maryland
health services
cost review commission

645th Meeting of the Health Services Cost Review Commission

September 9, 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 July 22, 2026

Specific Matters

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

Docket Status – Cases Closed

2699A University of Maryland Medical Center
2700A University of Maryland Medical Center

1. Docket Status – Cases Open

2701R Brook Lane
2702A Johns Hopkins Health System
2703N TidalHealth Peninsula Regional

Subjects of General Applicability

2. Final Staff Recommendation Request to Access HSCRC Confidential Data: Primary Care Coalition (Nexus Montgomery Regional Partnership)
3. Report from the Executive Director
    a. Model Monitoring
    b. Policy Calendar
4. Quality Programs Strategy Discussion

5. EQIP Performance (CY 2025)
6. Final Recommendation: AHEAD Transition Funding Distribution
7. Final Recommendation: Update to The Accounting and Budget Manual
8. Hearing and Meeting Schedule

maryland
health services
cost review commission

644th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION JULY 22, 2026

Chairman Joshua Sharfstein, M.D. called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Commissioners Jon Blum, M.P.P., Nicki McCann, J.D., Ricardo Johnson, J.D., Farzaneh Sabi, M.D and Benjamin Stallings, M.D. Joining via Zoom, Commissioner David Maine, M.D. Upon a motion made by Commissioner Johnson and seconded by Commissioner Sabi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:10 p.m.

REPORT OF JULY 22, 2026, CLOSED SESSIONS

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the July 22, 2026, Closed Sessions.

ANNOUNCEMENT

Chairman Sharfstein opened the meeting by clarifying that, despite announcing his departure at the previous session, he returned to chair one final meeting at the request of the Governor's Office. He introduced a new Commissioner, Dr. Benjamin Stallings, who has 35 years of experience in healthcare, including 30 years as Director of the Department of Imaging at Doctors Hospital and his current role as Medical Director at Holy Cross Hospital. Dr. Stallings highlighted his extensive leadership history across the state of Maryland, having served as prior president of both the Prince George's County Medical Society and MedChi (the Maryland State Medical Society), along with executive board service for the Dimensions Healthcare System under the University of Maryland Medical System.

Dr. Kromm also announced key additions and transitions within the HSCRC leadership team, including Mr. William Henderson stepping into the role of Deputy Executive Director to oversee both healthcare economics and financial policy teams. To fill the vacancy left in the health economics division, he introduced Dr. Jonathan Thornhill as the new Deputy Director of Health Economics, who has an extensive background in health economics, policy, technology, and value-based care payment models gained from previous leadership roles at CMMI, the Johns Hopkins Applied Physics Lab, and UNC Healthcare.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 10, 2026, PUBLIC MEETING AND CLOSED SESSIONS

Upon motion made by Commissioner Johnson and seconded by Commissioner McCann, the Commission voted unanimously to approve the minutes of the June 10, 2026, Public Meeting and Closed Sessions and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

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

ITEM III
OPEN CASE

2699A	University of Maryland Medical Center
2700A	University of Maryland Medical Center
2701R	Brook Lane

ITEM IV
PRESENTATION: UNIVERSITY OF MARYLAND MEDICAL SYSTEM- SICKLE CELL PROGRAM

Dr. Tiffany Wiggins, Vice President and Chief Health Impact Officer for the University of Maryland Medical System, Dr. Enrico Novelli, Professor of Medicine and Hematologist, University of Maryland School of Medicine, Dr. Mark Gladwin, Dean of the University School of Medicine and Vice President for Medical Affairs, University of Maryland, Baltimore, and Dr. Taofeek Owonikoko, Executive Director, University of Maryland Marlene and Stewart Greenebaum Comprehensive Cancer Center, presented updates on the University of Maryland Medical System and School of Medicine Sickle Cell Program.

Dr. Wiggins highlighted the significant burden of sickle cell disease in Maryland, which affects approximately 8,000 residents, emphasizing that many patients remain disconnected from comprehensive and coordinated care. This disconnection leads to substantial equity gaps, unmet social needs, delayed treatments, and high healthcare costs estimated at six to ten times higher than age-matched peers, with lifetime costs exceeding $1.6 million per patient. Much of this financial and clinical strain is driven by avoidable emergency department visits and hospital readmissions, presenting a critical opportunity for the state to improve care quality and lower costs through proactive, timely interventions.

University of Maryland Medical System (UMMS) is uniquely positioned to address this crisis, already serving around 1,700 individuals with sickle cell disease annually across its network.

Pointing to successful care models, Dr. Wiggins noted that the UMMS downtown campus has seen adult outpatient visits triple over the past decade, while the Capital Region Sickle Cell Disease Clinic in Prince George's County achieved a 65 percent drop in emergency department visits and a 34 percent decline in pain crisis admissions within two years of opening. These results demonstrate that shifting from reactive crisis management to proactive longitudinal care delivers clear health improvements, though rising demand continues to challenge providers state-wide.

Dr. Novelli outlined the operational challenges and strategic vision for sickle cell disease care within the UMMS. He highlighted that emergency department visits doubled between 2023 and 2026, creating severe system pressure with a 65 percent admission rate and long hospital stays, despite keeping time to pain relief relatively low. While UMMS remains at the forefront of advanced treatments serving as Maryland's sole provider of FDA-approved gene therapies, overall patient access to these therapies remains constrained. To address these systemic pressures, UMMS is proposing a "hub-and-spoke" care model centered at the UMMS downtown campus, supported by affiliate sites, to expand access, standardize protocols, and coordinate with community organizations on social determinants of health. Key acute care goals include cutting time to initial analgesia down to national benchmarks, assigning high-priority triage scores, and opening a dedicated emergency department sickle cell treatment unit. For preventive care, UMMS plans to expand telemedicine, open a community-centered medical home at Mondawmin Health Village, and launch an "80/80/80 Care Cascade" framework to optimize the use of hydroxyurea, a proven disease-modifying therapy. By moving care upstream, improving adherence to disease-modifying treatments, expanding access to curative therapies, and reducing emergency department visits and hospitalizations, the initiative aims to significantly lower healthcare costs while establishing a consistent, equitable standard of care statewide.

Dr. Owonikoko expressed the joint commitment of the University of Maryland School of Medicine and Medical System to improving care for all Marylanders with sickle cell disease, emphasizing that their efforts are already actively underway. He highlighted key institutional actions, including the recruitment of Dr. Novelli, whom he praised as a top global expert in sickle cell care, and the strategic involvement of Dr. Wiggins to integrate population health expertise into acute care models. Dr. Mark Gladwin reiterated Dr. Owonikoko’s commitment to transforming sickle cell care and shared that the system is completing recruitment for its pediatric leadership to head the pediatric gene therapy and CAR-T program. Presenting recent internal data, Dr. Gladwin noted that while 1,700 patients interacted with the downtown and Capital Region campuses over the past year generating $28 million in total care costs, only 40 percent were prescribed hydroxyurea. Citing long-term clinical data, he stressed that maximizing utilization of this inexpensive generic drug represents a powerful, immediate opportunity to reduce hospitalizations, lower mortality, and bend the overall cost curve.

No action was taken on this agenda item.

ITEM V
CONFIDENTIAL DATA REQUEST: JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Chairman Sharfstein recused himself.

Mr. Curtis Wills, Assistant Chief, Healthcare Data Management and Integrity, presented the *Confidential Data Request: Johns Hopkins Bloomberg School of Public Health* (see "*Confidential Data Request: Johns Hopkins Bloomberg School of Public Health"* available on the HSCRC website).

Mr. Wills presented the staff Recommendation regarding a data request from the Johns Hopkins University Bloomberg School of Public Health in collaboration with Brown University. The researchers are requesting statewide confidential inpatient and outpatient hospital discharge data from 2019 through 2026 to evaluate Maryland's 2019 law requiring local jails to provide medications for opioid use disorder (MOUD). Because the implementation occurred in stages across facilities, the project functions as a natural experiment to study the impact of MOUD access on post-release treatment engagement, healthcare utilization, overdose encounters, and recidivism across demographic groups.

To ensure data privacy and security, CRISP will link the HSCRC discharge data to public court records and provide only de-identified files to the study team. Johns Hopkins will store the de-identified data in a secure, encrypted research enclave with role-based access, and all files will be destroyed with formal certification sent to the HSCRC upon project completion. The request received IRB and MDA Strategic Data Initiative approvals in July 2026, as well as a unanimous approval recommendation from the HSCRC Confidential Data Review Committee.

Mr. Wills presented the staff's Recommendations as follows:

1. The request by the Johns Hopkins University, Bloomberg School of Public Health for access to the basic inpatient and outpatient confidential discharge data for Calendar Years 2019 through 2026 be approved.

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

Commissioner Stallings asked how researchers will identify and select specific patient data from the larger dataset without infringing on privacy. He also inquired about the protocols and liabilities in place should a data breach occur.

Ms. Claudine Williams, Principal Deputy Director, Healthcare Data Management and Integrity, explained that researchers narrow the scope by submitting a specific patient panel to CRISP, which links the matching HSCRC data and strips out all personal identifiers before returning the de-identified file to the study team. Regarding potential security incidents, she noted that the HSCRC Data Use Agreement (DUA) contains explicit breach policies and provisions. These

provisions outline mandatory notification protocols for informing both the HSCRC and affected patients depending on the nature of the breach.

Commissioner Blum requested a motion to adopt the staff's recommendation. Commissioner Johnson moved to approve the staff's recommendation, seconded by Commissioner McCann. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM VI
REPORT FROM THE EXECUTIVE DIRECTOR

Update on Medicare FFS Savings

Dr. Jon Kromm, Executive Director, briefly noted that there is no Medicare fee-for-service savings update available for the current month, which is standard practice due to having only a couple of months of data. The first update for FY 2027 will be presented during the September meeting.

Policy Calendar Update

Mr. William Henderson, Deputy Executive Director, provided a comprehensive operational update, reviewing completed initiatives and outlining the agency's strategic transition into its next planning phase ahead of the split global budget implementation in January 2028. He highlighted recent milestones including updates to the market shift demographic and surge policies, the global budget carve-out vote, approval of the CARE Innovation model, and an approved inpatient length-of-stay policy alongside joint state agency efforts surrounding AHEAD metrics, workforce initiatives, post-acute strategies, and Total Cost of Care (TCOC) targets. Looking ahead, Mr. Henderson outlined five key focus areas for the next six months: rate adjustments and assessments, financial policy reviews, quality program alignments with CMS, rolling out the CARE Innovation programs, and ongoing multi-agency coordination.

To prepare for the transition to Medicare global budgets, staff plan to present a detailed roadmap at the September 2026 Commission meeting, targeting early 2027 to finalize all policy adjustments. This timeline ensures hospitals have ample time to adapt prior to the FY 2028 Update Factor process and the finalization of Medicare specifications. He stated that staff capacity over the next six months will be dedicated exclusively to refining existing policies rather than launching new initiatives. Staff will collaborate closely with stakeholders over the coming weeks to finalize this implementation schedule for the September meeting.

No action was taken on this agenda item.

ITEM VII
FINAL RECOMMENDATION: GLOBAL BUDGET CARVE OUT

Ms. Prudence Akindo, Associate Director, Financial Methodologies and Mr. William Henderson, Deputy Executive Director, presented the staff's *Final Recommendation: Global Budget Carve Out* (see "*Final Recommendation: Global Budget Carve Out*" available on the HSCRC website).

Ms. Akindo presented the Final Recommendations for updating the Global Budget Revenue (GBR) Carve Out Methodology under the AHEAD model. The policy uses Medicare Severity Diagnosis Related Groups (MS-DRGs) to establish a simplified, stable framework to remove expensive and highly complex acute care predominantly concentrated at Academic Medical Centers (AMCs) and specialty-designated hospitals from fixed global budgets. Reflecting feedback from 13 stakeholder organizations, staff refined the proposed carve-out list, notably removing two neonatal ICU DRGs and selecting specific craniotomy DRGs to prevent unintended upcoding risks. These adjustments brought the total in-state carve-out volume to approximately $1.7 billion (8.4 percent of total statewide in-state revenue), with an additional $226 million attributed to out-of-state patients.

Addressing implementation concerns, she confirmed that the Carve Out Policy takes effect July 1, 2026, rejecting opt-in or delayed rollout options to maintain market stability and prevent competitive distortions. Under the approved framework, carve-out baselines for larger facilities are established using Calendar Year (CY) 2025 performance updated to FY 2027, whereas small-volume hospitals in the bottom two quintiles utilize an inflated three-year average to smooth out year-over-year volume fluctuations. Reimbursements for carve-out services will apply uniformly to both in-state and out-of-state patients, funded at 100 percent of charges through FY 2027 before aligning with Medicare unit-rate models upon the full AHEAD transition in 2028.

Ms. Akindo detailed how the Carve Out Policy interacts with existing HSCRC mechanisms and operational guidelines. Carve-out volumes will be excluded from core volume policies such as Market Shift Adjustments, Surge Funding calculations, and out-of-state revenue shifts while remaining subject to quality performance distributions. Additionally, the standalone Complexity and Innovation policy will officially sunset once the Carve Out Policy takes effect. She noted that the policy intentionally protects patient access to costly, cutting-edge modalities like CAR-T cell therapies across all hospital settings, ensuring care delivery is not restricted solely to primary academic hubs. She highlighted strong alignment between the HSCRC and CMMI carve-out service lists, noting an 87 percent overlap in overall charges and zero clinical disagreements.

Ms. Akindo presented the staff's Final Recommendations on the Global Budget Carve Out Policy as follows:

1. Adopt the less restrictive carve-out list, effective July 1, 2026, removing approximately 8.4 percent of statewide revenue associated with highly specialized care from population-based methodologies.
    - The proposed carve-out list prioritizes highly specialized tertiary and quaternary care performed at AMCs (61 percent), with expansions to include certain tertiary services also performed at non-AMCs (39 percent).
    - The list may be updated effective January 1, 2028, based on desired alignment with a final CMMI list.

2. Use CY 2025 charges, inflated to FY 2027, as the baseline for carve-out eligible volume to be removed from global budgets.

    - The baseline for lower volume hospitals would be based on a three-year average.

3. Fund all eligible carve-out volume under this policy at 100 percent variable costs and hold hospitals 100 percent liable for volatility.

4. Determine the carve-out list using in-state volumes, but reimbursements also apply consistently to out-of-state patients.

5. Sunset the current Complexity and Innovation Policy upon approval of the Carve-Out Policy.

    - All prospective adjustments in FY 2027 rates will be reversed and retrospective adjustments for FY 2025 and FY 2026 will be applied.

2. Removal of all carve-out cases from all other volume methodologies including the Market Shift, Demographic Adjustment, Surge Funding and Repatriation/Expatriation Policies.

    - Continue including carve-out eligible cases in the quality pay-for-performance and PAU Redistribution assessments.

2. Review the carve-out list annually for potential revisions and to understand the impact of the policy.

    - Material changes will be brought to the Commission for approval.

3. Carve out volumes eligible under the existing Outpatient Cosmetic Surgery program effective July 1, 2027.

Testimony:

Dr. Brenda Banwell, Chair of Pediatrics and Pediatrician-in-Chief, Johns Hopkins, offered testimony on behalf of Johns Hopkins and the University of Maryland Medical System in strong support of the draft carve-out policy, effective July 2026. She emphasized that the policy is essential for advancing complex pediatric healthcare under the AHEAD model, improving upon prior frameworks by offering greater predictability, stability, and real-time funding for tertiary and quaternary care.

Dr. Banwell advocated for protecting and sustaining access to life-saving, advanced pediatric therapies across Maryland. Beyond congenital heart procedures, she highlighted that the carve-out policy is vital for supporting pediatric organ transplantation, ECMO, advanced trauma care,

CAR-T cell therapy for childhood leukemia, and emerging cell and gene therapies for pediatric neurological diseases. On behalf of families across the state, she respectfully urged the Commission to adopt the recommended Carve-Out policy.

Dr. David Marcozzi, Chief Clinical Officer, University of Maryland Medical Center, echoed Dr. Banwell's support, framing the staff Recommendation as a necessary evolution in state hospital payment policy that provides stable, predictable funding for highly specialized and complex clinical programs. Reflecting on Maryland's experience with fixed global budgets, he emphasized that extending carve-out mechanisms to areas like complex heart disease, organ transplantation, craniotomies, and specialized oncology preserves critical academic capacity.

He stressed that volume-based funding ensures academic medical centers remain ready to receive transferred patients whose needs exceed community hospital capabilities. Dr. Marcozzi noted that implementing the Recommendation immediately provides a crucial 18-month runway before Medicare hospital global budgets take effect in January 2028, allowing health systems to adjust smoothly without risking patient access to specialized care.

Q&A

Commissioner Blum asked staff and the guest speakers what specific criteria will be used to monitor carve-out cases moving forward. He inquired about what circumstances or data points would prompt the Commission to change course by adding or subtracting procedures from the approved carve-out list. Ms. Akindo explained that staff will monitor the list annually, adding new DRGs if they meet the carve-out criteria or removing existing ones if a service becomes widely dispersed across all state hospitals. Additionally, staff will monitor volumes against the 15 percent allotment threshold, adjusting the list if the total carve-out volume approaches that limit.

Commissioner Deliberations:

Commissioner Maine voiced overall support for the Carve Out Policy while highlighting critical structural considerations and long-term risks. He noted that shifting the carve-out revenue ceiling under AHEAD from 5 percent to 15 percent represents a major policy shift, expressing relief that staff's refined proposal landed at a modest 8.4 percent of revenue rather than maxing out the limit before understanding the impact on seven-year fee-for-service savings targets. He pointed out that over 60 percent of carve-out funds are going to the Academic Medical Centers and cautioned that transferring 100 percent of volume volatility under a 100 percent variable cost framework creates unequal risk, particularly comparing large centers with broad carve-out service lines to smaller hospitals.

Looking ahead, Commissioner Maine noted the need for a transparent, defensible governing framework to guide future additions or removals from the carve-out list, specifically asking how staff will balance algorithmic outputs against clinical judgment on marginal cases. While acknowledging stakeholder anxieties around technical execution, he expressed trust in staff's

ability to implement the policy retroactively (effective July 1, 2026). He concluded by asking staff to share their thinking on whether 100 percent volume volatility is truly sustainable for the long-term success of the AHEAD model.

Mr. Henderson explained that the staff chose a 100 percent variable cost structure primarily for its simplicity and to maintain consistency with CMMI's approach. He noted that financial risk and volatility are heavily concentrated within Academic Medical Centers, whereas community hospitals experience a much lower impact (averaging around 3 percent to 4 percent of revenue). To protect smaller facilities from single-year distortions, staff incorporated a three-year baseline average for small-volume hospitals, and he affirmed that staff remain open to making future accommodations if a small facility experiences an unexpected spike or drop in volume.

Regarding future governance and criteria for adjusting the carve-out list, Mr. Henderson explained that new MS-DRGs will serve as an automatic trigger for staff evaluation. He noted that staff will rely on health system stakeholders to surface existing DRGs that become increasingly specialized and warrant addition to the list. Conversely, for removing procedures, staff will analyze dispersion data across hospitals and plan to present a structured framework during their first annual review that explicitly defines the dispersion threshold required to trigger a DRG's removal.

The Commissioners focused on the financial, operational, and clinical risks of the proposed Carve Out Policy. Commissioner Sabi raised concerns regarding access to care and length-of-stay (LOS) dynamics, noting that many carve-out DRGs naturally feature long stays. She cautioned that prioritizing these complex admissions could inadvertently crowd out access for non-carve-out services at academic and specialty centers. To mitigate potential LOS "creep" and spending growth within the carved-out cases, Commissioners discussed potential governors and monitoring mechanisms, ultimately agreeing to conduct an initial six-month review in April 2027 to ensure the policy functions as intended without approaching the 15 percent aggregate revenue ceiling.

Financial predictability and growth modeling were also discussed. Commissioners inquired about estimated cost impacts, pointing out that shifting these services to a volume-driven model might incentivize differential volume or coding growth, potentially adding percentage points to the Total Cost of Care Growth Targets. While staff noted that year-over-year charges for these DRGs actually declined slightly between 2023 and 2025, they acknowledged that coding audits and detailed DRG-level tracking will be necessary to distinguish genuine clinical growth from administrative upcoding. Commissioners discussed existing Medicare outlier models as possible backstops to recalibrate funding if expenditures exceed expectations.

The staff addressed stakeholder concerns regarding implementation timing, weighing requests for delays against the benefits of an immediate July 1, 2026, start. Several Commissioners expressed their desire for clear line-of-sight on cost projections but ultimately acknowledged that starting earlier provides a necessary real-world baseline. Citing consensus from the

Payment Models Volume Workgroup, Commissioners noted that both staff and health systems recognize the policy as an evolving framework. Beginning immediately allows the agency to refine mechanics, establish auditing protocols, and resolve technical uncertainties well ahead of the full 2028 AHEAD transition.

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

ITEM VIII
FINAL RECOMMENDATION: UPDATE FACTOR WITH ADJUSTMENTS FOR INDIVIDUAL MARKET STABILIZATION AND UNCOMPENSATED CARE

Ms. Caitlin Cooksey, Deputy Director, Hospital Rate Regulation and Mr. William Henderson, Executive Deputy Director, presented the staff's *Final Recommendation: Update Factor with Adjustments for Individual Market Stabilization and Uncompensated Care* (see "*Final Recommendation: Update Factor with Adjustments for Individual Market Stabilization and Uncompensated Care* " available on the HSCRC website).

Dr. Kromm outlined the background and policy context that brought the Commission to the topic of uncompensated care mitigation. He reminded the Commissioners there were growing concerns in the fall from industry stakeholders, Commissioners, and staff that Maryland hospitals were facing a potential surge in uncompensated care. This anticipated growth was driven by projected coverage losses across both the individual insurance market due to changes in Advanced Premium Tax Credits (APTC) and Medicaid enrollment. To model these impacts, HSCRC staff collaborated closely with the Maryland Insurance Administration (MIA) and the Maryland Health Benefit Exchange (MHBE).

To address these challenges, staff developed a comprehensive, multi-pronged strategy designed to mitigate financial strain while preserving patient access. Recognizing that maintaining comprehensive insurance is the most effective defense, the first prong focuses on individual market stabilization to prevent coverage loss at the outset. For individuals who do lose coverage, the plan enhances the long-standing HSCRC Uncompensated Care Fund and directs support toward Federally Qualified Health Centers (FQHCs), ensuring patients can access essential primary care in the appropriate community setting rather than relying solely on hospital emergency departments.

Ms. Cooksey presented the staff's Final Recommendations, outlining public feedback and staff responses following the June 10th Commission meeting. Stakeholder input centered on uncompensated care (UCC) adequacy, market stabilization funding, and prospective hospital adjustments. In response to hospital requests for larger prospective rate increases, she noted that staff prefer a multi-pronged approach rather than directing all resources strictly to hospital UCC reserves. Staff maintained that a $25 million increase (0.1 percent) to the UCC Fund is

currently appropriate, with plans to monitor unaudited data throughout the year and release reserves no earlier than January 2027.

The refined proposal directs $100 million in one-time Rate Year (RY) 2027 funding to the Maryland Health Benefit Exchange (MHBE) to support reinsurance and subsidies under Maryland's 1332 waiver. Responding to stakeholder comments regarding legal authority and operational mechanics, Ms. Cooksey explained that HSCRC holds statutory authority to adjust hospital rates to promote financial stability, address uncompensated care, and support state waiver components. The assessment will be allocated proportionally across hospital revenue as a one-time charge, with inter-agency roles to be formalized through a Memorandum of Understanding (MOU) with MHBE.

Following stakeholder feedback on alternative care settings, the Final Recommendation incorporates a new $25 million allocation to support Federally Qualified Health Centers (FQHCs) and local health departments. This safety-net funding aims to expand primary and preventive care access for uninsured residents, steering care away from emergency departments. Ms. Cooksey clarified that while some payers suggested directing all market stabilization funds to MHBE, splitting support between individual market subsidies, FQHCs, and hospital UCC reserves provides a more balanced safety net across the continuum of care. She noted that prioritizing individual market stability protects consumers from coverage loss while simultaneously insulating hospitals from uncompensated care growth.

Ms. Cooksey presented the staff's Final Recommendations as follows:

1. Allocate $100 million to the Maryland Health Benefit Exchange (MHBE) special fund to provide funds for reinsurance and Maryland premium subsidies.
2. Allocate $50 million to the UCC Fund for coverage losses that Maryland cannot mitigate, such as loss of coverage due to immigration status. This would be divided into two buckets:
    a. $25 million for Federally Qualified Health Centers (FQHCs) and local health departments to provide primary care to avoid hospital utilization
    b. $25 million to increase the reserves in the UCC Fund

Q&A

Commissioner McCann asked for confirmation that voting in favor of the current proposal would not bind the Commission or indicate future support for continuing these funding streams into RY 2028. Chairman Sharfstein confirmed that the Commission vote applies strictly to RY 2027 and does not commit to future funding. He clarified that while the Recommendation represents the right policy for the current year, any extension into RY 2028 would require a separate evaluation and vote based on prevailing circumstances next year.

Testimony:

Ms. Nora Hoban, CEO, Mid Atlantic Association of Community Health Centers, expressed appreciation to the HSCRC Commissioners and staff for their collaborative work on addressing uncompensated care and healthcare affordability. Speaking on behalf of community partners, she commended the Commission for adopting a multi-pronged approach to safety-net funding, particularly highlighting the inclusion of $25 million in RY 2027 to support Federally Qualified Health Centers (FQHCs) and local health departments. Ms. Hoban emphasized that investing directly in community-based primary care keeps vulnerable and uninsured Marylanders connected to preventive services, ultimately reducing avoidable emergency department visits and stabilizing the broader healthcare ecosystem.

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance, Maryland Hospital Association (MHA), speaking on behalf of MHA's member hospitals and health systems, she emphasized that rising uncompensated care is no longer a future possibility but a real-time reality already placing severe financial strain on hospitals and threatening patient access to essential acute care services. While expressing hope that the staff's proposed preventive tactics yield their intended results, Ms. Terry urged that state policies must remain directly responsive to the immediate, high UCC burden health systems are experiencing today.

Addressing the proposed $25 million for FQHCs and local health departments, Ms. Terry noted that while MHA values strengthening primary care safety nets, this funding should complement rather than replace adequate UCC support for hospitals. She urged that any safety-net funding be strictly one-time, count toward the state's primary care investment targets, and include clear accountability mechanisms to prove it successfully averts hospital UCC costs. She cautioned the Commission to carefully consider its statutory boundaries, reminding leadership that HSCRC's core mandate is setting rates reasonably related to hospital costs and ensuring all legal and regulatory authorities are fully established before implementing these external interventions.

Mr. Adam Kellerman, Director of Healthcare Payment, MHA, presented the MHA's analysis that illustrated state-projected coverage losses could drive UCC up by $158 million in RY 2027. He explained that while MHA supports marketplace stabilization through MHBE, proposed allocation changes will not address the major coverage losses already occurring in 2026, including a 10 percent drop in Marketplace enrollment (over 24,000 individuals) that could generate $60 million in additional UCC costs. Highlighting that this surge far exceeds the staff's proposed $25 million reserve increase and does not factor in rising bad debt from enrollment in lower-coverage Bronze plans, Mr. Kellerman reiterated MHA's request for a prospective $158 million UCC adjustment in hospital rates to support the growing number of uninsured patients.

Mr. Kevin Lindamood, President and CEO, Health Care for the Homeless, expressed strong support for the staff recommendation to invest in community-based primary care. Speaking as a leader of Maryland's primary provider of integrated health care and supportive housing for people experiencing or at risk of homelessness, he highlighted that the proposal aligns with the AHEAD model and offers an effective, cost-conscious response to rising uncompensated care and anticipated coverage losses.

Mr. Lindamood warned that without targeted support, FQHCs would be forced to scale back vital services, driving uninsured individuals back to hospital emergency rooms as providers of last resort. He emphasized that FQHCs are already subject to rigorous federal, state, and client accountability, and he assured the Commission that community providers are eager to be held fully accountable for these funds. He urged the Commission to approve the proposal to preserve accessible, cost-effective care in community settings.

Rev. Melody Hession-Sigmon, Lutheran Director for Public Policy in Maryland, Delaware-Maryland Synod of the Evangelical Lutheran Church in America, expressed support for the RY 2027 Recommendation. While acknowledging that the proposed funding for the Maryland Health Benefit Exchange (MHBE) was lower than advocated for, she appreciated the Commission's commitment to re-evaluate the funding in a year to adapt to rapidly changing circumstances. She highlighted the ongoing rise in Medicaid coverage losses and urged the Commission to continue stewarding its resources effectively to address immediate community needs and alleviate unnecessary suffering. Rev. Hession-Sigmon also voiced strong appreciation for directing funds toward local health departments and community health centers, emphasizing its critical role in supporting immigrant communities and refugees who face mounting vulnerabilities and coverage losses.

Mr. Arin Foreman, Vice President and Deputy Chief of Staff, CareFirst BlueCross BlueShield, began by expressing disappointment regarding the Commission's decision at its June meeting to approve over $200 million in incremental costs that had not been made public prior to the vote. He stressed that the public deserves a more transparent and inclusive process. Regarding the specific funding allocation, Mr. Foreman framed the decision as a choice between investing upstream in reinsurance and subsidies to keep individuals insured versus accepting higher healthcare prices that force people out of coverage and drive-up uncompensated care (UCC). He noted that focusing on UCC avoidance through reinsurance and subsidies is the right choice, as it directly benefits both patients and hospitals.

Addressing the proposed $25 million for FQHCs and local health departments, Mr. Foreman clarified that CareFirst's concerns were grounded in the process rather than the substance. While recognizing the vital role these organizations play in caring for vulnerable populations and avoiding UCC, he criticized the decision to add this $25 million as an incremental cost just weeks after the annual Update Factor vote. He argued that the Update Factor should serve as a firm ceiling rather than a starting point, noting that the $1 billion increase approved the prior month should have absorbed the $25 million rather than passing additional costs to the public. In closing, he acknowledged that the presented funding would help vulnerable individuals but strongly urged the Commission to adopt a more inclusive stakeholder process and limit ad hoc rate increases moving forward.

Ms. Stephanie Klapper, Deputy Director, Maryland Citizens Health Initiative and the Maryland Healthcare for All Coalition, expressed strong support on behalf of her organization for the proposed RY 2027 UCC adjustment. Highlighting that federal policy shifts, such as HR1

rules and the expiration of enhanced premium tax credits, threaten to strip health coverage from tens of thousands of residents. She emphasized that losing coverage drives patients to emergency rooms, increasing uncompensated care and driving up insurance premiums for everyone. Ms. Klapper strongly endorsed allocating $100 million to the MHBE Fund to support reinsurance and state subsidies, noting that protecting reinsurance prevents an estimated 17,000 Marylanders from losing coverage while maintaining state subsidies preserves critical gains for young adults and lower-income families.

In addition to market stabilization funds, Ms. Klapper voiced appreciation for the $25 million allocation to FQHCs and local health departments to treat uninsured residents and reduce avoidable emergency room visits. She urged the Commission to finalize the proposal, noting that protecting affordable healthcare access stabilizes insurance pools, enhances health equity across age and demographic groups, and lowers overall costs across the state system.

Mr. Robert Laughlin, Consumer, is a Baltimore City resident, working two jobs without employer-provided health insurance, and testified in strong support of the proposal to increase the RY 2027 UCC adjustment by $150 million. He shared how Maryland's Young Adult Subsidy program transformed his life by drastically lowering his monthly premiums and deductibles on Maryland Health Connection, which allowed him to receive life-saving medical treatment.

Mr. Laughlin warned that affordable coverage for thousands of Marylanders is threatened by the expiration of federal Enhanced Premium Assistance, which makes state-level funding vital. He emphasized that approving the proposal would raise $100 million for state subsidy and reinsurance programs, preventing severe premium spikes that would force him and others to drop their insurance. Beyond protecting individual health and financial stability, he noted that the proposal yields significant economic benefits for Maryland by fostering a healthier risk pool, lowering uncompensated care costs, reducing overall healthcare expenses, and boosting workforce productivity.

Dr. Meg Sullivan, Deputy Secretary, Public Health, Maryland Department of Health, expressed strong support on behalf of the Maryland Department of Health for the proposed plan. She emphasized the importance of the reinsurance and subsidies funds, as well as the critical role played by FQHCs and other safety net providers. These providers are essential for keeping individuals out of emergency rooms and hospitals, which directly helps reduce uncompensated care costs across the state. She reaffirmed MDH's full endorsement of the Recommendation.

Dr. Doug Jacobs, Executive Director, Maryland Health Care Commission (MHCC), outlined the state's plan regarding FQHCs. MHCC is collaborating with MDH to create a fully transparent proposal, which will be posted for public comment. He underscored that established evidence proves continuity in primary care, particularly through FQHCs, reduces uncompensated care that would otherwise lead to emergency department visits and inpatient hospital admissions.

Addressing concerns about governance, Dr. Jacobs noted that state leaders are actively focused on incorporating robust accountability mechanisms into the plan. He emphasized that

the state intends to require appropriate reporting to ensure funds are specifically allocated toward uncompensated care services that support comprehensive health coverage.

Ms. Johanna Fabian-Marks, Executive Director, Maryland Health Benefit Exchange (MHBE), expressed strong support and appreciation for the proposal. Echoing Dr. Sullivan's previous sentiments, she highlighted that the proposed investments in insurance affordability programs managed through the MHBE will directly and significantly help Marylanders stay insured while reducing overall uncompensated care.

Q&A

Commissioner Stallings asked how the $100 million designated for the health exchange will practically work to reduce individual premium costs for Marylanders. Additionally, he questioned what would happen to any remaining funds as a result of insufficient impact on patient utilization of health care resources. Dr. Kromm explained that the policy is designed to stabilize health coverage and prevent premium increases that could cause consumers to drop their insurance, rather than expanding coverage to new areas. He noted that funding from the policy proposal flows into Maryland's existing Reinsurance Fund and state-based subsidy program. Allocation decisions are guided by extensive actuarial estimations submitted to the federal government as part of Maryland's 1332 waiver, with any remaining funds directed to state-based subsidies through a transparent, public process approved by the MHBE Board.

Ms. Fabian-Marks confirmed Dr. Kromm's explanation, adding that the MHBE works in close partnership with the Maryland Insurance Administration (MIA) to run extensive actuarial models. This modeling identifies the optimal split between reinsurance and state subsidies to maximize overall enrollment and maintain market stability. Once finalized, these recommendations are presented to their Board of Trustees for a formal vote.

Commissioner McCann asked whether FQHCs are obligated to treat all patients regardless of their insurance status and asked whether FQHCs would consider adopting a capped revenue global budget system to gain financial stability. Ms. Hoban confirmed that FQHCs are federally required to treat every patient regardless of their insurance status or ability to pay. Regarding revenue models, she explained that while FQHCs are eager to expand value-based care arrangements having already achieved great success under programs like the Maryland Primary Care Program (MDPCP), transitioning to a total risk-based global budget model is challenging. Although these facilities provide comprehensive care (including dental, behavioral, and maternal health) to all individuals, a full-risk system would require state-wide reimbursement rates capable of sustaining these high-cost, essential safety-net services.

Mr. Lindamood emphasized that FQHCs operate under strict federal regulations by the Health Resources and Services Administration (HRSA), which explicitly mandate that no patient may be turned away due to an inability to pay. He noted that while FQHCs are required to maintain a sliding fee scale, centers like Health Care for the Homeless choose not to charge patients for care to ensure fees do not become a barrier. Consequently, FQHCs frequently waive these

costs or write them off as bad debt. He added that all centers report their uninsured data to HRSA using consistent, strictly audited methods to ensure complete transparency.

Chairman Sharfstein asked how financial stress impacts the amount or scope of care a FQHCs can provide given that they are prohibited from refusing any patients. Mr. Lindamood explained that to stay financially viable as uninsured rates rise, FQHCs must make tough operational decisions, such as reducing services, reallocating staff, or closing specific health centers. Despite piecing together various public and private grants, growing financial pressure ultimately forces centers to limit where and what care they can offer.

Commissioner Blum asked whether the $25 million fund allocated for FQHCs would be used strictly to cover patient care claims or if a portion would need to be set aside for system development and infrastructure. Dr. Jacobs responded that the full $25 million is intended strictly to cover uncompensated patient care, specifically comprehensive primary care rather than infrastructure development, since the delivery model already exists. He noted that detailed operational specifics, including eligible services and rates, will be articulated in a formal plan developed alongside MDH and stakeholders for public comment.

Commissioner Deliberations

Commissioner Johnson praised the staff's creative and proactive strategy to address uncompensated care upstream by preserving individual market coverage and supporting primary care rather than solely reacting to hospital-based financial crises. Commissioner Maine noted the balanced design between market stabilization and hospital reserve funds but cautioned that underfunding hospital-level uncompensated care could create compounding financial strains on acute care facilities, given the data lags and coverage shocks associated with shifting federal policies.

The discussion highlighted differing perspectives on the long-term role of the rate-setting system for community safety-net providers. Commissioner McCann expressed strong support for the one-time allocation due to current extraordinary circumstances but voiced serious reservations about establishing hospital rate funds as an ongoing revenue source for FQHCs, warning against substituting government funding with hospital dollars. Chairman Sharfstein countered that funding preventive, community-based care directly advances the overarching goals of Maryland's Total Cost of Care model, while noting that the current action remains strictly a single-year commitment subject to future re-evaluation.

The Commissioners focused on establishing rigorous evaluation metrics and governance structures to measure the return on investment. Commissioners emphasized the need to determine whether these upstream interventions effectively avert hospital uncompensated care and stabilize insurance pools compared to traditional global budget allocations. Dr. Kromm confirmed that the formal MOU will be executed among the HSCRC, the MHBE, and other partner state agencies to establish clear reporting requirements, ensure financial transparency, and evaluate program effectiveness before any potential future funding is considered.

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

ITEM IX
DRAFT RECOMMENDATION: UPDATE TO THE ACCOUNTING AND BUDGET MANUAL

Mr. Wayne Nelms, Chief, Audit & Integrity presented the *Draft Recommendation: Update to the Accounting and Budget Manual* (see "*Draft Recommendation: Update to the Accounting and Budget Manual"* available on the HSCRC website).

Mr. Nelms presented the staff's Draft Recommendation to update the HSCRC Accounting and Budget Manual, noting that this systematic refresh overhauls the 1970s-era document to align with current CMS guidelines, HSCRC practices, and new data submission processes. The latest revisions update six sections to improve usability and streamline content, due in part to recent stakeholder workgroup discussions regarding Relative Value Units for Labor and Delivery rate centers. Mr. Nelms outlined the timeline for staff to receive public comments (through August 12, 2026), a formal review with the Division of Administrative, Executive, and Legislative Review (AELR) and publication in the Maryland Register. Staff plan to return for a final Commission vote in September to make the updates effective October 1, 2026.

Mr. Nelms presented the staff's recommendation as follows:

1. The revisions to the Accounting and Budget Manual to align with CMS guidelines and current HSCRC practices approved.

2. The revisions to the Accounting and Budget Manual will be effective October 1, 2026.

No action was taken on this agenda item.

FAREWELL

Dr. Jon Kromm opened by expressing personal and professional gratitude to Chairman Sharfstein, praising his friendship, mentorship, and years of dedicated public service to Maryland. Dr. Kromm then announced his own departure, as this was his final session as Executive Director after three years leading the agency. Reflecting on his tenure, he highlighted major structural milestones achieved alongside the Commissioners and state partners, including navigating two intensive negotiation rounds with federal regulators, establishing a sustainable transition framework for hospital global budgets under the AHEAD model, and significantly deepening inter-agency collaboration across Maryland's health and human services sector. Concluding his remarks, he expressed profound appreciation for the HSCRC staff, praising their extraordinary work ethic, intelligence, and integrity in managing a massive regulatory portfolio. He voiced total confidence in the agency's future under Deputy Executive Director William Henderson, who is stepping up as interim leader to guide the Commission through its upcoming

policy calendar, and offered a final note of thanks to all virtual stakeholders and system partners.
Commission Counsel Mr. Lustman paid tribute to both Dr. Jon Kromm and Chairman Sharfstein, expressing deep appreciation for Dr. Kromm, noting that staff look forward to celebrating his contributions further. Mr. Lustman commended Chairman Sharfstein for his uncompromising commitment to improving healthcare for Marylanders and praised with great admiration and respect his meticulous "obsession" with attention to detail.

In his closing remarks, Chairman Sharfstein commended Dr. Kromm for his impressive versatility and skill across the full spectrum of healthcare policy highlighting his ability to negotiate across multiple presidential administrations and balance policies ranging from cutting-edge high-tech care to expanding primary safety-net services. He noted that Dr. Kromm's unique, humble leadership style naturally brings people together, predicting that long after his departure, people will deeply appreciate his accomplishments and the legacy he leaves with his team.

ITEM X
HEARING AND MEETING SCHEDULE

September 9, 2026,	Time to be determined 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:35 P.M.

Closed Session Minutes
of the
Health Services Cost Review Commission
July 22, 2026

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103, §3-104 and §3-305(b)7 for the purpose of discussing the administration of the Model and receiving legal advice from Counsel.

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

The administrative session was called to order by motion at 12:05 p.m.

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

Joining on Zoom: Commissioner Maine.

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Claudine Williams, Christa Speicher, Cait Cooksey, Erin Schurmann, Laura Goodman, Jonathan Thornhill, Prudence Akindo and William Hoff.

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

Item I

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

Item II

Mr. William Henderson, Executive Deputy Director, updated the Commission, and the Commission discussed the TCOC model monitoring.

Item III

Mr. Henderson also updated the Commission, and the Commission discussed the FY26 Hospital Financial Condition through May 2026.

Item IV

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

The Closed Session was adjourned at 1:00 p.m.

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 9, 2026

maryland
health services
cost review commission

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:	2512
BALTIMORE, MARYLAND	*	PROCEEDING:	2702A

I. INTRODUCTION

On July 31, 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 Blue Cross and Blue Shield Association Blue Distinction Centers for Transplants (BDCT) for solid organ and bone marrow transplant services. The System requests that the Commission approve the arrangement for one year beginning September 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 between JHHC and the Hospital holds the Hospital harmless from any shortfalls in payment from the global

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the System's application for an alternative method of rate determination with Blue Cross Blue Shield Association Blue Distinction Centers for Transplants for solid organ and bone marrow transplant services for one-year beginning September 1, 2026. The System must file a renewal application annually for continued participation.

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

Final Staff Recommendation to Access HSCRC Confidential Patient Level Data from The Primary Care Coalition (Nexus Montgomery Regional Partnership, LLC)

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request from The Primary Care Coalition for access to the basic inpatient and outpatient confidential discharge data for Calendar Years 2021 through 2026 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

maryland
health services
cost review commission

Final Staff Recommendation for Access to the HSCRC Confidential Patient Level Data Request from The Primary Care Coalition (Nexus Montgomery Regional Partnership, LLC)

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a Final Recommendation for Commission consideration at the September 9, 2026 Public Commission Meeting.

SUMMARY STATEMENT

The Primary Care Coalition (PCC), on behalf of the Nexus Montgomery collaborative of six (6) Montgomery County hospitals, requests continued access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient and Outpatient) for Calendar Years **2021 through 2026**. Nexus Montgomery was originally formed under the FY 2016 Regional Partnership Implementation Grant and has since expanded into a multi-program, multi-hospital collaboration focused on reducing unnecessary hospital utilization, improving care coordination, supporting behavioral health crisis response, enhancing maternal health outcomes, strengthening skilled nursing facility (SNF) transitions, and addressing social determinants of health through coordinated community partnerships.

Access to HSCRC encounter-level data is critical for measuring utilization trends, evaluating program effectiveness, quantifying return on investment (ROI), monitoring risk-adjusted readmissions, assessing discharge patterns, analyzing length of stay and throughput, and identifying population-level needs across the six hospitals. The data enables Nexus Montgomery to collectively analyze patient utilization both within Nexus hospitals and across other Maryland hospitals, which is essential for evaluating program performance and meeting reporting obligations for hospital boards and funding partners.

The PCC has requested additional elements, including point of origin, ambulance run number, voluntary vs. involuntary psychiatric admission type, and arrival/discharge times that will allow more accurate stratification of behavioral health crisis encounters, improved SNF readmission analysis, alignment of emergency department (ED) overstay definitions with statewide standards, and enhanced maternal health outcome tracking.

The PCC will continue to receive, store, secure, analyze, and report HSCRC data under strict HIPAA compliance, with access restricted to approved PCC data personnel. All analyses will remain at the aggregate level and no data will be shared outside approved entities.

BACKGROUND

Nexus Montgomery is a long-standing collaborative of Holy Cross Hospital (Silver Spring), Holy Cross Germantown, Adventist White Oak Medical Center, Adventist Shady Grove Medical Center, MedStar Montgomery Medical Center, and Suburban Hospital. Through PCC's leadership, these hospitals coordinate population-level programs aimed at reducing avoidable utilization and improving care quality. Program areas include:

- Behavioral Health crisis diversion and coordination
- High Utilizer management
- Skilled Nursing Facility Alliance performance improvement
- Hard-to-Place inpatient and ED overstay interventions
- Social Health Alliance referrals and resource alignment
- Workforce development training
- Integrated Maternal Health Services coordination

Encounter-level HSCRC data allows PCC to:

- Track utilization patterns across all hospitals patients visit
- Monitor year-over-year trends
- Stratify outcomes by zip code, discharge disposition, hospital, and program participation
- Compare high utilizers to baseline populations

- Calculate risk-adjusted readmissions
- Assess ROI of interventions
- Identify barriers and opportunities for improvement
- Support hospitals in meeting HSCRC transformation and community health obligations

The public HSCRC data files lack the patient-level specificity required for stratification, linkage with program data sets, zip code-based analysis, and encounter-level trend monitoring, making the confidential datasets essential.

No program participant is contacted based on HSCRC data, and HSCRC data is not used for recruitment. Patients enter programs through standard hospital or community provider channels. All analysis is conducted using aggregate results to preserve confidentiality.

PCC maintains detailed HIPAA compliance protocols, restricted access controls, secure SharePoint storage with encrypted devices, Microsoft Intune authentication, annual HIPAA training, and NIST-compliant data destruction practices. Only three PCC staff members have access to HSCRC data.

The PCC received MDH Strategic Data Initiative (SDI) approval on August 3, 2026.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

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

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

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

STAFF RECOMMENDATION

1. The request from the Primary Care Coalition for access to the basic inpatient and outpatient confidential discharge data for Calendar Years 2021 through 2026 be approved.

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

HSCRC AHEAD Model Policy Timeline 2026-2027

maryland health services cost review commission

FY 2027 Policy Development Goals

Evolve HSCRC policies in a way that:

- Maintains affordability for non-Medicare payers
- Maintains core incentives of the policies
- Coordinates with CMMI-designed Medicare fee-for-service (FFS) global budgets
- Provides hospitals with guidance about revenue policies in sufficient detail to: a) provide line of sight to total revenue streams starting in January 1, 2028; and b) to allow operational and financial planning
- Establishes the paths available to hospitals in event of financial disruptions during the transition

Policy Development Guidelines

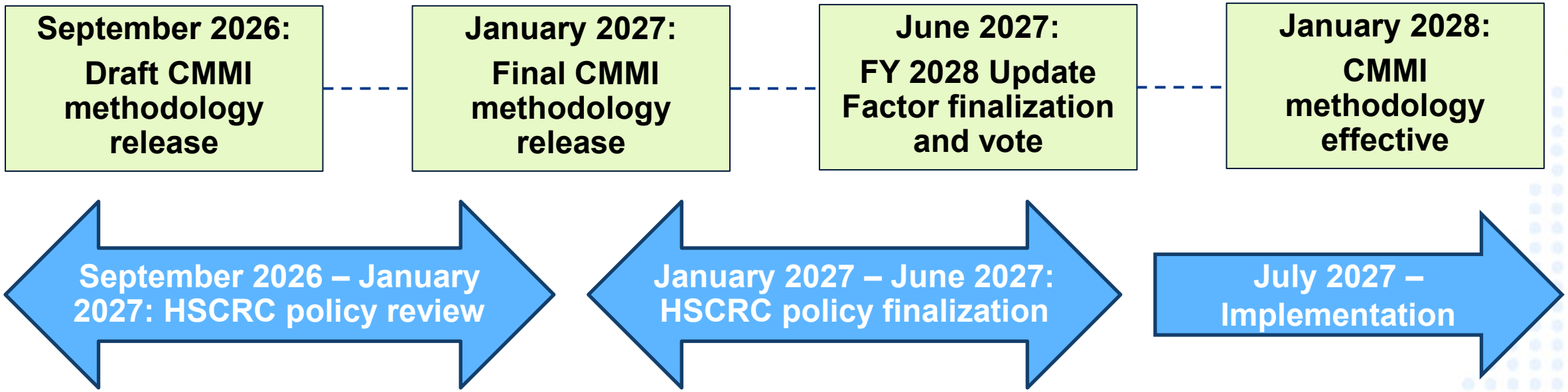
- Initially, the HSCRC approach will pursue incremental changes to HSCRC-managed policies. More substantive alterations will be pursued in the near term only where: 1) incremental change is not viable; or 2) there is consensus among hospitals, payers and the State that substantive change is necessary.
- HSCRC will align with CMMI policies where: 1) they are appropriate for populations under HSCRC hospital global budgets; 2) they align with the State's vision and goals for the health care system, as well as HSCRC's legislative mandate; and 3) the administrative cost of the transition to the CMMI approach is merited given the policy outcomes.
- As a result, the goal of the current workplan is to generate a 'Minimum Viable Product' for the bridge period and not a perfect end state. In the meantime, HSCRC will accumulate a list of ideas to incubate as the transition period progresses.

Policy Timeline 2026-2027: Looking AHEAD

Adjustments and Assessments	Funds and fees the support innovative partnerships, model operations and other state assessments
Financial Policies	Methodologies that inform the update factor
Quality Programs	Hospital quality initiatives that incentivize quality of care, in alignment with state and national priorities
Care Innovation	Initiatives that facilitate transformative programming to support hospital patients and communities
Model Operations	Review of HSCRC operational processes to ensure integration with new processes under the AHEAD Model
Multi-Agency and Legislative Initiatives	Policies that involve significant leadership outside HSCRC, with a role for HSCRC in policy development and implementation

Integrating with CMMI Timeline

HSCRC will manage its policy review and refinement activities in conjunction with ongoing changes in the CMMI methodology, *i.e.,* between the release of the draft and final Medicare FFS Hospital Global Budget methodology.



Calendar

Topic	Jul. 2026	Aug. 2026	Sept. 2026	Oct. 2026	Nov. 2026	Dec. 2026	Jan. 2027	Feb. 2027	Mar. 2027	Apr. 2027	May 2027	Jun. 2027
Strategy Discussions: Workplan and Quality												
Transition Support: Bridge Adjustment				D				F				
Assessments and Adjustments				R					R			UF
Core Volume Policies: Market Shift, Surge, Demographic					D			F				
Funding Appropriateness Policies: Full Rate, Integrated Efficiency, Capital						D		F				
Incremental Volume Policies: Repatriation, Out-of-State, Deregulation							D		F			
Carve-Outs (Drug and Service), PAU							D			F		
Quality: Quality Based Reimbursement and ED Best Practices				D		F						
Quality: Maryland Hospital Acquired Conditions					D		F					
Quality: Readmissions Reduction Program						D		F				
Quality: Potentially Avoidable Utilization												UF
HOPE Regional and Statewide Initiatives							F					
Care Innovation												
Model Operations												
Multi-Agency and Legislative												

Sept. 1st: CMMI HGB Draft Specifications

Jan. 15th: CMMI HGB Final Specifications

Model Operations

Description: Review of HSCRC operational processes to ensure integration with new processes under the AHEAD Model.

Topics and Timeline

- October-April: Data and Reporting *(Discerning the impact of the Medicare FFS transition on reporting)*
- September-June: Multi-Payer Global Budget Revenue *(Rate model mechanics and compliance for FY 2028 and forward)*
  - Rate Model Process
  - Rebase Volumes
  - Compliance
  - Cost-Shift Operationalization
  - FY 2028-Specific Issues
  - Administrative
- Ongoing: Medicare FFS Hospital Global Budget *(Coordination with CMMI)*
- Ongoing: Analyses and Evaluations *(Studies and reports generated outside of formal Commission policies)*

Stakeholder Engagement

- Biweekly meeting scheduled with Payment Models Workgroup starting September 10th
  - Ensures opportunities for stakeholder input
  - Will cancel if agenda is limited
- Meeting with other relevant stakeholder groups
- Potentially additional industry-level meetings with CMMI
- Calendar allows for additional comment and review time after draft workplans
- Open to other venues for stakeholder engagement

maryland
health services
cost review commission

Moving AHEAD Together: Future of Maryland Hospital Quality Programs

September HSCRC Commission Meeting

9/9/2026

Today's Discussion

- Background on Quality Programs
- AHEAD Quality Transition
- Future of Quality Programs
- RY 2029 Quality Priorities

Background

Hospital Quality Programs

The following are HSCRC's main quality payment incentive programs:

Maryland Hospital Acquired Conditions (MHAC) Program

Motivates hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

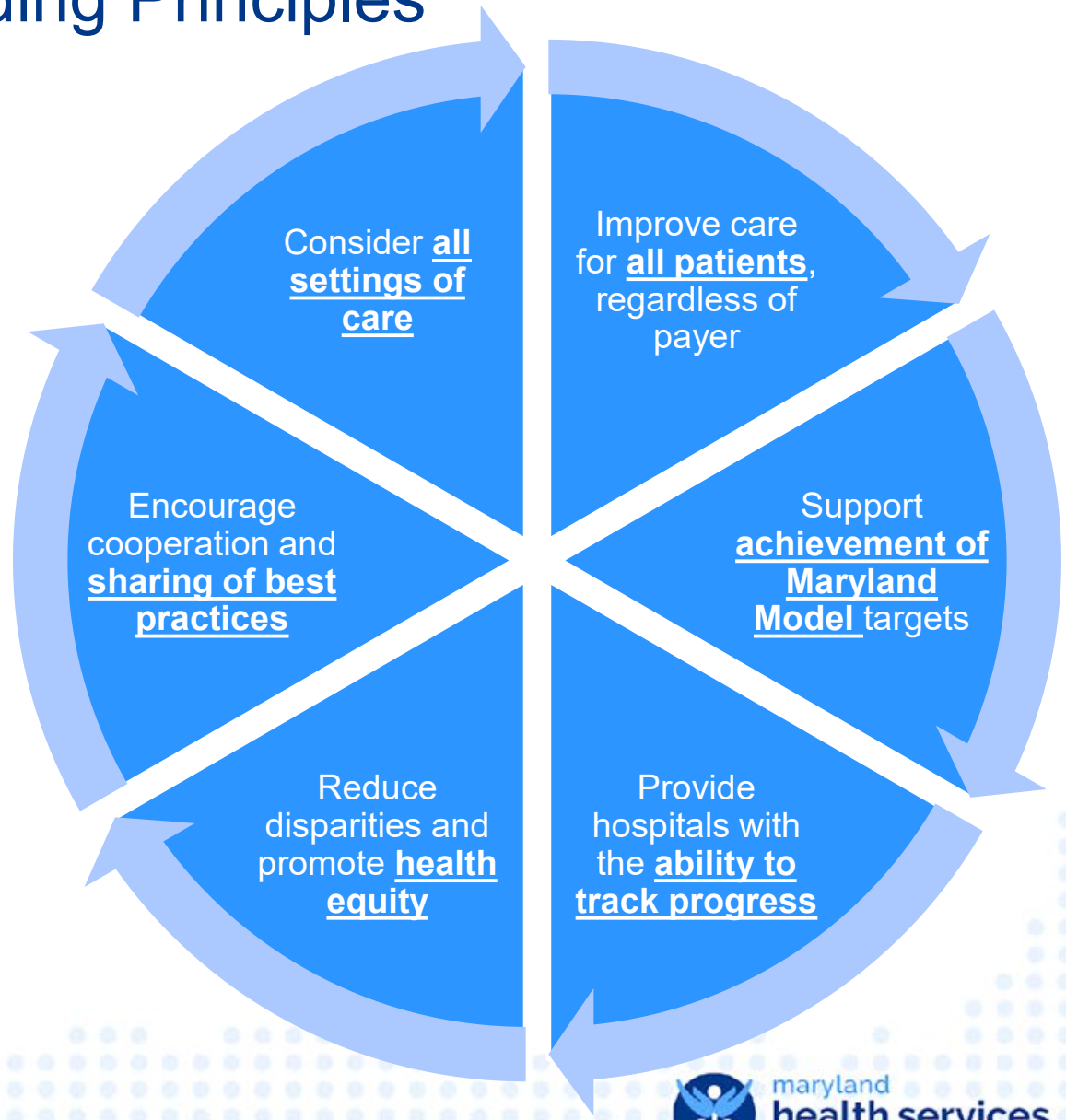
Since start of Model, Maryland has been granted waivers from CMS hospital quality programs through an annual exemption process. Waiver required the State:

- To implement hospital quality programs that used similar categories of quality measures
- To meet or exceed the revenue at-risk under the CMS quality programs on an all-payer basis (i.e., 6%).

HSCRC Quality Program Guiding Principles

The goal of the HSCRC Quality Programs is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.

The diagram includes differentiators from CMS and areas of importance to MD that inform decisions on program design. For example, “Encourage Cooperation and Sharing of Best Practices” is why programs do not relatively rank hospitals in the State.



Accomplishments & Lessons Learned

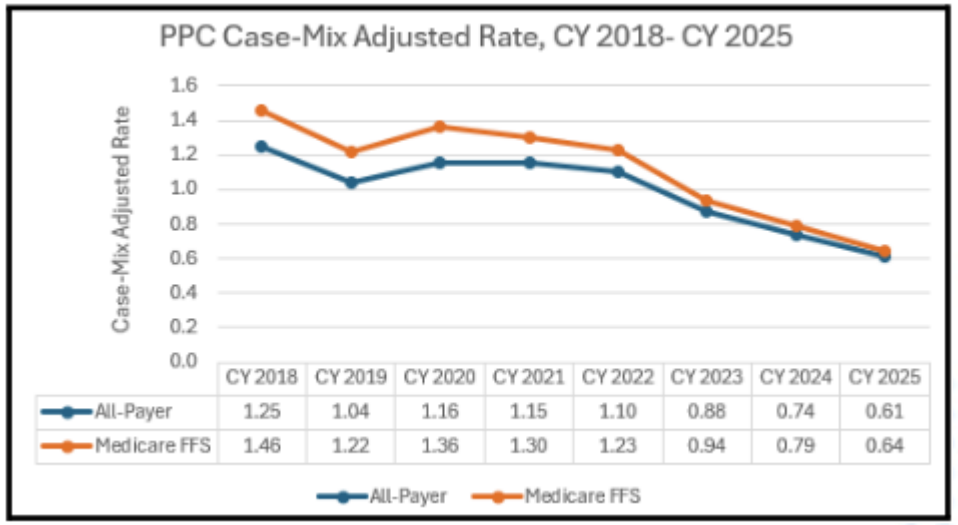
Over the course of the Maryland Model hospitals have:

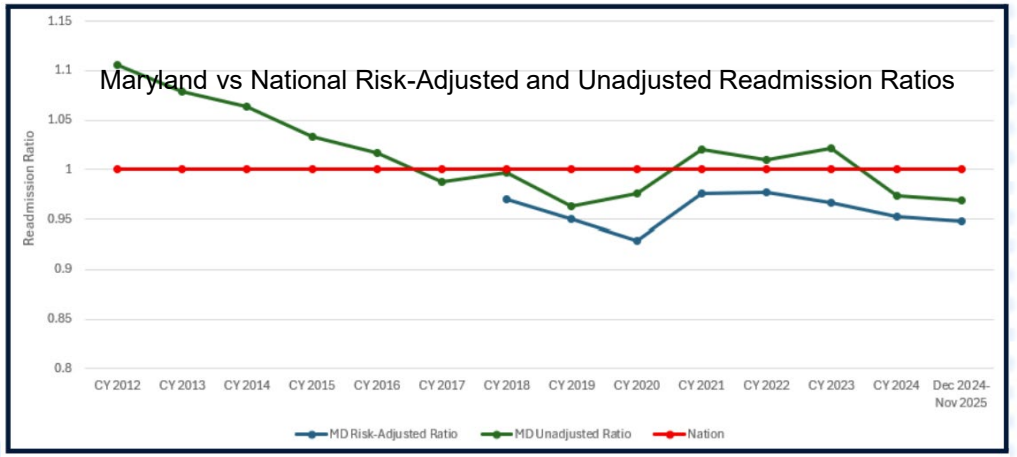
- Reduced readmission rates for All Payers, Medicare FFS and Medicaid FFS & MCO.
- Reduced hospital acquired complications as measured by PPCs and PSIs.
- Reduced avoidable admissions as measured by AHRQ PQIs.
- Met requirements for adjusting global budget revenue based on quality

Maryland continues to have opportunities to improve on:

- Patient experience
- Care Transitions
- ED and hospital throughput

Performance variability across hospitals indicates opportunities for further improvement and the value of collaboration.





AHEAD Quality Transition

AHEAD Quality Program Transition Timelines

- Medicare FFS global budgets start in CY 2028
- As allowed under the AHEAD Contract and based on stakeholder input, the HSCRC has informed CMMI of the State's preference to delay the transition to the CMS quality programs until CY 2030 (using CMS FFY2030 performance*)
  - This delay allows hospitals time to prepare for transition
  - For CY2028 and CY 2029, CMMI will implement revenue adjustments based on Maryland's all-payer quality programs
- Maryland may continue quality programs for non-Medicare FFS or Multi-Payer global budgets

*See Appendix slide for timeline of CMS performance periods based on the FY2030 transition

Future of Quality Programs

Maryland Hospital Quality Incentives under AHEAD

Medicare Fee-for-Service

CMS Quality Programs

- **Hospital Value Based Purchasing (HVBP)**
- **Hospital Acquired Conditions Reduction**
- **Hospital Readmission Reduction**

AHEAD Specific Incentives

- **Effectiveness Adjustment:** Revenue linked to unplanned readmissions, ED visits, and avoidable admissions
- **Community Improvement Bonus:** Focus on hospital-wide readmissions and avoidable admissions

Other Payers

Medicaid, Commercial, & Medicare Advantage

HSCRC Quality Programs

- **Quality Based Reimbursement (QBR)**
- **Maryland Hospital Acquired Conditions (MHAC) Program**
- **Readmission Reduction Incentive Program (RRIP)**
- **Potentially Avoidable Utilization (PAU)**

maryland health services cost review commission

Future of Quality Programs

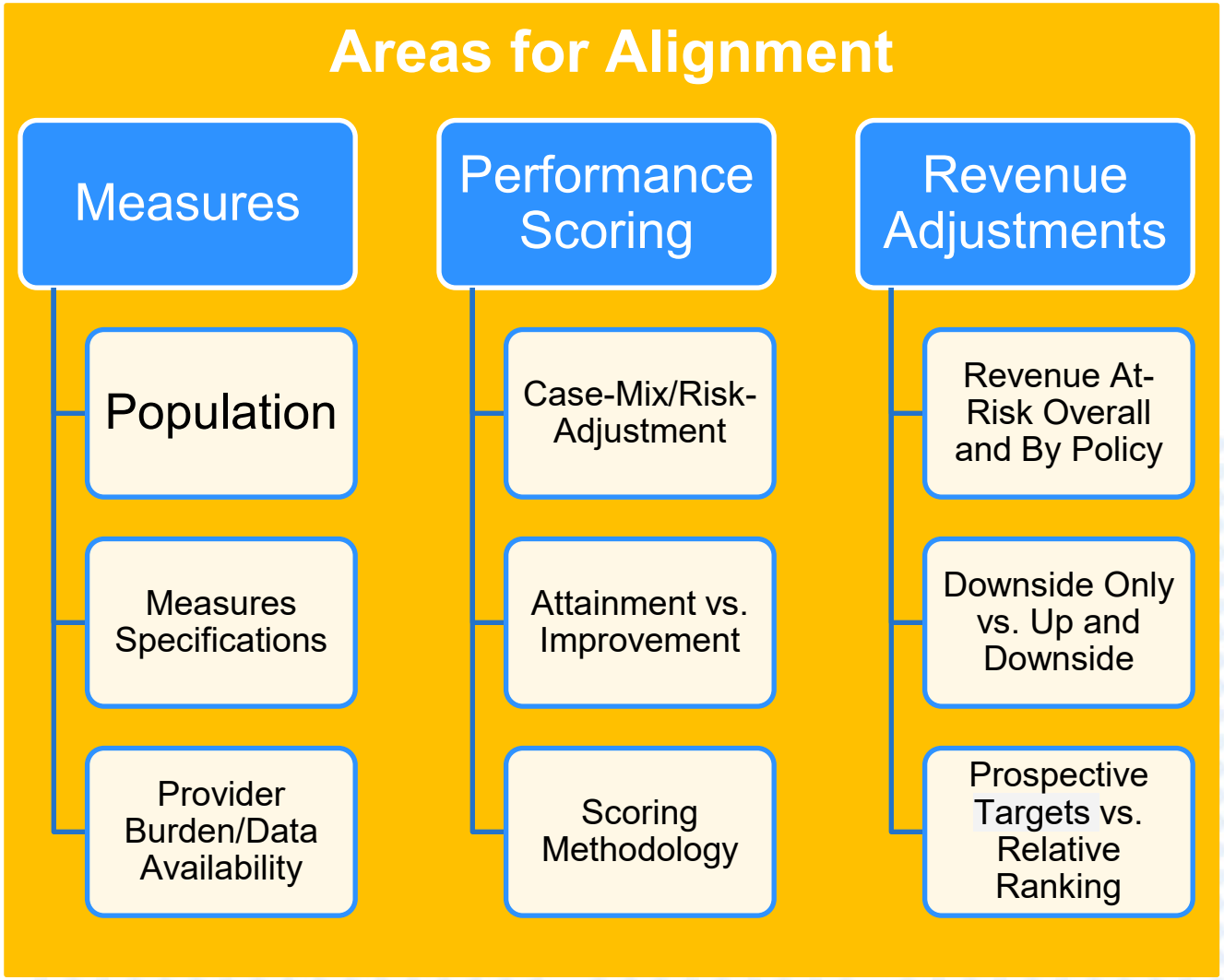
What Do We Mean By Alignment?

Alignment can be exact match or conceptual and focus on areas of quality and program design.

Industry Principles related to Alignment: (proposed by MHA at August PMWG, see Appendix for additional principles)

"Align with federal quality programs to reduce administrative burden, promote consistency, and focus hospital resources on patient care and improvement efforts"

"Limit downside financial risk to enable investment in efforts to preserve access to care and drive quality improvement"



Maryland vs. CMS Quality Program Alignment Continuum: Measures

Mapping quality measures from full national alignment to unique state measures

100% Aligned | Partial/Differing Logic | MD Specific

CMS Measures

HCAHPS, THA-TKA, Sepsis Bundle & NHSN HAIs

Complete alignment on measures, with minor timeline differences noted specifically for HCAHPS, Sepsis Bundle & NHSN HAI reporting.

≈20% of Revenue At-Risk

CMS Measure, All-Payer

Patient Safety Index

Applies to All-Payers in Maryland using AHRQ All-Payer risk adjustment parameters. CMS only tracks Medicare populations using Medicare specific risk-adjustment parameters

Conceptual Alignment

Mortality & Readmissions

Maryland uses All-Payer, all-condition measures. MD assesses both Inpatient and 30-day Mortality. CMS focuses on 30-day condition-specific outcomes for Medicare only.

Potentially Preventable Complications

Assesses in-hospital complications similar to PSI and NHSN HAIs used in CMS programs but uses a proprietary measure logic. Required by CMS under the All-Payer and TCOC Model.

≈75% of Revenue At-Risk

Maryland Only

ED LOS, Medicaid TFU & Avoidable Admissions*

These metrics are tracked exclusively under Maryland state initiatives; CMS quality programs do not utilize them.

*Avoidable Admissions aligns with AHEAD Model

≈5% of Revenue At-Risk

Some differences in measure weighting due to different components and efficiency measures in MD not included quality programs (included in other HSCRC methodologies)

Revenue At-Risk as a % of Total Revenue

- MD 6% upside and downside on all payer revenue
- CMS 2% upside and 6% downside on Medicare FFS revenue with varying exposure on other payers

Maryland vs. CMS Quality Program Alignment Continuum: Scoring

Mapping scoring methodologies from full national alignment to Maryland specific methodology

100% Aligned

Current Maryland

CMS Scoring

HVBP:

- Better of Improvement and attainment
- Retrospective standards
- Points: 0-10 per measure

HACRP:

- Attainment only
- Concurrent standards
- Winsorized z-scores

HRRP:

- Attainment only stratified by dual peer groups
- Concurrent standards
- Risk-adjusted excess readmissions (i.e., no credit for better performance)

Generally Aligned; ED LOS is improvement only

Not Aligned; Exploring alignment opportunities

Not Aligned; Staff recommend maintaining improvement

Maryland Scoring

QBR:

- Better of Improvement and attainment
- Retrospective standards
- Points: 0-10 per measure

MHAC:

- Attainment only
- Retrospective standards
- Points: 0-100

RRIP:

- Better of improvement or attainment
- Retrospective standards

Maryland vs. CMS Quality Program Alignment Continuum: Revenue Adjustments

100% Aligned

CMS Revenue Adjustments

HVBP:

- Relative ranking
- Rewards and penalties scaled up to 2%
- Revenue neutral

HACRP:

- Relative ranking
- Full 1% penalty for bottom quartile of hospitals

HRRP:

- Scaled penalties up to 3% for excess readmission for any of the conditions (e.g., FY26 >75% of hospitals had some penalty)

Should MD continue to align on total revenue at-risk (i.e., 6%)?

Should MD maintain rewards for MHAC and RRIP?

Should MD continue to prioritize the ability to track financial implications during performance period?

Current Maryland

Maryland Revenue Adjustments

QBR:

- Preset scale based on national data (i.e., not relatively ranked)
- Rewards and penalties scaled up to 2%

MHAC:

- Concurrent scale using state average as cut point
- Rewards and penalties scaled up to 2%

RRIP:

- Preset scales for improvement and attainment
- Rewards and penalties scaled up to 2%

RY 2029 Priorities

RY 2029 Quality Program Policy Timelines

Tentative Commission Meeting Timelines										
	September	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
QBR	**RY 2029 Quality Overview**	**Draft**		**Final**						
MHAC			**Draft**		**Final**					
RRIP				**Draft**		**Final**				
ED Best Practices**			**Draft**		**Final**	For stakeholder discussion: Transition from Monitoring Policy to Learning Collaborative				
PAU*									**Draft**	**Final**

*PAU is included in update factor policy; PMWG will need to discuss future PAU adjustment including potential alignment with AHEAD PAU measures (e.g., effectiveness adjustment)
**Based on PMWG/ED Subgroup and September Commission discussion: If transitioning to learning collaborative then draft and final policy may not be required

RY2029 Priorities

QBR

No major changes proposed

Continue ED LOS and Medicaid timely follow-up

MHAC

Consider removing PPCs from payment

Explore methodology alignment

Total amount at-risk

RRIP

Consider measure changes for alignment

Determine improvement and attainment goal

Best Practices

Sunset pay for reporting and develop learning collaborative to address ED and hospital throughput

Assist CMMI and industry with transition to CMS programs and AHEAD quality adjustments

Appendix

CMS Transition Timeline

Transition Timeline		Performance Year 1	Performance Year 2	Performance Year 3	Performance Year 4	Performance Year 5
CY --->	Policy	2025	2026	2027	2028	2029	2030
RY 2027	MHAC, RRIP, QBR, PAU	Performance Period (varies by measure)	All-Payer Revenue Adjustments				
RY 2028			Performance Period (varies by measure)	To Be Determined^			
RY 2029				Performance Period (varies by measure)	TBD Non-Medicare FFS HGBs^ / Medicare FFS HGBs		
RY 2030					Performance Period (varies by measure)	TBD Non-Medicare FFS HGBs^	
FY 2030	HVBP				HVBP PCE & Safety Domains*		Medicare Revenue Adjustments**
			HVBP Mortality Measures & THA-TKA Complications				
	HRRP			Medicare Condition Specific Readmissions			
	HACRP		CMS PSI-90				
				NHSN HAI			

*Efficiency domain is also on this timeframe. CMMI has indicated MD hospitals may not be measured on efficiency but this needs to be confirmed.

**CMS revenue adjustments for quality programs are implemented on FFY October-September timeframe. AHEAD revenue adjustments implemented on CY; awaiting final decision on whether the timeframe will be moved back one quarter or if multiple years will be averaged.

^Need to work with rate setting, CMMI, and stakeholders to figure out timeframe for RY vs. CY revenue adjustments

RY29 QUALITY POLICIES GUIDING PRINCIPLES

August 17, 2026

Maryland
Hospital Association

EMERGING PRINCIPLES FOR HSCRC QUALITY POLICIES

GOAL OF HSCRC QUALITY POLICIES

HSCRC'S quality policies must support hospitals in achieving success and optimizing performance in federal quality programs and position Maryland as a national leader in the AHEAD model

PRINCIPLES

- Provide adequate lead time to support successful transition and implementation
- Align with federal quality programs to reduce administrative burden, promote consistency, and focus hospital resources on patient care and improvement efforts
- Limit downside financial risk to enable investment in efforts to preserve access to care and drive quality improvement
- Focus incentives on encouraging the transition of care to lower-cost settings where appropriate
- Account for broader policy, market, and other factors that influence performance, including patient acuity, social risks, behavioral health access, and payer-driven utilization of observation stays

EMERGING STANDARD FOR HSCRC HAVING DIFFERENT QUALITY MEASURES

OVERARCHING REQUIREMENTS FOR CONTINUATION OR ADOPTION OF NON-ALIGNED MEASURES

To support hospital success in CMS quality programs and the AHEAD Model, a non-aligned measure must advance a compelling State quality objective that is not addressed by a CMS quality program measure and be narrowly tailored to achieve the objective

SPECIFIC REQUIREMENTS

- **Evidence-Based and Clinically Meaningful Outcomes –** measure must address demonstrated performance gap and be supported by evidence that it improves patient outcomes, safety, and care delivery and access, rather than incentivizing documentation, coding optimization, or process compliance alone
- **Administrative Simplicity –** measure must leverage existing data sources, prioritize electronic reporting, and minimize unnecessary reporting requirements and operational burden
- **Validation and Testing –** measure must be subject to monitoring and validation periods before being tied to financial incentives or penalties to assess feasibility, reliability, and unintended consequences
- **Ongoing Evaluation –** measure must be periodically reassessed and retired when it no longer demonstrates value, effectiveness, or addresses an ongoing need
- **Transparency and Stakeholder Engagement –** selection or continuation of measure must allow a standardized and transparent process with stakeholder input

maryland
health services
cost review commission

Episode Quality Improvement Program – PY4 Results

HSCRC Commission Mtg

9/9/2026

Partnership HSCRC, CRISP, & MedChi

maryland
health services
cost review commission

HSCRC, CRISP & MedChi Partnership

- **HSCRC**
- **Policy & Program Sponsor**
  - Establishes value-based care strategy
  - Designs program requirements and incentives
  - Sets performance measures and methodologies
  - Evaluates outcomes and cost savings.

- **CRISP**
- **Program Administrator & Data Infrastructure**
  - Operates Maryland's HIE infrastructure
  - Administers statewide programs
  - Provides analytics, reporting, and performance dashboards
  - Supports Practitioner onboarding and program operations
  - Manages tools such as the EQIP Enrollment Portal (EEP)

- **MedChi, The Maryland State Medical Society**
- **Physician Recruitment, Education & Ongoing Support**
  - Recruits physician participation
  - Provides education and ongoing support
  - Hosts practitioner workgroups and information sessions

Quality Payment Program (QPP) Update

maryland
health services
cost review commission

QPP Incentive Payment Issue and Resolution

Background

- During performance year 2 (PY2), there was an issue with the processing of Qualifying Practitioners (QP) determinations and incentive payments.
- As a result, some eligible practitioners:
  - Did **not** receive their QPP incentive payment, and/or
  - Were incorrectly assessed a Merit-Based Incentive Payment System (MIPS) penalty.

CMS Action

- CMS agreed to remove MIPS penalties associated with the error.

HSCRC Action

- HSCRC is establishing a process for Practitioners and entities to apply for compensation for missed QPP incentive payments.
- Eligible Practitioners impacted by the error may receive an estimated payment based on available data.

HSCRC QPP Application and Payment

Fall 2026: Application Period Opens

- Entities submit applications on behalf of affected practitioners
- Applicants must provide supporting documentation demonstrating eligibility for the PY2 payment
- CRISP/HSCRC reviews and vets each application
- Eligibility and payment amounts verified
- All applications must be submitted by the established year-end deadline

CY 2027: Payment Distribution

- Approved applications will be forwarded for payment processing to eligible practitioners

EQIP PY4 (CY 2025) Results

maryland
health services
cost review commission

EQIP PY4 Program Growth Highlights

- **New Episodes Added:**
  - **4 new** episodes in PY4
- **Entity Participation:**
  - **52 new entities** in PY4, bringing total participation to **128 entities**
  - **76 entities** carried over from PY3
- **Episode Volume:**
  - PY4: **158,698 episodes** (+10% vs. PY3's 144,260 episodes)

EQIP PY3 vs. PY4 Performance Highlights

- **Positive Savings Generated:**
  - PY4: **96.3M** (+58.4% vs PY3's $60.8M)
- **Entities Achieving Shared Savings:**
  - PY4: **97 of 128 entities (75%)** met performance thresholds
  - PY3: **67 of 117 entities (57%)** met performance thresholds
- **Net Distribution to Entities:**
  - PY4: **$35.8.1M**
  - PY3: **$29.1M**
- **Program Guardrail:**
  - A **3% minimum savings rate** is required to ensure statistically significant savings before payouts occur.

**Numbers are considered preliminary*

Breakout Year for Savings in PY4

$96.3M +58% YoY

Savings generated

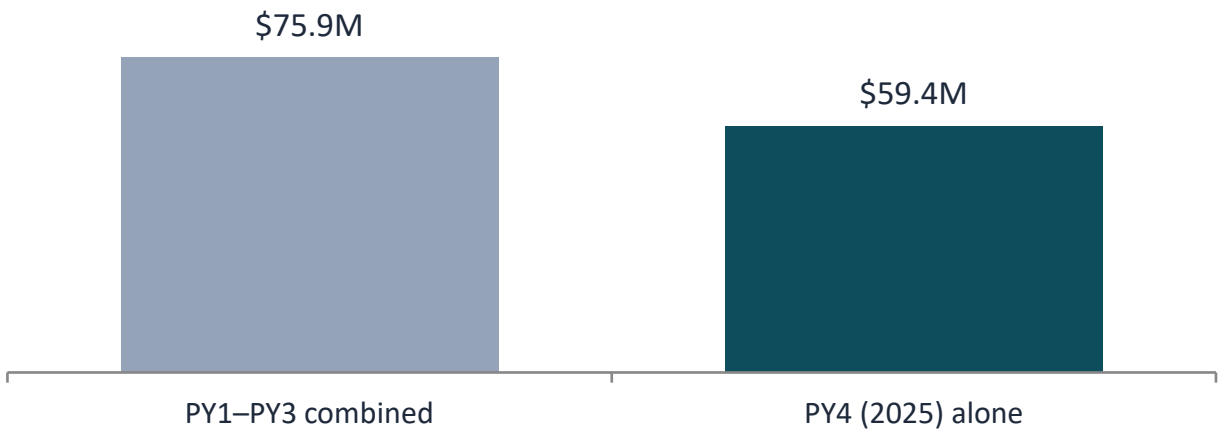
$59.4M +49% YoY

Shared savings (MST + Shared Savings Tiers)

$35.8M +23% YoY

Distributed to participants (after Quality and CAP Adjustments)

Shared savings: prior three years combined vs PY4 alone ($M)



Why this matters

The program is growing fast. In PY4 it generated **44% of all shared savings in program history**

75% of entities received shared savings in PY4

maryland health services cost review commission

PROGRAM STATUS REPORT

Four years of reconciled results

$2.15B

Medicare Expenditures running through program episodes

Across 4 program years

$214M

Total savings generated

Entities that finished better than their target price

$135M

Shared savings

MST and shared savings tier

$97M

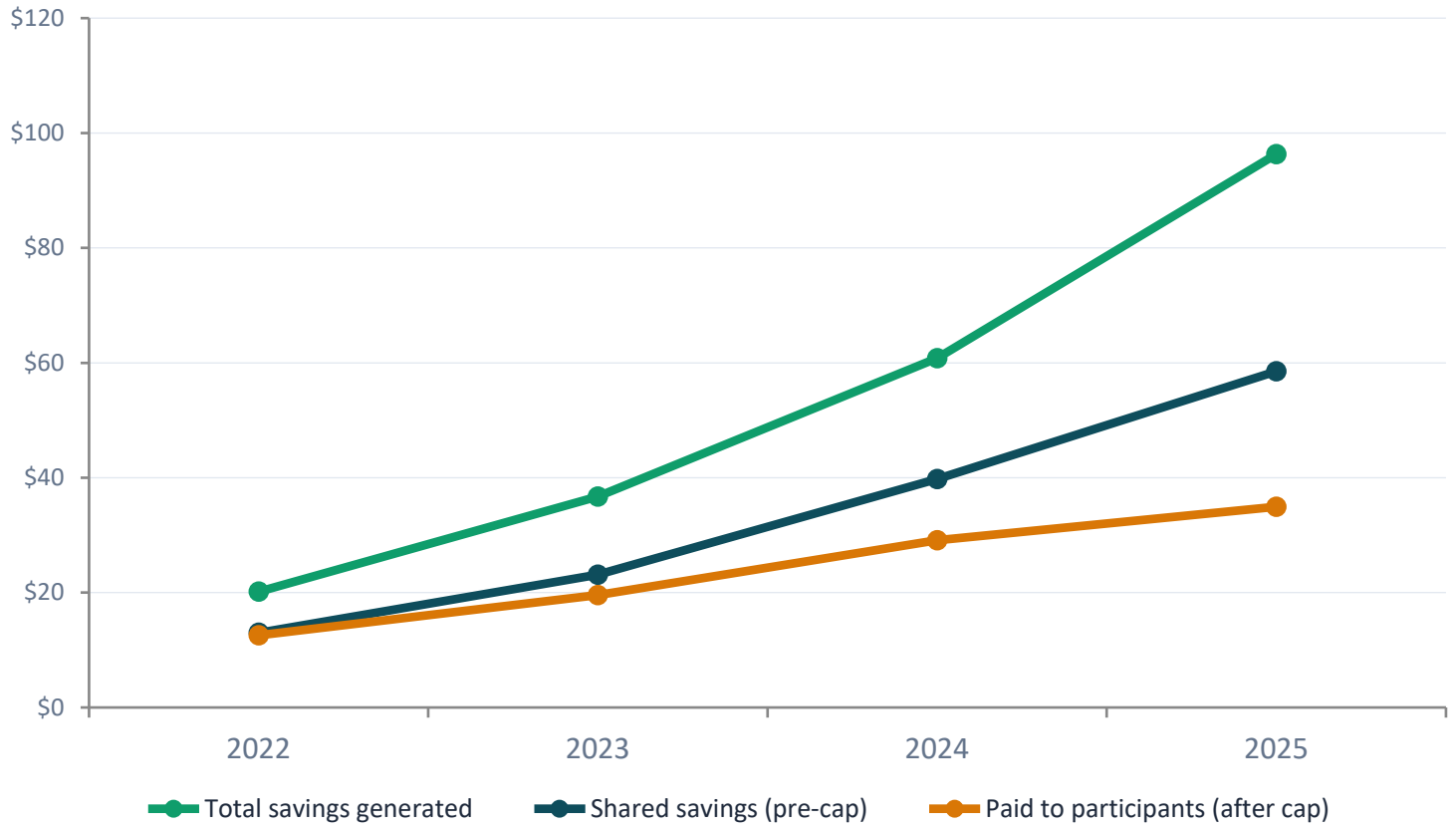
Paid to participants

Quality adjustment and 25% cap

Savings are scaling fast — shared savings grew from $13.0M to $59.4M in four years, and the program now generates 15¢ of savings for every dollar of spend it touches (up from 5¢).

maryland health services cost review commission

Year Over Year Results



Since PY1, total program savings have grown nearly five-fold, increasing from 20.15M to $96.32M (378% growth)

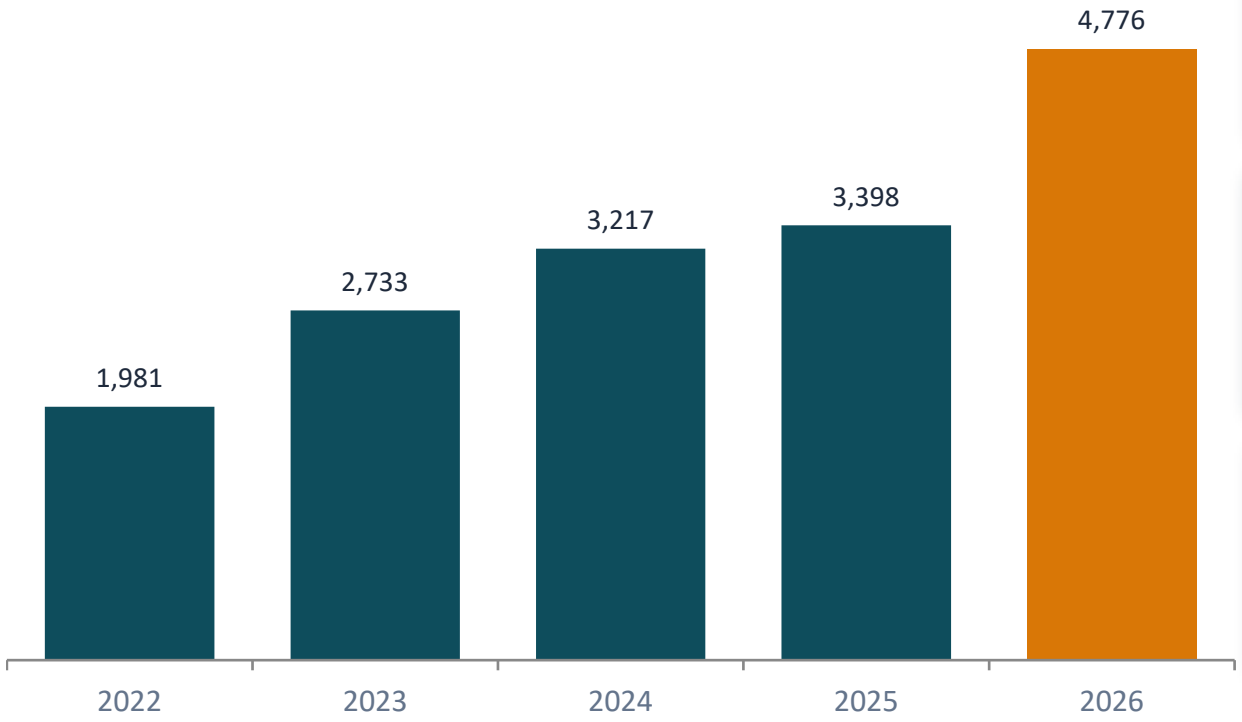
Savings generated is climbing about **$25M a year**; the amount paid to participants only about **$8M a year.**

The widening gap is caused by the practitioner's maximum incentive

Earned savings above **25% of an entity's Part B collections** can't be paid out per program policy. As savings outpace that Part B base, a growing share is left at the ceiling each year

maryland health services cost review commission

Year Over Year Scaling



Participating Care partners by year

50 → 128 → 205

EQIP Entities (2022 → 2025 → 2026)

22 → 66 → 123

Unique episode categories offered
(2022 → 2025 → 2026)

3.5% → 4.5% → 5.7% → 5.1%

Share of MD Part A+B expenditures touched by EQIP
(2022 → 2023 → 2024 → 2025)

maryland health services cost review commission

Assessment and Next Steps

maryland
health services
cost review commission

Overall Assessment & Next Steps

- **Program Year 5 (CY2026):**
  - 205 Participating Entities
  - 123 Episodes
  - 39 Specialties
  - 5141 Participating Care Practitioners
- **Program Year 6 (CY2027):**
  - 261 Entities applied for PY6
  - 144 Episodes
  - 40 Specialties (adding Gynecology)
  - 7853 Care partners submitted; pending CMS vetting and contract execution.
- **Program Year 7 (CY2028):**
  - EQIP and MedChi will begin engaging participants and stakeholders to evaluate opportunities for expanding the program through the addition of new episode categories in PY7 (CY2028).

PY5 Quality Measure Update: Maintaining Advanced APM Status

CMS Requirement for PY5

To maintain EQIP's Advanced Alternative Payment Model (APM) status, CMS required the program to add the All-Cause Hospital-Wide Readmission Measure beginning in PY5

IMPACT

- Quality measure portfolio expanded from **3 to 4 measures**
- Aligns EQIP with CMS quality reporting expectations
- Reinforces accountability for care quality and patient outcomes across the continuum of care

EQIP Quality Measure Portfolio (PY5)

Measure	MIPs Measure #
Advanced Care Plan	MIPS #047
Documentation of Current Medications in the Medical Record	MIPS #130
Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-up	MIPS #128
2026 All Cause Hospital-Wide Readmission Measure (HWR)	MIPS #479

Practice Transformation Grant (PTG) Program

- **What is The Practice Transformation Grant (PTG) Program?**
  - The Practice Transformation Grant (PTG) program was created to help EQIP participants that have not yet achieved desired performance outcomes build the capabilities needed to succeed in value-based care. Through financial support, analytics, workflow improvement, EHR optimization, care management, and coaching, PTG helps practices transform care delivery, improve patient outcomes, and reduce the total cost of care
  - **PTG helps practices:**
    - Build practice transformation capabilities
    - Improve quality and patient outcomes
    - Strengthen care management and operational processes
    - Reduce avoidable healthcare costs
    - Succeed under EQIP and value-based care models

EQIP Practice Transformation Grant (PTG) Program Update

Positive Participant Feedback

- In June, HSCRC surveyed participating entities regarding their experience with the Practice Transformation Grant (PTG) program.
- Responses were overwhelmingly positive, indicating that participating practices continue to find value in the support, resources, and transformation activities provided through PTG.

Early Program Observations

- Positive impact observed on participant quality measure performance
- Practice report meaningful benefits from participation and transformation efforts
- Impact on Shared savings and overall financial performance is still being evaluated.

Looking Ahead

- HSCRC remains interested in continuing practice transformation
- Future program modifications are being explored to:
  - Enhance effectiveness;
  - Increase scalability; and
  - Broaden Participation across additional Practitioners and practices.

MedChi's Partnership

maryland
health services
cost review commission

MedChi's Role in EQIP

Recruitment	Education	Technical Assistance	Ongoing Administrative Support	Program and Episode Development	EQIP Subgroup Committee
Increase practitioner participation in EQIP	Build participant understanding and readiness	Help participants navigate requirements and overcome challenges	Maintain engagement and provide continued program support	Represent and protect physician interest in program updates and episode development	Increase collaboration and engagement among EQIP stakeholders

MedChi Recruitment and Enrollment Summary

During recruitment for Performance Year 6 (Calendar Year 2027), MedChi assisted prospective and returning organizations with EQIP enrollment.

Overall Snapshot:

Total Organizations Reached	181
Total Organizations Enrolled	145
Enrollment Rate	80.1%

Prospect Statistics:

Total Active Prospects	77
Total Enrolled Prospects	49
Enrollment Rate	63.6%

Returning Organization Statistics:

Total Returning Organizations	104
Total Returning Organizations Enrolled	104
Enrollment Rate	100%

MedChi EQIP Entities

A MedChi Entity allows participating practitioners to enroll in EQIP as part of a group, while MedChi manages the entity's administrative responsibilities, including setup, maintenance, and program communications.

MedChi Entity Statistics:

PY3 (CY2024):	PY4(CY2025):	PY5(CY2026):	PY6(CY2027)*:	Growth Since 2024
8 entities consisting of;	**8 entities** consisting of;	**9 entities** consisting of;	**13 entities** consisting of;	***62.5%*** in entities
57 organizations and;	**66 organizations** and;	**67 organizations** and;	**101 organizations** and;	***77.2%*** in organizations
114 practitioners.	**150 practitioners**.	**147 practitioners**.	**259 practitioners**.	***127.2%*** in practitioners

**PY6 numbers are preliminary and subject to change pending final CMS vetting, auditing, and contracting processes.*

Additional Administrative Support

In addition to managing the MedChi Entities, MedChi also offers administrative support to all EQIP entities regardless of their size or affiliation.

MedChi can also be designated as a direct Administrative Proxy to EQIP Entities upon request.

MedChi Administrative Proxy Statistics:

PY3 (CY2024):	PY4(CY2025):	PY5(CY2026):	PY6(CY2027)*:	Growth Since 2024
1 entity	**8 entities**	**33 entities**	**41 entities**	***4,000%*** growth in MedChi-administered entities

**PY6 numbers are preliminary and subject to change pending final CMS vetting, auditing, and contracting processes.*

MedChi Practice Testimonials

"Olivia and the entire MedChi team have been invaluable to our organization's success in EQIP. They [the MedChi EQIP team] are subject-matter experts in the program, and we have appreciated their support throughout enrollment, roster development, and management of the program's performance requirements."

Josh Hollander
Director of Value-Based Care, Clearway Pain Solutions

"Working with the MedChi EQIP team has been the sole reason we have been able to participate in Medicare meaningful use programs. The entire team has been extremely accessible and always quick to provide meaningful support. I can't endorse their [the MedChi EQIP team's] efforts highly enough."

Manav Singla, MD
Physician, Allergy Asthma Specialists of Maryland

"My MedChi EQIP team has been integral to my practice's success with this program. They [the MedChi EQIP team] are always available and responsive to my questions. They [the MedChi EQIP team] have a strong understanding of the program and guide me toward the appropriate resources. Being part of EQIP enhances the quality of patient care while still generating shared savings. Joining the EQIP program has been a good decision for my practice."

Bhawna Bahethi, MD
Physician

"Working with Olivia and her team at MedChi has been an exceptional experience. From the very beginning, they [the MedChi EQIP team] were knowledgeable, supportive, and genuinely invested in making the process as smooth as possible. What initially felt like a daunting and overwhelming journey quickly became simple and manageable thanks to their [the MedChi EQIP team's] clear guidance, responsiveness, and expertise. Their [the MedChi EQIP team's] team made a lasting positive impression, and I would recommend them [the MedChi EQIP team] to anyone seeking to join the program."

Anu Sharma, MD
Rheumatologist, Center for Rheumatic Diseases and Osteoporosis

maryland
health services
cost review commission

RY2027 Update Factor:
AHEAD Funding Distribution Recommendation

September 9, 2026

$50m AHEAD Funding Allocation Call for Comments

1. How should AHEAD transition funds be allocated among the following options?
    - a) Funds should be allocated according to revenue by hospital as this is the simplest methodology.
    - b) Funds should be allocated in a way that favors smaller non-system hospitals as (a) these hospitals do not benefit from the economies of scale of larger systems and (b) many transition costs are fixed regardless of hospital size and therefore should not be allocated based on size. Under this approach Staff could set a per hospital amount or cap the size of the global budget eligible for allocation at a hospital or system level (e.g. systems of size greater than X are treated as size X).
    - c) Some amount of funding should be segregated and provided to a neutral service provider such as CRISP or MHA to procure shared technical support for all hospitals. This approach would prevent duplicative cost across hospitals and allow for the industry to leverage a common best-in-class solution for common needs but would add complexity to distributing and accessing the funding.
2. Are there specific approaches to any of items 1a to 1c the commenter would recommend?
3. What level of accountability should be required of hospitals to demonstrate the funding was being used responsibly and for the purposes it was intended? Options could range from a short report from management on the use of funds to detailed cost reporting with auditing of reported amounts. As required activities move along that continuum the level of accountability increases but so does the administrative burden on hospitals and Staff.

Recommendation

Staff believe the recommended solution balances simplicity against fairness. Establishing a per-hospital base provides greater resources to smaller hospitals without need for a more complex analysis. A simple attestation provides the Commission with some insight into spending without costly audit or review procedures that would drain industry and staff resources during the critical AHEAD transition.

1. A $500,000 fixed cost element awarded to all acute care hospitals totaling $21.5 million. Staff believe there is a fixed cost element to AHEAD preparation regardless of the size and scale of each facility.
2. The remaining $28.5 million allocated based on Gross Patient Revenue of each facility.
3. Freestanding Medical Facilities and Shock Trauma revenues are included in their parent facility (see specific list later in this recommendation).
4. Each hospital will be required to submit an attestation, signed by the CFO, by July 31 following each of RY2027 and RY2028 enumerating how these funds were used during the year and a brief description of each item. Systems may submit a single attestation.

Appendix: Stakeholder Comments

AHEAD Comment Letters Received

Letters were received from:

1. Christiana Care
2. Maryland Citizens' Health Initiative (MCHI)/Healthcare For All
3. University of Maryland Medical System (UMMS)
4. League of Life & Health Insurers of Maryland
5. Maryland Hospital Association (MHA)
6. United States of Care
7. Mercy Medical Center
8. Frederick Health
9. LifeBridge Health
10. Luminis Health
11. Adventist HealthCare
12. MedStar Health
13. Kaiser Permanente
14. Johns Hopkins Health System (JHHS)
15. Health Means Everything (HME)
16. Garrett Regional Medical Center

Comments generally focused on 6 areas:

1. Opposition to Revenue-Based Allocation
2. Simple Revenue-Based Allocation
3. Blended or Tiered Revenue Base approach
4. Shared Services Set Aside
5. Oversight
6. Adequacy of $50 million in Funding

1. Opposition to Revenue-Based Allocation

- Needs-Based/Gap-Focused: The League of Life and Health Insurers of Maryland and Kaiser Permanente oppose revenue-based allocations, arguing that revenue is a poor proxy for readiness need. They advocate for assessments based on identified readiness gaps. Similarly, Health Means Everything (HME) and USofCare urge the Commission to weight funds toward smaller, non-system, and rural hospitals, incorporating factors like uncompensated care burdens and payer mix.

  HSCRC Response: This funding is one-time funding. Staff appreciate the comments to provide this based on need, however, creating an allocation based on need or readiness would add additional complexities to one-time funding. Our updated proposed allocation approach provide a $500k portion of fixed funding to all hospitals. FMFs/FSEs/STC have been included in their parent facility.

2. Simple Revenue-Based Allocation

- LifeBridge Health, Mercy Medical Center,Frederick Health and UMMS, argue that an allocation based on hospital revenue is the most simple and transparent approach. They note that readiness investments—such as coding staff, MS-DRG transitions, and software—correlate strongly with hospital size and volume.

HSCRC Response: Staff typically agree with this notion. However, believe that there is likely a fixed cost element associated with this transition. As a result, staff have updated the allocation to include a fixed value for each hospital and allocate the remainder based on revenue.

3. Blended or Tiered Approaches

- Many organizations advocate for hybrid models to address the unique needs of smaller or independent facilities that lack the economies of scale enjoyed by larger systems.
    - Adventist HealthCare recommends a blend of 80% revenue-based and 20% based on "days cash on hand" to direct more support to hospitals with less capacity to self-fund
    - ChristianaCare, Johns Hopkins Health System (JHHS), Luminis Health, and the MHA propose a two-tiered structure combining a fixed base amount for all hospitals (to offset fixed costs) with a variable component (based on GBR or size).
    - Garrett Regional Medical Center explicitly recommends a three-part methodology: 25% base, 50% volume/size, and 25% rural/special population adjustment.

HSCRC Response:Staff appreciate the comments and ideas we received on a hybrid or two tiered approach. Staff have updated the allocation to include $500k fixed portion and the remainder is allocated based on revenue.

4. Shared Services Set Aside

- MHA, JHHS, and the Maryland Citizens' Health Initiative (MCHI) support reserving a portion of funds for shared technical assistance to reduce duplicative efforts across the state.
- Adventist HealthCare, Frederick Health, Luminis Health, and MedStar Health oppose shared services arguing that transition needs are highly hospital-specific and that centralized procurement would create unnecessary complexity and delay.

HSCRC Response: While a technical assistance fund would have some benefit, given the short time window and amount involved Staff did not believe the added complexity involved was merited.

5. Oversight of Reporting

- LifeBridge, MedStar, Mercy, UMMS, and JHHS, advocate for streamlined accountability, such as a brief management report or executive attestation. They argue that rigorous reporting would impose an administrative burden disproportionate to the funding amount.
- League, Kaiser Permanente, USofCare, and MCHI argue for strict fiscal oversight, including itemized budgets, implementation plans, and authority for the HSCRC to recoup unused or misused funds. HME recommends a proportionate approach that requires detailed cost reporting only above a certain dollar threshold and includes consumer-facing measures regarding affordability and patient experience.

  HSCRC Response: Staff believe that a breakdown of cost reporting with a CFO attestation would be appropriate level of oversight for this one-time funding. Staff appreciate the comments received supporting strict oversight,

6. Adequacy of $50 million

- The MHA emphasizes that transitioning to separate payment systems for Medicare and Medicaid and commercial payers will require significant resources. They note that the necessary investments will exceed the current $50 million and urge HSCRC to increase the funding amount.
- League of Life & Health Insurers of Maryland and Kaiser Permanente stated the oppose adding the $50 million to hospital rates outside the standard rate-development process.

HSCRC Response: This funding was a Commissioner approved amendment to the Rate Year 2027 Update Factor Recommendation voted and approved on June 10, 2026.

Staff do not agree with providing additional funding for this transition. This funding is one-time and will be provided to hospitals in RY 2027 and RY 2026. Staff also do not agree with providing additional funding outside of the 'official' Update Factor review and process.

maryland
health services
cost review commission

maryland
health services
cost review commission

Final Recommendation on AHEAD Funding Allocation:

RY 2027 Update Factor

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

Table of Contents

Overview

As part of the Update Factor Recommendation on June 10, 2026, the following Amendments to the staff's Final Recommendation were approved:

1. Increase the Update Factor by $50 million to provide targeted funding to hospitals to assist with AHEAD readiness.
    - Under this proposal, the $50 million would be built into rates for both Rate Years 2027 and 2028, with a formal evaluation scheduled at the end of Rate Year 2027 to ensure the money is being spent as intended.
2. Directs staff to develop and present a plan to the Commissioners in September detailing the specific criteria and distribution methods for this funding, aiming to prioritize transparency, accountability, and the reduction of duplicative operational efforts while allowing an opportunity for public comment.

Staff requested comments from stakeholders on the second item. This recommendation outlines the comments we received and Staff's proposed recommendation.

Call for Comments

Staff's public notice and call for comments included the following:

1. How should AHEAD transition funds be allocated among the following options?
    - a) Funds should be allocated according to revenue by hospital as this is the simplest methodology.
    - b) Funds should be allocated in a way that favors smaller non-system hospitals as (a) these hospitals do not benefit from the economies of scale of larger systems and (b) many transition costs are fixed regardless of hospital size and therefore should not be allocated based on size. Under this approach Staff could set a per hospital amount or cap the size of the global budget eligible for allocation at a hospital or system level (e.g. systems of size greater than X are treated as size X).
    - c) Some amount of funding should be segregated and provided to a neutral service provider such as CRISP or MHA to procure shared technical support for all hospitals. This approach would prevent duplicative cost across hospitals and allow for the industry to leverage a common best-in-class solution for common needs but would add complexity to distributing and accessing the funding.
2. Are there specific approaches to any of items 1a to 1c the commenter would recommend?
3. What level of accountability should be required of hospitals to demonstrate the funding was being used responsibly and for the purposes it was intended? Options could range from a short report from management on the use of funds to detailed cost reporting with

auditing of reported amounts. As required activities move along that continuum the level of accountability increases but so does the administrative burden on hospitals and Staff.

Recommendations

Staff reviewed public comments as discussed below and are recommending the following allocation for one-time funding in RY 2027 and RY 2028.

1. A $500,000 fixed cost element awarded to all acute care hospitals totaling $21.5 million. Staff believe there is a fixed cost element to AHEAD preparation regardless of the size and scale of each facility.
2. The remaining $28.5 million allocated based on Gross Patient Revenue of each facility.
3. Freestanding Medical Facilities and Shock Trauma revenues are included in their parent facility (see specific list later in this recommendation).
4. Each hospital will be required to submit an attestation, signed by the CFO, by July 31 following each of RY2027 and RY2028 enumerating how these funds were used during the year and a brief description of each item. Systems may submit a single attestation.

Staff believe the recommended solution balances simplicity against fairness. Establishing a per-hospital base provides greater resources to smaller hospitals without need for a more complex analysis. A simple attestation provides the Commission with some insight into spending without costly audit or review procedures that would drain industry and staff resources during the critical AHEAD transition.

Stakeholder Comments

HSCRC Staff received 16 public comment letters. These comment focus areas are noted below and include Staff's responses in italics.

1. Opposition to a Revenue-Based Allocation

   The League of Life and Health Insurers of Maryland and Kaiser Permanente oppose revenue-based allocations, arguing that revenue is a poor proxy for readiness need. They advocate for assessments based on identified readiness gaps. Similarly, Health Means Everything (HME) and USofCare urge the Commission to weight funds toward smaller, non-system, and rural hospitals, incorporating factors like uncompensated care burdens and payer mix.

   HSCRC Response: This funding is one-time funding. Staff appreciate the comments to provide this based on need, however, creating an allocation based on need or readiness would add additional complexities to one-time funding. Our updated proposed allocation approach provide a $500k portion of fixed funding to all hospitals. FMFs/FSEs/STC have

been included in their parent facility.

2. Support of Simple Revenue-Based Allocation

   LifeBridge Health, Mercy Medical Center,Frederick Health and UMMS, argue that an allocation based on hospital revenue is the most simple and transparent approach. They note that readiness investments—such as coding staff, MS-DRG transitions, and software—correlate strongly with hospital size and volume.

   HSCRC Response: Staff typically agree with this notion. However, believe that there is likely a fixed cost element associated with this transition. As a result, staff have updated the allocation to include a fixed value for each hospital and allocate the remainder based on revenue.

3. Support of Blended or Tiered Approaches

   Many organizations advocate for hybrid models to address the unique needs of smaller or independent facilities that lack the economies of scale enjoyed by larger systems.

   Adventist HealthCare recommends a blend of 80% revenue-based and 20% based on "days cash on hand" to direct more support to hospitals with less capacity to self-fund

   ChristianaCare, Johns Hopkins Health System (JHHS), Luminis Health, and the MHA propose a two-tiered structure combining a fixed base amount for all hospitals (to offset fixed costs) with a variable component (based on GBR or size).

   Garrett Regional Medical Center explicitly recommends a three-part methodology: 25% base, 50% volume/size, and 25% rural/special population adjustment.

   HSCRC Response: *Staff appreciate the comments and ideas we received on a hybrid or two tiered approach. Staff have updated the allocation to include $500k fixed portion and the remainder is allocated based on revenue.*

4. Shared Service Set Aside

   MHA, JHHS, and the Maryland Citizens' Health Initiative (MCHI) support reserving a portion of funds for shared technical assistance to reduce duplicative efforts across the state.

   Adventist HealthCare, Frederick Health, Luminis Health, and MedStar Health oppose shared services arguing that transition needs are highly hospital-specific and that centralized procurement would create unnecessary complexity and delay.

   HSCRC Response: While a technical assistance fund would have some benefit, given the short time window and amount involved Staff did not believe the added complexity

involved was merited.

5. Oversight of Reporting

   LifeBridge, MedStar, Mercy, UMMS, and JHHS, advocate for streamlined accountability, such as a brief management report or executive attestation. They argue that rigorous reporting would impose an administrative burden disproportionate to the funding amount.

   League, Kaiser Permanente, USofCare, and MCHI argue for strict fiscal oversight, including itemized budgets, implementation plans, and authority for the HSCRC to recoup unused or misused funds. HME recommends a proportionate approach that requires detailed cost reporting only above a certain dollar threshold and includes consumer-facing measures regarding affordability and patient experience.

   HSCRC Response: Staff believe that a breakdown of cost reporting with a CFO attestation would be appropriate level of oversight for this one-time funding. Staff appreciate the comments received supporting strict oversight,

6. Prospective Hospital UCC Funding

   The MHA emphasizes that transitioning to separate payment systems for Medicare and Medicaid and commercial payers will require significant resources. They note that the necessary investments will exceed the current $50 million and urge HSCRC to increase the funding amount.

   League of Life & Health Insurers of Maryland and Kaiser Permanente stated the oppose adding the $50 million to hospital rates outside the standard rate-development process.

   HSCRC Response: This funding was a Commissioner approved amendment to the Rate Year 2027 Update Factor Recommendation voted and approved on June 10, 2026.

   Staff do not agree with providing additional funding for this transition. This funding is one-time and will be provided to hospitals in RY 2027 and RY 2026. Staff also do not agree with providing additional funding outside of the 'official' Update Factor review and process.

Recommendations

Staff reviewed public comments as discussed below and are recommending the following allocation for one-time funding in RY 2027 and RY 2028.

1. A $500,000 fixed cost element awarded to all acute care hospitals totaling $21.5 million. Staff believe there is a fixed cost element to AHEAD preparation regardless of the size and scale of each facility.

2. The remaining $28.5 million allocated based on Gross Patient Revenue of each facility.
3. Freestanding Medical Facilities and Shock Trauma revenues are included in their parent facility.
    a. Cambridge and Queen Anne's included in Easton
    b. Grace included in Sinai
    c. McCready included in Peninsula
    d. Bowie included in Capital Region
    e. Aberdeen included in Upper Chesapeake
    f. Shock Trauma included in University of Maryland Medical Cen
4. Each hospital will be required to submit an attestation, signed by the CFO, by July 31 following each of RY2027 and RY2028 enumerating how these funds were used during the year and a brief description of each item. Systems may submit a single attestation.

Appendix I: Comment Letters

Christiana Care
Maryland Citizens' Health Initiative (MCHI)/Healthcare For All
University of Maryland Medical System (UMMS)
League of Life & Health Insurers of Maryland
Maryland Hospital Association (MHA)
United States of Care
Mercy Medical Center
Frederick Health
LifeBridge Health
Luminis Health
Adventist HealthCare
MedStar Health
Kaiser Permanente
Johns Hopkins Health System (JHHS)
Health Means Everything (HME)
Garrett Regional Medical Center

Appendix II: Allocation

Maryland Hospital Funding for AHEAD Participation

			Fixed Portion	Variable Portion	Total Funding
			$ 21,500,000	$ 28,500,000	$ 50,000,000
1	Meritus	$ 540,426,100	$ 500,000	$ 684,025	$ 1,184,025
2	University Medical Center	$ 2,284,864,718	$ 500,000	$ 2,891,985	$ 3,391,985
3	Capital Region Medical Center	$ 506,883,871	$ 500,000	$ 641,570	$ 1,141,570
4	Holy Cross	$ 638,008,057	$ 500,000	$ 807,536	$ 1,307,536
5	Frederick Health	$ 464,628,200	$ 500,000	$ 588,086	$ 1,088,086
6	Aberdeen FMF	$ -	$ -	$ -	$ -
8	Mercy	$ 717,488,100	$ 500,000	$ 908,135	$ 1,408,135
9	Johns Hopkins Hospital	$ 3,311,615,560	$ 500,000	$ 4,191,558	$ 4,691,558
10	Shore Medical Dorchester	$ -	$ -	$ -	$ -
11	St. Agnes	$ 568,926,800	$ 500,000	$ 720,099	$ 1,220,099
12	Sinai	$ 1,028,782,492	$ 500,000	$ 1,302,144	$ 1,802,144
13	Grace Medical Center	$ -	$ -	$ -	$ -
15	Franklin Square	$ 743,866,299	$ 500,000	$ 941,522	$ 1,441,522
16	Adventist White Oak	$ 449,898,829	$ 500,000	$ 569,443	$ 1,069,443
17	Garrett County	$ 103,987,850	$ 500,000	$ 131,619	$ 631,619
18	Montgomery General	$ 241,848,927	$ 500,000	$ 306,112	$ 806,112
19	Peninsula Regional	$ 650,222,000	$ 500,000	$ 822,995	$ 1,322,995
22	Suburban	$ 472,166,684	$ 500,000	$ 597,628	$ 1,097,628
23	Anne Arundel	$ 791,316,592	$ 500,000	$ 1,001,581	$ 1,501,581
24	Union Memorial	$ 524,653,148	$ 500,000	$ 664,061	$ 1,164,061
27	Western Maryland Health System	$ 418,657,200	$ 500,000	$ 529,900	$ 1,029,900
28	St. Mary's	$ 256,129,031	$ 500,000	$ 324,186	$ 824,186
29	JH Bayview Medical Center	$ 867,460,833	$ 500,000	$ 1,097,957	$ 1,597,957
30	Shore Medical Chestertown	$ 59,088,059	$ 500,000	$ 74,789	$ 574,789
32	ChristianaCare, Union	$ 212,930,725	$ 500,000	$ 269,509	$ 769,509
33	Carroll County	$ 290,567,437	$ 500,000	$ 367,775	$ 867,775
34	Harbor Hospital	$ 241,447,815	$ 500,000	$ 305,604	$ 805,604
35	Charles Regional	$ 196,648,598	$ 500,000	$ 248,901	$ 748,901
37	Shore Medical Easton	$ 347,330,605	$ 500,000	$ 439,621	$ 939,621
38	UMMC Midtown	$ 285,799,427	$ 500,000	$ 361,740	$ 861,740
39	Calvert	$ 197,883,196	$ 500,000	$ 250,464	$ 750,464
40	Northwest	$ 322,316,773	$ 500,000	$ 407,961	$ 907,961
43	Baltimore Washington	$ 554,612,093	$ 500,000	$ 701,980	$ 1,201,980
44	Greater Baltimore Medical Center	$ 534,931,449	$ 500,000	$ 677,070	$ 1,177,070
45	McCready*	$ -	$ -	$ -	$ -
48	Howard County	$ 401,287,682	$ 500,000	$ 507,915	$ 1,007,915
49	Upper Chesapeake	$ 497,754,547	$ 500,000	$ 630,015	$ 1,130,015
51	Doctors Community	$ 326,288,251	$ 500,000	$ 412,988	$ 912,988
55	Laurel Medical	$ 44,865,832	$ -	$ 56,787	$ 56,787
2004	Good Samaritan	$ 328,543,894	$ 500,000	$ 415,843	$ 915,843
5050	Shady Grove	$ 580,014,272	$ 500,000	$ 734,132	$ 1,234,132
2001	Rehab & Ortho Institue	$ 156,242,273	$ 500,000	$ 197,758	$ 697,758
60	Fort Washington	$ 72,730,959	$ 500,000	$ 92,057	$ 592,057
61	Atlantic General	$ 140,018,931	$ 500,000	$ 177,224	$ 677,224
62	Southern Maryland	$ 361,328,378	$ 500,000	$ 457,338	$ 957,338
63	St. Joseph	$ 506,646,499	$ 500,000	$ 641,270	$ 1,141,270
88	Queen Anne FSE	$ -	$ -	$ -	$ -
333	Bowie FSE	$ 24,873,230	$ -	$ 31,482	$ 31,482
5033	Levindale	$ 70,446,064	$ 500,000	$ 89,165	$ 589,165
8992	Shock Trauma	$ -	$ -	$ -	$ -
65	Germantown	$ 180,505,379	$ 500,000	$ 228,468	$ 728,468
		$ 22,516,933,659	$ 21,500,000	$ 28,500,000	$ 50,000,000

Gross Patient Revenue Derived from FY 2025 Scheudle RE

ChristianaCare
Suite C3-348
4000 Nexus Drive
Wilmington, DE 19803
www.christianacare.org
August 10, 2026

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

Submitted via email: hscrc.payment@maryland.gov

Re: Comments on AHEAD Transition Funds Allocation

Dear Dr. Kromm and Members of the Commission,

ChristianaCare welcomes the opportunity to provide feedback to the Health Services Cost Review Commission (HSCRC) on the AHEAD transition funds allocation. We appreciate the Commission's commitment to ensuring all Marylanders have access to high-value, affordable healthcare. These comments are intended to reflect our shared purpose in improving care quality, health outcomes, and cost-efficiency across the state.

Allocation Methodology

ChristianaCare does not support allocating AHEAD transition funds solely based on hospital revenue. A significant portion of AHEAD implementation costs are fixed and unavoidable. Hospitals will be required to make substantial upfront investments in information technology, reporting systems, workforce training, analytics capabilities, and care transformation infrastructure regardless of their size, patient volume, or revenue base. As a result, a revenue-based allocation methodology would disproportionately advantage larger systems and could leave smaller, rural, and community hospitals, including ChristianaCare's Union Hospital, without sufficient resources to support successful implementation.

Instead, ChristianaCare strongly recommends a two-tiered allocation methodology that combines a fixed distribution with a variable distribution. Under this approach, each hospital would first receive an equal base amount to help offset fixed implementation expenses. The remaining funds could then be allocated through a variable percentage based on Global Budget Revenue (GBR) or another proportional measure. This structure would promote equity across hospitals of varying sizes while recognizing differences in scale,

operational complexity, and resource needs. By aligning funding with both the fixed and variable costs of implementation, this approach would help ensure that hospitals of all sizes have the capacity to meet AHEAD requirements, contribute to the state's population health and affordability goals, and support successful implementation of the model statewide.

Reporting & Accountability

ChristianaCare believes the reporting requirements associated with AHEAD transition funding should be designed to promote accountability while minimizing unnecessary administrative burden. Maryland hospitals already operate within a highly regulated environment, and requiring comprehensive audits of transition fund expenditures may create significant administrative burden and expense that outweigh the incremental oversight benefits provided. If the Commission determines that additional oversight is warranted, it could consider a risk-based approach that reserves more detailed review for exceptional circumstances rather than applying comprehensive audit requirements uniformly across all hospitals.

While some level of oversight is both appropriate and necessary, ChristianaCare recommends a streamlined reporting framework centered on management attestation. Under this approach, hospitals would provide an attestation from senior leadership confirming that transition funds were used for AHEAD-related implementation activities, accompanied by a brief narrative describing how the funds were utilized. Expenditures could be reported by broad categories, such as technology and information systems, workforce development, analytics and reporting infrastructure, care transformation initiatives, and other implementation-related costs.

In addition, hospitals should report progress toward key implementation milestones and identify anticipated future investment needs. This approach would provide meaningful transparency regarding the use of public funds, support accountability for implementation progress, and promote efficient stewardship of limited administrative resources. Such a framework would allow hospitals to dedicate more resources to successful AHEAD implementation rather than compliance activities.

Conclusion

In conclusion, ChristianaCare urges the Commission to adopt an AHEAD transition funding approach that is equitable, practical, and focused on successful implementation across all Maryland hospitals. A funding methodology that combines a fixed base allocation with a variable component tied to hospital size or revenue would appropriately recognize both the fixed and variable costs associated with implementation and help ensure that hospitals of all sizes have the resources necessary to succeed under the AHEAD Model. In addition, a streamlined reporting framework centered on management attestation, broad expenditure categories, and implementation milestones would provide meaningful accountability and transparency while minimizing unnecessary administrative burden. Such an approach would maximize the impact of transition funding and support Maryland's shared goals of improving

health outcomes, advancing care transformation, and maintaining affordability for patients and communities.

We appreciate the opportunity to provide these comments and look forward to continuing to work with the Commission to support the successful implementation of the AHEAD Model.

Sincerely,

Geoff Heath

Geoff Heath
Senior Director, Government Affairs
ChristianaCare

August 6, 2026

William Henderson, Acting Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: hscrc.payment@maryland.gov

RE: Comments on AHEAD Transition Funds

Dear Mr. Henderson,

Thank you for the opportunity to provide written comments regarding the allocation of the $50 million in AHEAD Transition Funds. Maryland Citizens' Health Initiative (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders.

We commend the Health Services Cost Review Commission (HSCRC) for using the AHEAD model to balance consumer costs, access, and care quality. By moderating hospital rate growth and simplifying negotiations between health systems and insurers, the model protects Marylanders from potential disruptions in care. We also applaud recent HSCRC initiatives to address uncompensated care—specifically the $100 million allocation to the Maryland Health Benefit Exchange, which prevents coverage loss for tens of thousands of residents, and the $25 million investment in federally qualified health centers and local health departments. These efforts, alongside the existing uncompensated care pool, are vital protections.

In order for the AHEAD model to be successful it will be important to make operational investments so that hospitals can successfully implement the new federal and state requirements.

Following careful consideration of the options presented by the Commission, we advocate for the prioritization of **Option 1c**.

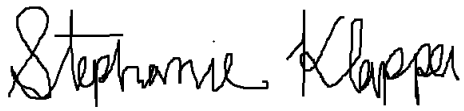
We believe that segregating a portion of the funding to be provided to a neutral service provider—such as CRISP or the Maryland Hospital Association—to procure shared technical support for all hospitals is the most efficient and effective use of these resources. This centralized approach would protect individual hospital systems from using resources on redundant efforts, allowing the industry to leverage common, best-in-class solutions for shared implementation needs. By streamlining these support services, the state can ensure consistent, high-quality standards across the board while minimizing the duplicative costs that would otherwise arise if each facility were to undertake these efforts in isolation.

2600 St. Paul Street Baltimore, MD 21218
www.healthcareforall.com
Phone (410)235-9000 Fax (410)235-9000

Regarding the level of accountability required of hospitals (**Question 3**), we urge the Commission to prioritize oversight. Given the substantial nature of these funds, we advocate for an accountability framework that includes detailed cost reporting and auditing of reported amounts. Ensuring that public resources are used for their intended purposes is important. While we acknowledge the administrative effort this requires, we believe this level of transparency is necessary to maintain public trust and guarantee that the transition to the AHEAD Model is managed with a high standard of fiscal integrity.

Thank you for your continued work to expand access to high-quality, affordable health care for all Marylanders. We look forward to seeing the positive impact these funds will have as our health system moves forward with these critical innovations to support the success of the AHEAD model.

Sincerely,



Stephanie Klapper
Deputy Director, Maryland Citizens' Health Initiative

2600 St. Paul Street Baltimore, MD 21218
www.healthcareforall.com
Phone (410)235-9000 Fax (410)235-9000

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829

CORPORATE OFFICE

August 10, 2026

William Henderson
Acting Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comments re: AHEAD Transition Funds

Dear William:

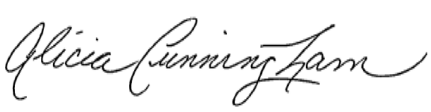
On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, thank you for the opportunity to submit comments in response to the Health Services Cost Review Commission's ("HSCRC" or "the Commission") request for written comments for the AHEAD transition funds.

UMMS supports a simple approach to the allocation of AHEAD transition funds. We feel that an allocation based upon revenue would be adequate since readiness investment is strongly impacted by size of hospitals. For example, number of Medicare Cost Reports, education and training for various levels of executives and staff through a hospital/health system, coding and documentation, including staffing, software investment, auditing support and data analytics.

To minimize the administrative burden to both hospitals and state, we would propose that the Commission require a one-time management level summary report from each health system or non-system affiliated hospital to explain how funding was used.

Thank you again for seeking input from stakeholders.

Sincerely,



Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services
University of Maryland Medical System

The League of Life and Health Insurers of Maryland

August 10, 2026

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

Re: AHEAD Transition Funding

Dear Dr. Kromm:

On behalf of the League of Life and Health Insurers of Maryland, we appreciate the opportunity to comment on the allocation and accountability requirements for the AHEAD transition funding approved for Rate Years 2027 and 2028. At its July 22 meeting, the Commission approved an amendment adding $50 million to hospital rates in each year for targeted AHEAD readiness activities, subject to an evaluation after RY 2027 and the development of distribution and accountability standards.

Ad hoc rate increases undermine affordability. The League strongly opposes additions to hospital rates outside the Commission's ordinary rate-development process. Since staff presented the Update Factor recommendation in June, the Commission has added $175 million to hospital rates. Late-stage rate changes interfere with health plans' established budgets and premium projections, make hospital spending less predictable, and impair plans' ability to manage costs for members and purchasers.

The League is particularly concerned that the Commission approved this adjustment before determining hospitals' actual readiness needs, eligible uses, or accountability standards. Approving substantial funding first and establishing its justification and conditions later creates a troubling precedent.

The adjustment is also in tension with AHEAD's affordability goals. The model requires Maryland to establish an all-payer cost growth target intended to constrain spending and promote affordability across payers. Adding $50 million to hospital rates in each of two years without first demonstrating need increases costs for commercial payers and risks undermining one of AHEAD's central objectives.

Allocation should be based on demonstrated need. The League opposes a methodology based predominantly on hospital revenue. Such an approach would direct the largest shares to hospitals and systems already receiving the most regulated revenue, regardless of their incremental

AHEAD costs. Hospital revenue is not a reliable measure of readiness need, and larger systems should not receive larger subsidies solely because of their scale.

A limited revenue component may be appropriate where certain implementation costs vary by institutional size, but it should be capped and combined with demonstrated need and the authority to recoup unused or improperly spent funds. The League could also support targeted assistance for hospitals that demonstrate insufficient capacity to meet specific AHEAD requirements, particularly where inadequate readiness could threaten access or model participation.

HSCRC should also consider a methodology based entirely on identified readiness gaps. Under this approach, each applicant would be assessed against a standardized framework and required to identify the specific capabilities it lacks. Funding could then address validated needs such as interoperability, workforce capacity, payment administration, and care-transition infrastructure.

Multi-stakeholder applications involving hospitals, health plans, primary-care organizations, and other partners should also be eligible. Such initiatives would better reflect AHEAD's total-cost-of-care objectives than hospital-only allocations. Awards should be tied to defined needs, measurable deliverables, and benefits across participating organizations.

Shared technical assistance may reduce costs and duplication. The League could support reserving a portion of the funding for common technical assistance where a shared solution would reduce duplicative spending and lower statewide implementation costs. Any shared-service arrangement should require competitive procurement, clearly defined deliverables, safeguards against duplicate reimbursement, and meaningful payer participation in governance.

CRISP may be well positioned to perform certain data-exchange or technical functions, but it should not receive funding automatically without a defined scope, cost analysis, and appropriate oversight. The Maryland Hospital Association should not administer the funding. Managing and overseeing ratepayer-supported funds is not an appropriate role for a trade association that represents and advocates for the recipients.

HSCRC should impose strong accountability requirements. Strict oversight is essential because payers and their members will finance the adjustment through hospital rates. Before receiving funds, each recipient should submit an implementation plan identifying:

- The specific AHEAD requirement being addressed;
- Existing resources and an itemized budget;
- Measurable goals and deadlines; and
- A plan to sustain any recurring costs after the transition period.

Funding should be limited to documented AHEAD expenses. General operating deficits, routine compensation increases, unrelated capital projects, and costs that would have occurred without AHEAD should be excluded or subject to heightened scrutiny.

The RY 2027 evaluation should be more than a reporting exercise; it should determine whether and how RY 2028 funds are distributed. HSCRC should retain authority to withhold, reduce, reallocate, or offset funding based on recipients' performance and documented need. No funding should continue beyond RY 2028 without another evaluation, public comment, and Commission approval.

HSCRC also should not assume that the full $50 million must be distributed in either year. If demonstrated readiness needs are lower than the amount available, the balance should be removed from hospital rates, used to offset a future Update Factor, returned to payers through rate reductions, or redirected through a transparent process to another clearly defined AHEAD priority.

The League supports Maryland's successful implementation of AHEAD. However, implementation funding should not weaken the model's affordability objectives or become an unrestricted increase in hospital revenue. We appreciate the Commission's consideration of these comments. If you have any questions or would like to speak with us further on these topics, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

Matthew Celentano
Executive Director

Maryland
Hospital Association

August 10, 2026

William Henderson
Interim Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to comment on the implementation of the $50 million in funding to support hospital readiness for the AHEAD Model (AHEAD Transition Funds) approved as part of the Rate Year 2027 update factor. MHA appreciates the Commission's recognition of the investments hospitals will need to make to manage the AHEAD Model transition.

The transition to AHEAD Model policies and programs is unprecedented and resource intensive. For decades, Maryland's all-payer system has relied on consistent payment policies across all payers. In less than 18 months, however, hospitals will operate under two payment systems, one for Medicare and another for Medicaid and commercial payers. To prepare for the transition to this bifurcated system, hospitals are allocating additional resources to finance, revenue cycle, and clinical operations teams to support Medicare cost reporting, clinical documentation, and new payment processes. Hospitals are also making significant investments to support various technology upgrades to ensure operational readiness, as well as assess national quality programs and modify workflows to manage different quality programs across payers.

These and other necessary hospital investments will exceed the $50 million approved by the Commission. Given this, we respectfully urge HSCRC to consider increasing the amount of funding provided under this policy to support a successful transition to the AHEAD Model.

We offer the following additional comments for consideration by HSCRC.

Allocation of Funding
While HSCRC could allocate funding strictly in proportion to each hospital's share of statewide global budget revenue, the funding should be distributed in a manner that ensures all hospitals have sufficient resources to make necessary transition-related investments. As noted by HSCRC staff, some transition costs may not necessarily be correlated with hospital size, and small, independent hospitals may not be able to achieve the same economies of scale as their peers that are affiliated with systems. To address this challenge, HSCRC should consider establishing a

minimum funding level for these hospitals and distribute the remaining funding amount to all other hospitals in proportion to their GBR.

On the question of whether funding should be directed to a shared services pool, MHA recommends that a substantial portion of the funding be provided directly to hospitals and a more limited portion be set aside to support shared technical assistance. While there may be some services that could be shared across all hospitals in the state, such as high-level education on Medicare prospective payment systems or Medicare cost reporting, hospitals are in different places in terms of their operational readiness for AHEAD and have unique transition needs based on their resources, patient populations served, and payer mix. MHA stands ready to assist HSCRC as a neutral service provider to procure shared technical support if HSCRC decides to allocate a portion of the funding for this purpose.

Accountability for Use of Funding

As with all policies, it is important to ensure any funding allocation is being used for its intended purposes for the sake of accountability and transparency. This goal can and should be achieved without placing undue administrative strain on HSCRC staff and hospitals, particularly at a time when their efforts are focused on the Model transition. We encourage HSCRC to limit hospital reporting to the estimated amount of funding used for staffing, operations, technology, and other activities including but not limited to technical assistance. More robust reporting requirements, such as detailed accounting on the use of funds, would divert valuable resources from preparing for the transition to AHEAD and be counterintuitive to the purpose of the funding.

Continued Funding in RY 2028

Many of the investments hospitals must make in RY 2027 in preparation for the new AHEAD policies and programs are not one-time investments and will carry over into RY 2028. While the start of bifurcated hospital global budgets and the transition to national quality programs in CY 2028 and federal FY 2030, respectively, represent key transition milestones, hospitals will need to sustain many of the aforementioned investments in future years, with some becoming a permanent part of hospitals' operating budgets, to successfully operate under AHEAD. Hospitals will need to permanently expand revenue cycle and clinical documentation improvement (CDI) resources and obtain MS-DRG grouper software programs, to name a few. For this reason, it is critical that the increase in rates to support these efforts continue in RY 2028.

****

MHA appreciates the steps HSCRC has taken to support hospitals in the transition to AHEAD policies and programs and stands ready to assist HSCRC with the implementation of this funding. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Kevin Sexton, Chair
Jonathan Blum
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Dr. Benjamin Stallings

August 10, 2026

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

Submitted via email to hscrc.payment@maryland.gov

Dear Executive Director Kromm,

Thank you for the opportunity to comment to the HSCRC on AHEAD Transition Funds. United States of Care (USofCare) is a multi-state, non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care regardless of who they are, where they live, or how much money they make. In Maryland, we've worked with stakeholders and agencies, including HSCRC, to ensure the consumer perspective is heard during the development of pragmatic patient-first care solutions, most recently through implementation of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.

The AHEAD Model will provide much-needed financial certainty to health care providers while also benefiting Maryland families across the state by shifting the way in which care is delivered in order to expand access to preventive and primary care, prioritize population health, improve health outcomes, and lower health care costs in the State. We believe that the transition funds approved by the HSCRC will provide an important incentive for hospital participation in the AHEAD Model, which is critical to Model success. We encourage the HSCRC to consider the following when developing an approach to distributing these resources:

1. ***How should AHEAD transition funds be allocated?***
   We strongly encourage the HSCRC to consider a combination of allocating funds via methods 1b, by allocating based on size of hospital global budget, and 1c outlined in the request for comments. As highlighted by the HSCRC, smaller, non-system hospitals do not benefit from the economies of scale of larger systems. Additionally, these hospitals are more likely to be facing financial challenges resulting in less investment into the improvements necessary to transition to the value based payment (VBP) models under AHEAD. We strongly recommend the HSCRC not allocate transition funds by revenue, which would further entrench the imbalances between larger, more profitable hospitals and smaller, non-system hospitals.

2. ***Are there specific approaches to any of the items 1a to 1c the commenter would recommend?***
   We would strongly encourage the HSCRC to look to other state's models to support VBP transitions developed under the Rural Health Transformation Program (RHTP) to inform this effort. While we recognize that the impact of many of these programs is more longterm, the approaches taken provide a helpful framework for distributing transition funding.

- As a part of Maine's initiative leveraging RHTP funding to support provider VBP transition, the state developed clear "Principles to Prioritize Allocation of RHTP Provider Funds." We strongly recommend the HSCRC develop a set of principles to help guide the distribution of AHEAD transition funds to hospitals.
- Rhode Island chose to take a similar approach with their RHTP funding, offering transition funds to hospitals and primary care clinics for strategic improvement projects to help support VBP transition (initiative 11). Additionally, the state also directed funding towards a targeted technical assistance (TA) program providing support tailored to each hospital's needs during their transition to state-approved alternative payment models, most notably AHEAD.
- Alaska directed RHTP funding towards "transitional planning grants" to support and incentivize providers to adopt VBP models. The initial awardees of these funds and their approach will be announced no later than August 1st.
- North Carolina also included VBP TA support in their RHTP initiatives. Notably, the state chose to operationalize this TA via organizations selected to serve as leads for the North Carolina Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hub. These organizations will work together as a regional network to implement the VBP TA initiative.

3. ***What level of accountability should be required of hospitals to demonstrate the funding was being used responsibly and for the purposes it was intended?***

We encourage HSCRC to develop a comprehensive process to ensure these dollars are awarded and spent responsibly, subject to strict accountability mechanisms. Fortunately, HSCRC's Regional Partnership Catalyst Grant Program (RPCGP), which funds regional hospital groups, local health departments, primary care providers, and community-based organizations to implement population health initiatives, provides a road map for action. HSCRC may consider the following components, many of which already exist within the RPCGP, when structuring AHEAD Transition Funding accountability mechanisms:

- **Identify allowable/non-allowable uses:** HSCRC should provide guidance to hospitals on the front end to identify what these dollars can and can't be used for, such as executive compensation, advertising or marketing, or other categories of spending not related to the AHEAD transition.
- **Adopt category cost caps:** Establishing spending caps for certain services can allow HSCRC to direct and monitor where spending occurs. A similar policy can be found in Arizona's Rural Health Transformation Program (RHTP) application, which caps direct and indirect administrative costs, for example, at 7% of overall spending.
- **Require hospitals to submit detailed budgets:** HSCRC should have an idea about how hospitals plan to use this funding. Requiring hospitals to submit detailed budgets allows HSCRC to keep tabs on this funding and revisit any spending awards should hospitals' investments shift. Additionally, this could be used to ensure that hospitals are utilizing this money on *new* spending related to

the AHEAD transition, instead of replacing what they were already spending on IT and data needs.

- **Sunset the use of funds:** Should the funding not be utilized by a certain date, HSCRC should emphasize that this money would return to HSCRC if not spent.
- **Establish oversight of spending:** HSCRC should conduct periodic audits of reported spending and/or require hospitals to submit detailed cost reports to ensure proper use of funding dollars.
- **Require public disclosure:** HSCRC should publicly post the funding amounts given to beach hospital, what it was spent on, and any leftover funding returned to HSCRC.

Thank you for the opportunity to provide comments on the distribution of AHEAD Transition Funds. We appreciate all you do to expand access to quality, affordable health care for all Marylanders. Please do not hesitate to reach out if you have any questions.

Sincerely,

Kelsey Wulfkuhle
Senior State Advocacy Manager
kwulfkuhle@usofcare.org

Eric Waskowicz
Senior State Policy Manager
ewaskowicz@usofcare.org

EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER

Mercy
HEALTH SERVICES

University Affiliated

Sponsored by the Sisters of Mercy

August 4, 2026

Ms. Erin Schurmann
Associate Director, Strategic Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: AHEAD Transition Funds – Mercy Medical Center

Dear Ms. Schurmann,

Thank you for the opportunity to comment on the proposed allocation and accountability framework for AHEAD transition funding, including the options to allocate funds based on hospital revenue, provide additional support to smaller hospitals, or reserve funding for shared industry resources.

1. **How should AHEAD transition funds be allocated among the proposed options?**

   Mercy Medical Center recommends AHEAD transition funds be allocated to hospitals based on hospital revenue. This approach is simple, transparent, and appropriately aligns funding with the size and scope of each hospital's operations.

   While some transition initiatives may require regional or statewide approaches, the administrative challenge and burden of allocating transition funds in this manner outweigh the benefits. Allocating funds based on revenue will provide flexibility at the hospital level to address organization specific needs or participate in broader collaborative efforts.

2. **Are there specific approaches to any of items 1a to 1c the commenter would recommend?**

   Mercy recommends the simplistic approach of allocating funds by hospital revenue for the reasons stated above.

3. **What level of accountability should be required of hospitals to demonstrate the funding was being used responsibly and for the purpose it was intended?**

   Accountability requirements should be straightforward and not administratively burdensome. A brief management report describing how the funds were used and how the expenditures supported the AHEAD transition activities should provide sufficient oversight and accountability.

Thank you for the opportunity to provide comments.

Sincerely,

Justin C. Deibel, Executive Vice President & CFO

345 ST. PAUL PLACE BALTIMORE, MD 21202-2123 410-332-9202 FAX 410-962-1303
TTY 1-800-735-2258 *http://www.MDMERCY.com*

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701

240-566-3300

August 10, 2026

Dear Commissioners and HSCRC payment model staff,

Thank you for the opportunity to comment on the Health Services Cost Review Commission (HSCRC) allocation of the $50 million AHEAD Transition Funds for rate year 2027. We appreciate the Commission's recognition that hospitals require additional resources to prepare for the January 2028 AHEAD transition.

Frederick Health will be making both external and internal investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. As part of our efforts to effectively plan for the transition to this bifurcated system, we will need to allocate additional resources to finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require us to hire new coding staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, generate new reporting and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). With the assistance of external consultants, Frederick will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

While an allocation of these funds according to revenue may make sense for variable related expenses, we agree with the payment model staff that many of these transition costs are fixed regardless of hospital size. As a stand-alone hospital, Frederick Health does not benefit from the same economies of scale as larger systems and recommends that funds be allocated in a way that acknowledges smaller stand-alone hospitals. Frederick Health also advocates for keeping a direct funding to hospitals approach versus to a third-party service provider to ensure focused attention to specific hospital nuances and technology that vary across the State. Frederick Health further recommends a higher level of accountability reporting for these funds with a letter from management validating that the funds were used appropriately and in full.

Sincerely,

Hannah Jacobs

Hannah Jacobs
Senior Vice President and CFO
Frederick Health

LIFEBRIDGE HEALTH®

CARE BRAVELY

William Henderson
Interim Executive Director, Health Services Cost Review Commission
4160 Patterson Ave, Baltimore, MD 21215

August 10, 2026

Dear William -

LifeBridge Health appreciates the opportunity to provide comments on the proposed methodology for allocating the $25million of AHEAD transition funding, approved in the final Update Factor Recommendation for fiscal year 2027. Given the limited size of the transition fund as well as all hospitals faced with similar transitional operational issues, we encourage the Health Services Cost Review Commission (HSCRC) to adopt an approach that is straight-forward, transparent, and minimizes administrative burden.

The Commission should allocate the funds proportionally based on each hospital's regulated revenue. This is the most straightforward and equitable methodology because it relies on an existing metric that is consistently applied across the regulated hospital system. By contrast, methodologies that seek to allocate funding based on certain hospital attributes introduce subjective policy judgments that are difficult to administer and may lead to disputes regarding eligibility.

Similarly, we encourage HSCRC to keep accountability requirements proportionate to the size and purpose of the funding. Hospitals should only be required to submit a brief management attestation or concise summary confirming that the funds were used for AHEAD-related transition activities consistent with HSCRC's stated objectives. Hospitals are already managing significant reporting obligations under Maryland's unique payment system and the forthcoming AHEAD model. Requiring detailed cost reporting, audits, or extensive documentation would consume valuable administrative resources that would be better directed toward implementing the operational, clinical, and data infrastructure necessary for successful model implementation.

Sincerely,

Jen Nickoles, President & CEO
LifeBridge Health

David Krajewski, EVP and CFO
LifeBridge Health

cc: Mr. Kevin Sexton, Chairman

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

August 10, 2026

William Henderson
Acting Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson,

I am writing on behalf of Luminis Health to provide comments regarding the allocation of the $50 million in AHEAD transition funds.

We recommend the HSCRC establish a minimum funding level for smaller independent hospitals, with the remaining funds distributed among all other hospitals based on their respective shares of GBR. This approach recognizes that AHEAD transition costs may vary based on factors beyond hospital size and that independent hospitals may face greater challenges in absorbing these costs due to fewer shared resources, infrastructure, and system level supports available to larger health systems.

We do not support allocating a portion of the funding to neutral service providers, such as CRISP or MHA, given the absence of a clearly defined purpose or implementation plan for how those resources would be used. In addition, much of the work required for the AHEAD transition is specific to each hospital and cannot be readily standardized or shared across organizations. Directing funding to individual hospitals would allow each organization to allocate resources based on its unique transition needs, priorities, and operational requirements, ensuring that the funding is used where it can have the greatest impact.

We also want to advocate for permanent funding, as ongoing investment will be required to support the bifurcated systems and methodologies and ensure their long-term sustainability.

Thank you for the opportunity to provide comments.

Sincerely,

Kathy Talbot

Kathy Talbot
VP, Revenue Strategy & Optimization

CC: Kevin Sexton, Chairman
Jonathan Blum, Commissioner
Ricardo Johnson, Commissioner
Dr. David Maine, Commissioner
Nicki McCann, Commissioner
Dr. Farzaneh Sabi, Commissioner
Dr. Benjamin Stallings, Commissioner

Adventist HealthCare

August 10, 2026

William Henderson
Interim Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: AHEAD Readiness Funding

Dear Mr. Henderson,

Adventist HealthCare appreciates the opportunity to respond to Staff's questions regarding the allocation and oversight of the $50 million in AHEAD transition funding, and we support the Commission's goal of moving these resources to hospitals quickly.

Adventist HealthCare is preparing Shady Grove Medical Center, White Oak Medical Center, and Fort Washington Medical Center for the AHEAD Model, and because the performance period has already begun, that preparation is well underway. Our system-wide inventory traces every readiness cost to a specific AHEAD requirement. Nearly half of our documented costs are already incurred, roughly three quarters are incurred or committed, and more than 80 percent are recurring annual operating costs. Population health, equity, and care transformation represent nearly a quarter of the total, and finance, revenue cycle, and bi-weekly Medicare payment operations approximately another quarter. Acting quickly is critical because any care that is not documented and billed to meet the new CMS requirements from day one can result in missed or delayed revenue, while hospitals continue to carry the costs of readiness on their own balance sheets.

In summary, Adventist HealthCare recommends that the Commission:

- Allocate a substantial base share of the funding, for example 80 percent, by hospital revenue, and distribute the remainder by days cash on hand, calculated at the hospital level, so more support reaches hospitals with the least capacity to self-fund readiness.
- Default to a straight revenue-based allocation if the blend cannot be finalized before the September vote, so every hospital receives timely funding.
- Direct all transition funding to hospitals, with no set aside for new statewide shared services that hospitals do not have time to wait for.

1. **How should AHEAD transition funds be allocated among the following options?**
    a. **Option 1: Funds allocated according to hospital revenue**
    b. **Option 2: Funds allocated in a way that favors smaller non-system hospitals**
    c. **Option 3: Some amount of funding should be segregated and provided to a neutral service provider, such as CRISP or MHA, to procure shared technical support for all hospitals**

Adventist HealthCare's first preference is a blended approach that draws on Options 1 and 2. Provide a substantial base share of the funding, for example 80 percent, allocated according to hospital revenue, with the remainder distributed according to days cash on hand, directing proportionally more funding to hospitals with the least financial capacity to absorb readiness costs. If a blended methodology cannot be implemented before the September vote, we recommend defaulting to Option 1 alone; under a revenue-based allocation, Adventist HealthCare's share is anticipated to only cover approximately half of the costs we have documented to date. Timely partial funding for every hospital is preferable to a delayed or contested methodology that leaves hospitals carrying recurring readiness costs while the new documentation requirements put revenue at risk.

Option 2's aim of protecting smaller hospitals is legitimate, but size and system affiliation are poor proxies for need. The core capabilities in our internal cost inventory, including MS-DRG coding and documentation, grouper licensing, quality reporting, bi-weekly Medicare payment operations, and audit and appeals readiness, do not scale down for smaller facilities, and distinct part units add obligations wherever they exist. For Adventist HealthCare, the document cost of these capabilities alone already exceeds our anticipated share of the funding. A days cash on hand adjustment directs more support to hospitals with the least capacity to absorb these costs, whatever their size or affiliation.

We do not recommend a shared services set-aside under Option 3. The needs that statewide procurement could genuinely meet are a small fraction of readiness costs, because this spending is overwhelmingly hospital specific. For example, each hospital must license, configure, and operate its own systems and workflows. Nearly half of our documented costs are already incurred, and organizing shared procurement across competing hospitals would take months and raise antitrust considerations the preparation window does not allow. Statewide support is already funded by hospitals through other avenues such as CRISP and MHA, and every dollar set aside would come out of funding that will cover only a fraction of the readiness costs hospitals have identified.

2. Are there specific approaches to any of the items 1a to 1c the commenter would recommend?

We recommend that Staff adopt the following methodology, which relies entirely on information the Commission already collects:

- Distribute a substantial base share of the funding, for example 80 percent, according to hospital revenue, to support the minimum readiness capabilities that every hospital must establish regardless of size or system affiliation.
- Distribute the remainder according to each hospital's days cash on hand, using audited data already reported to the Commission, calculated at the hospital level rather than the health system level, with proportionally greater funding to hospitals with fewer days cash on hand. Hospitals must absorb these costs through available liquidity and operating cash flow while AHEAD payment flows stabilize; days cash on hand is an objective, comparable measure of that financial capacity.

Establish the allocation prospectively from data on file, and publish the methodology, the underlying data, and the resulting calculation so that each hospital can verify its allocation. Cost applications, itemized budgets, and readiness narratives would exceed Staff's capacity to review before the September vote, delay funding that is needed now, and impose burden out of proportion to funds representing well under one percent of hospitals' global budget revenues.

3. What level of accountability should be required of hospitals to demonstrate the funding was being used responsibly and for the purposes it was intended?

No separate cost application, expenditure report, or routine reconciliation should be required. The funding will cover only a fraction of documented readiness costs and well under one percent of hospitals' global budget revenues, and accountability should match the materiality of the funds distributed. A hospital that diverted these funds would arrive at the performance period unprepared, with far more revenue at risk than the funding provides, and the cost categories in this letter make clear what hospitals must spend on to be ready. We therefore recommend a simple executive attestation confirming that the funds were applied to AHEAD readiness and that ordinary business records support that use, with additional reporting limited to targeted follow-up when Staff identifies a concern.

We appreciate the Commission's continued partnership with Maryland hospitals as the state prepares for AHEAD. We respectfully ask the Commission to allocate a substantial base share of the funding by hospital revenue, distribute the remainder by days cash on hand at the hospital level, default to a revenue-based allocation if the blend cannot be completed for the September vote, and adopt accountability centered on executive attestation. This approach moves funding to hospitals quickly and fairly and gives the Commission appropriate assurances that the funds service their intended purpose. We welcome the opportunity to discuss these comments with Staff.

Sincerely,

Katie Eckert

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

cc: Kevin Sexton, Incoming 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

MedStar Health

8094 Sandpiper Circle
Nottingham, MD 21236

MedStarHealth.org

Revenue Management and
Reimbursement

August 10, 2026

William Henderson
Interim - Executive Director
Health Service Review Commission
4601 Patterson Avenue
Baltimore, Md

Dear Mr. Henderson:

On behalf of MedStar Health, thank you for the opportunity to comment on the distribution & hospital accountability options for the AHEAD transition funds that were approved as part of the FY2027 Annual Update.

The AHEAD transition funds are an important component of the FY2027 Annual Update as Maryland hospitals continue to prepare themselves for the full implementation of the AHEAD model. MedStar believes the costs associated with the AHEAD model transition will vary widely across hospitals and health systems as internal strategies are developed in preparation for the upcoming changes. Additionally, MedStar believes every hospital in the state will require some level of spending, regardless of the size, or geography, or any other factor. Finally, MedStar supports a simplified approach to this distribution. Therefore, MedStar proposes the following distribution methodology for the AHEAD transition funds.

Funding Distribution

To ensure adequate funding for all hospitals, including smaller facilities that will still require some level of fixed spending, MedStar would propose that all hospitals regardless of size or revenue base, receive some minimum level of funding from the $50M that was approved as part of the Annual Update. This portion of the distribution will provide funding to cover fixed expenses that all hospitals will incur during this transition. The remainder of the funding should then be distributed proportionally based on Hospital revenues. This proportional distribution will provide funding for other more variable expenses that will inevitably be incurred proportionate to the size and complexity of the individual facility.

Additionally, MedStar does not support the idea raised regarding the allocation of a portion of these funds to a shared services pool. While a well-intended idea, this arrangement will create further complication and an unnecessary distraction. MedStar believes the effort necessary to create the infrastructure to implement this idea would be better served in other areas.

MedStar believes the distribution outlined above provide for a fair allocation of the approved funding, while also remaining simple to execute, allowing HSCRC staff and industry stakeholders to focus on the many important issues we face as we work toward the AHEAD model transition.

Hospital Accountability

Just as the distribution methodology should be relatively simple, the accountability measures should be simple as well. MedStar therefore supports the idea of a simple management report to track the usage of this funding. While this funding

is vitally important to hospitals as we prepare for the AHEAD transition, it should not distract hospitals, or HSCRC staff, from the important, necessary work that must be completed prior to January 1, 2028.

MedStar Health appreciates the Commission's attention to this important topic and welcomes continued engagement with the Commission as well as the HSCRC Staff.

Sincerely,

Michael Wood
VP – Revenue Management & Reimbursement, MedStar Health

cc: Cait Cooksey, HSCRC
Jonathan Blum, MPP
Ricardo Johnson
David Maine, MD
Nicki McCann, JD
Farzaneh Sabi, MD
Benjamin Stallings II, MD

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

August 10, 2026

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

RE: AHEAD Transition Funding

Dear Dr. Kromm:

Kaiser Permanente appreciates the opportunity to comment on the allocation and accountability requirements for the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model transition funding approved by the Health Services Cost Review Commission (HSCRC) for Rate Years (RY) 2027 and 2028.

Kaiser Permanente is the largest private not-for-profit integrated health care delivery system in the United States, delivering health care to over 12.9 million members in nine states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, Virginia, and the District of Columbia, provides and coordinates complete health care services for over 766,000 members. In Maryland, we deliver care to approximately 436,000 members.

We support the comments submitted to the HSCRC by the League of Life and Health Insurers of Maryland, and share the League's opposition to ad-hoc additions to hospital rates outside the HSCRC's ordinary rate development process. Mid-year rate increases create significant implementation and financial challenges for health plans. These adjustments are especially concerning when approved before the HSCRC has established eligible uses, distribution criteria, or accountability requirements. Because health plans and their members ultimately finance these adjustments through hospital rates, affordability should be a central consideration whenever the HSCRC adds new funding.

Furthermore, we echo the League's recommendation for strict oversight and accountability in how these funds are awarded, spending of these funds is documented, and the impact of these funds in supporting successful AHEAD model implementation is evaluated. The HSCRC should retain authority to withhold or offset unspent or unsupported amounts and should condition RY 2028 distributions on the results of the RY 2027 evaluation.

* * *

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 610 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Thank you for the opportunity to comment. Please feel free to contact me at christopher.e.west@kp.org or (804) 525-8105 with questions.

Sincerely,

Christopher E. West

Christopher E. West
Head of Government Relations
Kaiser Permanente Mid-Atlantic Region

August 10, 2026

William Henderson
Interim Executive Director
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 feedback regarding the allocation of the $50M in AHEAD transition funding approved in the RY2027 update factor. JHHS appreciates the Commission's recognition of the substantial work to prepare for the CY2028 implementation of AHEAD model changes, and offers the following comments on the allocation methodology and accountability mechanisms.

JHHS recommends that the $50M be allocated in two parts: a fieldwide component administered through the Maryland Hospital Association (MHA), and a direct-to-hospital component distributed on a graduated basis that directs the largest per-hospital shares to the State's smaller and independent hospitals. Smaller and independent hospitals face many of the same fixed readiness requirements as larger systems, with far less capacity to absorb them. A distribution weighted toward those hospitals therefore directs limited dollars to where the impact for a successful CY2028 transition is most significant.

- First, JHHS recommends that $10M be directed to MHA to support fieldwide technical assistance, modeling, and consulting services on behalf of all Maryland hospitals. A meaningful portion of the readiness work ahead may be duplicative if undertaken by each hospital, inclusive of modeling impact of AHEAD methodology changes, developing analytics, and securing specialized technical and consulting expertise.
- Second, JHHS recommends that the remaining $40M be distributed directly to hospitals on a graduated basis according to organization size, with the largest per-hospital allocations directed to smaller, independent hospitals, moderate allocations to mid-sized systems, and the smallest allocations to large systems. JHHS recognizes that this approach would require the Commission and the field to develop a defined methodology, and would welcome the opportunity to work with staff and MHA to develop this methodology.

The success of the AHEAD model is a collective undertaking. Directing proportionally more support to the hospitals with the least capacity to absorb these costs, and pooling a portion of the funds for fieldwide use is, in JHHS's view, the allocation most likely to produce a successful transition for the State as a whole.

Regarding the level of accountability required to demonstrate responsible use of funds for their intended purposes, JHHS recommends a short report from each system or hospital on the use of funds. Given the significant internal readiness efforts already underway and the high level of engagement from

the hospital industry in ongoing AHEAD policy development, a brief report would appropriately balance accountability with the administrative burden that detailed cost reporting would impose on both hospitals and staff. Further, this funding will cover only a portion of any system's overall AHEAD readiness costs and therefore will not be in excess compared to the AHEAD transition costs that all hospitals will incur.

JHHS appreciates the work of Commissioners and staff to support the required efforts of hospitals as the State undertakes this significant model transition in CY2028, and looks forward to further collaboration on AHEAD model readiness and implementation.

Sincerely,

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

August 10, 2026

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

Re: HSCRC Written Comment Period: AHEAD Transition Funds

Dear Dr. Jon Kromm and HSCRC Commissioners:

Health Means Everything (HME) appreciates the opportunity to comment on the allocation of AHEAD (Achieving Healthcare Efficiency through Accountable Design) transition funds, and on the accountability standards that should apply to their use. From a consumer perspective, the process by which the HSCRC determined the amount of funding needed to help hospitals through this transition was difficult to follow and seemed to lack transparency. We appreciate the Commission's efforts to bring at least some degree of transparency to how these funds will be allocated and monitored.

Overall, HME supports an allocation methodology weighted toward smaller, non-system hospitals, with additional weight given to rural facilities and to the hospitals that will carry the heaviest uncompensated care burden because of federal policy changes. We also encourage the Commission to treat the development and strengthening of partnerships between hospitals and Federally Qualified Health Centers (FQHCs) as a favored use of these funds. Regarding accountability, we urge the Commission to implement reporting requirements that meaningfully demonstrate how funds were used, and to ensure that required reporting captures whether these investments actually improved affordability and patient experience for all Marylanders.

Allocation Methodology

HME supports allocating funds in a way that favors smaller, non-system hospitals. We agree with the HSCRC that smaller and independent hospitals may not benefit from the economies of scale available to larger systems, which can spread transition work across already existing relationships with vendors or staff. As the HSCRC mentions, many transition costs are fixed regardless of hospital size. Allocating based on revenue alone would therefore direct the most support to the hospitals best positioned to absorb these costs independently, and the least to those with the fewest resources.

HME's recommendation to weight funding toward smaller and rural hospitals reflects the level of need likely to be observed in the populations those hospitals serve. Rural residents are more likely to have low incomes, be covered by Medicaid, and be uninsured. Additionally, Medicaid covers a higher share of residents in rural areas than in urban ones, and accounts for roughly one-fifth of inpatient discharges at rural hospitals. These hospitals therefore carry elevated levels of uncompensated care tied to higher uninsured rates, and they operate on smaller margins than large, urban systems. For example, nearly half of rural hospitals nationally sustained negative operating margins from patient services between 2017 and 2022. Rural hospital closures have also been concentrated in communities with larger Black and Hispanic populations. HME believes that this kind of transition funding will have a greater impact on small and rural hospitals that have long been under resourced.

HME also recommends that the HSCRC incorporate an uncompensated care factor into the allocation calculation. We believe the calculation should account for both historic uncompensated care and where that burden is expected to fall going forward. Because of federal changes, including the expiration of the enhanced premium tax credits and new Medicaid eligibility and community engagement requirements, historic data alone will not capture the uncompensated care hospitals are about to absorb. HME notes that facilities serving high concentrations of Medicaid expansion adults and Marketplace enrollees may absorb a disproportionate share of uncompensated care costs. We therefore recommend that the HSCRC utilize payer mix and service-area demographics to identify those hospitals and weight the allocation accordingly.

Lastly, HME encourages the Commission to identify hospital partnerships with FQHCs as an eligible use of transition funding. FQHCs serve medically underserved areas and populations regardless of ability to pay, and research shows that increases in FQHC funding lead to lower emergency department use, particularly for non-emergent and primary-care-treatable conditions. Funds supporting the infrastructure (e.g., technologies, staffing, etc.) needed to establish and maintain formal partnerships between hospitals and

FQHCs would be an investment with benefits that could be realized across Maryland's health care environment.

Accountability for the Use of Funds

HME agrees that the accountability standard should balance administrative burden against an appropriate record of how funds are used. However, we also note that detailed cost reporting would impose the largest administrative burden on smaller hospitals. HME therefore recommends a proportionate approach where all recipients report on a standardized set of measures using consistent cost categories, so that amounts can be compared across hospitals and aggregated statewide. Additionally, above a defined dollar threshold set by the HSCRC, recipients should be subject to detailed cost reporting. We also recommend the HSCRC provide guidance to hospitals on what constitutes appropriate use of these funds. During the HSCRC meeting where these funds were approved, the discussion on what hospitals need to purchase, build, or modify to prepare for AHEAD was overly broad and it was not clear how these needs were above and beyond the normal operational needs of hospitals. Ensuring these funds are used for AHEAD-specific transition needs is a vital component of accountability.

HME notes that expenditure reporting alone establishes only that funds were used appropriately, not what they accomplished for the Marylanders these hospitals serve. Therefore, HME recommends that reporting incorporates consumer-facing measures that reflect affordability and patient experience. Affordability indicators could include uncompensated care and charity care volumes, financial assistance application and approval rates, patient cost-sharing obligations, and hospital practices regarding medical debt and collections. Patient experience measures could include access and wait times, experience of care measures, and other standardized survey measures already collected by hospitals.

HME also recommends that summary reporting on the use of transition funds be made publicly available. Finally, HME notes that consumers and stakeholders should have an opportunity to review and comment on the reporting measures before they are finalized.

Conclusion

HME appreciates the Commission's recognition of the importance of AHEAD transition funds and its attention to the practical realities of AHEAD implementation. We look forward to continued engagement as these methodologies are finalized.

Thank you for your consideration.

Ashiah Parker

Chair, Health Means Everything Consumer Alliance

WVU Medicine
GARRETT REGIONAL MEDICAL CENTER

August 10, 2026

William Henderson
Interim Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Support for Funding to Assist Maryland Hospitals in the Transition to the AHEAD Model

Dear Mr. Henderson:

On behalf of Garrett Regional Medical Center and the communities we serve in rural Western Maryland, I am writing to express strong support for dedicating $50 million in funding to assist Maryland hospitals as they transition from the Total Cost of Care Model to the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.

Maryland has long been recognized as a national leader in value-based care. However, the transition to AHEAD represents one of the most significant operational, financial, regulatory, and reporting transformations hospitals have faced since the inception of the All-Payer Model. Successful implementation will require additional administrative infrastructure, workforce investment, data analytics capabilities, quality reporting resources, financial modeling, care redesign efforts, and regulatory compliance support.

The transition to AHEAD is unprecedented and resource intensive. For decades, Maryland's all-payer system has relied on consistent payment methodologies across payers. Under AHEAD, hospitals will be required to operate within multiple payment frameworks, creating substantial new demands on finance, revenue cycle, clinical operations, quality, and compliance teams. Hospitals must invest in Medicare cost reporting capabilities, clinical documentation improvement resources, technology upgrades, financial modeling, and new reporting processes to support operational readiness.

While all Maryland hospitals will incur costs during this transition, a one-size-fits-all funding approach would fail to recognize the vast differences in organizational size, resources, and geographic challenges across the state. Rural hospitals face unique barriers that warrant special consideration. Facilities serving rural communities operate with

lower patient volumes, smaller administrative teams, limited access to specialized expertise, workforce shortages, and greater financial vulnerability.

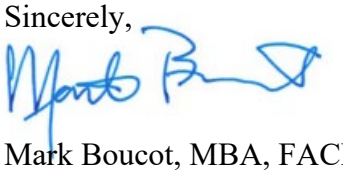
Small and independent hospitals often lack the economies of scale available to larger health systems and therefore face disproportionately higher implementation costs relative to available resources. A funding methodology should recognize these differences and ensure that smaller hospitals receive sufficient support to establish the infrastructure necessary for successful participation in AHEAD.

Recommended Allocation Methodology
1. Base Allocation for All Hospitals (25%)
2. Volume/Size-Based Allocation (50%)
3. Rural and Special Population Adjustment (25%)

While initial transition funding is critically important, many of the investments required for AHEAD implementation will extend beyond Rate Year 2027. Workforce expansion, clinical documentation improvement resources, data analytics capabilities, regulatory reporting infrastructure, and software requirements will become ongoing operational expenses.

Thank you for your leadership and for considering the needs of hospitals across Maryland during this historic transition.

Sincerely,



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

cc:
Kevin Sexton, Chair
Jonathan Blum
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Dr. Benjamin Stallings

maryland
health services
cost review commission

Final Recommendations: Accounting and Budget (A&B) Manual Updates, Effective October 1, 2026

September 9, 2026

Final Recommendations – A&B Manual Updates

- HSRC convened a workgroup on November 6, 2025, to review and update the Labor & Delivery Relative Value Units (RVUs) and guidelines for this rate center. The work group comprised key industry stakeholders, including representatives from Maryland Hospitals, the Maryland Hospital Association, Health Insurance Companies, and Hospital Consultants.
- The updates focuses on three key objectives:

  Streamlining Content: Removing outdated and irrelevant information.

  Filling Gaps: Integrating new or missing details.

  Improving Usability: Enhancing how readers navigate, view, and search the manual.

GBMC Comments & HSCRC Response

- GBMC provided the following 2 comments related to the updates made to Labor & Delivery in Section 700 (Appendix D):
  - Is there an opportunity to further define ‘incision time’?
  - Is it necessary to define the difference between what is billed for emergent or urgent procedures?
- Staff response:
  - HSCRC held several Labor & Delivery work group meetings which included hospital staff (clinicians, administrators, and billing personnel), payers, MHA, and industry consultants. All updates to the manual were reviewed by these interested parties.
  - Therefore, staff feel that making additional changes to the manual after these work group meetings would unilaterally override the consensus reached.

Staff Recommendations – A&B Manual Updates

- The revisions to the Accounting and Budget Manual be approved. These revisions are specific to CMS guidelines and the current practices at the HSCRC.
- The revisions to the Accounting and Budget Manual go into effect on **October 1, 2026.**

maryland
health services
cost review commission

Final Recommendation:

Accounting and Budget Manual Updates

Effective October 1, 2026

September 9, 2026

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

maryland
health services
cost review commission

Relative Value Units for Labor and Delivery Services

On November 6, 2025, the HSCRC staff convened a dedicated workgroup to review and update the Labor & Delivery Relative Value Units (RVUs) and guidelines for this rate center. The work group comprised key industry stakeholders, including representatives from Maryland Hospitals, the Maryland Hospital Association, Health Insurance Companies, and Hospital Consultants.

The workgroup concluded that the state's technical instructions must be revised to align with recent updates issued by the Centers for Medicare & Medicaid Services (CMS).

Adopting these updated guidelines is critical for several key reasons:

- **Regulatory Alignment and Compliance:** Aligning Maryland's technical instructions with CMS standards ensures consistency with national federal coding and billing frameworks. This prevents regulatory friction and ensures that state reporting metrics remain accurate and comparable on a national scale.
- **Equitable and Accurate Reimbursement:** Labor and Delivery services have evolved significantly with advancements in clinical practice and resource utilization. Updating the guidelines ensures that hospital reimbursement accurately reflects the modern intensity, time, and resources required by clinical staff, thereby protecting the financial viability of maternal health services.
- **Standardization Across Payers:** By involving hospitals, payers, and consultants in the consensus process, these updated guidelines establish a clear, standardized methodology. This transparency reduces administrative burden, minimizes billing disputes, and streamlines the claims review process across all private and public insurance providers.

Additional Accounting and Budget Manual Updates

HSCRC also engaged I^3 Healthcare Consulting in a multi-year project to assist staff with modernizing the Annual Filing process. The overall goal of the Annual Filing Modernization (AFM) project was to obtain additional information about the operational costs at regulated hospitals to better improve HSCRC oversight. The AFM project consisted of the following workstreams: 1) Physician Allocation; 2) Cost Center Alignment; 3) Overhead Reallocation; 4) Annual Filing Submission; and 5) Revisions to the Accounting and Budget Manual. This Recommendation addresses the Revisions to the Accounting and Budget Manual.

First drafted in the late 1970s and last updated in 2024, the Accounting and Budget Manual (the Manual) has undergone periodic updates over the years. This latest revision focuses on three key objectives:

- **Streamlining Content:** Removing outdated and irrelevant information.
- **Filling Gaps:** Integrating new or missing details.
- **Improving Usability:** Enhancing how readers navigate, view, and search the manual.

A summary of changes to the Manual are as follows:

Section 200 (Chart of Accounts)	Updated language contained in the Anesthesiology section
Section 400 (Reporting Requirements)	Updated the requirements for specific reports and reformatted the section
Section 500 (Reporting Instructions)	Provided an overview of reports, and removed detailed reporting instructions
Section 700 (Appendix D)	Updated language contained in the Labor & Delivery section
Appendix B (Hospital List)	Updated the list of regulated hospitals and added additional reporting details
Appendix C (Cost Center Codes)	Added additional reporting details

Feedback from GBMC

On August 11, Greater Baltimore Medical Center (GBMC) provided the following two (2) comments related to the updates made to Labor & Delivery in Section 700 (Appendix D):

- Is there an opportunity to further define 'incision time' as it related to the 'decision to incision time' 30-minute qualification for emergent c-sections? We've seen instances where auditors question whether the incision is skin or uterine.
    - Is the time-based metric here necessary or could the definition of an emergent procedure simply be the below?
        - *An emergent procedure is where the absence of immediate medical attention could result in severe life threatening or possibly disabling conditions to the patient or fetus.*
- Is the below language necessary if there is no variation between what is billed for emergent or urgent procedures?
    - *It could become emergent if not diagnosed or treated in a timely manner, but where the patient's condition is stable enough to tolerate a short delay beyond the 30-munte decision-to-incision window.*
        - If it needs to remain to provide clarity between emergent and urgent procedures, can a 'short delay' be further defined?

maryland
health services
cost review commission

HSCRC Response to GBMC

From November 2025 through March 2026, HSCRC hosted 6 technical work group meetings to discuss proposed changes to Labor & Delivery rate center. These meetings included hospital staff (clinicians, administrators, and billing personnel), payers, MHA, and industry consultants. All updates to the manual were reviewed by these interested parties. Therefore, staff feel that making additional changes to the manual after the workgroup meetings would unilaterally override the consensus reached.

Staff Recommendation

1. The revisions to the Accounting and Budget Manual are approved. These revisions are specific to CMS guidelines and the current practices at the HSCRC.
2. The revisions to the Accounting and Budget Manual go into effect on **October 1, 2026.**

The next HSCRC Public Meeting is Wednesday, October 21, 2026.

maryland
health services
cost review commission