



Maryland  
Hospital Association

December 2, 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: Regulatory Working Group Proposal for Cost-Shifting and Medicare Advantage**

Dear Secretary Seshamani,

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, thank you for the opportunity to provide comments on the Regulatory Working Group's recently released proposal for cost shifting and Medicare Advantage (MA).

As we shared in our Nov. 4 letter, a responsible, balanced cost shifting policy is in the best interest of the state, Marylanders, and the entire health care system and can be implemented while maintaining affordability for consumers and commercial payers. We are concerned that the proposed \$435 million increase to commercial rates does not adequately rebalance costs across the health care system and will threaten Marylanders' access to essential hospital services, the financial stability of hospitals, and the state's success under AHEAD.

We respectfully urge the Regulatory Working Group to consider the following comments and those offered by hospitals in preparing the proposal for submission to Governor Moore.

Cost Shifting Policy

**It is critical for the state to advance a cost shifting policy that fully offsets AHEAD's Medicare total cost of care savings (TCOC) requirement and corresponding reductions in hospital payments from Medicaid and Medicare Advantage**—estimated at \$870 million by the Regulatory Working Group. Given that the state and hospitals will be held accountable for Medicare total cost of care savings starting in January, the policy should be implemented beginning in CY 2026. A delayed cost shift of a lesser magnitude will leave Maryland hospitals in a financial position that may limit their ability to maintain the level of services currently provided to Maryland communities and invest in necessary population health initiatives.

Additionally, we request that the Regulatory Working Group provide additional information on the methodology that was used to estimate the \$870 million reduction in hospital payments. We also ask that the Regulatory Working Group advance a policy with sufficient flexibility to update the cost shift allocation to account for revised Medicare savings targets or estimates of corresponding reductions in hospital payments from Medicaid and Medicare Advantage.

### *Implications on Access to Care*

As noted in our previous letter, an insufficient cost-shifting policy will have direct consequences for access to hospital care. Without the ability to rebalance payment reductions from public payers, Maryland hospitals will experience financial strain that could require them to scale back services or eliminate them altogether to sustain operations. Behavioral health services, obstetrical services, cardiology services, and subsidized community programs that generate limited revenue but provide critical public health benefits are among those services at risk. These reduced offerings would likely impact the communities that need them most as they are generally served by hospitals with a higher public payer mix.

### *Affordability*

MHA shares the Regulatory Working Group's commitment to maintaining the affordability of health care coverage and services. MHA modeling shows that the increase in commercial reimbursement rates necessary to fully offset hospital payment reductions from public payers can be achieved while maintaining affordability for payers, consumers, and businesses given Maryland's significantly lower commercial hospital reimbursement rates.

While Maryland's commercial insurance premiums are 4% lower than the United States average for an individual and more on par with the national average for a family, commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country as noted by the Regulatory Working Group.<sup>1</sup>

The average commercial hospital reimbursement rate in Maryland in FY 2024 was approximately 178% of national Medicare fee-for-service rates, well below publicly available regional benchmarks from Milliman (250%) and RAND (324%).<sup>2,3</sup> This data suggests that commercial payers can pass more of these reduced costs to consumers in the form of lower premiums and bear more of the responsibility of increased rates without raising premiums. As we noted in our public testimony, the state's cost shifting policy must strive for balance between access to care for communities and affordability for employers and consumers.

### *Medicare TCOC Savings Target*

The proposed \$435 million increase in commercial rates represents only half of the cost shift allocation needed to offset the reduction in payments from public payers to hospitals due to the Medicare TCOC savings requirement. It should also be noted that the estimated total reduction in payments from public payers (\$870 million) assumes an average annual national Medicare per-beneficiary expenditure growth rate of 4.99% and a cumulative savings target of \$460 million through Performance Year 7 of AHEAD (CY 2032). Should the actual per-beneficiary Medicare expenditure growth rate as measured by the United States Per Capita Cost (USPCC) exceed this conservative estimate of 4.99%, the state's Medicare savings target and total reduction in hospital payments from public payers over the next seven years will be higher than \$460 million

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<sup>1</sup> 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)

<sup>2</sup> Milliman, 2024. White Paper – Commercial Reimbursement Benchmarking, available [here](#)

<sup>3</sup> RAND, 2024. Prices Paid to Hospitals by Private Health Plans, available [here](#)

and \$870 million, respectively. The policy should allow for flexibility to modify the cost shifting allocation based on updated USPCC trend data.

### *Medicaid Enrollment and Uncompensated Care*

The overarching goal of the Regulatory Working Group, as described in the Governor's Sept. 23 directive, is to address issues related to the implementation of AHEAD and H.R.1. However, the proposed \$435 million shift is based *solely* on the estimated reductions in hospital payments from public payers due to the Medicare TCOC savings requirement and does not account for large, anticipated increases in uncompensated care and reductions in enrollment in Medicaid due to H.R.1. Federal work requirements, reduced retroactive coverage, and other changes are expected to result in a 12 to 15% decline in enrollment between FY 2027 and FY 2028. These changes will cut hospital Medicaid payments by \$5.5 billion over the next decade according to estimates from the Maryland Department of Health. These impacts will result in greater use of emergency departments for non-emergent care needs and higher levels of uncompensated care statewide. The cost shifting allocation should be updated to account for the disproportionate effect of these policies on hospitals.

### *Hospital Utilization Reductions*

In its proposal, the Regulatory Working Group acknowledges that Maryland hospitals have significantly reduced utilization under the TCOC Model and that achieving additional savings through further reductions in utilization under AHEAD will be more difficult. In fact, an MHA analysis of all-payer data from the National Academy for State Health Policy's (NASHP) Hospital Cost Tool found that overall hospital utilization in Maryland decreased by 13 percent between 2013 and 2023, compared to a 10 percent increase in hospital utilization nationally over the same period.<sup>4</sup> Despite this steep decline in utilization, the proposal assumes that hospitals can continue to make progress in curbing unnecessary utilization, specifically by reducing inpatient days per 1,000 and readmissions to the 25<sup>th</sup> national percentile. On an all-payer basis, however, Maryland's average hospital discharges per capita is fifth lowest in the nation. We value the Model's aims of reducing utilization where possible but question whether these assumptions are reasonable due to the maturity of the Model and the anticipated increased demand for hospital services resulting from the changing demographics of the population and reductions in Medicaid enrollment. Moreover, we remain concerned that further reducing hospital utilization to achieve savings targets may have unintended consequences for access to and quality of care. The state must prioritize preservation of access in discussions about opportunities to achieve efficiencies in delivery of care and in determining the appropriate level of cost shifting.

### *Hospital Investments Under AHEAD*

The Regulatory Working Group advanced the position that achieving required TCOC savings solely through a cost shift would detract from state and hospital efforts to lower acute care costs through population health improvements and investments in primary care. There are, however, components of AHEAD other than the Medicare TCOC savings target that incentivize efforts in support of model goals, including the incentives inherent in the fixed revenue structure of hospital global budgets, the all-payer and Medicare primary care investment targets, Population

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<sup>4</sup> National Academy for State Health Policy (NASHP). Hospital Cost Tool. Available [here](#).

Health Accountability Plans, and other Medicare hospital global budgets incentives, including the Community Improvement Bonus and TCOC Performance Adjustment. Furthermore, a hospital's ability to invest in population health, preventive health, and chronic disease management initiatives envisioned under AHEAD hinges on their financial health. A cost shifting policy that does not fully offset the reduction in hospital payments from public payers will constrain resources and limit the ability of hospitals to make these critical investments.

### Medicare Advantage Policy

The Regulatory Working Group is proposing an annual \$150 million subsidy program for Medicare Advantage plans that would begin in 2027, continue indefinitely, and be funded through an additional 11.55% public payer differential for their beneficiaries with the cost offset by increases in rates for other payers. **The proposed subsidies for MA plans should not come at the expense of a cost shifting policy that does not fully offset reductions in hospital payments at this decisive moment for Maryland hospitals.** In its proposal, the Working Group aims to adopt, in a parallel effort, policy solutions for both cost shifting and Medicare Advantage while upholding the values of health care quality, access, outcomes, and affordability. The effort to subsidize MA plans should yield to the priority of ensuring hospitals have the resources needed to sustain operations, preserve access to care for their communities, and successfully transition to AHEAD. Any proposal to subsidize MA plans must have clearly defined goals, be limited in time and scope, establish robust standards that require investments to support the health of members and eliminate wrongful denials, and require carriers to adopt a detailed plan to achieve financial stability without dependence upon state subsidies.

### *Policy Duration and Scope of Discounts*

As the policy has been described, the proposed discounts for MA plans are not limited in duration or scope. These subsidies should serve as a temporary fix, not a long-term solution. The discounts provide immediate support but may also contribute to reliance on outside funding and unintentionally delay investments in efficiencies that promote self-sufficiency of plans. The Working Group estimates a program cost of \$150 million while also acknowledging that this cost is likely to increase if the subsidies achieve their intended goal of stabilizing the market and that hospitals will bear the risk of a larger-than-anticipated discount. The infinite nature of the subsidies presents a significant risk to hospitals at a time when they can least afford it. To support predictability and plan accountability, any program for MA plans must be time limited, have an annual cap on the amount of funding for subsidies, and specify factors that will be used to reduce and discontinue program funding in future years.

### *MA Policy Goals and Criteria for Qualified Plans*

In addition to the criteria specified in the proposal, there should be clearly defined goals for the MA policy and strong guardrails and accountability measures for plan participation. MA plans should be required to demonstrate meaningful investment in population health and member support services. MA plans must also adhere to reasonable utilization review standards, including compliance with benchmarks for medical necessity determinations, prior authorization processes, and minimal rates of prior authorization and claim denials. This is a particular concern as hospitals across the state continue to face a troubling and persistent increase in inappropriate and excessive MA denials: a trend that has worsened in recent years. From FY 2019 to FY 2024,

medical necessity denials for MA plans in Maryland increased by 233%. These denials have caused patient delays and imposed significant administrative burdens and financial strain, exacerbating ongoing sustainability challenges for hospitals. In addition, plans should be required to show measurable improvements in star ratings over time as evidence of their commitment to quality and patient outcomes. Without these safeguards, hospitals risk absorbing the costs of plan incentives without corresponding improvements in care delivery or patient health.

#### *All-Payer Revenue Limit*

Under the terms of the AHEAD Agreement, the state must limit annual all-payer hospital revenue growth to a specified limit of 3.58% starting in CY 2026. The state must ensure that any revenue support for MA plans is removed from the evaluation of state performance on this target.

#### Conclusion

Maryland hospitals' ability to provide access to care for our communities 24/7/365 and drive towards the population health objectives of AHEAD depends on a cost shifting policy that sufficiently rebalances costs across the system and supports their financial stability.

Thank you for your continued leadership and support of the hospital field in our ongoing efforts to improve the health and wellbeing of Marylanders. We look forward to continuing to engage with the Regulatory Working Group on these important policy issues and others over the next several months.

Please contact me with any questions.

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  
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Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission  
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