



Maryland
Hospital Association

November 4, 2025

Meena Seshamani, M.D., Ph.D.
Secretary, Maryland Department of Health
Herbert R. O'Connor State Office Building
201 West Preston Street
Baltimore, MD 21201

Re: AHEAD Regulatory Working Group – Cost-Shifting Policy

Dear Secretary Seshamani,

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, thank you for the opportunity to comment on the cost-shifting policy that the multi-agency Regulatory Working Group is developing. There are many policy issues related to the forthcoming transition to the AHEAD Model and the impact of H.R.1 that need to be addressed, and we appreciate the state's prioritization of this policy issue given its vital importance for our health system and communities.

Of all the important policy issues the Working Group has been charged with tackling, cost shifting is perhaps the most pressing. Maryland hospitals are being asked to execute legal agreements with the Centers for Medicare & Medicaid Services (CMS) committing them to participate for a decade in the AHEAD Model at a time when a significant amount of uncertainty remains regarding the financial methodologies under the Model. It is critical that the state has a clear policy framework for cost shifting in place before the AHEAD Participation Agreement signature deadline.

A responsible cost-shifting policy is in the best interest of the state, Marylanders, and the entire health care system. Maryland must adopt a policy that allows for necessary rebalancing of costs across the system to support Marylanders' access to essential hospital services, the financial stability of hospitals, and the state's success under AHEAD. We urge the Regulatory Working Group to consider the following comments as it develops its proposal for the Governor in the coming weeks.

Guiding Principles for Cost Shifting

MHA and its member hospitals identified several guiding principles to serve as the foundation for the Working Group's cost shifting policy framework and methodology.

The cost-shifting policy framework and methodology must:

1. Enable hospitals to maintain the level of services they currently provide, address unmet needs in their community, improve population health, and achieve financial stability to support these objectives
2. Ensure the burden of lower contributions from public payers (Medicare FFS, Medicare Advantage, and Medicaid) is not borne solely by hospitals given the limited opportunity to generate savings through reduced hospital utilization
3. Strive for balance between access to care for communities and affordability for employers and consumers
4. Advance an approach to cost shifting that can increase commercial revenue to fully offset the reduction in payments from public payers
5. Allow for incremental cost shift increases corresponding with lower contributions from public payers
6. Use a methodology that provides predictability and sufficient flexibility to respond to changing conditions
7. Exclude the cost-shifting policy adjustment from the all-payer hospital revenue growth limit

Stable Hospitals Are Critical to Communities

As the state plans its cost-shifting approach, it is important to consider the more than 5 million people who are cared for at hospitals each year. From delivering 65,000 babies to treating about 1.1 million in emergency departments, hospitals are caring for Maryland 24/7/365. No Marylander is turned away due to inability to pay, including some 358,900 uninsured and even more underinsured Marylanders. Hospitals provide life-saving interventions for emergencies (e.g., injuries, trauma, stroke, heart attack), deliver high-quality care for acute illnesses and injuries, manage complex conditions using advanced technology and specialized expertise, and ensure smooth transitions to post-acute or rehabilitation care for recovery. These services are especially critical for areas of the state where there are limited options for health care services.

Additionally, hospitals are leading interventions to promote healthy lifestyles through campaigns on nutrition, exercise, and smoking cessation. To support healthy communities, hospitals provide screenings and early detection for chronic diseases like diabetes and cancer. For patients impacted by social drivers of health, hospitals are addressing housing, food security, and transportation and partnering with organizations to support underserved and at-risk populations. In addition, hospitals are leading vaccination drives and public health initiatives to prevent disease outbreaks.

In addition to the acute care and community wellness role that hospitals play, hospitals are also economic hubs of their communities. As major employers, hospitals directly and indirectly employ over 223,000 Marylanders and contribute \$35 billion in economic impact every year. The cost-shifting policy will not only affect access to health care services but will have implications on the economic viability of communities around the state.

The Pressing Need for Cost Shifting

Maryland hospitals are confronting substantial reductions in payments from public payers as a result of the forthcoming transition to AHEAD while marked declines in Medicaid and Marketplace enrollment due to changes in the federal policy landscape are looming. Together these policy changes not only have the potential to weaken the financial stability of hospitals but are also likely to cause an influx of sicker patients who require more emergency services. Cost shifting will help mitigate the effects of these hurdles on hospitals and communities across the state.

Significant Reductions in Payments under AHEAD

Under the renegotiated terms of the AHEAD Model, Maryland is expected to achieve \$460 million in Medicare savings through progressively greater annual savings targets between 2026 and 2033. Though these savings requirements pertain to spending on a total cost of care basis, the AHEAD State Agreement memorializes CMS' intent to ensure these targets are met through reductions to Medicare hospital global budget payments. These savings are projected to result in corresponding reductions in hospital payments from Medicaid and Medicare Advantage, which taken together with the Medicare savings, amounts to a total hospital payment reduction of \$855 million over the next seven years. This increased savings requirement on the state, however, cannot be borne exclusively by hospitals as noted in Governor Moore's Sept. 23 directive establishing the Working Group.

Limited Opportunities to Reduce Hospital Utilization

Medicare total cost of care savings under AHEAD can be driven by three primary mechanisms: (1) reductions in Medicare hospital global budget payments, (2) reductions in nonhospital or out-of-state hospital utilization, and (3) movement of care to lower-cost, nonhospital settings. Maryland hospitals have achieved significant reductions in avoidable utilization under the All-Payer and Total Cost of Care models through care transformation, population health initiatives, and community partnerships, so the opportunities for further utilization reduction without compromising access or quality are now limited. According to a recent HSCRC analysis, per-capita hospital utilization in Maryland decreased by 10% between 2013 and 2023 after accounting for changes in the demographics of the population, compared to a 3% increase in hospital utilization nationally over the same period. The state cannot sustain a health care system that relies on further reducing hospital utilization to meet savings goals, especially given we expect an increased demand for hospital services as the population grows and ages.

Reduced Enrollment and Increased Uncompensated Care

Maryland's Medicaid program, which serves more than 1.5 million residents, including 331,000 adults covered through the ACA expansion, faces significant risks under provisions of H.R.1 (OBBBA). Provisions such as federal work requirements, stricter renewal processes, immigrant eligibility restrictions, and reduced retroactive coverage could cause 175,000 to 235,000 Marylanders to lose coverage between FY 2027 and FY 2028, representing a 12% to 15% decline in enrollment. These provisions would also reduce federal Medicaid funding by up to \$2.7 billion annually and cut hospital Medicaid payments by \$5.5 billion over the next decade, according to an estimate from the Maryland Department of Health (MDH). Medicaid coverage losses, coupled with the expected decline in Marketplace enrollment due to the anticipated loss

of federal enhanced premium tax credits, will result in greater use of emergency departments for non-emergent care needs and higher levels of uncompensated care across the state—two issues the state and Maryland hospitals have worked so hard to address in recent years. Without coverage, Marylanders may delay or forgo necessary care altogether, which will adversely affect health outcomes and lead to higher long-term health care costs.

Increases in uncompensated care will exacerbate the financial strain hospitals are experiencing due to substantial and persistent cost pressures associated with inflation, payer denials, and physician costs, and steep increases in technology and drug costs, while the aging population and increasing prevalence of chronic disease are expected to drive higher utilization and costs. These challenges directly affect care quality and jeopardize the ability of hospitals to sustain essential services and respond to the growing needs of their communities. Moreover, they have left hospitals resource constrained at a time when they need to be strengthened to maintain access, drive population health improvements, and continue to deliver high quality care under AHEAD.

Market Capacity for Cost Shifting

MHA and Maryland hospitals are committed to ensuring health care coverage and services are both accessible and affordable to Marylanders. A reasonable increase in commercial reimbursement and premiums over time would allow the state to remain competitive on affordability, provide predictability for payers, and maintain the hospital infrastructure that preserves access to timely and necessary health care for our communities.

Commercial Hospital Reimbursement

Maryland has achieved more than \$650 million in cumulative Medicare TCOC savings through CY 2024 while improving quality, reducing unnecessary utilization, and expanding access to care. Although these savings have been primarily driven by significant reductions in hospital expenditures, they have historically accrued to the benefit of commercial payers, not hospitals and health systems. Furthermore, under the All-Payer and TCOC Models, Maryland hospital cost growth has been limited to 3.58% annually, well below the national hospital cost growth rate of 4.8% over the last decade. Commercial hospital reimbursement rates have remained comparatively low while hospitals have absorbed rising costs and federal payment constraints. As the state transitions to the AHEAD Model, it is necessary for commercial payers to share the responsibility of preserving access by maintaining the financial stability of the hospitals that serve Marylanders.

MHA believes that cost shifting is both affordable and manageable. Our preliminary analysis indicated that the average commercial hospital reimbursement rate in Maryland in FY 2024 was approximately 178% of Medicare fee-for-service rates. We modeled the increase in commercial revenue necessary to fully offset the \$460 million Medicare TCOC savings requirement under AHEAD and corresponding reductions in hospital payment from Medicaid and Medicare Advantage, which amounts to a total reduction of \$855 million. This modeling suggests that even after applying a full cost shift that accounts for the reduction in payments from public payers,

average commercial hospital reimbursement rates in Maryland would still be well below regional benchmarks according to Milliman (250%) and RAND (324%).^{1,2}

It is important to note, however, that this estimated increase in commercial hospital reimbursement rates does not account for other factors that should be considered in determining the appropriate level of cost shifting. These include the lower inflationary adjustment and other revenue adjustments applied under CMS' methodology for Medicare hospital global budget payments or the aforementioned impacts of H.R.1. Nonetheless, the comparison to national reimbursement rates demonstrates that the market can support an increase at this level.

Impact on Commercial Insurance Premiums

The estimated impact on commercial insurance premiums would be limited given hospital costs represent a fraction of total premiums. A gradual increase in reimbursement rates over the next seven years would result in a modest increase in premiums that the market can support and that is justified to preserve access to essential hospital care. In fact, according to data from the Kaiser Family Foundation (KFF), the average annual premium for an individual enrolled in an employer-sponsored commercial insurance plan in Maryland in 2023 was \$7,870, 4% less than the United States average and less than other states in the region including Pennsylvania (3%), Virginia (3%), West Virginia (10%), New York (17%), and New Jersey (23%), as well as the District of Columbia (11%).³

Preserving Access & Improving Health for the Future

Implementation of the state's cost-shifting policy will have direct consequences for access preservation and quality of care. Without the ability to rebalance payment reductions from public payers, Maryland hospitals will experience resource constraints and financial conditions that could limit service availability, reduce responsiveness to community needs, and constrain necessary investments in population health initiatives. The result will be diminished access to timely and essential hospital care.

In recent conversations about the current environment, hospital leaders from across the state have expressed their desire to continue to meet the full range of acute care needs of the communities they serve. They have also expressed concerns about forthcoming changes further straining operating budgets and limiting resources to a point where they may need to consider scaling back certain services and programs or eliminating them altogether. Behavioral health services, obstetrical services, cardiology services, and other subsidized community programs that generate limited revenue but provide a critical public health benefit are among those services at risk. These reduced offerings would be most likely to affect our neediest communities as they are generally served by hospitals with a greater proportion of Medicare and Medicaid patients (higher public payer mix).

¹ Milliman, 2024. White Paper – Commercial Reimbursement Benchmarking, available [here](#)

² RAND, 2024. Prices Paid to Hospitals by Private Health Plans, available [here](#)

³ Kaiser Family Foundation, 2024. Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, available [here](#); based on the Medical Expenditure Panel Survey (MEPS)

Significant financial pressures will also make it increasingly difficult for hospitals and health systems to invest in the population health, preventive health, and chronic disease management initiatives central to the state's success under AHEAD and necessary to continue meaningful progress in reducing overall health care costs and improving the health and wellbeing of all Marylanders. The ability of hospitals to engage in these vital investments depends on their financial health and sustainability.

An important feature of our all-payer model has been to maintain equitable access to health care services for all Marylanders and avoid the two-tiered system where uninsured and underinsured patients can only receive services from safety-net hospitals. A framework for cost shifting is essential to maintain this environment of equitable hospital access and support the economic viability of the communities hospitals serve.

Conclusion

Thank you for your leadership during this transition. A successful transition from the long-standing all-payer system requires a balanced cost-shifting policy to safeguard access to care, maintain affordability, and facilitate the state's success under the AHEAD Model. We look forward to continuing to engage with the Regulatory Working Group on this important issue and others over the coming weeks and months.

Sincerely,



Melony G. Griffith
President & CEO

cc: Perrie Briskin, Medicaid Director, Maryland Department of Health
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Dr. Elizabeth Kromm, Assistant Secretary, Maryland Department of Health
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
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