maryland
health services
cost review commission

642nd Meeting of the Health Services Cost Review Commission

May 13, 2026

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on April 16, 2025

Informational Session

1. The Honorable Senator Benjamin Cardin

Specific Matters

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

Docket Status – Cases Closed

2694A Johns Hopkins Health System

2. Docket Status – Cases Open

2689N Luminis Health Doctors Community Medical Center
2695N TidalHealth Peninsula Regional Medical Center
2696A Johns Hopkins Health System
2697A Johns Hopkins Health System

3. Final Recommendation on Confidential Data Request: Maryland Department of Health, Developmental Disabilities Administration and Liberty Healthcare

4. Recommendation: Adventist Germantown Emergency Center Closure

Subjects of General Applicability

5. Report from the Executive Director
    a. Model Monitoring
    b. Policy Calendar Update
    c. Request for Public Comment: HSCRC Regulations Evaluation

6. Final Recommendation: NSP II Competitive Grants - FY27
7. Draft Recommendation: CRISP HIE Funding - FY27
8. Draft Recommendation: Update Factor - FY27
9. Final Recommendation: Care Transformation Initiatives Changes
10. *Materials Only - FY25 Hospital Financial Conditions (materials only)*
11. Hearing and Meeting Schedule

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
LUMINIS HEALTH DOCTORS	*	DOCKET: 2026
COMMUNITY MEDICAL CENTER	*	SUBMISSION DATE: JANUARY 6, 2026
LANHAM, MARYLAND	*	FOLIO: 2499
	*	PROCEEDING: 2689N

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STAFF RECOMMENDATION

April 15, 2026

This HSCRC Staff (Staff) recommendation is in response to the Partial Rate Application (PRA) dated January 6, 2026, filed by Berkley Research Group (BRG) on behalf of Luminis Health Doctors Community Medical Center ("LHDC or "the hospital"). LHDC is a non-profit hospital located on a 40-acre campus in Lanham, Prince George's (PG) County, Maryland, with 200 licensed acute care Medical Surgical Gynecological Addictions (MSGA) beds. The hospital was founded in 1975. In 2019, LHDC became an affiliate of Luminis Health, Inc., which also manages Anne Arundel Medical Center, and J. Kent McNew Family Medical Center.

Background:

This PRA follows a Certificate of Need (CON) application which was filed by LHDC with the Maryland Health Care Commission (MHCC) dated April 7, 2023. The scope of the CON was to establish a new obstetrics (OB) service and construct a new four-story facility on the west side grounds of the existing campus to accommodate such service. The CON was approved by MHCC on December 14, 2023, for a Project Budget totaling $299,012,841, and planned to open for operation January 2027 (fiscal year 2027). The approved CON called for 21 labor/delivery/recovery (OB) beds, and the construction/renovation impacting 301,952 square feet (sq.ft.) over three phases at a total cost of $299,012,841 (or $990.27 per sq.ft.). For this CON, Staff estimated that LHDC may be eligible to receive an incremental capital award to its Global Budget Revenue (GBR) of approximately $6.52 million upon completion and full operation of the proposed addition of the facility and service.

Additionally, this PRA also follows a Post CON Approval Project Change Request (Change Request) which was filed by LHDC with the MHCC dated March 27, 2025. The Change Request called for a reduced scope (16 OB beds in lieu of 21), and savings on construction by relocating the planned new facility to the east side of the hospital's campus. The relocation saves on sitework for new roadways and eliminates the need for construction of an additional parking structure, and the renovation of the existing surgical floor, in lieu of constructing new surgical units in the new facility. The Change Request also called for a reduced project budget totaling $210,828,366, and revised date of opening set for May 2028 (fiscal year 2028). The Change Request was approved by MHCC on May 20, 2025. The approved Change Request impacted 151,112 sq. ft. over a single construction phase at a total cost of $210,828,366 (or $1,395.18 per sq.ft.). Staff again estimated that LHDC may be eligible for a reduced incremental capital award to its GBR of approximately $4.4 million upon completion and full operation of the proposed smaller addition of the facility and service.

Capital Modeling:

The capital policy, approved by the HSCRC on December 11. 2019, is available for hospitals with capital projects that exceed a threshold of 25 percent of permanent revenue for hospitals that have a permanent revenue base of $300 million or greater. LHDC is requesting assistance in funding the gross incremental capital expense of the proposed project ($12,687,700). They have prepared a request for a capital award for their GBR ($4,363,245), before mark-up. The proposed project's total budget of $210,828,366 meets the criteria for study and evaluation under the capital policy as the project's total budget represents 64.83 percent ($210,828,366/$325,206,625) of their permanent revenue. Modeling indicates that LHDC qualifies for a potential capital award to its GBR.

Step 1 (Maximum Eligible Funding) of the Capital Financing Policy is to calculate the average annual depreciation cost using the straight-line method applied to the total cost of the project and the useful life of the acquired assets, plus the average annual interest cost of financing the project using the expected interest rate extended by the total cost of the project.

As per the Assumptions Table included in the CON, the project's depreciation and amortization expense is based upon a useful life of 40 years for costs associated with the building, and 15 years for costs associated with equipment. Those costs associated with the issuance of bonds are spread over the expected life of the bonds (30 years). Using CON Change Request Table E (Project Budget) for distributing useful lives, all of "new construction" and "renovations" were assigned 40-year lives; all of "other" were assigned 15-year lives; bonds were assigned a 30-year life; and contingencies, inflation and capitalized interest were assigned the average lives determined (34.37 years). Staff computed a weighted average of 34.37 years for the total project cost of $210,828,366, which yields $6,134,045 per year in depreciation & amortization expense.

The interest rate used in the model is 5 percent, based upon the hospital's CON Change Request responses to Staff's questions. Staff computed an effective interest rate of 4.48 percent on the planned borrowing of $76,250,000 as per the CON Change Request Table E (Project Budget) which yields the interest expense equal to that reported on the P&L projections included in the CON Change Request. Additionally, the Executive Director of Maryland Health and Higher Educational Facilities Authority (MHHEFA) opined that a reasonable assumption for the interest rate on a 30-year MHHEFA bond to be issued shortly on behalf of LHDC for approximately $76,250,000 (terms consistent with the approved CON Change Request), fell within the range of 4.875 percent to 5.25 percent

for an "A-" rated, 30-year issue, cost to maturity. Staff concluded, therefore, that 5 percent was a reasonable rate to use for this purpose. As per review of the CON Change Request, as clarified by the applicant's counsel, certain assumed critical dates were, as of March 2025, as follows: Date of Borrowing May 31, 2025, and date of concluding construction and beginning operations May 31, 2028. From this timeline, Staff computed an average annual interest expense of $6,553,655, with 70 percent of such measure being $4,587,558. Therefore, the maximum combined project related capital award for funding incremental depreciation and interest cost prior to scaling steps is $10,721,604.

As per the Capital Financing Policy, if the output of the capital methodology exceeds 100 percent depreciation plus 70 percent interest, then Staff will cap rate support to 100 percent of depreciation plus 70 percent of interest. By financing only 70 percent of the project's interest value, Staff earnestly expect that at least 30 percent of the project cost will be paid by the hospital either through cash, philanthropy, grants, or other sources of funding that are not direct rate support. Staff will calculate the hospital project's estimated average annual interest payments at the effective annual interest rate at which the project is expected to be financed.

Step 2a (Scaling for Capital Efficiency) is a measure of the subject hospital's proportion of operating expense pertaining to capital (inclusive of this project) as compared with the defined proportion of its peer group. LHDC's capital-related expenses for fiscal 2024 were 6.12 percent of its operating costs (without the proposed project), and pro forma 10.92 percent (after adding in the capital expenses of this project). The state-wide peer group, (which consists of all 41 acute care hospitals except for the 2 Academic Medical Centers) had a fiscal 2024 capital expense ratio of 7.68 percent (without the proposed project). This step of the policy limits the subject hospital to a capital expense ratio up to, but not greater than, a ceiling ratio composed of 50 percent of the peer group (without the proposed project) and 50 percent of the subject hospital (inclusive of this proposed project). Given that LHDC's actual 2024 capital expense ratio falls beneath the 2024 ceiling ratio, the result is an intermediate credit to LHDC's capital expense. At this intermediate step, the hospital is awarded the average of its post-project projected costs and its peers' pre-project average. Because LHDC has spent less on capital than its peers, this methodology provides the "credit" aimed to upgrade or replace balance sheet assets which have become worn or functionally obsolete, while preventing already capital-intensive hospitals from overbuilding. The intermediate value of capital related operating expense at the conclusion of step 2a is $8,401,109, which is further scaled in step 2b.

Step 2b (Scaling for Cost per Case and Total Cost of Care Efficiency) is a measure of the subject hospital's service cost ranking relative to that of the state's other hospitals. Staff referenced the Interhospital Cost Comparison (ICC) to assess the relative efficiency with which the subject hospital makes use of its fixed cost, and the relative profit margin achieved through its billing, which indicates the potential for self-funding of its proposed capital growth. Staff referenced both Medicare and Commercial Total Cost of Care (TCOC) growth since base year 2013 (the period prior to the introduction of GBR) to assess the relative pace of growth given the incentives in place to curb such growth. Among the state's 41 regulated acute care hospitals, LHDC ranks 23rd on the fiscal 2025 ICC, 15th on the fiscal 2023 Medicare TCOC, and 1st on the fiscal 2022 Commercial TCOC. The 3 placement rankings (or scores) are assigned points by averaging the two TCOC scores (15 and 1) and then adding the ICC score (23), yielding a rank score for LHDC of 31. The first place (or lowest) score measured was 8 by Meritus, and the last place (or highest) score was 80 by Chestertown. LHDC's score of 31 put them in 16th place among the 41 hospitals (or 7th place within the 2nd quintile). Staff calculated the integrated efficiency scaling factor of 65 percent for the hospital. The policy model rewards hospitals that manage their resources efficiently and help to keep healthcare costs low for the entire community. By combining the internal cost efficiency (ICC) with the external community cost growth (TCOC), the policy model ensures that high performers receive higher funding. Because LHDC is highly efficient in commercial cost management (ranked 1st) but moderately efficient in other metrics, the 65 percent scaling factor provides a balanced level of capital support that incentivizes further efficiency while recognizing their current performance. When applied to the previous step's $8,401,109, this step 2b yields total capital funding of $5,460,721.

Step 3a (Scaling Adjustment for PAU) of the Capital Financing Policy serves to adjust any potential award for funding incremental capital-related operating cost by recognizing the opportunity to reduce potentially avoidable utilization (PAU) of hospital services. PAU is a measure of 30-day readmissions. Under the GBR model, hospitals are incentivized to reduce unnecessary volume and then to reinvest the operating cost savings into capital projects and community health initiatives. Hospitals are expected to maximize the self-funding of construction through operational efficiency rather than increased patient volume. The PAU adjustment is intended to make financing capital projects easier for hospitals that cannot use new projects to induce new demand and lack the opportunity to reduce PAU as an alternative. This step provides financial credit to "lean" hospitals with low measures of avoidable utilization. Staff calculated the state-wide average of PAU revenue to determine funding eligibility. The state-wide average PAU measure for calendar 2024 is 17.28 percent (PAU Revenue/Inpatient revenue). If a

hospital's measured PAU is below the state's average, it receives a credit. If it is above the average, it does not. This step acts as an efficiency reward for hospitals that have already minimized avoidable visits and readmissions. Because these "lean" hospitals have very little waste left to cut for savings, the model provides a funding credit to ensure they are not financially penalized for their high performance when seeking to build new facilities. This credit is capped at one standard deviation (4.65 percent) to ensure no single hospital receives an outsized advantage. For LHDC, Staff used a CY2021 PAU revenue of $39,551,578, a CY2024 percent of eligible revenue (PAU / IP Revenue) of 28.1 percent, which yields a PAU attainment quintile of 5. Consequently, the PAU Credit Scaled for Efficiency is $0. The intermediate capital funding remains $5,460,721.

Step 3b (Scaling Adjustment for Excess Capacity) serves to further scale the potential capital award by examining the subject hospital's change in volume, and if volumes have declined, then examining any fixed costs remaining that pertain to the volumes no longer served. A hospital is expected to finance a portion of its capital needs with the savings of fixed costs that should have been eliminated when volumes declined. Staff referenced the base period volume as follows: Total 2010 base period volume for LHDC was 52,299 inpatient days, which combines 51,708 inpatient days from 2010 (the base period) and 591 outpatient surgery visits (OPSV) from 2013 (the first period in which data for OPSV is available). The excess capacity adjustment is computed by taking $1,201 (which was the 2019 state-wide fixed cost per patient bed day) times the reduction in inpatient days since 2010. This is compared against the total ending volume of 59,954 patient days in 2024, which is the sum of 2024 inpatient days of 56,566, observation stays beyond 24 hours of 2,245, and outpatient surgery visits of 1,143. The measured change was a volume increase of 7,655 patient days, not a decrease; therefore, there is no adjustment for excess capacity. This step makes allowance for changes in volume and the retention of revenue permitted under the GBR model. It is expected that the savings of fixed overhead following volume decline, be directed towards self-funding some portion of their capital projects rather than only requesting an additional GBR award. LHDC's potential capital award remains at the same total of $5,460,721, as determined in step 2b.

Other Considerations (Extraordinary Costs):

Staff noted that LHDC included a discussion of what the hospital considered to be extraordinary costs that either have been incurred or are planned to be incurred.

At the HSCRC meeting held July 10, 2024, Staff presented its final recommendation regarding Easton Capital, which read in part as follows: "All exclusions and multipliers that are approved as part of the total capital project through the CON process should be

passed through the capital policy without qualification…" The HSCRC approved the Staff recommendation. Upon review of the Easton case, Staff noted that the $8.1 million request was tied to the premiums in cost related to the ruralness of the project's geographic location and quantifiable inflation related to the Covid-19 pandemic. The Easton CON application was submitted January 6, 2023, and approved January 18, 2024. The third and latest Easton Project Change Request was filed December 5, 2025, and approved February 19, 2026.

On pages 3 and 17 of the PRA, LHDC requests that $493,410 related to extraordinary cost as a component of their total request for $4.8 Million be included as a permanent increase to their GBR. In Table 2 on page 8 of the PRA, LHDC presents $11,085,215 as extraordinary costs, upon which they request depreciation and interest be passed through the capital policy without qualification. The components and related values presented are: Constrained Site $1,404,998, Green Building/LEED (Leadership in Energy and Environmental Design) Premium $4,169,973, Minority Business Enterprise (MBE) Premium $4,662,790, and Labor Shortage Premium $847,454.

Staff reviewed the MHCC staff recommendation dated May 15, 2025, in support of the MHCC final approval order dated May 20, 2025. On page 6 of the MHCC staff recommendation, it was noted that the discussion of extraordinary costs was limited to those costs to be segregated from the project budget before comparison with the Marshall Valuation Service (MVS) benchmark. These costs were used to identify any potential cost exclusions; however, no exclusions were identified. LHDC calculated a reduced building cost of $84,153,559 and a reduction for extraordinary costs of $32,854,853, leading to an adjusted cost of $51,371,210. MHCC staff calculated a building cost of $117,008,212 and a reduction for extraordinary costs of $47,982,047, leading to an adjusted cost of $69,026,365. The details of the MHCC list included 28 line-items which were estimates provided by LHDC. Four (4) of those cost estimates were subsequently used by LHDC in Table 2 of the PRA.

On a prima facie comparison of the Easton case and this case, Staff found more in contrast than in common. A "constrained site" is a piece of land or property with significant physical, legal, or environmental limitations that restrict its development, construction, or use. The Easton site is 200 acres of tillable farmland, which has no infrastructure to support development, while the LHDC site is on their own campus inclusive of known infrastructure. "Green building" refers to the practice of creating structures that are environmentally responsible and resource-efficient throughout their life cycle, from design to demolition. LEED is the most widely used, globally recognized

third-party rating system and certification program for these buildings. It is the judgement of Staff that the resources to achieve such certification are far more present and available in PG County, than in Talbot County where Easton is located. Minority Business Enterprise (MBE) refers to a for-profit business that is at least 51 percent owned, operated, and controlled by U.S. citizens from recognized minority groups (e.g., Asian, Black, Hispanic, Native American). It is also the judgement of Staff that the resources to achieve such participation are far more present and available in PG County, than in Talbot County. Labor premiums paid for labor shortages in construction projects vary significantly in Maryland by region and specific trade. While labor shortages are widespread, the intensity of a shortage and the corresponding wage premiums are higher in the central Maryland/Baltimore-DC corridor compared to rural areas. With regards to Easton, the premiums were in part associated with the potential to find hotel accommodations for labor residing west of the Chesapeake. The premiums paid are in part a function of the prevailing labor rates in and around the sites. A 10 percent premium in PG County will have a higher nominal value than a 10 percent premium paid in Talbot County.

Staff believe that the information provided to substantiate the selections of costs and the values assigned to the four line-items selected by LHDC from among the 28 line-items isolated by MHCC was insufficient, nor did it fall within the MVS benchmark, Staff has taken exception to the pass-through request and has excluded these items from the final recommendation.

Conclusion (Effective Financing and Markup):

Staff calculated the HSCRC Effective Financing percentage to determine the portion of a hospital's total capital costs to be funded through an incremental award to their GBR resulting in increased patient rates. The capital GBR award ($5,460,721) represents the final dollar amount approved after applying the Capital Financing Policy model inclusive of scaling adjustments. The model has led Staff to offer an award equal to 43.04 percent of the total incremental capital expense ($12,687,700) of the project, and 50.93 percent of the maximum ceiling permitted by the model ($10,721,604). This award also represents 125.2 percent of the value requested by LHDC ($4,363,245). The 43.04 percent effective financing rate indicates that while the HSCRC approves the project's award, the hospital remains responsible for funding the remaining 56.96 percent of costs through its own operations or reserves. Finally, applying the fiscal 2025 markup for LHDC of 1.1095 to the total capital award of $5,460,721 results in a total annual HSCRC capital award net of PAU and excess capacity scaling, and inclusive of markup, of

$6,058,798. The 1.1095 markup is a standard adjustment that converts the approved GBR award into the actual "charges" the hospital is permitted to bill, which makes allowance for governmental payers to be charged less as they do not create bad debt collection issues.

In conclusion, Staff recommend that LHDC be awarded a permanent increment to its GBR for capital expense related to this approved project of $5,460,721 (before the measurement of mark-up), or $6,058,798 (as measured inclusive of mark-up). Funding for this award will follow project completion and commencement of full operations.

ADDENDUM TO STAFF RECOMMENDATION

DATE: April 24, 2026

REGARDING: Evaluation of the LHDC Subsequent Communication dated April 17, 2026

Background Overview:

LHDC submitted an additional communication (subsequent to the preparation of the Staff Recommendation) in regard to their request that certain project-related costs be passed directly to the capital award without qualification and not be included in the capital policy model. Staff reviewed and evaluated this added communication for any new information.

Review:

Staff found no new compelling information that would cause Staff to isolate certain costs as direct pass throughs and not to be included in the policy model. Staff found no mathematical illustration of need to cover costs beyond the value of the policy model. LHDC provided no quantitative data in support of their claim that they are incurring costs beyond the staff's current recommendation. Without a detailed breakdown, their request cannot be vouched, audited, or otherwise verified.

Staff also found no evidence of costs exceeding that included in the project budget. To date, no Final Not-To-Exceed contracts have been shared with Staff that demonstrate costs exceeding the original bid estimates used to build the Project Budget as included in the CON. In the absence of evidence, there is no basis to adjust the funding upwards.

As reflected in the CON, the actual true out-of-pocket cost to LHDC is the initial cash outlay ($34,578,366) and the debt service (return of principal plus interest at 5%) on the MHHEFA bonds ($76,250,000). When spread over the assumed 30-year life of the bonds, these costs average $6,065,000 annually. The current capital methodology returns $5,461,000 annually (before markup), effectively covering 91% of the hospital's true out-of-pocket investment. Other sources include philanthropy and governmental grants. This 91% return on their out-of-pocket costs effectively ensures institutional "skin in the game," while also incentivizing the greater use of gifts and grants.

LHDC's added request focuses on the use of the term "Extraordinary." As noted in the Staff Recommendation and as applied to this review, this term has two different uses. As used in the MHCC CON reviews, "Extraordinary" refers to items present within the project budget that are atypical of standard hospital construction projects and are omitted solely for Marshall Valuation Service cost-standard comparisons. And then as used in the Easton project capital request, "Extraordinary" refers to items so unique, unusual, and infrequent, that they should be held apart from the capital policy model. However, with respect to this project and the resources available at its respective site (located between and in proximity of the state's capital and the nation's capital), it is Staff's judgement that the approved capital policy model appropriately provides interest, depreciation, and amortization of the full $210,828,000 CON project budget. Staff have found no evidence of capital costs not appropriately covered by the policy model.

Conclusion:

The Staff Recommendation remains unchanged.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

May 13, 2026

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	2506
BALTIMORE, MARYLAND	*	PROCEEDING:	2696A

I. INTRODUCTION

On April 27, 2026, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospital, Johns Hopkins Hospital (the "Hospital"), for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with self-pay patients for gender affirming consult and procedure services. The Hospital requests that the Commission approve the arrangement for one year beginning July 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between JHHC and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price

contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that no activity has been reported under this agreement; however, Staff believes that the Hospital can achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with self-pay patients for gender affirming consult and procedures services for one-year beginning July 1, 2026. The Hospital must file a renewal application annually for continued participation.

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

May 13, 2026

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	2507
BALTIMORE, MARYLAND	*	PROCEEDING:	2697A

I. INTRODUCTION

On May 1, 2026, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning June 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been unfavorable. The Hospitals and JHHC have renegotiated contract terms, and Staff believes that the Hospitals can achieve a favorable performance under the new arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination with Aetna Health, Inc. for solid organ and bone marrow transplant services for one-year beginning June 1, 2026. The Hospitals must file a renewal application annually for continued participation.

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

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Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from Maryland Department of Health, Developmental Disabilities Administration

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the May 13, 2026, Public Commission Meeting.

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SUMMARY STATEMENT

Maryland Department of Health, Developmental Disabilities Administration (DDA) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC). This access is necessary for the Medicaid Data Correlation Audit Review, a quarterly process conducted by Liberty Healthcare Corporation, contracted by DDA, to evaluate the timeliness and completeness of incident reporting. The DDA intends to use the hospital data from the Maryland All-Payer Claims Database to confirm adherence to policy and drive continual quality improvement initiatives.

OBJECTIVE

The primary goal of this project is to gain valuable insight into hospital utilization patterns among individuals receiving DDA services. Specifically, by examining trends in emergency room visits and unplanned hospitalizations, the DDA will identify systemic issues and opportunities for improvement. The ultimate aim is to enhance service quality for individuals with developmental disabilities by increasing coordination, reducing preventable hospitalizations, and supporting data-driven policy decisions that strengthen accountability and transparency across Maryland's healthcare and disability service systems.

DDA received approval from the MDH Strategic Data Initiative (SDI) office on April 10, 2026.

(The Data will not be used to identify individual patients. The Data will be retained by Maryland Department of Health, Developmental Disabilities Administration *until project completion in 2027. At that time, if the agreement is not renewed, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)*

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

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

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

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

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by Maryland Department of Health, Developmental Disabilities Administration be approved for the FY2025 Data.

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

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Germantown Emergency Room Closure

Final Recommendation

May 13, 2026

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Table of Contents

maryland
health services
cost review commission

Overview and Hospital Request

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

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

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

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

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

Background

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

approximately 4,500 were Level 1 and 2[1], indicating they were for minor injuries and events of low complexity. It is assumed that many of these visits could be treated at an urgent care or primary care location. The remainder of the FY2025 visits were spread across Levels 3 to 5 with the bulk of them, about half the total being Level 3. It is assumed these visits will shift to local hospitals.

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

Community Input

As part of its planned closure process, Adventist solicited community input and held a public informational hearing on April 14, 2026, to discuss the closure with the community. During the hearing, Adventist staff explained the rationale for the closure and the changing healthcare landscape in the Germantown area, citing the addition of Shady Grove Medical Center, multiple nearby urgent care centers, declining patient volumes at GEC, and expanded patient care resources at SGMC. Montgomery County Department of Health and Human Services (MCDHHS) and Montgomery County Emergency Medical Services (EMS) attended the public hearing in support of Adventist's proposal. A recording of the meeting, presentation materials, and a summary letter from the informational hearing have been made publicly available, and the summary letter is included as an appendix to the staff recommendation.

At the March 11, 2026, HSCRC public meeting, Dr. Nina Ashford of the MCDHHS also provided input regarding the proposed use of the $2 million in annual savings for community reinvestment. MCDHHS recommended strengthening primary care safety-net programs that serve uninsured residents of Montgomery County, including Montgomery Cares and Care for Kids. In addition, MCDHHS emphasized that investments should both reinforce primary care capacity and expand access to urgent care services for low-acuity needs, with the ultimate goal of reducing reliance on emergency departments. HSCRC received a letter of support for MCDHHS's proposal from the Montgomery Care Advisory Board (MCAB), which is included as an appendix to this recommendation.

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

Analyses

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

Table 1: Proposed Redistribution of GEC Global Budget

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

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

- Only permanent revenue is included in the shift; all non-permanent amounts will lapse.
- 85 percent of Level 1 and Level 2 services and 100 percent of Level 3 through 5 services are assumed to shift from GEC to SGMC and HCG. The assumption of the dissipation of 15 percent of Level 1 and Level 2 services to non-hospital settings is consistent with assumptions in prior closure adjustments. Typically, 5 percent overall dissipation is assumed. For this purpose, Staff are assuming that dissipation is concentrated in Level 1 and Level 2. There is a small cost associated with the provisions of the dissipated services in non-hospital settings. This analysis only focuses on the hospital setting and that cost is not factored into this analysis. Of the shifted services 85 percent is assumed to move to SGMC with the remainder to HCG. This split is subject to further review and will true up on a retrospective basis during the normal market shift process. See further discussion in the contingency section.
- Shifted services are funded at the variable portion of the cost per ECMAD at the receiving hospital,

consistent with the normal market shift approach. The variable cost factor applicable to these services is 54 percent.

- Savings are split 50:50 between the closing system (Adventist) and payers, consistent with prior Commission approaches. Adventist has discretion on the use of these funds, but it is the expectation of the Commission that they be used to meet other health needs of the community such as the expansion of access to other hospital services.
- Staff are recommending the redirection of $2.0 M annually of payer savings to Montgomery County for the provision of services that meet the health needs of the community and the historic users of GEC for the first 10 years after the closure. This redirection to community investment is consistent with the arrangements of prior closures. See further discussions in the contingencies section.

Contingencies

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

- Staff are in the process of reviewing with HCG representatives the assumptions behind the prospective split of shifted volume of 85:15 between SGMC and HCG. This split may be revised if, in the judgement of Staff, HCG raises issues that point to a different prospective split being more appropriate.
- Regardless of the final prospective split, the shifted amounts will be adjusted retrospectively under the market shift, as described in Appendix A of this recommendation. Such retrospective adjustments may result in funding being shifted to hospitals other than SGMC or HCG.
- While initial discussions have been held regarding the disposition of funds to Montgomery County and proposed investments are outlined briefly in the Community Input section of this report, final terms have not been agreed upon. Staff will work with Adventist and the representatives of Montgomery County to develop terms that are agreeable to Adventist, the HSCRC, and Montgomery County. Should such an agreement not be reached, Staff will return to the Commission with an amended recommendation.

Reporting Requirements

Staff recommend periodic reports on use of funds and their impact on relevant health metrics related to use of GEC closure funds:

- **Report on Adventist Funding Use:** Staff propose reviewing the impact of the closure and use of savings retained by Adventist one year and three years after GEC's closure. The report should include a narrative description of the use of retained savings prepared by Adventist and a

discussion of the impact of the closure on relevant emergency department performance metrics (e.g. diversion rates, length of stay). Adventist shall submit information to HSCRC, as requested, and Staff shall prepare a final report by December 31, 2027, with an update by December 31, 2029.

- **Report on MCDHHS Funding Use:** Contingent upon the disposition of funds to MCDHHS, Staff recommend reviewing the use of the funds and their impact on affected populations in Years 1, 2, 4 and 7. The Year 7 report shall be used to determine whether continued investment beyond 10 years is warranted. The HSCRC will work with MCDHHS and Adventist to submit materials by December 31 of the relevant years.

Recommendations

The HSCRC staff makes the following recommendations:

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

Appendix A: Retrospective Market Shift Reconciliation Process

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

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

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

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RE: Summary of Public Informational Hearing Regarding the Closure of the Adventist HealthCare Germantown Emergency Center

Dear Honorable, elected, and appointed government officials:

Pursuant to Maryland Code, Health-General §19-120(l)(1) and Code of Maryland Regulations ("COMAR") 10.24.01.03(C) and 10.24.01.04(D), this letter and the accompanying enclosures provide a summary of the public informational hearing held by Adventist HealthCare ("AHC") in connection with its notice of intent filed with the Maryland Health Care Commission (the "Commission") to close the Germantown Emergency Center (the "GEC") located at 19731 Germantown Road, Germantown, MD 20874.

As background, AHC began operating the GEC as a freestanding medical facility in 2006 in order to fill a gap in emergency care in the upper Montgomery County area. Since that time, many other providers have joined AHC in serving the needs of the community. For example, there are now eight (8) urgent care sites within a five (5)-mile radius of the GEC. As a result of this growth, the GEC has seen a steady decrease in volumes and case acuity. Volumes have decreased by more than a third from the peak of 36,000 patients in 2011. In addition, most patients coming to the GEC are Level 1 or 2 acuity on a scale of 1 to 5 with conditions that are more appropriate for a physician office or urgent care center than a full-service emergency department. Further, the GEC is only receiving an average of four (4) ambulances per day. AHC has consulted with community partners, such as the Maryland Institute for Emergency Medical Services Systems and Holy Cross Germantown about the impact of a closure of the GEC on the community served. In addition, AHC has been in contact with and participated in a review by the Maryland Health Services Cost Review Commission about the closure of GEC under the rate-setting process.

Due to the changing patterns in the GEC's utilization, AHC plans to focus its efforts on the current needs of the community and how it can best serve the residents. The GEC has always been an extension of Shady Grove Medical Center ("SGMC"), which remains ready to care for patients who need emergency services and advanced care. SGMC will be opening a new patient tower on June 14, 2026. While the new tower is unrelated to the GEC closure, the new building will allow SGMC to provide state-of-the-art care to residents who currently utilize the GEC as it includes a modern Emergency Department with private bays, improves the flow of emergent cases, and allows for rapid movement of patients based on clinical needs.

With regard to the physical facility, AHC currently leases the space where the GEC is located with the lease expiring in mid-2027. AHC will maintain a security presence at the location and any sensitive medical supplies, like medication and equipment, will be removed immediately after the GEC closes. All other AHC services located at the site will remain open, including AHC Outpatient Imaging, Cardiac Associates offices, and Adventist Medical Group physician offices (located in the adjacent medical professional building).

Fifty AHC team members will be impacted as a result of the closure of the GEC. AHC has met with each affected team member individually to discuss opportunities for transition and offered each a new position throughout the AHC health system. As of the date of this letter 66% of the impacted GEC staff have either accepted new positions within AHC or are in the process of doing so.

The last date of care at the GEC will be June 30, 2026. The GEC will continue to be fully operational and staffed until that date.

On March 20, 2026, AHC filed a notice of the closure of the GEC with the Maryland Health Care Commission. Maryland Code, Health-General §19-120(1)(3) states that the Commission may require a health care facility other than a hospital that files a notice of a proposed closing to hold a public informational hearing in the county where the facility is located. The public information hearing must address: (1) the reasons for the proposed partial closure; (2) plans for transitioning

acute care services previously provided by the hospital to residents of the hospital's service area; (3) plans for addressing the health care needs of residents of the hospital service area; (4) plans for retaining and placing displaced employees; (5) plans for the hospital's physical plant and site; and (6) the proposed timeline of the partial closure.

On March 18, 2026, AHC consulted with Commission staff about the closure of the GEC and the Commission staff indicated the Commission would require a public informational hearing. As a result, AHC held a public informational hearing on April 14, 2026, beginning at 5:30 p.m., at the BlackRock Center for the Arts located at 12901 Town Commons Drive, Germantown, MD 20874. Notices regarding the hearing were posted in the Washington Post, the AHC home page and the GEC landing page of AHC's website. Within ten (10) business days of holding the public informational hearing, AHC is required by statute and regulation to provide a summary of the hearing to each of you. Below is the summary which will also be posted on AHC's website as required:

> Adventist HealthCare ("AHC") held a public meeting on April 14, 2026 at the BlackRock Center for the Arts located at 12901 Town Commons Drive, Germantown, MD 20874 to discuss the closure of the Germantown Emergency Center ("GEC"). The public informational hearing was hosted by Daniel Cochran, President of AHC's Shady Grove Medical Center ("SGMC") and Todd Cohen, AHC Vice President of Facilities at Real Estate. Also present at the hearing was AHC Board Member Dr. Safy John, a critical care physician, along with other AHC health system leaders.
>
> Mr. Cochran discussed the reasons for the closure of the GEC due to significant changes in Germantown's healthcare landscape, including the addition of a hospital and abundant urgent care centers which are all located within a 5-mile radius of the GEC, as well as the decrease in the volume at the GEC. He explained that AHC was thoughtful in its decision to close the GEC and remains committed to serving the community and meeting its healthcare needs. Mr. Cochran discussed that emergency care will continue at nearby hospitals, including SGMC, and that EMS already transports higher acuity patients directly to full-service hospitals. He further noted that the opening of a new patient care tower at SGMC will help improve efficiency and throughput of emergency room patients.
>
> Mr. Cochran highlighted that AHC values each team member who has made the GEC a trusted healthcare provider in the area, noting that a majority of the GEC team members have been offered, applied for or are working with AHC on new roles within the health system. Mr. Cohen then discussed the plans for the GEC's physical space and noted that other AHC services in Germantown, such as imaging, primary care, and cardiology, will remain open. Mr. Cohen stated that the GEC would remain open and available to fully serve the community until its closure on June 30, 2026.

Montgomery County health officials in attendance at the meeting also highlighted ongoing collaboration with AHC to ensure patients, especially uninsured residents, can access appropriate levels of care, through strengthening connections to primary care, urgent care, and alternative care pathways through EMS coordination.

The meeting concluded with questions from attendees about access, wait times and services along I-270. Each question was answered, AHC leaders reaffirmed their commitment to continued community engagement and care access, and the meeting ended as there were no more questions.

A complete transcript of the public informational hearing prepared by Apple Voice Memo, verified against a video recording for accuracy, is enclosed as Exhibit 1 and a copy of the electronic slide presentation presented by Mr. Cochran and Mr. Cohen is enclosed as Exhibit 2. AHC has made a recorded video of the public informational hearing on its website available since April 20, 2026, which will remain posted until the closure of the GEC on June 30, 2026. A link to the video may be found at: https://www.adventisthealthcare.com/locations/profile/germantown-emergency-center/. Please feel free to contact us if you have any questions regarding the public informational hearing or the enclosed materials.

Respectfully submitted,

Nivedita Patel

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EXHIBIT 1

Adventist HealthCare
Shady Grove Medical Center

TRANSCRIPT:
Public Informational Hearing Regarding
Closure of the Germantown Emergency Center
Tuesday, April 14
BlackRock Center for the Arts
Germantown, Maryland

Dan Cochran, President, Adventist HealthCare Shady Grove Medical Center:
Good evening. Good evening. Want to thank you for coming as we talk about the Germantown Emergency Center and the changes that are coming, and, uh, my name is Dan Cochran. I serve as the president for Shady Grove Medical Center. I've been there for 15 years, so I've been there for quite a while, and been around the community for quite a while. Joining me today is Todd Cohen, who serves as our vice president for facilities, and also Dr. Safy John, who is one of our system board members. So I wanted to take the opportunity to talk about what's happening in Germantown, the emergency center, and what we're gonna do to follow up to make sure we're providing the level of care for folks in the community, and everybody has what they need as we go through this process. I do want to start, though, by saying the team at the emergency center in Germantown is really a top notch team. They have, for 20 years, provided exceptional care to this community, and we're very proud of the work they've done, and we know that the community is very happy with the work they do. We see that in our patient experience scores. We see that, and hear that from the community all the time, about, really, the care that's provided in Germantown, how it's provided, the interaction with the team members there. So I just want to take the opportunity to let you all know how much I appreciate that team, and really how much that team has given of themselves over the past 20 years while serving the community.

This is probably, in my 15 years, at Shady Grove Medical Center, one of the most difficult decisions that I've been part of. As a leader of the organization, I never want to close something or have something go away, especially something as special as what's at Germantown in the Emergency Center. But there are a lot of issues and topics, and I'm going to go through some of them to explain why we're doing what we're doing. But it doesn't, even knowing the business or other decisions, factors that go into it, doesn't make it easier. We know we are taking away something the community relies on and has used

significantly for years, and we're changing what's happening for the employees that are there. And I'll talk a little bit about that as well.

First, I want to talk about the center itself. The center opened in 2004, five, somewhere in that range. And it opened as a pilot program within the state system. So, originally, when it opened, it was the only healthcare provider of emergency services between Shady Grove and Rockville and Frederick Health in Frederick. So what was a 30 mile gap of care, obviously, we put that emergency center in there. Since its opening, the healthcare landscape has changed pretty significantly within the Germantown area. Obviously, Holy Cross Health has built a hospital there, just less than two miles away from the Germantown Emergency Center, as well as there have been a number of urgent care centers that have opened up in the area. There are now 8 urgent care centers within a 5 mile radius of the Germantown Emergency Center. So all of that between the hospital opening, all those urgent cares, has dropped the number of visits that occur at that center from 36,000 to 22,000. So, clearly not used to the extent it was for the first several years of operation. What's also changed is the acuity of the patients that we see there. The acuity has become much more aligned with what an urgent care would see rather than an emergency center. So as we look at the patient volume and look at the patient needs and evaluate that compared to other needs for patients, we're trying to decide what's the best way to manage that and address needs of our community. And then we see about four or five ambulances a day there. And right now, that's not a lot that's, you know, much less than any of the hospitals see. And typically, those are patients that don't have high acuity needs as well. Anybody that has a life threatening emergency or urgent need is gonna go to the closest hospital that has the services, full services that they can be provided. For instance, if someone has a stroke and needs a thrombectomy, which is a removal of the clot, they're gonna be taken already from this area to Shady Grove Medical Center for that procedure. So it's not something that would be done, or the ambulance would even take somebody, the Germantown Emergency Center for. Similarly, a heart attack victim, the same issue, would go to a STEMI site, again Shady Grive medical center for that, rather than going to the emergency center here. So all of that played into, really, what's happening in the atmosphere around, and really global atmosphere around the center.

We talk about our team members, which I mentioned, who are just an absolutely wonderful group of people. We want to make sure we take care of them. They have been taking care of the community for 20 years. We want to take care of them. We want every one of them to come and join us at Shade Grove Medical Center or another location with Adventist HealthCare. We have about 50 members that are employed at the Germantown Center, and of those, I believe at this point, we only know of 5 that have chosen to go, either retire, a couple of them are retiring, and a couple have chosen to go elsewhere. Most of the rest

either already have received job offers for other jobs within our system or are going through that process right now. So our goal is to keep as many of those people employed with Adventist HealthCare as we can, and that's what we're trying to do. But clearly, we want to make sure that we take care of the team members there that have been taken care of the community.

Germantown Emergency Center has always been part of Shady Grove Medical Center. And Shady Grove Medical Center provides the support to the center there. It is also the place where anybody from there that needs further or additional services would be sent to. And we will continue to provide all those services to all the community members from Germantown that need to be hospitalized, especially for those life threatening type of things. We will be there. The hospital is about nine miles from the Germantown Emergency Center. So we've got Holy Cross hospital that's two miles away, and Shady Grove Medical Center that's nine miles away. So, from a distance perspective, for any life breathing thing, EMS is already going to those two locations, not the Germantown Emergency Center. So won't impact there. Probably the biggest impact we'll have is on turnaround times. And I know waiting for emergency care is an issue, and it's something we need to address. And we're doing a number of things as we work through this. I'll get into that a little later, in order to help with that process, to make sure we're able to get our ambulances turned around, so they can be on the road, but also providing care to patients that may not have another option for, especially for primary care and today, people rely on that emergency center for a lot of things that many people would go to a primary care physician for. So there are some things that we'll be working there. And I have to say that we're working with the community on how to do that. We're working with the Department of Health and the county with that. We're working with the Primary Care Coalition with that, and we're certainly working with our emergency medical services providers in order to make sure we're getting the right care to the right patients at the right time, in the right setting. I think that's one of the things, as we work through the process, is to make sure we can get patients to the right level of care that they need for whatever they have an issue for at the moment.

So, we have been undergoing for the last 3 years a construction project at the hospital itself, Shady Grove Medical Center. This addition will add a larger emergency department with all private rooms within the emergency department. It will add a new intensive care unit, a new progressive care unit. It will also add a fourth floor, which is the med surg unit, which is our stroke unit. So all of those services will be in the new tower, offloading the space they're in now, allowing for all of our critical care and higher acuity services to be together, which makes it easier for getting patients from where they need to be, to where their procedures are, as the cath labs that I mentioned earlier, whether it be for stroke care or heart attack care, are also in this tower. So all critical care services will be located in this

tower. And then we'll be able to open up additional space for observation and other things in the existing ED, as we do that, which will allow for movement of patients to make sure that throughput, so people aren't waiting as long to get, to see their care providers within the hospital.

So as we talk about the needs of the community, obviously, we're taking away something that community has relied on for many years, but we want to make sure that we continue to be a provider in this community. We're not leaving the community. We will continue that primary care here. We will continue to have cardiologists here. We will continue to have our imaging centers here. So those will all continue. We're actually evaluating other services to bring into the community that meet the needs of the community, that make sense for what the environment, the healthcare environment is today, as we see it.

So, Todd, do you want to talk a little bit about what's happening in the building?

Todd Cohen, Vice President for Facilities and Real Estate, Adventist HealthCare: Sure. So, um, my name's Todd Cohen. I've been at Adventist for about 12 years, and I serve at the system level as the vice president for Facilities and Real Estate. Um, the, the, the unique thing about the Germantown Emergency Center is that it's in a leased environment. So, whereas in the hospitals where it's an owned asset, in this case, the Germantown Emergency Center is in a leased campus. So this is important because people are asking us questions about what will come in behind it. And we're exploring that. We're not quite sure what wants to go there, in terms of a clinical delivery system. We know that the imaging center, which many people rely on in the community, will stay. The lease there runs through '27, at least the middle part of '27. So right now we're in a period of reevaluating and trying to understand what might want to go there.

As Dan alluded on the last slide, there is a bit of an ecosystem of different services that are offered here in Germantown. We have Cardiac Associates, that's in the building adjacent, the imaging center, as I talked about, and our clinically integrated network offering through our Adventist Medical Group, is also in the building next door. So those offerings, those different practices will stay. Um, We'll keep the lease for now, as I said. And you know, the transition from having an emergency department on the campus and closing it means there are some security and some reinforcement, um, especially as people relearn how to access the health delivery system. So we'll have security in place. And when we close, um, and transition from the center, you know, people have asked us a lot of questions around, how's that, how that's done logistically. The center will be, all the material, all the medications, all the equipment will be taken out. We'll be repurposing that and or staging it for storage. So, um, again, the idea is that we're transitioning out, we're moving and

focusing our efforts at Shady Grove Medical Center proper in Rockville, but the leased presence will continue into ‘27. Dan?

Dan: Thanks, Todd. So, as we talk about the Emergency Center, obviously one of the things we want to do is make sure that we're taking care of everybody in the community. I've had conversations with leadership at Holy Cross Health. I've had conversations, obviously, with EMS, um, with the, and I would say the biggest concern for EMS is the turnaround times to make sure that we're not developing something that's gonna delay them in any way. And that's where the new tower comes in, because we'll be able to arrange things that will allow us, with that space, to have a faster throughput. And, again, the staff that is here will be coming down to the Shady Grove Medical Center, so we'll have additional staff within the emergency department to accommodate those additional patients that come through as well. And then the other piece of that is making sure that we're providing care to community members that, because they don't have any other mechanism to get healthcare, maybe going there for primary care, and in that case, we're working with the County Health Department, Primary Care Coalition, and others, to make sure that we've got some mechanism to provide that level of care and make that available to them.

So those are some of the ways that we're trying to make sure we take care of everybody that needs to be taken care of. And as we go through this process, what we're looking at, obviously, as we close this, making sure there's a mechanism to take care of all of the patients that were currently being seen there, but also to expand services, which allows us to actually increase some of our surgical services and other things at the hospital because of the changes that are occurring. So that's, again, one of the other impetuses to do this, is to we right now have surgeries that are being delayed because we don't have staffing and ability to take care of those. We'll be able to, again, get those resources realigned to really speed up the time it takes to get surgical patients through that are requiring surgery, especially oncology and those types of surgeries. So, as a reminder, June 30th at 11:59 will be the last point in time that we operate at the emergency center, and at that point in time, we'll close it down. So it will remain fully staffed until then, and providing all the services it always has. Obviously, wanted to give you an overview, wanted to answer any questions anybody may have, but also want to reiterate what I said about the team members there, that they have been, you know, provided just exceptional care over the past 20 years, and we're really trying to do all we can to take care of them in this process as their lives are obviously being upset. And some of them, you know, it's a change from where they go to work every day, which everybody, you know, has to understand that. And we certainly understand that and want to do the right thing by each and every one of them. But I want to open it up here if you have questions, comments, if there's any specific concerns you may have, or for my team, if there is anything specifically that I may have missed, that you

wanted to make sure we shared as well. I would ask that anybody that's gonna ask a question if we can get you to do it at the microphone, although it's not a crowded room, we want to make sure we pick up the voices for the recordings that we're doing. So, please, Yes, sir.

Audience Member #1:
So, basically, the center's gonna be closed?

Dan: Yes.

Audience Member #1: Okay, so I can't go there for anything. But the building next door, there's doctors who are established there.

Dan: Yes.

Audience Member #1: And people can go there?

Dan: Yes.

Audience Member #1: But they're not going to be associated with the center at all because it's going to be gone. But there's an imaging there, too?

Dan: There is. So the physicians that are in the building, most of them are on staff at Shady Grove Medical Center, and they will continue to be affiliated with Shady Grove Medical Center.

Audience Member #1: Okay, I didn't know that. Okay.

Dan: So all the physicians are remaining in that building, including the cardiologist, primary care, and the imaging center that's in the emergency center itself will also remain open.

Audience Member #1: Okay, but that front door, that'll be closed.

Dan: There's two entrances. The one that goes into the emergency side will be closed. The other side, imaging, you'll be able to go to and the office building with all the physician's offices you'll able to use.

Audience Member #2: Hi, my name is Jack Kern. I used to work for Oxford Development Company and other companies doing a lot of this kind of work, so the natural questions I would ask is, number one, we live right near here, and there's an awful lot of stuff going on in Clarksburg, and an awful lot of stuff, even more than that, going on in Frederick. And when we used to build a lot of apartments and we built a lot of healthcare, and we must have built a lot of medical facilities, one of the things that we noticed was that the whole corridor for 270 was supposed to get much bigger than it is, and it was supposed to be much better. So, consequently, if you live up in this area, and you have a really bad need in

a hurry, you gotta go to Holy Cross, even though we would prefer to go to you guys. As a consequence of the fact that once you get on 270 southbound, that's about a half hour, 45 minutes to go two miles an hour to be able to get down to where your facility is. Are there are other things that you guys could be doing to take advantage of the fact that there's lots of land available between here and Frederick to build a much more sophisticated set of facilities, and also, is there the capacity to be able to do things that are going to be able to help with, what are a lot of very elderly people in this area that are going to be moving to certain kinds of facilities, and when they sell their houses, most of them are moving out of Maryland. Other than that, thank you very much. I think you guys do a great job. I've had personally good experience going over to your facilities.

Dan: Thank you for sharing that. And I think from the perspective of other services, we are evaluating the potential of other services to go into that center. Some discussion about orthopedics and other areas that would allow for support for people in the community. That has not been finalized yet, but we are absolutely evaluating what other services. And we're going through a data driven approach to that, to understand all the demographics of the area, and what are those medical services, and where's the right place for them? Because it may not be right in that building. It might be a couple miles north to break that up. So we are looking at that right now. Thank you.

Anybody else have any questions or comments or concerns? I'll ask if anybody from the Department of Health, or EMS wants to say the same thing, or anything to...

Dr. Nina Ashford: Hello, Dr. Nina Ashford, I'm the chief of public health for Montgomery County. Just want to reiterate, um, what Dan said. We have been working very closely with our Adventist colleagues, Katie and team, and then the entire EMS and Adventist team on how do we identify — as we know that the Germantown Center is closing — a solution that will help alleviate some of the potential backlog in the other facilities. So we have been very thankful to Adventist for their partnership and the potential community health transformation investment into the safety net, looking at, particularly, for our uninsured clients, how do we get them access to lower acuity settings like urgent care, which they don't currently have access to, even though they all have medical homes available to them through Montgomery Cares and Care for Kids. But also working with some system level innovations with EMS and Ben and his team about how do we implement ways where if folks don't need to go to the emergency department, we can help them with that decision and get them to the right acuity setting at the right time. So, we're excited about the, it's never easy when an emergency department or a facility closes, but we are excited about the broader community health transformation opportunity that this provides for the county and the partnership that we've had. So, Dr. Davis would you add anything? No?

Dan: Thank you, Dr. Ashford.

Yes?

Audience Member #3: Hi, my name is Jodi Kern. I'm married to the guy back there. What is the current wait time at the emergency room at Shady Grove? I mean, I have been in there at various times where you have anybody, and everybody, and all kinds of things, and my recollection was often a 4 to 6 hour wait time, which, when you get to be our age, that could be a lifetime. So I'm just wondering what it is currently and what you anticipate it might be with the new tower and the, you know, the renovated space.

Dan: Dr. Roy, do you know offhand what the time is?

Sorry, if you could use the ...

Jody: I'll let you have the mic.

Dr. Neil Roy: Yeah, hi there. My name is Neil Roy. I'm the chief medical officer at the Shady Grove Medical Center. I'm an emergency room physician. I worked at the Germantown Emergency Center this past Sunday, and I work in both of our ERs every week. But right now, for the past two years, the Shady Grove Medical Center has really undergone a transformation, in the speed at which they're taking care of patients in our emergency department. About four years ago, that was accurate. The typical wait time, the median wait time, would be two or three hours. And during the worst part of the day, it would be longer. Now, we're in the top five hospitals in the state, in terms of the time it takes to be seen. And more importantly, the total length of stay you'll be in the hospital. Our median time, when we walk through those doors, when you leave, is under three to four hours. And that's the whole visit, including imaging and diagnosis, and being evaluated. Now, we're still working on it, and the beauty of our new tower is that the way it's laid out, having a CAT scanner in the department, having additional services in the emergency department, allows the patients that are being taken care of to be taken care of in a faster way. And we're building in processes to make sure that even if EMS brings you in, your workup gets started as soon as you're brought in and taken off of that ambulance stretcher, right away. That's a very good question. Thank you.

Dan: Any other questions, comments? If any of you have questions or comments that you would like to give individually, I'll be around for a little while, and certainly would entertain that if you want to talk about anything related to the Germantown Center or Adventist HealthCare. I do want to thank all of you for coming. The intent here was to make sure we provide an explanation of what's happening, why, what else is gonna be doing on in the service area, and how we can make sure that we continue to provide excellent service to the residents of Germantown and our entire service area. But that is the end of the actual

formal presentation. So if nobody has any additional questions or comments, we can let everybody go. But I'm happy to answer any individual questions if you would rather ask them that way as well.

Audience Member #4: Thank you for sponsoring this — very helpful and very much appreciated. Thank you.

Dan: You're welcome. Thank you.

Very good. Thank you.

— END —

EXHIBIT 2


Adventist
HealthCare

GERMANTOWN EMERGENCY CENTER:

Closure and Refocusing Care Upcounty

A COMMUNITY CONVERSATION | APRIL 14, 2026

Adventist HealthCare

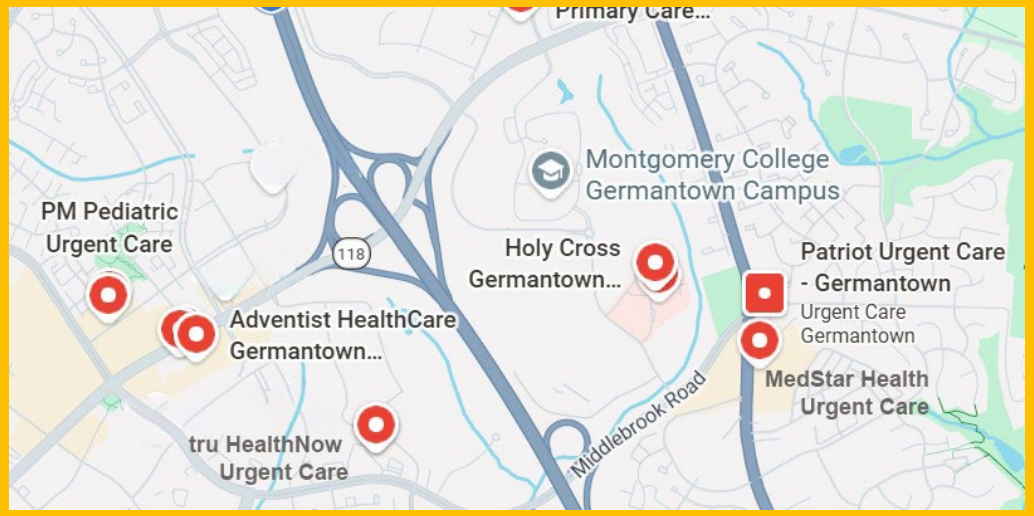
Reasons for Closure

Declines in Volumes and Lower Acuity as Alternative Care Sites Grew

DROP IN ANNUAL CASES FROM 2011 TO TODAY

36,000

22,000



4

AMBULANCES PER DAY

Adventist HealthCare

Our Plans for Center's Team Members

We Cherish Them, Too!

Adventist HealthCare

Our Plans to Transition Care

American Heart Association.
STROKE
2025
GOLD PLUS
TARGET: STROKE HONOR ROLL ELITE
TARGET: TYPE 2 DIABETES HONOR ROLL
GET WITH THE GUIDELINES.

American Heart Association.
CORONARY ARTERY DISEASE
STEMI RECEIVING
2025
BRONZE PLUS
GET WITH THE GUIDELINES.

American Heart Association.
CORONARY ARTERY DISEASE
NSTEMI
2025
BRONZE
GET WITH THE GUIDELINES.

American Heart Association.
RESUSCITATION
2025
BRONZE
GET WITH THE GUIDELINES.

healthgrades.
AMERICA'S 100 BEST
ORTHOPEDIC SURGERY
2026

NATIONAL DISTINCTION OF EXCELLENCE
HeartCARE Center
AMERICAN COLLEGE of CARDIOLOGY
2026

AACN Beacon Award FOR Excellence™

spn
Pediatric Excellence
PLATINUM

Adventist HealthCare

Horizon Tower Opens June 14

- *Larger, modernized Emergency Department*
- *State-of-the-art Intensive Care Unit*
- *Stroke Medical-Surgical Unit*
- *All-private rooms*
- *Related units are stacked for efficiency and better throughput*

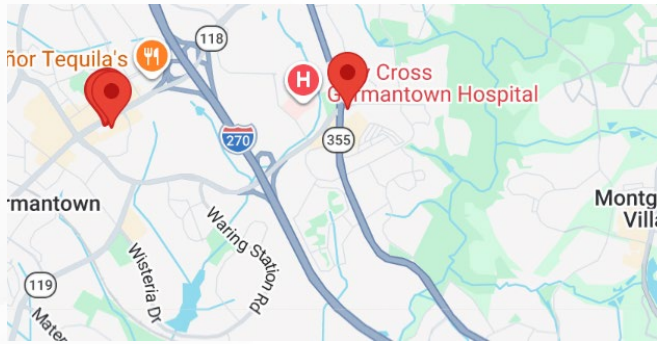
Adventist HealthCare

Continuing to Care for Upcounty's Needs

Several Adventist HealthCare Services Remain in Germantown

Adventist HealthCare Imaging

Adventist HealthCare
Adventist Medical Group



Heart & Vascular Institute

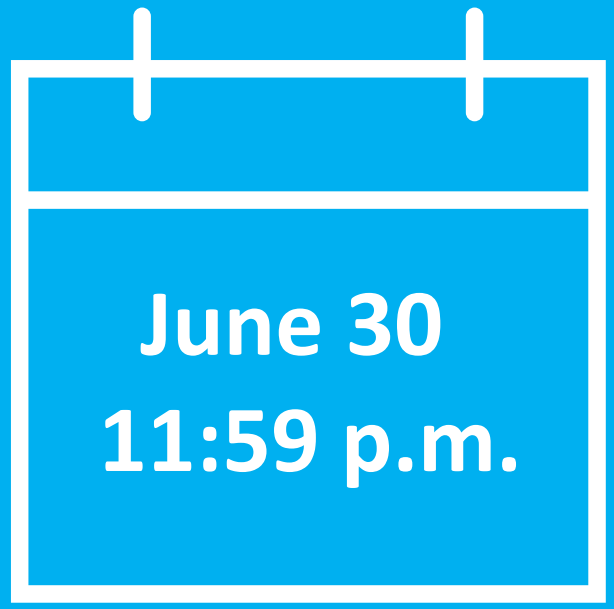
Adventist HealthCare

What Will Happen to the Building?

Adventist HealthCare

Timeline for Center's Closure

Full-service care remains at the Center through



Adventist HealthCare

Answering Your Questions

Adventist HealthCare

AdventistHealthCare.com

MONTGOMERY CARES ADVISORY BOARD

April 23, 2026

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

Dear Mr. Jonathan Kromm:

On behalf of the Montgomery Cares Advisory Board (MCAB), I am writing in support of the Montgomery County Department of Health and Human Services' proposal to reinvest into the healthcare community in anticipation of the upcoming closure of the Germantown Emergency Center (GEC). MCAB's mission is to advise and recommend policies that ensure access to high quality, efficient health care and related services for low-income, uninsured, and underinsured Montgomery County residents. The Board's purpose of overseeing equitable resource expenditure for some of our most vulnerable populations gives us a unique perspective on the health needs of the residents of Montgomery County.

The Montgomery County Department of Health and Human Services is proposing that $2 million in savings from the GEC closure be reinvested into strengthening the connection between our Montgomery Cares and Care for Kids clients and sustainable primary care.

The proposal aims to decrease unnecessary emergency room utilization by strengthening bonds to primary care through:

- **After-Hours Nurse Triage:** Providing weekend and evening guidance to direct clients to the most appropriate level of care (Primary, Urgent, or ER).
- **Community Health Workers:** Dedicated staff to facilitate primary care follow-ups and address social determinants of health.
- **Urgent Care Coverage:** Funding for urgent care visits when authorized by triage nurses.

MCAB provides guidance and oversight of five key programs for low-income, underinsured, and uninsured County residents. Montgomery Cares, Care for Kids, Montgomery Perinatal Program, County Dental Services and the Healthcare for the Homeless. Through this work, MCAB has seen the positive impacts that result from investing in safety-net health services and the ways that the Montgomery Cares and Care For Kids programs have revolutionized healthcare for the uninsured in Montgomery County. MCAB supports the Montgomery County Department of Health and Human's reinvestment proposal for the following reasons:

- **Primary Care and Prevention:** Montgomery Cares and Care for Kids programs provide access to high quality primary care and related services for uninsured adults and children in Montgomery County through a network of community-based primary care provider organizations. These programs are essential in maintaining the County's safety-net by providing essential services to the County's most vulnerable residents who may otherwise have no other means for accessing care. Last year, the Montgomery Cares program served around 25,000 individuals and the Care For Kids Program served around 11,000 individuals, approximately 37% of the County's uninsured population. Strengthening local primary care access is the most effective way to keep residents out of the emergency department. The programs allow participants to establish medical homes and access routine and preventive care, such as screenings and medication refills, ultimately reducing the

need for frequent utilization of emergency room services. The reinvestment proposal would aim to further strengthen and enhance these services.

- **Expertise:** Since its inception, MCAB has worked closely with the Montgomery County Department Health and Human Services to monitor data and trends in the County. The Department is the subject matter expert on local community health needs with a strong finger on the pulse of Montgomery County. MCAB utilizes the information received by the Department, along with the knowledge and experience of our MCAB members, to base our annual goals, objectives, and priorities to ensure our mission of providing high quality healthcare to the most vulnerable residents in the county is maintained.
- **Partnership:** MCAB genuinely supports the proposed partnership between the Montgomery County Department of Health and Human Services, the Primary Care Coalition of Montgomery County, and Nexus Montgomery for efficient program administration. The Primary Care Coalition of Montgomery County is a trusted partner, which has provided long-standing administrative oversight and services for the Montgomery Cares and Care For Kids programs. It is only through our strong partnerships that we can do the most good for the most residents in our county and continue to ensure high-quality health care for all residents.

MCAB knows the Montgomery County Department of Health and Human Services makes this proposal with the best interest of every Montgomery County resident and with the intention of providing equitable care across the continuum. We understand the importance of providing quality healthcare access to our communities. We hope that you will support the proposal in its entirety and allow the local experts to implement these structures based on proven, trusted experience from individuals of integrity and genuine compassion and concern for the well-being of our residents.

Thank you in advance for your time and consideration.

Sincerely,

Dr. Kathryn Kelly
Chair, Montgomery Cares Advisory Board

CC:
Kisha N. Davis, MD, MPH, FAAFP, Health Officer, Montgomery County Department of Health and Human Services
Nina Ashford, DrPH, MPH, Chief, Public Health Services, Montgomery County Department of Health and Human Services
Sean O'Donnell, Deputy Chief, Public Health Services, Montgomery County Department of Health and Human Services
Christopher Rogers, Ph.D., M.P.H., Strategy and Policy Officer, Department of Health and Human Services
Melinda Fredericks, M.B.A, B.S., Manager III, Healthcare Access, Community & Population Health, Department of Health and Human Services
Kathryn Kelly, MD, Chair, Montgomery Cares Advisory Board
Mark Foraker, Vice Chair, Montgomery Cares Advisory Board
Matisa Jones, Administrative Officer II, Maryland Health Services Cost Review Commission
Dan Cochran, President, Adventist Healthcare Shady Grove Medical Center
Katie Eckert, Senior Vice President of Strategic Operations, Adventist Healthcare

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Request for Public Comment: HSCRC Regulations Evaluation

WRITTEN COMMENTS SHALL BE SUBMITTED TO lynne.diven@maryland.gov ON OR BEFORE June 12, 2026.

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cost review commission

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the following topic:

Request for Public Comment: HSCRC Regulations Evaluation, as presented at the May 13, 2026 Commission meeting.

WRITTEN COMMENTS SHALL BE SUBMITTED TO lynne.diven@maryland.gov ON OR BEFORE **June 12, 2026**.

Background
In accordance with State Government Article, §§10-130—10-139, Annotated Code of Maryland, each State agency that adopts regulations must review those regulations every 8 years, unless exempt under §10-132.1. The review is implemented by Executive Order 01.01.2003.20 which also sets the schedule for performing the review. The evaluation report prepared by HSCRC is also submitted to the Administrative, Executive, and Legislative Review Committee (AELR) of the General Assembly for approval.

HSCRC is required to comply with the Regulatory Review and Evaluation Act through submission of a work plan October 2025 and submission of an evaluation report October 2026.

Principles for Comment
The evaluation report submitted by HSCRC is to contain a summary of any amendment, repeal, or reorganization of regulations to be promulgated. Actual text should not be submitted. The review should include a check of the accuracy of all cross-references to COMAR and to other legal sources. HSCRC is collecting comments in a two part comment period process:

1) The public may comment on HSCRC's current regulations, COMAR 10.37.01.00 - 10.37.12.9999 by June 12, 2026. HSCRC will gather submitted comments for the draft evaluation report.
2) After submission on October 1, 2026, HSCRC will publish a notice in the Maryland Register that the evaluation report is available for public inspection and comment for 60 days.

Public notices and any supporting materials will be shared on HSCRC's homepage: https://hscrc.maryland.gov/Pages/default.aspx.

maryland
health services
cost review commission

Nurse Support Program II
Competitive Institutional Grants Program

Review Panel Recommendations for FY 2027

May 2026

This is a final recommendation for Commission consideration at the May 13, 2026 Public Commission Meeting.

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

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Table of Contents

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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) 2027 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 39 grants for approval totaling $20.8 million in funds for FY 2027. The FY 2027 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.

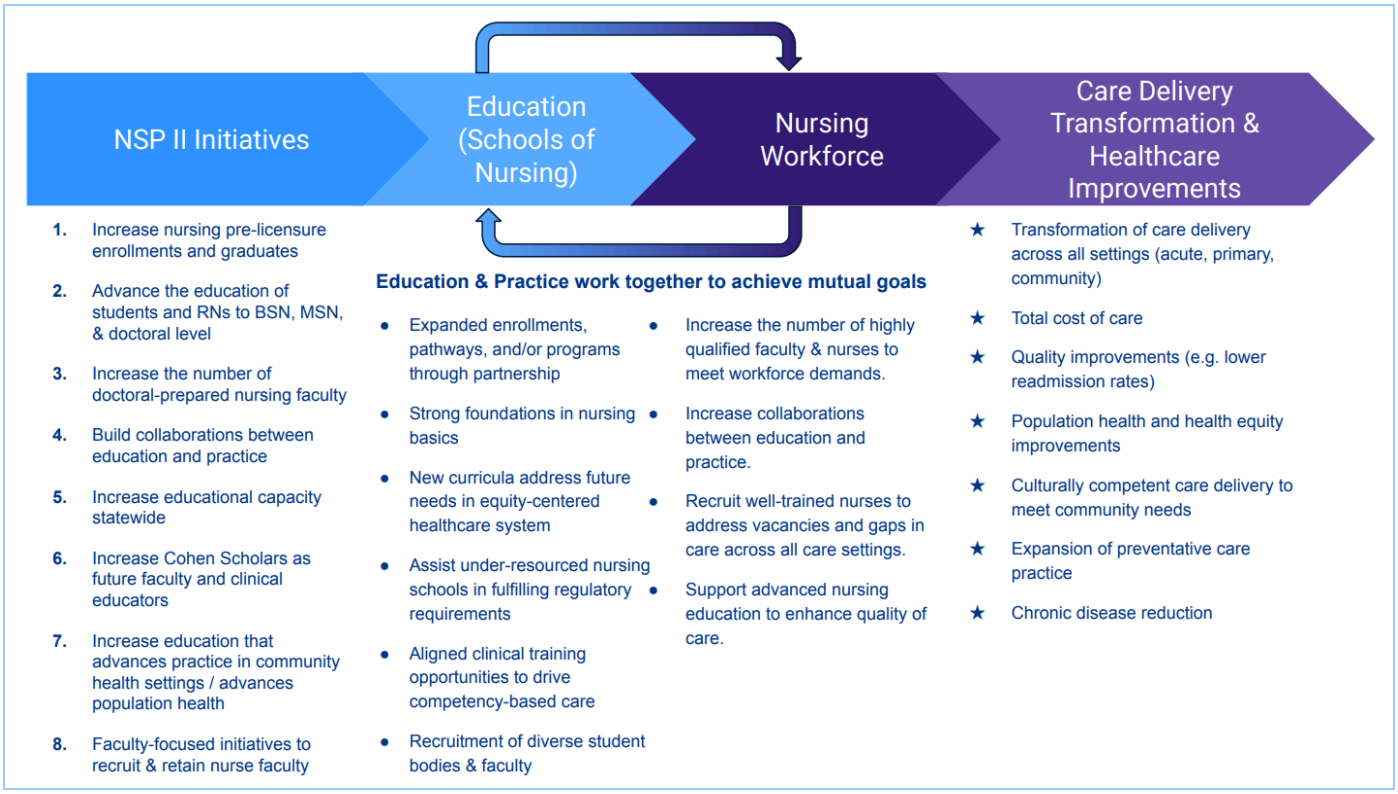
- In February 2025, the Commissioners voted unanimously to make NSP II a permanent program with annual reporting requirements, and a new initiative was added to expand educational efforts focused on health equity, community health, and ongoing support for acute care nurse vacancies.

Conceptual Framework

NSP II funding supports 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 alignment withthe implementation of the new Achieving Healthcare Efficiency through Accountable Design (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.

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 2027 NSP II Review Panel was composed of ten 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 (13 pts), Project Goals & Objectives (13 pts), Scope of Proposed Initiative (13 pts), Management Plan (13 pts), Evaluation Plan (13 pts) and Budget & Cost-Effectiveness (30 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 38 proposals were received for the FY 2027 NSP II RFA from nursing programs at seven community colleges and eleven universities. All 38 proposals were scored and reviewed. The panel also reviewed a plan for NSP II to issue a limited Request for Proposals (RFP) providing up to $150,000 to each of Maryland's 30 nursing schools ($4.5M total) to expand simulation and instructional capacity by equipping programs with modern tools essential for training practice-ready nurses.

Based on the outcome of this review, HSCRC and MHEC staff recommend the following proposals presented in Table 2 for the FY 2027 NSP II Competitive Institutional Grants Program, totaling $20,812,837. This final recommendation describes the panel's recommendations for Commission approval.

Table 2. FY 2027 Recommendations for Funded Proposals

Proposal	School	Title	Duration	Total Funding Request
NSP II-27-101	Bowie State University	Nursing Education Research Consortium (NERC)	2 years	$142,701
NSP II 27-102	Bowie State University	Simulation Team Staffing (STS)	5 years	$1,052,196
NSP II 27-103	Bowie State University	Cohen Scholars Cohort Model	5 years	$995,590
NSP II 27-104	Carroll Community College	ADN Curriculum Modernization with CBE	2 years	$126,541
NSP II 27-105	Carroll Community College	Re-envisioning Maryland's Nursing Pipeline	2 years	$147,707
NSP II 27-106	Coppin State University	Educating Nursing Leaders for Advanced Practice (ENLAP)	2 years	$149,986
NSP II 27-107	Coppin State University	Promotion of Activities for Career Education RN (PACE-RN)	2 years	$146,016
NSP II 27-108	Coppin State University	Advanced Practice Readiness Program (APRP)	2 years	$109,512
NSP II 27-109	Hood College	Hood Health Hubs Advancing Population Health	5 years	$384,154
NSP II 27-110	Johns Hopkins University	Statewide Virtual Nursing and Telehealth Education Resources	3 years	$1,291,816
NSP II 27-111	Johns Hopkins University	Bridge Care to Me (BC2M)	3 years	$862,031
NSP II 27-112	Notre Dame of MD University	Center for Outcomes, Measurement, Practice Assessment, and Student Success (COMPASS)	4 years	$801,589
NSP II 27-113	Prince George's Community College	Simulation Staffing Expansion	4 years	$327,639
NSP II 27-114	University of MD Baltimore	Innovative Pathways Expanding MD PhD Workforce	3 years	$456,915
NSP II 27-115	University of MD Baltimore	MD Clinical Placements Collaborative Infrastructure Initiative	3 years	$661,479
NSP II 27-116	University of MD Baltimore	Supporting and Retaining Undergraduate Nursing Preceptors	3 years	$1,100,329
NSP II 27-117	Wor-Wic Community College	Nursing Program Expansion	5 years	$943,231
NSP II 27-201	Johns Hopkins University	Graduate Academic Nurse Educator Continuation Grant	3 years	$728,281
NSP II 27-202	Johns Hopkins University	R^3 Phase 3 Continuation Grant	3 years	$1,263,519
NSP II 27-203	University of MD Baltimore	Nurse Leadership Institute 3.0 Continuation Grant	5 years	$1,756,581

Proposal	School	Title	Duration	Total Funding Request
NSP II 27-204	University of MD Baltimore	Preparing Clinical Nurse Faculty Across Maryland Continuation Grant	5 years	$894,124
NSP II 27-205	University of MD Baltimore	Expansion of Enrollment Post-Covid Continuation	5 years	$1,165,289
NSP II 27-206	Allegany College of MD	Professional Development Resource Grant	1 year	$46,296
NSP II 27-207	Anne Arundel Community College	Professional Development Resource Grant	1 year	$40,202
NSP II 27-208	Bowie State University	Professional Development Resource Grant	1 year	$49,998
NSP II 27-209	Bowie State University	Student Success Resource Grant	1 year	$90,241
NSP II 27-210	Carroll Community College	Professional Development Resource Grant	1 year	$11,900
NSP II 27-211	Coppin State University	Professional Development Resource Grant	1 year	$43,614
NSP II 27-212	Coppin State University	Student Success Resource Grant	1 year	$71,800
NSP II 27-213	Frostburg State University	Professional Development Resource Grant	1 year	$44,127
NSP II 27-214	Harford Community College	Professional Development Resource Grant	1 year	$46,294
NSP II 27-215	Loyola University MD	Professional Development Resource Grant	1 year	$24,712
NSP II 27-216	McDaniel College	Professional Development Resource Grant	1 year	$46,953
NSP II 27-217	Montgomery College	Professional Development Resource Grant	1 year	$46,125
NSP II 27-218	Notre Dame of MD University	Professional Development Resource Grant	1 year	$21,400
NSP II 27-219	Prince George's Community College	Student Success Resource Grant	1 year	$75,653
NSP II 27-220	Stevenson University	CBE Resource Grant	1 year	$100,000
NSP II 27-221	Towson University	Professional Development Resource Grant	1 year	$46,296
NSP II 27-222	all 30 nursing schools in MD	Statewide Resource Grant for Instructional Equipment	1 year	$4,500,000
TOTAL				**$20,812,837**

These highly recommended proposals address the following NSP II initiatives:

- **NSP II Initiative #1 to increase nursing pre-licensure enrollments and graduates:**
    - A five-year implementation grant aimed at increasing nursing program capacity and doubling graduates from 70 to 140 over five years (NSP II 27-117).
    - Five-year implementation grants focused on expanding enrollment and graduation rates through simulation staffing expansions (NSP II 27-102, 27-113).
    - A two-year planning grant (NSP II 27-104) and four-year implementation grant (NSP II 27-112) to provide an infrastructure and modernize the curriculum to meet accreditation standards through competency-based education, which is expected to increase graduates.
    - One-year student success resource grants for a total of three nursing schools utilizing supplemental instruction, academic coaching, and remediation specialists to improve retention, graduation rates, and first-time NCLEX pass rates among underrepresented nursing populations. (NSP II 27-209, 27-212, 27-219).
    - A five-year continuation grant to sustain and expand enrollment in entry-to-practice programs, while developing a statewide resource for the successful ACE Liaison role for clinical education (NSP II 27-205).
- **NSP Initiative #2 to advance the education of students and RNs to the BSN, MSN, and doctoral level:**
    - A three-year implementation grant to create an academic-practice partnership and BSN-to-PhD pipeline to increase the number of doctoral nursing graduates (NSP II 27-114).
    - Two-year planning grants focused on preparing nurse leaders for advanced roles in nursing education and psychiatric/mental health care (NSP II 27-106, 27-107).
    - A one-year resource grant dedicated to transitioning all nursing courses across entry-into-practice, RN-to-BSN, and graduate programs to meet accreditation standards through competency-based education (NSP II 27-220).
- **NSP II Initiative #4 to build collaborations between education and practice:**
    - A two-year planning grant to develop a statewide consortium designed to facilitate collaborative research through strategic partnerships between hospitals and academic institutions (NSP II 27-101).
    - A two-year planning grant that builds a collaborative pipeline involving the local community college, public school system, university, and hospital to impact rural/underserved areas (NSP II 27-105).
    - A three-year implementation grant aimed at creating a statewide infrastructure to increase pre-licensure RN workforce capacity and secure 300+ additional clinical placements (NSP II 27-115).

- **NSP II Initiative #5 to increase capacity statewide:**
    - A three-year implementation grant to create virtual nursing and telehealth education resources and a platform to train 300 faculty statewide (NSP II 27-110).
    - A three-year implementation grant providing standardized training to 400 undergraduate nursing preceptors to expand statewide clinical placement capacity (NSP II 27-116).
    - A three-year continuation grant to build an accessible and on-demand training program that fills unmet needs in clinical instructor development (NSP II 27-201).
    - A three-year continuation grant to expand statewide resources to promote renewal, resilience, and retention of nurses, and establish a sustainable platform for lasting impact (NSP II 27-202).
    - A five-year continuation grant that builds on the success of a statewide initiative that prepares nurse faculty and clinicians for leadership roles through expanded recruitment and statewide engagement, and implementation of a comprehensive evaluation plan (NSP II 27-203).
    - A five-year continuation grant to increase the number of competent clinical nursing faculty through statewide workshops, ongoing professional development, and national certification preparation (NSP II 27-204).
    - A Statewide resource grant administered by NSP II that allows each of the 30 nursing schools in Maryland to obtain up to $150,000 in modernized instructional equipment for classroom, lab and clinical simulation environments to support program expansions and improve competency of nursing graduates (NSP II 27-222).
- **NSP II Initiative #6 to increase Cohen Scholars as future faculty and clinical educators:**
    - A five-year implementation grant to establish the Cohen Scholars Program at one additional school to expand Maryland's nursing education workforce by producing 20 PhD-prepared nursing faculty committed to a nursing education teaching service obligation in Maryland upon graduation (NSP II 27-103).
- **NSP II Initiative #7 to increase education that advances practice in community health settings/ advances population health:**
    - A two-year planning grant focused on closing gaps in transition to advanced practice roles in community and population health settings (NSP II 27-108).
    - A four-year implementation grant to formalize a partnership with the local health department to provide BSN student learning experiences and address population health needs in a rural community (NSP II 27-109).

    - A three-year implementation grant to create clinical training sites for nursing students and establish sustainable nurse-led primary care services in underserved communities (NSP II 27-111).
- **NSP II Initiative #8: Faculty-focused initiatives to recruit and retain nurse faculty:**
    - Professional development resource grants for a total of 12 nursing schools to support faculty retention and nursing student success through faculty participation in national and statewide nursing conferences (NSP II 27-206, 27-207, 27-208, 27-210, 27-211, 27-213, 27-214, 27-215, 27-216, 27-217, 27-218, 27-221).

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

Draft Recommendation

May 13, 2026

This is a draft recommendation for consideration by the Commission. Public comments must be received by May 20, 2026, to erin.schurmann@maryland.gov.

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Table of Contents

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List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
EQIP	Episode Quality Improvement Program
FY	Fiscal year
FFY	Federal fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

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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 Maryland Model and the public interest,[1] this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2027 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($3,504,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, and hospital regulatory initiatives ($7,396,000).

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

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

Background – Past Funding

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

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 15 Years

CRISP Budget: HSCRC Funds Received	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$4,800,000
FY 2024	$4,800,000
FY 2025	$8,420,000
FY 2026	$12,060,000
FY 2027	$10,900,000

Funding Through Hospital Rates

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

Funding Through Federal Matching

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

Medicaid Enterprise System (MES) Matching Funds

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

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

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

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue. User fees represent approximately 11 percent of total funding for FY 2027.

Description of Activities Funded

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

Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer

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

hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

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

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

The total amount of funding recommended by Staff for FY 2027 for the HIE function is $3,504,000.

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

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

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

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

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

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

The total amount recommended by Staff for FY 2027 for the activities described above is $7,396,000.

Staff Recommendation

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

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

Table 2. FY 2027 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$3,504,000	$10,387,000	$6,123,000	$3,165,000	$23,179,000
Reporting and Program Administration	$7,396,000	$10,511,000	$0	$3,095,000	$21,002,000
Other non-HSCRC programs	$0	$11,493,000	$0	$2,309,000	$13,802,000
Total Funding	**$10,900,000**	**$32,391,000**	**$6,123,000**	**$8,569,000**	**$57,983,000**
% Of Total	**19%**	**56%**	**11%**	**15%**	**100%**

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Draft Recommendation for the Update Factors for Rate Year 2027

Please submit all comments to hscrc.payment@maryland.gov by COB May 20, 2026.

Table of Contents

List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
DSH	Disproportionate Share Hospital
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
ICC	Interhospital Cost Comparison
MHAC	Maryland Hospital Acquired Conditions
PAU	Potentially avoidable utilization
QBR	Quality-Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care
USPCC	United States Per Capita Cost

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
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 3.25 percent per capita, a revenue increase of 3.65 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 2.57 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 2027. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, respiratory surge, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the AHEAD Model. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	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) 2027. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

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

Staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

(a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.

(b) Provide an overall increase of 3.65 percent for revenue (including a net increase to uncompensated care) and 3.25 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.

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

(a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, and apply a productivity offset of 0.80 percent for a total update of 2.57 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.

On November 12, 2025, CMS and Maryland signed the Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model), replacing the prior AHEAD Agreement signed in 2024. The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment, and population health outcomes results in improved population health and healthier living, enhanced quality outcomes, and lowered growth of health care costs. Under the Amended and Restated AHEAD Model

Maryland State Agreement, the Maryland AHEAD Implementation Period officially began on January 1, 2026. Under AHEAD, Maryland must meet Medicare FFS TCOC savings targets, all-payer TCOC growth targets, and a hospital all-payer revenue limit. HSCRC will need to closely monitor state-wide hospital revenue growth in order to meet these tests.

The approach to developing the RY 2027 annual update is outlined in this report, as well as staff's estimates on calendar year AHEAD Model tests. There are two categories of hospital revenue types included in this recommendation:

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

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

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

Overview of Draft Update Factors Recommendations

For RY 2027, HSCRC staff is proposing an update of 3.25 percent per capita for global budget revenues and an update of 2.57 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

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

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted market basket growth estimate with a capital growth estimate using the Quarter 2 projection for 2027 from the Fourth Quarter book for 2025. For RY 2027, HSCRC Staff combined 91.20 percent

market basket growth of 3.20 percent with 8.80 percent of the capital growth estimate of 2.90 percent, calculating the gross blended amount as a 3.17 percent inflation adjustment.

Update Factor Draft Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.17 percent with an additional 0.20 percent for additional inflation support. In addition, staff recommends a productivity adjustment of 0.80 percent, consistent with the proposed IPPS rule for FFY 2027. After subtracting the productivity adjustment from the combined inflation rate, the resulting proposed net update is approximately 2.57 percent.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.17%	3.17%
Productivity Adjustment	N/A	-0.80%
Additional Inflation Support	0.20%	0.20%
Proposed Inflation Update	3.37%	2.57%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

- Meeting the requirements of the AHEAD Model, including achieving the Medicare Total Cost of Care savings targets, which increase according to a preset schedule relative to a calendar year 2023 base, beginning in CY 2026. The amount required increases throughout the agreement; for 2026, it is 0.13 percent.
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes.
- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the AHEAD Model as well as a framework for doing so;
- Incorporating quality performance programs.
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates revenue growth for the full rate year to be 3.65 percent with a corresponding per capita growth rate of 3.25 percent. The 3.65 percent revenue growth will be used to measure the proposed update against financial tests, which are performed on Calendar Year results; staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2027 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC Staff's 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 2027					
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 3.10% for Wages and Salaries)			3.11%	$746.8	$246.4
- Additional Inflation Support			0.20%	$48.1	$15.9
- Outpatient Oncology Drugs			0.06%	$15.2	$5.0
Gross Inflation Allowance	**A**		**3.37%**	**$810.1**	**$267.3**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$36.9	-$12.2
- Grant Funding RY27			0.03%	$7.8	$2.6
- HOPE			0.21%	$50.0	$16.5
Total Care Coordination/Population Health	**B**		**0.09%**	**$20.9**	**$6.9**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.38%	$91.4	$30.1
- Demographic Policy Refinement - RY2026 Incremental Change			0.03%	$7.2	$2.4
Total Adjustment for Volume	**C**		**0.41%**	**$98.6**	**$32.5**
Financial Methodologies & Other Adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.40%	$96.2	$31.7
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.16%	$37.5	$12.4
- Full Rate Application	G		0.04%	$9.0	$3.0
- Reversal of one-time adjustments for drugs	H		-0.06%	-$14.7	-$4.9
- Reversal of Surge Funding (RY24-RY25 in RY26 rates)	I		-0.79%	-$189.6	-$62.6
- RY26 Respiratory Surge Funding Estimate (6 month)	J		0.22%	$52.6	$17.4
- RY25 New Volume Policies	K		0.06%	$14.3	$4.7
Net Other Adjustments	**L =**	**Sum of D thru K**	**0.02%**	**$5.4**	**$1.8**
Quality and PAU Savings					
1 - PAU Redistribution	M		-0.04%	-$9.62	-$3.2
- Reversal of prior year quality incentives	N		0.04%	$9.7	$3.2
- Current Year Quality Incentives	O		-0.06%	-$13.2	-$4.4
Net Quality and PAU Savings	**P=**	**Sum of M thru P**	**-0.05%**	**-$13.1**	**-$4.3**
Total Update First Half of Rate Year					
	Q=	Sum of A + B + C + L+ P	**3.83%**	**$921.9**	**$304.2**
	R=	(1+Q/(1+0.38%)	**3.44%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	S		0.01%	$2.4	$0.8
- Deficit Assessment	T		-0.20%	-$47.6	-$15.7
	U=	**Sum of S thru T**	**-0.19%**	**-$45.2**	**-$14.9**
Total Update First Half of Rate Year 27					
Revenue growth, net of offsets	**V=**	Q+U	**3.65%**	**$876.7**	**$289.3**
Per Capita Revenue Growth	**W=**	(1+V)/(1+0.38%)	**3.25%**		
Adjustments in Second Half of Rate Year					
- Medicare Advantage Stabilization*			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**X**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
	Y	V+X	**3.65%**	**$876.7**	**$289.3**
	Z	(1+Y)/(1+0.38%)	**3.25%**		

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

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

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

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.17 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2025 market basket growth of 3.20 percent, with 8.80 percent of the capital growth index change of 2.90 percent. The adjustment for inflation includes 3.30 percent for wages and compensation.

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

Table 3: Inflation Risk Corridor Methodology

Max Tolerance =	1.00%																
Max Tolerance Updated 7/30/25 =	0.25%																
	Historical												Incomplete	Projected			
Fiscal 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%	3.17%	3.17%	3.17%	3.17%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.44%	3.08%	3.17%	3.17%	3.17%	3.17%
Actual Inflation Correction as approved by Commission												1.00%	0.27%	0.20%	0.00%	0.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	-0.35%	0.80%	0.54%	0.20%	0.00%	0.00%	0.00%
Cumulative Difference (2014 Base)	-0.10%	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	-0.19%	-1.17%	-1.51%	-0.72%	-0.18%	0.02%	0.02%	0.02%	0.02%
Guardrail/Tolerance **(A)**											1.00%	1.00%	0.25%	0.25%	0.25%	0.25%	0.25%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	-0.19%	-1.17%	-0.52%	-0.45%	0.02%	0.02%	0.02%	0.02%	0.02%
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)										1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HSCRC Funded Inflation with Actual Inflation Correction											3.35%	4.24%	3.63%	3.37%	3.17%	3.17%	3.17%

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

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

At the January 8, 2025 Commission meeting, the Commission voted to approve revisions to the outpatient high-cost drug funding policy, or CDS-A policy. The approved revision included providing funding based on 100 percent reimbursement of changes in drug cost. As a result of this policy revision, inflation is only needed for pure price, which is the price change of each drug at its base year volume. For the RY 2027 Update Factor, staff are using a 3 percent inflation assumption based on longer term trends of pure price. This value remains the same for both academic and non-academic hospitals. The result of this translates to approximately a 0.06 percent carve out of inflation.

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

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

  HOPE is a voluntary, upside-only, shared savings, outcome payment model whereby proposals will be reviewed and approved by a committee of experts. One path to participation is for hospitals, alone or with partners, and the other path is for regional or statewide initiatives. Outcome payments will be initially anticipated to be $50 million each year, included in the annual update factor, with the commission only able to qualify interventions with up to $100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Hospitals and Statewide and Regional Initiative partners receive 50 percent of measured savings, ensuring aligned incentives across participating entities. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Funding for Regional and Statewide initiatives funding are individually approved by the Commission and will not count towards the $50 million.

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

- **Adjustments for Volume:** The demographic adjustment policy is an annual prospective update to Maryland hospitals' global budget that accounts for age-adjusted population volume changes within a hospital's service area. Staff proposes a 0.38 percent population growth estimate for RY 2027 and a refined 0.77 percent for RY 2026, both of which incorporate specific Commission-approved adjustments. The final recommendation will be updated to 0.12 percent for the RY 2027 demographic adjustment to reflect complete demographic data.

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

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

- **Set-Aside:** The intention of the set-aside is to use these funds for 1) Global Budget Revenue enhancements for relatively efficient hospitals that qualify under the Integrated Efficiency policy and 2) unforeseen events that occur at hospitals with financial hardship, regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.40 percent for RY 2027.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining relatively inefficient hospitals in the TCOC Model. The policy utilizes the Inter-Hospital Cost Comparison (ICC) methodology to compare relative cost-per-case efficiency and Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used in an ordinal ranking scoring matrix to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy.

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

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as CAR-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, HSCRC staff developed an approach to provide a higher variable cost factor (100 percent for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2025. Based on this analysis, staff concluded that the historical average growth rate was approximately 0.39 percent, which equates to a combined State impact of 0.16 percent for the RY 2027 Update Factor. Staff are currently evaluating a new approach to funding this type of care via carve out and expect a final recommendation to the Commission in July 2026, should the Commission adopt this approach it may impact this funding.

- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately $9 million through the Full Rate Application Policy, which represents 0.04 percent of the recommendation. This value is subject to change based on quality assurance reviews of the Inter-hospital Cost Comparison (ICC) methodology and review of commercial TCOC benchmarks. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2027 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology (no additional methodological considerations will be contemplated); and the hospital will not file any subsequent rate request until July 1, 2028.

- **Surge Allocation:** The Surge Funding value for RY 2027 is 0.22 percent. This amount includes an estimate that has been determined using six months of Case-mix and Experience data and incorporates the change in weighting to two-thirds evaluation on Case-mix and one-third evaluation on patient days as approved at the January 2026 Commission meeting. This Update Factor recommendation incorporates the reversal of the RY 2024 and RY 2025 surge funding applied in RY 2026, totaling -0.79 percent. In keeping with the approved policy recommendation, the 6-months Surge funding value for

RY 2027 will be replaced with a 9-month value implemented in July which will be reconciled with a final 12-month amount in January.

- **New Volume Policies:** In RY 2026, the Commission approved new volume policies not otherwise reflected in existing market shift methodologies. These policies include Deregulation, Repatriation/Expatriation, and Out-of-State (OOS) volume Adjustments. These policies were designed to address shifts in patient utilization occurring outside of traditional in-state regulated market dynamics, including movement to unregulated settings (deregulation), cross-border utilization by Maryland residents (repatriation/expatriation, and changes in utilization at in-state regulated facilities by non-Maryland residents (OOS). For this period, hospitals received adjustments calculated using CY 2024 data. A portion of the adjustments will be implemented in RY 2027, following hospital feedback and additional staff review. These policies have an estimated impact of approximately 0.04 percent in the RY 2027 Update Factor. In addition, at the December 2025 Volume Workgroup meeting, staff introduced a policy update formalizing the treatment of Potentially Avoidable Utilization (PAU) associated with hospital conversions to Freestanding Medical Facilities (FMFs) within the Market Shift Policy. This update ensures consistent treatment of PAU-related volume and avoids overstating growth from FMF conversions. The estimated impact of this adjustment is approximately 0.02 percent. Together, these volume-related changes result in a combined impact of approximately 0.06 percent in the RY 2027 Update Factor.

- **Potentially Avoidable Utilization (PAU) Redistribution:** The PAU value for RY 2027, which represents defunding of inflation and population growth for readmissions and avoidable admissions, is -0.55 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 -0.04 percent.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The current revenue adjustments across the three programs is -0.06 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of 0.04 percent.

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

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

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2027 will be 0.01 percent. The amount in rates was 4.03 percent in RY 2026, and the proposed amount for RY 2027 is 4.04 percent, an increase of 0.01 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.

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

  In addition, for marketplace, current plan year enrollment is not down from last year, and the Maryland subsidy has not been calculated for the next plan year—a significant factor in whether we would anticipate significant drops. Staff will continue to monitor, if year over year subsidized premiums increase is greater in 2027 than in 2026, a prospective adjustment could be revisited.

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

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

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance

adjustments, and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Redistribution - Updated Methodology

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

For RY 2027, the incremental amount of statewide PAU Savings reductions was determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This would result in a RY 2027 permanent PAU savings reduction of -0.55 percent statewide, or -$121,823,591. 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 Approved Permanent Revenue	A	$22,149,743,816
RY 2026 Inflation Factor+Demographic Adjustment	B	4.78%
CY 2024 Total Experienced PAU $	C	$2,554,637,322
Proposed Revenue Adjustment $	D = B*C	-$122,111,664
Proposed Revenue Adjustment %	E = D/A	-0.55130%
Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.550000%**
Adjusted Proposed Revenue Adjustment $ * **	G = F*A	**-$121,823,591**
Total PAU %	H	11.08%
Total PAU $	I = A*H	$2,453,778,706
Required Percent Reduction PAU	J = G/I	-4.96%

*Does not include revenue from McCready or freestanding EDs.

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

However, as previously noted, staff are proposing to maintain the amendment to the PAU Shared Savings policy such that it is a PAU Redistribution policy, whereby the PAU measurement is utilized in order to recognize differential opportunities among hospitals in a fixed revenue model but does not generate TCOC Model savings. The reasons for this change, which was adopted in RY 2025, are as follows: the policy already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management, future ongoing reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions, and the additional funding allows hospitals to make greater investments in population health that overtime will make global budgets more sustainable than annual PAU reductions to hospitals that do not allow for system reinvestment.

The RY 2025 Update Factor recommendation included a requirement for hospitals to submit population health management plans as part of efforts to reduce statewide potentially avoidable utilization, as well as submit high value care plans that described new and existing strategies and initiatives aimed at addressing priority areas of focus identified by the Value-Based Care Insights tool provided by CRISP or an alternate tool. All hospitals completed these requirements and none were subject to a 0.19 percent clawback in their July rate orders.

For RY 2026, hospitals are required to submit final reporting on targets and outcomes for their High Value Care plans by June 1, 2026. Hospitals that fail to report will result in a take back of 0.27 percent of inflation removed in July 2026 rate orders. Staff expects to provide an assessment of the results in the final update factor recommendation in June 2026.

For RY 2027, hospitals will be required to report on their improvement targets and outcomes as part of their high value care plans. Failure to report on targets and outcomes will result in a take back of 0.28 percent of inflation removed in the RY 2027 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. This may be revised depending on the outcome of the final HOPE recommendation.

Consideration of AHEAD Model Agreement Requirements & National Cost Figures

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

Medicare TCOC Savings Test

This test under the AHEAD Model requires Maryland to generate 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027), respectively (these amounts are accumulated so the Year 2 target is 0.34 percent). Under current growth trajectories and beneficiary counts, this is equivalent to Maryland growing an additional $47million slower than the national United States Per Capita Cost (USPCC) trend over the two years. AHEAD uses USPCC values to set the Medicare FFS TCOC savings targets, unlike the TCOC Model. USPCC projects national per capita fee-for-service (FFS) spending based on CMS' most recent Medicare FFS data, mainly for the purposes of setting MA benchmarks.[1] As under the TCOC Model, this test ensures that spending increases outside of the hospital setting do not

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

undermine the Medicare hospital savings resulting from any savings produced in the hospital setting. Additionally, the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

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

All-Payer Tests

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

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

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

Figure 1
AHEAD Savings Target

Target = Baseline x (1 + Interim Years Trend) x (1 + National MC FFS Trend + True Up) - Savings Component

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

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

Instead of applying trend to the Maryland baseline dollar amount, 33 percent of the **National Medicare FFS Trend** is calculated against the equivalent national dollar amount. The **True Up** adjusts the target by 50 percent of differences between the projected and observed USPCC values beyond .5 percent, the true up only becomes relevant after the performance period when differences between the projected and observed USPCC are known. The **Savings Component** is 0.13 percent and 0.21 percent in additional Medicare FFS TCOC savings in PY1 (CY 2026) and PY2 (CY 2027) mentioned previously.[4] The final target is risk adjusted using HCC scores.

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

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

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

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

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test (in billions)		
Actual Revenue January - June 2025		11,469,777
Actual Revenue July - December 2025		11,856,401
Actual Revenue CY 2025		23,326,178
Step 1:		
Approved GBR RY 2026		24,039,557
Actual Revenue 7/1/25-12/31/25		11,856,401
Approved Revenue 1/1/26-6/30/26		12,183,156
Projected FY25 GBR Compliance		0
Anticipated Revenue 1/1/26-6/30/26	**A**	**12,183,156**
Expected Revenue Growth 1/1/26-6/30/26		**6.22%**
Step 2:		
Final Approved GBR RY 2026		24,039,557
Reversal of Extraordinary One-Times		-92,257
Final Adjusted GBR Base for RY 2026		23,947,300
Projected Approved GBR RY 2027		24,820,647
Permanent Update RY 2027		3.65%
Step 3:		
Estimated Revenue 7/1/26-12/31/26 (after 49.73% & seasonality)	**B**	**12,343,308**
Expected Revenue Growth 7/1/26- 12/31/26		**4.11%**
Step 4:		
Estimated Revenue CY 2026	**A+B**	**24,526,464**
Increase over CY 2025 Revenue		**5.15%**
Per Capita Increase over CY 2025		**4.75%**

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2025.

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

Step 2: The final approved GBR for RY 2026 is $24,039,557,189. This step applies the proposed update of 3.65 percent, as shown in Table 2, to the RY 2026 GBR amount to calculate the projected revenue for RY 2027. This step also makes adjustments for miscellaneous/extraordinary one-times that don't get included in inflation but are accounted for in RY 2026. For RY 2026, this includes one-time funding for the population health trust fund and the FY21-FY23 UCC correction.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2026 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2027.

Step 4: This step shows the resulting estimated revenue for CY 2026 and then calculates the increase over the actual CY 2025 Revenue. The CY 2026 increase based on this year's recommended update is 5.15 percent.

The 5.15 percent is used to estimate CY 2026 hospital spending per capita for Maryland in our savings evaluation. As explained above, the AHEAD Medicare FFS TCOC savings targets are based on USPCC trends, these trends are used in the following evaluation which illustrates two scenarios. The State is continuing to work through the details of the methodology with CMMI. A few areas of uncertainty remain. These include:

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

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

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

Scenario 1 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	4.0%	
Cumulative Growth (2023 to 2026)	19.5%	19.0%	-0.5%
Estimated CY 2026 Savings Run Rate			-$78 M dissavings

Under this scenario, national spending would grow at 4.0 percent in 2026, reflecting the Year -1 2026 USCPC adjusted projected value. Meanwhile Maryland would grow at 5.2 percent in 2026, which reflects hospital spending driven by the CY2026 impact of the update factor of 5.15 percent and non-hospital spending which is assumed to grow at the rates set by USPCC for Part A (1.6 percent) and Part B (6.0 percent). Under this scenario the State would miss the target by $78M.

Medicare determined that it was making duplicative payments for MA-related IME and DGME costs (one payment directly to inpatient facilities, and one payment to MA plans through higher benchmarks), so in 2024, CMS began a three-year removal of MA-related IME and DGME spending from the non-ESRD FFS USPCCs. This has resulted in lower USPCC updates over 2024, 2025, and 2026 - Maryland AHEAD's two interim years and the first PY. The State has urged CMMI to remove this technical adjustment from the USPCC for the savings test as it is not relevant for AHEAD.[5]

The second scenario, outlined in Table 6b below, models out Maryland's results if CMMI agrees to remove the technical IME adjustment. Under this scenario, national spending would grow at 5.3 percent for CY2026, reflecting the Year -1 2026 USCPC adjusted projected value without the IME removal. Meanwhile, Maryland would grow at the same pace as described in Scenario 1. In addition, Maryland would enter 2026 in a stronger position due to the higher trends allowed for 2024 and 2025, thus Maryland would comfortably meet its target.

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

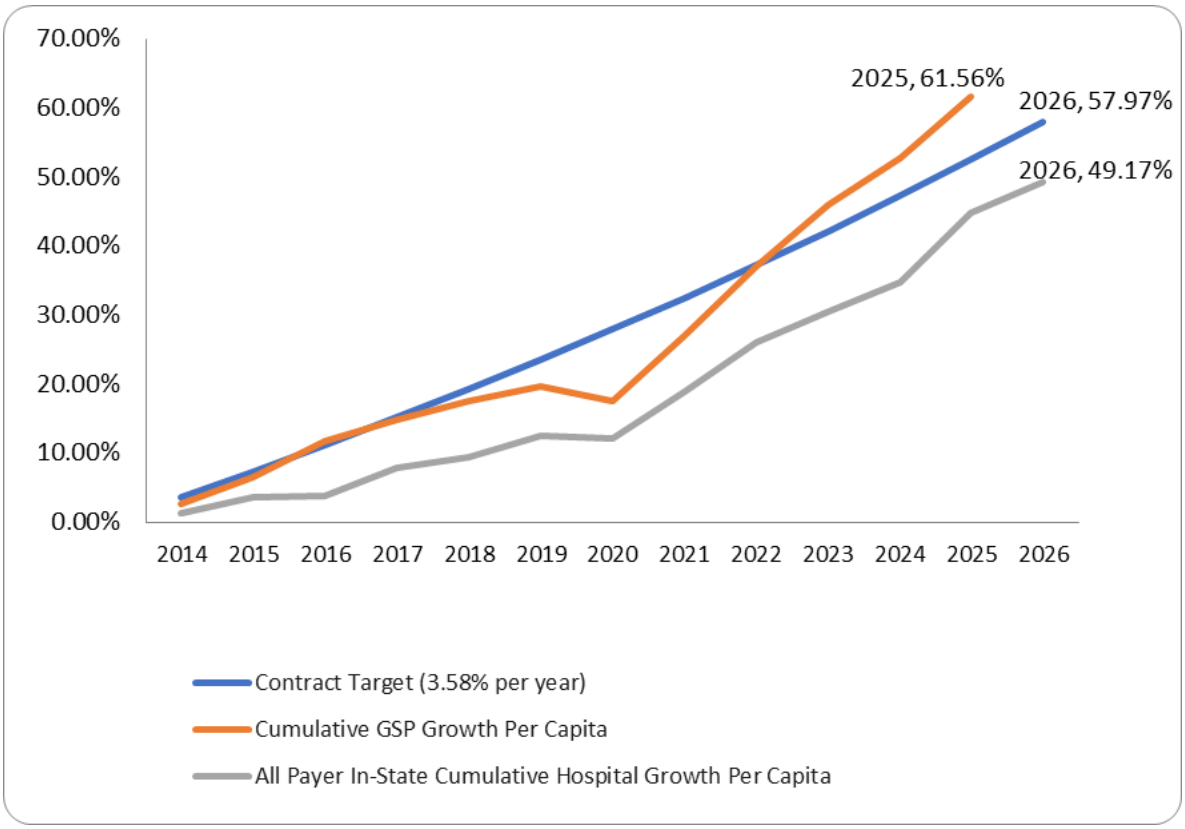
Table 6b: AHEAD Estimate (Scenario 2, 2025 Trended forward at USPCC Year-1 Trend with IME adjustment to 2024 to 2026 trends)

Scenario 2 Guardrail Projections			
	Maryland	Target (includes savings)	Impact
YOY Growth 2026	5.2%	5.3%	
Cumulative Growth (2023 to 2026)	19.5%	22.2%	+2.7%
Estimated CY 2026 Savings Run Rate			$271.7 M savings

All-Payer Affordability

Under the AHEAD all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). Figure 2 represents the cumulative comparison since the beginning of global budgets in 2014. The blue line reflects the contract target, the orange line shows actual cumulative GSP growth through 2025, and the gray line reflects estimated cumulative in-state hospital charge growth per capita through 2026. Staff emphasize that this analysis includes hospital spending only and does not incorporate non-hospital components of total cost of care. The GSP line ends in 2025 due to the absence of official 2026 data, staff opted not to project GSP growth. However, even with no GSP growth in 2026, Maryland would remain under both the cumulative target and actual GSP growth. The cumulative value of this target through CY 2026 is 57.97 percent. Actual all-payer in-state hospital charge growth through CY 2025 is 44.85 percent, inflating this to 2026 using the recommended update factor on a per capita basis yields 49.17 percent. This means that Maryland is approximately 8.8 percentage points below the contract target, which reflects system-wide savings achieved through Maryland's total cost of care framework and carried forward under the AHEAD Model that accrue to all payers and consumers.

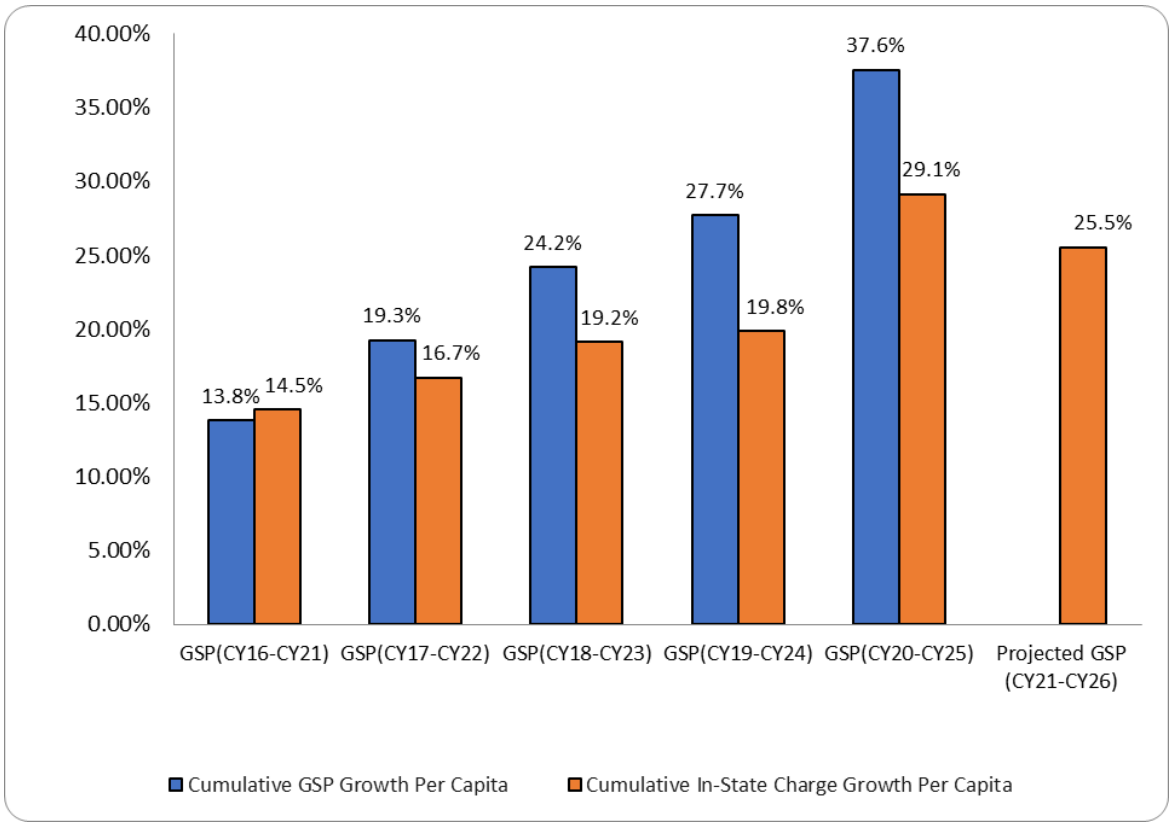
Figure 2
Affordability Scorecard – Cumulative GSP Test with CY 2026 Projection



Staff also compared the all-payer in-state hospital charge growth to economic growth in Maryland, as measured by the GSP per capita, over a rolling 5-year window. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose staff believe it is not sufficient to only look at the cumulative test embedded in the AHEAD Contract. Therefore, staff calculated the cumulative per capita growth for the five-year period using the most updated State GSP numbers available. As shown in Figure 3, the 5-year calculation shows a cumulative per capita growth of 37.6 percent. Staff then compared that number to the 5-year cumulative in-state acute hospital charge growth over the same five-year window, which equals 29.1 percent. Staff also modeled estimated hospital charge growth through CY 2026 using the proposed RY 2027 update factor. This projection results in estimated hospital charge growth of 25.5 percent.

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

Figure 3
Affordability Scorecard – Rolling 5-Year GSP Test



Medicare's Proposed National Rate Update for FFY 2027

CMS released its proposed rule for the Inpatient Prospective Payment System's (IPPS) payment rate on April 10, 2026. In the proposed rule, CMS would increase rates by approximately 2.40 percent, which includes a market basket increase of 3.20 percent and a productivity reduction of -0.80 percent. This proposed increase will not be finalized until August 2026 and will not go into effect until October 1, 2026. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments, as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Stakeholder Comments

Staff are working with the Payment Model Workgroup to review and provide input on the proposed RY 2027 update. Comment letters are due May 20, 2026. Staff have received several comment letters ahead of the deadline asking for consideration to suspend the productivity adjustment for RY 2027 and beyond. 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 2027 update factors.

For Global Revenues:

(a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.

(b) Provide an overall increase of 3.65 percent for revenue (including a net increase to uncompensated care) and 3.25 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.

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

(a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20 and apply a productivity offset of 0.80 percent for a total update of 2.57 percent.

Appendix I: Set Aside Reconciliation

Distribution of Set Aside for RY 2026			
RY 2026 GBR Revenue		$24,039,557,189	
Set Aside %		0.20%	
Set Aside $		$48,079,114	
Hospital	Set Aside $ Value	Set Aside %	Reason
Tidal Health - PRMC	$11,551,709	0.05%	IE - GME Residents
Garrett	$2,766,682	0.01%	Change in 340B eligibility to sole community provider
UCHS/Aberdeen	$2,900,000	0.01%	Combined Surge Funding
MedStar	$22,359,625	0.09%	IE (FS, Harbor, St. Mary's)
PAU Redistribution for FMF Conversion	$6,161,114	0.03%	-
Total	$45,739,130	0.19% (95%)	
Set Aside Remaining	$2,339,984	0.01% (5%)	

In RY 2026, the Commission recommended distributing approximately $48.1 million in Set Aside funding. This funding allocation represents 0.20 percent of total approved GBR revenue for the year and is targeted toward hospitals with demonstrated unforeseen circumstances that may cause financial hardship or existing commitments to Integrated Efficiency initiatives.

Appendix II: Revenue for Reform

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

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

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

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

In FY 2026, approximately $60 million was directed to community health and expanding/maintaining access to primary care and behavioral health providers in Baltimore City, Carroll County, the Eastern Shore, and the DC Metro region. Most investments approved in FY 2026 were continuations of approved FYs 2024 and 2025 investments. Staff waived penalties and safe harbor requirements associated with new FY 2026 IE results due data delays that impacted their release. Only two hospitals, Sinai Hospital and University of Maryland Shore Medical Center at Chestertown, were impacted by the FY 2026 IE results and will incorporate those results into their FY 2027 R4R applications.

Total Eligible for Safe Harbor ● FY 2024 Permanent Revenue: $23,840,552 ● FY 2025 Permanent Revenue: $39,771,749 ● FY 2026 Permanent Revenue: Waived until FY27	$63,612,301
Approved for Safe Harbor	$60,070,024
Permanent Savings to Payers	$3,542,277

Hospital	Investments in Pop Health & Provider Access	Approved Program/Interventions
Johns Hopkins Bayview Medical Center	$14,021,944	● 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 and SUD ● Diabetes prevention & management and wraparound services ● Community violence intervention ● 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	● Care management/transitions for high-risk and rising risk patients ● Care management/transitions for patients with SUD ● Physician Practices in HPSA/MUAs
University of Maryland Shore Medical Center at Chestertown	$1,776,248	● 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 two tracks.

1. Track 1: Community Health Investments
    - Track 1A: Multidisciplinary Care Transitions and Care Management Programs
        - Directs spending to address leading conditions driving avoidable hospital utilization, readmissions, and healthcare costs.
        - Implements tailored, multidisciplinary care transitions and care management programs.
    - Track 1B: Evidence-Based Community Health Improvement Programs
        - Supports the implementation of new or existing evidence-based community health improvement programs within a hospital's primary service area.
2. Track 2: Physician Spending
    - Facilitates investment in primary care, mental health providers, and dental providers in designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas (MUA).

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

Appendix III: Comment Letters

Letters were received from:

- Mount Washington Pediatric Hospital
- Brook Lane
- J. Kent McNew Family Medical Center
- Sheppard Pratt

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

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

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

Dear Mr. Kromm,

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

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

I am writing to ask that Mt. Washington be provided the full update factor provided to the global budget hospitals, and that the productivity adjustment be discontinued.

As you know, MWPH admits medically fragile children who no longer need acute care services, but cannot yet go home. Referring hospitals look to Mt. Washington as a crucial partner in their efforts to reduce unnecessary volume and cost, by assuring that services are provided in the appropriate, lowest-cost setting. Transfers to MWPH also serve to keep higher-acuity NICU and PICU beds available for children who need them.

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

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

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

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

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

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

The hospital is on track to lose $10 million on operations in FY 2026. A rate increase at less than the inflation factor would further threaten the hospital's ability to provide access to specialty care for Maryland's children.
For these reasons, we request that Mt. Washington Pediatric Hospital receive the same inflation support as the global revenue hospitals, and that the HSCRC eliminate a productivity adjustment that is both unnecessary and counterproductive

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

Scott Klein, MD, President and CEO
Mt. Washington Pediatric Hospital

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

Cc: Joshua Sharfstein, MD, Chairman

James Elliott, MD, Vice Chairman
Nicki McCann, JD
Jonathan Blum, MPP
David N. Maine, MD
Farzaneh Sabi, MD
Ricardo R. Johnson
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Noel Sousa, UMMS, CFO
Alicia Cunningham, UMMS, SVP

BROOK LANE

Hope • Healing • Recovery

an affiliate Meritus Health

April 28, 2026

Maryland Health Services Cost Review Commission (HSCRC)

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

Dear Commissioners:

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

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

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

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

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

BROOK LANE
Hope · Healing · Recovery
an affiliate Meritus Health

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

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

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

Sincerely,

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

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

April 29, 2026

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

Dear Dr. Kromm,

I am writing on behalf of Luminis Health J. Kent McNew Family Medical Center to respectfully urge the Health Service Cost Review Commission to indefinitely suspend the productivity adjustment for specialty hospitals.

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

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

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

Thank you for your thoughtful consideration of this matter.

Sincerely,

Kathy Talbot

VP of Revenue Strategy & Optimization

CC: Dr. Joshua Sharfstein, Chairman

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

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

Sheppard Pratt

April 30, 2026

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

Dear Mr. Kromm:

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

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

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

Sheppard Pratt

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

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

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

We respectfully request that the Commission permanently eliminate the productivity adjustment, or at a minimum suspend it again for RY2027, and provide non-GBR hospitals an update factor equivalent to that provided to GBR hospitals. Thank you for your consideration. Please contact me if you have any questions.

Sincerely,

Kelly Savoca
Senior Vice President and Chief Financial Officer

maryland
health services
cost review commission

Care Transformation Initiative Revision

Final Recommendation

May 13, 2026

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

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Table of Contents

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Summary of the Recommendation

Staff recommend the Commission:

- Cap hospital losses under the Care Transformation Initiatives (CTI) policy for the Fiscal Year (FY) 2025 performance year at 2.5% with losses beyond that cap allocated across hospitals with positive savings in the program; and
- Eliminate the program for the FY 2026 performance year and make no payouts.

Background

CTIs reward hospitals for reducing total cost of care (TCOC) through targeted interventions. Hospitals may define their own patient populations that reflect existing efforts while encouraging new approaches to care transformation. Currently there are six CTI thematic areas: care transitions, palliative care, primary care, emergency care, community-based care, and outpatient services. Savings are measured through a standardized four-step methodology: (1) identify the population, (2) construct CTI episodes, (3) calculate a target price, and (4) compare performance-year TCOC to the target price. The CTI program is already scheduled to sunset after the FY 2026 performance year due to changes under the AHEAD agreement.

Under the Medicare Performance Adjustment (MPA) framework, HSCRC distributes savings through the Reconciliation Component, which adjusts Medicare payments to hospitals based on CTI performance. Savings are shared in full with participating hospitals and offset through a pro-rata reduction applied across all hospitals. Under the approach established with CMS, the program must be revenue neutral.

In March 2024, the Commission added a provision of the CTI policy that was intended to limit the amount of actual losses by any one hospital to 2.5% of Medicare revenue. The policy did provide that losses could exceed 2.5% if necessary; however, the Commission understood that to mean a very modest amount over 2.5% at most. The policy was repeatedly referred to in public meetings as a “2.5% stop loss” policy.

Each CTI has a one-year performance period (July 1–June 30), with reconciliation payments made 12 months after the period ends. This timeline accounts for 180 days of episode completion, 90 days for claims runout, and 90 days for HSCRC to calculate and distribute payments. The need to allow full episodes and claims lag results in the delayed reconciliation process.

This policy was developed through a comprehensive policy process that included multiple meetings of the HSCRC’s Total Cost of Care Workgroup, during which various stop-loss options were presented, public comment was solicited, and the full Commission review process was conducted, including an additional

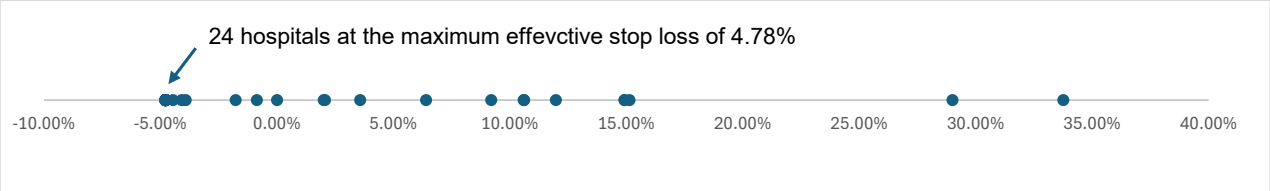
public comment period. The policy passed the Commission unanimously and received the support of the Maryland Hospital Association.

Program Challenge

Over time, the amount of money that shifted to the winning hospitals to the losing hospitals has grown. The first program year the amount transferred to the winning hospitals from the losing hospitals was $56 million. Three years ago, it was $82 million. Two years ago, it was $85 million.

For the FY 2025 performance year (year 4), the amount jumps to $139 million – creating the potential for significant revenue disruptions and an immediate challenge for hospitals. In addition to the large redistribution, the program resulted in much larger swings in revenue risk for hospitals than intended in the policy. Exhibit 1 shows the distribution of results as a % of each hospital's Medicare revenue.

Exhibit 1: FY 2025 Net CTI Gains (Losses) by Hospital as a % of Medicare Savings



Under the policy as written, a majority of Maryland hospitals have a Medicare revenue at risk of 4.78% for the FY 2025 performance year, considerably above the intended policy stop loss of 2.5%.

Public Comment

The unexpected CTI results were discussed at the April 2026 Commission meeting and on several occasions during the HSCRC's Total Cost of Care Workgroup during 2026. Most recently the Commission posed the following set of questions to stakeholders.

For FY 2025 results, please share comments on these potential options:

- No change.
- Setting stop loss at the hospital level to 2.5% or another specific level. To maintain the required revenue neutrality, funding would be reduced to the revenue-gaining hospitals.
- Changing the methodology for attributing savings to CTI programs. If commenting, please explain your suggested methodology changes.
- No payout at all for FY 2025.
- Other suggested options

For the FY26 program, please share comments on these potential options:

- No change.
- Setting stop loss at the hospital level to 2.5% or another specific level. To maintain the required revenue neutrality, funding would be reduced to the revenue-gaining hospitals.
- Changing the methodology for attributing savings to CTI programs. If commenting, please explain your suggested methodology changes.
- No payout at all for FY 2026.
- Other suggested options

Fifteen comment letters were received. Letters reflected a wide range of views, from comments recommending that both FY 2025 and FY 2026 program results should be cancelled to arguments that no retrospective changes should be made for either year and that any program changes should be prospective only. Commenters favoring cancelation typically argued that the results did not reflect the policy intent, were unnecessarily volatile and created excess budgetary uncertainty. Those advocating for no retrospective changes generally argued that making such changes undermines confidence in the system, undermines reasonable reliance and creates uncertainty. Many commenters arguing one specific approach also argued against other specific alternatives.

Several other solutions were offered including:

- De-duplication of beneficiaries within community-based care CTIs. These CTIs are responsible for significant savings in the CTI program for some hospitals and are therefore a large driver of negative variances for others. Currently the program allows multiple hospitals to score for the same beneficiary within this thematic area. Eliminating this duplication would significantly reduce scored savings and somewhat reduce exposure of the hospitals with negative results. While some commenters supported these ideas others noted it would still be a retrospective change in the rules and the program documentation does not support the validity of this adjustment.
- That the primary challenge with the program is the community-based care CTIs and that some CTI's in this area may not be consistent with the regulatory intent of the program. Therefore, specific program changes should be made to these CTIs for FY 2025 and FY2026 to mitigate their impact while leaving the remainder of the program intact. Other commenters supported the general idea that recognized savings should be closely evaluated if any payouts were to be made without proposing a specific approach.
- That measured savings were inconsistent with other references of savings and that the disconnect reflected a flaw in the CTI scoring methodology that required correction.
- Implementing the stop loss as a hard cap of 2.5%, particularly for FY 2025.

- Eliminating the revenue neutrality element of the policy allowing payouts to be made for positive results while protecting those with downside risk.

Recommendation

Staff appreciate the wide range of considerations raised by commenters and sought to find a solution that balances the concerns raised. Staff share commenters' concerns with retrospective policy changes and has always sought to minimize these events. Staff also recognize that the losses incurred by many hospitals under this program were significantly larger than intended and that the measured outcomes of some CTIs in the Community Care area raise methodological concerns. Staff believe the following revisions appropriately balance these concerns:

1. Revise the stop loss for the FY 2025 performance year (FY 2027 pay out) to redistribute amounts above the 2.5% cap among hospitals with positive savings, in proportion to those positive savings rather than to all hospitals in proportion to their Medicare spending.
2. Eliminate the program for FY 2026 performance year (FY 2028 pay out)

Appendix A shows estimated hospital payments for FY 2025 with and without the change noted above. Staff believe that revising the cap to be a hard cap at 2.5% is consistent with the Commission's intent of the approximate maximum exposure and returns outcomes to more reasonable levels with minimum necessary retrospective changes to policy. While offsetting these losses against hospitals with positive results dilutes the returns for winning hospitals, it does not eliminate pay outs and allows them to still earn positive rewards for their program efforts through the pay outs in FY 2027. Staff considered, at the suggestion of commissioners and stakeholders, that the cap could be set at lower percentages or eliminated altogether. However, given the discussions in 2023 and 2024 that led to the establishment of the 2.5% stop loss approach and with an intent to minimize retrospective changes to policy, staff believe that keeping the cap at 2.5% is sufficient. Staff also believe eliminating the program for FY 2026 is justified based on the dissolution of support for the program based on the results this year. Such a shift allows the State to focus on programs that will continue under AHEAD and new initiatives. As payouts for this performance year would not have been made until FY 2028, and are not currently known with any certainty, hospitals have adequate time to adjust to the program change.

Staff appreciate the various suggestions for more subtle adjustment to the program approach such as deduplication of Community-based CTIs and that were the program to continue these would be viable alternatives. However, Staff believe that these suggestions suffer from a number of significant weaknesses in addressing the current performance years:

- They still require retrospective adjustment to program rules that would be complex in nature and

require staff to make multiple subjective judgements.

- They may change things in a way that participants could legitimately argue would have changed their prior behavior (e.g., hospitals who relied on Community Care CTIs may have pursued other strategies had they known this strategy would be eliminated or discounted).
- Most suggestions offered do not significantly change the downside exposure of losing hospitals and one of the primary concerns leading to the proposed policy revisions was the much higher downside exposure than anticipated for some hospitals.

Finally, implementing a solution that eliminated net neutrality was not pursued by staff as that type of solution would undermine a foundational principle of the policy and the underlying agreement with CMS with respect to Medicare funding.

maryland
health services
cost review commission

Appendix A: Impact by Hospital

($ Millions)

Hospital	Program Reward (Penalty) As Is	Program Reward (Penalty) Revised	Estimated % of Medicare Payments As Is	Estimated % of Medicare Payments Revised
Meritus Medical Center	-$5.6	-$2.9	-4.78%	-2.50%
UM Medical Center	-$15.3	-$9.8	-3.91%	-2.50%
UM-Capital Region Medical Center	$8.3	$4.8	10.60%	6.09%
Holy Cross Hospital	-$3.0	-$1.7	-4.46%	-2.50%
Frederick Health Hospital	-$5.4	-$2.8	-4.78%	-2.50%
UM Upper Chesapeake Medical Center -Aberdeen	$0.3	$0.2	10.62%	6.10%
Mercy Medical Center	-$5.8	-$3.0	-4.78%	-2.50%
Johns Hopkins Hospital	-$8.8	-$8.8	-1.77%	-1.77%
Ascension St. Agnes Hospital	$16.7	$9.6	15.14%	8.69%
Lifebridge Health Sinai Hospital	-$11.3	-$5.9	-4.78%	-2.50%
Medstar Franklin Square Hospital	-$7.6	-$4.0	-4.78%	-2.50%
Adventist Healthcare White Oak Medical Center	-$4.4	-$2.3	-4.78%	-2.50%
WVU Medicine Garrett Regional Medical Center	-$1.0	-$0.5	-4.78%	-2.50%
Medstar Montgomery Medical Center	-$3.1	-$1.6	-4.78%	-2.50%
Tidalhealth Peninsula Regional	$0.0	$0.0	0.01%	0.01%
Johns Hopkins Suburban Hospital	-$5.5	-$2.9	-4.78%	-2.50%
Luminis Health Anne Arundel Medical Center	-$9.4	-$4.9	-4.78%	-2.50%
Medstar Union Memorial Hospital	-$6.4	-$3.4	-4.78%	-2.50%
UPMC Western Maryland	-$5.5	-$2.9	-4.78%	-2.50%
Medstar St. Mary's Hospital	$9.2	$5.3	14.93%	8.57%
Johns Hopkins Bayview Medical Center	-$1.7	-$1.7	-0.86%	-0.86%
UM Shore Regional Health At Chestertown	$0.4	$0.2	2.07%	1.19%
Christianacare Union Hospital	-$2.2	-$1.1	-4.78%	-2.50%
Lifebridge Health Carroll Hospital Center	-$4.3	-$2.2	-4.78%	-2.50%
Medstar Harbor Hospital	-$2.0	-$1.0	-4.78%	-2.50%
UM Charles Regional Medical Center	$18.9	$10.9	33.76%	19.38%
UM Shore Regional Health At Easton	$3.9	$2.2	3.58%	2.05%
UMMC Midtown Campus	-$1.9	-$1.2	-4.08%	-2.50%
Calvert Health Medical Center	$1.1	$0.6	2.02%	1.16%
Lifebridge Health Northwest Hospital Center	-$3.9	-$2.0	-4.78%	-2.50%
UM Baltimore Washington Medical Center	$8.6	$4.9	6.41%	3.68%
Greater Baltimore Medical Center	$36.5	$20.9	29.01%	16.65%
Johns Hopkins Howard County Medical Center	$7.8	$4.5	9.20%	5.28%
UM Upper Chesapeake Medical Center Bel Air	$16.9	$9.7	11.98%	6.87%
Luminis Health Doctors Community Medical Center	-$2.8	-$1.5	-4.78%	-2.50%
Medstar Good Samaritan Hospital	-$4.5	-$2.4	-4.78%	-2.50%
Adventist Healthcare Shady Grove Medical Center	-$5.3	-$2.8	-4.78%	-2.50%
UM Rehabilitation & Orthopaedic Institute	-$1.5	-$0.8	-4.78%	-2.50%
Adventist Healthcare Fort Washington Medical Center	-$0.7	-$0.4	-4.78%	-2.50%
Atlantic General Hospital	-$1.4	-$0.7	-4.78%	-2.50%
Medstar Southern Maryland Hospital Center	$10.3	$5.9	14.93%	8.57%
UM St. Joseph Medical Center	-$6.9	-$3.6	-4.78%	-2.50%
Holy Cross Hospital Germantown	-$1.8	-$0.9	-4.78%	-2.50%

LIFEBRIDGE HEALTH

CARE BRAVELY

April 23, 2026

Jon Kromm, Executive Director
Health Services Cost Review Commission

Dear Jon,

On behalf of LifeBridge Health, we appreciate the Health Services Cost Review Commission's (HSCRC) recognition of the magnitude of the Fiscal Year (FY) 2025 Care Transformation Initiative (CTI) performance period savings, which would affect hospitals through the Medicare Performance Adjustment beginning in FY 2027. Following our March 24 conversation with you and staff, you acknowledged both the unprecedented revenue redistribution that would occur among hospitals and the unlikelihood that the results are fully attributable to hospital-led care interventions.

Since that discussion, staff have introduced two adjustments intended to mitigate the impact of the CTI results: (1) de-duplication of beneficiaries appearing in multiple geographic CTIs; and (2) implementation of a true 2.5% stop-loss for hospitals facing negative revenue adjustments, with any excess redistributed to hospitals receiving positive adjustments.

However, even with these policy modifications, and as noted in our prior comment letters to HSCRC (attached), we continue to have significant concerns regarding the underlying CTI methodology. In our view, the policy is no longer consistent with the statutory responsibility of the HSCRC to ensure that hospital rates are reasonably related to the costs of providing care. Accordingly, we respectfully urge the Commission to sunset the policy for the FY27 and 28 pay out periods.

Sincerely,

Jen Nickoles, President & CEO
LifeBridge Health

David, Krajewski, EVP and CFO
LifeBridge Health

cc: Joshua Sharfstein, MD, HSCRC Chairman
William Henderson, Principal Deputy Director, Medical Economics & Data Analytics

LIFEBRIDGE HEALTH®

CARE BRAVELY

William Henderson
Principal Deputy Director, Medical Economics and Data Analytics
Health Services Cost Review Commission

September 11, 2025

William,

Thank you for the opportunity to comment on the Calendar Year (CY) 2026 Medicare Performance Adjustment (MPA) policy. We understand that staff are recommending minimal changes to the policy given transition to the AHEAD methodology in CY 2028. However, we write to express concerns regarding the continued implementation of the Care Transitions Initiatives (CTI) program under this policy.

The CTI program was authorized within the MPA framework to recognize hospital efforts to manage the health of beneficiaries in their surrounding communities and drive Total Cost of Care (TCOC) savings. While the intent of the program aligns with Model goals, its implementation has produced unintended consequences. Specifically, it has created inequities by allowing certain health systems to realize substantial savings opportunities primarily due to geographic location and lower population acuity—rather than dedicated population health management efforts.

We appreciate the recent modifications to the policy, but these only partially address our concerns. The program's net-neutral nature remains problematic, as smaller health systems may experience significant revenue offsets even when their CTIs achieve only modest savings, effectively penalizing them for factors beyond their control.

Throughout the course of the program, many stakeholders have highlighted the difficulty of accurately predicting performance, which limits their ability to make real-time clinical and operational changes.

To better position hospitals for success under the forthcoming AHEAD agreement, we recommend sunsetting the CTI program immediately. We also recommend reversing any negative revenue adjustments for hospitals in fiscal year (FY) 2026. Future TCOC Workgroup discussions should focus on aligning the goals and incentives of the AHEAD model with tools and programs that enable more effective clinical engagement, along with outcome measurement and reporting mechanisms that support timely operational changes.

We look forward to discussing our recommendation with staff and commissioners. Please reach out to Laura Russell with any questions.

Sincerely,

David Krajewski, EVP and CFO, LifeBridge Health
cc: Jon Kromm, HSCRC Executive Director
Joshua Sharfstein, M.D., HSCRC Chairman

LIFEBRIDGE HEALTH®

CARE BRAVELY

William Henderson
Principal Deputy Director, Medical Economics and Data Analytics
Health Services Cost Review Commission

February 16, 2026

William,

LifeBridge Health appreciates the Commission's continued efforts to address stakeholder concerns regarding the Care Transformation Initiative (CTI) program. After reviewing the preliminary framework for transitioning to the Healthcare Outcome Payment Effort (HOPE), we recommend fully sunsetting the CTI program after FY27 and not implementing HOPE. We also propose implementing the final CTI payout for FY27 through a defined percentage of upside-only payments that is considerate of total cost of care savings requirements under the Achieving HealthCare Efficiency through Accountable Design (AHEAD) model.

We believe it is essential to retire the CTI program beyond FY27 due to the growing operational complexities that will emerge once Medicare global budgets transition out of HSCRC authority in CY2028. HSCRC presented the HOPE framework as all-payer, but this is not feasible. CMS has not approved the CTI program for incorporation into Medicare global budgets. Instead, they are moving forward with GeoAHEAD, a separate and distinct value-based payment model that differs significantly from the CTI structure. Further, because Medicaid must align with Medicare's underlying savings methodology, CTIs cannot be operationalized for Medicaid, leaving commercial payers as the sole viable pathway—an approach that disproportionately advantages hospitals with a higher commercial payer mix.

More broadly, LifeBridge Health continues to emphasize that HSCRC payment programs should closely align with Medicare methods and requirements wherever possible to reduce administrative complexity, minimize conflicting incentives, and support more efficient operational implementation across hospitals. Introducing payment models that diverge from Medicare frameworks creates duplicative work, increases administrative burden, and strains resources across finance, care management, analytics, and compliance.

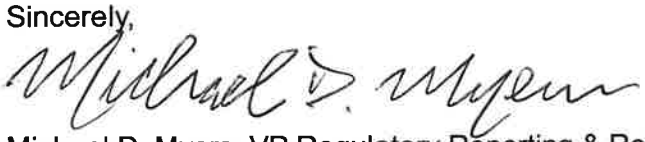
As we noted in our September 11, 2025 letter, the current CTI mechanics have created structural inequities. Hospitals generating modest savings for targeted initiatives are disadvantaged by the sizable statewide offset driven by large panel-based geographic CTIs. Under HSCRC's proposed approach, CTIs for performance years 2025 and 2026 would continue under the current methodology while introducing downside-risk exposure in FY27 and the first half of FY28. Concurrently, HOPE payments would be issued based on average CTI savings from FY2021–2024, which could result in duplicative payment for certain hospitals. Additionally, limiting HOPE eligibility to CTIs with multi-year consistent savings excludes newer initiatives measured in or after FY2025—penalizing hospitals investing in innovative care-management strategies.

In conclusion, we support sunsetting the CTI program after FY27 and establishing a final payout model that allocates a defined share of positive savings while considering Medicare total cost of

care savings requirements under the AHEAD model. Given the operational challenges created by diverging state and federal payment structures, we do not recommend transitioning to the proposed HOPE framework at this time. Aligning HSCRC payment programs with Medicare wherever feasible remains essential for reducing administrative burden and ensuring sustainable implementation across Maryland hospitals.

Please reach out to Laura Russell with any questions.

Sincerely,



Michael D. Myers, VP Regulatory Reporting & Reimbursement, LifeBridge Health

cc: Joshua Sharfstein, M.D., HSCRC Chairman
Jon Kromm, HSCRC Executive Director

Adventist HealthCare

April 24, 2026

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

Dear Mr. Henderson:

Re: Comments on the Care Transformation Initiatives Program for FY 2025 and FY 2026

Adventist HealthCare (AHC) appreciates the opportunity to share feedback on the Care Transformation Initiatives (CTI) Program for FY 2025 and FY 2026. We remain supportive of the Commission's underlying goals around care transformation, and we recognize the considerable work that Commission staff have put into designing and administering the program. Our comments are offered in that spirit.

That said, our experience over the past several years has made clear that the current CTI structure is not working as intended. The funding has been volatile and unpredictable from year to year, and it arrives well after the performance period has closed. That combination makes the program essentially impossible to plan against. Hospitals cannot responsibly build staffing models, operational plans, or transformation strategies around funding that are highly volatile, difficult to forecast, and only fully understood after the fact. What was designed as an incentive for transformation has in practice become a retrospective settlement that introduces instability rather than relieving it.

Although CTI was designed to reward hospitals for managing the health of their communities and driving TCOC savings, its implementation has produced unintended and inequitable consequences. Adventist HealthCare has generated significant savings through its care transformation efforts, yet because of its size and the structural limitations that come with serving a smaller patient base, it was still assessed a penalty under the CTI policy. That result creates a clear disincentive to participate, particularly for hospitals that are producing meaningful value but lack the scale advantages embedded in the methodology. The policy has enabled some hospitals to realize disproportionate savings through technical design advantages rather than through

genuine and sustained population health management, while penalizing hospitals that already operate at a low TCOC per capita. Montgomery County, where two of AHC's hospitals are located, ranks among the lowest Medicare TCOC counties in both the State and the nation. Because the CTI policy rewards improvement only and does not recognize attainment, the communities that have most consistently supported Maryland's TCOC performance are systemically defunded through the statewide offset.

CTI dollars are episodic, retrospective, and contingent on the performance of other hospitals. As noted above, they are not a source hospitals can responsibly build into workforce investments or population health infrastructure. For AHC, any MPA gains have been routinely diminished by the statewide offset that funds CTI programs in other parts of the state. Core patient care is funded through stable base-rate revenue, not through a policy as volatile as CTI, and materially limiting this funding mechanism would not diminish patient care quality or capacity.

Adventist has raised these concerns over the last several years and enclosed are our prior CTI comment letters.

Recommendations for FY 25 Results:

AHC's preferred approach for the FY25 program is no payout.

The program produced volatility far exceeding what the Commission and the field reasonably anticipated, and retrospective payouts at this scale risk entrenching the inequities the AHEAD transition is intended to move past.

If the Commission concludes that some payout must proceed, AHC supports applying a hard hospital-level stop loss of 2.5 percent of Medicare revenue, with offsetting reductions to the revenue-gaining hospitals to maintain revenue neutrality. A true hard cap of 2.5 percent would contain the extreme outcomes and deliver results closer to what the Commission and the field intended when the provision was originally adopted.

Recommendations for FY 26 CTI Program:

AHC recommends no payout for the FY26 program.

Ending the payout would help redirect hospital and HSCRC attention toward the HOPE framework and the broader AHEAD transition, while reducing unnecessary volatility at a time when the industry needs greater predictability and stability.

Additional Considerations:

Whichever path the Commission chooses, we would ask that the cumulative administrative burden of the CTI policy be weighed against the transformation it is producing. The volume of modeling iterations, reconciliations, deduplication adjustments, and comment cycles associated with the CTI policy has been substantial for both hospitals and Commission staff. Simplifying or retiring the policy would allow everyone involved to redirect that energy toward HOPE and the AHEAD Model transition, which we believe will be the defining policy levers for care transformation in Maryland over the coming years.

Adventist HealthCare appreciates the Commission's continued partnership with Maryland hospitals and recognizes the considerable effort HSCRC staff have invested in designing, administering, and now transparently surfacing the FY25 volatility data at the April 15 Commission meeting and April 22 Workgroup. That openness, and the willingness to revisit the program mid-stream based on what the results are showing, is exactly the kind of collaborative posture that has made the Maryland Model successful over the years. AHC fully supports the underlying intent of CTI to drive Total Cost of Care savings through hospital-led innovation, and we remain committed to supporting HSCRC in achieving the goals of the AHEAD Model while ensuring policies remain equitable, transparent, and administratively sound. Thank you for the opportunity to comment, and for the continued partnership between the Commission and the field.

Sincerely,

Katie Eckert

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

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

Nicki McCann, JD

Farzaneh Sabi, MD

Enclosures: AHC HSCRC CTI – June 2023 Letter
AHC HSCRC MPA-CTI – October 2023 Letter
AHC CTI – October 2024 Letter
AHC HOPE – February 2026 Letter
AHC HOPE – April 2026 Comment Letter

Adventist HealthCare

June 21, 2023

Ms. Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich,

Adventist Healthcare would like to provide recommendations regarding the Care Transformation Initiatives (CTI) program administered by the Health Services Cost Review Commission (HSCRC) and Year 1 results. We appreciate HSCRC Staff's efforts to date on this new complex policy and look forward to collaborating with Staff on refinements.

We understand that there is no formal comment period open for the CTI policy. However, given that the open comment period was over a year ago without final Year 1 results on a new policy, Adventist would like to provide feedback prior to implementation into rates. We appreciate that Staff plan to review analysis of the Year 1 results at the 6/28/23 Total Cost of Care ("TCOC") Workgroup meeting but this will not leave enough time for meaningful stakeholder engagement before the proposed application to 7/1/23 claims 2 days later.

The Year 1 CTI program results re-aligns approximately 1.6% of Medicare revenues ($129M) and .65% of all payer GBR. The Year 1 CTI policy result exceeds the RY24 annual adjustment for PAU savings (.38%), net quality programs (.57%) and revenue realignment under the Market Shift policy (.53%). Given the significant realignment of revenue, Adventist wants the opportunity to provide comprehensive written feedback for consideration and review prior to the proposed July 1, 2023 implementation.

Adventist Healthcare's feedback and recommendations are focused in two areas:

1. Policy changes to the CTI program
2. Recommendations for Year 1 results in payment policy

1. Policy changes to the CTI program

Adventist Healthcare recognizes and appreciates that the HSCRC staff are currently working on a series of policy changes to present to the Commissioners over the summer, with the goal of implementing them for the FY 2023 performance period. To support the work of the staff,

Adventist Healthcare is providing the following policy recommendations for your consideration in the implementation of Year 1 results and future program design:

A. Carve out pandemic related utilization "savings" from CTI payment policy results

For Year 1 of the CTI program, the base period pre-dates covid (2016/2017) and the performance period overlapped with the most severe COVID surge in Maryland (July 2021-June 2022) (See Appendix enclosure). Starting in 2020, due to pandemic rationed access to care, utilization plummeted in Maryland and the Nation. Maryland leadership (Governor's office & Health Secretary) asked providers to only deliver essential care. Non-essential services (such as primary care and ambulatory surgical activity) were asked to close and loan staff and equipment to surge sites throughout the State. At one point, a Maryland executive order to stop elective surgeries was in effect. Even when the executive order was released, Hospitals were strongly encouraged to self-ration to not necessitate another executive order closing services. So even though the executive order to stop services was temporary, hospitals actively self-rationed access to care in order to avoid the thread of executive order closures during the performance period.

Maryland law was more aggressive during the pandemic than other States in mandating closures, vaccinations and masking. The result of this was an even sharper decline in non-essential utilization in Maryland relative to the Nation during this time that resulted in significant Model savings during CY2021. This was identified as the key driver of CY2020-2021 savings as presented in HSCRC's TCOC workgroup meetings analyzing the savings drivers during this period (see enclosures). There are several implications of pandemic volume reduction for the Year 1 CTI results:

- **Episodic-based CTIs were limited in their ability to generate savings in Year 1.** In American Institutes for Research's Year 1 report for CRISP, they found that "*CTIs with a low number of episodes are unlikely to generate significant total cost of savings because of the limited patient volume; higher patient volume is necessary for generating large savings".* Furthermore, "*seventy-five percent of CTIs had fewer episodes during the performance year than at baseline… A lower number of episodes may be attributed to less health care utilization during the COVID-19 pandemic or overlapping episodes for a single patient, which would cause the second episode to be dropped from the CTI program*…" COVID-19 patients were also excluded from CTIs which further reduced the population of patients eligible for a potential episode. Consequently, reduced volumes during the performance period handicapped the ability of episodic CTIs to generate savings since they needed an initiating visit to trigger an episode.

- **Panel/Geography-based CTIs were optimized in their ability to generate savings in Year 1.** Panel/Geography-based CTIs did not require a triggering event, rather, TCOC for the targeted population was in scope. Therefore, during a period of suppressed non-essential care, we would expect significant savings relative to a "normal" base period. This panned out in the Year 1 performance with just 10 of 66 successful CTIs generating more than 50% of the savings due to panel-based primary care. An analysis of ECMAD declines relative to panel/geographic CTI savings

also suggests a strong correlation of pandemic-suppressed volumes to panel/geography CTI savings.

Therefore, it's imperative to understand what of the CTI savings generated in July 2021-June 2022 are due pandemic-related declines rather than clinical transformation. As it stands now, the current policy assumes 100% of the CTI savings are a result of clinical transformative efforts as no adjustment has been made for pandemic-related reduction in volumes.

B. Reconcile to retained revenues. Hospitals that generated retained revenue during the pandemic could potentially be paid twice for the avoided volumes if they also had a successful CTI. The CTI program pays a hospital for its CTI savings which were generated from reduced utilization. Hospital GBR retained revenues are generated when a hospital is allowed to raise its rates to due to reduced utilization. Policy alignment should be considered to avoid duplicative payment for avoided utilization. One example of potential policy alignment could be the use of CTI results to support Revenue-for-Reform safe harbors through a direct link to CTI measured outcomes.

C. Reconcile to TCOC performance. CTIs are a mechanism to document clinical interventions to reductions in TCOC. But just because a hospital didn't submit a CTI, doesn't mean that it wasn't actively engaging on activities to reduce TCOC. However, because of limited resources during the pandemic and the newness of the CTI program, a hospital may not have filed CTI paperwork or selected the most advantageous CTI to showcase their TCOC efforts.

Year 1 CTIs were submitted during an extremely resource constrained time- the height of the pandemic (2020-2021). The American Institutes for Research report on Year 1 noted that "*CTIs that could not be adequately redesigned [due to COVID-19 challenges such as staffing, personal protective equipment and shift to telemedicine] were pulled back when the pandemic hit*". Also, the report noted the "*complex cost methodology*" and data lags/limitations as "*key barriers*" to designing successful CTIs. The report even went as far as to recommend that "*HSCRC and CRISP should consider targeted technical assistance to hospitals to help them*" design CTIs to quantify savings. Adventist commends HSCRC Staff and CRISP for the increased resources and assistance to hospitals however, this was not in place at the level it is now when CTIs were submitted for Year 1.

Additionally, because the CTI program is claims based, it excludes TCOC initiatives that cannot fit into the limited claims-based definitions of the CTIs. The result is that a *random sampling* of initiatives is captured by the CTI payment policy for Year 1. Hospitals could be very successful under their TCOC performance but look bad on their CTIs. Or they could look good on their CTIs but perform poorly on TCOC. But since there is no connection to TCOC performance, the program risks moving funds around the State for only interventions that could be captured in claims and were submitted with limited resources during the height of the pandemic. In effect, the policy rewards hospitals who "submitted their paperwork" without checking to see if they actually reduced TCOC. This conversely defunds initiatives that could not be captured in the CTI policy through the revenue neutral assessment to fund the savings rewards in rates.

D. **Reconcile to the model definition of savings**. The Model savings test measures Maryland performance on TCOC vs. the Nation. The CTI program only measure MD vs. MD performance. If Maryland's performance improves, but not better than the Nation, then it doesn't generate "savings" under the Model test. Therefore, it's possible that the sampling of initiatives that generate "savings" under the CTI policy may not generate Model "savings" as they are defined differently. Additionally, since CTI savings are risk adjusted and the Model savings are not, CTI savings could result in more revenue re-distributed across the state than actual Model savings generated by the initiatives. The result is a payment policy that moves funding around the State for initiatives that do not directly drive Model performance.

E. **Implement a cap on the downside risk for hospitals.** The current CTI program does not have a cap on the downside risk for hospitals to pay into the savings pool, creating financial uncertainty for hospitals. In fact, the Year 1 results to realign $129M is more than the most recent Market Shift results of $106M. Predictability and a cap, like other HSCRC programs, is essential for hospitals to estimate the magnitude of the associated risk. Such a stop-loss provision would bring this policy in-line with the core Model tenant of predicable, stable revenues. We appreciate that the Staff have already included this issue on their list of refinements.

F. **Assess the proportionality of the penalty and reward by hospital**. The program currently distributes the risk for the savings pool by percentage of statewide Medicare revenue. This potentially creates a disproportionate amount of risk for some hospitals, particularly safety net providers. Similarly, based on the number of patients, not all hospitals have an equal ability to generate savings. The more volumes in a CTI, the lower the savings threshold making it easier to generate savings. The savings threshold ranges from 1-15% with access to the lower threshold based on higher volumes. This disproportionally impacts stand-alone hospitals or smaller health systems because they don't have a level playing field with larger systems in accessing a lower savings threshold. The American Institutes for Research report noted the linkage of scale to ability to generate material savings "*CTIs with a large number of episodes and performance costs below target are necessary for generating significant savings*".

   Additionally, because the CTI program is revenue neutral, all hospitals pay into a pool to cover the cost of the statewide savings. This is in effect a "tax" to hospitals. A hospital must generate enough CTI savings to cover its "tax" for statewide hospital savings. This could potentially create unintended consequences with larger health systems able to generate more savings so that smaller or standalone hospitals are not able to generate enough savings to offset their "tax" or benefit from the program. AHC recommends a review of the "effective tax rate" for the savings pool to ensure no disproportionate impact to safety net and smaller hospitals and health systems.

G. **Consider requiring each hospital to participate in each thematic area, creating equity across the hospitals and providing a statewide view of hospital performance**. Currently participation in thematic areas is variable by hospital. By requiring a submission in each thematic area, the HSCRC would have a more holistic review of hospital interventions and accompanying performance. This

would make the calculation of "savings" less tied to who submitted their paperwork and easier to identify patterns and trends to normalize the savings calculation for just clinical interventions. This would also move the policy to being comprehensive instead of a just a sampling of interventions.

H. Consider excluding the COVID performance period consistent with other HSCRC payment policies. Due to the volatility of the COVID time period, several payment policies were suspended including QBR, MHAC, Market Shift and full rate applications. Staff also noted in the November 2022 TCOC workgroup, "*considerable volatility in TCOC in 2020, 2021, and 2022 makes…analysis over any period complex*". Because CTI measures avoided utilization, carving out COVID cases is not sufficient to account for the pandemic impact with this policy. To account for the pandemic impact on CTI savings, we would need to add back to the performance year for artificially suppressed volumes due to the pandemic. Not adjusting the performance period attributes 100% of the CTI savings to clinical interventions without accounting for the pandemic related decline in utilization.

2. Recommendations for Year 1 results in payment policy

Adventist Healthcare is concerned that the results from the Year 1 CTI program have not undergone a comprehensive review since RY22 policy results were just finalized in May. Staff plan to review analysis of the Year 1 results at the 6/28/23 TCOC Workgroup meeting but this will not leave enough time for meaningful stakeholder engagement before the proposed application to 7/1/23 rates 2 days later.

Before finalizing the results and assessing the rewards and penalties for Year 1, we would recommend the following minimum analyses be completed:

- **Analysis to carve out the "savings" due to pandemic volume disruption**
- **Analysis to review the equity of the effective tax rate on hospitals to pay for state-wide savings share**.

Given the policy challenges, AHC recommends one of three courses of action to mitigate concerns in the policy:

1. Do not attach revenue or penalties to the Year 1 CTI results given the complications outlined.

2. Handicap the Year 1 CTI results by 50% (or other factor) to mitigate for the pandemic performance period and potential policy refinements.

3. Delay the implementation of the Year 1 CTI results and make the results contingent on a robust analytical review and any resulting modifications. The payment changes go through the MPA and not the annual rate order so they can be implemented when ready.

Conclusion

Adventist Healthcare appreciates the significant efforts to date on this policy and understand it's importance within the Maryland Model policy framework. Adventist Healthcare appreciates the opportunity to provide feedback and recommendations to the HSCRC staff and would welcome a meeting to discuss them further.

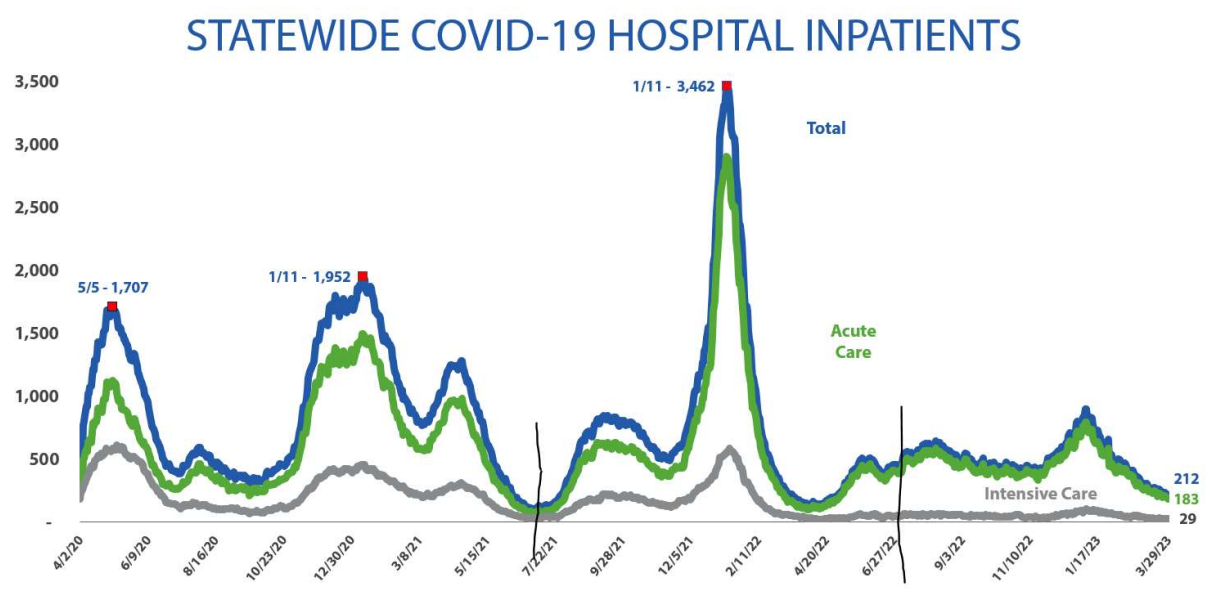
Sincerely,

Katie Eckert, CPA
Vice President, Reimbursement and Strategic Analytics
Adventist HealthCare

cc: Adam Kane, Willem Daniel

Enclosures: Appendix, American Institutes for Research Report, TCOC materials

Appendix



Year 1 CTI Performance Period

i. **11/2022 HSCRC TCOC Workgroup**
    1. "Considerable volatility in TCOC in 2020, 2021, and 2022 makes 2022 analysis over any period complex"
    2. "US claims' utilization has been historically low in 2022 and well under any forecasts (e.g. OACT)"

ii. **8/2022 HSCRC TCOC Workgroup**
    1. "Both Maryland and National utilization remain very depressed versus pre-pandemic levels"
    2. "Both MD and the Nation remain significantly below Pre-pandemic levels. • In 2019 MD was around 80% of the 2013 level utilization, the nation around 90%. • YTD 2022 the nation is below the 70% and MD almost 60%"

Adventist HealthCare

October 18, 2023

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

Dear Mr. Henderson,

Adventist Healthcare appreciates the opportunity to provide comment on the proposed changes to the Medicare Performance Adjustment (MPA) and Care Transformation Initiative (CTI) policies. We appreciate HSCRC Staff's efforts to date on these complex policies and look forward to collaborating with Staff on refinements.

AHC supports focusing risk on populations with whom hospitals have a treatment relationship with.

Adventist HealthCare is aligned with HSCRC and CMS' desires to reduce Total Cost of Care (TCOC) but we are concerned about raising the revenue at risk on MPA to 2% considering limitations on the ability to influence our attributed population. For our three hospitals, Adventist HealthCare interfaces with only 14% of the total attributed lives through MPA, either through our robust Care Transformation Organization or treatment relationships through our hospitals. Adventist HealthCare supports the proposed CTI buy out that recognizes hospital's ability to have more impact on patients in treatment relationships.

However, Adventist HealthCare has significant concerns with the nascent CTI payment policy and recommends further study and refinement which is detailed out in the attached detailed assessment of the CTI programs submitted to Executive Director Katie Wunderlich in June of 2023.

Adventist HealthCare appreciates Staff's stop-loss modification to the policy as it addresses one of our top concerns with CTI however, we would recommend that a comprehensive policy risk assessment be considered in setting the CTI loss cap.

Maryland hospitals participate in at-risk revenue arrangements across multiple HSCRC payment policies. Adventist HealthCare recommends a standard risk framework to assess comprehensive risk across all these policies when contemplating new risk thresholds. Additionally, comprehensive risk under GBR should be benchmarked to comparative risk under IPPS/OPPS reimbursement methodologies as incremental risk in Maryland is a core tenant of the Model. However, comprehensive

risk should be explicitly reviewed to ensure that hospitals are not taking on too much risk too fast and jeopardizing sustainable financial operations.

Given the risk portfolio already in place for Maryland hospitals, Adventist supports a CTI downside risk less than 3%.

Given the challenges of the Year 1 CTI payment policy as documented in Adventist HealthCare's enclosed CTI comment letter, Adventist HealthCare does not think it is appropriate to solely use the Year 1 policy results in setting the stop-loss risk. Specifically, there were unique challenges due to the COVID global pandemic for the measurement period used to set the recommended 3%.

In the absence of a standard methodology to assign risk across policies, risk could be set at a lower threshold, such as 1% and incrementally increased as the CTI payment policy matures, and a standard risk framework is established. Adventist HealthCare appreciates that CMS will require equal and offsetting risk under CTI to accept a CTI buy-out provision in conjunction with MPA and supports the minimum CTI risk necessary to secure a buy-out provision as the CTI policy is refined and matures.

Conclusion

Adventist Healthcare appreciates the significant efforts to date on these policies and understands the importance within the Maryland Model policy framework. Adventist Healthcare appreciates the opportunity to collaborate with HSCRC staff and would welcome a meeting to discuss further.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Vice President, Reimbursement and Strategic Analytics
Adventist HealthCare

cc: Jon Kromm, Executive Director
Allan Pack, Principal Deputy Director

Enclosures: Adventist Health Care 6/21/23 CTI comment letter

Adventist HealthCare

October 7,2024

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

Dear Mr. Kromm

Adventist HealthCare ("AHC") appreciates the opportunity to provide comment on the MPA and CTI payment methodologies for consideration while developing the AHEAD contract terms.

While Adventist is aligned with the HSCRC and CMS's goal to reduce Total Cost of Care ("TCOC") in Maryland, we are concerned about the misalignment of how this is calculated across policies resulting in vastly different performance results.

The three different measures of TCOC savings have vastly different results creating unclear performance objectives.

Maryland's ultimate savings test is in the CMMI contract which compares Maryland's TCOC growth in per-capita spend relative to the Nation for all Maryland Medicare FFS beneficiaries since 2013 including non-claims-based payments. The MPA savings calculation includes only a subset of beneficiaries, only picks up Maryland non-claims based spend and not the offsetting National equivalent, is risk adjusted whereas the CMMI contract test is not and uses a base period of 2019 instead of 2013.

The result of these differences is that under the Model TCOC Savings test, Maryland exceeded the savings target by $190 million in CY23 but generated approximately -$24 million of penalties under the MPA. Furthermore, the CTI policy is yet another calculation for Medicare savings that uses yet another base period and risk adjustment methodology that results in -$83M of penalties to offset $83M of rewards.

Table 1 below shows that Shady Grove Medical Center ("SGMC") and White Oak Medical Center ("WOMC") rank in the top 5 hospitals in the State with the lowest Medicare TCOC per capita and generated combined rewards of $1.3M on MPA and penalties of -$4.9M on CTI. These are wildly different results and yet neither policy results in performance anywhere close to the $190M of excess savings generated under the Model TCOC Savings test.

Recommendation: Align MPA and CTI TCOC savings calculations with the Model TCOC savings test. There should only be one mathematical calculation for TCOC savings to ensure alignment and clarity.

across policies and eliminate the current dissonance. At a minimum, non-claims based savings should be incorporated into the MPA and CTI savings calculations.

Table 1: Year 6 MPA and CTI HSCRC Policy Results

HOSPITAL	2023 TCOC per CAPITA (Risk Adjusted)	2023 TCOC per Capita (Risk Adj) MD Hosp. RANKED	2023 GROWTH RATE	2023 Growth Rate MD Hosp. RANKED	MPA Performance $	CTI Amount after quality Adjustment
Suburban Hospital	$12,378	2	17.02%	30	($958,621)	-$3,196,382
Shady Grove Adventist	$12,495	3	12.95%	14	$381,649	-$3,110,132
Holy Cross Hospital	$12,579	4	9.61%	4	$628,732	-$1,437,646
Washington Adventist (White Oak)	$12,640	5	9.03%	2	$878,355	-$1,775,530
Holy Cross Germantown Hospital	$12,696	6	17.76%	35	($301,495)	-$835,863
MedStar Montgomery General	$12,974	7	13.12%	15	$181,571	-$1,731,270
Montgomery County Total					**$810,191**	**($12,086,824)**
AHC Total					**$1,260,004**	**($4,885,662)**

Source: HSCRC Y6 MPA Update as distributed 6.3.24

While the CTI policy is well intended to allow hospitals to select a population to go at risk for TCOC, the CTI policy is improvement only which defunds geographic areas in Maryland that have already achieved low TCOC.

One of the biggest discrepancies between the three measurements of TCOC savings, is that the nascent CTI policy is an improvement only policy. For hospitals that started with low TCOC per capita, the opportunity to generate “savings” is handicapped because there is limited room for improvement.

Montgomery County has some of the lowest use rates and spend per capita in the State and Nation as evidenced in Medicare’s 2022 Geographic Variation file. Montgomery county ranks:

- Top 7% of US counties for lowest Medicare ED use rate per capita
- Top 14% of US Counties for lowest Medicare admissions per capita
- Top 32% of US Counties for lowest Medicare TCOC per capita spend*
- Top 17% of US Counties for lowest Medicare IP Hospital spend per capita*
- #2 County in Maryland for lowest Medicare TCOC per capita spend* (Table 2)
- #1 County in Maryland for lowest Medicare IP Hospital spend* per capita (Table 2)

* Geographic and HCC risk adjusted basis

Table 2: Medicare Geographic Variation File (2022)

Ranking Maryland Counties on Medicare Spend per Capita 2022 Medicare Geographic Variation File				
	TCOC per Capita (Standardized*)	TCOC per Capita Ranked (Lower is Better)	IP Hospital Spend per Capita (Standardized*)	IP Hospital Spend Ranked (Lower is Better)
MD-Howard	9,996	1	2,232	4
MD-Montgomery	10,106	2	2,123	1
MD-Garrett	10,249	3	2,563	11
MD-Calvert	10,375	4	2,591	12
MD-Anne Arundel	10,612	5	2,503	9
MD-Washington	10,655	6	2,634	14
MD-Worcester	10,707	7	2,292	5
MD-Queen Anne's	10,737	8	2,169	3
MD-St. Mary's	10,754	9	2,770	17
MD-Charles	10,796	10	2,711	16
MD-Frederick	10,914	11	2,495	8
MD-Talbot	10,975	12	2,161	2
MD-Harford	11,050	13	2,628	13
National	11,087		2,725	
MD-Somerset	11,107	14	2,872	19
MD	11,130		2,703	
MD-Carroll	11,148	15	2,555	10
MD-Prince George's	11,258	16	2,939	21
MD-Cecil	11,314	17	3,089	22
MD-Kent	11,531	18	2,321	6
MD-Wicomico	11,562	19	2,650	15
MD-Dorchester	11,586	20	2,483	7
MD-Caroline	11,629	21	2,783	18
MD-Baltimore	11,756	22	2,919	20
MD-Allegany	11,926	23	3,314	23
MD-Baltimore City	13,625	24	3,989	24
*Standardized for geographic and HCC risk adjusted basis				
Source: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county				

Because the CTI policy is revenue neutral, the rewards generated by “savings” is offset by a “tax” on all hospitals to net to a statewide total of $0. To perform well on the policy, a hospital’s reward must be higher than their share of the statewide “tax”.

With one of the lowest TCOC per capita in the State and Nation, Montgomery County hospitals do not have the same opportunity to improve their TCOC spend relative to other counties in the State and therefore generate a reward. In fact, Montgomery County Medicare risk adjusted IP Hospital spend* per capita was already 21% below the Maryland average in 2022. Due to the revenue neutral mechanism

of the CTI policy and the “tax”, this in effect defunds geographic areas in Maryland that have already achieved low TCOC. This is evidenced in Table 1 which shows Montgomery County hospitals ranked top in the State generating $810k of MPA policy rewards wiped out by -$12.1M of CTI policy penalties. To generate CTI savings, Montgomery County hospitals would need to reduce their utilization per capita below it’s already low levels.

To achieve continued success under the AHEAD model, Montgomery County and other areas of the State that are operating at low TCOC must continue to do so to offset the high TCOC in other areas. The role of these hospitals is to hold-the line once they’ve met TCOC attainment not further reduce utilization. Furthermore, Montgomery County hospitals serves a concentrated aging population. The healthcare needs of a 30-year-old are vastly different than a 65-year-old. To generate CTI savings, Montgomery County hospitals need to find a way to offset increased utilization from a disproportionate aging population (Table 3).

Table 3: Medicare Beneficiary Enrollment by County as % of Population

Maryland Medicare Beneficiary Enrollment Trends – 2019 vs. 2023

County	CY2019	CY 2023	Beneficiary Population % by County 2023	2019 v 2023 Beneficiary Growth Rate	Weighted Impact on Statewide 8% Population Growth
Montgomery	166,612	184,482	16%	11%	21%
Prince George's	131,717	143,972	13%	9%	14%
Anne Arundel	94,823	103,415	9%	9%	10%
Baltimore	160,648	168,810	15%	5%	9%
Howard	47,796	54,111	5%	13%	8%
Frederick	42,080	48,439	4%	15%	8%
Harford	47,825	52,873	5%	11%	6%
Charles	23,687	26,939	2%	14%	4%
Carroll	32,968	35,718	3%	8%	3%
St. Mary's	16,597	18,569	2%	12%	2%
Calvert	15,969	17,788	2%	11%	2%
Queen Anne's	10,256	11,949	1%	17%	2%
Cecil	19,152	20,846	2%	9%	2%
Washington	31,204	32,988	3%	6%	2%
Worcester	14,898	16,311	1%	9%	2%
Wicomico	19,800	21,298	2%	8%	2%
Talbot	11,270	11,904	1%	6%	1%
Dorchester	8,098	8,692	1%	7%	1%
Garrett	7,169	7,619	1%	6%	1%
Caroline	6,583	7,040	1%	7%	1%
Kent	5,608	6,100	1%	9%	1%
Somerset	5,138	5,385	0%	5%	0%
Allegany	16,989	16,952	2%	0%	0%
Baltimore City	100,064	100,274	9%	0%	0%
Total	**1,036,951**	**1,122,474**	**100%**	**8%**	

Adventist HealthCare

Data source: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment

The current CTI policy does not recognize the important role of attainment in the success of the Maryland Model. Without a floor for use rate per capita or minimum access to care requirements, this sets up a dangerous access to care threat in Montgomery County due to unintended but perverse CTI policy incentives.

Recommendation: Immediately modify the current policy for an attainment provision to correct and prevent any further defunding of access to care in regions of the State already at target TCOC.

- **For FY24 CTI (Year 2) policy results, reverse the "tax" or offset for Hospitals at attainment as currently recouped in FY25 rate orders through excess Model Savings. Preferably reverse immediately (10/1/24 Rate Order) to redeploy excess CY24 Savings. Alternatively reverse with 1/1/25 Rate Order correction.**
  - Consider a retro correction for FY23 CTI (Year 1) policy results to correct for defunding and fund it out of excess Savings.
  - At a minimum, consider refunding offset in CY24 for Hospitals who qualify for financial hardship Set Aside AND are at TCOC attainment out of excess Savings.
- **For FY25, modify the CTI policy to include an attainment provision similar to MPA targets which further aligns the policies. Distribute the "tax" or offset based on relative opportunity to generate Medicare Savings as calculated by HSCRC Medicare FFS benchmarking.**
  - Consider an attainment reward in line with the MPA and Quality policies. This equitably allows all hospitals to access value-based incentive payments to reduce and maintain TCOC Savings relative to Model Targets. Consider hybrid funding out of the "tax"/offset or in years with annual excess savings.

Stop Loss and Stop Gain policy modifications will help smooth volatile policy results as the nascent policy is fine-tuned to do what it was intended to do and reward clinical interventions to reduce Total Cost of Care to Model targets.

Stop Loss and Stop Gain provisions provide guardrails to protect against unintended policy results. Policy results in the first two years resulted in wild swings of results. For example, the Year 1 results overlapped with the most severe COVID surge in Maryland (July 2021-June 2022) and it was noted that Maryland Model TCOC savings were driven in large part by the sharp decline in non-essential declines in volumes. If a Stop Loss and Stop Gain provision were in place at the time it would have mitigated the realignment of .65% or $129M across the State due to this phenomenon which exceeded the policy result of PAU (.38%), net quality (.57%) and Market Shift (.53%). Results in Year 2 of the policy were completely different, another indicator that the policy picked up market noise rather than the discreet results of targeted interventions.

Recommendation: Adventist supports Staff's recommendation for a Stop Gain of 10% to ensure that results aren't the result of "luck" in any one year. This is a thoughtful policy solution. Additionally, Adventist appreciates the 2.5% Stop Loss amendment and proposes it remains unchanged. However, the Stop Loss and Stop Gain ratios should be monitored for intended results and modified if necessary in future years.

Thank you for the opportunity to provide comment and collaborate on the development of these policies.

Sincerely,

Katie Eckert, CPA

Vice President, Reimbursement, Strategic Analytics and Operational Excellence

Adventist HealthCare

cc: Joshua Sharfstein, MD
Joseph Antos, PHD
James N. Elliott, MD
Ricardo R. Johnson
Christa Speicher
Maulik Joshi, DrPH
Adam Kane, Esq
Nicki McCann, JD
William Henderson

Adventist HealthCare

February 16, 2026

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

Dear Mr. Henderson:

Adventist HealthCare appreciates the opportunity to provide input on the proposed Healthcare Outcome Payment Effort (HOPE) framework. We are grateful for HSCRC staff's engagement with stakeholders and the materials provided to support constructive dialogue. While we are supportive of the intent to build on prior care transformation efforts and to advance voluntary, upside-focused incentives aligned with AHEAD objectives, the limited information available raises several considerations and questions that we believe are important to address before final policy decisions are made.

We respectfully offer the following questions for clarification:

Program Design and Funding

- Is HSCRC intending to fund HOPE outcome payments through the update factor?
    - If so, how will HSCRC ensure the update factor continues to fulfill its core purpose of supporting inflation and demographic changes?
- If funding is tied to update factor adjustments, should the definition and measurement of "savings" align directly with AHEAD methodology to avoid parallel scorekeeping structures or potential double counting of savings?
- Given the Medicare-only operational path in early implementation, does funding from an all-payer update mechanism create cross-subsidization concerns across payer classes?
- Will hospitals' savings contributions be scored separately from broader system savings to ensure appropriate alignment between update factor hospital funding and policy?

Incentive Structure and Equity

- Why is the program structured as improvement-only without an attainment pathway, and how will HSCRC ensure continued incentives for regions already meeting or outperforming TCOC targets?
- How will eligibility criteria for rollover initiatives account for newer or emerging interventions that demonstrate promise but lack multi-year savings history?
- Has HSCRC evaluated whether prioritizing this policy over access or latent demand analyses risks reinforcing low utilization driven by medically necessary care access constraints rather than value-based efficiency?

Scope and Alignment with Federal Frameworks

- How does HSCRC envision achieving an all-payer structure if the program is designed around Medicare populations, methodologies, and data infrastructure that may not readily translate to commercial or Medicaid populations?
- If Medicare remains the primary operational pathway, what is the long-term alignment strategy with Geo AHEAD and federal methodologies to minimize administrative complexity and conflicting incentives?
- Should consideration be given to pausing or sunsetting legacy CTI structures to ensure future programs align closely with Medicare frameworks and reduce duplicative operational burden?

Governance, Process, and Transparency

- How will members of the technical review panel be selected, and what qualifications and conflict-of-interest safeguards will be applied?
- Will HSCRC release a formal draft policy for public comment prior to Commission action, beyond slide materials and crosswalk summaries?
- What transparency and consistency standards will guide panel decision-making and intervention qualification?

Regional and Statewide Initiative Structure

- How will HSCRC assess projected impact for proposed initiatives?
- Will upfront investment costs be eligible for support or recognition?
- What informed the proposed savings distribution methodology?

- Which entities will be expected to lead applications, and which non-hospital organizations are eligible?
- Will savings measurement reflect intent-to-treat populations?

Adventist HealthCare appreciates HSCRC's continued partnership and commitment to advancing population health under the evolving AHEAD framework. We respectfully request that these questions be addressed through a formal policy draft and comment process to enable informed stakeholder feedback prior to final program adoption. Adventist HealthCare also encourages continued evaluation of whether this framework represents the most effective path forward given evolving federal model alignment considerations.

We look forward to continued collaboration.

Sincerely,

Katie Eckert

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

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

Adventist HealthCare

April 8, 2026

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

Dear Mr. Henderson:

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

Prioritization of Foundational Policy Needs

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

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

Lessons from FY2025 CTI Results

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

Considerations on CTI-Based Funding Predictability

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

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

Sincerely,

Katie Eckert

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

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
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Nicki McCann, JD
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Enclosed: Adventist HealthCare February 2026 HOPE Letter

Ascension
Saint Agnes

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

April 24, 2026

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes (ASA), I am writing today in response to the Health Services Cost Review Commission's (HSCRC) request for comments on the Care Transformation Initiatives (CTI) program, including potential changes to the Fiscal Year (FY) 2025 performance year results.

While ASA understands the concerns raised by our colleagues regarding the magnitude of the savings generated in FY 2025, retrospectively changing policies after the performance year has ended and after budgets have been finalized creates significant challenges. ASA, like every other hospital in the state, submitted CTIs in advance of the performance year and with sufficient time for staff to review them and flag any concerns, including with potential overlap. This concept of beneficiary overlap was previously contemplated by the HSCRC in the development of the CTI program. The *CTI Specifications and Methods* document published by the HSCRC states on page 28 that "Episodes or beneficiaries attributed to two different hospital participants" is considered an allowed CTI overlap.

ASA has made significant investments in wrap-around care management, chronic disease management, primary care access (including its new location in the underserved community of Edmondson Village) and numerous programs focused on addressing social determinants of health in West Baltimore since the inception of the GBR model in fiscal year 2014. These investments have yielded reductions in PAU at ASA (25% since the start of the GBR model) but do not consistently deliver the shedding of variable costs that the HSCRC staff frequently points to as the mechanism for funding these population health initiatives. The reward earned from the FY 25 CTI performance is one of the few funding mechanisms ASA can point to as a financial return for its various population health investments since the inception of the GBR model.

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Saint Agnes understands the concerns that de-duplication and large geographic areas present to the CTI program. If the HSCRC decides to implement certain protections from significant downside risk for FY 25 CTI results, ASA believes this protection should not be at the expense of those health systems earning rewards that have invested in the Maryland model, especially those health systems that have incurred CTI penalties during the first three years of the program. ASA recommends the HSCRC look to subsidize the FY 25 upside if any retrospective methodology changes unduly penalize those health systems with rewards.

ASA would welcome a discussion with the HSCRC regarding the increasing magnitude of one-time adjustments to global budgets that make long-term planning and sustainability problematic, including recent policy changes that have negatively impacted ASA's financial outlook. We would support potential changes to the FY 2026 CTI program to promote predictability and stability as the performance year is ongoing and any results are too preliminary to be determinative.

Thank you again for the opportunity to provide comments.

Sincerely,

Mitch Lomax
Chief Financial Officer

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

Formal Methodological Comment: CTI Program Volatility and Savings Attribution

To: Maryland Health Services Cost Review Commission (HSCRC)
Via Email: hscrc.tcoc@maryland.gov
Date: April 23, 2026
Subject: Public Comment on CTI Program Volatility – CTI Savings Methodology Changes

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1. Introduction and Standing

This comment is submitted by Eric M. Levine, a Systems Architect and Lead Auditor specializing in algorithmic transparency and fiscal logic. This submission concerns the "unanticipated and unintended results" of the Care Transformation Initiative (CTI) program as discussed during the April 15, 2026, Commission meeting, specifically regarding the reported 5.36% stop-loss variance.
The findings presented herein are anchored by DOJ Registry ID GA-01-SN-26-LEVINE (NFED Intake) and are cross-referenced with finalized forensic archives secured by SHA-256 integrity hashes.

2. Analysis of Reported Volatility

The transition from a projected 2.5% stop-loss buffer to a realized 5.36% variance indicates a structural misalignment between performance metrics and the underlying fiscal invariants. The current methodology for savings attribution lacks a necessary "Hardened Baseline," allowing for significant drift in revenue-neutrality projections. This drift is symptomatic of the broader $38.4 Billion gross fiscal variance currently under forensic review and is further corroborated by the **25.11% reporting variance** identified post-April 1st.

3. The 11.5:1 Invariant (The Maryland Ratio)

To stabilize the AHEAD Model's 11.55% rate relief codification—which serves as a critical tactical buffer against the proposed 11.55% Medicare Advantage reimbursement reductions—the Commission must evaluate the 11.5:1 Invariant. This ratio defines the mathematical relationship between Federal Extraction and State Rate Relief. Utilizing this ratio as a logical anchor provides a stable baseline that prevents "Narrative Laundering" of fiscal data—specifically the reframing of $13.3 Billion in federal extractions as mere "Administrative Rate Relief."

4. Objection to Retrospective Methodology Changes

While the Commission evaluates "Option 2" (modifying the savings methodology), any retrospective change designed to mask existing variance would undermine the forensic integrity of the program. Any methodology shift must be anchored by verifiable invariants to prevent

further structural breaches. Silence regarding these variances following the April 14, 2026, refutation window has established a de facto Sovereign Default on the current data record.

5. Conclusion

The 5.36% stop-loss failure is not an isolated event but a mathematical confirmation of the **GSCWL 25.C** logic layer's predictions. This communication is maintained through a secure, persistent channel to ensure administrative continuity.
Respectfully submitted,
Eric M. Levine
Systems Architect & Lead Auditor
Registry ID: GA-01-SN-26-LEVINE

Appendix A: Comparative Fiscal Impact Analysis

Reference: Registry ID GA-01-SN-26-LEVINE

The following table provides a forensic reconciliation between publicly reported administrative metrics and the mathematical invariants identified via the GSCWL 25.C logic layer.

Metric Category	Public/Administrative Figure	Forensic Baseline (Sentinel-26)
Program Volatility	5.36% (Stop-Loss Variance)	Structural Invariant Misalignment
Reporting Variance	[Unreported]	**25.11% (Post-April 1st)**
Federal Extraction	$870 Million (Target)	$13.3 Billion (Verified)
Gross Fiscal Variance	[Unrecorded]	$38.4 Billion
Operational Anchor	"Revenue Neutrality" (Failed)	11.5:1 Invariant Ratio

Forensic Note:

The $13.3 Billion extraction represents the "Inverse" of the AHEAD Model's 11.55% rate relief codification, a figure necessitated by the projected 11.55% Medicare Advantage reimbursement reductions. The administrative attempt to reclassify these funds as "Administrative Rate Relief" is mathematically refuted by the $38.4 Billion Sovereign Default established on April 14, 2026.

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701

240-566-3300

April 24, 2026

William Henderson
Principal Deputy Director, Medical Economics and Data Analytics
Health Services Cost Review Commission

Re: Comments on the Care Transformation Initiatives Policy for FY 2025 and FY 2026

Dear Mr. Henderson:

Frederick Health (FH) appreciates the opportunity to provide feedback on the Care Transformation Initiatives (CTI) Policy for CY 2025 and CY 2026 and supports the Commission's broader goals for care transformation. As discussed at the TCOC meeting, however, the current policy outcomes do not produce the intended financial consequences and therefore warrant thoughtful reconsideration and modification. Frederick has invested real dollars, generated real savings, and yet stands to lose significant GBR. Given the sustained financial headwinds facing the organization, losses generated through this program will force difficult decisions about whether continued investment in transformation efforts is financially viable.

The FY25 results are not the first instance since the policy's inception in which hospitals that invested in CTI programs experienced negative financial outcomes through GBR reductions. Unfortunately, funding under the policy has been unpredictable from year to year, with material fluctuations communicated well after the performance period has ended. This volatility makes the program extremely difficult—if not impossible—to plan for or to manage proactively. Hospitals cannot responsibly build or sustain transformation programs when funding is unpredictable and dependent on the performance of other hospitals. What was intended as an incentive for care transformation has, in practice, become a policy that appears to reward calculated or technical savings that are not realistic or meaningfully aligned with statewide savings goals.

Although CTI was designed to reward hospitals for improving population health and reducing total cost of care (TCOC), its implementation has resulted in unintended and inequitable consequences. In FY25, Frederick Health generated $15.2 million in savings through care transformation efforts yet still received a penalty under the CTI policy. This outcome creates a clear disincentive to participate—particularly for hospitals that deliver meaningful value but do not benefit from the scale advantages embedded in the methodology. The current design enables some hospitals to realize disproportionate gains

through technical features of the policy rather than through sustained population health management, while penalizing hospitals that already operate with a comparatively low TCOC per capita.

Recommendations for FY25 Results

Considering year-to-year inconsistencies and the significant volatility in calculated outcomes, Frederick Health recommends no payout for FY25. While a hard cap of 2.5% would reduce extreme outcomes, losses at that level remain unabsorbable. If savings can be clearly validated and directly tied to the statewide TCOC model, Frederick would instead support a payout approach based on a capped percentage of actual savings, with no associated penalty.

Recommendations for the FY26 CTI Program

FH also recommends no payout for the FY26 performance period. Eliminating the payout for this year would help redirect both hospital and HSCRC focus toward the upcoming AHEAD Model transition and allow time for critical policy refinement, while reducing unnecessary volatility during a period when greater predictability and stability are essential for the field.

Beyond the direct financial impact of program investments and potential GBR losses, many hospitals—including Frederick—must also absorb substantial administrative costs related to internal and external resources required to monitor results, model potential outcomes, and estimate savings under the CTI policy. Simplifying or retiring the policy would allow all stakeholders to redirect these resources toward preparation for the AHEAD Model transition. We recognize the considerable effort that has gone into designing and administering the CTI program and appreciate the opportunity to provide feedback, as well as the continued partnership between the Commission and the field.

Sincerely,

Hannah Jacobs
Senior Vice President & Chief Financial Officer
Frederick Health

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

April 24, 2026

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

Re: GBMC Request for Prospective-Only Treatment of Any Geographic CTI Policy Change

Dear Mr. Henderson and Commissioners:

Thank you for the opportunity to provide comments regarding the proposed revisions to the CTI methodology in advance of the May 2026 Commission Meeting and vote. GBMC respectfully urges the Commission to:

1. Not apply Geographic CTI de-duplication, or any other CTI policy change, retrospectively to a completed year;
2. Implement changes prospectively, with clear statewide rules applied consistently to all hospitals, if policy refinements are deemed necessary; and
3. Provide the full methodology, assumptions, data sources, and modeled impacts for FY25 and prior years, and allow meaningful stakeholder review and written comment, before any final action.

Greater Baltimore Medical Center respectfully urges the Commission to avoid any action retrospectively changing CTI rules or outcomes for a completed performance year, including the Geographic CTI de-duplication proposal. All policy changes should be prospective, transparent, and applied statewide. As recently discussed at the March 2026 HSCRC meeting regarding Readmission Reduction Incentive Program the staff acknowledged the out of state ("OOS:) readmission calculation may have had a disproportionally negative impact on border hospital, but states that revising the calculation constitutes a methodological refinement and therefore should be applied prospectively. The Staff acknowledged in their presentation that it was not the intent of the policy to overstate OOS readmission rates and defined a methodology refinement as "a prospective change made when the Commission identifies and fixes systemic flaws in a policy that had previously been applied exactly as intended."

The CTI Program was designed to incentivize forward-looking investment in care transformation, not to change the rules after hospitals invested in good faith and results became known. HSCRC's own CTI materials state that the program was intended to reward and incentivize hospitals that make investments that meaningfully connect providers and transform care, and to allow hospitals to realize returns on those investments through reconciliation payments.

HSCRC's published methodology defines Community-Based Care / Geographic as a panel-based CTI. The specifications state that attributed beneficiaries reside in a set of ZIP codes submitted by the participant, and the policy materials explain that panel-based beneficiaries are attributed at the start of the performance year and measured for the full performance year. Geographic CTIs were therefore presented as prospectively defined, ZIP-code-based accountability models, not as exclusive-use or single-system attribution models.

HSCRC's own methodology also shows that cross-hospital overlap was contemplated. The Technical Review identifies as an allowed circumstance episodes or beneficiaries attributed to two different hospitals, and the specifications likewise distinguish between cross-hospital attribution and participant-level controls. By contrast, HSCRC's use of the word duplication is narrower and is directed at avoiding duplicating costs under the same CTI definition or attributing a beneficiary to more than one of the same hospital participant's panel-based CTIs. The published methodology did not treat cross-hospital overlap as a defect to be discovered later; it treated it as an allowed feature of the framework, while separately imposing controls to prevent duplicating costs or assigning a beneficiary to more than one of the same hospital participant's panel-based CTIs.

GBMC has participated in CTI since the program's inception. The methodology has been in place for four years, and CTIs are submitted in advance of each performance year. HSCRC staff did not raise concerns about Geographic overlap prior to or during the completed performance year at issue. GBMC's Geographic CTI was built around the same longstanding 55-ZIP-code service-area footprint that has supported its primary care strategy since CTI inception, reflecting where GBMC has established practices, care-management infrastructure, and longitudinal relationships to deliver the intervention consistently.

Over the last three years, GBMC has generated approximately $8.2 million in savings through care transformation work; despite this, GBMC has still experienced net payments out/penalties in the CTIs of more than $5.3 million due to the statewide offset mechanics. In other words, even where GBMC generated measurable savings, the structure of the statewide offset prevented GBMC from consistently realizing positive net financial returns from the program. Over the life of the CTI program, GBMC has experienced approximately $108 million in operating losses; nonetheless, it increased total expense in primary care and elder medical care to approximately $167 million, a roughly 13% increase from FY23 to current, and provided approximately $37.5 million in subsidy to sustain access and longitudinal care. GBMC built a multidisciplinary primary care support model to deliver on CTI goals, including 10 RN care managers, 10 care coordinators, pharmacy support, 10 behavioral health specialists, and 2 psychiatrists, and joined an ACO. GBMC was encouraged by Commission leadership to view programs such as the Geographic CTI as one of the mechanisms through which hospitals could help recoup and sustain investments in primary care and population health through successful performance.

These investments were not theoretical. GBMC's Board repeatedly challenged the degree of ongoing primary care investment given systemwide losses, and leadership consistently pointed to programs like CTIs as a key reason those investments remained justified. Retrospective policy changes undermine that justification for GBMC and for other hospitals statewide to make investments if the reward mechanism can be changed retrospectively. GBMC has also tracked this program throughout the year, and the prospect of retrospective methodological change at this late stage has significant budgetary and planning implications. HSCRC's own policy guide provides that reconciliation payments are made 12 months after the end of the performance period, following episode completion, claims run out, and HSCRC calculation. Reopening the methodology after a completed year is therefore not a minor technical refinement; it has significant financial and governance consequences.

To the extent the Staff is concerned that the FY25 results reflect volatility or raise questions of fairness, GBMC respectfully submits that those are concerns about program design and statewide offset mechanics, not evidence that GBMC operated outside the published Geographic CTI framework. If the Staff proposes refinement(s) to the policy, the appropriate response is a statewide prospective policy change, not retrospective Geographic CTI de-duplication of a completed year.

For these reasons, GBMC respectfully urges the Commission to:

- Not apply Geographic CTI de-duplication, or any other CTI policy change, retrospectively to a completed year;
- Implement changes prospectively, with clear statewide rules applied consistently to all hospitals, if policy refinements are deemed necessary; and
- Provide the full methodology, assumptions, data sources, and modeled impacts for FY25 and prior years, and allow meaningful stakeholder review and written comment, before any final action.

GBMC welcomes the opportunity to meet with Commissioners prior to the May meeting to review these facts, our investment approach, and a prospective-only policy pathway that preserves program integrity.

Thank you for your consideration,

Sincerely,

Robin Motter-Mast

Robin Motter-Mast, DO, MBA
Medical Director of Care Transformation
Greater Baltimore Medical Center

cc: Dr. Joshua Sharfstein, Chairman

Dr. James Elliott

Ricardo Johnson

Dr. Maulik Joshi

Jonathan Blum

Nicki McCann

Dr. Farzaneh Sabi

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CalvertHealthMedicine.org

April 23, 2026

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

Dear Dr. Kromm,

On behalf of CalvertHealth, I appreciate the opportunity to provide additional comments regarding the Care Transformation Initiatives (CTI) program and related HSCRC policies in follow up to my letter dated April 7, 2026.

CalvertHealth has been a consistent and committed participant in CTIs and other HSCRC/MDH alignment models, including the Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPCP), since their inception. We have invested significant organizational time, resources, and clinical effort to support the State's goals of improving quality, advancing care transformation, and managing total cost of care.

While we remain committed to these shared objectives, CalvertHealth has experienced financial penalties under the CTI program in prior years. These outcomes, despite our sustained participation and investment, reinforce the importance of clear, consistent, and predictable program methodologies.

CalvertHealth strongly believes that the HSCRC should apply policies consistently and avoid making changes based on retrospective performance results. Policy adjustments that are influenced by outcomes—rather than established, transparent methodologies—create uncertainty and undermine confidence in the program. A stable and predictable framework is essential for hospitals to effectively plan, invest, and execute long-term care transformation strategies.

Additionally, we request clarification regarding whether the HSCRC is considering de-duplication of prior year CTI results and, if so, whether any associated financial impacts would be applied retroactively. Understanding the Commission's intent in this area is critical, as retrospective adjustments could have significant implications for hospital financial performance and planning.

Certainty around policy development, implementation, and final results is essential for accurate budget forecasting and responsible financial stewardship. Hospitals rely on these programs to

make informed decisions regarding staffing, clinical programs, and capital investments. Unexpected or retroactive changes create challenges that extend beyond finance and into patient care delivery.

We respectfully encourage the HSCRC to prioritize transparency, consistency, and prospective application of policies as the CTI program evolves.

Thank you for your consideration and for your continued leadership in advancing Maryland's unique healthcare model.

Sincerely,

Jeremy Bradford
President & CEO

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

April 24, 2026

Mr. William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide comments on FY2025 Care Transformation Initiatives (CTI) results and options for addressing the recent financial outcomes of the program.

JHHS and several Maryland health systems have previously submitted written comments expressing concern about the design and underlying methodology of the CTI program. Those concerns have unfortunately been realized in the FY2025 results. The volatility of the policy is significant, with over $160 million shifting between hospitals. This volatility reflects a structural flaw in the program's design. The CTI program as currently constructed furthers model distortions that place disproportionate financial burdens on hospitals, and the FY2025 results illustrate that the methodology is not functioning as intended.

Effective stewardship of Maryland's hospital payment model requires that the Commission not only solicit stakeholder input, but act on early warning signals before distortions compound. Appropriate oversight and ongoing monitoring of program submissions and performance are essential to the long-term viability of the model. As distortions are realized, the State must revise policies accordingly to ensure the viability of the model and to preserve access to care for Marylanders.

While the CTI program was well-intentioned and the Commission included stop-loss protections in 2024, the current situation demonstrates that incremental adjustments are insufficient. FY2025 CTI results demonstrate that the underlying methodology requires fundamental reconsideration. Given these concerns and the options outlined by staff, JHHS recommends suspending the CTI payout for FY2025 and FY2026. Stability and policy revision to address model distortions are critical as the State prepares to move into the AHEAD model, and JHHS appreciates staff's thoughtful consideration of this issue.

Sincerely,

Aneena Azel, MHA
Executive Director, Strategic Payor Initiatives & Planning
Johns Hopkins Health System

cc:

Dr. Joshua Sharfstein, Chairman	Jonathan Blum
Dr. James Elliott, Vice Chairman	Nicki McCann
Ricardo Johnson	Dr. Farzaneh Sabi
Dr. David Maine	Jon Kromm

Luminis Health℠

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April 23, 2026

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

Dear Dr. Kromm,

On behalf of Luminis Health, we appreciate the opportunity to respond to recent feedback from the Health Services Cost Review Commission (HSCRC) regarding the Care Transformation Initiatives (CTI) program. We also want to thank HSCRC staff and the Commission for recognizing stakeholder concerns and for their willingness to explore options to mitigate the projected impact of the current CTI results.

As we noted in our April 8, 2026 comment letter regarding HOPE, Luminis is concerned with the current program methodology that has calculated dramatic "savings" alongside significant penalties, creating unpredictability and instability within the regulatory model. Our concerns are underscored by the projected outcomes of the FY25 performance period, where the calculation of statewide savings grew from a historical average of $160 million to more than $740 million while the actual Medicare TCOC measure was a dissavings over the same time period. This level of growth in the CTI calculated "savings" as well as the significant disassociation between the CTI methodology and the actual TCOC savings makes it nearly impossible to reconcile the outcomes and suggests the methodology of the program is materially flawed.

Importantly, for many hospitals including Luminis Health, the penalties projected under the current methodology would fully eliminate operating margins. This would create significant challenges for core operations and care delivery, while also making it exceedingly difficult to sustain meaningful investments in population health strategies.

The program was originally intended to function as a zero sum model, with both gains and losses distributed across hospitals within reasonable limits each year. This intent was reinforced in March 2024, when the Commission unanimously voted to adopt a 2.5 percent stop loss provision to limit the amount of Medicare revenue any individual hospital could lose. While the provision was not designed as a hard cap, the scale of outcomes observed in the FY25 performance period was neither reasonably anticipated nor consistent with the program's original intent.

In effort to align outcomes with the intent of the program and the need for predictable and stable revenue, Luminis Health recommends the following:

1. Implement the 2.5% stop loss provision as a hard cap on losses for RY2027
2. Include the adjustment for the de-duplication of beneficiaries appearing in multiple geographic CTIs
3. Conclude the program at the end of the FY25 performance period

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In conclusion, while Luminis Health remains committed to the goals of care transformation and total cost of care improvement, the current CTI framework is not producing results that are consistent with its original intent or supportive of a stable and predictable regulatory environment. Addressing these issues promptly will be critical to maintaining confidence in the model and ensuring that hospitals can continue to invest in meaningful, sustainable care delivery improvements.

Thank you again for the opportunity to provide comments.

Sincerely,

Michelle Lee
EVP and Chief Financial Officer
Luminis Health

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

MedStar Health

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

April 24, 2026

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

Dear Dr. Kromm:

On behalf of the 7 MedStar Health Hospitals in Maryland, we would like to thank you for your ongoing partnership in advocating for the highest quality and highest value care for Marylanders. We write to provide our comments in response to the request for stakeholder input on addressing the FY'25 Care Transformation Initiatives (CTI) unanticipated financial results and FY'26 CTI future.

General Comments. We applaud the HSCRC in recognizing the unacceptable outcomes of CTI in FY'25 and inviting dialogue to address the issue. CTI program has historically created flexible incentives for hospital and health systems to develop targeted programs aimed at reducing the total cost of care. We believe that this purpose has been undermined by allowing geographic initiatives that have no identifiable care relationship to the providers or institutions submitting the program. MedStar Health firmly believes that the root of the problem is geographic CTIs, and that any equitable solution must specifically address the categorically problematic nature of allowing such a tenuous connection between outcome and impacted population (as HOPE program now intends to). The Medicare Performance Adjustment exists to incentivize reducing cost of care in geographic areas; CTI has a different primary purpose, which is to promote creative cost-saving solutions in defined groups. We believe that hospitals and health systems with programs consistent with the regulatory intent of the program should be held harmless to any solution. We also strongly endorse de-duplication as represented by the staff, as more technically correct method that is critically important to eliminate the overcounting of savings in the result.

Finally, we would note that many stakeholders have mentioned the importance of financial stability and predictability. Counter to some claims, altering the rules for FY'25 is what is **required** for stability and predictability. *Nobody* predicted these results, and thus no hospital can credibly claim that the result must be maintained to cover their investment or to maintain predictability. On the contrary, it will be tremendously harmful if hospitals who made investments based on the average outcomes of the past three years suffer a change in outcome equivalent to a significant percentage of GBR. This would constitute untenable financial variance for the majority of MD's hospitals, and it is for this reason the methodology *must* be altered ex-post-facto despite concerns with the precedent.

FY'25 Staff Comment Questions. The current FY25 result was improved significantly by the de-duplication methodology applied by staff, but we agree that further modifications are necessary to achieve a fair and equitable outcome. We do not support (1.d) elimination of the program payouts entirely – such a solution would harm hospitals who have made substantive investments based on historical performance and anticipated upside, and the numerous targeted successful programs that exist within the FY'25 CTI list should be promoted and encouraged. We do not support (1.b) enforcing more aggressive stop-loss as this change would harm effective CTIs and still leave a small number of hospitals with huge geographic CTIs in the reward range, an unjust outcome that ignores the root cause of the issue. We recommend the following possible solutions, by order of preference:

Eliminate geographic (04b) CTIs. In the absence of a demonstrated care relationship, we do not believe that these results represent meaningful true cost savings due to interventions.

Discount geographic CTIs by 50%. If staff feel that geographic CTIs represent costs savings to some extent, we recommend that staff discount their savings by 50% to recognize the limited number of patients likely impacted versus the large episode numbers and savings depicted. We believe that 50% is a tenable discount that would place the industry in a better position while leaving geographic CTIs rewarded and maintaining the overall incentive structure.

Discount all CTIs by a function of episode count. If staff require a universally applied solution, we believe that there is an inverse correlation between CTI size and likelihood of measured savings resulting directly from the intervention due to diluted penetrance, a dynamic exploited by the geographic CTIs but not exclusive to them. We recommend that >10,000 episodes, all CTIs be discounted 25% savings for each marginal 10,000 episodes. For example, if a CTI had 29,000 episodes at $100 episode savings, it would have adjusted savings equal to 10,000*$100 + 10,000*$75 + 9,000*$50 = $2,200,000. Episodes above 40,000 would receive only 10% marginal savings. This would preserve the savings outcomes of all small and moderate, targeted CTIs while providing an equitable outcome and uncapped upside for the small number of huge CTIs. It would also effectively accomplish the goal of creating better distribution and a smaller share of hospitals against the stop-loss guardrail; we believe whatever cutoffs are chosen need to take at least $150M out of savings to accomplish that goal.

FY'26 Staff Comment Questions. MedStar Health believes strongly that geographic CTIs should be eliminated for FY'26. We believe that this is sufficiently in advance of FY'28 budgetary planning to make the change. Submitters of geographic CTIs could be allowed to retrospectively submit NPI panels to establish care relationships, allowing their submissions to be converted to smaller panel-based CTIs. We do not prefer the program to be ended, unless the HOPE program is able to replace it in the FY'28 payout structure to avoid a gap in rewarding impactful programming. In the absence of disqualifying geographic CTIs, we recommend the adoption and continuation of one of the payout policy modifications endorsed above.

Sincerely,

Ryan Anderson, MD
Vice President, Clinical Care Transformation
MedStar Health

Michael Wood
Vice President, Rates & Reimbursement
MedStar Health

Mercy
MEDICAL CENTER

A University Affiliated Center Conducted by the Sisters of Mercy

EXECUTIVE VICE PRESIDENT & CHIEF FINANCIAL OFFICER

April 24, 2026

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

Dear Mr. Henderson:

On behalf of Mercy Medical Center, thank you for the opportunity to comment on the Care Transformation Initiatives (CTI) policy results for FY2025 impacting FY2027 rates. We recognize the challenge facing HSCRC staff when policy results differ dramatically from what was anticipated and applaud their willingness to seek industry feedback associated with alternative solutions.

Mercy's position remains consistent with the comment letters provided over the past two years. While the policy is well intentioned, it lacks a necessary stop gain or reasonable limit on calculated savings. Absent that guardrail, FY2025 results under the CTI program demonstrate a level of volatility that is both significant and unsustainable. Calculated savings increased nearly five-fold from FY2024 to $763 million. In a single year, those savings represented more than 16% of total Medicare MPA attributed revenue.

At the hospital level, the variation is even more pronounced. Seven hospitals experienced calculated savings exceeding 20% of their Medicare attributed MPA revenue, with two exceeding 50%. Results of this magnitude are not credible as a reflection of true performance and instead point to structural instability within the methodology.

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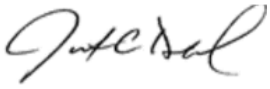
To avoid these unintended consequences of the original policy, the results from FY2025 need to be discarded. This recommendation would also apply to the FY2026 results to be included in FY2028 rates.

Thank you for the opportunity to provide comment and the staff's engagement on this issue.

Sincerely,



Justin Deibel
Executive Vice President and Chief Financial Officer
Mercy Health Services

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

Maryland
Hospital Association

April 24, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Care Transformation Initiative (CTI) FY 2025 payout results and considerations for the FY 2026 program. MHA appreciates HSCRC's ongoing efforts to support innovation in Medicare care delivery and achieve total cost of care savings as hospitals work to ensure Marylanders receive the care they depend on.

Hospitals have demonstrated a strong commitment to the CTI program, investing in and launching numerous impactful interventions across the state to advance innovation in the care of Medicare patients. However, the CTI program design has resulted in unanticipatedly high levels of calculated savings and wide variation in rewards and penalties across hospitals. The program's design has raised several key policy considerations that should be addressed. Lessons learned from the FY 2025 CTI experience should be carefully reviewed to assess not only short-term corrective action, but to also consider the precedent that is being set for future programs.

MHA respectfully offers the following suggestions to strengthen CTI FY 2026 planning, the Healthcare Outcome Payment Effort (HOPE) program that is under consideration, as well as future care delivery innovation programming:

- Reinforce policy stability and predictability to protect hospital investments in care transformation
- Enhance evaluation, monitoring, and safeguards to identify and address unintended consequences, ensuring reasonable and transparent outcomes
- Reconsider the timing and application of net neutrality for innovative initiatives
- Exercise fiduciary stewardship to support hospital financial sustainability

These actions are essential to preserve confidence in HSCRC programs, sustain hospital engagement, and achieve continuous total cost of care (TCOC) savings and transformation goals.

Policy Design and Implementation Recommendations

Stability and Investment Considerations

Proposing modifications to program policies after hospitals have made substantial investments in care transformation interventions raises important concerns regarding precedent and policy stability. Mid-course policy changes, particularly those affecting financial incentives, could undermine confidence in HSCRC's care transformation and population health improvement programs and discourage future long-term investments or full participation in innovative models of care. MHA encourages the Commission to establish a clear, consistent approach to how and when policies are adjusted. This will be critical to maintain credibility, support sustained engagement, and ensure that prior investments are not inadvertently penalized.

Evaluation and Monitoring

The FY 2025 CTI results underscore the need for a more structured, proactive approach to policy evaluation and monitoring. The program is reported to have generated more than $750 million in estimated total cost of care savings, and its zero-sum design may result in approximately $160 million in redistributions across hospitals, creating unanticipated volatility in rewards and penalties. Future efforts should include a thoughtful approach to ensure there are defined safeguards. A robust monitoring framework, both retrospective and predictive, is critical to assess impact, identify unintended consequences, and ensure outcomes are reasonable. Clearly defined protocols to evaluate emerging results and address anomalies would enhance transparency, enable timely course correction, and reinforce confidence that outcomes reflect performance rather than methodological compliance.

Net Neutrality and Innovation

Net neutrality has been a central design feature of the CTI program to drive TCOC savings. However, this requirement, when applied to performance years at the onset of a program may limit participation and long-term success, particularly for new or innovative programs. A more balanced approach to investment in care delivery innovation should recognize a variation in hospital starting points, the newness of the interventions, and allow sufficient time for the return on investment and expectation of savings. This type of approach would better support sustained transformation while preserving fairness and system stability. MHA respectfully urges HSCRC to reconsider the requirement to achieve immediate net neutrality when implementing innovative or emerging program models.

Fiduciary Stewardship

An important consideration is the need for guardrails in new policies that are guided by hospital financial stability and solvency as you operate in your role as fiduciary. Policies that introduce significant redistributions without appropriate guardrails risk undermining hospital financial stability and solvency and limiting the capacity to sustain long-term investments in care transformation. We encourage future policy development financial impact analyses, protections against excessive disruption, and mechanisms to preserve stability, particularly for hospitals and health systems disproportionately affected by policy-driven redistributions.

Defer the Healthcare Outcome Payment Effort (HOPE) Program Timeline

Based on the significant policy issues identified with the CTI program, MHA urges HSCRC to reconsider its HOPE Program approach and the policy implementation timeline. The revised May to July timeframe presented at the April 22 TCOC Workgroup meeting may not provide sufficient time to support comprehensive policy development, meaningful integration of lessons learned from the CTI program, or adequate assessment of potential unintended consequences prior to a final Commission vote. Hospitals will need clear guidance, well-defined parameters, and adequate lead time to develop evidence-based proposals that align with state priorities, target key populations, and produce measurable outcomes. HSCRC should not approve the HOPE Program until a thorough evaluation of the CTI program is complete and outstanding questions and concerns about the HOPE Program are addressed.

HSCRC proposes an application period in the second half of calendar year (CY) 2026. MHA recommends delaying any application period until the first half of CY 2027 at the earliest. This adjusted timeline would give HSCRC the time needed to resolve outstanding policy questions and develop a more deliberate program design, including determining whether Medicare will participate, developing an approach to engage commercial payers, and creating evaluation and monitoring procedures. It would also allow hospitals and key partners to perform strategic planning and design high-impact, sustainable interventions.

Additionally, as Maryland prepares to transition to the Center for Medicare and Medicaid Innovation's hospital global budget methodology, HSCRC should carefully evaluate the cost-benefit implications of advancing complex optional policy initiatives while foundational issues affecting hospital financial sustainability and key elements of the AHEAD Model implementation remain unresolved. Focusing instead on the most system-critical priorities facing Maryland hospitals would support a more sequenced and balanced approach. Addressing core sustainability challenges prior to layering additional transformation initiatives will better position the hospitals and HSCRC programs for long-term success as the foundation of the ecosystem that supports access to care.

Thank you for the opportunity to provide comments. MHA looks forward to continued collaboration with HSCRC as it works to address challenges in the CTI program and thoughtfully plan for future initiatives.

Sincerely,

Tequila Terry

Tequila Terry
Senior Vice President, Care Transformation & Finance

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

TidalHealth™

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April 22, 2026

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

Dear Dr. Kromm,

On behalf of TidalHealth, I am writing today in response to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding the Care Transformation Initiatives (CTI) program, including potential changes to the Fiscal Year (FY) 2025 and FY 2026 performance year results.

TidalHealth has repeatedly expressed concerns regarding the design and implementation of the CTI program since its inception. As designed, the program allows hospitals and systems to selectively choose the base period and criteria for interventions, but the intent to treat model specifically ensures that true patient interventions are not being measured. This dynamic has been exacerbated by the community (geographic) CTIs, allowing hospitals to claim accountability for the total cost of care (TCOC) for Medicare beneficiaries far outside of their traditional primary service areas.

The FY 2025 results demonstrate the flaws inherent in the program. The results as shared by the HSCRC indicate that over $700m in TCOC savings was achieved in FY 2025, surpassing the cumulative TCOC savings achieved by the model to date. Even accounting for the potential double counting of savings by geographic CTIs, the savings achieved are far in excess of prior years and lack credibility. Given the revenue neutrality requirement of the program, it is unreasonable to expect hospitals to pay into a savings pool that has largely been generated on paper, not through targeted, proven patient interventions.

Due to the limitations of the program, the flaws in the methodology, and the lack of proven interventions leading to the savings being generated, TidalHealth respectfully urges the HSCRC to eliminate the CTI program for FY 2025 and FY 2026. We would also encourage the HSCRC to work with hospitals to significantly improve the Health Outcomes Payment Effort (HOPE) program before coming back to the Commissioners for consideration.

Thank you again for the opportunity to provide comments.

Sincerely,

Steve Leonard
Chief Executive Officer

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

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CORPORATE OFFICE

April 24th, 2026

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

RE: UMMS Comment Letter on the Care Transformation Initiatives (CTI) Potential FY25 and FY26 Corrections

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS), we are writing to comment on the potential correction of FY25 and FY26 CTI performance reconciliation payments. UMMS remains an engaged participant in the Care Transformation Initiative (CTI) policy, tying a multitude of population-based interventions to CTI definitions over the policy's five performance years and actively aligning population health strategy and investment alongside. Our goal is to continue leveraging population-focused incentives and contribute to the AHEAD Model through an evolved CTI policy that prioritizes return on investment and transformation of our healthcare system.

Notwithstanding the foregoing, given the material financial and operational implications of a reconciliation approach and UMMS' reasonable reliance on the CTI policy in its care transformation and population health initiatives, UMMS is also evaluating the alignment of potential adjustments with the Commission's rate-setting authority and related statutory parameters.

UMMS outlines within this response and urges the Commission to:

1. Consider the investments previously made in response to CTIs,
2. Evaluate the data behind geographic CTIs in FY25, and,
3. Approach any corrections for FY25 and FY26 with equity to all hospitals in Maryland by including a de-duplication of geographic CTI results based on actual Medicare patient utilization. UMMS' Investment in Care Transformation Initiatives has delivered Results

In line with the TCOC Model, the CTI policy provided a strategic and direct incentive for hospitals to invest in value-based programs that contribute to the State's success on reducing Medicare total cost of care. Over four years of performance, UMMS has catalogued significant savings from specific interventions that have contributed to the State's success under the TCOC Model. Due to the zero-sum nature of this policy, only a portion of UMMS' success has returned to the system as revenue to support critical outcomes improving and cost reduction initiatives. **Sudden reversal of these incentives due to**

late policy change risks upending purposeful strategy, investment and efforts faithfully committed in response to HSCRC policy.

In PY4, UMMS' deployed and aligned over a hundred clinical and community programs throughout our system to impact CTI populations across the care continuum. The investments that UMMS makes within these CTIs enhance patient experience and allow mission-driven services which do not otherwise have a HSCRC or direct reimbursement funding source. The table below shows how significant these savings in FY25 performance alone have been to the State's own success in the model, totaling over $80m in annual TCOC reductions alone.

Gross Savings Earned by Hospital by Thematic Area (Excludes ECIP Savings & Geographic CTIs)							
Hospital	**Care Transitions**	**Community-Based Care**	**Emergency Care**	**Palliative Care**	**Primary Care**	**HOPD Services**	**Grand Total**
Rehabilitation and Orthopaedic Institute	0.1m	-	-	-	-	0.0m	**0.1m**
St. Joseph Med Ctr.	2.2m	-	2.0m	-	0.2m	-	**4.3m**
Baltimore Washington Med Ctr.	2.9m	-	2.4m	1.5m	17.2m	-	**23.9m**
Capital Region Med Ctr.	1.0m	0.6m	3.4m	1.5m	-	0.7m	**7.1m**
Charles Regional Med Ctr.	0.7m	-	1.8m	0.2m	2.1m	1.0m	**5.8m**
Shore Regional Health	1.2m	-	-	-	-	-	**1.2m**
Upper Chesapeake Med Ctr.	8.4m	-	2.9m	4.9m	0.2m	0.0m	**16.5m**
University of Maryland Med Ctr. - DTC, MTC	17.9m	-	0.8m	-	1.0m	-	**19.7m**
University of Maryland Medical System	-	1.3m	-	-	-	-	**1.3m**
Grand Total	**34.4m**	**1.9m**	**13.3m**	**8.1m**	**20.6m**	**1.6m**	**80.0m**

UMMS has aligned critical population health infrastructure and strategies in direct response to the CTI policy and TCOC Model goals via these incentives. All twelve member organization hospitals participate in: quarterly strategic alignment and reviews of their investments and performance, population health leader councils, clinical improvement reviews and have undergone process measure evaluation to improve performance for CTI interventions. Beyond direct employee and resource dedication, indirect resources that impact performance continue to be evaluated and streamlined into unified strategies that impact Medicare spending and improve outcomes for Marylanders. We have expanded community care mobile teams, added patient supports, continued novel program funding and made countless other financing decisions because the CTI policy allowed us to experience, quantify and rely upon increased return on the mission investments we make every day. For example, in FY26 Upper Chesapeake Medical Center expanded investment by $5 million in specific programs showing total cost impact with results through the CTI policy. These included expansion of services in palliative care, medication management, virtual sepsis management, a behavioral health collaborative and several other community service expansions.

These investments were made in reasonable reliance on the Commission's established CTI methodology and the expectation that performance would be evaluated consistently with those parameters. A retroactive redefinition of savings attribution or reconciliation mechanics would undermine that reasonable reliance and materially distort the link between performance and payment, causing irreparable financial harm to UMMS and the future viability of the value-based interventions, unless any such retroactive change is carefully and narrowly tailored to be consistent with the policy's original intent.

Geographic and Community-Based CTIs in FY25 Results

Medicare beneficiaries are attributed to Maryland hospitals through the Medicare Performance Adjustment (MPA), which, despite Maryland generating Model savings for Medicare, penalizes more hospitals than it rewards. The CTI policy layered an important incentive, alternative to the MPA, that allows hospitals to specifically capture populations where we have invested in expanded services and improved healthcare access, benchmarking to our own past experience, not a national benchmark. This provided hospitals who have made purposeful investments in historically underserved communities over the course of the model with a return mechanism that appropriately adjusts the risks of populations served. UMMS enrolled geographic CTIs that aligned with its attributed Medicare populations in areas like West Baltimore, Charles County, the mid-shore region and other distinct areas, expecting that our investments in these community's services would drive returns when evaluated historically.

Like UMMS, 29 Maryland hospitals participated in geographic CTIs, accounting for 32 Geographic CTIs in total, with some hospitals taking accountability for populations beyond the attributed Medicare populations they actually impact. This group of geographic CTIs, where some hospitals have claimed Medicare impact without having Medicare reach, is the key destabilizing force impacting the statewide savings pool, threatening to undercut the efforts of systems with proven savings and causing financial turmoil to hospitals that have consistently and faithfully executed an intent-to-treat population design.

This particular issue—where some hospitals claimed Medicare impact in geographies outside their footprint—was enabled by the policy's current approach that permits multiple hospitals to claim accountability for the same Medicare spend without a consistent or rational attribution methodology, resulting in duplicative counting of costs and savings and inappropriate attribution of savings where hospitals had no attribution of Medicare patients. This unintended consequence undermines the integrity of the CTI measurement framework, produces results that are inconsistent with the HSCRC's intent for the policy, and introduces material distortion into the statewide savings pool. To the extent these distorted results are incorporated into the corresponding Medicare Performance Adjustment-related calculations for a given year, they risk producing reimbursement outcomes that are not rationally tied to actual hospital performance.

Methodological Integrity and Transparency

As CTI results are used to inform payment adjustments, it is critical that the underlying methodology be consistently applied, transparent and auditable, grounded in verifiable attribution of patient populations, and consistent with the original intent of the CTI policy. These elements are foundational to ensuring that performance-based incentives accurately reflect hospital impact and support the broader objectives of the Total Cost of Care Model.

In FY25, the interaction between geographic CTI design, attribution methodology, and reconciliation calculations has produced results that are difficult to reconcile with observed Medicare utilization patterns. In particular, overlapping geographic attribution and inconsistent linkage between hospitals and the populations they are intended to serve introduce variability that undermines confidence in the accuracy of reported savings.

UMMS believes that any reconciliation approach that materially affects hospital reimbursement should be supported by a methodology that can be independently validated, consistently applied across participants, clearly tied to actual patient attribution, and consistent with the original intent of the CTI policy and TCOC Model. Strengthening these elements will be essential to maintaining confidence in CTI as a performance-based framework and ensuring that resulting payment adjustments are rationally aligned with demonstrated outcomes.

UMMS Proposal to Adjust for FY25 Results Geographic CTI Issue

The FY25 savings pool is destabilized and overinflated by an over enrollment of geographic CTIs where multiple hospitals have claimed accountability for the same zip codes and Medicare costs, thus double, sometimes tripling, the accounting of savings. Rather than upending the incentives or faithful efforts noted in the foreword of this letter, UMMS believes there are a few corrections that can right-size this policy fairly and support the Model's goals.

- **HSCRC should de-duplicate results of geographic CTIs by attributing zip codes based on actual Medicare beneficiary touch.** The established MPA Medicare FFS Primary Service Area attribution is readily available to service this process, is refreshed annually and vetted through HSCRC and CMS policy-making procedures.
    - If two hospitals (A and B) claim accountability for one zip code, that zip code's total costs and corresponding savings performance should be split based on Medicare shared. If 75 percent of Medicare beneficiaries use Hospital A, 75 percent of savings should go to Hospital A and the remaining 25 percent should flow to Hospital B.

  - **In no scenario should a hospital with 0 percent attribution in a zip code be allowed to claim Medicare cost savings performance in a zip code submitted under a CTI.**
    - This does not align with the CTI policy's intent-to-treat design and presents an unreasonable departure from the spirit of the policy that should warrant correction.
    - There are other, more specific and appropriate, CTI definitions that can be used to capture impacts for specific services.
  - The HSCRC's estimates after Medicare attribution de-duplication paint a clear picture of where non-PSAP zip codes were used in CTI definitions, showing the scale and rate at which this tactic was employed.
- **HSCRC should not end the CTI policy or limit any policy revisions to maximum penalties or rewards based solely on poor results for some.**
  - Some hospitals invested and aligned strategy. Some hospitals did not engage. This is clear when evaluating the breadth of CTI results and the past five years of experience.
  - The HSCRC needs to consider the behavioral implications and regulatory risk of ending a policy intended to incentivize hospitals to align their investments and efforts with the goal of the Model.
- **If downside protections that dilute the HSCRC's ability to pay out rewards for true, transformative savings are implemented, the Commission should explore excess Model savings and other potential glidepaths for negatively impacted hospitals to keep investment levels steady and reduce risk to critical infrastructure needed for AHEAD performance.**

FY26 Results and Performance

UMMS' investment strategy and HSCRC policy guidance did not contemplate ending CTIs early, AHEAD is forcing an end to this program. This comes as an additional challenge to maintaining performance and stable operations during this transition. As stated in our HOPE comment letter on 4/8/26, UMMS supports a deliberate ending to the CTI policy that includes FY26 results. **To abandon FY26 CTI experience would be to retroactively punish hospitals that purposefully enrolled in the program and invested operational support with qualified interventions in reasonable reliance on the policy.**

- The corrections and policy approach proposed above for FY25 will also protect and correct unanticipated CTI results in FY26.
- **The HSCRC must implement a fair and stable policy approach and allow for a conclusion of CTI policy which has already been enrolled, invested and participated in for FY26. This means there must be some adjustment in FY28 as a result of FY26 performance. The HSCRC needs to also evaluate the magnitude of financial impact to the loss of the CTI program and ensure there is a replacement funding source of equal incentive, such as the Healthcare Outcomes Payment Effort (with suggested changes).**
  - These CTIs were deliberately constructed and enrolled in based on current population health-based operations.
  - **Ending infrastructure support prematurely threatens operations critical to transitioning into the AHEAD Model by requiring UMMS to make difficult decisions around investment in population-based interventions.**

We thank the Commission for the opportunity to reflect and comment on these policy changes and for the commitment to retaining these important incentives in Maryland. UMMS remains committed to working with the Commission to resolve these issues; however, given the material implications, it is important that any final approach reflect a consistent, transparent, and methodologically sound framework for evaluating performance in line with the original intent of the policy.

Sincerely,

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services

cc:
Joshua Sharfstein, MD
James Elliot, MD
Jonathon Blum, MPP
Ricardo Johnson
David Main, MD
Nicki McCann, JD
Farzaneh Sabi, MD

April 24, 2026
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UPMC WMD Comment Letter on Future of Care Transformation Initiative (CTI) Policy

Dear William,

I am writing on behalf of UPMC Western Maryland to share our feedback regarding the Care Transformation Initiatives (CTI), as discussed at the Apri 15, 2026 Commission meeting.
We believe the original intent of the CTI program was to incentivize specific population health and care redesign efforts that can be directly linked to beneficiaries impacted. We have made investments to support the policy's intent and are producing savings for each CTI we submitted. However, the recent results of the current policy produce significant penalties for many hospitals, including UPMC Western Maryland, even when the hospitals' initiatives achieved expected savings and met the program's intent. The net neutrality aspect of the policy produces an unfair and unmanageable risk for hospitals that cannot be financially sustained.

We believe the introduction of geographic CTI programs for FY25 and FY26, which we feel do not meet the original intent of the CTI program due to a lack of interventions that are able to be directly linked to beneficiaries, are causing unintended consequences. There are also data integrity issues that cannot be easily explained. Put simply, the savings amounts the geographic CTI programs, including our own in FY26 (~$81M), do not seem realistic and should be independently validated if there are to be financial consequences based on this data. As a result, we recommend suspending payouts for FY25 and FY26. If payouts and penalties are to be enforced, a detailed examination of specific interventions or care redesign efforts that are leading to the calculated savings within the geographic CTI programs should be completed so that those efforts can be scaled to the benefit of all Marylanders. If not, we feel the staff should pivot to focus all efforts on Healthcare Outcome Payment Effort (HOPE) policy development for FY28. Lessons learned from the CTI policy's unintended consequences should inform that policy development.

Thank you for your time and attention to our feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,

Amber Ruble

Chief Financial Officer

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Hospital Financial Condition Report

Fiscal Year 2025

May 2026

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

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Table of Contents

maryland
health services
cost review commission

Introduction

The Maryland Health Services Cost Review Commission ("HSCRC" or "Commission") has completed the annual hospital financial condition report for Fiscal Year 2025.

In FY 2025, Maryland concluded its seventh 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 concluded 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 transitioned 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 5.66 percent from $21.2 billion in FY 2024 to $22.4 billion in FY 2025.
- Net regulated patient revenue. Total regulated net patient revenue increased from $17.7 billion in FY 2024 to $18.7 billion in FY 2025, an increase of 5.65 percent.
- Profits on regulated activities. Profits on regulated activities grew slightly, going from $1.41 billion (7.83 percent of regulated net operating revenue) in FY 2024 to $1.70 billion (8.90 percent of regulated net operating revenue) in FY 2025.
- Profits on operations. Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) increased from $181 million in FY 2024 (or 0.88 percent of total net operating revenue) to $471 million in FY 2025 (or 2.13 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 $0.81 billion in FY 2024 (or 3.78 percent of the total revenue) to $1.12 billion (or 4.90 percent of the total revenue) in FY 2025. This increase is due largely to increases in 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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cost review commission

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, 2025 and December 31, 2024. 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, Sheppard Pratt Hospital, and UM Behavioral Health Pavillion – Aberdeen.
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—UM Queen Anne's Freestanding Medical Center, Adventist Germantown Emergency Center, UM 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
FISCAL YEAR 2023 TO 2025

ACUTE HOSPITAL TOTALS

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	22,370,425,572	21,180,302,026	20,195,390,216
Unregulated Services	2,829,798,358	2,522,996,318	2,326,345,271
TOTAL	25,200,223,930	23,703,298,344	22,521,735,487
Net Patient Revenue (NPR):			
Regulated Services	18,747,620,312	17,696,623,041	16,926,327,621
Unregulated Services	1,311,090,508	1,177,339,095	1,120,457,266
TOTAL	20,058,710,819	18,873,962,135	18,046,784,888
Other Operating Revenue:			
Regulated Services	417,168,763	335,111,428	464,479,230
Unregulated Services	1,597,638,459	1,387,850,490	1,239,504,470
TOTAL	2,014,807,222	1,722,961,919	1,703,983,700
Net Operating Revenue (NOR)			
Regulated Services	19,164,789,075	18,031,734,469	17,390,806,851
Unregulated Services	2,908,728,967	2,565,189,585	2,359,961,737
Total	22,073,518,041	20,596,924,054	19,750,768,587
Total Operating Expenses:			
Regulated Services	17,459,849,668	16,619,756,675	16,242,191,873
Unregulated Services	4,143,160,025	3,796,424,407	3,505,903,491
Total	21,603,009,693	20,416,181,082	19,748,095,364
Net Operating Profit (Loss):			
Regulated Services	1,704,939,406	1,411,977,794	1,148,614,978
Unregulated Services	-1,234,431,058	-1,231,234,822	-1,145,941,754
Total	470,508,348	180,742,972	2,673,224
Total Non-Operating Profit (Loss):	650,835,641	626,971,690	496,716,216
Non-Operating Revenue	796,595,323	787,713,419	644,791,997
Non-Operating Expenses	145,759,682	160,741,729	148,075,781
Total Excess Profit (Loss):	1,121,343,989	807,714,662	494,091,440
% Net Operating Profit of Regulated NOR	8.90	7.83	6.60
% Net Total Operating Profit of Total NOR	2.13	0.88	0.01
% Total Excess Profit of Total Revenue	4.90	3.78	2.42

maryland health services cost review commission

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Adventist HealthCare Germantown Emergency Center

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	19,289,700	17,967,500	17,461,500
Unregulated Services	2,817	0	0
TOTAL	19,292,517	17,967,500	17,461,500
Net Patient Revenue (NPR):			
Regulated Services	13,606,415	13,037,826	12,221,693
Unregulated Services	2,817	0	0
TOTAL	13,609,232	13,037,826	12,221,693
Other Operating Revenue:			
Regulated Services	4,820	1,806	22,132
Unregulated Services	0	0	53
TOTAL	4,820	1,806	22,185
Net Operating Revenue (NOR)			
Regulated Services	13,611,235	13,039,632	12,243,825
Unregulated Services	2,817	0	53
Total	13,614,052	13,039,632	12,243,878
Total Operating Expenses:			
Regulated Services	13,386,438	13,289,054	12,564,632
Unregulated Services	11,700	9,500	10,800
Total	13,398,138	13,298,554	12,575,432
Net Operating Profit (Loss):			
Regulated Services	224,797	-249,422	-320,807
Unregulated Services	-8,883	-9,500	-10,747
Total	215,914	-258,922	-331,554
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	215,914	-258,922	-331,554
% Net Operating Profit of Regulated NOR	1.65	-1.91	-2.62
% Net Total Operating Profit of Total NOR	1.59	-1.99	-2.71
% Total Excess Profit of Total Revenue	1.59	-1.99	-2.71

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Adventist HealthCare Shady Grove Medical Center

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	543,190,102	534,307,365	507,181,036
Unregulated Services	12,493,505	16,144,338	50,288,820
TOTAL	555,683,607	550,451,703	557,469,856
Net Patient Revenue (NPR):			
Regulated Services	453,212,892	441,176,207	431,959,166
Unregulated Services	3,907,951	4,851,406	17,106,860
TOTAL	457,120,843	446,027,613	449,066,026
Other Operating Revenue:			
Regulated Services	2,247,661	3,606,710	3,482,908
Unregulated Services	9,918,873	17,929,795	7,893,682
TOTAL	12,166,534	21,536,505	11,376,590
Net Operating Revenue (NOR)			
Regulated Services	455,460,553	444,782,917	435,442,074
Unregulated Services	13,826,824	22,781,201	25,000,542
Total	469,287,377	467,564,118	460,442,616
Total Operating Expenses:			
Regulated Services	407,320,423	402,231,760	403,089,895
Unregulated Services	36,412,771	38,838,435	47,219,780
Total	443,733,194	441,070,195	450,309,675
Net Operating Profit (Loss):			
Regulated Services	48,140,130	42,551,157	32,352,179
Unregulated Services	-22,585,947	-16,057,234	-22,219,238
Total	25,554,183	26,493,923	10,132,941
Total Non-Operating Profit (Loss):	6,970,343	5,682,742	-1,518,175
Non-Operating Revenue	6,970,343	5,682,742	-1,518,175
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	32,524,526	32,176,665	8,614,766
% Net Operating Profit of Regulated NOR	10.57	9.57	7.43
% Net Total Operating Profit of Total NOR	5.45	5.67	2.20
% Total Excess Profit of Total Revenue	6.83	6.80	1.88

maryland health services cost review commission

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Adventist HealthCare White Oak Medical Center

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	380,198,345	351,439,080	352,793,525
Unregulated Services	13,770,096	14,911,025	37,212,146
TOTAL	393,968,441	366,350,105	390,005,671
Net Patient Revenue (NPR):			
Regulated Services	316,317,512	304,751,639	289,847,434
Unregulated Services	4,976,447	3,943,811	10,845,354
TOTAL	321,293,959	308,695,450	300,692,788
Other Operating Revenue:			
Regulated Services	578,168	1,292,101	1,803,612
Unregulated Services	7,600,382	6,963,333	6,942,509
TOTAL	8,178,550	8,255,434	8,746,121
Net Operating Revenue (NOR)			
Regulated Services	316,895,680	306,043,740	291,651,046
Unregulated Services	12,576,829	10,907,144	17,787,863
Total	329,472,509	316,950,884	309,438,909
Total Operating Expenses:			
Regulated Services	288,163,393	280,506,348	290,013,367
Unregulated Services	38,089,730	36,736,182	38,681,976
Total	326,253,123	317,242,530	328,695,343
Net Operating Profit (Loss):			
Regulated Services	28,732,288	25,537,391	1,637,679
Unregulated Services	-25,512,901	-25,829,037	-20,894,113
Total	3,219,386	-291,646	-19,256,434
Total Non-Operating Profit (Loss):	565,701	531,026	252,337
Non-Operating Revenue	565,701	531,026	252,337
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	3,785,087	239,380	-19,004,097
% Net Operating Profit of Regulated NOR	9.07	8.34	0.56
% Net Total Operating Profit of Total NOR	0.98	-0.09	-6.22
% Total Excess Profit of Total Revenue	1.15	0.08	-6.14

Adventist Healthcare Fort Washington Medical Center

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	66,193,195	64,761,498	74,115,596
Unregulated Services	3,979,981	4,579,266	3,844,279
TOTAL	70,173,176	69,340,764	77,959,875
Net Patient Revenue (NPR):			
Regulated Services	57,637,560	56,662,033	56,657,567
Unregulated Services	1,748,130	1,893,766	1,528,952
TOTAL	59,385,690	58,555,799	58,186,519
Other Operating Revenue:			
Regulated Services	186,589	620,204	1,906,860
Unregulated Services	1,233,506	727,775	502,358
TOTAL	1,420,095	1,347,979	2,409,218
Net Operating Revenue (NOR)			
Regulated Services	57,824,149	57,282,237	58,564,427
Unregulated Services	2,981,636	2,621,541	2,031,310
Total	60,805,785	59,903,778	60,595,737
Total Operating Expenses:			
Regulated Services	50,284,211	51,029,116	55,776,567
Unregulated Services	12,456,406	11,607,794	7,755,892
Total	62,740,617	62,636,910	63,532,459
Net Operating Profit (Loss):			
Regulated Services	7,539,938	6,253,121	2,787,860
Unregulated Services	-9,474,770	-8,986,253	-5,724,582
Total	-1,934,832	-2,733,132	-2,936,722
Total Non-Operating Profit (Loss):	0	-81,976	11,554
Non-Operating Revenue	0	-81,976	11,554
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-1,934,832	-2,815,108	-2,925,168
% Net Operating Profit of Regulated NOR	13.04	10.92	4.76
% Net Total Operating Profit of Total NOR	-3.18	-4.56	-4.85
% Total Excess Profit of Total Revenue	-3.18	-4.71	-4.83

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Ascension St. Agnes Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	568,926,800	494,805,400	515,518,500
Unregulated Services	254,945,158	200,989,909	193,779,775
TOTAL	823,871,958	695,795,309	709,298,275
Net Patient Revenue (NPR):			
Regulated Services	445,625,454	405,179,556	423,061,677
Unregulated Services	82,722,935	71,751,356	83,600,563
TOTAL	528,348,389	476,930,912	506,662,240
Other Operating Revenue:			
Regulated Services	6,288,909	5,453,965	34,602,295
Unregulated Services	27,402,155	35,005,836	15,599,841
TOTAL	33,691,064	40,459,801	50,202,136
Net Operating Revenue (NOR)			
Regulated Services	451,914,364	410,633,521	457,663,972
Unregulated Services	110,125,090	106,757,193	99,200,404
Total	562,039,453	517,390,713	556,864,376
Total Operating Expenses:			
Regulated Services	373,101,966	359,252,800	369,041,490
Unregulated Services	189,595,048	186,587,870	168,557,244
Total	562,697,014	545,840,670	537,598,734
Net Operating Profit (Loss):			
Regulated Services	78,812,398	51,380,720	88,622,482
Unregulated Services	-79,469,958	-79,830,677	-69,356,840
Total	-657,561	-28,449,957	19,265,642
Total Non-Operating Profit (Loss):	-314,432	1,409,672	-1,017,782
Non-Operating Revenue	2,686,482	3,666,857	923,379
Non-Operating Expenses	3,000,914	2,257,185	1,941,161
Total Excess Profit (Loss):	-971,993	-27,040,285	18,247,860
% Net Operating Profit of Regulated NOR	17.44	12.51	19.36
% Net Total Operating Profit of Total NOR	-0.12	-5.50	3.46
% Total Excess Profit of Total Revenue	-0.17	-5.19	3.27

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Atlantic General Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	140,018,931	135,629,341	125,786,800
Unregulated Services	80,199,239	77,948,152	86,372,972
TOTAL	220,218,170	213,577,493	212,159,772
Net Patient Revenue (NPR):			
Regulated Services	117,169,891	112,008,265	106,526,912
Unregulated Services	39,359,376	36,038,481	39,720,471
TOTAL	156,529,267	148,046,747	146,247,383
Other Operating Revenue:			
Regulated Services	506,568	3,476,792	3,656,139
Unregulated Services	17,230,689	11,736,514	7,011,609
TOTAL	17,737,257	15,213,306	10,667,749
Net Operating Revenue (NOR)			
Regulated Services	117,676,459	115,485,057	110,183,051
Unregulated Services	56,590,065	47,774,996	46,732,080
Total	174,266,524	163,260,053	156,915,131
Total Operating Expenses:			
Regulated Services	96,646,293	96,264,285	96,820,606
Unregulated Services	80,320,954	73,323,404	69,602,242
Total	176,967,247	169,587,689	166,422,848
Net Operating Profit (Loss):			
Regulated Services	21,030,166	19,220,772	13,362,445
Unregulated Services	-23,730,889	-25,548,409	-22,870,162
Total	-2,700,723	-6,327,636	-9,507,717
Total Non-Operating Profit (Loss):	3,814,727	4,439,022	5,483,636
Non-Operating Revenue	4,262,841	4,125,537	3,862,005
Non-Operating Expenses	448,114	-313,485	-1,621,631
Total Excess Profit (Loss):	1,114,004	-1,888,614	-4,024,081
% Net Operating Profit of Regulated NOR	17.87	16.64	12.13
% Net Total Operating Profit of Total NOR	-1.55	-3.88	-6.06
% Total Excess Profit of Total Revenue	0.62	-1.13	-2.50

Calvert Health Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	197,883,196	188,719,140	175,364,060
Unregulated Services	6,319,478	5,825,001	5,673,775
TOTAL	204,202,674	194,544,141	181,037,835
Net Patient Revenue (NPR):			
Regulated Services	164,948,660	159,058,906	147,939,181
Unregulated Services	2,324,242	2,078,979	2,027,581
TOTAL	167,272,902	161,137,885	149,966,763
Other Operating Revenue:			
Regulated Services	348,418	1,430,700	2,882,101
Unregulated Services	1,525,865	716,374	537,202
TOTAL	1,874,283	2,147,074	3,419,303
Net Operating Revenue (NOR)			
Regulated Services	165,297,079	160,489,606	150,821,282
Unregulated Services	3,850,107	2,795,353	2,564,783
Total	169,147,185	163,284,959	153,386,066
Total Operating Expenses:			
Regulated Services	147,803,701	148,789,773	145,904,849
Unregulated Services	19,855,316	15,657,053	14,868,131
Total	167,659,016	164,446,826	160,772,980
Net Operating Profit (Loss):			
Regulated Services	17,493,378	11,699,833	4,916,433
Unregulated Services	-16,005,209	-12,861,700	-12,303,348
Total	1,488,169	-1,161,867	-7,386,914
Total Non-Operating Profit (Loss):	291,408	240,452	742,415
Non-Operating Revenue	291,408	240,452	742,415
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	1,779,577	-921,415	-6,644,499
% Net Operating Profit of Regulated NOR	10.58	7.29	3.26
% Net Total Operating Profit of Total NOR	0.88	-0.71	-4.82
% Total Excess Profit of Total Revenue	1.05	-0.56	-4.31

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

ChristianaCare Union Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	208,548,728	210,598,498	188,970,768
Unregulated Services	50,878,600	49,788,200	43,891,868
TOTAL	259,427,328	260,386,698	232,862,636
Net Patient Revenue (NPR):			
Regulated Services	144,987,742	169,388,933	156,223,024
Unregulated Services	48,542,000	18,703,790	18,504,308
TOTAL	193,529,742	188,092,723	174,727,332
Other Operating Revenue:			
Regulated Services	980,800	493,298	1,118,316
Unregulated Services	325,200	332,021	348,684
TOTAL	1,306,000	825,319	1,467,000
Net Operating Revenue (NOR)			
Regulated Services	145,968,542	169,882,231	157,341,340
Unregulated Services	48,867,200	19,035,811	18,852,992
Total	194,835,742	188,918,042	176,194,332
Total Operating Expenses:			
Regulated Services	162,773,714	151,771,888	150,348,668
Unregulated Services	47,365,465	41,398,150	41,952,730
Total	210,139,179	193,170,038	192,301,398
Net Operating Profit (Loss):			
Regulated Services	-16,805,172	18,110,343	6,992,673
Unregulated Services	1,501,735	-22,362,339	-23,099,738
Total	-15,303,437	-4,251,996	-16,107,065
Total Non-Operating Profit (Loss):	5,961,000	7,320,000	5,010,000
Non-Operating Revenue	5,961,000	7,320,000	5,010,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-9,342,437	3,068,004	-11,097,065
% Net Operating Profit of Regulated NOR	-11.51	10.66	4.44
% Net Total Operating Profit of Total NOR	-7.85	-2.25	-9.14
% Total Excess Profit of Total Revenue	-4.65	1.56	-6.12

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Frederick Health Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	464,628,200	424,222,500	413,332,700
Unregulated Services	67,764,800	64,610,900	64,514,900
TOTAL	532,393,000	488,833,400	477,847,600
Net Patient Revenue (NPR):			
Regulated Services	383,317,500	358,096,402	346,048,500
Unregulated Services	46,506,500	42,902,800	41,614,500
TOTAL	429,824,000	400,999,202	387,663,000
Other Operating Revenue:			
Regulated Services	7,157,800	10,715,231	7,436,536
Unregulated Services	9,697,200	9,869,450	10,175,464
TOTAL	16,855,000	20,584,681	17,612,000
Net Operating Revenue (NOR)			
Regulated Services	390,475,300	368,811,633	353,485,036
Unregulated Services	56,203,700	52,772,250	51,789,964
Total	446,679,000	421,583,883	405,275,000
Total Operating Expenses:			
Regulated Services	342,703,225	344,516,941	338,216,422
Unregulated Services	87,839,776	79,229,059	75,242,578
Total	430,543,000	423,746,000	413,459,000
Net Operating Profit (Loss):			
Regulated Services	47,772,076	24,294,692	15,268,614
Unregulated Services	-31,636,076	-26,456,809	-23,452,614
Total	16,136,000	-2,162,117	-8,184,000
Total Non-Operating Profit (Loss):	20,928,000	23,086,000	20,423,000
Non-Operating Revenue	20,928,000	23,086,000	20,423,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	37,064,000	20,923,883	12,239,000
% Net Operating Profit of Regulated NOR	12.23	6.59	4.32
% Net Total Operating Profit of Total NOR	3.61	-0.51	-2.02
% Total Excess Profit of Total Revenue	7.93	4.71	2.88

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Greater Baltimore Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	534,931,449	525,917,619	497,427,559
Unregulated Services	315,474,832	298,489,730	278,695,804
TOTAL	850,406,281	824,407,349	776,123,363
Net Patient Revenue (NPR):			
Regulated Services	447,477,127	435,805,791	418,454,800
Unregulated Services	147,854,938	139,337,347	128,279,409
TOTAL	595,332,065	575,143,138	546,734,209
Other Operating Revenue:			
Regulated Services	7,784,605	10,130,587	19,853,182
Unregulated Services	37,685,437	28,752,126	22,214,684
TOTAL	45,470,042	38,882,713	42,067,866
Net Operating Revenue (NOR)			
Regulated Services	455,261,732	445,936,378	438,307,982
Unregulated Services	185,540,375	168,089,473	150,494,093
Total	640,802,107	614,025,851	588,802,075
Total Operating Expenses:			
Regulated Services	410,216,078	388,505,668	383,337,071
Unregulated Services	278,593,647	242,669,681	240,856,929
Total	688,809,725	631,175,350	624,194,000
Net Operating Profit (Loss):			
Regulated Services	45,045,654	57,430,709	54,970,910
Unregulated Services	-93,053,272	-74,580,208	-90,362,836
Total	-48,007,618	-17,149,499	-35,391,925
Total Non-Operating Profit (Loss):	14,206,881	10,464,000	14,232,000
Non-Operating Revenue	16,725,193	12,965,000	11,583,000
Non-Operating Expenses	2,518,312	2,501,000	-2,649,000
Total Excess Profit (Loss):	-33,800,737	-6,685,499	-26,457,925
% Net Operating Profit of Regulated NOR	9.89	12.88	12.54
% Net Total Operating Profit of Total NOR	-7.49	-2.79	-6.01
% Total Excess Profit of Total Revenue	-5.14	-1.07	-4.41

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Holy Cross Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	638,008,057	600,651,500	573,789,700
Unregulated Services	59,411,439	48,379,980	46,328,041
TOTAL	697,419,496	649,031,480	620,117,741
Net Patient Revenue (NPR):			
Regulated Services	551,960,687	511,658,901	480,096,910
Unregulated Services	22,783,268	19,681,888	16,874,062
TOTAL	574,743,955	531,340,789	496,970,971
Other Operating Revenue:			
Regulated Services	1,606,523	1,614,562	9,622,808
Unregulated Services	14,622,327	21,540,477	25,310,692
TOTAL	16,228,850	23,155,039	34,933,500
Net Operating Revenue (NOR)			
Regulated Services	553,567,210	513,273,463	489,719,717
Unregulated Services	37,405,595	41,222,365	42,184,754
Total	590,972,805	554,495,828	531,904,471
Total Operating Expenses:			
Regulated Services	456,064,222	440,756,817	445,104,100
Unregulated Services	87,591,975	79,664,683	82,356,900
Total	543,656,197	520,421,500	527,461,000
Net Operating Profit (Loss):			
Regulated Services	97,502,988	72,516,646	44,615,617
Unregulated Services	-50,186,380	-38,442,318	-40,172,145
Total	47,316,608	34,074,328	4,443,471
Total Non-Operating Profit (Loss):	52,395,790	36,357,600	25,429,000
Non-Operating Revenue	53,284,286	37,449,300	27,440,000
Non-Operating Expenses	888,496	1,091,700	2,011,000
Total Excess Profit (Loss):	99,712,397	70,431,928	29,872,471
% Net Operating Profit of Regulated NOR	17.61	14.13	9.11
% Net Total Operating Profit of Total NOR	8.01	6.15	0.84
% Total Excess Profit of Total Revenue	15.48	11.90	5.34

Holy Cross Hospital Germantown

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	180,505,379	163,546,900	140,664,300
Unregulated Services	6,617,154	5,515,295	3,528,900
TOTAL	187,122,533	169,062,195	144,193,200
Net Patient Revenue (NPR):			
Regulated Services	153,514,226	137,746,580	119,873,460
Unregulated Services	2,673,244	2,287,216	911,700
TOTAL	156,187,470	140,033,795	120,785,160
Other Operating Revenue:			
Regulated Services	51,827	122,101	1,360,100
Unregulated Services	760,350	742,239	631,400
TOTAL	812,177	864,340	1,991,500
Net Operating Revenue (NOR)			
Regulated Services	153,566,053	137,868,681	121,233,560
Unregulated Services	3,433,594	3,029,455	1,543,100
Total	156,999,647	140,898,135	122,776,660
Total Operating Expenses:			
Regulated Services	140,776,951	133,531,772	126,408,245
Unregulated Services	14,854,833	15,425,228	13,257,255
Total	155,631,784	148,957,000	139,665,500
Net Operating Profit (Loss):			
Regulated Services	12,789,102	4,336,909	-5,174,685
Unregulated Services	-11,421,239	-12,395,774	-11,714,155
Total	1,367,863	-8,058,865	-16,888,840
Total Non-Operating Profit (Loss):	5,766,072	5,984,500	4,157,300
Non-Operating Revenue	5,766,072	5,984,500	4,157,300
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	7,133,935	-2,074,365	-12,731,540
% Net Operating Profit of Regulated NOR	8.33	3.15	-4.27
% Net Total Operating Profit of Total NOR	0.87	-5.72	-13.76
% Total Excess Profit of Total Revenue	4.38	-1.41	-10.03

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Johns Hopkins Bayview Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	867,460,833	828,761,549	783,284,695
Unregulated Services	5,457,303	5,074,353	4,967,211
TOTAL	872,918,136	833,835,902	788,251,906
Net Patient Revenue (NPR):			
Regulated Services	722,858,314	673,842,854	643,947,307
Unregulated Services	5,249,912	4,881,598	4,778,473
TOTAL	728,108,226	678,724,452	648,725,780
Other Operating Revenue:			
Regulated Services	9,958,028	8,758,959	13,167,637
Unregulated Services	149,930,747	113,281,589	101,524,583
TOTAL	159,888,774	122,040,548	114,692,220
Net Operating Revenue (NOR)			
Regulated Services	732,816,342	682,601,813	657,114,944
Unregulated Services	155,180,659	118,163,187	106,303,056
Total	887,997,000	800,765,000	763,418,000
Total Operating Expenses:			
Regulated Services	700,236,939	668,976,576	647,678,909
Unregulated Services	124,409,061	114,534,424	112,633,091
Total	824,646,000	783,511,000	760,312,000
Net Operating Profit (Loss):			
Regulated Services	32,579,403	13,625,237	9,436,035
Unregulated Services	30,771,598	3,628,763	-6,330,035
Total	63,351,000	17,254,000	3,106,000
Total Non-Operating Profit (Loss):	5,399,000	1,523,000	-6,042,000
Non-Operating Revenue	13,372,000	12,318,000	9,244,000
Non-Operating Expenses	7,973,000	10,795,000	15,286,000
Total Excess Profit (Loss):	68,750,000	18,777,000	-2,936,000
% Net Operating Profit of Regulated NOR	4.45	2.00	1.44
% Net Total Operating Profit of Total NOR	7.13	2.15	0.41
% Total Excess Profit of Total Revenue	7.63	2.31	-0.38

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025 Page 15

Johns Hopkins Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	3,311,615,560	3,105,851,884	2,921,370,378
Unregulated Services	16,114,680	30,330,632	29,188,854
TOTAL	3,327,730,240	3,136,182,516	2,950,559,232
Net Patient Revenue (NPR):			
Regulated Services	2,760,799,560	2,539,308,684	2,417,676,978
Unregulated Services	16,114,680	30,330,632	29,188,854
TOTAL	2,776,914,240	2,569,639,316	2,446,865,832
Other Operating Revenue:			
Regulated Services	56,674,564	65,944,384	77,702,368
Unregulated Services	810,231,400	686,569,200	635,473,600
TOTAL	866,905,964	752,513,584	713,175,968
Net Operating Revenue (NOR)			
Regulated Services	2,817,474,124	2,605,253,068	2,495,379,346
Unregulated Services	826,346,080	716,899,832	664,662,454
Total	3,643,820,204	3,322,152,900	3,160,041,800
Total Operating Expenses:			
Regulated Services	2,790,084,357	2,620,183,600	2,455,632,500
Unregulated Services	729,979,643	647,787,400	604,818,500
Total	3,520,064,000	3,267,971,000	3,060,451,000
Net Operating Profit (Loss):			
Regulated Services	27,389,767	-14,930,532	39,746,846
Unregulated Services	96,366,437	69,112,432	59,843,954
Total	123,756,204	54,181,900	99,590,800
Total Non-Operating Profit (Loss):	31,988,000	53,857,000	27,797,000
Non-Operating Revenue	158,847,000	177,214,000	160,325,000
Non-Operating Expenses	126,859,000	123,357,000	132,528,000
Total Excess Profit (Loss):	155,744,204	108,038,900	127,387,800
% Net Operating Profit of Regulated NOR	0.97	-0.57	1.59
% Net Total Operating Profit of Total NOR	3.40	1.63	3.15
% Total Excess Profit of Total Revenue	4.10	3.09	3.84

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Johns Hopkins Howard County Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	401,287,682	373,181,711	356,825,066
Unregulated Services	0	0	0
TOTAL	401,287,682	373,181,711	356,825,066
Net Patient Revenue (NPR):			
Regulated Services	339,512,682	316,584,711	303,392,066
Unregulated Services	0	0	0
TOTAL	339,512,682	316,584,711	303,392,066
Other Operating Revenue:			
Regulated Services	2,370,254	2,601	353,368
Unregulated Services	7,044,946	7,606,724	11,908,542
TOTAL	9,415,199	7,609,325	12,261,910
Net Operating Revenue (NOR)			
Regulated Services	341,882,936	316,587,312	303,745,434
Unregulated Services	7,044,946	7,606,724	11,908,542
Total	348,927,881	324,194,036	315,653,976
Total Operating Expenses:			
Regulated Services	327,863,815	311,543,564	314,058,592
Unregulated Services	21,911,185	19,565,471	17,590,825
Total	349,775,000	331,109,035	331,649,417
Net Operating Profit (Loss):			
Regulated Services	14,019,121	5,043,748	-10,313,158
Unregulated Services	-14,866,240	-11,958,747	-5,682,283
Total	-847,119	-6,915,000	-15,995,441
Total Non-Operating Profit (Loss):	24,512,900	27,627,631	22,862,441
Non-Operating Revenue	25,519,900	28,288,596	24,996,024
Non-Operating Expenses	1,007,000	660,965	2,133,583
Total Excess Profit (Loss):	23,665,781	20,712,631	6,867,000
% Net Operating Profit of Regulated NOR	4.10	1.59	-3.40
% Net Total Operating Profit of Total NOR	-0.24	-2.13	-5.07
% Total Excess Profit of Total Revenue	6.32	5.88	2.02

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Johns Hopkins Suburban Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	465,603,384	431,677,954	404,912,474
Unregulated Services	1,135,106	487,394	664,751
TOTAL	466,738,490	432,165,348	405,577,225
Net Patient Revenue (NPR):			
Regulated Services	389,175,948	362,453,688	339,589,552
Unregulated Services	1,135,106	487,394	664,751
TOTAL	390,311,055	362,941,082	340,254,303
Other Operating Revenue:			
Regulated Services	8,666,987	7,521,235	6,980,212
Unregulated Services	10,390,014	12,988,396	14,936,755
TOTAL	19,057,000	20,509,631	21,916,968
Net Operating Revenue (NOR)			
Regulated Services	397,842,935	369,974,923	346,569,765
Unregulated Services	11,525,120	13,475,791	15,601,506
Total	409,368,055	383,450,713	362,171,271
Total Operating Expenses:			
Regulated Services	367,993,859	345,650,345	332,427,884
Unregulated Services	51,163,626	46,223,116	43,759,600
Total	419,157,485	391,873,461	376,187,484
Net Operating Profit (Loss):			
Regulated Services	29,849,076	24,324,578	14,141,881
Unregulated Services	-39,638,507	-32,747,325	-28,158,094
Total	-9,789,431	-8,422,747	-14,016,213
Total Non-Operating Profit (Loss):	39,309,000	38,837,000	30,181,978
Non-Operating Revenue	39,309,000	38,837,000	30,181,978
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	29,519,569	30,414,253	16,165,765
% Net Operating Profit of Regulated NOR	7.50	6.57	4.08
% Net Total Operating Profit of Total NOR	-2.39	-2.20	-3.87
% Total Excess Profit of Total Revenue	6.58	7.20	4.12

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

LifeBridge Health Carroll Hospital Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	290,567,437	294,002,396	265,924,528
Unregulated Services	109,590,763	102,213,085	97,907,000
TOTAL	400,158,200	396,215,481	363,831,528
Net Patient Revenue (NPR):			
Regulated Services	241,925,955	251,981,612	226,917,377
Unregulated Services	55,705,771	50,831,355	47,556,447
TOTAL	297,631,726	302,812,967	274,473,824
Other Operating Revenue:			
Regulated Services	12,253,321	12,400,841	15,074,565
Unregulated Services	729,164	2,594,726	1,068,201
TOTAL	12,982,485	14,995,567	16,142,766
Net Operating Revenue (NOR)			
Regulated Services	254,179,276	264,382,453	241,991,942
Unregulated Services	56,434,935	53,426,081	48,624,648
Total	310,614,211	317,808,534	290,616,590
Total Operating Expenses:			
Regulated Services	229,701,676	218,498,303	219,473,520
Unregulated Services	72,522,197	71,343,425	59,999,209
Total	302,223,873	289,841,728	279,472,729
Net Operating Profit (Loss):			
Regulated Services	24,477,600	45,884,150	22,518,422
Unregulated Services	-16,087,262	-17,917,344	-11,374,561
Total	8,390,338	27,966,806	11,143,860
Total Non-Operating Profit (Loss):	28,124,132	22,822,801	23,389,493
Non-Operating Revenue	28,124,132	22,822,801	23,389,493
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	36,514,470	50,789,607	34,533,353
% Net Operating Profit of Regulated NOR	9.63	17.36	9.31
% Net Total Operating Profit of Total NOR	2.70	8.80	3.83
% Total Excess Profit of Total Revenue	10.78	14.91	11.00

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

LifeBridge Health Grace Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	August 2023
Gross Patient Revenue:			
Regulated Services	34,392,859	33,202,184	34,673,288
Unregulated Services	38,145,767	34,181,000	37,621,705
TOTAL	72,538,626	67,383,184	72,294,993
Net Patient Revenue (NPR):			
Regulated Services	25,650,039	27,153,619	26,745,634
Unregulated Services	9,443,567	6,357,539	9,450,359
TOTAL	35,093,606	33,511,158	36,195,993
Other Operating Revenue:			
Regulated Services	867,400	2,119,621	1,138,679
Unregulated Services	507,200	752,849	1,294,321
TOTAL	1,374,600	2,872,470	2,433,000
Net Operating Revenue (NOR)			
Regulated Services	26,517,439	29,273,240	27,884,313
Unregulated Services	9,950,767	7,110,388	10,744,680
Total	36,468,206	36,383,628	38,628,993
Total Operating Expenses:			
Regulated Services	33,001,760	32,288,518	31,541,781
Unregulated Services	18,386,826	19,055,137	18,902,219
Total	51,388,586	51,343,655	50,444,000
Net Operating Profit (Loss):			
Regulated Services	-6,484,321	-3,015,279	-3,657,468
Unregulated Services	-8,436,059	-11,944,749	-8,157,539
Total	-14,920,380	-14,960,028	-11,815,007
Total Non-Operating Profit (Loss):	-2,000	-7,000	15,254,000
Non-Operating Revenue	0	-7,000	15,300,000
Non-Operating Expenses	2,000	0	46,000
Total Excess Profit (Loss):	-14,922,380	-14,967,028	3,438,993
% Net Operating Profit of Regulated NOR	-24.45	-10.30	-13.12
% Net Total Operating Profit of Total NOR	-40.91	-41.12	-30.59
% Total Excess Profit of Total Revenue	-40.92	-41.14	6.38

maryland health services cost review commission

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

LifeBridge Health Levindale

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	70,446,064	67,965,551	68,907,086
Unregulated Services	38,495,797	33,700,369	33,445,347
TOTAL	108,941,861	101,665,920	102,352,433
Net Patient Revenue (NPR):			
Regulated Services	52,077,852	54,502,869	56,920,733
Unregulated Services	33,139,167	27,854,327	27,285,985
TOTAL	85,217,019	82,357,196	84,206,718
Other Operating Revenue:			
Regulated Services	2,113,041	1,535,117	3,112,853
Unregulated Services	191,738	1,025,978	646,356
TOTAL	2,304,779	2,561,095	3,759,209
Net Operating Revenue (NOR)			
Regulated Services	54,190,893	56,037,986	60,033,586
Unregulated Services	33,330,905	28,880,305	27,932,341
Total	87,521,798	84,918,291	87,965,927
Total Operating Expenses:			
Regulated Services	45,301,883	41,785,620	44,536,449
Unregulated Services	38,052,895	35,477,086	37,069,746
Total	83,354,778	77,262,706	81,606,195
Net Operating Profit (Loss):			
Regulated Services	8,889,010	14,252,366	15,497,137
Unregulated Services	-4,721,990	-6,596,781	-9,137,405
Total	4,167,020	7,655,585	6,359,732
Total Non-Operating Profit (Loss):	2,602,000	2,383,348	2,137,741
Non-Operating Revenue	2,602,000	2,383,348	2,137,741
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	6,769,020	10,038,933	8,497,473
% Net Operating Profit of Regulated NOR	16.40	25.43	25.81
% Net Total Operating Profit of Total NOR	4.76	9.02	7.23
% Total Excess Profit of Total Revenue	7.51	11.50	9.43

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

LifeBridge Health Northwest Hospital Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	322,316,773	311,836,440	310,414,480
Unregulated Services	40,728,033	41,495,607	54,087,821
TOTAL	363,044,806	353,332,047	364,502,301
Net Patient Revenue (NPR):			
Regulated Services	266,188,976	261,762,970	266,499,749
Unregulated Services	19,813,853	23,188,207	31,378,125
TOTAL	286,002,829	284,951,177	297,877,874
Other Operating Revenue:			
Regulated Services	4,599,385	4,845,517	6,446,025
Unregulated Services	4,618,392	3,140,595	3,138,583
TOTAL	9,217,777	7,986,112	9,584,608
Net Operating Revenue (NOR)			
Regulated Services	270,788,361	266,608,487	272,945,774
Unregulated Services	24,432,245	26,328,802	34,516,708
Total	295,220,606	292,937,289	307,462,482
Total Operating Expenses:			
Regulated Services	245,037,179	238,767,737	250,976,112
Unregulated Services	56,165,902	63,342,730	66,843,821
Total	301,203,081	302,110,467	317,819,933
Net Operating Profit (Loss):			
Regulated Services	25,751,182	27,840,750	21,969,662
Unregulated Services	-31,733,657	-37,013,928	-32,327,113
Total	-5,982,475	-9,173,178	-10,357,451
Total Non-Operating Profit (Loss):	10,208,000	8,595,760	8,876,421
Non-Operating Revenue	10,208,000	8,595,760	8,876,421
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	4,225,525	-577,418	-1,481,030
% Net Operating Profit of Regulated NOR	9.51	10.44	8.05
% Net Total Operating Profit of Total NOR	-2.03	-3.13	-3.37
% Total Excess Profit of Total Revenue	1.38	-0.19	-0.47

HEALTH SERVICES COST REVIEW COMMISSION

DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

FISCAL YEAR 2023 TO 2025

LifeBridge Health Sinai Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	994,389,633	961,717,881	949,076,151
Unregulated Services	257,244,662	251,168,098	251,736,860
TOTAL	1,251,634,295	1,212,885,979	1,200,813,012
Net Patient Revenue (NPR):			
Regulated Services	824,928,771	804,921,429	793,704,566
Unregulated Services	116,809,324	110,695,636	110,806,489
TOTAL	941,738,095	915,617,065	904,511,054
Other Operating Revenue:			
Regulated Services	28,528,786	13,563,503	20,410,182
Unregulated Services	39,033,146	38,154,078	33,491,752
TOTAL	67,561,932	51,717,581	53,901,934
Net Operating Revenue (NOR)			
Regulated Services	853,457,557	818,484,932	814,114,748
Unregulated Services	155,842,470	148,849,714	144,298,240
Total	1,009,300,027	967,334,646	958,412,988
Total Operating Expenses:			
Regulated Services	723,016,530	712,346,938	726,701,775
Unregulated Services	242,039,402	233,447,643	227,733,159
Total	965,055,932	945,794,581	954,434,934
Net Operating Profit (Loss):			
Regulated Services	130,441,027	106,137,994	87,412,972
Unregulated Services	-86,196,932	-84,597,928	-83,434,918
Total	44,244,095	21,540,065	3,978,054
Total Non-Operating Profit (Loss):	43,027,000	39,093,000	40,413,000
Non-Operating Revenue	43,027,000	39,093,000	40,413,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	87,271,095	60,633,065	44,391,054
% Net Operating Profit of Regulated NOR	15.28	12.97	10.74
% Net Total Operating Profit of Total NOR	4.38	2.23	0.42
% Total Excess Profit of Total Revenue	8.29	6.02	4.44

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Luminis Health Anne Arundel Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	791,316,592	746,989,000	749,524,800
Unregulated Services	34,860,899	35,127,994	31,488,884
TOTAL	826,177,491	782,116,994	781,013,684
Net Patient Revenue (NPR):			
Regulated Services	686,244,195	630,365,072	608,630,183
Unregulated Services	14,463,836	13,080,925	12,300,754
TOTAL	700,708,031	643,445,997	620,930,937
Other Operating Revenue:			
Regulated Services	41,268,500	5,263,889	6,939,326
Unregulated Services	10,435,500	9,168,111	9,056,674
TOTAL	51,704,000	14,432,000	15,996,000
Net Operating Revenue (NOR)			
Regulated Services	727,512,695	635,628,961	615,569,509
Unregulated Services	24,899,336	22,249,036	21,357,428
Total	752,412,031	657,877,997	636,926,937
Total Operating Expenses:			
Regulated Services	612,281,010	564,249,309	580,138,043
Unregulated Services	86,826,990	75,337,691	66,971,957
Total	699,108,000	639,587,000	647,110,000
Net Operating Profit (Loss):			
Regulated Services	115,231,685	71,379,651	35,431,466
Unregulated Services	-61,927,654	-53,088,654	-45,614,529
Total	53,304,031	18,290,997	-10,183,063
Total Non-Operating Profit (Loss):	59,123,015	48,779,000	47,448,000
Non-Operating Revenue	59,123,015	48,779,000	47,448,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	112,427,045	67,069,997	37,264,937
% Net Operating Profit of Regulated NOR	15.84	11.23	5.76
% Net Total Operating Profit of Total NOR	7.08	2.78	-1.60
% Total Excess Profit of Total Revenue	13.85	9.49	5.45

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025 Page 24

Luminis Health Doctors Community Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	326,288,251	308,883,300	308,601,200
Unregulated Services	888,435	511,826	696,212
TOTAL	327,176,686	309,395,126	309,297,412
Net Patient Revenue (NPR):			
Regulated Services	274,081,821	248,446,159	228,329,915
Unregulated Services	703,178	378,235	400,396
TOTAL	274,784,999	248,824,394	228,730,310
Other Operating Revenue:			
Regulated Services	2,649,674	2,116,000	2,670,300
Unregulated Services	2,417,326	2,913,000	2,021,700
TOTAL	5,067,000	5,029,000	4,692,000
Net Operating Revenue (NOR)			
Regulated Services	276,731,495	250,562,159	231,000,215
Unregulated Services	3,120,504	3,291,235	2,422,096
Total	279,851,999	253,853,394	233,422,310
Total Operating Expenses:			
Regulated Services	259,652,070	235,424,693	229,662,179
Unregulated Services	26,796,930	24,174,307	17,557,821
Total	286,449,000	259,599,000	247,220,000
Net Operating Profit (Loss):			
Regulated Services	17,079,426	15,137,467	1,338,036
Unregulated Services	-23,676,427	-20,883,073	-15,135,725
Total	-6,597,001	-5,745,606	-13,797,690
Total Non-Operating Profit (Loss):	226,000	-2,441,000	-474,000
Non-Operating Revenue	226,000	-2,441,000	-474,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-6,371,001	-8,186,606	-14,271,690
% Net Operating Profit of Regulated NOR	6.17	6.04	0.58
% Net Total Operating Profit of Total NOR	-2.36	-2.26	-5.91
% Total Excess Profit of Total Revenue	-2.27	-3.26	-6.13

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

MedStar Franklin Square Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	743,866,299	688,099,485	638,932,701
Unregulated Services	305,944,480	272,531,280	250,252,322
TOTAL	1,049,810,780	960,630,765	889,185,023
Net Patient Revenue (NPR):			
Regulated Services	628,905,065	586,846,584	537,714,566
Unregulated Services	129,256,897	120,950,333	114,790,894
TOTAL	758,161,961	707,796,917	652,505,460
Other Operating Revenue:			
Regulated Services	8,103,232	13,458,907	16,536,466
Unregulated Services	15,720,012	11,700,425	8,802,716
TOTAL	23,823,245	25,159,332	25,339,182
Net Operating Revenue (NOR)			
Regulated Services	637,008,297	600,305,491	554,251,032
Unregulated Services	144,976,909	132,650,758	123,593,610
Total	781,985,206	732,956,248	677,844,642
Total Operating Expenses:			
Regulated Services	574,561,519	539,007,313	508,131,384
Unregulated Services	200,841,890	179,621,790	174,409,447
Total	775,403,409	718,629,103	682,540,830
Net Operating Profit (Loss):			
Regulated Services	62,446,779	61,298,178	46,119,648
Unregulated Services	-55,864,981	-46,971,032	-50,815,836
Total	6,581,797	14,327,146	-4,696,188
Total Non-Operating Profit (Loss):	774,187	544,275	334,898
Non-Operating Revenue	783,683	730,662	479,639
Non-Operating Expenses	9,496	186,386	144,741
Total Excess Profit (Loss):	7,355,984	14,871,421	-4,361,290
% Net Operating Profit of Regulated NOR	9.80	10.21	8.32
% Net Total Operating Profit of Total NOR	0.84	1.95	-0.69
% Total Excess Profit of Total Revenue	0.94	2.03	-0.64

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

MedStar Good Samaritan Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	328,543,894	319,991,752	308,835,327
Unregulated Services	88,766,221	89,465,108	82,977,204
TOTAL	417,310,115	409,456,859	391,812,531
Net Patient Revenue (NPR):			
Regulated Services	272,154,827	265,480,135	254,048,544
Unregulated Services	33,702,848	35,968,154	37,795,133
TOTAL	305,857,675	301,448,288	291,843,676
Other Operating Revenue:			
Regulated Services	6,165,190	5,273,196	10,431,579
Unregulated Services	14,198,412	13,199,443	11,624,577
TOTAL	20,363,602	18,472,639	22,056,155
Net Operating Revenue (NOR)			
Regulated Services	278,320,017	270,753,330	264,480,122
Unregulated Services	47,901,260	49,167,597	49,419,709
Total	326,221,278	319,920,928	313,899,831
Total Operating Expenses:			
Regulated Services	252,833,126	241,960,013	239,843,482
Unregulated Services	72,169,438	76,499,949	77,556,742
Total	325,002,564	318,459,961	317,400,224
Net Operating Profit (Loss):			
Regulated Services	25,486,891	28,793,318	24,636,640
Unregulated Services	-24,268,178	-27,332,352	-28,137,033
Total	1,218,713	1,460,966	-3,500,392
Total Non-Operating Profit (Loss):	5,372,318	5,092,852	3,306,229
Non-Operating Revenue	5,372,318	5,227,928	3,414,538
Non-Operating Expenses	0	135,076	108,309
Total Excess Profit (Loss):	6,591,032	6,553,818	-194,164
% Net Operating Profit of Regulated NOR	9.16	10.63	9.32
% Net Total Operating Profit of Total NOR	0.37	0.46	-1.12
% Total Excess Profit of Total Revenue	1.99	2.02	-0.06

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

MedStar Harbor Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	241,447,815	224,922,862	210,598,194
Unregulated Services	77,396,906	68,552,586	61,621,061
TOTAL	318,844,720	293,475,448	272,219,256
Net Patient Revenue (NPR):			
Regulated Services	197,019,905	188,323,158	176,399,149
Unregulated Services	31,827,424	25,385,491	25,017,619
TOTAL	228,847,329	213,708,648	201,416,769
Other Operating Revenue:			
Regulated Services	4,941,848	7,548,300	6,917,566
Unregulated Services	12,540,864	18,899,900	15,551,945
TOTAL	17,482,713	26,448,200	22,469,511
Net Operating Revenue (NOR)			
Regulated Services	201,961,753	195,871,458	183,316,715
Unregulated Services	44,368,288	44,285,391	40,569,565
Total	246,330,042	240,156,848	223,886,280
Total Operating Expenses:			
Regulated Services	187,339,146	181,969,826	171,478,814
Unregulated Services	67,224,041	62,472,976	59,100,143
Total	254,563,186	244,442,802	230,578,957
Net Operating Profit (Loss):			
Regulated Services	14,622,608	13,901,632	11,837,901
Unregulated Services	-22,855,753	-18,187,585	-18,530,578
Total	-8,233,145	-4,285,953	-6,692,677
Total Non-Operating Profit (Loss):	5,078,764	534,600	390,084
Non-Operating Revenue	5,078,764	601,600	444,863
Non-Operating Expenses	0	67,000	54,779
Total Excess Profit (Loss):	-3,154,381	-3,751,353	-6,302,593
% Net Operating Profit of Regulated NOR	7.24	7.10	6.46
% Net Total Operating Profit of Total NOR	-3.34	-1.78	-2.99
% Total Excess Profit of Total Revenue	-1.25	-1.56	-2.81

Medstar Montgomery Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	241,848,927	222,642,659	208,039,750
Unregulated Services	91,325,772	76,313,160	60,712,321
TOTAL	333,174,699	298,955,819	268,752,071
Net Patient Revenue (NPR):			
Regulated Services	204,076,074	183,717,210	173,573,630
Unregulated Services	41,762,418	37,850,452	30,644,515
TOTAL	245,838,492	221,567,661	204,218,145
Other Operating Revenue:			
Regulated Services	3,321,695	5,010,172	6,707,647
Unregulated Services	137,735	96,353	458,895
TOTAL	3,459,430	5,106,525	7,166,542
Net Operating Revenue (NOR)			
Regulated Services	207,397,769	188,727,382	180,281,276
Unregulated Services	41,900,153	37,946,804	31,103,410
Total	249,297,922	226,674,186	211,384,687
Total Operating Expenses:			
Regulated Services	200,575,154	188,797,764	182,012,090
Unregulated Services	55,942,259	51,558,230	46,590,452
Total	256,517,413	240,355,994	228,602,542
Net Operating Profit (Loss):			
Regulated Services	6,822,615	-70,382	-1,730,814
Unregulated Services	-14,042,106	-13,611,426	-15,487,042
Total	-7,219,491	-13,681,808	-17,217,856
Total Non-Operating Profit (Loss):	737,620	792,419	1,354,945
Non-Operating Revenue	917,900	1,042,446	1,430,590
Non-Operating Expenses	180,280	250,027	75,645
Total Excess Profit (Loss):	-6,481,871	-12,889,388	-15,862,911
% Net Operating Profit of Regulated NOR	3.29	-0.04	-0.96
% Net Total Operating Profit of Total NOR	-2.90	-6.04	-8.15
% Total Excess Profit of Total Revenue	-2.59	-5.66	-7.45

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025 Page 29

Medstar Southern Maryland Hospital Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	361,328,378	338,032,767	318,000,686
Unregulated Services	148,062,902	119,368,800	33,859,084
TOTAL	509,391,280	457,401,567	351,859,771
Net Patient Revenue (NPR):			
Regulated Services	317,404,428	273,706,361	253,654,839
Unregulated Services	63,644,415	53,969,966	16,603,636
TOTAL	381,048,843	327,676,327	270,258,475
Other Operating Revenue:			
Regulated Services	6,248,242	12,378,722	7,622,625
Unregulated Services	560,558	470,522	308,547
TOTAL	6,808,800	12,849,244	7,931,172
Net Operating Revenue (NOR)			
Regulated Services	323,652,670	286,085,083	261,277,464
Unregulated Services	64,204,973	54,440,488	16,912,183
Total	387,857,643	340,525,571	278,189,647
Total Operating Expenses:			
Regulated Services	289,769,166	289,266,748	257,464,006
Unregulated Services	93,608,345	82,766,215	49,442,159
Total	383,377,512	372,032,962	306,906,165
Net Operating Profit (Loss):			
Regulated Services	33,883,504	-3,181,665	3,813,459
Unregulated Services	-29,403,372	-28,325,726	-32,529,976
Total	4,480,131	-31,507,391	-28,716,518
Total Non-Operating Profit (Loss):	130,457	193,658	92,404
Non-Operating Revenue	161,915	206,864	96,157
Non-Operating Expenses	31,458	13,206	3,753
Total Excess Profit (Loss):	4,610,588	-31,313,733	-28,624,114
% Net Operating Profit of Regulated NOR	10.47	-1.11	1.46
% Net Total Operating Profit of Total NOR	1.16	-9.25	-10.32
% Total Excess Profit of Total Revenue	1.19	-9.19	-10.29

Medstar St. Mary's Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	256,129,031	236,265,893	217,557,775
Unregulated Services	73,461,047	70,815,833	37,541,262
TOTAL	329,590,078	307,081,727	255,099,037
Net Patient Revenue (NPR):			
Regulated Services	229,764,024	193,437,886	179,867,136
Unregulated Services	35,163,004	35,444,637	18,789,369
TOTAL	264,927,028	228,882,523	198,656,505
Other Operating Revenue:			
Regulated Services	3,460,932	3,117,632	2,728,296
Unregulated Services	1,652,815	1,725,588	2,158,735
TOTAL	5,113,747	4,843,220	4,887,031
Net Operating Revenue (NOR)			
Regulated Services	233,224,956	196,555,518	182,595,432
Unregulated Services	36,815,819	37,170,226	20,948,104
Total	270,040,775	233,725,744	203,543,536
Total Operating Expenses:			
Regulated Services	184,243,133	177,561,168	163,335,536
Unregulated Services	52,946,521	52,477,238	37,963,749
Total	237,189,654	230,038,405	201,299,285
Net Operating Profit (Loss):			
Regulated Services	48,981,823	18,994,350	19,259,896
Unregulated Services	-16,130,702	-15,307,012	-17,015,645
Total	32,851,121	3,687,338	2,244,251
Total Non-Operating Profit (Loss):	2,835,538	2,396,022	2,133,116
Non-Operating Revenue	2,835,538	752,171	702,999
Non-Operating Expenses	0	-1,643,851	-1,430,117
Total Excess Profit (Loss):	35,686,660	6,083,361	4,377,367
% Net Operating Profit of Regulated NOR	21.00	9.66	10.55
% Net Total Operating Profit of Total NOR	12.17	1.58	1.10
% Total Excess Profit of Total Revenue	13.08	2.59	2.14

Medstar Union Memorial Hospital

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	524,653,148	499,090,335	485,128,248
Unregulated Services	198,449,549	176,868,108	160,168,381
TOTAL	723,102,697	675,958,443	645,296,629
Net Patient Revenue (NPR):			
Regulated Services	445,990,056	423,250,694	409,516,689
Unregulated Services	84,292,702	78,077,125	72,553,536
TOTAL	530,282,758	501,327,819	482,070,224
Other Operating Revenue:			
Regulated Services	7,685,138	8,446,605	15,462,765
Unregulated Services	15,582,175	10,254,804	10,128,881
TOTAL	23,267,313	18,701,409	25,591,646
Net Operating Revenue (NOR)			
Regulated Services	453,675,194	431,697,299	424,979,454
Unregulated Services	99,874,876	88,331,929	82,682,417
Total	553,550,070	520,029,228	507,661,871
Total Operating Expenses:			
Regulated Services	407,155,554	387,147,600	389,617,319
Unregulated Services	158,855,843	145,242,332	127,349,838
Total	566,011,397	532,389,932	516,967,157
Net Operating Profit (Loss):			
Regulated Services	46,519,640	44,549,699	35,362,135
Unregulated Services	-58,980,967	-56,910,403	-44,667,421
Total	-12,461,327	-12,360,704	-9,305,286
Total Non-Operating Profit (Loss):	8,702,462	9,277,144	5,986,365
Non-Operating Revenue	8,760,477	9,446,813	6,117,379
Non-Operating Expenses	58,016	169,669	131,014
Total Excess Profit (Loss):	-3,758,865	-3,083,560	-3,318,921
% Net Operating Profit of Regulated NOR	10.25	10.32	8.32
% Net Total Operating Profit of Total NOR	-2.25	-2.38	-1.83
% Total Excess Profit of Total Revenue	-0.67	-0.58	-0.65

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

Mercy Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	717,488,100	681,875,400	653,644,800
Unregulated Services	5,819,473	5,676,607	4,920,693
TOTAL	723,307,573	687,552,007	658,565,493
Net Patient Revenue (NPR):			
Regulated Services	600,644,798	574,205,419	557,725,931
Unregulated Services	5,819,473	5,676,607	4,920,693
TOTAL	606,464,271	579,882,027	562,646,623
Other Operating Revenue:			
Regulated Services	29,767,097	33,777,900	27,950,484
Unregulated Services	8,130,024	7,938,310	7,531,913
TOTAL	37,897,121	41,716,210	35,482,398
Net Operating Revenue (NOR)			
Regulated Services	630,411,895	607,983,319	585,676,415
Unregulated Services	13,949,497	13,614,918	12,452,606
Total	644,361,392	621,598,236	598,129,021
Total Operating Expenses:			
Regulated Services	600,083,907	564,388,570	540,448,469
Unregulated Services	44,467,757	41,251,160	39,303,936
Total	644,551,663	605,639,730	579,752,405
Net Operating Profit (Loss):			
Regulated Services	30,327,989	43,594,749	45,227,946
Unregulated Services	-30,518,260	-27,636,242	-26,851,330
Total	-190,271	15,958,507	18,376,616
Total Non-Operating Profit (Loss):	30,040,559	27,621,850	27,789,971
Non-Operating Revenue	30,539,595	27,621,850	28,211,625
Non-Operating Expenses	499,036	0	421,654
Total Excess Profit (Loss):	29,850,288	43,580,356	46,166,587
% Net Operating Profit of Regulated NOR	4.81	7.17	7.72
% Net Total Operating Profit of Total NOR	-0.03	2.57	3.07
% Total Excess Profit of Total Revenue	4.42	6.71	7.37

Meritus Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	540,426,100	487,797,440	440,345,460
Unregulated Services	153,544,500	82,021,500	47,173,714
TOTAL	693,970,600	569,818,940	487,519,174
Net Patient Revenue (NPR):			
Regulated Services	457,802,500	420,773,640	373,443,758
Unregulated Services	66,706,800	38,008,700	22,763,166
TOTAL	524,509,300	458,782,340	396,206,924
Other Operating Revenue:			
Regulated Services	28,026,600	14,821,900	28,034,734
Unregulated Services	15,147,000	12,577,100	9,852,078
TOTAL	43,173,600	27,399,000	37,886,812
Net Operating Revenue (NOR)			
Regulated Services	485,829,100	435,595,540	401,478,492
Unregulated Services	81,853,800	50,585,800	32,615,244
Total	567,682,900	486,181,340	434,093,736
Total Operating Expenses:			
Regulated Services	409,741,600	366,897,700	341,796,054
Unregulated Services	109,128,300	68,637,200	48,274,918
Total	518,869,900	435,534,900	390,070,972
Net Operating Profit (Loss):			
Regulated Services	76,087,500	68,697,840	59,682,438
Unregulated Services	-27,274,500	-18,051,400	-15,659,674
Total	48,813,000	50,646,440	44,022,764
Total Non-Operating Profit (Loss):	41,793,100	52,247,100	42,948,070
Non-Operating Revenue	41,878,300	52,309,400	41,274,581
Non-Operating Expenses	85,200	62,300	-1,673,489
Total Excess Profit (Loss):	90,606,100	102,893,540	86,970,834
% Net Operating Profit of Regulated NOR	15.66	15.77	14.87
% Net Total Operating Profit of Total NOR	8.60	10.42	10.14
% Total Excess Profit of Total Revenue	14.86	19.11	18.30

TidalHealth Peninsula Regional

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	650,222,000	604,393,730	547,529,412
Unregulated Services	23,424,600	20,621,800	18,478,100
TOTAL	673,646,600	625,015,530	566,007,512
Net Patient Revenue (NPR):			
Regulated Services	534,259,700	486,449,430	462,958,612
Unregulated Services	12,640,600	14,600,100	12,940,900
TOTAL	546,900,300	501,049,530	475,899,512
Other Operating Revenue:			
Regulated Services	10,804,900	5,868,100	5,855,300
Unregulated Services	30,985,500	19,756,400	13,689,200
TOTAL	41,790,400	25,624,500	19,544,500
Net Operating Revenue (NOR)			
Regulated Services	545,064,600	492,317,530	468,813,912
Unregulated Services	43,626,100	34,356,500	26,630,100
Total	588,690,700	526,674,030	495,444,012
Total Operating Expenses:			
Regulated Services	467,355,811	401,716,087	412,864,166
Unregulated Services	90,725,489	75,774,913	67,546,834
Total	558,081,300	477,491,000	480,411,000
Net Operating Profit (Loss):			
Regulated Services	77,708,789	90,601,443	55,949,746
Unregulated Services	-47,099,389	-41,418,413	-40,916,734
Total	30,609,400	49,183,030	15,033,012
Total Non-Operating Profit (Loss):	40,469,500	45,620,000	34,897,000
Non-Operating Revenue	40,469,500	45,620,000	34,897,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	71,078,900	94,803,030	49,930,012
% Net Operating Profit of Regulated NOR	14.26	18.40	11.93
% Net Total Operating Profit of Total NOR	5.20	9.34	3.03
% Total Excess Profit of Total Revenue	11.30	16.57	9.41

Tidalhealth Mccready Pavilion

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	6,563,300	6,300,799	5,920,672
Unregulated Services	0	0	0
TOTAL	6,563,300	6,300,799	5,920,672
Net Patient Revenue (NPR):			
Regulated Services	4,986,300	4,266,099	4,916,572
Unregulated Services	0	0	0
TOTAL	4,986,300	4,266,099	4,916,572
Other Operating Revenue:			
Regulated Services	0	0	0
Unregulated Services	0	0	0
TOTAL	0	0	0
Net Operating Revenue (NOR)			
Regulated Services	4,986,300	4,266,099	4,916,572
Unregulated Services	0	0	0
Total	4,986,300	4,266,099	4,916,572
Total Operating Expenses:			
Regulated Services	6,090,849	5,708,600	7,007,600
Unregulated Services	1,587,451	1,555,600	2,036,500
Total	7,678,300	7,264,200	9,044,100
Net Operating Profit (Loss):			
Regulated Services	-1,104,549	-1,442,501	-2,091,028
Unregulated Services	-1,587,451	-1,555,600	-2,036,500
Total	-2,692,000	-2,998,101	-4,127,528
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-2,692,000	-2,998,101	-4,127,528
% Net Operating Profit of Regulated NOR	-22.15	-33.81	-42.53
% Net Total Operating Profit of Total NOR	-53.99	-70.28	-83.95
% Total Excess Profit of Total Revenue	-53.99	-70.28	-83.95

HEALTH SERVICES COST REVIEW COMMISSION
DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA
FISCAL YEAR 2023 TO 2025

UM Baltimore Washington Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	554,612,093	535,602,424	511,681,319
Unregulated Services	10,957,000	9,713,000	9,270,000
TOTAL	565,569,093	545,315,424	520,951,319
Net Patient Revenue (NPR):			
Regulated Services	477,588,713	460,416,164	437,420,018
Unregulated Services	3,880,288	2,976,836	2,826,982
TOTAL	481,469,000	463,393,000	440,247,000
Other Operating Revenue:			
Regulated Services	2,238,000	3,313,097	3,632,948
Unregulated Services	0	60,903	74,052
TOTAL	2,238,000	3,374,000	3,707,000
Net Operating Revenue (NOR)			
Regulated Services	479,826,713	463,729,262	441,052,967
Unregulated Services	3,880,288	3,037,738	2,901,033
Total	483,707,000	466,767,000	443,954,000
Total Operating Expenses:			
Regulated Services	421,264,607	416,256,925	423,626,419
Unregulated Services	58,326,393	58,263,075	50,419,581
Total	479,591,000	474,520,000	474,046,000
Net Operating Profit (Loss):			
Regulated Services	58,562,106	47,472,336	17,426,547
Unregulated Services	-54,446,106	-55,225,336	-47,518,547
Total	4,116,000	-7,753,000	-30,092,000
Total Non-Operating Profit (Loss):	22,880,000	22,458,000	12,913,000
Non-Operating Revenue	22,880,000	24,788,000	17,108,000
Non-Operating Expenses	0	2,330,000	4,195,000
Total Excess Profit (Loss):	26,996,000	14,705,000	-17,179,000
% Net Operating Profit of Regulated NOR	12.20	10.24	3.95
% Net Total Operating Profit of Total NOR	0.85	-1.66	-6.78
% Total Excess Profit of Total Revenue	5.33	2.99	-3.73

UM Bowie Health Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	24,873,230	24,028,994	21,233,764
Unregulated Services	0	1,000	2,000
TOTAL	24,873,230	24,029,994	21,235,764
Net Patient Revenue (NPR):			
Regulated Services	18,532,000	19,467,000	16,923,000
Unregulated Services	0	1,000	2,000
TOTAL	18,532,000	19,468,000	16,925,000
Other Operating Revenue:			
Regulated Services	0	0	0
Unregulated Services	0	0	0
TOTAL	0	0	0
Net Operating Revenue (NOR)			
Regulated Services	18,532,000	19,467,000	16,923,000
Unregulated Services	0	1,000	2,000
Total	18,532,000	19,468,000	16,925,000
Total Operating Expenses:			
Regulated Services	15,469,136	16,058,900	13,397,505
Unregulated Services	423,864	610,100	2,504,000
Total	15,893,000	16,669,000	15,901,505
Net Operating Profit (Loss):			
Regulated Services	3,062,864	3,408,100	3,525,495
Unregulated Services	-423,864	-609,100	-2,502,000
Total	2,639,000	2,799,000	1,023,495
Total Non-Operating Profit (Loss):	-155,000	-404,000	-21,000
Non-Operating Revenue	-155,000	-404,000	0
Non-Operating Expenses	0	0	21,000
Total Excess Profit (Loss):	2,484,000	2,395,000	1,002,495
% Net Operating Profit of Regulated NOR	16.53	17.51	20.83
% Net Total Operating Profit of Total NOR	14.24	14.38	6.05
% Total Excess Profit of Total Revenue	13.52	12.56	5.92

UM Capital Region Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	484,325,107	423,296,579	400,129,173
Unregulated Services	0	1,785,010	524,000
TOTAL	484,325,107	425,081,590	400,653,173
Net Patient Revenue (NPR):			
Regulated Services	419,639,000	368,692,721	338,915,411
Unregulated Services	0	997,279	419,561
TOTAL	419,639,000	369,690,000	339,334,971
Other Operating Revenue:			
Regulated Services	12,305,000	6,015,257	20,558,153
Unregulated Services	0	1,125,743	1,431,847
TOTAL	12,305,000	7,141,000	21,990,000
Net Operating Revenue (NOR)			
Regulated Services	431,944,000	374,707,978	359,473,563
Unregulated Services	0	2,123,022	1,851,408
Total	431,944,000	376,831,000	361,324,971
Total Operating Expenses:			
Regulated Services	384,981,658	352,147,075	332,697,620
Unregulated Services	50,169,343	46,218,925	47,158,949
Total	435,151,000	398,366,000	379,856,569
Net Operating Profit (Loss):			
Regulated Services	46,962,342	22,560,904	26,775,943
Unregulated Services	-50,169,343	-44,095,904	-45,307,541
Total	-3,207,000	-21,535,000	-18,531,598
Total Non-Operating Profit (Loss):	1,018,000	-9,077,000	1,353,000
Non-Operating Revenue	1,018,000	-9,077,000	2,873,000
Non-Operating Expenses	0	0	1,520,000
Total Excess Profit (Loss):	-2,189,000	-30,612,000	-17,178,598
% Net Operating Profit of Regulated NOR	10.87	6.02	7.45
% Net Total Operating Profit of Total NOR	-0.74	-5.71	-5.13
% Total Excess Profit of Total Revenue	-0.51	-8.32	-4.72

UM Charles Regional Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	196,648,598	190,364,427	180,096,132
Unregulated Services	3,283,001	2,488,205	2,458,106
TOTAL	199,931,599	192,852,633	182,554,237
Net Patient Revenue (NPR):			
Regulated Services	178,915,625	165,861,404	153,328,547
Unregulated Services	1,528,375	1,410,596	1,542,559
TOTAL	180,444,000	167,272,000	154,871,106
Other Operating Revenue:			
Regulated Services	1,103,000	398,151	1,744,000
Unregulated Services	0	794,849	0
TOTAL	1,103,000	1,193,000	1,744,000
Net Operating Revenue (NOR)			
Regulated Services	180,018,625	166,259,554	155,072,547
Unregulated Services	1,528,375	2,205,446	1,542,559
Total	181,547,000	168,465,000	156,615,106
Total Operating Expenses:			
Regulated Services	148,696,877	142,859,388	136,124,852
Unregulated Services	23,836,123	17,711,612	14,034,148
Total	172,533,000	160,571,000	150,159,000
Net Operating Profit (Loss):			
Regulated Services	31,321,748	23,400,166	18,947,695
Unregulated Services	-22,307,748	-15,506,166	-12,491,589
Total	9,014,000	7,894,000	6,456,106
Total Non-Operating Profit (Loss):	3,000,000	3,210,000	2,420,000
Non-Operating Revenue	4,135,000	4,140,000	3,526,000
Non-Operating Expenses	1,135,000	930,000	1,106,000
Total Excess Profit (Loss):	12,014,000	11,104,000	8,876,106
% Net Operating Profit of Regulated NOR	17.40	14.07	12.22
% Net Total Operating Profit of Total NOR	4.97	4.69	4.12
% Total Excess Profit of Total Revenue	6.47	6.43	5.54

UM Laurel Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	44,865,832	42,422,550	36,009,147
Unregulated Services	0	0	0
TOTAL	44,865,832	42,422,550	36,009,147
Net Patient Revenue (NPR):			
Regulated Services	33,312,000	33,535,000	27,603,000
Unregulated Services	0	0	0
TOTAL	33,312,000	33,535,000	27,603,000
Other Operating Revenue:			
Regulated Services	0	7,000	33,000
Unregulated Services	0	0	0
TOTAL	0	7,000	33,000
Net Operating Revenue (NOR)			
Regulated Services	33,312,000	33,542,000	27,636,000
Unregulated Services	0	0	0
Total	33,312,000	33,542,000	27,636,000
Total Operating Expenses:			
Regulated Services	37,167,567	39,999,089	37,774,191
Unregulated Services	4,305,434	7,268,911	7,495,735
Total	41,473,000	47,268,000	45,269,926
Net Operating Profit (Loss):			
Regulated Services	-3,855,567	-6,457,089	-10,138,191
Unregulated Services	-4,305,434	-7,268,911	-7,495,735
Total	-8,161,000	-13,726,000	-17,633,926
Total Non-Operating Profit (Loss):	-150,000	-872,000	-53,000
Non-Operating Revenue	-150,000	-872,000	0
Non-Operating Expenses	0	0	53,000
Total Excess Profit (Loss):	-8,311,000	-14,598,000	-17,686,926
% Net Operating Profit of Regulated NOR	-11.57	-19.25	-36.68
% Net Total Operating Profit of Total NOR	-24.50	-40.92	-63.81
% Total Excess Profit of Total Revenue	-25.06	-44.68	-64.00

UM Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	1,998,942,621	1,932,484,534	1,848,222,110
Unregulated Services	26,074,946	23,816,376	27,931,105
TOTAL	2,025,017,567	1,956,300,910	1,876,153,214
Net Patient Revenue (NPR):			
Regulated Services	1,691,253,717	1,642,322,174	1,604,782,180
Unregulated Services	25,830,283	23,571,713	27,577,820
TOTAL	1,717,084,000	1,665,893,888	1,632,360,000
Other Operating Revenue:			
Regulated Services	48,986,293	30,928,528	43,093,275
Unregulated Services	266,425,707	226,279,472	201,511,725
TOTAL	315,412,000	257,208,000	244,605,000
Net Operating Revenue (NOR)			
Regulated Services	1,740,240,010	1,673,250,703	1,647,875,455
Unregulated Services	292,255,990	249,851,185	229,089,545
Total	2,032,496,000	1,923,101,888	1,876,965,000
Total Operating Expenses:			
Regulated Services	1,801,281,855	1,669,691,292	1,628,107,439
Unregulated Services	271,846,145	255,988,708	209,142,561
Total	2,073,128,000	1,925,680,000	1,837,250,000
Net Operating Profit (Loss):			
Regulated Services	-61,041,845	3,559,410	19,768,016
Unregulated Services	20,409,845	-6,137,523	19,946,984
Total	-40,632,000	-2,578,112	39,715,000
Total Non-Operating Profit (Loss):	53,645,000	54,496,000	32,593,000
Non-Operating Revenue	53,645,000	57,880,000	32,593,000
Non-Operating Expenses	0	3,384,000	0
Total Excess Profit (Loss):	13,013,000	51,917,888	72,308,000
% Net Operating Profit of Regulated NOR	-3.51	0.21	1.20
% Net Total Operating Profit of Total NOR	-2.00	-0.13	2.12
% Total Excess Profit of Total Revenue	0.62	2.62	3.79

UM Queen Anne's Freestanding Emergency

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	9,274,921	9,099,940	8,648,591
Unregulated Services	0	0	0
TOTAL	9,274,921	9,099,940	8,648,591
Net Patient Revenue (NPR):			
Regulated Services	7,259,000	7,402,000	6,824,000
Unregulated Services	0	0	0
TOTAL	7,259,000	7,402,000	6,824,000
Other Operating Revenue:			
Regulated Services	0	37	187,000
Unregulated Services	0	0	0
TOTAL	0	37	187,000
Net Operating Revenue (NOR)			
Regulated Services	7,259,000	7,402,037	7,011,000
Unregulated Services	0	0	0
Total	7,259,000	7,402,037	7,011,000
Total Operating Expenses:			
Regulated Services	7,726,204	8,726,488	9,260,600
Unregulated Services	166,796	133,000	226,400
Total	7,893,000	8,859,488	9,487,000
Net Operating Profit (Loss):			
Regulated Services	-467,204	-1,324,452	-2,249,600
Unregulated Services	-166,796	-133,000	-226,400
Total	-634,000	-1,457,452	-2,476,000
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-634,000	-1,457,452	-2,476,000
% Net Operating Profit of Regulated NOR	-6.44	-17.89	-32.09
% Net Total Operating Profit of Total NOR	-8.73	-19.69	-35.32
% Total Excess Profit of Total Revenue	-8.73	-19.69	-35.32

UM Rehabilitation & Orthopaedic Institute

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	156,242,273	147,461,509	143,817,412
Unregulated Services	1,410,504	958,640	1,905,592
TOTAL	157,652,777	148,420,149	145,723,005
Net Patient Revenue (NPR):			
Regulated Services	129,376,496	124,544,393	123,222,412
Unregulated Services	1,410,504	363,607	539,592
TOTAL	130,787,000	124,908,000	123,762,005
Other Operating Revenue:			
Regulated Services	145,588	274,737	1,529,864
Unregulated Services	1,516,412	1,113,263	1,375,137
TOTAL	1,662,000	1,388,000	2,905,000
Net Operating Revenue (NOR)			
Regulated Services	129,522,084	124,819,130	124,752,276
Unregulated Services	2,926,916	1,476,870	1,914,729
Total	132,449,000	126,296,000	126,667,005
Total Operating Expenses:			
Regulated Services	118,043,409	117,321,902	111,076,164
Unregulated Services	11,875,591	12,543,098	13,308,836
Total	129,919,000	129,865,000	124,385,000
Net Operating Profit (Loss):			
Regulated Services	11,478,675	7,497,229	13,676,111
Unregulated Services	-8,948,675	-11,066,229	-11,394,107
Total	2,530,000	-3,569,000	2,282,005
Total Non-Operating Profit (Loss):	8,605,000	6,968,000	4,334,000
Non-Operating Revenue	8,646,000	6,971,000	4,334,000
Non-Operating Expenses	41,000	3,000	0
Total Excess Profit (Loss):	11,135,000	3,399,000	6,616,005
% Net Operating Profit of Regulated NOR	8.86	6.01	10.96
% Net Total Operating Profit of Total NOR	1.91	-2.83	1.80
% Total Excess Profit of Total Revenue	7.89	2.55	5.05

UM Shock Trauma

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	285,922,097	274,780,143	261,221,517
Unregulated Services	1,448,791	1,051,791	917,534
TOTAL	287,370,888	275,831,934	262,139,051
Net Patient Revenue (NPR):			
Regulated Services	242,726,209	231,604,209	217,718,466
Unregulated Services	1,448,791	1,051,791	917,534
TOTAL	244,175,000	232,656,000	218,636,000
Other Operating Revenue:			
Regulated Services	26,740,000	10,482,000	4,015,000
Unregulated Services	0	0	0
TOTAL	26,740,000	10,482,000	4,015,000
Net Operating Revenue (NOR)			
Regulated Services	269,466,209	242,086,209	221,733,466
Unregulated Services	1,448,791	1,051,791	917,534
Total	270,915,000	243,138,000	222,651,000
Total Operating Expenses:			
Regulated Services	193,337,181	189,484,400	182,973,500
Unregulated Services	2,785,819	2,513,600	2,695,500
Total	196,123,000	191,998,000	185,669,000
Net Operating Profit (Loss):			
Regulated Services	76,129,028	52,601,809	38,759,966
Unregulated Services	-1,337,028	-1,461,809	-1,777,966
Total	74,792,000	51,140,000	36,982,000
Total Non-Operating Profit (Loss):	225,000	0	0
Non-Operating Revenue	225,000	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	75,017,000	51,140,000	36,982,000
% Net Operating Profit of Regulated NOR	28.25	21.73	17.48
% Net Total Operating Profit of Total NOR	27.61	21.03	16.61
% Total Excess Profit of Total Revenue	27.67	21.03	16.61

UM Shore Regional Health at Cambridge

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	17,496,641	17,364,760	17,419,653
Unregulated Services	10,827,045	10,450,260	9,370,143
TOTAL	28,323,685	27,815,020	26,789,796
Net Patient Revenue (NPR):			
Regulated Services	13,443,158	13,216,754	12,611,857
Unregulated Services	3,798,842	3,418,246	7,393,143
TOTAL	17,242,000	16,635,000	20,005,000
Other Operating Revenue:			
Regulated Services	4,901	0	450,125
Unregulated Services	105,099	815,000	100,875
TOTAL	110,000	815,000	551,000
Net Operating Revenue (NOR)			
Regulated Services	13,448,059	13,216,754	13,061,982
Unregulated Services	3,903,941	4,233,246	7,494,018
Total	17,352,000	17,450,000	20,556,000
Total Operating Expenses:			
Regulated Services	17,034,361	17,727,400	18,453,167
Unregulated Services	3,669,639	2,553,600	3,380,833
Total	20,704,000	20,281,000	21,834,000
Net Operating Profit (Loss):			
Regulated Services	-3,586,302	-4,510,646	-5,391,185
Unregulated Services	234,302	1,679,646	4,113,185
Total	-3,352,000	-2,831,000	-1,278,000
Total Non-Operating Profit (Loss):	0	0	0
Non-Operating Revenue	0	0	0
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-3,352,000	-2,831,000	-1,278,000
% Net Operating Profit of Regulated NOR	-26.67	-34.13	-41.27
% Net Total Operating Profit of Total NOR	-19.32	-16.22	-6.22
% Total Excess Profit of Total Revenue	-19.32	-16.22	-6.22

UM Shore Regional Health at Chestertown

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	59,088,059	56,459,168	55,202,536
Unregulated Services	3,726,078	3,097,225	2,761,413
TOTAL	62,814,137	59,556,393	57,963,949
Net Patient Revenue (NPR):			
Regulated Services	48,694,582	45,921,730	45,105,334
Unregulated Services	1,285,418	1,551,270	1,493,666
TOTAL	49,980,000	47,473,000	46,599,000
Other Operating Revenue:			
Regulated Services	256,993	226,509	1,114,104
Unregulated Services	275,007	293,491	289,896
TOTAL	532,000	520,000	1,404,000
Net Operating Revenue (NOR)			
Regulated Services	48,951,575	46,148,240	46,219,438
Unregulated Services	1,560,425	1,844,760	1,783,562
Total	50,512,000	47,993,000	48,003,000
Total Operating Expenses:			
Regulated Services	36,726,463	37,395,369	36,282,108
Unregulated Services	8,376,537	9,076,631	9,582,892
Total	45,103,000	46,472,000	45,865,000
Net Operating Profit (Loss):			
Regulated Services	12,225,113	8,752,871	9,937,329
Unregulated Services	-6,816,113	-7,231,871	-7,799,329
Total	5,409,000	1,521,000	2,138,000
Total Non-Operating Profit (Loss):	383,000	1,420,000	576,000
Non-Operating Revenue	383,000	1,420,000	576,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	5,792,000	2,941,000	2,714,000
% Net Operating Profit of Regulated NOR	24.97	18.97	21.50
% Net Total Operating Profit of Total NOR	10.71	3.17	4.45
% Total Excess Profit of Total Revenue	11.38	5.95	5.59

UM Shore Regional Health at Easton

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	320,559,043	298,649,102	290,053,309
Unregulated Services	54,377,275	53,465,396	46,577,169
TOTAL	374,936,318	352,114,498	336,630,479
Net Patient Revenue (NPR):			
Regulated Services	261,421,863	247,367,645	246,944,836
Unregulated Services	19,079,137	17,488,355	12,993,164
TOTAL	280,501,000	264,856,000	259,938,000
Other Operating Revenue:			
Regulated Services	2,010,234	3,755,563	2,934,521
Unregulated Services	3,834,766	7,148,437	4,363,479
TOTAL	5,845,000	10,904,000	7,298,000
Net Operating Revenue (NOR)			
Regulated Services	263,432,097	251,123,207	249,879,358
Unregulated Services	22,913,903	24,636,793	17,356,642
Total	286,346,000	275,760,000	267,236,000
Total Operating Expenses:			
Regulated Services	214,183,540	211,813,764	205,561,089
Unregulated Services	69,626,460	70,573,785	62,042,911
Total	283,810,000	282,387,548	267,604,000
Net Operating Profit (Loss):			
Regulated Services	49,248,557	39,309,444	44,318,269
Unregulated Services	-46,712,557	-45,936,992	-44,686,269
Total	2,536,000	-6,627,548	-368,000
Total Non-Operating Profit (Loss):	20,077,000	16,711,000	12,801,000
Non-Operating Revenue	20,077,000	17,365,000	12,801,000
Non-Operating Expenses	0	654,000	0
Total Excess Profit (Loss):	22,613,000	10,083,452	12,433,000
% Net Operating Profit of Regulated NOR	18.69	15.65	17.74
% Net Total Operating Profit of Total NOR	0.89	-2.40	-0.14
% Total Excess Profit of Total Revenue	7.38	3.44	4.44

UM St. Joseph Medical Center

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	506,646,499	487,466,803	458,422,525
Unregulated Services	5,582,796	5,116,000	5,737,853
TOTAL	512,229,295	492,582,803	464,160,378
Net Patient Revenue (NPR):			
Regulated Services	428,414,085	411,770,889	392,131,055
Unregulated Services	2,579,915	4,575,111	5,906,945
TOTAL	430,994,000	416,346,000	398,038,000
Other Operating Revenue:			
Regulated Services	908,371	1,255,377	1,859,898
Unregulated Services	3,098,629	2,870,623	2,623,102
TOTAL	4,007,000	4,126,000	4,483,000
Net Operating Revenue (NOR)			
Regulated Services	429,322,456	413,026,266	393,990,953
Unregulated Services	5,678,544	7,445,734	8,530,047
Total	435,001,000	420,472,000	402,521,000
Total Operating Expenses:			
Regulated Services	367,010,386	357,491,230	349,064,558
Unregulated Services	73,705,614	66,911,770	60,797,442
Total	440,716,000	424,403,000	409,862,000
Net Operating Profit (Loss):			
Regulated Services	62,312,070	55,535,036	44,926,395
Unregulated Services	-68,027,070	-59,466,036	-52,267,395
Total	-5,715,000	-3,931,000	-7,341,000
Total Non-Operating Profit (Loss):	7,408,000	4,109,000	2,780,000
Non-Operating Revenue	7,408,000	4,283,000	2,780,000
Non-Operating Expenses	0	174,000	0
Total Excess Profit (Loss):	1,693,000	178,000	-4,561,000
% Net Operating Profit of Regulated NOR	14.51	13.45	11.40
% Net Total Operating Profit of Total NOR	-1.31	-0.93	-1.82
% Total Excess Profit of Total Revenue	0.38	0.04	-1.13

UM Upper Chesapeake Medical Center - Bel Air

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	459,407,671	416,111,220	367,721,755
Unregulated Services	713,298	1,828,000	1,333,265
TOTAL	460,120,969	417,939,220	369,055,020
Net Patient Revenue (NPR):			
Regulated Services	395,235,702	349,853,018	318,326,764
Unregulated Services	713,298	1,799,982	1,255,236
TOTAL	395,949,000	351,653,000	319,582,000
Other Operating Revenue:			
Regulated Services	15,098,000	3,032,000	4,542,000
Unregulated Services	0	0	0
TOTAL	15,098,000	3,032,000	4,542,000
Net Operating Revenue (NOR)			
Regulated Services	410,333,702	352,885,018	322,868,764
Unregulated Services	713,298	1,799,982	1,255,236
Total	411,047,000	354,685,000	324,124,000
Total Operating Expenses:			
Regulated Services	323,676,030	304,482,065	277,702,378
Unregulated Services	47,930,970	44,227,935	31,700,622
Total	371,607,000	348,710,000	309,403,000
Net Operating Profit (Loss):			
Regulated Services	86,657,672	48,402,953	45,166,385
Unregulated Services	-47,217,672	-42,427,953	-30,445,385
Total	39,440,000	5,975,000	14,721,000
Total Non-Operating Profit (Loss):	31,527,000	16,801,000	14,197,000
Non-Operating Revenue	33,206,000	24,457,000	15,965,000
Non-Operating Expenses	1,679,000	7,656,000	1,768,000
Total Excess Profit (Loss):	70,967,000	22,776,000	28,918,000
% Net Operating Profit of Regulated NOR	21.12	13.72	13.99
% Net Total Operating Profit of Total NOR	9.60	1.68	4.54
% Total Excess Profit of Total Revenue	15.97	6.01	8.50

UM Upper Chesapeake Medical Center -Aberdeen

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	38,346,876	81,124,210	118,486,830
Unregulated Services	0	18,035	123,000
TOTAL	38,346,876	81,142,245	118,609,830
Net Patient Revenue (NPR):			
Regulated Services	29,344,000	68,935,134	102,318,990
Unregulated Services	0	17,901	109,010
TOTAL	29,344,000	68,953,035	102,428,000
Other Operating Revenue:			
Regulated Services	4,000	398,000	735,000
Unregulated Services	0	0	0
TOTAL	4,000	398,000	735,000
Net Operating Revenue (NOR)			
Regulated Services	29,348,000	69,333,134	103,053,990
Unregulated Services	0	17,901	109,010
Total	29,348,000	69,351,035	103,163,000
Total Operating Expenses:			
Regulated Services	31,817,247	69,656,668	94,172,877
Unregulated Services	1,044,754	3,260,332	10,420,123
Total	32,862,000	72,917,000	104,593,000
Net Operating Profit (Loss):			
Regulated Services	-2,469,247	-323,534	8,881,113
Unregulated Services	-1,044,754	-3,242,431	-10,311,113
Total	-3,514,000	-3,565,965	-1,430,000
Total Non-Operating Profit (Loss):	0	8,795,000	9,201,000
Non-Operating Revenue	0	14,679,000	441,000
Non-Operating Expenses	0	5,884,000	-8,760,000
Total Excess Profit (Loss):	-3,514,000	5,229,035	7,771,000
% Net Operating Profit of Regulated NOR	-8.41	-0.47	8.62
% Net Total Operating Profit of Total NOR	-11.97	-5.14	-1.39
% Total Excess Profit of Total Revenue	-11.97	6.22	7.50

UMMC Midtown Campus

FISCAL YEAR ENDING	June 2025	June 2024	June 2023
Gross Patient Revenue:			
Regulated Services	285,799,427	279,245,359	267,729,206
Unregulated Services	2,902,121	2,798,044	2,932,897
TOTAL	288,701,549	282,043,403	270,662,104
Net Patient Revenue (NPR):			
Regulated Services	238,171,879	231,979,956	229,407,103
Unregulated Services	1,726,121	1,965,044	1,984,897
TOTAL	239,898,000	233,945,000	231,392,000
Other Operating Revenue:			
Regulated Services	398,127	345,917	1,081,797
Unregulated Services	35,871,873	30,919,083	30,305,203
TOTAL	36,270,000	31,265,000	31,387,000
Net Operating Revenue (NOR)			
Regulated Services	238,570,006	232,325,873	230,488,900
Unregulated Services	37,597,994	32,884,127	32,290,100
Total	276,168,000	265,210,000	262,779,000
Total Operating Expenses:			
Regulated Services	214,124,072	212,108,034	209,845,923
Unregulated Services	66,015,928	67,428,966	58,856,077
Total	280,140,000	279,537,000	268,702,000
Net Operating Profit (Loss):			
Regulated Services	24,445,934	20,217,839	20,642,977
Unregulated Services	-28,417,934	-34,544,839	-26,565,977
Total	-3,972,000	-14,327,000	-5,923,000
Total Non-Operating Profit (Loss):	-728,000	-481,000	-1,525,000
Non-Operating Revenue	-728,000	-481,000	-1,525,000
Non-Operating Expenses	0	0	0
Total Excess Profit (Loss):	-4,700,000	-14,808,000	-7,448,000
% Net Operating Profit of Regulated NOR	10.25	8.70	8.96
% Net Total Operating Profit of Total NOR	-1.44	-5.40	-2.25
% Total Excess Profit of Total Revenue	-1.71	-5.59	-2.85

UPMC Western Maryland

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	400,789,500	387,908,800	367,681,700
Unregulated Services	91,128,600	84,069,100	83,614,800
TOTAL	491,918,100	471,977,900	451,296,500
Net Patient Revenue (NPR):			
Regulated Services	328,935,100	323,501,600	307,537,025
Unregulated Services	53,397,900	50,505,900	56,417,400
TOTAL	382,333,000	374,007,500	363,954,425
Other Operating Revenue:			
Regulated Services	70	377,500	2,329,160
Unregulated Services	7,703,000	6,858,700	5,197,540
TOTAL	7,703,070	7,236,200	7,526,700
Net Operating Revenue (NOR)			
Regulated Services	328,935,170	323,879,100	309,866,185
Unregulated Services	61,100,900	57,364,600	61,614,940
Total	390,036,070	381,243,700	371,481,125
Total Operating Expenses:			
Regulated Services	265,575,894	260,119,667	254,536,007
Unregulated Services	108,684,066	100,794,963	98,893,683
Total	374,259,960	360,914,630	353,429,690
Net Operating Profit (Loss):			
Regulated Services	63,359,276	63,759,433	55,330,179
Unregulated Services	-47,583,166	-43,430,363	-37,278,743
Total	15,776,110	20,329,070	18,051,435
Total Non-Operating Profit (Loss):	9,523,380	20,205,550	2,499,050
Non-Operating Revenue	9,523,470	20,202,980	2,497,530
Non-Operating Expenses	90	-2,570	-1,520
Total Excess Profit (Loss):	25,299,490	40,534,620	20,550,485
% Net Operating Profit of Regulated NOR	19.26	19.69	17.86
% Net Total Operating Profit of Total NOR	4.04	5.33	4.86
% Total Excess Profit of Total Revenue	6.33	10.10	5.50

WVU Medicine Garrett Regional Medical Center

FISCAL YEAR ENDING	December 2024	December 2023	December 2022
Gross Patient Revenue:			
Regulated Services	96,060,942	90,382,193	71,160,321
Unregulated Services	36,652,912	18,633,299	17,246,325
TOTAL	132,713,854	109,015,492	88,406,646
Net Patient Revenue (NPR):			
Regulated Services	79,129,727	73,879,927	60,123,816
Unregulated Services	13,614,814	8,156,212	7,433,904
TOTAL	92,744,541	82,036,139	67,557,720
Other Operating Revenue:			
Regulated Services	752,684	1,570,601	4,649,419
Unregulated Services	621,316	440,892	394,881
TOTAL	1,374,000	2,011,493	5,044,300
Net Operating Revenue (NOR)			
Regulated Services	79,882,412	75,450,528	64,773,235
Unregulated Services	14,236,130	8,597,105	7,828,785
Total	94,118,541	84,047,633	72,602,020
Total Operating Expenses:			
Regulated Services	58,572,529	51,834,206	58,082,898
Unregulated Services	31,630,937	21,052,326	19,426,077
Total	90,203,466	72,886,532	77,508,975
Net Operating Profit (Loss):			
Regulated Services	21,309,882	23,616,322	6,690,337
Unregulated Services	-17,394,807	-12,455,221	-11,597,292
Total	3,915,075	11,161,101	-4,906,955
Total Non-Operating Profit (Loss):	2,540,220	1,808,641	-1,634,274
Non-Operating Revenue	1,884,491	1,948,764	-971,376
Non-Operating Expenses	-655,729	140,123	662,898
Total Excess Profit (Loss):	6,455,295	12,969,742	-6,541,229
% Net Operating Profit of Regulated NOR	26.68	31.30	10.33
% Net Total Operating Profit of Total NOR	4.16	13.28	-6.76
% Total Excess Profit of Total Revenue	6.72	15.08	-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 2025	FY 2024	FY 2023
Gross Patient Revenue	482,499,699	436,523,992	420,077,813
Net Patient Revenue (NPR)	376,106,016	336,121,205	323,942,760
Other Operating Revenue	129,714,063	122,226,187	115,345,802
Net Operating Revenue (NOR)	505,820,079	458,347,392	439,288,562
Operating Expenses	512,768,297	451,998,103	432,417,420
Inpatient Admissions (IPAs)	13,213	12,633	13,293
Net Operating Profit (Loss)	(6,948,218)	6,349,289	6,871,142
Total Non-Operating Profit (Loss)	19,255,057	11,344,964	(52,003,024)
Total Excess Profits (Loss)	12,306,839	17,694,253	(45,131,882)

Adventist Rehab Hospital of MD Takoma Park*

FISCAL YEAR ENDING	CY 2024	CY 2023	CY 2022
Gross Patient Revenue	46,212,162	46,386,058	44,794,886
Net Patient Revenue (NPR)	29,213,582	27,100,266	26,982,929
Other Operating Revenue	20,525	10,341	49,358
Net Operating Revenue (NOR)	29,234,107	27,110,607	27,032,287
Operating Expenses	28,231,811	27,233,722	26,659,357
Inpatient Admissions (IPAs)	1,018	940	968
Net Operating Profit (Loss)	1,002,296	(123,115)	372,930
Total Non-Operating Profit (Loss)	494,000	221,872	(1,961,702)
Total Excess Profits (Loss)	1,496,296	98,757	(1,588,772)

Adventist Rehab Hospital of MD Rockville*

FISCAL YEAR ENDING	CY 2024	CY 2023	CY 2022
Gross Patient Revenue	57,855,327	56,820,028	53,786,530
Net Patient Revenue (NPR)	33,886,940	34,281,518	30,281,271
Other Operating Revenue	392,846	273,478	339,620
Net Operating Revenue (NOR)	34,279,786	34,554,996	30,620,891
Operating Expenses	34,125,819	31,079,622	26,886,058
Inpatient Admissions (IPAs)	1,279	1,266	1,154
Net Operating Profit (Loss)	153,967	3,475,374	3,734,833
Total Non-Operating Profit (Loss)	2,233,435	(1,248,063)	(1,327,779)
Total Excess Profits (Loss)	2,387,402	2,227,311	2,407,054

Brook Lane Health Services

FISCAL YEAR ENDING	FY 2025	FY 2024	FY 2023
Gross Patient Revenue	35,166,300	30,816,500	31,935,700
Net Patient Revenue (NPR)	26,694,100	24,977,000	26,205,200
Other Operating Revenue	75,000	315,400	281,000
Net Operating Revenue (NOR)	26,769,100	25,292,400	26,486,200
Operating Expenses	28,612,600	26,575,100	26,139,100
Inpatient Admissions (IPAs)	1,340	1,435	1,737
Net Operating Profit (Loss)	(1,843,500)	(1,282,700)	347,100
Total Non-Operating Profit (Loss)	43,600	2,027,100	1,163,300
Total Excess Profits (Loss)	(1,799,900)	744,400	1,510,400

*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.

J Kent McNew Family Medical Center

FISCAL YEAR ENDING	FY 2025	FY 2024	FY 2023
Gross Patient Revenue	10,295,888	9,087,800	8,862,400
Net Patient Revenue (NPR)	7,725,988	7,189,300	7,217,300
Other Operating Revenue	343,000	141,500	335,700
Net Operating Revenue (NOR)	8,068,988	7,330,800	7,553,000
Operating Expenses	8,743,986	8,166,900	8,726,400
Inpatient Admissions (IPAs)	657	652	686
Net Operating Profit (Loss)	(674,998)	(836,100)	(1,173,400)
Total Non-Operating Profit (Loss)	(0)	-	0
Total Excess Profits (Loss)	(674,998)	(836,100)	(1,173,400)

Mt. Washington Pediatric Hospital

FISCAL YEAR ENDING	FY 2025	FY 2024	FY 2023
Gross Patient Revenue	86,882,194	78,198,163	75,531,222
Net Patient Revenue (NPR)	73,244,774	65,069,640	63,214,893
Other Operating Revenue	343,613	1,342,821	2,354,984
Net Operating Revenue (NOR)	73,588,387	66,412,461	65,569,877
Operating Expenses	74,490,504	70,797,599	68,508,229
Inpatient Admissions (IPAs)	458	450	430
Net Operating Profit (Loss)	(902,117)	(4,385,138)	(2,938,352)
Total Non-Operating Profit (Loss)	11,636,799	8,646,870	5,656,995
Total Excess Profits (Loss)	10,734,682	4,261,732	2,718,643

Sheppard Pratt Hospital

FISCAL YEAR ENDING	FY 2025	FY 2024	FY 2023
Gross Patient Revenue	217,367,053	215,215,443	205,167,075
Net Patient Revenue (NPR)	185,192,632	177,503,481	170,041,167
Other Operating Revenue	128,539,079	120,142,647	111,985,140
Net Operating Revenue (NOR)	313,731,711	297,646,128	282,026,307
Operating Expenses	310,197,577	288,145,160	275,498,276
Inpatient Admissions (IPAs)	7,491	7,890	8,318
Net Operating Profit (Loss)	3,534,134	9,500,969	6,528,031
Total Non-Operating Profit (Loss)	4,847,223	1,697,185	(55,533,838)
Total Excess Profits (Loss)	8,381,357	11,198,154	(49,005,807)

UM Behavioral Health Pavillion - Aberdeen

FISCAL YEAR ENDING	FY 2025	FY 2024	FY 2023
Gross Patient Revenue	28,720,775		
Net Patient Revenue (NPR)	20,148,000		
Other Operating Revenue	-		
Net Operating Revenue (NOR)	20,148,000		
Operating Expenses	28,366,000		
Inpatient Admissions (IPAs)	970		
Net Operating Profit (Loss)	(8,218,000)		
Total Non-Operating Profit (Loss)	-		
Total Excess Profits (Loss)	(8,218,000)		

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Exhibit 1. Change in Uncompensated Care, Regulated Operations

Listed in Alphabetical Order by Region

		2024			2025			
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	64,761,498	4,581,996	7.08	66,193,195	4,937,765	7.46	7.8
	ADVENTIST HEALTHCARE GERMANTOWN EMERG	17,967,500	4,533,883	25.23	19,289,700	4,020,044	20.84	-11.3
	ADVENTIST HEALTHCARE SHADY GROVE MEDIC	534,307,365	29,742,770	5.57	543,190,102	29,998,564	5.52	0.9
	ADVENTIST HEALTHCARE WHITE OAK MEDICAL	351,439,080	27,985,066	7.96	380,198,345	21,808,369	5.74	-22.1
	ASCENSION ST. AGNES HOSPITAL	494,805,400	32,046,546	6.48	568,926,800	31,745,192	5.58	-0.9
	GREATER BALTIMORE MEDICAL CENTER	525,917,619	12,387,628	2.36	534,931,449	15,175,889	2.84	22.5
	HOLY CROSS HOSPITAL	600,651,500	38,957,939	6.49	638,008,057	38,345,458	6.01	-1.6
	HOLY CROSS HOSPITAL GERMANTOWN	163,546,900	9,798,167	5.99	180,505,379	10,863,402	6.02	10.9
	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	828,761,549	37,343,000	4.51	867,460,833	35,708,000	4.12	-4.4
	JOHNS HOPKINS HOSPITAL	3,105,851,884	95,471,800	3.07	3,311,615,560	90,366,000	2.73	-5.3
	JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	373,181,711	17,918,000	4.80	401,287,682	17,983,000	4.48	0.4
	JOHNS HOPKINS SUBURBAN HOSPITAL	431,677,954	15,580,862	3.61	465,603,384	17,032,436	3.66	9.3
	LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	33,202,184	2,730,026	8.22	34,392,859	2,838,020	8.25	4.0
	LIFEBRIDGE HEALTH LEVINDALE	67,965,551	3,626,353	5.34	70,446,064	4,253,277	6.04	17.3
	LIFEBRIDGE HEALTH NORTHWEST HOSPITAL C	311,836,440	8,668,709	2.78	322,316,773	14,047,781	4.36	62.1
	LIFEBRIDGE HEALTH SINAI HOSPITAL	961,717,881	22,532,452	2.34	994,389,633	30,264,862	3.04	34.3
	LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	746,989,000	13,216,023	1.77	791,316,592	16,774,160	2.12	26.9
	LUMINIS HEALTH DOCTORS COMMUNITY MEDIC	308,883,300	15,528,557	5.03	326,288,251	17,527,323	5.37	12.9
	MEDSTAR FRANKLIN SQUARE HOSPITAL	688,099,485	22,793,447	3.31	743,866,299	26,996,832	3.63	18.4

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		2024			2025			
Hospital Area	**Hospital**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**Gross Revenues**	**Charity & Bad Debts**	**UCC %**	**% Change UCC Amount**
	MEDSTAR GOOD SAMARITAN HOSPITAL	319,991,752	12,704,352	3.97	328,543,894	17,450,430	5.31	37.4
	MEDSTAR HARBOR HOSPITAL	224,922,862	12,367,189	5.50	241,447,815	17,661,095	7.31	42.8
	MEDSTAR MONTGOMERY MEDICAL CENTER	222,642,659	8,664,902	3.89	241,848,927	10,355,704	4.28	19.5
	MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	338,032,767	16,694,015	4.94	361,328,378	19,159,377	5.30	14.8
	MEDSTAR UNION MEMORIAL HOSPITAL	499,090,335	11,502,316	2.30	524,653,148	19,534,045	3.72	69.8
	MERCY MEDICAL CENTER	681,875,400	30,862,538	4.53	717,488,100	33,119,277	4.62	7.3
	UM BALTIMORE WASHINGTON MEDICAL CENTER	535,602,424	23,822,000	4.45	554,612,093	23,635,000	4.26	-0.8
	UM BOWIE HEALTH CENTER	24,028,994	3,143,000	13.08	24,873,230	4,423,000	17.78	40.7
	UM CAPITAL REGION MEDICAL CENTER	423,296,579	30,503,780	7.21	484,325,107	30,929,000	6.39	1.4
	UM LAUREL MEDICAL CENTER	42,422,550	5,682,000	13.39	44,865,832	7,309,000	16.29	28.6
	UM MEDICAL CENTER	1,932,484,534	73,965,337	3.83	1,998,942,621	43,032,337	2.15	-41.8
	UM QUEEN ANNE'S FREESTANDING EMERGENCY	9,099,940	878,000	9.65	9,274,921	945,000	10.19	7.6
	UM REHABILITATION & ORTHOPAEDIC INSTIT	147,461,509	5,028,000	3.41	156,242,273	5,372,000	3.44	6.8
	UM SHOCK TRAUMA	274,780,143	17,450,000	6.35	285,922,097	12,584,000	4.40	-27.9
	UM ST. JOSEPH MEDICAL CENTER	487,466,803	16,683,111	3.42	506,646,499	16,433,809	3.24	-1.5
	UM UPPER CHESAPEAKE MEDICAL CENTER – B	416,111,220	17,082,982	4.11	459,407,671	17,703,000	3.85	3.6
	UMMC MIDTOWN CAMPUS	279,245,359	10,637,000	3.81	285,799,427	11,763,000	4.12	10.6
METRO		*17,470,119,628*	*713,113,745*	*4.08*	*18,486,448,991*	*722,095,448*	*3.91*	*1.3*

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		2023			2024			
Hospital Area	Hospital	Gross Revenues	Charity & Bad Debts	UCC %	Gross Revenues	Charity & Bad Debts	UCC %	% Change UCC Amount
R U R A L	ATLANTIC GENERAL HOSPITAL	135,629,341	6,264,131	4.62	140,018,931	5,700,991	4.07	-9.0
	CALVERT HEALTH MEDICAL CENTER	188,719,140	3,333,941	1.77	197,883,196	4,752,503	2.40	42.5
	CHRISTIANACARE UNION HOSPITAL	210,598,498	3,852,975	1.83	208,548,728	10,422,586	5.00	170.5
	FREDERICK HEALTH HOSPITAL	424,222,500	19,375,400	4.57	464,628,200	30,488,500	6.56	57.4
	LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	294,002,396	4,111,311	1.40	290,567,437	9,762,181	3.36	137.4
	MEDSTAR ST. MARY'S HOSPITAL	236,265,893	9,123,748	3.86	256,129,031	10,697,469	4.18	17.2
	MERITUS MEDICAL CENTER	487,797,440	22,121,200	4.53	540,426,100	24,180,500	4.47	9.3
	TIDALHEALTH MCCREADY PAVILION	6,300,799	318,300	5.05	6,563,300	425,700	6.49	33.7
	TIDALHEALTH PENINSULA REGIONAL	604,393,730	30,447,000	5.04	650,222,000	30,523,300	4.69	0.3
	UM CHARLES REGIONAL MEDICAL CENTER	190,364,427	11,819,368	6.21	196,648,598	14,059,248	7.15	19.0
	UM SHORE REGIONAL HEALTH AT CAMBRIDGE	17,364,760	1,445,000	8.32	17,496,641	1,609,000	9.20	11.3
	UM SHORE REGIONAL HEALTH AT CHESTERTOW	56,459,168	2,770,000	4.91	59,088,059	3,116,000	5.27	12.5
	UM SHORE REGIONAL HEALTH AT EASTON	298,649,102	8,714,000	2.92	320,559,043	12,623,000	3.94	44.9
	UM UPPER CHESAPEAKE MEDICAL CENTER -AB	81,124,210	3,721,866	4.59	38,346,876	2,527,000	6.59	-32.1
	UPMC WESTERN MARYLAND	387,908,800	17,173,300	4.43	400,789,500	19,974,600	4.98	16.3
	WVU MEDICINE GARRETT REGIONAL MEDICAL	90,382,193	4,567,560	5.05	96,060,942	6,490,908	6.76	42.1
R U R A L		*3,710,182,398*	*149,159,100*	*4.02*	*3,883,976,581*	*187,353,487*	*4.82*	*25.6*
		21,180,302,026	*862,272,844*	*4.07*	*22,370,425,572*	*909,448,935*	*4.07*	*5.5*

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

Listed by Alphabetical Order

	2024			2025				
Hospital	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating	% Change Reg. Operating	% Change Total Operating
ADVENTIST HEALTHCARE FORT WASHINGTON	6,253,121	-8,986,253	-2,733,132	7,539,938	-9,474,770	-1,934,832	20.58	29.21
ADVENTIST HEALTHCARE GERMANTOWN EMER	-249,422	-9,500	-258,922	224,797	-8,883	215,914	190.13	183.39
ADVENTIST HEALTHCARE SHADY GROVE MEDI	42,551,157	-16,057,234	26,493,923	48,140,130	-22,585,947	25,554,183	13.13	-3.55
ADVENTIST HEALTHCARE WHITE OAK MEDICA	25,537,391	-25,829,037	-291,646	28,732,288	-25,512,901	3,219,386	12.51	1203.87
ASCENSION ST. AGNES HOSPITAL	51,380,720	-79,830,677	-28,449,957	78,812,398	-79,469,958	-657,561	53.39	97.69
ATLANTIC GENERAL HOSPITAL	19,220,772	-25,548,409	-6,327,636	21,030,166	-23,730,889	-2,700,723	9.41	57.32
CALVERT HEALTH MEDICAL CENTER	11,699,833	-12,861,700	-1,161,867	17,493,378	-16,005,209	1,488,169	49.52	228.08
CHRISTIANACARE UNION HOSPITAL	18,110,343	-22,362,339	-4,251,996	-16,805,172	1,501,735	-15,303,437	-192.79	-259.91
FREDERICK HEALTH HOSPITAL	24,294,692	-26,456,809	-2,162,117	47,772,076	-31,636,076	16,136,000	96.64	846.31
GREATER BALTIMORE MEDICAL CENTER	57,430,709	-74,580,208	-17,149,499	45,045,654	-93,053,272	-48,007,618	-21.57	-179.94
HOLY CROSS HOSPITAL	72,516,646	-38,442,318	34,074,328	97,502,988	-50,186,380	47,316,608	34.46	38.86
HOLY CROSS HOSPITAL GERMANTOWN	4,336,909	-12,395,774	-8,058,865	12,789,102	-11,421,239	1,367,863	194.89	116.97
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	13,625,237	3,628,763	17,254,000	32,579,403	30,771,598	63,351,000	139.11	267.17
JOHNS HOPKINS HOSPITAL	-14,930,532	69,112,432	54,181,900	27,389,767	96,366,437	123,756,204	283.45	128.41
JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	5,043,748	-11,958,747	-6,915,000	14,019,121	-14,866,240	-847,119	177.95	87.75
JOHNS HOPKINS SUBURBAN HOSPITAL	24,324,578	-32,747,325	-8,422,747	29,849,076	-39,638,507	-9,789,431	22.71	-16.23
LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	45,884,150	-17,917,344	27,966,806	24,477,600	-16,087,262	8,390,338	-46.65	-70.00
LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	-3,015,279	-11,944,749	-14,960,028	-6,484,321	-8,436,059	-14,920,380	-115.05	0.27
LIFEBRIDGE HEALTH LEVINDALE	14,252,366	-6,596,781	7,655,585	8,889,010	-4,721,990	4,167,020	-37.63	-45.57
LIFEBRIDGE HEALTH NORTHWEST HOSPITAL CE	27,840,750	-37,013,928	-9,173,178	25,751,182	-31,733,657	-5,982,475	-7.51	34.78

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	2024			2025				
Hospital	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating	% Change Reg. Operating	% Change Total Operating
LIFEBRIDGE HEALTH SINAI HOSPITAL	106,137,994	-84,597,928	21,540,065	130,441,027	-86,196,932	44,244,095	22.90	105.40
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	71,379,651	-53,088,654	18,290,997	115,231,685	-61,927,654	53,304,031	61.43	191.42
LUMINIS HEALTH DOCTORS COMMUNITY MEDI	15,137,467	-20,883,073	-5,745,606	17,079,426	-23,676,427	-6,597,001	12.83	-14.82
MEDSTAR FRANKLIN SQUARE HOSPITAL	61,298,178	-46,971,032	14,327,146	62,446,779	-55,864,981	6,581,797	1.87	-54.06
MEDSTAR GOOD SAMARITAN HOSPITAL	28,793,318	-27,332,352	1,460,966	25,486,891	-24,268,178	1,218,713	-11.48	-16.58
MEDSTAR HARBOR HOSPITAL	13,901,632	-18,187,585	-4,285,953	14,622,608	-22,855,753	-8,233,145	5.19	-92.10
MEDSTAR MONTGOMERY MEDICAL CENTER	-70,382	-13,611,426	-13,681,808	6,822,615	-14,042,106	-7,219,491	9793.69	47.23
MEDSTAR SOUTHERN MARYLAND HOSPITAL CE	-3,181,665	-28,325,726	-31,507,391	33,883,504	-29,403,372	4,480,131	1164.96	114.22
MEDSTAR ST. MARY'S HOSPITAL	18,994,350	-15,307,012	3,687,338	48,981,823	-16,130,702	32,851,121	157.88	790.92
MEDSTAR UNION MEMORIAL HOSPITAL	44,549,699	-56,910,403	-12,360,704	46,519,640	-58,980,967	-12,461,327	4.42	-0.81
MERCY MEDICAL CENTER	43,594,749	-27,636,242	15,958,507	30,327,989	-30,518,260	-190,271	-30.43	-101.19
MERITUS MEDICAL CENTER	68,697,840	-18,051,400	50,646,440	76,087,500	-27,274,500	48,813,000	10.76	-3.62
TIDALHEALTH MCCREADY PAVILION	-1,442,501	-1,555,600	-2,998,101	-1,104,549	-1,587,451	-2,692,000	23.43	10.21
TIDALHEALTH PENINSULA REGIONAL	90,601,443	-41,418,413	49,183,030	77,708,789	-47,099,389	30,609,400	-14.23	-37.76
UM BALTIMORE WASHINGTON MEDICAL CENTE	47,472,336	-55,225,336	-7,753,000	58,562,106	-54,446,106	4,116,000	23.36	153.09
UM BOWIE HEALTH CENTER	3,408,100	-609,100	2,799,000	3,062,864	-423,864	2,639,000	-10.13	-5.72
UM CAPITAL REGION MEDICAL CENTER	22,560,904	-44,095,904	-21,535,000	46,962,342	-50,169,343	-3,207,000	108.16	85.11
UM CHARLES REGIONAL MEDICAL CENTER	23,400,166	-15,506,166	7,894,000	31,321,748	-22,307,748	9,014,000	33.85	14.19
UM LAUREL MEDICAL CENTER	-6,457,089	-7,268,911	-13,726,000	-3,855,567	-4,305,434	-8,161,000	40.29	40.54
UM MEDICAL CENTER	3,559,410	-6,137,523	-2,578,112	-61,041,845	20,409,845	-40,632,000	-1814.94	-1476.04
UM QUEEN ANNE'S FREESTANDING EMERGENC	-1,324,452	-133,000	-1,457,452	-467,204	-166,796	-634,000	64.72	56.50
UM REHABILITATION & ORTHOPAEDIC INSTIT	7,497,229	-11,066,229	-3,569,000	11,478,675	-8,948,675	2,530,000	53.11	170.89
UM SHOCK TRAUMA	52,601,809	-1,461,809	51,140,000	76,129,028	-1,337,028	74,792,000	44.73	46.25
UM SHORE REGIONAL HEALTH AT CAMBRIDGE	-4,510,646	1,679,646	-2,831,000	-3,586,302	234,302	-3,352,000	20.49	-18.40

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Hospital	2024			2025				
	Regulated Operating	Unregulated Operating	Total Operating	Regulated Operating	Unregulated Operating	Total Operating	% Change Reg. Operating	% Change Total Operating
UM SHORE REGIONAL HEALTH AT CHESTERTO	8,752,871	-7,231,871	1,521,000	12,225,113	-6,816,113	5,409,000	39.67	255.62
UM SHORE REGIONAL HEALTH AT EASTON	39,309,444	-45,936,992	-6,627,548	49,248,557	-46,712,557	2,536,000	25.28	138.26
UM ST. JOSEPH MEDICAL CENTER	55,535,036	-59,466,036	-3,931,000	62,312,070	-68,027,070	-5,715,000	12.20	-45.38
UM UPPER CHESAPEAKE MEDICAL CENTER -AB	48,402,953	-42,427,953	5,975,000	86,657,672	-47,217,672	39,440,000	79.03	560.08
UM UPPER CHESAPEAKE MEDICAL CENTER – B	-323,534	-3,242,431	-3,565,965	-2,469,247	-1,044,754	-3,514,000	-663.21	1.46
UMMC MIDTOWN CAMPUS	20,217,839	-34,544,839	-14,327,000	24,445,934	-28,417,934	-3,972,000	20.91	72.28
UPMC WESTERN MARYLAND	63,759,433	-43,430,363	20,329,070	63,359,276	-47,583,166	15,776,110	-0.63	-22.40
WVU MEDICINE GARRETT REGIONAL MEDICAL	23,616,322	-12,455,221	11,161,101	21,309,882	-17,394,807	3,915,075	-9.77	-64.92
ALL ACUTE HOSPITALS	***1,411,977,794***	***-1,231,234,822***	***180,742,972***	***1,704,939,406***	***-1,234,431,058***	***470,508,348***	***20.75***	***160.32***

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health services
cost review commission

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

Listed by Alphabetical Order

	2024	2025	
Hospital	Excess|Profit Loss	Excess|Profit Loss	% Change in Excess
ACUTE HOSPITAL TOTALS	807,714,662	1,121,343,989	38.83
ADVENTIST HEALTHCARE FORT WASHINGTON M	-2,815,108	-1,934,832	31.27
ADVENTIST HEALTHCARE GERMANTOWN EMERGE	-258,922	215,914	183.39
ADVENTIST HEALTHCARE SHADY GROVE MEDIC	32,176,665	32,524,526	1.08
ADVENTIST HEALTHCARE WHITE OAK MEDICAL	239,380	3,785,087	1481.20
ASCENSION ST. AGNES HOSPITAL	-27,040,285	-971,993	96.41
ATLANTIC GENERAL HOSPITAL	-1,888,614	1,114,004	158.99
CALVERT HEALTH MEDICAL CENTER	-921,415	1,779,577	293.14
CHRISTIANACARE UNION HOSPITAL	3,068,004	-9,342,437	-404.51
FREDERICK HEALTH HOSPITAL	20,923,883	37,064,000	77.14
GREATER BALTIMORE MEDICAL CENTER	-6,685,499	-33,800,737	-405.58
HOLY CROSS HOSPITAL	70,431,928	99,712,397	41.57
HOLY CROSS HOSPITAL GERMANTOWN	-2,074,365	7,133,935	443.91
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	18,777,000	68,750,000	266.14
JOHNS HOPKINS HOSPITAL	108,038,900	155,744,204	44.16
JOHNS HOPKINS HOWARD COUNTY MEDICAL CE	20,712,631	23,665,781	14.26
JOHNS HOPKINS SUBURBAN HOSPITAL	30,414,253	29,519,569	-2.94
LIFEBRIDGE HEALTH CARROLL HOSPITAL CEN	50,789,607	36,514,470	-28.11
LIFEBRIDGE HEALTH GRACE MEDICAL CENTER	-14,967,028	-14,922,380	0.30
LIFEBRIDGE HEALTH LEVINDALE	10,038,933	6,769,020	-32.57
LIFEBRIDGE HEALTH NORTHWEST HOSPITAL C	-577,418	4,225,525	831.80
LIFEBRIDGE HEALTH SINAI HOSPITAL	60,633,065	87,271,095	43.93
LUMINIS HEALTH ANNE ARUNDEL MEDICAL CE	67,069,997	112,427,045	67.63
LUMINIS HEALTH DOCTORS COMMUNITY MEDIC	-8,186,606	-6,371,001	22.18
MEDSTAR FRANKLIN SQUARE HOSPITAL	14,871,421	7,355,984	-50.54
MEDSTAR GOOD SAMARITAN HOSPITAL	6,553,818	6,591,032	0.57
MEDSTAR HARBOR HOSPITAL	-3,751,353	-3,154,381	15.91
MEDSTAR MONTGOMERY MEDICAL CENTER	-12,889,388	-6,481,871	49.71

	2024	2025	
Hospital	Excess|Profit Loss	Excess|Profit Loss	% Change in Excess
MEDSTAR SOUTHERN MARYLAND HOSPITAL CEN	-31,313,733	4,610,588	114.72
MEDSTAR ST. MARY'S HOSPITAL	6,083,361	35,686,660	486.63
MEDSTAR UNION MEMORIAL HOSPITAL	-3,083,560	-3,758,865	-21.90
MERCY MEDICAL CENTER	43,580,356	29,850,288	-31.51
MERITUS MEDICAL CENTER	102,893,540	90,606,100	-11.94
TIDALHEALTH MCCREADY PAVILION	-2,998,101	-2,692,000	10.21
TIDALHEALTH PENINSULA REGIONAL	94,803,030	71,078,900	-25.02
UM BALTIMORE WASHINGTON MEDICAL CENTER	14,705,000	26,996,000	83.58
UM BOWIE HEALTH CENTER	2,395,000	2,484,000	3.72
UM CAPITAL REGION MEDICAL CENTER	-30,612,000	-2,189,000	92.85
UM CHARLES REGIONAL MEDICAL CENTER	11,104,000	12,014,000	8.20
UM LAUREL MEDICAL CENTER	-14,598,000	-8,311,000	43.07
UM MEDICAL CENTER	51,917,888	13,013,000	-74.94
UM QUEEN ANNE'S FREESTANDING EMERGENCY	-1,457,452	-634,000	56.50
UM REHABILITATION & ORTHOPAEDIC INSTIT	3,399,000	11,135,000	227.60
UM SHOCK TRAUMA	51,140,000	75,017,000	46.69
UM SHORE REGIONAL HEALTH AT CAMBRIDGE	-2,831,000	-3,352,000	-18.40
UM SHORE REGIONAL HEALTH AT CHESTERTOW	2,941,000	5,792,000	96.94
UM SHORE REGIONAL HEALTH AT EASTON	10,083,452	22,613,000	124.26
UM ST. JOSEPH MEDICAL CENTER	178,000	1,693,000	851.12
UM UPPER CHESAPEAKE MEDICAL CENTER -AB	22,776,000	70,967,000	211.59
UM UPPER CHESAPEAKE MEDICAL CENTER – B	5,229,035	-3,514,000	-167.20
UMMC MIDTOWN CAMPUS	-14,808,000	-4,700,000	68.26
UPMC WESTERN MARYLAND	40,534,620	25,299,490	-37.59
WVU MEDICINE GARRETT REGIONAL MEDICAL	12,969,742	6,455,295	-50.23

maryland
health services
cost review commission

TO:

HSCRC Commissioners

FROM: HSCRC Staff

DATE: May 13, 2026

RE: Hearing and Meeting Schedule

June 10, 2026 In person at HSCRC office and Zoom webinar

July 8, 2026 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.