



Maryland
Hospital Association

January 5, 2026

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 principles for physician payment recently released by the Health Services Cost Review Commission (HSCRC). We know that *Care Takes All of Us* and appreciate the Commission's recognition of the substantial financial losses hospitals incur due to the rising costs of employing or contracting with essential physicians and urge swift policy action to address this important issue.

It is becoming increasingly expensive for Maryland hospitals to maintain essential physician coverage. Physicians are critical to the ability of hospitals to provide lifesaving, acute care and other health care services that communities rely on. Given this, the exorbitant costs of employing or contracting with physicians and the corresponding financial losses are unavoidable since hospitals require sufficient medical staff to perform the basic functions of providing daily, lifesaving care to patients. The current global budget and rate structure does not include a funding mechanism that enables hospitals to recover expenditures for physician services that are not fully reimbursed by payers. These losses are not sustainable, especially as the state and its providers transition to the AHEAD Model. Without relief, hospitals will face financial instability and resource constraints that threaten their ability to sustain core operations and preserve access to care in every community.

MHA stands ready to support efforts to identify a policy solution. In the meantime, we offer the following comments for consideration as the Commission evaluates its engagement on this issue.

Losses on Physician Services are Significant and Rising

We appreciate HSCRC's efforts to collect actionable data through the clinician cost schedule (CCS) as part of regular hospital reporting and to leverage that data to inform policy discussions. Initial data presented by HSCRC at the Oct. 8 Commission meeting indicates a substantial net loss to hospitals associated with these expenses. Staff shared that in FY 2024, 38 of Maryland's 45 acute care hospitals incurred \$1.49 billion in clinical compensation costs, but generated only \$600 million in offsetting revenue, resulting in a net loss of \$890 million.¹ Hospital-based

¹ These figures do not include clinician support costs.

clinicians, based on HSCRC's definition alone, accounted for \$453 million (51%) in net losses, while surgical specialists (\$233 million), non-surgical specialists (\$155 million), and primary care providers (\$54 million) accounted for relatively smaller losses. Among hospital-based physicians, anesthesiologists (\$131 million), hospitalists (\$108 million), and emergency medicine physicians (\$63 million) contribute to the greatest losses.

An MHA survey of 38 of its member hospitals produced similar findings and found that net losses attributable to hospital-based physicians across all specialties grew by 55% between FY 2013, or the most recent period for which data was available, and FY 2023.²

Drivers of Increased Losses on Physician Services

As noted above, in recent years, Maryland hospitals have seen a significant increase in financial losses due to the rising costs associated with employing and contracting with physicians who are critical to the healthcare services provided by hospitals and health systems. This trend can largely be attributed to two factors: low physician reimbursement from commercial payers and an increase in private equity acquisitions of physician practices.

The Hilltop Institute, in a December 2025 report prepared for the Maryland Health Care Commission (MHCC), highlighted Maryland's relatively low physician reimbursement rates compared to other states.³ The report cites a 2020 Health Care Cost Institute (HCCI) study that found, in 2017, Maryland's commercial physician reimbursement rates averaged 104% of Medicare rates, the third lowest among all states, and significantly lower than the national average of 122%.⁴ While the data is based on claims from 2017, Hilltop notes, more recent data supports this finding. Another MHCC report found that average commercial reimbursement rates varied by provider specialty, with average payments for certain specialties including ophthalmology, dermatology, gastroenterology, psychiatry, and pediatrics lower than Medicare rates in 2021.⁵ The same report found that reimbursement from all commercial payers declined from 2019 to 2020, and again from 2020 to 2021. Beyond the financial strain on hospitals, low reimbursement rates can threaten access to essential hospital care by making it more difficult to recruit and retain physicians. This further exacerbates workforce shortages and gaps in care, especially in underserved areas.

The expanding role of private equity in physician practice acquisitions is also a challenge. When private equity firms enter local markets, the costs hospitals incur to contract essential physician services often rise significantly. In certain regions of Maryland, private equity-backed physician practices now account for more than 30% of the market. Analyses show that such acquisitions frequently drive-up costs for both patients and employers. A national study shows that these acquisitions were associated with price increases in eight of 10 specialties, including oncology at 16.4%, gastroenterology at 14%, obstetrics/gynecology at 8.8%, and radiology at 8.2%.⁶ These

² Survey included 38 hospitals. Base years differ due to respondent data availability; 30 hospitals (FY 2013), 7 hospitals (FY 2016), 1 hospital (FY 2017). In comparing base years to FY 2023, MHA adjusted for inflation.

³ 2025. The Hilltop Institute. Insurer and Provider Concentration in Maryland. Available [here](#).

⁴ 2020. HCCI. Comparing Commercial and Medicare Professional Services Prices. Available [here](#).

⁵ 2021. MHCC. Payments for Professional Services in Maryland (In-Network services only). Available [here](#).

⁶ 2023. American Antitrust Institute; Petris Center; Washington Center for Equitable Growth. Monetizing medicine: private equity and competition in physician practice markets. Available [here](#).

price increases add financial strain, particularly in hospital-based specialties where rising contractual costs place an even heavier burden on hospitals. The continued growth of private equity-backed practices introduces new pressures that add to hospitals' financial responsibilities and can affect access to care. Ongoing monitoring will be important to understand how these dynamics evolve over the next several years.

Principles for a Policy Solution

The set of principles shared by HSCRC lays a strong foundation for a policy solution. Any approach advanced by the state should provide sufficient support for hospitals to preserve access to essential care by covering losses on physician services, include a reasonable benchmark and standardized methodology, and be designed to address needs at all hospitals.

At a minimum, the policy should provide funding for physician services that are necessary to operate an acute care hospital and preserve access to essential hospital care, including but not limited to hospitalists, emergency department physicians, anesthesiologists, behavioral health specialists, radiologists, gastroenterologists, infectious disease specialists, intensivists, and obstetricians. The approach should include flexibility to tailor support based on which provider types and services are most needed in specific communities. Furthermore, any support should be paired with efforts to address underlying cost drivers, which could include policies or contracting approaches that increase professional reimbursement and reduce losses for physician services.

MHA supports a funding mechanism that enables hospitals to recover expenditures for physician services not fully reimbursed by payers through an increase in hospital rates. The policy could initially provide full funding for losses on physician services with a gradual decrease over time to incentivize improvements in negotiated contractual arrangements and encourage adoption of other policy solutions to address low physician reimbursement. MHA also would support efforts to establish a floor for physician reimbursement based on a percentage of the Medicare physician fee schedule and adjusting commercial differentials to enforce these requirements to more directly address a root cause of losses on physician services

HSCRC's Statutory Authority

Along with the principles for physician payment, HSCRC shared that it cannot provide funding to support physician costs under Maryland statute. While the Commission may not have the authority to directly regulate physician charges, it has the responsibility to ensure the rates set for regulated hospital services are reasonably related to the hospital's aggregate costs.⁷ Given the expenses associated with employing or contracting with hospital-based physicians are essential to the operation of hospitals and their ability to provide regulated acute care services, these costs must be considered when determining whether regulated rates are sufficient. Therefore, we believe HSCRC can provide support for physician costs through hospital rates and global budgets under its existing authority. If there is any uncertainty on this matter, MHA supports a legislative remedy to clarify the Commission's statutory authority.

⁷ See Section 19-219 of the Health-General Article.

Maryland hospitals are facing unsustainable financial losses due to the rising costs of employing and contracting with physicians. This growing crisis threatens hospitals' ability to sustain core operations and preserve access to care for the communities they serve. MHA urges swift action to address this important issue and ensure every Marylander has access to necessary care. We welcome the opportunity to support the state's efforts to identify a policy solution.

Sincerely,



Melony G. Griffith
President & CEO

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