



Maryland  
Hospital Association

April 8, 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 our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation for the Healthcare Outcome Payment Effort (HOPE) framework, including the Care Transformation Framework (CTF) and Regional and Statewide Initiatives (RSI) pathways.

MHA appreciates HSCRC's intent to establish the HOPE framework to continue key hospital interventions that were developed under the former Care Transformation Initiative (CTI) program. As a successor to CTIs, the HOPE program aims to achieve a more predictable and accountable payment structure. To succeed HOPE must enable hospitals and community partners to confidently invest in interventions, equitably share savings, and sustainably support population health initiatives aligned with the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model and broader system transformation goals.

MHA's review of the draft recommendation proposed for FY 2027 reveals significant questions about the program's design and its implications for hospitals. As HSCRC transitions from CTIs to the HOPE framework, clear and detailed guidance is needed on the funding, qualifications of initiatives, claims data sources, one-time infrastructure payment requirements, and the overlap with other HSCRC population health programs to support effective hospital planning, implementation, and optimization.

Based on feedback from our member hospitals and health systems, MHA encourages HSCRC to delay the HOPE framework timeline, including the CTF and RSI pathways, by one year. This would allow for more deliberate policy development and a balanced consideration of competing priorities and ensure stronger implementation. We respectfully offer the following comments for consideration.

#### **Changes to TCOC Program Design**

The proposed CTF design marks a significant departure from the current CTI model by moving away from a Total Cost of Care (TCOC) framework to a narrower focus on inpatient and emergency department expenditures, while also requiring hospitals to submit proposals within a

compressed timeline. While this limited scope may ease initial implementation and data collection, particularly for non-Medicare payers, it moves away from the AHEAD Model's core objectives to strengthen primary care and care coordination and achieve long-term population health improvement. Additionally, advancing the HOPE concept by FY 2027 under this structure risks prioritizing speed over multi-payer alignment, potentially limiting the program's long-term impact compared to a TCOC-based approach. Accordingly, MHA requests clear, specific clarification on:

- How will the program drive meaningful reductions in TCOC if its measurement framework is limited to inpatient and emergency department expenditures?
- What mechanisms will ensure the program is aligned with AHEAD's goals?

### **Source of Funding**

HSCRC indicated that the CTF pathway will not be funded through the update factor, separating it from base rate updates. While earned outcome payments are projected at \$50 million annually, more clarity is needed on the sustainability and mechanics of the funding framework. MHA urges HSCRC to provide clear, definitive guidance on near- and long-term funding, including:

- How will earned outcome payments be funded in FY 2028 and subsequent fiscal years if not funded through the update factor?
- What is the source and total amount of RSI funding and how will the shared savings structure work?

### **Qualification of Individual Initiatives**

The HOPE policy allows hospitals to submit individual CTF initiatives with projected savings validated by Commission staff. Based on a \$50-million payment cap, HSCRC indicated interventions will be qualified up to this cap in projected averted hospital costs. It remains unclear how many initiatives will be approved or whether individual proposals will face a savings threshold. Increased participation could dilute payments if many initiatives succeed, making it difficult for hospitals to assess the potential return on investment for participating in the program. MHA requests clarification on:

- Will HSCRC establish a maximum projected savings threshold per proposal? If so, how will that threshold be determined relative to the program's overall \$50 million cap?
- What specific criteria and methodology will HSCRC use to evaluate and prioritize proposals if total projected savings exceed available funding?
- How many CTF initiatives does HSCRC expect to approve for earned outcome payments?

### **All-Payer Scope**

HSCRC indicated that HOPE is intended to be an all-payer initiative and that the goal is to work with the Center for Medicare and Medicaid Innovation (CMMI) to include Medicare under the program. The uncertainty around Medicare participation and commercial data reliability makes it difficult for hospitals to commit to participation in HOPE and investing in initiatives in the near-term when the program could change significantly in the future. MHA requests clarification on:

- What is HSCRC's contingency plan if CMMI does not participate? How will hospitals, especially those with a high volume of Medicare patients, be protected after making upfront investments based on an assumed all-payer model?
- What strategy and timeline will HSCRC use to secure, standardize, and operationalize commercial payer data to ensure it is timely, complete, and usable for performance measurement?
- What assurances can HSCRC provide that case-mix based methodologies will produce sufficiently accurate and credible all-payer insights, and how will data gaps or inconsistencies be addressed?

### **Savings Measurement**

The HOPE policy draft recommendation indicates that FY 2026 performance data may be evaluated, as appropriate, to inform FY 2028 outcome payments since the formal measurement period begins in FY 2027 and would otherwise provide only one year of data. The recommendation then says that staff will continue to prioritize reliable measurement but will allow payouts based on a single year of performance during the transitional period. MHA requests clarity on:

- Under what circumstances does HSCRC anticipate using FY 2026 data in combination with FY 2027 data to establish a two-year measurement period for FY 2028 outcome payments, rather than relying on a single year of performance?
- How does HSCRC envision prioritizing reliable measurement if outcome payments during the transition period may be based on only one year of performance (FY 2027)?

### **FY 2027 Transition—Conditions for One-Time Payment**

HSCRC's FY 2027 transition proposal includes a one-time, proportionally distributed payment intended to support care transformation infrastructure, contingent on hospitals designating a population health leader and submitting a written commitment to develop a HOPE proposal by a specified date. MHA recognizes the intention to support continuity of existing initiatives and to have hospitals receiving funds commit to submitting a HOPE proposal. However, the compressed timeline described by HSCRC may make it difficult for hospitals to develop and submit a successful proposal, particularly given HOPE's significantly different design features and scope of planning, internal coordination, and partnership development required. Furthermore, without assurance that submitted proposals will be approved or receive ongoing funding, hospitals risk making substantial upfront investments without a clear path to sustained support. This underscores the need for a more predictable and durable long-term funding approach to maintain care transformation infrastructure. Given this, MHA seeks clarification on:

- How will HSCRC mitigate the risks to hospitals that are asked to commit resources and make upfront investments while proposal approval and ongoing funding remain uncertain?
- What protections or contingencies will be available to hospitals that make good-faith investments in CTFs if their submitted proposals are not approved?
- Has HSCRC considered alternative approaches, such as phased implementation or pilot participation, to better align funding certainty with the upfront investments hospitals must make?

### **Program Overlap and Transitions**

MHA appreciates HSCRC's efforts to align HOPE with existing initiatives, but the overlap with programs such as Revenue for Reform, New Paradigms in Care Delivery, and the broader population health landscape remain unclear. With multiple ongoing efforts, including the Care Redesign Program, High Value Care Plans, Population Health Inventory, Hospital Community Benefit, and the AHEAD-required Hospital Population Health Accountability Plan (PHAP), hospitals need clarity to prevent duplication, misalignment, and administrative burden. In response to HSCRC's request for thematic areas for CTF, MHA encourages the Commission to consider the AHEAD PHAP measures as foundational themes and strongly urges a comprehensive crosswalk showing how these initiatives intersect with HOPE, including whether the same interventions can be applied across programs.

The proposed HOPE timeline leaves insufficient time for thorough policy design, meaningful incorporation of lessons learned from the CTI program, or careful consideration of potential unintended consequences. Hospitals need clear guidance and predictability to develop well-designed, evidence-based proposals that align with state priorities, address key populations, and deliver measurable impact. MHA urges HSCRC to extend the planning timeline by one year and establish clear design parameters to support strategic planning, focus on high-impact interventions, and achieve meaningful, sustainable outcomes.

Thank you for the opportunity to provide input. We welcome continued dialogue on the HOPE framework and broader population health initiatives to ensure programs can be implemented effectively and achieve their intended impact.

Sincerely,



Tequila Terry  
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair HSCRC  
Jonathan Blum  
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