maryland
health services
cost review commission

631st Meeting of the Health Services Cost Review Commission

May 14, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on April 9, 2025

Specific Matters

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

Docket Status – Cases Closed

2670A University of Maryland Medical Center

2. Docket Status – Cases Open

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

Informational Subjects

1. Presentation: Advancing Innovation in Maryland (AIM) Winners
    a. “Engage with Heart”, Terris King ScD
    b. “Meritus Food “Farm”acy”, Miranda Ramsey, VP, Physician Services and Beth Fields Dowdell, DNP, CRNP, Director, Community Health and Outpatient Care Management

Subjects of General Applicability

2. Report from the Executive Director
    a. Model Monitoring
    b. CY 2024 Quality Monitoring Update

3. Final Recommendation: NSP II Competitive Grants

4. Draft Recommendation: CRISP Funding

5. Draft Recommendation: Update Factor

6. *Materials Only - No Presentations*
    a. Maternal and Child Health Fund Report - FY 2024 Activities
    b. Hospital Financial Conditions Report - FY 2024

7. Hearing and Meeting Schedule

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MINUTES OF THE 630th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION APRIL 9, 2025

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

ANNOUNCEMENT

Chairman Sharfstein announced the appointment of Dr. Meena Seshamani as the Secretary of Health for Maryland, pending Maryland Senate confirmation, and welcomed her via Zoom. He noted her extensive work in both hospital and public sectors. He specifically mentioned her recent role as the National Director of the Medicare program, where she spearheaded significant innovations such as new rural hospital designations, behavioral health programs, and prescription cost negotiation. Dr. Sharfstein emphasized her background as a health economist and otolaryngologist, describing her as a highly thoughtful and sensible national figure in health policy.

Dr. Seshamani thanked everyone for their ongoing work and provided brief comments on her vision for healthcare for Maryland. She stated that her prior experience at MedStar Health, where she led Care Transformation and served on committees with the HSCRC, was a significant factor in her decision to become Secretary of Health. She believes Maryland's unique payment model is a key driver of change in how people are cared for. She emphasized the importance of giving the state flexibility and autonomy to implement improvements that suit local populations, engaging in practical models, and setting reasonable performance and cost-saving targets. She considers all of this core to the future work and highlights the strength of the Commission in its representation of the diverse healthcare ecosystem.

REPORT OF APRIL 9, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on April 9, 2025, in the Closed Session.

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

Upon motion made by Commissioner Kane and seconded by Vice Chairman Elliott, the Commission voted unanimously to approve the minutes of March 12, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2669A Johns Hopkins Health System

ITEM III
OPEN CASES

2668R Johns Hopkins Howard County Medical Center
2670A University of Maryland Medical Center

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

Chairman Sharfstein outlined the purpose of the Advancing Innovation in Maryland (AIM) Awards and introduced three recipients of the Award: Dr. Will Garneau, Dr. Malik Burnett and Dr. Megan Tschudy.

Pilot Integration of Methadone Treatment Information into CRISP

Dr. Will Garneau, MD, MPH, MHS, Assistant Professor, Johns Hopkins University School of Medicine and Dr. Malik Burnett, MD, MBA, MPH, Medical Director, REACH Health Services, presented on the Pilot Integration of Opioid Treatment Program (OTP) Data into Maryland CRISP.

Dr. Garneau highlighted the critical issue of inaccessible methadone dosage data for opioid use disorder patients within Maryland's Health Information Exchange system, Chesapeake Regional Information System for Our Patients (CRISP), as this information resides only within individual OTPs. Lack of comprehensive data significantly impedes effective inpatient treatment, a challenge exacerbated by the proliferation of potent synthetic opioids such as fentanyl. This deficiency often results in suboptimal initial dosing strategies, leading to patient dissatisfaction, increased instances of discharge against medical advice (AMA), and ultimately, elevated mortality and readmission rates. Building on this critical need, Dr. Garneau and colleagues propose integrating this vital information into CRISP to enable clinicians to provide timely and appropriate care, thereby improving patient outcomes and reducing healthcare costs.

Dr. Burnett presented details of the proposed solution that leverages Netsmart's Care Connect platform, which consolidates data from the widely utilized Methasoft Electronic Health Record (EHR) system (employed by approximately 80 percent of OTPs), to develop a data integration algorithm. This algorithm aims to facilitate real-time sharing of critical methadone dosage information with hospitals, establishing a bi-directional information exchange between OTP and acute care settings to enhance the continuity of patient care. Following the successful initial implementation, the project intends to expand its scope to six Baltimore City hospitals. Key operational considerations include strict adherence to federal regulations concerning OTP data privacy and the acquisition of comprehensive patient consent for information sharing. Furthermore, the initiative may explore the potential for advocating state legislation to mandate statewide integration of OTP data with CRISP, drawing upon successful data-sharing models implemented in other states.

Leveraging CRISP to Share the Asthma Action Plan Across Hospital-based, Ambulatory and School-based Healthcare Providers

Dr. Megan Tschudy, MD, MPH, Associate Professor, Pediatrics Johns Hopkins School of Medicine presented and updated on the Leveraging CRISP to Share the Asthma Action Plan Across Hospital-based, Ambulatory and School-based Healthcare Providers.

Dr. Tschudy presented an initiative to leverage the CRISP system to streamline the sharing of asthma action plans among hospital-based, ambulatory, and school-based healthcare providers. She highlighted the significant negative health and educational outcomes associated with poorly managed asthma in children, including high rates of ED visits, hospitalizations, school absences, and impaired academic performance. The current paper-based process for asthma action plans is cumbersome, often resulting in schools not having the necessary information or medication for students with asthma, and it lacks interoperability with emergency rooms, specialists, and home visiting programs.

Dr. Tschudy proposed transitioning to a CRISP-based, electronic asthma action plan, which would allow clinicians to directly input the plan into the system, making it readily accessible to schools. This shift is particularly timely given the recent Maryland law mandating the availability of albuterol in all schools. Electronic transmission would eliminate the burden on families to deliver paper forms and medications to the school. Furthermore, it would enable better care coordination by allowing emergency rooms, specialists, and home visiting programs to view and utilize the asthma action plan. While there would be initial design and implementation costs for CRISP and clinician education, the anticipated benefits include significant cost savings for health systems and schools through reduced ED visits, hospitalizations, and school absences, as well as a decreased administrative burden for clinicians and families. Dr. Tschudy also emphasized the alignment of this initiative with state goals to reduce asthma exacerbations and address disparities, and she suggested the potential for this infrastructure to be adapted for sharing other critical health information with schools, such as mental health safety plans.

No action was taken on this agenda item.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through December 2024 (for claims paid through February 2025). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is -2.40 percent below the nation through December 2024, and that Maryland Medicare hospital and non-hospital growth through August resulted in savings of $253 million.

Legislative Update

Ms. Janice Lepore, Chief of Policy and Government Affairs and Ms. Megan Renfrew, Deputy Director, Policy & Consumer Protection, presented the Legislative Update.

Ms. Lepore provided an overview of the recently ended legislative session, as well as the post-session next steps. Ms. Lepore also highlighted several priority bills that were tracked by the team, noting that the sunset for the HSCRC User Fee Assessment formula and the Maternal and Child Health Population Health Improvement Fund was signed into law, while others await the governor's action.

Ms. Lepore reviewed several tasks that the HSCRC are responsible for as a result of legislative action, including calculating user fees, managing appropriations for funding programs, implementing the AHEAD Model, and completing two mandated reports. Additionally, the team will be engaging in a number of activities including updating regulations, convening and participating in stakeholder workgroups, revising guidance on financial assistance and medical debt, updating community benefit reporting, participating in the re-established Maryland Health Insurance Coverage Protection Commission, and preparing several reports.

Announcements

Dr. Jon Kromm, Executive Director, announced the departure of Ms. Megan Renfrew, stating this would be her last official meeting after four and a half years of critical service at the HSCRC. He lauded Ms. Renfrew as a valuable "cultural driver" who positively influenced the organization, particularly through her strong advocacy of the consumer perspective, which he believes she has successfully instilled in her colleagues. Ms. Renfrew's contributions would be irreplaceable.

No action was taken on these agenda items.

ITEM VI
FINAL RECOMMENDATION: MARYLAND HOSPITAL ACQUIRED CONDITIONS (MHAC) POLICY FOR RY 2027

Dianne Feeney, Associate Director, Quality Methodologies, presented the staff's Final Recommendations for the Maryland Hospital Acquired Conditions (MHAC) Policy for RY 2027. (see "Final Recommendations Maryland Hospital Acquired Conditions (MHAC) Policy for RY 2027" available on the HSCRC website).

Ms. Feeney reviewed the rationale and plan for transitioning the MHAC program to a volume-weighted complication composite measurement for assessing hospital performance on potentially preventable complications (PPCs). This would replace the current approach that excludes PPCs for hospitals with fewer than two expected or 20 at-risk cases. This proposed change, developed with input from clinical, coding, and hospital experts, aims to improve both the content validity by including more PPC measures for hospitals of all sizes and the reliability of the assessment, as demonstrated by an increase in the statewide reliability score from 0.39 to 0.76. While most stakeholders support this transition, concerns from academic medical centers regarding fair assessment due to their unique patient populations will be further explored, and hospitals are encouraged to continue using the established process for addressing case-specific preventability concerns.

Ms. Feeney presented the staff's Final Recommendation for the MHAC policy for RY 2027 as follows:

1. Use Solventum™ (previously 3M) Potentially Preventable Complication (PPC) to assess hospital acquired complications.
   a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
   b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
   c. Engage hospitals on specific PPC increases to understand trends and discuss potential quality concerns.
2. Assess performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2024 and 2025.
3. Assess hospital performance based on statewide attainment standards.
4. Score hospital performance on a PPC composite that includes all payment PPC weighted by hospital specific expected volume and Solventum™ cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent:

a. Use a continuous linear scale that ranges from 0 to 100 percent without a hold harmless zone.
b. Establish the cut point for penalties and rewards as the average hospital MHAC score as determined through prospective modeling.
c. Retrospectively assess the average hospital MHAC scores and propose to the Commissioners that the cut point be modified if the actual average score is more than +/- 10 percent different from the prospectively modeled average MHAC score.

6. Consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program, e.g., digitally specified measures.

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance of Maryland Hospital Association (MHA) stated their support for the staff's MHAC recommendation on behalf of MHA and its member hospitals and health systems. Ms. Terry also urged HSCRC to further focus on assessing unique and rare procedures that may have higher complication rates to ensure hospitals are not disproportionately impacted and to continue assessing these procedures for the most effective implementation of the recommendation.

Mr. Mark Boucot, MBA, FACHE, President and CEO, Garrett Regional Medical Center, expressed appreciation for the new composite measurement approach and thanked the HSCRC team for their openness, vision, and transparency in reviewing the program. He specifically highlighted the staff's responsiveness to concerns raised by GRMC as a small hospital outlier. Under the previous methodology, GRMC would have received a penalty despite achieving zero PPCs in 2024; an issue that the composite score appropriately addresses. He commended the inclusion of significant nosocomial events like respiratory failure, pulmonary embolism, and sepsis in the composite, emphasizing the importance of all hospitals striving to reduce these occurrences. Mr. Boucot concluded by reiterating GRMC's strong support for the composite methodology, viewing it as a fair and balanced way to ensure all Maryland hospitals are on equal footing in achieving high-quality care, especially noting the hard work and consistent effort required for smaller facilities like GRMC to maintain excellent records.

Chairman Sharfstein asked Mr. Boucot to identify one specific change or action that he believes has been instrumental in helping GRMC achieve a low number of preventable complications. Mr. Boucot stated that the implementation of Lean Six Sigma as a performance improvement model was the key change that helped GRMC significantly reduce hospital-acquired conditions. He noted that when he became CEO 12 years prior, GRMC was among the worst-performing hospitals in Maryland for MHACs. Through diligent application of Lean Six Sigma, they systematically addressed each PPC, leading to a dramatic improvement in their performance and recognition as a top 20 rural hospital nationally.

Commissioner McCann stated that she would appreciate the opportunity to work with the Quality Team to better understand where there is deterioration in performance versus where changes are due to the methodology. She believes this intersection is important for decision-making. Ms. Feeney explained that staff has analyzed the correlation between the current and

proposed methodologies, finding a strong correlation of 0.82 statewide. To further mitigate concerns, staff is recommending a retrospective review of average scores and are also examining alignment with external benchmarks like the CMS Hospital Acquired Condition (HAC) program, where poor performers in their system also tend to rank low nationally. While acknowledging the need for further investigation, Ms. Feeney emphasized their efforts to ensure the validity of the assessment and expressed openness to collaboration and additional ideas, also recognizing Mathematica's significant contribution to the policy's fidelity.

Chairman Sharfstein called for a motion to adopt the staff's Final Recommendation. Vice Chairman Elliott moved for approval, which was seconded by Commissioner Kane. Chairman Sharfstein voted by proxy on behalf of Commissioner Johnson. **The motion passed unanimously in support of the staff's final recommendation.**

ITEM VII
FINAL RECOMMENDATION: READMISSION REDCUTION INCENTIVE PROGRAM (RRIP) POLICY FOR RY 2027

Ms. Princess Collins Taylor, Chief, Quality Initiatives, presented the staff's Final Recommendations for Readmission Reduction Incentive Program (RRIP) Policy for RY 2027 (see "Final Recommendations for Readmission Reduction Incentive Program (RRIP) Policy for RY 2027" available on the HSCRC website).

Ms. Taylor presented the staff's final recommendation for the RRIP. She noted that the program incentivizes hospitals to enhance patient care quality and value by evaluating 30-day all-payer, all-condition, all-cause inpatient readmissions. Ms. Tayor described the financial implications of the program including two (2) percent revenue at-risk, based on both improvement (compared to the base period) and attainment (with adjustments for out-of-state readmissions). An additional 0.5 percent reward is available for reducing readmission disparities based on race, area deprivation index, and Medicaid status.

Under the AHEAD model, Maryland is required to set an all-payer readmission goal. The Commission-approved RRIP RY 2026 policy established a four-year (CY 2022-2026) improvement goal of five (5) percent. Stakeholders raised concerns about using CY 2022 as the base period due to lower volumes and readmission rates, high rates COVID-19 cases, service mix differences, instability of a single-year base period, high potential penalties in Rate Year 2026, and performance degradation that was already accounted for in RY 2025. To address these concerns, staff analyzed volume and readmission trends using all-payer and Medicare data and the impact of COVID-19. When Omicron surge admissions in early 2022 were removed, there was minimal change in the overall readmission rate (11.28% for the full year vs. 11.30% for March-December). Maryland also experienced a greater degradation in readmissions in calendar year 2023 compared to 2022 than the national average (based on Medicare data).

Due to the difficulty in determining if CY 2022 or 2023 data was an anomaly, staff recommends a two-year blended base period of calendar years 2022 and 2023 for Rate Year 2027, with an

improvement goal of 3.78 percent. They also recommend retrospectively applying this blended base period to Rate Year 2026 with a 2.53 percent improvement goal.

The feedback received regarding the proposed Rate Year 2027 draft policy primarily focused on the two-year blended base period. Other concerns included the improvement target, out-of-state adjustment (excluding transfers), the Excess Days in Acute Care (EDAC) measure, and the disparity gap methodology. Staff ‘s rationale for not significantly modifying the Rate Year 2027 policy or recommendations included the assertion that the blended base period is the fairest option, the reasonableness of the target, and the appropriateness of the out-of-state adjustment. Additionally, the EDAC measure is not recommended for payment policy yet, and staff plans to further refine the disparity gap incentive over the next year.

Ms. Taylor presented the staff’s Final Recommendation for the Readmission Reduction Incentive Program Policy for RY 2027 as follows:

1. Maintain the readmissions measure with a 5% improvement target through calendar year 2026 from a blended base period of calendar years 2022 and 2023.
2. Retroactively apply the blended base period to Rate Year 26 (calendar year 2024 performance).
3. Maintain the attainment target calculation (2% revenue at risk) and the 0.5% revenue for reducing disparities.
4. Monitor ED and observation revisits by adjusting the readmission measure and through the EDAC measure for potential future inclusion.

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance of Maryland Hospital Association (MHA) commended the staff for their flexibility in retrospectively adjusting the base period for Rate Year 2026. She noted this was important because the lingering impact of COVID-19 in CY 2022 had artificially suppressed volumes, potentially distorting analysis and benchmarks, and thus the recent data improvements appeared more significant. However, MHA continues to advocate for using CY 2023 as the base period moving forward.

Ms. Terry also encouraged staff to consider the declining denominator as hospitals shift lower acuity patients to more appropriate settings, which could leave more complex cases in hospitals and potentially affect readmission rates. She reiterated MHA's commitment to working collaboratively to reduce readmissions while maintaining high-quality, patient-centered care and to collaborating on future efforts to enhance the RRIP program and meet statewide AHEAD model goals for readmissions.

Mr. Mark Boucot, MBA, FACHE, President/CEO, Garrett Regional Medical Center (GRMC), expressed his gratitude to the Commission and team for their broad perspective in addressing the issue. He highlighted a unique situation at Garrett Regional Medical Center, where they experienced very few COVID-19 admissions in 2022, unlike the rest of the state, and were hit later in 2023. This resulted in an extremely low readmission rate for them in 2022. While acknowledging the need for aggregate mathematical consistency statewide, he pointed out the anomaly of Garrett's low 2022 performance.

He also noted Garrett's historically low readmission rates over the past decade, which began to change in 2024 due to difficulties in transferring patients to larger facilities facing nursing shortages. Mr. Boucot expressed gratitude for not including transfers in the readmission measure, as it had disadvantaged them. However, he hopes the state can further examine the out-of-state adjustment factor, as it has also negatively impacted Garrett. Despite Garrett's historically strong performance, he noted they would likely be penalized for not meeting attainment due to the mathematical calculations.

Commissioner Sabi highlighted the long-standing debate on readmissions, specifically the impact of declining hospital admissions on the denominator. She argued that non-clinical factors like social determinants and insufficient respite care are key drivers of both the initial admissions and readmissions, necessitating a shift in perspective across the healthcare industry to improve outpatient support and address these underlying social issues to curb rising readmission rates.

Commissioner Kane asked for clarification on the out-of-state transfer methodology. Ms. Taylor explained that the out-of-state ratio calculation was derived from Chronic Conditions Warehouse (CCW) data that allows them to differentiate between transfers and actual readmissions out of state, which is used in the attainment calculation. She acknowledged that because Maryland's data doesn't capture admissions occurring outside the state, a patient's transfer out of a Maryland hospital and a later return could be counted as a readmission. This issue is mitigated by using the out-of-state ratio from the CCW. Staff is also conducting further analysis using Medicaid and other data sources to assess the extent of this issue within the case mix data.

Chairman Sharfstein called for a motion to adopt the staff's Final Recommendation. Commissioner Sabi moved for approval, which was seconded by Commissioner Joshi. Chairman Sharfstein voted by proxy on behalf of Commissioner Johnson. **The motion passed unanimously in support of the staff's final recommendation.**

ITEM VIII
FINAL RECOMMENDATION: MEDICARE PERFORMANCE ADJUSTMENT (CY2025/FY2027 PAYMENT)

Ms. Christa Speicher, Deputy, Director, Payment Reform presented the staff's Final Recommendation for CY 2025 Medicare Performance Adjustment (MPA Year 7) (see "Final Recommendation for Medicare Performance Adjustment, Calendar Year 2025" available on the HSCRC website).

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model ("the 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 Global Budget Revenue (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:

1. **Traditional Component:** Holds hospitals accountable for Medicare, the TCOC of an attributed patient population.
2. **Reconciliation Component:** Rewards hospitals for Care Transformation Initiatives (CTIs); and
3. **Savings Component:** Allows the Commission to adjust hospital rates to achieve the Medicare savings targets.

Ms. Speicher presented the staff's Final Recommendation for MPA Year 7, which includes modifications to two Components as follows:

1. Include non-claims-based payments in the MPA savings target on a go-forward basis, beginning in Calendar Year 2025. This replicates a one-time adjustment made previously to reflect newly available data.
2. Revise the CTI offset distribution by implementing a tiered stop-loss mechanism. This aims to incorporate an attainment aspect into the CTI, which is currently improvement-only. The tiered stop-loss will mirror the traditional MPA's scaled growth adjustments, recognizing that hospitals in lower-cost areas may have less opportunity for improvement. This change is recommended to be effective for all CTI starting July 1, 2025. A previously proposed retrospective adjustment for CTI with positive impacts was not approved by CMS and has been removed.

The staff's recommendations focus on integrating non-claims-based payments into the MPA savings calculations prospectively and revising the CTI offset distribution to include an attainment component through a tiered stop-loss system, effective mid-2025.

Chairman Sharfstein called for a motion to adopt the staff's Final Recommendation. Commissioner Sabi moved for approval, which was seconded by Vice Chairman Elliott. Chairman Sharfstein voted by proxy on behalf of Commissioner Johnson. **The motion passed unanimously in support of the staff's final recommendation.**

ITEM I IX
PRESENTATION: FY 2024 HOSPITAL SYSTEM FINANCIAL RESULTS

Mr. William Henderson, Principal Deputy Director, Medical Economic and Data Analytics presented the FY 2024 Hospital System Financial Results (see "FY 2024 Hospital System Financial Results" available on the HSCRC website).

Mr. Henderson reviewed the results of an analysis of the audited financials of Maryland hospitals and health systems. He outlined the four-level framework for analyzing operating results:

- **Level 1: Hospital Operating Regulated Business:** This focuses solely on the business activities regulated by HSCRC.

- **Level 2: Hospital Operating Regulated Entity:** This includes the regulated entity and all its subsidiaries, potentially encompassing non-regulated activities like physician practices. This level and Level 1 are typically used in ongoing HSCRC work.
- **Level 3: System (Parent of Regulated Entity):** This broadens the view to the entire health system parent, primarily including Maryland-domiciled hospitals and their out-of-state entities and related health businesses.
- **Level 4: System + Non-Operating Results:** This level includes the same entities as Level 3 but adds non-operating income, primarily investment returns.

For balance sheet metrics, the analysis focused solely on the system level, as capital and investment decisions are typically made at this level, and audit opinions are issued at the system level.

Mr. Henderson then detailed the four key metrics analyzed:

- **Margins (Revenue - Expenses / Revenue):** A higher number indicates better financial performance in covering current expenses.
- **Days Cash on Hand:** Measures the number of days a hospital could cover operating expenses with its current cash balance, assuming zero revenue.
- **Debt to Capitalization:** The ratio of debt to the overall assets of the system.
- **Average Age of Plant:** Indicates the average age of the organization's fixed assets, though Mr. Henderson expressed less confidence in this metric as a sole indicator. An alternative metric, property, plant, and equipment per unit of service, was also presented but not considered definitive.

Staff compared Maryland performance among Maryland hospitals over time, without including national or other external benchmarks due to data comparability issues and uncertainty about the appropriate national reference point. Mr. Henderson presented initial findings across the four levels for various (anonymized) health systems and statewide totals for Fiscal Year 2024. Key observations included:

- Strong regulated operating margins (Level 1) statewide.
- A significant drop in margins at Level 2 due to losses in non-regulated businesses (primarily physician practices) within the regulated entity. This level showed a significant percentage of hospitals and systems losing money.
- Varied performance at Levels 3 and 4 depending on the system's organization, out-of-state holdings, and non-operating income. He illustrated this with examples of three different systems (F, I, and L) showing diverse performance across the different levels, highlighting the complexity of system-level analysis and the need to avoid over-relying on a single metric or level.

Vice Chairman Elliott asked for a comparison of Maryland hospitals' debt to capitalization levels and their credit ratings relative to other hospitals within the state, particularly in the context of borrowing capacity. Mr. Henderson acknowledged Vice Chairman Elliott's question about bond ratings and stated that this information would be covered in the coming slides.

Mr. Henderson continued with the analysis of the audited financial results of Maryland hospitals and health systems, utilizing the multi-level framework described above and focusing on key metrics including margins, days cash on hand, debt to capitalization, and age of plant.

Key Findings:

- **Regulated Operating Margins (Level 1):** After a dip in FY22-FY23 due to COVID-19 and inflation, these margins have rebounded to a healthy 7.8% in FY24, consistent with pre-pandemic levels.
- **Total Margins of Regulated Entity (Level 2):** This metric, encompassing unregulated physician businesses, presents a concern. While historically in the 2-3% range, it significantly declined, reaching negative territory (median) in FY24, indicating that half of hospitals are losing money at this level. This is primarily attributed to rising physician costs outpacing regulated revenue growth.
- **System-Level Margins (Levels 3 & 4):** System margins showed a similar dip in FY22-FY23 with a slight recovery in FY24. Inclusion of non-operating income (investment returns) generally improves system-level margins but introduces vulnerability to market fluctuations.
- **Bond Ratings:** Most Maryland hospital systems maintain stable investment-grade bond ratings, although there were a few downgrades in FY24 and FY25. Interest costs remain a relatively small portion of the regulated expenses.
- **Days Cash on Hand:** This metric has generally improved since pre-Global Budget Revenue (GBR) years and remained stable through FY24, suggesting adequate liquidity, although smaller systems show some vulnerability.
- **Debt to Capitalization:** This ratio has shown a positive downward trend (indicating less reliance on debt), although weaker hospitals may not have experienced the same level of improvement.
- **Average Age of Plant:** This metric reveals a concerning trend of increasing age of fixed assets, potentially indicating under-investment. However, Mr. Henderson cautioned against interpreting this metric in isolation due to factors like asset mix and potential asset retirement strategies. An alternative metric, Property, Plant, and Equipment per Equivalent Patient Day (EIPD), suggests increased capital investment per unit of service.

Mr. Henderson acknowledged that the financial picture is complex. While regulated operating margins are healthy, the drag from non-regulated physician costs on overall hospital entity margins is a significant concern. Balance sheets appear generally strong, but the increasing age

of plants warrants further scrutiny. No immediate solvency crises are anticipated, but smaller systems face potential risks related to managing physician costs. Mr. Henderson highlighted a divergence in financial performance between regulated hospital operations and the broader regulated entity due to physician costs, alongside generally stable balance sheets but a concerning trend in the age of physical plants. Future efforts will concentrate on better understanding physician costs and capital investment strategies.

Commissioner McCann asked if the days cash on hand, debt to capital, and age of plant metrics presented at the system level, rather than at the individual hospital level. Mr. Henderson responded that it was all system level.

Commissioner McCann stated that 2013 is a poor benchmark for assessing financial health due to low update factors imposed to avoid failing a previous waiver test. She also suggested that all health systems should be treated consistently, regardless of domicile or out-of-state assets, and that a one-size-fits-all approach to evaluating hospital financial condition seems ineffective given the significant differences among them. Mr. Henderson acknowledged the concern with using CY 2013 as a benchmark, noting that the pre-GBR financial reality included challenging years, and influenced the shift to the new system. He also recognized the difficulty of comparing systems with varying degrees of Maryland-based operations, suggesting that requiring audited financials specifically for Maryland operations could be a solution, though it presents practical challenges with accounting and reporting standards.

Commissioner McCann commented that the average age of plant metric warrants a more robust and difficult conversation, as its appropriateness varies among hospitals based on factors like reduced licensed beds post-GBR or the need for growth. She suggested that the Commission needs to have a difficult discussion about the future of certain hospitals, questioning whether continued investment in all existing acute care hospitals is warranted, especially compared to areas needing additional capital investment.

No action was taken on this agenda item.

ITEM X
HEARING AND MEETING SCHEDULE

May 14, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:50 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

April 9, 2025

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

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

The Administrative Session was called to order by motion at 12.:05 p.m.

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

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Allen Pack, Claudine Williams, Cait Cooksey, Christa Speicher, Megan Renfrew, Erin Schurmann, Bob Gallion, Prudence Akindo and William Hoff.

Joining by Zoom: Alyson Schuster and Deb Rivkin

Also attending was Assistant Attorney General Stan Lustman.

Item I

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

Item II

Mr. Henderson also updated the Commission, and the Commission discussed the FY2025 Hospital Financial Condition through April 3, 2025.

The Closed Session was adjourned at 12:35 p.m.

A Trust-Based Model of Community Health

engAGE With Heart Program Update

Autumn 2024

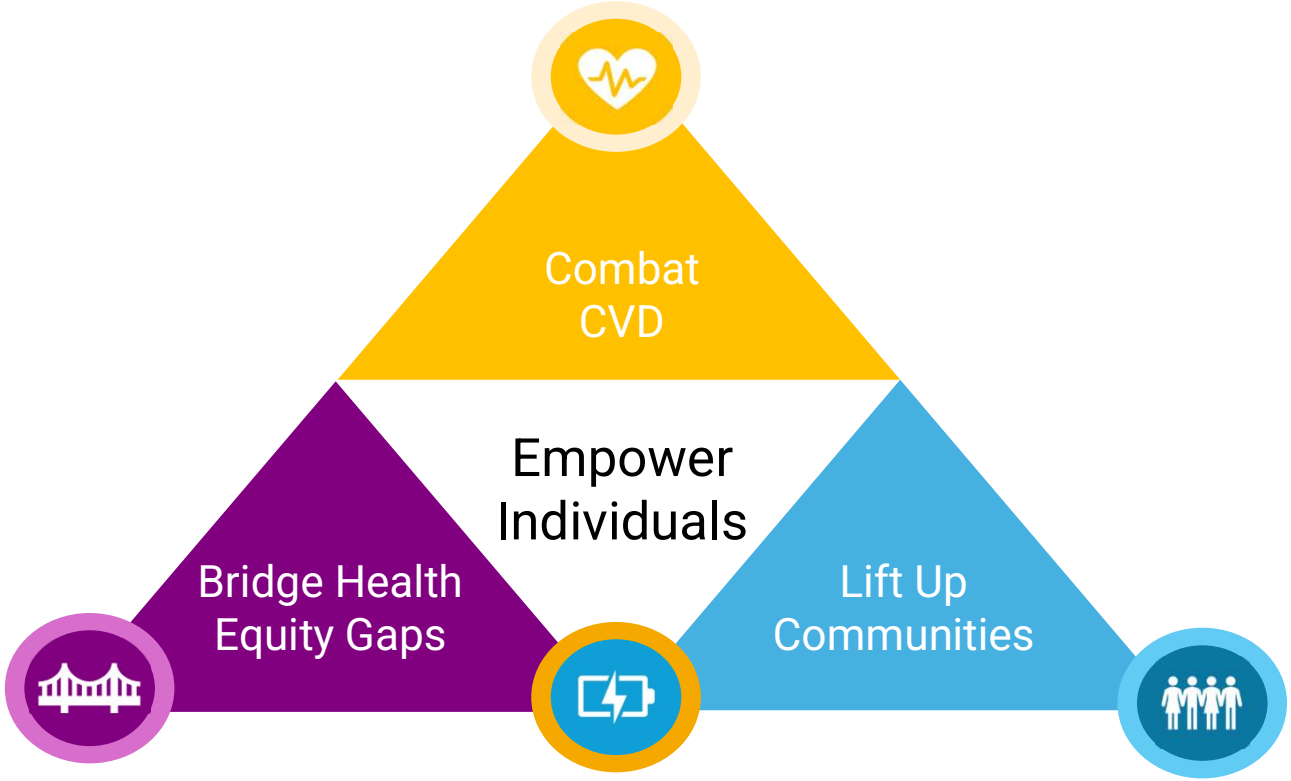
How We Got Here

“The distrust that African Americans have of the healthcare system in the United States of America is justified, to a great extent. This is because there is a litany of issues that African Americans have been through, both historically and currently, that show unequal treatment.”

–Pastor Terris King

Defined Our Shared Goals

Collaborated with community leaders and key stakeholders to identify common objectives that align with both the community's needs and program goals.



Our Community Health Delivery Model Is Reimagining Healthcare in Underserved Communities

Our community health delivery model connects traditional healthcare systems with community-based approaches, expanding an ecosystem of trust. We bring preventative care services directly into the community and engage individuals as neighbors and friends through local hubs, rather than as patients.

THE IMPACT

FOR HEALTHCARE

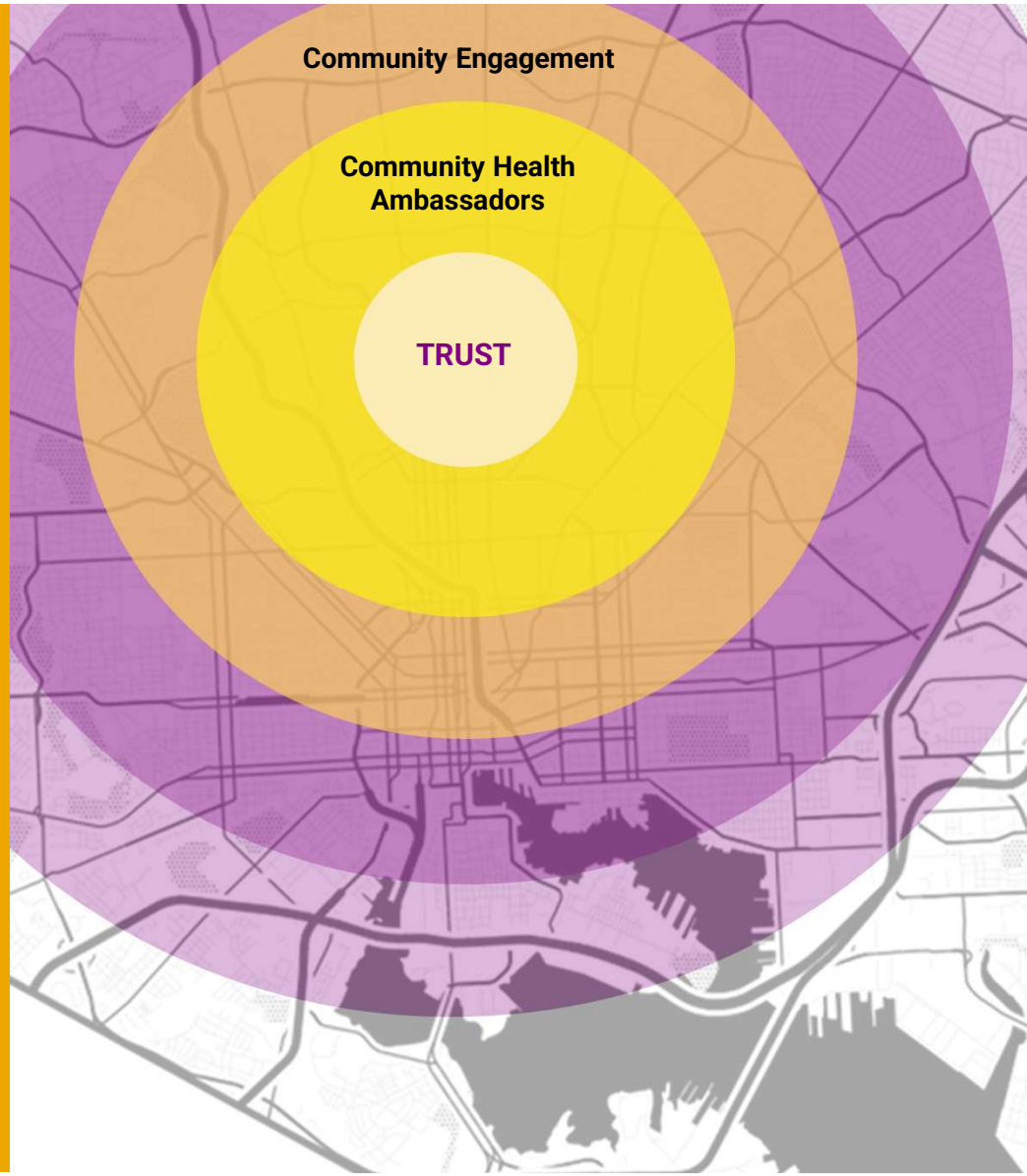
- ✓ Reduces strain on traditional healthcare system
- ✓ Achieves cost savings while enhancing care quality cc
- ✓ Promotes healthy lifestyle changes and medication adherence

FOR COMMUNITY

- ✓ Makes healthcare more approachable and accessible
- ✓ Improves community engagement, empowerment & behaviors
- ✓ Strengthens connection between the community and national program partners

Building a Sustainable Future Through an Ecosystem of Trust

- **Improved community health:** Early detection, chronic disease prevention, healthy food and lifestyle behaviors, compliance with doctors' orders, adherence to medication protocols
- **Infrastructure for success:** Support system built through trusted relationships and credibility of CHA network
- **Embedded partnerships:** External program partners gain trust and build relationships in the community, which must be sustained over time



Meritus Health Food Farmacy

Miranda Ramsey
Vice President, Physician Services
Beth Fields Dowdell, DNP, CRNP, CEN, NRP
Director, Community Health and Outpatient Care Management

May 14, 2025

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MERITUS SCHOOL OF OSTEOPATHIC MEDICINE
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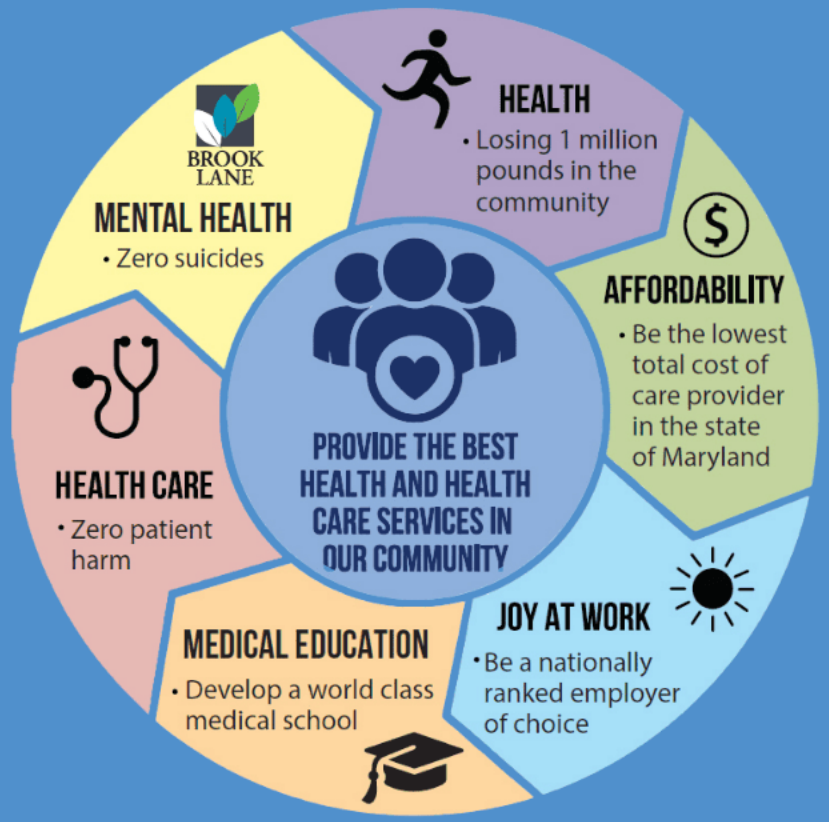
MARYLAND

Meritus Health

Meritus Mission:

Improve the health of the community by providing the best healthcare, health services and medical education.

- **Anchor organization for the region**
- **Over 4,300 Team Members**
- **$700 million in annual revenue**
- **Serve over 200,000 people**



Meritus Medical Center

- 327 Bed Teaching Hospital
- Level III Trauma Center
- 75,000 Emergency room visits annually
- 500,000 ambulatory visits annually
- 2,100 deliveries annually
- 4,000 Trauma visits annually
- 250 plus providers in Meritus Medical Group
- Meritus Home Health
- Equipped for Life (Medical Equipment Company)

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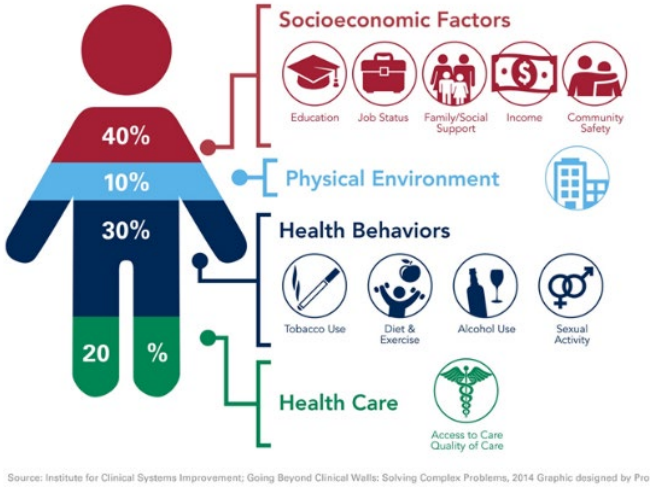
- 65 bed Mental Health Hospital
- 6 bed Crisis Center
- Mental Health Urgent Care Center
- 2 Laurel Hall Schools

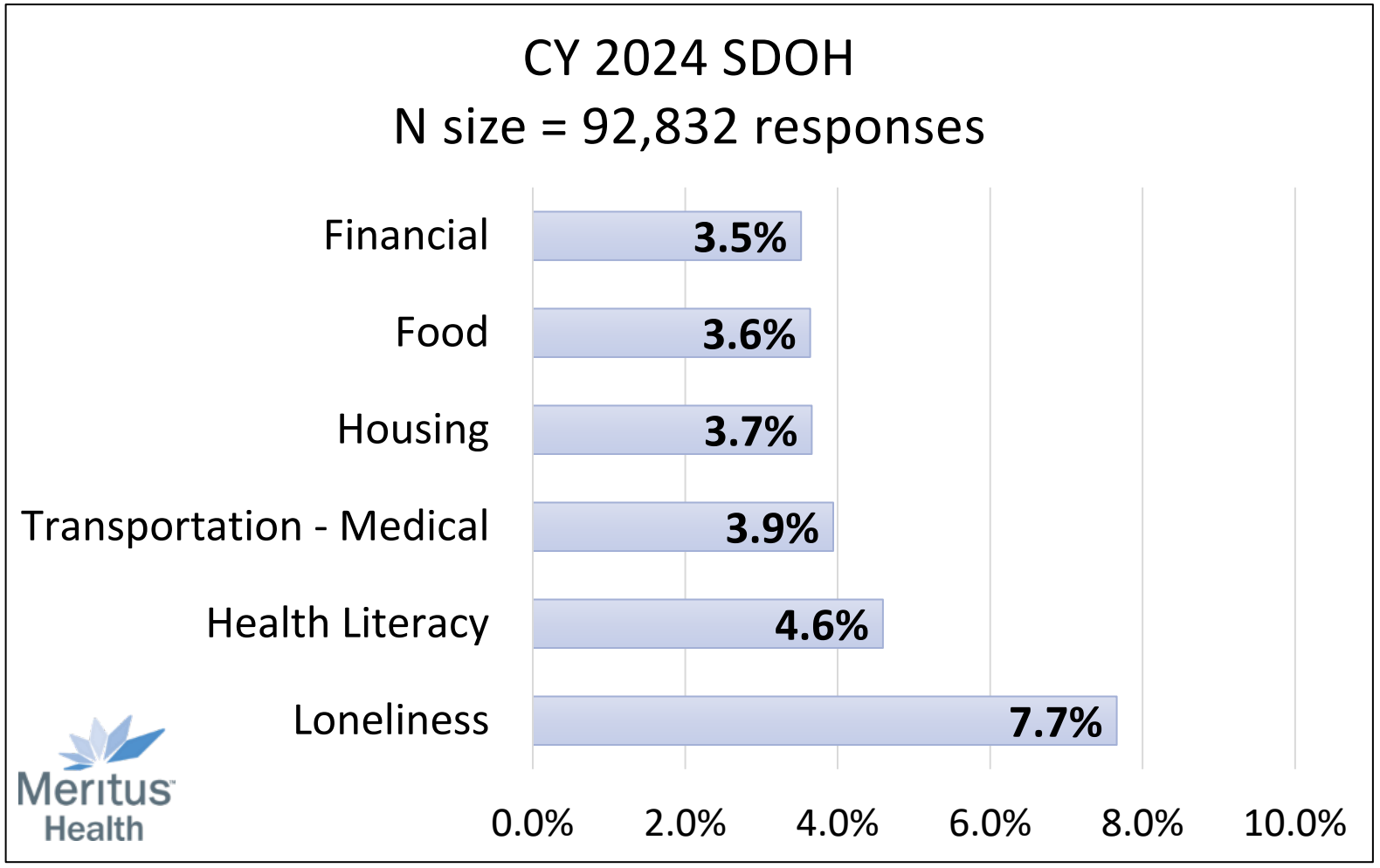
Meritus School of Osteopathic Medicine

- Starting summer of 2025
- First medical school in Maryland in 100 years
- Residencies:
  - Family Medicine (6 per year)
  - Psychiatry (5 per year)
- Residencies in Development:
  - General Surgery
  - Internal Medicine
  - Anesthesiology

Social Determinants of Health (SDOH)

- SDOH impacts 65% to 80% of health status outside of medical care
- Began SDOH screenings via EPIC in October 2020
- Screening all patients routinely now





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First Started to Address Loneliness and Transportation

Loneliness: Care Caller Program

- **2021**: Began with 1 volunteer caller and 2 participants through an Institute for Healthcare Improvement (IHI) collaborative.
  - Aim was 50% of participants would be less lonely in 4 months.
- **2023**: 39 callers, 114 participants, 1,027 calls, over 10,000 minutes, 96% of respondents stated they felt less lonely within 4 months.
- **2024:** 85 volunteer callers + 2 paid, 355 participants, 169,772 minutes, 6,397 calls
  - Publication: Feldmiller E, Messner L, Gona SR, Joshi M. **Eradicating the Loneliness Epidemic: One Phone Call at a Time.** J Healthcare Qual. 2024 Sep-Oct 01;46(5):300-305. doi: 10.1097/JHQ.0000000000000441.

Transportation: Meritus Free Transport

Aim: No patient will miss an appointment due to lack of transportation

2024 services increased with support of MPC to purchase additional vans.

- FY25 will exceed 17,000 free rides (8+ vans)

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Now Addressing Food

Food Insecurity

- Washington County is a Food Desert

- CY 2024: 3,000 patient ambulatory visits reported concerns about food insecurity; 1,200 patients were discharged from hospital with documented malnutrition.

- **2023-** non-perishable Care to Share Boxes placed at 3 locations across campus to increase access to food.

- **2024** – 1 perishable box placed on campus
- $100k a year spent on food

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Our Strategy – A Food Farmacy

Combine “Well Wheels” and “Diabetic Door Dash” AIM Winners (Thank you) to create one project –

Meritus Food Farmacy

Goals of the Food Farmacy:

- Improve access to healthy foods based on medical diagnoses.
- Increase patient understanding of nutrition and how food affects their medical diagnosis.
- Eliminate barriers to healthy eating.
- Improve health outcomes.
  - Will be evaluated based on follow-up visit with medical provider and CRISP Pre/Post Data of ER and Hospitalizations.
- 12 month plan: 900 individuals treated; $400k approximate investment

Enrollment Criteria:

- Referral by Meritus Medical Group provider or hospital dietitian during admission.
- 150 participants per week for 8 weeks each. Each participant will receive approx. $50 food per week including perishable and non-perishable food, as well as recipes.
- Participants will have indicated Food Insecurity and have a diagnosis of: Malnutrition, Pregnant patients, COPD, Asthma, CHF, Hypertension, Coronary Artery Disease, Diabetes.

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Meritus Food Farmacy

Location: Robinwood (Professional Office Building). A kiosk for food pick-up. Limited delivery for those with transportation barriers using Meritus Transport.

Patients will have access to weekly cooking demonstrations and individual visits with a Registered Dietitian.

Hours: Monday-Friday 8:30a.m. to 5:00p.m.

Champions: Chief Medical Officer, Endocrinologist, Cardiologist, Hospitalist, Primary Care Medical Director

Documentation: Epic EHR

Care to Share Box: Still available in the Emergency Department.

Go Live: Soft Launch on May 5th

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Thoughts

- SDOH are significant
- Focused, system wide efforts on a SDOH has potential
- Access to healthy food is a major impact on health
- Lots of great examples of food programs – e.g., *Good Food Means Good Health* – A partnership between UMMS, Children National, Unity Health; *Healing the Mind and Body with Fresh Food* – A Partnership between Johns Hopkins and Maryland Food Bank
- Could we consider a state wide approach (HSCRC supported?) for helping people with medical conditions to get healthy food, with the opportunity for hospitals to participate?

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Update on Medicare FFS Data & Analysis

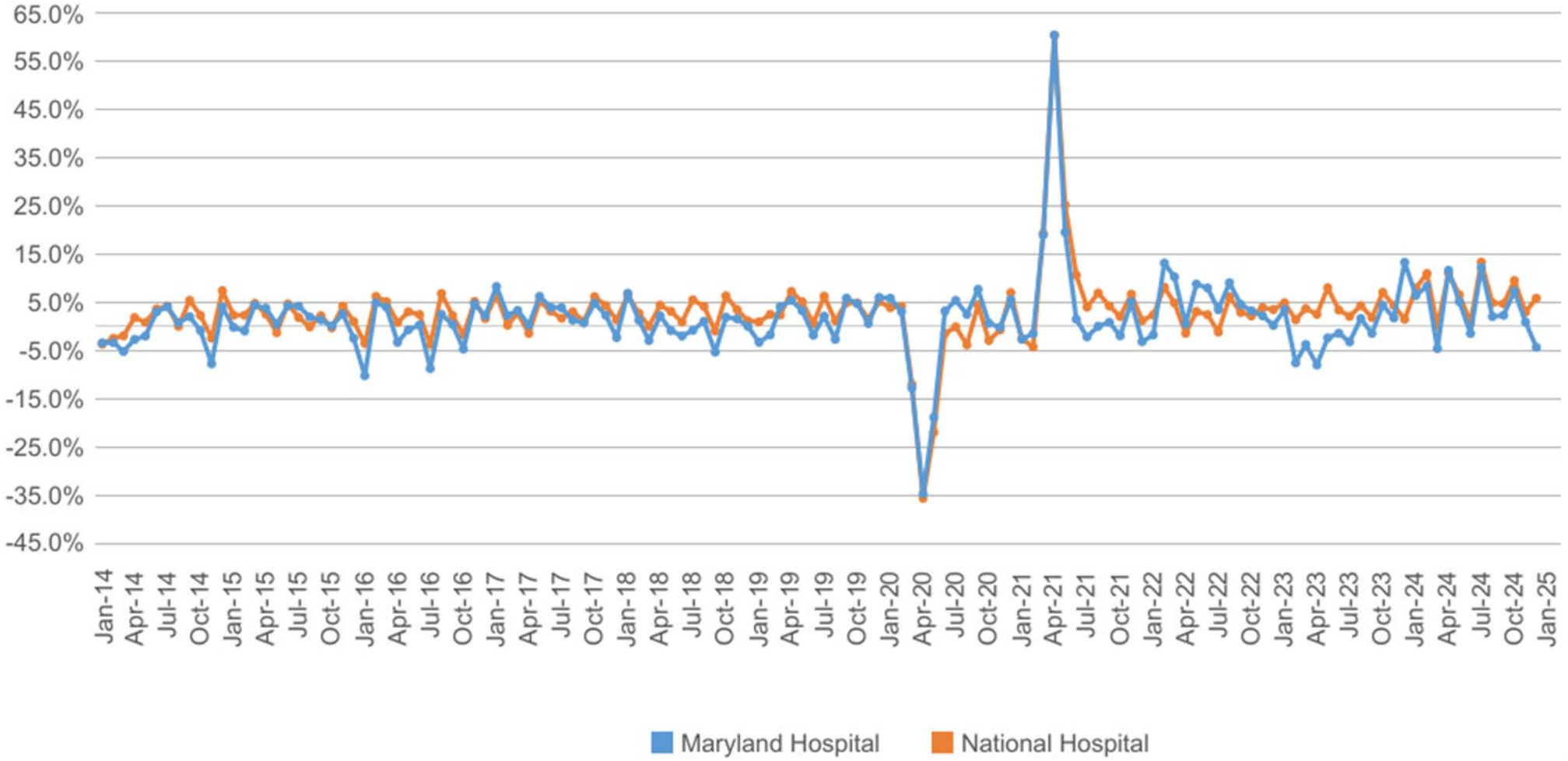
May 2025 Update – FINAL DATA

Data through December 2024, Claims paid through March 2025

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

Medicare Hospital Spending per Capita

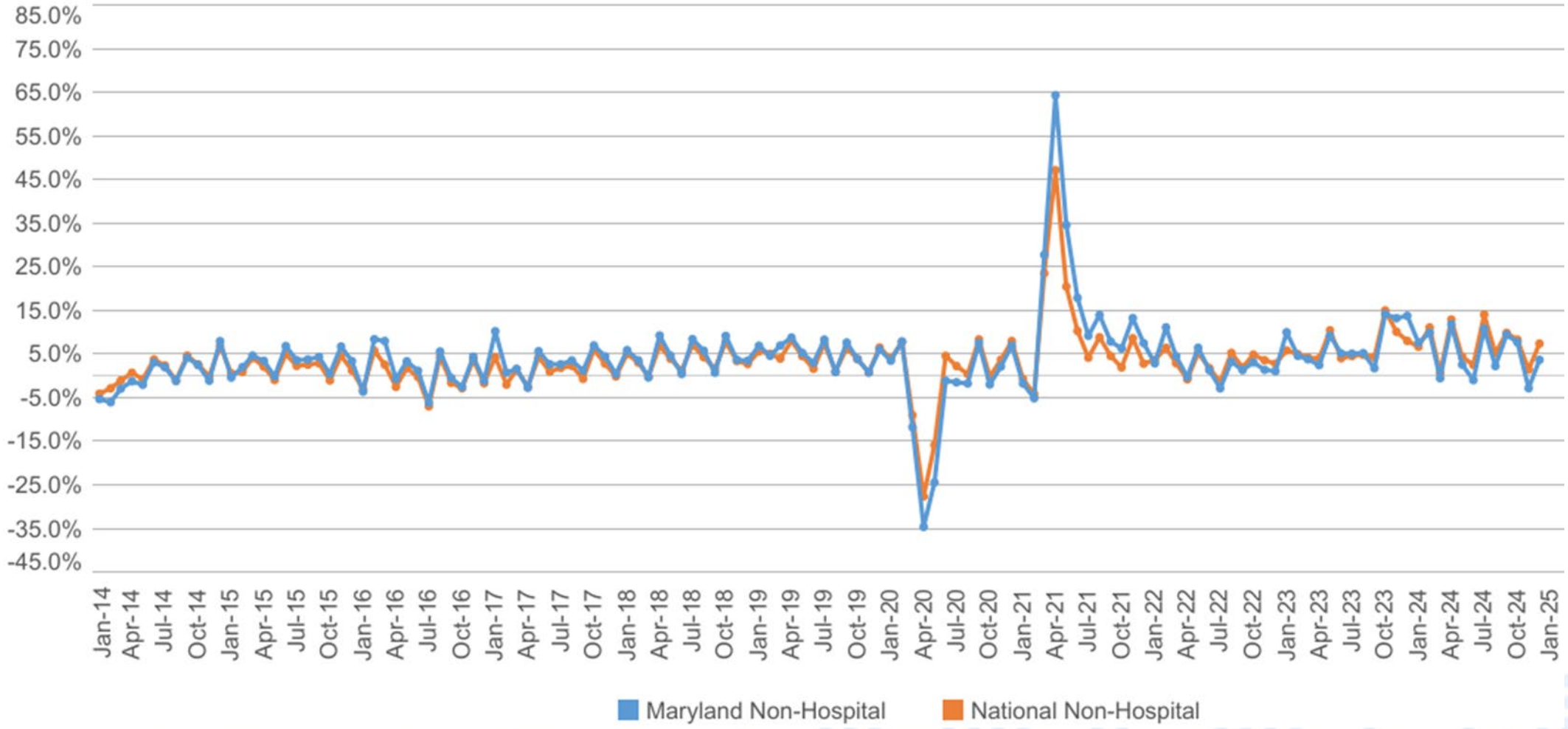
Actual Growth Trend (CY month vs. Prior CY month)



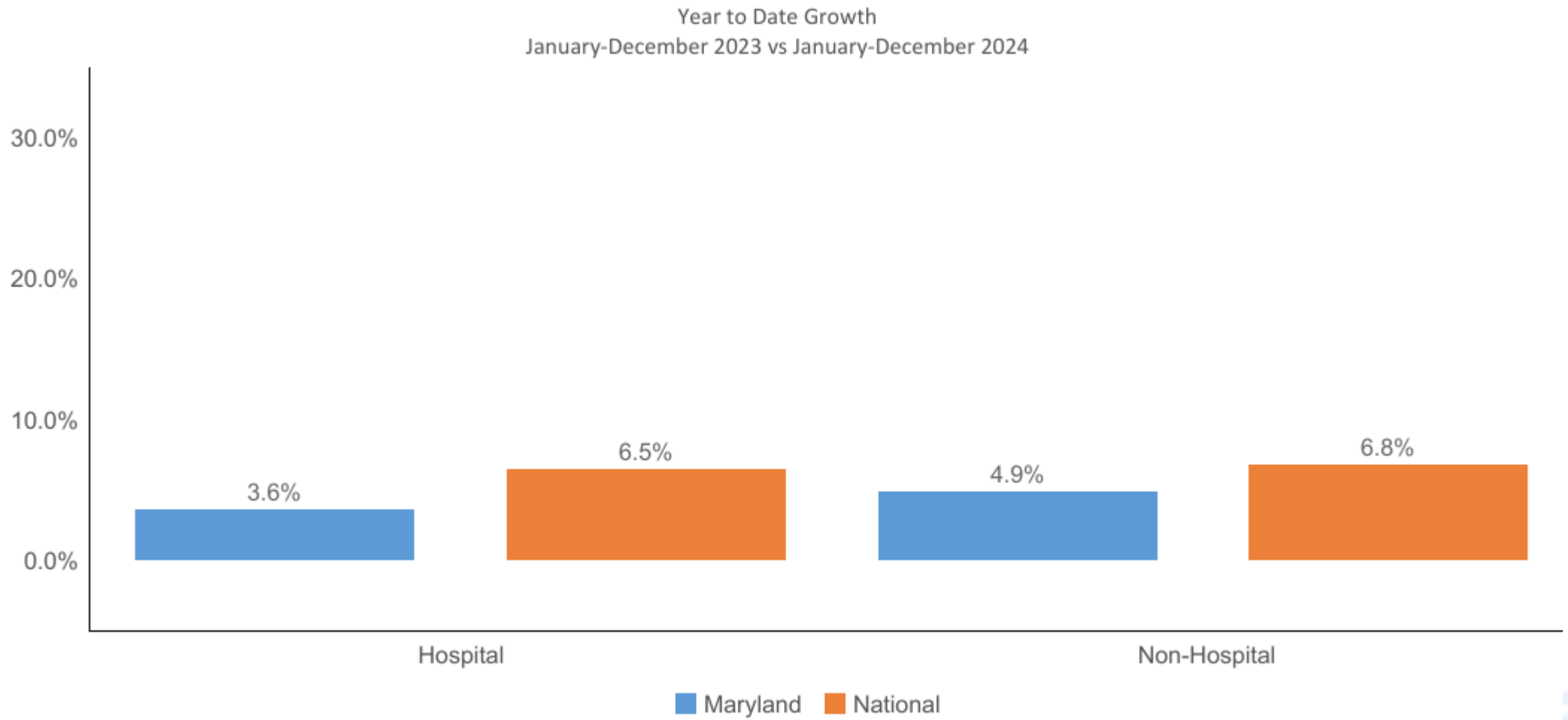
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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



Medicare Hospital and Non-Hospital Payments per Capita



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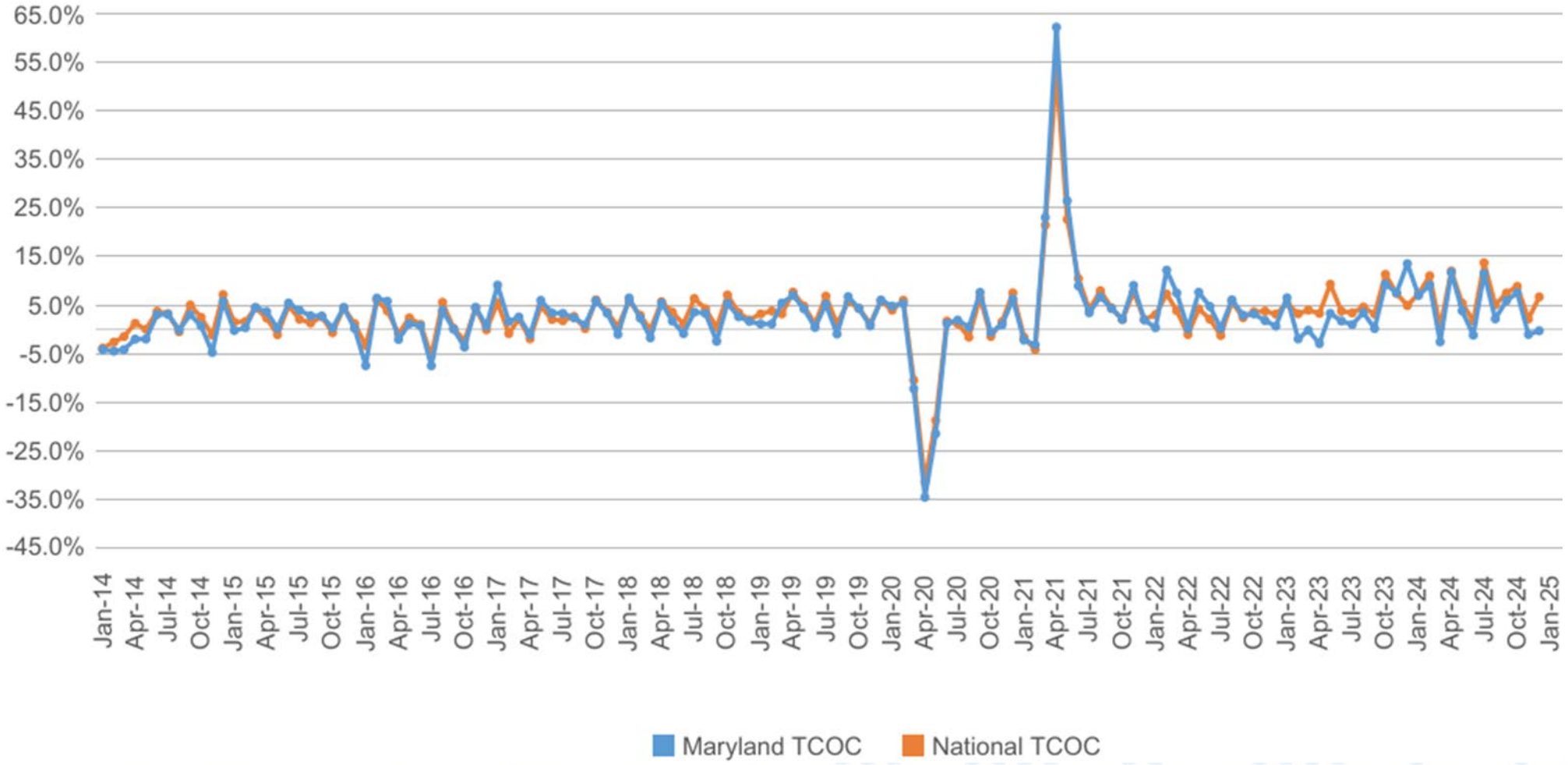
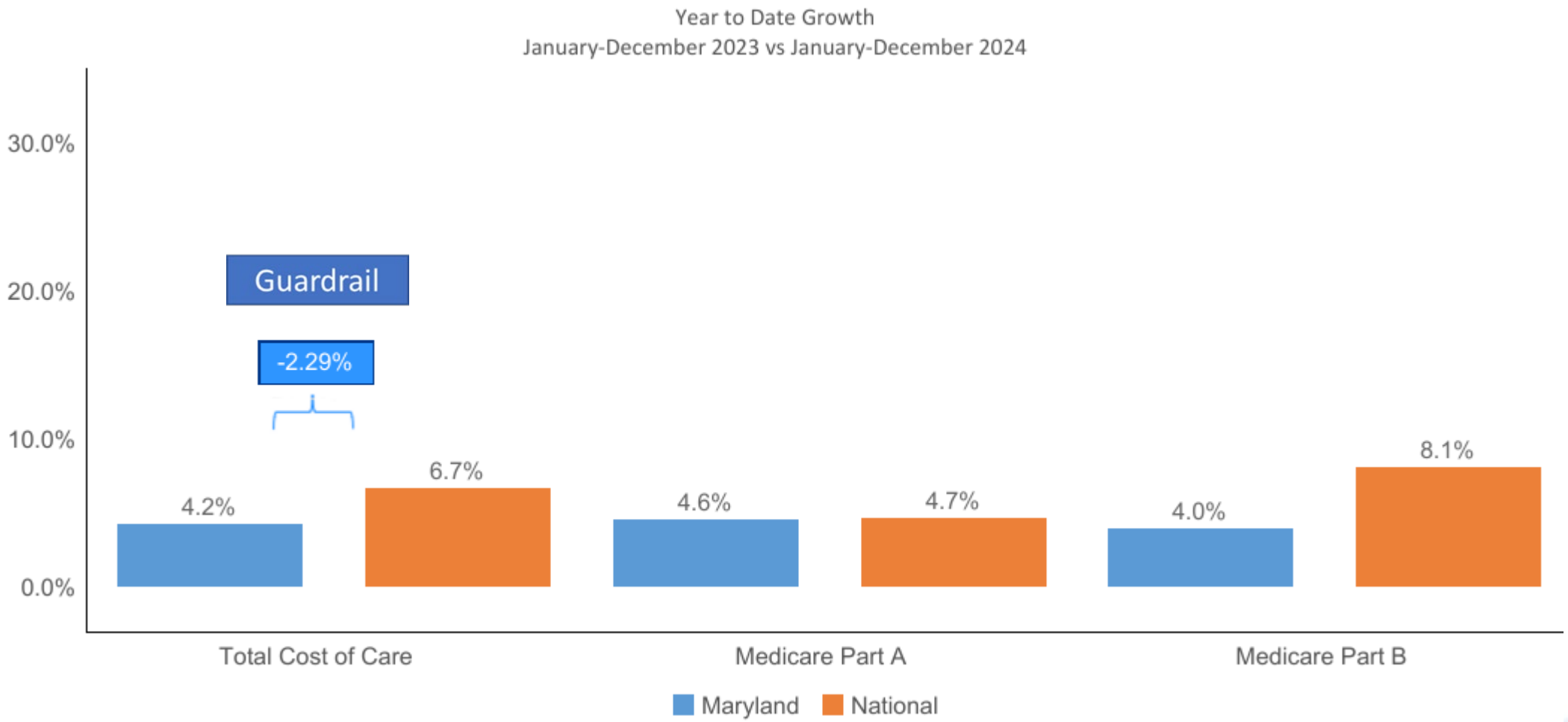
Medicare Total Cost of Care Spending per Capita

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



CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



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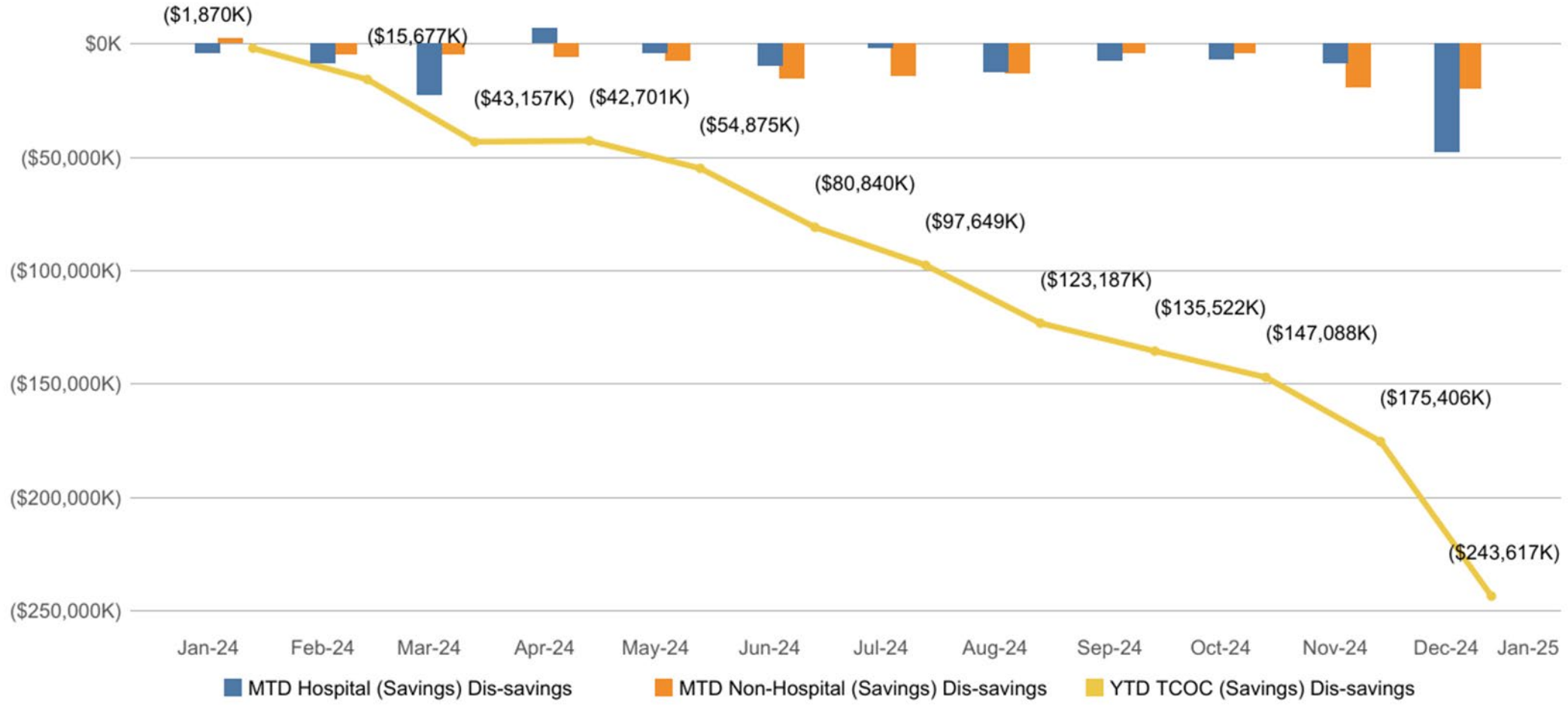
Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2024



A positive number represents dissavings/excess growth

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CY 2024 Statewide Quality Performance

HSCRC Commission Meeting

May 2025

CY 2024 Statewide Quality Performance

Today's presentation provides statewide results for the following TCOC model targets and SIHIS measures:

- TCOC Medicare Readmissions Target & All-Payer Readmissions
- TCOC Complications Target (Potentially Preventable Complications)
- SIHIS Timely Follow Up after Acute Exacerbation of a Chronic Condition
- SIHIS Avoidable Admissions
- SIHIS Readmission Disparities

Maryland Readmission Performance

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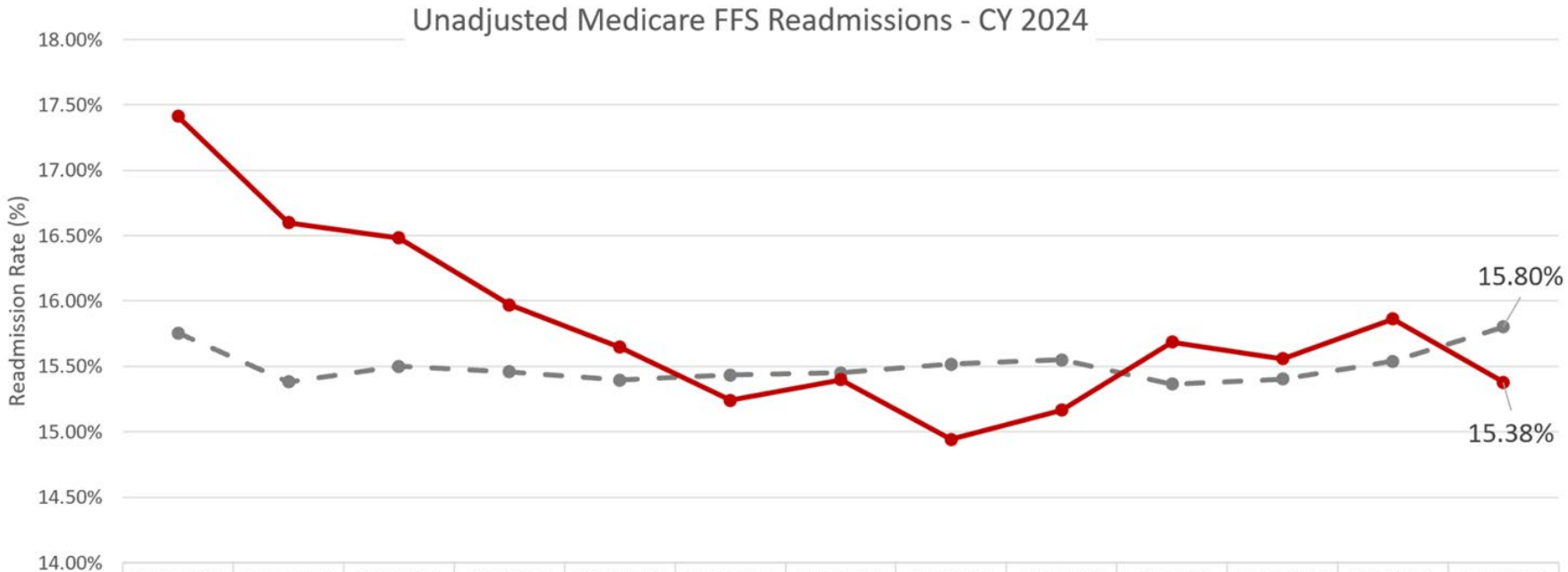
Readmissions Performance

- Medicare FFS: Readmission Contractual Target
  - The TCOC model historically required MD to perform better than the Nation on unadjusted all-cause Medicare FFS 30-day readmissions
  - Starting in CY23, CMMI agreed to switch to a risk-adjusted readmission measure (i.e., adapted CMS Hospital-Wide Readmission measure) to compare Medicare performance in MD compared to the Nation
- Readmissions Reduction Incentive Program (RRIP)
  - Program was established to ensure readmissions improvements for Medicare and All-Payers
  - Evaluates 30-day All-Payer, All-Cause, All-Condition Readmissions

Unadjusted Medicare FFS Readmission Rates, MD vs Nation



	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.38%

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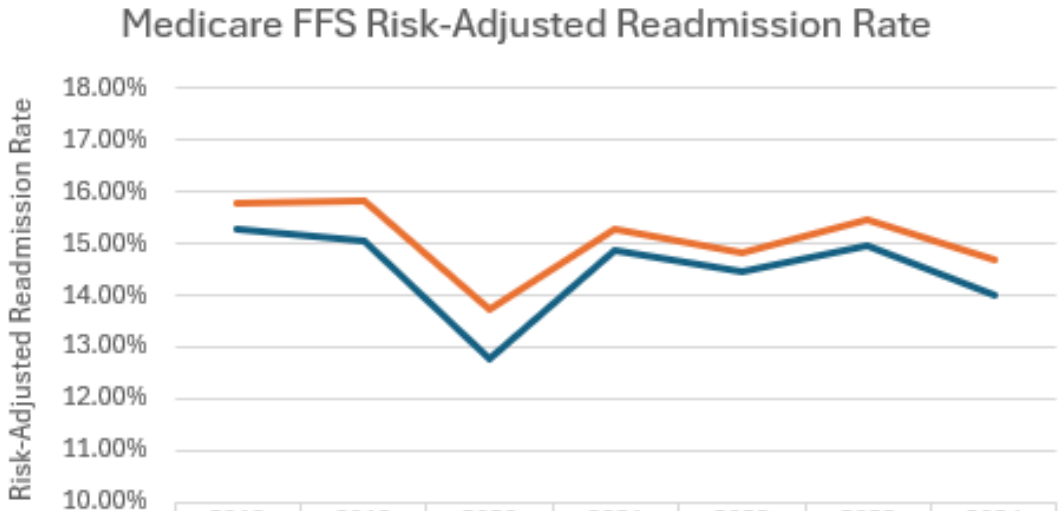
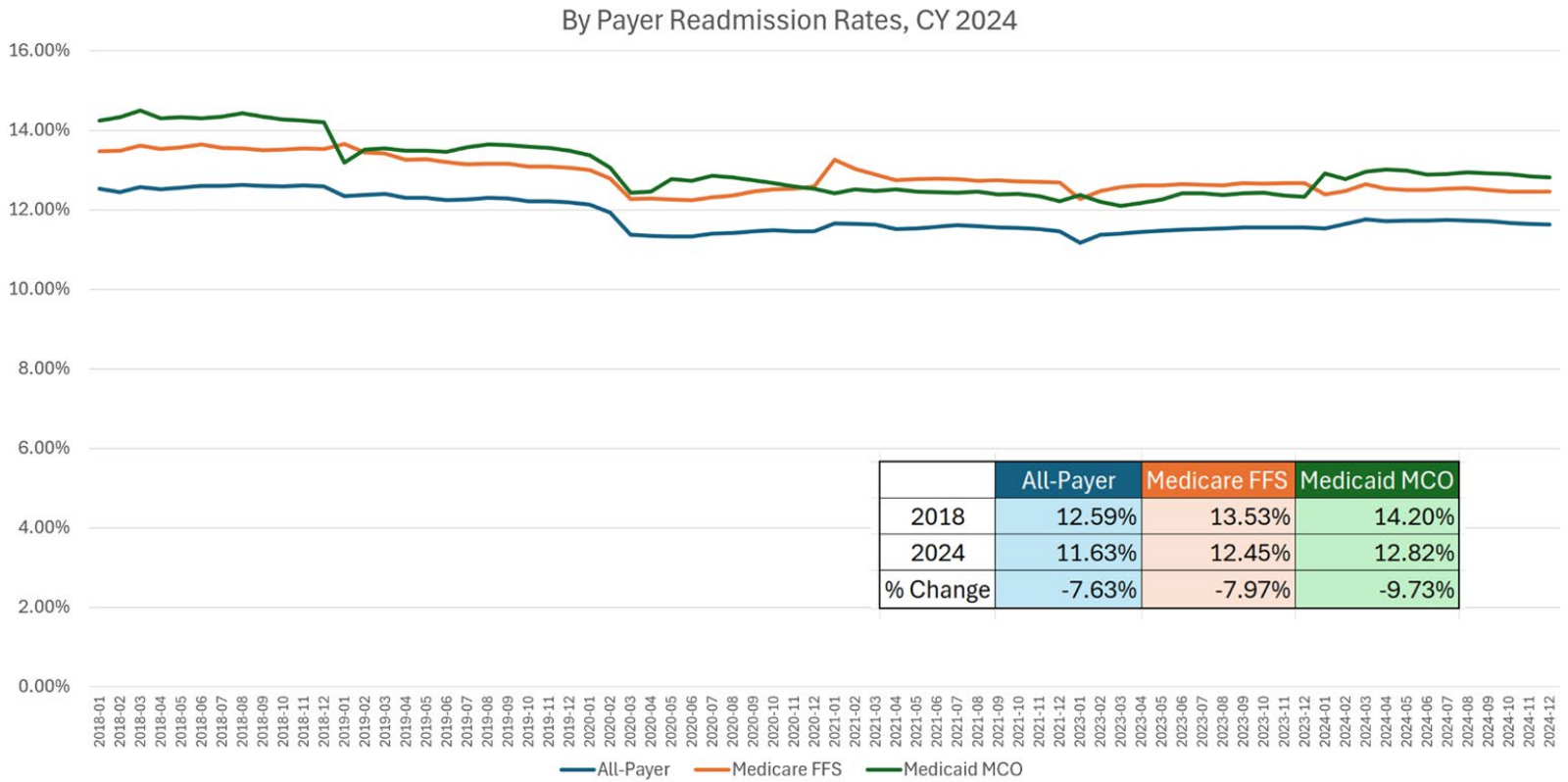
Current Test: MD TCOC Hospital-Wide All-Cause Readmissions



	2018	2019	2020	2021	2022	2023	2024
MD	15.29%	15.05%	12.77%	14.88%	14.47%	14.94%	14.00%
Nation	15.76%	15.84%	13.74%	15.26%	14.81%	15.45%	14.69%

RRIP Case-Mix Adjusted Readmission Rates



	All-Payer	Medicare FFS	Medicaid MCO
2018	12.59%	13.53%	14.20%
2024	11.63%	12.45%	12.82%
% Change	-7.63%	-7.97%	-9.73%

Potentially Preventable Complications

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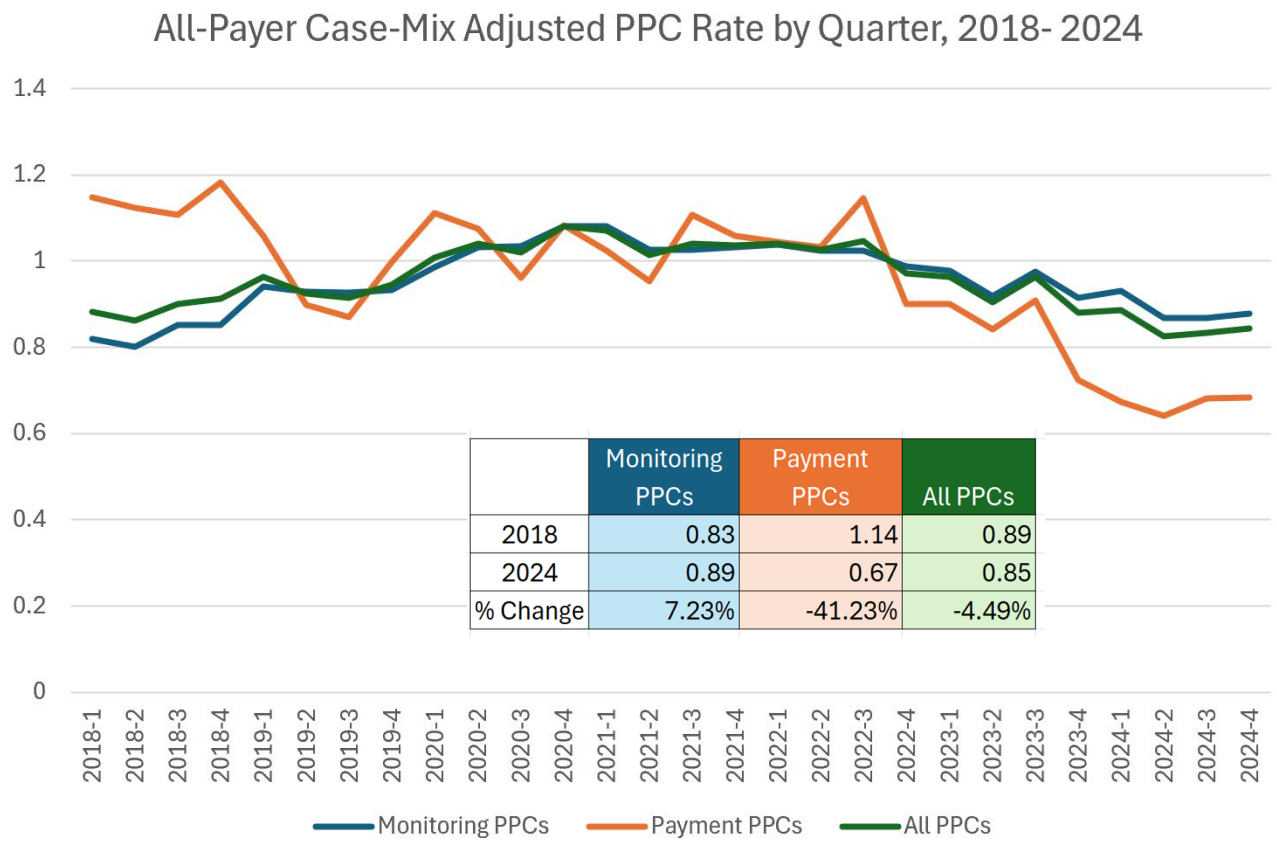
Potentially Preventable Complications (PPCs)

- PPCs are complications that are acquired during a hospital stay that were not present on admission
  - Based on a classification system developed by Solventum, previously 3M Health Information System (3M)
- Under the TCOC Model, Maryland cannot exceed the CY 2018 PPC rates for complications included in the MHAC payment program to maintain improvements made under the All-Payer Model.

TCOC Complication Target Achieved for CY2024



	Monitoring PPCs	Payment PPCs	All PPCs
2018	0.83	1.14	0.89
2024	0.89	0.67	0.85
% Change	7.23%	-41.23%	-4.49%

	Payment PPCs	CY 2024 O/E Ratio
3	Acute PE & Resp Failure w/o Vent	0.73
4	Acute PE & Resp Fail w/ Vent	0.62
7	Pulmonary Embolism	0.86
9	Shock	0.77
16	Venous Thrombosis	0.52
28	In-Hospital Trauma and Fractures	0.82
35	Septicemia & Severe Infections	0.68
37	Post-Op Infec & Deep Wound Disrup w/o Proc	0.87
41	Post-Op Hemor. & Hematoma w/ Control or I&D Proc	0.65
42	Accidental Puncture/Laceration During Invasive Proc	0.60
47	Encephalopathy	0.20
49	Iatrogenic Pneumothrax	0.70
60	Major Puerperal Infec & Other Major OB Compl	0.65
61	Other Compl of OB Surgical & Perineal Wounds	0.96
67	Pneumonia	0.76

SIHIS Measure: TFU

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Medicare FFS Timely Follow Up (TFU)

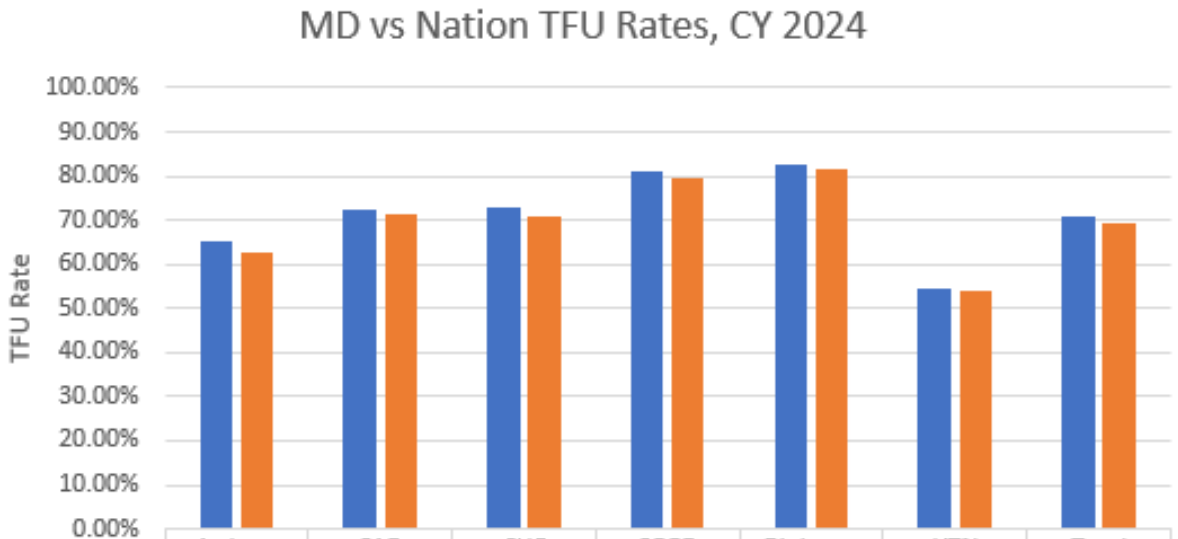
The TFU measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six chronic conditions in which a follow-up was received within the time frame recommended by clinical practice:

- Hypertension (follow-up within 7 days)
- Asthma (follow-up within 14 days)
- Congestive Heart failure (CHF)(follow-up within 14 days)
- Coronary artery disease (CAD)(follow-up within 14 days)
- Chronic obstructive pulmonary disease (COPD) (follow-up within 30 days)
- Diabetes (follow-up within 30 days)

	SIHIS Target
2018 Baseline	70.85%
2021 Year 3 Milestone	72.38% 2.16 percent improvement
2023 Year 5 Milestone	73.42% 3.62 percent improvement
2026 Year 8 Final Target	75% or 0.50% better than national rate 5.86 percent improvement

Note: Beginning with CY 2025, logic updates will be implemented which changes the follow-up time frames and stratifies by acuity for some patients

MD vs Nation CCW TFU Performance



	Asthma	CAD	CHF	COPD	Diabetes	HTN	Total
MD	65.24%	72.32%	73.05%	80.93%	82.80%	54.29%	70.79%
Nation	62.89%	71.43%	71.09%	79.38%	81.55%	54.07%	69.30%

Through CY 2024, Maryland's performance is better in total and for all 6 of the chronic conditions compared to the nation. While not achieving the SIHIS improvement target, Maryland is achieving the goal of performing better than the nation.

SIHIS Measure: PQIs

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AHRQ Prevention Quality Indicators (PQIs)

The AHRQ PQIs are population based indicators that identify hospitalizations that might have been avoided through access to high-quality outpatient care, thus providing insights into the quality of health services in a community.

- There are ten individual PQI measures that are included in the overall PQI composite measure (PQI-90), which is risk-adjusted based on age and sex.
    - These ten measures are also grouped into three other specific composites
        - Acute composite(PQI 91)
        - Chronic composite (PQI 92)
        - Diabetic-related admissions composite (PQI 93) - can also be included in the chronic composite
- **SIHIS Goal:** Reduce avoidable admissions from CY 2018 through CY 2026 by 25 percent, as measured by the AHRQ PQI-90

AHRQ PQI-90 Performance: Grouper Concerns

The AHRQ grouper is updated annually and all assessment years, including the baseline rates are re-calculated using the new grouper norms

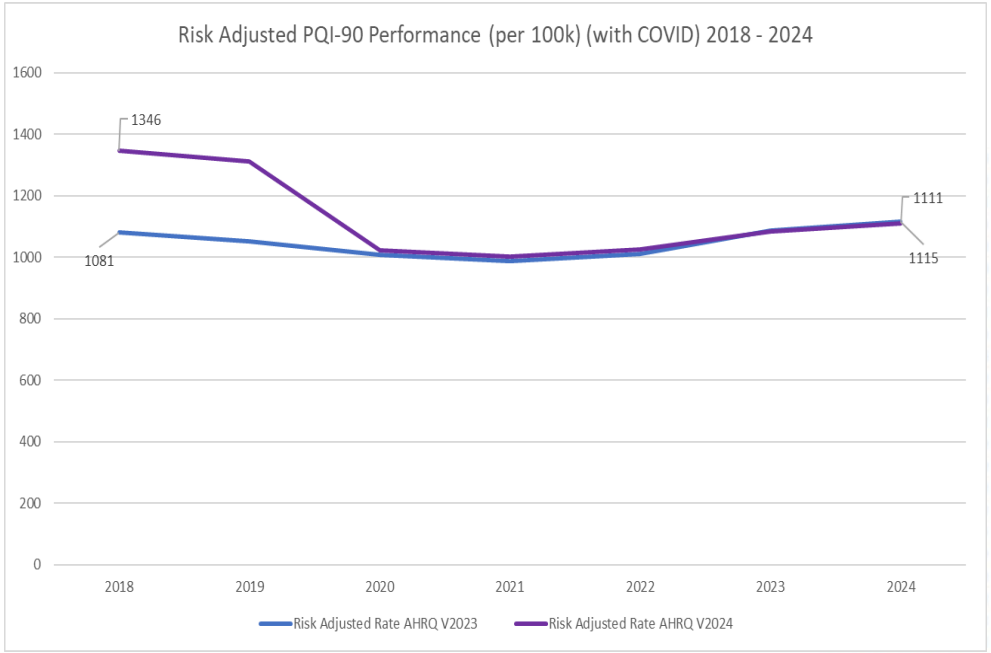
- During CY 2024, AHRQ Version 2023, which uses CY2019 and CY2020 for norms, was used to assess performance

The AHRQ version 2023 grouper shows that Maryland has experienced a 3.2 percent increase across all PQIs in CY 2024 from the 2018 baseline

- The AHRQ version 2023 grouper baseline rates are suppressed making current performance appear higher than the baseline rate

The AHRQ version 2024 grouper shows that Maryland has experienced a 17.5 percent decrease across all PQIs in CY 2024 from the 2018 baseline

- The AHRQ 2024 grouper, which uses CY 2021 for norms, more closely aligns with previous grouper versions and unadjusted trends



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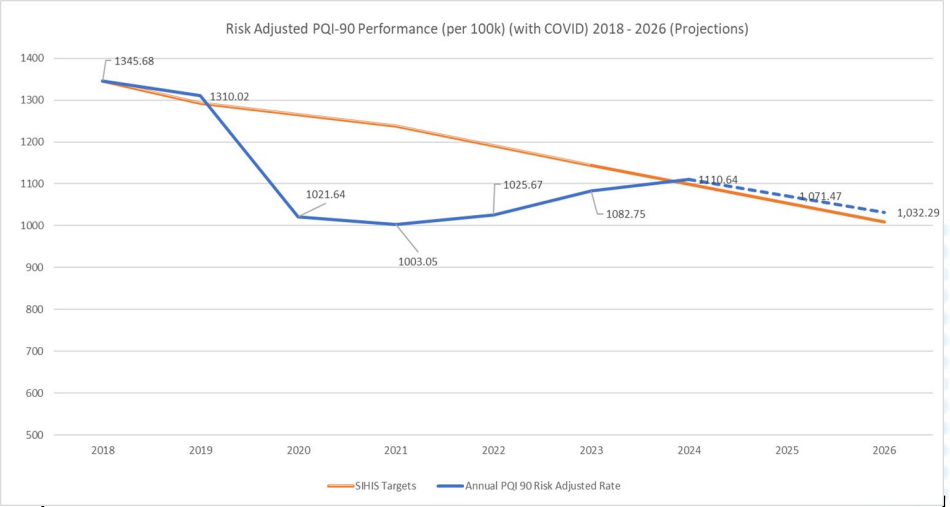
AHRQ PQI-90 Performance under SIHIS

To support Maryland's success under SIHIS, Maryland hospitals are held financially accountable under the TCOC Model for all-payer PQI admissions through the PAU Policy

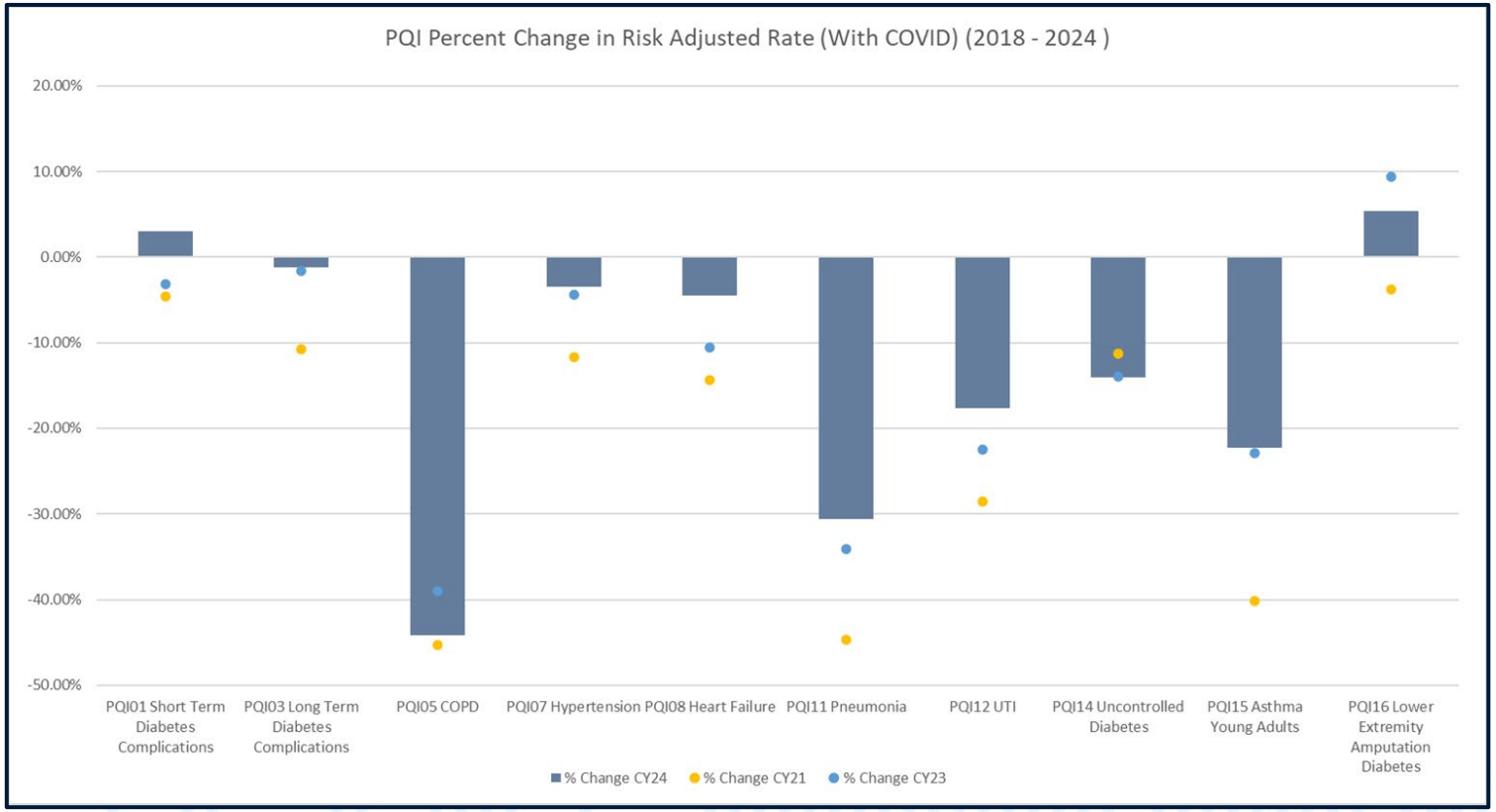
- Using the AHRQ version 24 grouper, Maryland has experienced a 17.5 percent decrease across all PQIs in CY 2024 from the 2018 baseline.
  - However, PQI rates have trended slightly upwards since the drastic decrease seen in CY 2020 and CY 2021. Between CY 2023 and CY 2024 there was about a 3% increase
  - It is not surprising to see increases in PQIs post-covid. However it is commendable that there is still sustained improvement relative to a 2018 base
  - While trends over the past six years (2018-2024) indicate the State may slightly miss the 2026 Year 8 final target, the anticipated miss is slight (assuming the 6 year annual trend continues)
  - Improvement could increase if some of the recent growth is due to delayed care due to the pandemic as hospital utilization slowly reverts to pre-pandemic levels



Goal: Reduce Avoidable Admissions

Measure	AHRQ Risk-Adjusted PQIs Goal	Goal Status (AHRQ Grouper v2024)
2018 Baseline	1,346 admits per 100,000	**1,346 admits per 100,000**
2021 Year 3 Target	8 percent improvement	**25 percent improvement**
2023 Year 5 Target	15 percent improvement	**20 percent improvement**
2026 Year 8 Final Target	25 percent improvement	**TBD**

Prevention Quality Indicator (PQI) Performance



**AHRQ v2024 Software*

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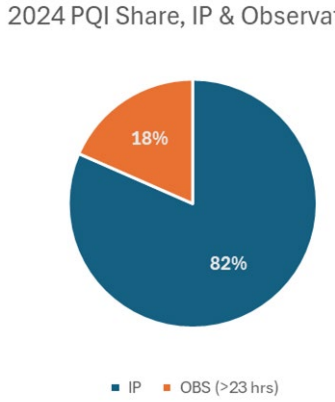
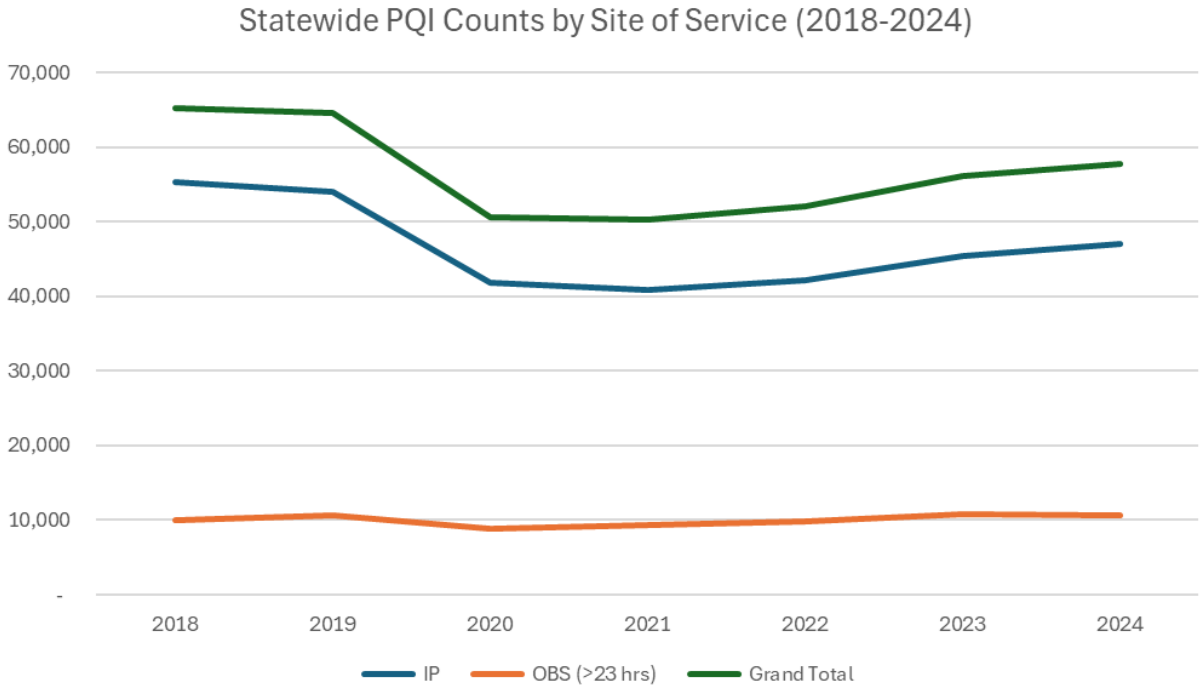
Statewide Unadjusted PQI Trends by Site of Service



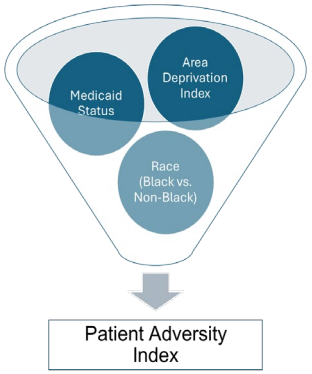


Site of Service	% change	Variance between 2024 and 2018
IP	-15%	(8,189)
OBS **(>23 hrs only)**	7%	674
Total	**-13%**	

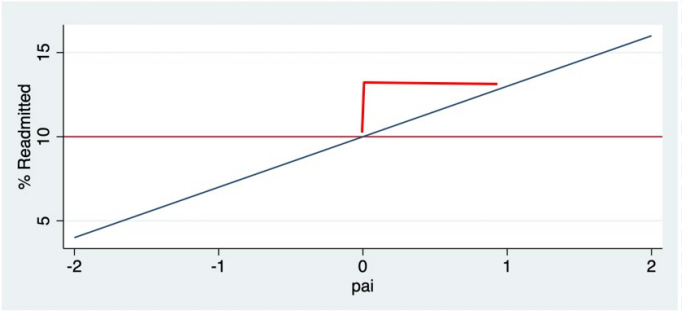
SIHIS Measure: Readmissions Disparity Gap

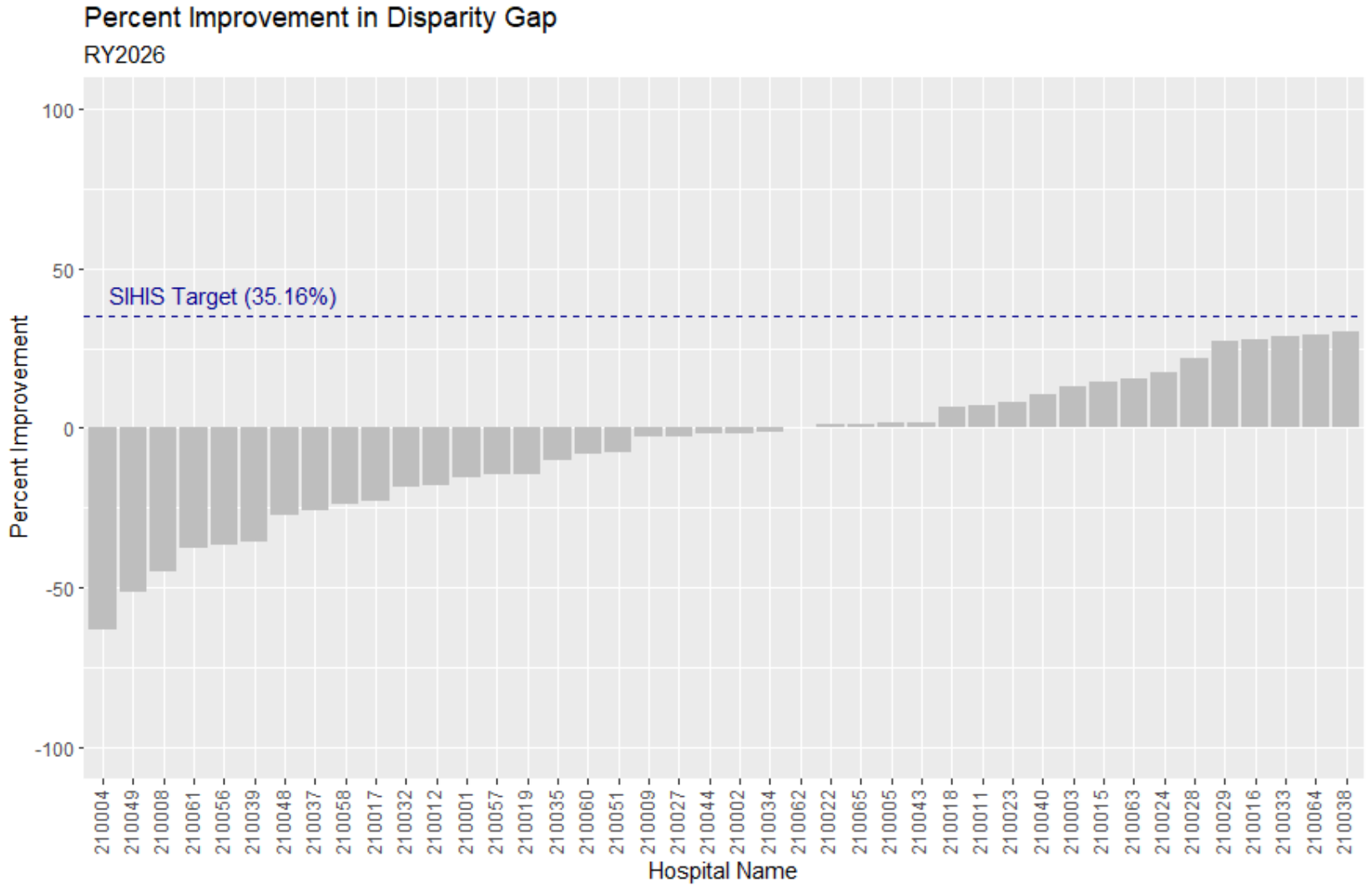
Readmissions Disparity Gap

- The SIHIS goal is for 50% of MD hospitals to reduce their disparity gap in readmissions by 50% or more, when compared to CY 2018.
- The *disparity gap* is a reflection of how readmission risk within a hospital changes for patients with varying levels of the Patient Adversity Index (PAI)
- The RRIP's Disparity Gap component incentivizes hospitals to reduce disparities in readmissions by rewarding hospitals up to 0.5% of their IP revenue for being on track to reduce disparities in readmissions by 50% in CY 2026
    - For CY2024, the reward threshold was -35.16% and benchmark was -57.96%



Larger value = Higher adversity




Percent Improvement in Disparity Gap
RY2026
100
50
0
-50
-100
SIHIS Target (35.16%)
Percent Improvement
210004
210049
210008
210061
210056
210039
210048
210037
210058
210017
210032
210012
210001
210057
210019
210035
210060
210051
210009
210027
210044
210002
210034
210062
210022
210065
210005
210043
210018
210011
210023
210040
210003
210015
210063
210024
210028
210029
210016
210033
210064
210038
Hospital Name

Concerns

- Results raise concerns that an increasing number of hospitals are not able to meet improvement targets

Potential Hypotheses

- Hospitals not improving
  - Possibly due to lack of resources needed to address issues, early progress resulting in harder subsequent improvements, limitations in addressing non-hospital based social needs, among other factors
- Measurement Concerns
  - Decline in one PAI component washing out improvement in another
  - Shrinkage effects of model are limiting improvement
  - Inherent issues with statistical modeling
- Incentive Structure Concerns

CY 2024 Statewide Quality Updates

Maryland has exceeded its two TCOC contractual quality targets:

- Medicare FFS Readmissions: ~3% better than the national average
- All-Payer Complications: ~41% improvement in payment PPCs from 2018

Maryland continues to monitor SIHIS quality targets and has shown promising results in most measures:

- Timely Follow Up: ~2.15% better than national average
- Avoidable admissions: 20% improvement 2018-2023, 5% above required SIHIS goal
- Additional work is needed to ensure success in reducing disparities in readmissions

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Nurse Support Program II

Competitive Institutional Grants Program

Final Recommendations for FY 2026

May 14, 2025

Erin Schurmann, HSCRC
Laura Schenk, MHEC
Kimberly Ford, MHEC

FY26 NSP II Recommended Proposals

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

Funding - Grouped by Initiatives

Workforce Entry & Degree Advancement (Initiatives 1 & 2):

- Funding requested: $754,797
- Grant types: 3 planning & 1 implementation
- Timeframes: 1–2 years
- Proposal highlights:
  - Develop a hybrid LPN-to-RN pathway
  - Launch RN-BSN & MSN online programs to prepare 30+ BSN/MSNs by 2027
  - Create a new DNP track in public health nursing
  - Build faculty expertise in data-driven program improvements

Faculty Pipeline & Retention (Initiatives 3 & 6)

- Funding requested: $8,748,700
- Grant types: 2 implementation & 5 continuation
- Timeframes: 4 years
- Proposal highlights:
  - Launch a new PhD in Nursing Education program
  - Produce an additional 94 Cohen Scholars with the obligation to teach in Maryland

Clinical Partnerships & Teaching Innovation (Initiatives 4 & 5)

- Funding requested: $7,752,737
- Grant types: 2 planning, 1 implementation, 2 continuation & 8 resource
- Timeframes: 1–4 years
- Proposal highlights:
  - Develop preceptor models in community/ primary care & acute care settings
  - Equip nurses & faculty across the state with essential skills for technology-enhanced practice
  - Expand nationally-recognized statewide initiatives:
    - Maryland Clinical Simulation Resource Consortium (MCSRC)
    - Faculty Academy and Mentorship Initiative of Maryland (FAMI-MD)
    - LeadNursingForward.org (LNF)
  - Professional development support for 7 schools of nursing

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Nurse Support Program II
Competitive Institutional Grants Program

Review Panel Recommendations for FY 2026

May 2025

This is a final recommendation for Commission consideration at the May 14, 2025 Public Commission Meeting.

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Introduction

This final staff recommendation presents the Nurse Support Program II (NSP II) Competitive Institutional Grant Review Panel for Fiscal Year (FY) 2026 to advance nursing education and grow the nursing workforce in Maryland. These final recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission). Staff are recommending 24 grants for approval totaling $ 17.2 million in funds for FY 2026. The FY 2026 NSP II recommendations align with the overarching goals of NSP I and II to support excellence in nursing practice and education.

Background

The HSCRC initiated nurse education support funding (formerly titled the Nurse Education Support Program or NESP) in 1986 through the collaborative efforts of hospitals, payers, and nursing representatives. In 2000, HSCRC implemented the Nurse Support Program I (NSP I) to address the issues of recruiting and retaining nurses in Maryland hospitals. In 2005, seventy-nine percent (79 percent) of the RN programs reported that they had met or exceeded their enrollment capacity. The shortage of qualified nursing faculty was identified as the fundamental obstacle to expanding the enrollments in nursing programs, thereby exacerbating the nursing shortage. The HSCRC proactively created Nurse Support Program II (NSP II) to address the barriers to nursing education through statute with the Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund. The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses.

NSP II is distinct from, and in addition to, the NSP I hospital-specific program but shares a mutual goal to increase the number of nurses in Maryland hospitals. NSP II focuses on expanding the capacity to educate more nurses through increasing faculty and strengthening nursing education programs at Maryland higher education institutions. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of up to 0.10 percent of regulated gross patient revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused statewide initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025. On February 12, 2025, HSCRC Commissioners voted to approve NSP II as a permanent program with the requirement of annual reporting on funded initiatives and program outcomes.

NSP II works closely with NSP I and stakeholders in hospitals and schools of nursing in Maryland to ensure that grant funding is addressing current needs of the state's nursing workforce. Since its inception, the NSP II program has gone through several revisions, including:

- The Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222] was amended in 2016 to delete "bedside" to ensure the best nursing skills mix for the workforce was not limited to just bedside nurses.

- In 2012, the NSP II program was modified to include support for development of new and existing nursing faculty through doctoral education grants. Revisions to the Graduate Nurse Faculty Scholarship (GNF) included renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, and sunsetting the living expense grant component.

- In 2012, the NSP I and NSP II initiatives were aligned with the National Academy of Medicine (NAM), formerly the Institute of Medicine, *Future of Nursing* report recommendations (2010). In 2021, the NAM released the *Future of Nursing 2020-2030* to chart the path over the next decade. The NSP I and NSP II Advisory Group met to consider how the new recommendations should be incorporated into the NSP programs and agreed that nurse retention should be the critical takeaway item to focus the joint efforts.

- In Spring 2020, the GNF was renamed the Cohen Scholars (CS) program. Additionally, the evaluation responsibility for this program was transitioned from the MHEC Office of Student Financial Assistance (OSFA) to the NSP II staff for future oversight. During the transition, NSP II staff clarified the NSP II eligible service facilities and standardized the teaching obligation for all GNF/CS recipients.

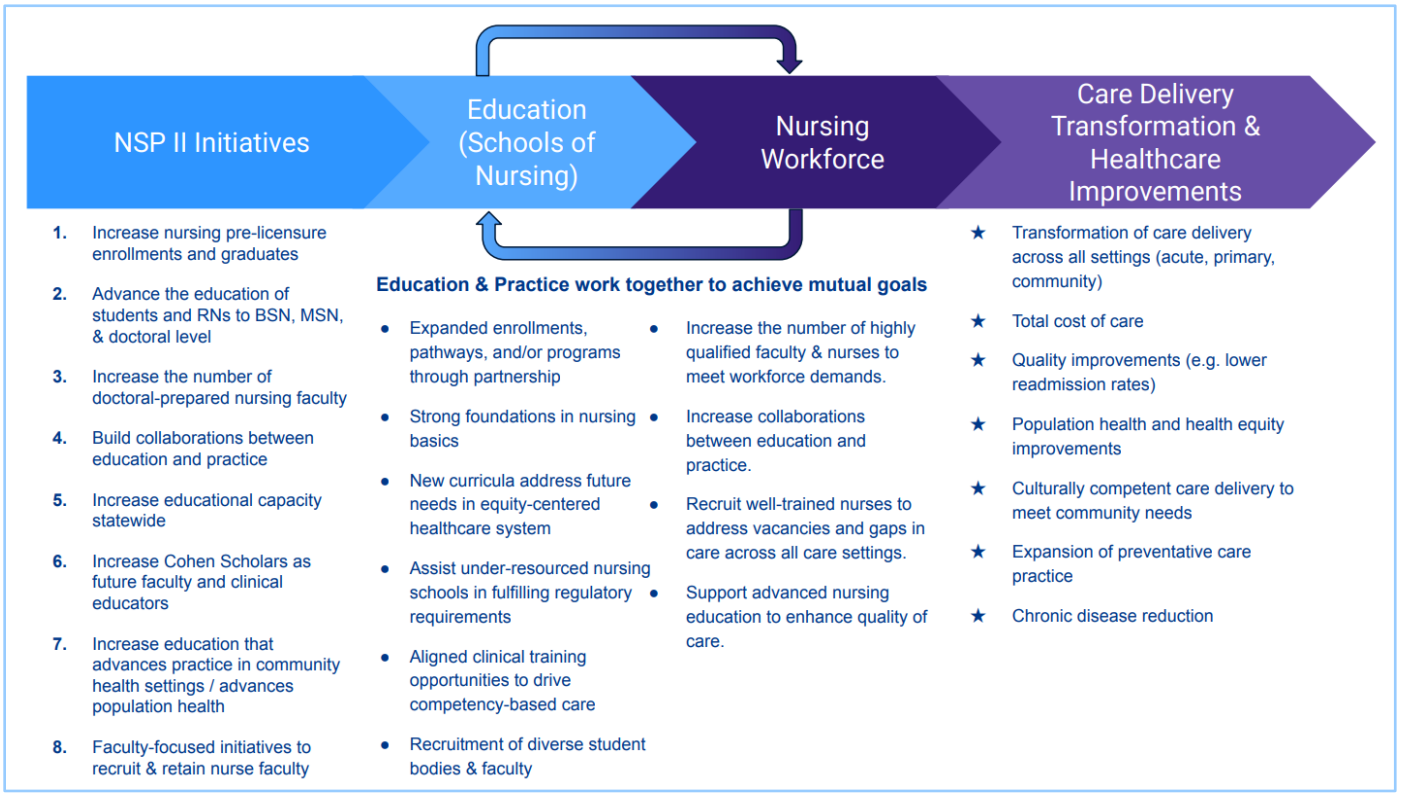
- In February 2025, the Commissioners unanimously voted to make NSP II a permanent program with annual reporting requirements, and a new initiative was added to expand educational efforts focused on health equity, community health, and ongoing support for acute care nurse vacancies.

Conceptual Framework

NSP II funding is to be used to support nursing education initiatives at all of the schools of nursing in Maryland with the goal of increasing educational capacity to meet the needs of the Maryland nursing workforce and improve the delivery and quality of care in all settings (Figure 1). Through NSP II funded initiatives, leaders in nursing education and nursing practice work together to increase the capacity to educate more nurses to grow the nursing workforce in Maryland. The collaboration between nursing schools and hospitals is a vital and interdependent one, where each supports the other's mission. Hospitals rely on nursing schools to supply them with skilled nurses, while nursing schools rely on hospitals to provide

practical, clinical training to their students. NSP II initiatives are focused on supporting the essential educational components that underpin nursing practice, including the development of clinical skills, the integration of evidence-based practices, and the cultivation of leadership abilities, all of which are critical to bridging the gap between classroom learning and real-world healthcare environments. The result of a strong relationship between education and practice is a highly trained, qualified and diverse nursing workforce that is prepared to transform the quality of care in all settings.

Figure 1. Conceptual Framework for Nurse Support Program II



NSP II Initiatives

NSP II employs a three-prong strategy for increasing the number of nurses through strengthening nursing faculty and nursing educational capacity in the state with the ultimate goal of increasing the quality of care and reducing hospital costs. These goals are achieved by (1) increasing the number of nursing lecture and clinical faculty, (2) supporting schools and departments of nursing in expanding academic capacity and curriculum, and (3) providing support to enhance nursing enrollments and graduation for an adequate supply of nurses to meet the demands of Maryland's hospitals and health systems.

In 2012, the Nurse Support Program I and II initiatives were aligned with the Institute of Medicine (IOM) recommendations in its *Future of Nursing* report and included the following aims:

1. Ensuring nursing educational capacity for Nursing Pre-Licensure Enrollments and Graduates, including Associate Degree in Nursing (ADN), Bachelor of Science in Nursing (BSN), Master of Science Entry and Second Degree BSN Entry preparation for licensure by the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to determine safety of new graduate nurses to enter practice.
2. Advancing academic preparation of entry-level nurses and experienced nurses to meet the needs of hospitals and health systems for a higher proportion of registered nurses with a Baccalaureate (BSN) or higher degree in Nursing.
3. Increasing the number of nurses and nurse faculty with graduate education and doctoral degrees to prepare them as leaders, researchers, and educators in academic and clinical settings, and advanced practice nurses.
4. Building collaborations between nursing education and practice for improved nursing competency through seamless academic progression and lifelong learning to improve patient outcomes and satisfaction.
5. Developing statewide resources and models for clinical simulation, leadership, interprofessional education, alternative clinical practice sites, and clinical faculty preparation.
6. Ensuring a cadre of qualified faculty and clinical nursing instructors with efforts to provide graduate educational support, recruit new faculty, retain experienced educators, and increase the number of certified nurse faculty in the specialty practice of nursing education.
7. Advancing the practice of nursing in provision of primary services as nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.
8. Providing for the nursing workforce data infrastructure for future workforce analysis.

In addition, with Maryland's current Total Cost of Care (TCOC) Model and the implementation of the new States Advancing All-Payer Health Equity and Development (AHEAD) Model, it is essential to prioritize initiatives that advance population health goals and prepare nurses to practice in community health settings. In accordance with the NSP II statute, the program must also track, analyze, and prioritize initiatives that support the recruitment and retention of underrepresented nursing groups. Through investments in NSP II-funded initiatives, Maryland has established itself as a leader in developing a sustainable, successful model for growing a diverse nursing workforce, while advancing progress toward national goals (Table 1).

Table 1. Pathway for NSP II Initiatives to Achieve State & National Goals

NSP II Initiative	Related NSP II Grant Outcome	Related Statewide & National metrics (data source)
1. Increase nursing pre-licensure enrollments and graduates	# Additional nursing pre-licensure graduates	Location Quotient, RN employment & wages (U.S. Bureau of Labor Statistics)
		NCLEX-RN pass rates (MBON; NCSBN)
		Nurse residency turnover & retention rates (MONL/MNRC; NSI)
2. Advance the education of students and RNs to BSNs, MSN and Doctoral level	# Additional nursing higher degrees completed	National Nursing Workforce Survey (NCSBN)
3. Increase the number of Doctoral-prepared nurse faculty	# Additional nursing faculty at Doctoral level	Proportion of nurses & nurse faculty with Doctoral degree (AACN; HRSA)
4. Build collaborations between education and practice (*Examples:* clinical education models, dedicated education units, pipelines to nursing, community-based health partnerships)	Collaborative results are specific to grant initiative (*Examples:* # of additional clinical education spots, # of additional partnerships)	Specific to grant initiative
5. Increase capacity statewide (*Examples:* faculty professional development, statewide simulation resources, nursing workforce center, nurse resiliency program)	Statewide results are specific to grant initiative (*Examples:* # of additional resources, workshops, activities or modules)	Specific to grant initiative
6. Increase Cohen Scholars as future faculty and clinical educators	# Additional Cohen Scholars	Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN)
7. Increase education that advances practice in community health settings / advances population health	Community / Population health results are specific to grant initiative *(Examples:* # of additional providers, community services provided, patient encounters)	Mortality rates, chronic disease prevalence, health behaviors, access to care (County Health Rankings & Roadmaps)
		Hospital readmission rates (HSCRC Casemix Data)
8. Faculty-focused initiatives to recruit & retain nurse faculty	# Nurse faculty recruited & retained, # Certified nurse educators	Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN); CNE® data (NLN's CNE® portal)

RN = Registered Nurse; MBON = Maryland Board of Nursing; NCSBN = National Council of State Boards of Nursing; MONL = Maryland Organization of Nurse Leaders; MNRC = Maryland Nurse Residency Collaborative; NSI = Nursing Solutions Inc.; BSN = Bachelor of Science in Nursing; MSN = Master of Science in Nursing; AACN = American Association of Colleges of Nursing; HRSA = Health Resources and Services Administration; AHRQ = Agency for Healthcare Research and Quality; CNE® = Certified Nurse Educator; NLN = National League for Nursing.

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Staff Recommendations for the Competitive Institutional Grants Program

The Competitive Institutional Grants Program builds educational capacity and increases the number of nurse educators to adequately supply hospitals and health systems with well-prepared nurses. The NSP II Competitive Grants Review Panel members are selected based upon their expertise relative to the grant program. The FY 2026 NSP II Review Panel was composed of eight members with backgrounds in healthcare, regulation, nursing education, and hospital administration, and included former NSP II project directors, NSP I and NSP II staff members.

Each grant proposal is compared to and evaluated against the criteria outlined in the Request for Applications (RFA) using a consistent scoring rubric. The scoring rubric assigns a maximum number of points to each section of the grant proposal, including: Abstract (5 pts), Overview (15 pts), Project Goals & Objectives (15 pts), Scope of Proposed Initiative (15 pts), Management Plan (15 pts), Evaluation Plan (15 pts) and Budget & Cost-Effectiveness (20 pts), for a total maximum of 100 possible points. The scoring rubric with guiding questions and a summary score sheet are distributed to the review panelists with a copy of each proposal. Every reviewer on the panel uses the same scoring rubric and guidelines when evaluating proposals and completed forms are submitted to NSP II staff. Every reviewer is asked to provide constructive comments on the strengths, weaknesses and suggested improvements for the proposal in a manner that can be shared with the applicant. When scoring each proposal, reviewers provide one of the following initial funding recommendations: highly recommend, recommend, recommend with revision or not recommend.

After the independent review panelist recommendations have been received, NSP II staff compile and verify the recommendations. Application scores, budgets and any budget revisions are recomputed to ensure mathematical accuracy. The review process concludes with a reviewer debriefing meeting where the strengths, weaknesses and opportunities, and the logic behind each reviewer's score are discussed in order to reach a consensus. Through the review panel debriefing process, final recommendations are formulated for each proposal. Reviewer comments are combined and appropriately paraphrased as needed for each proposal. These comments are shared with the applicants whose proposal was not recommended to help them to better prepare future grant proposals. Reviewer identity is kept confidential at all times. A total of 30 proposals were received for the FY 2026 NSP II RFA from nursing programs at three community colleges and ten universities. All 30 proposals were scored and reviewed by the NSP II Review Panel.

Based on the outcome of this review, HSCRC and MHEC staff recommend the following 24 proposals presented in Table 5 for the FY 2026 NSP II Competitive Institutional Grants Program, totaling $17,256,234. This final recommendation describes the panel's recommendations for Commission approval.

Table 5. FY 2026 Recommendations for Funded Proposals

Proposal	School	Title	Duration	Total Funding Request
NSP II-26-101	Bowie State University	Increasing the PhD Nurse Faculty Workforce	4 years	$2,267,404
NSP II 26-102	Morgan State University	Cohen Scholars Cohort Model	4 years	$360,038
NSP II 26-103	Morgan State University	Increasing Capacity by Going Online and Expanding Graduate Offerings	2 years	$463,196
NSP II 26-105	University of Maryland, Baltimore	AI in Maryland Higher Education	4 years	$578,633
NSP II 26-106	Johns Hopkins University	Bring Care 2 ME	1 year	$150,000
NSP II 26-108	Notre Dame of MD University	Advancing Trends in Program Assessment	1 year	$18,857
NSP II 26-109	Prince George's Community College	Expanding Transition to RN Program Enrollment	2 years	$130,000
NSP II 26-110	University of Maryland, Baltimore	Preceptor Program for Undergraduate Nursing Education	1 year	$145,308
NSP II 26-111	University of Maryland, Baltimore	DNP in Population Health/ Public Health Nursing	2 years	$142,744
NSP II 26-201	Allegany College of Maryland	Professional Development Resource Grant	1 year	$50,000
NSP II 26-202	Frostburg State University	Professional Development Resource Grant	1 year	$43,591
NSP II 26-203	McDaniel College	Professional Development Resource Grant	1 year	$41,119
NSP II 26-204	Montgomery College	Professional Development Resource Grant	1 year	$49,680
NSP II 26-206	Notre Dame of MD University	Professional Development Resource Grant	1 year	$46,343
NSP II 26-207	Salisbury University	Be a Maryland Nurse Educator- Addressing Nurse Retention through LeadNursingForward.org, Resource Grant	1 year	$100,000
NSP II 26-208	Salisbury University	Professional Development Resource Grant	1 year	$50,000

NSP II 26-209	Towson University	Professional Development Resource Grant	1 year	$50,000
NSP II 26-210	Johns Hopkins University	Cohen Scholars Cohort Model Continuation Grant	4 years	$2,262,173
NSP II 26-211	Montgomery College	Maryland Clinical Simulation Resource Consortium Continuation Grant	4 years	$4,151,912
NSP II 26-212	Notre Dame of MD University	Cohen Scholars Cohort Model Continuation Grant	4 years	$774,440
NSP II 26-213	Salisbury University	Cohen Scholars Cohort Model Continuation Grant	4 years	$868,914
NSP II 26-214	Salisbury University	Faculty Academy and Mentorship Initiative of Maryland Continuation Grant	4 years	$2,296,151
NSP II 26-215	Stevenson University	Cohen Scholars Cohort Model Continuation Grant	4 years	$703,670
NSP II 26-216	University of Maryland, Baltimore	Cohen Scholars Cohort Model Continuation Grant	4 years	$1,512,061
TOTAL				**$17,256,234**

These highly recommended proposals address the following NSP II initiatives:

- NSP II Initiative #1 to increase nursing pre-licensure enrollments and graduates:
    - A one-year planning grant that aims to enhance faculty expertise in multi-dimensional assessment, focusing on student persistence and retention, teaching quality, and program accountability to build faculty and staff capacity for interpreting assessment data and driving meaningful improvements within the School of Nursing. (NSP II 26-108)
    - A two-year planning grant to develop a hybrid transition course that supports Licensed Practical Nurses in advancing to Registered Nurse roles. The course will expand access, increase program capacity, and offer flexible learning through online instruction and in-person clinical skills training. (NSP II 26-109)
- NSP Initiative #2 to advance the education of students and RNs to the BSN, MSN, and doctoral level:
    - A two-year implementation grant to launch fully online RN-to-BSN and MSN programs, expanding access for working nurses and increasing the number of bachelor's- and master's-prepared RNs in Maryland. The initiative supports statewide workforce goals by offering flexible, accelerated pathways that accommodate professional schedules and

promote lifelong learning. By 2027, the programs aim to increase capacity by graduating an additional 20 BSN-prepared and 12 MSN-prepared nurses. (NSP II 26-103)

  - A two-year planning grant to develop a Doctor of Nursing Practice (DNP) degree track in Advanced Public Health Nursing. The program will prepare doctoral-level nurses to lead population health initiatives, address health inequities, and influence policy through a curriculum developed in collaboration with public health agencies. This initiative will strengthen the public health nursing workforce, address faculty shortages, and expand Maryland's capacity to meet critical public health needs. (NSP II 26-111)

- NSP II Initiative #3 to increase the number of doctoral-prepared nursing faculty:
  - A four-year implementation grant to establish a PhD program in Nursing Education, addressing the urgent need for PhD-prepared nursing faculty in Maryland. Launching in Fall 2025, the program aims to graduate its first cohort of at least five PhD-prepared nurses by 2029, with 20 additional students on track to complete the program by 2033. This initiative directly supports statewide workforce goals by expanding access to affordable, rigorous doctoral education and strengthening the future nursing faculty pipeline. (NSP II 26-101)
- NSP II Initiative #4 to build collaborations between education and practice:
  - A one-year planning grant to develop educational and operational plans for a nurse-managed community primary care site that will expand access to services and strengthen the nursing workforce pipeline. The project will design clinical preceptorships for high school, pre-licensure, and advanced practice nursing students, and develop training frameworks and competency evaluations. (NSP II 26-106)
  - A one-year planning grant to pilot a preceptor development program to strengthen the preceptor-student learning experience in undergraduate nursing education. Building on nearly 20 years of academic-practice partnership experience, the project will assess preceptor needs, design a best practices program to reduce burnout and improve retention, and pilot the model at two Maryland hospitals. Outcomes will include evaluation of preceptor well-being, role satisfaction, and intention to stay in their preceptor role. (NSP II 26-110)
- NSP II Initiative #5 to increase capacity statewide:
  - A three-year implementation grant to train 100 Maryland nurse educators in foundational Artificial Intelligence (AI) skills and advance 40 to mastery. Through webinars, mentorship, and an innovation symposium, the program will enhance faculty efficiency, expand teaching

capacity, and better prepare future nurses for technology-enhanced practice, directly supporting statewide workforce expansion goals. (NSP II 26-105)

- A resource grant to expand the www.LeadNursingForward.org web resource aimed at addressing the nursing faculty shortage in Maryland. By adding content focused on nurse educator retention and innovative strategies to support the workforce, this project will provide accessible, up-to-date information on becoming and staying a nurse educator, contributing to long-term solutions for the state's healthcare delivery needs. (NSP II 26-207)
- A four-year continuation grant to support the Maryland Clinical Simulation Resource Consortium (MCSRC), a program that has enhanced simulation-based learning in Maryland's nursing schools and healthcare facilities. The funding will enable the development of 480 simulation education leaders, certify 100 healthcare simulation educators, and produce 28 educational videos as statewide resources. These efforts will enhance faculty competencies, integrate emerging technologies, and strengthen the nursing education pipeline, ultimately preparing a skilled workforce to meet Maryland's growing healthcare demands. (NSP II 26-211)
- A four-year continuation grant to update and expand the Faculty Academy and Mentorship Initiative of Maryland (FAMI-MD), a program that has trained over 600 nurse educators. The project aims to update the curriculum, enhance participant and facilitator diversity through statewide recruitment, and establish standardized training and evaluation processes. By preparing 400 nurse experts for clinical teaching roles, this initiative will improve faculty retention and support increased enrollments in Maryland's nursing programs. (NSP II 26-214)
- Professional development resource grants for a total of 7 Schools of Nursing to support faculty retention and nursing student success through faculty participation in national and statewide nursing conferences. (NSP II 26-201, 26-202, 26-203, 26-204, 26-206, 26-208, & 206-209)

- NSP II Initiative #6 to increase Cohen Scholars as future faculty and clinical educators:
  - A four-year implementation grant to initiate the Cohen Scholars Program at one school to expand Maryland's nursing education workforce. Through scholarships awarded to students pursuing graduate degrees and teaching certificates, Cohen Scholars commit to a nursing education teaching service obligation in Maryland upon graduation. The program ensures a steady pipeline of new nurse faculty, clinical educators, and professional

development specialists needed to meet the state's growing healthcare and workforce demands. (NSP II 26-102)

- Four-year continuation grants for a total of five schools to continue the Cohen Scholars program to sustain and expand the successful preparation of new nurse educators in Maryland. Cohen Scholars complete graduate degrees and teaching certificates and fulfill a nursing education teaching service obligation within the state. Continued support will ensure a steady pipeline of qualified nurse faculty, clinical educators, and professional development specialists to meet Maryland's healthcare workforce needs and address faculty shortages.(NSP II 26-210, 26-212, 26-213, 26-215, 26-216)

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This content was drafted with the assistance of a generative AI tool (ChatGPT). The content has been reviewed and verified to be accurate and complete, and represents the intent of the Nurse Support Program I & II, funded by the Health Services Cost Review Commission.

CRISP
Chesapeake Regional Information System for our Patients

CRISP HSCRC Funding Request

May 2025

CRISP Background

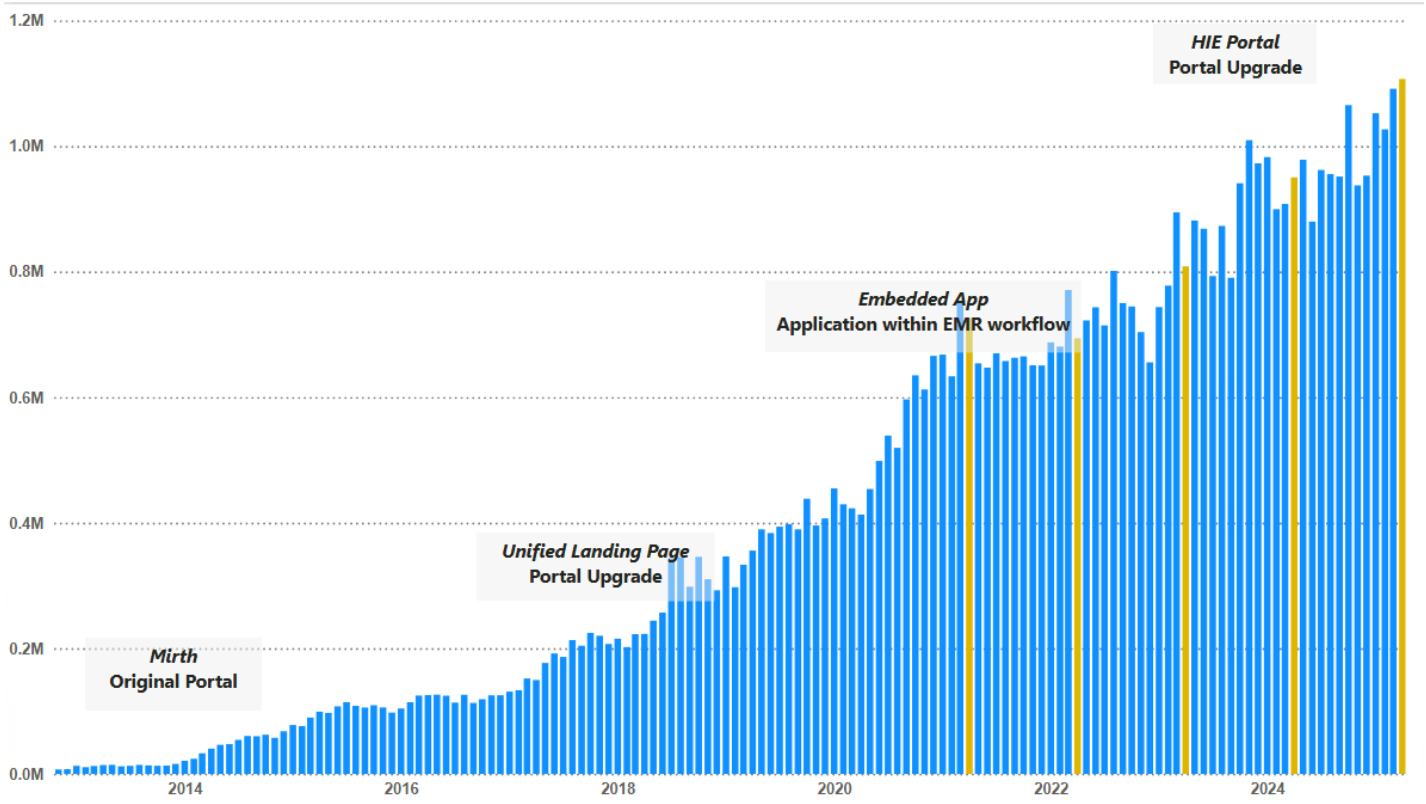
- State-Designated Health Information Exchange (**HIE**) and Health Data Utility (**HDU**)
- Shared infrastructure reused across multiple states
- **Key Benefits:**
  - Help healthcare providers deliver faster, better care by promoting data sharing across the region
  - Assist in the evaluation of public health interventions
  - Coordinate care between different providers, ensuring a more cohesive healthcare experience for patients
  - Lower patient healthcare costs by reducing repeated tests

***Vision**: To advance health and wellness by deploying health information technology solutions adopted through **cooperation** and **collaboration**.*

Key Statistics

- Utilization growth is steady
  - 44,000 Active Users
  - 1,500 CEND users
  - 15.6M unique alerts delivered in past 90 days
  - 175,600 unique alerts delivered per day
- Continuous innovation to support health care system
  - CEND
  - My Patient Summary
  - Patient Consent for Sensitive Data
  - AIM Winners
  - Public Health Reports (Maternal health, SUVI, etc.)

Patient Queries Over Time



HSCRC Staff Funding Recommendation

Direct HIE Operations	$3,229,000
Reporting and Program Administration	$9,831,000
Maryland Total	**$13,060,000**
Reserves	*$1,000,000*
Funding Request	**$12,060,000**

Maryland Revenue	Hospital Rates	Federal Funds	User Fees	MDH	Total
HIE Operations	$3.2M	$9.4M	$5.9M	$3.2M	**$21.7M**
Reporting and Program Admin	$9.8M	$9.7M	----	$3.1M	**$22.6M**
Other Non-HSCRC Programs	----	$3.6M	----	*$2.3M*	**$5.9M**
Total Funding	**$13.0M**	**$22.7M**	**$5.9M**	**$8.6M**	**$50.2M**
Percent of Total	*26%*	*45%*	*12%*	*17%*	*100%*

Note: This schedule does not include CRISP projects anticipated to be funded entirely by MDH or federal grants

- **Key Takeaways:**

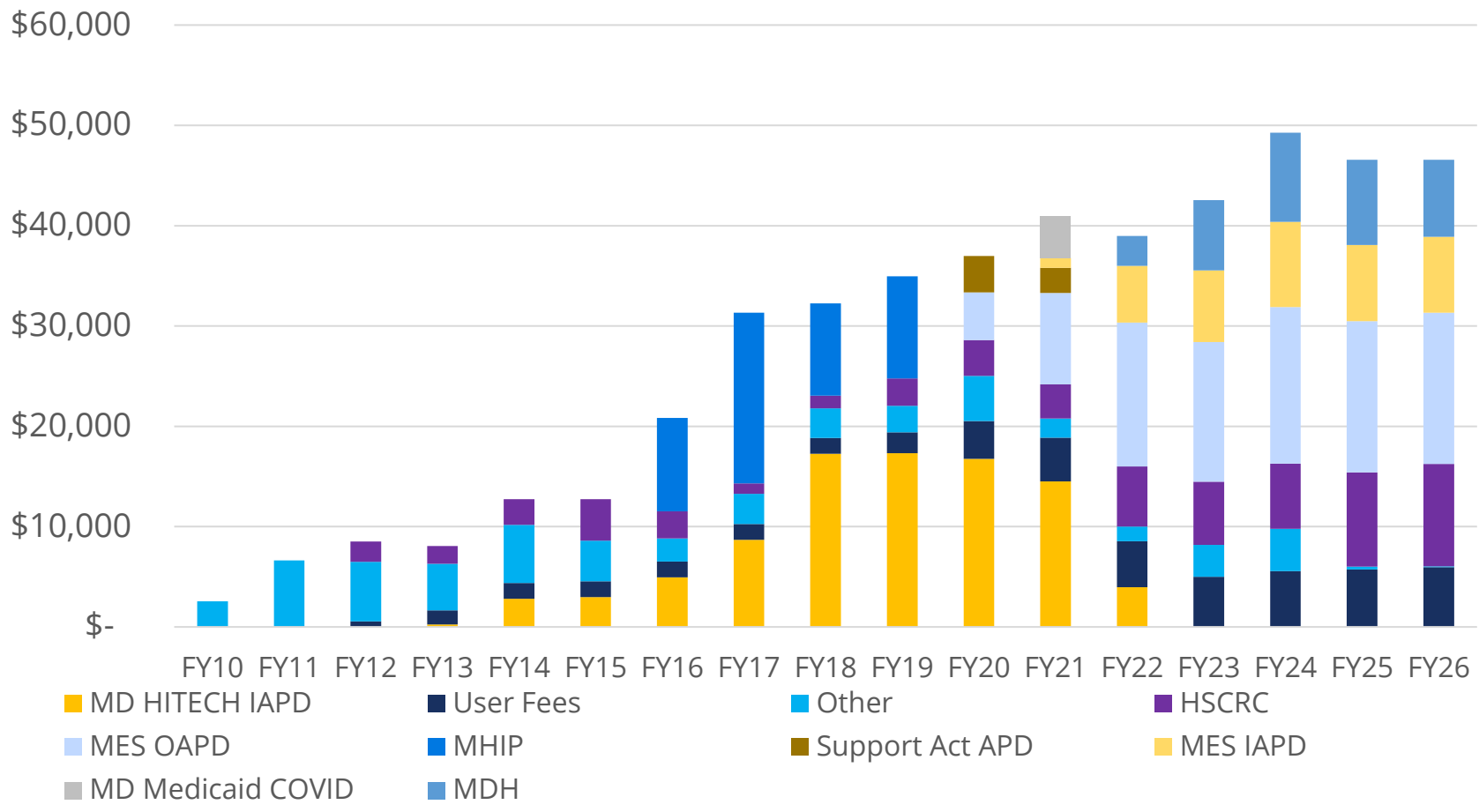
1. Direct HIE Operations funding is consistent with prior years, including project investments to enhance operations and maintain compliance with federal standards.
2. The federal Medicaid matching rate for new development and ongoing operations may shift from 90/10 and 75/25 respectively in FY25 to 50/50 in FY26.
3. New priorities are anticipated related to AHEAD. In addition, potential changes in Medicaid match rates may impact budget.

Long-term Funding Trend

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

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

Actual/Projected Spending by Source



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

Draft Recommendation

May 14, 2025

This is a draft recommendation for consideration by the Commission. Public comments must be received by May 21, 2025, to william.henderson@maryland.gov

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

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List of Abbreviations

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

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Policy Overview

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

Summary of the Recommendation

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

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

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

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

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

Background – Past Funding

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

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

CRISP Budget: HSCRC Funds Received	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$4,800,000
FY 2024	$4,800,000
FY 2025	$8,420,000
FY 2026	$12,060,000

Funding Through Hospital Rates

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

Funding Through Federal Matching

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

Medicaid Enterprise System (MES) Matching Funds

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

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

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

Other Funding

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

Description of Activities Funded

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

Category 1: HIE Operations Funding and Infrastructure

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

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

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

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

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

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

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

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

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

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

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

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

Staff Recommendation

Staff is recommending the Commission approve a total of $12,060,000 in funding through hospital rates in FY 2026 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of $13,060,000 but proposes to use $1,000,000 of prior reserves, limiting the actual assessment to $12,060,000.

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

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

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

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

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Draft Update Factor Recommendation

May 14, 2025

Policy Objective and Update Factor Components

- The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.

- One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.

- CY 2025 is the final year under the Total Cost of Care Agreement. Beginning January 2026 we will be under the AHEAD requirements.

Components Include:

- Inflation
- Care Coordination
  - Regional Partnerships
- Population and Demographic Adjustments
- Quality/ PAU
  - MHAC, QBR, RRIP
- Other Adjustments
  - Unforeseen Adjustments
  - Complexity & Innovation
  - Capital Adjustments/FRA increases
- Revenue Offsets with Neutral Impact of Financial Statements
  - Deficit Assessment
  - Uncompensated Care

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.74%	$166.0	$54.8
- RY2026 Revision to Prior Year Estimates			0.76%	$170.5	$56.3
Total Adjustment for Volume	**C**		**1.50%**	**$336.5**	**$111.1**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.20%	$44.9	$14.8
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.20%	$44.9	$14.8
- Reversal of one-time adjustments for drugs	G		-0.05%	-$11.2	-$3.7
- Capital Funding & Estimated Increase for Full Rate Applications	H		0.13%	$28.6	$9.4
- UCC Fund Revision	I		0.30%	$67.2	$22.2
Net Other Adjustments	**J =**	**Sum of D thru I**	**0.78%**	**$174.3**	**$35.3**
Quality and PAU Savings					
- PAU Redistribution	K		-0.03%	-$6.73	-$2.2
- Reversal of prior year quality incentives	L		-0.16%	-$34.9	-$11.5
-QBR, MHAC, Readmissions					
- Current Year Quality Incentives	M =		-0.06%	-$14.1	-$4.6
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.6**	**-$18.4**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.41%**	**$1,184.9**	**$368.8**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.64%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	Q		-0.44%	-$98.7	-$32.6
- Deficit Assessment	R =		0.70%	$158.0	$52.1
Net decreases	**S =**	Q + R	**0.26%**	**$59.2**	**$19.5**
Total Update First Half of Rate Year 26					
Revenue growth, net of offsets	**T =**	O + S	**5.68%**	**$1,274.1**	**$388.4**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.90%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**V =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**W =**	T + V	**5.68%**	**$1,274.1**	**$420.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.90%**		

Demographic Adjustment Overview

Purpose

- Designed to **adjust for hospital volume changes due to population changes**, without allowing for increases in hospital volume due to potentially avoidable utilization (PAU).
- Generally **provides additional funding to the system** because population is growing - serves as **governor** to total new volume funding.

Adjustment is relative to current Maryland experience only, so no overall secular changes are accounted for

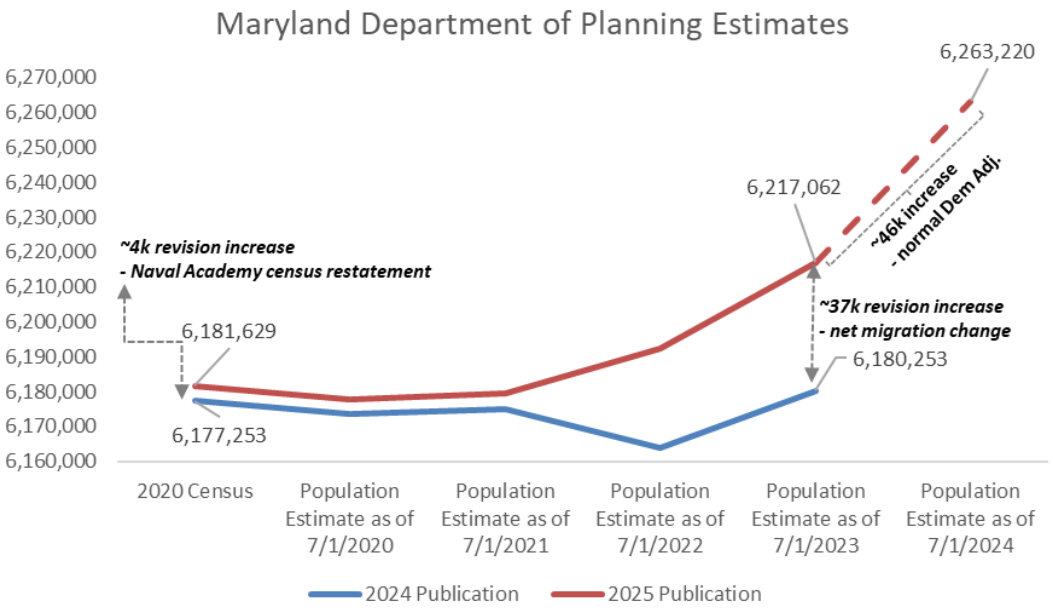
How it Works

Uses ZIP code population projections by age cohort to apportion anticipated hospital volume growth, allocated by a hospital's market share so that hospitals gaining market share will gain more demographic adjustment

Methodology

1. **Base population estimates** attributed by hospital's share of volume in a given ZIP code and age cohort
2. **Age adjusted population growth rates** are calculated by ZIP code and age cohort, adjusted for Statewide age costs
3. **Hospital-specific age adjusted population growth** is calculated by multiplying hospital-specific base population by age-adjusted population growth rates, using ZIP codes and adjusted by age cohort
4. **Age Adjusted Growth Scaled to Population Growth** incorporates adjustments for potentially avoidable utilization and a scaling adjustment to ensure the Demographic Adjustment is not more than population growth - no variable cost factor is applied

Restatement of Population Growth



- Staff did not intend to reconcile changes to prior year Planning estimates until 2030; however, staff amended that thinking because:
  - Planning revised the 2020 census, not just growth since the census
  - Planning's changes to growth since the census are very material
- To correct for Planning's new estimates, staff are putting forward for consideration that the RY 2026 DA (and subsequent DA's) reconcile to the cumulative Planning estimate from 2020 to most recent year population count

RY 2023 - RY 2025 UCC Regression Error

- UCC fund calculation involves a 50/50 blend of UCC Actuals AND Predicted UCC using a logistic regression
- The logistic regression determines the probability of UCC using payer type, area deprivation index (ADI) and site of service variables **at the patient level**
  - If an ADI variable is not available, the hospital specific average ADI is used
- From FY21 - FY23, the ADI variable changed and was not properly captured in the calculation, which resulted in **hospital ADI averages** in all instances
- Due to this error, there were incorrect coefficients and misapplication of erroneous coefficients
  - Generally, the error adversely affected hospitals with lower than average ADI scores, i.e., those hospitals with wealthier patient populations
  - Statewide UCC was not affected because the policy is redistributive

The smaller the ventile the more affluent the patient (ranges from 0-100 in units of 5)

	Payer Status	Site of Service	ADI (Ventiles)	Hosp Avg ADI	UCC Probability
Patient 1 (known ADI)	Commercial	ED	90	22.33	
Patient 2 (unknown ADI)	Commercial	ED	NA	22.33	
Correct UCC Methodology for Patient 1	Commercial	ED	90	90	0.53
Correct UCC Methodology for Patient 2	Commercial	ED	NA	22.33	0.27
Incorrect Application for Patient 1	Commercial	ED	90	22.33	0.18
Incorrect Application for Patient 2	Commercial	ED	NA	22.33	0.18

UCC Fund Revision Impact

- Statewide, UCC was funded correctly; however, given the incorrect development and application of coefficients, distribution via the UCC pool was flawed
- Net impact for adversely affected hospitals across 3 years (RY 2023 - RY 2025)
  - Individual hospital basis = ~$102M
    - RY 2023: ~$32.4M
    - RY 2024: ~$34.9M
    - RY 2025: ~$34.5M
  - Hospital system basis = ~$67.2M
    - RY 2023: ~$20.7M
    - RY 2024: ~$22.9M
    - RY 2025: ~$23.8M

Possible Solutions

	Budget Neutral or Hold Harmless	System or Hospital	Duration of time	Funding
Option 1 (Ensure Intended Policy Result)	Ensure budget neutrality by offsetting funding corrections by the same amount of revenue that was incorrectly provided to hospitals	Implement on a hospital basis, as that is the unit of measurement for the UCC policy	Settle over one year to remedy methodology error expediently OR settle over time (e.g. 3 years) to mitigate rate impact by accounting for "credit" in UCC pool	Increase statewide UCC markup in rates to recognize funding AND/OR Utilize available fund balance in UCC Fund
Option 2 (Account for Adverse Impact)	Hold hospitals harmless by not clawing back funding from institutions that were overfunded through the methodology error	Take into account the net effect to hospital systems to mitigate the clawback from hospitals that were overfunded		
Staff Recommendation	Hold hospitals harmless, as they tended to be rural and safety net hospitals. Clawback would be disruptive as hospitals may generally assume that UCC policy is being implemented pro forma.	Utilize system approach to mitigate rate impact, as was done with CARES reconciliations	Settle over one year to reduce complexity and because rate impact is mitigated by system approach. Utilize 3 years if hospitals are not held harmless	Use UCC Fund first to mitigate rate impact but leave 1 month balance and then use rate support

Integrated Efficiency Policy Background

Purpose

- To formulaically **penalize and reward hospital efficiency** while maintaining:
  - the TCOC Model's incentive to **reduce avoidable utilization**
  - Compliance with the HSCRC's statutory mandate to ensure **that total costs are reasonable** and that aggregate **charges are reasonably related to aggregate costs**
- Will be used to **scale annual inflation for poor performing outliers**; staff can also use the ranking to **evaluate GBR rate enhancement requests**

How it Works

Ranks hospitals on an efficiency matrix according to all-payer cost per case efficiency using a volume adjusted Inter-hospital Cost Comparison (ICC) methodology and Medicare and Commercial TCOC performance

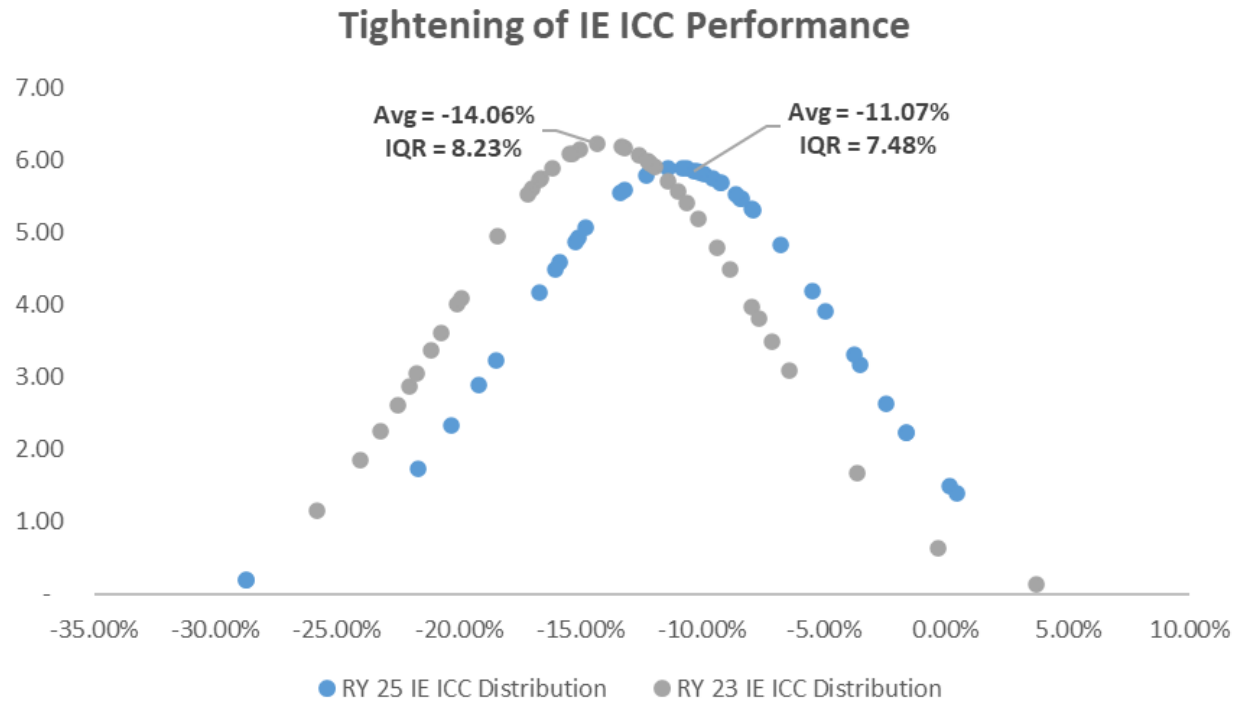
Methodology

- The most efficient hospital receives a rank of 1 under both the ICC and TCOC ranking
- Total Integrated Efficiency rank is the sum of a hospital's ICC and TCOC rank

Hospitals are arrayed into quartiles based on overall efficiency -

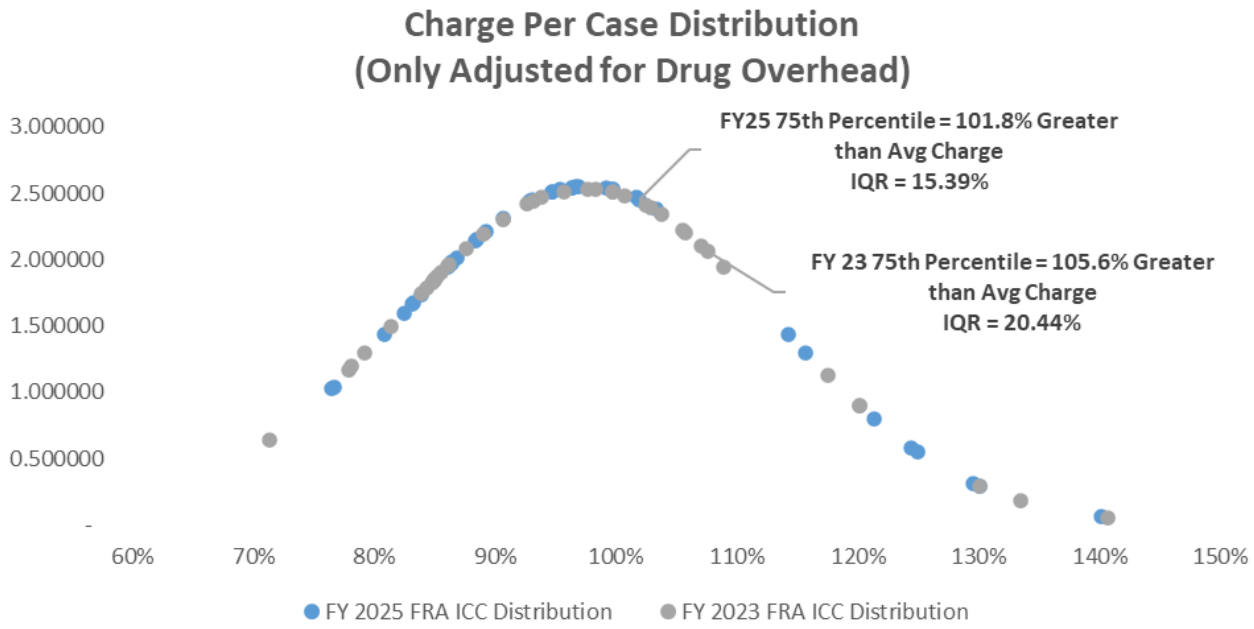
4th quartile is penalized regardless of performance variance from 3rd quartile

Concerns with Ongoing Implementation of Integrated Efficiency



- A methodology that relies on ordinal ranking to determine outliers AND continually scales hospitals accordingly may eventually penalize hospitals closer to average performance, i.e., the cliff effect
- A visual tightening of the distribution of ICC performance in the Integrated Efficiency policy and a shrinking Interquartile Range suggest future ordinal ranking approaches may penalize future performers that are not “outliers”

Concerns with Ordinal Ranking



- A review of Hospital's Charge Per Case narrowing further highlights concern about ongoing reliance of ordinal ranking method

  In light of methodology concern, staff are recommending a threshold by which hospitals will not be penalized in Integrated Efficiency

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

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
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- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.74%	$166.0	$54.8
- RY2026 Revision to Prior Year Estimates			0.76%	$170.5	$56.3
Total Adjustment for Volume	**C**		**1.50%**	**$336.5**	**$111.1**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.20%	$44.9	$14.8
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.20%	$44.9	$14.8
- Reversal of one-time adjustments for drugs	G		-0.05%	-$11.2	-$3.7
- Capital Funding & Estimated Increase for Full Rate Applications	H		0.13%	$28.6	$9.4
- UCC Fund Revision	I		0.30%	$67.2	$22.2
Net Other Adjustments	**J =**	**Sum of D thru I**	**0.78%**	**$174.3**	**$35.3**
Quality and PAU Savings					
- PAU Redistribution	K		-0.03%	-$6.73	-$2.2
- Reversal of prior year quality incentives	L		-0.16%	-$34.9	-$11.5
-QBR, MHAC, Readmissions					
- Current Year Quality Incentives	M =		-0.06%	-$14.1	-$4.6
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.6**	**-$18.4**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.41%**	**$1,184.9**	**$368.8**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.64%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	Q		-0.44%	-$98.7	-$32.6
- Deficit Assessment	R =		0.70%	$158.0	$52.1
Net decreases	**S =**	Q + R	**0.26%**	**$59.2**	**$19.5**
Total Update First Half of Rate Year 26					
Revenue growth, net of offsets	**T =**	O + S	**5.68%**	**$1,274.1**	**$388.4**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.90%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**V =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**W =**	T + V	**5.68%**	**$1,274.1**	**$420.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.90%**		

Revenue Scenarios

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2024		10,772,404,416
Actual Revenue July - December 2024		11,019,304,349
Actual Revenue CY 2024		21,791,708,765
Step 1:		
Approved GBR RY 2025		22,436,402,668
Actual Revenue 7/1/24-12/31/24		11,019,304,349
Approved Revenue 1/1/25-6/30/25		11,417,098,319
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/25-6/30/25	**A**	**11,417,098,319**
Expected Revenue Growth 1/1/25-6/30/25		**5.98%**
Step 2:		
Final Approved GBR RY 2025		22,436,402,668
Reversal of Extraordinary One-Times		-150,893,207
Final Adjusted GBR Base for RY 2025		22,285,509,461
Projected Approved GBR RY 2026		23,551,039,020
Permanent Update RY 2026		5.68%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,639,516,636
Projected RY26 Increase over RY25		6.08%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,780,796,623**
Expected Revenue Growth 7/1/25- 12/31/25		**6.91%**
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,197,894,942**
Increase over CY 2024 Revenue		**6.45%**
Per Capita Increase over CY 2024		**5.67%**

MC FFS Guardrail Tests - Proposed Scenarios

- All scenarios uses HSCRC revenue projection for Part A and Part B MD Hospital
- Dropped pre-pandemic baselines (but not trend references)
- For MD Non-Hospital and US Hospital and Non-Hospital

  Scenario 1: 2024 Trended forward at 2017 - 2019 Trend

  Scenario 2: 2024 Trended forward at 2015 - 2019 Trend

  Scenario 3: 2024 Trended forward at 2022 - 2024 Trend

  Scenario 4: 2024 Trended forward using USPCC projections

CY 25 Guardrail Scenario 1: 2024 Trended forward at 2017 - 2019 Trend

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

Scenario 1 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,427	$13,886	Predicted Variance
YOY Growth	5.3%	3.9%	1.4% Over
Estimated CY 2025 Savings Run Rate			$637.6 M

CY 25 Guardrail Scenario 2: 2024 Trended forward at 2015 - 2019 Trend

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

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,348	$13,746	Predicted Variance
YOY Growth	4.8%	2.9%	1.9% Over
Estimated CY 2025 Savings Run Rate			$564.7 M

CY 25 Guardrail Scenario 3: 2024 Trended forward at 2022 - 2024 Trend

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

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,513	$14,141	Predicted Variance
YOY Growth	5.9%	5.8%	0.1% Over
Estimated CY 2025 Savings Run Rate			$809.9 M

CY 25 Guardrail Scenario 4: 2024 Trended forward using USPCC projections

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

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,505	$14,033	Predicted Variance
YOY Growth	5.9%	5.0%	0.9% Over
Estimated CY 2025 Savings Run Rate			$717.9 M

Scenario 4 is based on the United States Per Capita Cost (USPCC) data published by CMS.

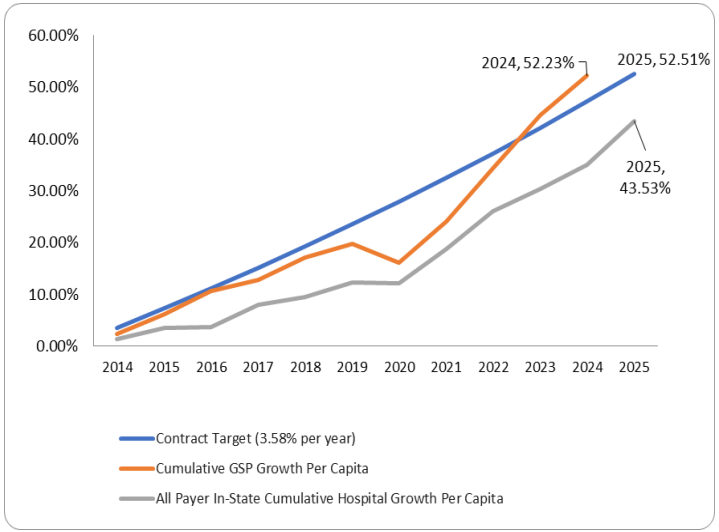
USPCC trend information can be found here: https://www.cms.gov/files/document/2026-announcement.pdf

All-Payer Affordability

- The Total Cost of Care contract all-payer test aims to limit all-payer in-state hospital charge growth to 3.58 percent per annum over the life of the contract.The cumulative value of this target through CY 2025 is 52.51 percent *(as shown by blue line on Table 7).*
- Actual all-payer in-state hospital charge growth through CY 2024 is 35.06 percent, inflating this to 2025 using the recommended update factor on a per capita basis yields 43.53 percent *(as shown by grey line on Table 7).*
- Maryland is approximately 9 percentage points below the contract target, which is an indication of savings generated by the TCOC Model that accrue to all payers and consumers. The cumulative GSP line *(as shown by orange line in Table 7)* ends in 2024 due to the absence of official 2025 data, therefore staff opted not to project GSP growth. However, even with no growth in 2025, Maryland would remain under both the cumulative target and actual GSP growth.

Table 7

Affordability Scorecard – Cumulative GSP Test with CY 2025 Projection



Update Factor Recommendation for Non-Global Budget Revenue Hospitals

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.36%	3.36%
Productivity Adjustment	N/A	-0.80%
Additional Inflation Support	0.00%	0.00%
Proposed Inflation Update	3.36%	2.56%

Recommendations

For Global Revenues:

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

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

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

Appendix

Inflation Risk Corridor Methodology

Inflation Catch-Up Methodology

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

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

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Draft Recommendation for the Update Factors for Rate Year 2026

Please submit all comments to hscrc.payment@maryland.gov by COB May 21, 2025.

Table of Contents

List of Abbreviations

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

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The draft recommendation provides an annual update factor of 4.90 percent per capita, a revenue increase of 5.68 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 2.56 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2026. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Executive Summary

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

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

Staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

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

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

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

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

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

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

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

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

Introduction & Background

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

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

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

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

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland, and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals only affects the hospitals price, not volume.

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

Overview of Draft Update Factors Recommendations

For RY 2026 HSCRC staff is proposing an update of 4.90 percent per capita for global budget revenues and an update of 2.56 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

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

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.36 percent. Furthermore, the staff recommends a productivity adjustment of 0.80 percent in line with the proposed IPPS rule for FFY 2026. When this productivity adjustment is deducted from the gross blended inflation rate of 3.36 percent, the result is a proposed net update of 2.56 percent.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.36%	3.36%
Productivity Adjustment	N/A	-0.80%
Additional Inflation Support	0.00%	0.00%
Proposed Inflation Update	3.36%	2.56%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

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

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

Net Impact of Adjustments

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

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
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Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

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

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

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

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

Table 3: Inflation Risk Corridor Methodology

Inflation Catch-Up Methodology

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

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

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

At the January 8, 2025 Commission meeting, the Commission voted to approve revision to the outpatient high-cost drug funding policy or CDS-A policy. The approved revision included providing funding based on 100 percent reimbursement of changes in drug cost. As a result of this policy revision, inflation is only needed for pure price which is the price change of each drug at its base year volume. In the RY 2026 Update Factor, staff are using a 1 percent inflation based on longer term trends of pure price. This value is the same for both academic and non-academic hospitals. The result of this translates to 0.02 percent carve out of inflation.

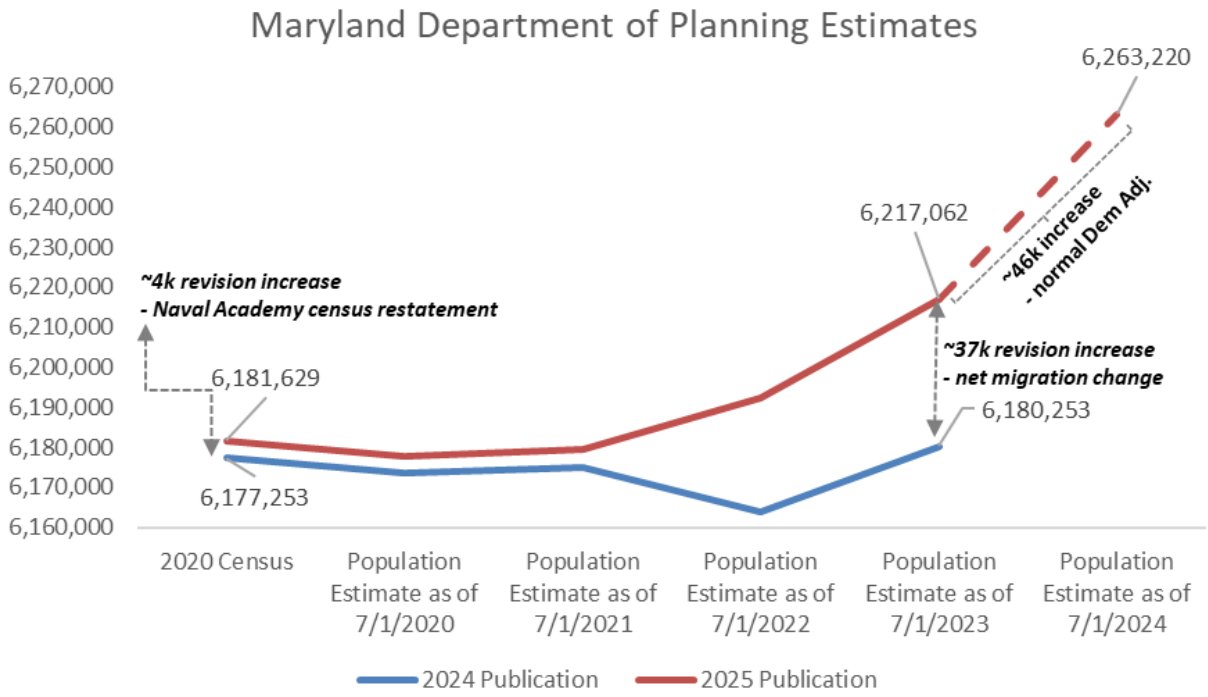
- **Care Coordination / Population Health:** In RY 2025, several grant programs focused on Care Coordination and Population Health were implemented, which contributed to hospital revenues. These programs included the Behavioral Health and Maternal and Child Health Improvement Fund Assessment. The funds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

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

2026 is approximately 0.13 percent, bringing the total Care Coordination/Population Health adjustment in this recommendation to 0.03 percent.

- **Adjustments for Volume:** Staff are proposing a population growth estimate of 0.74 percent for RY 2026 (~46 thousand lives) in line with the historical methodology of increasing global budgets by the most recent year-over-year population growth estimate from the Maryland Department of Planning. In addition to applying the standard methodology, staff are also proposing to reflect revised historical data from the Maryland Department of Planning. These revisions were significant and included a census restatement that added 4,405 lives, as well as a 2023 base year restatement for net migration, which added 36,809 lives (see Figure 1 below).

Figure 1: Maryland Department of Planning Revisions to Population Estimates



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

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

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining relatively inefficient hospitals in the TCOC Model. The policy utilizes the Inter-Hospital Cost Comparison (ICC) methodology to compare relative cost-per-case efficiency and Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used in an ordinal ranking scoring matrix to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. In prior years, the Integrated Efficiency policy has redirected funding from hospitals if they were in the bottom quartile of the scoring matrix; however, a methodology that relies on ordinal ranking to determine outliers AND continually scales hospitals accordingly may eventually penalize hospitals closer to average performance, i.e., the cliff effect. Additionally, staff have discussed with the Payment Model Workgroup that there is a clear tightening of performance in the ICC and generally in hospital charge per case, suggesting the policy is working but the current ongoing application may be inappropriate (see Figure 2 below):

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

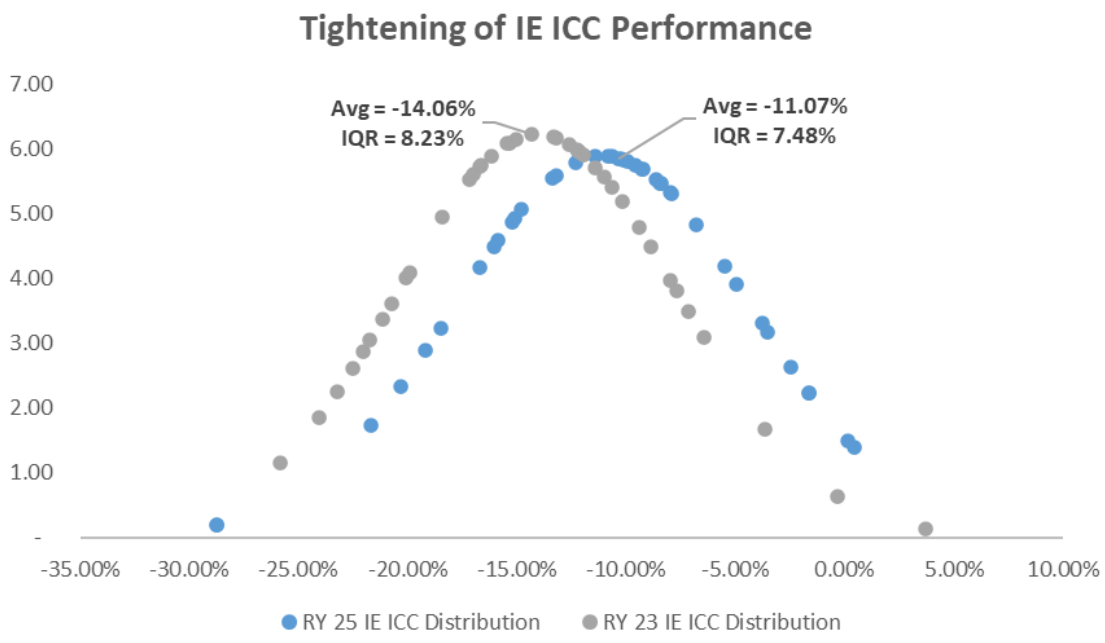
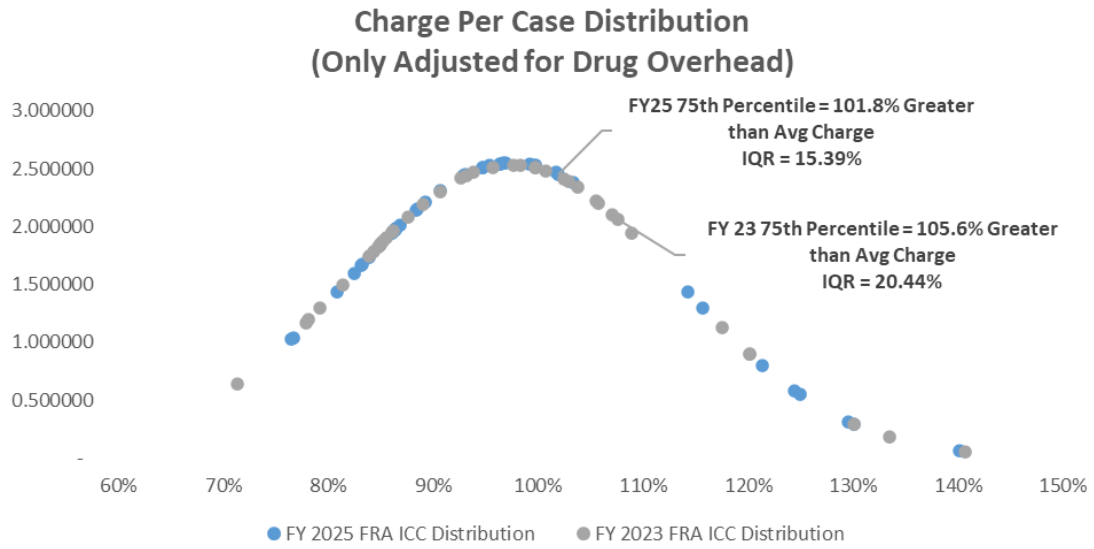


Figure 2b: Hospital Charge Per Case Distribution



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

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

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

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

- **Set-Aside:** The intention of the set-aside is to use these funds for 1) Global Budget Revenue enhancements for relatively efficient hospitals that qualify under the Integrated Efficiency policy and 2) unforeseen events that occur at hospitals with a financial hardship, regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.20 percent for RY 2026.

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

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

- **Potentially Avoidable Utilization (PAU) Redistribution:** The PAU value for RY 2026, which represents defunding of inflation and population growth for readmissions and avoidable admissions, is -0.53 percent. This policy was refined in RY 2025 to be revenue-neutral across the State; however, there were concerns that the policy may reward hospitals that have not improved PAU performance under the TCOC Model. As a result of this concern, rewards for individual hospitals are capped at 0.0 percent, and minor negative scaling is still applied to hospitals that have worse PAU performance than the statewide average. The net result of the PAU Redistribution policy, as represented on Table 2, is -0.03 percent.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The current revenue adjustments across the three programs is -0.06 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of -0.16 percent.

- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately $28.6 million through the Full Rate Application Policy, which represents 0.13 percent of the recommendation. This value is subject to change based on quality assurance reviews of the Inter-hospital Cost Comparison (ICC) methodology and review of commercial TCOC benchmarks. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2026 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology (no additional methodological considerations will be contemplated); and the hospital will not file any subsequent rate request until July 1, 2027.

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

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

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2026 will be -0.44 percent. The amount in rates was 4.46 percent in RY 2025, and the proposed amount for RY 2026 is 4.02 percent, a decrease of -0.44 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.
- **Deficit Assessment:** The Legislature approved a funding increase of $150,000 from RY 2025 which increases the total assessment to $444,825,000 in RY 2026. The value

associated with this increase that will be applied to payers is represented by 0.70 percent in Table 2.

Additional Revenue Variables

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

PAU Redistribution - Updated Methodology

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

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

Table 4: PAU Shared Savings Adjustment

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

*Does not include revenue from McCready, or freestanding EDs.

** Inflation factor is subject to revisions related to updated data and Commission approval

However, as previously noted, staff are proposing to maintain the amendment to the PAU Shared Savings policy such that it is a PAU Redistribution policy, whereby the PAU measurement is utilized in order to recognize differential opportunities among hospitals in a fixed revenue model but does not generate TCOC Model savings. The reasons for this change, which was adopted in RY 2025, are as follows: the policy already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management, future ongoing

reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions, and the additional funding allows hospitals to make greater investments in population health that overtime will make global budgets more sustainable than annual PAU reductions to hospitals that do not allow for system reinvestment.

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

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

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

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

Medicare Financial Test

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

coordinate care and to collaborate outside of their traditional sphere for better patient care. AHEAD continues this focus.

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

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

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

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

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2024		10,772,404,416
Actual Revenue July - December 2024		11,019,304,349
Actual Revenue CY 2024		21,791,708,765
Step 1:		
Approved GBR RY 2025		22,436,402,668
Actual Revenue 7/1/24-12/31/24		11,019,304,349
Approved Revenue 1/1/25-6/30/25		11,417,098,319
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/25-6/30/25	**A**	**11,417,098,319**
Expected Revenue Growth 1/1/25-6/30/25		**5.98%**
Step 2:		
Final Approved GBR RY 2025		22,436,402,668
Reversal of Extraordinary One-Times		-150,893,207
Final Adjusted GBR Base for RY 2025		22,285,509,461
Projected Approved GBR RY 2026		23,551,039,020
Permanent Update RY 2026		5.68%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,639,516,636
Projected RY26 Increase over RY25		6.08%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,780,796,623**
Expected Revenue Growth 7/1/25- 12/31/25		**6.91%**
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,197,894,942**
Increase over CY 2024 Revenue		**6.45%**
Per Capita Increase over CY 2024		**5.67%**

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2024.

Step 1: The table uses global revenue for RY 2025 and actual revenue for the last six months for CY 2024 to calculate the projected revenue for the first six months of CY 2025 (i.e., the last six

months of RY 2025). Hospitals currently project they will be able to charge all of RY 2024 revenue, for this reason, staff have kept the projected RY 2025 compliance line at zero.

Step 2: The final approved GBR for RY 2025 is $22,436,402,668. This step applies the proposed update of 5.68 percent, as shown in Table 2, to the RY 2025 GBR amount to calculate the projected revenue for RY 2026. This step also makes adjustments for miscellaneous/extraordinary one-times that don't get included in inflation but are accounted for in RY 2025 and RY 2026. For RY 2025, this includes one-time funding AHEAD preparation, surge funding, and set aside above the approved value in RY 2025. The RY 2026 miscellaneous inputs include the remaining surge funding and population health trust funding.

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

Step 4: This step shows the resulting estimated revenue for CY 2025 and then calculates the increase over the actual CY 2024 Revenue. The CY 2025 increase based on this year's recommended update is 6.45 percent. The 6.45 percent is used to estimate CY 2025 hospital spending per capita for Maryland in our guardrail and savings policy, which is explained in the next section.

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

In addition to the three scenarios based on historic trends, Staff added a 4th scenario this year. Scenario 4 is based on the United States Per Capita Cost (USPCC) data published by CMS[1]. Staff added this scenario as USPCC is used in target setting in the future under the AHEAD model. At this time staff have not confirmed with CMS the exact approach to be used to apply USPCC data for CY 2026, therefore Scenario 4 should be seen as an approximation of the target setting that might occur with AHEAD, rather than an exact representation.

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

The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2025 growth of 6.45 percent, shown in Table 5 to Maryland hospital spending per capita from 2024. These analyses assume that Medicare growth equals All-Payer growth.

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

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

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,427	$13,886	Predicted Variance
YOY Growth	5.3%	3.9%	1.4% Over
Estimated CY 2025 Savings Run Rate			$637.6M

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

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

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,348	$13,746	Predicted Variance
YOY Growth	4.8%	2.9%	1.9% Over
Estimated CY 2025 Savings Run Rate			$564.7 M

Scenario 3, shown in Table 6c, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 3 takes the trend from the prior period (2022 to 2024) and trends the data forward using 2024 as the base. This approach results in a higher estimate of national trends and larger projected savings than Scenario 2. Previously staff have included a scenario that only uses the most recent year, this was not included this year as discussed in the introduction to this section.

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

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,513	$14,141	Predicted Variance
YOY Growth	5.9%	5.8%	0.1% Over
Estimated CY 2025 Savings Run Rate			$809.9 M

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

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

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,505	$14,033	Predicted Variance
YOY Growth	5.9%	5.0%	0.9% Over
Estimated CY 2025 Savings Run Rate			$717.9 M

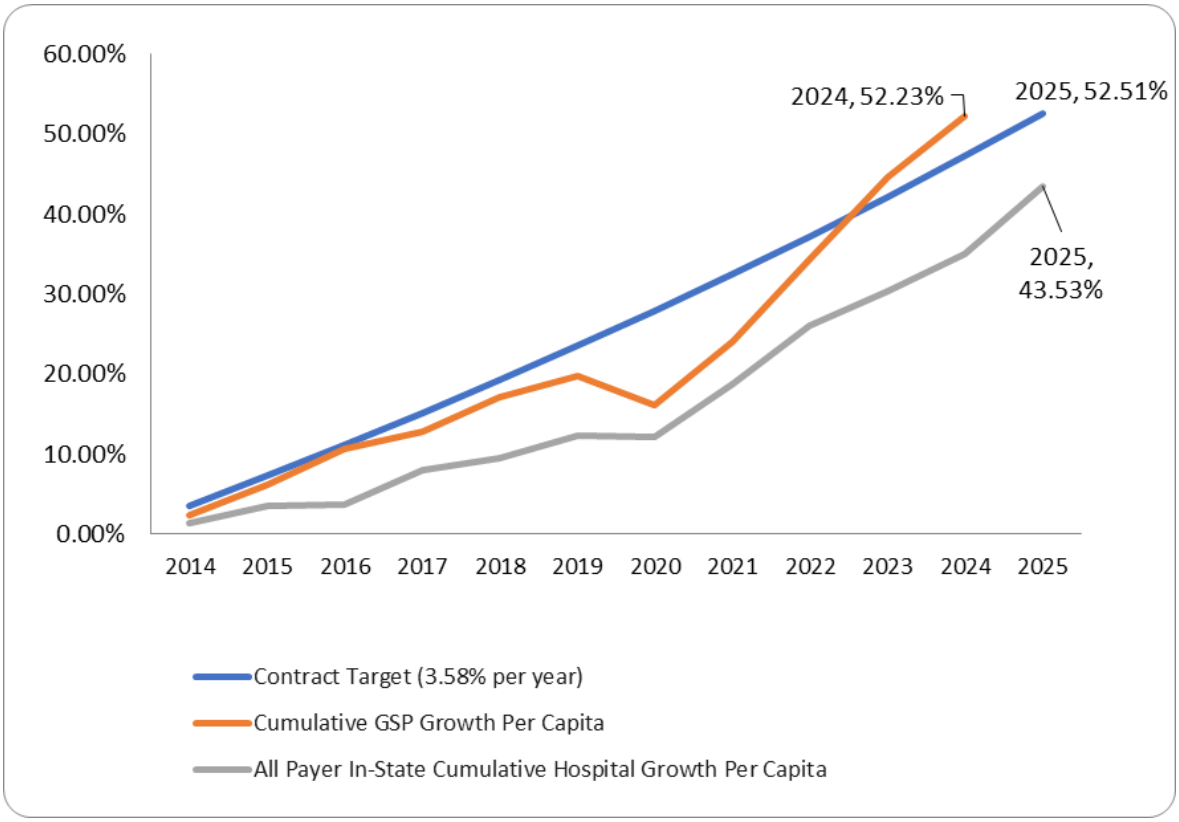
In addition to modeling the CY 2025 guardrail position, staff also modeled estimated savings under each scenario; these are shown in each table above. The guardrail can not be above the Nation by 1 percent in any year or above the Nation by any percent in two consecutive years. The guardrail position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

In all the above scenarios, Maryland is set to achieve the savings target for CY 2025 with varying degrees of cushion. In the most conservative scenario, shown in Table 6b, estimated savings is projected to be $564 million, which is above both the CY 2025 TCOC Model target ($372 Million) and the CY 2026 AHEAD target (estimated to be $525 Million). However, this scenario does result in a guardrail violation as Maryland would be anticipated to exceed national growth by more than 1 percent. However, under Scenarios 3 and 4, which reflect more recent national trend experience, Maryland would not trip the guardrail while also producing significant savings above target.

All-Payer Affordability

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

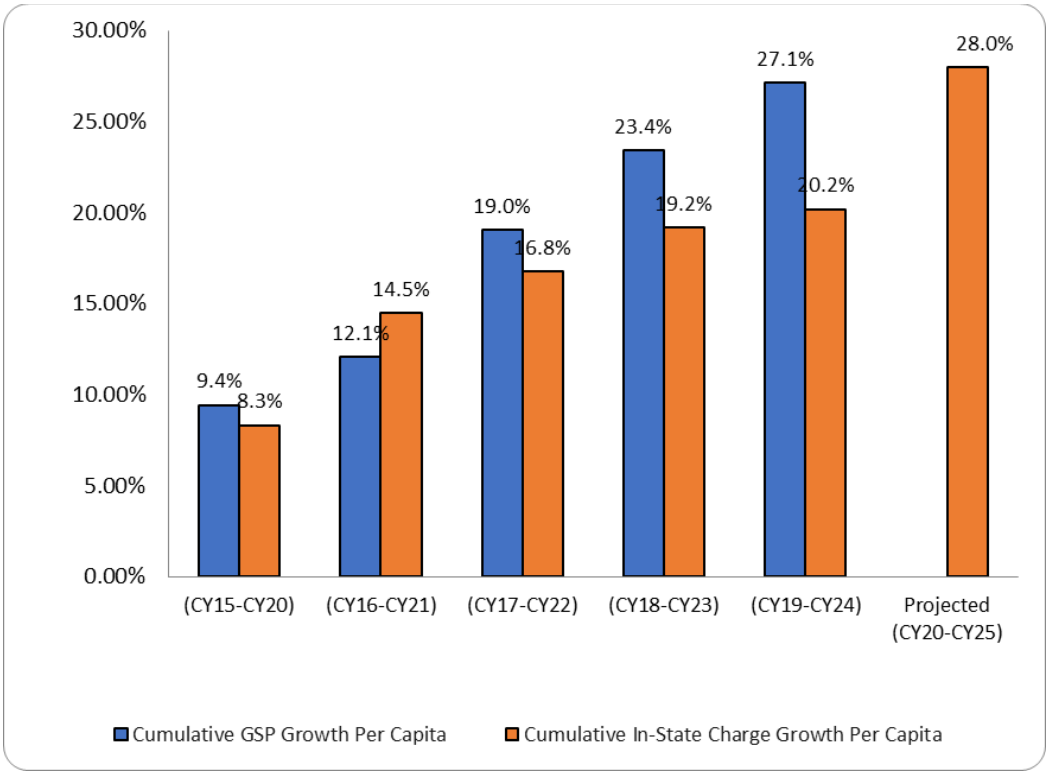
Figure 3
Affordability Scorecard – Cumulative GSP Test with CY 2025 Projection



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

This rolling five-year test provides a complementary view to the cumulative analysis. While the margin between hospital charge growth and GSP is smaller under this test, the results still indicate that hospital spending growth remains below the State's economic growth, reinforcing the affordability goals of the Model.

Figure 4
Affordability Scorecard – Rolling 5-Year GSP Test



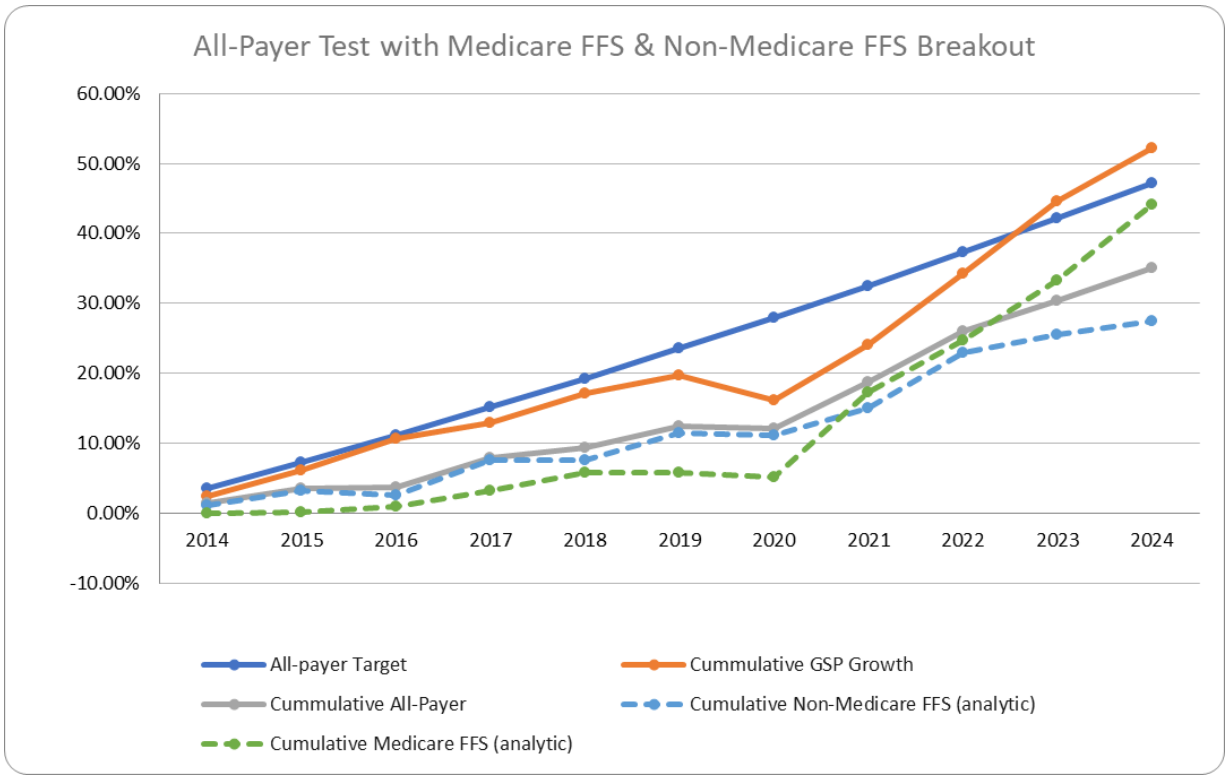
All-Payer Test with Medicare FFS & Non-Medicare FFS

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

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

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

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



Medicare's Proposed National Rate Update for FFY 2026

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

Stakeholder Comments

Staff are working with the Payment Model Workgroup to review and provide input on the proposed RY 2026 update. This section will be updated for the Final Recommendation to reflect formal comments received.

Recommendations

Based on the currently available data and the staff's analyses to date, HSCRC staff provides the following draft recommendations for the RY 2025 update factors.

For Global Revenues:

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

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

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

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

(e) To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact

of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.

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

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

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

Appendix I: Set Aside Reconciliation

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

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

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

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

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

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

Appendix II: Revenue for Reform

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

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

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

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

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

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

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

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

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

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

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

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

Maryland
DEPARTMENT OF HEALTH

Maternal and Child Health Population Health Improvement Fund

Program Year Three – FY 2024

Annual Report

November 2024

Table of Contents

Background

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of healthcare quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. In December 2020, the State submitted its proposal for population health priorities of the TCOC Model, which aligns statewide efforts across three domains: hospital quality, care transformation across the system, and total population health. Under the third domain, total population health, the State identified three key health priority areas for improvement: diabetes, opioid use, and maternal and child health (MCH). CMMI approved the State's proposal on March 17, 2021.

While the State identified diabetes and opioid use as key population health priority areas in the first year of the TCOC Model, the third priority area—MCH—was not selected until fall 2020. Consistent with the State's guiding principle to select goals, measures, and targets that are all-payer in nature, maternal and child health was deliberately considered as a priority area even though it is not primarily Medicare-focused. The selection of maternal and child health as a priority area reflects its importance in the State and acknowledges both the longstanding history of disparities, as well as the potential for improvement.

The U.S. faces higher maternal and infant mortality rates[1] compared to other industrialized countries, with large racial/ethnic disparities for each outcome. Between 2016 and 2020, Black non-Hispanic women had a maternal mortality ratio (MMR) 2.6 times greater than White non-Hispanic women, a disparity that has persisted since the 1940s. In Maryland, similar disparities in rates were observed for 2016-2020; the Black non-Hispanic MMR was 2.3 times the White non-Hispanic MMR.[2]

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 6.8 percent of children have asthma.[3]

As part of the proposal, the State identified two areas to improve MCH as measured by both overall reduction, as well as stratified by race and ethnicity:

- Severe maternal morbidity rate; and
- Asthma-related emergency department (ED) visit rates for ages 2-17.

[1] A maternal death is defined by the World Health Organization (WHO) as "the death of a female from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy." Source: World Health Organization. (n.d.). https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

[2] Maryland Department of Health. (2022). *Maryland Maternal Mortality Review: 2022 Annual Report Health – General Article §13-1212.* https://health.maryland.gov/phpa/mch/Documents/MMR/2022%20MMR%20Report.pdf

[3] Centers for Disease Control. (2023). *Table C1: Child Current Asthma Prevalence and Weighted Numbers* [Data file]. Retrieved from https://www.cdc.gov/asthma/brfss/2021/child/tableC1.html

Table 1A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed 2023 Rates, Maryland by Race/Ethnicity

Race	Baseline 2018[4,5]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target
NH White	181.4	7.5% decrease	250.7 (+38.2%)	15% decrease
NH Black	334.2	10% decrease	452.3 (+35.3%)	20% decrease
Hispanic	242	10% decrease	282.8 (+16.9%)	20% decrease
NH Asian	249	10% decrease	293.1 (+17.7%)	20% decrease
Other	205.2	10% decrease	294.3 (+43.4%)	20% decrease
Total	243.1	9.6% decrease	319.0 (+31.2%)	18.7% decrease

Table 1B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed 2023 Rates, Maryland by Race/Ethnicity

Race	Baseline 2018[4,5]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target
NH White	59.0	7.5% decrease	83.8 (+42.0%)	15% decrease
NH Black	124.3	10% decrease	168.7 (+35.7%)	20% decrease
Hispanic	57.2	10% decrease	66.1 (+15.6%)	20% decrease
NH Asian	93.4	10% decrease	68.4 (-26.8%)	20% decrease
Other	59.5	10% decrease	94.7 (+59.2%)	20% decrease
Total	80.7	9.6% decrease	103.9 (+28.7%)	18.7% decrease

[4] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.

[5] Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data, including blood transfusions. Accessed November 3, 2023.

Table 2. Childhood Asthma-ED Visit Rates per 1,000, Maryland by Race/Ethnicity

Race	Baseline 2018[6,7]	2023 Year 5 Target	2023 Rate (% Change)	2026 Year 8 Target	2026 Year 8 Target
NH White	4.1	3.5	3.3 (-19.5%)	3.0	26% decrease
NH Black	19.1	14.36	14.6 (-23.6%)	9.6	50% decrease
Hispanic	5.4	4.7	6.1 (+13.0%)	4.0	25% decrease
NH Asian	2.7	2.6	3.5 (+29.6%)	2.5	9% decrease
Other	10.6	7.3	8.1 (-23.6%)	5.5	48% decrease
Total	9.2	7.2	7.5 (-21.7%)	5.3	42% decrease

In 2021, the Health Services Cost Review Commission (HSCRC) approved cumulative funding of $40 million across four years (Fiscal Year (FY) 2022 through FY 2025) to support MCH investments led by Medicaid and the Prevention and Public Health Administration (PHPA) under the Maryland Department of Health ("the Department"), in conjunction with the Medicaid HealthChoice managed care organizations (MCOs). This funding has supported the scaling of existing statewide evidence-based programs and promising practices, as well as the expansion of new services for mothers and children. Additionally, using the funding in this manner creates an opportunity for the State to receive federal match funding to nearly double the investment, specifically for the Medicaid programs. Approval of this investment was contingent upon Commissioner approval of the proposed programs (outlined below); the Department and HSCRC staff work in close partnership to oversee and monitor implementation.

Funds are added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment. Hospitals transfer funds to the Maternal and Child Health Population Health Improvement Fund ("the Fund"). The Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), receives funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund is currently slated to sunset in 2025; as of fall 2024, the HSCRC and Department leadership are preparing a formal extension request to the Maryland General Assembly.

The Fund committed $8 million in annual funding from FY 2022 through FY 2025 to support Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area. As noted earlier, these monies are eligible for federal matching dollars, bringing the combined total to $16 million annually. An additional $2 million in annual funding is directed to PHPA to support childhood asthma initiatives and additional interventions to address severe maternal morbidity.

[6] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.
[7] CRISP analysis of HSCRC data, including blood transfusions. Accessed November 3, 2023.

Funding supports the following MCH initiatives within Maryland Medicaid:

- Home Visiting Services pilot expansion;
- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- HealthySteps, a clinic-based intensive prenatal and postpartum case management framework; and
- MOM Program (formerly the Maternal Opioid Misuse (MOM) Model) expansion/intensive case management for high-risk pregnancies.

Funding to PHPA supports the expansion and/or implementation of mutually-reinforcing programs:

- Asthma home visiting program (Medicaid partnership);
- Community-based asthma home visiting initiatives (all-payer); and
- Community-based perinatal home-visiting services and CenteringPregnancy implementation (all-payer).

The initiatives were selected to build, expand, and sustain existing evidence-informed innovations in the state to ensure a continuum of support services to improve maternal and child health outcomes. These initiatives, while selected previously in FY 2022, support more recently-released action plans such as the Moore-Miller Administration 2024 State Plan, the Department's Women's Health Action Plan (May 2024) and Maryland's State Health Improvement Plan (State Health Improvement Plan).

The Memorandum of Agreement (MOA) between the HSCRC and the Department that governs the Fund requires the Department to submit an annual report that will outline progress toward the Fund's goals.

This document serves as the annual report for the second year of funding and details the progress of the five Medicaid programs and the initiatives under Public Health Services; further outcome measures will be incorporated into future reports as data become available. The report culminates with a report on FY 2024 expenditures and spending plans for upcoming years.

Medicaid Programs

This section presents an overview and implementation update for each of the Medicaid programs supported by the Fund, followed by a synopsis of preliminary data from calendar year (CY) 2023, due to claims run-out.[8]

Home Visiting Services Expansion

Program Overview

In 2017, the Department established a Medicaid Home Visiting Services (HVS) Pilot under the authority of the §1115 HealthChoice demonstration to test a service expansion initiative in Maryland aimed at improving both maternal and child health. This pilot included reimbursement for two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Both models employ specific developmental and health screenings, and have an established track record of improving the health

[8] Run-out refers to the length of time that providers are allowed to submit claims after a service has been provided. Providers submitting claims to MCOs have six months following provision of a service for their run-out period.

and well-being of both the birthing parent and the child. Sites requesting coverage for this service must maintain certification of accreditation or fidelity by the national HFA or NFP organization. Effective January 13, 2022, as catalyzed by the Fund, Maryland promulgated regulations that provided coverage for both models to shift from a pilot to a new statewide benefit for Medicaid participants.

Implementation Update-PY3

As of September 2024, there are 16 sites enrolled as Medicaid providers for home visiting services, covering 14 of 24 Maryland jurisdictions. The Department continues to serve as a resource for home visiting programs as they enroll as Medicaid providers and implement Medicaid billing mechanisms.

In CY 2023, there were 5,412 HVS services delivered to 627 unique participants, for an average of 8.6 per participant. The demographic breakdowns of these participants are below. Note: for the tables below and throughout the document, small cell values (counts between one and 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

Table 3. Medicaid Home Visiting Services (HVS) Utilization, CY 2023

HVS Utilization	
Total Participants	627
Number of Services	5,412
Services per Participants	8.6

Table 4A. Medicaid Home Visiting Services (HVS) Participant Demographics: Age Groups, CY 2023

Age Groups	HVS
Under 2	398
03 to 11	61
12 to 15	0
16 to 21	30
Over 21	84
Total	573

Table 4B. Medicaid Home Visiting Services (HVS) Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	HVS
Asian	*
Black	119
White	204
Hispanic	220
Native American	*
Other	28
Total	573

Table 4C. Medicaid Home Visiting Services (HVS) Participant Demographics: Regions, CY 2023

Region	HVS
Baltimore City	*
Baltimore Suburban	40
Eastern Shore	142
Southern Maryland	34
Washington Suburban	131
Western Maryland	219
Out of State	*
Total	573

Doula Reimbursement

Program Overview

Effective February 21, 2022, the Department began Medicaid coverage for doula/birth worker services to Medicaid participants. A doula, or birth worker, is a trained professional who provides continuous physical, emotional and informational support to birthing parents before, during and after birth. Certified doulas serving Medicaid participants provide person-centered, culturally competent care that supports the racial, ethnic and cultural diversity of members while adhering to evidence-based best practices.

Under Maryland Medicaid's reimbursement model, doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits. Medicaid provides coverage for up to eight perinatal (*i.e.,* prenatal and postpartum) visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals eight or fewer visits per birthing parent. Doulas can enroll as individual providers or be affiliated with a doula

practice that bills for provided services on their behalf. To recruit more doula providers and, in line with other states' rates, Maryland Medicaid increased the reimbursement rate for attendance at labor and delivery in July 2023. All doulas must be trained by one of 30 Medicaid-approved doula certifying organizations. The Department is continually expanding this list to increase the number of enrolled doulas, as detailed below.

Doula Implementation - PY3 Update

As of the beginning of October 2024, there are 26 doulas enrolled as Medicaid providers. During the year, the Department monitored doula provider enrollment and implemented several measures to build out the network. First, the Department permitted MCOs to use single case agreements with doulas until network adequacy requirements are reached. Second, the Department updated its regulations, effective June 2024, to: 1) facilitate quicker expansion of the number of approved doula certification organizations; and 2) make the doula benefit self-referral until 2025–a temporary removal of an administrative step for the doulas, *i.e.,* contracting with MCOs after registering Medicaid providers with the Department. Third, Medicaid implemented a bi-annual nominations process to add additional certification programs, in order to increase the number of doulas who are eligible to become Medicaid providers. As of September 2024, there are 30 approved certification organizations. Lastly, as noted earlier, the Department increased the rate for attendance at labor and delivery from $350 to $800 on July 1, 2023.

In CY 2023, 220 doulas services were delivered to 69 unique Medicaid participants, for an average of 3.2 services per participant. The demographic breakdowns of these participants are below. Maryland Medicaid will continue its efforts to partner with the Department's Maternal and Child Health Bureau (MCHB) to promote the doula benefit and bolster the doula workforce across the state.

Table 5. Medicaid Doula Services Utilization, CY 2023

Doula Utilization				
	Prenatal	**Labor and Delivery**	**Postpartum**	**Total**
Total Participants	55	*	*	**69**
Number of Services	188	*	*	**220**
Services per Participants	3.4	*	*	**3.2**

Table 6A. Medicaid Doula Services Participant Demographics: Age Groups, CY 2023

Age Groups	Doulas
Under 2	0
03 to 11	0
12 to 15	*
16 to 21	*
Over 21	59
Total	61

Table 6B. Medicaid Doula Services Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	Doulas
Asian	*
Black	42
White	*
Hispanic	*
Native American	*
Other	*
Total	61

Table 6C. Medicaid Doula Services Participant Demographics: Regions, CY 2023

Region	Doulas
Baltimore City	*
Baltimore Suburban	23
Eastern Shore	*
Southern Maryland	*
Washington Suburban	23
Western Maryland	*
Out of State	0
Total	61

CenteringPregnancy

CenteringPregnancy

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to prenatal care through CenteringPregnancy. CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. The model focuses on three core components: health assessment, interactive learning and community building. Facilitators support a cohort of eight to 10 individuals of similar gestational age through a curriculum of 10, 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions. Discussion topics include medical and non-medical aspects of pregnancy, such as nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care. Studies have shown that CenteringPregnancy improves health outcomes, such as decreased risk of preterm birth, as well as improves patient satisfaction. [9]

CenteringPregnancy Implementation - PY3 Update

Following an MCO infrastructure support program in CY 2022, effective January 1, 2023, the Department began paying an enhanced rate to CenteringPregnancy providers for prenatal care visits. The enhanced payment supports the overall operations of CenteringPregnancy practices and may be billed alongside the typical prenatal care procedure code for up to 10 perinatal care visits per pregnancy (*i.e.,* the period from conception to 60 days postpartum).

There are three active CenteringPregnancy practices in Maryland as of October 2024, including one funded by the MCHB's grant (additional detail under 'Public Health Programs', below). Medicaid anticipates that the rest of MCHB's funded providers will work towards the CenteringPregnancy model implementation, and enroll as Medicaid providers in 2025 due to the partnership and grants from the Department's MCHB.

In CY 2023, 777 CenteringPregnancy services were billed for 357 unique participants, for an average of 2.2 per participant, the demographic breakdown is below. The Department believes these numbers may be artificially low due to underbilling, as CY 2023 was the first year of implementation of the enhanced rate. To increase uptake and monitor adherence, Medicaid and the Centering Healthcare Institute, CenteringPregnancy's parent organization, continue to partner to support providers. Medicaid attends the bi-annual Centering Consortium of Maryland to connect with providers, answer Medicaid-related questions, and encourage provider enrollment in Medicaid. The Centering Healthcare Institute and Medicaid collaborate in the event that issues arise between Consortium meetings.

[9] Centering Healthcare Institute. (2020). *Centering Saves Lives & Money.* Centering Healthcare Institute: Payment Policy & Advocacy. Downloaded from: https://centeringhealthcare.org/why-centering/payment.

Table 7. Medicaid CenteringPregnancy Utilization, CY 2023

CenteringPregnancy Utilization	
Total Participants	345
Number of Services	864
Services per Participants	2.5

Table 8A. Medicaid CenteringPregnancy Participant Demographics: Age Groups, CY 2023

Age Groups	Centering Pregnancy
Under 2	0
03 to 11	*
12 to 15	*
16 to 21	66
Over 21	281
Total	357

Table 8B. Medicaid CenteringPregnancy Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	Centering Pregnancy
Asian	*
Black	127
White	49
Hispanic	164
Native American	*
Other	12
Total	357

Table 8C. Medicaid CenteringPregnancy Participant Demographics: Regions, CY 2023

Region	Centering Pregnancy
Baltimore City	61
Baltimore Suburban	48
Eastern Shore	32
Southern Maryland	*
Washington Suburban	158
Western Maryland	56
Out of State	*
Total	357

HealthySteps

Program Overview

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to early childhood well-being through HealthySteps. HealthySteps, a program of the national accrediting body ZERO TO THREE[10], is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention at accredited, or pending accreditation HealthySteps sites. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide referrals to external services, and follow-up to the whole family.

HealthySteps Implementation - PY3 Update

Similar to CenteringPregnancy, on January 1, 2023 the Department began providing an enhanced payment for evaluation and management (E&M) services rendered by providers at a HealthySteps sites categorized as accredited or pending accreditation, following an MCO infrastructure support program. Like CenteringPregnancy, the enhanced payment supports the overall operations of HealthySteps practices, including the salary of the HealthySteps Specialist. The enhanced payment should be billed alongside each well-child visit or E&M service the child receives, regardless of the tier the child is placed into.

There is one eligible provider in Maryland (University of Maryland Pediatrics Associates) and three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC, and Anacostia locations), however in 2023 only one provider billed HealthySteps

[10] What We Do. (n.d.). https://www.healthysteps.org/what-we-do/

services. In addition, Kaiser Permanente transformed its practices in South Baltimore and Woodlawn into HealthySteps sites to comply with the new Medicaid requirement in late 2023. Maryland's implementation of the HealthySteps program, including the enhanced Medicaid payment, was recognized by the Prenatal-to-3 Policy Impact Center at Vanderbilt University in 2023.[11]

Maryland's efforts align closely with recent CMS guidance,[12] clarifying Early and Periodic Screening, Diagnosis and Treatment requirements for Medicaid and CHIP, in its emphasis on improving care for children with specialized needs, early identification, and family-centric treatment of pediatric mental health disorders.

In CY 2023, 3,176 HealthySteps services were billed for 1,372 unique participants, for an average of 2.3 services per participant, the demographic breakdown is below. The Department believes these numbers may be artificially low due to underbilling, as CY 2023 was the first year of implementation of the enhanced rate. In tandem, the University of Maryland conducted a quality improvement study on its HealthySteps site that demonstrated a variable, but improved rate of reimbursement of the HealthySteps service over the course of the year, after monthly reminders and education of residents and attending physicians.13 Maryland Medicaid will continue to work closely with ZERO TO THREE, along with HealthySteps providers, to promote the enhanced payment of rendered HealthySteps services.

Maryland Medicaid staff continue this engagement with partners through external opportunities, including presenting at the 2024 Pediatric Mental Health Summit, and updating policy experts on Maryland's strategy to support HealthySteps practices. Moreover, Maryland Medicaid staff work alongside HealthySteps providers in the State by serving on the advisory board for the Health Resources and Services Administration's (HRSA) Transforming Pediatrics for Early Childhood (TPEC), University of Maryland and Johns Hopkins University High Five for P-5: Improving Health Equity Through Early Child Development Supports.

It is important to note that the reimbursement model allows for an enhanced payment service to be billed alongside each well-child visit provided at a HealthySteps site. However, this reimbursement model–and the resulting Medicaid data–do not reflect the intensity of services received by each patient according to their tier; therefore, a 'dose-response' evaluation cannot be used for HealthySteps services.

[11] Prenatal-to-3 Policy Impact Center. 2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/

[12] State Health Office Letter [#24-005]: RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. September 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

[13] Onigbanjo M, Connors, K, and Edwards, S "Using Enhanced Rates to Support and Financially Maintain a HealthSteps Program at a Primary Care Practice". Poster Presentation. Pediatric Academic Societies Region IV Annual Meeting, Charlottesville, VA. February 24, 2024

Table 9. Medicaid HealthySteps Utilization, CY 2023

HealthySteps Utilization	
Total Participants	1,370
Number of Services	3,171
Services per Participants	2.3

Table 10A. Medicaid HealthySteps Participant Demographics: Age Groups, CY 2023[14]

Age Groups	HealthySteps
Under 2	974
03 to 11	395
12 to 15	0
16 to 21	*
Over 21	*
Total	1,370

Table 10B. Medicaid HealthySteps Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	HealthySteps
Asian	*
Black	1,162
White	60
Hispanic	46
Native American	*
Other	73
Total	1,370

[14] As HealthySteps services are for those ages zero to three, any claim for individuals above aged 4 is considered a billing error.

Table 10C. Medicaid HealthySteps Participant Demographics: Regions, CY 2023

Region	HealthySteps
Baltimore City	981
Baltimore Suburban	365
Eastern Shore	*
Southern Maryland	*
Washington Suburban	13
Western Maryland	*
Out of State	0
Total	1,370

MOM Case Management Services (MOM Program)

Program Overview

The MOM program addresses fragmentation in the care of pregnant and postpartum Medicaid participants with opioid use disorder (OUD) through enhanced case management services, with an emphasis on increasing health service utilization, as well as screening and referral for social determinants of health.

Initially funded as part of a CMMI demonstration, the MOM program has supported efforts in increasing provider capacity to treat the maternal OUD population; in addition, in FY 2022, the demonstration funded a per member, per month (PMPM) payment to MCOs for the enhanced case management services. Starting July 1, 2022, the payments transitioned to the Fund, with federal matching dollars authorized under the §1115 HealthChoice demonstration. As of January 1, 2023, Maryland has ceased its participation in the federal CMMI demonstration; implementation of MOM case management services continued seamlessly.

MOM Program Implementation - PY3 Update

MOM program services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year before expanding to select counties a year later. Starting January 1, 2023, the MOM program became available statewide, open to all eligible HealthChoice members. As of the end of September 2024, there have been 106 participants in the MOM program; the demographic breakdown of those who participated in CY 2023 is below. Program participants to date have demonstrated an interest in engaging in treatment for their OUD, as well as efforts to change life circumstances, including enrolling in educational courses, learning to drive and securing stable housing. The program experienced a sharp increase in enrollment following the statewide expansion.

In CY 2023, the Department leveraged support from both the Fund and CMMI to continue two partnerships–with the Maryland Addiction Consultation Service (MACS) and Bowie State University–to augment MOM's impact. Through the partnership, MACS continued the MACS for MOMs program to build provider capacity to better treat the maternal OUD population. The program includes teleECHO clinics, a warmline for phone consultations, and a variety of trainings, including those for receiving a DATA 2000 Waiver which allows providers to prescribe buprenorphine. To strengthen the MOM program by making it more attractive to communities of color, the Department partnered with Historically Black Colleges and Universities (HBCUs), led by Bowie State, to tailor the program to be more culturally responsive to Maryland's Black population.

Bowie State University finished their research in December 2023. Their study examined wrap-around social service providers who were outside of the MOM program, but who have successfully recruited and retained women from similarly stigmatized populations. Many participants praised the MOM program and expressed beliefs about its value and potential to be impactful to the clients it aims to serve. Funding for MACS for MOMs has since transitioned over to MCHB. During this year, MACS for MOM is conducting a needs assessment to understand what further challenges and resources are needed.

Table 11. Medicaid MOM Program Utilization, CY 2023

MOM Utilization	
Total Participants	57
Number of Services	250
Services per Participants	4.4

Table 12A. Medicaid MOM Participant Demographics: Age Groups, CY 2023

Age Groups	MOM
Under 2	0
03 to 11	0
12 to 15	*
16 to 21	*
Over 21	56
Total	57

Table 12B. Medicaid MOM Participant Demographics: Race/Ethnicity, CY 2023

Race/Ethnicity	MOM
Asian	0
Black	*
White	46
Hispanic	*
Native American	*
Other	*
Total	57

Table 12C. Medicaid MOM Participant Demographics: Regions, CY 2023

Region	MOM
Baltimore City	*
Baltimore Suburban	16
Eastern Shore	*
Southern Maryland	*
Washington Suburban	*
Western Maryland	24
Out of State	0
Total	57

PY3 Medicaid Performance

To assess the outcomes of the Maryland Medicaid MCH Initiatives, the Hilltop Institute at the University of Maryland, Baltimore County analyzed the administrative data from the program participants, based off of several relevant HEDIS measures. For the purposes of the analysis, all program participants were identified based on FFS claims and MCO encounters that include the program-specific procedure codes, provider types, and ICD-10 diagnosis codes designated by the Department.

Due to enrollment increases, the PY3 report is the first year that there is a sufficient number of participants for the metrics to be reported at the program level. Results are presented for enrollees who had at least one qualifying visit as well as enrollees who met the minimum evaluation inclusion criteria. To meet the inclusion criteria for the evaluation, HVS, HealthySteps, doula services, and CenteringPregnancy participants

were required to have at least three visits, and MOM program participants had to be enrolled in the program for at least three months. All enrollees who met the inclusion criteria and were enrolled after their respective programs' start dates were flagged as evaluation-eligible. It is important to note that many of the measure criteria also include a delivery in 2023, which reduces the number of participants included below.

All records were deduplicated so that each enrollee had one record that contained their enrollment start date, the number of program visits or number of months enrolled, and the evaluation eligibility flag. Each enrollee was then sorted into a cohort by calendar year according to the enrollment start date. Thereafter, the demographic variables birth data, sex, and region were obtained and merged from Hilltop Medicaid data sets. The 1184 newborn data set was used to merge infants to their mothers and mothers to their infants where possible, keeping the infants' birth weight, sex, and date of birth.

Separately, Hilltop used the diagnoses and the revenue and procedure codes provided by the Department to identify claims and encounters for cesarean section deliveries, SMM, and birth complications. Identified claims and encounters were collapsed so that there was only one record per enrollee with flags indicating if they experienced the above medical conditions. HEDIS software was used to provide the flags indicating whether enrollees had timely prenatal visits, postpartum care, childhood immunizations, child well-care visits and neonatal intensive care unit (NICU) admission for CY 2023. Medical and procedure flags were then merged with the cohort data sets to create a data set of mother and infant pairs with enrollee demographics and evaluation and measure flags.

It should be noted that although enrollment has increased, the sample size is small for certain programs. Therefore, care should be used when interpreting some of the results. Again, for the tables below and throughout the document, small cell values (less or equal to 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

Data Results

Note: In the tables below, 'denom' stands for denominator, and 'numer' stands for numerator.

Timely Initiation of Prenatal Care

Prenatal care plays a crucial role in supporting healthier pregnancies and infants; the early initiation of prenatal care - ideally in the first trimester - is particularly important. The preliminary data presented in the PY 2 report identified the timely attendance at a prenatal visit metric as a potential place for growth. The three benefits that had sufficient CY 2023 data to report ranged from a 36.1 percent (HVS) to a 58.1 percent completion rate (doula services), indicating that there is still room for improvement.

Table 13. Deliveries in where Participant had a Prenatal Visit in the First Trimester, on or before the Enrollment Start Date or within 42 Days of Enrollment in the Organization, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	13	36.1%	28	*	*
Doula Services	31	18	58.1%	18	*	*
CenteringPregnancy	73	40	54.8%	60	34	56.7%
MOM	25	*	*	22	*	*

Postpartum Care Visits - Seven through 84 Days

After giving birth, a postpartum care visit provides an important opportunity to evaluate the birthing individual's healing from labor and delivery, in addition to screening for postpartum depression. The PY 2 report also identified timely attendance at a postpartum visit metric as another potential place for improvement. This year's data shows a similar trend, reinforcing the idea that there is opportunity for growth in this area. The two benefits that had sufficient data to publish, doula services and CenteringPregnancy, ranged from 56.7 percent to 60.0 percent completion of a timely postpartum visit within 7 and 84 days of delivery.

Table 14A. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	17	54.8%	18	*	*
CenteringPregnancy	73	42	57.5%	60	36	60.0%
MOM	25	*	*	23	*	*

Postpartum Care Visits - Seven through 84 Days

As part of discussions to improve timely attendance at a postpartum visit, stakeholders raised the possibility that participants are attending postpartum visit beyond the 84 day postpartum period due to lack of appointment availability. To account for this, the analysis added an additional metric which extended the time period of postpartum visit to 120 days following the birth. The CY 2023 data shows a minimal improvement for HVS and CenteringPregnancy data and no change for the doula services.

Table 14B. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	11	30.6%	28	*	*
Doula Services	31	17	54.8%	18	*	*
CenteringPregnancy	73	44	60.3%	60	37	61.7%
MOM	25	*	*	22	*	*

Cesarean Births

While cesarean births can be warranted in some cases, reducing unnecessary cesareans is a priority in maternal health. In CY 2023 only one of the benefits, CenteringPregnancy, had a reportable number of cesarean births. There was a notable difference between the groups that had any services and those who met evaluation criteria.

Table 15. Deliveries that were Cesarean Section among Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	*	*	18	*	*
CenteringPregnancy	73	44	60.3%	60	24	40.0%
MOM	25	*	*	22	*	*

Severe Maternal Morbidity

As outlined above (see *Background*), SMM is an area of particular importance to the State. The CY 2023 data shows preliminary positive results for this metric: two of the benefits had no instances of SMM and the remaining two each had very few instances of it.

Table 16. Pregnancies Associated with Severe Maternal Morbidity among Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	*	*	28	*	*
Doula Services	31	0	0.0%	18	0	0
CenteringPregnancy	73	*	*	60	*	*
MOM	25	0	0.0%	22	0	0

Birth Complications

Birth complications, while related to SMM, refer to any problems that occur during labor and delivery that affect the birthing parent or baby.[15] As with any type of medical complication, reducing ones that occur during birth are a priority. The CY 2023 data is extremely promising - none of the benefits had a single instance of a birth complication during this time.

Table 17. Percentage of Deliveries that had Birth Complications among MCH Participants, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	0	0.0%	28	0	0.0%
Doula Services	31	0	0.0%	18	0	0.0%
CenteringPregnancy	73	0	0.0%	60	0	0.0%
MOM	25	0	0.0%	22	0	0.0%

Infant Birth Weight

Infant birth weight can be a good indicator of the newborn's overall health. Low birth weight (less than 2,500 grams) and very low birth weight (less than 1,500 grams)[16] can be caused by a variety of factors including gestational age, multiple gestation pregnancies, maternal health, and environmental factors.

In CY 2023, the proportion of infants of normal birth weight whose birthing parent was enrolled in HVS, doula services, and CenteringPregnancy ranges from 89.3 percent to 94.4 percent. The proportion of infants of normal weight whose birthing parent was enrolled in in the MOM program

[15] Only around 3 percent of the birth complication ICD-10 codes appear on the list of SMM codes, primarily ones related to anesthesia complications.

[16] Centers for Disease Control. (2024). *Birthweight and Gestation.* https://www.cdc.gov/nchs/fastats/birthweight.htm

increased from 80 percent to 86.4 percent when any dose was compared with those who meet inclusion criteria. The reason that a smaller proportion of individuals in the MOM program have an infant of a normal birth weight may be related to the fact that those with prenatal exposure of opioids are at a greater risk of being of low birth weight.[17]

Table 18A. Newborns who are Normal, Low, or Very Low Birth Weight for all Participants Enrolled before Delivery, CY 2023

	CY 2023				
	Denom	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	
				Counts	Percent
HVS	36	*	*	33	91.7%
Doula Services	31	*	*	28	90.3%
CenteringPregnancy	73	*	*	68	93.2%
MOM	25	*	*	20	80.0%

Table 18B. Newborns who are Normal, Low, or Very Low Birth Weight for all Participants Enrolled before Delivery and who meet the Inclusion Criteria, CY 2023

	CY 2023				
	Denom	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	
				Counts	Percent
HVS	28	*	*	25	89.3%
Doula Services	18	*	*	17	94.4%
CenteringPregnancy	60	*	*	55	91.7%
MOM	22	*	*	19	86.4%

Neonatal Intensive Care Unit (NICU) Admissions

In cases where a newborn is experiencing health issues following its birth, they may be admitted to a NICU of a hospital. While important for treatment, these admissions can be stressful for the family and newborn, as well as costly. The CY 2023 data appears promising regarding NICU hospitalizations. For any participants of any dose, two of the four benefits had zero NICU admissions and for those who met evaluation criteria, only one benefit had any participants admitted to the NICU.

[17] Yen, E., & Davis, J. M. (2022). The immediate and long-term effects of prenatal opioid exposure. Frontiers in pediatrics, 10, 1039055. https://doi.org/10.3389/fped.2022.1039055

While MOM did have some infants admitted to the NICU, it was a very small number. This is notable as infants exposed to opioids or medications for the treatment of OUD are at risk for a condition called neonatal abstinence syndrome (NAS) which often requires them to be admitted to the NICU.

Table 19. Percentage of Infants with a NICU Admission near Date of Birth, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	36	0	0.0%	28	0	0.0%
Doula Services	31	*	*	18	0	0.0%
CenteringPregnancy	73	0	0.0%	60	0	0.0%
MOM	25	*	*	22	*	*

Child Well-Care Visits

An important tool for keeping children healthy is that they receive a well-child visit from a provider at the cadence recommended by the American Academy of Pediatrics. The CY 2023 data shows that around one quarter of HVS participants and up to 43 percent of HealthySteps participants had received a well-care visit during the calendar year. The Department's Health Choice evaluation shows that, for 2022, 57 percent of Medicaid participants received their well-child visits in the first 15 months.[18] The Department will continue to investigate these rates, and work with MCOs and providers to increase the rate of well-child visits among its participants.

Table 20. Number of Children with at least one Qualifying Visit who Received a Well-Care Visit during the Calendar Year by Program Enrollment, CY 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2023					
	Denom	Numer	Percent	Denom	Numer	Percent
HVS	361	87	24.1%	297	74	24.9%
HealthySteps	1,151	495	43.0%	394	73	18.5%

[18] The Hilltop Institute. (2024, June 30). Evaluation of the Maryland Medicaid HealthChoice program: CY 2018 to CY 2022. https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice%20Monitoring%20and%20Evaluation/HealthChoice%20Post-Award%20Forum/2024/Final%20HealthChoice%20Evaluation%20CY%202018-CY%202022.docx.pdf

Childhood Immunizations

As part of the well-care visits described above, children receive immunizations against a variety of diseases at a set schedule. By the age of two, children should have received the following vaccines: diphtheria, tetanus, and acellular pertussis (DTAP); polio (IPV); measles, mumps, and rubella (MMR); haemophilus influenzae type B (HiB); hepatitis B (HepB); chicken pox (VZV); pneumococcal conjugate (PCV); hepatitis A (HepA); rotavirus (RV); and influenza (Influ); several of which are combined into "combination 3". In CY 2023, MMR had the largest completion rate and influenza had the smallest.

Table 21A. Number of Children Aged 2 Years Old Enrolled in Home Visiting Services (HVS) that Received Childhood Immunizations, CY 2023

	CY 2023												
		DTAP		IPV		MMR		HiB		HepB		VZV	
	Denom	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
At Least One Qualifying Visit	49	29	59.2%	37	75.5%	40	81.6%	39	79.6%	30	61.2%	40	81.6%
Meets Eval. Inclusion Criteria	40	21	52.5%	29	72.5%	32	80.0%	31	77.5%	24	60.0%	32	80.0%

Table 21A. Cont.

	CY 2023										
		PCV		HepA		RV		Influ		Combo 3	
	Denom	Count	%	Count	%	Count	%	Count	%	Count	%
At Least One Qualifying Visit	49	33	67.3%	39	79.6%	31	63.3%	19	38.8%	23	46.9%
Meets Eval. Inclusion Criteria	40	25	62.5%	31	77.5%	23	57.5%	15	37.5%	17	42.5%

Table 21B. Vaccination Acronym List

DTAP	Diphtheria, Tetanus and Acellular Pertussis	**PCV**	Pneumococcal conjugate
IPV	Polio Vaccine	**HepA**	Hepatitis A
MMR	Measles, Mumps and Rubella Vaccine	**RV**	Rotavirus
HiB	Haemophilus Influenzae type B Vaccine	**Influ**	Influenza
HepB	Hepatitis B	**Combo 3**	Combination 3 (DTaP, IPV, MMR, HiB, HepB, VZV, PCV)
VZV	Chicken Pox Vaccine		

Public Health Programs

The Public Health Services/Prevention and Health Promotion Administration administers funds to improve maternal and child health. Specifically, for the Fund, the MCHB implements the maternal health initiatives, and the Environmental Health Bureau (EHB) implements initiatives related to asthma.

Maternal Health Initiatives

Home Visiting Expansion

Program Overview

Home visiting programs can impact maternal morbidity in different ways, including: 1) creating human- to-human relationships that enable home visitors to provide tailored support based on the specific needs of each family; 2) reducing pregnancy induced hypertensive disorders, preterm birth, and maternal depression; 3) creating connections between mothers and health practitioners in the community, breaking down barriers to care, and strengthening the link between healthcare resources and the families who need them; 4) providing screenings for maternal depression both prenatal and postpartum and connecting mothers in need with the appropriate community-based behavioral health care; 5) providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and 6) targeting social determinants of health (SDOH) affecting families, such as social support, parental stress, access to health care, income and poverty status and environmental conditions.[19]

The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds 12 jurisdictions and 15 programs that meet federal evidence-based criteria across Maryland. Maryland Medicaid reimburses three MIECHV sites operating under the Nurse-Family Partnership and Healthy Families America models. As part of the Department's efforts to improve maternal and population health, the Department is awarding a total of $2.26 million over three years (August 15, 2022 through June 30, 2025) to four sites through the Fund.

Implementation Update

Since Fall 2022, the Department has supported four sites to provide expanded home visiting models. Two sites (Montgomery County and Washington County) are utilizing funds to expand existing home visiting programs, while the other two sites (Baltimore Healthy Start and Family Tree) utilize funds to pilot a new, evidence-based home visiting curriculum. What follows is a brief description of each of the four sites.

> **Montgomery County Health Department** utilizes funding to expand its Babies Born Healthy (BBH) program, a prenatal care coordination initiative that connects its participants to home visiting services and offers the March of Dimes Becoming Mom (BAM) curriculum for all BBH participants who wish to participate through group classes or individual sessions. This program enhances maternal understanding through a collaborative community-based model of care, offering prenatal education and ensuring access to quality prenatal care. The program focuses on providing services to

[19] American Academy of Pediatrics. Home visiting to Reduce Maternal Mortality and Morbidity Act. https://www.socialworkers.org/LinkClick.aspx?fileticket=7mhUWCPtNL4%3D&portalid=0

the following high-risk zip codes in Montgomery County: 20903, 20904, 20906, and 20912.

Washington County Health Department began the expansion of their existing home visiting services via the local program affiliate of HFA, which is currently funded by MIECHV. The program successfully organized and conducted three virtual family groups, with an average monthly attendance of 18 families. The virtual family groups have proven invaluable, facilitating meaningful connections among families, providing essential parenting insights, and creating a platform for the sharing of experiences. The Washington County Health Department is a Medicaid-enrolled HVS provider, meaning that the expansion will further benefit the Fund's Medicaid investments as well.[20]

Baltimore Healthy Start (BHS) collaborated with Chase Brexton Glen Burnie Health Center, Total Health Care, and with the Administrative Care Coordination Unit (ACCU) of the Anne Arundel County Department of Health to expand home visiting services to postpartum women in the following zip codes: 20724, 21060, 21061, 21225 and 21226. This initiative utilizes the Great Kids curriculum, designed for home visits to commence from prenatal to when a child reaches 36 months of age. In addition to the home visits, families who are in need of the services are offered the standard BHS case management and care coordination services through Baltimore Healthy Start's clinical partner. In summer 2024, BHS shifted its partnership from Chase Brexton Glen Burnie to Total Health Care, with which it has existing relationships in Baltimore City.

The Family Tree facilitated the expansion of home visiting services in Baltimore City through the Parents as Teachers (PAT) model. Home visitors conduct regular visits, supporting families from pregnancy through their child's kindergarten year. The PAT curriculum addresses critical areas including mental health, nutrition, maternal depression, substance use and domestic violence. In FY 2023, the program received certification to operate as a PAT-affiliated site from the Parents as Teachers National Center, successfully recruited and onboarded staff to empower the growth of the PAT home visiting initiative. The program's collaborative efforts extended to partnerships with the following organizations: Health Care Access Maryland (HCAM), Urban Strategies, and The Parent Helpline.

Collectively between FY 2022 and FY 2024, Fund-supported Home Visiting Expansion Initiatives enrolled over 109 families to home visiting programs in priority jurisdictions. Table 22 indicates the number of those enrolled by race and ethnicity and Table 23 indicates the number of enrolled by insurance provider. The majority of the home visiting sites experienced challenges with recruitment of staff for the expansion of their programs. The Department will continue to provide technical support to its Fund grantees in FY 2025 to enhance the enrollment of all home visiting sites to improve SMM rates in the state.

[20] Washington County Health Department is an approved Medicaid HVS provider therefore solely Medicaid funds were used for Medicaid participants.

Table 22: Number of Enrolled in Fund-Supported Home Visiting Expansion by Race/Ethnicity

Race/Ethnicity	No. Enrolled
non-Hispanic White	*
non-Hispanic Black	82
Hispanic	14
Asian	*
Native American/ Alaska Native	*
Multiracial NOT Hispanic	*
Multiracial and Hispanic	*

Table 23: Number of Enrolled in Fund-Supported Home Visiting Expansion by Insurance

Enrolled Insurance Type	No. Enrolled
Medicaid	93
Private	*
Uninsured	13
Other	*

Increasing Access to CenteringPregnancy Sites

Program Overview

The effectiveness of CenteringPregnancy is shown most dramatically among Black birthing persons in Maryland, who disproportionately experience adverse maternal outcomes. In response to the disproportionate (SMM) severe maternal morbidity rates affecting Black birthing persons in Maryland, the Department has reserved a total of $429,197 for a period of three years (from FY 2022 to FY 2025) to fund the implementation of CenteringPregnancy in seven additional sites across Maryland. In alignment, participating practices may be eligible for Medicaid's CenteringPregnancy enhanced reimbursement benefit, detailed above.

Implementation Update

During FY 2022 to FY 2025, funding was allocated to expand CenteringPregnancy in five new sites across Maryland. In FY 2024 and FY 2025, the MCHB also braided funding with its BBH program, to fund an

additional six sites. This expansion will result in a total of 11 funded sites and aims to enhance quality maternal healthcare access, particularly for at-risk populations.

Mercy Health Foundation received funding in FY 2022 through April 2024. Funds supported the launch of CenteringPregnancy at one of their OB/GYN practices in downtown Metropolitan Baltimore. As of April 2024, Mercy Health Foundation has successfully enrolled 156 individuals and hosted 29 Centering cohorts over two years. They achieved accreditation in July 2024.

Since 2022, the Department has partnered with the **Centering Healthcare Institute** to support the recruitment and provision of start-up funds to sites interested in implementing the CenteringPregnancy model. Based on an open application process and assessment of readiness, four prenatal clinics, strategically located in Baltimore County, Montgomery County, and Prince George's County, were recruited in FY 2023 and FY 2024. Utilizing the braided BBH funding, Centering Healthcare Institute recruited an additional four sites in FY 2024, located in Baltimore City, Frederick, and Montgomery Counties. The eight currently-funded clinics are:

- Kaiser Gaithersburg in Montgomery County
- Mary's Center Silver Spring in Montgomery County
- University of Maryland St. Joseph's Women's Health Associates in Baltimore County
- Luminis Health Greenbelt in Prince George's County
- Frederick Health in Frederick County
- Baltimore Medical System at Yard 56 in Baltimore City
- CCI Health Silver Spring in Montgomery County
- Lifebridge Sinai Hospital in Baltimore City

Currently, St. Joseph's is enrolled with Medicaid to bill for the enhanced rate. The Department anticipates that sites will complete their implementation plans, apply for accreditation, and enroll Medicaid providers between November 2024 and July 2025. Site timelines may differ depending if they entered during the two-year Centering Implementation Plan, or the one-year Centering365 model. All sites receive the same high-quality technical assistance, training, and support from the Centering Healthcare Institute. Once accredited or pending accreditation, Maryland Medicaid provides enhanced reimbursement to CenteringPregnancy-certified providers and MCOs that are enrolled in the CenteringPregnancy model, thus allowing for sustainability.

Improving Childhood Asthma Initiatives

Program Overview

Environmental home visiting programs have been shown to improve asthma outcomes, including adolescent asthma, by addressing asthma triggers in the home and other related environments. This section describes the efforts of the Department to improve childhood asthma outcomes. The Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program benefits children suffering from moderate to severe asthma by providing up to six home visits from a local health department (LHD) community health worker (CHW), facilitated by a supervising case manager. The

program emphasizes cooperative goal setting with the family to reduce or eliminate asthma triggers such as environmental tobacco smoke, pets, fabrics, the presence of vermin due to inadequate sanitation, or other critical objectives.

In addition to the identification of environmental triggers, the follow up visits include parent education and provision of supplies shown to reduce asthma severity, including a high efficiency particulate air (HEPA) vacuum cleaner and other interventions demonstrated to improve outcomes for children with moderate to severe asthma.

Implementation Update

The Department has utilized funds from Maryland Medicaid's CHIP Health Services Initiative (HSI) to support the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program operating in 11 jurisdictions: Anne Arundel, Baltimore, Charles, Dorchester, Frederick, Harford, Montgomery, Prince George's, St. Mary's, and Wicomico Counties, as well as Baltimore City.

The program also ensures care coordination amongst providers who interact with the child through the use of asthma action plans. In FY 2024, 897 children with asthma received services through this program. In support of the goal of addressing health disparities, 72 percent of the children with asthma served in the program were Black or African American.

Table 24. Children with moderate to severe asthma served in the Medicaid/CHIP Home Visiting program, by jurisdiction (2020-2024)[21]

Jurisdiction	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Anne Arundel*	-	-	-	92	158
Baltimore	*	*	14	122	146
Baltimore City	17	40	183	251	331
Charles	46	*	*	11	*
Dorchester	86	17	24	57	32
Frederick	13	12	*	18	24
Harford	263	109	82	96	59
Montgomery*	-	-	-	23	72
Prince George's	49	31	84	36	12
St. Mary's	0	53	36	35	35
Wicomico	54	38	85	66	22
Total	530	315	521	807	897

[21]The addition of Anne Arundel and Montgomery County, and expanded staffing of the 9 original jurisdictions, was made possible in 2022 with additional funding through the Health Services Cost Review Commission. That funding ends in 2025.

Improving Referrals to Local Health Department Asthma Home Visiting Programs

One of the most significant challenges to the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program is recruiting families into the program. The Department developed several strategies to improve the referral process, including:

- Finder files developed by the Hilltop Institute using fee-for-service (FFS) claims as well as MCO encounters to identify children who may be eligible for services, which are then distributed to LHD nurse case managers;
- Care alerts to health care providers through the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP);
- Direct electronic referrals to LHDs of children recently discharged from emergency departments or inpatient admissions for asthma exacerbations through CRISP; and
- Direct referrals from hospitals and managed care organizations to LHD home visiting programs.

Taken together, these strategies have significantly increased referrals to LHD home visiting programs and improved the recruitment of families into the program. In particular, on September 8, 2022, the first direct electronic referrals of children with recent emergency department visits or hospitalizations due to asthma were from CRISP to LHDs and have continued at the rate of at least 10 children per LHD per week. Table 25 below shows the growth in and impact of CRISP referrals on asthma enrollment in the home visiting program over time. It should be noted that the decrease in 2024 is due in part to the fact that it includes totals only through June 30, 2024, and a technical programming error that resulted in several weeks of interrupted referrals to the LHDs that have since been corrected.

Table 25. Number and Status of Children Referred to Local Health Department Home Visiting Programs by CRISP, 2022-2024

Status of Child/Family	CY 2022	CY 2023	CY 2024	Total
Attempting to enroll/determine eligibility	53	64	63	180
Could not contact family	360	787	349	1,496
Family/child discharged from Program	205	307	147	659
Family/child eligible and enrolled in Program	24	163	140	327
Family/child eligible but declines participation in Program	234	770	356	1,360
Family/child lost to follow up	106	228	69	403
Family/child NOT eligible for Program	92	301	168	561
Family/child pending eligibility determination	*	*	*	*
Total	1,075	2,622	1,293	4,990

Community-Based and Other Programs Focused on Asthma

In addition to the $1 million from the Fund used to strengthen the LHD-operated Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program, the Department released a $250,000 competitive request for applications for community-based programs to address pediatric asthma. The Green and Healthy Homes Initiative, Inc. (GHHI) received funding for two programs, one in Baltimore City, the other in Prince George's County, two jurisdictions with high numbers of children with more severe asthma. With these funds, GHHI is addressing asthma through both educational interventions and home-based interventions and will also expand the number of children and families in the state who may be eligible for services.

The GHHI program is using a tiered intervention approach to conduct interventions to reduce exposures to home-based environmental asthma triggers such as dust-borne antigens, mold and other asthma triggers. All properties approved to participate in the program receive a resident education, an environmental assessment and an asthma trigger reduction prevention supplies kit (cleaning supplies to control dust and other triggers). Based on the home environment and the severity of the child's asthma, additional supplies and services may also be provided, including air purifiers, dehumidifiers or air conditioners, mold remediation, as well as Tier I Plus services by GHHI Environmental Health Educators, Environmental Assessors and Hazard Reduction Workers. Those receiving Tier II services will receive Tier I Plus services as well.

Tier I Asthma Trigger Reduction Interventions include:

- HEPA Vacuum
- Simple Green
- Buckets (2)
- Gloves
- Sponges
- Mop
- Mop Refill
- Pillowcases (2)
- Mattress cover
- Smoke Detector
- Carbon Monoxide Detector
- Basic IPM—Integrated Pest Management

Tier II Higher Level Asthma Trigger Reduction Interventions include:

- Air purifying machine installation
- Dehumidifier installation
- Air conditioner installation
- Intermediate to Severe IPM-Integrated Pest Management
- Mold remediation
- Plumbing repair
- CO/smoke detector installation

- Door replacement
- Gutter replacement
- Stabilization of baseboards
- Air filter replacement
- Caulk building corners
- R-9 Fiberglass
- Dryer vent install
- Drain cleaning

There were delays at the Department in making both awards to GHHI from the original intended start date of August 19, 2022 to the actual contract award letter in April 2023. This resulted in delays in starting the project that have affected enrollment numbers described subsequently. The most recent GHHI interim report for Prince George's County summarizes the performance measures and progress to date.

> Objectives: The original intention was to enroll a total of 210 children in the Program over 42 months (3.5 years). In the initial six months, GHHI planned to enroll and serve 30 asthma-diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 60 clients annually for the next 36 months. In total, 210 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and Tier I Plus and Tier II asthma trigger reduction housing interventions.
>
> Interim Report Update: GHHI received 2,300 referrals of Prince George's County children ages two to 17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI started serving clients in Prince George's County after receiving their award letter in April 2023 and hiring staff. Because of these delays from the originally planned start date of August 2022, MDH agreed to consolidate the deliverables of Years 1 and 2. As of April 30, 2024, GHHI had met its original goal for Years 1-2 of the award (90 families served). The Year 3 goal of 60 clients served by June 30, 2024 was not met; only 50 clients were enrolled and served. GHHI has ten unserved clients from its Year 4 goal of 60 clients, which then increased the target to 70 clients. As of October 22, 2024, 19 of 70 clients had been completed.

In Baltimore City, GHHI has also had some challenges in receiving referrals from its primary source (a large managed care organization).

Objectives: A total of 280 children will be enrolled in the Program over 42 months. In the initial six months, GHHI planned to enroll and serve 40 asthma diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 80 clients annually for the next 36 months. In total, 280 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and asthma trigger reduction housing interventions.

Interim Report Update: GHHI received 1,900 referrals of Baltimore City children ages two to 17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. From the date of the grant award in April 2023, through August 31, 2023, GHHI met its target of serving 120 clients. From August 31, 2023 through February 28, 2024, GHHI met its Year 3 target of 80 clients served. For Year 4, GHHI's goal for Baltimore City is to serve 80 clients in total; as of October 10, 2024 they have served 67 of 80.

Asthma Community of Practice (CoP) and Provider Education

The Asthma Community of Practice (CoP) was created by EHB with the vision that all people and families living with asthma in Maryland receive the best possible care so that asthma does not affect their quality of life, and with the mission of improving practice through information and resource sharing. The purpose of the Asthma CoP is to:

1. Serve as a forum to exchange best practices and information regarding asthma treatment, management, and prevention;
2. Improve collaboration among stakeholders involved in asthma care; and
3. Ensure that Marylanders with asthma get the best possible care and access to prevention services.

In FY 2024 EHB successfully held three Asthma CoP meetings (August and November of 2023, and March 2024). More than 100 people now receive invitations to the meetings, and represent asthma stakeholders across the state, including care providers, academic researchers, parents, insurance companies and MCOs, medical systems, local health departments, school health personnel, and community health workers.

Public Health Program Performance

The Department's staff closely monitor performance on the SMM and childhood asthma goals as part of their ongoing implementation responsibilities under the Fund. COVID-19 has had an undeniable impact on SMM and childhood asthma goals.

Pandemic lockdowns led to a notable decrease in ED visits for asthma exacerbation. This decline can be attributed to reduced exposure to viral infections, environmental allergens, limited access to primary physicians, and families being hesitant to seek ED care. At the onset of the pandemic, the CDC categorized individuals with moderate to severe asthma as a high-risk group vulnerable to severe COVID-19 outcomes.[22] Consequently they advocated for strategies to mitigate asthma exacerbation risks, including avoiding triggers, adhering to prescribed medications, following personalized asthma action plans.

The Department remains committed to closely monitoring childhood asthma rates across pre- pandemic,

[22] Moore WC, Ledford DK, Carstens DD, Ambrose CS. Impact of the COVID-19 Pandemic on Incidence of Asthma Exacerbations and Hospitalizations in US Subspecialist-Treated Patients with Severe Asthma: Results from the CHRONICLE Study. J Asthma Allergy. 2022 Aug 31;15:1195-1203. doi: 10.2147/JAA.S363217. PMID: 36068863; PMCID: PMC9441176.

pandemic, post pandemic periods to ensure optimal improvement in asthma management and child health, while improving overall well-being and reducing asthma related issues.

Severe Maternal Morbidity Performance

Statewide Performance

The State's SMM rate has increased since 2018 and remains above the State's 2018 baseline. In FY 2023, an SMM literature review was conducted to better understand the continued rise in SMM cases. The literature review suggested that blood-transfusion-only events may artificially inflate the prevalence of SMM and in 2021 Federal partners (HRSA) updated the SMM indicators to exclude blood transfusions alone, due to lack of specificity.[23] Other significant contributors of elevated SMM rates revealed in the literature review included: COVID-19, comorbidities, hypertension, mental health, racial disparities, clinical level, and patient factors.

In FY 2024, the Department began working with CRISP to understand the impact of blood transfusions on the state SMM rate. This is in response to an update made by HRSA to remove blood transfusions as one of the procedure codes in its definition of SMM. Upon further analysis, the Department and CRISP discovered that blood-transfusion-only events account for 66 percent of all SMM events. In January 2024 CRISP updated their dashboard to show SMM rates with blood transfusion and SMM rates excluding blood-transfusion-only events.

Based on data through June 2024, Maryland had 319.0 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 99.7 hospitalizations per 10,000 higher than the 2023 target (219.3) and 75.9 hospitalizations per 10,000 higher than the 2018 baseline (243.1). Over the same period, approximately two thirds of the SMM events that occurred involved blood transfusions only. Removing these events, the SMM rate of cases with blood transfusions excluded was 107.3 events per 10,000 delivery discharges.

[23] Federally Available Data (FAD) Resource Document for FY25/FY23 Application/Annual Report. (2024, July 10). https://mchb.tvisdata.hrsa.gov/Admin/FileUpload/DownloadContent?fileName=FadResourceDocument.pdf&isForDownload=False

Figure 1. SMM Hospitalizations for Rolling 12- Months, 2018 - June 2024

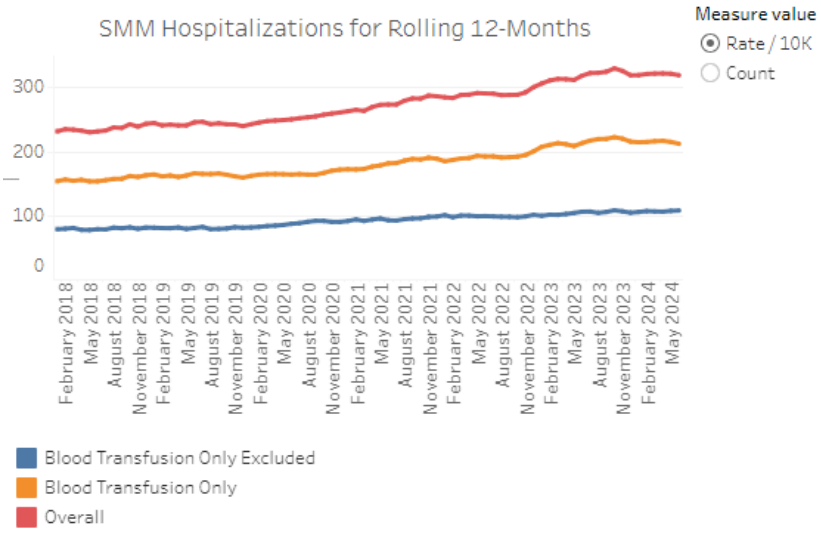


Table 26A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	243.1	9.6% decrease (Not Met)	319.0	197.6	-121.4
SMM Events	1,585	-	1,900	-	-
Eligible Deliverables	65,199	-	59,557	-	-

Table 26B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	80.7	9.6% decrease (Not Met)	107.3	65.6	-41.7
SMM Events	526	-	639	-	-
Eligible Deliverables	65,199	-	59,557	-	-

Health disparities are also increasing due to challenges discussed earlier in this report, further illustrating the critical need to invest in evidence-based interventions dedicated to addressing maternal health.

Figure 2A, Figure 2B, Table 27A, and Table 27B show SMM rates disaggregated by race and ethnicity. While disparity gaps have decreased slightly compared to last year's report, substantial progress is still required to meet the 2026 target rates.

Figure 2A. SMM Hospitalizations, Including Blood Transfusions, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2024

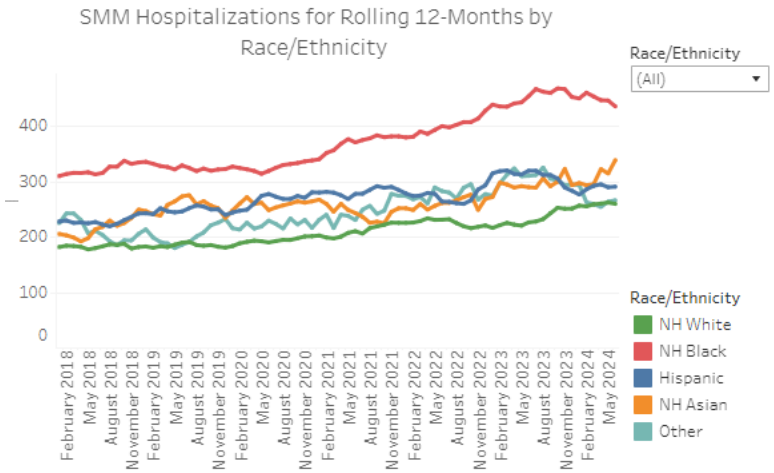


Figure 2B. SMM Hospitalizations, Excluding Blood Transfusion-Only Events, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2024

Table 27A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland by Race/Ethnicity

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	181.4	7.5% decrease (Not Met)	259.3	15% decrease	-105.1	1.0
NH Black	334.2	10% decrease (Not Met)	435.4	20% decrease	-168.0	1.7
Hispanic	242.0	10% decrease (Not Met)	290.3	20% decrease	-96.7	1.1
NH Asian	249.0	10% decrease (Not Met)	338.4	20% decrease	-139.2	1.3
Other	205.2	10% decrease (Not Met)	265.8	20% decrease	-101.6	1.0
Statewide Total	243.1	9.6% decrease (Not Met)	319.0	18.7% decrease	-121.4	1.2

Table 27B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2023-June 2024 Rates, Maryland by Race/Ethnicity

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	59.0	7.5% decrease (Not Met)	50.2	15% decrease	-42.0	1.0
NH Black	124.3	10% decrease (Not Met)	99.5	20% decrease	-63.9	1.8
Hispanic	57.2	10% decrease (Not Met)	45.8	20% decrease	-25.8	0.8
NH Asian	93.4	10% decrease (Met)	74.7	20% decrease	-16.7	1.0
Other	59.5	10% decrease (Not Met)	47.6	20% decrease	-43.5	1.0
Statewide Total	80.7	9.6% decrease (Not Met)	65.6	18.7% decrease	-41.7	1.2

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward for SMM rates including blood transfusions, in line with Statewide performance (Figure 3A). However, when excluding blood transfusion-only events, rates among Medicaid participants have remained fairly stable in recent years (Figure 3B). Additionally, while Medicaid SMM rates are higher than commercial SMM rates, both including and excluding blood transfusions, Medicaid SMM rates have grown at a slower pace than commercial SMM rates since 2018. SMM rates and percent increases are highest among individuals with Medicare, though counts are low and rates may be unstable; interpret with caution (Tables 28A and 28B).

Figure 3A. SMM Rates, Including Blood Transfusions, by Payer, 2018-2023, Excluding Medicare[24,25]

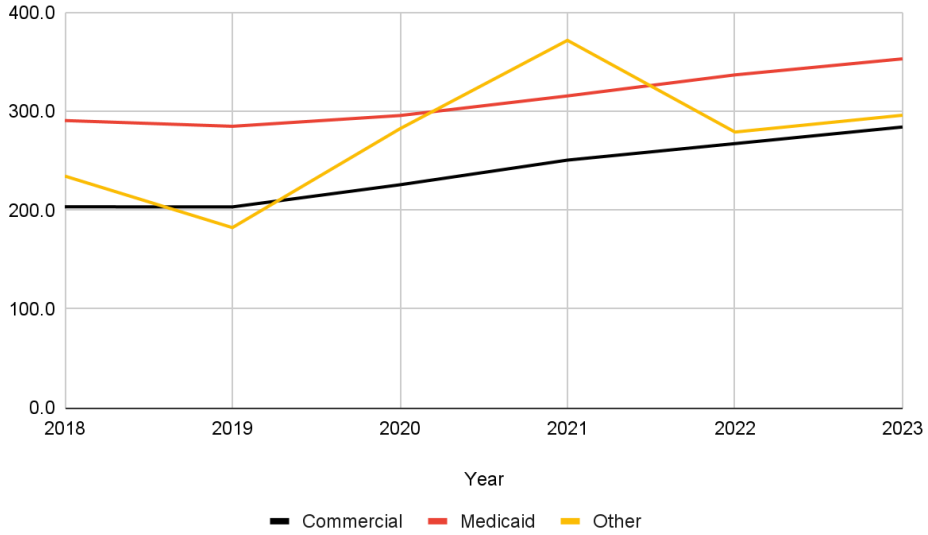


Figure 3B. SMM Rates, Excluding Blood Transfusion-Only Events, by Payer, 2018-2023, Excluding Medicare[24,25]

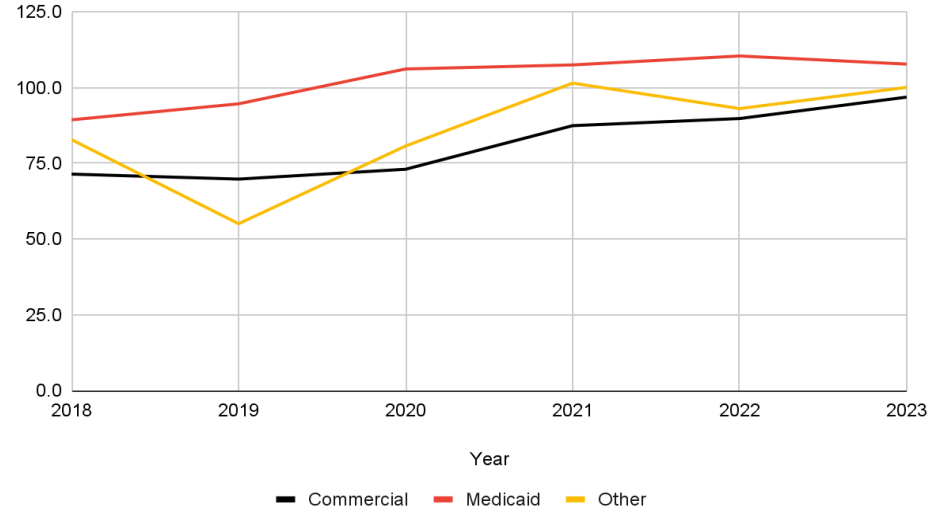


Table 28A. SMM Rate, Including Blood Transfusions, by Payer, 2018 – 2023[28,29]

Payer	2018	2019	2020	2021	2022	2023	% Change Since 2018
Commercial	203.5	203.4	225.8	250.8	267.5	284.3	+39.7%
Medicaid	290.9	285.0	295.9	315.8	337.1	353.3	+21.5%
Medicare	692.3	641.5	848.7	962.3	717.5	1315.8	+90.1%
Other	234.6	182.4	282.5	372.1	279.2	296.2	+26.3%

[24] Source: MCHB Data & Epidemiology Program analysis of Health Services and HSCRC in-patient case-mix as of September 2024.

[25] Note: Medicare data are not shown in the figure due to low counts of SMM events, and to allow better visualization.

Table 28B. SMM Rate, Excluding Blood Transfusion-Only Events, by Payer, 2018 – 2023[26,27]

Payer	2018	2019	2020	2021	2022	2023	% Change Since 2018
Commercial	71.4	69.8	73.1	87.4	89.8	96.9	+35.7%
Medicaid	89.4	94.6	106.1	107.5	110.4	107.8	+20.6%
Medicare	423.1	*	516.6	502.1	*	684.2	+61.7%
Other	82.8	55.1	80.7	101.5	93.1	100.1	+20.9%

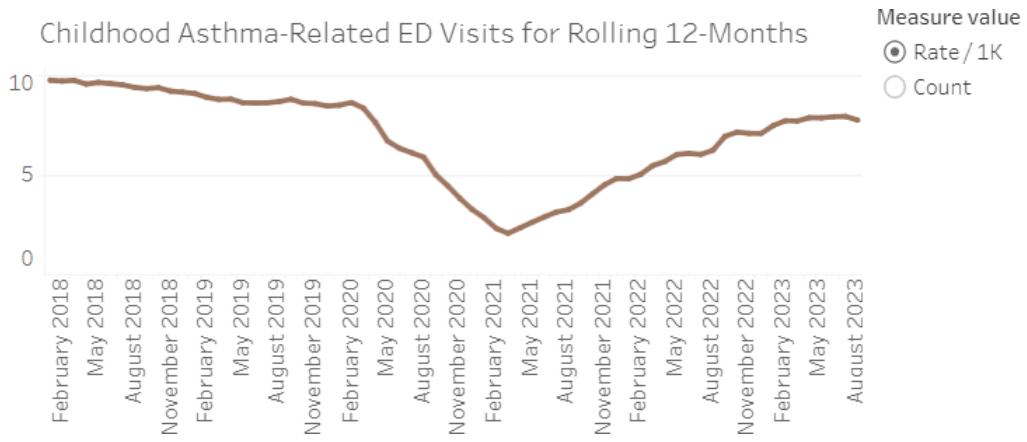
Childhood Asthma Emergency Department (ED) Visit Rate

As is true for hospitals nationally, Maryland hospitals saw sharp declines in ED volumes in 2020 and early 2021 due to COVID-19. Understandably, Maryland's asthma-related ED visit rate for ages 2-17 declined during this period. While 2022 volumes are trending back to 2018 baselines, they are still artificially low. Despite lower ED volumes, staff believe that the underlying dynamics of childhood asthma in Maryland did not change and is working in earnest to implement interventions that will reduce childhood asthma and associated health disparities.

Statewide Performance

Based on data through August 2022, Maryland had 6.2 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.0 visits per 1,000 children lower than the 2023 target.

Figure 4. Childhood Asthma-Related ED Visits for Rolling 12-Months



[26] Source: MCHB Data & Epidemiology Program analysis of Health Services and HSCRC in-patient case-mix as of September 2024.

[27] Note: Medicare data are not shown in the figure due to low counts of SMM events, and to allow better visualization.

Table 29. Childhood Asthma-Related ED Visits Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Different - Most Recent 12 months to Target
Rates per 1,000	9.2	7.8	7.2	0.6
Total Count	10,974	9,258	-	-

As with the SMM rate, the impacts of COVID-19 have had a deleterious impact on health disparities, most notably with the non-Hispanic Black population. Continued investment in initiatives and programs to address childhood asthma is critical to eliminating these disparities and putting Maryland back on a path to reach the improvement goals.

Figure 5. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

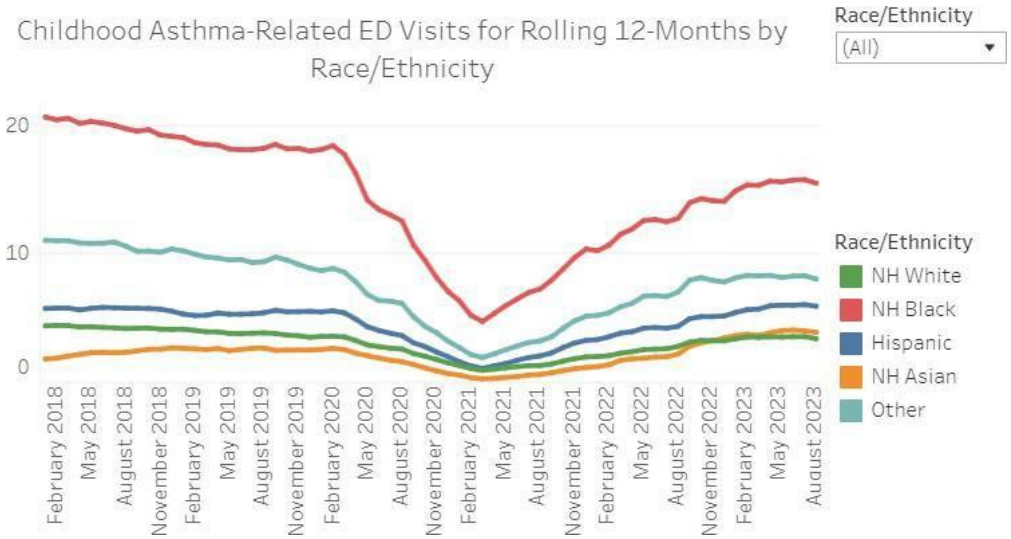


Table 30. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

Race	2018	2023 Year 5 Target	2026 Year 8 Target	Absolute Change	Relative Percentage Change
Total	9.2	7.2	5.3	3.9	42%
NH White	4.1	3.5	3.0	1.1	26%
NH Black	19.1	14.36	9.6	9.6	50%
Hispanic	5.4	4.7	4.0	1.4	25%
NH Asian	2.7	2.6	2.5	0.2	9%
Other	10.6	7.30	5.5	5.1	48%

Performance by Payer

The State is also monitoring performance by payer. As stated earlier in the report, the State believes these declines in the asthma-related ED visit rate in Maryland mirror both State and national reductions in overall ED visits due to COVID-19. Continued and expanded interventions to address childhood asthma are critical to preventing further growth in health disparities resulting from patients potentially not seeking care during the pandemic.

Table 31. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-September 2022

Payer	2018	2019	2020	2021	2022	% Change since 2018
Medicaid	13.3	12.5	5.0	7.1	6.8	-49%
Non - Medicaid	5.4	4.8	1.7	2.6	3.0	-44%

Year Three Spending

The Medicaid program devoted its efforts in FY 2024 to continuing expansion of all implemented benefits. As detailed above, implementation efforts spanned benefit design, systems changes for both payment and provider enrollment, and development and approval of regulations (state authority) and Medicaid State Plan Amendments (federal authority), in addition to provider enrollment and education. The Medicaid program intends to continue to maximize the Fund's contribution by pulling down federal matching funds, which relies

on service implementation.

Utilization of some services was lower than desired. Therefore, Medicaid developed flexibilities for new doula providers that decrease the administrative burden of provider enrollment, with the goal of increasing the number of providers, and therefore access. Similarly, Medicaid reached out to the Centering Healthcare Institute and ZERO TO THREE to discuss strategies to troubleshoot low rates of claiming for CenteringPregnancy and HealthySteps services.

The Medicaid program is building the full $16 million into its budget for CY 2025 and expects service delivery to increase as provider networks continue to grow and additional participants become aware of the new benefits. Medicaid will continue to work with PHPA to support the conversion of the MPRA–a major referral source for MCH programs–from paper to electronic, and increase outreach and awareness amongst the IMHS pilot sites.

PHPA dedicated FY 2024 to providing technical support to grantees as they continue the implementation of the asthma and maternal health initiatives.

Table 32. PHPA Grant Funds Expenditures - FY 2024

Initiative	FY 2024 Spending
Asthma Home Visiting Program	$427,408
Community-Based Asthma Programs	$233,558
Maternal Home Visiting	$866,613
CenteringPregnancy	$188,280
Program Total	**$1,715,859**

Compared to FY 23, spending by all sites increased substantially. Staffing challenges continued to impact all grantees, which contributed to sites not being able to spend their full award. The Department is working with all sites to address these challenges and will support the sites in their final year as they begin planning for sustainability and continuation of grant activities in FY 25.

Conclusion

In FY 2024, the Department remains committed to strategically investing in maternal and child health initiatives, through these evidence-based initiatives. Preliminary data shows positive outcomes for several key measures, in addition to identifying some measures in need of further monitoring. The Department will actively use its programmatic data to improve the delivery of the services and tailor strategies effectively, ensuring that resources reach those who need them most.

The various interventions align with priorities of the State and the Department as well as national

recommendations to improve the prenatal-to-childhood system of care in Maryland[28]. The Department will continue to facilitate seamless coordination and collaboration among various stakeholders. Fostering peer-to-peer learning opportunities to offer guidance and support to home visiting sites and community-based asthma programs will allow further alignment, collaboration, and integration amongst home visiting sites, LHDs, and community-based health organizations, which ultimately lead to improved outcomes and better care.

Finally, the Department looks forward to continued partnership with the HSCRC to strengthen maternal child health across the State. The commissioners and key stakeholders identified improving MCH as a critical priority for Maryland, and the Department remains a committed partner in this important work.

[28] Prenatal-to-3policy.2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/ Accessed 6 December 2024

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Hospital Financial Condition Report

Fiscal Year 2024

May 2025

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Introduction

The Maryland Health Services Cost Review Commission ("HSCRC" or "Commission") has completed the annual hospital financial condition report for Fiscal Year 2024.

In FY 2024, Maryland concluded its sixth year under the Total Cost of Care agreement. Under the Maryland TCOC Model, the State of Maryland is leading a transformative effort to improve care and lower healthcare spending. The TCOC Model builds on the successes of the All-Payer Model, a 5-year demonstration project with CMS, which began January 1, 2014 and ended December 31, 2018. The TCOC Model, which began in January 2019 and will conclude in December 2025, has progressively transformed care delivery across the health care system with the objective of controlling total healthcare costs, improving health and quality of care. More information on Maryland's progress under the TCOC Model can be found on the HSCRC website at https://hscrc.maryland.gov/Pages/legal-reports.aspx. Beginning on January 1, 2026, the State of Maryland will be transitioning to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

Data on the collective financial performance of Maryland acute hospitals are summarized below.

- Gross regulated revenue. Gross patient revenue on regulated services increased 4.95 percent from $20.2 billion in FY 2023 to $21.2 billion in FY 2024.
- Net regulated patient revenue. Total regulated net patient revenue increased from $16.9 billion in FY 2023 to $17.7 billion in FY 2024, an increase of 4.73 percent.
- Profits on regulated activities. Profits on regulated activities remained effectively constant, going from $1.15 billion (6.60 percent of regulated net operating revenue) in FY 2023 to $1.41 billion (7.83 percent of regulated net operating revenue) in FY 2024.
- Profits on operations. Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) increased from $3 million in FY 2023 (or 0.01 percent of total net operating revenue) to $181 million in FY 2024 (or 0.88 percent of total net operating revenue). This increase is largely driven by the change in regulated profits.
- Total excess profit. Total excess profits (which include profits and losses from regulated and unregulated operating and non-operating activities) increased from $494 million in FY 2023 (or 2.42 percent of the total revenue) to $808 million (or 3.78 percent of the total revenue) in FY 2024. This increase is due largely to increases in non-operating revenue.

Maryland is the only state in which uncompensated care is financed by all payers, including Medicare and Medicaid. The payment system builds the predicted cost of uncompensated care into the rates, and all payers pay the same rates for hospital care. Because the rates cover predicted uncompensated care amounts, hospitals have no reason to discourage patients who are likely to be without insurance. Thus, Maryland continues to be the only state in the nation that assures its citizens that they can receive care at any hospital, regardless of their ability to pay. As a result, there are no charity hospitals in Maryland; patients who are unable to pay are not transferred into hospitals of last resort.

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Contents of Report

Under its mandate to publicly disclose information about the financial operations of all hospitals, the Maryland Health Services Cost Review Commission (HSCRC or Commission) has prepared this report of comparative financial information from the respective hospitals.

This report combines the financial data of hospitals with a June 30 fiscal year end with the hospitals with a December 31 year end of the previous year, e.g., June 30, 2024 and December 31, 2023. All of the financial data in this report have been combined in this fashion.

Gross Patient Revenue, Net Patient Revenue, Other Operating Revenue, Net Operating Revenue, Percentage of Uncollectible Accounts, Total Operating Costs, Operating Profit/Loss, Non-Operating Revenue and Expense, and Total Excess Profit/Loss, as itemized in this report, were derived from the Annual Report of Revenue, Expenses, and Volumes (Annual Report) submitted to the HSCRC. The Annual Report is reconciled with the audited financial statements of the respective institutions.

This year's Disclosure Statement also includes the following three Exhibits:

- Exhibit I - Change in Uncompensated Care (Regulated Operations)
- Exhibit II - Change in Total Operating Profit/Loss (Regulated and Unregulated Operations)
- Exhibit III – Total Excess Profit/Loss (Operating and Non-Operating Activities)

The following explanations are submitted in order to facilitate the reader's understanding of this report:

Gross Patient Revenue refers to all regulated and unregulated patient care revenue and should be accounted for at established rates, regardless of whether the hospital expects to collect the full amount. Such revenues should also be reported on an accrual basis in the period during which the service is provided; other accounting methods, such as the discharge method, are not acceptable. For historical consistency, uncollectible accounts (bad debts) and charity care are included in gross patient revenue.

Net Patient Revenue means all regulated and unregulated patient care revenue realized by the hospital. Net patient revenue is arrived at by reducing gross patient revenue by contractual allowances, charity care, bad debts, and payer denials. Such revenues should be reported on an accrual basis in the period in which the service is provided.

Other Operating Revenue includes regulated and unregulated revenue associated with normal day-to-day operations from services other than health care provided to patients. These include sales and services to non-patients and revenue from miscellaneous sources, such as rental of hospital space, sale of cafeteria meals, gift shop sales, research, and Medicare Part B physician services. Such revenue is common in the regular operations of a hospital but should be accounted for separately from regulated patient revenue. Additionally, this revenue includes the funds received through the PRF under the Federal CARES Act.

Net Operating Revenue is the total of net patient revenue and other operating revenue.

Uncompensated Care is composed of charity and bad debts. This is the percentage difference between billings at established rates and the amount collected from charity patients and patients who pay less than their total bill, if at all. For historical consistency, uncollectible accounts are treated as a reduction in revenue.

Total Operating Expenses equal the costs of HSCRC-regulated and unregulated inpatient and outpatient care, plus costs associated with Other Operating Revenue. Operating expenses are presented in this report in accordance with generally accepted accounting principles with the exception of bad debts. For historical consistency, bad debts are treated as a reduction in gross patient revenue.

Operating Profit/Loss is the profit or loss from ordinary, normal recurring regulated and unregulated operations of the entity during the period. Operating Profit/Loss also includes restricted donations for specific operating purposes if such funds were expended for the purpose intended by the donor during the fiscal year being reported upon.

Non-Operating Profit/Loss includes realized as well as unrealized investment income, extraordinary gains, and other non-operating gains and losses.

Total Excess Profit/Loss represents the bottom-line figure from the Annual Cost Report of the institution. It is the total of the Operating Profit/Loss and Non-Operating Profit/Loss.

Financial information contained in this report provides only an overview of the total financial status of the institutions. Additional information concerning the hospitals, in the form of Audited Financial Statements and reports filed pursuant to the regulations of the HSCRC, is available in PDF under Financial Data Reports/Financial Disclosure on the HSCRC website at http://hscrc.maryland.gov/Pages/pdr-annual-reports.aspx.

Notes to the Financial Data

1. Revenues and expenses applicable to physician Medicare Part B professional services are only included in regulated hospital data in hospitals that had HSCRC-approved physician rates on June 30, 1985, and that have not subsequently requested that those rates be removed so that the physicians may bill Medicare FFS.
2. The specialty hospitals in this report are Adventist Rehabilitation Hospital of Maryland; Takoma Park and Rockville, Brook Lane Health Services, J Kent McNew Family Medical Center, Mt. Washington Pediatric Hospital, and Sheppard Pratt Hospital.
3. Adventist Behavioral Health Care-Rockville merged with Washington Adventist to become Adventist- White Oak in May of 2018 and is reported as one acute care facility beginning CY 2018.
4. In accordance with Health-General Article, Section 19-3A-07, eight free-standing medical facilities—Queen Anne's Freestanding Medical Center, Germantown Emergency Center, Bowie Health Center, UM Laurel Medical Center, UM Shore Medical Center at Cambridge, UM Upper Chesapeake Medical Center at Aberdeen, Grace Medical Center, and TidalHealth McCready Pavilion—fall under the rate-setting jurisdiction of the HSCRC.

maryland health services cost review commission

Details of the Disclosure of Hospital Financial and Statistical Data: Acute Hospitals

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
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ACUTE HOSPITAL TOTALS

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	21,180,302,026	20,195,390,216	19,518,221,932
Unregulated Services	2,522,996,318	2,326,345,271	2,179,157,113
TOTAL	23,703,298,344	22,521,735,487	21,697,379,045
Net Patient Revenue (NPR):			
Regulated Services	17,696,623,041	16,926,327,621	16,635,025,507
Unregulated Services	1,177,339,095	1,120,457,266	1,065,881,799
TOTAL	18,873,962,135	18,046,784,888	17,700,907,306
Other Operating Revenue:			
Regulated Services	335,111,428	464,479,230	386,126,491
Unregulated Services	1,387,850,490	1,239,504,470	1,123,783,419
TOTAL	1,722,961,919	1,703,983,700	1,509,909,910
Net Operating Revenue (NOR)			
Regulated Services	18,031,734,469	17,390,806,851	17,021,151,998
Unregulated Services	2,565,189,585	2,359,961,737	2,189,665,218
Total	20,596,924,054	19,750,768,587	19,210,817,216
Total Operating Expenses:			
Regulated Services	16,619,756,675	16,242,191,873	15,921,642,690
Unregulated Services	3,796,424,407	3,505,903,491	3,141,321,067
Total	20,416,181,082	19,748,095,364	19,062,963,757
Net Operating Profit (Loss):			
Regulated Services	1,411,977,794	1,148,614,978	1,099,509,308
Unregulated Services	-1,231,234,822	-1,145,941,754	-951,655,849
Total	180,742,972	2,673,224	147,853,459
Total Non-Operating Profit (Loss):	626,971,690	496,716,216	-541,223,631
Non-Operating Revenue	787,713,419	644,791,997	-69,937,904
Non-Operating Expenses	160,741,729	148,075,781	471,285,727
Total Excess Profit (Loss):	807,714,662	494,091,440	-502,706,172
% Net Operating Profit of Regulated NOR	7.83	6.60	6.46
% Net Total Operating Profit of Total NOR	0.88	0.01	0.77
% Total Excess Profit of Total Revenue	3.78	2.42	-2.63

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ADVENTIST HEALTHCARE FORT WASHINGTON MEDICAL CENTER

FISCAL YEAR ENDING	December 2023	December 2022	December 2021
Gross Patient Revenue:			
Regulated Services	64,761,498	74,115,596	63,872,312
Unregulated Services	4,579,266	3,844,279	879,950
TOTAL	69,340,764	77,959,875	64,752,263
Net Patient Revenue (NPR):			
Regulated Services	56,662,033	56,657,567	54,912,174
Unregulated Services	1,893,766	1,528,952	348,146
TOTAL	58,555,799	58,186,519	55,260,320
Other Operating Revenue:			
Regulated Services	620,204	1,906,860	5,039,531
Unregulated Services	727,775	502,358	1,541,105
TOTAL	1,347,979	2,409,218	6,580,636
Net Operating Revenue (NOR)			
Regulated Services	57,282,237	58,564,427	59,951,705
Unregulated Services	2,621,541	2,031,310	1,889,250
Total	59,903,778	60,595,737	61,840,956
Total Operating Expenses:			
Regulated Services	51,029,116	55,776,567	54,926,584
Unregulated Services	11,607,794	7,755,892	6,315,863
Total	62,636,910	63,532,459	61,242,447
Net Operating Profit (Loss):			
Regulated Services	6,253,121	2,787,860	5,025,121
Unregulated Services	-8,986,253	-5,724,582	-4,426,612
Total	-2,733,132	-2,936,722	598,509
Total Non-Operating Profit (Loss):	-81,976	11,554	39,885
Non-Operating Revenue	-81,976	11,554	39,885
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,815,108	-2,925,168	638,394
% Net Operating Profit of Regulated NOR	10.92	4.76	8.38
% Net Total Operating Profit of Total NOR	-4.56	-4.85	0.97
% Total Excess Profit of Total Revenue	-4.71	-4.83	1.03

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ATLANTIC GENERAL HOSPITAL

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	135,629,341	125,786,800	124,940,915
Unregulated Services	77,948,152	86,372,972	77,996,357
TOTAL	213,577,493	212,159,772	202,937,272
Net Patient Revenue (NPR):			
Regulated Services	112,008,265	106,526,912	107,405,501
Unregulated Services	36,038,481	39,720,471	35,114,762
TOTAL	148,046,747	146,247,383	142,520,263
Other Operating Revenue:			
Regulated Services	3,476,792	3,656,139	5,459,316
Unregulated Services	11,736,514	7,011,609	5,516,518
TOTAL	15,213,306	10,667,749	10,975,834
Net Operating Revenue (NOR)			
Regulated Services	115,485,057	110,183,051	112,864,817
Unregulated Services	47,774,996	46,732,080	40,631,280
Total	163,260,053	156,915,131	153,496,096
Total Operating Expenses:			
Regulated Services	96,264,285	96,820,606	91,997,795
Unregulated Services	73,323,404	69,602,242	62,129,271
Total	169,587,689	166,422,848	154,127,066
Net Operating Profit (Loss):			
Regulated Services	19,220,772	13,362,445	20,867,022
Unregulated Services	-25,548,409	-22,870,162	-21,497,992
Total	-6,327,636	-9,507,717	-630,970
Total Non-Operating Profit (Loss):	4,439,022	5,483,636	2,097,332
Non-Operating Revenue	4,125,537	3,862,005	-2,242,326
Non-Operating Expenses	-313,485	-1,621,631	-4,339,658
Total Excess Profit (Loss):	-1,888,614	-4,024,081	1,466,362
% Net Operating Profit of Regulated NOR	16.64	12.13	18.49
% Net Total Operating Profit of Total NOR	-3.88	-6.06	-0.41
% Total Excess Profit of Total Revenue	-1.13	-2.50	0.97

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Adventist HealthCare Germantown Emergency Center

FISCAL YEAR ENDING	December 2023	December 2022	December 2021
Gross Patient Revenue:			
Regulated Services	17,967,500	17,461,500	14,669,400
Unregulated Services	0	0	0
TOTAL	17,967,500	17,461,500	14,669,400
Net Patient Revenue (NPR):			
Regulated Services	13,037,826	12,221,693	9,909,121
Unregulated Services	0	0	0
TOTAL	13,037,826	12,221,693	9,909,121
Other Operating Revenue:			
Regulated Services	1,806	22,132	375,604
Unregulated Services	0	53	1,612
TOTAL	1,806	22,185	377,216
Net Operating Revenue (NOR)			
Regulated Services	13,039,632	12,243,825	10,284,725
Unregulated Services	0	53	1,612
Total	13,039,632	12,243,878	10,286,337
Total Operating Expenses:			
Regulated Services	13,289,054	12,564,632	11,504,018
Unregulated Services	9,500	10,800	227,100
Total	13,298,554	12,575,432	11,731,118
Net Operating Profit (Loss):			
Regulated Services	-249,422	-320,807	-1,219,293
Unregulated Services	-9,500	-10,747	-225,488
Total	-258,922	-331,554	-1,444,781
Total Non-Operating Profit (Loss):	0	0	135
Non-Operating Revenue	0	0	135
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-258,922	-331,554	-1,444,646
% Net Operating Profit of Regulated NOR	-1.91	-2.62	-11.86
% Net Total Operating Profit of Total NOR	-1.99	-2.71	-14.05
% Total Excess Profit of Total Revenue	-1.99	-2.71	-14.04

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Adventist HealthCare Shady Grove Medical Center

FISCAL YEAR ENDING	December 2023	December 2022	December 2021
Gross Patient Revenue:			
Regulated Services	534,307,365	507,181,036	495,127,100
Unregulated Services	16,144,338	50,288,820	16,253,627
TOTAL	550,451,703	557,469,856	511,380,727
Net Patient Revenue (NPR):			
Regulated Services	441,176,207	431,959,166	418,257,656
Unregulated Services	4,851,406	17,106,860	5,571,408
TOTAL	446,027,613	449,066,026	423,829,064
Other Operating Revenue:			
Regulated Services	3,606,710	3,482,908	21,117,325
Unregulated Services	17,929,795	7,893,682	10,439,409
TOTAL	21,536,505	11,376,590	31,556,734
Net Operating Revenue (NOR)			
Regulated Services	444,782,917	435,442,074	439,374,981
Unregulated Services	22,781,201	25,000,542	16,010,817
Total	467,564,118	460,442,616	455,385,798
Total Operating Expenses:			
Regulated Services	402,231,760	403,089,895	385,177,238
Unregulated Services	38,838,435	47,219,780	43,136,100
Total	441,070,195	450,309,675	428,313,338
Net Operating Profit (Loss):			
Regulated Services	42,551,157	32,352,179	54,197,743
Unregulated Services	-16,057,234	-22,219,238	-27,125,283
Total	26,493,923	10,132,941	27,072,460
Total Non-Operating Profit (Loss):	5,682,742	-1,518,175	6,006,212
Non-Operating Revenue	5,682,742	-1,518,175	6,006,212
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	32,176,665	8,614,766	33,078,672
% Net Operating Profit of Regulated NOR	9.57	7.43	12.34
% Net Total Operating Profit of Total NOR	5.67	2.20	5.94
% Total Excess Profit of Total Revenue	6.80	1.88	7.17

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Adventist HealthCare White Oak Medical Center

FISCAL YEAR ENDING	December 2023	December 2022	December 2021
Gross Patient Revenue:			
Regulated Services	351,439,080	352,793,525	331,339,300
Unregulated Services	14,911,025	37,212,146	30,726,934
TOTAL	366,350,105	390,005,671	362,066,234
Net Patient Revenue (NPR):			
Regulated Services	304,751,639	289,847,434	276,084,921
Unregulated Services	3,943,811	10,845,354	10,620,197
TOTAL	308,695,450	300,692,788	286,705,119
Other Operating Revenue:			
Regulated Services	1,292,101	1,803,612	23,108,913
Unregulated Services	6,963,333	6,942,509	7,085,450
TOTAL	8,255,434	8,746,121	30,194,363
Net Operating Revenue (NOR)			
Regulated Services	306,043,740	291,651,046	299,193,834
Unregulated Services	10,907,144	17,787,863	17,705,647
Total	316,950,884	309,438,909	316,899,481
Total Operating Expenses:			
Regulated Services	280,506,348	290,013,367	276,626,334
Unregulated Services	36,736,182	38,681,976	38,750,907
Total	317,242,530	328,695,343	315,377,240
Net Operating Profit (Loss):			
Regulated Services	25,537,391	1,637,679	22,567,500
Unregulated Services	-25,829,037	-20,894,113	-21,045,259
Total	-291,646	-19,256,434	1,522,241
Total Non-Operating Profit (Loss):	531,026	252,337	310,669
Non-Operating Revenue	531,026	252,337	310,669
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	239,380	-19,004,097	1,832,910
% Net Operating Profit of Regulated NOR	8.34	0.56	7.54
% Net Total Operating Profit of Total NOR	-0.09	-6.22	0.48
% Total Excess Profit of Total Revenue	0.08	-6.14	0.58

HEALTH SERVICES COST REVIEW COMMISSION
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Ascension St. Agnes Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	494,805,400	515,518,500	472,142,600
Unregulated Services	200,989,909	193,779,775	184,992,816
TOTAL	695,795,309	709,298,275	657,135,416
Net Patient Revenue (NPR):			
Regulated Services	405,179,556	423,061,677	398,306,873
Unregulated Services	71,751,356	83,600,563	81,430,382
TOTAL	476,930,912	506,662,240	479,737,255
Other Operating Revenue:			
Regulated Services	5,453,965	34,602,295	12,957,053
Unregulated Services	35,005,836	15,599,841	14,718,186
TOTAL	40,459,801	50,202,136	27,675,239
Net Operating Revenue (NOR)			
Regulated Services	410,633,521	457,663,972	411,263,926
Unregulated Services	106,757,193	99,200,404	96,148,567
Total	517,390,713	556,864,376	507,412,494
Total Operating Expenses:			
Regulated Services	359,252,800	369,041,490	338,784,720
Unregulated Services	186,587,870	168,557,244	160,021,556
Total	545,840,670	537,598,734	498,806,276
Net Operating Profit (Loss):			
Regulated Services	51,380,720	88,622,482	72,479,206
Unregulated Services	-79,830,677	-69,356,840	-63,872,988
Total	-28,449,957	19,265,642	8,606,217
Total Non-Operating Profit (Loss):	1,409,672	-1,017,782	-3,596,439
Non-Operating Revenue	3,666,857	923,379	-1,075,761
Non-Operating Expenses	2,257,185	1,941,161	2,520,678
Total Excess Profit (Loss):	-27,040,285	18,247,860	5,009,778
% Net Operating Profit of Regulated NOR	12.51	19.36	17.62
% Net Total Operating Profit of Total NOR	-5.50	3.46	1.70
% Total Excess Profit of Total Revenue	-5.19	3.27	0.99

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

CALVERT HEALTH MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	188,719,140	175,364,060	170,683,940
Unregulated Services	5,825,001	5,673,775	5,700,611
TOTAL	194,544,141	181,037,835	176,384,551
Net Patient Revenue (NPR):			
Regulated Services	159,058,906	147,939,181	146,104,685
Unregulated Services	2,078,979	2,027,581	2,219,140
TOTAL	161,137,885	149,966,763	148,323,826
Other Operating Revenue:			
Regulated Services	1,430,700	2,882,101	2,619,083
Unregulated Services	716,374	537,202	446,000
TOTAL	2,147,074	3,419,303	3,065,083
Net Operating Revenue (NOR)			
Regulated Services	160,489,606	150,821,282	148,723,768
Unregulated Services	2,795,353	2,564,783	2,665,140
Total	163,284,959	153,386,066	151,388,909
Total Operating Expenses:			
Regulated Services	148,789,773	145,904,849	135,429,252
Unregulated Services	15,657,053	14,868,131	10,975,471
Total	164,446,826	160,772,980	146,404,723
Net Operating Profit (Loss):			
Regulated Services	11,699,833	4,916,433	13,294,516
Unregulated Services	-12,861,700	-12,303,348	-8,310,331
Total	-1,161,867	-7,386,914	4,984,186
Total Non-Operating Profit (Loss):	240,452	742,415	149,422
Non-Operating Revenue	240,452	742,415	149,422
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-921,415	-6,644,499	5,133,608
% Net Operating Profit of Regulated NOR	7.29	3.26	8.94
% Net Total Operating Profit of Total NOR	-0.71	-4.82	3.29
% Total Excess Profit of Total Revenue	-0.56	-4.31	3.39

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

ChristianaCare Union Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	210,598,498	188,970,768	181,753,068
Unregulated Services	49,788,200	43,891,868	47,489,711
TOTAL	260,386,698	232,862,636	229,242,779
Net Patient Revenue (NPR):			
Regulated Services	169,388,933	156,223,024	154,198,417
Unregulated Services	18,703,790	18,504,308	17,289,981
TOTAL	188,092,723	174,727,332	171,488,398
Other Operating Revenue:			
Regulated Services	493,298	1,118,316	-6,101,000
Unregulated Services	332,021	348,684	7,758,000
TOTAL	825,319	1,467,000	1,657,000
Net Operating Revenue (NOR)			
Regulated Services	169,882,231	157,341,340	148,097,417
Unregulated Services	19,035,811	18,852,992	25,047,981
Total	188,918,042	176,194,332	173,145,398
Total Operating Expenses:			
Regulated Services	151,771,888	150,348,668	159,376,660
Unregulated Services	41,398,150	41,952,730	41,900,765
Total	193,170,038	192,301,398	201,277,425
Net Operating Profit (Loss):			
Regulated Services	18,110,343	6,992,673	-11,279,243
Unregulated Services	-22,362,339	-23,099,738	-16,852,784
Total	-4,251,996	-16,107,065	-28,132,027
Total Non-Operating Profit (Loss):	7,320,000	5,010,000	-6,539,000
Non-Operating Revenue	7,320,000	5,010,000	-6,539,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	3,068,004	-11,097,065	-34,671,027
% Net Operating Profit of Regulated NOR	10.66	4.44	-7.62
% Net Total Operating Profit of Total NOR	-2.25	-9.14	-16.25
% Total Excess Profit of Total Revenue	1.56	-6.12	-20.81

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

Frederick Health Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	424,222,500	413,332,700	400,842,400
Unregulated Services	64,610,900	64,514,900	95,879,300
TOTAL	488,833,400	477,847,600	496,721,700
Net Patient Revenue (NPR):			
Regulated Services	358,096,402	346,048,500	341,532,928
Unregulated Services	42,902,800	41,614,500	58,443,105
TOTAL	400,999,202	387,663,000	399,976,033
Other Operating Revenue:			
Regulated Services	10,715,231	7,436,536	7,027,256
Unregulated Services	9,869,450	10,175,464	5,251,744
TOTAL	20,584,681	17,612,000	12,279,000
Net Operating Revenue (NOR)			
Regulated Services	368,811,633	353,485,036	348,560,185
Unregulated Services	52,772,250	51,789,964	63,694,849
Total	421,583,883	405,275,000	412,255,033
Total Operating Expenses:			
Regulated Services	344,516,941	338,216,422	332,628,724
Unregulated Services	79,229,059	75,242,578	75,767,276
Total	423,746,000	413,459,000	408,396,000
Net Operating Profit (Loss):			
Regulated Services	24,294,692	15,268,614	15,931,461
Unregulated Services	-26,456,809	-23,452,614	-12,072,427
Total	-2,162,117	-8,184,000	3,859,033
Total Non-Operating Profit (Loss):	23,086,000	20,423,000	-11,431,000
Non-Operating Revenue	23,086,000	20,423,000	-11,431,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	20,923,883	12,239,000	-7,571,967
% Net Operating Profit of Regulated NOR	6.59	4.32	4.57
% Net Total Operating Profit of Total NOR	-0.51	-2.02	0.94
% Total Excess Profit of Total Revenue	4.71	2.88	-1.89

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

GREATER BALTIMORE MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	525,917,619	497,427,559	495,095,020
Unregulated Services	298,489,730	278,695,804	257,349,424
TOTAL	824,407,349	776,123,363	752,444,444
Net Patient Revenue (NPR):			
Regulated Services	435,805,791	418,454,800	428,239,517
Unregulated Services	139,337,347	128,279,409	123,596,263
TOTAL	575,143,138	546,734,209	551,835,780
Other Operating Revenue:			
Regulated Services	10,130,587	19,853,182	11,454,033
Unregulated Services	28,752,126	22,214,684	13,067,404
TOTAL	38,882,713	42,067,866	24,521,437
Net Operating Revenue (NOR)			
Regulated Services	445,936,378	438,307,982	439,693,550
Unregulated Services	168,089,473	150,494,093	136,663,667
Total	614,025,851	588,802,075	576,357,217
Total Operating Expenses:			
Regulated Services	388,505,668	383,337,071	396,054,498
Unregulated Services	242,669,681	240,856,929	209,676,445
Total	631,175,350	624,194,000	605,730,943
Net Operating Profit (Loss):			
Regulated Services	57,430,709	54,970,910	43,639,052
Unregulated Services	-74,580,208	-90,362,836	-73,012,778
Total	-17,149,499	-35,391,925	-29,373,726
Total Non-Operating Profit (Loss):	10,464,000	14,232,000	76,191,000
Non-Operating Revenue	12,965,000	11,583,000	21,523,000
Non-Operating Expenses	2,501,000	-2,649,000	-54,668,000
Total Excess Profit (Loss):	-6,685,499	-26,457,925	-62,518,726
% Net Operating Profit of Regulated NOR	12.88	12.54	9.92
% Net Total Operating Profit of Total NOR	-2.79	-6.01	-5.10
% Total Excess Profit of Total Revenue	-1.07	-4.41	-10.46

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

HOLY CROSS HOSPITAL

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	600,651,500	573,789,700	573,097,200
Unregulated Services	48,379,980	46,328,041	43,212,274
TOTAL	649,031,480	620,117,741	616,309,474
Net Patient Revenue (NPR):			
Regulated Services	511,658,901	480,096,910	491,435,451
Unregulated Services	19,681,888	16,874,062	14,745,549
TOTAL	531,340,789	496,970,971	506,181,000
Other Operating Revenue:			
Regulated Services	1,614,562	9,622,808	8,412,868
Unregulated Services	21,540,477	25,310,692	13,699,132
TOTAL	23,155,039	34,933,500	22,112,000
Net Operating Revenue (NOR)			
Regulated Services	513,273,463	489,719,717	499,848,319
Unregulated Services	41,222,365	42,184,754	28,444,681
Total	554,495,828	531,904,471	528,293,000
Total Operating Expenses:			
Regulated Services	440,756,817	445,104,100	461,368,595
Unregulated Services	79,664,683	82,356,900	62,491,446
Total	520,421,500	527,461,000	523,860,041
Net Operating Profit (Loss):			
Regulated Services	72,516,646	44,615,617	38,479,723
Unregulated Services	-38,442,318	-40,172,145	-34,046,765
Total	34,074,328	4,443,471	4,432,959
Total Non-Operating Profit (Loss):	36,357,600	25,429,000	-32,140,000
Non-Operating Revenue	37,449,300	27,440,000	-34,236,140
Non-Operating Expenses	1,091,700	2,011,000	-2,096,140
Total Excess Profit (Loss):	70,431,928	29,872,471	-27,707,041
% Net Operating Profit of Regulated NOR	14.13	9.11	7.70
% Net Total Operating Profit of Total NOR	6.15	0.84	0.84
% Total Excess Profit of Total Revenue	11.90	5.34	-5.61

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

Holy Cross Hospital Germantown

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	163,546,900	140,664,300	141,903,900
Unregulated Services	5,515,295	3,528,900	2,855,806
TOTAL	169,062,195	144,193,200	144,759,706
Net Patient Revenue (NPR):			
Regulated Services	137,746,580	119,873,460	124,352,558
Unregulated Services	2,287,216	911,700	722,748
TOTAL	140,033,795	120,785,160	125,075,306
Other Operating Revenue:			
Regulated Services	122,101	1,360,100	284,326
Unregulated Services	742,239	631,400	618,531
TOTAL	864,340	1,991,500	902,857
Net Operating Revenue (NOR)			
Regulated Services	137,868,681	121,233,560	124,636,884
Unregulated Services	3,029,455	1,543,100	1,341,279
Total	140,898,135	122,776,660	125,978,163
Total Operating Expenses:			
Regulated Services	133,531,772	126,408,245	125,596,841
Unregulated Services	15,425,228	13,257,255	8,895,159
Total	148,957,000	139,665,500	134,492,000
Net Operating Profit (Loss):			
Regulated Services	4,336,909	-5,174,685	-959,957
Unregulated Services	-12,395,774	-11,714,155	-7,553,880
Total	-8,058,865	-16,888,840	-8,513,837
Total Non-Operating Profit (Loss):	5,984,500	4,157,300	-585,000
Non-Operating Revenue	5,984,500	4,157,300	-585,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,074,365	-12,731,540	-9,098,837
% Net Operating Profit of Regulated NOR	3.15	-4.27	-0.77
% Net Total Operating Profit of Total NOR	-5.72	-13.76	-6.76
% Total Excess Profit of Total Revenue	-1.41	-10.03	-7.26

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	828,761,549	783,284,695	778,281,041
Unregulated Services	5,074,353	4,967,211	4,760,509
TOTAL	833,835,902	788,251,906	783,041,550
Net Patient Revenue (NPR):			
Regulated Services	673,842,854	643,947,307	650,301,388
Unregulated Services	4,881,598	4,778,473	4,579,726
TOTAL	678,724,452	648,725,780	654,881,114
Other Operating Revenue:			
Regulated Services	8,758,959	13,167,637	7,919,718
Unregulated Services	113,281,589	101,524,583	86,249,166
TOTAL	122,040,548	114,692,220	94,168,884
Net Operating Revenue (NOR)			
Regulated Services	682,601,813	657,114,944	658,221,105
Unregulated Services	118,163,187	106,303,056	90,828,893
Total	800,765,000	763,418,000	749,049,998
Total Operating Expenses:			
Regulated Services	668,976,576	647,678,909	680,557,337
Unregulated Services	114,534,424	112,633,091	93,038,663
Total	783,511,000	760,312,000	773,596,000
Net Operating Profit (Loss):			
Regulated Services	13,625,237	9,436,035	-22,336,231
Unregulated Services	3,628,763	-6,330,035	-2,209,771
Total	17,254,000	3,106,000	-24,546,002
Total Non-Operating Profit (Loss):	1,523,000	-6,042,000	-9,774,000
Non-Operating Revenue	12,318,000	9,244,000	2,018,000
Non-Operating Expenses	10,795,000	15,286,000	11,792,000
Total Excess Profit (Loss):	18,777,000	-2,936,000	-34,320,002
% Net Operating Profit of Regulated NOR	2.00	1.44	-3.39
% Net Total Operating Profit of Total NOR	2.15	0.41	-3.28
% Total Excess Profit of Total Revenue	2.31	-0.38	-4.57

JOHNS HOPKINS HOSPITAL

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	3,105,851,884	2,921,370,378	2,832,180,125
Unregulated Services	30,330,632	29,188,854	25,855,580
TOTAL	3,136,182,516	2,950,559,232	2,858,035,705
Net Patient Revenue (NPR):			
Regulated Services	2,539,308,684	2,417,676,978	2,386,916,325
Unregulated Services	30,330,632	29,188,854	25,855,580
TOTAL	2,569,639,316	2,446,865,832	2,412,771,905
Other Operating Revenue:			
Regulated Services	65,944,384	77,702,368	54,501,692
Unregulated Services	686,569,200	635,473,600	574,740,600
TOTAL	752,513,584	713,175,968	629,242,292
Net Operating Revenue (NOR)			
Regulated Services	2,605,253,068	2,495,379,346	2,441,418,017
Unregulated Services	716,899,832	664,662,454	600,596,180
Total	3,322,152,900	3,160,041,800	3,042,014,197
Total Operating Expenses:			
Regulated Services	2,620,183,600	2,455,632,500	2,375,734,100
Unregulated Services	647,787,400	604,818,500	544,403,900
Total	3,267,971,000	3,060,451,000	2,920,138,000
Net Operating Profit (Loss):			
Regulated Services	-14,930,532	39,746,846	65,683,917
Unregulated Services	69,112,432	59,843,954	56,192,280
Total	54,181,900	99,590,800	121,876,197
Total Non-Operating Profit (Loss):	53,857,000	27,797,000	-125,166,000
Non-Operating Revenue	177,214,000	160,325,000	81,364,000
Non-Operating Expenses	123,357,000	132,528,000	206,530,000
Total Excess Profit (Loss):	108,038,900	127,387,800	-3,289,803
% Net Operating Profit of Regulated NOR	-0.57	1.59	2.69
% Net Total Operating Profit of Total NOR	1.63	3.15	4.01
% Total Excess Profit of Total Revenue	3.09	3.84	-0.11

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

JOHNS HOPKINS HOWARD COUNTY MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	373,181,711	356,825,066	344,977,080
Unregulated Services	0	0	0
TOTAL	373,181,711	356,825,066	344,977,080
Net Patient Revenue (NPR):			
Regulated Services	316,584,711	303,392,066	299,814,034
Unregulated Services	0	0	0
TOTAL	316,584,711	303,392,066	299,814,034
Other Operating Revenue:			
Regulated Services	2,601	353,368	211,173
Unregulated Services	7,606,724	11,908,542	10,124,605
TOTAL	7,609,325	12,261,910	10,335,778
Net Operating Revenue (NOR)			
Regulated Services	316,587,312	303,745,434	300,025,207
Unregulated Services	7,606,724	11,908,542	10,124,605
Total	324,194,036	315,653,976	310,149,812
Total Operating Expenses:			
Regulated Services	311,543,564	314,058,592	308,768,658
Unregulated Services	19,565,471	17,590,825	16,677,641
Total	331,109,035	331,649,417	325,446,299
Net Operating Profit (Loss):			
Regulated Services	5,043,748	-10,313,158	-8,743,451
Unregulated Services	-11,958,747	-5,682,283	-6,553,036
Total	-6,915,000	-15,995,441	-15,296,487
Total Non-Operating Profit (Loss):	27,627,631	22,862,441	-22,289,503
Non-Operating Revenue	28,288,596	24,996,024	47,899,198
Non-Operating Expenses	660,965	2,133,583	70,188,701
Total Excess Profit (Loss):	20,712,631	6,867,000	-37,585,990
% Net Operating Profit of Regulated NOR	1.59	-3.40	-2.91
% Net Total Operating Profit of Total NOR	-2.13	-5.07	-4.93
% Total Excess Profit of Total Revenue	5.88	2.02	-10.50

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2022 TO 2024

Johns Hopkins Suburban Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	431,677,954	404,912,474	392,501,910
Unregulated Services	487,394	664,751	719,009
TOTAL	432,165,348	405,577,225	393,220,919
Net Patient Revenue (NPR):			
Regulated Services	362,453,688	339,589,552	337,029,398
Unregulated Services	487,394	664,751	719,009
TOTAL	362,941,082	340,254,303	337,748,407
Other Operating Revenue:			
Regulated Services	7,521,235	6,980,212	3,412,502
Unregulated Services	12,988,396	14,936,755	16,411,948
TOTAL	20,509,631	21,916,968	19,824,450
Net Operating Revenue (NOR)			
Regulated Services	369,974,923	346,569,765	340,441,900
Unregulated Services	13,475,791	15,601,506	17,130,957
Total	383,450,713	362,171,271	357,572,857
Total Operating Expenses:			
Regulated Services	345,650,345	332,427,884	316,142,049
Unregulated Services	46,223,116	43,759,600	41,401,100
Total	391,873,461	376,187,484	357,543,149
Net Operating Profit (Loss):			
Regulated Services	24,324,578	14,141,881	24,299,851
Unregulated Services	-32,747,325	-28,158,094	-24,270,143
Total	-8,422,747	-14,016,213	29,708
Total Non-Operating Profit (Loss):	38,837,000	30,181,978	-42,082,464
Non-Operating Revenue	38,837,000	30,181,978	3,661,112
Non-Operating Expenses	0	0	45,743,576
Total Excess Profit (Loss):	30,414,253	16,165,765	-42,052,756
% Net Operating Profit of Regulated NOR	6.57	4.08	7.14
% Net Total Operating Profit of Total NOR	-2.20	-3.87	0.01
% Total Excess Profit of Total Revenue	7.20	4.12	-11.64

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

LifeBridge Health Carroll Hospital Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	294,002,396	265,924,528	258,148,447
Unregulated Services	102,213,085	97,907,000	93,956,464
TOTAL	396,215,481	363,831,528	352,104,911
Net Patient Revenue (NPR):			
Regulated Services	251,981,612	226,917,377	222,667,123
Unregulated Services	50,831,355	47,556,447	45,063,987
TOTAL	302,812,967	274,473,824	267,731,110
Other Operating Revenue:			
Regulated Services	12,400,841	15,074,565	11,097,800
Unregulated Services	2,594,726	1,068,201	995,887
TOTAL	14,995,567	16,142,766	12,093,687
Net Operating Revenue (NOR)			
Regulated Services	264,382,453	241,991,942	233,764,923
Unregulated Services	53,426,081	48,624,648	46,059,874
Total	317,808,534	290,616,590	279,824,797
Total Operating Expenses:			
Regulated Services	218,498,303	219,473,520	212,285,619
Unregulated Services	71,343,425	59,999,209	56,999,964
Total	289,841,728	279,472,729	269,285,583
Net Operating Profit (Loss):			
Regulated Services	45,884,150	22,518,422	21,479,304
Unregulated Services	-17,917,344	-11,374,561	-10,940,090
Total	27,966,806	11,143,860	10,539,214
Total Non-Operating Profit (Loss):	22,822,801	23,389,493	-28,360,910
Non-Operating Revenue	22,822,801	23,389,493	-28,360,910
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	50,789,607	34,533,353	-17,821,696
% Net Operating Profit of Regulated NOR	17.36	9.31	9.19
% Net Total Operating Profit of Total NOR	8.80	3.83	3.77
% Total Excess Profit of Total Revenue	14.91	11.00	-7.09

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2022 TO 2024

LifeBridge Health Grace Medical Center

FISCAL YEAR ENDING	June 2024	August 2023	August 2022
Gross Patient Revenue:			
Regulated Services	33,202,184	34,673,288	28,774,744
Unregulated Services	34,181,000	37,621,705	31,685,405
TOTAL	67,383,184	72,294,993	60,460,149
Net Patient Revenue (NPR):			
Regulated Services	27,153,619	26,745,634	22,835,537
Unregulated Services	6,357,539	9,450,359	9,067,895
TOTAL	33,511,158	36,195,993	31,903,432
Other Operating Revenue:			
Regulated Services	2,119,621	1,138,679	684,729
Unregulated Services	752,849	1,294,321	633,929
TOTAL	2,872,470	2,433,000	1,318,658
Net Operating Revenue (NOR)			
Regulated Services	29,273,240	27,884,313	23,520,266
Unregulated Services	7,110,388	10,744,680	9,701,824
Total	36,383,628	38,628,993	33,222,090
Total Operating Expenses:			
Regulated Services	32,288,518	31,541,781	30,265,814
Unregulated Services	19,055,137	18,902,219	12,832,326
Total	51,343,655	50,444,000	43,098,140
Net Operating Profit (Loss):			
Regulated Services	-3,015,279	-3,657,468	-6,745,547
Unregulated Services	-11,944,749	-8,157,539	-3,130,503
Total	-14,960,028	-11,815,007	-9,876,050
Total Non-Operating Profit (Loss):	-7,000	15,254,000	-65,289
Non-Operating Revenue	-7,000	15,300,000	-65,289
Non-Operating Expenses	0	46,000	0
Total Excess Profit (Loss):	-14,967,028	3,438,993	-9,941,339
% Net Operating Profit of Regulated NOR	-10.30	-13.12	-28.68
% Net Total Operating Profit of Total NOR	-41.12	-30.59	-29.73
% Total Excess Profit of Total Revenue	-41.14	6.38	-29.98

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2022 TO 2024

LifeBridge Health Levindale

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	67,965,551	68,907,086	74,237,915
Unregulated Services	33,700,369	33,445,347	33,408,387
TOTAL	101,665,920	102,352,433	107,646,302
Net Patient Revenue (NPR):			
Regulated Services	54,502,869	56,920,733	62,903,329
Unregulated Services	27,854,327	27,285,985	27,351,004
TOTAL	82,357,196	84,206,718	90,254,333
Other Operating Revenue:			
Regulated Services	1,535,117	3,112,853	1,227,272
Unregulated Services	1,025,978	646,356	937,295
TOTAL	2,561,095	3,759,209	2,164,567
Net Operating Revenue (NOR)			
Regulated Services	56,037,986	60,033,586	64,130,601
Unregulated Services	28,880,305	27,932,341	28,288,299
Total	84,918,291	87,965,927	92,418,900
Total Operating Expenses:			
Regulated Services	41,785,620	44,536,449	46,951,946
Unregulated Services	35,477,086	37,069,746	38,194,096
Total	77,262,706	81,606,195	85,146,042
Net Operating Profit (Loss):			
Regulated Services	14,252,366	15,497,137	17,178,655
Unregulated Services	-6,596,781	-9,137,405	-9,905,797
Total	7,655,585	6,359,732	7,272,858
Total Non-Operating Profit (Loss):	2,383,348	2,137,741	-2,714,061
Non-Operating Revenue	2,383,348	2,137,741	-2,714,061
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	10,038,933	8,497,473	4,558,797
% Net Operating Profit of Regulated NOR	25.43	25.81	26.79
% Net Total Operating Profit of Total NOR	9.02	7.23	7.87
% Total Excess Profit of Total Revenue	11.50	9.43	5.08

LifeBridge Health Northwest Hospital Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	311,836,440	310,414,480	301,664,524
Unregulated Services	41,495,607	54,087,821	53,218,504
TOTAL	353,332,047	364,502,301	354,883,028
Net Patient Revenue (NPR):			
Regulated Services	261,762,970	266,499,749	260,293,639
Unregulated Services	23,188,207	31,378,125	29,878,438
TOTAL	284,951,177	297,877,874	290,172,077
Other Operating Revenue:			
Regulated Services	4,845,517	6,446,025	5,837,860
Unregulated Services	3,140,595	3,138,583	2,548,045
TOTAL	7,986,112	9,584,608	8,385,905
Net Operating Revenue (NOR)			
Regulated Services	266,608,487	272,945,774	266,131,499
Unregulated Services	26,328,802	34,516,708	32,426,483
Total	292,937,289	307,462,482	298,557,982
Total Operating Expenses:			
Regulated Services	238,767,737	250,976,112	240,746,541
Unregulated Services	63,342,730	66,843,821	64,580,794
Total	302,110,467	317,819,933	305,327,335
Net Operating Profit (Loss):			
Regulated Services	27,840,750	21,969,662	25,384,958
Unregulated Services	-37,013,928	-32,327,113	-32,154,311
Total	-9,173,178	-10,357,451	-6,769,353
Total Non-Operating Profit (Loss):	8,595,760	8,876,421	-12,378,353
Non-Operating Revenue	8,595,760	8,876,421	-12,378,353
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-577,418	-1,481,030	-19,147,706
% Net Operating Profit of Regulated NOR	10.44	8.05	9.54
% Net Total Operating Profit of Total NOR	-3.13	-3.37	-2.27
% Total Excess Profit of Total Revenue	-0.19	-0.47	-6.69

HEALTH SERVICES COST REVIEW COMMISSION
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LifeBridge Health Sinai Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	961,717,881	949,076,151	940,026,414
Unregulated Services	251,168,098	251,736,860	244,585,232
TOTAL	1,212,885,979	1,200,813,012	1,184,611,646
Net Patient Revenue (NPR):			
Regulated Services	804,921,429	793,704,566	804,616,796
Unregulated Services	110,695,636	110,806,489	103,455,884
TOTAL	915,617,065	904,511,054	908,072,680
Other Operating Revenue:			
Regulated Services	13,563,503	20,410,182	21,562,272
Unregulated Services	38,154,078	33,491,752	36,827,823
TOTAL	51,717,581	53,901,934	58,390,095
Net Operating Revenue (NOR)			
Regulated Services	818,484,932	814,114,748	826,179,068
Unregulated Services	148,849,714	144,298,240	140,283,707
Total	967,334,646	958,412,988	966,462,775
Total Operating Expenses:			
Regulated Services	712,346,938	726,701,775	715,834,671
Unregulated Services	233,447,643	227,733,159	196,501,424
Total	945,794,581	954,434,934	912,336,095
Net Operating Profit (Loss):			
Regulated Services	106,137,994	87,412,972	110,344,397
Unregulated Services	-84,597,928	-83,434,918	-56,217,717
Total	21,540,065	3,978,054	54,126,680
Total Non-Operating Profit (Loss):	39,093,000	40,413,000	-42,611,000
Non-Operating Revenue	39,093,000	40,413,000	-42,611,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	60,633,065	44,391,054	11,515,680
% Net Operating Profit of Regulated NOR	12.97	10.74	13.36
% Net Total Operating Profit of Total NOR	2.23	0.42	5.60
% Total Excess Profit of Total Revenue	6.02	4.44	1.25

Luminis Health Anne Arundel Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	746,989,000	749,524,800	724,138,500
Unregulated Services	35,127,994	31,488,884	36,451,004
TOTAL	782,116,994	781,013,684	760,589,504
Net Patient Revenue (NPR):			
Regulated Services	630,365,072	608,630,183	630,312,825
Unregulated Services	13,080,925	12,300,754	13,450,805
TOTAL	643,445,997	620,930,937	643,763,631
Other Operating Revenue:			
Regulated Services	5,263,889	6,939,326	9,335,100
Unregulated Services	9,168,111	9,056,674	12,805,700
TOTAL	14,432,000	15,996,000	22,140,800
Net Operating Revenue (NOR)			
Regulated Services	635,628,961	615,569,509	639,647,925
Unregulated Services	22,249,036	21,357,428	26,256,505
Total	657,877,997	636,926,937	665,904,431
Total Operating Expenses:			
Regulated Services	564,249,309	580,138,043	612,124,120
Unregulated Services	75,337,691	66,971,957	70,726,980
Total	639,587,000	647,110,000	682,851,100
Net Operating Profit (Loss):			
Regulated Services	71,379,651	35,431,466	27,523,805
Unregulated Services	-53,088,654	-45,614,529	-44,470,474
Total	18,290,997	-10,183,063	-16,946,669
Total Non-Operating Profit (Loss):	48,779,000	47,448,000	-10,882,000
Non-Operating Revenue	48,779,000	47,448,000	-10,882,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	67,069,997	37,264,937	-27,828,669
% Net Operating Profit of Regulated NOR	11.23	5.76	4.30
% Net Total Operating Profit of Total NOR	2.78	-1.60	-2.54
% Total Excess Profit of Total Revenue	9.49	5.45	-4.25

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Luminis Health Doctors Community Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	308,883,300	308,601,200	263,081,000
Unregulated Services	511,826	696,212	1,335,820
TOTAL	309,395,126	309,297,412	264,416,820
Net Patient Revenue (NPR):			
Regulated Services	248,446,159	228,329,915	220,183,871
Unregulated Services	378,235	400,396	1,049,498
TOTAL	248,824,394	228,730,310	221,233,369
Other Operating Revenue:			
Regulated Services	2,116,000	2,670,300	5,063,959
Unregulated Services	2,913,000	2,021,700	2,635,041
TOTAL	5,029,000	4,692,000	7,699,000
Net Operating Revenue (NOR)			
Regulated Services	250,562,159	231,000,215	225,247,829
Unregulated Services	3,291,235	2,422,096	3,684,539
Total	253,853,394	233,422,310	228,932,369
Total Operating Expenses:			
Regulated Services	235,424,693	229,662,179	229,922,488
Unregulated Services	24,174,307	17,557,821	14,363,989
Total	259,599,000	247,220,000	244,286,477
Net Operating Profit (Loss):			
Regulated Services	15,137,467	1,338,036	-4,674,659
Unregulated Services	-20,883,073	-15,135,725	-10,679,450
Total	-5,745,606	-13,797,690	-15,354,108
Total Non-Operating Profit (Loss):	-2,441,000	-474,000	-1,566,707
Non-Operating Revenue	-2,441,000	-474,000	-1,566,707
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-8,186,606	-14,271,690	-16,920,815
% Net Operating Profit of Regulated NOR	6.04	0.58	-2.08
% Net Total Operating Profit of Total NOR	-2.26	-5.91	-6.71
% Total Excess Profit of Total Revenue	-3.26	-6.13	-7.44

HEALTH SERVICES COST REVIEW COMMISSION
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FISCAL YEAR 2022 TO 2024

MEDSTAR MONTGOMERY MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	222,642,659	208,039,750	192,883,685
Unregulated Services	76,313,160	60,712,321	48,749,814
TOTAL	298,955,819	268,752,071	241,633,499
Net Patient Revenue (NPR):			
Regulated Services	183,717,210	173,573,630	165,505,846
Unregulated Services	37,850,452	30,644,515	24,411,299
TOTAL	221,567,661	204,218,145	189,917,144
Other Operating Revenue:			
Regulated Services	5,010,172	6,707,647	2,349,101
Unregulated Services	96,353	458,895	596,860
TOTAL	5,106,525	7,166,542	2,945,960
Net Operating Revenue (NOR)			
Regulated Services	188,727,382	180,281,276	167,854,946
Unregulated Services	37,946,804	31,103,410	25,008,158
Total	226,674,186	211,384,687	192,863,105
Total Operating Expenses:			
Regulated Services	188,797,764	182,012,090	165,949,011
Unregulated Services	51,558,230	46,590,452	39,626,915
Total	240,355,994	228,602,542	205,575,926
Net Operating Profit (Loss):			
Regulated Services	-70,382	-1,730,814	1,905,935
Unregulated Services	-13,611,426	-15,487,042	-14,618,757
Total	-13,681,808	-17,217,856	-12,712,822
Total Non-Operating Profit (Loss):	792,419	1,354,945	981,872
Non-Operating Revenue	1,042,446	1,430,590	812,248
Non-Operating Expenses	250,027	75,645	-169,624
Total Excess Profit (Loss):	-12,889,388	-15,862,911	-11,730,950
% Net Operating Profit of Regulated NOR	-0.04	-0.96	1.14
% Net Total Operating Profit of Total NOR	-6.04	-8.15	-6.59
% Total Excess Profit of Total Revenue	-5.66	-7.45	-6.06

HEALTH SERVICES COST REVIEW COMMISSION
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MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	338,032,767	318,000,686	299,185,641
Unregulated Services	119,368,800	33,859,084	33,291,557
TOTAL	457,401,567	351,859,771	332,477,198
Net Patient Revenue (NPR):			
Regulated Services	273,706,361	253,654,839	254,863,540
Unregulated Services	53,969,966	16,603,636	16,594,518
TOTAL	327,676,327	270,258,475	271,458,058
Other Operating Revenue:			
Regulated Services	12,378,722	7,622,625	5,607,028
Unregulated Services	470,522	308,547	80,878
TOTAL	12,849,244	7,931,172	5,687,906
Net Operating Revenue (NOR)			
Regulated Services	286,085,083	261,277,464	260,470,568
Unregulated Services	54,440,488	16,912,183	16,675,396
Total	340,525,571	278,189,647	277,145,964
Total Operating Expenses:			
Regulated Services	289,266,748	257,464,006	258,261,875
Unregulated Services	82,766,215	49,442,159	39,722,146
Total	372,032,962	306,906,165	297,984,021
Net Operating Profit (Loss):			
Regulated Services	-3,181,665	3,813,459	2,208,693
Unregulated Services	-28,325,726	-32,529,976	-23,046,750
Total	-31,507,391	-28,716,518	-20,838,057
Total Non-Operating Profit (Loss):	193,658	92,404	-46,462
Non-Operating Revenue	206,864	96,157	-49,737
Non-Operating Expenses	13,206	3,753	-3,275
Total Excess Profit (Loss):	-31,313,733	-28,624,114	-20,884,519
% Net Operating Profit of Regulated NOR	-1.11	1.46	0.85
% Net Total Operating Profit of Total NOR	-9.25	-10.32	-7.52
% Total Excess Profit of Total Revenue	-9.19	-10.29	-7.54

HEALTH SERVICES COST REVIEW COMMISSION
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FISCAL YEAR 2022 TO 2024

MEDSTAR ST. MARY'S HOSPITAL

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	236,265,893	217,557,775	204,364,194
Unregulated Services	70,815,833	37,541,262	34,336,640
TOTAL	307,081,727	255,099,037	238,700,833
Net Patient Revenue (NPR):			
Regulated Services	193,437,886	179,867,136	178,963,251
Unregulated Services	35,444,637	18,789,369	18,156,949
TOTAL	228,882,523	198,656,505	197,120,200
Other Operating Revenue:			
Regulated Services	3,117,632	2,728,296	2,410,654
Unregulated Services	1,725,588	2,158,735	1,437,313
TOTAL	4,843,220	4,887,031	3,847,967
Net Operating Revenue (NOR)			
Regulated Services	196,555,518	182,595,432	181,373,905
Unregulated Services	37,170,226	20,948,104	19,594,262
Total	233,725,744	203,543,536	200,968,167
Total Operating Expenses:			
Regulated Services	177,561,168	163,335,536	158,185,301
Unregulated Services	52,477,238	37,963,749	31,521,314
Total	230,038,405	201,299,285	189,706,615
Net Operating Profit (Loss):			
Regulated Services	18,994,350	19,259,896	23,188,604
Unregulated Services	-15,307,012	-17,015,645	-11,927,051
Total	3,687,338	2,244,251	11,261,552
Total Non-Operating Profit (Loss):	2,396,022	2,133,116	2,212,794
Non-Operating Revenue	752,171	702,999	143,597
Non-Operating Expenses	-1,643,851	-1,430,117	-2,069,197
Total Excess Profit (Loss):	6,083,361	4,377,367	13,474,347
% Net Operating Profit of Regulated NOR	9.66	10.55	12.78
% Net Total Operating Profit of Total NOR	1.58	1.10	5.60
% Total Excess Profit of Total Revenue	2.59	2.14	6.70

MEDSTAR UNION MEMORIAL HOSPITAL

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	499,090,335	485,128,248	442,852,891
Unregulated Services	176,868,108	160,168,381	148,115,366
TOTAL	675,958,443	645,296,629	590,968,257
Net Patient Revenue (NPR):			
Regulated Services	423,250,694	409,516,689	392,956,967
Unregulated Services	78,077,125	72,553,536	66,498,473
TOTAL	501,327,819	482,070,224	459,455,440
Other Operating Revenue:			
Regulated Services	8,446,605	15,462,765	5,679,794
Unregulated Services	10,254,804	10,128,881	9,550,979
TOTAL	18,701,409	25,591,646	15,230,772
Net Operating Revenue (NOR)			
Regulated Services	431,697,299	424,979,454	398,636,760
Unregulated Services	88,331,929	82,682,417	76,049,452
Total	520,029,228	507,661,871	474,686,213
Total Operating Expenses:			
Regulated Services	387,147,600	389,617,319	384,331,913
Unregulated Services	145,242,332	127,349,838	116,424,249
Total	532,389,932	516,967,157	500,756,162
Net Operating Profit (Loss):			
Regulated Services	44,549,699	35,362,135	14,304,847
Unregulated Services	-56,910,403	-44,667,421	-40,374,797
Total	-12,360,704	-9,305,286	-26,069,949
Total Non-Operating Profit (Loss):	9,277,144	5,986,365	-3,868,881
Non-Operating Revenue	9,446,813	6,117,379	3,745,557
Non-Operating Expenses	169,669	131,014	7,614,438
Total Excess Profit (Loss):	-3,083,560	-3,318,921	-29,938,831
% Net Operating Profit of Regulated NOR	10.32	8.32	3.59
% Net Total Operating Profit of Total NOR	-2.38	-1.83	-5.49
% Total Excess Profit of Total Revenue	-0.58	-0.65	-6.26

MERCY MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	681,875,400	653,644,800	628,565,000
Unregulated Services	5,676,607	4,920,693	4,524,767
TOTAL	687,552,007	658,565,493	633,089,767
Net Patient Revenue (NPR):			
Regulated Services	574,205,419	557,725,931	543,501,058
Unregulated Services	5,676,607	4,920,693	4,524,767
TOTAL	579,882,027	562,646,623	548,025,825
Other Operating Revenue:			
Regulated Services	33,777,900	27,950,484	25,966,248
Unregulated Services	7,938,310	7,531,913	7,074,789
TOTAL	41,716,210	35,482,398	33,041,037
Net Operating Revenue (NOR)			
Regulated Services	607,983,319	585,676,415	569,467,306
Unregulated Services	13,614,918	12,452,606	11,599,556
Total	621,598,236	598,129,021	581,066,862
Total Operating Expenses:			
Regulated Services	564,388,570	540,448,469	519,261,181
Unregulated Services	41,251,160	39,303,936	29,873,492
Total	605,639,730	579,752,405	549,134,673
Net Operating Profit (Loss):			
Regulated Services	43,594,749	45,227,946	50,206,124
Unregulated Services	-27,636,242	-26,851,330	-18,273,935
Total	15,958,507	18,376,616	31,932,189
Total Non-Operating Profit (Loss):	27,621,850	27,789,971	-24,446,599
Non-Operating Revenue	27,621,850	28,211,625	23,576,083
Non-Operating Expenses	0	421,654	48,022,682
Total Excess Profit (Loss):	43,580,356	46,166,587	7,485,590
% Net Operating Profit of Regulated NOR	7.17	7.72	8.82
% Net Total Operating Profit of Total NOR	2.57	3.07	5.50
% Total Excess Profit of Total Revenue	6.71	7.37	1.24

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MERITUS MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	487,797,440	440,345,460	430,476,300
Unregulated Services	82,021,500	47,173,714	23,561,502
TOTAL	569,818,940	487,519,174	454,037,802
Net Patient Revenue (NPR):			
Regulated Services	420,773,640	373,443,758	367,921,730
Unregulated Services	38,008,700	22,763,166	13,219,671
TOTAL	458,782,340	396,206,924	381,141,401
Other Operating Revenue:			
Regulated Services	14,821,900	28,034,734	10,783,472
Unregulated Services	12,577,100	9,852,078	9,322,315
TOTAL	27,399,000	37,886,812	20,105,787
Net Operating Revenue (NOR)			
Regulated Services	435,595,540	401,478,492	378,705,202
Unregulated Services	50,585,800	32,615,244	22,541,986
Total	486,181,340	434,093,736	401,247,188
Total Operating Expenses:			
Regulated Services	366,897,700	341,796,054	347,434,163
Unregulated Services	68,637,200	48,274,918	37,562,302
Total	435,534,900	390,070,972	384,996,465
Net Operating Profit (Loss):			
Regulated Services	68,697,840	59,682,438	31,271,039
Unregulated Services	-18,051,400	-15,659,674	-15,020,316
Total	50,646,440	44,022,764	16,250,723
Total Non-Operating Profit (Loss):	52,247,100	42,948,070	-39,660,252
Non-Operating Revenue	52,309,400	41,274,581	-37,455,579
Non-Operating Expenses	62,300	-1,673,489	2,204,673
Total Excess Profit (Loss):	102,893,540	86,970,834	-23,409,529
% Net Operating Profit of Regulated NOR	15.77	14.87	8.26
% Net Total Operating Profit of Total NOR	10.42	10.14	4.05
% Total Excess Profit of Total Revenue	19.11	18.30	-6.43

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FISCAL YEAR 2022 TO 2024

MedStar Franklin Square Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	688,099,485	638,932,701	609,274,994
Unregulated Services	272,531,280	250,252,322	237,164,763
TOTAL	960,630,765	889,185,023	846,439,757
Net Patient Revenue (NPR):			
Regulated Services	586,846,584	537,714,566	525,436,568
Unregulated Services	120,950,333	114,790,894	108,073,284
TOTAL	707,796,917	652,505,460	633,509,852
Other Operating Revenue:			
Regulated Services	13,458,907	16,536,466	6,430,735
Unregulated Services	11,700,425	8,802,716	10,451,248
TOTAL	25,159,332	25,339,182	16,881,983
Net Operating Revenue (NOR)			
Regulated Services	600,305,491	554,251,032	531,867,303
Unregulated Services	132,650,758	123,593,610	118,524,532
Total	732,956,248	677,844,642	650,391,835
Total Operating Expenses:			
Regulated Services	539,007,313	508,131,384	512,777,069
Unregulated Services	179,621,790	174,409,447	156,708,942
Total	718,629,103	682,540,830	669,486,011
Net Operating Profit (Loss):			
Regulated Services	61,298,178	46,119,648	19,090,234
Unregulated Services	-46,971,032	-50,815,836	-38,184,410
Total	14,327,146	-4,696,188	-19,094,176
Total Non-Operating Profit (Loss):	544,275	334,898	-177,523
Non-Operating Revenue	730,662	479,639	-325,389
Non-Operating Expenses	186,386	144,741	-147,866
Total Excess Profit (Loss):	14,871,421	-4,361,290	-19,271,700
% Net Operating Profit of Regulated NOR	10.21	8.32	3.59
% Net Total Operating Profit of Total NOR	1.95	-0.69	-2.94
% Total Excess Profit of Total Revenue	2.03	-0.64	-2.96

MedStar Good Samaritan Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	319,991,752	308,835,327	290,128,587
Unregulated Services	89,465,108	82,977,204	77,363,556
TOTAL	409,456,859	391,812,531	367,492,143
Net Patient Revenue (NPR):			
Regulated Services	265,480,135	254,048,544	248,308,811
Unregulated Services	35,968,154	37,795,133	31,486,588
TOTAL	301,448,288	291,843,676	279,795,398
Other Operating Revenue:			
Regulated Services	5,273,196	10,431,579	3,757,201
Unregulated Services	13,199,443	11,624,577	11,239,623
TOTAL	18,472,639	22,056,155	14,996,824
Net Operating Revenue (NOR)			
Regulated Services	270,753,330	264,480,122	252,066,011
Unregulated Services	49,167,597	49,419,709	42,726,211
Total	319,920,928	313,899,831	294,792,222
Total Operating Expenses:			
Regulated Services	241,960,013	239,843,482	236,480,754
Unregulated Services	76,499,949	77,556,742	75,165,709
Total	318,459,961	317,400,224	311,646,463
Net Operating Profit (Loss):			
Regulated Services	28,793,318	24,636,640	15,585,257
Unregulated Services	-27,332,352	-28,137,033	-32,439,498
Total	1,460,966	-3,500,392	-16,854,241
Total Non-Operating Profit (Loss):	5,092,852	3,306,229	3,348,877
Non-Operating Revenue	5,227,928	3,414,538	3,246,852
Non-Operating Expenses	135,076	108,309	-102,025
Total Excess Profit (Loss):	6,553,818	-194,164	-13,505,364
% Net Operating Profit of Regulated NOR	10.63	9.32	6.18
% Net Total Operating Profit of Total NOR	0.46	-1.12	-5.72
% Total Excess Profit of Total Revenue	2.02	-0.06	-4.53

HEALTH SERVICES COST REVIEW COMMISSION
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FISCAL YEAR 2022 TO 2024

MedStar Harbor Hospital

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	224,922,862	210,598,194	201,748,417
Unregulated Services	68,552,586	61,621,061	53,352,061
TOTAL	293,475,448	272,219,256	255,100,478
Net Patient Revenue (NPR):			
Regulated Services	188,323,158	176,399,149	171,380,326
Unregulated Services	25,385,491	25,017,619	22,024,335
TOTAL	213,708,648	201,416,769	193,404,661
Other Operating Revenue:			
Regulated Services	7,548,300	6,917,566	5,703,676
Unregulated Services	18,899,900	15,551,945	14,181,554
TOTAL	26,448,200	22,469,511	19,885,230
Net Operating Revenue (NOR)			
Regulated Services	195,871,458	183,316,715	177,084,002
Unregulated Services	44,285,391	40,569,565	36,205,889
Total	240,156,848	223,886,280	213,289,890
Total Operating Expenses:			
Regulated Services	181,969,826	171,478,814	168,127,219
Unregulated Services	62,472,976	59,100,143	50,270,520
Total	244,442,802	230,578,957	218,397,738
Net Operating Profit (Loss):			
Regulated Services	13,901,632	11,837,901	8,956,783
Unregulated Services	-18,187,585	-18,530,578	-14,064,631
Total	-4,285,953	-6,692,677	-5,107,848
Total Non-Operating Profit (Loss):	534,600	390,084	479,038
Non-Operating Revenue	601,600	444,863	419,674
Non-Operating Expenses	67,000	54,779	-59,365
Total Excess Profit (Loss):	-3,751,353	-6,302,593	-4,628,810
% Net Operating Profit of Regulated NOR	7.10	6.46	5.06
% Net Total Operating Profit of Total NOR	-1.78	-2.99	-2.39
% Total Excess Profit of Total Revenue	-1.56	-2.81	-2.17

TIDALHEALTH MCCREADY PAVILION

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	6,300,799	5,920,672	5,787,875
Unregulated Services	0	0	0
TOTAL	6,300,799	5,920,672	5,787,875
Net Patient Revenue (NPR):			
Regulated Services	4,266,099	4,916,572	4,781,775
Unregulated Services	0	0	0
TOTAL	4,266,099	4,916,572	4,781,775
Other Operating Revenue:			
Regulated Services	0	0	0
Unregulated Services	0	0	0
TOTAL	0	0	0
Net Operating Revenue (NOR)			
Regulated Services	4,266,099	4,916,572	4,781,775
Unregulated Services	0	0	0
Total	4,266,099	4,916,572	4,781,775
Total Operating Expenses:			
Regulated Services	5,708,600	7,007,600	7,076,800
Unregulated Services	1,555,600	2,036,500	1,673,100
Total	7,264,200	9,044,100	8,749,900
Net Operating Profit (Loss):			
Regulated Services	-1,442,501	-2,091,028	-2,295,025
Unregulated Services	-1,555,600	-2,036,500	-1,673,100
Total	-2,998,101	-4,127,528	-3,968,125
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,998,101	-4,127,528	-3,968,125
% Net Operating Profit of Regulated NOR	-33.81	-42.53	-48.00
% Net Total Operating Profit of Total NOR	-70.28	-83.95	-82.98
% Total Excess Profit of Total Revenue	-70.28	-83.95	-82.98

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TidalHealth Peninsula Regional

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	604,393,730	547,529,412	519,263,843
Unregulated Services	20,621,800	18,478,100	18,879,400
TOTAL	625,015,530	566,007,512	538,143,243
Net Patient Revenue (NPR):			
Regulated Services	486,449,430	462,958,612	442,248,543
Unregulated Services	14,600,100	12,940,900	14,084,200
TOTAL	501,049,530	475,899,512	456,332,743
Other Operating Revenue:			
Regulated Services	5,868,100	5,855,300	4,412,400
Unregulated Services	19,756,400	13,689,200	12,292,600
TOTAL	25,624,500	19,544,500	16,705,000
Net Operating Revenue (NOR)			
Regulated Services	492,317,530	468,813,912	446,660,943
Unregulated Services	34,356,500	26,630,100	26,376,800
Total	526,674,030	495,444,012	473,037,743
Total Operating Expenses:			
Regulated Services	401,716,087	412,864,166	404,379,923
Unregulated Services	75,774,913	67,546,834	41,116,077
Total	477,491,000	480,411,000	445,496,000
Net Operating Profit (Loss):			
Regulated Services	90,601,443	55,949,746	42,281,020
Unregulated Services	-41,418,413	-40,916,734	-14,739,277
Total	49,183,030	15,033,012	27,541,743
Total Non-Operating Profit (Loss):	45,620,000	34,897,000	-66,174,000
Non-Operating Revenue	45,620,000	34,897,000	-66,174,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	94,803,030	49,930,012	-38,632,257
% Net Operating Profit of Regulated NOR	18.40	11.93	9.47
% Net Total Operating Profit of Total NOR	9.34	3.03	5.82
% Total Excess Profit of Total Revenue	16.57	9.41	-9.50

UM Baltimore Washington Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	535,602,424	511,681,319	514,054,373
Unregulated Services	9,713,000	9,270,000	9,527,000
TOTAL	545,315,424	520,951,319	523,581,373
Net Patient Revenue (NPR):			
Regulated Services	460,416,164	437,420,018	443,233,728
Unregulated Services	2,976,836	2,826,982	3,302,272
TOTAL	463,393,000	440,247,000	446,536,000
Other Operating Revenue:			
Regulated Services	3,313,097	3,632,948	5,286,256
Unregulated Services	60,903	74,052	91,744
TOTAL	3,374,000	3,707,000	5,378,000
Net Operating Revenue (NOR)			
Regulated Services	463,729,262	441,052,967	448,519,984
Unregulated Services	3,037,738	2,901,033	3,394,016
Total	466,767,000	443,954,000	451,914,000
Total Operating Expenses:			
Regulated Services	416,256,925	423,626,419	405,603,829
Unregulated Services	58,263,075	50,419,581	39,577,171
Total	474,520,000	474,046,000	445,181,000
Net Operating Profit (Loss):			
Regulated Services	47,472,336	17,426,547	42,916,155
Unregulated Services	-55,225,336	-47,518,547	-36,183,155
Total	-7,753,000	-30,092,000	6,733,000
Total Non-Operating Profit (Loss):	22,458,000	12,913,000	-21,947,000
Non-Operating Revenue	24,788,000	17,108,000	27,179,000
Non-Operating Expenses	2,330,000	4,195,000	49,126,000
Total Excess Profit (Loss):	14,705,000	-17,179,000	-15,214,000
% Net Operating Profit of Regulated NOR	10.24	3.95	9.57
% Net Total Operating Profit of Total NOR	-1.66	-6.78	1.49
% Total Excess Profit of Total Revenue	2.99	-3.73	-3.18

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UM Bowie Health Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	24,028,994	21,233,764	18,495,626
Unregulated Services	1,000	2,000	3,097,000
TOTAL	24,029,994	21,235,764	21,592,626
Net Patient Revenue (NPR):			
Regulated Services	19,467,000	16,923,000	12,866,997
Unregulated Services	1,000	2,000	1,274,000
TOTAL	19,468,000	16,925,000	14,140,997
Other Operating Revenue:			
Regulated Services	0	0	28,000
Unregulated Services	0	0	0
TOTAL	0	0	28,000
Net Operating Revenue (NOR)			
Regulated Services	19,467,000	16,923,000	12,894,997
Unregulated Services	1,000	2,000	1,274,000
Total	19,468,000	16,925,000	14,168,997
Total Operating Expenses:			
Regulated Services	16,058,900	13,397,505	14,602,485
Unregulated Services	610,100	2,504,000	4,637,900
Total	16,669,000	15,901,505	19,240,385
Net Operating Profit (Loss):			
Regulated Services	3,408,100	3,525,495	-1,707,488
Unregulated Services	-609,100	-2,502,000	-3,363,900
Total	2,799,000	1,023,495	-5,071,388
Total Non-Operating Profit (Loss):	-404,000	-21,000	145,000
Non-Operating Revenue	-404,000	0	0
Non-Operating Expenses	0	21,000	-145,000
Total Excess Profit (Loss):	2,395,000	1,002,495	-4,926,388
% Net Operating Profit of Regulated NOR	17.51	20.83	-13.24
% Net Total Operating Profit of Total NOR	14.38	6.05	-35.79
% Total Excess Profit of Total Revenue	12.56	5.92	-34.77

UM CAPITAL REGION MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	423,296,579	400,129,173	386,755,056
Unregulated Services	1,785,010	524,000	594,000
TOTAL	425,081,590	400,653,173	387,349,056
Net Patient Revenue (NPR):			
Regulated Services	368,692,721	338,915,411	305,326,990
Unregulated Services	997,279	419,561	473,086
TOTAL	369,690,000	339,334,971	305,800,077
Other Operating Revenue:			
Regulated Services	6,015,257	20,558,153	19,609,181
Unregulated Services	1,125,743	1,431,847	962,819
TOTAL	7,141,000	21,990,000	20,572,000
Net Operating Revenue (NOR)			
Regulated Services	374,707,978	359,473,563	324,936,171
Unregulated Services	2,123,022	1,851,408	1,435,905
Total	376,831,000	361,324,971	326,372,077
Total Operating Expenses:			
Regulated Services	352,147,075	332,697,620	310,678,725
Unregulated Services	46,218,925	47,158,949	54,878,861
Total	398,366,000	379,856,569	365,557,586
Net Operating Profit (Loss):			
Regulated Services	22,560,904	26,775,943	14,257,446
Unregulated Services	-44,095,904	-45,307,541	-53,442,955
Total	-21,535,000	-18,531,598	-39,185,509
Total Non-Operating Profit (Loss):	-9,077,000	1,353,000	-1,341,000
Non-Operating Revenue	-9,077,000	2,873,000	-334,000
Non-Operating Expenses	0	1,520,000	1,007,000
Total Excess Profit (Loss):	-30,612,000	-17,178,598	-40,526,509
% Net Operating Profit of Regulated NOR	6.02	7.45	4.39
% Net Total Operating Profit of Total NOR	-5.71	-5.13	-12.01
% Total Excess Profit of Total Revenue	-8.32	-4.72	-12.43

UM Charles Regional Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	190,364,427	180,096,132	175,776,450
Unregulated Services	2,488,205	2,458,106	2,406,582
TOTAL	192,852,633	182,554,237	178,183,032
Net Patient Revenue (NPR):			
Regulated Services	165,861,404	153,328,547	148,767,000
Unregulated Services	1,410,596	1,542,559	2,406,582
TOTAL	167,272,000	154,871,106	151,173,582
Other Operating Revenue:			
Regulated Services	398,151	1,744,000	1,927,000
Unregulated Services	794,849	0	0
TOTAL	1,193,000	1,744,000	1,927,000
Net Operating Revenue (NOR)			
Regulated Services	166,259,554	155,072,547	150,694,000
Unregulated Services	2,205,446	1,542,559	2,406,582
Total	168,465,000	156,615,106	153,100,582
Total Operating Expenses:			
Regulated Services	142,859,388	136,124,852	142,479,255
Unregulated Services	17,711,612	14,034,148	12,873,745
Total	160,571,000	150,159,000	155,353,000
Net Operating Profit (Loss):			
Regulated Services	23,400,166	18,947,695	8,214,745
Unregulated Services	-15,506,166	-12,491,589	-10,467,163
Total	7,894,000	6,456,106	-2,252,418
Total Non-Operating Profit (Loss):	3,210,000	2,420,000	-3,678,000
Non-Operating Revenue	4,140,000	3,526,000	4,173,000
Non-Operating Expenses	930,000	1,106,000	7,851,000
Total Excess Profit (Loss):	11,104,000	8,876,106	-5,930,418
% Net Operating Profit of Regulated NOR	14.07	12.22	5.45
% Net Total Operating Profit of Total NOR	4.69	4.12	-1.47
% Total Excess Profit of Total Revenue	6.43	5.54	-3.77

UM LAUREL MEDICAL CENTER

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	42,422,550	36,009,147	34,414,585
Unregulated Services	0	0	0
TOTAL	42,422,550	36,009,147	34,414,585
Net Patient Revenue (NPR):			
Regulated Services	33,535,000	27,603,000	23,271,008
Unregulated Services	0	0	0
TOTAL	33,535,000	27,603,000	23,271,008
Other Operating Revenue:			
Regulated Services	7,000	33,000	51,000
Unregulated Services	0	0	0
TOTAL	7,000	33,000	51,000
Net Operating Revenue (NOR)			
Regulated Services	33,542,000	27,636,000	23,322,008
Unregulated Services	0	0	0
Total	33,542,000	27,636,000	23,322,008
Total Operating Expenses:			
Regulated Services	39,999,089	37,774,191	31,792,997
Unregulated Services	7,268,911	7,495,735	6,822,032
Total	47,268,000	45,269,926	38,615,029
Net Operating Profit (Loss):			
Regulated Services	-6,457,089	-10,138,191	-8,470,989
Unregulated Services	-7,268,911	-7,495,735	-6,822,032
Total	-13,726,000	-17,633,926	-15,293,021
Total Non-Operating Profit (Loss):	-872,000	-53,000	251,000
Non-Operating Revenue	-872,000	0	0
Non-Operating Expenses	0	53,000	-251,000
Total Excess Profit (Loss):	-14,598,000	-17,686,926	-15,042,021
% Net Operating Profit of Regulated NOR	-19.25	-36.68	-36.32
% Net Total Operating Profit of Total NOR	-40.92	-63.81	-65.57
% Total Excess Profit of Total Revenue	-44.68	-64.00	-64.50

UM Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	1,932,484,534	1,848,222,110	1,807,461,729
Unregulated Services	23,816,376	27,931,105	31,613,671
TOTAL	1,956,300,910	1,876,153,214	1,839,075,400
Net Patient Revenue (NPR):			
Regulated Services	1,642,322,174	1,604,782,180	1,552,393,415
Unregulated Services	23,571,713	27,577,820	31,314,585
TOTAL	1,665,893,888	1,632,360,000	1,583,708,000
Other Operating Revenue:			
Regulated Services	30,928,528	43,093,275	36,938,807
Unregulated Services	226,279,472	201,511,725	177,726,193
TOTAL	257,208,000	244,605,000	214,665,000
Net Operating Revenue (NOR)			
Regulated Services	1,673,250,703	1,647,875,455	1,589,332,222
Unregulated Services	249,851,185	229,089,545	209,040,778
Total	1,923,101,888	1,876,965,000	1,798,373,000
Total Operating Expenses:			
Regulated Services	1,669,691,292	1,628,107,439	1,579,289,840
Unregulated Services	255,988,708	209,142,561	181,935,160
Total	1,925,680,000	1,837,250,000	1,761,225,000
Net Operating Profit (Loss):			
Regulated Services	3,559,410	19,768,016	10,042,382
Unregulated Services	-6,137,523	19,946,984	27,105,618
Total	-2,578,112	39,715,000	37,148,000
Total Non-Operating Profit (Loss):	54,496,000	32,593,000	-56,592,000
Non-Operating Revenue	57,880,000	32,593,000	-56,592,000
Non-Operating Expenses	3,384,000	0	0
Total Excess Profit (Loss):	51,917,888	72,308,000	-19,444,000
% Net Operating Profit of Regulated NOR	0.21	1.20	0.63
% Net Total Operating Profit of Total NOR	-0.13	2.12	2.07
% Total Excess Profit of Total Revenue	2.62	3.79	-1.12

UM Queen Anne's Freestanding Emergency

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	9,099,940	8,648,591	8,125,994
Unregulated Services	0	0	0
TOTAL	9,099,940	8,648,591	8,125,994
Net Patient Revenue (NPR):			
Regulated Services	7,402,000	6,824,000	6,747,000
Unregulated Services	0	0	0
TOTAL	7,402,000	6,824,000	6,747,000
Other Operating Revenue:			
Regulated Services	37	187,000	135,000
Unregulated Services	0	0	0
TOTAL	37	187,000	135,000
Net Operating Revenue (NOR)			
Regulated Services	7,402,037	7,011,000	6,882,000
Unregulated Services	0	0	0
Total	7,402,037	7,011,000	6,882,000
Total Operating Expenses:			
Regulated Services	8,726,488	9,260,600	7,637,000
Unregulated Services	133,000	226,400	623,000
Total	8,859,488	9,487,000	8,260,000
Net Operating Profit (Loss):			
Regulated Services	-1,324,452	-2,249,600	-755,000
Unregulated Services	-133,000	-226,400	-623,000
Total	-1,457,452	-2,476,000	-1,378,000
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-1,457,452	-2,476,000	-1,378,000
% Net Operating Profit of Regulated NOR	-17.89	-32.09	-10.97
% Net Total Operating Profit of Total NOR	-19.69	-35.32	-20.02
% Total Excess Profit of Total Revenue	-19.69	-35.32	-20.02

UM Rehabilitation & Orthopaedic Institute

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	147,461,509	143,817,412	135,127,734
Unregulated Services	958,640	1,905,592	372,227
TOTAL	148,420,149	145,723,005	135,499,960
Net Patient Revenue (NPR):			
Regulated Services	124,544,393	123,222,412	116,733,734
Unregulated Services	363,607	539,592	372,227
TOTAL	124,908,000	123,762,005	117,105,960
Other Operating Revenue:			
Regulated Services	274,737	1,529,864	2,458,768
Unregulated Services	1,113,263	1,375,137	1,120,232
TOTAL	1,388,000	2,905,000	3,579,000
Net Operating Revenue (NOR)			
Regulated Services	124,819,130	124,752,276	119,192,501
Unregulated Services	1,476,870	1,914,729	1,492,459
Total	126,296,000	126,667,005	120,684,960
Total Operating Expenses:			
Regulated Services	117,321,902	111,076,164	103,360,706
Unregulated Services	12,543,098	13,308,836	11,858,294
Total	129,865,000	124,385,000	115,219,000
Net Operating Profit (Loss):			
Regulated Services	7,497,229	13,676,111	15,831,796
Unregulated Services	-11,066,229	-11,394,107	-10,365,835
Total	-3,569,000	2,282,005	5,465,960
Total Non-Operating Profit (Loss):	6,968,000	4,334,000	-5,068,000
Non-Operating Revenue	6,971,000	4,334,000	-5,068,000
Non-Operating Expenses	3,000	0	0
Total Excess Profit (Loss):	3,399,000	6,616,005	397,960
% Net Operating Profit of Regulated NOR	6.01	10.96	13.28
% Net Total Operating Profit of Total NOR	-2.83	1.80	4.53
% Total Excess Profit of Total Revenue	2.55	5.05	0.34

UM Shock Trauma

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	274,780,143	261,221,517	255,045,568
Unregulated Services	1,051,791	917,534	822,463
TOTAL	275,831,934	262,139,051	255,868,031
Net Patient Revenue (NPR):			
Regulated Services	231,604,209	217,718,466	215,985,537
Unregulated Services	1,051,791	917,534	822,463
TOTAL	232,656,000	218,636,000	216,808,000
Other Operating Revenue:			
Regulated Services	10,482,000	4,015,000	4,076,000
Unregulated Services	0	0	0
TOTAL	10,482,000	4,015,000	4,076,000
Net Operating Revenue (NOR)			
Regulated Services	242,086,209	221,733,466	220,061,537
Unregulated Services	1,051,791	917,534	822,463
Total	243,138,000	222,651,000	220,884,000
Total Operating Expenses:			
Regulated Services	189,484,400	182,973,500	190,569,100
Unregulated Services	2,513,600	2,695,500	2,795,900
Total	191,998,000	185,669,000	193,365,000
Net Operating Profit (Loss):			
Regulated Services	52,601,809	38,759,966	29,492,437
Unregulated Services	-1,461,809	-1,777,966	-1,973,437
Total	51,140,000	36,982,000	27,519,000
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	51,140,000	36,982,000	27,519,000
% Net Operating Profit of Regulated NOR	21.73	17.48	13.40
% Net Total Operating Profit of Total NOR	21.03	16.61	12.46
% Total Excess Profit of Total Revenue	21.03	16.61	12.46

UM Shore Regional Health at Cambridge

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	17,364,760	17,419,653	23,879,668
Unregulated Services	10,450,260	9,370,143	5,786,824
TOTAL	27,815,020	26,789,796	29,666,492
Net Patient Revenue (NPR):			
Regulated Services	13,216,754	12,611,857	18,668,361
Unregulated Services	3,418,246	7,393,143	1,949,640
TOTAL	16,635,000	20,005,000	20,618,001
Other Operating Revenue:			
Regulated Services	0	450,125	322,275
Unregulated Services	815,000	100,875	110,725
TOTAL	815,000	551,000	433,000
Net Operating Revenue (NOR)			
Regulated Services	13,216,754	13,061,982	18,990,635
Unregulated Services	4,233,246	7,494,018	2,060,365
Total	17,450,000	20,556,000	21,051,001
Total Operating Expenses:			
Regulated Services	17,727,400	18,453,167	22,137,535
Unregulated Services	2,553,600	3,380,833	6,053,465
Total	20,281,000	21,834,000	28,191,000
Net Operating Profit (Loss):			
Regulated Services	-4,510,646	-5,391,185	-3,146,900
Unregulated Services	1,679,646	4,113,185	-3,993,099
Total	-2,831,000	-1,278,000	-7,139,999
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,831,000	-1,278,000	-7,139,999
% Net Operating Profit of Regulated NOR	-34.13	-41.27	-16.57
% Net Total Operating Profit of Total NOR	-16.22	-6.22	-33.92
% Total Excess Profit of Total Revenue	-16.22	-6.22	-33.92

UM Shore Regional Health at Chestertown

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	56,459,168	55,202,536	54,346,448
Unregulated Services	3,097,225	2,761,413	2,680,252
TOTAL	59,556,393	57,963,949	57,026,699
Net Patient Revenue (NPR):			
Regulated Services	45,921,730	45,105,334	47,554,455
Unregulated Services	1,551,270	1,493,666	1,018,545
TOTAL	47,473,000	46,599,000	48,573,000
Other Operating Revenue:			
Regulated Services	226,509	1,114,104	887,216
Unregulated Services	293,491	289,896	424,784
TOTAL	520,000	1,404,000	1,312,000
Net Operating Revenue (NOR)			
Regulated Services	46,148,240	46,219,438	48,441,671
Unregulated Services	1,844,760	1,783,562	1,443,329
Total	47,993,000	48,003,000	49,885,000
Total Operating Expenses:			
Regulated Services	37,395,369	36,282,108	35,804,495
Unregulated Services	9,076,631	9,582,892	8,876,505
Total	46,472,000	45,865,000	44,681,000
Net Operating Profit (Loss):			
Regulated Services	8,752,871	9,937,329	12,637,176
Unregulated Services	-7,231,871	-7,799,329	-7,433,175
Total	1,521,000	2,138,000	5,204,000
Total Non-Operating Profit (Loss):	1,420,000	576,000	-324,000
Non-Operating Revenue	1,420,000	576,000	-324,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	2,941,000	2,714,000	4,880,000
% Net Operating Profit of Regulated NOR	18.97	21.50	26.09
% Net Total Operating Profit of Total NOR	3.17	4.45	10.43
% Total Excess Profit of Total Revenue	5.95	5.59	9.85

UM Shore Regional Health at Easton

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	298,649,102	290,053,309	285,433,473
Unregulated Services	53,465,396	46,577,169	39,206,124
TOTAL	352,114,498	336,630,479	324,639,596
Net Patient Revenue (NPR):			
Regulated Services	247,367,645	246,944,836	247,710,351
Unregulated Services	17,488,355	12,993,164	17,203,649
TOTAL	264,856,000	259,938,000	264,913,999
Other Operating Revenue:			
Regulated Services	3,755,563	2,934,521	3,167,904
Unregulated Services	7,148,437	4,363,479	7,409,096
TOTAL	10,904,000	7,298,000	10,577,000
Net Operating Revenue (NOR)			
Regulated Services	251,123,207	249,879,358	250,878,255
Unregulated Services	24,636,793	17,356,642	24,612,744
Total	275,760,000	267,236,000	275,490,999
Total Operating Expenses:			
Regulated Services	211,813,764	205,561,089	180,470,544
Unregulated Services	70,573,785	62,042,911	51,269,456
Total	282,387,548	267,604,000	231,740,000
Net Operating Profit (Loss):			
Regulated Services	39,309,444	44,318,269	70,407,711
Unregulated Services	-45,936,992	-44,686,269	-26,656,712
Total	-6,627,548	-368,000	43,750,999
Total Non-Operating Profit (Loss):	16,711,000	12,801,000	-20,369,000
Non-Operating Revenue	17,365,000	12,801,000	-20,369,000
Non-Operating Expenses	654,000	0	0
Total Excess Profit (Loss):	10,083,452	12,433,000	23,381,999
% Net Operating Profit of Regulated NOR	15.65	17.74	28.06
% Net Total Operating Profit of Total NOR	-2.40	-0.14	15.88
% Total Excess Profit of Total Revenue	3.44	4.44	9.17

UM St. Joseph Medical Center

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	487,466,803	458,422,525	431,502,933
Unregulated Services	5,116,000	5,737,853	5,926,278
TOTAL	492,582,803	464,160,378	437,429,211
Net Patient Revenue (NPR):			
Regulated Services	411,770,889	392,131,055	371,749,613
Unregulated Services	4,575,111	5,906,945	5,274,387
TOTAL	416,346,000	398,038,000	377,024,000
Other Operating Revenue:			
Regulated Services	1,255,377	1,859,898	2,366,320
Unregulated Services	2,870,623	2,623,102	2,593,680
TOTAL	4,126,000	4,483,000	4,960,000
Net Operating Revenue (NOR)			
Regulated Services	413,026,266	393,990,953	374,115,933
Unregulated Services	7,445,734	8,530,047	7,868,067
Total	420,472,000	402,521,000	381,984,000
Total Operating Expenses:			
Regulated Services	357,491,230	349,064,558	327,302,815
Unregulated Services	66,911,770	60,797,442	55,723,185
Total	424,403,000	409,862,000	383,026,000
Net Operating Profit (Loss):			
Regulated Services	55,535,036	44,926,395	46,813,118
Unregulated Services	-59,466,036	-52,267,395	-47,855,118
Total	-3,931,000	-7,341,000	-1,042,000
Total Non-Operating Profit (Loss):	4,109,000	2,780,000	-937,000
Non-Operating Revenue	4,283,000	2,780,000	-937,000
Non-Operating Expenses	174,000	0	0
Total Excess Profit (Loss):	178,000	-4,561,000	-1,979,000
% Net Operating Profit of Regulated NOR	13.45	11.40	12.51
% Net Total Operating Profit of Total NOR	-0.93	-1.82	-0.27
% Total Excess Profit of Total Revenue	0.04	-1.13	-0.52

UM Upper Chesapeake Medical Center -Aberdeen

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	81,124,210	118,486,830	119,935,431
Unregulated Services	18,035	123,000	335,000
TOTAL	81,142,245	118,609,830	120,270,431
Net Patient Revenue (NPR):			
Regulated Services	68,935,134	102,318,990	99,536,000
Unregulated Services	17,901	109,010	335,000
TOTAL	68,953,035	102,428,000	99,871,000
Other Operating Revenue:			
Regulated Services	398,000	735,000	3,834,000
Unregulated Services	0	0	0
TOTAL	398,000	735,000	3,834,000
Net Operating Revenue (NOR)			
Regulated Services	69,333,134	103,053,990	103,370,000
Unregulated Services	17,901	109,010	335,000
Total	69,351,035	103,163,000	103,705,000
Total Operating Expenses:			
Regulated Services	69,656,668	94,172,877	95,704,640
Unregulated Services	3,260,332	10,420,123	9,896,360
Total	72,917,000	104,593,000	105,601,000
Net Operating Profit (Loss):			
Regulated Services	-323,534	8,881,113	7,665,360
Unregulated Services	-3,242,431	-10,311,113	-9,561,360
Total	-3,565,965	-1,430,000	-1,896,000
Total Non-Operating Profit (Loss):	8,795,000	9,201,000	-13,592,000
Non-Operating Revenue	14,679,000	441,000	15,808,000
Non-Operating Expenses	5,884,000	-8,760,000	29,400,000
Total Excess Profit (Loss):	5,229,035	7,771,000	-15,488,000
% Net Operating Profit of Regulated NOR	-0.47	8.62	7.42
% Net Total Operating Profit of Total NOR	-5.14	-1.39	-1.83
% Total Excess Profit of Total Revenue	6.22	7.50	-12.96

UM Upper Chesapeake Medical Center Bel Air

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	416,111,220	367,721,755	366,388,840
Unregulated Services	1,828,000	1,333,265	3,200,679
TOTAL	417,939,220	369,055,020	369,589,519
Net Patient Revenue (NPR):			
Regulated Services	349,853,018	318,326,764	317,079,321
Unregulated Services	1,799,982	1,255,236	3,200,679
TOTAL	351,653,000	319,582,000	320,280,000
Other Operating Revenue:			
Regulated Services	3,032,000	4,542,000	5,380,903
Unregulated Services	0	0	169,097
TOTAL	3,032,000	4,542,000	5,550,000
Net Operating Revenue (NOR)			
Regulated Services	352,885,018	322,868,764	322,460,224
Unregulated Services	1,799,982	1,255,236	3,369,776
Total	354,685,000	324,124,000	325,830,000
Total Operating Expenses:			
Regulated Services	304,482,065	277,702,378	270,200,776
Unregulated Services	44,227,935	31,700,622	30,444,224
Total	348,710,000	309,403,000	300,645,000
Net Operating Profit (Loss):			
Regulated Services	48,402,953	45,166,385	52,259,448
Unregulated Services	-42,427,953	-30,445,385	-27,074,448
Total	5,975,000	14,721,000	25,185,000
Total Non-Operating Profit (Loss):	16,801,000	14,197,000	-23,964,000
Non-Operating Revenue	24,457,000	15,965,000	26,100,000
Non-Operating Expenses	7,656,000	1,768,000	50,064,000
Total Excess Profit (Loss):	22,776,000	28,918,000	1,221,000
% Net Operating Profit of Regulated NOR	13.72	13.99	16.21
% Net Total Operating Profit of Total NOR	1.68	4.54	7.73
% Total Excess Profit of Total Revenue	6.01	8.50	0.35

UMMC MIDTOWN CAMPUS

FISCAL YEAR ENDING	June 2024	June 2023	June 2022
Gross Patient Revenue:			
Regulated Services	279,245,359	267,729,206	245,010,325
Unregulated Services	2,798,044	2,932,897	3,947,919
TOTAL	282,043,403	270,662,104	248,958,244
Net Patient Revenue (NPR):			
Regulated Services	231,979,956	229,407,103	201,317,081
Unregulated Services	1,965,044	1,984,897	2,981,919
TOTAL	233,945,000	231,392,000	204,299,000
Other Operating Revenue:			
Regulated Services	345,917	1,081,797	1,049,060
Unregulated Services	30,919,083	30,305,203	27,356,940
TOTAL	31,265,000	31,387,000	28,406,000
Net Operating Revenue (NOR)			
Regulated Services	232,325,873	230,488,900	202,366,141
Unregulated Services	32,884,127	32,290,100	30,338,859
Total	265,210,000	262,779,000	232,705,000
Total Operating Expenses:			
Regulated Services	212,108,034	209,845,923	207,147,111
Unregulated Services	67,428,966	58,856,077	59,991,889
Total	279,537,000	268,702,000	267,139,000
Net Operating Profit (Loss):			
Regulated Services	20,217,839	20,642,977	-4,780,970
Unregulated Services	-34,544,839	-26,565,977	-29,653,030
Total	-14,327,000	-5,923,000	-34,434,000
Total Non-Operating Profit (Loss):	-481,000	-1,525,000	-1,160,000
Non-Operating Revenue	-481,000	-1,525,000	-1,160,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-14,808,000	-7,448,000	-35,594,000
% Net Operating Profit of Regulated NOR	8.70	8.96	-2.36
% Net Total Operating Profit of Total NOR	-5.40	-2.25	-14.80
% Total Excess Profit of Total Revenue	-5.59	-2.85	-15.37

UPMC Western Maryland

FISCAL YEAR ENDING	December 2023	December 2022	December 2021
Gross Patient Revenue:			
Regulated Services	387,908,800	367,681,700	357,297,100
Unregulated Services	84,069,100	83,614,800	83,742,620
TOTAL	471,977,900	451,296,500	441,039,720
Net Patient Revenue (NPR):			
Regulated Services	323,501,600	307,537,025	301,478,620
Unregulated Services	50,505,900	56,417,400	56,871,270
TOTAL	374,007,500	363,954,425	358,349,890
Other Operating Revenue:			
Regulated Services	377,500	2,329,160	8,250,690
Unregulated Services	6,858,700	5,197,540	4,141,940
TOTAL	7,236,200	7,526,700	12,392,630
Net Operating Revenue (NOR)			
Regulated Services	323,879,100	309,866,185	309,729,310
Unregulated Services	57,364,600	61,614,940	61,013,210
Total	381,243,700	371,481,125	370,742,520
Total Operating Expenses:			
Regulated Services	260,119,667	254,536,007	237,708,128
Unregulated Services	100,794,963	98,893,683	93,964,842
Total	360,914,630	353,429,690	331,672,970
Net Operating Profit (Loss):			
Regulated Services	63,759,433	55,330,179	72,021,182
Unregulated Services	-43,430,363	-37,278,743	-32,951,632
Total	20,329,070	18,051,435	39,069,550
Total Non-Operating Profit (Loss):	20,205,550	2,499,050	3,724,850
Non-Operating Revenue	20,202,980	2,497,530	6,334,080
Non-Operating Expenses	-2,570	-1,520	2,609,230
Total Excess Profit (Loss):	40,534,620	20,550,485	42,794,400
% Net Operating Profit of Regulated NOR	19.69	17.86	23.25
% Net Total Operating Profit of Total NOR	5.33	4.86	10.54
% Total Excess Profit of Total Revenue	10.10	5.50	11.35

WVU Medicine Garrett Regional Medical Center

FISCAL YEAR ENDING	December 2023	December 2022	June 2022
Gross Patient Revenue:			
Regulated Services	90,382,193	71,160,321	71,160,321
Unregulated Services	18,633,299	17,246,325	17,246,325
TOTAL	109,015,492	88,406,646	88,406,646
Net Patient Revenue (NPR):			
Regulated Services	73,879,927	60,123,816	60,123,816
Unregulated Services	8,156,212	7,433,904	7,433,904
TOTAL	82,036,139	67,557,720	67,557,720
Other Operating Revenue:			
Regulated Services	1,570,601	4,649,419	4,649,419
Unregulated Services	440,892	394,881	394,881
TOTAL	2,011,493	5,044,300	5,044,300
Net Operating Revenue (NOR)			
Regulated Services	75,450,528	64,773,235	64,773,235
Unregulated Services	8,597,105	7,828,785	7,828,785
Total	84,047,633	72,602,020	72,602,020
Total Operating Expenses:			
Regulated Services	51,834,206	58,082,898	58,082,898
Unregulated Services	21,052,326	19,426,077	19,426,077
Total	72,886,532	77,508,975	77,508,975
Net Operating Profit (Loss):			
Regulated Services	23,616,322	6,690,337	6,690,337
Unregulated Services	-12,455,221	-11,597,292	-11,597,292
Total	11,161,101	-4,906,955	-4,906,955
Total Non-Operating Profit (Loss):	1,808,641	-1,634,274	-1,634,274
Non-Operating Revenue	1,948,764	-971,376	-971,376
Non-Operating Expenses	140,123	662,898	662,898
Total Excess Profit (Loss):	12,969,742	-6,541,229	-6,541,229
% Net Operating Profit of Regulated NOR	31.30	10.33	10.33
% Net Total Operating Profit of Total NOR	13.28	-6.76	-6.76
% Total Excess Profit of Total Revenue	15.08	-9.13	-9.13

maryland
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cost review commission

Details of the Disclosure of Hospital Financial and Statistical Data: Specialty Hospitals

ALL SPECIALTY HOSPITALS

Year Ending	FY 2024	FY 2023	FY 2022
Gross Patient Revenue	436,523,992	420,077,813	339,906,894
Net Patient Revenue (NPR)	336,356,907	323,942,760	273,322,820
Other Operating Revenue	121,980,985	115,345,802	108,789,931
Net Operating Revenue (NOR)	458,337,892	439,288,562	382,112,751
Operating Expenses	451,998,103	432,417,420	392,644,075
Inpatient Admissions (IPAs)	12,633	13,293	11,682
Net Operating Profit (Loss)	6,339,790	6,871,142	(10,531,324)
Total Non-Operating Profit (Loss)	11,344,964	(52,003,024)	(13,432,685)
Total Excess Profits (Loss)	17,684,754	(45,131,882)	(23,964,008)

Adventist Rehab Hospital of MD Takoma Park*

FISCAL YEAR ENDING	CY 2023	CY 2022	CY2021
Gross Patient Revenue	46,386,058	44,794,886	32,538,372
Net Patient Revenue (NPR)	27,100,266	26,982,929	22,382,267
Other Operating Revenue	10,341	49,358	115
Net Operating Revenue (NOR)	27,110,607	27,032,287	22,382,382
Operating Expenses	27,233,722	26,659,357	18,362,768
Inpatient Admissions (IPAs)	940	968	886
Net Operating Profit (Loss)	(123,115)	372,930	4,019,614
Total Non-Operating Profit (Loss)	221,872	(1,961,702)	(899,041)
Total Excess Profits (Loss)	98,757	(1,588,772)	3,120,573

Adventist Rehab Hospital of MD Rockville*

FISCAL YEAR ENDING	CY 2023	CY 2022	CY2021
Gross Patient Revenue	56,820,028	53,786,530	45,203,257
Net Patient Revenue (NPR)	34,281,518	30,281,271	30,791,805
Other Operating Revenue	273,478	339,620	1,211,994
Net Operating Revenue (NOR)	34,554,996	30,620,891	32,003,799
Operating Expenses	31,079,622	26,886,058	30,221,210
Inpatient Admissions (IPAs)	1,266	1,154	1,090
Net Operating Profit (Loss)	3,475,374	3,734,833	1,782,589
Total Non-Operating Profit (Loss)	(1,248,063)	(1,327,779)	(1,538,633)
Total Excess Profits (Loss)	2,227,311	2,407,054	243,957

Brook Lane Health Services

FISCAL YEAR ENDING	FY 2024	FY 2023	FY2022
Gross Patient Revenue	30,816,500	31,935,700	26,289,600
Net Patient Revenue (NPR)	24,977,000	26,205,200	21,693,300
Other Operating Revenue	315,400	281,000	580,300
Net Operating Revenue (NOR)	25,292,400	26,486,200	22,273,600
Operating Expenses	26,575,100	26,139,100	24,790,900
Inpatient Admissions (IPAs)	1,435	1,737	1,471
Net Operating Profit (Loss)	(1,282,700)	347,100	(2,517,300)
Total Non-Operating Profit (Loss)	2,027,100	1,163,300	0
Total Excess Profits (Loss)	744,400	1,510,400	(2,517,300)

*The HSCRC does not set rates for the Adventist Rehab facilities as more than 66 2/3% of their patient revenue comes from governmental payers.

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J Kent McNew Family Medical Center

FISCAL YEAR ENDING	FY 2024	FY 2023	FY2022
Gross Patient Revenue	9,087,800	8,862,400	9,168,500
Net Patient Revenue (NPR)	7,189,300	7,217,300	6,606,500
Other Operating Revenue	141,500	335,700	671,500
Net Operating Revenue (NOR)	7,330,800	7,553,000	7,278,000
Operating Expenses	8,166,900	8,726,400	9,320,900
Inpatient Admissions (IPAs)	652	686	775
Net Operating Profit (Loss)	(836,100)	(1,173,400)	(2,042,900)
Total Non-Operating Profit (Loss)	-	0	0
Total Excess Profits (Loss)	(836,100)	(1,173,400)	(2,042,900)

Mt. Washington Pediatric Hospital

FISCAL YEAR ENDING	FY 2024	FY 2023	FY2022
Gross Patient Revenue	78,198,163	75,531,222	69,697,681
Net Patient Revenue (NPR)	65,069,640	63,214,893	59,322,840
Other Operating Revenue	1,342,821	2,354,984	1,592,786
Net Operating Revenue (NOR)	66,412,461	65,569,877	60,915,626
Operating Expenses	70,797,599	68,508,229	64,585,597
Inpatient Admissions (IPAs)	450	430	410
Net Operating Profit (Loss)	(4,385,138)	(2,938,352)	(3,669,971)
Total Non-Operating Profit (Loss)	8,646,870	5,656,995	(6,280,329)
Total Excess Profits (Loss)	4,261,732	2,718,643	(9,950,300)

Sheppard Pratt Hospital

FISCAL YEAR ENDING	FY 2024	FY 2023	FY2022
Gross Patient Revenue	215,215,443	205,167,075	166,177,984
Net Patient Revenue (NPR)	177,739,183	170,041,167	139,132,608
Other Operating Revenue	119,897,445	111,985,140	105,404,736
Net Operating Revenue (NOR)	297,636,629	282,026,307	244,537,344
Operating Expenses	288,145,160	275,498,276	254,683,600
Inpatient Admissions (IPAs)	7,890	8,318	7,825
Net Operating Profit (Loss)	9,491,469	6,528,031	(10,146,256)
Total Non-Operating Profit (Loss)	1,697,185	(55,533,838)	(4,714,682)
Total Excess Profits (Loss)	11,188,654	(49,005,807)	(14,860,938)

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Exhibit 1. Change in Uncompensated Care, Regulated Operations

Listed in Alphabetical Order by Region

		2023			2024			
Hospital Area	Hospital	Gross Revenues	Charity & Bad Debts	UCC %	Gross Revenues	Charity & Bad Debts	UCC %	% Change UCC Amount
M E T R O	ADVENTIST HEALTHCARE FORT WASHINGTON M	74,115,596	5,217,536	7.04	64,761,498	4,581,996	7.08	-12.2
	ADVENTIST HEALTHCARE GERMANTOWN EMERG	17,461,500	3,063,741	17.55	17,967,500	4,533,883	25.23	48.0
	ADVENTIST HEALTHCARE SHADY GROVE MEDIC	507,181,036	31,331,804	6.18	534,307,365	29,742,770	5.57	-5.1
	ADVENTIST HEALTHCARE WHITE OAK MEDICAL	352,793,525	29,756,936	8.43	351,439,080	27,985,066	7.96	-6.0
	ASCENSION ST. AGNES HOSPITAL	515,518,500	32,969,900	6.40	494,805,400	32,046,546	6.48	-2.8
	GREATER BALTIMORE MEDICAL CENTER	497,427,559	12,898,243	2.59	525,917,619	12,387,628	2.36	-4.0
	HOLY CROSS HOSPITAL	573,789,700	42,630,380	7.43	600,651,500	38,957,939	6.49	-8.6
	HOLY CROSS HOSPITAL GERMANTOWN	140,664,300	9,716,500	6.91	163,546,900	9,798,167	5.99	0.8
	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	783,284,695	42,300,000	5.40	828,761,549	37,343,000	4.51	-11.7
	JOHNS HOPKINS HOSPITAL	2,921,370,378	93,212,400	3.19	3,105,851,884	95,471,800	3.07	2.4
	JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	356,825,066	15,838,000	4.44	373,181,711	17,918,000	4.80	13.1
	JOHNS HOPKINS SUBURBAN HOSPITAL	404,912,474	14,836,188	3.66	431,677,954	15,580,862	3.61	5.0
	LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	34,673,288	2,191,750	6.32	33,202,184	2,730,026	8.22	24.6
	LIFEBRIDGE HEALTH LEVINDALE	68,907,086	4,394,850	6.38	67,965,551	3,626,353	5.34	-17.5
	LIFEBRIDGE HEALTH NORTHWEST HOSPITAL C	310,414,480	9,893,718	3.19	311,836,440	8,668,709	2.78	-12.4
	LIFEBRIDGE HEALTH SINAI HOSPITAL	949,076,151	25,056,586	2.64	961,717,881	22,532,452	2.34	-10.1
	LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	749,524,800	45,558,463	6.08	746,989,000	13,216,023	1.77	-71.0
	LUMINIS HEALTH DOCTORS COMMUNITY MEDIC	308,601,200	41,280,913	13.38	308,883,300	15,528,557	5.03	-62.4
	MEDSTAR FRANKLIN SQUARE HOSPITAL	638,932,701	25,988,129	4.07	688,099,485	22,793,447	3.31	-12.3

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		2023			2024			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
	MEDSTAR GOOD SAMARITAN HOSPITAL	308,835,327	12,889,582	4.17	319,991,752	12,704,352	3.97	-1.4
	MEDSTAR HARBOR HOSPITAL	210,598,194	11,182,890	5.31	224,922,862	12,367,189	5.50	10.6
	MEDSTAR MONTGOMERY MEDICAL CENTER	208,039,750	9,399,674	4.52	222,642,659	8,664,902	3.89	-7.8
	MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	318,000,686	14,854,427	4.67	338,032,767	16,694,015	4.94	12.4
	MEDSTAR UNION MEMORIAL HOSPITAL	485,128,248	16,401,093	3.38	499,090,335	11,502,316	2.30	-29.9
	MERCY MEDICAL CENTER	653,644,800	28,691,823	4.39	681,875,400	30,862,538	4.53	7.6
	UM BALTIMORE WASHINGTON MEDICAL CENTER	511,681,319	23,130,000	4.52	535,602,424	23,822,000	4.45	3.0
	UM BOWIE HEALTH CENTER	21,233,764	3,189,000	15.02	24,028,994	3,143,000	13.08	-1.4
	UM CAPITAL REGION MEDICAL CENTER	400,129,173	27,689,259	6.92	423,296,579	30,503,780	7.21	10.2
	UM LAUREL MEDICAL CENTER	36,009,147	4,950,000	13.75	42,422,550	5,682,000	13.39	14.8
	UM MEDICAL CENTER	1,848,222,110	69,225,715	3.75	1,932,484,534	73,965,337	3.83	6.8
	UM QUEEN ANNE'S FREESTANDING EMERGENCY	8,648,591	542,233	6.27	9,099,940	878,000	9.65	61.9
	UM REHABILITATION & ORTHOPAEDIC INSTIT	143,817,412	4,940,000	3.43	147,461,509	5,028,000	3.41	1.8
	UM SHOCK TRAUMA	261,221,517	16,150,000	6.18	274,780,143	17,450,000	6.35	8.0
	UM ST. JOSEPH MEDICAL CENTER	458,422,525	16,718,092	3.65	487,466,803	16,683,111	3.42	-0.2
	UM UPPER CHESAPEAKE MEDICAL CENTER – B	367,721,755	15,620,971	4.25	416,111,220	17,082,982	4.11	9.4
	UMMC MIDTOWN CAMPUS	267,729,206	10,428,000	3.89	279,245,359	10,637,000	3.81	2.0
METRO		*16,714,557,560*	*774,138,795*	*4.63*	*17,470,119,628*	*713,113,745*	*4.08*	*-7.9*

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		2023			2024			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
R U R A L	ATLANTIC GENERAL HOSPITAL	125,786,800	4,941,710	3.93	135,629,341	6,264,131	4.62	26.8
	CALVERT HEALTH MEDICAL CENTER	175,364,060	3,706,300	2.11	188,719,140	3,333,941	1.77	-10.0
	CHRISTIANACARE UNION HOSPITAL	188,970,768	9,006,304	4.77	210,598,498	3,852,975	1.83	-57.2
	FREDERICK HEALTH HOSPITAL	413,332,700	20,634,700	4.99	424,222,500	19,375,400	4.57	-6.1
	LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	265,924,528	7,943,568	2.99	294,002,396	4,111,311	1.40	-48.2
	MEDSTAR ST. MARY'S HOSPITAL	217,557,775	7,703,970	3.54	236,265,893	9,123,748	3.86	18.4
	MERITUS MEDICAL CENTER	440,345,460	17,693,232	4.02	487,797,440	22,121,200	4.53	25.0
	TIDALHEALTH MCCREADY PAVILION	5,920,672	267,400	4.52	6,300,799	318,300	5.05	19.0
	TIDALHEALTH PENINSULA REGIONAL	547,529,412	19,665,100	3.59	604,393,730	30,447,000	5.04	54.8
	UM CHARLES REGIONAL MEDICAL CENTER	180,096,132	10,946,585	6.08	190,364,427	11,819,368	6.21	8.0
	UM SHORE REGIONAL HEALTH AT CAMBRIDGE	17,419,653	1,504,542	8.64	17,364,760	1,445,000	8.32	-4.0
	UM SHORE REGIONAL HEALTH AT CHESTERTOW	55,202,536	2,814,000	5.10	56,459,168	2,770,000	4.91	-1.6
	UM SHORE REGIONAL HEALTH AT EASTON	290,053,309	9,282,157	3.20	298,649,102	8,714,000	2.92	-6.1
	UM UPPER CHESAPEAKE MEDICAL CENTER -AB	118,486,830	5,841,010	4.93	81,124,210	3,721,866	4.59	-36.3
	UPMC WESTERN MARYLAND	367,681,700	17,015,600	4.63	387,908,800	17,173,300	4.43	0.9
	WVU MEDICINE GARRETT REGIONAL MEDICAL	71,160,321	4,613,257	6.48	90,382,193	4,567,560	5.05	-1.0
R U R A L		*3,480,832,656*	*143,579,434*	*4.12*	*3,710,182,398*	*149,159,100*	*4.02*	*3.9*
		20,195,390,216	*917,718,229*	*4.54*	*21,180,302,026*	*862,272,844*	*4.07*	*-6.0*

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Exhibit 2. Change in Total Operating Profit/Loss, Regulated and Unregulated Operations

Listed by Alphabetical Order

	2023			2024				
Hospital	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating	% Change Reg. Operating	% Change Total Operating
ADVENTIST HEALTHCARE FORT WASHINGTON	2,787,860	-5,724,582	-2,936,722	6,253,121	-8,986,253	-2,733,132	124.30	6.93
ADVENTIST HEALTHCARE GERMANTOWN EMER	-320,807	-10,747	-331,554	-249,422	-9,500	-258,922	22.25	21.91
ADVENTIST HEALTHCARE SHADY GROVE MEDI	32,352,179	-22,219,238	10,132,941	42,551,157	-16,057,234	26,493,923	31.52	161.46
ADVENTIST HEALTHCARE WHITE OAK MEDICA	1,637,679	-20,894,113	-19,256,434	25,537,391	-25,829,037	-291,646	1459.37	98.49
ASCENSION ST. AGNES HOSPITAL	88,622,482	-69,356,840	19,265,642	51,380,720	-79,830,677	-28,449,957	-42.02	-247.67
ATLANTIC GENERAL HOSPITAL	13,362,445	-22,870,162	-9,507,717	19,220,772	-25,548,409	-6,327,636	43.84	33.45
CALVERT HEALTH MEDICAL CENTER	4,916,433	-12,303,348	-7,386,914	11,699,833	-12,861,700	-1,161,867	137.97	84.27
CHRISTIANACARE UNION HOSPITAL	6,992,673	-23,099,738	-16,107,065	18,110,343	-22,362,339	-4,251,996	158.99	73.60
FREDERICK HEALTH HOSPITAL	15,268,614	-23,452,614	-8,184,000	24,294,692	-26,456,809	-2,162,117	59.12	73.58
GREATER BALTIMORE MEDICAL CENTER	54,970,910	-90,362,836	-35,391,925	57,430,709	-74,580,208	-17,149,499	4.47	51.54
HOLY CROSS HOSPITAL	44,615,617	-40,172,145	4,443,471	72,516,646	-38,442,318	34,074,328	62.54	666.84
HOLY CROSS HOSPITAL GERMANTOWN	-5,174,685	-11,714,155	-16,888,840	4,336,909	-12,395,774	-8,058,865	183.81	52.28
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	9,436,035	-6,330,035	3,106,000	13,625,237	3,628,763	17,254,000	44.40	455.51
JOHNS HOPKINS HOSPITAL	39,746,846	59,843,954	99,590,800	-14,930,532	69,112,432	54,181,900	-137.56	-45.60
JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	-10,313,158	-5,682,283	-15,995,441	5,043,748	-11,958,747	-6,915,000	148.91	56.77
JOHNS HOPKINS SUBURBAN HOSPITAL	14,141,881	-28,158,094	-14,016,213	24,324,578	-32,747,325	-8,422,747	72.00	39.91
LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	22,518,422	-11,374,561	11,143,860	45,884,150	-17,917,344	27,966,806	103.76	150.96
LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	-3,657,468	-8,157,539	-11,815,007	-3,015,279	-11,944,749	-14,960,028	17.56	-26.62
LIFEBRIDGE HEALTH LEVINDALE	15,497,137	-9,137,405	6,359,732	14,252,366	-6,596,781	7,655,585	-8.03	20.38
LIFEBRIDGE HEALTH NORTHWEST HOSPITAL CE	21,969,662	-32,327,113	-10,357,451	27,840,750	-37,013,928	-9,173,178	26.72	11.43

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Hospital	2023			2024			% Change Reg. Operating	% Change Total Operating
	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating		
LIFEBRIDGE HEALTH SINAI HOSPITAL	87,412,972	-83,434,918	3,978,054	106,137,994	-84,597,928	21,540,065	21.42	441.47
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	35,431,466	-45,614,529	-10,183,063	71,379,651	-53,088,654	18,290,997	101.46	279.62
LUMINIS HEALTH DOCTORS COMMUNITY MEDI	1,338,036	-15,135,725	-13,797,690	15,137,467	-20,883,073	-5,745,606	1031.32	58.36
MEDSTAR FRANKLIN SQUARE HOSPITAL	46,119,648	-50,815,836	-4,696,188	61,298,178	-46,971,032	14,327,146	32.91	405.08
MEDSTAR GOOD SAMARITAN HOSPITAL	24,636,640	-28,137,033	-3,500,392	28,793,318	-27,332,352	1,460,966	16.87	141.74
MEDSTAR HARBOR HOSPITAL	11,837,901	-18,530,578	-6,692,677	13,901,632	-18,187,585	-4,285,953	17.43	35.96
MEDSTAR MONTGOMERY MEDICAL CENTER	-1,730,814	-15,487,042	-17,217,856	-70,382	-13,611,426	-13,681,808	95.93	20.54
MEDSTAR SOUTHERN MARYLAND HOSPITAL CE	3,813,459	-32,529,976	-28,716,518	-3,181,665	-28,325,726	-31,507,391	-183.43	-9.72
MEDSTAR ST. MARY'S HOSPITAL	19,259,896	-17,015,645	2,244,251	18,994,350	-15,307,012	3,687,338	-1.38	64.30
MEDSTAR UNION MEMORIAL HOSPITAL	35,362,135	-44,667,421	-9,305,286	44,549,699	-56,910,403	-12,360,704	25.98	-32.84
MERCY MEDICAL CENTER	45,227,946	-26,851,330	18,376,616	43,594,749	-27,636,242	15,958,507	-3.61	-13.16
MERITUS MEDICAL CENTER	59,682,438	-15,659,674	44,022,764	68,697,840	-18,051,400	50,646,440	15.11	15.05
TIDALHEALTH MCCREADY PAVILION	-2,091,028	-2,036,500	-4,127,528	-1,442,501	-1,555,600	-2,998,101	31.01	27.36
TIDALHEALTH PENINSULA REGIONAL	55,949,746	-40,916,734	15,033,012	90,601,443	-41,418,413	49,183,030	61.93	227.17
UM BALTIMORE WASHINGTON MEDICAL CENTE	17,426,547	-47,518,547	-30,092,000	47,472,336	-55,225,336	-7,753,000	172.41	74.24
UM BOWIE HEALTH CENTER	3,525,495	-2,502,000	1,023,495	3,408,100	-609,100	2,799,000	-3.33	173.47
UM CAPITAL REGION MEDICAL CENTER	26,775,943	-45,307,541	-18,531,598	22,560,904	-44,095,904	-21,535,000	-15.74	-16.21
UM CHARLES REGIONAL MEDICAL CENTER	18,947,695	-12,491,589	6,456,106	23,400,166	-15,506,166	7,894,000	23.50	22.27
UM LAUREL MEDICAL CENTER	-10,138,191	-7,495,735	-17,633,926	-6,457,089	-7,268,911	-13,726,000	36.31	22.16
UM MEDICAL CENTER	19,768,016	19,946,984	39,715,000	3,559,410	-6,137,523	-2,578,112	-81.99	-106.49
UM QUEEN ANNE'S FREESTANDING EMERGENC	-2,249,600	-226,400	-2,476,000	-1,324,452	-133,000	-1,457,452	41.13	41.14
UM REHABILITATION & ORTHOPAEDIC INSTIT	13,676,111	-11,394,107	2,282,005	7,497,229	-11,066,229	-3,569,000	-45.18	-256.40
UM SHOCK TRAUMA	38,759,966	-1,777,966	36,982,000	52,601,809	-1,461,809	51,140,000	35.71	38.28
UM SHORE REGIONAL HEALTH AT CAMBRIDGE	-5,391,185	4,113,185	-1,278,000	-4,510,646	1,679,646	-2,831,000	16.33	-121.52

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	2023			2024				
Hospital	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**Regulated Operating**	**Unregulated Operating**	**Total Operating**	**% Change Reg. Operating**	**% Change Total Operating**
UM SHORE REGIONAL HEALTH AT CHESTERTO	9,937,329	-7,799,329	2,138,000	8,752,871	-7,231,871	1,521,000	-11.92	-28.86
UM SHORE REGIONAL HEALTH AT EASTON	44,318,269	-44,686,269	-368,000	39,309,444	-45,936,992	-6,627,548	-11.30	-1700.96
UM ST. JOSEPH MEDICAL CENTER	44,926,395	-52,267,395	-7,341,000	55,535,036	-59,466,036	-3,931,000	23.61	46.45
UM UPPER CHESAPEAKE MEDICAL CENTER -AB	8,881,113	-10,311,113	-1,430,000	-323,534	-3,242,431	-3,565,965	-103.64	-149.37
UM UPPER CHESAPEAKE MEDICAL CENTER – B	45,166,385	-30,445,385	14,721,000	48,402,953	-42,427,953	5,975,000	7.17	-59.41
UMMC MIDTOWN CAMPUS	20,642,977	-26,565,977	-5,923,000	20,217,839	-34,544,839	-14,327,000	-2.06	-141.89
UPMC WESTERN MARYLAND	55,330,179	-37,278,743	18,051,435	63,759,433	-43,430,363	20,329,070	15.23	12.62
WVU MEDICINE GARRETT REGIONAL MEDICAL	6,690,337	-11,597,292	-4,906,955	23,616,322	-12,455,221	11,161,101	252.99	327.45
ALL ACUTE HOSPITALS	***1,148,614,978***	***-1,145,941,754***	***2,673,224***	***1,411,977,794***	***-1,231,234,822***	***180,742,972***	***4,126.10***	***1,577.34***

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Exhibit 3A. Total Excess Profit/Loss, Operating and Non-Operating Activities

Listed by Alphabetical Order

	2023	2024	
Hospital	Excess|Profit Loss	Excess|Profit Loss	% Change in Excess
ACUTE HOSPITAL TOTALS	494,091,440	807,714,662	63.47
ADVENTIST HEALTHCARE FORT WASHINGTON M	-2,925,168	-2,815,108	3.76
ADVENTIST HEALTHCARE GERMANTOWN EMERGE	-331,554	-258,922	21.91
ADVENTIST HEALTHCARE SHADY GROVE MEDIC	8,614,766	32,176,665	273.51
ADVENTIST HEALTHCARE WHITE OAK MEDICAL	-19,004,097	239,380	101.26
ASCENSION ST. AGNES HOSPITAL	18,247,860	-27,040,285	-248.18
ATLANTIC GENERAL HOSPITAL	-4,024,081	-1,888,614	53.07
CALVERT HEALTH MEDICAL CENTER	-6,644,499	-921,415	86.13
CHRISTIANACARE UNION HOSPITAL	-11,097,065	3,068,004	127.65
FREDERICK HEALTH HOSPITAL	12,239,000	20,923,883	70.96
GREATER BALTIMORE MEDICAL CENTER	-26,457,925	-6,685,499	74.73
HOLY CROSS HOSPITAL	29,872,471	70,431,928	135.78
HOLY CROSS HOSPITAL GERMANTOWN	-12,731,540	-2,074,365	83.71
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	-2,936,000	18,777,000	739.54
JOHNS HOPKINS HOSPITAL	127,387,800	108,038,900	-15.19
JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	6,867,000	20,712,631	201.63
JOHNS HOPKINS SUBURBAN HOSPITAL	16,165,765	30,414,253	88.14
LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	34,533,353	50,789,607	47.07
LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	3,438,993	-14,967,028	-535.22
LIFEBRIDGE HEALTH LEVINDALE	8,497,473	10,038,933	18.14
LIFEBRIDGE HEALTH NORTHWEST HOSPITAL C	-1,481,030	-577,418	61.01
LIFEBRIDGE HEALTH SINAI HOSPITAL	44,391,054	60,633,065	36.59
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	37,264,937	67,069,997	79.98
LUMINIS HEALTH DOCTORS COMMUNITY MEDIC	-14,271,690	-8,186,606	42.64
MEDSTAR FRANKLIN SQUARE HOSPITAL	-4,361,290	14,871,421	440.99
MEDSTAR GOOD SAMARITAN HOSPITAL	-194,164	6,553,818	3475.41
MEDSTAR HARBOR HOSPITAL	-6,302,593	-3,751,353	40.48
MEDSTAR MONTGOMERY MEDICAL CENTER	-15,862,911	-12,889,388	18.75

	2023	2024	
Hospital	Excess|Profit Loss	Excess|Profit Loss	% Change in Excess
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	-28,624,114	-31,313,733	-9.40
MEDSTAR ST. MARY'S HOSPITAL	4,377,367	6,083,361	38.97
MEDSTAR UNION MEMORIAL HOSPITAL	-3,318,921	-3,083,560	7.09
MERCY MEDICAL CENTER	46,166,587	43,580,356	-5.60
MERITUS MEDICAL CENTER	86,970,834	102,893,540	18.31
TIDALHEALTH MCCREADY PAVILION	-4,127,528	-2,998,101	27.36
TIDALHEALTH PENINSULA REGIONAL	49,930,012	94,803,030	89.87
UM BALTIMORE WASHINGTON MEDICAL CENTER	-17,179,000	14,705,000	185.60
UM BOWIE HEALTH CENTER	1,002,495	2,395,000	138.90
UM CAPITAL REGION MEDICAL CENTER	-17,178,598	-30,612,000	-78.20
UM CHARLES REGIONAL MEDICAL CENTER	8,876,106	11,104,000	25.10
UM LAUREL MEDICAL CENTER	-17,686,926	-14,598,000	17.46
UM MEDICAL CENTER	72,308,000	51,917,888	-28.20
UM QUEEN ANNE'S FREESTANDING EMERGENCY	-2,476,000	-1,457,452	41.14
UM REHABILITATION & ORTHOPAEDIC INSTIT	6,616,005	3,399,000	-48.62
UM SHOCK TRAUMA	36,982,000	51,140,000	38.28
UM SHORE REGIONAL HEALTH AT CAMBRIDGE	-1,278,000	-2,831,000	-121.52
UM SHORE REGIONAL HEALTH AT CHESTERTOW	2,714,000	2,941,000	8.36
UM SHORE REGIONAL HEALTH AT EASTON	12,433,000	10,083,452	-18.90
UM ST. JOSEPH MEDICAL CENTER	-4,561,000	178,000	103.90
UM UPPER CHESAPEAKE MEDICAL CENTER -AB	7,771,000	5,229,035	-32.71
UM UPPER CHESAPEAKE MEDICAL CENTER – B	28,918,000	22,776,000	-21.24
UMMC MIDTOWN CAMPUS	-7,448,000	-14,808,000	-98.82
UPMC WESTERN MARYLAND	20,550,485	40,534,620	97.24
WVU MEDICINE GARRETT REGIONAL MEDICAL	-6,541,229	12,969,742	298.28

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
May 14, 2025

RE:
Hearing and Meeting Schedule

June 11, 2025 In person at HSCRC office and Zoom webinar

July 9, 2025 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.