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637th Meeting of the Health Services Cost Review Commission

December 10, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on November 12, 2025

Specific Matters

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

Docket Status – Cases Closed

2657A Johns Hopkins Health System- Extension Request

2. Docket Status – Cases Open

2683A Johns Hopkins Health System
2684A University of Maryland Medical Center

Subjects of General Applicability

3. Report from the Executive Director
    a. Model Monitoring
    b. Policy Calendar Update

4. Presentation: HCAHPS Learning Collaborative Panel/Report Highlights

5. Surge Policy
    a. RY 2026 Surge Allocations - Final Recommendation
    b. Future Surge Considerations - Draft Recommendation

6. Final Recommendation: Marketshift Improvements (VCF, Geographies, Exclusions)

7. Final Recommendation: Select Volume Realignment

8. Final Recommendation: ED Best Practices Policy - RY 2028
9. Draft Recommendation: MHAC - RY 2028
10. Draft Recommendation: MPA - CY 2026 Performance / FY 2028 Payment
11. Materials Only - Maternal and Child Health Fund - Year 4 Activities Report
12. Hearing and Meeting Schedule

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

December 10, 2025

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2493
BALTIMORE, MARYLAND	*	PROCEEDING:	2683A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 20, 2025, on behalf of its member hospitals (the "Hospitals"), Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for solid organ and bone marrow transplants, cardiovascular services and CAR-T services with Emerging Therapy Solutions formerly known as Life Trac (a subsidiary of Allianz Insurance Company of North America). The System requests approval of the arrangement for a period of one year beginning December 1, 2025.

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been 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 Hospitals' request for participation in an alternative method of rate determination for solid organ and bone marrow transplants, cardiovascular services and CAR-T for a one-year period commencing December 1, 2025, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

December 10, 2025

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND	*	DOCKET:	2025
MEDICAL CENTER	*	FOLIO:	2494
BALTIMORE, MARYLAND	*	PROCEEDING:	2684A

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed a renewal application with the HSCRC on November 25, 2025, for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval from the HSCRC to continue to participate in a global price arrangement for solid organ and bone marrow transplants with Blue Cross Blue Shield Association Blue Distinction Centers for Transplants (BDCT). The Hospital requests approval of the arrangement for a period of one year beginning December 1, 2025.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. (FPI), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

price contract. FPI maintains it has been active in similar types of fixed fee contracts for several years, and that FPI 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 Hospital can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for participation in an alternative method of rate determination for solid organ and bone marrow transplants with BDCT for a one-year period commencing December 1, 2025, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered 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 MOU with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Draft Recommendation for Surge Funding Policy

December 10, 2025

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
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This document contains the draft staff recommendations for updating the Surge Funding Policy. Please submit comments on this draft to the Commission by Wednesday December 18, 2025, via email to allani.pack@maryland.gov and prudence.akindo@maryland.gov

Key Methodology Concepts, Definitions, and Abbreviations

1. Average Daily Census (ADC) – Monthly Inpatient volume by cost center divided by days in the month
2. Average Length of Stay (ALOS) – Sum of length of stay divided by number of admissions
3. CMS - Centers for Medicare & Medicaid Services
4. CY - Calendar year
5. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as case-mix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.
6. FFS - Fee-for-service
7. FY - Fiscal Year, typically refers to a State fiscal year from July 1 through the following June 30
8. FFY - Federal fiscal year refers to the period of October 1 through September 30
9. Global Budget Revenue (GBR) - a single, fixed-income budget for hospitals to cover all services for all payers, including Medicare, Medicaid, and commercial insurance. The goal is to control costs, improve quality of care, and ensure a stable financial environment for hospitals.
10. HSCRC or Commission - Health Services Cost Review Commission
11. Length of Stay (LOS) – Monthly Inpatient volume by cost center divided by the number of licensed beds for the month
12. Major Diagnostic Category (MDC) – A classification system used in healthcare to group patients with similar principal diagnoses for billing and reporting purposes
13. Respiratory syncytial virus (RSV) – also called human orthopneumovirus, is a virus that causes infections of the respiratory tract
14. RY - Rate year, which is July 1 through June 30 of each year
15. TCOC - Total Cost of Care, which is a measure of beneficiary's total healthcare spending, regardless of site of service

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Executive Overview

This draft policy recommendation reflects updates to the RY 2026 Respiratory Surge Funding policy reinstated by the Commission at the July 2025 Commission meeting. It also reflects additional assessments made by staff with stakeholder engagement to justify the limited use of patient days in the surge model.

Introduction

Maryland's global budget system, which provides hospitals with annual prospective budgets, guarantees Maryland hospitals a greater source of financial stability should significant changes in volumes occur. Typically, the GBR is a revenue cap that disincentivizes hospitals from growing unnecessary volumes and limits revenues to population-related utilization growth. The RY 2020 GBR did not include additional volumes for a pandemic such as COVID-19, and because of large surges in COVID-19 related cases, hospitals found themselves with insufficient revenue in their original GBRs to treat those cases.

At the height of the COVID-19 pandemic, Staff recommended and the Commission approved additional funding in hospital GBRs for the treatment of COVID-19 related cases, if the volume for those cases caused the hospital to exceed its original GBR. Under normal circumstances, hospitals experiencing volume increases would reduce charges to ensure that they do not overcharge their GBRs. However, given the unpredictability and huge surges in COVID-19 volumes (which had not been accounted for in hospital GBRs), providing additional COVID-19 revenues enabled hospitals to maintain their charges as volumes rose, thereby providing hospitals with significant funding relief.

Staff suspended the COVID Surge Policy because COVID had become endemic after the Omicron surge in 2022. However, in response to growing industry concerns, staff conducted studies revealing that COVID continues to create periodic strain on GBR volumes particularly with the confluence of other respiratory illnesses such as influenza, pneumonia, and RSV. The growth in respiratory conditions in RY 2024 and RY 2025 led to the reinstatement of the surge policy and given future projected increases in volumes for these cases, the Commission has tasked staff with creating a more formal approach for surge funding.

This policy recommendation will detail the work staff have done with the Volume Workgroup and the methods by which staff and stakeholders concluded that modifications to the surge policy are necessary, especially as they relate to the use of patient days in surge funding calculations.

Background

Maryland hospitals are experiencing surges in volumes related to respiratory conditions like influenza, RSV, and COVID. Respiratory illness outbreaks in Maryland are routinely reported to local health departments and MDH. The Maryland Emerging Infectious Program (EIP) divides respiratory illness outbreaks into COVID-19 and non-COVID-19 respiratory outbreaks. During the 2024-2025 influenza season, 480 COVID-19 outbreaks and 534 non-COVID-19 respiratory outbreaks were reported. The most reported outbreak was influenza (65.7%), followed by influenza-like illness (12.7%), RSV (9.2%), and pneumonia (8.4%) with the number of outbreaks peaking in early February.[1]

A review of volume changes from 2019-2024 show a significant rise in respiratory volumes with 2024 being the first year since the COVID-19 pandemic that respiratory volumes had returned to a 2019 baseline causing use rate growth beyond market shift. Considering these sustained cost increases in respiratory cases, staff proposed and the Commission approved the reinstatement of the Surge policy in RY 2024. The surge funding in RY 2024 recognized use rate growth of respiratory conditions in the prior

[1] Annual Maryland Influenza Season Summary: 2024-2025 https://health.maryland.gov/phpa/influenza/fluwatch/Past%20Flu%20Season%20Summaries/2024-2025%20Influenza%20Summary.pdf See Appendix 1 with for graph of influenza hospitalizations in Maryland by week and season

year using unit rates measured in patient days.

Commissioner directives involved creating a more permanent approach to surge funding, advancing a blended approach that allowed hospitals to receive adjustments equivalent to two thirds of what they would receive under the RY 2024 methodology which used patient days exclusively, and one third of what they would receive under a case-mix adjusted weighting methodology, or an ECMAD based approach. The decision to use ECMADs in surge funding calculations was based on staff concerns that using patient days as the volume statistic diverges from typical HSCRC policies and potentially rewards hospitals for longer LOS and/or creates a perverse incentive to not manage LOS in order to access additional funding. Commissioners expressed a desire that patient days be further de-emphasized, hence, directing staff to assess the necessity of using patient days in future surge funding calculations.

Overview of Surge Funding Calculation

Surge funding as determined during the COVID-19 pandemic was calculated as follows:

COVID Surge Funding = COVID Standard Charges - (Hospital GBR - Non-COVID Standard Charges)

The COVID and non-COVID standard charges were assessed by counting the rate center units for cases with a COVID ICD-10 code and all other ICD-10 codes, respectively. The rate center units were then multiplied by the relevant rates included in the hospitals' most recent rate order. Assessing the additional COVID revenues using the standard rate on the rate order ensured that hospitals did not have to lower their charges as volumes rose due to the COVID surge.

The table below shows an example of a hospital with a GBR of $360 million, where $60 million of non-COVID volume has dissipated. In the first example, the hospital charges $80 million for COVID units (assessed at the standard charges), which exceeds the revenue associated with dissipated volume ($60 million, again assessed at standard charges) and thus the hospital receives net COVID funding of $20 million. In the second example, the hospital charges only $20 million for COVID and the dissipated volume covers the additional COVID volume in its entirety. In this case, while the hospital receives no additional revenue - no revenue is removed from the hospital GBR either, GBR compliance notwithstanding. According to the formula, the hospital receives the greater of $0 or COVID Volume – (GBR – Non-COVID Volumes).

Table 1: COVID-19 Surge Funding Calculation

	GBR	Non-COVID Standard Charges	COVID Standard Charges	Additional GBR Funding for COVID Surge
	A	*B*	*C*	*D = C - (A - B)*
Example 1	$360M	$300M	$80M	$20M
Example 2	$360M	$300M	$20M	($40M)

Expansion of surge funding to include all respiratory cases

Staff reinstated the surge funding policy that existed during the COVID public health emergency in RY 2024 with the following amendments:

1. Broaden the definition of surge funding to include all respiratory cases (not just COVID cases) and calculated growth from a 2019 base period. Respiratory cases as defined include all cases with a respiratory major diagnostic category (MDC) and sepsis cases with co-occurring COVID diagnosis.

2. In order to avoid funding volume growth twice, offset any potential surge funding by the full-rate review rewards that hospitals received in rate year 2025 as well as other applicable revenue adjustments.

If a hospital were in an overcharge position such that its volumes multiplied by its standard rates exceed its GBR, it could be eligible for surge funding. After meeting that criterion, a hospital would receive the lesser of that overage relative to its GBR or the growth in all respiratory volumes from rate year 2019 to rate year 2024.

	GBR	Standard Charges	Standard Revenue over/under charge	FY19 Respiratory MDC and Sepsis Patients with COVID	FY24 Respiratory & Sepsis Patients with COVID	Growth in FY19 -FY24 respiratory Volumes (Using patient days)	Additional GBR Funding for Respiratory Surge
	A	*B*	*C = B - A*	*D = FY19 Respiratory volumes * standard rates*	*E = FY24 Respiratory volumes * standard rates*	*F = E - D*	*G = (if C AND F > 0 , then take the lesser of C and F, otherwise cap at $0)*
Example 1	$480M	$520M	$40M	$30M	$34M	$4M	$4M
Example 2	$393M	$397M	$4M	$19M	$18M	($1M)	$ -
Example 3	$85M	$79M	($6M)	$7M	$10M	$3M	$ -

Table 2: Respiratory Surge Funding Calculation

Blended approach to surge funding using ECMADs and Patient Days

In July 2025, given growing concern that the use of patient days in surge funding calculations potentially rewards hospitals for longer LOS and/or creates a perverse incentive to not manage LOS in order to access additional funding, Commissioners approved the reinstatement of the surge funding policy with a blended approach where two thirds of the weight is applied to surge calculations using patient days (as described above) and one third weight applied to calculations using ECMADs (calculated as described above but with the use of ECMADs as the volume statistic). Staff were also directed to perform further studies and engage in stakeholder workgroups to determine ways to further deemphasize the use of patient days in surge funding calculations.

Initial calculations using 9 months of rate year 2025 data and the blended approach rendered $100.4 million in additional funding to hospitals for all respiratory conditions in rate year 2026.[2] Per Commission vote, the 100.4 million in Rate year 2026 is capped and only its distribution amongst hospitals that qualify can be changed.

Methodology Assessment

In this section, Staff will analyze current concerns and/or potential advancements to the Surge funding policy.

RY 2026 Surge Funding Cap

In November 2025, Staff utilized the final 12-months of rate year 2025 case-mix data, which was not available when Commissioners approved a $100.4M allotment for surge funding in RY 2026 based on the blended approach of patient days and ECMADs. Surge funding using 12 months of data and the same blended approach identified approximately a $164.6 million growth in respiratory cases.[3] However, because the Commission vote caps the total rate year 2026 surge funding at the 9-month amount ($100.4 million), staff have normalized the surge amount such that it is equivalent to the 9 month cap approved by the Commission.[4] This results in a slightly different distribution across hospitals, but staff recommend using this value as the baseline for Commissioner consideration, as it comports with the initial intention of the surge policy to assess the extent to which the GBR budgeted volumes across the entire year may offset infectious disease surges.

Additional analyses performed by staff to assess the necessity of patient days in surge calculations (discussed below in this report) support an alternative blended approach using two thirds ECMADs and one third patient days. This approach results in $124.8 million[5] growth in respiratory cases for RY 2025 volumes and addresses the Commission's desire to de-emphasize the use of patient days in surge funding calculations.

The update factor recommendation was clear that surge funding regardless of the full year assessment, is capped at $100.4 million. Hence, Staff will defer to Commissioners to consider amending the cap on surge funding. The various options Commissioners may consider are as follows:

[2] See column 2 in Table 3

[3] See column 4 in Table 3

[4] See column 3 in Table 3

[5] See column 5 in Table 3

Table 3: Surge Funding Allotments

Reason for Allotment	*Update Factor Cap*	*Update Factor Cap*	*Full RY 2025 Allotment*	*Full RY 2025 Allotment*
Weighting	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*2/3 ECMADs & 1/3 Patient Days*
Data Period	*9-Months*	*12-Months*	*12-Months*	*12-Months*
Hospital Name	*Currently in Rates*	*Staff Baseline Recommendation*	*For Commissioner Consideration*	*For Commissioner Consideration*
Johns Hopkins	$14,026,512	$20,028,816	$32,851,194	$22,570,701
Anne Arundel	$10,757,326	$9,461,990	$15,519,523	$11,685,614
Sinai	$7,775,162	$5,966,732	$9,786,613	$11,032,604
Peninsula	$7,345,706	$7,708,399	$12,643,290	$9,343,320
Carroll	$6,984,378	$6,109,941	$10,021,504	$7,651,843
Northwest	$6,639,657	$5,977,732	$9,804,655	$6,818,479
Frederick	$4,222,455	$4,636,930	$7,605,476	$6,493,282
Howard County	$4,532,684	$4,579,463	$7,511,219	$6,256,406
St. Agnes	$6,370,364	$5,053,142	$8,288,146	$6,012,547
Meritus	$3,689,794	$4,038,899	$6,624,587	$5,510,801
MedStar Fr Square	$3,218,330	$4,323,254	$7,090,986	$5,074,017
ChristianaCare, Union	$3,125,891	$3,009,902	$4,936,831	$3,923,947
HC-Germantown	$3,772,741	$2,017,206	$3,308,614	$3,454,816
MedStar Montgomery	$2,593,083	$2,194,885	$3,600,043	$2,969,056
UMMC Midtown	$472,761	$2,220,150	$3,641,482	$2,846,283
Mercy	$2,585,403	$2,214,963	$3,632,975	$2,579,710
MedStar Southern MD	$1,477,679	$1,792,849	$2,940,625	$2,468,371
UM-BWMC	$3,045,663	$2,956,685	$4,849,545	$2,424,773
MedStar St. Mary's	$1,844,500	$1,810,546	$2,969,652	$2,138,372
MedStar Union Mem	$1,592,907	$1,665,239	$2,731,320	$1,365,660
UMMC & Shock Trauma	$0	$1,464,988	$2,402,869	$1,201,434
Suburban	$2,245,992	$645,416	$1,058,610	$529,305
UM-Chestertown	$384,810	$294,731	$483,416	$241,708
MedStar Harbor	$641,407	$169,880	$278,637	$139,318
Garrett	$0	$30,386	$49,839	$99,678
UM-Charles Regional	$427,480	$0	$0	$0
UM-Easton	$600,441	$0	$0	$0
Statewide	**$100,373,126**	**$100,373,126**	**$164,631,651**	**$124,832,046**

Staff will also consider the timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount that funding as needed. Staff recommend moving forward, a 9-month estimate of surge funding be built into July rate orders and then reconciled in subsequent July rate orders based on the full fiscal year evaluation.

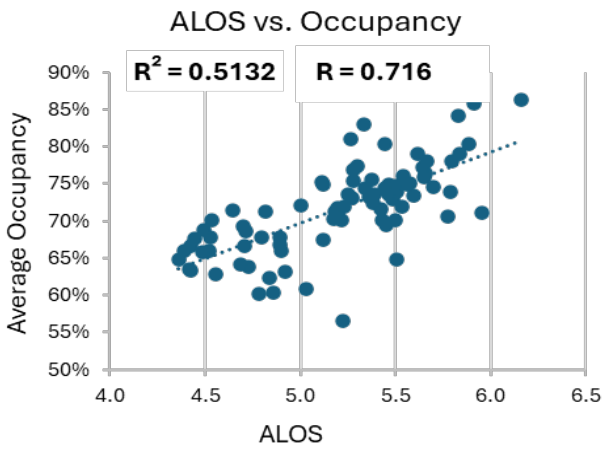
Do patient days need to be factored in the surge funding policy?

Staff are concerned that using patient days as the volume statistic diverges from typical HSCRC policies and could potentially reward hospitals for longer LOS and/or create a perverse incentive to not manage LOS in order to access additional funding. To assess the necessity of using patient days in surge funding calculations, staff developed four distinct questions to which analyses were performed using both hospital case-mix and hospital experience data to gain a more holistic picture.[6]

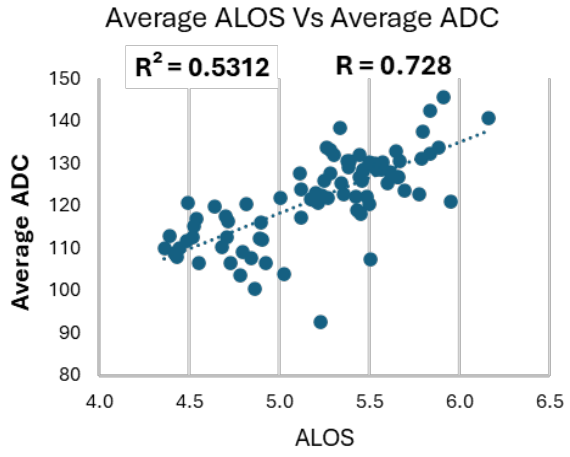
Question 1: What is the correlation between ALOS, ADC, and Occupancy?

Staff ran two linear regression models[7] on the correlation between average length of stay (ALOS) and occupancy rate (graph 1a.) and the correlation between average daily census (ADC) and ALOS (graph 1b.). Staff wanted to test the degree to which ALOS increases as occupancy and/or ADC increases, as this might suggest that at various census thresholds, LOS management is compromised and ECMADS may not capture that phenomenon entirely.

Graph 1a. Correlation between ALOS and Occupancy



Graph 1b. Correlation between ALOS and ADC



As shown on the graphs above, both models produced correlation coefficients of 0.72 and 0.73, respectively, indicating that longer patient stays have a relatively strong positive correlation to increased occupancy and ADC. However, because neither was a perfect correlation it is not reliable to conclude that patient days are the sole factor contributing to hospital resource strain. At the same time, ADC and occupancy do exhibit a statistically significant relationship with ALOS and explain over 50 percent of the variation in ALOS as shown by the R square statistics (51% in graph 1a, and 53% in graph 1b) suggesting that patient days should be utilized to some extent in surge funding calculations.

Question 2: Does ALOS and Occupancy increase in surge months (i.e., winter)?

To test whether increases in ALOS, ADC, and occupancy rates tended to occur concurrently during the respiratory season, which might suggest that at various census thresholds, LOS management is

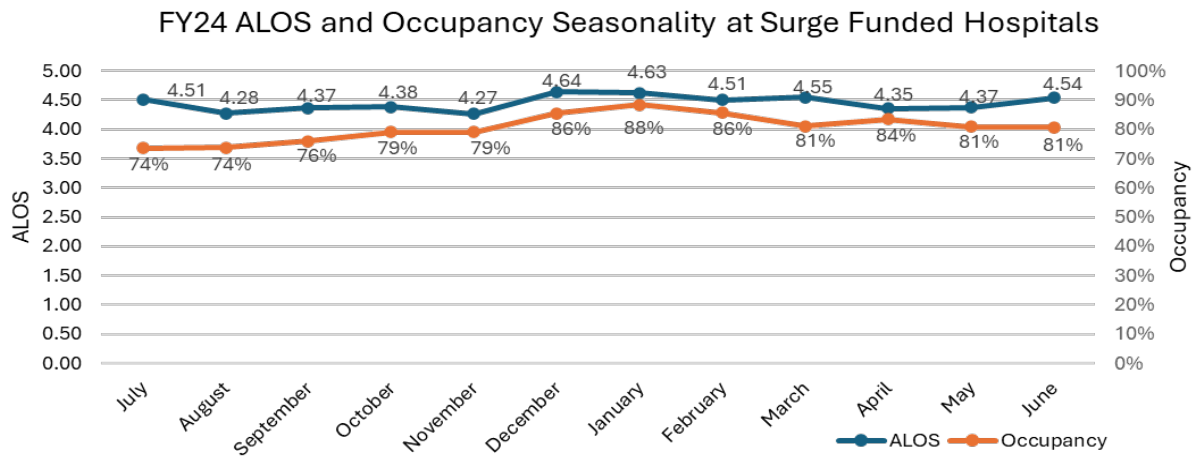
[6] See Appendix 2 for table summarizing all four questions, the corresponding analyses, and the results

[7] Linear regression models used statewide hospital experience data limited to the PEDS, MIS, MSG, and DEF rate centers

compromised (which may not be captured using calendar year based ECMADS), staff used hospital experience data[8] for those hospitals slated to receive surge funding and compared their monthly ALOS and occupancy rates in FY24.

As shown on the graph below, monthly ALOS in FY24 ranged between 4.27 and 4.64 throughout the year for hospitals that received surge funding with very minor increases occurring from December to March. The variation is so minimal that staff cannot definitively conclude that seasonality influences ALOS, ADC, and occupancy rates, suggesting that hospital-specific factors, rather than a universal seasonal surge, drive resource strain. Consequently, based on this analysis staff recommend de-emphasizing patient days in surge funding calculations.

Graph 2: ALOS and Occupancy Rates at Surge Hospitals during Surge Months



Question 3: How long does LOS for surge cases compare during surge months to non-surge months?

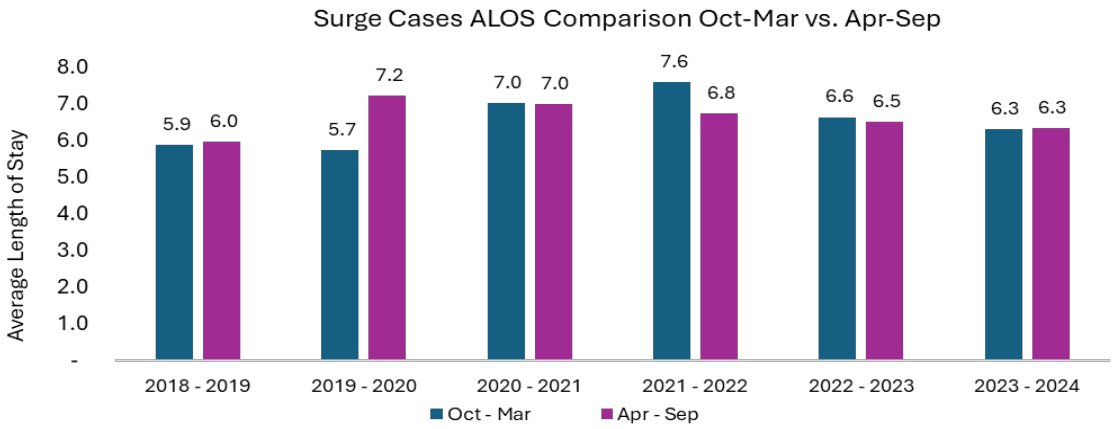
Staff used hospital case-mix data to test whether the LOS for respiratory cases was different during the respiratory season (fall and winter months) versus non respiratory season (spring and summer months).[9] If LOS for surge cases tends to be higher during the respiratory season, it could suggest that calendar year weights are not properly capturing LOS exacerbations that occur during the respiratory season.

As shown on the bar chart below, results of this analysis did not support the need to include patient days in surge funding calculations since ALOS was not consistently higher for surge cases during the respiratory season. The minimal variations in ALOS between respiratory versus non-respiratory seasons annually suggests that annual ECMAD weights properly capture length of stay exacerbations even during the fall/winter months.

[8] Used statewide hospital experience data limited to the PEDS, MIS, MSG, and DEF rate centers for hospitals receiving surge funding only

[9] The case mix data was limited to cases with a respiratory MDC (04) or a respiratory principal diagnosis (A419 or A4189)

Graph 3: ALOS Comparison Between Surge and Non-surge Months



Question 4: Do non-surge cases with similar ECMAD weights have a lower ALOS than surge cases?

Staff assessed the ECMADs and LOS variations between surge versus non-surge cases of similar weight. If the LOS for surge cases tend to be higher than that of non-surge cases with a similar ECMAD weight, then it could suggest that the ECMADs for surge cases are underweighted. Staff used the hospitals' case-mix data to identify surge cases[10] and non-surge cases.[11] The analysis resulted in an ALOS for surge cases at 4.4 days while that of non-surge cases was at 2.9 days. The results of the analysis suggest that patient days should be used in surge funding calculations, as surge cases tend to experience longer LOS than non-surge cases. However, it is important to acknowledge that included in the non-surge category are cases with higher drugs and supply charges, which would drive up the ECMAD weight but not necessarily have a lower LOS case profile.

Per the results of these analyses conducted to assess the use of patient days in the surge model as shown above, the response to two questions (Q1 and Q4) support the use of patient days in some capacity, while the majority strongly support the use of ECMAD in the surge model. Therefore, Staff recommend that RY 2027 surge funding calculations be based on a blended approach with two thirds weight applied to the ECMADs approach and one third weighting on patient days, as opposed to the inverse that is currently being used in the RY2026 surge funding policy. This also aligns with Commissioner discussions on de-emphasizing the use of patient days because their use could potentially reward hospitals for longer LOS and/or create a perverse incentive to not manage LOS in order to access additional funding.

Additional Considerations

Staff believe that patient days should be considered in the evaluation of surge funding for all the reasons stated above. However, staff are concerned that several hospitals with longer inpatient length of stay performance may not have qualified for additional funding if length of stay was better optimized. Specifically, 46 percent of the funding provided in the full year RY 2025 assessment will be distributed to hospitals that have length of stay that exceeds national average performance, as evaluated by RY 2025 case-mix data using 2021 Healthcare Cost and Utilization Project (HCUP) norms. Additional analyses, e.g., Medicare Part A 2024 claims, adjusted for age, gender, MS-DRG, comorbidities, using National Norms, yield similar findings.

[10] Cases with a respiratory MDC (04) or a respiratory principal diagnosis (A419 or A4189)

[11] The case mix data cases with an ECMAD weight between 1.5 and 1.6 (the average weight range for all identified surge cases)

In light of this concern, staff recommend that 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 include: increased financial sustainability of the model; greater incentives to create value-based care arrangements with post-acute providers, and hospital alternatives such as hospital at home; and improved hospital throughput, emergency department LOS, and patient satisfaction.

Recommendations

Based upon completion of the full 12-month rate year 2025 surge funding calculations and the various analysis done to assess the blended approach, Staff recommendation is as follows:

1. Funding provided in rate year 2026 should be based on the full fiscal year evaluation 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 consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed

2. Staff defer to the Commissioners to consider amending the cap on surge funding in RY 2026, as the Update Factor recommendation was clear that the value regardless of the full year assessment is set at $100.4M. Options are as follows:

    a. Status Quo - $100.4M based on 12 months of RY 2025 volume data with 66 percent patient day, 33 percent ECMAD evaluation

    b. Full Rate Year Allotment- $164.6 based on 12 months of RY 2025 volume data with 66 percent patient day, 33 percent ECMAD evaluation

    c. Full Rate Year Allotment and Advancement to New Weighting Approach- $124.8 based on 12 months of RY 2025 volume data with 33 percent patient day, 66 percent ECMAD evaluation

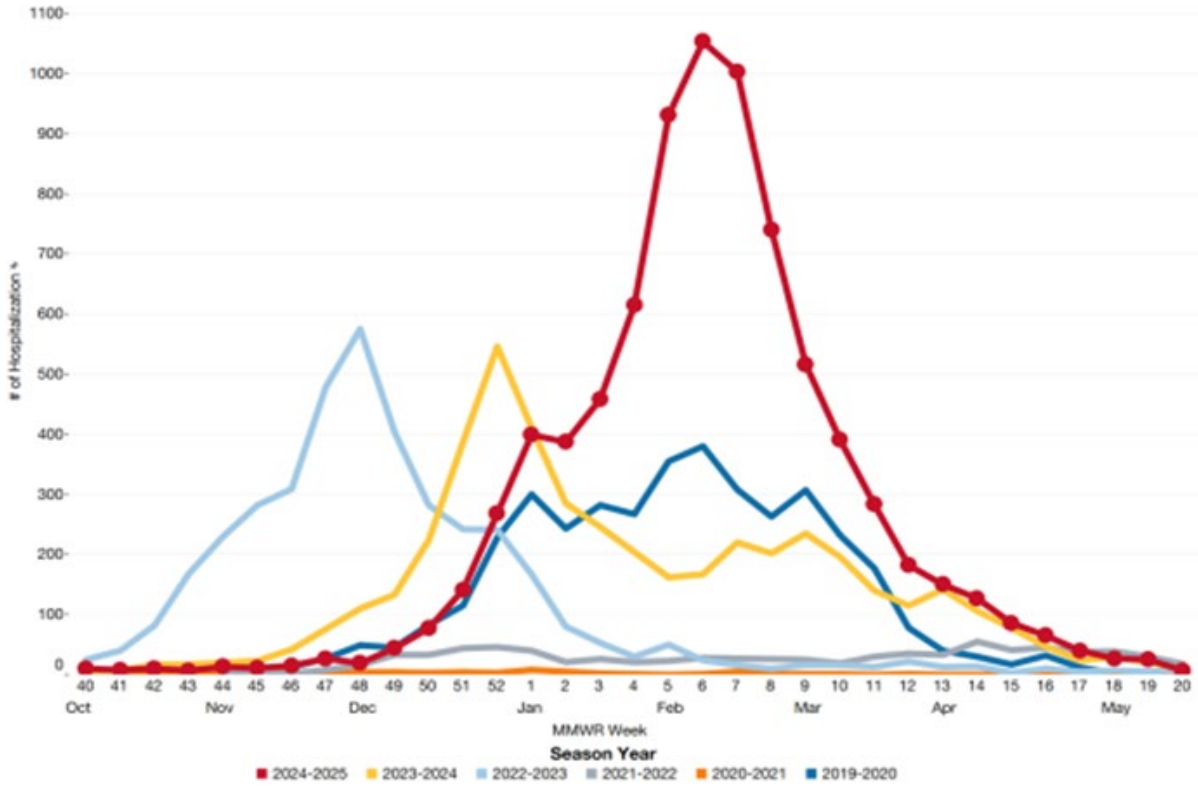
3. Moving forward, staff recommend a 9-month estimate of surge funding to be built into July rate orders and then reconciled in subsequent July rate orders based on the full fiscal year evaluation (similar to the QBR process). Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed

4. In RY 2027, any surge funding provided should be based on 66 percent ECMAD evaluation and 33 percent patient day evaluation,

5. 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.

Appendix 1: Influenza Associated Hospitalizations in Maryland by week and Season

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



Appendix 2: Summary of Analyses to Support the Use of patient days

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.

maryland
health services
cost review commission

Final Recommendation for Market Shift Refinement

December 10, 2025

Health Services Cost Review Commission

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This document contains the final staff recommendations for updating the Market Shift methodology.

Key Methodology Concepts, Definitions, and Abbreviations

1. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The historical standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as prior analyses indicated that 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.

2. Service Lines – Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology

3. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.

4. AHEAD - Achieving Healthcare Efficiency through Accountable Design

5. CMS - Centers for Medicare & Medicaid Services

6. CY - Calendar year

7. FFS - Fee-for-service

8. FY - Fiscal Year, typically refers to a State fiscal year from July 1 through the following June 30

9. FFY - Federal fiscal year refers to the period of October 1 through September 30

10. GBR - Global Budget Revenue

11. HSCRC - Health Services Cost Review Commission

12. RY - Rate year, which is July 1 through June 30 of each year

13. TCOC - Total Cost of Care

Table of Contents

Executive Overview

This draft policy update reflects a mature evolution of Maryland's Total Cost of Care model, addressing real-world data challenges, aligning incentives, and enhancing responsiveness to system change. The revised Market Shift methodology ensures the program remains financially sound, statistically valid, and adaptable—in line with both the original intent of the GBR model and the forward-looking goals of the upcoming AHEAD Model.

Introduction

As part of the All-Payer Model (2014) and the Total Cost of Care Model (2019), Maryland transformed its healthcare system to a population-based model, moving from volume-based payments to focusing on total hospital spending per capita and outcomes: readmissions, in-hospital complications, potentially avoidable utilization, and total cost of care, among others. The State exceeded all contractual targets through 2024.[1]

A key component was the Global Budget Revenue (GBR) methodology, which provided hospitals with annual prospective budgets. To address population-related utilization changes and market shifts, the HSCRC developed at the start of the All-Payer Model the Demographic Adjustment and Market Shift Adjustment methodologies. The Demographic Adjustment accounts for age-adjusted growth/decline.

The Market Shift Adjustment evaluates patient movement between hospitals, transferring funds at a 50 percent variable cost factor. This aimed to ensure a competitive market while controlling statewide volume growth. In 2019, the HSCRC modified the Market Shift policy in keeping with the long standing Commission tradition to constantly review and evolve policies.[2] However, concerns have emerged regarding the accuracy of the 50 percent variable cost factor and the overall reliability of the market shift. Stakeholders argue that:

a) The 50 percent variable cost factor provides inadequate funding for growing hospitals and may retain excess revenue for declining ones, leading to inefficiencies.

b) Granular market shift calculations for small regions or service lines can be statistically unstable and inaccurate.

c) During major system realignments, the policy is too imprecise and delayed to account for events like facility closures or intersystem shifts.

To address these, staff have engaged technical experts from the field in a Volume Workgroup since July 2025 and discussed three potential changes:

- **Variable Cost Factor:** Re-evaluating the calculation to determine its accuracy and to differentiate between inpatient/outpatient and surgical/medical services.

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[1] Limiting all-payer hospital spending per capita in line with the growth of the economy, saving Medicare a total of at least $795 million by keeping Maryland's Medicare per beneficiary growth below the national growth rate (currently the State has cumulatively saved $3.6 billion), reducing Medicare readmissions to the national average (currently 2.7% lower than national average; 4.7% on a risk adjusted basis), reducing hospital acquired complications by 30 percentage (currently the State has reduced from 2018 to 2024 by 41 percent), moving virtually all hospital payment methodologies to approved population based approaches, and effectively incentivizing hospitals to engage in site neutral activities that improve the affordability of the system.

[2] In 2019, the Commission voted to consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level. This effectively reduced the defined markets in the Market Shift methodology from potentially being in excess of 20,000 to approximately 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) went from approximately 7,000 to 1,000 - Final Recommendation Market Shift Consolidation

- **Market Definitions and Reliability:** Aggregating service lines where clinical overlap exists and potentially excluding from Market Shift unreliable low-volume services.
- **Service Line Exclusions:** Considering temporary exclusions from the Market Shift policy for material system realignments, similar to the proposed AHEAD Model Specifications.[3]

The policy recommendation herein will describe the work of the Volume Workgroup and the methods by which staff and stakeholders concluded that modifications to the Market Shift policy are warranted.

Background

The Market Shift, initially implemented in RY 2015 based on CY 2014 calculations, is an algorithm designed to reallocate funding when patients transfer from one hospital to another. It does not account for overall volume changes; increases or decreases in volume not quantified as shifts are addressed through the Demographic Adjustment, Full Rate Applications, or retained (without revenue adjustments) by hospitals as an incentive to reduce avoidable utilization.[4] Avoidable utilization is defined by Commission policy as readmissions and avoidable admissions, but also includes areas identified by hospital operators, such as services that can be more efficiently delivered in other settings such as sleep labs in hospital facilities, when Commission policies are less prescriptive.

The Market Shift algorithm, chosen by staff in collaboration with industry and payer stakeholders, was selected because it avoids creating incentives for volume growth beyond population growth. This makes it a more sustainable health financing method compared to others that implement revenue caps without addressing underlying cost management, such as the Medicare Physician Sustainable Growth Rate System.[5]

Due to its reciprocal nature—a hospital receiving additional volume funding only if another hospital experiences a corresponding decline in the same service and geography—the net statewide adjustment typically fluctuates around $0. Between CY14 and CY24, the average statewide market shift was ~$2.2 million, typically realigning ~$50 million among all hospitals.

Overview of Market Shift Calculation

The Market Shift Adjustment (MSA) methodology is an algorithm to calculate MSAs for a specific service line (e.g., orthopedic surgery) and a defined geographic location (e.g., ZIP code) using the case-mix adjusted volume measurement of equivalent case-mix adjusted discharges (ECMADS) for regulated inpatient and outpatient services. In total, there are 45 service lines, 32 inpatient and 13 outpatient, that are determined by 3M's aggregation of inpatient All Patients Refined Diagnostic Related Groupings (APR-DRG's), and HSCRC's aggregation of 3M's outpatient Enhanced Ambulatory Patient Groupings (EAPG's). The outpatient groupings are based on hospital rate center analyses to indicate the general services received at the hospital (e.g., emergency room services), while the inpatient service line aggregation is based on the diagnosis and/or procedure a patient receives (e.g., cardiothoracic surgery). There are also over 264 geographies in the Market Shift, as there are zip code level analyses for dense

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[3] https://www.cms.gov/files/document/ahead-tech-specs-v30.pdf - page 41

[4] Various failsafes exist in the Model to ensure that hospitals do not retain too much revenue for averted volume, including GBR Corridors, which necessitate that a hospital has to provide 95 percent of its budgeted volumes in order to recoup its entire global budget, and efficiency policies that withhold annual inflation updates if a hospital's charge per case and total cost of care performance deviates too drastically from statewide norms.

[5] The [Sustainable Growth Rate System] first set of problems relates to its design as a strict budgetary tool, with no mechanism for influencing provider performance toward improved care and prudent use of resources. In comparing total spending with a calculated target, the SGR formula aggregates spending across all physicians furnishing services to Medicare beneficiaries and, therefore, does not provide incentives for individual physician practices to control health care spending or improve care quality. Moreover, the SGR system does little to counter the volume incentives that are inherent in fee-for-service payments." - (page 4) - https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun11_Ch01.pdf

parts of the State and 15 county level analyses for less dense parts of the State. After arraying volume in various service lines and geographies, the market shift algorithm compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with utilization decreases.

It is important to note that not all revenue is included in the MSA. For instance, potentially avoidable utilization (PAU), which consists of 30 day readmissions and Prevention Quality Indicators,[6] is excluded because the Commission does not want to reward hospitals for growth in PAU, nor does it want to disincentivize hospitals from reducing PAU. The scope of volume evaluated in the MSA is as follows:

Table 1: Scope of Volume Addressed in Market Shift Calculation

Included (~75%)	Excluded (~25%)
-In-state Inpatient Discharges	-Out-of-state Units and Cases
-In-state Outpatient Visits	-High Cost Outpatient Drug Codes
	-Quaternary Cases
	-PAU Cases
Policy Adjustments	
-Market Shift Adjustments	-Out-of-state Policy
-Demographic Adjustment	-CDS-A
-Other Volume Adjustments	-Complexity and Innovation
-Full Rate Application	

Table 2 provides an illustration of the market shift calculation for ZIP code 21000 and the General Surgery service line. Within this ZIP code, the total volume increase is 654 equivalent case-mix adjusted discharges (ECMADs), and the decline is 129 ECMADs. Applying the "lesser of the two" rule, i.e., the Market Shift algorithm, the allowed market shift is limited to 129 ECMADs, which is allocated to other hospitals with volume increases proportional to this hospital's volume increase in total utilization. In the end, the net impact of market shift volumes in each ZIP code and service line combination equals zero - dollar values deviate slightly from $0 due to different price structures for each hospital.

[6] Readmissions are admissions to a hospital (defined as inpatient admission or observation stay greater than 23 hours) within a specified time period after a discharge from the same or another hospital. In the PAU measure, readmissions are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions. Hospitalizations for ambulatory sensitive conditions are measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs). In the PAU measure, PQIs are measured on inpatient admissions and observation stays greater than 23 hours for ambulatory care sensitive conditions

Table 2: Example Calculation of Market Shift Algorithm

ZIP Code 21000 General Surgery	Volume CY13	Volume CY14	Volume Growth	Hospital's Proportion of Total Increase/Decline	Market Shift
	A	B	C=B-A	D=C/Subtotal C	E=D*Allowed Market Shift
Hospital A	1,000	1,500	500	76%	99
Hospital B	500	600	100	15%	20
Hospital C	50	100	50	8%	10
Hospital D	-	4	4	1%	1
Utilization Increase	1,550	2,204	654	100%	129
Hospital E	500	400	(100)	78%	(100)
Hospital F	50	25	(25)	19%	(25)
Hospital G	4	-	(4)	3%	(4)
Utilization Decline	554	425	(129)	100%	(129)
ZIP Code Total	**2,104**	**2,629**	**525**	-	0
Allowed Market Shift			**129**		

Summary:

1. **Array all APR-DRG's and EAPG's into service lines and geographies** for each hospital based on 3M inpatient service line specifications, HSCRC outpatient service line specifications based on rate center analyses, and geographies based on the patient's residency – zip code level for denser parts of the State and county level for the 15 rural jurisdictions in the State.
2. **Remove from consideration all excluded market shift revenue**, including potentially avoidable utilization, out-of-state volume, categorical exclusions, oncology drugs, and chronic cases from the MSA algorithm
3. **Run the Market Shift algorithm to determine growth**, both increases and decreases in volume for each service line and geography
4. **Calculate final market shift adjustment** by multiplying the volumes that have been deemed market shifts by a hospital's unique service line average charge per equivalent case mix adjusted discharge, inclusive of a standard variable cost factor. The average charge includes all charges and therefore includes outlier charges built into the base of each hospitals GBR

Methodology Assessment

In this section staff will analyze current concerns and/or potential advancements to the Market Shift methodology (Variable Cost Factor, Market Definitions and Stability, and Service Line Exclusions) and identify methods by which to evaluate these issues. Staff will further outline modifications to the Market Shift that will create greater reliability/precision in the results.

Variable Cost Factor

Prior staff assessments of the variable cost factor utilized in the Market Shift policy concluded it was 50 percent. However, due to the thoughtful work of various industry stakeholders and the Maryland Hospital Association (MHA), it was determined that the Commission evaluation could be improved if it used direct costs from the annual filings submitted to the HSCRC, e.g., nursing staff expenditures, in lieu of the

cruder approach of utilizing a generalized cost to charge ratio to approximate total costs from hospital charges. Staff agreed with this proposed improvement but also noted that the MHA proposal had a few other areas that could be improved as well, namely estimating variability of costs through linear regressions[7] versus assuming all direct costs are 100 percent variable and estimating that indirect costs, e.g., financial accounting, had limited variability of 10 percent versus assuming there was no variability in indirect costs. By using the original Commission evaluation plus the various improvements described above, the Volume workgroup coalesced on a hybrid approach that increased the statewide variable cost factor from 50 percent to 59 percent.[8]

Table 3a: Hybrid Approach to Variable Cost Factor Calculation

	HSCRC	MHA	Hybrid
Service Setting for calculation	Calculated separately for IP and OP	Calculated separately for IP and OP	**IP & OP are combined since costs are combined in Annual Filings**
Direct Cost Calculation	Applies Direct cost to charge ratio to case-mix charges	Uses Direct cost from M-schedule from cost report	**Uses direct cost from M-schedule from cost report**
Charge Bucket	HSCRC classifies rate centers into different charge buckets for calculation	Directly uses rate centers	**Uses more granular charge buckets to balance low volumes with unique properties of certain services**
Direct Variable Cost Percent	Direct cost % * Direct cost variability by charge buckets	Assumed 100% of the direct costs as variable	**Direct cost variability (Calculated at the charge bucket level by way of a linear regression model using volumes and inflation adjusted costs from the Annual Filing cost reports) * Direct costs**
Indirect Variable Cost Percent	(1 – Statewide direct costs as % of Adj charges) * 10%	Not considered	**Indirect cost % * 10%**
Variable Cost Factor	Indirect variable cost percent + Direct variable cost as a % of adj charges	Op1 – Direct expense/Level IV Exp Op2 – (Direct exp + Pat care OD – plant) / Level IV Exp Op3 – Level I Exp/ Level IV Exp	**Indirect variable cost percent + Direct variable cost** **The final VCF is a weighted average of VCFs calculated across charge buckets**

[7] Regressions are single year assessments in keeping with the intention of year over year market shift assessments. Over time, staff would anticipate higher variability. See Appendix 1a for Detailed Variable Cost Factor Calculation; see appendix 1b for results of Variability Statistics Using Linear Regressions

[8] Evaluation was tested across multiple years of data to confirm its reliability

Table 3b: Results of Hybrid Approach to Variable Cost Factor Calculation

Calculation Component		Emerg	Observation	Lab & Tests	MSS & CDS	OR	Other	R&B	Clinic	Therapy	Total
Total Cost (M-Sched Level 3)	A	$ 1,131,998,574	$ 422,338,075	$ 2,454,722,481	$ 4,205,740,888	$ 2,259,425,315	$ 287,983,334	$ 5,659,016,420	$ 570,969,148	$ 554,735,133	**$ 17,546,930,368**
Direct Costs:											
Direct Costs (D_Direct)	B	$ 648,775,164	$ 236,194,068	$ 1,317,868,952	$ 3,218,830,565	$ 1,113,049,368	$ 137,139,572	$ 2,980,604,780	$ 276,303,996	$ 350,281,156	**$ 10,279,047,622**
Direct Cost %	C=B/A	57%	56%	54%	77%	49%	48%	53%	48%	63%	**59%**
Direct Cost Variability	D	100%	88%	65%	100%	96%	100%	100%	100%	62%	**94%**
Direct Variable Cost	E=D*B	$ 648,775,164	$ 207,850,780	$ 856,614,819	$ 3,218,830,565	$ 1,068,527,394	$ 137,139,572	$ 2,980,604,780	$ 276,303,996	$ 217,174,317	**$ 9,611,821,386**
Direct Variable Cost %	F=E/A	57%	49%	35%	77%	47%	48%	53%	48%	39%	**55%**
Indirect Costs:											
Indirect Costs	G=A-B	$ 483,224,411	$ 186,144,007	$ 1,136,853,529	$ 986,910,323	$ 1,146,375,946	$ 150,843,763	$ 2,678,411,640	$ 294,665,152	$ 204,453,976	**$ 7,267,882,746**
Indirect Cost %	H=G/A	43%	44%	46%	23%	51%	52%	47%	52%	37%	**41%**
Indirect Cost Variability	I	10%	10%	10%	10%	10%	10%	10%	10%	10%	**10%**
Indirect Variable Cost	J=G*I	$ 48,322,441	$ 18,614,401	$ 113,685,353	$ 98,691,032	$ 114,637,595	$ 15,084,376	$ 267,841,164	$ 29,466,515	$ 20,445,398	**$ 726,788,275**
Indirect Variable Cost %	K=J/A	4%	4%	5%	2%	5%	5%	5%	5%	4%	**4%**
Variable Cost Percent	L=K+F	**62%**	**54%**	**40%**	**79%**	**52%**	**53%**	**57%**	**54%**	**43%**	**59%**
Fixed Cost Percent	M=1-L	38%	46%	60%	21%	48%	47%	43%	46%	57%	**41%**

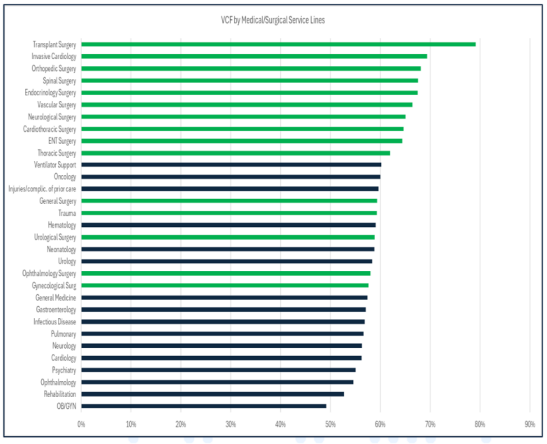
Staff also, per workgroup request, calculated the variable cost factor for each service line in the Market Shift policy, using the same method. The reason for this request was that stakeholders previously have noted that the 50 percent variable cost factor (or 59 percent under the new calculation) is a statewide average that may not be indicative of service lines with inherently higher variable costs, e.g., surgical service lines that have unique device costs for each procedure. As expected, this analysis did indicate there was significant cost variation in surgical versus medical service lines and between inpatient and outpatient services:

Table 4: Service Line Results of Hybrid Approach to Variable Cost Factor Calculation

Inpatient Service Lines

Medical SL Average: **57%**

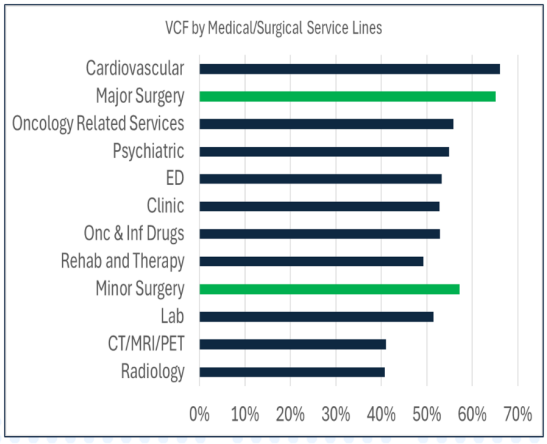
Surgical SL Average: **66%**



Outpatient Service Lines

Medical SL Average: **54%**

Surgical SL Average: **63%**



Further discussion amongst the Volume workgroup members was whether the Commission should use the statewide calculated variable cost factor, the service line specific variable factor, or the medical and surgical variable cost factor groupings. **While there were no strong opinions expressed, in light of these findings staff recommend, effective immediately, that for all volume policies the Commission adopt the newly calculated variable cost factors for inpatient medical and surgical and outpatient medical and surgical in lieu of the statewide average variable cost factor or the service line specific variable cost factors.** The reason for this recommendation is as follows:

1) The new assessment of determining variable costs uses far more precise methods, which when replicated across multiple years yielded very similar results.
2) There is limited variance amongst surgical and medical groupings, once inpatient and outpatient demarcation is established; the lone outlier is transplant surgery but the volumes for this service line are primarily handled through a standalone policy (*Complexity and Innovation*[9]) that independently recognizes the higher variable costs for quaternary services.
3) The use of four variable cost factors versus 45 will reduce administrative complexity, especially as this finding is extended to all volume policies, e.g., deregulation, repatriation.
4) The linear regressions to determine variability in direct costs are an improvement to prior methods of calculating variable costs, but caution should be taken when using them to precisely determine the variable costs of each service line in the State, as single-variate regressions can incorrectly attribute the effects of an unincluded variable to the variable that is included, otherwise known as omitted variable bias.

Market Shift Statistical Stability

Stakeholders noted that numerous small markets lead to statistical instability, especially in year-over-year growth comparisons. To assess Market Shift stability, staff used bootstrapping simulations and the Intraclass Correlation Coefficient (ICC). This method allowed for modeling hypothetical Market Shift configurations, helping the Volume Workgroup evaluate hypothetical proposals for improved reliability.

Reliability means consistent results from repeated measurements. For example, if there are two different tests for assessing blood pressure, the reading has strong reliability if the two tests yield similar results, stronger still if there are similar readings across additional testing approaches, i.e., 3 or more. For marketshift assessments, staff could not apply different tests, but instead ran many simulations through the bootstrapping[10] method to see if the market shift adjustments for hospitals were fairly similar when there is a replacement of discharge data for a given hospital's services in a given market.

After simulations, the ICC (0-1) assesses between group variability versus variability across simulations; higher values mean more reliable assessments. A score closer to 1 indicates consistent Market Shift assessments, suggesting detected variation is due to patient selection (e.g., better service offerings) rather than random simulation-induced variation.[11]

Staff analysis shows statewide Market Shift reliability is moderate (ICC=0.52), strong for outpatient service lines (Weighted Average ICC[12] = 0.87), and moderate for some inpatient service lines but generally poor overall due to several low-volume medical and surgical service lines (Average ICC = 0.39)

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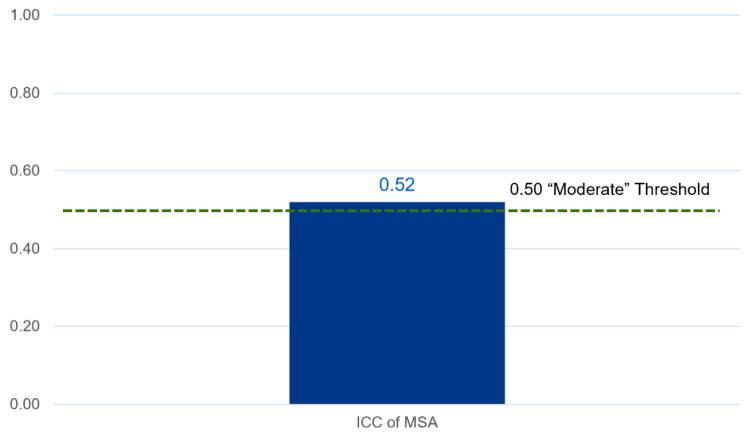
[9] Complexity & Innovation

[10] For more information on bootstrapping, please see Appendix 2

[11] For more information on Interclass Correlation Coefficient, please see Appendix 3

[12] To weight each service line ICC staff used charges as a percentage of total inpatient or outpatient revenue.

Table 5 : Hospital Service Line Reliability of Simulated Data without Aggregation



Reliability	ICC Range
Poor	< 0.50
Moderate	0.50 – 0.75
Good	0.75 – 0.90
Excellent	≥ 0.90

Source: Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. Journal of Chiropractic Medicine, 15(2), 155-163.

Less than excellent reliability on a statewide basis was expected due to two main factors: a) the inherent trade-off in reliability when moving away from a fee-for-service model, which, while highly reliable, perpetuates a "sick care" system that incentivizes acute care over preventative services; and b) the significant disaggregation of inpatient service lines, resulting in low-volume assessments, especially for high dollar services, that inherently lead to lower reliability scores.

Staff modelled four hypothetical reconfigurations of the Market Shift for the Volume Workgroup, but only two of them showed promise in improving the baseline statewide reliability score of 0.52:

- Assessing all inpatient surgical service lines in line with the Maryland Health Care Commission's four regions for Certificate of Need evaluations (Statewide ICC = 0.51)
- Assessing all inpatient surgical service lines on a statewide basis (Statewide ICC = 0.51)
- Consolidating, based on clinical review, Spinal Surgery with Neurological Surgery, Thoracic Surgery with Cardiothoracic Surgery, and Ventilator Support with Pulmonary service lines (Statewide ICC = 0.54)
- Excluding from Marketshift assessments Endocrinology Surgery, ENT Surgery, Gynecological Surgery, Ophthalmologic Surgery, Thoracic Surgery, Urological Surgery, and Ventilator Support (Statewide ICC = 0.57)

The final configuration was seemingly the most attractive to the Volume Workgroup because of its significant impact on reliability and due to the fact that these services are not ideally suited for population based methodologies/interventions as they are high cost, low volume service lines that are often not preventable and/or occur much later in the disease cycle, e.g., hysterectomies

In light of these findings, staff recommend, once a comprehensive discussion with the field takes place on what is excluded from the market shift assessment, removing from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support - equivalent to 2.5 percent of in-state revenue; and consolidating Spinal Surgery and Neurological Surgery. Staff additionally recommend that any services removed from Market Shift be handled similar to the Out-of-State volume policy, namely still part of global budgets but volume variable

and only adjusted for when volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases.

Staff are recommending a CY 2026 implementation because it provides the hospital field with an opportunity to adapt to new methods for calculating volume changes. This approach also can be more readily absorbed by the AHEAD contract provision, effective January 1, 2026, which permits an additional 5 percent of in-state services to fall outside of population-based methodologies.

Staff did not recommend consolidation of Thoracic Surgery with Cardiothoracic Surgery, and Ventilator Support with Pulmonary, because instead the former, in both cases, are to be removed from Market Shift and handled through this alternative methodology. Increasing the magnitude of those carveouts further by consolidating with other service lines would jeopardize the State's ability to maintain 90 percent of in-state revenues within population based methodologies as required by the AHEAD model contract

Service Line Exclusions

Under normal circumstances, the Market Shift policy addresses changes in hospital selection across all-payer in-state services. However, over the past decade, the Commission has occasionally departed from this methodology when there are significant system realignments, e.g., payer initiated shifts, that require more precise and real time methods of evaluation. This is consistent with the Commission's authority, as detailed in the Global Budget Agreements between the HSCRC and individual hospitals, to modify global budgets for "…service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share and other relevant factors that are pertinent to the effective operation of the GBR model…"[13]

To effectuate departures from the Market Shift policy, staff have either altered (on a temporary basis) the Market Shift assessment, e.g., combining hospitals when a facility conversion occurs, or removed data from the Market Shift and and assessed volume change independent of the Market Shift algorithm, e.g., payer initiated shifts that move entire populations from one hospital to another.

The benefit of this approach is that it avoids the imprecision of the market shift methodology that naturally occurs when there is a purposeful, material realignment in the market. For example, if a hospital realigns services within its health system, while other hospitals experience utilization growth due to natural population changes, a portion of the realignment will be partially attributed to other facilities outside of the system that are experiencing use rate growth due to secular demographic changes (see example below).

[13] Global Budget Agreement

Table 6 : Example of Purposeful System Realignment Interacting with Marketshift Policy

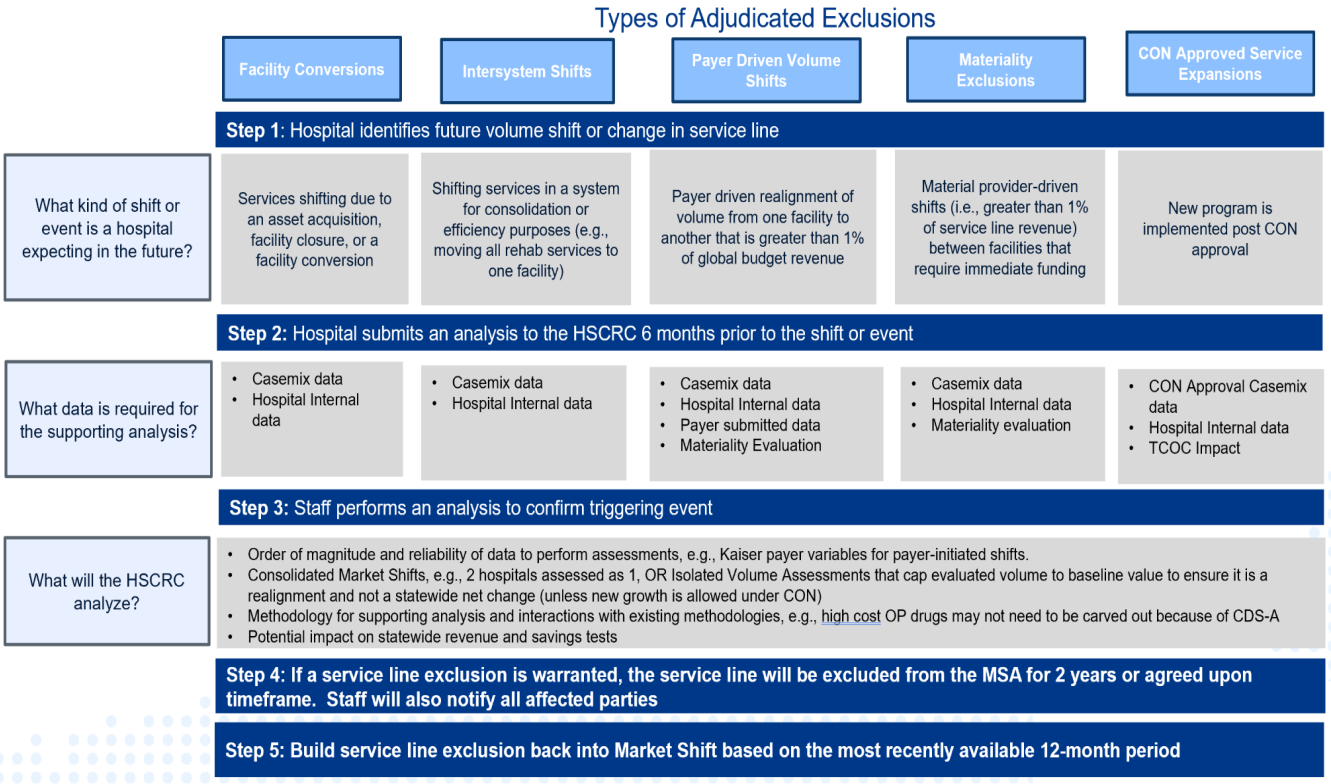
			Hospital A (System 1)	Hospital B (System 2)	Hospital C (System 2)	Total	Comments
Normal Marketshift Assessment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C	Market Driven Volume Changes	5	-2	-3	0	
	D = B+C	Total Volume Change	15	-2	-3	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		5			
	F=D/Total Growth or Decline* E	Awarded Marketshift	5	-2	-3	0	Must equal 0 to ensure only shifts are quantified
	G=A+B+F	New Baseline Volume	115	98	97	310	*5 units of volume are shifted from Hospital B & C to Hospital A*
			Hospital A (System 1)	**Hospital B (System 2)**	**Hospital C (System 2)**	**Total**	**Comments**
Normal Marketshift Assessment interacting with Purposeful System Realignment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C1	Market Driven Volume Changes	5	-2	-3		
	C2	System Realignment	0	-8	8		*System 2 elects to shift 8 units of volume between its hospitals (e.g., consolidation of rehab program)*
	D = B+C	Total Volume Change	15	-10	5	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		10			
	F=D/Total Growth or Decline* E	Awarded Marketshift	7.5	(10.0)	2.5	0	Must equal 0
	G=A+B+F	New Baseline Volume	117.5	90.0	102.5	310	*An additional 2 units of volume are shifted from Hospital B to Hospital A because the system realingment is scored as a marketshift*

Net Effect	***An additional 2.5 volume units are awarded due to population growth, which is misattributed as a marketshift***	***All Volume Decline is Correctly Scored***	***2.5 volume units related to system realingment are NOT awarded due to interaction with marketshift***

In light of these historical practices, and to better align with the proposed AHEAD Financial Specifications that similarly intend to account for these activities through a "Service Line Adjustment,"[14] **staff propose that the following triggers and processes be employed to exclude service lines from Market Shift for a temporary period of time:**

[14]"Service Line Adjustments (SLA) adjust prospective HGBs to account for anticipated revenue changes from pre-planned service line changes, including additions, eliminations, expansions, or contractions of service lines within a given market area." https://www.cms.gov/files/document/ahead-tech-specs-v30.pdf (Page 41)

Table 8 : Triggering Events and Processes for Service Line Exclusions



While there were no concerns raised by the Volume Workgroup over what staff put forward as a service line exclusion and the process therein, one member did question whether the Payer Driven Volume Shift category, as currently defined, could be utilized to address one additional phenomenon in the market, namely when an insurer deems a hospital to be out of network. Staff do not know if this is a workable solution because unlike a typical Payer Driven Volume Shift, the volume realignment will not be localized between two hospitals, and it is unclear where the transition (if any) will land. Plus, there is no actor in this occurrence that has an incentive to assist staff with precisely realigning volume among the various regulated entities.

Normally, HSCRC policy would account for volume shifts of this kind through a combination of Market Shift and Deregulation, but given the unique nature of this activity, staff are bringing it forward for Commissioner consideration.

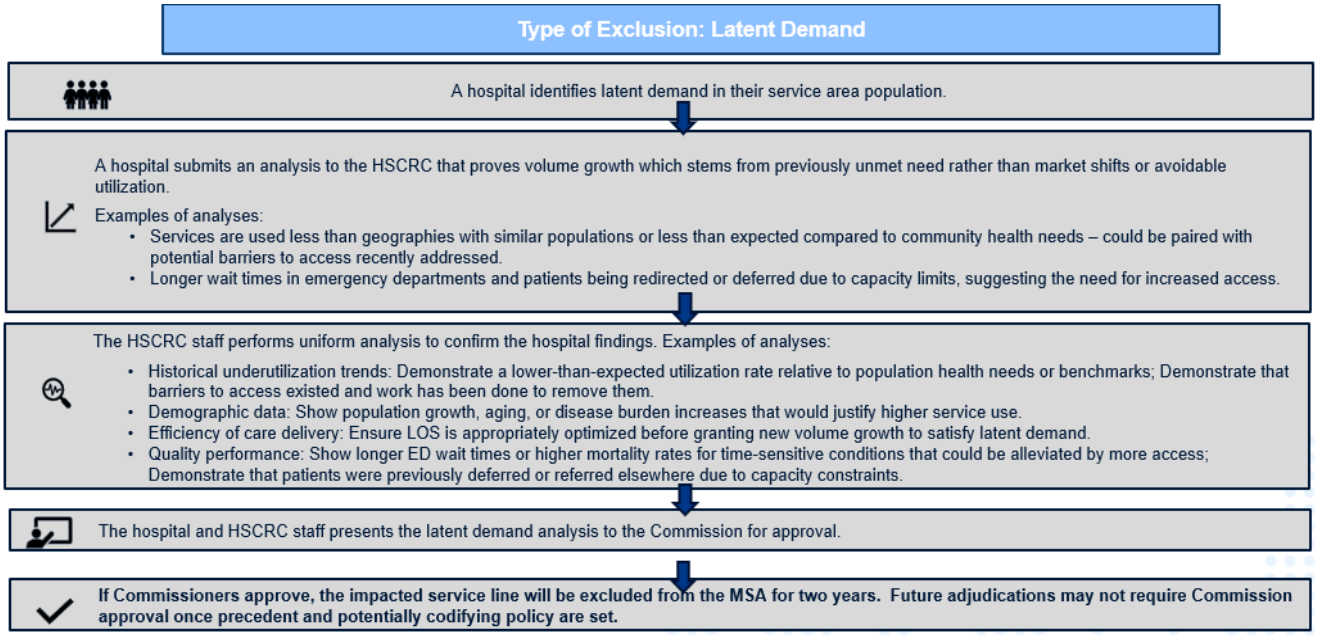
Additional Considerations for Future Policies

Staff wish to explore an additional service line exclusion of "Latent Demand" for future policy development. This term may be defined as a potential need for a healthcare service that is not currently

being realized in the market. A potential future policy consideration could be developed to create a semi-automatic approval process where hospitals can submit volume increase requests related to latent demand that are not large enough for a CON application but should be addressed independent of the Market Shift and Demographic Adjustment policies.

For a potential process for Latent Demand, please see exhibit below:

Table 9 : Process for Potential Latent Demand Service Line Exclusions



Stakeholder Feedback

Staff received comment letters from nine stakeholders and several verbal comments and questions from Commissioners. The comments from stakeholders and Commissioners can be broadly categorized into seven areas of concern.

Table 10: Summary of Public Comments:

Topics	Adventist	JHHS	LifeBridge	Luminis	UMMS	MedStar	CareFirst	MHA	HME Coalition	Commiss-ioners
Variable Cost Factor (VCF) Methodology	✓	✓	✓	✓	✓	✓		✓		✓
Service Line Consolidation and Exclusions	✓	✓	✓	✓	✓	✓		✓		✓
Temporary Service Line Exclusion Process		✓			✓	✓		✓		✓
Latent Demand and Future Policy Alignment	✓				✓	✓		✓		✓
Payer-Initiated Market Shifts						✓	✓		✓	✓
Transparency and Consumer Impact						✓			✓	✓
Other MSA Refinements		✓		✓	✓	✓				

Staff will address each stakeholder comment area below:

1. Variable Cost Factor Methodology Comments: Stakeholders broadly support moving from a single statewide variable cost factor to four empirically derived factors, seeing this as an improvement that better reflects costs and improves the accuracy of funding for volume shifts. They recommend periodic review and consistent application of the new methodology, with some noting recalibration may be needed as the state enters the AHEAD model.

Table 11: Summary of Variable Cost Factor Comments

Organization	Summary of Comments
JHHS	Johns Hopkins Health System (JHHS) supports the proposed refinements to the VCF methodology. JHHS emphasized the importance of periodic re-evaluation of these factors to maintain accuracy as care delivery evolves, and new technologies emerge.
Adventist	Adventist HealthCare (AHC) supports the VCF refinements and recommends applying them consistently across all volume-related policies; however, the Demographic Adjustment should remain as-is until further discussions take place around possible updates to the policy. AHC suggests reevaluating VCFs every 3-5 years to reflect the evolving cost structures.
Luminis	Luminis Health supports immediate adoption of updated VCFs, citing that the proposed factors (57% inpatient medical, 66% inpatient surgical, 54% outpatient medical, 63% outpatient surgical) better reflect current cost structures compared to the longstanding 50% estimate.
LifeBridge	LifeBridge Health supports the VCF updates but noted that recalibration may be necessary under the AHEAD Model as Medicare global budgets transition to CMS methodologies.
MHA	MHA supports the recommended VCF changes and values HSCRC's collaboration with hospitals. The use of four calculated VCFs and a new statewide average reflects a more empirical approach and improves funding for volume shifts.
UMMS	UMMS considers the proposed inpatient/outpatient medical and surgical split for variable cost factors (VCFs) a reasonable compromise but expresses a preference for service line–specific VCFs, recommending that the assignment of factors be based on the distribution of charges or ECMADs and that these factors be regularly revisited for accuracy.
MedStar	MedStar supports the use of specific VCFs for inpatient and outpatient services but strongly urges HSCRC to implement service line-specific VCFs for even greater accuracy. They also urge the HSCRC to apply the new and more accurate variable cost factors retroactively from 2019 to 2024 Marketshift adjustments

Staff Response: *Staff appreciate the positive feedback regarding the revisions to the variable cost factor.*

Staff agree that this calculation should be revisited every 3-5 years to ensure significant deviations from the current calculation are captured.

Staff do not concur with UMMS' and Medstar's recommendation that the variable cost factor should be applied at a service line level, as this creates unnecessary administrative complexity and places a level of precision on regression estimates that is unwise.

Additionally, staff do not concur with the recommendation from Medstar to retroactively apply the revised variable cost factor calculations to volume change from 2019 to 2024. The application of a 50% variable cost factor was not a calculation error, which would allow for a retrospective adjustment, and HSCRC policy generally is to make amendments to methodology on a go forward basis. Also, it appears that this recommendation is driven by the assessment that hospitals had significant growth from 2019 to 2024. If the Commission were to entertain this request, staff would recommend revising all volume change from 2014 to 2024 and potentially consider revising volume change before the start of global budgets when for periods of time an 85% variable cost factor was utilized.

2. Service Line Consolidation and Exclusions Comments: Stakeholders generally support consolidating or removing low-volume service lines to improve reliability, but caution that exclusions could impact access to specialized care and limit flexibility under the AHEAD Model's 10 percent limit on carve-outs. There is broad agreement that any changes should be

carefully managed, with clear criteria and ongoing review to ensure compliance and protect essential services for patients.

Table 12: Summary of Service Line Consolidation and Exclusion Comments

Organization	Summary of Comments
JHHS	JHHS cautions against exclusions that count toward the AHEAD 10% carve-out and emphasized prioritizing tertiary and quaternary care to ensure access for Marylanders. JHHS expressed concern that limiting these services could jeopardize specialized care availability and requested clarity on CMS reimbursement for excluded services.
UMMS	UMMS opposes exclusion of proposed service lines until AMC carve-out negotiations are finalized. UMMS highlights that the current proposal would consume 2.5% of carve-out capacity in addition to the 2.6% already allocated to outpatient drugs, leaving insufficient room for academic carve-outs.
Adventist	AHC supports removal of low-volume service lines to reduce random variation but urged caution given AHEAD's limitations on carve-outs. AHC recommended applying the Out-of-State methodology for adjudicating excluded lines and suggested an annual reconciliation process to simplify administration. AHC also suggests HSCRC consider annual fee-for-service–style reconciliation, similar to CDS-A, to simplify administration and promote long-term consistency.
Luminis	Luminis Health supports removal and consolidation of selected service lines, noting that this change recognizes the limitations of applying the methodology to low-volume or highly variable lines.
MHA	MHA supports the consolidation of certain surgical lines and recommends reassessing reliability post-Medicare exclusion. MHA also urged HSCRC to clarify whether excluded services will be considered outside population-based methodologies under AHEAD, as this interpretation could have material implications for compliance with the 90% revenue requirement.
MedStar	MedStar cautions against excluding service lines from market shift without a comprehensive, stakeholder-informed evaluation of all services excluded from population-based payment, emphasizing that exclusions should be reserved for services with highly variable costs and not rushed under the AHEAD Model's 10% carve-out limit.
LifeBridge	LifeBridge Health opposes exclusions if they count toward the AHEAD carve-out limit, noting that even low-volume services could significantly impact the 10% threshold and reduce flexibility for future policy adjustments.

Staff Response: *Staff appreciate the generally positive feedback concerning the proposed service line exclusions.*

Staff agree, however, that a more comprehensive discussion with the field should take place on what service lines should be prioritized for exclusion given the limited flexibility under the current Model (5 percent) and the AHEAD Model (15 percent). Staff, therefore, recommends postponing the implementation of this exclusion until that work is completed.

3. Temporary Service Line Exclusion Process Comments: Stakeholders support a standardized process for temporary service line exclusions, with flexibility in notification timing and inclusion of latent demand as a triggering event. They request clear criteria for what qualifies as a triggering event, recommend access impact analysis for significant payer-driven changes, and emphasize that adjustments should not negatively affect other hospitals.

Table 13: Summary of Temporary Service Line Exclusion Process Comments

Organization	Summary of Comments
UMMS	UMMS supports a standardized process for temporary exclusions with flexibility on notification timing when shifts are not known six months in advance.
MHA	MHA requests clarification on triggering events, including payer-driven shifts and physician office closures, and recommends requiring access impact analysis for significant payer-driven changes. MHA also asked that only hospitals directly impacted by the shift be eligible to request adjustments.
JHHS	JHHS supports the idea of creating a process to request service line exclusions; however, it is essential to ensure that such adjustments do not negatively affect other hospitals.
MedStar	MedStar supports excluding new services with CON approval from market shift calculations and recommends that MIEMSS designation as a trauma or specialty center should also qualify as a triggering event for exclusion.

Staff Response: *Staff appreciate the general positive feedback on this proposal.*

Staff do not concur with UMMS request that there should be a flexibility in the timing of these requests, as delayed notice will make this policy proposal very difficult to administer and could result in a violation of one of the guiding principles Johns Hopkins cited for this activity, namely to "not negatively affect other hospitals," which undoubtedly will occur if hospitals that are losing volumes have limited time to respond to volume dissipation brought on by temporary service line exclusions.

Staff concur with Medstar's request to broaden the definition of CON approved services to new designations, such as stroke center, but would note that this expanded definition should be limited to certifications approved by the Joint Commission and should only account for services not otherwise provided by another facility.

4. Latent Demand and Future Policy Alignment Comments: Stakeholders recommend a standardized, annual process for evaluating latent demand using shared data and transparent assumptions, rather than relying only on hospital analyses. They support adopting CMS-like policies that allow hospitals to retain revenue for unmet needs and backfill services, and agree that latent demand should be included as a triggering event for temporary adjustments.

Table 14: Summary of Latent Demand and Future Policy Alignment Comments

Organization	Summary of Comments
Adventist	Adventist HealthCare highlighted the need for a standardized statewide framework to assess unmet care needs and latent demand, cautioning against reliance solely on hospital-submitted analyses and recommending a transparent, data-driven process.
MHA	MHA encourages adoption of CMS-like latent demand and population health reinvestment policies to allow hospitals to retain revenue for unmet needs and backfill services when service lines are contracted or removed.
UMMS	UMMS supports the inclusion of latent demand as a triggering event for temporary adjustments.
MedStar	MedStar supports developing a policy to fund hospitals meeting latent demand due to historical access challenges and stresses the need for clear, transparent criteria for evaluating and funding such demand.

Staff Response: *Staff are pleased to hear support for developing a Latent Demand trigger to be included in the new paradigm of Service Line Exclusions.*

While staff currently do not have a definitive basis for what constitutes a Latent Demand service line exclusion, staff hope to work with the field in the coming months to establish the various

metrics that could be used to establish that trigger and at the same time be used to adjudicate determinations for latent demand requests.

Similar to prior policy development, this may necessitate hospital requests at first, but over time staff believe that established evaluations for identifying latent demand can become automatic triggers, thus easing the burden on hospitals that are considering offering more services in their communities to resolve unmet latent demand.

5. Payer-Initiated Market Shifts Comments: Stakeholders call for consistent, system-wide policies to address payer-initiated market shifts and large network changes. They emphasize that applying the same volume realignment approach to all payers, not just Kaiser, will help ensure fairness and maintain the integrity of hospital funding during significant disruptions. Some stakeholders requested that payers be responsible for notifying the HSCRC when a shift will occur.

Table 15: Summary of Payer-Initiated Market Shifts Comments

Organization	Summary of Comments
CareFirst	CareFirst recommends applying the Kaiser volume policy to all payer-initiated market shifts and prospectively adjusting hospital revenues for network-driven changes to ensure equity. CareFirst argues that failing to adjust for these shifts allows hospitals losing volume to retain full GBR while underfunding hospitals receiving additional patients, creating inequity and distorting GBR integrity.
HME Coalition	Health Means Everything Coalition supports systemic application of volume realignment policies beyond Kaiser to address large-scale network disruptions, citing recent disputes that could impact thousands of Marylanders.
MedStar	MedStar opposes placing the notification burden on hospitals for payer-initiated service realignments and recommends that payers be responsible for notification when such shifts are likely to trigger materiality thresholds.

Staff Response: *Staff concur that payer-initiated market shifts could apply to any payer. However, payers should be required to provide a plan for the market shift that can ensure that the shift of volume is predictable, for known reasons, and for a defined period of time. Additionally, the projected shift has to be material, i.e., greater than 1% of a hospital GBR, and the payer must provide detailed data to substantiate the proposed realignment. If a payer is unwilling to provide necessary information to effectuate these shifts, adjustments will not be made or the Commission could consider utilizing its own authorities, e.g., suspension of the prompt payer discount, to compel payers to provide the necessary data and plans for the intended shifts.*

Staff also concur with comments that a consistent volume realignment approach for payer-initiated market shifts is necessary.

6. Transparency and Consumer Impact Comments: Stakeholders call for greater transparency and consumer focus, recommending more accessible information, longer public input, and ongoing monitoring, while emphasizing stakeholder involvement and clear evaluation criteria in policy development.

Table 16: Summary of Transparency and Consumer Impact Comments

Organization	Summary of Comments
HME Coalition	Health Means Everything Coalition recommends longer public comment periods, consumer-friendly summaries of policy impacts (similar to legislative fiscal notes), and monitoring affordability and access impacts of Market Shift changes.
MedStar	MedStar emphasizes the importance of stakeholder input, transparent evaluation criteria, and collaborative policy development throughout the market shift refinement process.

Staff Response: *Staff appreciate the requests for greater transparency.*

Currently, all meetings (Commissioner meetings and workgroup meetings) are available to public audiences and recordings of meetings are available on the HSCRC website.

Staff will make a concerted effort moving forward, however, to send out more notifications for workgroup meetings so that the broader stakeholder community is well aware when these discussions amongst HSCRC staff, hospitals, payers, and other interested parties are occurring.

Staff disagree with the comment that there needs to be longer public input, as the workgroup meetings serve as a replacement for the typical required regulations process and generally are more well received by stakeholders because complicated methodologies are explained and discussed in greater and clearer detail than promulgated regulations.

7. Other MSA Refinement Comments: Stakeholders recommend establishing routine, standardized processes for regrouping outpatient procedures and evaluating policy changes, to reduce administrative delays and financial disincentives. They also call for greater clarity on reimbursement for excluded services under new models, urge that major policy updates, such as those related to Market Shift, be revisited after AHEAD methodology is finalized to ensure alignment and address demographic trends, and consideration that the updated VCFs be used to retroactively adjust Market Shift funding from prior periods.

Table 17: Summary of Other MSA Refinement Comments

Organization	Summary of Comments
UMMS	UMMS recommends adopting a routine annual process for regrouping outpatient procedures that migrate from inpatient-only status. UMMS noted that the current ad hoc process creates significant lag and financial disincentives for shifting care to lower-cost settings.
JHHS	JHHS requested clarification on how CMS intends to reimburse hospitals for excluded services under AHEAD, noting uncertainty could create financial risk.
Luminis	Luminis Health urged HSCRC to revisit the Market Shift policy after AHEAD methodology is finalized to ensure alignment and avoid conflicting incentives. Luminis Health express concerned that HSCRC has not fully considered the impact of aging demographics driving service growth in certain areas independent of Market Shift.

Staff Response: *Over the next 12 months, staff will continue to work with the field and the broader stakeholder community to ensure, to the best extent possible, that market shift assessments are aligned with the new methodologies outlined in the AHEAD Model, which are still currently under review by CMMI.*

Staff disagree with Luminis' contention that the Commission has not yet considered the impacts of aging impacts on service growth, independent of the Marketshift, as the current Demographic Adjustment allocates funding based on age adjusted growth and staff will be releasing in the

November Commission meeting a recommendation to potentially amend the population governor in the Demographic Adjustment to allow for risk adjusted population growth.

Staff share UMMS's concern that the current ad hoc process of evaluating inpatient and outpatient services when procedures move off of the inpatient only list creates significant lag and financial disincentives for shifting care to lower-cost settings. However, there is not readily available formulaic approach to handling this phenomenon, thus staff offer the following process:

Table 18: Process for Evaluating Marketshifts for Services Moving off of Inpatient Only List

1)	Staff requests that stakeholders provide the HCPCS/CPT codes associated with services where material shifts from IP to OP occur each year (ideally by September) ▪ This is consistent with the annual update process for CMS' IP Only (IPO) List.
2)	Staff will review annual updates to CMS' IPO List, which are identified in the OPPS Final Rule.
3)	Staff will evaluate whether ECMADs have materially increased statewide in a particular OP service line, while a corresponding IP service line has experienced a material decline. If this is found to have occurred, Staff will analyze further to identify if the changes are due to shifts from IP to OP.

Recommendations

Staff recommend the following updates to the current Commission Methodologies:

1. Effective immediately, adopt for all volume policies the newly calculated variable cost factors for inpatient medical (57 percent) and surgical (66 percent) and outpatient medical (54 percent) and surgical (63 percent) in lieu of the historical standard of 50 percent.

2. Once a more comprehensive discussion with the field takes place on what service lines should be prioritized for exclusion, given the limited flexibility under the current Model (5 percent) and the AHEAD Model (15 percent), remove from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support, and consolidate Spinal Surgery and Neurological Surgery.

   Any volume changes for services removed from the Market Shift as a result of this recommendation shall be adjudicated similar to the Out-of-State Volume policy, i.e., a revenue adjustment will only occur when the volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases

3. Officially establish the process, described herein, by which Service Line Exclusions from the Market Shift policy can be triggered and adjudicated provided one of the following criteria is met:
   a. Facility Conversions
   b. Intersystem Shifts
   c. Payer Driven Volume Shifts
   d. Material Provider Initiated Shifts
   e. CON Approved Service Line Expansions

Appendix 1. Variable Cost Factor Calculation

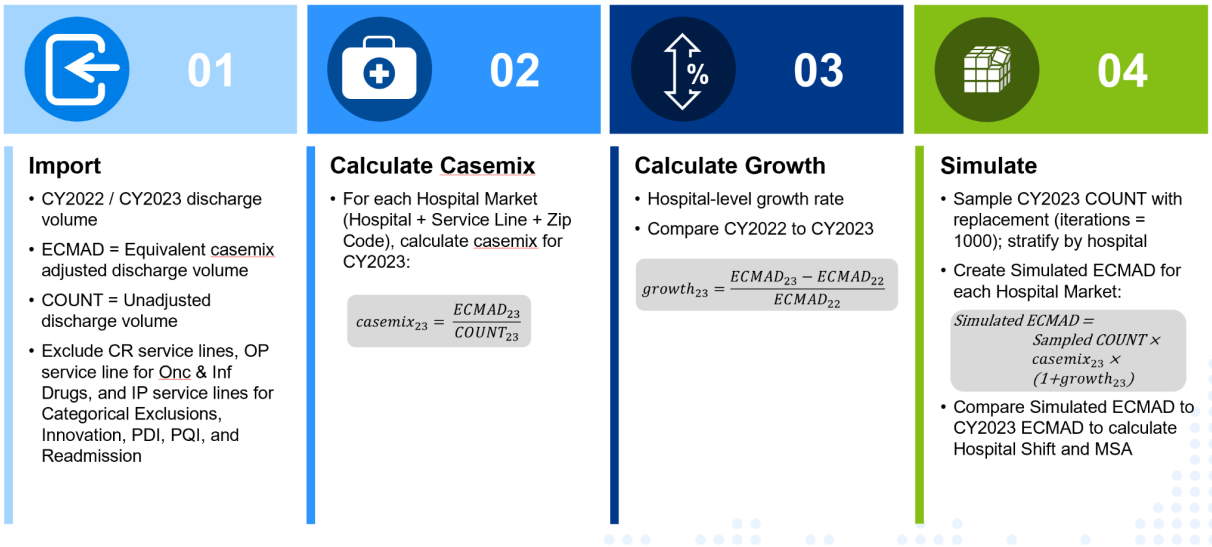
1. Level 3 costs are obtained from M schedule of annual filing cost report for the entire state by charge bucket
2. Direct costs are obtained from M schedule of annual filing cost report (D_Direct)
3. Direct Cost % = Direct Cost from step 2 / Level 3 costs
4. Apply direct cost variability to direct costs to calculate direct variable costs
5. **Direct variable cost % =** Direct variable cost / Level 3 costs
6. Indirect Costs % = (Level 3 Costs – Direct Variable Costs from step 2) / Level 3 costs
7. Apply indirect cost variability (10%) to indirect costs to obtain indirect variable cost
8. **Indirect variable cost % =** Indirect variable Costs / Level 3 costs
9. **Absolute Variable cost % =** Direct variable cost % + Indirect variable cost % (Calculated by charge bucket)
10. **Variable cost % =** Weighted average of absolute variable cost % based on total costs by charge bucket

Appendix 1b. Direct Cost Variability By Charge Bucket Using Linear Regressions

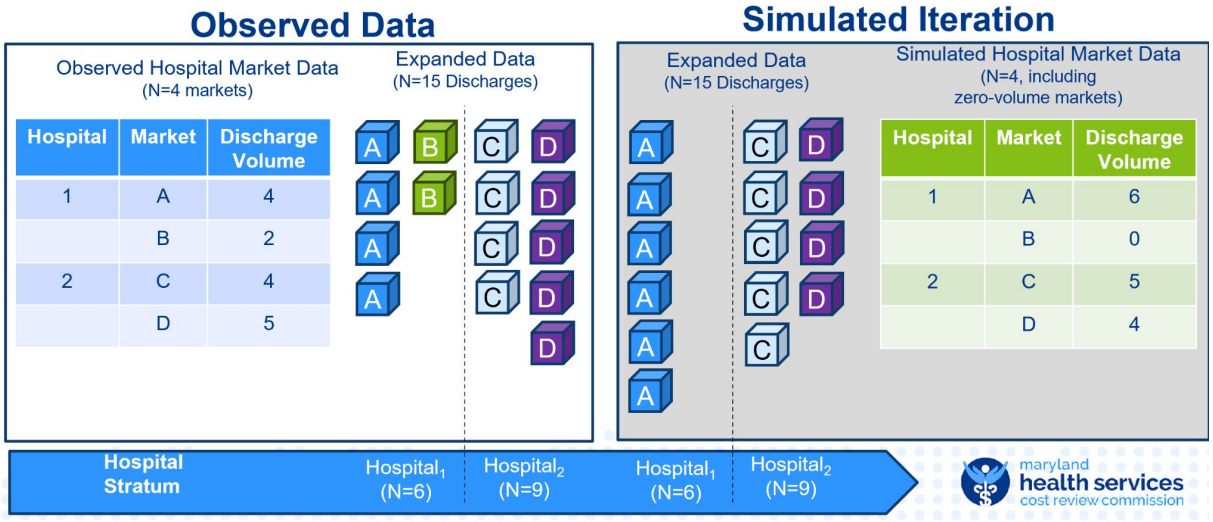
Charge Buckets	Calculated Direct Cost Variability					
	FY24	FY23	FY22	FY19	FY18	FY17
R&B	100%	100%	100%	100%	100%	100%
OR	66%	70%	70%	66%	66%	68%
Lab & Tests	64%	68%	67%	58%	75%	61%
MSS & CDS(1)	100%	100%	100%	100%	100%	100%
Therapy	57%	65%	61%	65%	62%	63%
Emerg	100%	100%	100%	100%	100%	100%
Observation	97%	98%	93%	77%	79%	83%
Clinic	100%	100%	100%	100%	100%	100%
Other(1)	100%	100%	100%	100%	100%	100%

Note (1): MSS/CDS and Other are assumed to be 100% variable with volumes. Analysis was not performed to validate this assumption.

Appendix 2a. Detail on Bootstrapping Method in Markets Shift Simulations



Appendix 2b. Detailed Example of Bootstrapping Method



Appendix 3. Detail on Interclass Correlation Coefficient

- Intraclass Correlation Coefficient (ICC) is a measure of reliability, where ICC = 0 indicates no reliability and ICC = 1 perfect reliability, i.e., all measures in a group are identical.

$$\text{ICC} = \frac{variance\ between\ groups\ (V_b)}{variance\ between\ groups\ (V_b) + variance\ within\ groups(V_w)}$$

- Each MSA in the simulation is used in the above formula such that:

V_b: The variation between group means, measured around the overall (grand) mean.

V_w: The variation among MSAs within the same group, measured around each group's mean.

- Group means are the average MSA across 1000 simulations for each hospital service line
- Grand Mean is the average of all the MSAs across all the hospital service lines.

Signal: Variation between hospital service line MSAs for a given simulation.

Noise: Variation of hospital service line MSAs across simulations.

LIFEBRIDGE HEALTH.

CARE BRAVELY

October 15, 2025

Allan Pack, Principal Deputy Director
Health Services Cost Review Commission
4160 Patterson Ave., Baltimore, MD 21215

Dear Allan,

LifeBridge appreciates the opportunity to provide feedback on the proposed revisions to the Market Shift Policy. We offer the following comments regarding the variable cost factor approach, considerations for ongoing policy implementation, and exclusion of certain service lines.

Variable Cost Factor and Ongoing Policy Implementation

LifeBridge is supportive of the changes to the overall variable cost factors (VCFs) and use of specific VCFs for both inpatient and outpatient services. As noted by HSCRC, the changes reflect an improvement using hospital reported direct cost per unit within each category.

As hospital Medicare global budgets transition to the Centers for Medicare & Medicaid Services (CMS) financial methodologies under the AHEAD model agreement, it may be necessary to revisit and recalibrate the VCFs used in the Market Shift Policy should HSCRC continue to apply the current policy to non-Medicare payers.

Service Line Exclusions

The draft policy proposes excluding certain service lines in order to: (1) improve statistical reliability and (2) recognize that these services do not align with population-based methodologies and represent relatively low statewide volume. As outlined in the draft, these services would remain part of hospital global budget revenue (GBR) and be adjudicated using a materiality threshold, consistent with the treatment of out-of-state volumes. However, during the Public Session discussion it was clarified that the service-line exclusions would result in the cases and overall revenue counting toward the 10% exclusion category for revenue not under population-based methodologies under the AHEAD Agreement.

While LifeBridge acknowledges the services constitute relatively low volume and revenue, and ordinarily do not result in meaningful market-shift adjustments, we are not supportive of the change if it requires the services to be excluded from the 90% population-based classification under AHEAD. While relatively low volume and revenue on a statewide basis (2.5 - 3% was cited by Staff during Oct 8 HSCRC public meeting), this is meaningful within the 10% AHEAD exclusion category. Without understanding how excluded services may change or grow under the AHEAD agreement, we do not believe it is appropriate to exclude the services from the Market Shift Policy at this time.

Thank you for your consideration. If you have any questions, please reach out to Laura Russell or Michael Myers.

Sincerely,

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

Adventist HealthCare

October 15, 2025

Allan Pack
Principal Deputy Director, Quality and Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack:

Adventist HealthCare ("AHC") appreciates the opportunity to provide comment on the proposed changes to the Market Shift Policy.

We are extremely grateful for HSCRC staff's thoughtful and collaborative work on this effort. This process reflects an excellent example of how HSCRC staff and providers can work together to develop balanced policy solutions through shared analysis and open dialogue. Overall, AHC supports the draft recommendations and recognizes the significant progress represented in this update to the Market Shift Policy.

Variable Cost Factor

We strongly support the Commission's proposed refinements to the Variable Cost Factor (VCF) methodology. The decision to use four high-level categories, rather than service-line-specific factors, achieves an appropriate balance between accuracy and administrative simplicity. By utilizing cost data from the Annual Cost Filings, HSCRC more accurately funds volume changes based on the actual costs that hospitals incur in caring for patients.

The incorporation of a linear regression model to estimate direct cost variability represents one of the more meaningful improvements in the hybrid model. This data-driven approach better measures the expected change in cost for each unit of volume rather than relying on fixed assumptions about cost variability.

To ensure continued accuracy, we recommend re-evaluating the VCFs every three to five years to reflect evolving cost structures. We also encourage HSCRC to apply these refined VCFs consistently across all volume-related policies including Market Shift, Deregulation, Out-of-State, and Repatriation to promote coherence and fairness in how volume changes are funded. However, we recommend that the Demographic Adjustment should remain unchanged until further discussions occur regarding potential revisions to that policy. We support adopting the updated VCFs immediately.

Changes to Geographic and Service Line Definitions

We support HSCRC's goal of reducing random variation in the Market Shift Policy through refinements to geographic and service line groupings. We are comfortable with the removal of seven low-volume service lines from the Market Shift Policy, though we recommend caution given AHEAD's limitations on carve-outs. We also support the consolidation of spinal surgery and neurological surgery into a single category.

While we agree that applying the Out-of-State methodology to these low-volume service lines may work, their small size may cause them to trigger adjustments each year due to a single encounter. HSCRC may wish to consider an annual fee-for-service–style reconciliation, similar to CDS-A, to simplify administration and promote long-term consistency. We support adopting these changes effective Calendar Year 2026.

Future Considerations

We appreciate HSCRC staff's recognition of latent demand as an important factor in protecting and maintaining access to medically necessary care for all Marylanders. Unmet care needs, particularly in growing or capacity-constrained regions, warrant a thoughtful and equitable policy approach. However, determining latent demand should not rely solely on individual hospital submissions and analyses.

Rather than placing the burden of proof solely on hospitals, HSCRC should establish a standardized annual process—advanced through the Volume Workgroup—for evaluating latent demand. The group's prior work shows that transparent, data-driven methods can meaningfully improve policy. A consistent framework grounded in shared data, transparent assumptions, and joint technical review would ensure equitable treatment across hospitals and allow resources to remain focused on patient care.

This standardized process should not preclude hospitals from submitting their own analyses but instead provide a supportive foundation for both regulators and providers to ensure access and reimbursement for medically necessary care. Establishing a statewide framework to systematically assess unmet need would promote fairness, reduce administrative complexity, and strengthen Maryland's commitment to equitable access under the AHEAD Model.

Recommendations

Adventist HealthCare supports the following changes to the Market Shift Policy:

1. **Adopt the proposed Variable Cost Factor methodology, applying it to the inpatient medical/surgical and outpatient medical/surgical categories.**
2. **Consolidate the Spinal Surgery and Neurological Surgery service lines.**
3. **Remove low-volume service lines from the Market Shift Policy to reduce random variation and improve stability.**
4. **Develop a standardized annual evaluation process for latent demand, created and reviewed through the Volume Workgroup that can be used in addition to hospital led analysis.**

Conclusion

We sincerely appreciate the Commission's collaboration with Maryland hospitals and the ongoing opportunity to participate in this transparent and constructive policy development process. HSCRC's engagement and responsiveness throughout this effort have strengthened both the technical foundation and the fairness of the Market Shift Policy. Adventist HealthCare looks forward to continued partnership with the Commission and our peers as we refine policies that advance equity, accuracy, and alignment under the Maryland Model and AHEAD.

Sincerely,

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

cc: Jon Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman
Ricardo R. Johnson
Maulik Joshi, DrPH
Nicki McCann, JD
Farzaneh Sabi, MD

CareFirst BlueCross BlueShield
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October 15, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on both the Draft Recommendation on Market Shift Refinement and the Draft Recommendation on Select Hospital Volume Realignment. We are broadly supportive of both policies and commend the staff on the work and analytical rigor reflected in these policies. However, we also believe that the policies would be strengthened by creating a formal policy to handle all payer-initiated market shifts.

The Draft Recommendation on Market Shift Refinement suggests that the Health Services Cost Review Commission (the Commission) would carve out payer-driven realignment of volume from the market shift adjustment. Staff would then prospectively adjust hospital revenues to reflect the expected destinations of that realigned volume, based on hospital and payer submitted data. Historically, the Commission has made exceptions to its market shift policy for Kaiser Permanente (Kaiser) but has not adjusted hospital rates for volume changes driven by network changes between hospitals and payers.

We recommend that the Commission apply the Kaiser volume policy that is outlined in the Draft Recommendation on Select Hospital Volume Realignment to volume changes resulting from network changes for the following reasons:

1. The market shift policy was designed to ensure that revenue follows patients. When patient utilization patterns shift from one hospital to another, the market shift policy ensures that the recipient hospital has sufficient revenue to provide care. The market shift policy also ensures that the initiating hospital's rates are reduced so that the hospital's remaining patients are not overcharged. Payer-initiated market shifts are rare but can drive large volume shifts. Given the magnitude of payer-initiated market shifts, it is critical that hospitals receiving an influx of patients are adequately reimbursed to address costs incurred to provide care for those patients.

2. Based on current policy, in the event of a payer-initiated market shift, the hospital going out of network and thus seeing reduced volume will still be permitted to charge their full global budgeted revenue (GBR). If revenues are not prospectively adjusted at both the receiving and sending hospitals, this would artificially inflate rates charged to patients remaining at the hospital removed from one payer's network and artificially deflate rates charged to patients at other facilities seeing more volume. This poses a clear equity problem.

3. Commission staff believe that Kaiser should be treated differently than other payers – we do not agree. Staff contend that Kaiser volume changes are localized between a small number of hospitals whereas other payers redistribute volume from one hospital to many. While volume generally disperses to many hospitals, the distribution of volume changes is a critical part of

setting premiums in payer rate filings. Payers can predict the distribution of that shift with a high degree of accuracy. CareFirst does not believe that distributing volume to more than one hospital is a sufficiently difficult analytic process to warrant the maldistribution of revenues and patient volumes that results from waiting. Moreover, staff's own policy recommendation does not require predicting where volumes will shift. Instead, staff propose carving Kaiser volume out of the GBR, allowing it to be reimbursed through a volume-variable evaluation, and then rebasing global budgets on the basis of the actual observed market shifts. This could be done across all payers.

Again, CareFirst commends the staff on its analysis and refinement to the market shift policy and the volume policy for select hospitals. CareFirst believes that if the policy works for Kaiser, it should be applied to all payer-initiated market shifts. Thank you for the opportunity to comment.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
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CORPORATE OFFICE

October 15, 2025

Allan Pack
Principal Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding Market Shift Refinements

Dear Allan:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, UMMS is writing in response to the draft staff recommendation for Market Shift Refinement. We would first like to commend staff for their openness in re-evaluating several of the most important volume methodologies and for convening a workgroup to garner industry feedback. It is extremely important that this flexibility exists as the dynamics of Maryland healthcare continue to change and transform and it is critical that the state's payment policies be agile enough to evolve with industry dynamics.

UMMS supports the staff's recommendation(s) with one exception and offers the following comments:

Variable Cost Factor
UMMS supports changing the variable cost factors in Market Shift and other payment policies to more accurately reflect true cost of care. While we would ideally prefer a serviceline specific variable cost factor, we feel that a med/surg split for both inpatient and outpatient is a reasonable compromise. Given that most servicelines are heterogeneous such that they include both medical and surgical DRGs/EAPGs, UMMS would recommend evaluating the distribution of charges or ECMADs when determining which variable cost factor is assigned to each serviceline. We also recommend that the variable cost factors be revisited with some degree of frequency to ensure their continued accuracy.

Service Line Consolidations & Exclusions
UMMS supports the idea of consolidating service lines and service areas to alleviate small cell sizes that create instability in the market shift calculation. UMMS does not, however, support the exclusion of the proposed service lines. Under new AHEAD terms, the state is required to maintain 90% of in-state all payer revenue under a population-based methodology. Excluding these servicelines would use up 2.5% of that revenue in addition to the 2.6% that is allocated to outpatient drugs. No agreement has been reached on tertiary and quaternary carve-outs for the Academic hospitals, which would require more than the remaining 4.9% of state revenue. Given the specialized nature of tertiary and quaternary care, UMMS believes those carve-outs should be prioritized and that the state should not commit to further carve-outs until the negotiations have been

finalized regarding AMC carve-outs. Once we understand the remaining capacity to carve out other volume, then the proposal to exclude targeted servicelines can be re-visited.

Service Line Exclusions

UMMS supports the idea of creating consistency and a more standardized approach for temporarily carving volume out of the market shift policy. We support the staff's recommended triggering events for temporarily modifying the market shift and establishing a future latent demand triggering event. With respect to timing and notification, hospitals do attempt to plan for service line changes, however, there are often when those shifts are not known 6 months ahead of time. We encourage the staff to be flexible with the notification timeframe when situationally necessary.

Other Recommended Changes

UMMS would like to strongly recommend that the staff adopt a routine policy of evaluating service shifts from inpatient to outpatient. While transitioning volume to a lower cost setting, the market shift inherently produces inequity in the treatment of that volume as the inpatient reductions often do not balance the outpatient increases due to market dynamics in each service line. To handle this in the past, HSCRC has re-grouped targeted outpatient cases into inpatient service lines to eliminate any financial dis-incentives to shift the volume, as with Total Knee and Hip replacements. Currently when procedures move from inpatient to outpatient, a special request must be made and there is a significant lag in the methodology being adjusted. UMMS strongly suggests that the staff create a routine annual process for re-grouping outpatient procedures that come off the inpatient only list published by CMS each year. This would ensure neutrality in ECMADs, and hospital approved revenue.

We appreciate the opportunity to provide feedback on the proposed Market Shift Refinements. Please let us know if you have any additional questions

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Jon Blum, MPP
Nicki McCann, JD
Maulik Joshi, DPh
Ricardo R. Johnson, JD
Fabi Sabi, MD

Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS President and CEO
Noel Sousa, UMMS Chief Financial Officer

HEALTH MEANS Everything

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

RE: DRAFT RECOMMENDATIONS FOR MARKET SHIFT IMPROVEMENTS (VCF, MARKETS, EXCLUSIONS)

Dear Dr. Kromm and HSCRC commissioners:

We write to you as members of the Health Means Everything Coalition, focused on affordable, high-quality care for Marylanders. The coalition recently formed to advocate for greater transparency, accountability, and equity in the state's healthcare system on behalf of consumers, particularly amid ongoing state and federal transitions, such as implementation of the AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model and decisions regarding the Medicare Advantage program. The coalition members include grassroots organizations, businesses, public health experts and others interested in a healthcare system for Marylanders that keeps people healthy and prices affordable.

To that end, the Health Means Everything Coalition believes the Health Services Cost Review Commission represents an opportunity for community engagement and action on behalf of residents burdened by rising healthcare costs. We believe it is more important than ever for the Commission to fulfill its potential in overseeing the aspects of our state healthcare delivery system under its purview. We hope to encourage transparency, advance healthcare accessibility, and make the work more accessible to the public.

HEALTH MEANS Everything

Our coalition sees value in publicizing the work of the Health Care Services Cost Review Commission, and we hope to encourage the Commission, in turn, to make its work more comprehensible and accessible to the public. We believe centering the average healthcare user in Maryland as the audience for policy change discussions can reframe conversations in a way that encourages broader participation and improves the system for all participants.

As such, we propose the Commission offer longer periods of access for public comment and allow consumers to weigh in prior to the completion of draft recommendations. To facilitate greater public involvement in health policy decisions – which we imagine is a goal shared by our coalition and the Commission – we recommend the HSCRC lengthen its public comment periods and enable such comments to be provided earlier in the deliberation process. Similarly, greater transparency and consistency around the specifics of workgroup meetings and full Commission meetings could aid in that endeavor.

We additionally propose the Commission consider implementing an internal policy on estimating and communicating cost changes for consumers in an easily digestible format. Complex policy moves do not easily translate to dollars and cents for the average family, so laying policy out in a more consumer-friendly manner would aid public understanding. We propose offering an explainer similar to the fiscal notes found in legislation before the Maryland General Assembly that translates how changes to hospital global budgets will impact patients' costs. A consumer-friendly breakdown of the methodology used for pricing decisions and other policy determinations would further public understanding and transparency.

With respect to the Commission's Draft Recommendation on Market Shift Improvements, we appreciate the Commission seeking to ensure hospital payment rates reflect relevant shifts in utilization. Updates to the variable cost factor have the potential to rightly shift payments in a way that ultimately keeps out of pocket costs down for consumers. However, we stress again that without a more explicit assessment of how these changes impact underlying costs to consumers, it is difficult to provide a consumer-focused assessment of their value.

From a consumer perspective, our belief is that revenue should follow patients to the hospital where they receive services to ensure patients receive the benefit of funding from the facilities they choose to utilize. Moreover, we do not believe patients who continue to receive services from a hospital that experiences an outflow of patients should be put in a position where their costs may ultimately serve to subsidize the hospital's loss of patients. To that end, we recommend the HSCRC monitor the impact of any changes to the Market Shift Adjustment on care accessibility and affordability.

Furthermore, in implementing these goals, we believe the policy proposed in the Commission's Draft Recommendation for Select Hospital Volume Realignment may offer useful tools, if brought to bear in a systemic fashion rather than as an ad hoc solution for the more case-specific problem presented by Kaiser. The current hospital market is seeing dynamic shifts that may impact coverage for thousands to millions of Marylanders (e.g. ongoing network disputes between UnitedHealthcare and Johns Hopkins University). Large-scale changes in health insurance networks disrupt Marylanders' access to their trusted providers and, in an all-payer global budget system, can distort hospital prices. To ensure stability for Marylanders and facilitate the Commission's timely response to these large-scale volume shifts, the HSCRC should integrate this ad hoc approach in the broader global budget methodology.

We will continue to follow issues like the new Medicaid work requirements, preserving access to Medicare Advantage, and implementation of Maryland's AHEAD Model, and look for places where consumer perspectives might benefit the Commission. We will also seek to advocate for consumers at the Maryland General Assembly and beyond.

Thank you for your time and consideration. We look forward to working with you on behalf of Maryland families.

Sincerely,

Ashiah Parker
Chair, Health Means Everything Coalition

Coalition Members:

Central Maryland Chamber of Commerce
No Boundaries Coalition
New Bethlehem Baptist Church
Step Up Maryland
Flowers Whiting Initiative
Echo Strategy & Co.
The Treehouse Project
DMP Advocacy

Ed Beranek
Vice President of Revenue Management and Reimbursement
Jberane1@jhmi.edu

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

October 15, 2025

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

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Market Shift Refinement.

JHHS appreciates the HSCRC staff's willingness to continue to review polices that are out of alignment under the current system. JHHS has been consistent in its policy commentary that the existing volume policies must better align revenue with the cost of providing medically necessary care. In general, JHHS supports the proposed refinements to the market shift policy.

JHHS has advocated for a more precise variable cost factor application for many years. Though the state has not moved to a full, service line specific set of variable cost factors, the current proposal certainly moves the policy in the right direction, and JHHS thanks staff for their hard work. Moving forward, these variable cost factors should be evaluated on a periodic basis to ensure continued accuracy as care evolves and technologies advance.

Regarding service line exclusions, JHHS is concerned that under the AHEAD Model these exclusions would count against the 10% hospital global budget exclusion limit, and it is critical that the state thoughtfully prioritizes the services that count towards that restricted amount. Other exclusions that carry more volatility and cost – namely, quaternary and tertiary care - must not be limited to ensure access to this specialized care for Marylanders. We also will need to understand how CMS intend to reimburse hospitals for the excluded services.

JHHS agrees with the intent to establish a process by which a service line exclusion can be requested; however, it is crucial that other hospitals would not be adversely impacted by this adjustment if granted to a specific hospital.

JHHS appreciates the opportunity to comment on the market shift policy refinements. Volume policies must be more responsive to changes in volumes and must fund these changes at a reasonable level. JHHS believes that staff's recommendations will help achieve that goal. JHHS appreciates staff's efforts to formulate these policy refinements and looks forward to further collaboration to improve existing methodologies.

Sincerely,

Ed Beranek

Ed Beranek
Vice President
Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
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Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
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MedStar Health

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MedStarHealth.org

October 17, 2025

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

Dear Executive Director Kromm,

On behalf of MedStar Health Inc. (MedStar) and our seven Maryland acute care hospitals, I write to provide comments on the draft staff Recommendation for Market Shift Refinement presented during the October 8, 2025 public session. MedStar appreciates the work of HSCRC staff on this policy refinement and commends them for their responsiveness to long-held industry concerns with the accuracy of the market shift methodology – many of which are addressed in this policy refinement. The draft recommendation contains many of the policy proposals and revisions that were developed through the workgroup process and a collaborative effort between HSCRC staff and industry stakeholders. MedStar thanks HSCRC staff for their good faith collaborative work in the development of this draft recommendation.

Overall, MedStar is supportive of the revisions to the market shift methodology that are being proposed by staff as they increase the accuracy of the calculation, more accurately align funding in hospital global budgets with the cost of patient care and exclude patient care service lines which are not appropriate for assessment in the current market shift methodology as designed. To further improve the accuracy of the market shift methodology, MedStar proposes a few further revisions for staff and HSCRC commissioner consideration which are detailed below.

While establishing and applying variable cost factors specific to IP Med/Surg and OP Med/Surg is a welcome step, service line specific variable cost factors should be used when calculating market shift global budget adjustments to better align funding with cost and address discrepancies.

Staff's proposal to use specific variable cost factors for Inpatient Medical, Inpatient Surgical, Outpatient Medical, and Outpatient Surgical patient volumes is a welcome advancement of the market shift policy that will result in greater alignment of revenue with patient volumes in Maryland. To this end, MedStar supports this aspect of the draft recommendation. However, as discussed in the policy paper and during the workgroup when developing this policy, staff have calculated and validated variable cost factors for each market shift service line and has elected to not apply them. MedStar believes this limits the improvement to the accuracy of the market shift calculation. MedStar urges the commission and staff to consider a revision that applies service line specific variable cost factors when calculating market shift adjustments – these factors have already been calculated by staff and the increase in complexity to the calculation is well worth the tradeoff of improved funding accuracy for Maryland hospitals.

Revised variable cost factors should be applied retrospectively to volume shifts in the 2019-2022 market shift period, 2022-2023 market shift period, and 2023-2024 market shift period.

Staff's recommendation to make the new variable cost factors effective immediately (2025 market shift calculation) is welcomed, however, this would fail to address the volume over/under funding at hospitals that has occurred over the past few years as major volume changes occurred in the market due to the direct and lasting indirect impacts of the COVID19 pandemic. The 2019-2022 market shift assessment period saw roughly a $650 million decline in patient volumes statewide, followed by sharp rebounds in the 2022-2023 and 2023-2024 period. MedStar urges the HSCRC to apply the new and more accurate variable cost factors retroactively in these three market shift periods and make permanent as well as one-time adjustments to hospital global budgets to more appropriately fund hospitals for volume growth and declines.

Exclusion of any service lines from market shift should not occur without a comprehensive evaluation of all patient care services excluded from population-based payment with input from stakeholders.

As it stands, the AHEAD Model is set to begin in Maryland on January 1, 2026 with major ramifications for the state's reimbursement methodologies and hospital financial performance. Maryland's contract with CMMI will only allow for 10% of in-state revenue to be excluded from the population-based payment model. This limit, while a key component of ensuring the state achieves the AHEAD models required savings, constrains the number of services that can be paid through a more volume variable reimbursement chassis – a payment model arguably more appropriate for funding the costs associated with services with highly variable expenses (Outpatient Oncology Drugs) and certain highly specialized and expensive services that if not funded appropriately can significantly erode hospital financial performance if volumes increase.

It is critical for hospital financial performance, which remains below historical performance and below national peer performance, that the HSCRC ensure that the 10% of revenue carved out from population based payment in AHEAD is directed towards funding services where it is most appropriate – based on the cost variability of the service and the potential impact changes in volumes can have on overall hospital financial health. Discussions around what services will be excluded from population-based payment and account for the 10% allowed under AHEAD remain ongoing and the HSCRC should not limit their flexibility by carving out 2%-3% through exclusions to market shift. While MedStar appreciates staff's reasoning for proposing the exclusion of 7 service lines with low volume counts that compromises the accuracy and reliability that the market shift methodology appropriately adjusts revenue in line with volume shifts, these services do not present the same cost and financial challenges to hospitals and do not have major differences in their cost variability when volumes change.

Deciding which services will be carved out from hospital global budgets in AHEAD has major ramifications on hospital finances, our ability to meet the state's total cost of care targets, costs to patients in Maryland, and ensuring adequate levels of access. These decisions should not be rushed and should be made in the time allowed between the start of AHEAD in 2026 and when changes to reimbursement policy become effective in 2028.

Applicants approved by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) for designation as a trauma center or specialty center for stroke, cardiac intervention, and neonatal patient care in order to meet the care needs of Marylander's should be included as a market shift exclusion triggering event.

MedStar agrees with staff's recommendation to exclude new services that have received CON approval from the MHCC from the market shift calculation to fund new volume growth at hospitals that is needed to meet the demands of Marylanders. However, CON approval should not be the exclusive trigger for HSCRC staff to exclude a service from market shift. Similar to MHCC's evaluation process in determining community needs for new hospital services, MIEMSS is charged in assessing applicants seeking designation as a trauma center or specialty center, ensuring that facilities meet care standards and can respond to the needs of Marylanders across the state. To meet MIEMSS standards for designation as a trauma or specialty center, hospitals must incur significant costs to have the appropriate care teams in place, facilities, and care equipment required for treating patients with severe and complex diagnosis. This includes specialty physician coverage, on-call coverage 24/7, dedicated care units, dedicated clinical care teams, and specialty training

for clinical care teams. Hospitals incur these costs to care for Marylanders requiring prompt, high-quality, specialty care during times of acute illness and meet the regional needs of the community. Given the complexity and cost associated with these designations, MedStar believes these approvals should be considered as a triggering event for an exclusion for market shift.

MedStar supports the exploration of a policy refinement to potentially provide volume funding to hospitals when a new service is meeting latent demand in the community caused by historical lack of access or care shortages.

While designed to sever the connection between revenue and patient volumes and increase investment in population health and efficient care delivery, fixed global hospital budgets and the constraints they impose/incentives to reduce patient volumes when not appropriate could result in Marylanders with historical challenges accessing care not getting the care they need and deserve. Development of a policy to assess where health service access challenges exist, the drivers of these challenges, and a potential mechanism to fund new investment in services to alleviate these care gaps and meet the demands of patients is worth exploring. MedStar would happily work collaboratively with staff and other stakeholders in the development of such policy refinement. If the development of this policy does move forward, MedStar stresses the need for clear and transparent evaluation criteria for hospitals to be given access to this funding – particularly around how access to a service in a market will be defined, metrics for comparing access, differentiating latent demand due to access challenges from use rate changes, and appropriate care delivery levels.

Finally, MedStar is strongly opposed to the notion that the burden of notification falls to hospitals when payers initiate service realignment across participating providers. When payor driven shifts occur, hospital management does not always receive timely notification prior to service shifts and often the impacts are not discovered until after they have commenced. As good faith partners in the Maryland healthcare system, payors should be responsible for notifications when initiating service shifts where it is believed to be of a magnitude that would trigger the exclusion materiality threshold.

Thank you for the opportunity to provide input on the draft market shift revisions presented during the October 2025 public session and we hope you consider MedStar's proposed changes to the policy. We believe that these changes will improve hospital funding in Maryland and more appropriately align revenue with the cost of patient care. We hope to continue to work collaboratively with the Commission, staff, and other stakeholders on this topic. If you have any questions or would like to discuss this topic further, please do not hesitate to reach out directly.

Sincerely,

Mike Wood

Mike Wood
Vice President – Revenue Management & Reimbursement
MedStar Health

Maryland
Hospital Association

October 15, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Market Shift Refinement. We appreciate HSCRC staff for their work to strengthen the reliability of the current market shift methodology and ensure that volume changes due to market shifts are more precisely funded.

Maryland hospitals face significant uncertainty with regard to the core financial methodologies that will be used to determine their Medicare payments and revenue under the AHEAD Model. At the same time, disruption to the long-standing all-payer system and the potential for two sets of financial methodologies—one for Medicare and another for Medicaid and commercial payers—will add complexity to an inherently complex payment structure.

Recognizing that the Centers for Medicare & Medicaid Services (CMS) will not finalize its Medicare hospital global budget methodology until late next year or early 2027, we appreciate HSCRC taking a thoughtful approach to market shift policy development and urge staff, to the extent practicable, to pursue alignment between its methodology and CMS' to limit complexity and reduce the administrative burden on hospitals.

We offer the following comments for consideration by HSCRC staff and Commissioners.

Variable Cost Factor
MHA supports the recommended changes to the variable cost factor (VCF) and appreciates the collaboration between HSCRC staff and the hospital field on this issue over the past several months. Although we previously urged HSCRC to adopt an alternative methodology that evaluates costs on a more granular service line basis, the HSCRC recommendation is, nonetheless, an improvement as it adopts a more empirically based approach when establishing specific VCFs for certain service categories. The use of four calculated VCFs for inpatient medical (57%), inpatient surgical (66%), outpatient medical (54%), and outpatient surgical (63%) service lines in lieu of the statewide average—and a newly calculated statewide average (59%)—is responsive to feedback from the hospital field and a welcomed improvement over the existing policy, which funds volume changes at a 50% variable cost factor. These policy

refinements will more accurately account for and sufficiently fund volume changes due to hospital-to-hospital shifts in the market.

Market Definitions and Reliability

MHA supports HSCRC's efforts to evaluate and improve the reliability of market shift assessments, including those reflected in the draft recommendation, in response to concerns raised by the hospital field about the methodology not accurately capturing shifts in smaller geographic areas of measurement for certain services. The proposed consolidation of certain inpatient surgical service lines (spinal surgery and neurological surgery) and other low-volume inpatient service lines (endocrinology surgery, ENT surgery, gynecological surgery, ophthalmologic surgery, thoracic surgery, urological surgery, ventilator support) would improve the methodology by increasing reliability and isolating true shifts in volume between hospitals.

Given that CMS will begin setting Medicare hospital global budgets in 2028, we encourage staff to consider rerunning its simulations to ensure the proposed service line consolidations and exclusions result in similar improvements in reliability when Medicare is excluded. Staff should also revisit whether refining markets more generally using broader geographic regions would improve market shift reliability once Medicare volumes have been removed from the simulation.

Relationship to AHEAD Revenue Requirement

According to staff estimates, the service line exclusions included in the draft recommendation account for 2.5% of in-state revenue. Though it was determined that two other sets of service lines could be consolidated based on clinical overlap (thoracic surgery with cardiothoracic surgery and ventilator support with pulmonary) and that doing so would improve reliability, staff decided against recommending their consolidation because thoracic surgery and ventilator support are already to be excluded and "increasing the magnitude of those carveouts further by consolidating with other service lines would jeopardize the State's ability to maintain 90 percent of in-state revenues within population based methodologies as required by the AHEAD model contract." Staff also shared their view that any service lines excluded from the market shift would not be considered as being under population-based methodologies because they would be subject to volume variable funding with no cap on volume growth.

MHA has expressed concern about the 90% revenue requirement as it is at a level that is unduly limiting on the state and hospitals. We question the assertion that services excluded from the market shift should be considered excluded from hospital global budgets given they are still part of hospital GBR and revenue adjustments for these service lines are governed by a materiality threshold and variable cost factor. It is critical that the state and Maryland hospitals understand what criteria will be used to determine what portion of revenue is considered "excluded", and we urge HSCRC to consider this viewpoint further.

Temporary Service Line Exclusions

MHA appreciates HSCRC's interest in memorializing a standardized, formal process through which hospitals can request temporary exclusions to the market shift related to large shifts in volume that may not be precisely accounted for in the market shift methodology; however, we respectfully request that staff consider the following comments and any other feedback provided by members of the HSCRC Volume Subgroup before moving forward with this policy.

Under the draft recommendation, there would be five types of "triggering events" for which hospitals could request temporary exclusion from the market shift including facility conversions, intersystem shifts, payer driven volume shifts, materiality exclusions, and CON approved service expansions. Clarification from staff is needed on what types of events would be considered "payer driven volume shifts" other than Kaiser-initiated realignment efforts and whether shifts from non-hospital settings to hospitals (e.g., in the event of a physician's office closure) of a certain magnitude would be considered under the "materiality exclusions" category.

Additionally, certain payer driven shifts, such as a carrier decision to exclude a hospital from its network, could have negative impacts on access to services. For significant shifts resulting from such an action, HSCRC should consider requiring completion of an access impact analysis which could enable adoption of strategies to mitigate disruption in patient access to care. Finally, for payer driven volume shifts, important clarification is needed to ensure that only hospitals directly impacted by the shift can request an adjustment under the proposed process.

Staff cite a desire to align with AHEAD's Service Line Adjustment methodology for Medicare hospital global budgets as a reason for proposing to formalize the service line exclusion approach. MHA generally supports methodology alignment efforts, however, it should be noted that AHEAD's service line adjustment has not been discussed broadly with the hospital field and, as a result, is not yet well understood. CMS' methodology contemplates adjustments for service line additions and expansions related to unmet needs and importantly, allows hospitals to retain a portion of revenue associated with the volume of a contracted or removed service line to invest in population health activities. For the sake of alignment and consistent incentives across payers, we encourage HSCRC to consider adopting a similar policy as hospitals need the ability to backfill services through a streamlined process to expand access and address unmet needs when there are purposeful shifts of services from a hospital, especially due to payer driven volume shifts. We also ask that HSCRC continue to engage in discussions with Commissioners and Volume Subgroup members about the adoption of a "latent demand" policy that allows for hospital volume adjustments related to the unmet needs of the communities they serve.

****

Thank you for the opportunity to comment on these important policy changes and for your collaboration with stakeholders on the issues addressed by this draft recommendation. We look forward to continuing to work together on HSCRC policy development in the coming months. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick D. Carlson

Patrick Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

October 14, 2025

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

Dear Dr. Kromm,

On behalf of Luminis Health, I write in support of the HSCRC staff's recommended refinements to the Market Shift policy.

We support the immediate adoption of the updated variable cost factors (VCF) for inpatient and outpatient medical and surgical services:

- Inpatient Medical: 57%
- Inpatient Surgical: 66%
- Outpatient Medical: 54%
- Outpatient Surgical: 63%

These adjustments reflect a data driven improvement over the longstanding broadly applied estimate of 50% and better align with current cost structures and market realities.

We also support the proposed removal and consolidation of the selected service lines from the Market Shift policy. This change recognizes the limitations of applying the methodology to low volume or highly variable service lines. Additionally, we agree with using materiality thresholds consistent with the Out-of-State Volume policy to adjudicate any volume changes in the excluded service lines.

As Maryland prepares for the transition to the AHEAD Model, we strongly encourage the HSCRC to revisit the Market Shift policy once the AHEAD methodology is finalized. Currently, the AHEAD calculation is focused on changes in market share for a defined service area vs only funding volume growth where there is a decline and vice versa. Ensuring alignment between these policies will be essential to avoid conflicting incentives and the ensuing unintended consequences and inconsistencies

While we support the concepts of the proposed updated VCF when calculating Market Shift, we are concerned that the HSCRC still has not fully taken into consideration the challenges of an aging demographic where certain services will continue to grow in certain geographies – not through the virtue of Market Shift, but rather through the natural change in a population. The current methodologies do not take this type of volume change into consideration and current demographic adjustments to rates do not fully fund such changes. We strongly urge the Commission to take a renewed approach to funding the volumes resulting from the aging of our population and the associated increasing costs of delivering that care.

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

Thank you for the opportunity to comment and for the continued efforts to improve and modernize these important methodologies.

Sincerely,

S. Michelle Lee
Interim Chief Financial Officer
Luminis Health

maryland
health services
cost review commission

maryland
health services
cost review commission

Final Recommendation for Select Hospital Volume Realignment

Table of Contents

List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care

Executive Summary

The approach outlined in this draft recommendation aims to simplify the process for handling Kaiser Permanente's (KP) material market shift in hospital utilization, reduce the scope of affected facilities, and provide more accurate, real-time reimbursements. It also ensures that volume-based adjustments are consistent with Maryland's established methodologies while accommodating KP's ongoing efforts to realign its healthcare delivery model.

Section I: Facts

Kaiser Permanente is an integrated healthcare delivery system that provides health plan coverage and coordinated medical services for its members. KP has over 750,000 members in the Mid-Atlantic States Region, which includes Maryland. KP is the largest Medicare Advantage and second largest Commercial insurance carrier in Maryland . While KP does not operate its own hospital facilities in Maryland, it partners with a network of hospitals (KP Core Hospitals). Permanente Physicians and Kaiser Foundation Health Plan staff are embedded in these hospitals to provide direct care to KP members and coordinate their care within their integrated delivery system. Although KP members can access emergency services at any hospital and utilize non-emergent services when clinically appropriate in out of network locations, the majority of hospital utilization for KP members occurs at KP Core Hospitals.

The volumes and reimbursements associated with KP patients operate under the same population based methodologies that all payers are subject to in Maryland. Specifically, KP patient volumes at regulated hospitals are adjusted for anticipated use rates in line with population growth through the annual Demographic Adjustment policy and every six months are also adjusted for changes in market selection/patient choice through the Market-shift policy.

Kaiser Permanente is currently in the process of realigning its members amongst its Core Hospitals and is actively pursuing a strategy of consolidating its members to these facilities. This process is underway and should be finalized sometime in early calendar year 2026.

Section II: Issue

Under normal circumstances, the Market-shift policy, which evaluates all payers and all in-state services,[1] addresses changes in hospital selection. However, over the past decade, the Commission has occasionally departed from this methodology during significant payer-initiated shifts and instead has assessed shifts isolated to unique payers. This is consistent with the Commission's authority, as detailed in the Global Budget Agreements between the HSCRC and individual hospitals, to modify global budgets for "…service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share and other relevant factors that are pertinent to the effective operation of the GBR model…"[2]

The benefit of this approach is that it avoids the imprecision of the market shift methodology that naturally occurs when there is a purposeful, material realignment in the market. For example, if a hospital system realigns services within its health system, while other hospitals experience utilization growth due to natural population changes, a portion of the realignment will be partially attributed to other facilities outside of the system that are experiencing use rate growth due to secular demographic changes (see example below).

Table 1: Example of Purposeful System Realignment Interacting with Marketshift Policy

			Hospital A (System 1)	Hospital B (System 2)	Hospital C (System 2)	Total	Comments
Normal Marketshift Assessment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C	Market Driven Volume Changes	5	-2	-3	0	
	D = B+C	Total Volume Change	15	-2	-3	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		5			
	F=D/Total Growth or Decline* E	Awarded Marketshift	5	-2	-3	0	Must equal 0 to ensure only shifts are quantified
	G=A+B+F	New Baseline Volume	115	98	97	310	*5 units of volume are shifted from Hospital B & C to Hospital A*
			Hospital A (System 1)	**Hospital B (System 2)**	**Hospital C (System 2)**	**Total**	**Comments**
Normal Marketshift Assessment interacting with Purposeful System Realignment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C1	Market Driven Volume Changes	5	-2	-3		
	C2	System Realignment	0	-8	8		*System 2 elects to shift 8 units of volume between its hospitals (e.g., consolidation of rehab program)*
	D = B+C	Total Volume Change	15	-10	5	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		10			
	F=D/Total Growth or Decline* E	Awarded Marketshift	7.5	(10.0)	2.5	0	Must equal 0
	G=A+B+F	New Baseline Volume	117.5	90.0	102.5	310	*An additional 2 units of volume are shifted from Hospital B to Hospital A because the system realingment is scored as a marketshift*

Net Effect	***An additional 2.5 volume units are awarded due to population growth, which is misattributed as a marketshift***	***All Volume Decline is Correctly Scored***	***2.5 volume units related to system realingment are NOT awarded due to interaction with marketshift***

[1] Limited exceptions to this are high cost outpatient drugs that are handled through a unique volume variable methodology known as the CDS-A policy (insert CDS-A link) and unique quaternary cases performed at the State's two academic medical centers, which are addressed through the Complexity and Innovation policy (https://hscrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Innovation%20Policy%20v3%20%28002%29.pdf)

[2] https://hscrc.maryland.gov/Pages/gbr-tpr.aspx

This is the inherent tradeoff caused by using population-based methodologies. While these approaches effectively incentivize a shift away from the traditional "sick care" model, which often rewards providers for acute care services over preventative ones, they also introduce a degree of imprecision in revenue allocation. This imprecision can be particularly noticeable when significant market changes occur.

Section III: Proposal and Relevant Considerations

The Commission has previously used a prospective adjustment and then a zero-sum evaluation, similar to the Market-shift Policy, to address KP-initiated shifts in hospital global budgets due to their growth and dissipation. This method allowed for real-time funding adjustments, which was crucial given the scale of these market shifts. Following these prospective adjustments, staff utilized Market-shift datasets and KP-submitted data to finalize the settlement of KP volumes and revenues among affected hospitals.

While past prospective adjustments were generally accurate, they often involved extensive negotiations with hospitals, retrospective data submissions from KP, and reconciliations of the initial adjustments.

Considering the numerous steps in this adjudication process and the broader impact of the proposed KP shift across several hospitals, staff are now proposing an alternative approach. Specifically:

1) Scope Limitation: Limit the scope of affected hospitals to facilities with material KP 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.[3] All other KP volume will be handled through the normal Market-shift policy.

2) Rate Order Adjustment (January 2026): In January 2026 rate orders, remove KP funding across hospitals that had material KP volumes, based on Fiscal Year 2025 KP submitted data. KP 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 Market-shift Policy.

3) KP Carve-Out from Global Budgets (January 1, 2026 - December 31, 2026): Carve out KP volumes and revenue from global budgets from January 1, 2026, through December 31, 2026, utilizing the variable cost factor that the Commission will vote on during the December 2025 Commission meeting. This will allow them to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates, inclusive of a variable cost factor.

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

[3] For a complete list of affected hospitals, please see Appendix 1. These hospitals may change slightly once RY 2025 data is available.

Market-shift. If volumes do deviate from the prior KP cap, staff will implement a pro rata reduction to material KP facilities.[4]

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 KP Shifts (Early 2026): Retrospectively assess in early 2026, in line with Commission Market-shift analyses, any KP 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 27) or in January 2027 rate orders if the adjudication process lags.

A key consideration in this approach is the TCOC contract provision that 95 percent of in-state volume is assessed under a population-based methodology, while the AHEAD Model allows 85 percent. Because staff will conduct a retrospective assessment and potential pro rata reduction to ensure that volumes do not exceed the Fiscal Year 2025 volume base, staff believe this proposed method aligns with the tenets of a population-based methodology and does not count against the 95 percent requirement.

To effectuate this proposal, staff also need to consider GBR compliance. For the hospitals affected by this recommendation, staff will create a supplemental schedule to submit along with the monthly experience data. The schedule will provide volume and revenue data by rate center (experience data) for patients where KP is the primary payer. Staff will use this data to monitor monthly compliance with GBR. For year-end compliance, staff will take the hospital-reported KP revenue for the year and deduct it from the hospital's total actual revenue in the "GBR1" tab of the rate model, so hospitals are not penalized for patient volume carved out of their GBR. Finally, staff will reconcile the hospital's submitted experience data schedule for KP with the case-mix data to ensure that the submission is accurate.

Section IV: Stakeholder Feedback

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

Table 2: Summary of Stakeholder Comments

[4] Staff will allow for minimal deviation to account for population growth if hospitals and Kaiser can prove insurance conversion.

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

Staff will address each stakeholder comment area below:

1. Data Transparency & Validation Comments: 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.

Table 3: Data Transparency & Validation Comments

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.

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 percent of the $698M in volume will not move because it is already in its core facilities, ~25 percent percent ($175M) will not move because Kaiser anticipates ongoing use of non-core facilities for emergencies and out-of-network migration, ~11 percent ($78M, $46M with VCF applied) will potentially move due to this realignment, and ~5 percent 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:

Table 4: Kaiser Summary Schedule for Realignment ($ Millions based on CY 2024 Charges(

	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%		

2. Inclusion of Elective & Emergent Volume Comments: 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.

Table 5: Inclusion of Elective & Emergent Volume Comments

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.

Staff Response: *Staff disagree 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, but staff do 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.

3. Financial Impact & Policy Scope Comments: 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.

Table 6: Financial Impact & Policy Scope Comments

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).
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.

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 in the following way:*

- *Greater than 5 percent of total Kaiser Revenue statewide regardless of Kaiser share of GBR (NEW!)*
- *Greater than $5 million in annual charges and greater than 2 percent of global budget revenue, however,*
- *Various Exclusions (NEW!)*
    - *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 hospitals affected from 19 to 13 (see table below for hospitals affected by this recommendation). Staff do 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.

Table 7: Hospitals Affected by Volume Realignment Recommendation (RY 2025 charges)

		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	

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.

As stated in the Commission meeting and formally authored in this final recommendation, staff will utilize the variable cost factor that will be voted on during the December Commission meeting to adjust for Kaiser shifts (presumably 59 percent on average).

4. Process, Timeline and Broader Applicability Comments: 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.

Table 8: Process, Timeline and Broader Applicability Comments

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.

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 do 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 percent 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.

5. Other Topics: 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.

Table 9: Other Topic Comments

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.

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.

Section V: Final Recommendations

1) From January 1, 2026 through June 30, 2027, remove, for select hospitals, KP volumes and revenues evaluated in the Market-shift policy from global budget revenues. A variable cost factor will be employed. Select hospitals are defined as follows:
    a) Greater than 5 percent of total Kaiser Revenue statewide regardless of Kaiser share of GBR (NEW!)
    b) Greater than $5 million in annual charges and greater than 2 percent of global budget revenue, however,
    c) Various Exclusions (NEW!)
        i) Specialty Hospitals – Shock Trauma, Shady Grove Hospital

ii) 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)

2) Allow removed KP volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates. A variable cost factor will be employed.
3) On July 1, 2027, build back into global budgets removed KP volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026 through December 31, 2026.
4) Apply retrospective adjustments (both permanent and one-time) if hospitals can verify that Kaiser volumes were replaced with other volumes that are currently unsupported by Demographic, Marketshift, or related adjustment (NEW!).

Adventist HealthCare

October 29, 2025

Allan Pack
Principal Deputy Director, Quality & Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack:

Re: Draft Recommendation – Select Hospital Volume Realignment

Adventist HealthCare (AHC) appreciates the opportunity to comment on the draft recommendation for *Select Hospital Volume Realignment*. We value the Commission's efforts to modernize policies that ensure funding follows patients in a timely manner. As a long-standing partner in advancing Maryland's population health goals, AHC supports policies that balance payer innovation, equitable hospital funding, and the sustainability of community access to medically necessary care.

While we share the intent to improve how funding flows for material volume shifts. we have significant concerns that, as drafted, the policy could produce unintended consequences that substantially threaten both access and financial stability for hospitals. We offer the following observations and recommendations in the spirit of collaboration and shared accountability.

Intent vs. Implementation

The proposed policy aims to streamline the process for large-scale payer-initiated volume shifts, which has historically been resource-intensive and slow. AHC agrees that a more predictable, transparent process would be beneficial. However, the draft approach—particularly the immediate removal of all KP-related volumes from global budgets and real-time reimbursement beginning January 1, 2026—introduces operational and financial uncertainty without sufficient definition of scope or data transparency.

The lack of detail on KP's implementation plan—including designated premier hospitals, targeted service lines, and treatment of elective vs. emergency volumes—limits hospitals' ability to assess potential impacts and effective policy development. **AHC recommends that HSCRC require a standardized data and operational template from KP (or any payer seeking prospective funding movement) to ensure transparency and alignment of funds flow.**

Data Validation and Transparency

The draft recommendation appears to rely primarily on Kaiser's internal data for modeling anticipated patient movement. While appropriate for reference, HSCRC's all-payer hospital data remains the gold standard for independent validation. When hospitals request global budget adjustments, HSCRC staff independently validate all analyses using internal data sources. The same level of rigor should apply when a payer initiates a funding change.

We recommend that HSCRC conduct an independent analysis to confirm KP's projections and review elective versus emergent cases by service line. Such validation would ensure that prospective revenue transfers are equitable, data-driven, and consistent with Maryland's rate-setting standards.

Differentiation Between Emergent and Elective Cases

At AHC, approximately 97% of KP-originating encounters enter through the Emergency Department. These cases are unplanned, medically necessary, and often life-threatening. Treating them as discretionary shifts subject to immediate budget removal risks undermining emergency access and delaying care.

We recommend excluding emergency-department-sourced encounters—including resultant inpatient admissions—from the realignment policy and allowing them to flow through the existing Market Shift mechanism. This approach aligns with KP's intent to focus on elective and planned services that can be prospectively managed without jeopardizing emergency care.

Financial Sustainability and Access Risk

The current proposal would remove roughly $20 million in annual revenue from AHC's Montgomery County hospitals beginning January 1, 2026—nearly equal to our system's annual operating margin. With less than 30 days' notice, these funds would be carved out of AHC's global budgets, forcing hospitals to operate at risk to recapture KP volumes or backfill through the Market Shift policy. Otherwise, operations would need to contract immediately to align with reduced funding.

Because Market Shift is zero-sum, hospitals can recover funding only when others lose equivalent volume. In high-demand regions like Montgomery and Prince George's Counties—where latent need is significant and capacity already constrained—such declines are unlikely. Montgomery County's low per-capita ED use but long wait times highlight this unmet demand. Even if our hospitals continue serving patients at current or higher levels, AHC would not be reimbursed under Market Shift and would face an immediate $20 million gap if KP volume is effectively moved.

This mismatch between funding removal and patient demand destabilizes access and penalizes hospitals in growing markets. Without a means to fund latent demand that fills vacated capacity, the policy risks reducing supported volume in high-need areas. Additionally, the current 2% of global budget revenue or $5 million threshold for automatic adjustments is overly broad and could trigger significant destabilization. **We recommend narrowing the policy to target only material patient movements consistent with verified payer plans—such as the top 80% of projected elective cases targeted—to ensure funding remains proportionate and appropriate.**

For AHC, the draft adjustment could cause immediate shortfalls and require targeted cost reductions—including service rationalization—to preserve solvency given the scale and timing of the change. While such measures may be necessary for financial viability, they risk undermining the Total Cost of Care, the AHEAD Model, and access to medically necessary care. **We do not believe this is the policy's intent and recommend a risk assessment focused on access and hospital financial sustainability to ensure the policy aligns with a "do no harm" principle.**

Technical Concerns

Several technical elements require clarification. It is unclear whether funds will be removed and reimbursed at the draft Market Shift variable cost factor rate of 59% or at 100% of the HSCRC rate order. The reference to "real-time reimbursement through a volume-variable equalization using HSCRC rates" could be interpreted as funding at 100%, which would significantly alter the policy's design. It is unclear how the policy will be technically implemented and the financial impact to hospitals. **We recommend that the financial impact and technical specifications are finalized before final policy approval.**

The treatment of Potentially Avoidable Utilization (PAU) also requires clarification. If KP-related PAU volumes are removed from originating hospitals without corresponding payment at receiving hospitals, it could defund upstream care management resources. Conversely, if originating hospitals backfill with PAU volumes, Market Shift will not pay out PAU-related funding. Addressing this long-standing policy gap is essential to ensure that PAU resources follow the patient ensuring access to medically necessary care.

Total Cost of Care (TCOC) Impact Analysis

HSCRC should conduct a TCOC impact analysis to determine whether the proposed realignment would generate measurable statewide savings. This should include modeling scenarios at 50%, 80%, and 100% KP patient movement success rates to evaluate potential savings from reduced length of stay, efficiency gains, or variable cost factor adjustments. Understanding the magnitude and source of savings will clarify whether funds should accrue to the State's TCOC performance or be reinvested in affected communities.

Workgroup Process and Policy Development

The standard HSCRC workgroup process—allowing for stakeholder engagement, data validation, and consensus building—was not followed before this proposal reached the Commission. Implementing a mid-year negative policy adjustment with less than 30 days' notice would undermine Maryland's prospective rate-setting framework and introduce unnecessary operational risk.

We recommend convening a technical workgroup to refine the policy before implementation and postponing any vote until these analyses and discussions are complete. This approach ensures the policy is data-driven, equitable, and consistent with the collaborative process that has long supported Maryland's success under the Total Cost of Care Model. **We also recommend standard notice requirements for material shifts, such as 6 months in advance to ensure smooth transitions of operations.**

Recommendations

To strengthen the policy and align it with the Maryland Model's principles of equity, transparency, and sustainability, Adventist HealthCare recommends the following actions:

1. **Require standardized payer submissions** outlining implementation plans, affected hospitals, targeted service lines, and treatment of elective vs. emergency cases prior to any funding adjustments.
2. **Conduct independent HSCRC validation** of payer-reported data using HSCRC hospital data and analyses comparing elective versus emergent care and service lines and estimated TCOC impact.

3. **Exclude emergency-originating volumes** (including resulting admissions) from the carve-out and allow them to flow through the standard Market Shift policy.
4. **Narrow the scope** of the carve-out to focus on elective and pre-scheduled cases aligned with the payer's verified plan rather than applying a blanket carve-out to all KP cases.
5. **Refine the funding threshold** by revising the current 2% of global budget or $5 million trigger to a narrower, data-driven range targeting verified material shifts—such as the top 80% of projected elective cases—to ensure proportionality and stability.
6. **Complete a risk assessment of the policy impact** on access and hospital financials to ensure the policy aligns with a "do no harm" principle.
7. **Follow the technical workgroup process for policy development** consistent with HSCRC policy development process and finalize financial impact and technical specifications before approval. Include addressing technical concerns for policy implementation and PAU funding.
8. **Consider standard advance notice** for material shifts such as 6 months to ensure smooth transitions of operations.
9. **Consider a phased, pilot approach for a real-time reimbursement model** by prospectively moving funds for targeted volumes and allowing up to 100% volume reimbursement on backfill volumes for an initial six-month period. This would support real-time funds flow, prevent downside risk for originating hospitals, and provide data to evaluate payer implementation and patient movement.

Conclusion

Adventist HealthCare appreciates the Commission's leadership in refining Maryland's rate-setting system to improve how funding flows for material volume shifts. We remain committed to working collaboratively with HSCRC staff and stakeholders to design a policy that allows funding to follow patients while safeguarding access, equity, and financial sustainability of our hospitals.

For more than 100 years, Adventist HealthCare has served the Maryland community with a mission of extending God's care through the ministry of physical, mental, and spiritual healing, and we remain steadfast in that commitment as we work together to ensure a sustainable future for Maryland's hospitals and patients.

Sincerely,

Katie Eckert

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

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

Nicki McCann, JD
Farzaneh Sabi, MD
Allison Taylor, JD

CareFirst BlueCross BlueShield
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Owings Mills, MD 21117-5559
carefirst.com

October 15, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on both the Draft Recommendation on Market Shift Refinement and the Draft Recommendation on Select Hospital Volume Realignment. We are broadly supportive of both policies and commend the staff on the work and analytical rigor reflected in these policies. However, we also believe that the policies would be strengthened by creating a formal policy to handle all payer-initiated market shifts.

The Draft Recommendation on Market Shift Refinement suggests that the Health Services Cost Review Commission (the Commission) would carve out payer-driven realignment of volume from the market shift adjustment. Staff would then prospectively adjust hospital revenues to reflect the expected destinations of that realigned volume, based on hospital and payer submitted data. Historically, the Commission has made exceptions to its market shift policy for Kaiser Permanente (Kaiser) but has not adjusted hospital rates for volume changes driven by network changes between hospitals and payers.

We recommend that the Commission apply the Kaiser volume policy that is outlined in the Draft Recommendation on Select Hospital Volume Realignment to volume changes resulting from network changes for the following reasons:

1. The market shift policy was designed to ensure that revenue follows patients. When patient utilization patterns shift from one hospital to another, the market shift policy ensures that the recipient hospital has sufficient revenue to provide care. The market shift policy also ensures that the initiating hospital's rates are reduced so that the hospital's remaining patients are not overcharged. Payer-initiated market shifts are rare but can drive large volume shifts. Given the magnitude of payer-initiated market shifts, it is critical that hospitals receiving an influx of patients are adequately reimbursed to address costs incurred to provide care for those patients.

2. Based on current policy, in the event of a payer-initiated market shift, the hospital going out of network and thus seeing reduced volume will still be permitted to charge their full global budgeted revenue (GBR). If revenues are not prospectively adjusted at both the receiving and sending hospitals, this would artificially inflate rates charged to patients remaining at the hospital removed from one payer's network and artificially deflate rates charged to patients at other facilities seeing more volume. This poses a clear equity problem.

3. Commission staff believe that Kaiser should be treated differently than other payers – we do not agree. Staff contend that Kaiser volume changes are localized between a small number of hospitals whereas other payers redistribute volume from one hospital to many. While volume generally disperses to many hospitals, the distribution of volume changes is a critical part of

setting premiums in payer rate filings. Payers can predict the distribution of that shift with a high degree of accuracy. CareFirst does not believe that distributing volume to more than one hospital is a sufficiently difficult analytic process to warrant the maldistribution of revenues and patient volumes that results from waiting. Moreover, staff's own policy recommendation does not require predicting where volumes will shift. Instead, staff propose carving Kaiser volume out of the GBR, allowing it to be reimbursed through a volume-variable evaluation, and then rebasing global budgets on the basis of the actual observed market shifts. This could be done across all payers.

Again, CareFirst commends the staff on its analysis and refinement to the market shift policy and the volume policy for select hospitals. CareFirst believes that if the policy works for Kaiser, it should be applied to all payer-initiated market shifts. Thank you for the opportunity to comment.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

Ascension
Saint Agnes

Allan Pack
Director, Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

October 29, 2025

Dear Mr. Pack,

On behalf of Ascension Saint Agnes, I am writing today to respond to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding Select Hospital Volume Realignment, specifically the process for handling Kaiser Permanente's (KP) material market shift in hospital utilization. Ascension Saint Agnes appreciates the intent of the staff recommendation to simplify the methodology for redistributing revenue for hospitals impacted by KP's ongoing efforts to redefine their healthcare delivery model. Ascension Saint Agnes transitioned from a core KP hospital facility in 2019. The immediate loss of global budget revenue was disruptive and the revenue shift reconciliation process took several years before the reconciliation was complete and a permanent revenue base was established. Ascension Saint Agnes agrees that a more straightforward methodology should be explored but cautions against a methodology that may be disruptive to hospitals that provide limited elective services to KP members.

The HSCRC recommendation proposes to limit the scope of affected hospitals for this new methodology to hospitals with greater than $5 million in annual charges and greater than 2 percent of global budget revenue which results in 19 hospitals being in scope. This includes care originating from hospitals emergency departments. Ascension Saint Agnes believes revenue associated with emergency department visits should be excluded as this is care KP will likely be unsuccessful in redirecting to its core hospitals. Patients generally seek emergent care in acute hospitals that are within close proximity. Baltimore City represents the third largest city/county in Maryland for KP members as 15% of hospital care originates from the city (based on an analysis of patient residency using statewide hospital utilization data). KP's two primary Baltimore region core hospitals, University of Maryland Baltimore Washington Medical Center

Ascension Saint Agnes
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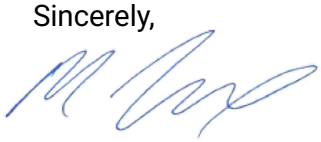
and University of Maryland St. Joseph Medical Center, are located in suburban communities that present challenges for city residents that may not have access to reliable transportation, meaning KP members will seek care at hospitals located in the city including Ascension Saint Agnes.

KP's South Baltimore County Medical Center is located 2 miles from Ascension Saint Agnes in Halethorpe and offers urgent care in addition to other specialty services. KP members visiting the South Baltimore County Medical Center will naturally seek the closest acute care hospital if their urgent condition actually warrants emergent care. Since emergent care is not likely to shift with KP's latest efforts to reorganize their delivery model, Ascension Saint Agnes believes hospitals that have immaterial elective business with KP (e.g. <$1M or 0.5% or less of KP elective volume as a % of total GBR) be excluded from the limited scope of 19 hospitals.

Thank you again for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,



Mitch Lomax
Chief Financial Officer, Ascension Saint Agnes

cc: Dr. Joshua Sharfstein, Chairman, HSCRC
Dr. James Elliott, Vice Chairman, HSCRC
Jon Blum, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Dr. Farzeneh Sabi, Commissioner, HSCRC
Dr. Jon Kromm, Executive Director, HSCRC

Maryland
Hospital Association

October 29, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Select Hospital Volume Realignment. We appreciate HSCRC's interest in ensuring that volumes and revenues are properly attributed to hospitals. We respectfully ask that staff provide stakeholders with the additional information and clarification needed to fully understand the proposed policy and its impact on hospitals before bringing it to the Commission for a vote.

Access Implications

MHA supports market shift policy refinements aimed at ensuring revenue follows the patient. It is also important to ensure that policies do not unintentionally impede access to care. There is an assumption in the proposed policy that because of the Kaiser Permanente realignment, most if not all Kaiser Permanente volumes statewide will shift to Kaiser Permanente core hospitals. However, Kaiser Permanente patients will continue to visit hospitals across the state when emergency care is needed. It may not be feasible to transfer Kaiser Permanente patients who present at emergency departments in non-core hospitals and are then admitted for inpatient care. As such, we urge HSCRC to analyze the portion of Kaiser Permanente volumes at impacted hospitals that result from emergency department visits (including subsequent inpatient admissions) and consider whether it is appropriate to include these volumes in the policy. We also ask that HSCRC consider requiring Kaiser to complete an access impact analysis which could enable adoption of strategies to mitigate disruption in patient access to care.

As we shared in our comment letter on the Draft Recommendation for Market Shift Refinement, HSCRC policies should support hospitals in backfilling services to address "latent demand" or unmet needs when there are purposeful shifts of services from a hospital, especially due to payer-driven volume shifts. The market shift adjustment requirement that there be a corresponding decline in the same service and geography may hinder hospitals impacted by the realignment from backfilling services to improve access to care for the communities they serve. Due to this limitation, it is important that HSCRC prioritize discussions with Commissioners and Volume Subgroup members about the adoption of a streamlined latent demand policy.

Policy Timeline, Analyses, and Data Source

Given that this is a payer-specific policy predicated on the broader temporary service line exclusions process included in the Draft Recommendation for Market Shift Refinement, the two policy recommendations should be considered on the same timeline and allow for a two-month review period. Consideration of the proposal at the December Commission meeting would support alignment of the two policies and provide more time for impacted hospitals to evaluate anticipated volume and revenue impacts of the proposal.

Kaiser Permanente's current realignment efforts and the draft policy under consideration will result in the movement of a significant amount of volume and revenue statewide. Therefore, it is imperative that hospitals understand the mechanics of the proposed market shift and global budget revenue carve out and be equipped with estimates of the policy's financial impact. Though the draft recommendation includes a table showing the amount of potentially impacted revenue at each of the 19 facilities identified as having "material Kaiser Permanente volume," HSCRC staff should share analyses that break down this volume further by setting and service type and, in particular, shows how much of this volume comes through hospital emergency departments.

HSCRC proposed removing revenues in January 2026 rate orders based on FY 2025 data submitted by Kaiser and noted during the October Commission meeting that there has historically been a discrepancy between data submitted by hospitals and by payers. If HSCRC is to use Kaiser's data as the basis for revenue adjustments, we ask that impacted hospitals be allowed the opportunity to validate the data before any rate order adjustments are made.

Thank you for the opportunity to comment on this important policy. We would be happy to discuss this issue further with staff prior to the release of the final recommendation next month. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

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CORPORATE OFFICE

October 29, 2025

Allan Pack
Principal Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding Select Hospital Volume Realignment

Dear Allan:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, UMMS is writing in response to the draft staff recommendation for Select Hospital Volume Realignment. We believe that when payer driven shifts significantly move volume, hospitals who receive volume should be fully funded on a real time basis. We also understand that the lagged funding dynamics of the global budget volume policies present a difficulty for Hospitals whose volume declines as a result of these shifts. In theory, they should be adjusted for the intentional, payer-driven shift, in real time as well, but that does not happen in a vacuum. The reality is that the payer-driven shift cannot be separated from backfill dynamics, including ongoing demand that currently puts pressure on hospital emergency rooms. The lagged nature of funding for the backfill creates a difficult funding reality for the sending hospital when the intentional, payer-driven dynamic is isolated and adjusted on a different timeline.

Acknowledging these complex dynamics, while we agree with commission staff that significant payer driven volume shifts need to be addressed in a timely way, we have some significant concerns about the methodology put forward by the staff:

Differential Treatment of Hospitals

The staff recommendation, as proposed, would segregate hospitals into 2 categories: material and immaterial, where Kaiser volume would be adjusted on a real time basis for material hospitals while other hospitals will not be adjusted until a market shift calculation is run for CY 2026 in July 2027. We feel strongly that all hospitals should be treated consistently and adjusted for Kaiser volume shifts in real time, regardless of materiality.

Variable Cost Factor

UMMS feels strongly that the revised variable cost factors proposed by commission staff as part of the market shift refinement proposal be used for Kaiser volume realignment, for both interim revenue recognition and final settlement. We further believe that the variable cost factors should be applied differentially for inpatient and outpatient medical and surgical volume.

Timing of Settlement Period

Staff are currently proposing that the final settlement be based upon CY 2026 volume, which will likely understate future ongoing volume due to timing delays in operationalizing such large volume shifts. We propose that the commission evaluate actual volume and if there exists a ramp up period in the first part of CY 2026, the time period used in the final settlement should be shifted or adjusted to more accurately reflect ongoing volume at each hospital.

Identification of Kaiser Patients

The draft staff recommendation proposes that Kaiser patients be identified by primary payer. Given that Kaiser offers many insurance products, we would propose that the staff refine the recommendation to use the health plan code as an identifier (Kaiser is health plan code 107) to ensure all volume is captured. Historical Kaiser shifts have utilized all three payers to identify volume and we believe the commission should follow previous methodology. Should Kaiser provided data be used to identify patients for volume funding or settlement purposes, then we require that Kaiser share data at least quarterly with hospitals so that we can reconcile our internal data with Kaiser data.

Final Settlement

Commission staff have recommended that the final settlement be neutral among the material hospitals. UMMS again feels strongly that all hospitals, regardless of the magnitude of Kaiser volume, be treated consistently and that volume and revenue recognized by receiving hospitals during the transition should not be clawed back due to arbitrary neutrality requirements.

UMMS Proposed Interim Settlement

Given the magnitude of the anticipated volume shifts and the volume of unknown variables, UMMS proposes that the commission staff undertake an interim settlement evaluation after 6 months of data is available. This will allow both commission staff and the industry to evaluate the approved approach for the transition period and final settlement and address hospital concerns. We suggest this be done via an industry workgroup and that any required technical revisions be made at that time.

We appreciate the opportunity to provide feedback on the proposed Select Hospital Volume Realignment recommendation. Please let us know if you have any additional questions.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Jon Blum, MPP
Nicki McCann, JD
Maulik Joshi, DPh
Ricardo R. Johnson, JD
Fabi Sabi, MD

Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS President and CEO
Noel Sousa, UMMS Chief Financial Officer

KAISER PERMANENTE®

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

October 28, 2025

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

RE: Select Hospital Volume Realignment

Dear Dr. Kromm:

Thank you for the opportunity to provide comment. Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

Although 19 hospitals are within the scope of this proposal (i.e., greater than $5 million in annual charges and greater than 2% of global budget revenue), the impact will be less than many hospitals may think. The expected impact only represents $75 million (0.8%) of the $9.5 billion in total revenue at these 19 hospitals combined.

To further explain, KP accounts for 7.4% of the revenue at these hospitals, or about $698 million. Looking at KP's 2024 volumes and utilization patterns, approximately 60% of KP's volume is already at the 4-6 hospitals where other services will be consolidated, and this 60% will not move.

Another 25% of KP's volume, which is in the other hospitals within scope, will not move. This includes things like emergency services and certain specialties like behavioral health.

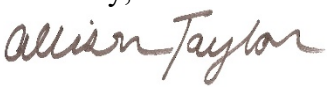
KP is planning to shift the remaining 15% of its total volume, which equates to 11% of KP hospital spend in the impacted hospitals. These are primarily elective services. As noted above, this is approximately $75M (0.8%) throughout the hospitals in-scope.

KP will continue to follow state and federals laws on network adequacy.

[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 39 hospitals and over 650 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.

Kaiser Permanente is happy to meet with the HSCRC and any hospital that would like to discuss the specific impact to their facility. Please reach out to Allison Taylor at allison.w.taylor@kp.org or (919) 818-3285 to arrange that.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente

LIFEBRIDGE HEALTH

CARE BRAVELY

October 29, 2025

Allan Pack
Principal Deputy Director, Quality and Population Based Methodologies
Health Services Cost Review Commission
4160 Patterson Ave. Baltimore, MD 21215

Re: LifeBridge Health Comments on Draft Recommendation for Select Hospital Realignment

Allan,

We are writing in response to the *Draft Recommendation for Select Hospital Volume Realignment*. We respectfully urge the Commission to reject staff's recommendation for several reasons.

Inclusion of Emergency Related Care

The recommendation overlooks the impact on hospitals where most Kaiser-related volume originates in the emergency department (ED). Staff noted that Kaiser Permanente (KP) intends to realign preferred providers for select non-ED services; however, such payer-driven shifts are already addressed in the revised Market Shift Policy presented at the same meeting. Volume changes related to a specific payer should remain under the Market Shift Policy to ensure consistent and equitable treatment across all hospitals and payers.

It was suggested at the October 8 meeting that in instances where a Kaiser patient presents to an ED of a non-Kaiser-preferred hospital, the patient would be transferred to a Kaiser-preferred facility. Such transfers impose additional clinical and administrative measures which may result in redundancy and inefficiency in a patient's overall care as it requires the transferring hospital, which remains responsible under EMTALA to:

- Stabilize the patient prior to transfer;
- Confirm the receiving facility's capacity and acceptance;
- Provide complete medical documentation for continuous/uninterrupted care; and
- Ensure safe transfer with qualified personnel and appropriate medical equipment.

In addition to the complexities of the transition of care between two distinct hospital facilities, it may also result in slower patient throughput to other ED patients.

For these reasons, revenue related to an encounter emanating with an emergency department encounter should be carved-out of staff's draft proposal. As an example, at Northwest hospital, staff identified 3% of charges tied to Kaiser volumes for calendar year (CY) 2024. Our analysis of fiscal yar 2025 data identifies 97% of all Kaiser encounters originating in the ED. In addition, the fiscal year 2025 data reflects 2.24% of total charges are tied to Kaiser volumes, indicating considerable variability to the calendar year 2024 data cited in the Staff analysis which represents only a six-month time difference utilizing encounters between July 2024-June 2025.

Impact/Uncertainty of Financial Adjustment

The payment methodology under the draft policy remains unclear. The draft recommendation alludes to "exclude KP volumes and revenues from global budgets, reimbursing KP volumes and revenues in real time using volume-variable methodology at HSCRC rates." Although not part of the formal recommendation, it was explained that variable costs would be removed at 59% and hospitals would be paid under existing HSCRC rates with a reconciliation process that would also be required to occur. To date, Staff have not further outlined the mechanics in a detailed manner. Without a transparent reconciliation framework, hospitals are unable to assess the fiscal implications of the adjustments set to occur on January 1st, 2026, with current year fiscal performance likely to be impacted. Hospitals, having had the stability of the global budget revenue methodology undermined real-time, will be at risk to realize volumes at current levels to remain whole. To the extent, as illustrated in the Northwest Hospital example, volumes are almost exclusively emergency department based, there is significant risk related to the adjustment.

Overall Policy Alignment

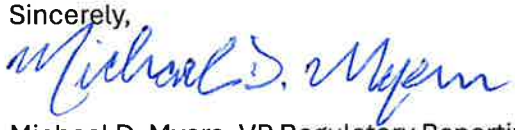
Proposed revisions to the Market Shift Policy outline payer-initiated volume shifts as an instance where service line exclusions may occur, with a requirement for associated data and analyses to occur six months prior to the shift. The Volume Realignment Proposal put forth for KP lacks these same procedural safeguards. To date, Staff have not released (nor has KP shared) any information or data submitted related to its intended realignment.

Finally, staff's proposal that Kaiser-initiated volume shifts warrant prospective treatment departs from the established HSCRC Market Shift Policy, under which similar volume shifts occur retrospectively. During the October 8 meeting, staff stated that such differential treatment is justified because Kaiser operates under both payer and provider functions. However, this rationale conflicts with the core principle of Maryland's all-payer rate-setting system—that hospital rates must be set uniformly for all payers.

Ultimately we do not believe the policy can be approved without further clarification related to the mechanics and amount of each hospital's proposed adjustment, as well as the associated reconciliation. Additionally, while we understand the HSCRC intent to improve the market-shift adjustment that may occur with a meaningful change in a payer realigning its member network, we do not believe emergency related encounters, which will continue to present based on need, should be included in any proposed adjustment.

As always, we appreciate the opportunity to provide comment. If you would like to discuss any of our recommendations, please don't hesitate to reach out to Laura Russell or myself directly.

Sincerely,



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

cc: Jon Kromm, PhD, HSCRC Executive Director
Joshua Sharfstein, MD, HSCRC Chairman.

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

October 29, 2025

Mr. Allan Pack
Principal Deputy Director, Quality & Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Draft Recommendation for Select Hospital Volume Realignment

Dear Mr. Pack,

Thank you for the opportunity to provide comment and feedback on the Draft Recommendation for Select Hospital Volume Realignment. Luminis Health supports proactive and timely initiatives to balance priorities of access to care, stability of the care delivery system and innovation; and we are encouraged to see the HSCRC take on volume matters proactively.

The Draft Recommendation seeks to proactively consider the implications of a significant realignment of care initiated by Kaiser Permanente (KP). The unique nature of KP being both a payer and a provider of healthcare necessitates a unique approach to Hospital GBR revenue and to the implications of volumes and market shift. Due to the direct patient care delivery model of KP in regulated Maryland hospitals, in KP ambulatory settings and through Permanente physicians, KP has the unique ability to direct patients to specific locations consistent with their care delivery and business goals. This is unique to KP and we do not view this recommended methodology to be applicable to any other payers in the State of Maryland.

The unique nature of KP's integrated delivery and payer model necessitates that a planned care realignment to Core Hospitals be funded prospectively, as has been the practice in the past to address significant changes initiated by KP. Luminis Health is in support of a fair and appropriate prospective funding methodology. The draft recommendation as presented, however, appears to be a blunt instrument that does not attempt to focus the approach to a select group of specific hospitals but instead proposes to make a wholesale change to 19 hospitals, utilizing self-reported KP revenue data. We would suggest that the recommendation be honed to be a more precise targeted solution that is more likely to provide a more stable outcome.

To strengthen the approach, we request that the HSCRC consider the following:

- KP should be required to share its care realignment plan to ensure transparency. The State of Maryland has long enjoyed the benefits of transparent healthcare provider data and as a provider of healthcare that can directly impact hospital-based care, KP should be held to the same transparency standard in this case.

- HSCRC should validate the revenue associated with the planned volume realignment and provide Hospitals with adequate time to review and consider the information provided.
- The methodology should be vetted through an open and collaborative process that contemplates the impact and outcomes of implementation. This will help avoid unintended consequences of the methodology and will allow Hospitals to better understand the approach.

In conclusion, Luminis Health is in support of a proactive methodology to address KP's care delivery and business plan and we appreciate the efforts of the HSCRC to continue to advance policy and methodologies to address Hospital reimbursement. We remain committed to working in partnership with the HSCRC staff to address and update policies that provide new approaches and advance initiatives to improve access to care and stabilize the care delivery system in the State.

Sincerely,

S. Michelle Lee
Interim Chief Financial Officer
Luminis Health

cc: Dr. Jon Kromm, PhD, Executive Director, HSCRC

MedStar Health

8094 Sandpiper Circle
Suite O
Nottingham, MD 2123

MedStarHealth.org

October 31, 2025

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

Dear Executive Director Kromm,

On behalf of MedStar Health Inc. and our seven Maryland acute care hospitals, I write to provide comments on the Draft Recommendation for Select Hospital Volume Realignment presented by HSCRC staff during the October 2025 public session. The draft recommendation, if approved, would carve out Kaiser Permanente volumes from 19 hospital global budgets and reimburse these hospitals on a volume variable basis for the January 2026-June 2027 18-month period. After the 18 months, a reconciliation will be completed, and hospital global budgets will be adjusted accordingly based on actual volume shifts. While MedStar appreciates staff's intent in bringing this policy proposal forward – namely to align funding with major volume shifts on a real time basis – MedStar believes deviation from the standard market shift methodology in this dramatic fashion sets a dangerous precedent and is not warranted. Further, the scale of the volume shift projected to occur among the 19 hospitals is estimated to be $75M in total, 0.8% of total hospital global budgets. This magnitude of volume realignment does not drive a need to align funding with patient volumes any more than the shifts that occur and are captured through the bi-annual market shift calculation.

As such, and for the reasons outlined herein, MedStar does not support the approval of this draft recommendation as currently written. MedStar would urge the HSCRC & staff to work with stakeholders over a more appropriate policy development timeframe to refine the proposed methodology or handle hospital global budget adjustments according to existing volume funding policies.

Deviates from hallmarks of Maryland reimbursement policy – predictable & stable revenues that are adjusted retrospectively to account for volume changes and other funding needs.

A fundamental component of the Maryland reimbursement system and Global Budgets is the predictable and stable nature of hospital revenues. Unfortunately, this policy as drafted, will remove revenue from global budgets for 19 hospitals midway through FY2026, in a way that has never been done before, and is completely unanticipated by hospitals. Further, this puts these revenues at risk for these 19 hospitals on a real-time basis, something that does not occur within the Maryland system today. MedStar believes the approach, while well intended, undermines the predictable nature of hospital revenues and urges the Staff to continue to collaborate with stakeholders on a better approach for this policy.

Treating Kaiser Permanente differently than other payors by carving it out of global budgets and the market shift policy based on their data rather than HSCRC data is a dangerous precedent that undermines the principles of the Maryland Model.

This policy as it is written is a clear deviation from existing HSCRC policies that govern the funding of volume changes across the state. MedStar is concerned that this recommendation will set a precedent by which other payors seeking to realign service delivery and consolidate services across hospitals will seek to have global budget revenue adjustments made at their initiative and be excluded from the standard market shift methodology. The draft recommendation lacks clear parameters that establish and differentiate between carrier/providers such as Kaiser and other insurance carriers. Allowing such a precedent to be set could result in more instability for hospital revenues in future periods, creating uncertainty for hospitals as they budget and plan for investments.

Additionally, instead of using the hospital data submissions which all HSCRC policies rely on when determining global budget adjustments, staff is proposing using Kaiser Permanente submitted data to remove funding from hospital GBRs in January 2026. Reliance on Kaiser Permanente data to determine what revenue and volume is removed from hospital global budgets may not accurately account for the services delivered by hospitals to Kaiser patients. Any adjustment made should use HSCRC data submissions as is standard for other HSCRC policies.

Increases complexity of managing hospital global budget revenue and rate compliance for hospitals and adds reporting burden when hospital resources need time and availability to respond to the changes coming from the implementation of AHEAD.

Hospital reimbursement teams have limited band width and are resource constrained. Across health systems, these same people are the ones involved in all HSCRC reporting requirements as well as supporting hospitals as they navigate and analyze the reimbursement impacts of AHEAD and other policy changes. Introducing a supplemental compliance submission that hospital reimbursement teams will need to submit monthly for Kaiser Permanente volumes and revenues needlessly adds to workloads at a time when resources are already stretched thin. Additionally, carving out Kaiser volumes and revenues will impact annual GBR compliance management and is being proposed mid-way through the fiscal year – leaving hospitals with a shortened timeframe to correct rates and overall global budget revenue compliance if needed.

Given the amount of disruption in the healthcare sector currently and the extensive list of policies and methodologies that must be developed or modified to be implemented AHEAD, now is not the right time to implement this policy change.

Again, thank you for the opportunity to comment on the draft policy. If you have any questions about anything in this letter, or wish to discuss anything further, please do not hesitate to contact me directly.

Sincerely,

Mike Wood

Mike Wood
Vice President, Revenue Management & Reimbursement
MedStar Health

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

October 29, 2025

Allan Pack
Principal Deputy Director, Quality & Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Pack,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide feedback on the draft recommendation for Select Hospital Volume Realignment. JHHS appreciates staff for their efforts to update the Health Cost Review Commission (HSCRC) volume policies. JHHS notes the following concerns:

Broader Applicability

JHHS agrees with the need for realignment of the market shift policy, and thanks staff for their efforts to revise this policy over the past few months. However, the need for the Select Hospital Volume Realignment policy, which allows a deviation from the standard market shift policy, demonstrates the challenges of the Maryland model. Several volume policies are already in place, and though this draft policy aims to address the issues created by the market shift policy, this is indicative of the larger issue; the current volume policies must be revised and realigned broadly, as these unintended dynamics created by these policies adversely impact multiple stakeholders. JHHS has shared generally supportive comments on the proposed market shift policy revisions, but on this proposal, would note that if exceptions are needed for Kaiser, this may also be needed by other payors. To that end, broader applicability should be considered if volume changes are anticipated and intentional due to payor-initiated network changes.

Unintended Consequences

While JHHS recognizes the intention of the policy, we are concerned about the unintended consequences of the draft recommendation, particularly on hospitals that are already at capacity. For example, Suburban Hospital will be impacted by this policy and is currently experiencing capacity challenges; though Kaiser volume will be moved out of Suburban, that volume will undoubtedly be backfilled due to current demand for medically necessary care. The draft policy does not recognize this concern. As written, the policy will result in a downward

adjustment to hospital global budgets without consideration of a hospital's capacity, leaving a hospital to manage similar volumes with reduced funding. Capacity and demand must be considered before any downward adjustment is implemented.

Process

Finally, though there is currently an established workgroup focused on volume policies, this policy required more stakeholder input and discussion in that forum. JHHS hopes that future policies will better utilize the established process.

JHHS could be supportive of this policy if it addressed unintended impacts to hospitals that may lose payor-specific volume but whose overall volume does not change given the demand for medically necessary care. 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. We hope the above concerns regarding broader applicability, unintended consequences, and process are given further consideration as staff move to a final recommendation.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi

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Final Recommendations for Extension of the Hospital Best Practice Policy for Rate Year 2028

December 10, 2025

This document contains the staff final recommendations for extending the Hospital Best Practice Policy for RY 2028. Comments were received during the comment period and the HSCRC response is included in this final recommendation.

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Introduction

The Hospital Best Practice Policy was approved by the HSCRC in March 2025 and implemented by Maryland hospitals in April 2025. Unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy is designed to focus on the structure and process of care delivery in Maryland hospitals. During the initial year (CY2025), the policy focused on processes that drive emergency department (ED) and hospital throughput to address the long ED length of stay (ED LOS) experienced by patients in Maryland. Specifically, the HSCRC approved a set of six best practices for RY 2027 and required hospitals to select and report data on two best practices by the end of CY 2025 (Submission before 12/31/2025). If data is not submitted by hospitals in Year 1, an accountability penalty of 0.1 % all-payer inpatient revenue will be assessed. The HSCRC staff along with the Best Practice subgroup will review the data submitted in December 2025, analyze and summarize the performance, impact, and lessons learned to share across all Maryland hospitals. Staff plan to present these results in the Spring of 2026 to the Commissioners. Staff propose for RY 2028 (CY 2026 performance) that continued monitoring will provide a valuable opportunity to continue to share lessons learned and implement best practices across hospitals and to hard-wire processes that are yielding improvements in ED and hospital throughput.

For RY 2028 staff are recommending to maintain the requirements of the RY 2027 Best Practice policy that was approved in March 2025. As discussed below, the staff continue to engage with hospitals on these Best Practices and support the Commission's extension of the policy for RY 2028.

Assessment

Since approval of the RY 2027 policy, hospital stakeholders have met on a regular basis to select the two best practices for their hospitals and develop the tiers needed to assess the robustness of each best practice. Through this policy, hospitals have engaged in working together to share lessons learned and evaluate the fidelity and consistency of these Best Practices within their institutions. Hospitals will need to submit the reporting template for the Best Practices to HSCRC no later than December 31, 2025 to avoid an accountability penalty of 0.1% all-payer inpatient revenue. The report will include performance metrics, rationale for implementation/expansion of the particular best practices selected by each hospital, and any lessons learned or suggested improvements to the process. This data will be reviewed, analyzed and summarized to share with the HSCRC Commission, ED Wait Time Reduction Commission, and Maryland hospital partners.

The HSCRC staff recommend that we continue the monitoring phase of the Best Practice measures to ensure adequate time to understand the impact of each best practice at individual hospitals and across the state, as well as determine how this program will be integrated into and align with the AHEAD model transition. In addition, HSCRC believes that with the AHEAD transition in progress, hospitals should continue to hardwire existing practices to ensure consistency and improvement in RY 2028. Hospitals will provide written notice with justification, if they intend to adopt a different approved best practice in RY 2028. The Appendix includes the RY2028 final policy with additional details on the Best Practices.

Stakeholder Feedback

- Feedback was obtained in preparation for the draft recommendation presented during the October 8, 2025 HSCRC Commission meeting. Support for the draft recommendation was received from stakeholders representing 35 hospitals.
- During the comment period, two letters were received.
    - MHA submitted a letter of support with caution to be mindful of the larger context of alignment of quality payment and monitoring programs as we transition to AHEAD.
    - Adventist HealthCare submitted a letter suggesting that the current policy requiring two "tiered" best practices creates an administrative burden in combination with the transition from Maryland-specific to National Quality programs over the next two years as we transition to AHEAD.

HSCRC Response to Stakeholder Feedback

- HSCRC staff appreciate the feedback from stakeholders and the continued engagement from hospitals.
- HSCRC staff agrees with stakeholders that alignment of programs and reduced administrative burden is important as we transition to AHEAD. The recommendation put forth by the staff is designed to reduce administrative burden and increase alignment by:
    - Continuing monitor-only status for the best practices rather than transitioning to pay for performance.
    - The tier structures within each best practice are designed for future state to be tied to incentives and/or analysis of impact of tiers on outcomes. At this time, hospitals are not required to escalate tiers in CY 2026 (RY 2028), but rather can use the tiers to track performance internally and across the state.
    - Allowing hospitals to continue with the same two best practices in CY 2026 (RY 2028) initially selected and implemented in CY 2025 (RY 2027). This continuation decreases administrative burden, allows time and effort to be directed towards hard-wiring existing processes rather than

developing new ones, and provides adequate data for the HSCRC, the ED WTR Commission and the ED-Hospital Best Practice subgroup to analyze and identify opportunities and trends.

- Preliminary data indicates that improvements are being seen in important metrics such as ED Boarding Time, Left Without Being Seen and OP LOS. As we move towards alignment with the national programs, these metrics are included in the proposed CY 2027 electronic clinical quality measure program.
- The ED Wait Time Reduction Commission has also recommended that we leverage the best practices implemented in CY 2025 and has suggested that in CY 2026, we prioritize these efforts and the clinical process and outcomes data gained from these processes.

Recommendations

The final recommendations for RY 2028:

1. Building upon the ongoing work of staff and key stakeholders, continue the specifications developed by the Best Practice subgroup on the six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, continue three tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers for future performance years will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to maintain and report data on the two implemented Best Practices for RY 2028.
    a. Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY2026 Best Practice program impact is assessed.

Appendix: RY 2027 Final Policy

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Final Recommendations on Hospital Best Practice Policy for Rate Year 2027

March 12, 2025

This document contains the staff final recommendations for RY 2027.

Table of Contents

List of Abbreviations

AHEAD	State's Advancing All-Payer Health Equity Approaches and Development Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Best Practices policy, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model and subsequent AHEAD model (Maryland Model), do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Maryland Model while guarding against unintended consequences and penalizing poor performance. The objective of implementing a Hospital Best Practice Policy is to track and incentivize hospitals to implement and strengthen operational structures and processes, which are designed to provide high quality, evidence-based care to all patients, at all times.	The Best Practice policy is a newly proposed pay-for-performance quality initiative that provides incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework. For Year 1, RY 2027, we propose to focus on best practices related to hospital throughput, that should ultimately reduce ED LOS. Specifically, during Year 1, HSCRC staff will collaborate with hospitals to finalize the best practices and tiers, develop infrastructure for data collection, and disseminate statewide monitoring reports to track performance. Hospitals will be expected to participate in the implementation of best practices and submission of data for tracking by an agreed upon deadline to avoid an "accountability" penalty of 0.1 percent of all-payer, Inpatient revenue. This penalty will be applicable to any hospital that does not implement and report on the selected best practices. This approach will allow sufficient time to establish workflows, report development, and validate data collection mechanisms. This Best Practice policy will initially focus on ED-Hospital Throughput Best Practices but is written with the intention of developing and standardizing best practices for various clinical processes and operations as appropriate.	For program Year 1, RY 27, hospitals will be required to implement or strengthen best practices designed to improve patient care and throughput and report data to the HSCRC to track intensity and fidelity to the best practices. For Year 1, there is no revenue at risk associated with performance. There will be an accountability penalty that will be assessed for not reporting on best practice measures. This penalty will be 0.1% of all-payer, inpatient revenue, to be assessed in the January 2026 rate update. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.). For program Year 2, RY 28, we recommend +/-0.25% inpatient revenue at risk associated with performance on designated best practice measures. This will be reassessed at the end of Year 1 after evaluating the impact of the best practices.	This policy ensures that the quality of care provided to consumers is evidence-based and patient-centered. by incentivizing specific types of best practices to address areas of concern. Hospitals that do not participate in implementation and data tracking of best practices will be penalized 0.1% of all-payer inpatient revenue through their Global budget. This penalty will only be assessed if a hospital does not report on their selected best practices. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	There is currently not a health equity measure in the Best Practice policy, but in future years, we can potentially stratify data collected to evaluate health disparities. Health equity incentives could be integrated in a subsequent rate year. Standardization of Best Practices across all patients should better ensure that all patients receive the same evidence-based interventions. By focusing on structures and processes, this program will allow all hospitals the potential to earn rewards regardless of the types of patients served or other barriers that impact outcomes such as ED LOS. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

Final Recommendations

This document puts forth for consideration the RY 2027 (CY 2025 performance period) final policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in Year 2 (RY 2028) after Year 1 (RY 2027) data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have +/-0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

INTRODUCTION

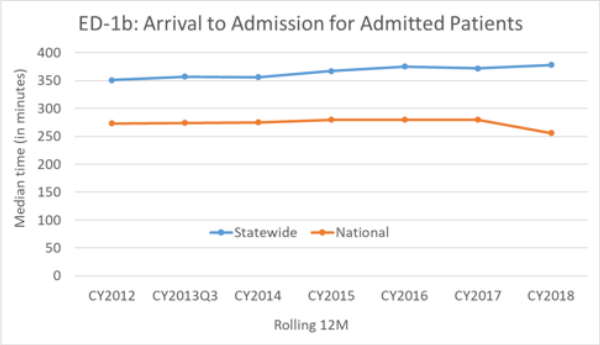
Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019 and will transition to the AHEAD Model in 2026. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, improved emergency department length of stay, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

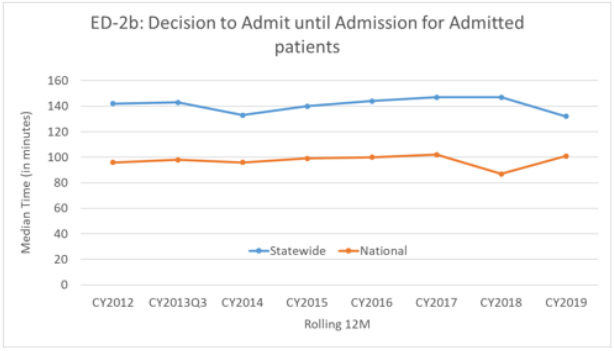
The Hospital Best Practice Policy is a new program that is being proposed for Commissioner consideration. The Best Practice Policy would be one of several quality pay-for-performance initiatives that provide +/- revenue at risk for hospitals to improve and maintain high-quality patient care and value over time. However, unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy would specifically provide +/- revenue at risk tied to the structure and process of care delivery in Maryland hospitals. During this initial year, the policy will focus on processes that drive ED and hospital throughput to address the long ED LOS experienced by patients in Maryland. Specifically, the commission will refine a set of up to six best practices for RY 2027 and require hospitals to select and report data on two best practices by the latter part of CY 2025. If data is not submitted by hospitals in Year 1, an accountability penalty will be implemented. After the initial year focused on development, implementation and reporting, the program will have a designated percentage of inpatient hospital revenue at-risk based on performance on best practice measures. In addition to this Best Practice policy, the RY 2027 Quality-Based Reimbursement Policy, which was approved at the December 2024 Commission meeting, has a financial incentive tied ED LOS. The ED-Hospital Throughput best practice measures are process and structural measures aligned to support the outcome measure, ED LOS, in the QBR program.

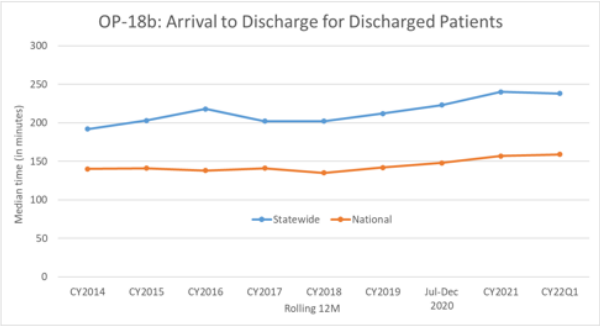
BACKGROUND

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[1] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program and voted to continue its inclusion in RY 2027. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 1.

Figure 1. Emergency Department Performance on CMS ED Wait Time Measures





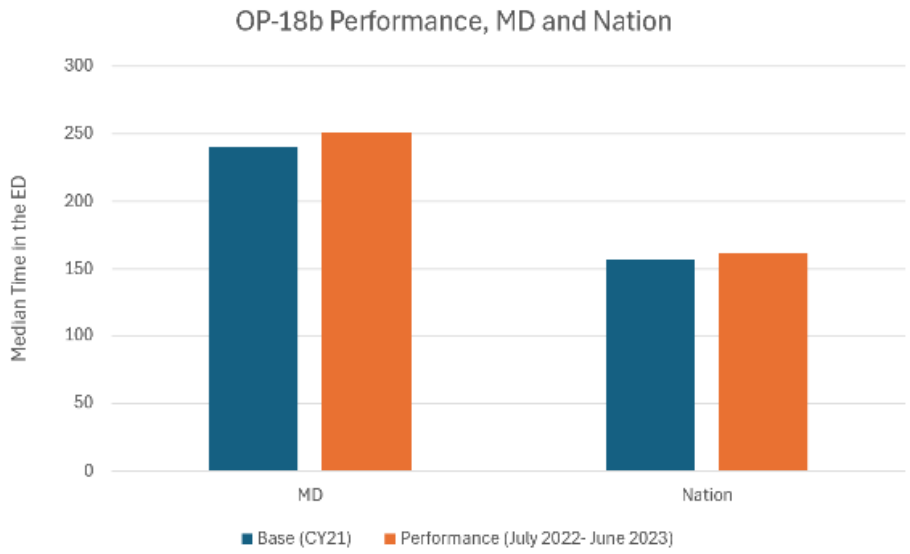


Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

As illustrated in Figure 2 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

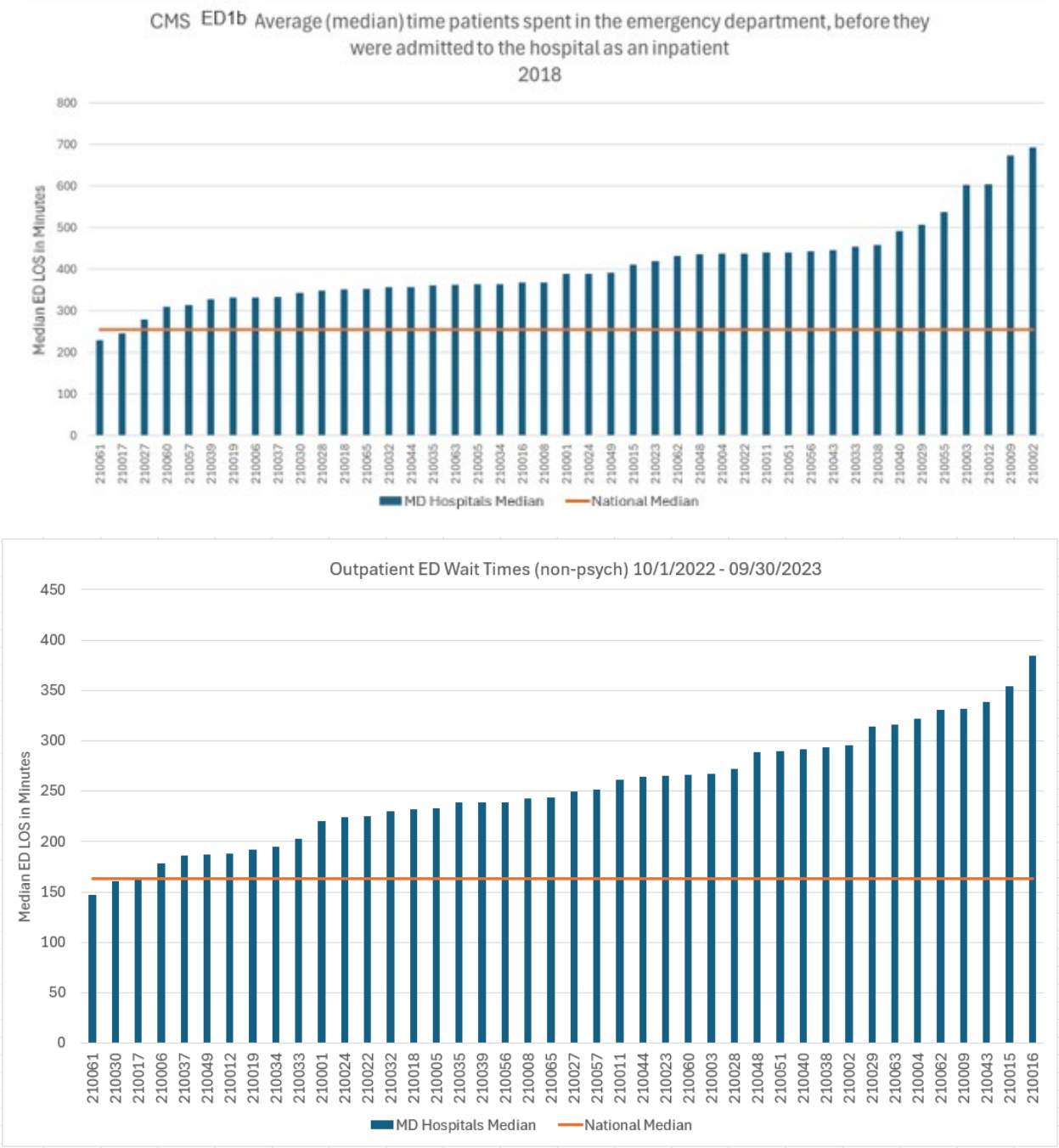
[1] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

Figure 2. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 3 shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 3. Maryland by Hospital and National Performance on ED Wait Times



Based on these results, staff believe all hospitals in Maryland have an opportunity to improve ED LOS. Furthermore, there has been increased public scrutiny on Maryland's ED Wait times, which has been consistently higher than all other states for the past decade. Several initiatives have been underway over the last two years to analyze Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new ED Wait Time Reduction Commission was established. The

ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a state goal for improvement in ED wait times. The development of Best Practices focused on ED-Hospital Throughput is one of the specific goals outlined by the ED Wait Time Reduction Commission. Appendix A provides additional background on initiatives that the HSCRC and hospitals have undertaken to address this issue.

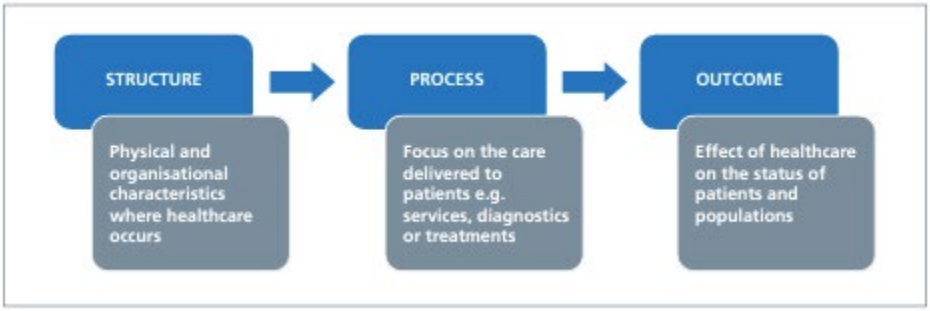
POLICY DEVELOPMENT AND IMPLEMENTATION

In this section, staff provide an overview of work done during CY 2024 to develop this Best Practice Policy. This includes discussion on why the Commission should develop incentives related to structure and process measures, description of stakeholder engagement, as well as an outline of the six best practices that have been selected and examples of tiers for assessing the intensity and fidelity to the best practices. The section concludes with next steps and recommendations for input.

Policy Origins

The Donabedian model of quality of care assesses three components as shown in Figure 4. While most current pay for performance incentives are focused on outcomes (i.e., mortality, complications, readmissions), structure and process measures are important to understand how changes in quality actually occur and are still required for some areas by CMS (e.g., attestation measures for health equity). There are several additional reasons why incentivizing structure and process measures should be considered in the case of ED LOS improvement. First, given that the ED LOS data collection and measure development is still underway, staff are hesitant to put additional revenue at risk on the outcome measure at this time. Second, the changes that can occur within a hospital to impact ED LOS may not be sufficient to improve the State's rankings nationally by themselves. This is because ED and hospital throughput is impacted by access to outpatient primary care, specialty care, behavioral health, and post-acute care. Third, there may be ways to reduce ED LOS to earn an incentive that would not result in better care for patients and these unintended consequences could be avoided by providing incentives to focus hospitals on better care delivery through optimization of known best practices. Hospitals in the State have demonstrated significant collaboration and engagement in this work. There will be an accountability measure in RY 2027 requiring data submission. Thus, staff feel that the current revenue at-risk on the outcome through QBR is sufficient at this time, but ensuring best practices such as the ones identified below will drive improvements in throughput as well as patient outcomes. By developing tiers and measures to assess the intensity and fidelity to these best practices, the State has a unique opportunity to improve more than just ED LOS. Thus, staff believe a mix of incentives on structure, process, and outcomes is appropriate and could be more impactful than simply adding more revenue to outcomes alone.

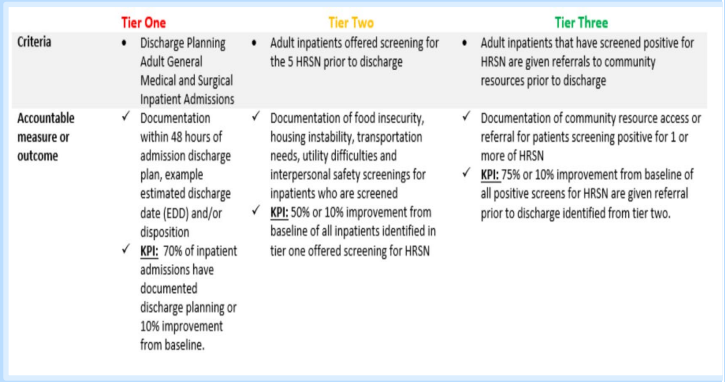
Figure 4. The Donabedian model for quality of care

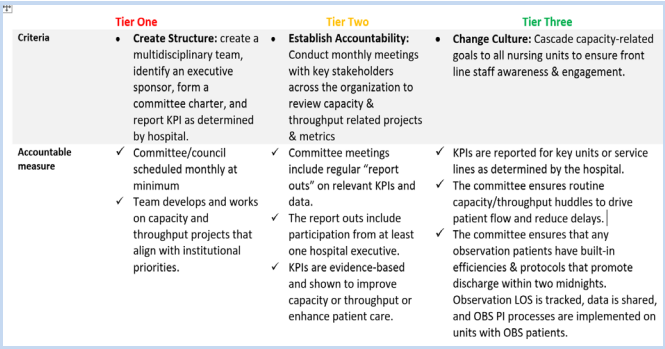


Stakeholder Process and Selected Best Practices

Staff formed an ED Subgroup in February 2024 to develop the ED LOS measure and incentive methodology for the RY 2026 QBR policy. By the fall of 2024, staff transitioned this subgroup to work on the development of ED and Hospital Best Practices to improve throughput and reduce ED LOS. This was also aligned, as mentioned above, with the ED Wait Time Reduction Commission's legislative mandate to focus on the sharing of best practices. Since September 2024, there have been eleven large subgroup meetings and multiple smaller workgroups focused on individual best practices. Specifically, the subgroup vetted over thirty best practice suggestions and narrowed down the list to six and proposed that hospitals be expected to implement or improve upon two best practices during CY 2025. While there were several discussions on whether to select two best practices that all hospitals must uniformly implement, hospitals felt strongly that options were needed since certain types of best practices may be more or less effective in different settings; additionally, since hospitals were engaged in the selection of the best practice options, measures and tiers for each of the options, the staff felt that providing choices would best maintain collaboration and address the variation in hospital settings. However, the selection of the number of best practice options, requirements for implementation, and focus of the best practices can change over time as this policy evolves. Figure 1 provides an overview of the six best practices for ED-Hospital Throughput. In addition, examples of how the best practices could be measured and tiered (i.e., assessed on intensity and fidelity) are provided. The idea would be that in future years hospitals would earn points based on the measures and could earn more points for higher intensity or fidelity to the best practice, as opposed to an all or nothing incentive.

Figure 1. ED-Hospital Throughput Best Practices

Best Practice	Measures	Points (0-10 scale)
Interdisciplinary Rounds & Early Discharge Planning		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Bed Capacity Alert System	**Tier 1**: Organization establishes one or more capacity metrics, examples could include: total number of patients in hospital, % hospital beds occupied, % of ED border c/w overall ED beds, NEDOC score, other hospital defined metrics. **Tier 2**: Organization establishes a bed capacity alert process (aka surge plan) driven by capacity metrics that triggers defined actions to achieve expedited throughput. Actions could include: Enhanced inpatient huddles to expedite discharges, rapid admission order turnarounds, hospitalist care in the ED, executive escalation, opening surge units, etc. **Tier 3**: Organization quantitatively demonstrates consistent activation of surge plans in response to bed capacity triggers. Internal metrics to be hospital defined and specific to hospital surge protocol. Examples could include: #/% of protocol activations, % discharges by specific time- maybe 1 p.m. and/or 3 p.m., etc.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Standardized Daily/Shift Huddles	The AHRQ defines a huddle as a short, standing meeting that is typically used in clinical settings to quickly share important information and touch base with a team, typically held at the beginning of each workday or shift. **Tier 1:** Implementation of, at minimum, daily huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges. KPI: Multidisciplinary daily huddles are being completed at X frequency as defined by each organization. **Tier 2:** Tier 1 requirements with the addition of a standardized infrastructure (standard scripting, documentation, and/or use of huddle boards). Tier 2 would also include an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput. **Tier 3:** Tier 1 and Tier 2 requirements, with the addition of monitoring and reporting of key performance indicators (KPIs) as drivers of process improvement r/t throughput. Example KPIs could include but are not limited to, percent of discharge orders written by noon, or percent patients leaving the facility by a designated time as determined by each facility.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

Best Practice	Measures	Points (0-10 scale)
Expedited Care Intervention (Expediting team, expedited care unit)	**Many best practices are proven to reduce Hospital Length of Stay and Boarding. Select one or more of the expediting practices listed below:** • Nurse Expediter • Discharge Lounge • Observation Unit (ED or Hospital based) • Provider Screening in Triage / Early Provider Screening Process • Dedicated CM and/or SW Resources in the ED **Tier 1:** Implement/Expand one (1) expedited care practice from the list above and report KPI as determined by the hospital. For example, LWBS, Inpatient LOS, Door to Provider Time, etc. **Tier 2:** Implement/Expand two (2) expedited care practices from the list above and report KPI for each practice as determined by the hospital. **Tier 3:** Implement/Expand three (3) expedited care practices from the list above and report KPI as determined by the hospital.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Patient Flow Throughput Performance Council		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Clinical Pathways & Observation Management	**Tier 1: Design and Implement Intervention** Hospitals will select and implement a clinical pathway tailored to a specific patient population. This clinical pathway should be based on the facility's unique patient needs and can incorporate existing pathways if already in place. **Tier 2: Develop Data Infrastructure** Hospitals will establish robust data collection and analysis systems to monitor and evaluate outcomes. These systems should emphasize comparing the effectiveness of inpatient and ambulatory management strategies for the selected patient population, enabling data-driven decision-making and continuous improvement. **Tier 3: Demonstrate Improvement** Hospitals will demonstrate a measurable decrease in unwarranted clinical variation and/or measurable improvement in outcomes specific to their chosen intervention.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

The initial proposal under consideration for the Best Practice policy was additional revenue at risk for performance on best practices for CY 2025. However, the work needed to refine the tiers and develop data collection is substantial. Furthermore, given concerns about the time it took to develop the ED LOS measure and incentive

concurrent to its use, staff believe additional time is needed to do this well. Finally, stakeholder engagement has been exceptional during this process and should be commended by providing this additional time for hospitals to develop the data collection needed to measure the tiers. Staff recommend that RY 2027 be focused on refinement and implementation of best practice measures, workflow redesign, and report development and validation. Therefore, RY 2027 efforts will be focused on development of the Best Practice tiers and data collection, and no revenue be tied to performance on the best practice measures for RY2027. There will be a 0.1 percent all-payer, IP revenue, accountability penalty tied to best practice implementation and data submission, meaning a penalty would be assessed if a hospital did not report data by October 2025 for its two selected best practices. Staff intend to continue the refinement of the best practices measures and tiers throughout RY 2027.

Stakeholder Feedback

The Best Practice subgroup has representation from all hospitals/health systems, as well as MHA and several other agencies and organizations. The subgroup members have been very engaged and actively involved in the development of the best practice recommendations. Overall, stakeholders have expressed support for the Best Practice Policy. The following has been called out in comment letters:

- Consideration of the effort required for data collection and reporting, allowing flexibility across health systems for alignment of measures with specific organizational opportunities
- Encourage flexible reporting timelines
- Request to shift data reporting deadline from October 2025 to December 2025
- Request for consideration of justifiable reporting delays in hospitals that are making a good faith effort in implementing best practices that may fall outside of the extraordinary circumstances exception policy. Noted above: We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).
- Hospitals have been investing significant resources to implement initiatives directed at optimizing throughput and decreasing both IP and ED LOS. They ask that we also support and lead efforts to address external factors driving throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- Suggestions to also consider concurrent evaluation of other measures in the context of ED Wait Times, throughput and patient outcomes including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience
- Stakeholders also note external drivers of throughput issues including workforce challenges, supply delays, and capacity constraints across the continuum of care. Stakeholders support and in many instances volunteer to assist with efforts to address these external challenges, including engagement with legislators to facilitate meaningful actions.
- Request consideration of the +/- 0.25% revenue at risk in future years. Note: Policy indicates we will evaluate year 1 results before determining revenue at risk for subsequent years

HSCRC Response to Stakeholder Feedback

- The HSCRC staff support flexibility of measure reporting across health systems to allow for targeted efforts at each hospital. This flexibility is reflected in the measures in the final draft recommendation.

- HSCRC supports flexible reporting timelines and would support a data reporting timeline that would request preliminary data reporting as data is available in CY2025 with a requirement to have a data submission in December 2025.
- As reflected in the policy, regarding justifiable reporting delays, HSCRC will follow our extraordinary exception policy to address any unforeseen events. HSCRC will consider each request for delayed reporting outside of this policy on a case-by-case basis.
- HSCRC staff supports the requested focus on external drivers of ED LOS and ED Wait Times, and are working with the ED Wait Time Reduction Commission and designated subgroups to address external factors driving: throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- External drivers related to capacity across the continuum of care, supplies, external throughput challenges, and workforce issues will be evaluated by the HSCRC staff in partnership with the ED Wait Time Reduction Commission and designated representatives from hospital and other health care organizations on the Capacity, Operations and Staffing Subgroup of the ED WTR Commission.
- HSCRC staff agree with the suggestion to concurrently evaluate other measures in the context of ED Wait Times, throughput and patient outcomes, including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience.
    - HSCRC staff and the ED WTR Data Subgroup have begun analyses focused on capacity and LOS and are in agreement with analysis of the other measures noted above in the comments.
    - Regarding the post-acute facility capacity and care transitions, legislative partners have volunteered to help facilitate collaboration between HSCRC, ED WTR Commission and hospitals and post-acute partners and support data analysis. We anticipate moving forward with this collaboration during this legislative session.
- HSCRC staff believes the request for consideration of the +/- 0.25 % revenue at risk for subsequent years has been addressed, as the policy notes that we will evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

FINAL RECOMMENDATIONS

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, three weighted tiers were developed with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).

3. We propose that subsequent rate years will have a +/- 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

APPENDIX A: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994, including the Maryland General Assembly Hospital Throughput Work Group Final Report in March 2024.

Historically, HSCRC has taken several steps to address emergency department length of stay concerns. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Previously, the HSCRC included ED LOS measures in the QBR program for two years. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the high correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals when the measures were in QBR, although some of the improvements were minimal. With the retirement of the chart-abstracted ED LOS measures, HSCRC continued to work to find a way to collect the data and include the results in QBR.

More recently, staff collaborated with CRISP and their contractor to collect the electronic Clinical Quality Measure (eCQM) ED-2 (Order of admission to admit time) for CYs 2022-2023. However, analyses of the ED-2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the ED measure due to an exclusion for stays where the patient spends more than one hour in observation care. Furthermore, CMS discontinued this eCQM measure in CY 2024, rendering it not feasible for hospitals to continue to report the eCQM at this time for use in the QBR program.

To determine the direction for inclusion of an ED throughput measure in the RY 2026 QBR policy that would begin with CY2024 performance, the Commission considered several measurement options proposed by staff as well as other initiatives underway to address this issue going forward.

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually

through the existing HSCRC case mix data submission process; the initial ad hoc electronic data pull and submission includes data from CY 2023 to serve as the performance baseline period, and from January through March 2024. Hospitals also provided an ad hoc submission in December 2024 that will correct any previously submitted data and provide data from April through September 2024; beginning with data from October 2024 going forward, the ED measure data elements will be included as part of the standard case mix submission process. The ED1 LOS measure captures the time of emergency department arrival to the time of physical departure from the emergency department for patients admitted to the facility. The population is all ED patients (pediatrics and adults) admitted to an inpatient (IP) bed and discharged from the hospital during the reporting period.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

In June of 2023, Commissioner Joshi convened HSCRC, MIEMSS, MHA, and MDH to propose the EDDIE project with the goal of reducing the time patients spent in the emergency department and pushed the HSCRC staff and MHA to begin this project immediately (i.e., not wait until the next policy year) given the importance of this issue. The EDDIE project focuses on short-term, rapid-cycle improvement in ED patient experience by collecting and publicly reporting on ED performance data and fostering a quality improvement process to address those metrics.

Specifically, starting in July 2023, hospitals are submitting data on measures that mirror the CMS ED 1 and OP 18 CMS measures on a monthly basis in accordance with an excel reporting template along with a memo provided by HSCRC staff that contains reporting instructions and high-level specifications. The HSCRC has requested that the measures submitted be stratified by behavioral health based on initial ICD codes. Additionally, the HSCRC has developed a reporting process by which MIEMSS provides monthly reporting on EMS turnaround times by hospital. This will provide hospital accountability for improving efficiency in handoffs by EMS personnel, which will in turn improve EMS unit availability and decrease response times.

The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is to provide a mechanism for Commission monitoring of timely ED performance data that brings on-going attention to this issue through public reporting, provides an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals improvement efforts relative to their aim statements. Once hospitals have submitted CY 2023 and CY 2024 patient level data, the staff will ask the Commissioners whether EDDIE data submissions are still needed.

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3

ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

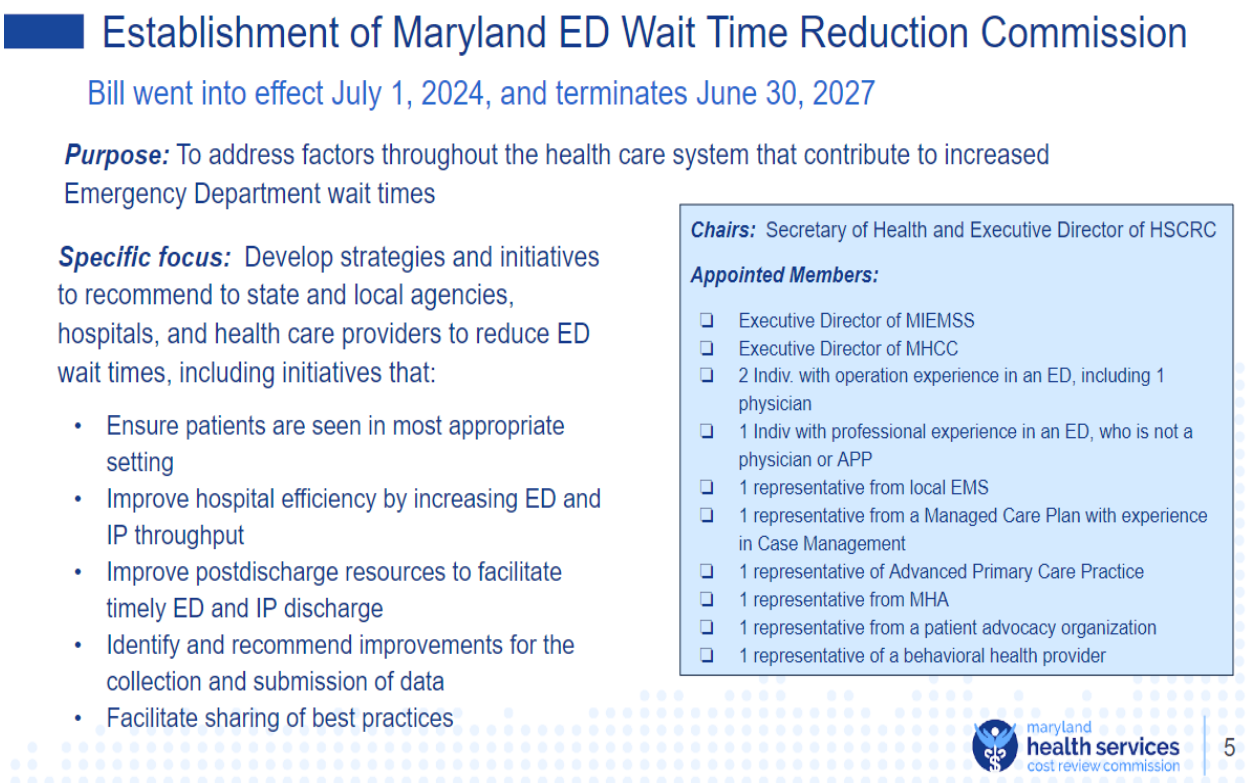
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), led a multi-stakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members included hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force was charged with making legislative, regulatory and/or policy recommendations in a report. The Maryland General Assembly Hospital Throughput Work Group Final Report was submitted in March 2024. The HSCRC staff were active participants in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

New Commission: Maryland Emergency Department Wait Time Reduction Commission

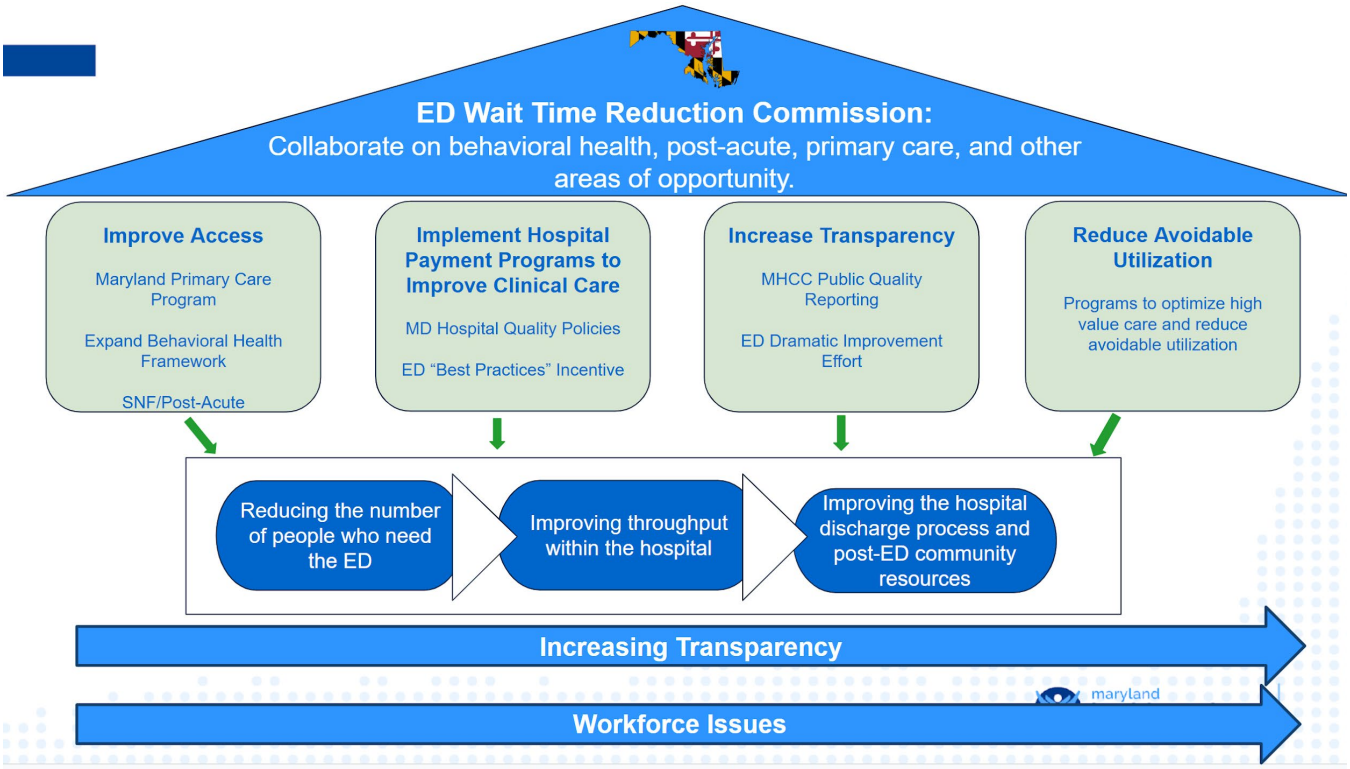
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and member representation on the ED Commission.

Figure E1. ED Wait Time Commission Description



The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access to hospital and community-based services that impact ED wait times, such as access to behavioral health care, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed, and the first meeting occurred in October 2024. Four subgroups have been established and are reporting up through the ED Wait Time Reduction Commission, including the ED Hospital Throughput Best Practices subgroup, which also reports up through the HSCRC Commission as it relates to hospital policy.

Figure E2. ED Wait Time Commission and Other Initiatives to Reduce ED Wait Times



ED Wait Time Reduction Commission Subcommittees

Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. Will support the strategic data-driven priorities of the ED Wait Time Reduction Commission
- Meetings every six to eight weeks

ED Hospital Throughput Best Practices

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing.
- Meetings every four weeks.

Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

Maryland
Hospital Association

October 16, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed policy to extend the Emergency Department Hospital Best Practice Policy for Rate Year 2028. MHA commends the Commission's structured approach, including tiered measures and required hospital participation, as a strategic effort to drive performance improvement across Maryland's hospitals.

MHA and its members share HSCRC's commitment to improving patient flow and reducing emergency department length of stay, recognizing that timely patient movement is essential for quality care, patient safety, and operational efficiency. Maryland hospitals have been actively engaged in efforts to enhance throughput and alleviate bottlenecks in the care continuum. Many of these efforts are already demonstrating promising results, and we appreciate HSCRC's recognition of the ongoing work by hospital leaders, frontline staff, and key stakeholders to address these challenges.

While we support the intent of this policy to drive system-wide improvements, we respectfully offer the following considerations and recommendations regarding the policy's potential extension beyond Rate Year 2028 and the broader Quality-Based Reimbursement Program (QBR):

Preserving the All-Payer Approach

Maryland's all-payer model has long supported innovative approaches and strong performance outcomes related to hospital quality. As Medicare separates from the all-payer system, MHA understands that some historic all-payer approaches for Medicare, Medicaid, and commercial payer performance may no longer be feasible. Nonetheless, for all future quality policy, we urge HSCRC to continue to align programming, measures, reporting, and timelines across payers and to use the Medicare quality program design as the standard in these areas wherever possible. This principle should be adopted by HSCRC as it plans for the transition.

[1] "QualityNet Home." n.d. Qualitynet.cms.gov. https://qualitynet.cms.gov/outpatient/oqr. Hospital OQR Program Important Dates CY 2027 PDF

Alignment with CMS Emergency Department (ED) Reporting Measures

When Maryland transitions to the national Centers for Medicare & Medicaid Services (CMS) quality model, it is critical that the ED Hospital Best Practices program aligns with Medicare's reporting structures. This alignment will reduce administrative burdens and ensure consistency across federal and state programs.

The recently updated Electronic Clinical Measures (eCQM) specifications for the 2026 reporting period, including OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) and OP-22 (Left Without Being Seen) offer a valuable opportunity for integration and alignment across payers. [1] These ED-related eCQMs, which were developed by CMS, can be foundational elements for the HSCRC's ED Best Practices framework. Aligning with these measures can streamline implementation and enhance data comparability across institutions.[1]

Additionally, CMS has proposed the Emergency Care Access and Timeliness (ECAT) eCQM, which includes four outcome metrics:[2]

- Patient wait time: 1 hour
- Patient left the ED without being evaluated
- Patient boarding time: 4 hours (from decision to admit to ED departure)
- Patient ED LOS: 8 hours (from ED arrival to physical departure)

This measure is scheduled for voluntary reporting in CY 2027 and mandatory reporting in CY 2028, with payment implications beginning in CY 2030.[2] When combined with voluntary sub-measures OP-18a through OP-18d, ED-related reporting would expand from two required measures to ten.[1] MHA recommends the Commission closely monitor CMS developments and build flexibility into the ED Best Practices framework to accommodate future federal requirements and opportunities to leverage alignment across payers.

Evaluation and Transparency

MHA appreciates staff's recommendation to assess program impact using CY 2025 and CY 2026 data. We encourage the Commission to publish interim findings and solicit public feedback before finalizing recommendations for future rate years. This will ensure the policy remains responsive to hospital field realities and evolving national standards.

It is also important to note that under the QBR program and the CMS Outpatient Quality Reporting (OQR) program, hospitals are already accountable for two mandatory ED reporting measures, along with four additional optional OP-18 measures. With the addition of ECAT, hospitals will be required to monitor ten ED measures. Some of these measures include performance thresholds or penalties for non-participation.[3] Considering the existing programs focus on improving ED throughput and accountability, we recommend HSCRC harmonize evaluations across payers to reduce administrative burden and avoid duplicative penalties.

[1] "QualityNet Home." n.d. Qualitynet.cms.gov. https://qualitynet.cms.gov/outpatient/oqr. Hospital OQR Program Important Dates CY 2027 PDF
[2] Emergency Care Access & Timeliness (HOQR) | eCQI Resource Center
[3] Heilman, Erin. 2024. "2024 Hospital OQR Program Requirements | Medisolv." Medisolv.com. Medisolv. May 17, 2024. https://blog.medisolv.com/articles/2024-hospital-oqr-requirements.

Timing and Strategic Implementation

If approved, the ED Hospital Best Practices policy extension will take effect in CY 2026 and CMS policies such as ECAT begin as early as CY 2027. Additionally, as the ED Wait Time Reduction Commission finalizes its recommendations, there may be implications for this HSCRC policy. Given these considerations, it is prudent to proceed with the ED Best Practices program, but with strategic caution. We recommend that HSCRC take adequate time to map Maryland's requirements to Medicare's expanding eCQM framework and ED Wait Time Reduction Commission recommendations. This side-by-side analysis will ensure coordination and harmonization across payers and strategies designed to improve ED throughput and more broadly hospital length of stay. Further, we recommend that HSCRC provide technical guidance and consider phased implementation strategies to support alignment and reduce reporting burdens.[2]

Thank you for the opportunity to comment. We support the goals of this initiative and look forward to its successful implementation in a way that balances innovation, alignment, and sustainability.

Sincerely,

Amanda Wright, RN MSN
Director, Quality and Clinical Care

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Alyson Schuster, Ph.D.

[1] "QualityNet Home." n.d. Qualitynet.cms.gov. https://qualitynet.cms.gov/outpatient/oqr. Hospital OQR Program Important Dates CY 2027 PDF
[2] Emergency Care Access & Timeliness (HOQR) | eCQI Resource Center
[3] Heilman, Erin. 2024. "2024 Hospital OQR Program Requirements | Medisolv." Medisolv.com. Medisolv. May 17, 2024. https://blog.medisolv.com/articles/2024-hospital-oqr-requirements.

Adventist HealthCare

October 15, 2025

Tina Simmons, MBA, BA, BSN, RN, LSSBBH, CPHQ
Associate Director, Quality Methodologies
Maryland Department of Health, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Tina Simmons,

Adventist HealthCare appreciates the opportunity to comment on the HSCRC Hospital Best Practice initiative. From the outset, we recommended limiting the requirement to a single best practice initiative to allow hospitals to focus on priorities most relevant to their unique circumstances while maintaining an effective policy framework. However, the current requirement for two tiered initiatives has created a substantial administrative burden, and HSCRC has not yet finalized the submission process.

Hospitals are preparing for the AHEAD model and aligning with CMS Value-Based Purchasing metrics, all while managing existing HSCRC quality programs. The volume and complexity of these concurrent initiatives will make the next two years particularly challenging. Accordingly, Adventist HealthCare wishes to express significant concern regarding the proposal to extend the Hospital Best Practice Policy for RY 2028.

Throughout this process, Adventist HealthCare has also noted that for many hospitals across Maryland—including our own—the primary driver of emergency department wait times is the lack of adequate acute and post-acute care capacity. While we remain committed to delivering world-class care under all circumstances, even the most efficient operations cannot fully overcome this systemic capacity constraint. The current policy does not address this fundamental cause of extended emergency department wait times across the state.

Sincerely,

Patsy M. McNeil, M.D., MBA, FACEP
Adventist HealthCare
Executive Vice President and System Chief Medical Officer

maryland
health services
cost review commission

Draft Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2028

December 10, 2025

This document contains staff draft recommendations for the RY 2028 Maryland Hospital Acquired Conditions Program. Comments are due by Thursday, December 18, 2025 and may be submitted to hscrc.quality@maryland.gov.

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List of Abbreviations

AHRQ	Agency for Health Care Research and Quality
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DRG	Diagnosis-Related Group
FFY	Federal Fiscal Year
FY	State Fiscal Year
HAC	Hospital-Acquired Condition
HAI	Hospital Associated Infection
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
MHAC	Maryland Hospital-Acquired Condition
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
PMWG	Performance Measurement Work Group
POA	Present on Admission
PPC	Potentially Preventable Complication
PSI	Patient Safety Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SIR	Standardized Infection Ratio
SOI	Severity of Illness
TCOC	Total Cost of Care
VBP	Value-Based Purchasing
YTD	Year to Date

Key Methodology Concepts and Definitions

Potentially Preventable Complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on **present-on-admission codes** to identify these post-admission complications.

At-risk discharge: Discharge that is eligible for a PPC based on the measure specifications

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar clinically and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of Diagnosis Related Groups with Severity of Illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same Diagnosis Related Group and Severity of Illness level.

Case-Mix Adjustment: Statewide rate for each PPC (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide **norms** are applied to each hospital's case-mix to determine the expected number of PPCs, a process known as **indirect standardization**.

Observed/Expected Ratio: PPC rates are calculated by dividing the observed number of PPCs by the expected number of PPCs. Expected PPCs are determined through case-mix adjustment.

Diagnostic Group-PPC Pairings: Complications are measured at the diagnosis and Severity of Illness level, of which there are approximately 1,200 combinations before one accounts for clinical logic and PPC variation.

Zero norms: Instances where no PPCs are expected because none were observed in the base period at the Diagnosis Related Group and Severity of Illness level.

Draft Recommendations

This document puts forth the RY 2028 Maryland Hospital Acquired Conditions (MHAC) draft policy recommendations for consideration. This policy discusses the AHEAD transition and potential options for incremental alignment of MHAC with the CMS Hospital Acquired Complications Reduction Program.

The draft recommendations for the RY 2028 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

1. Use Potentially Preventable Complication (PPC) composite and all-payer AHRQ Patient Safety Indicator 90 to assess hospital acquired complications.
2. Assess PPC performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs).
3. Assess hospital performance based on statewide attainment standards.
4. Set revenue at-risk at a maximum penalty at 2 percent and maximum reward at 2 percent using the average Maryland hospital score as the cut point for start of rewards.
5. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program under a non-Medicare FFS quality program.

Introduction

Maryland hospitals have been and are currently funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare & Medicaid Services (CMS) for the state to operate the All-Payer Model (CY 2014-CY 2018), the current Total Cost of Care (TCOC) Model (2019-2026) and the upcoming AHEAD model (CY 2026-CY 2035). Under the new AHEAD Model the state will transition in CY 2028 (Performance Year 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA),state leaders, other state health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup to develop a transition plan that increases the alignment between the state's

performance based payment programs and the CMS national programs over the initial years of the AHEAD model.

Under global budget systems, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important under global budgets to ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs to date have rewarded quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Maryland Hospital Acquired Conditions (MHAC) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for in-hospital complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. The MHAC program uses the Solventum Potentially Preventable Complication (PPC) measures of in-hospital complications such as sepsis, respiratory failure, pulmonary embolisms, and surgical-site infections.

Transitioning to the AHEAD Model

The AHEAD Model, which will begin in January 2026, includes a two year transition period where the state will maintain its all-payer rate setting system. The new CMS hospital global budgets will begin in CY 2028 and at that time the hospitals will be transitioned to the CMS quality programs for Medicare FFS and the state will administer quality programs for other payers. For RY 2028, which will assess CY 2026 performance, staff is working to assess all of the quality programs to determine opportunities for better alignment with the CMS programs. The initial focus of the state's transition work has been on aligning the Quality Based Reimbursement (QBR) program with the Hospital Value-Based Purchasing (HVBP) program; this effort also has implications for early steps to align the MHAC program with the CMS Hospital Acquired Conditions Reduction Program (HACRP) program. In-hospital complications are assessed in both the QBR and MHAC programs, as well as their CMS counterparts. Thus, changes to these policies and an evaluation of hospital complication measures should be considered in tandem. Appendix A provides a high-

level overview on quality assessments in the AHEAD Model, including a visual timeline for transitioning to the CMS quality programs in FFY 2029 or FFY 2030, with the earlier year transition contingent upon system implementation readiness.

This draft policy recommends options on early steps to align the MHAC program with HACRP in advance of the transition to the new AHEAD global budget system for Medicare FFS. The Assessment section of this draft MHAC policy includes an evaluation of performance on payment PPCs, as well as performance on the Agency for Healthcare Research and Quality's Patient Safety Index (AHRQ PSI) measures and the National Healthcare Surveillance Network Hospital Acquired Infections that are used in the CMS HACRP. For the RY 2028 MHAC policy, staff proposes to maintain the RY 2027 PPC composite measure and consider adding the all-payer AHRQ PSI composite. Currently, the all-payer AHRQ PSI measure is included in the QBR policy for Maryland and the Medicare PSI measure is included in the CMS HACRP program. Thus, to better align the Maryland programs with the CMS programs, staff recommends moving the AHRQ PSI composite into the MHAC program but maintaining its all-payer focus for CY 2026. The recommendation to maintain PPCs, which have been used in Maryland since the start of the APM in 2014, is based on their all-payer focus and broader assessment of complications than the PSIs or NHSN HAIs. However, staff recognizes that long term, additional work needs to be done to assess the appropriateness of continuing to use the PPCs given they are not used by CMS.

Thus, during CY 2026, staff proposes to engage stakeholders to assess opportunities for further alignment with CMS and to develop a complications program for State payers (i.e., non-Medicare FFS). Specifically, alignment entails consideration of measures, measurement domains and weighting, performance standards, performance periods, and revenue adjustment methodology. In a detailed or targeted sense, alignment can mean an exact replication of the CMS quality programs; in a broader sense, alignment can mean harmonizing with national hospital quality program priorities and intentions.

In addition to the Quality program Guiding Principles established at the beginning of the APM, the following criteria are proposed for deciding what measures to include in the policy and the weights:

1. Alignment with CMS quality programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible
4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Staff will continue to vet details of this transition across all of the RY 2028 quality policies with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Background

Overview of the MHAC Policy and Comparison with CMS Hospital Acquired Conditions Reduction Program

Because of the state's unique all-payer hospital model and its global budget system, Maryland does not participate in the federal pay-for-performance programs. Instead, the state administers the Maryland Hospital Acquired Conditions (MHAC) program, which relies on quality indicators validated for use with an all-payer inpatient population. The MHAC program was first implemented for Rate Year 2011. Measures used are based on a classification system developed by 3M Health Information Systems (3M), now Solventum. To identify potentially preventable complications (PPCs), the system uses the present-on-admission (POA) variable for eligible secondary diagnosis codes available in claims data to identify conditions not POA. The PPC system originally comprised specifications for 65 PPCs,[1] defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs.

The MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance. The program currently evaluates performance on a composite of 16 clinically significant PPCs. As discussed further below, the PPCs not included in the payment program are monitored for changes and possible adoption back into the program. The program provides both rewards and penalties, holding up to 2 percent of hospital inpatient revenue at risk and based on performance.

[1] In RY 2020, 45 out of 65 PPCs or PPC combinations were included in the program as 3M had discontinued some PPCs and others were deemed not suitable for a pay-for-performance program. The re-designed RY 2021 policy reduced the PPCs assessed to a focused list of 15 PPCs that were clinically actionable and had higher rates and greater variation across hospitals, and/or were clinically significant. In RY 2025, the policy was updated to include PPC 47 Encephalopathy, so there are now 16 payment PPCs.

Figure 1 below provides a comparison of the MHAC and HACRP programs. The CMS HACRP was established by the Affordable Care Act (ACA) of 2010 and implemented in FFY 2015. While the MHAC program and its national analog are similar in that they both evaluate hospital acquired conditions, there are some key differences, e.g., MHAC provides the potential for rewards so that all hospitals have an incentive to improve performance.

Figure 1. RY 2027 Maryland MHAC Program vs. FFY 2027 CMS HACRP Program

	Maryland MHAC Program	CMS HACRP Program[2]
Rewards/ Penalties	Provides rewards/penalties to hospitals based on performance of hospital-acquired conditions.	Reduces payments to hospitals based on their performance on measures of hospital-acquired conditions.
Revenue at Risk	Up to 2 percent of inpatient revenue for rewards or penalties based on preset scale	1 percent of Medicare hospital revenue for worst performing quartile of hospitals after performance period
Measures	16 Clinically significant PPCs	5 CDC NHSN HAI measures 1 AHRQ PSI 90 composite measure (Medicare)
Scoring Calculation	PPC composite score is calculated as the sum of the hospital's observed PPCs times the Solventum Cost Weight for each payment PPC measure divided by the sum of the hospital's expected PPCs times the Solventum Cost Weight for each payment PPC measure. $PPC\ Composite_j = \frac{(\sum_{i=1}^{16} ObservedPPC_{ij} * SolventumCostWeight_i)}{(\sum_{i=1}^{16} ExpectedPPC_{ij} * SolventumCostWeight_i)}$ Performance standard: Convert the PPC composite to a scaled score by comparing results to the threshold and benchmark that is set at average of 20th and 80th percentiles from the base period.	• Measure results- Standardized Infection Ratio (SIR) for each of 5 CDC NHSN HAI measure = Observed/Predicted CMS PSI 90 composite = weighted average of 10 component PSI measures. • Transform to scores- Winsorize results: Limit the distribution of measure results at the 5th and 95th percentiles to reduce outliers. Calculate each measure score as the z-score of winsorized results. $z = \frac{(x - \mu)}{\sigma}$ X=hospital score μ=national mean σ = std dev Total HAC score = Sum of z-scores for each measure the hospital is eligible. Hospitals need only one qualifying measure to be included. Each measure is equally weighted.
Base and Performance	Base: July, 2022-June 2024 Performance: CY 2025*	PSI 90 performance is July 1, 2023, to June 30, 2025.

[2] For additional technical details, please see https://qualitynet.cms.gov/inpatient/hac. Last accessed 11/24/2025.

	Maryland MHAC Program	CMS HACRP Program[2]
Periods	*CYs 2024 and 2025 for small hospitals	CDC NHSN HAI measures' performance is January 1, 2024, to December 31, 2025

While some of the PSIs in the AHRQ measure evaluate the same complications as the Solventum PPCs, there is a key difference in patient scope: PSIs are limited to surgical cases, similar PPCs also assess these complications for medical patients who meet the measure specification inclusion criteria. Appendix B provides data showing the variability in overlap in the patient populations and complication occurrences between the PSIs and PPCs. For example, it shows that for Iatrogenic Pneumothorax (PSI 6 and PPC 49) complication, 67 percent of the eligible discharges and 26 percent of assigned complications are included in both measures, but an additional 17 percent of discharges and 35 percent of pneumothorax cases are identified by the PSI measure only and 16 percent of eligible discharges and 39 percent of cases are identified by the PPC measure only. In addition, while PSI 13 focuses on post-operative sepsis, PPC 35 focuses on any sepsis and also other severe infections; only 6 percent of discharges are eligible and 11 percent of the sepsis cases are identified by both measures.

Exemption from Federal Hospital-Acquired Condition Programs

In order to maintain an all-payer quality program for in-hospital complications, the state must submit an annual report to CMS demonstrating that Maryland's MHAC program targets and results continue to be aggressive and progressive, i.e., that Maryland's performance meets or surpasses that of the nation. Specifically, the state must ensure that the improvements in complication rates observed under the All-Payer Model through 2018 are maintained throughout the TCOC model. An exemption request has been submitted to CMS for FFY 2026. CMS has granted Maryland exemptions from the federal pay-for-performance programs (including the HAC Reduction Program) each year through FFY 2025; if updated information regarding the RY 2026 exemption request is received, it will be included in the final policy. Staff will continue to need to submit an exemption request during the initial transition years under AHEAD and plan to include a discussion of alignment of complications measures for CMMI input.

MHAC Scoring Methodology

In an effort to improve the comprehensiveness and fairness of the MHAC program, the methodology for calculating hospital scores and applying revenue adjustments was modified in RY 2027. Specifically, the HSCRC staff worked with Mathematica to develop a composite PPC measure that weights both the

observed PPC count and the expected PPC count by the Solventum cost weights and then sums across the PPCs to get a weighted observed to expected ratio. This weighted O/E ratio is then compared to a threshold and benchmark to calculate the MHAC score (i.e., if better than the benchmark MHAC score is 100 percent, if worse than the threshold then the MHAC score is 0 percent, and those performing between the threshold and benchmark receive a relative score). This differs from RY 2021 through RY 2026 where the O/E ratio for each PPC was compared to a threshold and benchmark to calculate points, applying the Solventum cost weights to the points, and then adding up across the PPCs.[3]

Figure 2 provides an overview of the three steps in the MHAC methodology (also see Appendix C) that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

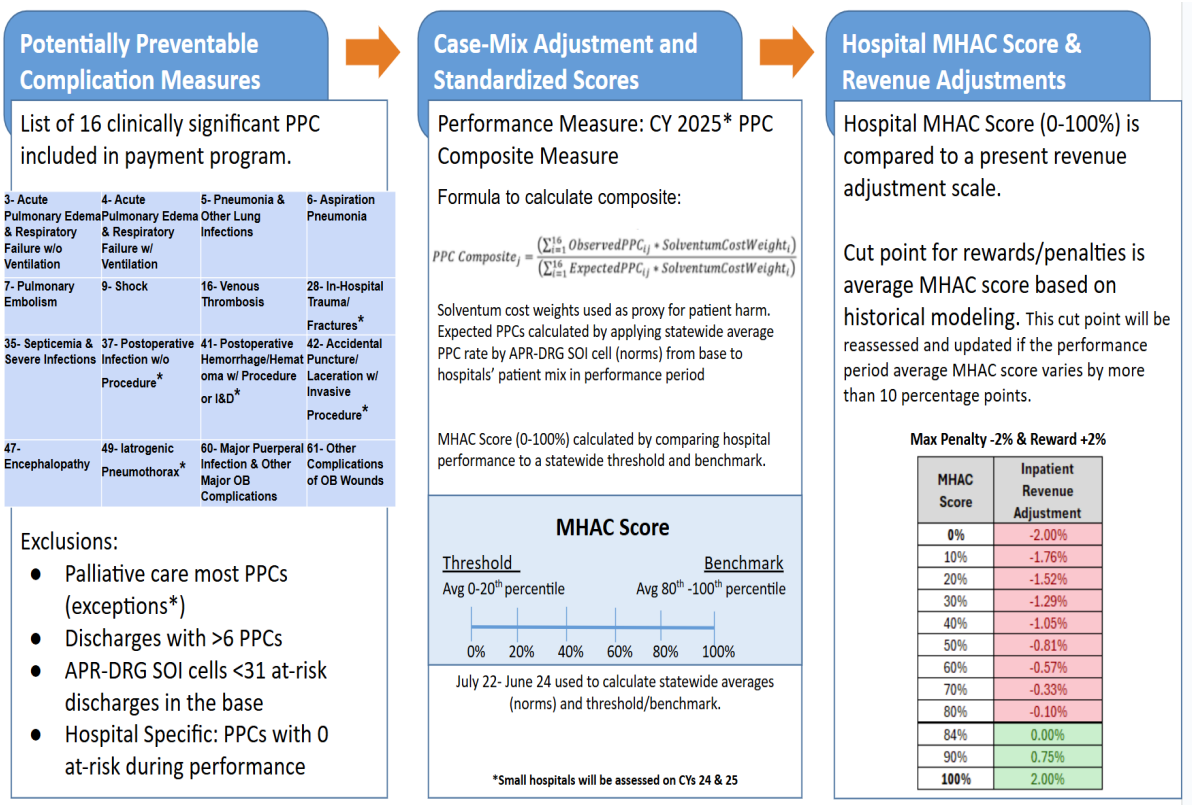
Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based diagnosis-severity of illness and hospital-level exclusions are applied to ensure fairness in assignment of complications.

Step 2. Case-mix adjustment is used to calculate observed to expected ratios that are then converted to a standardized point score (from 0-100 points) based on each hospital's attainment levels using a similar scoring methodology that is used for CMS Value-Based Purchasing and Maryland QBR program. Specifically, a composite PPC measure is used that weights both the observed PPC count and the expected PPC count by the Solventum cost weights and then sums these across the PPCs to get a weighted observed to expected ratio. This weighted O/E ratio is then compared to a threshold and benchmark to calculate the MHAC score (i.e., if better than the benchmark MHAC score is 100 percent, if worse than the threshold then the MHAC score is 0 percent, and those performing between the threshold and benchmark receive a relative score).

Step 3. The hospital's earned score is then compared to a linear scale to calculate the revenue adjustment percent. The scale is set prospectively and concurrently monitored so that hospitals can track potential revenue adjustments during the performance period; this scaling approach differs from national programs that relatively rank hospitals after the performance period. Additionally, the MHAC scaling differs in that it provides an opportunity for rewards, as opposed to HACRP that reduces payments by 1 percent for hospitals in the worst-performing quartile.

[3] The RY 2027 policy outlines the PPC Composite testing results.

Figure 2. Overview Rate Year 2027 MHAC Methodology



Assessment

This section provides an overview of performance for Maryland hospitals on complications measures, including Solventum PPCs, all-payer and medicare PSIs, and NHSN HAIs. Following the performance results, the staff recommendations on complication measures for RY 2028 is summarized. Staff then provides modeling of scores and revenue adjustments comparing the current methodology, HACRP, and the staff recommendation. The staff recommendation is based on the alignment considerations outlined above, the quality program guiding principles, and timing considerations related to staff resource limits and Commission priorities. Last, there is a discussion on staff priorities for CY 2026 for measuring in-hospital complications in CY 2027 to further align Maryland's program with the CMS HAC Reduction Program and develop a new complications program for all other payers.

Maryland Performance on Potentially Preventable Complications

Performance trends below show the observed to expected ratios for the PPCs currently included in the RY 2027 MHAC program. Under the All-Payer Model (APM), Maryland exceeded the contractual requirement of a 30 percent reduction in all PPCs. Throughout the TCOC Model, Maryland has continued to meet the contractual requirement on complications by maintaining the APM improvements for complications included in the payment program (i.e., not exceeding the CY 2018 PPC rates).

Currently there are sixteen PPCs included in the RY 2027 payment policy:

3	Acute Pulmonary Edema and Resp Failure w/o Ventilation
4	Acute Pulmonary Edema, Resp Failure w/ventilation
5	Pneumonia and Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption Without Procedure
41	Peri-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42	Accidental Puncture/ Laceration During Invasive Procedure
47	Encephalopathy
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds

The MHAC program was redesigned at the start of the TCOC model to focus on a smaller number of complication measures that met criteria developed by the Clinical Adverse Events Measures subgroup that was convened by the HSCRC. All other PPCs are still monitored and reconsidered annually for adoption back into the program. Appendix D provides the criteria that is used to select and re-evaluate complications for inclusion in the payment program versus monitoring, along with the statewide results for payment, monitoring, and all PPCs. Because CMS does not use the PPC measures, staff will need to evaluate whether PPCs will continue to be used as the state transitions to AHEAD. For RY 2028, staff is not recommending any changes to the payment PPCs as discussed further below.

Figure 3 below shows the statewide observed to expected (O/E) ratio from 2018 through CY 2025 YTD (July) for the payment PPCs. The O/E ratio presents the count of observed PPCs divided by the calculated

number of expected PPCs (which is generated using statewide historical averages by diagnosis and severity of illness level and applying them to the case-mix of discharges a hospital experiences during the performance period). An O/E ratio of greater than 1 indicates that there are more PPCs than expected, and conversely, an O/E ratio less than one indicates that there are fewer PPCs than expected. Overall, there has been almost a 55 percent decrease in the O/E ratio since 2018.

Figure 3. Payment PPCs Observed to Expected Ratios by Quarter CY 2018 to CY 2025 YTD July

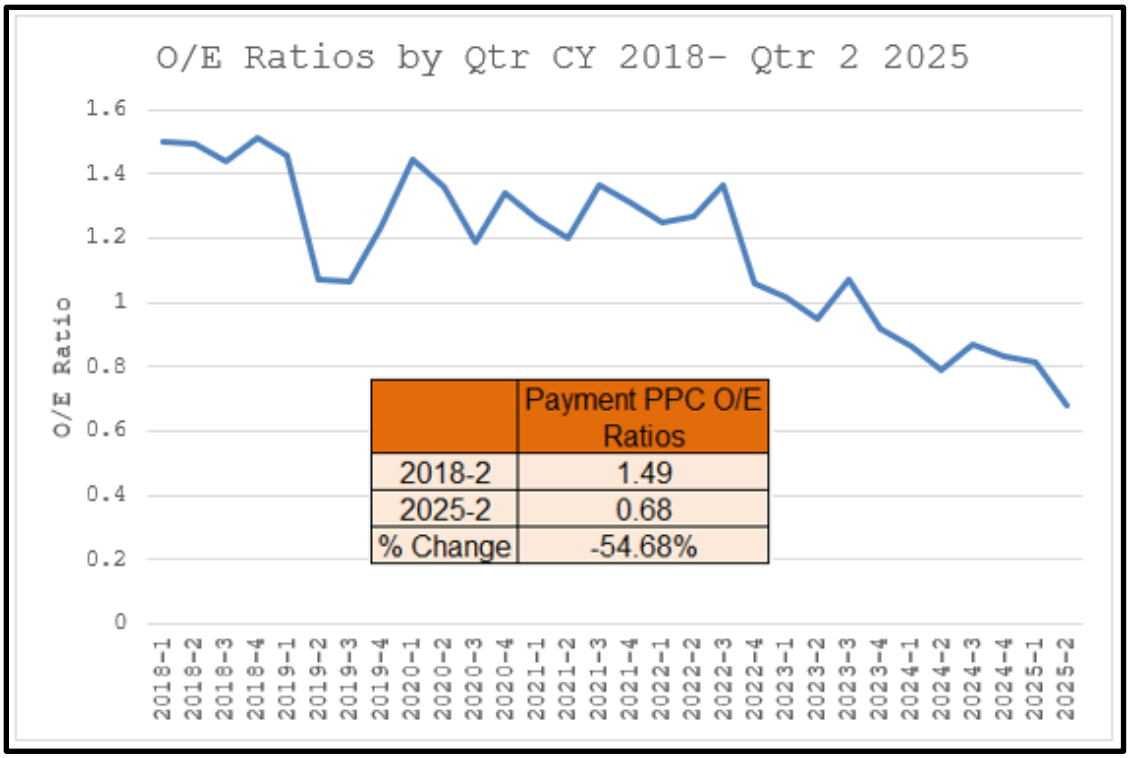
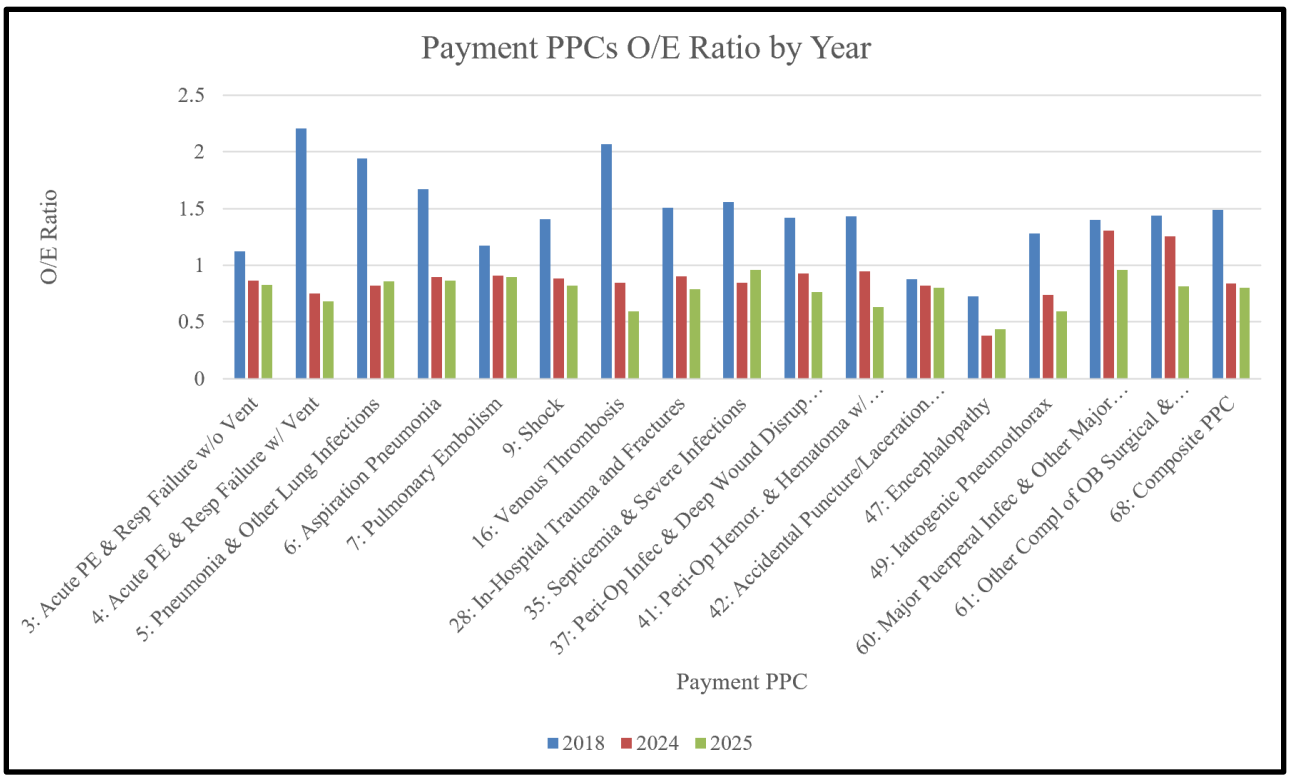


Figure 4 indicates how Maryland is performing relative to CY 2018 on each of the individual payment PPCs, which is the time period used to assess any backsliding on performance under the TCOC Model. Each of the PPCs included in the payment program have shown reductions since 2018, and most have had continued but much more modest reductions from CY 2023 and CY 2024. In CY 2025, all PPCs have an O/E ratio less than 1, indicating that statewide there are fewer PPCs than expected.

Figure 4. Payment PPCs Observed to Expected Ratios by Year, 2018, 2024, 2025



Maryland Performance on AHRQ Patient Safety Index Measures

The PSI-90 composite measure, which is one sixth of the national HACRP program, focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. Maryland's statewide performance compared to the nation on the PSI 90 Composite measure and the individual measures within the Composite for CY 2023 and CY 2024 are summarized below and illustrated in Figures 5 and 6[4].These data show:

- Compared to the nation, Maryland is better on the overall PSI-90 composite and on eight of the ten PSI indicators on an all-payer basis.
- Compared to 2023, Maryland has improved on the overall PSI-90 composite and on seven of the 10 indicators in 2024 on an all-payer basis.

[4] Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website

- Compared to the nation, Maryland has performed better than or on par on the overall PSI-90 composite in four of the last six years, 2019-2024. In CY 2024, Maryland had almost 20 percent fewer complications than expected on an all-payer basis.

Figure 5. All-Payer PSI 90 Composite and Component Indicators for Maryland Compared to the Nation in 2024, and Maryland's performance over time 2023-2024

PSI Name	Maryland 2024 Compared to the Nation 2024	Maryland 2024 Compared to Maryland 2023
PSI 90 Composite	Better	Improved
PSI 3 Pressure Ulcer	Worse	Improved
PSI 6-Iatrogenic pneumothorax	Better	Improved
PSI 8 In Hospital Fall and Fracture	Better	Worse
PSI 9 Perioperative Hemorrhage or Hematoma	Better	Improved
PSI 10 Postoperative Acute Kidney Injury w/Dialysis	Better	Worse
PSI 11 Postoperative Respiratory Failure	Better	Improved
PSI 12 Postoperative Pulmonary Embolism or DVT	Better	Improved
PSI 13 Postoperative Sepsis Rate	Better	Improved
PSI 14 Postoperative Wound Dehiscence	Better	Worse
PSI 15 Abdominopelvic Accidental Puncture or Lac	Worse	Improved

Figure 6. Maryland All-Payer State vs National PSI-90 Composite Performance

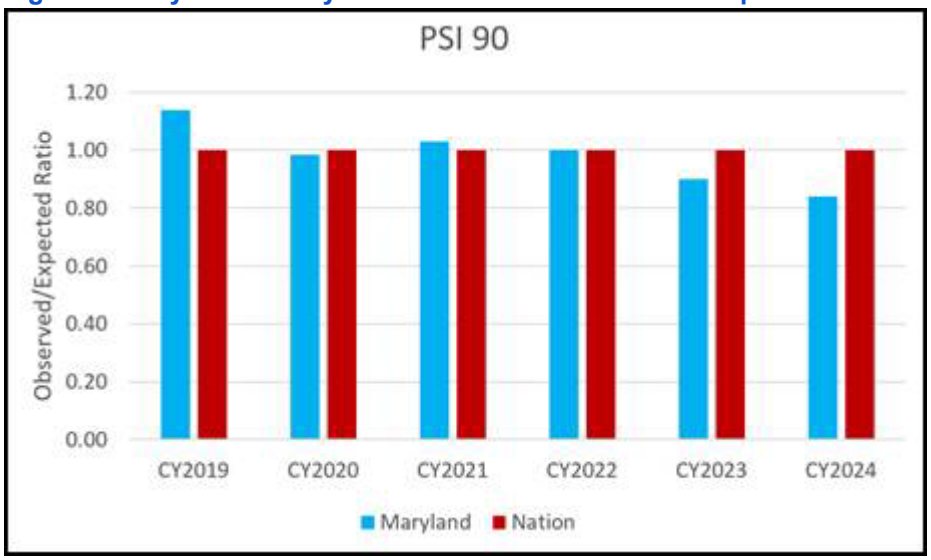
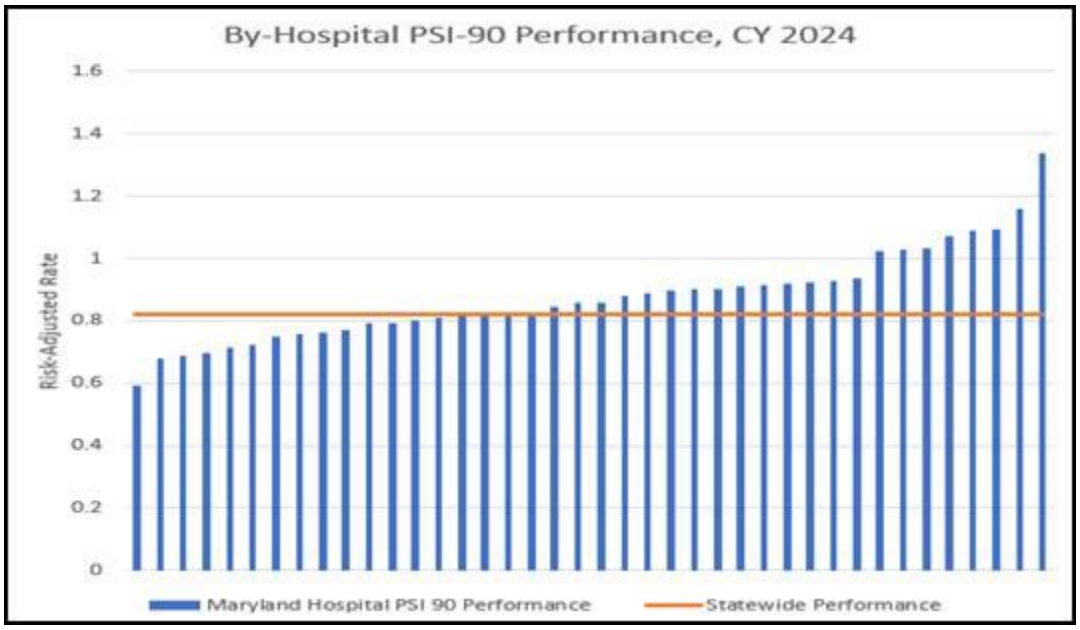


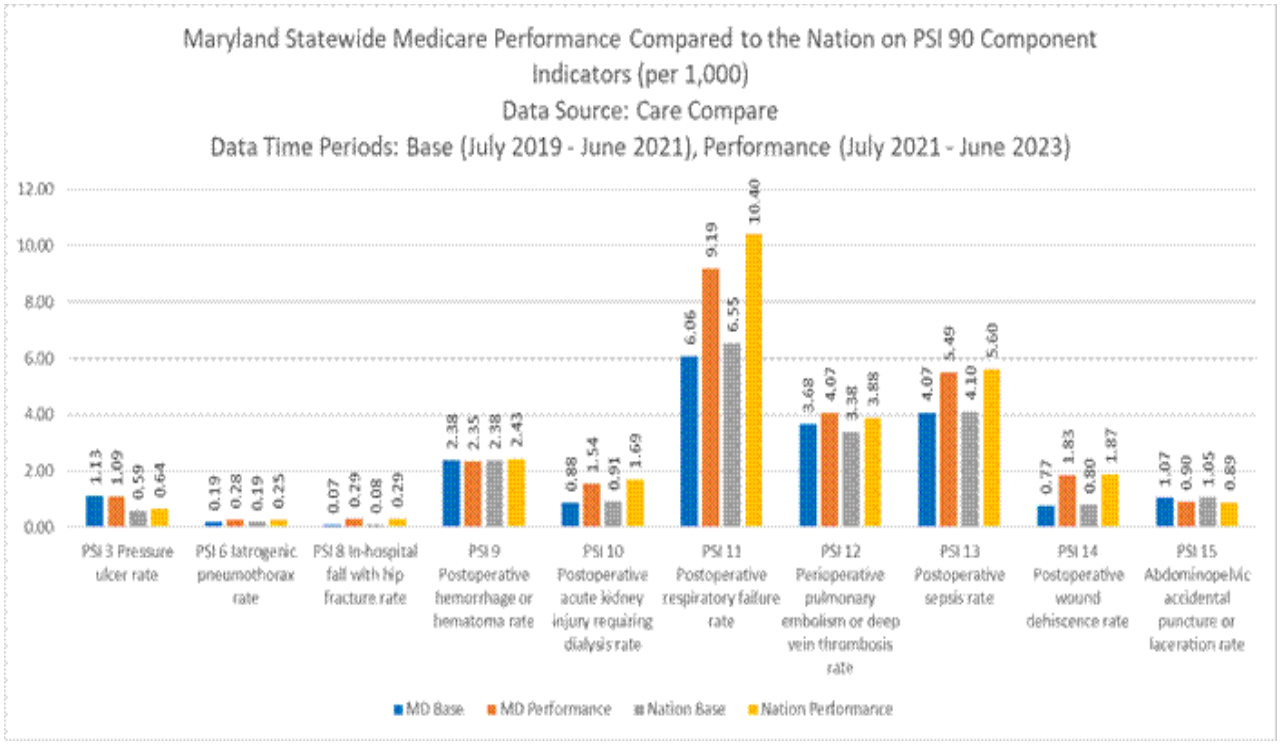
Figure 7 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2024; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

Figure 7. PSI-90 Composite All-payer Hospital-Level Performance, CY 2024



CMS Care Compare publishes PSI-90 component indicator rates per 1,000 for Medicare patients for the nation and by state. Based on the data available at the time of the RY 2026 exemption request (Figure 8), Maryland rates are lower (better) or on par with the nation for all component indicators for both the base and performance periods with exception of PSI 3 Pressure Ulcer. While the HACRP uses the Medicare PSIs, staff recommends continuing to use the all-payer PSIs from QBR in the MHAC program and note that there is moderate correlation between the all-payer and Medicare versions of the PSI measure.

Figure 8. Maryland Statewide Medicare Performance Compared to the Nation on PSI-90 Component Indicators (per 1,000), July 2019-June 2021 Compared to July 2021-June 2023



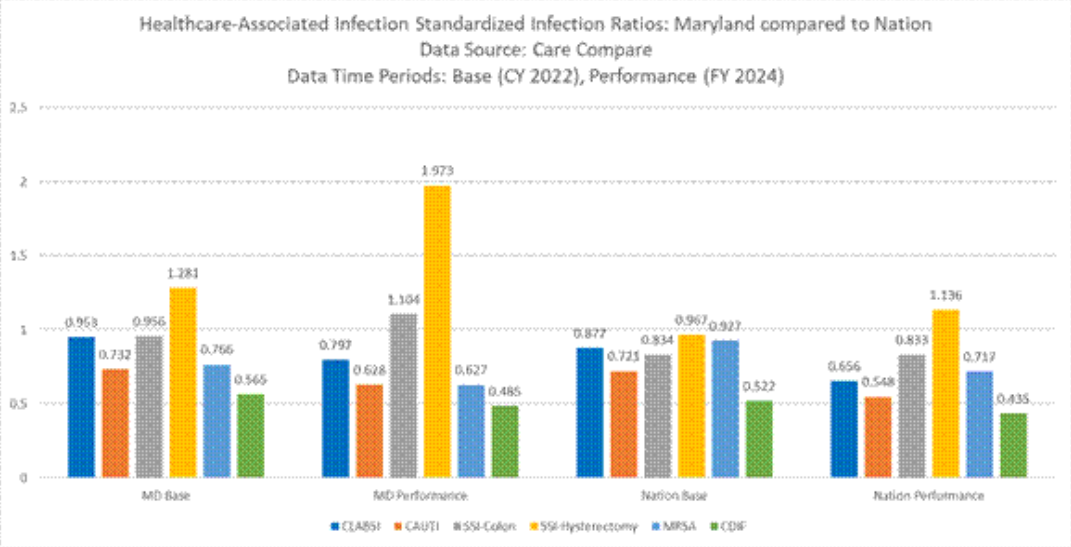
Maryland Performance on NHSN Healthcare-Associated Infections

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections, such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Care Compare has updated the Centers for Disease Control (CDC) National Health Safety Network Healthcare Associated Infection (HAI) Standardized Infection Ratio (SIR) data tables for the nation and by state through June 2024. Figure 9 below shows how Maryland performs relative to the nation, and how performance has changed over time for both Maryland and the nation.

- For the most recent time period, Maryland's performance is favorable compared to that of the nation on MRSA.
- Maryland is worse (higher SIRs) on SSI-hysterectomy, SSI-colon, and slightly worse on CAUTI, CDIF and CLABSI but given small sample sizes for some of these measures, most differences are not statistically significant.

- Both Maryland and the nation improved from the base to the performance period on four of the six HAI categories–CAUTI, CLABSI, CDIF and MRSA, and worsened on SSI-colon and SSI-hysterectomy.

Figure 9. NHSN SIR Values for CY22 compared to 7/1/23-6/30/24, Maryland versus the Nation



In Maryland the NHSN HAIs are included in the Quality Based Reimbursement (QBR) program, whereas nationally the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues and surveillance bias (i.e., higher testing for infections results in higher rates of identified infections). Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC), and/or what other measures should be considered for non-Medicare FFS quality policies. or the RY 2028 policy, staff is not recommending inclusion of the NHSN measures in the MHAC program due to these concerns and inclusion of the measures in QBR.

Digital Measures

The state and CMS are moving towards digital measures to reduce measurement burden and enhance measures with data from electronic health records. By 2030, the CMS goal is for all quality measures to be fully digital. Further, CMS noted the following in their 2022 Digital Quality Measures (dQM) Roadmap:

dQMs are designed to reduce administrative burden and costs, reduce the likelihood of manual data entry and interpretation errors, and provide more timely quality assessments by enabling automated, standardized data analysis directly from electronic data sources.[5]

As discussed in the QBR policy, the state is aligning the hospital digital measure reporting requirements with CMS but providing a small financial incentive for more timely reporting during the performance year and requiring the core clinical data elements for hybrid measures on an all-payer basis. Figure 10 provides a summary of the Electronic Clinical Quality Measures (eCQM) reporting requirements for CY 2026. As the state evaluates future options for complication measures, staff believes that digital measures should be considered to address areas of interest to stakeholders such as maternal morbidity or newer NHSN digital measures such as Hospital Onset Bacteremia.

Figure 10. CY 2026 Required Maryland and CMS Electronic Clinical Quality Measures (eCMQ) Reporting

- **Five eCQMs selected by CMS and three self-selected**
- **CMS-mandated eCQMs (Maryland is aligning with CMS)**:
  - **Safe Use of Opioids—Concurrent Prescribing**: (CMS506)
  - **Cesarean Birth**: (PC-02)
  - **Severe Obstetric Complications**: (PC-07)
  - **Hospital Harm—Severe Hyperglycemia**:newly required by CMS
  - **Hospital Harm—Severe Hypoglycemia**: newly required by CMS

Complication Measure Summary

In summary, the measure recommendations for the RY 2028 MHAC policy are the following:

- Maintain the use of RY 2027 PPCs given all-payer focus and broader applicability (i.e., medical and surgical patients included). Continue to use the new composite measure that offers a superior scoring approach, resulting in hospital specific scores with significantly increased content validity and reliability and better distinguishes hospital performance such that all hospitals are held accountable for PPCs that are most germane to the types of patients and services they provide.
- Add the all-payer AHRQ PSI composite to the MHAC program, assuming approval of its removal from QBR. The staff recommends the all-payer measure because the all-payer rate setting system

[5] Centers for Medicare & Medicaid Services. 2022. "Digital Quality Measurement Strategic Roadmap." https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadma p_032822.pdf.

is still in place for CY 2026 and the volume of discharges allows only one year of data to be needed. While some of the PPCs and PSIs address similar types of complications, staff believes adding the PSI composite as currently used in QBR is appropriate as it provides additional incentive weight for clinically important areas such as sepsis and adds areas of focus not included in the payment PPCs. Staff recommends that the all-payer PSI measure be weighted proportionally to its weight in the HACRP program (i.e., 1/6th of the total MHAC score); thus limiting the impact of the PSI measure on MHAC scores but ensuring hospitals focus on this CMS measure.

- Maintain the NHSN HAI measures in the QBR program but do not add to the MHAC program at this time given measurement concerns related to these surveillance measures.
- Re-convene the Clinical Adverse Events Measures subgroup in Spring of 2026 to assess available complication measures for use in a state program for non-Medicare payers. Assessment should consider alignment with CMS and the state's investments in PPCs, as well as opportunities to focus on non-Medicare priority areas such as maternal complications, digital measures, or areas of poor performance.

Hospital Scores and Revenue Adjustments

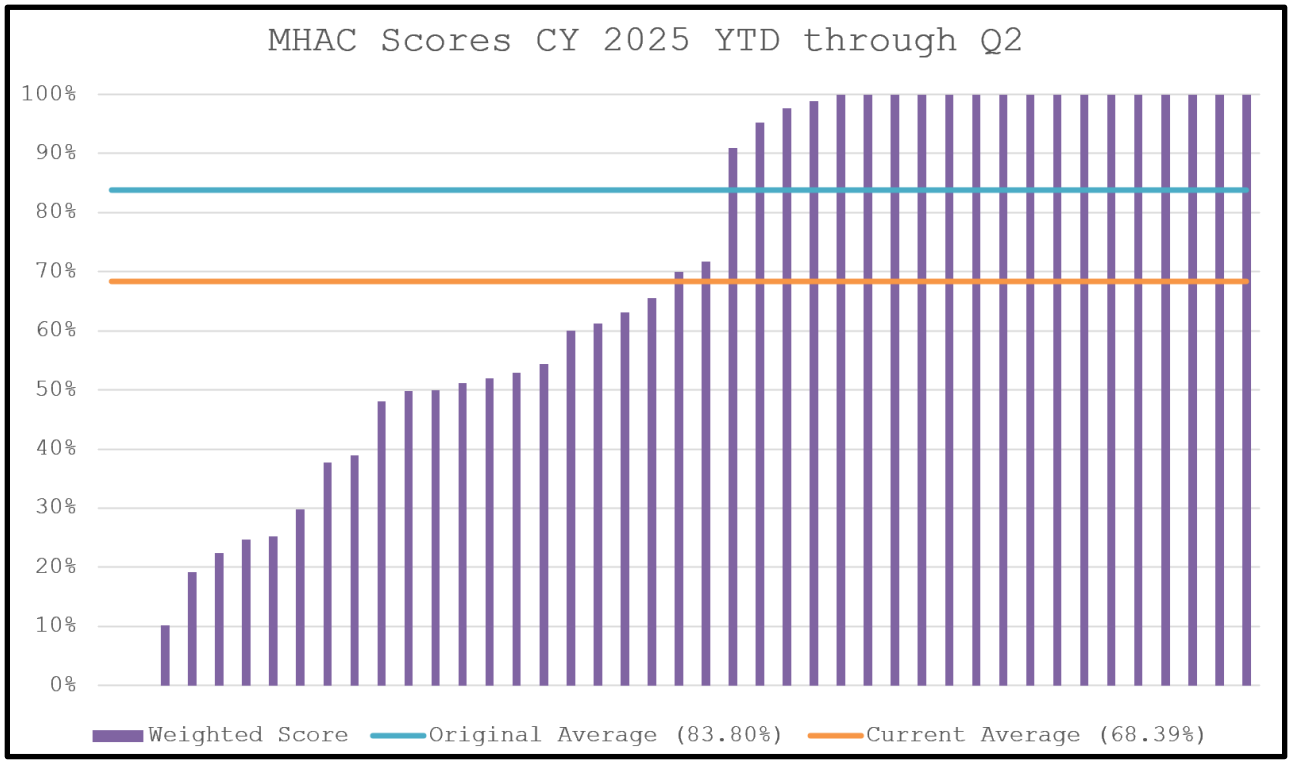
This section provides an overview of the MHAC and HACRP revenue adjustment methodology and then presents modeling of hospital scores and revenue adjustments for the current MHAC methodology, the estimated HACRP results for Maryland hospitals, and the proposed RY 2028 draft recommendations.

Comparison of MHAC and HACRP Scoring and Revenue Adjustment Methodology

The MHAC scoring methodology was significantly updated in RY 2027 based on stakeholder concerns. As discussed above, the approved RY 2027 MHAC policy recommended the use of a PPC composite measure that includes all payment PPCs for the one year performance period (two years for small hospitals) but weights the PPCs by the hospital's expected number of PPCs. This addressed concerns about construct validity as it ensured inclusion of lower volume complications but weighted hospital scores by largest areas of opportunity. Over the last year, staff has explored concerns about academic medical centers being disadvantaged under the PPC risk-adjustment methodology and impact of prospective versus concurrent normative values. Appendix E provides an overview of the results from these analyses. Based on these results, staff does not recommend any changes to the methodology at this time but will continue to support hospitals that submit clinical concerns to Solventum. The total MHAC score is then determined by

comparing the PPC composite results to a threshold and benchmark, which is the average of the hospital scores in the top and bottom 1/5th (i.e., the scores below and above the 20th and 80th percentiles) of scores calculated during the two year historical base period. If a hospital scores better than the benchmark, then the score is 100 percent and if the hospital scores worse than the threshold the hospital scores 0 percent, with all those in between receiving a score relative to the threshold and benchmark. Figure 11 provides RY 2027 YTD through June results by hospital, along with the current average score. In order to convert the scores to revenue adjustments, a linear scale from 0 to 100 percent is used and the cut point is the average hospital score. The RY 2027 policy recommended a preliminary cut point of 84 percent based on modeling; however, the actual average score will be used instead of this placeholder and is provided in the monthly reports for hospitals to track (currently 68 percent). The scaling distributes both rewards and penalties up to 2 percent of all-payer inpatient revenue.

Figure 11. MHAC Scores CY 2025 YTD through June



The HACRP scoring and revenue adjustments differ significantly from the MHAC methodology. First, each eligible measure is weighted equally and the performance periods are two years for all hospitals and measures. Thus, for FFY 2028, the performance periods for NHSN and PSI started in January 2024 and July 2023, respectively (i.e., 12 and 18 months of the performance period will elapse by the end of CY 2026). To calculate the scores, measure results are truncated at the 5th and 95th percentile and then results across measures are standardized using z-scores that compare each hospital's results to the national mean, divided by the standard deviation and summed across eligible measures. Then hospitals with a total HAC score greater than the 75th percentile (i.e., the worst-performing quartile) are subject to a full 1 percent payment reduction for all Medicare FFS patients. Unlike the MHAC program, the HACRP program does not provide rewards to hospitals.

Based on estimated results from CMMI for FFY 2025 HACRP, as shown in Figure 12, the state performed better than the 75th percentile of national performance (0.3178 vs 0.3667). The by-hospital results indicate that 16 of 43 Maryland hospitals would have been penalized under HACRP. However, it should be noted again, that there are concerns about small cell sizes and other biases in the NHSN measures since they were originally designed for surveillance purposes and not payment. Furthermore, small or unique hospitals such as UMD Chestertown, UMD Rehabilitation and Orthopedic Institute, and Levindale are included in hospitals that would be penalized but are not measured on most of the measures. For example, UMD Chestertown is only measured on c dif and had three observed cases in two years, exceeding the expected of 1.55 cases. However, the HSCRC does remain concerned that some of the larger hospitals in the State do appear to have opportunities for improvements on some of the complication measures relative to the nation.

Figure 12. HACRP Total HAC Scores, Maryland Compared with the Nation, FFY 2025

National 75th percentile Total HAC Score with and without Maryland Hospitals	Average Total HAC Score for Maryland Hospitals
0.3667 with MD 0.3652 without MD	0.3178

Figure 13 provides the RY 2025 MHAC and estimated FFY 2025 HACRP revenue adjustments for Maryland hospitals. As discussed above, HACRP assesses a full 1 percent penalty to the 16 out of 43 hospitals that are in the worst-performing quartile nationally. Staff believes the MHAC program should continue to provide scaled rewards and penalties for RY 2028 but welcome stakeholder feedback on total revenue at risk (+/- 2 percent) and not relatively rank MD hospitals retrospectively. Modeling of HACRP scores using the HSCRC scaling approach has been suggested by stakeholders. Using FFY 2025 HACRP scores and a linear scale using the minimum and maximum actual scores and average score based on National data, the net revenue adjustments are -$27.4 million with -$38.6 M in penalties and +$11.2 M in rewards. It also should be noted that FFY 2026 scores under HACRP are not yet available on Care Compare.

Figure 13. Maryland's FFY 2025 Estimated HACRP and RY 2025 Final MHAC Revenue Adjustments

Program	Statewide Net Total	%	Penalties	%	Rewards	%
MHAC	$ 39,309,084	0.33%	$ (8,879,421)	-0.07%	$ 48,188,505	0.41%
HACRP	$ (63,317,885)	-0.53%	$ (63,317,885)	-0.53%	$ -	-

Scores and Revenue Adjustment Modeling Results

Staff has modeled hospital scores using CY 2024/RY 2026 base and performance periods. Staff has also modeled and compared the revised RY 2027 MHAC methodology to the previous methodology and continue to support the use of the composite (results not shown). Figure 14 provides the statewide revenue adjustments with and without the addition of the all-payer PSI measure. Specifically, the PSI data for CY 2024 was compared to a benchmark and threshold that was calculated in the same way as the MHAC performance standards (i.e., average of the top and button quintile from base period) and 0-100 points was assigned based on attainment only. The PPC and PSI scores were then combined by weighting the PPCs as 5/6th and PSI as 1/6th of the overall score. The cut point was the average statewide score for each scenario (i.e., 80% for PPC only and 78% for PPCs and PSI). The figure shows that penalties remain similar when the PSI is added but rewards are reduced by almost $10 M statewide. Appendix E provides the by-hospital results for both models.

Figure 14. Estimated Revenue Adjustments with and without AHRQ PSI-90

RY 2026 Modeling	PPCs Only	PPCs and PSIs
Net Total $	**$30,107,361**	**$19,680,755**
Penalty $	-$42,239,158	-$42,753,131
Percent Inpatient	-0.36%	-0.36%
Reward $	$72,346,519	$62,433,886
Percent Inpatient	0.61%	0.53%

Draft Recommendations

The draft recommendations for the RY 2028 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

1. Use Potentially Preventable Complication (PPC) composite and all-payer AHRQ Patient Safety Indicator 90 to assess hospital acquired complications.
2. Assess PPC performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs).
3. Assess hospital performance based on statewide attainment standards.
4. Set revenue at-risk at a maximum penalty at 2 percent and maximum reward at 2 percent using the average Maryland hospital score as the cut point for start of rewards.
5. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program under a non-Medicare FFS quality program.

Appendix A: Quality Program Transition under AHEAD

Below are the high-level details of quality assessments in the AHEAD Model, based on staff's current understanding of the new AHEAD State Agreement requirements and discussions with CMMI staff:

- Maryland hospitals will move to CMS hospital quality programs for Medicare FFS either for FFY 2029 or FFY 2030 payment adjustments (i.e, performance period mid-2025 through CY2027 or mid-2026 through CY2028). Staff will need to continue to request a waiver from CMMI for the all-payer programs.
- RY 2028 (i.e., CY 2026 performance) will be under Maryland all-payer policies and CMS will implement the revenue adjustments in CY 2028 for the Medicare FFS global budgets (and HSCRC will implement for all other payers).
- State may continue quality adjustments to hospital global budgets for all other payers (i.e., non-Medicare FFS) and is required to report annually to CMMI on the quality programs including measures, performance, revenue adjustments.
- State will align non-Medicare FFS quality programs with the CMS programs to reduce hospital burden where feasible and appropriate, but also consider focus areas where the state could deviate from CMS based on State, payer, or other stakeholder priorities.

Figure A1. provides a potential timelines for quality program transition.

Figure A1. Timeline Options for Quality Program Transition

Potential Timelines

Color Key	Performance	Revenue
	All Payer	All-Payer
	Medicare FFS	Medicare
	Non-Medicare	Non-Medicare

		AHEAD Performance Year ---->	Performance Year 1				Performance Year 2				Performance Year 3				Performance Year 4				Performance Year 5			
Updated 10/10/2025	RY/FY & Payer	Policy	2025				2026				2027				2028				2029				2030			
Intermediate Transition	2026 All-Payer	All	All-Payer Revenue Adjustments																			
Qualitative Description: Maintains all-payer quality assessments PY1 only, creates minimal overlap in measurement sets, has a limited revenue adjustment gap, and provides time to prepare for National measures and develop non-Medicare quality measures.	2027 All-Payer	All	Performance Period: All-Payer Quality Programs*				All-Payer Revenue Adjustments															
	2028 All-Payer	All					Performance Period: All-Payer Quality Programs with CMS VBP Alignment*				All-Payer Revenue Adjustments				Non-Medicare Medicare Revenue							
	2029 Medicare	HVBP									Performance Period: PCE & Safety Domain								Medicare Revenue Adjustments			
		HRRP					Performance Period: Medicare Readmissions															
		HACRP					Performance Period: NHSN HAIs															
			Performance Period: CMS PSI-90																			
	2029 Non-Medicare	All									Non-Medicare Quality Programs								Non-Medicare Revenue Adjustments			
	2030 Medicare	HVBP													Performance Period: PCE & Safety							
		HRRP									Performance Period: Clinical Care Domain*											
		HACRP									Performance Period: Medicare Readmissions											
											Performance Period: NHSN HAIs											
											Performance Period: CMS PSI-90											
	2030 Non-Medicare	All													Non-Medicare Quality Programs							
Latest Transition	2026 All-Payer	All	All-Payer Revenue Adjustments																			
Qualitative Description: Maintains all-payer revenue adjustments and quality assessments PY1 & PY2, creates minimal overlap in measurement sets, has a limited revenue adjustment gap, and provides time to prepare for National measures and develop non-Medicare quality measures.	2027 All-Payer	All	Performance Period: All-Payer Quality Programs*				All-Payer Revenue Adjustments															
	2028 All-Payer	All					Performance Period: All-Payer Quality Programs with CMS VBP Alignment*				All-Payer Revenue Adjustments				Non-Medicare Medicare Revenue							
	2029 All-Payer	All									Performance Period: All-Payer Quality Programs with CMS Complications Alignment*								Non-Medicare Revenue Adjustments Medicare Revenue Adjustments			
	2030 Medicare	HVBP													Performance Period: PCE & Safety							
		HRRP					Performance Period: Clinical Care Domain*															
		HACRP									Performance Period: Medicare Readmissions											
											Performance Period: NHSN HAIs											
											Performance Period: CMS PSI-90											
	2030 Non-Medicare	All													Non-Medicare Quality Programs							

*Performance periods for certain measures start earlier or vary in Maryland based on hospital size. Care Compare measures (HCAHPS, NHSN) in QBR have one year performance period starting in October.

Intermediate option means hospital performance is already under some of the CMS quality measures (i.e., condition specific mortality, THA-TKA, CMS PSI). Other measures start CY2026 (i.e., condition specific readmissions and NHSN)

Appendix B: PPC and PSI Overlap

In advance of the RY 2021 MHAC policy, performance of individual PPCs considered "overlapping" with PSI 90 component measures was done. Results of this analysis in Figure B.1. below show significant variability in the Numerator and Denominator populations and their performance rates for each matched set of PSI/PPC combinations. Payment PPCs are highlighted in grey. Known differences in populations and logic of specifications account for some of these results. As an example, both PSI 13 and PPC 38 address Sepsis, however PSI 13 covers only postoperative Sepsis while PPC 38 is for all inpatients. Other differences include Age and Major Diagnostic Category (MDC) variables. Overall, these data suggest the measure specifications are not sufficiently aligned for PSIs and PPCs to be considered comparable across most of the "overlapping" measure sets. Instead measures within each measure set would be compared to their own historical performance rates in order to understand trends. This may have implications if the PSIs were to replace PPCs in the future and would require generating historical performance data for the PSIs. An updated overlap analysis is in process and will be presented in the final recommendation. Of final note, while PPCs are more comprehensive in some of their constructs but lack national comparative performance data and benchmarks, staff believes that inclusion of both PPCs and PSIs provides for comprehensive measurement of complications acquired in the hospital and makes progress toward aligning with the HAC RP program.

Figure B.1. PPC-PSI Overlap Analysis Results, 2016-2017

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 03: Pressure Ulcer PPC 31: Pressure Ulcers	PSI and PPC	78	5%	232,044	40%
	PSI Only	1,580	95%	347,286	59%
	PPC Only	0	0%	4,511	1%
	PSI and PPC	62	26%	678,312	67%

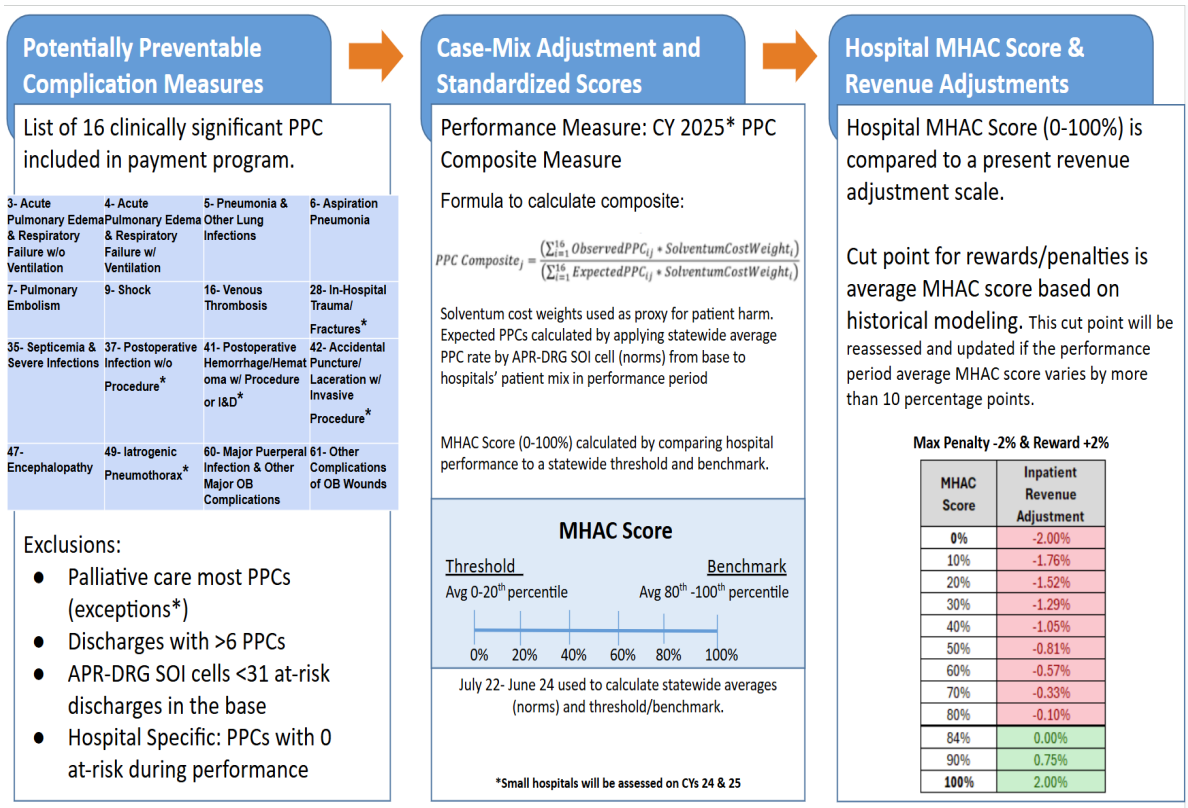
Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 06: Iatrogenic Pneumothorax Rate PPC 49: Iatrogenic Pneumothorax	PSI Only	85	35%	174,105	17%
	PPC Only	95	39%	158,280	16%
PSI 08: In Hospital Fall with Hip Fracture Rate PPC 28: In-Hospital Trauma and Fractures	PSI and PPC	46	24%	639,474	66%
	PSI Only	71	37%	76,032	8%
	PPC Only	77	40%	252,146	26%
PSI 09: Perioperative Hemorrhage or Hematoma Rate PPC 41: Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	PSI and PPC	124	21%	186,281	65%
	PSI Only	407	69%	34,501	12%
	PPC Only	62	10%	65,793	23%
PSI 10: Postoperative Acute Kidney Injury Requiring Dialysis Rate PPC 25: Renal Failure with Dialysis	PSI and PPC	18	11%	117,181	16%
	PSI Only	86	51%	17,122	2%
	PPC Only	66	39%	610,198	82%
PSI 11: Postoperative Respiratory Failure Rate PPC 03: Acute Pulmonary Edema and Respiratory Failure without Ventilation	PSI and PPC	79	5%	103,100	14%
	PSI Only	411	24%	12,119	2%
	PPC Only	1,234	72%	603,232	84%
PSI 11: Postoperative Respiratory Failure Rate PPC 04: Acute Pulmonary Edema and Respiratory Failure with Ventilation	PSI and PPC	122	9%	103,282	14%
	PSI Only	368	28%	11,937	2%
	PPC Only	819	63%	603,420	84%

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 07: Pulmonary Embolism	PSI and PPC	327	25%	193,929	22%
	PSI Only	876	67%	41,913	5%
	PPC Only	104	8%	646,464	73%
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 16: Venous Thrombosis	PSI and PPC	136	10%	193,882	22%
	PSI Only	1,067	77%	41,960	5%
	PPC Only	174	13%	646,632	73%
PSI 13: Postoperative Sepsis Rate PPC 35: Septicemia & Severe Infections	PSI and PPC	132	11%	25,838	6%
	PSI Only	305	26%	104,487	26%
	PPC Only	727	62%	270,936	68%
PSI 14: Postoperative Wound Dehiscence Rate PPC 38: Post-Procedural Infection and Deep Wound Disruption with Procedure	PSI and PPC	9	8%	44,734	16%
	PSI Only	56	53%	25,974	10%
	PPC Only	41	39%	201,391	74%
PSI 15: Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate PPC 42: Accidental Puncture/Laceration During Invasive Procedure	PSI and PPC	102	19%	118,342	13%
	PSI Only	89	16%	35,575	4%
	PPC Only	351	65%	770,804	83%

Appendix C. RY 2027 MHAC Program Methodology

In April 2025 the Commission approved staff recommendations for the Rate Year (RY) 2027 MHAC program. Figure C.1 below provides a summary overview of the approved RY 2027 MHAC methodology.

Figure C.1. Overview of RY 2027 Approved MHAC Methodology



The MHAC policy was redesigned in RY 2021 to modernize the program in alignment with the new Total Cost of Care Model. The RY 2027 final recommendations maintained the current complication measures but updated the methodology for calculating hospital scores and applying revenue adjustments. These changes are intended to address small cell size concerns and comprehensiveness of the program.

The methodology for the MHAC program measures hospital performance using the PPC composite Observed (O) /Expected (E) ratio. Expected number of PPCs are calculated using historical data on

statewide PPC rates by All Patient Refined Diagnosis Related Group and Severity of Illness Level (APR-DRG SOI). See below for details on how the expected number of PPCs are calculated for each hospital.

Observed and Expected PPC Values

The MHAC scores are calculated using the ratio of $Observed : Expected$ PPC values.

Given a hospital's unique mix of patients, as defined by APR-DRG category and Severity of Illness (SOI) level, the HSCRC calculates the hospital's expected PPC value, which is the number of PPCs the hospital would have experienced if its PPC rate were identical to that experienced by a normative set of hospitals.

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered "at-risk" for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

The rates of PPCs in the normative database are calculated for each diagnosis (APR-DRG) category and severity level by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single diagnosis and severity level is calculated as follows:

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of "at-risk" discharges

i = A diagnosis category and severity level

$$N_i = \frac{P_i}{D_i}$$

In the example, each normative value is presented as PPCs per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand discharges.

Once the normative expected values have been calculated, they can be applied to each hospital. In this example, the normative expected values are computed for one diagnosis category and its four severity levels.

Consider the following example in Figure C.2 for an individual diagnosis category.

Figure C.2. Expected Value Computation Example for one Diagnosis Category

A Severity of illness Level	B At-risk Discharges	C Observed Discharges with PPCs	D PPCs per discharge (unadjusted PPC Rate)	E Normative PPCs per discharge	F Expected # of PPCs	G Observed: Expected Ratio
			= (C / B)	(Calculated from Normative Population)	= (B x E)	= (C / E) rounded to 4 decimal places
1	200	10	.05	.07	14.0	0.7143
2	150	15	.10	.10	15.0	1.0000
3	100	10	.10	.15	15.0	0.6667
4	50	10	.20	.25	12.5	0.8000
Total	**500**	**45**	**.09**		**56.5**	**0.7965**

For the diagnosis category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column C). The overall rate of PPCs per discharge in column D, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column C) by the total number of discharges at risk for PPCs (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with PPCs for each SOI level for that diagnosis category is displayed in column E. The expected number of PPCs for each severity level shown in column F is calculated by multiplying the number of at-risk discharges (column B) by the normative PPCs per discharge rate (column E). The total number of PPCs expected for this diagnosis category is the expected number of PPCs for the severity levels.

In this example, the expected number of PPCs for the APR DRG category is 56.5, which is then compared to the observed number of discharges with PPCs (45). Thus, the hospital had 11.5 fewer observed discharges with PPCs than were expected for 500 at-risk discharges in this APR DRG category. This difference can be expressed as a percentage difference as well.

All APR-DRG categories and their SOI levels are included in the computation of the observed and expected rates, except when the APR-DRG SOI level has less than 30 at-risk discharges statewide.

MHAC Exclusions

The following exclusions are applied:

- Discharge is in an APR-DRG SOI cell has less than 31 statewide discharges; and
- Discharge has more than 6 PPCs (i.e., a catastrophic case, for which complications are probably not preventable).

Potentially Preventable Complications (PPCs) in Payment

During the RY 2021 MHAC redesign, the number of complication measures was reduced from 45+ to a subset of 14 complications that were clinically significant and actionable, as well as meeting measurement criteria such as higher statewide rates, variation across hospitals, and validity and reliability of individual PPCs. The PPCs not selected for payment are considered "monitoring PPCs" and are evaluated annually by staff and stakeholders to determine whether they should be put back into the payment program. For RY 2027, the same payment PPCs are being included as were included in the RY 2026 policy, as shown in Figure C.3. However, the two pneumonia related PPCs, which were combined previously into a single PPC referred to as PPC 67, are now assessed individually in RY 2027. Additional discussion on PPC selection for RY27 and discussion of the future of the program can be found in the policy and PMWG meeting documentation. Hospitals are now accountable for all 16 PPCs as long as they have at least one at-risk discharge for each PPC during the performance period (i.e., there is no longer a requirement of at least two expected and 20 at-risk and PPC inclusion is no longer determined during the base period).

Figure C.3. RY 2027 Payment PPCs

PPC Number	PPC Title
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
5	Pneumonia and Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis

PPC Number	PPC Title
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption without Procedure
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D
42	Accidental Puncture/Laceration During Invasive Procedure
47	Encephalopathy
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds

Performance Metric and Scoring

As stated above, for RY 2027, the performance on PPCs is assessed using a single composite measure that weights the component measures by the Solventum cost weights (as has been done previously) and the hospital-specific expected PPCs (new). Staff worked with Mathematica to test multiple ways to create a composite measure that better addressed small cell size issues and did not remove PPCs for a hospital with lower expected values. Specifically, Mathematica used data from FY 2018 through FY 2024 to model six iterations of Maryland hospital results under the existing methodology and three composite options. To inform decision making, staff assessed the content validity, predictive validity, and reliability of each composite option vs. the existing methodology across the six iterations of results. composite Option 1, which provides relatively higher weight within the composite for PPC measure based on hospital-specific expected numbers, was found to improve content validity and reliability the most and was selected for use in the program. By including all PPCs for a hospital with any at-risk discharges in the performance period, the modeling done by Mathematica shows that the number of payment PPCs evaluated increased for hospitals of all sizes. Figure C.4. shows the change in the average number of PPCs evaluated under the previous and new composite methodology by hospital size.

Figure C.4. Number of PPCs Evaluated Under Previous Method Vs. composite

Hospital Category	Number of Hospitals	Average Number of PPC Measures Evaluated using Previous Methodology	Average Number of PPC Measures Evaluated using composite Methodology
Small Hospitals	5	3.6	13.2
Medium Hospitals	13	10.5	14.2
Large Hospitals	24	13.7	15

Instead of scoring (i.e., assigning 0 to 100 points) at the individual PPC level, there is now only one threshold and benchmark value used to assess hospital performance on the PPC composite measure. The threshold and benchmark for the PPC composite measure are calculated using the base period data. As shown in the equation below, the PPC composite score is calculated as the sum of the hospital's observed PPCs times the Solventum Cost Weight for each payment PPC measure divided by the sum of the hospital's expected PPCs times the Solventum Cost Weight for each payment PPC measure.

$$PPC\ Composite_j = \frac{\left(\sum_{i=1}^{16} ObservedPPC_{ij} * SolventumCostWeight_i\right)}{\left(\sum_{i=1}^{16} ExpectedPPC_{ij} * SolventumCostWeight_i\right)}$$

The composite does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight. The expected PPCs for a PPC measure generally increases as the volume of at-risk discharges increases.

MHAC Score (0-100 percent)

Each hospital's final MHAC score was previously calculated by adding up the attainment points for each PPC and dividing by the total possible attainment points to get a percent score. Under the new scoring methodology, the PPC composite measure is compared to the threshold and benchmark and the result is the MHAC percent score. The threshold (worse performance) and benchmark (better performance) are calculated by averaging the PPC composite score for all hospitals in the bottom or top 20th percentile of performance in the base period, respectively.

If the PPC composite measure for the performance period is greater than the threshold, the hospital scores zero percent.

If the PPC composite measure for the performance period is less than or equal to the benchmark, the hospital scores 100 percent.

If the PPC composite measure is between the threshold and benchmark, the hospital scores between 0-100 percent. The formula to calculate the MHAC scores is as follows:

- MHAC Score = [99 * ((Hospital's PPC composite measure - Threshold)/ (Benchmark – Threshold))] + 0.5

Small Hospital Criteria Updates

Prior to the RY 2027 policy update, the MHAC program excluded individual PPCs for a hospital that did not meet the minimum criteria of 2 expected and 20 at-risk for any PPC in the two year "base" period. As discussed above, all hospitals with greater than zero at-risk discharges for a given PPC in the performance period, will have that PPC included in the new composite measure. Small hospitals (i.e., a hospital with less than 21,500 at-risk discharges or 22 expected PPCs in the two-year base period) will continue to be assessed using two years data.

Updated Scaling Methodology and Revenue At-Risk

The RY 2027 program uses a continuous scale with a full distribution of potential scores (scale of 0-100%) and the cut point of 84 percent (i.e., score at which penalties end and rewards begin) is based on the average hospital scores from modeling. The previously established "hold harmless zone" where hospitals were not rewarded or penalized, has been removed. Both the minimum and maximum revenue adjustment remain at 2 percent of inpatient revenue. Given the changes to the scoring methodology, the cut point for the revenue adjustment scale will be reassessed based on actual performance scores for RY 2027 and modified if the hospital average score varies by more than 10 percentage points.

RY2027 Base and Performance Periods

The base period is the historical time period used for determining performance standards, including the normative values used to calculate expected PPCs and the threshold and benchmark for scoring performance. For RY 2027 the base period is July 2022-June 2024. The performance period is CY 2025, but small hospitals will have a two year performance period (CY 2024 and CY 2025).

Appendix D: PPC Criteria and Performance

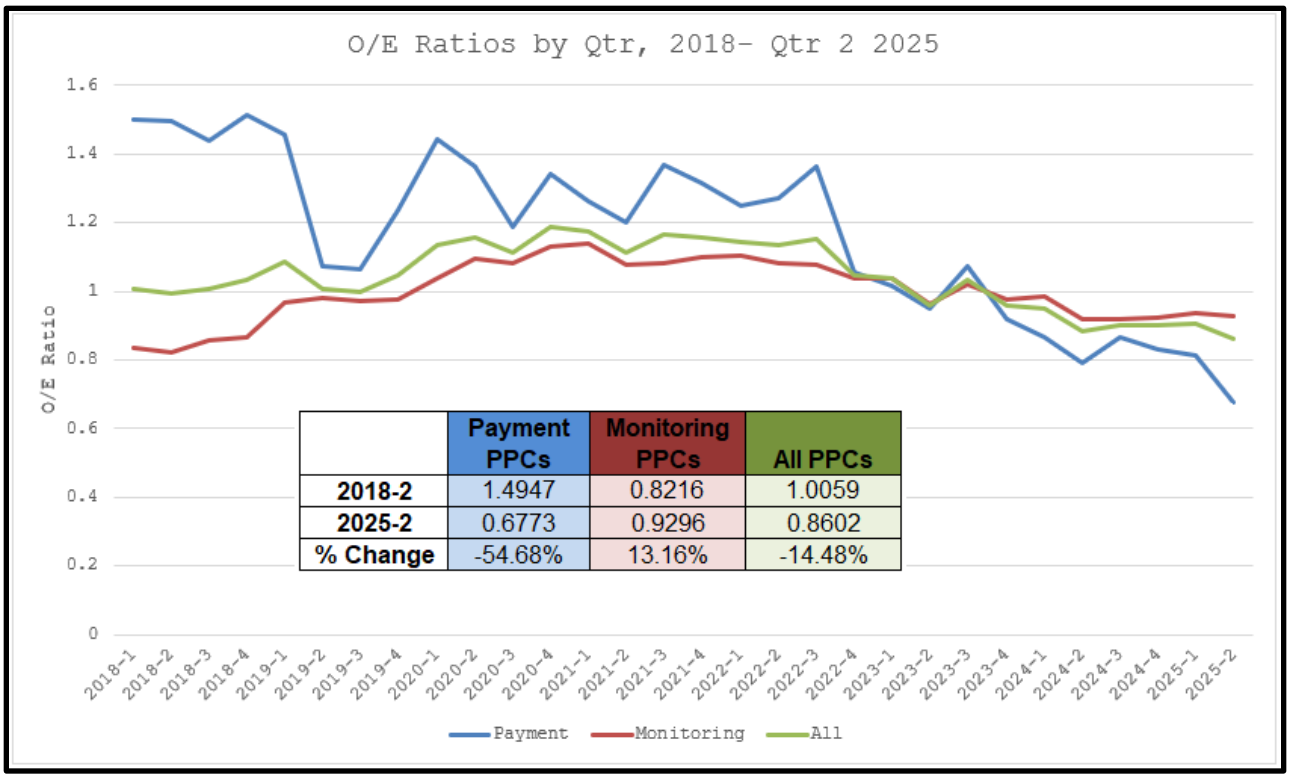
The RY 2021 MHAC policy redesign recommended monitoring the PPCs not selected for the MHAC Payment program. Each year the staff reviews PPCs results with stakeholders and determines whether any of the PPCs should be moved back into the payment program.

To determine whether any monitoring PPCs should be moved back into the payment program, staff and stakeholders have used the criteria listed below.

- PPC Data Analysis/Statistics
  - Greater than 50% increase in O/E ratio since 2018
  - Rate per 1,000 generally 0.5 or above
  - Volume of observed events 100 or above (over two years)
  - Significant variation across hospitals O/E ratios less than 0.85 and greater than 1.15
  - At least half of the hospitals are eligible for the PPC
- Additional Considerations
  - PSI overlap
  - Clinical significance
  - Potential influence of coding practices/changes
  - Opportunity for improvement/actionability
  - All-payer

Figure D.1. provides the quarterly PPC O/E ratios from CY 2018 through 2025 Q2 for monitored PPCs, payment PPCs and overall.

Figure D.1. All PPCs Observed to Expected Ratios by Quarter, CY 2018 to CY 2025 YTD



	Payment PPCs	Monitoring PPCs	All PPCs
2018-2	1.4947	0.8216	1.0059
2025-2	0.6773	0.9296	0.8602
% Change	-54.68%	13.16%	-14.48%

Appendix E: By Hospital MHAC Modeling

RY 2026 Estimated Scores			PPCs Only			PPCs and PSIs		
Hospital ID	Hospital Name	CY 24 Estimated Inpatient Revenue	MHAC Scores	Percent Adjustment	$ Adjustment	MHAC Scores	Percent Adjustment	$ Adjustment
210001	Meritus	$251,995,786	1.00	2.00%	$5,039,916	0.99	1.91%	$4,808,679
210002	UMMS- UMMC	$1,473,072,120	0.63	-0.42%	-$6,218,162	0.62	-0.41%	-$6,076,374
210003	UMMS- Capital Region	$309,492,831	0.36	-1.11%	-$3,446,840	0.30	-1.24%	-$3,845,051
210004	Trinity - Holy Cross	$413,940,590	0.53	-0.68%	-$2,835,054	0.48	-0.77%	-$3,184,252
210005	Frederick	$254,562,530	0.64	-0.41%	-$1,038,390	0.57	-0.55%	-$1,409,749
210008	Mercy	$220,664,524	0.60	-0.51%	-$1,131,723	0.64	-0.37%	-$827,466
210009	JHH- Johns Hopkins	$1,818,903,395	0.34	-1.14%	-$20,810,465	0.34	-1.12%	-$20,434,519
210011	St. Agnes	$254,764,484	0.82	0.20%	$517,386	0.81	0.27%	$698,318
210012	Lifebridge- Sinai	$519,012,883	1.00	2.00%	$10,380,258	0.96	1.60%	$8,316,472
210015	MedStar- Franklin Square	$371,862,302	1.00	2.00%	$7,437,246	0.94	1.42%	$5,276,126
210016	Adventist- White Oak	$242,890,872	0.96	1.58%	$3,833,611	0.92	1.24%	$3,006,037
210017	Garrett	$28,988,189	0.91	1.13%	$328,258	0.89	1.01%	$292,038
210018	MedStar- Montgomery	$96,052,028	0.55	-0.64%	-$611,637	0.56	-0.57%	-$547,896
210019	Tidal- Peninsula	$350,375,491	0.78	-0.06%	-$193,193	0.80	0.17%	$579,935
210022	JHH- Suburban	$249,484,035	0.70	-0.26%	-$651,946	0.68	-0.27%	-$664,905
210023	Luminis- Anne Arundel	$367,930,454	0.77	-0.08%	-$300,105	0.81	0.24%	$873,462
210024	MedStar- Union Mem	$267,917,283	0.90	1.04%	$2,781,897	0.91	1.17%	$3,123,185
210027	Western Maryland	$183,379,829	1.00	2.00%	$3,667,597	0.96	1.66%	$3,050,593
210028	MedStar- St. Mary's	$100,479,485	0.91	1.07%	$1,076,850	0.87	0.76%	$766,395
210029	JHH- Bayview	$471,786,218	0.67	-0.33%	-$1,571,608	0.62	-0.42%	-$1,989,337
210032	ChristianaCare, Union	$84,802,922	1.00	2.00%	$1,696,058	1.00	2.00%	$1,696,058
210033	Lifebridge- Carroll	$162,844,959	0.88	0.82%	$1,343,433	0.84	0.53%	$863,523
210034	MedStar- Harbor	$128,234,465	1.00	2.00%	$2,564,689	1.00	2.00%	$2,564,689
210035	UMMS- Charles	$97,586,229	0.81	0.09%	$84,700	0.77	-0.02%	-$24,239
210037	UMMS- Easton	$123,617,439	0.81	0.05%	$61,043	0.77	-0.04%	-$50,990
210038	UMMS- Midtown	$140,418,656	0.81	0.05%	$67,920	0.83	0.40%	$564,211
210039	Calvert	$80,925,064	0.68	-0.30%	-$245,568	0.70	-0.22%	-$179,285
210040	Lifebridge- Northwest	$160,861,387	1.00	2.00%	$3,217,228	0.93	1.39%	$2,233,160
210043	UMMS- BWMC	$325,584,009	0.78	-0.07%	-$220,921	0.81	0.28%	$909,865
210044	GBMC	$263,774,655	0.73	-0.17%	-$455,836	0.62	-0.41%	-$1,088,062
210048	JHH- Howard County	$220,287,562	0.46	-0.86%	-$1,887,682	0.44	-0.88%	-$1,933,999
210049	UM Upper Chesapeake	$236,862,562	1.00	2.00%	$4,737,251	0.87	0.79%	$1,875,468
210051	Luminis- Doctors	$187,232,106	0.85	0.47%	$887,645	0.87	0.85%	$1,584,150
210056	MedStar- Good Sam	$186,628,391	1.00	2.00%	$3,732,568	0.98	1.79%	$3,332,974
210057	Adventist- Shady Grove	$333,973,100	1.00	2.00%	$6,679,462	0.94	1.48%	$4,942,847
210058	UMMS- UMROI	$80,968,088	1.00	2.00%	$1,619,362	1.00	2.00%	$1,619,362
210060	Adventist-Ft. Washington	$37,782,970	0.64	-0.41%	-$153,838	0.67	-0.28%	-$104,320
210061	Atlantic General	$47,434,007	0.41	-0.98%	-$466,190	0.46	-0.83%	-$392,687
210062	MedStar- Southern MD	$210,921,411	0.95	1.49%	$3,132,806	0.88	0.91%	$1,913,613
210063	UMMS- St. Joe	$292,568,045	1.00	2.00%	$5,851,361	1.00	2.00%	$5,851,361
210064	Lifebridge- Levindale	$68,147,842	1.00	2.00%	$1,362,957	1.00	2.00%	$1,362,957
210065	Holy Cross Germantown	$94,710,748	0.83	0.26%	$245,017	0.82	0.35%	$328,408

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Medicare Performance Adjustment Calendar Year 2026

Draft Recommendation

December 2025

This is a draft recommendation for consideration by the Commission. Public comments must be received by December 22, 2025, to william.henderson@maryland.gov

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Recommendations for CY 2026 MPA Policy

This recommendation does not introduce any changes from the approved Medicare Performance Adjustment (MPA) policy from calendar year 2025 (CY 2025). The relevant policies will remain unchanged from the prior year. Staff recommend maintaining the current approach as the MPA is sunsetting when Medicare fee-for-service global budgets are implemented in 2028.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation maintains the current policy and related MPA Framework without modification.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers other than Medicare Fee-for-service. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2026 (also known as MPA Year 8). The Efficiency and Savings Component are governed via the MPA Framework adopted by the Commission in October 2019[1] (as amended in the MPA Year 6 recommendation adopted in 2024). These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount or inflator to the amount that Medicare pays on each claim submitted by the hospital.

MPA Traditional Component

Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2024, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022, 2023, 2024 and 2025 MPA policies, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are

[1] Available, starting on page 10, here: MPA Framework

calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a case-mix index (CMI) greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes, or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C

in Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D) = E

Example Calculation of MPA Targets

Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Starting last year, as described below, the rewards and penalties were scaled such that the maximum reward or penalty was 2%, which will be achieved at a 6% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 2%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.33%
Hospital B	$11,846	$11,941	0.80%	-0.27%
Hospital C	$11,792	$11,556	-2.00%	0.67%
Hospital D	$11,800	$11,033	-6.50%	2.00%
Hospital E	$11,294	$11,859	5.00%	-1.67%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program.

In the MPA Year 6 final recommendation, the Commission approved two changes to MPA policy beginning in 2024. MPA policy was revised to include an increase in the maximum revenue-at-risk as well as the addition of a population health measure to the quality adjustment included in the Traditional MPA. The amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA increased from 1% to ±2%. Increasing the revenue at risk under the MPA had been a stated goal of the Center for Medicare and Medicaid Services (CMS) for several years. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at ±6%.

In addition to increasing the revenue-at-risk, MPA policy was revised to add a population health metric to the quality adjustment included in the Traditional MPA and include it in the Calendar Year 2024 and future MPA adjustments according to the formula below (adjusted for 2% revenue-at-risk):

TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

In the MPA Year 7 final recommendation, the Commission approved a retroactive adjustment to correct the MPA savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments (NCBPs) resulting in a one-time increase to hospital rewards estimated at approximately $22.0 M from Medicare only, through Calendar Year 2023. The corrected 2024 targets were used in setting payments for that year which began July 1 of 2025. This adjustment in the MPA savings target is replicated on a go-forward basis beginning in Calendar Year 2025.

MPA Framework Reconciliation Component

Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being penalized for their non-participation. Additionally, the Offset incents participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers. In December of 2023 (MPA Year 6 recommendation), the Framework was amended to include a cap on the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

In the MPA year 7 recommendation, HSCRC revisited the CTI offset to incorporate an attainment aspect. The Commission approved tiering the stop loss applied during the offset in a way that mirrors the Traditional MPA Scaled Growth Adjustment. This will provide greater protection for hospitals with less opportunity without eliminating the incentive for all hospitals to drive savings. Table 4 shows the tiers.

Table 4: Scaled Stop Loss Tiers

Hospital Performance vs. Benchmark	Stop Loss
1st Quintile (-15% to + 1% Relative to Benchmark)	1.250%
2nd Quintile (+1% to +10% Relative to Benchmark)	1.875%
3rd Quintile (+10% to +15% Relative to Benchmark)	2.500%
4th Quintile (+15% to +21% Relative to Benchmark)	3.125%
5th Quintile (+21% to +28% Relative to Benchmark)	3.750%

Modeling using Year 2 CTI adjustments showed this change would have had the impact of shifting approximately $5 million from the highest cost quintiles to the lowest cost quintiles. Although as the portfolio of CTIs implemented changes each year the actual future impact could be less or more. However, consistent with stakeholder feedback that changes should not be applied to periods that have already been implemented, Staff implemented this change for CTIs starting July 1, 2025.

Future Areas of Focus

With no changes proposed for the Calendar Year 2026 MPA Recommendation, HSCRC staff will continue ongoing discussions with stakeholders and subject matter experts on the future of care redesign programs. Stakeholders will continue to participate in HSCRC-led workgroups throughout 2026 to provide feedback and engage in comprehensive discussions.

Maternal and Child Health Population Health Improvement Fund

Program Year Four – FY 2025

Annual Report

November 2025

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Background

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

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

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

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 6.8 percent of children have asthma.[3] As part of the proposal, the State identified two areas to improve MCH as measured by both overall reduction, as well as stratified by race and ethnicity:

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

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

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

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

Table 1. Severe Maternal Morbidity (SMM) Rates per 10,000 Deliveries, 2018 Baseline and Targets, Maryland by Race/Ethnicity[4] [5]

Race	Baseline: Including Blood Transfusions 2018	Baseline: Excluding Transfusion-Only Events 2018	2023 Year 5 Target	2026 Year 8 Target
NH White	181.4	59.0	7.5% decrease	15% decrease
NH Black	334.2	124.3	10% decrease	20% decrease
Hispanic	242.0	57.2	10% decrease	20% decrease
NH Asian	249.0	93.4	10% decrease	20% decrease
Other	205.2	59.5	10% decrease	20% decrease
Total	243.1	80.7	9.6% decrease	18.7% decrease

Table 2. Childhood Asthma-ED Visit Rates per 1,000, 2018 Baseline and Targets, Maryland by Race/Ethnicity[5]

Race	Baseline 2018	2023 Year 5 Target	2026 Year 8 Target
NH White	4.1	3.5	3.0
NH Black	19.1	14.4	9.6
Hispanic	5.4	4.7	4.0
NH Asian	2.7	2.6	2.5
Other	10.6	7.3	5.5
Total	9.2	7.2	5.3

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

[4] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.
[5] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

approval of the proposed programs (outlined below); the Department and HSCRC staff work in close partnership to oversee and monitor implementation.

Funds are added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment. Hospitals transfer funds to the Maternal and Child Health Population Health Improvement Fund ("the Fund"). The Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), receives funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners.

The Fund initially committed $8 million in annual funding from FY 2022 through FY 2025 to support Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area. House Bill 170 (2025) extended the sunset of this funding by 2 years from December 31st, 2025 to December 31st, 2027, meaning that the Department will administer this program for an additional 2 years.[6] The Budget Reconciliation and Financing Act of 2025 reallocated $13 million of the Fund to the general fund. However, Medicaid and PHPA are committed to spending down the remaining monies by 2027, and Medicaid will continue to maximize Fund dollars by pulling down federal match. The Department will evaluate sustainability plans for these investments after the Fund ends.

Funding supports the following MCH initiatives within Maryland Medicaid:

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

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

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

The initiatives were selected to build, expand, and sustain existing evidence-informed innovations in the state to ensure a continuum of support services to improve maternal and child health outcomes. These initiatives, while selected previously in FY 2022, support more recently-released action plans such as the Moore-Miller Administration 2024 State Plan, the Department's Women's Health Action Plan (May 2024) and Maryland's State Health Improvement Plan. These initiatives also align Medicaid with statewide efforts to reduce the cost of hospital care and improve access to primary care in line with our agreements with CMS through the Total Cost of Care Model and upcoming Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.

[6] 2025 Regular Session - House Bill 170/Chapter 29

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

This document serves as the annual report for the fourth year of funding and details the progress of the five Medicaid programs and the initiatives under Public Health Services; further outcome measures will be incorporated into future reports as data become available. The report culminates with a report on FY 2025 expenditures and spending plans for upcoming years.

Medicaid Programs

This section presents an overview and implementation update, in addition to demographic and utilization data for each of the Medicaid programs supported by the Fund: Home Visiting Services, doulas, CenteringPregnancy, HealthySteps, and MOM case management services. These summaries are then followed by an analysis of benefit quality performance using select maternal and child health metrics.

Table 3. Population Health Improvement Fund Medicaid Benefit Start Dates

Name	Start Date
CenteringPregnancy	January 1, 2023
Doulas	February 21, 2022
HealthySteps	January 1, 2023
Home Visiting Services	January 13, 2022
MOM Program[7]	July 1, 2021

Home Visiting Services Expansion

Program Overview

In 2017, the Department established a Medicaid Home Visiting Services (HVS) Pilot under the authority of the §1115 HealthChoice demonstration to test a service expansion initiative in Maryland aimed at improving both maternal and child health. This pilot included reimbursement for two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Both models employ specific developmental and health screenings, and have an established track record of improving the health and well-being of both the mother[8] and the child. Sites requesting coverage for this service must maintain certification of accreditation or fidelity by the national HFA or NFP organization. Effective January 13, 2022, as catalyzed by the Fund, Maryland promulgated regulations that provided coverage for both models to shift from a pilot to a new statewide benefit for Medicaid participants.

Implementation Update-PY4

As of September 2025, there are 12 sites enrolled as Medicaid providers for home visiting services, covering 14 of 24 Maryland jurisdictions. The Department continues to serve as a resource for home visiting programs as they enroll as Medicaid providers and implement Medicaid billing mechanisms.

[7] Initially launched as a small pilot program, MOM has been available statewide since January 1, 2023.

[8] This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

Since CY 2022, there were 2,531 HVS services delivered to 277 unique mothers[9] enrolled in the benefit, for an average of 9.1 visits per participant. During the same time period, there were a total of 20,013 services delivered to 746 unique children enrolled in the benefit for an average of 26.8 per participant.

Compared to the other benefits, the mothers enrolled in HVS tended to be slightly younger, with 60 percent falling between the ages of 19 and 29 at the time of enrollment. As one of the HVS models is only open to enrolled who have never had a previous live birth, a larger proportion of younger mothers is expected. Of the children enrolled in the HVS benefit, nearly three quarters are under the age of one. This distribution is likely due to the fact that most participants are enrolled while pregnant or immediately postpartum.

Geographically, the largest number of enrolled mothers live in Western Maryland (32.5 percent), followed by Southern Maryland (23.1 percent), and the Eastern Shore (19.1 percent). For children enrolled in HVS, however, the top three regions are Western Maryland (35.0 percent), the Eastern Shore (26.4 percent), and Washington Suburban (22.5 percent). While the distribution of participants may appear somewhat unexpected, this is likely due to the fact that HVS providers generally render services at the jurisdictional level. This structure likely explains why there is high enrollment being from relatively rural regions, for example Western Maryland and the Eastern Shore, as both are home to multiple HVS sites. By the same token, this may also explain why a more populous region such as Baltimore Suburban has comparatively few participants, as several jurisdictions in the region lack Medicaid HVS sites.

The most common race/ethnicity of the mothers enrolled in the benefit were White (39.7 percent), Black (31.4 percent), and Hispanic (22.0 percent). While this breakdown differs from the statewide average, it aligns almost perfectly with the race/ethnicity of individuals who gave birth in Western Maryland, Southern Maryland, and the Eastern Shore which comprise the largest proportion of HVS mothers enrolled. For the children enrolled in HVS, the most common race/ethnicity was Hispanic (41.4 percent), White (32.2 percent), and Black (20.2 percent). This does not align as closely with the breakdown of Medicaid enrollment for White and Black children of the same age in those regions, which account for 16.1 percent and 31.9 percent, respectively.

Note: for the tables below and throughout the document, small cell values (counts between one and 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

[9] This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

Table 4. Medicaid Home Visiting Services (HVS) Utilization[10] [11] [12] [13]

	HVS Mothers			HVS Children		
	Total Visits	Unique Enrollees	Per Enrollee	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-	-	-	-
CY 2022	141	31	4.5	1,130	148	7.6
CY 2023	883	130	6.8	7,156	505	14.2
CY 2024	1,507	237	6.4	11,727	642	18.3
Total	**2,531**	**277**	**9.1**	**20,013**	**746**	**26.8**

Table 5A. Medicaid Home Visiting Services (HVS) Participant Demographics: Age Groups[13] [14]

Parent

Age	HVS
Under 19	*
19 to 29	166
30 to 40	82
Over 40	*
Total	**277**

Child

Age	HVS
Under 1	553
Aged 1	112
Aged 2	65
Aged 3+	16
Total	**746**

[10] Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.
[11] This is the first year that the PHIF report has broken out the HVS data by mother and child. In previous reports, all of the participants were aggregated.
[12] As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.
[13] Data source: The Hilltop Institute
[14] The tables reflect the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

Table 5B. Medicaid Home Visiting Services (HVS) Participant Demographics: Race/Ethnicity[15] [16]

Parents

Race/Ethnicity	HVS
Asian	*
Black	87
White	110
Hispanic	61
Native American	*
Other	15
Total	**277**

Children

Race/Ethnicity	HVS
Asian	*
Black	151
White	240
Hispanic	309
Native American	*
Other	41
Total	**746**

Table 5C. Medicaid Home Visiting Services (HVS) Participant Demographics: Regions[16]

Parents

Region	HVS
Baltimore City	*
Baltimore Suburban	20
Eastern Shore	53
Southern Maryland	64
Washington Suburban	31
Western Maryland	90
Out of State	*
Total	**277**

[15] In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

[16] Data source: The Hilltop Institute

Children[17]

Region	HVS
Baltimore City	13
Baltimore Suburban	48
Eastern Shore	197
Southern Maryland	59
Washington Suburban	168
Western Maryland	261
Out of State	0
Total	**746**

Doula Reimbursement

Program Overview

Effective February 21, 2022, the Department began Medicaid coverage for doula/birth worker services to Medicaid participants. A doula, or birth worker, is a trained professional who provides continuous physical, emotional and informational support to mothers[18] before, during and after birth. Certified doulas serving Medicaid participants provide person-centered, culturally competent care that supports the racial, ethnic and cultural diversity of members while adhering to evidence-based best practices.

Under Maryland Medicaid's reimbursement model, doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits. Medicaid provides coverage for up to eight perinatal (*i.e.,* prenatal and postpartum) visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals eight or fewer visits per mother. Doulas can enroll as individual providers or be affiliated with a doula practice that bills for provided services on their behalf. To recruit more doula providers and, in line with other states' rates, Maryland Medicaid increased the reimbursement rate for attendance at labor and delivery in July 2023. All doulas must be trained by one of 30 Medicaid-approved doula certifying organizations. The Department is continually expanding this list to increase the number of enrolled doulas, as detailed below.

Doula Implementation - PY4 Update

As of the end of September 2025, there are 61 doulas enrolled as Medicaid providers, more than double the number from the previous year. During the year, the Department monitored doula provider enrollment and implemented several measures to build out the network. First, the Department permitted MCOs to use single case agreements[19] with doulas until network adequacy requirements are reached. Second, the Department updated its regulations, effective June 2024, to: 1) facilitate quicker expansion of the number of approved doula certification organizations; and 2) make the doula benefit self-referral until January 1,

[17] Data source: The Hilltop Institute

[18] This report uses the term "mother" to refer to the birthing parent. The Department recognizes and respects that individuals have a range of gender identities and do not always identify with this term.

[19] A single case agreement (SCA) is a one-time agreement between an insurance provider, in this case an MCO, and an out-of-network provider, in this case a doula.

2027 – a temporary removal of an administrative step for the doulas, *i.e.,* contracting with MCOs after registering Medicaid providers with the Department. Third, Medicaid implemented a nominations process to add additional certification programs, in order to increase the number of doulas who are eligible to become Medicaid providers. As of August 2025, there are 30 approved certification organizations; this is a major increase from the nine approved organizations when the benefit was first introduced in February 2022. The Department will host another iteration of the nominations process in the autumn of 2025. Lastly, as noted earlier, the Department increased the rate for attendance at labor and delivery from $350 to $800 on July 1, 2023.

Since CY 2022, 1,397 doulas services were delivered to 285 unique Medicaid participants, for an average of 4.9 services per participant. The sharp increase in the number of participants receiving doula services coincides with the increase in the number of enrolled providers, in addition to an increase in reimbursement rates. Maryland Medicaid will continue its efforts to partner with the Department's Maternal and Child Health Bureau (MCHB) to promote the doula benefit and bolster the doula workforce across the state.

The individuals enrolled in the doula benefit are very evenly distributed by age between the 19 to 29 and the 30 to 40 categories, at 49.8 and 47.4 percent, respectively. This aligns with the distribution of deliveries in the overall Medicaid population.

The vast majority of individuals enrolled in the doula benefit identify as Black (69.8 percent), followed by White (9.8 percent), and Hispanic (7.4 percent). This distribution reflects much of the academic literature, which describes doulas as playing a key role in improving birthing outcomes for Black individuals.

The geographic distribution of individuals enrolled in the doula benefit are predominantly located in Washington Suburban (36.5 percent) and Baltimore Suburban (33.7 percent), followed by Baltimore City (11.6 percent) and the Eastern Shore (11.2 percent). This aligns fairly closely with where the majority of Maryland's doulas are located - Washington Suburban, Baltimore City, and Baltimore Suburban regions - all of which have large Black populations.

Table 6. Medicaid Doula Services Utilization[20] [21] [22] [23]

	Doula		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	44	14	3.1
CY 2023	264	69	3.8
CY 2024	1,089	254	4.3
Total	**1,397**	**285**	**4.9**

Table 7A. Medicaid Doula Services Participant Demographics: Age Groups[22] [23]

Age	Doula
Under 19	*
19 to 29	142
30 to 40	135
Over 40	*
Total	**285**

Table 7B. Medicaid Doula Services Participant Demographics: Race/Ethnicity[22] [23] [24]

Race/Ethnicity	Doula
Asian	*
Black	199
White	28
Hispanic	21
Native American	*
Other	21
Total	**285**

[20] Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.
[21] As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.
[22] Data source: The Hilltop Institute
[23] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[24] In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

Table 7C. Medicaid Doula Services Participant Demographics: Regions[25] [26]

Region	Doula
Baltimore City	33
Baltimore Suburban	96
Eastern Shore	32
Southern Maryland	*
Washington Suburban	104
Western Maryland	12
Out of State	*
Total	**285**

CenteringPregnancy

Program Overview

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to prenatal care through CenteringPregnancy. CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. The model focuses on three core components: health assessment, interactive learning, and community building. Facilitators support a cohort of eight to 10 individuals of similar gestational age through a curriculum of 10, 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions. Discussion topics include medical and non-medical aspects of pregnancy, such as nutrition, common discomforts, stress management, labor and birth, breastfeeding, and infant care. Studies have shown that CenteringPregnancy improves health outcomes, such as decreased risk of preterm birth, as well as improves patient satisfaction.[27]

CenteringPregnancy Implementation - PY4 Update

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

By partnering with the Centering Healthcare Institute (CHI), the Department is able to expand the number of CenteringPregnancy sites and reduce maternal and infant disparities in the state. CHI provides training, technical assistance, and tools to help providers implement the CenteringPregnancy model. As of September 2025, there are 17 CenteringPregnancy sites. Eleven are currently accredited by CHI, with the remaining six expecting to receive accreditation by 2027. Currently there are seven Maryland Medicaid CenteringPregnancy providers and 13 funded by the MCHB's grant (additional detail under 'Public Health Programs', below). Medicaid anticipates that the rest of MCHB's funded providers will work towards the CenteringPregnancy model implementation, and enroll as Medicaid providers in 2025 due to the

[25] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[26] Data source: The Hilltop Institute
[27] Centering Healthcare Institute. (2020). *Centering Saves Lives & Money.* Centering Healthcare Institute: Payment Policy & Advocacy. Downloaded from: https://centeringhealthcare.org/why-centering/payment

partnership and grants from the Department's MCHB.

Since CY 2023, 4,060 CenteringPregnancy services were billed for 699 unique participants, for an average of 5.8 per participant, the demographic breakdown is below. Utilization of these services have clearly increased between CY 2023 and CY 2024, with the number of services rendered more than doubling, in addition to a large jump in unique enrollees during the same period. Medicaid will continue to work with CHI, CenteringPregnancy's parent organization, to build on this success by attending the bi-annual Centering Consortium of Maryland to connect with providers, answer Medicaid-related questions, and encourage provider enrollment in Medicaid.

The majority of participants enrolled in CenteringPregnancy reside in the Washington Suburban region (51.4 percent), followed by Baltimore City (15.3 percent) and Baltimore Suburban (15.2 percent). As CenteringPregnancy is a practice-based benefit, this geographic distribution reflects where CenteringPregnancy practices are located in Maryland. While the benefit is open to individuals in other regions, possibly fewer individuals have the time to travel such a distance for prenatal care.

The most common race/ethnicity of CenteringPregnancy enrollees is Hispanic (55.5 percent), followed by Black (30.2 percent) and White (10.6 percent). The race/ethnicity distribution of participants generally aligns with that of the regions in which the majority of enrollees live. For Washington Suburban, Baltimore City, and Baltimore Suburban combined, the largest proportion of deliveries is to Hispanic participants (41.1 percent), followed by Black (37.1 percent) and White (12.3 percent).

Individuals enrolled in CenteringPregnancy were generally younger than some of the other benefits. One possible explanation is that younger individuals or first time parents are more likely to want to participate in a group prenatal program.

Table 8. Medicaid CenteringPregnancy Utilization[28] [29] [30]

	CenteringPregnancy		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	-	-	-
CY 2023	1,341	344	3.9
CY 2024	2,719	622	4.4
Total	**4,060**	**699**	**5.8**

[28] Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.
[29] As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.
[30] Data source: The Hilltop Institute

Table 9A. Medicaid CenteringPregnancy Participant Demographics: Age Groups[31] [32]

Age	Centering Pregnancy
Under 19	54
19 to 29	409
30 to 40	215
Over 40	21
Total	**699**

Table 9B. Medicaid CenteringPregnancy Participant Demographics: Race/Ethnicity[31] [32] [33]

Race/Ethnicity	Centering Pregnancy
Asian	*
Black	211
White	74
Hispanic	388
Native American	*
Other	18
Total	**699**

Table 9C. Medicaid CenteringPregnancy Participant Demographics: Regions[31] [32]

Region	Centering Pregnancy
Baltimore City	107
Baltimore Suburban	106
Eastern Shore	55
Southern Maryland	*
Washington Suburban	359
Western Maryland	69
Out of State	*
Total	**699**

HealthySteps

Program Overview

Starting in 2022, the Department utilized the Fund to expand access to innovative approaches to early childhood well-being through HealthySteps. HealthySteps, a program of the national accrediting body

[31] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[32] Data source: The Hilltop Institute
[33] In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

"ZERO TO THREE"[34], is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention at accredited, or pending accreditation HealthySteps sites. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide referrals to external services, and follow-up to the whole family.

HealthySteps Implementation - PY4 Update
Similar to CenteringPregnancy, on January 1, 2023 the Department began providing an enhanced payment for evaluation and management (E&M) services rendered by providers at HealthySteps sites categorized as accredited or pending accreditation, following an MCO infrastructure support program. Like CenteringPregnancy, the enhanced payment supports the overall operations of HealthySteps practices, including the salary of the HealthySteps Specialist. The enhanced payment should be billed alongside each well-child visit or E&M service the child receives, regardless of the tier the child is placed into.

The first eligible provider in Maryland was University of Maryland Pediatrics Associates, in addition to three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC, and Anacostia locations). Later, Kaiser Permanente transformed its practices in South Baltimore and Woodlawn into HealthySteps sites to comply with the new Medicaid requirement in late 2023. Maryland's implementation of the HealthySteps program, including the enhanced Medicaid payment, was recognized by the Prenatal-to-3 Policy Impact Center at Vanderbilt University in 2023.[35]

Maryland's efforts align closely with recent CMS guidance,[36] clarifying Early and Periodic Screening, Diagnosis and Treatment requirements for Medicaid and CHIP, in its emphasis on improving care for children with specialized needs, early identification, and family-centric treatment of pediatric mental health disorders.

Since CY 2023, 11,719 HealthySteps services were billed for 3,428 unique participants, for an average of 3.4 services per participant, the demographic breakdown is below. Similar to CenteringPregnancy, the HealthySteps saw a steep uptake in utilization of the benefit. Between CY 2023 and CY 2024, the number in HealthySteps visits increased 168.9 percent and the number of unique participants saw a similarly large increase. Maryland Medicaid will continue to work closely with ZERO TO THREE, along with HealthySteps providers, to promote the enhanced payment of rendered HealthySteps services.

The youngest participants represented the largest portion of HealthySteps enrollees with 46.8 percent under the age of one, with the rest of the age bands accounting similar portions to one-another, ranging

[34] What We Do. (n.d.). https://www.healthysteps.org/what-we-do/
[35] Prenatal-to-3 Policy Impact Center. 2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/
[36] State Health Office Letter [#24-005]: RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. September 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

from 16.1 to 18.9 percent. This distribution is likely attributable to the fact that infants are brought to the doctor more frequently than older children.

The vast majority of enrollees reside in Baltimore City (51.8 percent) and Baltimore Suburban (43.6 percent). This distribution reflects where the limited number of HealthySteps sites are located. While individuals residing in other regions are permitted to receive the benefit, it is likely that fewer will due to the travel required.

As with other benefits with high concentrations in select jurisdictions, the distribution by race/ethnicity is closer to that of the regions in which they are located, rather than the state averages. In HealthySteps, the largest portion of enrollees by race/ethnicity are Black (70.2 percent) and Hispanic (10.7 percent). In the Baltimore City and Baltimore Suburban regions, these race/ethnicity groups also represent the largest portion of children from that group, however with fewer Black (42.4 percent) and more Hispanic (25.3 percent) participants.

Maryland Medicaid staff continue this engagement with partners through external opportunities, including presenting at the 2024 Pediatric Mental Health Summit, and updating policy experts on Maryland's strategy to support HealthySteps practices. In late PY4, the Department convened HealthySteps stakeholders to inform providers how to update their Medicaid enrollment to be eligible for the enhanced payment, as well as discuss barriers to billing. Moreover, Maryland Medicaid staff work alongside HealthySteps providers in the State by serving on the advisory board for the Health Resources and Services Administration's (HRSA) Transforming Pediatrics for Early Childhood (TPEC), University of Maryland and Johns Hopkins University High Five for P-5: Improving Health Equity Through Early Child Development Supports.

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

Table 10. Medicaid HealthySteps Utilization[37] [38] [39]

	HealthySteps		
	Total Visits	Unique Enrollees	Per Enrollee
CY 2021	-	-	-
CY 2022	-	-	-
CY 2023	3,177	1,369	2.3
CY 2024	8,542	3,138	2.7
Total	**11,719**	**3,428**	**3.4**

Table 11A. Medicaid HealthySteps Participant Demographics: Age Group[39] [40]

Age	HealthySteps
Under 1	1,606
Aged 1	621
Aged 2	552
Aged 3+	649
Total	**3,428**

Table 11B. Medicaid HealthySteps Participant Demographics: Race/Ethnicity[39] [40] [41]

Race/Ethnicity	HealthySteps
Asian	225
Black	2,408
White	170
Hispanic	367
Native American	23
Other	235
Total	**3,428**

[37] Dashes represent years in which the benefit is not yet active. The start dates are listed in Table 3.
[38] As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.
[39] Data source: The Hilltop Institute
[40] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[41] In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.

Table 11C. Medicaid HealthySteps Participant Demographics: Regions[42] [43]

Region	HealthySteps
Baltimore City	1,775
Baltimore Suburban	1,493
Eastern Shore	*
Southern Maryland	*
Washington Suburban	131
Western Maryland	11
Out of State	0
Total	**3,428**

MOM Case Management Services (MOM Program)

Program Overview

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

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

MOM Program Implementation - PY4 Update

MOM program services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year before expanding to select counties a year later. Starting January 1, 2023, the MOM program became available statewide, open to all eligible HealthChoice members. As of the end of September 2025, there have been 169 pregnancies to 166 unique participants in the MOM program; several participants have re-enrolled for subsequent pregnancies. A demographic breakdown of the unique MOM participants is listed below. Program participants to date have demonstrated an interest in engaging in treatment for their OUD, as well as efforts to change life circumstances, including enrolling in educational courses, learning to drive and securing stable housing. The program experienced a sharp increase in enrollment following the statewide expansion in CY 2023. The annual enrollment remained similar between CY 2023 and CY 2024 however there was a decrease in the number of visits per enrollee.

Of the benefits, MOM had the oldest enrollee base with 63.9 percent of participants between the ages 30

[42] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[43] Data source: The Hilltop Institute

to 40. Internal MOM data indicates that this is not the first child for a significant portion of MOM enrollees.

Geographically, the largest portion of MOM enrollees reside in Western Maryland (38.5 percent), followed by Baltimore Suburban (23.8 percent) and Baltimore City (16.4 percent). There are several possible explanations for this distribution, one being that the opioid epidemic is not equally spread across the state, some regions have higher rates than others. Zip codes with some of the highest rates of fatal opioid overdose are located in these regions. While not a one-to-one comparison, this may serve as a proxy for prevalence of OUD.

As with other benefits concentrated in select jurisdictions, the race/ethnicity breakdown of MOM enrollees differs from the statewide average. The largest portion of enrollees is White (71.3 percent), followed by Black (13.9 percent). This aligns more closely with the data from Western Maryland, where White participants account for 47.9 percent of deliveries; however this data represents the general population of this region, not specifically individuals with OUD.

In CY 2024, the Department leveraged support from both the Fund and CMMI to continue our partnership with the Maryland Addiction Consultation Service (MACS) to augment MOM's impact. Through the partnership, MACS continued the MACS for MOMs program to build provider capacity to better treat the maternal OUD population. The program includes teleECHO clinics, a warmline for phone consultations, and a variety of trainings, including those for receiving a DATA 2000 Waiver which allows providers to prescribe buprenorphine. Funding for MACS for MOMs has since transitioned over to MCHB.

In CY 2024, the Department worked closely with MCOs to help identify best practices for outreach, and implemented a new billing process to allow MCOs to submit electronic encounters for the MOM program.

Table 12. Medicaid MOM Program Utilization[44] [45] [46]

	MOM		
	Total Months	**Unique Enrollees**	**Per Enrollee**
CY 2021	14	*	*
CY 2022	39	*	*
CY 2023	477	58	8.2
CY 2024	384	59	6.5
Total	**914**	**122**	**7.5**

[44] The MOM benefit is reimbursed by member-month, therefore the utilization is listed by month.
[45] As some individuals were enrolled across calendar years, the totals at the bottom of the table may not align with the sum or average of the rows.
[46] Data source: The Hilltop Institute

Table 13A. Medicaid MOM Participant Demographics: Age Group[47] [48]

Age	MOM
Under 19	*
19 to 29	42
30 to 40	78
Over 40	*
Total	122

Table 13B. Medicaid MOM Participant Demographics: Race/Ethnicity[47] [48] [49]

Race/Ethnicity	MOM
Asian	0
Black	17
White	87
Hispanic	*
Native American	*
Other	12
Total	122

Table 13C. Medicaid MOM Participant Demographics: Regions[47] [48]

Region	MOM
Baltimore City	20
Baltimore Suburban	29
Eastern Shore	13
Southern Maryland	*
Washington Suburban	*
Western Maryland	47
Out of State	0
Total	122

PY4 Medicaid Performance

Methodology

To assess the outcomes of the Maryland Medicaid MCH Initiatives, the Hilltop Institute at the University of Maryland, Baltimore County analyzed the administrative data from the program participants, based on several relevant HEDIS measures, value sets, and Centers for Disease Control and Prevention (CDC) definitions.[50] For the purposes of the analysis, all program participants were identified based on FFS claims

[47] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.
[48] Data source: The Hilltop Institute
[49] In cases where an individual is listed as Hispanic along with any race, they are categorized as "Hispanic". The "Other" category includes individuals listed as two or more races, individuals with an unknown race, in addition to other identities.
[50] Some programming deviates from HEDIS specifications based on the specific program structures, as needed.

and MCO encounters that include the program-specific procedure codes, provider types, and ICD-10 diagnosis codes designated by the Department.

Due to enrollment increases and the decision to aggregate data for all calendar years, the PY4 report is the first year that there is a sufficient number of participants for the metrics to be reported at the program level without a large number of cells having to be suppressed.

Results are presented for enrollees who had at least one qualifying visit as well as enrollees who met the minimum evaluation inclusion criteria. To meet the inclusion criteria for the evaluation, HVS, HealthySteps, doula services, and CenteringPregnancy participants were required to have at least three visits, and MOM program participants had to be enrolled in the program for at least three months. All enrollees who met the inclusion criteria and were enrolled after their respective programs' start dates were flagged as evaluation-eligible. In addition to the data for enrollees in the benefits, this analysis presents a comparison group for each of the benefit populations: CenteringPregnancy - Mothers, Doula - Mothers, MOM - Mothers, Home Visiting Services - Mothers, Home Visiting Services - Children, and HealthySteps - Children. To create the comparison groups for the mothers, the Hilltop Institute performed a matching analysis that identified recently pregnant Medicaid participants who had similar characteristics as an enrollee in one of the PHIF benefits. The characteristics for the mother comparison groups include age (at program entry), region, comorbidity score[51], race, cohort year (i.e. calendar year in which pregnancy/birth occurred), and OUD diagnosis (for the MOM comparison group only). For the child comparison groups, the Hilltop Institute selected matching individuals based on age (at program entry), region, race and cohort year (birth year). In cases where the Hilltop Institute was unable to find an exact match they selected an individual with a very similar characteristic, for example selecting a 28 year old instead of a 29 year old. Only individuals who were enrolled in a benefit at the time a metric was measured were included in the calculations; for example, if someone were to enroll in home visiting services at 20 weeks gestation, they would not be included in the metric for early initiation of prenatal care since they were not yet receiving the benefit's services.

All records were deduplicated so that each enrollee had one record that contained their enrollment start date, the number of program visits or number of months enrolled, and the evaluation eligibility flag. When applicable, each enrollee was then sorted into a cohort by calendar year according to the enrollment start date. Thereafter, the demographic variables birth data, sex, and region were obtained and merged from Hilltop Medicaid data sets. The 1184 newborn data set[52] was used to merge infants to their mothers and mothers to their infants where possible, keeping the infants' birth weight, sex, and date of birth.

Separately, Hilltop used the diagnoses and the revenue and procedure codes provided by the Department to identify claims and encounters for cesarean deliveries, SMM, birth complications, and child developmental screenings. Identified claims and encounters were collapsed per program enrollment year with flags

[51] A person's comorbidity level is estimated based on the Johns Hopkins Adjusted Clinical Groups (ACG) methodology, which uses claims data to classify individuals based on their projected and/or actual utilization of health care services. Hilltop assigns individuals to one of four comorbidity categories (Low, Moderate, High, Very High) based on their claim records in the measurement years

[52] Hospitals are required to complete the 1184 Newborn Form and submit it to Medicaid for children born of Medicaid-eligible mothers in order to enroll the newborn in the mother's MCO effective on the date of birth.

indicating if they experienced the above medical conditions. HEDIS software was used to provide the flags indicating whether enrollees had timely prenatal visits, postpartum care, childhood immunizations, child well-care visits and neonatal intensive care unit (NICU) admission. Medical and procedure flags were then merged with the cohort data sets to create a data set of mother and infant pairs with enrollee demographics and evaluation and measure flags.

It should be noted that although enrollment has increased, the counts may be small for certain metrics, particularly ones where an outcome is expected to be rare (e.g. birth complications). Again, for the tables below and throughout the document, small cell values (less or equal to 10) are suppressed with an asterisk in accordance with CMS' guidelines to protect Medicaid participant confidentiality.

Quality Performance Highlights[53]

Overall, the PY4 data shows promising results for a variety of metrics, for both the mothers and children enrolled in the benefits.

- CenteringPregnancy: As a practice-based benefit, CenteringPregnancy enrollees had particularly strong results for metrics related to perinatal visits, specifically the timely initiation of prenatal care, in addition to postpartum visit completion rates.
    - Timely Initiation of Prenatal Care: Participants enrolled in CenteringPregnancy were **14.6 percent more likely** than the comparison group to initiate prenatal care in a timely manner.
    - Postpartum Care Visits: Individuals enrolled in CenteringPregnancy were **12.4 percent more likely** to complete a postpartum visit than their comparison group.

- Doulas: Individuals enrolled in the doula benefit performed particularly well for metrics measured during the prenatal period and at the time of delivery, namely timely initiation of prenatal care and cesarean delivery rates. This aligns with the timing of when the majority of enrollees received their doula care.
    - Timely Initiation of Prenatal Care: Participants enrolled in the doula benefit were **13.3 percent more likely** than the comparison group to initiate prenatal care in a timely manner.
    - Cesarean Births: Enrollees in the doula benefit saw a **20.6 percent lower** rate of cesarean deliveries than their comparison group.

- HealthySteps: As a practice-based benefit, HealthySteps enrollees had particularly high completion rates for metrics related to pediatric practices, most notably child well-care visits.
    - Well-Care Visits: Children enrolled in HealthySteps had a well-care visit completion rate **16.6 percent higher** than the comparison group, at a **99.8 percent completion rate**.

- Home Visiting Services: Individuals enrolled in HVS performed well in a fairly wide variety of metrics, with particularly strong results for timely initiation of prenatal care (for the mothers), as well as immunizations and well-care visit rates (for the children).
    - Immunizations: Children enrolled in HVS had a higher vaccination rate for each of the immunizations measured than the comparison group, ranging from a **177.5 percent to a**

[53] Unless otherwise stated, data in this section reflects individuals in the "meets evaluation criteria" group.

258.7 percent increase.

- Well-Care Visits: Children enrolled in HVS had a well-care visit completion rate **6.9 percent higher** than the comparison group, at a **97.9 percent completion rate.**

- MOM: Individuals in MOM tended to show especially positive outcomes for metrics measured after enrollees had been in the benefit for some time, specifically lower cesarean delivery rates and improved postpartum visit completion rates.
  - Cesarean Births: Enrollees in the MOM benefit saw a **19.0 percent lower rate** of cesarean deliveries than their comparison group.
  - Postpartum Care Visits: Individuals enrolled in MOM were **30.0 percent more likely** to complete a postpartum visit than their comparison group.

Data Results

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

Timely Initiation of Prenatal Care

Prenatal care plays a crucial role in supporting healthier pregnancies and infants; the early initiation of prenatal care - ideally in the first trimester - is particularly important. The data shows that individuals enrolled in the HVS, doula, and CenteringPregnancy benefits were far more likely to complete a timely prenatal visit than those in the comparison groups. This difference was particularly apparent for individuals in the doula services and CenteringPregnancy benefits who performed 13.3 percent to 14.6 percent higher than their comparison groups. This result was expected for those in CenteringPregnancy since the benefit centers around prenatal visits; the doula benefit aligns with studies that show individuals receiving doula care have greater attendance at prenatal visits.[54] While enrolled in the MOM benefit did not have as high a completion rate than those in their comparison, there was a clear improvement between those in the "at least one qualifying" and "meets evaluation criteria" groups, showing that a higher "dose" of the MOM benefit is associated with an increased rate of timely initiation of prenatal care.

[54] Falconi, A., et. al., (2022). Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. eClinicalMedicine, Volume 50, 2022, 101531, ISSN 2589-5370, https://doi.org/10.1016/j.eclinm.2022.101531.

Table 14. Deliveries in where Participant had a Prenatal Visit in the First Trimester, on or before the Enrollment Start Date or within 42 Days of Enrollment in the Organization[55] [56]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	69	86.3%	71	60	84.5%	166	132	79.5%
Doula Services	78	63	80.8%	58	47	81.0%	144	103	71.5%
CenteringPregnancy	108	96	88.9%	76	69	90.8%	298	236	79.2%
MOM[57]	34	19	55.9%	29	18	62.1%	81	54	66.7%

Postpartum Care Visits - Seven through 84 Days

After giving birth, a postpartum care visit provides an important opportunity to evaluate the mother's healing from labor and delivery, in addition to screening for postpartum depression. Two of the benefits, CenteringPregnancy and MOM, had higher completion rates than their respective comparison groups. This increase was particularly pronounced for the MOM benefit where the "meets evaluation criteria" group had a 30.0 percent higher rate than the comparison group. While individuals in the MOM benefit had lower completion rates than those in the other benefits, the MOM comparison group is also substantially lower than the other comparison groups.

Of individuals who enrolled in one of the benefits in the first trimester, postpartum completion rates were markedly higher. For this population, all four of the benefits showed a markedly higher completion rate than their respective comparison groups. This increase was particularly notable for individuals enrolled in the doula, CenteringPregnancy, and MOM benefits, which saw an increase ranging from 19 percent to 68 percent. When compared with participants who enrolled at any point in the pregnancy, individuals who enrolled during the first trimester consistently performed better, ranging from 7 percent to 21 percent. The cause of this improvement is not definitive, the "enrolled during the first trimester" comparison groups tended to do slightly better than "enrolled any time during the pregnancy" comparison groups, however not enough to account for the total increase. This suggests that individuals who enrolled earlier in the benefit and therefore had been in the benefit for longer when this metric was measured, meaning they had had a higher "dose" at that point.

The Department attempted to perform an analysis to establish whether visits from a doula during the postpartum period is associated with a higher postpartum visit completion rate, however there was insufficient data at this time.

[55] Data source: The Hilltop Institute

[56] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[57] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

Table 15A. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, Participants Enrolled Anytime During the Pregnancy[58] [59]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	83	71.6%	102	74	72.5%	428	306	71.5%
Doula Services	158	116	73.4%	120	88	73.3%	289	213	73.7%
CenteringPregnancy	184	146	79.3%	140	117	83.6%	830	617	74.3%
MOM[60]	56	33	58.9%	50	30	60.0%	143	66	46.2%

Table 15B. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 84 days after Delivery, Participants Enrolled During First Trimester[58] [59]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	62	77.5%	71	55	77.5%	166	124	74.7%
Doula Services	78	68	87.2%	58	51	87.9%	144	106	73.6%
CenteringPregnancy	108	96	88.9%	76	71	93.4%	298	232	77.9%
MOM	34	24	70.6%	29	21	72.4%	81	35	43.2%

Postpartum Care Visits - Seven through 120 Days

As part of discussions to improve timely attendance at a postpartum visit, stakeholders raised the possibility that participants are attending their postpartum visit beyond the 84 day postpartum period due to lack of appointment availability. To account for this, the analysis added an additional metric which extended the time period of postpartum visit to 120 days following the birth.

The data shows a very slight improvement in postpartum visit completion rates for participants in the HVS, doula, and CenteringPregnancy benefits when compared with the “within 84 days” metric. The comparison groups for each of the three benefits also showed a similar change between the two time spans. As with the “within 84 days" metric, the data showed that individuals enrolled in a benefit in the first trimester were more likely to complete a postpartum visit. The increase between the “enrolled during the first trimester” and “enrolled at any point during the pregnancy” groups was nearly identical to that of the “within 84 days” metric; the same was also observed for their respective comparison groups.

The enrollees in the MOM benefit showed no change between the “within 84 days” and the “within 120 days” metrics. It appears that the participants who completed their postpartum visits did so in a timely manner. As with the “within 84 days” metric, enrollees in the MOM and

[58] Data source: The Hilltop Institute

[59] The table reflects the sum of unique participants since the benefit’s inception. These start dates are listed in Table 3.

[60] The MOM benefit is reimbursed by member-month, therefore the “at least one qualifying visit” and “meets evaluation inclusion criteria” groups refers to the number of visits, rather than discrete visits.

CenteringPregnancybenefits were far more likely to complete a postpartum visit than those in their respective comparison groups.

Table 15C. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, Participants Enrolled Anytime During the Pregnancy[61] [62]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	86	74.1%	102	77	75.5%	428	318	74.3%
Doula Services	158	118	74.7%	120	89	74.2%	289	216	74.7%
CenteringPregnancy	184	149	81.0%	140	119	85.0%	830	627	75.5%
MOM[63]	56	33	58.9%	50	30	60.0%	143	70	49.0%

Table 15D. Deliveries in where Participant had a Postpartum Care Visit on or between 7 and 120 days after Delivery, Participant Enrolled During the First Trimester[61] [62]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	80	66	82.5%	71	59	83.1%	166	127	76.5%
Doula Services	78	69	88.5%	58	52	89.7%	144	108	75.0%
CenteringPregnancy	108	98	90.7%	76	72	94.7%	298	230	77.2%
MOM	34	24	70.6%	29	21	72.4%	81	38	46.9%

Cesarean Births

While cesarean births can be warranted in some cases, reducing unnecessary cesareans is a priority in maternal health.

The enrollees in the MOM and doula benefits both showed markedly lower cesarean delivery rates than their respective comparison groups. This is particularly notable as both of the comparison populations had extremely high cesarean rates, far higher than the state average.[64] For the doula benefit, the lower rate aligns with the literature that has shown doulas are associated with a reduction in cesarean deliveries.[65] While a reduction in cesarean deliveries is beneficial for many

[61] Data source: The Hilltop Institute

[62] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[63] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

[64] CDC, (n.d.). "Cesarean Deliveries: Birth Data Maps." https://www.cdc.gov/nchs/state-stats/births/cesareans.html

[65] Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus, 15(5), e39451. https://doi.org/10.7759/cureus.39451; Alvarado, G. et. al.., (2024). United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies, Women's Health Issues, Volume 34, Issue 4, 350-360. https://www.whijournal.com/action/showCitFormats?doi=10.1016%2Fj.whi.2024.03.001&pii=S1049-3867%2824%29000 21-5

populations, it is particularly so for individuals with OUD, like those enrolled in the MOM benefit. Many individuals with OUD also live with pain issues[66] and a surgery, such as a cesarean delivery, can exacerbate it. Post-surgery pain management while avoiding a recurrence of use (i.e. relapse) can pose difficulty for individuals with OUD.[67]

Enrollees in the HVS benefit had similar cesarean delivery rates to those in the comparison group. The rates were slightly worse for the "meets evaluation criteria" group than the "at least one qualifying" group.

Of the four benefits, CenteringPregnancy was the only one where enrollees were more likely to have a cesarean delivery than the comparison group. This data was also notable because the "meets evaluation criteria" group had a significantly higher rate than those in the "at least one qualifying" group. Because of this difference in the data, the Department performed an additional analysis to further investigate this trend. Additionally, the data showed that many enrollees delivered at one specific hospital with a high level birthing center, and these enrollees were more likely to have a cesarean. However this may simply indicate that there was something about the patient that necessitated a higher level of care. While there is no clear cause for a higher cesarean rate for individuals in the "meets evaluation criteria" group, one potential explanation is that individuals with even a slightly higher risk pregnancy may be more likely to attend multiple prenatal visits, meaning that they will be more concentrated in that analysis group.

Table 16. Deliveries that were Cesarean Section among Participants[68] [69]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	32	27.6%	102	31	30.4%	166	49	29.5%
Doula Services	158	54	34.2%	120	41	34.2%	144	62	43.1%
CenteringPregnancy	184	64	34.8%	140	56	40.0%	298	100	33.6%
MOM[70]	56	20	35.7%	50	18	36.0%	81	36	44.4%

[66] Hser, Y. I., Mooney, L. J., Saxon, A. J., Miotto, K., Bell, D. S., & Huang, D. (2017). Chronic pain among patients with opioid use disorder: Results from electronic health records data. Journal of substance abuse treatment, 77, 26–30. https://doi.org/10.1016/j.jsat.2017.03.006

[67] Ellis, J. D., Cairncross, M., Struble, C. A., Carr, M. M., Ledgerwood, D. M., & Lundahl, L. H. (2019). Correlates of treatment retention and opioid misuse among postpartum women in methadone treatment. Journal of addiction medicine, 13(2), 153-158.

[68] Data source: The Hilltop Institute

[69] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[70] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

Severe Maternal Morbidity

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

Table 17. Pregnancies Associated with Severe Maternal Morbidity among Participants[71] [72]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	0	0.0%	102	0	0.0%	166	0	0.0%
Doula Services	158	0	0.0%	120	0	0.0%	144	0	0.0%
CenteringPregnancy	184	*	*	140	*	*	298	0	0.0%
MOM[73]	56	0	0.0%	50	0	0.0%	81	0	0.0%

Birth Complications

Birth complications, while related to SMM, refer to any problems that occur during labor and delivery that affect the mother or baby.[74] As with any type of medical complication, reducing ones that occur during birth are a priority. The data shows preliminary positive results for this metric: three of the benefits had no instances of SMM and the remaining one had very few instances of it.

Table 18. Deliveries that had Birth Complications among Participants[71] [72]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Numer	Percent	Denom	Numer	Percent	Denom	Numer	Percent
HVS	116	*	*	102	*	*	166	*	*
Doula Services	158	0	0.0%	120	0	0.0%	144	0	0.0%
CenteringPregnancy	184	0	0.0%	140	0	0.0%	298	*	*
MOM[75]	56	0	0.0%	50	0	0.0%	81	0	0.0%

Infant Birth Weight

Infant birth weight can be a good indicator of the newborn's overall health. Low birth weight (less than 2,500 grams) and very low birth weight (less than 1,500 grams)[76] can be caused by a variety of factors including gestational age, multiple gestation pregnancies, maternal health, and environmental

[71] Data source: The Hilltop Institute

[72] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[73] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

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

[75] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

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

factors. Since infants being of very low birth weight is a relatively rare occurrence, there were not a reportable number for any of the four benefits, requiring that the low birth weight data also be suppressed. Due to this issue, the Department elected to only report the number of infants born of normal birth weight.

The proportion of infants of normal birth weight whose mother was enrolled in HVS, doula services, and CenteringPregnancy were generally similar to those in their respective comparison groups. While the proportion of infants of normal weight whose mother was enrolled in in the MOM program was similar between the "meets evaluation criteria" and the comparison groups, there was a clear improvement between "any qualifying" and the "meets evaluation criteria" groups. This indicates that mothers who received the MOM benefit for a longer period of time had better outcomes. The reason that a smaller proportion of individuals in the MOM program have an infant of a normal birth weight compared to those enrolled in the other benefits may be related to the fact that those with prenatal exposure to opioids are at a greater risk of being of low birth weight.[77]

Table 19. Newborns who are Normal Birth Weight for all Participants Enrolled before Delivery[78] [79]

	Any Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Normal Weight	Percent	Denom	Normal Weight	Percent	Denom	Normal Weight	Percent
HVS	116	103	88.8%	102	90	88.2%	166	150	90.4%
Doula Services	158	142	89.9%	120	105	87.5%	144	124	86.1%
CenteringPregnancy	184	173	94.0%	140	131	93.6%	298	275	92.3%
MOM[80]	56	44	78.6%	50	41	82.0%	81	66	81.5%

Neonatal Intensive Care Unit (NICU) Admissions

In cases where a newborn is experiencing health issues following its birth, they may be admitted to a NICU of a hospital. While important for treatment, these admissions can be stressful for the family and newborn, as well as costly. At this time, the Department has elected not to present the NICU admissions data as the counts are extremely low and it would be difficult to draw any conclusions from the results. Although still a very small number, the MOM benefit and their comparison both had more NICU admissions than the other benefits. This aligns with what is known about the population - infants exposed to opioids or medications for the treatment of OUD are at risk for a condition called neonatal abstinence syndrome (NAS) which often requires them to be admitted to the NICU.

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

[78] Data source: The Hilltop Institute

[79] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[80] The MOM benefit is reimbursed by member-month, therefore the "at least one qualifying visit" and "meets evaluation inclusion criteria" groups refers to the number of visits, rather than discrete visits.

Child Well-Care Visits

An important tool for keeping children healthy is that they receive a well-child visit from a provider at the cadence recommended by the American Academy of Pediatrics. The data shows that both HVS and HealthySteps had higher rates of children with any well-care visits than their respective comparison groups. The Department had anticipated the very high HealthySteps completion rate since the benefit is administered by the same provider office that provides the well-care visits; however the HVS completion rates were more notable as this benefit is offered by a completely different entity, often a local health department.

Table 20. Children with at least one Qualifying Visit who Received a Well-Care Visit during the Calendar Year by Program Enrollment[81] [82]

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria			Comparison Group		
	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care	Denom	Ave Well-Care Visits per Child	Children with Any Well-Care
HVS	692	5.5	97.5%	624	5.7	97.9%	2,597	3.9	91.6%
Healthy Steps	3,428	3.0	98.1%	1,764	4.0	99.8%	8,606	3.0	85.6%

Childhood Immunizations

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

Children enrolled in the HVS benefit - both those in "at least one qualifying" and "meets evaluation criteria" - had significantly higher vaccination rates than those in the comparison group. For several vaccinations, those in the "meets evaluation criteria" were greater than three times more likely to receive the vaccine.

For each of the vaccinations, HealthySteps enrollees had markedly lower completion rates than their comparison group. One possible explanation for the comparatively lower vaccination completion rates for individuals enrolled in the HealthySteps benefit is that many of the participants likely are served by the same small group of primary care providers. Because of this commonality, any differences associated with these provider's vaccination claims apply to all of the participants in the benefit,

[81] Data source: The Hilltop Institute

[82] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

artificially lowering the average. The Department will continue to monitor the vaccination completion rates for this population.

Table 21A. Children Aged 2 Years Old Enrolled in Home Visiting Services (HVS) and HealthySteps that Received Childhood Immunizations[83] [84]

		Denom	DTAP	IPV	MMR	HiB	HepB	VZV
HVS	At Least One Qualifying Visit	611	20.3%	23.6%	27.7%	25.2%	21.3%	27.3%
	Meets Eval. Inclusion Criteria	558	21.1%	24.7%	29.0%	26.5%	22.4%	28.7%
	Comparison Group	2,550	7.4%	8.9%	9.7%	9.3%	6.6%	9.6%
Healthy Steps	At Least One Qualifying Visit	2,227	6.7%	7.7%	8.7%	7.8%	7.4%	8.5%
	Meets Eval. Inclusion Criteria	1,480	5.9%	6.8%	7.6%	6.9%	6.7%	7.4%
	Comparison Group	7,339	11.7%	14.9%	17.5%	16.0%	12.4%	17.5%

Table 21A. Cont.

		Denom	PCV	HepA	RV	Influ	Combo 3
HVS	At Least One Qualifying Visit	611	21.4%	28.2%	21.1%	13.1%	15.7%
	Meets Eval. Inclusion Criteria	558	22.6%	29.6%	22.2%	13.8%	16.5%
	Comparison Group	2,550	7.7%	9.9%	7.7%	4.1%	4.6%
Healthy Steps	At Least One Qualifying Visit	2,227	6.7%	8.8%	7.2%	5.7%	6.2%
	Meets Eval. Inclusion Criteria	1,480	6.0%	7.6%	6.8%	5.3%	5.5%
	Comparison Group	7,339	12.9%	17.3%	12.8%	7.0%	8.3%

[83] Data source: The Hilltop Institute

[84] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

Table 21B. Vaccination Acronym List

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

Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool

Screenings for developmental, behavioral, and social delays using a validated standardized tool allow for earlier identification, meaning that appropriate therapies can be initiated sooner.

The data for this metric shows that both HVS and HealthySteps had completion rates either equivalent to or better than the comparison groups. Within each benefit, however, completion rates decreased over time. One notable trend is that the annual number of children screened remained fairly constant year over year (i.e. the numerator) however the rate decreased steadily as there was a sharp increase in the number of children enrolled in each benefit (i.e. the denominator).

While the completion decreased for both benefits, it was far greater for HealthySteps. There are several possible explanations for this change. First, HealthySteps has a somewhat complex claims/encounters submissions procedure, wherein providers are able to receive an enhanced payment for all pediatric evaluation and management (E&M) or well-child visits, not just ones where the child development specialist participates. It is possible that at the start of the benefit, some HealthySteps providers were only submitting the claim when the screening was performed, meaning that the ratio would be much higher. As providers became more familiar with the model, they began submitting claims/encounters as the Department intended, however this may have artificially lowered the completion rates. Another possibility is that as new providers became accredited, they had different billing procedures. Since there are so few HealthySteps providers, even one new provider could create noticeable changes to the annual rates. The Department will investigate this change further.

Table 22A. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 1[85]

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	38	71.1%	38	71.1%	213	63.4%
	CY 2023	159	66.0%	151	67.5%	180	63.3%
	CY 2024	233	65.7%	219	65.8%	203	62.6%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	356	83.4%	284	85.9%	924	50.3%
	CY 2024	700	51.0%	519	55.7%	2,269	51.5%

Table 22B. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 2[85]

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	29	79.3%	29	79.3%	103	62.1%
	CY 2023	80	77.5%	73	76.7%	121	62.0%
	CY 2024	133	65.4%	131	65.6%	112	63.4%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	256	84.8%	149	88.6%	463	59.0%
	CY 2024	597	47.2%	388	60.1%	1,300	62.2%

Table 22C. Children who were Screened for Risk of Developmental, Behavioral and Social Delays using a Standardized Tool, Aged 3[85]

Program	Year	Any Qualifying Visit		Meets Eval. Inclusion Criteria		Comparison Group	
		Denom	Percent	Denom	Percent	Denom	Percent
HVS	CY 2022	20	90.0%	18	88.9%	27	74.1%
	CY 2023	50	76.0%	47	76.6%	18	55.6%
	CY 2024	61	68.9%	58	69.0%	14	64.3%
HealthySteps	CY 2022	-	-	-	-	-	-
	CY 2023	246	66.7%	102	69.6%	515	48.9%
	CY 2024	518	37.5%	210	56.2%	1,001	54.3%

Doula-Specific Metrics

The doula benefit has three different visit types (prenatal visits, postpartum visits, and attendance at labor and delivery); participants have the option of selecting which types they wish to receive, up to nine visits per

[85] Data source: The Hilltop Institute

pregnancy. Since each participant has a different combination of visits, the Department elected to perform an analysis, comparing outcomes from the different visit types.

Four metrics were selected for this analysis. The first two metrics were for SMM and birth complications, comparing participants who had a doula at labor and delivery with those who had a doula but not during the delivery. Since there was not a single instance of either SMM or birth complications of anyone in the doula benefit, the analyses could not be performed. The third metric was completion of a postpartum care visit between seven and 84 days, comparing the participants who had a doula visit in the postpartum period and those who had a doula visit but not during the postpartum period (i.e. a prenatal visit and/or attendance at labor and delivery. Of individuals who receive doula services, relatively few receive doula visits in the postpartum period, therefore there were not enough to publish the analysis at this time. The fourth metric was for cesarean delivery, comparing participants who had a doula at labor and delivery with those who had a doula but not during the delivery. This metric did have sufficient data for an analysis, outlined below.

Cesarean Births among Doula Program Enrollees with and without a Doula at the Delivery

Of the individuals who received "any qualifying visit" of doula services, there was little difference in cesarean delivery rates between those who had a doula present at labor and delivery and those who did not. However when comparing those in the "meets evaluation criteria", there was a small decrease in cesarean deliveries among the enrollees who had a doula present at the birth. This indicates that the combination of prenatal visits *and* attendance of a doula at labor and delivery is associated with a reduction in cesarean deliveries. In addition to Table 23A, the data from this metric is presented as a contingency table in Table 23B which shows the number of individuals for the "exposure" categories (i.e. presence of a doula at labor and delivery) and the number of individuals for the "outcome" categories (i.e. cesarean delivery).

Table 23A. Number of Cesarean Deliveries among Doula Program Enrollees with and without a Doula at the Delivery[86] [87]

Program	Any Qualifying Visit				Meets Eval. Inclusion Criteria			
	Doula at Delivery	Denom	Cesarean Delivery	Percent	Doula at Delivery	Denom	Cesarean Delivery	Percent
Doula	Yes	91	31	34.1%	Yes	82	27	32.9%
	No	67	23	34.3%	No	38	14	36.8%

[86] Data source: The Hilltop Institute

[87] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

Table 23B. Contingency Table of Cesarean Deliveries among "Any Qualifying Visit" Doula Program Enrollees with and without a Doula at the Delivery[88] [89]

		Cesarean Performed		
		Yes	No	Total
Doula at Delivery	Yes	31	60	**91**
	No	23	44	**67**
	Total	**54**	**104**	**158**

Public Health Programs

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

Maternal Health Initiatives

Home Visiting Expansion

Program Overview

Home visiting programs can impact maternal morbidity in different ways, including: 1) creating human-to-human relationships that enable home visitors to provide tailored support based on the specific needs of each family; 2) reducing pregnancy-induced hypertensive disorders (e.g. preeclampsia), preterm birth, and maternal depression; 3) reducing barriers to care by connecting mothers and health practitioners (nurses, pediatric care, specialists, etc.); 4) providing screenings for maternal depression both prenatal and postpartum and connecting mothers in need with the appropriate community-based behavioral health care; 5) providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and 6) targeting social determinants of health (SDOH) affecting families, such as social support, parental stress, access to health care, income and poverty status and environmental conditions.[90]

The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds 18 jurisdictions and 21 programs that meet federal evidence-based criteria across Maryland. Maryland Medicaid reimburses ten MIECHV sites operating under the Nurse-Family Partnership and Healthy Families America models. As part of the Department's efforts to improve maternal and population health, the Department is awarding a total of $2.44 million over four years (August 15, 2022 through June 30, 2026) to four sites through the Fund. Three of those sites also receive MIECHV funding. In FY25, the Department supported an additional Nurse Family

[88] Data source: The Hilltop Institute

[89] The table reflects the sum of unique participants since the benefit's inception. These start dates are listed in Table 3.

[90] Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program a Report to Congress. 2016, mchb.hrsa.gov/sites/default/files/mchb/programs-impact/reportcongress-homevisiting.pdf.

Partnership program.

Implementation Update

Since Fall 2022, the Department has supported four sites to provide expanded home visiting models. Two sites (Montgomery County and Washington County) are utilizing funds to expand existing home visiting programs, while the other two sites (Baltimore Healthy Start and Family Tree) utilize funds to pilot a new, evidence-based home visiting curriculum. In Fall 2024, the Department supported an existing Nurse Family Partnership Program (St. Mary's County). What follows is a brief description of each of the five sites.

Montgomery County Health Department utilizes funding to expand its prenatal care coordination initiative Babies Born Healthy (BBH) to connect its participants to home visiting services and offers the March of Dimes Becoming A Mom (BAM) curriculum for those who wish to participate through group classes or individual sessions. This program enhances maternal understanding through a collaborative community-based model of care, offering prenatal education and ensuring access to quality prenatal care. The program focuses on providing services to the following high-risk zip codes in Montgomery County: 20903, 20904, 20906, and 20912.

Washington County Health Department began the expansion of their existing home visiting services via the local program affiliate of HFA, which is currently funded by MIECHV. The program successfully organizes and conducts family groups where home visiting staff convene families for educational and social experiences. Families describe the family groups as invaluable, where they facilitate meaningful connections among families, provide essential parenting insights, and create a platform for the sharing of experiences. The Washington County Health Department is a Medicaid-enrolled HVS provider, meaning that the expansion will further benefit the Fund's Medicaid investments as well.[91]

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

The Family Tree facilitated the expansion of home visiting services in Baltimore City through the Parents as Teachers (PAT) model. Home visitors conduct regular visits, supporting families from pregnancy through their child's kindergarten year. The PAT curriculum addresses critical areas including mental health, nutrition, maternal depression, substance use and domestic violence. The program received PAT certification in FY2023, and has since been able to recruit and onboard staff to grow the PAT home visiting initiative. The program's collaborative efforts extended to partnerships

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

with the following organizations: Health Care Access Maryland (HCAM), Urban Strategies, and The Parent Helpline.

St. Mary's County Health Department utilized funding for their Nurse Family Partnership (NFP) program through MIECHV. NFP is an evidence-based community health program offered to first-time moms facing significant socioeconomic barriers who struggle to access the resources and support needed to achieve the best health and wellness outcomes. The program pairs a first-time mom with a specially educated nurse, who will make regular visits with the mom starting in the early stages of pregnancy and lasting until the child's second birthday. This funding was used for outreach activities to the community for the recruitment of families into the program.

In FY 2025, fund-supported Home Visiting Expansion Initiatives enrolled 104 families to home visiting programs in priority jurisdictions. Table 24 indicates the number of those enrolled by race and ethnicity, Table 25 indicates the number enrolled by insurance provider, and Table 26 indicates the timing of enrollment. The majority of the home visiting sites experienced challenges with recruitment of home visiting staff for the expansion of their programs. In FY 2026, The Department will focus on shifting the funding focus from expansion of home visiting expansion to sustainability planning for grantees.

Table 24. Number of Enrolled in Fund-Supported Home Visiting Expansion by Race/Ethnicity in FY 2025[92]

Race/Ethnicity	No. Enrolled
non-Hispanic White	13
non-Hispanic Black	69
Hispanic	17
non-Hispanic Asian	*
non-Hispanic Native American/ Alaska Native	0
non-Hispanic Multiracial	*
Total	104

[92] Data source: Maryland Department of Health, Maternal and Child Health Bureau

Table 25. Number of Enrolled in Fund-Supported Home Visiting Expansion by Insurance Provider[93]

Enrolled Insurance Type	No. Enrolled
Medicaid	94
Private	0
Uninsured	*
Other	*
Total	104

Table 26. Number of Enrolled in Fund-Supported Home Visiting Expansion by Timing of Enrollment[93]

Timing of Enrollment	No. Enrolled
1st Trimester	14
2nd Trimester	50
3rd Trimester	24
Postpartum/Unknown	16
Total	104

In FY 2025, the five sites enrolled 104 new participants in home visiting programs with demographics as follows:

- 66 percent of enrollees identified as non-Hispanic Black
- 45 percent were ages 25-34 years old
- 90 percent were enrolled in Medicaid
- 85 percent of enrollments happened during the prenatal period
- 94 participants reported an end in pregnancy, all of which ended in a live birth

Increasing Access to CenteringPregnancy Sites

Program Overview

The effectiveness of CenteringPregnancy is shown most dramatically among Black birthing persons in Maryland, who disproportionately experience adverse maternal outcomes. In response to the disproportionate SMM rates affecting Black birthing persons in Maryland, the Department has reserved a total of $429,197 from the fund for a period of four years (from FY 2022 to FY 2026) for the implementation of

[93] Data source: Maryland Department of Health, Maternal and Child Health Bureau

CenteringPregnancy. Braided with state general funds, this will result in a total of $846,194 for the expansion of 13 additional CenteringPregnancy sites across Maryland. In alignment, participating non-Federally Qualified Health Center (FQHC) practices may be eligible for Medicaid's CenteringPregnancy enhanced reimbursement benefit, detailed above.

Implementation Update
During FY 2022 to FY 2025, PHIF funding was allocated to expand CenteringPregnancy in five new sites across Maryland. In FY 2024 and FY 2025, funding for six additional sites was allocated using braided funding from the Babies Born Healthy (BBH) program, a program whose goal is to reduce disparities in infant mortality. In FY 2026, the BBH program will continue to fund the expansion of two additional sites. This expansion will result in a total of 13 funded sites and aims to enhance quality maternal healthcare access, particularly for at-risk populations.

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

Since 2022, the Department has partnered with the **Centering Healthcare Institute** to support the recruitment and provision of start-up funds to sites interested in implementing the CenteringPregnancy model. Based on an open application process and assessment of readiness, four prenatal clinics, strategically located in Baltimore County, Montgomery County, and Prince George's County, were recruited in FY 2023 and FY 2024. Utilizing the braided BBH funding, Centering Healthcare Institute recruited an additional four sites in FY 2024, located in Baltimore City, Frederick, and Montgomery Counties. In FY 2025, they recruited one additional site in Montgomery County. One site had to close due to leadership changes. The active sites implemented by Centering Healthcare Institute include:

- Baltimore Medical System at Yard 56
- CCI Greenbelt
- CCI Health Services Silver Spring
- Chesapeake Health Care
- Frederick Health
- Greater Baden Medical Services: Capitol Heights II
- Kaiser Permanente Gaithersburg Medical Center
- Kaiser Permanente Largo
- Luminis Health Greenbelt
- Luminis Health Women's Collaborative Care
- Maternal Care Center at Shady Grove
- Mercy Medical Center
- Michel Mirowski Medical Office Building OBGYN
- University of Maryland Baltimore Washington Medical Group - Glen Burnie
- University of Maryland Women's Center
- Women's Health Associates (U of Maryland - St Joseph's Medical Center)

In FY25, seven of the sites received accreditation from the Centering Healthcare Institute. In FY25, MCHB worked with Medicaid to facilitate connections and encourage provider enrollment, and will continue in FY26.

Site timelines may differ depending if they entered during the two-year Centering Implementation Plan, or the one-year Centering365 model. All sites receive the same high-quality technical assistance, training, and support from the Centering Healthcare Institute. Once accredited or pending accreditation, Maryland Medicaid provides enhanced reimbursement to CenteringPregnancy-certified providers and MCOs that are enrolled in the CenteringPregnancy model, thus allowing for sustainability.

Improving Childhood Asthma Initiatives

Program Overview

Environmental home visiting programs have been shown to improve childhood asthma outcomes, including adolescent asthma, by addressing asthma triggers in the home and other related environments. This section describes the efforts of the Department to improve childhood asthma outcomes. The Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program benefits children suffering from moderate to severe asthma by providing up to six home visits from a local health department (LHD) community health worker (CHW), facilitated by a supervising case manager. The program emphasizes cooperative goal setting with the family to reduce or eliminate asthma triggers such as environmental tobacco smoke, pets, fabrics, the presence of vermin due to inadequate sanitation, or other critical objectives.

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

Implementation Update

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

The program also ensures care coordination amongst providers who interact with the child through the use of asthma action plans. In FY 2025, 962 children with asthma received services through this program. In support of the goal of addressing health disparities, 63 percent of the children with asthma served in the program were Black or African American.

Table 27. Children with moderate to severe asthma served in the Medicaid/CHIP Home Visiting program, by jurisdiction (2020-2025)[94] [95]

Jurisdiction	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Anne Arundel	-	-	-	92	158	158
Baltimore	*	*	14	122	146	182
Baltimore City	17	40	183	251	331	254
Charles	46	*	*	11	*	12
Dorchester	86	17	24	57	32	51
Frederick	13	12	*	18	24	19
Harford	263	109	82	96	59	18
Montgomery	-	-	-	23	72	178
Prince George's	49	31	84	36	*	*
St. Mary's	*	53	36	35	35	26
Wicomico	54	38	85	66	22	60
Total	**530**	**315**	**521**	**807**	**897**	**962**

Improving Referrals to Local Health Department Asthma Home Visiting Programs

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

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

[94] The addition of Anne Arundel and Montgomery County, and expanded staffing of the 9 original jurisdictions, was made possible in 2022 with additional funding through the Health Services Cost Review Commission. That funding ends in 2027.

[95] Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

Taken together, these strategies have significantly increased referrals to LHD home visiting programs and improved the recruitment of families into the program. In particular, on September 8, 2022, the first direct electronic referrals of children with recent emergency department visits or hospitalizations due to asthma were from CRISP to LHDs and have continued at the rate of at least 10 children per LHD per week. Table 28 below shows the growth in and impact of CRISP referrals on asthma enrollment in the home visiting program over time.

Table 28. Number and Status of Children Referred to Local Health Department Home Visiting Programs by CRISP, 2022-2024[96]

Status of Child/Family	CY 2022	CY 2023	CY 2024	Total
Attempting to enroll/determine eligibility or pending eligibility determination	67	94	464	625
Could not contact family	454	1033	1076	2563
Family/child discharged from Program	207	340	439	986
Family/child eligible and enrolled in Program	16	56	160	232
Family/child eligible but declines participation in Program	295	994	1060	2349
Family/child lost to follow up	141	336	168	645
Family/child NOT eligible for Program	110	350	334	794
Total	**1290**	**3203**	**3701**	**8194**

Community-Based and Other Programs Focused on Asthma

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

The GHHI program used a tiered intervention approach to conduct interventions to reduce exposures to

[96] Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

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

Tier I Asthma Trigger Reduction Interventions included:

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

Tier II Higher Level Asthma Trigger Reduction Interventions included:

- Air purifying machine installation
- Dehumidifier installation
- Air conditioner installation
- Intermediate to Severe IPM-Integrated Pest Management
- Mold remediation
- Plumbing repair
- CO/smoke detector installation
- Door replacement
- Gutter replacement
- Stabilization of baseboards
- Air filter replacement
- Caulk building corners
- R-9 Fiberglass
- Dryer vent install
- Drain cleaning

There were delays at the Department in making both awards to GHHI from the original intended start date of August 19, 2022 to the actual contract award letter in April 2023. This resulted in delays in starting the project

that affected initial enrollment. Nonetheless GHHI received 2,300 referrals of children ages two to 17 in Baltimore City and Prince George's County who were diagnosed with asthma and whose asthma are deemed to be uncontrolled. The final report summarizes the objectives and final count of clients enrolled for each jurisdiction:

> Objectives: The original intention was to enroll a total of 210 children in the Program over 42 months (3.5 years). GHHI started serving clients in Prince George's County after receiving their award letter in April 2023 and hiring staff. Because of these delays from the originally planned start date of August 2022, MDH agreed to consolidate the deliverables of Years 1 and 2. As of April 30, 2024, GHHI had met its original goal for Years 1-2 of the award (90 families served). The Year 3 goal of 60 clients served by June 30, 2024 was not met; only 50 clients were enrolled and served. GHHI had ten unserved clients from its Year 4 goal of 60 clients, which then increased the target to 70 clients. In FY 2025, GHHI exceeded its goal by enrolling 71 clients.

Table 29. Findings and Enrollment from the Baltimore City and Prince George's County Regional Catalyst Award Asthma Initiatives, FY 2023 - FY 2025[97]

	Number of Regional Catalyst Clients Served			
	FY23	**FY24**	**FY25**	**Total**
Baltimore City	98	102	118	318
Prince George's	10	130	71	211
Total	**108**	**232**	**189**	**529**

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

> Objectives: A total of 280 children were to be enrolled in the Program over 42 months. In the first two years of the program, SFYs 2022 and 2023, GHHI enrolled 98 families through that period. However, GHHI exceeded their goals for SFYs 2024 and 2025, enrolling 102 and 118 families, respectively. In total, GHHI served 318 households, exceeding their goal of 280 households throughout the program period.

Asthma Community of Practice (CoP) and Provider Education

The Asthma Community of Practice (CoP) was created by EHB with the vision that all people and families living with asthma in Maryland receive the best possible care through information and resource sharing. The purpose of the Asthma CoP is to:

1. Serve as a forum to exchange best practices and information regarding asthma treatment, management, and prevention;
2. Improve collaboration among stakeholders involved in asthma care; and

[97] Data source: Maryland Department of Health, Environmental Health Bureau, Medicaid/CHIP Lead and Asthma Home Visiting Program

3. Ensure that Marylanders with asthma get the best possible care and access to prevention services.

In FY 2025 EHB successfully held three Asthma CoP meetings (dates: October 10, 2024; January 14, 2025; March 20, 2025). More than 100 people now receive invitations to the meetings, and represent asthma stakeholders across the state, including care providers, academic researchers, parents, insurance companies and MCOs, medical systems, local health departments, school health personnel, and community health workers.

Public Health Program Performance

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

While the asthma home visiting program was significantly affected by the COVID-19 pandemic and subsequent public health response, by late 2023 the home visiting programs had returned to essentially normal operations. Data on emergency department admissions took slightly longer to return to their pre-pandemic baseline and trajectory, but as noted elsewhere in the report, they have now fully done so. The Department remains committed to achieving the SIHIS goals, and to continuing childhood asthma emergency department rate reductions.

Severe Maternal Morbidity Performance

Statewide Performance

The State's SMM rate has increased since 2018 and remains above the State's 2018 baseline. In FY 2023, an SMM literature review was conducted to better understand the continued rise in SMM cases. The literature review suggested that blood-transfusion-only events may artificially inflate the prevalence of SMM and in 2021 Federal partners (HRSA) updated the SMM indicators to exclude blood transfusions alone, due to lack of specificity.[98] Other significant contributors of elevated SMM rates revealed in the literature review included: COVID-19, comorbidities, hypertension, mental health, racial disparities, clinical level, and patient factors. In FY 2024, the Department began working with CRISP to understand the impact of blood transfusions on the state SMM rate. This is in response to an update made by HRSA to remove blood transfusions as one of the procedure codes in its definition of SMM. Upon further analysis, the Department and CRISP discovered that blood-transfusion-only events account for 66 percent of all SMM events. In January 2024 CRISP updated their dashboard to show SMM rates with blood transfusion and SMM rates excluding blood-transfusion-only events.

Based on data through June 2025, Maryland had 316.1 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 118.4 hospitalizations per 10,000 higher than the 2026 target

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

(197.6) and 73.0 hospitalizations per 10,000 higher than the 2018 baseline (243.1). Over the same period, approximately two thirds of the SMM events that occurred involved blood transfusions only. Removing these events, the SMM rate of cases with blood transfusion-only events excluded was 111.0 events per 10,000 delivery discharges.

Figure 1. SMM Hospitalizations for Rolling 12- Months, 2018 - June 2025[99]

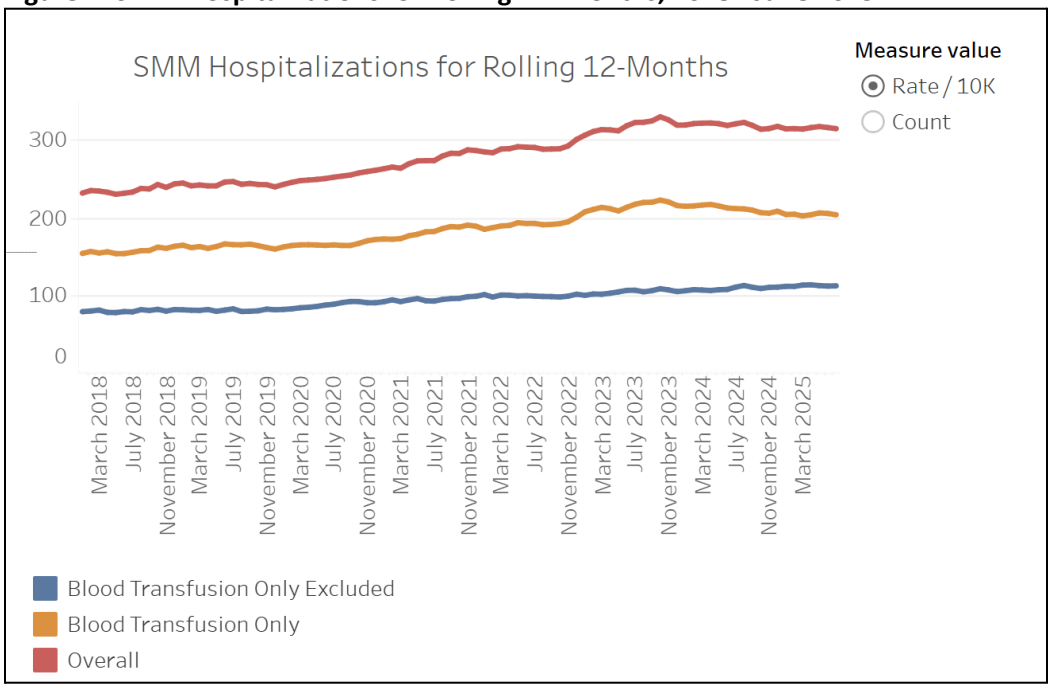


Table 30A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland[99]

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	243.1	9.6% decrease (219.8)	316.1	18.7% decrease (197.6)	-118.4
SMM Events	1,585		1,876		
Eligible Deliverables	65,199		59,354		

[99] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

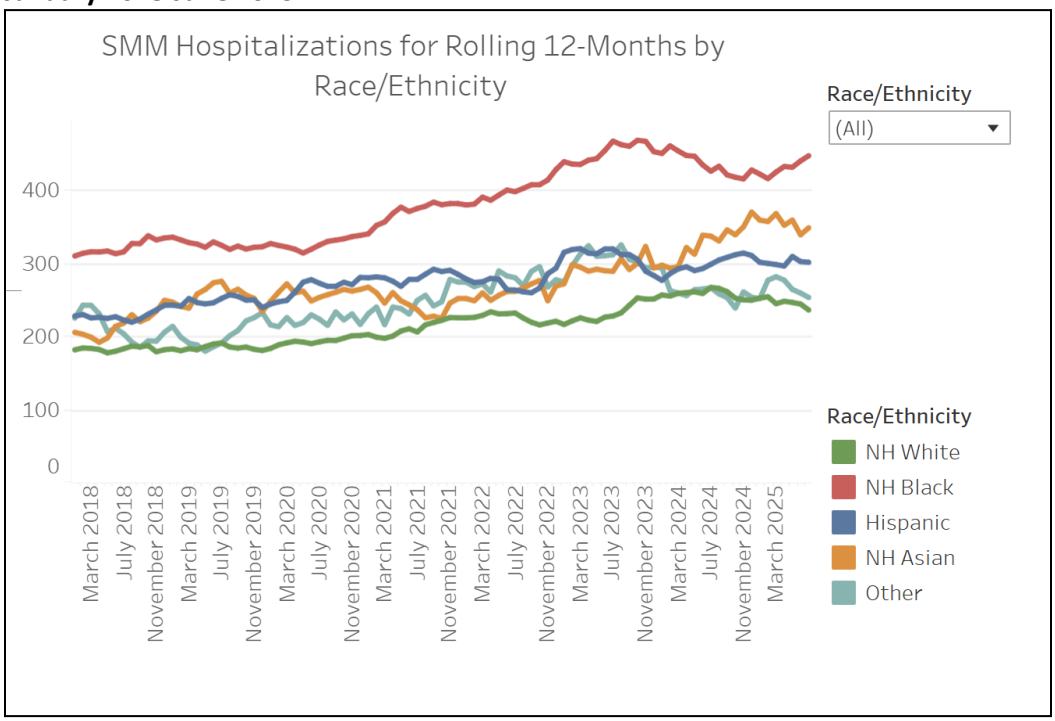
Table 30B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland[100]

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rate per 10,000	80.7	9.6% decrease (72.9)	111.0	18.7% decrease (65.6)	-45.4
SMM Events	526		659		
Eligible Deliverables	65,199		59,354		

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

Figure 2A, Figure 2B, Table 31A, and Table 31B show SMM rates disaggregated by race and ethnicity. While disparity gaps have decreased slightly compared to last year's report, substantial progress is still required to meet the 2026 target rates.

Figure 2A. SMM Hospitalizations, Including Blood Transfusions, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2025[100]



[100] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

Figure 2B. SMM Hospitalizations, Excluding Blood Transfusion-Only Events, for Rolling 12-Months by Race/Ethnicity, January 2018-June 2025[101]

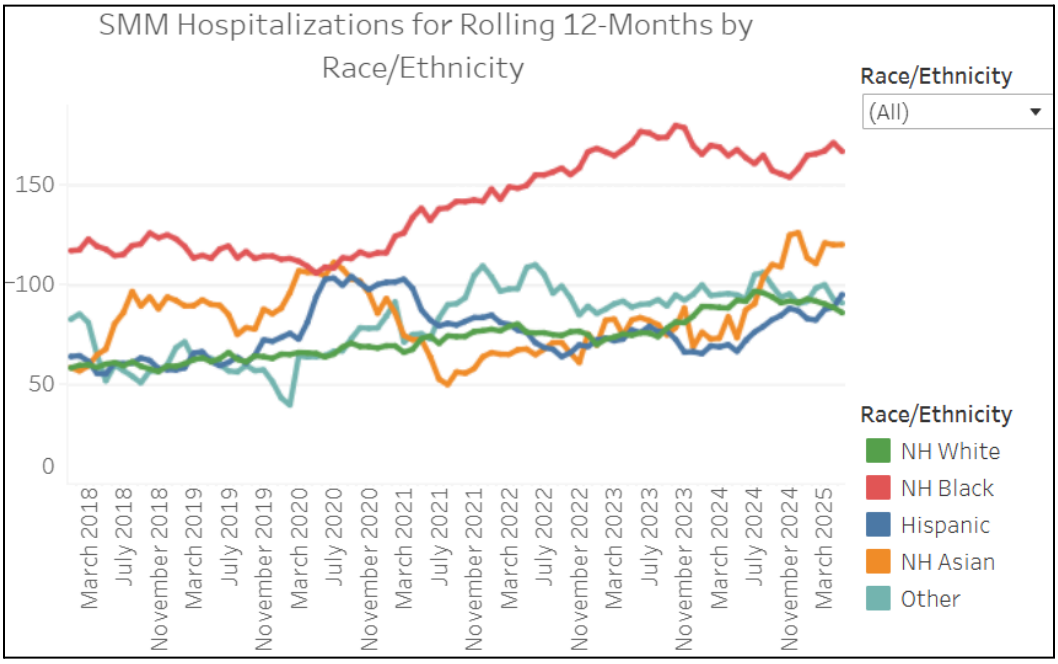


Table 31A. SMM Rates per 10,000 Deliveries, Including Blood Transfusions, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland by Race/Ethnicity[102]

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	181.4	7.5% decrease	243.8	15% decrease	-89.6	1.0
NH Black	334.2	10% decrease	440.2	20% decrease	-172.8	1.8
Hispanic	242.0	10% decrease	301.8	20% decrease	-108.2	1.2
NH Asian	249.0	10% decrease	338.5	20% decrease	-139.3	1.4
Other	205.2	10% decrease	258.8	20% decrease	-94.6	1.1
Statewide Total	**243.1**	**9.6% decrease**	**316.1**	**18.7% decrease**	**-118.4**	**1.3**

[101] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

[102] Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized August 2025.

Table 31B. SMM Rates per 10,000 Deliveries, Excluding Blood Transfusion-Only Events, 2018 Baseline, Targets, and Observed July 2024-June 2025 Rates, Maryland by Race/Ethnicity [103]

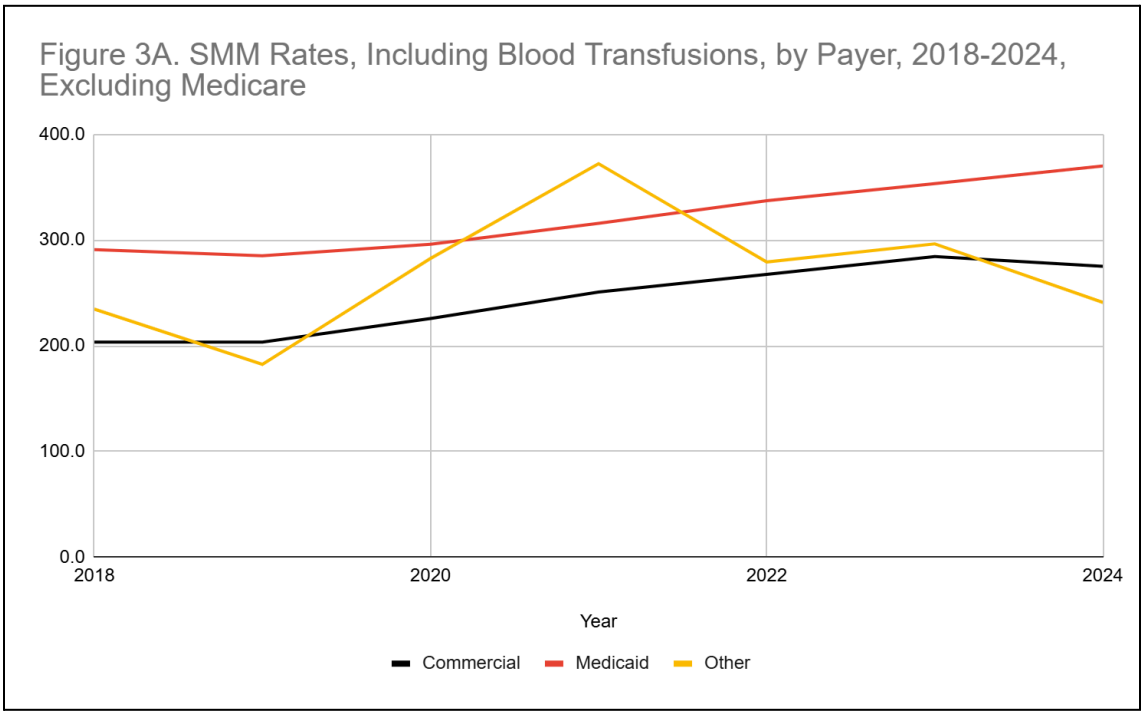
Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	59.0	7.5% decrease	85.5	15% decrease	-35.3	1.0
NH Black	124.3	10% decrease	169.2	20% decrease	-69.7	2.0
Hispanic	57.2	10% decrease	89.0	20% decrease	-43.2	1.0
NH Asian	93.4	10% decrease	112.8	20% decrease	-38.1	1.3
Other	59.5	10% decrease	93.9	20% decrease	-46.3	1.1
Statewide Total	**80.7**	**9.6% decrease**	**111.0**	**18.7% decrease**	**-45.4**	**1.3**

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward for SMM rates, in line with Statewide performance (Figure 3A and Figure 3B). Additionally, while Medicaid SMM rates are higher than commercial SMM rates, both including and excluding blood transfusions, Medicaid SMM rates have grown at a slower pace than commercial SMM rates since 2018. SMM rates and percent increases are highest among individuals with Medicare, though counts are low and rates may be unstable; interpret with caution (Tables 32A and 32B).

[103] Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized August 2025.

Figure 3A. SMM Rates, Including Blood Transfusions, by Payer, 2018-2024, Excluding Medicare[104] [105]



[104] Data Source: MCHB Data & Epidemiology Program analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

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

Figure 3B. SMM Rates, Excluding Blood Transfusion-Only Events, by Payer, 2018-2024, Excluding Medicare[106]

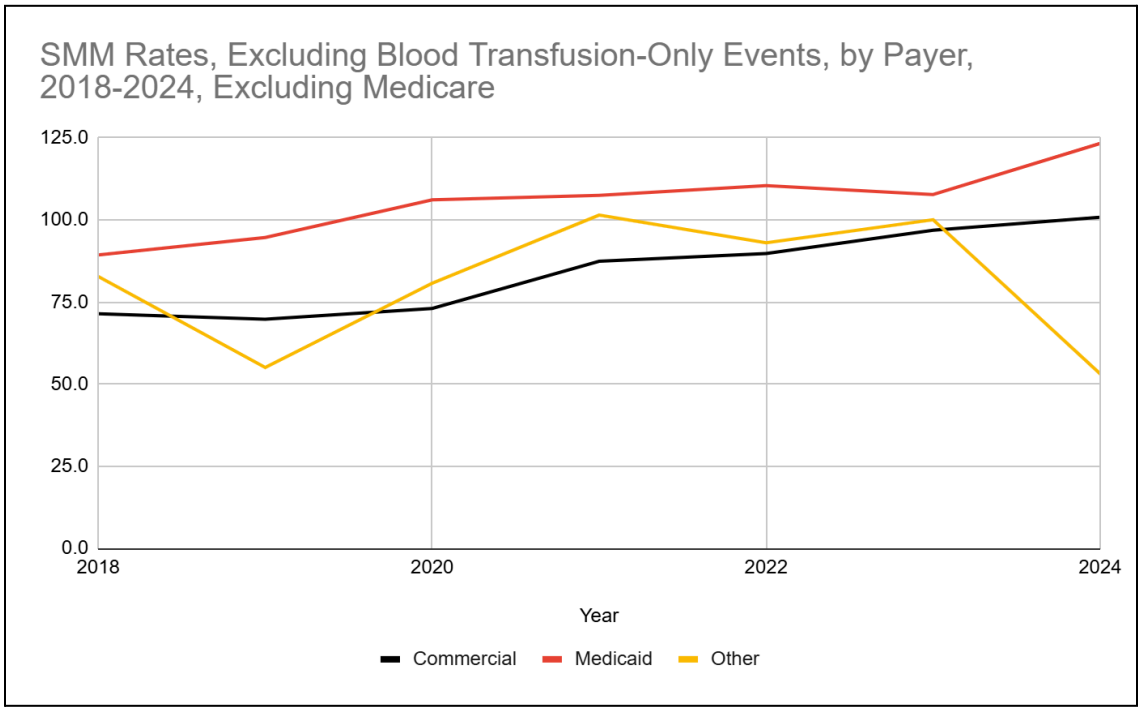


Table 32A. SMM Rate, Including Blood Transfusions, by Payer, 2018 – 2024[106] [107]

Payer	2018	2019	2020	2021	2022	2023	2024	% Change Since 2018
Commercial	203.5	203.4	225.8	250.8	267.5	284.3	275.1	+35.2%
Medicaid	290.9	285.0	295.9	315.8	337.1	353.3	369.9	+27.2%
Medicare	692.3	641.5	848.7	962.3	717.5	1315.8	687.8	-0.7%
Other	234.6	182.4	282.5	372.1	279.2	296.2	241.0	+2.7%

[106] Data Source: MCHB Data & Epidemiology Program Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.
[107] Note: Medicare data have low numerator counts. Interpret with caution.

Table 32B. SMM Rate, Excluding Blood Transfusion-Only Events, by Payer, 2018 – 2024[108] [109]

Payer	2018	2019	2020	2021	2022	2023	2024	% Change Since 2018
Commercial	71.4	69.8	73.1	87.4	89.8	96.9	100.8	+41.1%
Medicaid	89.4	94.6	106.1	107.5	110.4	107.8	123.3	+38.0%
Medicare	423.1	*	516.6	502.1	*	684.2	*	N/A
Other	82.8	55.1	80.7	101.5	93.1	100.1	53.2	-35.8%

Childhood Asthma Emergency Department (ED) Visit Rate

As is true for hospitals nationally, Maryland hospitals saw sharp declines in ED volumes in 2020 and early 2021 due to COVID-19. Understandably, Maryland's asthma-related ED visit rate for ages 2-17 declined during this period. Despite lower ED volumes, staff believe that the underlying dynamics of childhood asthma in Maryland did not change. By 2023, ED rates had recovered from their pandemic lows and resumed their downward trajectory after peaking in July of that year. More recently, rates have flattened out since the winter of 2023-2024, and the Department continues to monitor progress towards the original SIHIS goals.

Statewide Performance

Based on data through June 2025, Maryland had 6.9 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.6 visits per 1,000 children higher than the 2026 target.

[108] Data Source: MCHB Data & Epidemiology Program Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

[109] Medicare data have low numerator counts. Interpret with caution. Data for CY 2019, CY 2022, and CY 2024 are suppressed (*) due to count < 11, in alignment with HSCRC data use agreement.

Figure 4. Childhood Asthma-Related ED Visits for Rolling 12-Months, 2018 - June 2025[110]

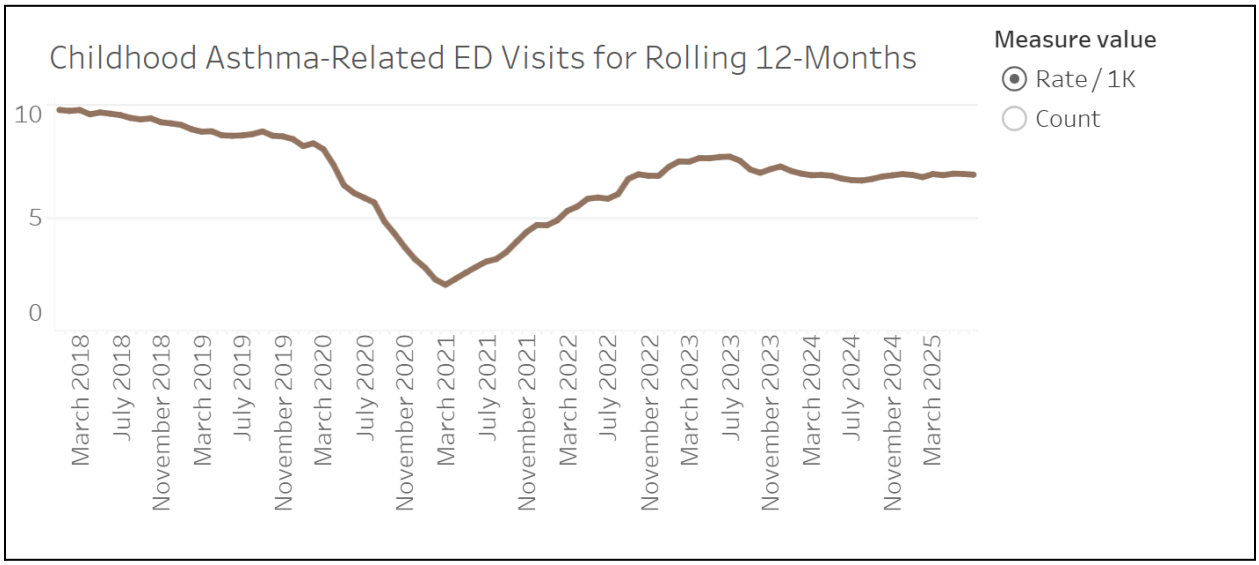


Table 33. Childhood Asthma-Related ED Visits Compared to 2023 and 2026 Target, 2018-June 2025[111]

	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months
Rates per 1,000	9.2	7.2	6.9	5.3	-1.6
Total Count	**10,974**		**8,555**		

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

[110] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

[111] Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized September 2025.

Figure 5. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018 - June 2025[112]

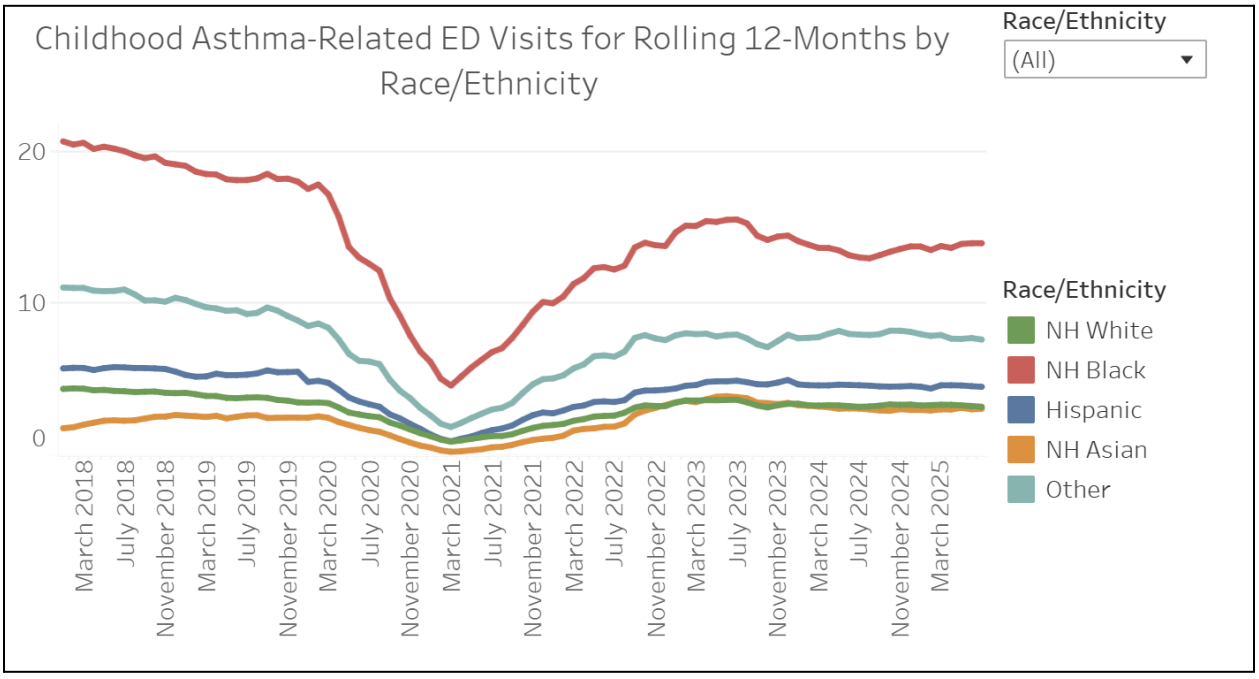


Table 34. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-June 2025[113]

Race/Ethnicity	2018 Baseline	2023 Target	Most Recent 12 Months	2026 Target	Change Required to Achieve 2026 Target from Most Recent 12 Months	Disparity Index - Most Recent 12 Months
NH White	4.1	3.5	3.2	3.0	-0.2	1.0
NH Black	19.1	14.4	13.9	9.6	-4.3	4.3
Hispanic	5.5	4.7	4.5	4.0	-0.5	1.4
NH Asian	2.6	2.6	3.0	2.5	-0.5	0.9
Other	10.3	7.3	7.7	5.5	-2.2	2.4
Total	**9.2**	**7.2**	**6.9**	**5.3**	**-1.6**	**2.2**

[112] Data Source: Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed September 11, 2025.

[113] Data Source: MCHB Data & Epidemiology Program summary of Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data. Accessed and summarized September 2025.

Performance by Payer

While the State is committed to improving asthma outcomes for all children, the emergency department visit rates for children on Medicaid have been higher than those of other payers, and the State has focused its efforts on the population of children served by Medicaid, through its home visiting program. The impacts can be seen below, in the significant decrease in visit rates from 2018, even after accounting for the impacts of COVID-19. Continued and expanded interventions to address childhood asthma are critical to preventing further growth in health disparities resulting from patients potentially not seeking care during the pandemic.

Figure 6. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-2024[114]

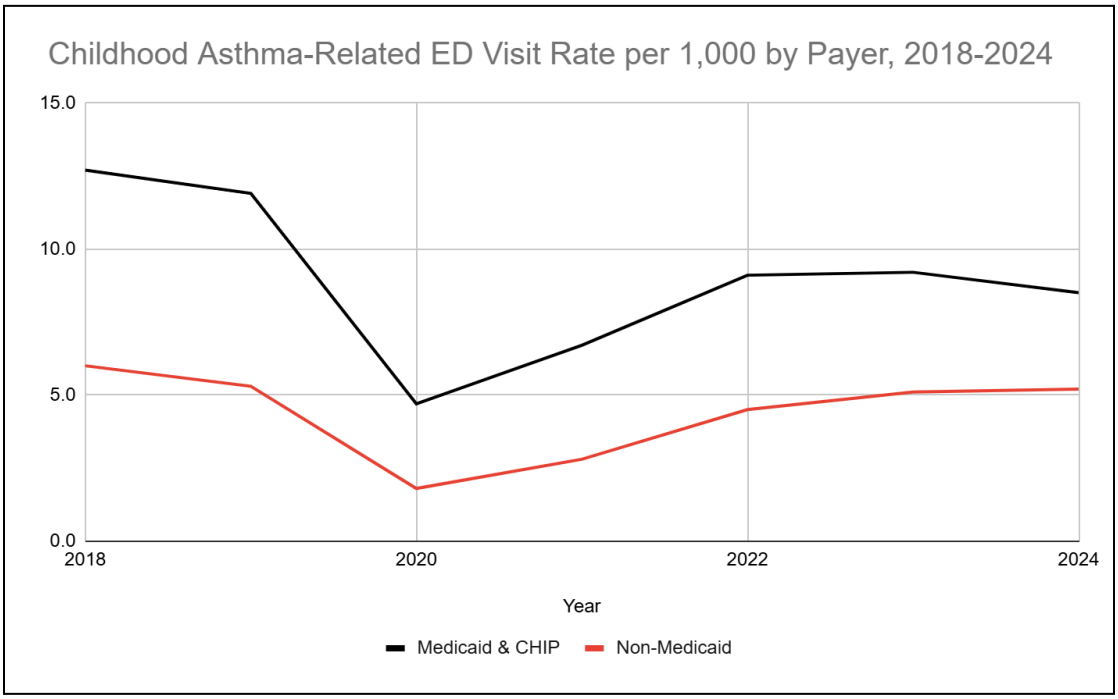


Table 35. Childhood Asthma-Related ED Visit Rate per 1,000 by Payer, 2018-2024[115]

Payer	2018	2019	2020	2021	2022	2023	2024	% Change since 2018
Medicaid & CHIP	12.7	11.9	4.7	6.7	9.2	9.2	8.5	-33.0%
Non - Medicaid	6.0	5.3	1.8	2.8	4.5	5.1	5.2	-12.6%

[114] Data Source: MCHB Data & Epidemiology Program and Environmental Health Bureau analysis of Health Services Cost Review Commission (HSCRC) data. Health Services and HSCRC in-patient case-mix as of September 2025.
[115] Data Source: MCHB Data & Epidemiology Program and Environmental Health Bureau analysis of Health Services Cost Review Commission (HSCRC) data. September 2025.

Year Four Spending

Medicaid

The Medicaid program continued its efforts in FY 2025 to expand all implemented benefits. As detailed above, implementation efforts included continued provider outreach, education, support and technical assistance, as well as implementation changes to support increased access. The Medicaid program intends to continue to maximize the Fund's contribution by pulling down federal matching funds, which relies on service implementation.

Due to efforts in PY3, utilization of HVS, Doulas, CenteringPregnancy and HealthySteps services all saw marked increases from CY23 to CY24. To build on this success, the Department will continue these efforts such as continuing the doula certification nomination process, and working with Centering Healthcare Institute and ZERO TO THREE to support providers and reimbursement. The Department will also work with the MCOs to increase MOM access and utilization.

Medicaid will continue to work with PHPA to support the conversion of the MPRA–a major referral source for MCH programs–from paper to electronic, and increase outreach and awareness amongst the IMHS pilot sites.

PHPA

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

Table 36. PHPA Grant Funds Expenditures - FY 2025[116]

Initiative	FY 2025 Spending
Asthma Home Visiting Program	$676,259
Community-Based Asthma Programs	$200,000
Maternal Home Visiting	$814,051
CenteringPregnancy	$64,852
Program Total	**$1,755,162**

Compared to FY24, spending by all sites increased substantially. Staffing challenges continued to impact all grantees, which contributed to sites not being able to spend their full award. The Department is working with all sites to address these challenges and will support the sites in their final year as they begin planning for sustainability and continuation of grant activities in FY 2025.

Conclusion

The Department remains committed to strategically investing in maternal and child health initiatives through these evidence-based initiatives. Preliminary data shows positive outcomes for several key measures, in

[116] Data source: Maryland Department of Health

addition to identifying some measures in need of further monitoring. The Department will actively use its programmatic data to improve the delivery of the services and tailor strategies effectively, ensuring that resources reach those who need them most.

PY4 saw a significant increase in utilization and access for Medicaid's MCH programs, and the Department will continue to build on the successful strategies that led to the increase, namely working with partner agencies to increase awareness and enacting policies to increase provider enrollment. Medicaid's MCH programs also demonstrated encouraging results in some quality measures, most notably marked higher rates of prenatal visits, continued low SMM and NICU visits, and reductions in c-section rates for doula and MOM recipients. The Department will continue to monitor all quality measures and look for opportunities of program improvement.

The Department will also continue to monitor performance on statewide SMM and asthma rates as the State recovers from the COVID-19 pandemic. Successes in Public Health's work include increased access to asthma home visiting services, reduced rates of childhood asthma-related ED visits for Medicaid participants, as well as increased number of CenteringPregnancy accredited sites. The Department will continue to investigate the impact of blood transfusions on SMM rates, and understand the opportunity for interventions.

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

Appendix 1. Region to Jurisdiction Mapping[117]

Region	Jurisdiction(s)
Baltimore City	Baltimore City
Baltimore Suburban	Anne Arundel Baltimore County Carroll Harford Howard
Eastern Shore	Caroline Cecil Dorchester Kent Queen Anne's Somerset Talbot Wicomico Worcester
Southern Maryland	Calvert Charles St. Mary's
Washington Suburban	Montgomery Prince George's
Western Maryland	Allegany Frederick Garrett Washington
Out of State	Not Maryland

[117] Data source: The Hilltop Institute