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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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 9, 2026

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	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.

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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.

Quality Programs Strategy Discussion

Staff will present updates on the transition to CMS hospital quality programs and facilitate Commissioner discussion on non-medicare FFS hospital quality policies under AHEAD. Topics will include alignment opportunities and state priorities to be addressed in RY 2029 policies and beyond.

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Final Recommendation on AHEAD Funding Allocation:

RY 2027 Update Factor

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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

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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.

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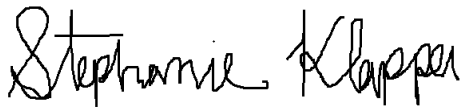
Regarding the level of accountability required of hospitals (**Question 3**), we urge the Commission to prioritize oversight. Given the substantial nature of these funds, we advocate for an accountability framework that includes detailed cost reporting and auditing of reported amounts. Ensuring that 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

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UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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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:

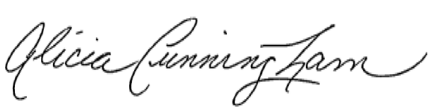
On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, thank you for the opportunity to submit comments in response to the Health Services Cost Review Commission's ("HSCRC" or "the Commission") request for written comments for the AHEAD transition funds.

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

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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

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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.

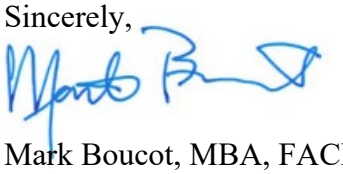
Small and independent hospitals often lack the economies of scale available to larger health systems and therefore face disproportionately higher implementation costs relative to available resources. A funding methodology should recognize these differences and ensure that smaller hospitals receive sufficient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

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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

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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?

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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.**

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TO:	HSCRC Commissioners
FROM:	HSCRC Staff
DATE:	**September 9, 2026**
RE:	Hearing and Meeting Schedule

October 21 2026 (Moved from October 14, 2026)

November 10, 2026

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

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