maryland
health services
cost review commission

Revenue for Reform Policy

Policy Guide

FY 2026 (July 2025 – June 2026)

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Revenue for Reform FY 2026 Policy Guide

Background

Under Global Budget Revenue (GBR) rate-setting methodologies, hospitals have retained revenue as volume declines, which results in higher charges for consumers. However, retained revenues are necessary to allow hospitals to invest in population health and other delivery system transformation. The Integrated Efficiency (IE) Policy addresses excessively high charges by withholding inflation from hospitals with excess costs relative to their peers. But currently, only traditional hospital costs are included in the Interhospital Cost Comparison (ICC). This potentially penalizes hospitals that have reinvested their retained revenues in population health management. The Revenue for Reform (R4R) policy is intended to safe harbor population health investments from the IE Policy. The R4R policy will separate hospital expenditures into 'core hospital expenditures' and 'population health expenditures.'

Costs Eligible for Safe Harbor

R4R is designed to integrate community health spending directly into hospitals' global budgets, expanding the reach of hospital-based investments into the broader community. Existing HSCRC policies—such as the Care Transformation Initiatives (CTI) and Global Budget Revenue (GBR) frameworks—primarily support interventions that hospitals deploy within their own systems. In contrast, R4R specifically targets interventions implemented **outside** of the hospital setting. **To qualify, associated costs must be recorded in unregulated or non-regulated cost centers.**

Per the IE Policy,[1] an intervention is considered to occur outside the hospital when services are provided off the hospital's campus and recorded in unregulated or non-regulated cost centers—even if hospital staff manage or deliver those services. By comparison, activities that take place within the hospital are typically directed at patients who are already admitted. These costs are treated as part of the standard cost of hospitalization and are not eligible for safe harbor treatment. Accordingly, to qualify as population health investments, expenditures must occur outside the regulated space and cost accounting structure, net of any revenue generated for those services.

Impact on Efficiency Standing & Ongoing Spending Requirements

Hospitals that request safe harbor for population health investments and are approved must continue to spend those dollars annually, regardless of ranking under the IE Policy. In other words, under the current policy, a hospital that requested $800,000 in safe harbor for a population health intervention must maintain the $800,000 investment annually, given that the dollars would otherwise be removed on a permanent

[1] Final Recommendation on Efficiency Policies. July 2023. Pp. 15-16. https://hscrc.maryland.gov/Documents/July%202023%20HSCRC%20Post%20Meeting.pdf

basis. If a hospital is deemed inefficient in multiple years, the hospital is responsible for investing the value of those dollars **in addition to** the prior year's efficiency adjustment.

Table 1. Spending Requirements Example

Year	Amount
FY 2024 Efficiency Cut / Approved for Safe Harbor	$500,000
FY 2025 Efficiency Cut / Approved for Safe Harbor	$200,000
FY 2026 Efficiency Cut / Approved for Safe Harbor	$100,000
Total Required Spend in FY 2026	$800,000 (FY 24 + 25 + 26)

Amounts approved for safe harbor in prior years are removed when calculating efficiency performance, so a hospital that requests safe harbor for population health investments will automatically improve its standing under the IE policy. **Under the R4R policy, hospitals must submit safe harbor applications annually for the entirety of their safe harbor request.**

Revenue for Reform Tracks

Hospitals may choose to include spending from Track 1 (Community Health Safe Harbor) or Track 2 (Physician Spending Safe Harbor). Each track is described below.

Track 1. Community Health Safe Harbor

Track 1A: Multidisciplinary Care Transitions and Care Management Programs

Hospitals must direct resources toward addressing the leading conditions that drive avoidable utilization, readmissions, and/or costs by implementing tailored, multidisciplinary care transition or care management programs. These programs are expected to be delivered outside of the hospital setting. Spending on activities that occur within the hospital is generally directed at patients who are already admitted. Such costs are considered part of the normal cost of a hospitalization and are not eligible for safe harbor treatment.

For purposes of this track, an intervention is considered to occur outside of the hospital if services are provided to beneficiaries off the hospital's campus and are recorded in unregulated or non-regulated cost centers—even if the intervention is staffed or managed by the hospital. **Qualifying programs must occur outside of the regulated space and cost accounting, net of revenue generated for those services.**

Programs that may be eligible include:

- Remote patient monitoring programs for specific chronic conditions (e.g. CHF, COPD)
- Care transition support post discharge to ensure patients have a medical home and immediate post discharge social supports are established
- Community Health Worker led home visiting care management programs connected to primary care

- Community pharmacist programs for chronic care management

For new interventions, the hospital must provide data to support selection of a specific condition or conditions and will need to provide a detailed description of the program structure, patient engagement/recruitment plan, staffing, careload, direct and indirect costs and outcome measures.

Track 1B: Evidence-Based Community Health Improvement Programs

Invest in existing or implement new evidence-based community health improvement programs within the hospital's primary service area.

Examples of evidence-based community health improvement programs include the following:

- Healthy housing programs to prevent lead poisoning and asthma
- CenteringPregnancy program (this would be done in partnership with a clinical practice and following the Centering Healthcare Institute's implementation and accreditation guidelines)
- CenteringParenting program
- Doula program - pre and/or post-natal, focus on birthing person and/or partner
- Community-based violence interruption program
- Hospital-based violence interruption program - applications involving this program will need to include a plan to integrate with a community-based violence interruption plan
- Food access programs (excludes general support of farmers markets)
- Falls prevention programs including home modification programs to enable individuals to remain independent and in their homes as they age
- Faith health initiative focusing on improved behavioral health and/or chronic disease prevention/management
- CDC recognized family healthy weight programs

If a hospital has an existing partnership with a community-based organization that already implements such a program, the hospital could choose to increase the financial support of the existing work in order to expand the number of individuals/families/clients served by the program. The hospital would need to work with the community partner to detail how the increased funding will specifically be used to grow or scale the program and define the outcome measures.

If a hospital seeks to bring one or more of these programs to their primary service area, the hospital will need to work with their local health department and local health improvement coalition to first determine if the work is already underway in the community and then to identify a community partner to operate the program.

Track 2. Physician Spending Safe Harbor

The hospital may include spending on primary care, mental health providers, and dental providers in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). HPSA designations identify areas and population groups experiencing a shortage of health professionals, including primary care[2], mental health, and dental professionals. MUAs are areas or populations designated as having too few primary care providers. If the hospital chooses to propose interventions under the Physician Spending safe harbor, the hospital must select a qualifying physician type in either a HPSA or MUA.

To support recruitment of **new** providers, hospitals may also offer one-time loan repayment assistance in the amount of $50,000 per provider.

[2] Eligible primary care practitioners include practitioners with a specialty code of General Practice (01), Family Medicine (08), Internal Medicine (11), Obstetrics and Gynecology (16), Pediatric Medicine (37), Geriatric Medicine (38), Nurse Practitioner (50), Clinical Nurse Specialist (89), Psychiatry (26), Preventive Medicine (84), Certified Nurse Midwife (42), and Physician Assistant (97). HSCRC is using the provider list defined in the Maryland Primary Care Program RFA. https://www.cms.gov/priorities/innovation/media/document/mdpcp-rfa-yr6.