maryland
health services
cost review commission

Kaiser Realignment Stakeholder Comments

November 25, 2025

Current Staff Recommendation: CY 2026 Kaiser Realignment

1. Scope Limitation: Limit the scope of affected hospitals to facilities with material Kaiser volume, defined as greater than $5 million in annual charges and greater than 2 percent of global budget revenue. This effectively reduces the scope from 54 facilities to 19 facilities. All other Kaiser volume will be handled through the normal Marketshift policy.

2. Rate Order Adjustment (January 2026): In January 2026 rate orders, remove Kaiser funding across hospitals that had material Kaiser volumes, based on Fiscal Year 2025 Kaiser submitted data. Kaiser out-of-state revenue and revenue associated with the high cost outpatient drugs evaluated in the Commission's CDS-A policy will not be removed, as they are not part of the Marketshift Policy.

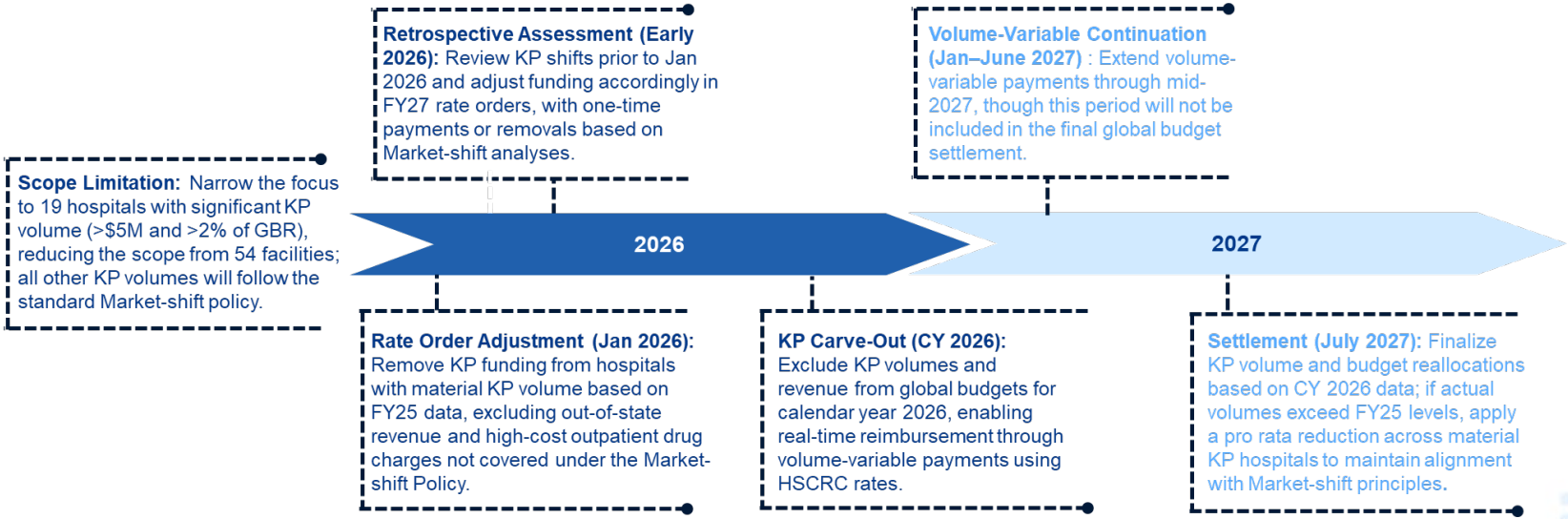
3. Kaiser Carve-Out from Global Budgets (January 1, 2026 - December 31, 2026): Carve out Kaiser volumes and revenue from global budgets from January 1, 2026, through December 31, 2026. This will allow them to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates.

4. Settlement of Reallocated Volumes/Budgets (July 2027): Settle in July 2027 the reallocated Kaiser volumes/global budgets based on actual experience from January 1, 2026, through December 31, 2026. This will necessitate an assessment across the designated material Kaiser hospitals to ensure that volume does not deviate from Fiscal Year 2025 volumes, thereby ensuring this is a methodology analogous to Marketshift. If volumes do deviate from the prior Kaiser cap, staff will implement a pro rata reduction to material Kaiser facilities.

5. Continuation of Volume Variable Methodology (January 1, 2027 - June 30, 2027): Continue the volume-variable methodology for January 1, 2027, through June 30, 2027. This period will not be used for the final settlement of global budgets.

6. Retrospective Assessment of Prior Kaiser Shifts (Early 2026): Retrospectively assess in early 2026, in line with Commission Marketshift analyses, any Kaiser shifts that occurred prior to January 1, 2026 (both increases and decreases). This one-time funding (or removal of funding) will be provided on July 1, 2026, rate orders (FY 26) or in January rate orders if the adjudication process lags

CY 2026 Kaiser Realignment Timeline



The proposed approach complies with the TCOC requirement that 95% of in-state volume be population-based, as retrospective assessments and pro rata adjustments will ensure volumes stay within FY25 levels. Staff will also implement a supplemental reporting schedule to monitor monthly and year-end GBR compliance, ensuring hospitals are not penalized for carved-out KP volumes.

Summary of Public Comments

Topics	Kaiser Permanente	CareFirst	Adventist	Ascension Saint Agnes	JHHS	MHA	UMMS	MedStar Health	Luminis Health	LifeBridge Health
Elective & Emergent Volume	✓		✓	✓	✓	✓				✓
Data Transparency & Validation	✓	✓	✓			✓	✓	✓	✓	✓
Financial Impact & Policy Scope	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Process, Timeline and Broader Applicability	✓	✓	✓		✓	✓	✓	✓	✓	✓
Other Topics			✓	✓	✓	✓	✓	✓		

- Staff received comment letters from ten stakeholders regarding the Draft Recommendation on Kaiser Permanente Volume Realignment.
- The comments from stakeholders can be broadly categorized into five areas of concern.

Inclusion of Elective & Emergent Volume Comments

Overall Summary: Stakeholders express concern about the impact of the draft policy on access, especially regarding emergency department (ED) encounters. Many recommend excluding ED encounters from the policy, as they are typically unplanned and medically necessary. Suggestions include analyzing KP ED volumes, requiring an access impact review, and ensuring policies prioritize system stability and patient access.

Staff Response: Staff disagrees with the assessment that this policy will negatively impact patient access. We believe the opposite is true: allowing Kaiser to transition a limited volume from select facilities to their core Kaiser hospitals will likely increase overall system capacity. This is because Kaiser patients will be less likely to become Emergency Department boarders while awaiting transfer to core Kaiser facilities.

Furthermore, in addressing concerns regarding financial sustainability, staff will put forward a mechanism allowing hospitals to receive retrospective adjustments (both permanent and one-time). This applies if hospitals can prove that Kaiser volumes were replaced with other volumes that are unsupported by Demographic, Marketshift, or related adjustments. This approach should mitigate concerns that this realignment will result in permanently lost revenue at facilities that are otherwise capable of resolving latent demand once Kaiser volumes transition.

Staff do share the concern that hospitals with Kaiser volumes that are predominantly emergency room related will undergo unnecessary disruption through this policy proposal, which is why staff will recommend limiting the scope of this proposal by amending the threshold for evaluation (see slide 6), but staff does not believe that ED volumes should be outright removed from the realignment, as Kaiser does intend to transition certain patients that present in an emergency room.

Comments were received from:	Adventist	Ascension Saint Agnes	JHHS	LifeBridge	MHA

See appendix for comment details.

Data Transparency & Validation Comments

Overall Summary: Stakeholders call for transparency and independent validation of data related to KP-related changes. Many urge the HSCRC to validate volumes using all-payer hospital data, share detailed analyses by setting and service type, and allow hospitals to confirm KP-submitted data before rate adjustments. Recommendations include quarterly data sharing, clear identification of KP patients, and full disclosure of KP's care realignment plans. KP is open to discussing specific impacts with affected hospitals.

Staff Response: In light of concerns from stakeholders, staff have shared RY 2025 casemix data that has been merged with Kaiser submitted claims, which will be the basis for implementation in January rate orders (should this policy proposal move forward). Initial responses from the field indicate that the data aligns very closely with Kaiser primary payer flags that are self reported by hospitals.

Kaiser has also had several meetings with affected hospitals to allay their concerns about the scope of this realignment. According to Kaiser, among the affected facilities, ~59% of the $698M in volume will not move because it is already in its core facilities, ~25% ($175M) will not move because Kaiser anticipates ongoing use of non-core facilities for emergencies and out-of-network migration, ~11% ($78M, $46M with VCF applied) will potentially move due to this realignment, and ~5% will be determined by market dynamics ($35M, $21M with VCF applied)

While Kaiser does not have an exact projection for the realignment, hence this market-based policy proposal, they do anticipate the same percentage dissipation at each hospital and have provided the following summary schedule:

$ Millions

	Core Facilities	Non-Core Facilities	Total	% of Total Kaiser Baseline
Total Baseline Kaiser Revenue	$411	$288	$699	
Total Baseline GBR Revenue	$2,899	$6,602	$9,501	
Anticipated Kaiser Retention	$411	$175	$586	84%
Anticipated Kaiser Realignment	$78	-$78	$0	11%
Anticipated Kaiser Realignment VCF Portion	$46	-$46	$0	*7%*
TBD by Market			$35	5%
TBD by Market VCF Portion			$21	*3%*
Anticipated Kaiser Revenue Post Realignment (59% VCF Applied)	$457	$242	$699	
Anticipated GBR Revenue Post Realignment (59% VCF Applied)	$2,945	$6,556	$9,501	
% Change in Baseline Kaiser Revenue	11%	-16%		
% Change in Baseline GBR Revenue	2%	-1%		

Comments were received from:	Adventist	CareFirst	LifeBridge	Luminis	MedStar	MHA	UMMS

See appendix for comment details.

Comments from Kaiser on the Policy Recommendation

Scope & Financial Impact

- 19 Maryland hospitals included - $9.5 billion in combined total revenue
- Expected realignment: $75 million (0.8% of total GBR revenue)
- KP accounts for 7.4% of revenue at these hospitals

Volume Distribution

- About 60% of KP's hospital volume is already concentrated at 4–6 hospitals where services will be consolidated, and this volume will not move.
- Another 25% of KP's volume (including emergency and behavioral health services) at other hospitals will also remain unchanged.
- KP plans to shift 11% of KP's hospital spending at the affected hospitals (mostly elective services). Remaining share of Kaiser volume will be determined by market dynamics and either remain at non-core facilities or realign to core facilities.

Other Comments

- KP will continue to follow all state and federal laws regarding network adequacy.
- KP is open to meeting with the HSCRC or any hospital to discuss specific impacts.

Financial Impact & Policy Scope

Overall Summary: Concerns are raised about the financial strain the proposed policy could impose on hospitals, as they may still face downward budget adjustments despite overall utilization remaining constant. Stakeholders recommend narrowing the scope to material elective cases, revising payment and reconciliation frameworks, and adjusting settlement periods. Stakeholders support limiting the policy to hospitals with significant KP volumes but suggest refining the criteria. Suggestions include excluding hospitals with immaterial elective KP business and better targeting significant shifts. Collaboration is urged to maintain stable revenues and avoid disruption. Stakeholders also requested clarification on the VCF that will be used to fund the volume shifts.

Staff Response: Staff do share the concern that hospitals with Kaiser volumes that are predominantly emergency room related will undergo unnecessary disruption through this policy proposal, which is why staff recommend amending the scope of this proposal to the following (see next slide for new hospital list):

- **Greater than 5% of total Kaiser Revenue statewide regardless of Kaiser share of GBR (NEW!)**
- **Greater than $5 million in annual charges and greater than 2% of global budget revenue, however,**
- **Various Exclusions**
  - **Specialty Hospitals – Shock Trauma, Shady Grove Hospital**
  - **Hospital with a preponderance of Kaiser revenue attributable to non-elective care (i.e., >96.85% of charges have an EMG rate center charge – top quartile for prior list of material Kaiser hospitals)**

This will reduce the scope of the hospital affected from 19 to 10. Staff does not believe that ED volumes should be outright removed from the realignment, as Kaiser does intend to transition certain patients that present in an emergency room.

As stated in the Commission meeting, staff will utilize a 59% variable cost to adjust for Kaiser shifts (assuming that the new variable factor is approved).

Staff also recommend applying retrospective adjustments (both permanent and one-time) if hospitals can prove that Kaiser volumes were replaced with other volumes that are currently unsupported by Demographic, Marketshift, or related adjustments. This approach should mitigate concerns that this realignment will result in permanently lost revenue at facilities that are otherwise capable of resolving latent demand once Kaiser volumes transition.

Comments were received from:	Adventist	Ascension Saint Agnes	CareFirst	JHHS	LifeBridge	Luminis	MedStar	MHA	UMMS

See appendix for comment details.

Financial Impact & Policy Scope cont.

			A	B	C		
Hospital	RY 2025 Kaiser Revenue under original Materiality Logic		% of Statewide Kaiser Revenue	% of Revenue Attributable to Case with a EMG Rate Center Charge	Greater Than 2% of GBR	RY 2025 Kaiser Revenue under New Materiality Logic	Reason for Exclusion
Ascension St. Agnes Hospital	$19,976,901		2.6%	99.29%	Yes	$0	B
Adventist HealthCare White Oak Medical Center	$12,777,196		1.6%	98.14%	Yes	$0	B
LifeBridge Health Northwest Hospital Center	$7,784,152		1.0%	97.75%	Yes	$0	B
UM CAPITAL REGION MEDICAL CENTER	$48,002,111		6.2%	97.19%	Yes	$48,002,111	
MEDSTAR MONTGOMERY MEDICAL CENTER	$6,394,280		0.8%	97.06%	Yes	$0	B
UM Charles Regional Medical Center	$6,586,774		0.8%	96.64%	Yes	$6,586,774	
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	$22,492,022		2.9%	95.34%	Yes	$22,492,022	
MedStar Harbor Hospital	$5,130,354		0.7%	91.02%	Yes	$5,130,354	
Adventist HealthCare Shady Grove Medical Center	$20,352,625		2.6%	88.69%	Yes	$0	Specialty Hospital
MedStar Franklin Square Hospital	$14,292,681		1.8%	83.01%	No	$0	A & C
Luminis Health Doctors Community Medical Center	$32,581,061		4.2%	71.07%	Yes	$32,581,061	
Holy Cross Hospital Germantown	$22,132,140		2.8%	64.10%	Yes	$22,132,140	
Johns Hopkins Suburban Hospital	$42,449,546		5.5%	48.09%	Yes	$42,449,546	
UM Baltimore Washington Medical Center	$48,027,550		6.2%	43.72%	Yes	$48,027,550	
UM St. Joseph Medical Center	$50,394,574		6.5%	43.25%	Yes	$50,394,574	
UM Medical Center	$44,480,746		5.7%	41.01%	Yes	$44,480,746	
Luminis Health Anne Arundel Medical Center	$35,327,185		4.5%	40.62%	Yes	$35,327,185	
HOLY CROSS HOSPITAL	$191,554,499		24.7%	36.16%	Yes	$191,554,499	
JOHNS HOPKINS HOSPITAL	$0		5.3%	36.04%	No	$41,075,921	
UM Shock Trauma	$13,667,115		1.8%	5.43%	Yes	$0	Specialty Hospital
Total	$644,403,513					$590,234,484	

Comments were received from:	Adventist	Ascension Saint Agnes	CareFirst	JHHS	LifeBridge	Luminis	MedStar	MHA	UMMS

See appendix for comment details.

Process, Timeline and Broader Applicability Comments

Overall Summary: Stakeholders request more time and engagement before the policy implementation, advocating for alignment with related market shift refinements, longer review periods, and stakeholder collaboration. Suggestions include advance notice requirements, interim settlement reviews, and procedural safeguards such as advance data review. Some stakeholders highlight the need for broader applicability if similar changes occur with other payers in the future.

Staff Response: In future iterations of the payer-initiated shifts that are excluded from the Marketshift methodology, staff will require at least 6 months advanced notice, in line with the recommendation outlined to Commissioners in the October Commission meeting. Staff believe this requirement will allay concerns regarding the need for advanced data review. Staff does not support the request to allow for interim settlement reviews, as this action will create additional administrative complexity that is unnecessary given staff's proposed revision to retrospectively assess resolved latent demand after payer-initiated realignment(s). Additionally, given the permanent and one-time nature of any retrospective assessment, staff do not anticipate that these adjustments will have any long-term impact on a hospital's liquidity.

As staff indicated in the Marketshift policy revisions, the service line exclusion logic will be made available to all-payers if the projected shift is material, i.e., greater than 1% of a hospital GBR, and if the payer who requested the shift provides a reasonable plan for the intended shift, as well as detailed data to substantiate the proposed realignment.

Comments were received from:	Adventist	CareFirst	JHHS	MedStar	MHA	LifeBridge	Luminis	UMMS

See appendix for comment details.

Other Topics

Overall Summary: Additional comments include requests for a Total Cost of Care impact analysis and addressing geographic access challenges. There are calls for phased or pilot approaches and for prioritizing discussions around broader volume policy issues during the state's transition to the AHEAD model. Concerns about fairness, regulatory obligations, and compliance burdens were also raised.

Staff Response: Given the zero-sum nature of this evaluation, which is in keeping with the Marketshift policy paradigm, staff do not believe that a Total Cost of Care impact analysis is necessary.

Staff share the concern, however, that this proposal does not allow for an extensive period for hospitals to modify their processes to effectuate a temporary fee-for-service reimbursement scheme, albeit within a capitated system. At the same time, staff continue to hear concerns from hospitals that already are receiving enhanced Kaiser volumes due to this realignment.

Comments were received from:	Adventist	Ascension Saint Agnes	JHHS	MedStar	MHA	UMMS

See appendix for comment details.

Appendix - Detailed Stakeholder Comments

Inclusion of Elective & Emergent Volume Comments

Overall Summary: Stakeholders express concern about the impact of the draft policy on access, especially regarding emergency department (ED) encounters. Many recommend excluding ED encounters from the policy, as they are typically unplanned and medically necessary. Suggestions include analyzing KP ED volumes, requiring an access impact review, and ensuring policies prioritize system stability and patient access.

Organization	Summary of Comments
JHHS	JHHS notes unintended consequences of the draft recommendation, particularly for hospitals already at capacity. Suburban Hospital will lose KP volume but will likely backfill due to demand for medically necessary care. JHHS emphasizes that capacity and demand must be considered before any downward adjustment.
Adventist	AHC highlights that approximately 97% of KP-originating encounters enter through the Emergency Department and are unplanned, medically necessary, and often life-threatening. AHC recommends excluding emergency-department-sourced encounters (including resultant inpatient admissions) from the realignment policy and allowing them to flow through the existing Market Shift mechanism.
Ascension Saint Agnes	Ascension Saint Agnes states that revenue associated with emergency department visits should be excluded because KP will likely be unsuccessful in redirecting emergent care to core hospitals. Patients generally seek emergent care at hospitals within close proximity.
MHA	MHA supports refining market shift policies to ensure revenue follows the patient without unintentionally impeding care access. They urge HSCRC to analyze KP volumes from emergency visits. MHA also recommends requiring KP to complete an access impact analysis to minimize patient access disruption.
LifeBridge	LifeBridge recommends excluding emergency-related encounters from the proposal and notes transfers from ED to KP-preferred facilities impose additional clinical and administrative measures that may slow patient throughput. They also recommend considering EMTALA obligations during patient transfers and associated inefficiencies.

Data Transparency & Validation Comments

Overall Summary: Stakeholders call for transparency and independent validation of data related to KP-related changes. Many urge the HSCRC to validate volumes using all-payer hospital data, share detailed analyses by setting and service type, and allow hospitals to confirm KP-submitted data before rate adjustments. Recommendations include quarterly data sharing, clear identification of KP patients, and full disclosure of KP's care realignment plans. KP is open to discussing specific impacts with affected hospitals.

Organization	Summary of Comments
CareFirst	CareFirst notes the need for using hospital and payer-submitted data to accurately adjust revenues prospectively based on expected market shifts.
Adventist	AHC expresses concern that the draft recommendation relies primarily on KP's internal data. AHC recommends HSCRC conduct independent validation using all-payer hospital data and review elective versus emergent cases by service line.
MHA	MHA requests HSCRC to share analyses that break down KP volume by setting and service type, particularly emergency department volumes. MHA also asks that hospitals be allowed to validate KP-submitted data before any rate order adjustments are made.
UMMS	UMMS recommends the staff refine the recommendation, identify KP patients using health plan code 107 and share data quarterly to ensure all volume is captured.
MedStar	MedStar raises concerns about the reliance on KP's submitted data for adjusting hospital GBRs. They emphasize the importance of using HSCRC data submissions, to more accurately reflect the services delivered to KP patients.
Luminis	Luminis recommends requiring KP to share its care realignment plan, validating revenue associated with planned volume realignment, and vetting methodology through an open collaborative process.
LifeBridge	LifeBridge recommends releasing information and data related to KP's intended realignment to align with procedural safeguards under Market Shift Policy.

Financial Impact & Policy Scope (1/2)

Overall Summary: Concerns are raised about the financial strain the proposed policy could impose on hospitals, as they may still face downward budget adjustments despite overall utilization remaining constant. Stakeholders recommend narrowing the scope to material elective cases, revising payment and reconciliation frameworks, and adjusting settlement periods. Stakeholders support limiting the policy to hospitals with significant KP volumes but suggest refining the criteria. Suggestions include excluding hospitals with immaterial elective KP business and better targeting significant shifts. Collaboration is urged to maintain stable revenues and avoid disruption. Stakeholders also requested clarification on the VCF that will be used to fund the volume shifts.

Organization	Summary of Comments
MHA	MHA supports limiting scope to hospitals with material KP volume but requests clarification on assumptions regarding KP volume shifts.
Luminis	Luminis recommends refining the recommendation to a more targeted solution rather than wholesale changes to 19 hospitals and limiting applicability to KP only.
CareFirst	CareFirst emphasizes that hospitals receiving an influx of patients due to payer-initiated market shifts must be adequately reimbursed to manage the costs of care. Not adjusting revenues for both sending and receiving hospitals could lead to inequitable patient charges.
JHHS	JHHS expresses concern that hospitals losing KP-specific volume may still maintain overall volume due to demand yet face downward budget adjustments.
Adventist	AHC states that Market Shift is zero-sum and cannot fund latent demand, creating financial risk. It is unclear whether funds will be reimbursed at 59% or 100% of the HSCRC rate order. AHC recommends narrowing the scope to material elective cases, conducting an access and sustainability risk assessment, and refining the funding threshold by revising the current 2% or $5 million trigger to a data-driven range targeting verified material shifts (e.g., top 80% of projected elective cases).

Financial Impact & Policy Scope (2/2)

Overall Summary: Concerns are raised about the financial strain the proposed policy could impose on hospitals, as they may still face downward budget adjustments despite overall utilization remaining constant. Stakeholders recommend narrowing the scope to material elective cases, revising payment and reconciliation frameworks, and adjusting settlement periods. Stakeholders support limiting the policy to hospitals with significant KP volumes but suggest refining the criteria. Suggestions include excluding hospitals with immaterial elective KP business and better targeting significant shifts. Collaboration is urged to maintain stable revenues and avoid disruption. Stakeholders also requested clarification on the VCF that will be used to fund the volume shifts.

Organization	Summary of Comments
Ascension Saint Agnes	Ascension Saint Agnes cautions against a methodology that may be disruptive to hospitals providing limited elective services to KP members and recommends excluding hospitals with immaterial elective KP business (e.g., <$1M or 0.5% of GBR).
UMMS	UMMS recommends applying revised variable cost factors for KP volume realignment for both interim revenue recognition and final settlement and applying these factors differentially for inpatient and outpatient medical and surgical volume. UMMS also recommends evaluating actual volume and adjusting the settlement period if there is a ramp-up delay.
MedStar	MedStar recommends staff to continue collaboration with stakeholders on a better approach that focuses on maintaining predictable and stable hospital revenues. MedStar warns that the draft policy adds complexity and puts revenues at risk especially for 19 hospitals midway through FY2026.
LifeBridge	LifeBridge recommends clarifying payment methodology and reconciliation framework to avoid financial risk for hospitals.

Process, Timeline and Broader Applicability Comments

Overall Summary: Stakeholders request more time and engagement before the policy implementation, advocating for alignment with related market shift refinements, longer review periods, and stakeholder collaboration. Suggestions include advance notice requirements, interim settlement reviews, and procedural safeguards such as advance data review. Some stakeholders highlight the need for broader applicability if similar changes occur with other payers in the future.

Organization	Summary of Comments
CareFirst	CareFirst criticizes delays in adjustments due to network changes, stating that distributing volume across hospitals is not complex enough to justify revenue maldistribution. They argue the policy applied to KP should also apply to all payer-initiated shifts and disagree with treating KP differently, noting similar principles could apply to other payers.
JHHS	JHHS emphasizes the need for more stakeholder input through the workgroup process and suggests considering broader applicability if exceptions for KP are allowed, as similar situations may arise with other payers.
Adventist	AHC states that implementing a midyear negative policy adjustment with less than 30 days' notice undermines Maryland's prospective rate-setting framework. AHC recommends postponing the vote, convening a technical workgroup, and requiring six months' advance notice for material shifts.
MHA	MHA recommends aligning this policy with Market Shift Refinement and allowing a two-month review period.
UMMS	UMMS recommends an interim settlement evaluation after six months of data via an industry workgroup to review the transition approach, address hospital concerns, and make technical revisions before final settlement.
MedStar	MedStar recommends working with stakeholders over a more appropriate policy development timeframe rather than implementing mid-year. They also recommend avoiding deviation from standard market shift methodology and warns against setting a precedent for differentiating carrier/providers such as KP from other insurance carriers.
Luminis	Luminis recommends vetting methodology through a collaborative process to avoid unintended consequences.
LifeBridge	LifeBridge recommends including procedural safeguards such as six-month advance data review required under Market Shift Policy.

Other Topics

Overall Summary: Additional comments include requests for a Total Cost of Care impact analysis and addressing geographic access challenges. There are calls for phased or pilot approaches and for prioritizing discussions around broader volume policy issues during the state's transition to the AHEAD model. Concerns about fairness, regulatory obligations, and compliance burdens were also raised.

Organization	Summary of Comments
JHHS	Though this policy emerged as a priority, JHHS is also concerned about the many substantial issues that must be addressed before the AHEAD model can be considered and urges the HSCRC to prioritize those consequential issues.
Adventist	AHC recommends HSCRC conduct a Total Cost of Care (TCOC) impact analysis to determine whether the proposed realignment would generate measurable statewide savings.
Ascension Saint Agnes	Ascension Saint Agnes highlights geographic challenges for KP members in Baltimore City accessing suburban core hospitals and notes proximity issues with KP's South Baltimore County Medical Center.
MHA	MHA suggests prioritizing discussions on adopting a streamlined latent demand policy to allow hospitals to backfill services when payer-driven shifts occur.
UMMS	UMMS recommends consistent treatment of hospitals and adjustments for KP volume shifts in real time, regardless of materiality.
MedStar	MedStar recommends avoiding increased compliance complexity and reporting burden during AHEAD implementation.

maryland
health services
cost review commission

Surge Funding Approach

November 2025

Volume Pressures

Last year's respiratory season was particularly intense, straining hospitals seeing large numbers of RSV, influenza, and COVID patients.

Flu Cases Surge in Maryland as Vaccination Rates Decline

Lauren Miller Dec 27, 2024 Updated Dec 27, 2024

Rise of pediatric flu cases is sending more children to the hospital

This flu season has been particularly bad for children, with many experiencing severe complications such as pneumonia, dehydration and organ failure.

Yesterday at 6:00 a.m. EST

7 min 546

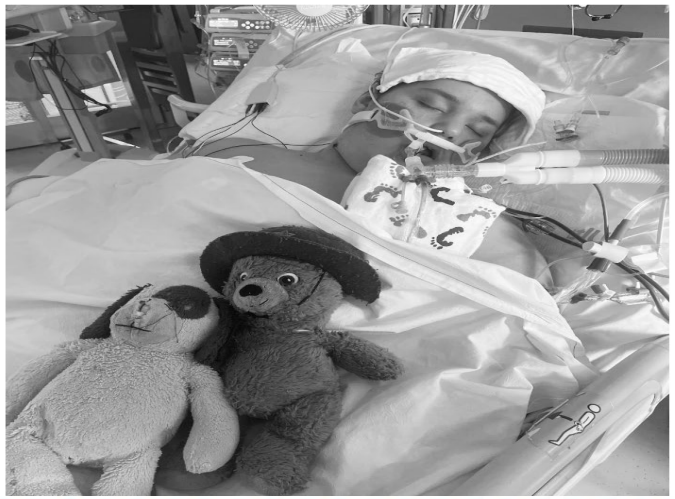
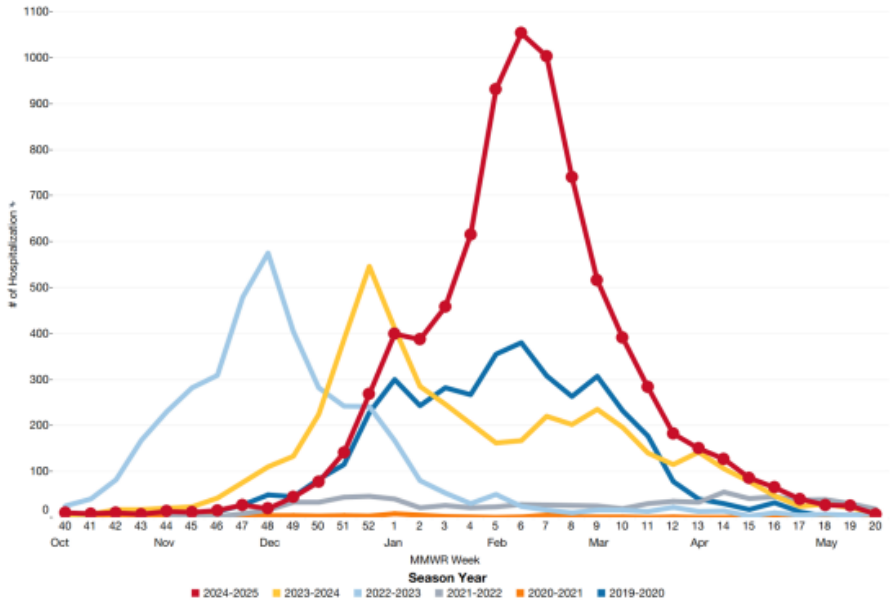


Figure 18: Influenza-Associated Hospitalizations in Maryland by Week and Season



Early warning signs for 2025-2026 (southern hemisphere flu season and H3N2 outbreaks underway in Canada and the UK) suggest there could be significant respiratory related hospitalizations again this year

Flu cases surge in the DMV: Here's what medical experts want you to know

by Kellye Lynn | Tue, February 11th 2025 at 5:07 AM
Updated Tue, February 11th 2025 at 6:56 AM

A doctor listening to a child's heartbeat. (FILE)

Maryland Flu Cases 'Very High'

If you have the flu or know someone who has the virus, you are not alone. Maryland is experiencing an explosion in cases in recent weeks.

Statewide data shows flu activity in Maryland is very high. Dr. Andy Catanzaro, Chief of Infectious Diseases at Adventist Healthcare White Oak Medical Center, said, "One in ten emergency room visits are related to flu-like illnesses. Since November 2024, more than 3,000 Maryland residents have been hospitalized because of respiratory viruses."

maryland health services cost review commission

July 2025 Commission Meeting Surge Funding Discussion

Due to the high respiratory season, Commissioners during the July Commission meeting discussed and ultimately approved a reinstatement of the Surge Funding Policy which:

- Provided hospitals with $100.4M in additional funding in RY2026 in recognition of the surge in respiratory hospitalizations based on 9 months of RY2025 data (includes all respiratory cases, not just COVID).
- Directed staff to revisit the distribution (and rationale therein) of the $100.4M at the hospital level later in a Volume Workgroup engagement. Per the Commission vote, the $100.4M in RY2026 cannot be changed, just the distribution.

Staff Considerations:

- The $100.4M in funding was calculated using a blended approach:
  - 2/3 weight applied to surge funding calculated using patient days as the volume statistic.
  - 1/3 weight applied to surge funding calculated using ECMADs as the volume statistic.
- Staff are concerned that using patient days as the volume statistic diverges from typical HSCRC policies by potentially incentivizing hospitals to increase LOS for respiratory patients.
- The following slides outline:
  - Updated findings for RY2025 surge (paid out in RY2026)
  - An analysis performed by Staff to determine whether it is necessary to use patient days in the Surge Funding Policy.
  - Additional considerations for future implementation of the Surge Funding Policy.

RY 2025 Findings

Hospital Name	FY25 Blended Approach (Funded in July 2025 Rates) (9-Months)	FY25 Blended Approach (12-Months)	FY25 Blended Approach Normalized to Commmission Appropriation
Johns Hopkins	$ 14,026,512	$ 32,851,194	$ 20,028,816
Anne Arundel	$ 10,757,326	$ 15,519,523	$ 9,461,990
Peninsula	$ 7,345,706	$ 12,643,290	$ 7,708,399
Carroll	$ 6,984,378	$ 10,021,504	$ 6,109,941
Northwest	$ 6,639,657	$ 9,804,655	$ 5,977,732
Sinai	$ 7,775,162	$ 9,786,613	$ 5,966,732
St. Agnes	$ 6,370,364	$ 8,288,146	$ 5,053,142
Frederick	$ 4,222,455	$ 7,605,476	$ 4,636,930
Howard County	$ 4,532,684	$ 7,511,219	$ 4,579,463
MedStar Fr Square	$ 3,218,330	$ 7,090,986	$ 4,323,254
Meritus	$ 3,689,794	$ 6,624,587	$ 4,038,899
ChristianaCare, Union	$ 3,125,891	$ 4,936,831	$ 3,009,902
UM-BWMC	$ 3,045,663	$ 4,849,545	$ 2,956,685
UMMC Midtown	$ 472,761	$ 3,641,482	$ 2,220,150
Mercy	$ 2,585,403	$ 3,632,975	$ 2,214,963
MedStar Montgomery	$ 2,593,083	$ 3,600,043	$ 2,194,885
HC-Germantown	$ 3,772,741	$ 3,308,614	$ 2,017,206
MedStar St. Mary's	$ 1,844,500	$ 2,969,652	$ 1,810,546
MedStar Southern MD	$ 1,477,679	$ 2,940,625	$ 1,792,849
MedStar Union Mem	$ 1,592,907	$ 2,731,320	$ 1,665,239
UMMC & Shock Trauma	$ -	$ 2,402,869	$ 1,464,988
Suburban	$ 2,245,992	$ 1,058,610	$ 645,416
UM-Chestertown	$ 384,810	$ 483,416	$ 294,731
MedStar Harbor	$ 641,407	$ 278,637	$ 169,880
Garrett	$ -	$ 49,839	$ 30,386
UM-Charles Regional	$ 427,480	$ -	$ -
UM-Easton	$ 600,441	$ -	$ -
Statewide	**$ 100,373,126**	**$ 164,631,651**	**$ 100,373,126**
		0.6097	

***NB: Using one third ECMADs and Two third Patient Days

- Surge policy modelling using 12 months of FY 25 data identifies $165M growth in respiratory cases
- Commissioner vote caps total RY2026 surge funding at $100.4M. Therefore, revenue adjustments cannot be changed but are normalized and redistributed by hospital

maryland health services cost review commission

Primary Question: Do patient days need to be factored in the surge funding policy?

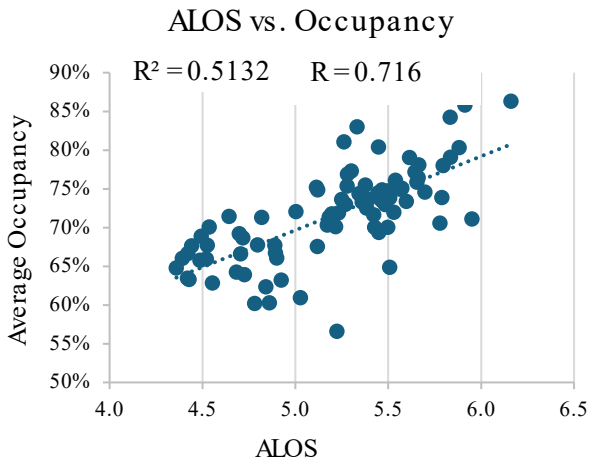
Supporting Questions	Analysis	Reason for Analysis	Takeaway
What is the correlation between ALOS, ADC, and Occupancy?	Ran linear regression comparison of statewide ALOS to average occupancy and ALOS to ADC for and ADC for DEF, MIS, MSG, and PED volumes.	If ALOS increases as ADC increases, it might suggest that a various census thresholds, LOS management is comprised and ECMADS may not capture that.	The correlation for ALOS vs Occupancy and ALOS vs ADC were both relatively strong (.7). This could support the need to use patient days in the calculation.
Does ALOS, ADC and occupancy increase in surge months (fall/winter)?	Compared ALOS, occupancy, and ADC for DEF, MIS, MSG, and PED rate centers by month for hospitals that received surge funding.	If ALOS and ADC increases tend to occur concurrently during the respiratory season, it might suggest that a various census thresholds, LOS management is comprised and ECMADS may not capture that.	In FY24, there was minimal variation in ALOS by month, which ranged between 4.27 and 4.64 for hospitals that received surge funding. This does not support the need to use patient days in the calculation.
How does LOS for surge cases compare during surge months (fall/ winter) to non-surge months?	Compared ALOS for surge cases (MDC = 04(Respiratory) or PRINDIAG = A419 or A4189) by quarters Q4 &Q1 (Oct-Mar) vs Q2 &Q3 (Apr-Sept).	If LOS for surge cases is different during the respiratory season, it might suggest that calendar year-based weights are not capturing broad based LOS exacerbation in the winter months	The ALOS was not consistently higher in Q4 &Q1 (Oct-Mar) vs Q2 &Q3 (Apr-Sept) for surge cases. This does not support the need to use patient days in the calculation.
Do non-surge cases with similar ECMAD weights have a lower LOS than surge cases?	Compare cases LOS for non-surge cases with an ECMAD weight of ~1.5 to the LOS for surge cases.	If LOS for surge cases is higher than non-surge cases with a similar ECMAD weight, this could suggest that the ECAMDS are underweighted for surge cases.	Surge cases have a longer LOS in comparison to non-surge cases with similar ECMAD weights. This could support the need to use patient days in the calculation.

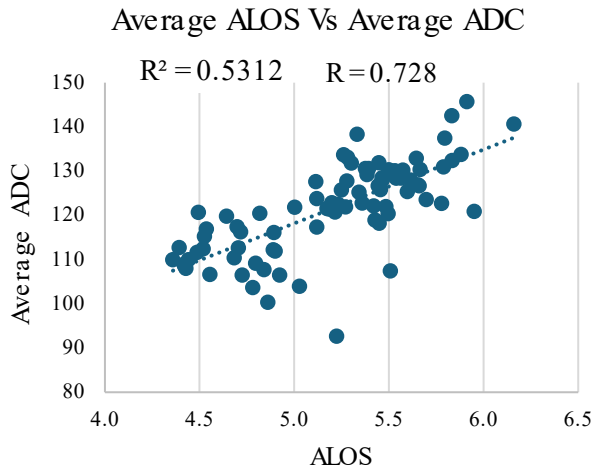
Q1: *What is the correlation between ALOS, ADC, and Occupancy?*

Conclusion

Longer patient stays have a relatively strong correlation to increased occupancy and ADC; however, there are likely other factors contributing to capacity and census.

Results and Interpretation





Source: Statewide regression for PED, MIS, MSG, and DEF cases using the experience data.

Should Surge Policy Use ECMADs and/or Patient Days?

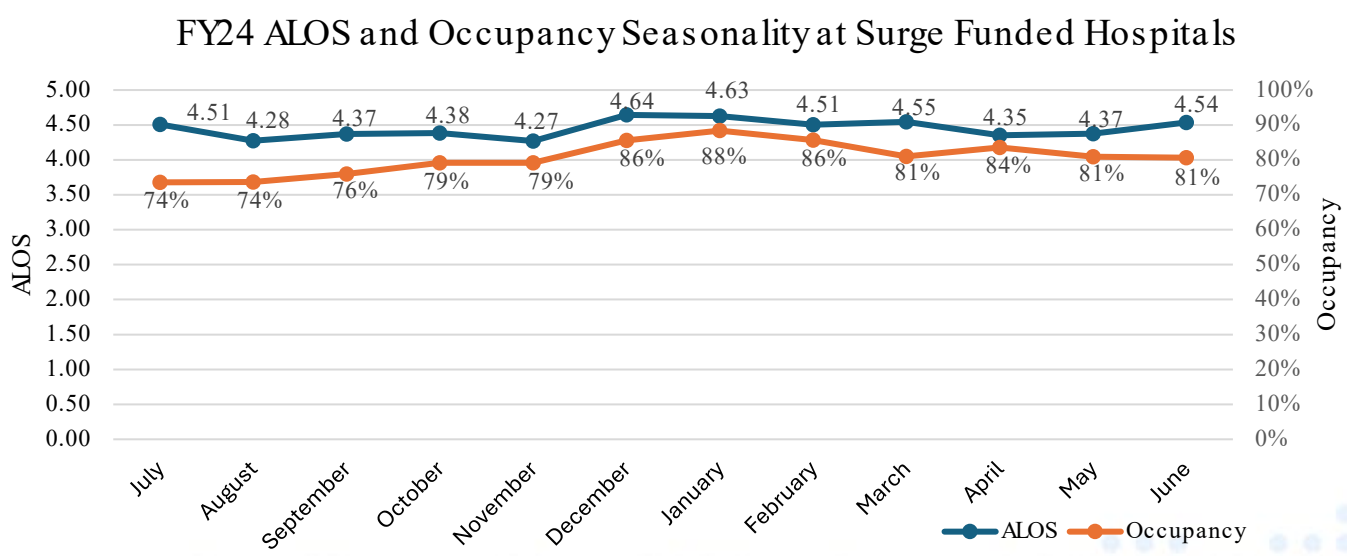
ECMADs	Patient Days Needed
✓	✓
Because the correlation is relatively strong but not perfect, it is not reliable to say that patient days are the sole factor contributing to hospital strain and other factors are likely at play.	Because Occupancy and ADC explain over 50% of the variation in ALOS, there is a statistically significant relationship between patient days census and ALOS, suggesting patient days should be utilized in some capacity.

Q2: *Does ALOS and Occupancy increase in surge months (e.g., winter)?*

Conclusion

Throughout the year, ALOS ranges between 4.27 and 4.64 by month for hospitals that received surge funding. While there is a slight increase from December to March, it is very minor.

Results and Interpretation



Source: PED, MIS, MSG, and DEF cases at hospitals that received surge funding using the experience data.

Should Surge Policy Use ECMADs and/or Patient Days?

ECMADs	Patient Days Needed
✓	
There was minimal variation between the lowest and highest Average Length of Stay (ALOS) during FY24.	

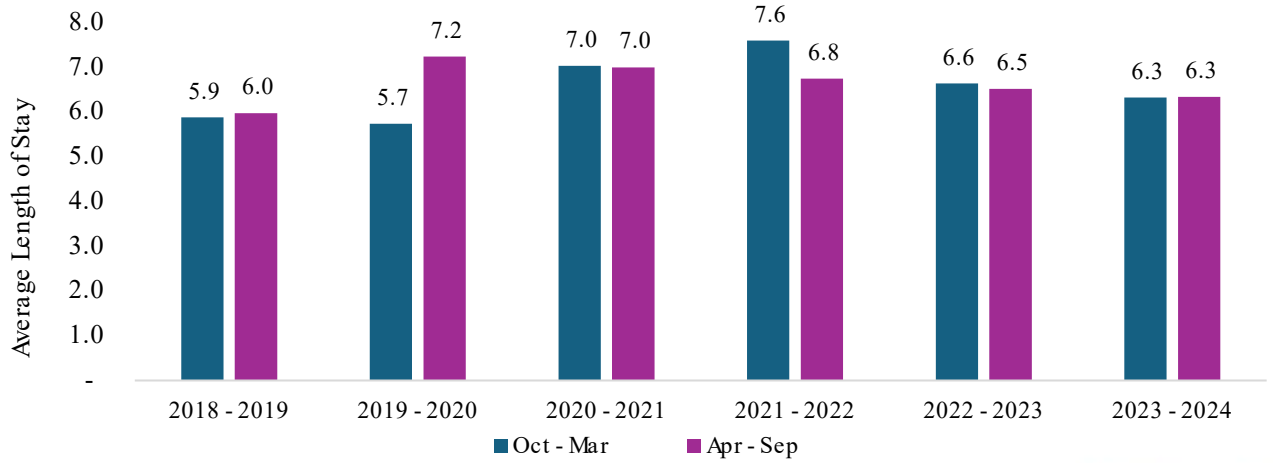
maryland health services cost review commission

Q3: *How does LOS for surge cases compare during surge months to non-surge months?*

Conclusion

Initial results challenge the assumption that the winter season has a higher LOS for surge cases as LOS was not consistently longer in the fall/winter vs spring/summer months between 2018-2024.

Results and Interpretation



Source: Surge cases (MDC = 04 (Respiratory) or PRINDIAG (Principal Diagnosis)= A419 or A4189) from the Casemix data.

Note: Apr-Sep 2024 is Apr-June given the availability of the data.

Should Surge Policy Use ECMADs and/or Patient Days?

ECMADs	Patient Days Needed
✓	
The data shows that a longer length of stay is not a consistent feature of the surge season.	

maryland health services cost review commission

Q4: *Do non-surge cases with similar ECMAD weights have a lower ALOS than surge cases?*

Conclusion

Surge cases experience longer ALOS than non-surge cases with similar acuity, potentially justifying the potential need for a funding component that accounts for patient days.

Results and Interpretation

Average Length of Stay (Similar ECMADS, FY19-FY24 Average)

4.4 Days for Surge Cases

2.9 Days for Non-Surge Cases

Source: Surge cases (MDC = 04 (Respiratory) or PRINDIAG (Principal Diagnosis)= A419 or A4189) and non surge cases with ECMADs weighted 1.50 to 1.65 (average ECMAD weight range for surge cases) from the Casemix data.

Should Surge Policy Use ECMADs and/or Patient Days?

ECMADs	Patient Days Needed
✓	✓
Further review that stratifies non-surge cases with higher drug or supply charges may explain a higher ECMAD weight but a lower LOS case profile.	The data clearly shows that surge cases experience a significantly longer length of stay than non-surge cases of similar acuity.

Scorecard

	Should Surge Policy Use ECMADs and/or Patient Days?	
Supporting Analysis	ECMADs Only	Patient Days Needed
Q1: There is a relatively strong correlation between ALOS and ADC/Occupancy %.	✓	✓
Q2: There was minimal variation between the lowest and highest ALOS during the months of FY24 across all MSG, ICU, DEF, and PED cases.	✓	
Q3: ALOS is not consistently longer in fall/winter compared to other months across surge cases.	✓	
Q4: Surge cases have a longer ALOS than non-surge cases with similar ECMAD weights (~1.5).		✓

Policy Considerations/Proposals

- Staff believe that funding provided in RY2026 based on RY2025 surge should be based on a full fiscal year evaluation, i.e., $164M, as this comports with the initial intention of the surge policy to assess the extent to which GBR budgeted volumes across the entire year may offset infectious disease surges
  - Staff will need to consider timing and measurement period against any full rate review funding awarded and discount as needed.
- Staff will leave it up to the Commissioners to consider amending the cap on surge funding in RY2026, as the Update Factor recommendation was clear that the value regardless of the full year assessment is set at $100.4M.
- Moving forward staff recommend a 9 month estimate of surge funding be built into July rate orders and then reconciled in January rate orders based on the full fiscal year evaluation (similar to QBR process).
  - Staff will need to consider timing and measurement period against any full rate review funding awarded and discount as needed.
- Staff recommend that in RY2027, any surge funding provided be based on 66% ECMAD evaluation and 33% patient day evaluation, as there are analyses to support the need for some consideration of patient days. This aligns with Commissioner discussion that in a future state patient days could be deemphasized because of the concern related to rewarding hospitals for LOS exacerbation.
- To further allay concerns regarding the need for a patient day evaluation in the Surge Funding Policy, staff recommend Commissioners adopt an independent IP LOS incentive that has been developed in concert with the Performance Measurement Workgroup to improve LOS performance more broadly in the State. Additional benefits of this policy proposal are as follows:
  - Increased financial sustainability of the Model
  - Greater incentives to create value base arrangements with post acute providers and hospital alternatives, e.g., Hospital at Home
  - Improved hospital throughput, ED LOS, and patient satisfaction