	4.46%	\$6,370,000	1.34%
UM Capital Region Health	\$398,366,000	\$41,464,774	\$18,592,370	\$22,872,404	5.74%	\$6,771,000	1.70%
UM Charles Regional Medical Center	\$158,383,973	\$14,921,744	\$3,509,547	\$11,412,197	7.21%	\$2,753,782	1.74%
UM Harford Memorial Hospital	\$56,289,000	\$3,798,355	\$877,875	\$2,920,480	5.19%	\$638,000	1.13%
UM Rehabilitation & Orthopaedic Institute	\$129,865,000	\$10,118,263	\$3,207,726	\$6,910,537	5.32%	\$1,357,000	1.04%
UM Shore Medical Center at Chestertown	\$46,472,000	\$9,994,510	\$702,812	\$9,291,698	19.99%	\$605,000	1.30%
UM Shore Medical Center at Easton	\$311,528,000	\$38,199,045	\$7,857,915	\$30,341,130	9.74%	\$5,321,000	1.71%
UM St. Joseph Medical Center	\$424,403,000	\$54,313,276	\$6,322,622	\$47,990,654	11.31%	\$5,356,000	1.26%
UM Upper Chesapeake Health	\$350,247,000	\$31,477,002	\$3,920,773	\$27,556,229	7.87%	\$3,188,000	0.91%
UMMC Midtown Campus	\$279,537,000	\$38,182,438	\$12,993,825	\$25,188,613	9.01%	\$4,181,000	1.50%
University of Maryland Medical Center	\$2,117,678,000	\$280,281,771	\$198,160,938	\$82,120,834	3.88%	\$22,233,000	1.05%
UPMC Western Maryland	\$378,032,957	\$64,224,306	\$16,742,981	\$47,481,325	12.56%	\$14,728,082	3.90%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense ³⁸	Amount of Community Benefit Amount included in Rates ³⁹	Total CB not included in hospital rates ⁴⁰	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Total, All Hospitals	\$20,860,182,517	\$2,353,379,619	\$988,799,469	\$1,364,580,150	6.54%	\$437,764,179	2.10%
Averages, All Hospitals	\$425,718,011	\$48,028,155	\$20,179,581	\$27,848,574	7.40%	\$8,933,963	2.20%

Appendix E. Methodology for Rate Support for Uncompensated Care, including Financial Assistance

Financial assistance amounts reported by hospitals in their community benefit reports (CBRs) may not match the financial assistance amounts applied in their global budgets for the same year. The financial assistance amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their GBRs are retrospective.

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

1. **Statewide Actual UCC in All-Payer Hospital Rates:** The HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percentage of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in rate year (RY) 2026, HSCRC staff will use RY 2024 statewide UCC experience of 3.99 percent to determine the UCC amount built into all hospital rates.
2. **Hospital Payments or Contributions to the UCC Fund:** The UCC Fund is then used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
 - i. **Hospital-Specific Actual UCC:** The HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital.
 - ii. **Hospital-Specific Predicted UCC:** The HSCRC uses a logistic regression model to predict a hospital's expected amount of UCC. This model takes into account Area Deprivation Index (ADI), payer type, and site of care.
 - iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature.
 - iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how

much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which the HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Table E1. UCC Methodology Example (\$ Millions)

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

The use of blended actual and predicted UCC to determine the amount of hospital contributions and withdrawals from the UCC funds serves to balance the policy goals of reimbursing hospitals for UCC provided to low-income patients while also incentivizing hospitals to minimize bad debt by encouraging them to use reasonable means to collect debt from patients who can afford to pay. Incorporating predicted UCC into this methodology provides hospitals with a financial incentive to collect payments (rather than writing debt off as bad debt without attempting to collect) so that UCC costs do not rise too quickly. This approach is critical to supporting Maryland's unique UCC system and ensuring access to care for low-income patients in the long run.

Appendix F. FY 2024 Hospital Community Benefit Aggregate Data

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit ⁴¹ less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
Unreimbursed Medicaid Costs							
T99	Medicaid Assessments	\$250,408,756	⁴²		\$243,785,176	\$6,623,580	\$6,623,580
Community Health Services							
A10	Community Health Education	\$15,504,807	\$8,309,385	\$570,011	\$1,906,913	\$21,337,268	\$13,027,883
A11	Support Groups	\$2,814,708	\$1,880,505	\$880	\$35,607	\$4,658,726	\$2,778,220
A12	Self-Help	\$1,943,620	\$926,589		\$265,387	\$2,604,822	\$1,678,233
A20	Community-Based Clinical Services	\$26,626,201	\$7,927,266		\$8,967,630	\$25,585,837	
A21	Screenings	\$5,000,455	\$3,965,567		\$2,512,705	\$6,453,318	\$2,487,751
A22	One-Time/Occasionally Held Clinics	\$1,501,672	\$82,570			\$1,584,242	\$1,501,672
A23	Clinics for Underinsured and Uninsured	\$6,236,643	\$2,275,189		\$1,616,088	\$6,895,743	\$4,620,555
A24	Mobile Units	\$3,416,095	\$1,514,074		\$1,626,196	\$3,303,973	\$1,789,899
A30	Health Care Support Services	\$83,706,267	\$35,666,315	\$4,857,222	\$11,243,878	\$103,271,482	\$67,605,167
A40	Other	\$7,583,207	\$2,929,314	\$728,741	\$1,583,091	\$8,200,689	\$5,271,375
A99	Total	\$154,333,676	\$65,476,773	\$6,156,854	\$29,757,495	\$183,896,100	\$118,419,327
Health Professions Education							
B10	Physicians/Medical Students	\$423,235,564	\$205,945,593	\$629,282	\$10,663,572	\$617,888,302	\$411,942,709
B20	Nurses/Nursing Students	\$32,705,538	\$17,232,006	\$4,477,961		\$45,443,893	\$28,211,888
B30	Other Health Professionals	\$22,210,494	\$10,016,262		\$263,310	\$31,963,446	\$21,947,184

⁴¹ "Net Community Benefit" refers to hospitals' costs minus their offsetting revenue and rate support totals.

⁴² Blank cells indicate a value of 0.

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit ⁴¹ less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
B40	Scholarships/Funding for Professional Education	\$3,827,807	\$1,677,015	\$344,977		\$5,099,845	\$3,422,830
B50	Other	\$1,491,961	\$1,397,762		\$435,576	\$2,454,147	\$1,056,385
B99	Total	\$483,471,364	\$236,268,637	\$5,452,220	\$11,438,147	\$702,849,634	\$466,580,996
Mission-Driven Health Services							
C99	Mission-Driven Health Services Total	\$1,548,720,177	\$156,035,156	\$77,610	\$809,779,641	\$894,898,083	\$738,862,927
Research							
D10	Clinical Research	\$12,284,502	\$5,994,337		\$5,284,687	\$12,994,152	\$6,999,815
D20	Community Health Research	\$1,232,414	\$755,687		\$197,276	\$1,790,826	\$1,035,138
D30	Other	\$550,861	\$243,339		\$145,295	\$648,905	\$405,566
D99	Total	\$14,067,778	\$6,993,363		\$5,627,258	\$15,433,883	\$8,440,520
Financial Contributions							
E10	Cash Donations	\$45,291,848	\$0		\$0	\$45,291,848	\$45,291,848
E20	Grants	\$6,681,545			\$3,151,973	\$3,585,728	\$3,529,572
E30	In-Kind Donations	\$2,045,460	\$38,831		\$133,615	\$1,950,676	\$1,911,845
E40	Cost of Fund Raising for Community Programs	\$9,314,102			\$6,804,897	\$2,509,205	\$2,509,205
E99	Total	\$63,332,955	\$94,987		\$10,090,485	\$53,337,456	\$53,242,470
Community-Building Activities							
F10	Physical Improvements and Housing	\$2,186,009	\$1,153,571		\$100,837	\$3,238,743	\$2,085,172
F20	Economic Development	\$990,857	\$182,309		\$133,731	\$1,039,435	\$857,126
F30	Community Support	\$7,780,482	\$3,532,553		\$4,059,379	\$7,253,656	\$3,721,103
F40	Environmental Improvements	\$590,642	\$299,262		\$19,568	\$870,337	\$571,074
F50	Leadership Development/Training for Community Members	\$478,018	\$356,410			\$834,428	\$478,018
F60	Coalition Building	\$6,868,537	\$2,485,751		\$2,712,648	\$6,641,640	\$4,155,889

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit ⁴¹ less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
F70	Advocacy for Community Health Improvements	\$1,955,959	\$373,951			\$1,809,352	\$1,435,401
F80	Workforce Development	\$2,157,915	\$1,125,789		\$2,156	\$3,190,653	\$2,064,864
F90	Other	\$57,028	\$15,879			\$72,906	\$57,028
F99	Total	\$23,065,447	\$9,525,475	\$90,895	\$7,548,877	\$24,951,149	\$15,425,675
Community Benefit Operations							
G10	Assigned Staff	\$9,605,066	\$5,324,499		\$343,433	\$14,586,132	\$9,261,633
G20	Community Health/Health Assets Assessments	\$952,355	\$689,987		\$19,283	\$1,623,059	\$933,072
G30	Other	\$1,939,096	\$582,142		\$96	\$2,521,142	\$1,939,000
G99	Total	\$12,496,517	\$6,596,627		\$362,812	\$18,730,333	\$12,133,706
Charity Care							
H00	Total Charity Care				\$437,764,179		
Foundation-Funded Community Benefits							
J10	Community Services	\$1,333,672	\$653,840		\$55,054	\$1,932,458	\$1,278,618
J20	Community Building	\$1,349,091	\$5,250		\$400,000	\$954,341	\$949,091
J30	Other					\$394,015	
J99	Total	\$3,076,777	\$659,090		\$455,054	\$3,280,813	\$2,621,724
Total Hospital Community Benefits							
A99	Community Health Services	\$154,333,676	\$65,476,773	\$6,156,854	\$29,757,495	\$183,896,100	\$118,419,327
B99	Health Professions Education	\$483,471,364	\$236,268,637	\$5,452,220	\$11,438,147	\$702,849,634	\$466,580,996
C99	Mission Driven Health Care Services	\$1,548,720,177	\$156,035,156	\$77,610	\$809,779,641	\$894,898,083	\$738,862,927
D99	Research	\$14,067,778	\$6,993,363		\$5,627,258	\$15,433,883	\$8,440,520
E99	Financial Contributions	\$63,332,955	\$94,987		\$10,090,485	\$53,337,456	\$53,242,470
F99	Community Building Activities	\$23,065,447	\$9,525,475	\$90,895	\$7,548,877	\$24,951,149	\$15,425,675

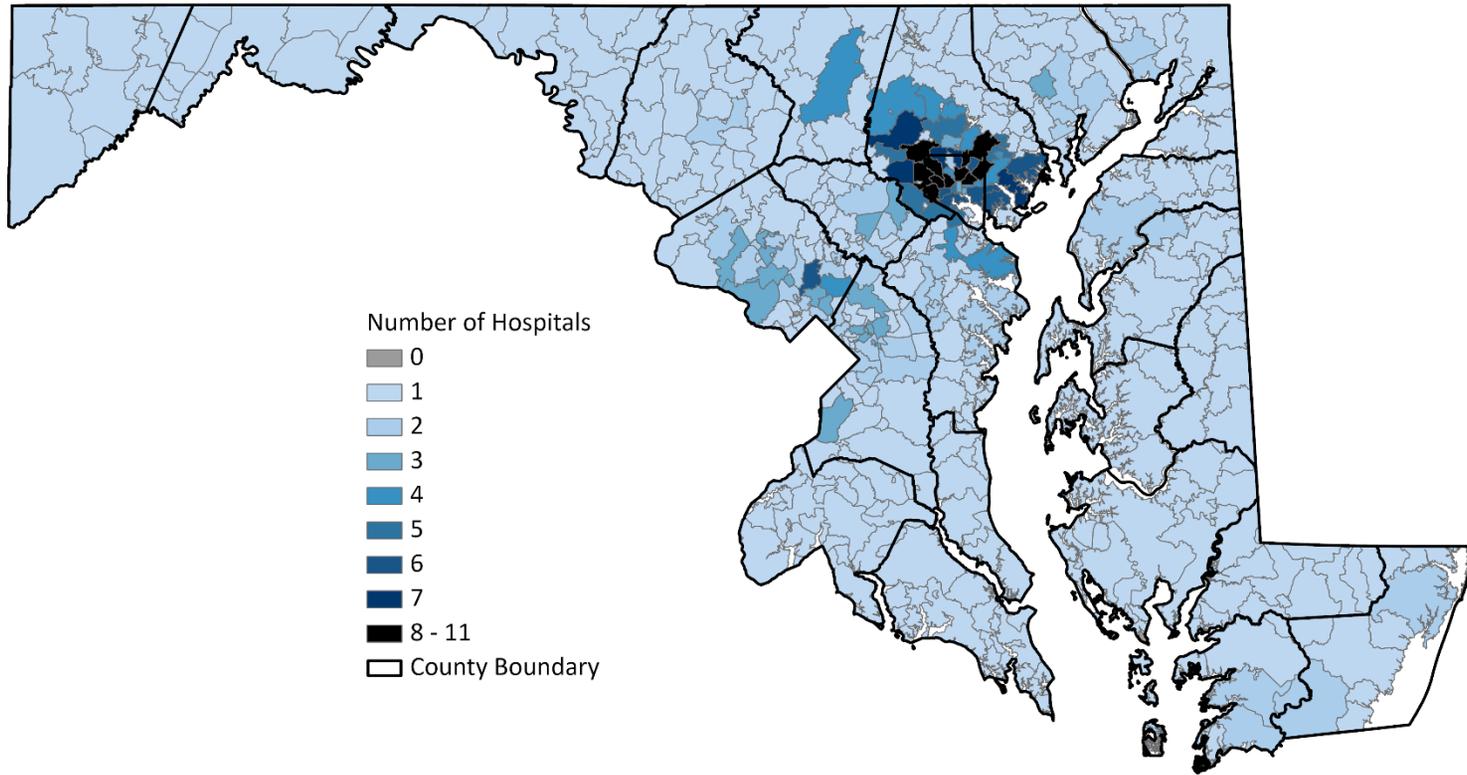
Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit ⁴¹ less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
G99	Community Benefit Operations	\$12,496,517	\$6,596,627		\$362,812	\$18,730,333	\$12,133,706
H99	Charity Care					\$437,764,179	\$437,764,179
J99	Foundation Funded Community Benefit	\$3,076,777	\$659,090		\$455,054	\$3,280,813	\$2,621,724
T99	Medicaid Assessments	\$250,408,756			\$243,785,176	\$6,623,580	\$6,623,580
K99	Total Hospital Community Benefit	\$2,552,973,447	\$481,650,108	\$11,777,579	\$1,118,844,944	\$2,341,765,210	\$1,860,115,103

Appendix G. Primary Service Areas and Community Benefit Service Areas

A primary service area (PSA) is the geographical region from which a hospital primarily draws its patients. The HSCRC determines a PSA for each hospital. Figure 1 shows how many hospitals claim each ZIP code in Maryland in their PSAs.⁴³ Other than the areas in and around Baltimore City/County and some areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

⁴³ For FY 2024, only three ZIP codes were not claimed to be in the PSA of at least one hospital: 20892 in southern Montgomery County (the National Institutes of Health), 21241 in western Baltimore City (the Social Security Administration), and 21627 in southern Dorchester County (Crocheron, MD, which had a population of 27 in 2020). Note that each of these ZIP codes is very small and therefore difficult to see on this map.

Figure G1. Hospitals Claiming the ZIP Code in Their PSAs, FY 2024*



Hospitals also report the methodology used to determine their community benefit service area (CBSA),⁴⁴ which may differ from their PSA. Maryland hospitals considered multiple factors when defining their CBSAs, with the most common factors being patient utilization patterns, such as ZIP codes with the highest percentages of hospital discharges and emergency department (ED) visits. Nine hospitals based their CBSAs on their PSAs, shown above.⁴⁵ Other hospitals defined their CBSAs as a combination of the primary service areas of each hospital in a regional hospital collaborative, using a region that has historically been the hospital's CBSA, by geographic proximity to the hospital, using regions served by the hospital's community benefit programs, and by demographic factors, including areas with high needs indicated by social determinants of health and areas with higher proportions of medically underserved or uninsured/underinsured residents. Table G1 summarizes the methods used by hospitals to determine their CBSAs.

Table G1. Methods Used by Hospitals to Identify Their CBSAs, FY 2024

CBSA Identification Factor	Number of Hospitals ⁴⁶
Patterns of Hospital Utilization by Patients	30
ZIP Codes in Their Global Budget Revenue Agreement (Primary Service Area)	9
ZIP Codes in Financial Assistance Policy	8
Other Method	27

Figure G2 displays the number of hospitals that claim each ZIP code as part of their CBSA. Most ZIP codes in Maryland were included in at least one hospital's CBSA.⁴⁷ Most ZIP codes in Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County, and Howard County were claimed by three or more hospitals, with numerous ZIP codes in Baltimore City claimed by eight or more hospitals. These results are very similar to those reported in FY 2023.

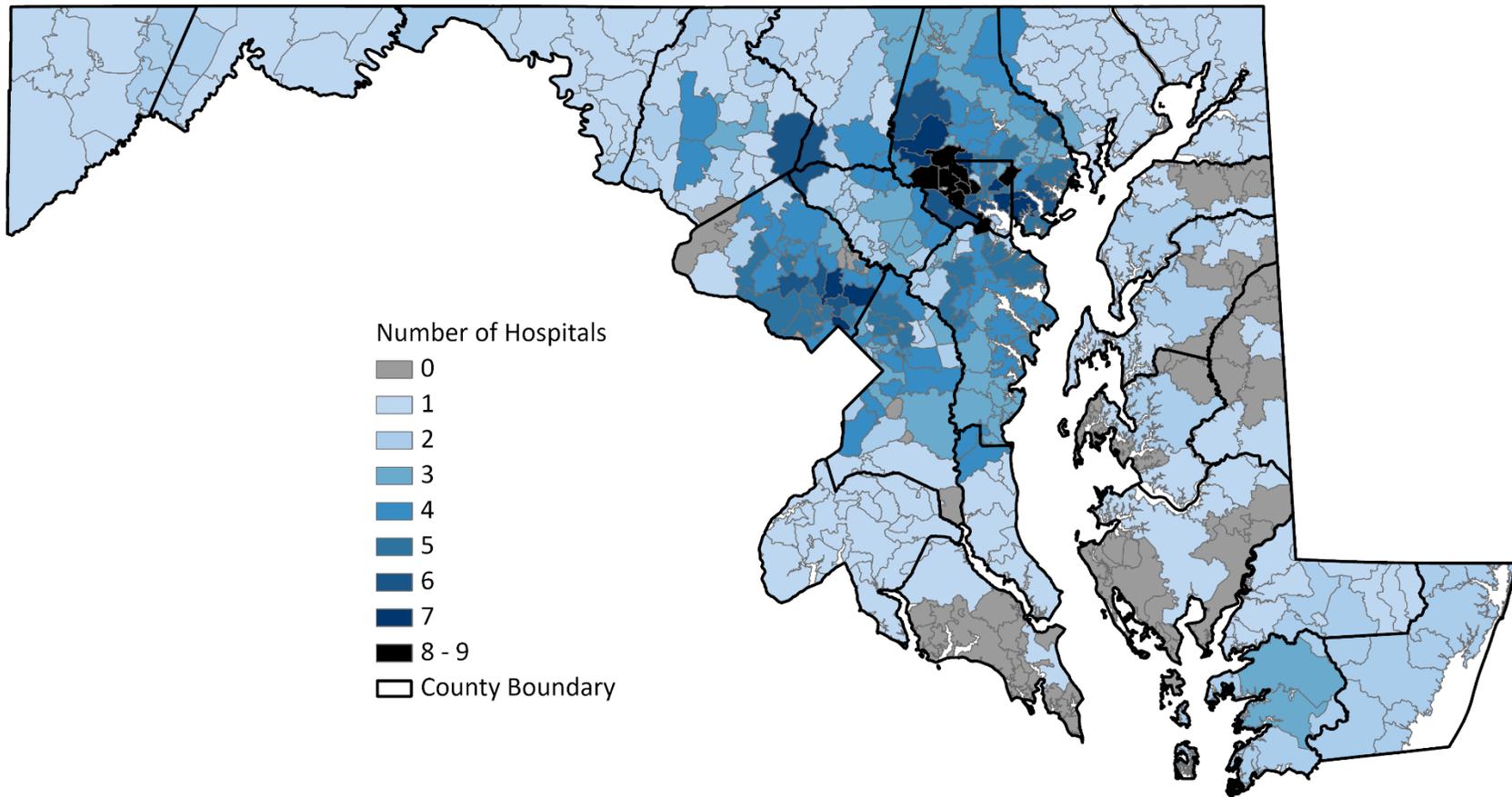
⁴⁴ Hospitals report the CBSA ZIP codes and selection methodology to the HSCRC and include that information in their federally mandated CHNAs (26 CFR § 1.501(r)-3(b)).

⁴⁵ The PSA is the geographic region where the hospital draws most of its patients. The PSA for each general acute care and chronic care hospital is defined in the hospital's Global Budget Agreement with the HSCRC. For specialty hospitals, the PSA is defined as the ZIP codes in which 60% of discharges are reported.

⁴⁶ Hospitals used multiple factors to determine their CBSA. As a result, the numbers in this column do not sum to 47.

⁴⁷

Figure G2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2024



Appendix H. Community Statistics by County

Hospitals report details about the communities located in their CBSAs/CHNAs, which help inform decisions about HCB activities. Table H1 displays examples of the county-level demographic measures used by the hospitals.

The following measures in Table H1 were derived from the five-year (2019-2023) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. Total population was derived from the 1-year and 5-year average American Community Survey estimates. The life expectancy three-year average (2019-2021) and the crude death rate (2021) were derived from the Department's Vital Statistics Administration, and the numerator for the percentage of the population enrolled in Medicaid was pulled from the Maryland Medicaid DataPort.

Table H1. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race : % White	Race: % Black	Ethnicity : % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		101,652	6.3	6.2	34.2	26.0	31.5	20.6	55.9	32.4	12.1	78.3	864.4
Allegany	2	57,393	11.2	4.1	50.9	36.6	22.1	3.5	91	9.6	1.9	74.1	1403.0
Anne Arundel	7	120,324	3.7	4.6	28.9	19.1	29.4	13.6	72.2	20.8	10	79.1	807.8
Baltimore	12	90,904	6.9	5.5	36	28.6	28.3	15.6	59.1	32.8	7.4	77.4	1019.0
Baltimore City	16	59,623	15.3	5.8	46.8	49.3	29.4	11.7	31.7	62.6	7.9	71.4	1140.0
Calvert	3	132,059	2.4	3.3	27.4	17.7	40.7	5.0	83.7	15.7	4.9	78.3	939.5
Caroline	1	66,368	9.4	7.1	50.9	39.6*	31.2	8.7	79.7	16.3	8.8	74.7	1140.0
Carroll	4	115,876	3.7	2.8	27.9	15.3	34.5	6.6	91.5	5.4	4.8	78.7	988.5
Cecil	1	91,146	7.8	3.8	36.9	28.4	29.1	6.4	88.7	9.7	5.4	74.5	1017.0
Charles	1	120,592	4.5	4.4	29.3	23.2	43.1	10.4	41.8	54.7	7.5	77.3	803.0
Dorchester	1	60,495	9.5	5.4	54.6	44.0*	26.9	5.6	68	31.6	5.9	74.1	1363.0

County	Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race : % White	Race: % Black	Ethnicity : % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Frederick	3	120,458	4.5	4.6	27.6	16.6	33.4	16.8	79.7	13.2	12.3	80.6	695.3
Garrett	1	69,031	7.6	6	46.8	31.6*	24.1	2.9	97.9	0.9	1.3	76.8	1249.0
Harford	2	111,317	4.6	3.7	30.7	20.6	32.1	8.1	79.6	17.1	5.6	78.3	905.7
Howard	5	146,982	3.3	4	25	16.2	28.8	26.8	56.3	22.7	8.4	82.8	593.7
Kent	2	74,402	6.2	5.3	45.4	28.1*	27	5.8	80.6	15.2	5.6	78.1	1285.0
Montgomery	9	128,733	4.9	6.8	29.6	19.8	32.4	42.5	53.3	21.2	20.6	83.8	636.2
Prince George's	10	100,708	6.6	11.2	34.9	27.9	35.5	30.1	18.1	63.1	21.7	78.4	756.0
Queen Anne's	3	113,347	3.4	5.7	35.8	17.5*	33.8	6	90.2	7.1	5.3	79.6	942.7
Saint Mary's	1	114,580	5.6	3.7	30.8	22.2	30.4	6.9	80.0	17.2	5.9	77.3	811.1
Somerset	3	52,462	15.7	3.4	54.6	41.3*	24.5	4.4	58.5	43.7	4.5	73.8	1248.0
Talbot	3	84,378	7.3	4.5	48.5	23.4	25.8	9.9	82.3	13.5	9.1	79.6	1298.0
Washington	1	74,157	8.6	6.1	42.6	33.4	29.5	9.4	84.5	15.1	7.3	75.2	1079.0
Wicomico	2	72,861	8.1	6.5	43.6	38.1	22.9	13.1	67.1	29.8	6.9	75.2	1069.0
Worcester	2	81,455	5.2	5.5	47.4	27.7*	22.7	6.8	84.3	14.3	3.9	78.3	1366.0
Source	48	49	50	51	52	53*	54	55	56	57	58	59	60

⁴⁸ As reported by hospitals in their FY 2024 Community Benefit Narrative Reports.

⁴⁹ American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Median Household Income (Dollars), <https://data.census.gov/cedsci/>.

⁵⁰ American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months Below the Federal Poverty Level – All Families.

⁵¹ American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.

⁵² American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.

⁵³ American Community Survey 1-Year Estimates 2023, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2023 enrollment, the Hilltop Institute (numerator). Starred values used American Community Survey 5-Year Estimates 2023, ACS Demographic and Housing Estimates, Total Population for the denominator because 2023 ACS 1-Year Estimates were unavailable for these counties.

⁵⁴ American Community Survey 5-Year Estimates 2019 – 2023, Selected Economic Characteristics, Commuting to Work – Workers 16 Years and Over – Mean Travel Time to Work (Minutes).

⁵⁵ American Community Survey 5-Year Estimates 2019 – 2023, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.

⁵⁶ American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.

⁵⁷ American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.

⁵⁸ American Community Survey 5-Year Estimates 2019 – 2023, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).

⁵⁹ Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2023, Table 7. Life Expectancy at Birth by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2021 – 2023.

⁶⁰ Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2023, Table 32B. Crude Death Rates by Race and Hispanic Origin, Region and Political Subdivision, Maryland, 2023.

Appendix I. Sources of Community Health Measures Reported by Hospitals

Other community health data sources reported by hospitals include the following:

- Baltimore Neighborhood Indicators Alliance
- CDC Behavioral Risk Factor Surveillance System
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Mental Health Surveillance and PRC Survey
- CDC National Center for Health Statistics
- CDC National Vital Statistics System
- CDC Wonder Database
- Center for Applied Research and Engagement Systems
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Commission on Cancer
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics and reports
- CRISP Public Health Dashboard
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- Health Resources and Services Administration
- Health Services Cost Review Commission
- Internal emergency department and health services quality data
- Kaiser Family Foundation analyses
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Center on Economic Progress
- Maryland Chronic Disease Burden reports

- Maryland Department of Health
- Maryland Department of Planning
- Maryland Electronic Medicaid database
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Misc. CDC statistics on geographic distribution of particular diseases
- Measure of America Opportunity Index by County
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Institutes of Health
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- State of Maryland’s Health Care Workforce Report
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Maryland School of Social Work
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Bureau of Labor Statistics.
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Appendix J. FY 2024 CHNA Links

Hospital	Link to CHNA
Adventist HealthCare Fort Washington Medical Center	https://www.adventisthealthcare.com/app/files/public/06933932-0e5e-4a74-b2a9-31e3e00a18e9/2023-CHNA-PGCHD.pdf
Adventist HealthCare Rehabilitation	https://www.adventisthealthcare.com/app/files/public/0327fd02-1252-4e44-819c-c85040001919/2023-CHNA-MCHC.pdf
Adventist HealthCare Shady Grove Medical Center	
Adventist HealthCare White Oak Medical Center	
Luminis Health Anne Arundel Medical Center	https://www.luminishealth.org/sites/default/files/2022-10/CHNA-2022-Anne-Arundel-Co1_0.pdf
Atlantic General Hospital Corporation	https://www.atlanticgeneral.org/images/AGH-2339-Community-Needs-Assessment-Rpt-2022-WEB.pdf
CalvertHealth Medical Center	https://www.healthycalvert.org/content/sites/calverthospital/CHNA/2023/CalvertHealth_FY_2023-2025_CHNA_Report_Final.pdf
Carroll Hospital Center	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Carroll%20Hospital%20CHNA.pdf
ChristianaCare Union Hospital	https://www.uhcc.com/about-us/community-benefit/reports/
Luminis Health Doctors Community Medical Center	https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf
Frederick Health Hospital	https://www.frederickhealth.org/documents/page%20links/community%20health/2022-Frederick-County-CHNA-final_202204290701407122.pdf
GRMC, Inc. DBA Garrett Regional Medical Center	https://mygarrettcounty.com/cha2024/
Greater Baltimore Medical Center	https://www.gbmc.org/our-community/community-health-needs-assessment
Holy Cross Germantown Hospital	https://www.holycrosshealth.org/about-us/community-involvement/community-benefit-planning/community-health-needs-assessment
Holy Cross Hospital	
Johns Hopkins Howard County Medical Center	https://www.hopkinsmedicine.org/-/media/johns-hopkins-howard-county/documents/2022_community_health_needs_assessment_and_implementation_strategy.pdf

Hospital	Link to CHNA
Johns Hopkins Bayview Medical Center	https://www.hopkinsmedicine.org/-/media/about/documents/community-health/health-needs-assessment/jhbmc-chna-2024.pdf
Johns Hopkins Hospital	
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Levindale%20Hospital%20CHNA.pdf
Luminis Health McNew Family Health Center	https://www.luminishealth.org/sites/default/files/2022-10/CHNA-2022-Anne-Arundel-Co1_0.pdf
MedStar Franklin Square Medical Center	https://bluetoad.com/publication/?i=821502&p=&pn=
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	
Mercy Medical Center	https://mdmercy.com/-/media/files/about-mercy/policies-and-documents/2024-chna.ashx
Meritus Medical Center	https://www.meritushealth.com/about/CHNA
Mt. Washington Pediatric Hospital	https://www.mwph.org/community/community-health-needs-assessment-and-reports
Northwest Hospital Center, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Northwest%20Hospital%20CHNA.pdf
Saint Agnes Healthcare, Inc.	https://healthcare.ascension.org/-/media/healthcare/compliance-documents/maryland/2023-chna-ascension-st-agnes-part-1.pdf
Sheppard Pratt	https://www.sheppardpratt.org/chna/
Sinai Hospital of Baltimore, Inc.	https://lifebridgehealth.org/sites/default/files/2024-06/2024%20Sinai%20Hospital_GMC%20CHNA.pdf

Hospital	Link to CHNA
Suburban Hospital	https://www.hopkinsmedicine.org/-/media/about/documents/community-health/health-needs-assessment/montgomery-county-chna-2022.pdf
TidalHealth McCready Pavilion	https://www.tidalhealth.org/community-outreach-partners/community-health-research-data
TidalHealth Peninsula Regional	
UM Baltimore Washington Medical Center	https://www.umms.org/bwmc/community/assessment-plan
UM Capital Region Health	https://www.umms.org/capital/-/media/files/um-capital/community/community-reports/2022-community-health-assessment.pdf?upd=20221109201957
UM Charles Regional Medical Center	https://www.umms.org/charles/community/assessment-implementation-plan
UM Rehabilitation & Orthopaedic Institute	https://www.umms.org/rehab/-/media/files/um-rehab/community/community-health-needs-assessment/202324-baltimore-city-chna.pdf?upd=20240910132354
UM Shore Regional Health	https://www.umms.org/shore/-/media/files/um-shore/community/community-health-reports/chna-2022.pdf
UM St. Joseph Medical Center	https://www.umms.org/sjmc/community/assessment
UM Upper Chesapeake Health	https://www.umms.org/uch/community/assessment-and-implementation-plan
UMMC Midtown Campus	https://www.umms.org/ummc/-/media/files/umms/community/needs-assessment/202324-baltimore-city-chna.pdf?upd=20240821134641
University of Maryland Medical Center	
UPMC Western Maryland	https://dam.upmc.com/-/media/upmc/about/community-commitment/documents/2022-chna/western-central-pa-and-maryland-chna-report.pdf?la=en&rev=44b0cd3152a54b179109565789740f8c&hash=B89293109EFB4E8C9FE83708B96A7ECD

Appendix K. FY 2024 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area	Number of Hospitals
Settings and Systems - Community	37
Social Determinants of Health - Health Care Access and Quality	36
Health Behaviors - Preventive Care	31
Health Conditions - Mental Health and Mental Disorders	29
Health Conditions - Diabetes	27
Social Determinants of Health - Social and Community Context	24
Health Conditions - Cancer	23
Health Conditions - Heart Disease and Stroke	23
Health Behaviors - Nutrition and Healthy Eating	23
Settings and Systems - Transportation	22
Social Determinants of Health - Economic Stability	21
Health Behaviors - Drug and Alcohol Use	19
Settings and Systems - Health Care	19
Social Determinants of Health - Education Access and Quality	18
Health Conditions - Pregnancy and Childbirth	17
Health Behaviors - Health Communication	16
Populations - Workforce	16
Health Conditions - Addiction	15
Health Behaviors - Physical Activity	15
Health Behaviors - Violence Prevention	14
Populations - Older Adults	13
Health Conditions - Overweight and Obesity	12
Settings and Systems - Housing and Homes	12
Settings and Systems - Workplace	12
Settings and Systems - Hospital and Emergency Services	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Behaviors - Vaccination	9
Populations - Children	9
Populations - Infants	9
Populations - Parents or Caregivers	9
Settings and Systems - Schools	9

CHNA Priority Area	Number of Hospitals
Health Behaviors - Injury Prevention	8
Health Conditions - Infectious Disease	7
Health Behaviors - Emergency Preparedness	7
Health Conditions - Respiratory Disease	6
Health Behaviors - Child and Adolescent Development	6
Populations - Women	6
Settings and Systems - Public Health Infrastructure	6
Health Conditions - Chronic Kidney Disease	5
Populations - Adolescents	5
Populations - People with Disabilities	5
Settings and Systems - Health Insurance	5
Health Conditions - Chronic Pain	4
Health Conditions - Oral Conditions	4
Health Behaviors - Family Planning	4
Health Behaviors - Tobacco Use	4
Health Conditions - Sensory or Communication Disorders	3
Health Conditions - Sexually Transmitted Infections	3
Health Conditions - Arthritis	2
Health Conditions - Blood Disorders	2
Health Conditions - Health Care-Associated Infections	2
Health Behaviors - Sleep	2
Populations - Men	2
Settings and Systems - Global Health	2
Settings and Systems - Health IT	2
Health Conditions - Osteoporosis	1
Populations - LGBT	1
Settings and Systems - Environmental Health	1
Settings and Systems - Health Policy	1
Health Conditions - Dementias	0
Health Conditions - Foodborne Illness	0
Health Behaviors - Safe Food Handling	0

*Data Source: As reported by hospitals on their FY 2024 financial reports.

Appendix L. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
GRMC, Inc. DBA Garrett Regional Medical Center	Jan-25
MedStar Franklin Square Medical Center	Jun-24
MedStar Good Samaritan Hospital	Jun-24
MedStar Harbor Hospital	Jun-24
MedStar Montgomery Medical Center	Jun-24
MedStar Southern Maryland Hospital Center	Jun-24
MedStar St. Mary's Hospital	Jun-24
MedStar Union Memorial Hospital	Jun-24
UM Charles Regional Medical Center	Jun-24
LifEBridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	Jun-24
Mt. Washington Pediatric Hospital	Jun-24
Northwest Hospital Center, Inc.	Jun-24
Sinai Hospital of Baltimore, Inc.	Jun-24
UM Upper Chesapeake Health	Jun-24
Johns Hopkins Hospital	Jun-24
Greater Baltimore Medical Center	Jun-24
Mercy Medical Center	Jun-24
Johns Hopkins Bayview Medical Center	May-24
Saint Agnes Healthcare, Inc.	May-24
UM St. Joseph Medical Center	Mar-24
UM Rehabilitation & Orthopaedic Institute	Mar-24
UMMC Midtown Campus	Mar-24
University of Maryland Medical Center	Mar-24
Carroll Hospital Center	Feb-24
CalvertHealth Medical Center	Nov-23
Holy Cross Germantown	Oct-22
Holy Cross Hospital	Oct-22
Adventist HealthCare Fort Washington Medical Center	Oct-22
Adventist HealthCare Rehabilitation	Oct-22
Adventist HealthCare Shady Grove Medical Center	Oct-22
Adventist HealthCare White Oak Medical Center	Oct-22
UPMC Western Maryland	Jun-22

Hospital	Date Most Recent CHNA was Completed
Suburban Hospital	Jun-22
Johns Hopkins Howard County Medical Center	Jun-22
UM Baltimore Washington Medical Center	Jun-22
UM Capital Region Health	Jun-22
UM Shore Regional Health	May-22
Sheppard Pratt	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
ChristianaCare Union Hospital	May-22
Meritus Medical Center	May-22
Atlantic General Hospital Corporation	May-22
Frederick Health Hospital	May-22
Luminis Health Anne Arundel Medical Center	Dec-21
Luminis Health Doctors Community Medical Center	Dec-21
Luminis Health McNew Family Health Center	Dec-21

Appendix M. CHNA External Participants and Their Level of Community Engagement During the CHNA Process

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community Driven/Led - To support the actions of community initiated, driven and/or led processes
Other Hospitals	17	26	17	28	8	9
Local Health Department	25	30	25	30	9	14
Local Health Improvement Coalition	23	29	19	25	6	15
Maryland Department of Health	17	16	4	11	2	2
Other State Agencies	5	7	3	8	0	0
Local Govt. Organizations	17	26	16	17	3	3
Faith-Based Organizations	20	25	25	20	1	5
School - K-12	19	21	16	16	1	2
School - Colleges, Universities, Professional Schools	20	20	18	17	2	2
Behavioral Health Organizations	21	28	18	19	2	5
Social Service Organizations	16	24	15	18	1	4
Post-Acute Care Facilities	8	12	5	9	0	0
Community/Neighborhood Organizations	19	26	19	18	2	5
Consumer/Public Advocacy Organizations	8	11	5	7	0	2

Other	14	23	15	9	1	3
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Appendix N. CHNA External Participants and the Recommended CHNA Practices They Engaged in

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	34	34	29	37	25	30	19	20
Local Health Department	38	32	35	41	27	27	27	22
Local Health Improvement Coalition	35	24	18	41	22	25	16	22
Maryland Department of Health	11	10	21	15	6	11	2	12
Other State Agencies	11	9	5	9	3	9	3	10
Local Govt. Organizations	33	19	14	28	6	17	18	15
Faith-Based Organizations	34	20	12	32	8	21	15	11
School - K-12	29	18	14	26	9	14	17	13
School - Colleges, Universities, Professional Schools	29	18	15	26	5	18	14	11
Behavioral Health Organizations	36	21	17	33	11	20	13	16
Social Service Organizations	33	20	17	30	10	18	18	13
Post-Acute Care Facilities	14	14	4	17	1	7	4	9
Community/Neighborhood Organizations	31	24	12	33	10	17	17	15
Consumer/Public Advocacy Organizations	14	13	7	14	4	8	5	9
Other	14	12	13	21	7	12	10	6

Appendix O. Hospitals Involving Staff/Departments in CHNA Efforts

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
CB/Community Health/Population Health Director (facility level)	1	13	32	30	27	26	30	31	12	3
CB/Community Health/Population Health Director (system level)	5	6	27	30	31	24	29	27	21	2
Senior Executives (CEO, CFO, VP, etc.) (facility level)	5	1	32	29	26	22	36	24	6	3
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	6	13	22	28	14	25	7	2	0
Board of Directors or Board Committee (facility level)	8	2	11	14	17	10	25	19	2	13
Board of Directors or Board Committee (system level)	19	6	2	10	12	0	11	3	1	5
Clinical Leadership (facility level)	0	0	32	26	28	26	43	32	11	1
Clinical Leadership (system level)	17	7	14	15	19	12	22	16	4	0
Population Health Staff (facility level)	4	11	31	24	22	20	30	30	12	1
Population Health Staff (system level)	11	8	23	24	25	20	25	22	19	0
Community Benefit staff (facility level)	1	13	33	32	29	30	33	31	19	1
Community Benefit staff (system level)	4	11	21	29	29	22	23	21	18	3
Physician(s)	5	0	25	19	21	21	37	24	6	2
Nurse(s)	8	0	27	21	19	24	36	31	6	0
Social Workers	11	0	21	14	18	23	32	32	4	0
Hospital Advisory Board	6	14	13	16	16	16	22	19	3	2
Other (specify)	12	1	3	3	2	3	3	3	1	2

Appendix P. Hospitals Reporting Community Benefit Internal Participants and Their Roles

Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting Health Needs That Will Be Targeted	Selecting the Initiatives That Will Be Supported	Determining How to Evaluate the Impact of Initiatives	Providing Funding for CB Activities	Allocating Budgets for Individual Initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other
CB/Community Health/Population Health Director (facility level)	3	13	30	30	29	17	28	29	30	2
CB/Community Health/Population Health Director (system level)	6	6	32	30	29	17	21	16	26	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	39	40	25	38	40	7	19	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	14	6	19	18	16	17	17	8	14	2
Board of Directors or Board Committee (facility level)	5	2	20	24	8	11	6	4	20	5
Board of Directors or Board Committee (system level)	16	6	15	17	4	7	4	2	6	2
Clinical Leadership (facility level)	2	0	36	33	24	10	11	27	22	0
Clinical Leadership (system level)	12	6	19	21	11	7	8	8	10	0
Population Health Staff (facility level)	6	13	24	23	24	11	13	25	26	1
Population Health Staff (system level)	13	8	19	17	24	6	16	14	24	0
Community Benefit staff (facility level)	3	12	24	25	26	12	15	28	30	0
Community Benefit staff (system level)	5	10	17	16	25	3	6	10	23	3
Physician(s)	6	0	24	22	16	3	3	28	17	3
Nurse(s)	4	0	26	25	19	6	7	34	22	1
Social Workers	9	0	21	18	13	4	4	32	16	0
Hospital Advisory Board	10	13	19	15	3	4	2	2	7	2
Other (specify)	12	1	2	1	2	2	3	3	4	1

The next HSCRC Public Meeting is on the
THIRD Wednesday of the month, **April 15, 2026**