



Maryland
Hospital Association

May 20, 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, thank you for the opportunity to comment on the Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2027. MHA appreciates the time staff have dedicated to ensuring a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

Maryland hospitals will be operating in a rapidly changing and challenging health care landscape in rate year 2027. The current economic environment, transition to bifurcated AHEAD Model policies, and federal policy changes impacting health coverage have added complexity and uncertainty at a time when many hospitals continue to confront financial challenges. MHA identified four ways HSCRC can strengthen its update factor recommendation to preserve access to care, ensure hospitals have sufficient resources for operational readiness and necessary investment, and help facilitate a successful transition to AHEAD, described below.

- **Monitor inflation throughout the rate year.** MHA supports the staff recommendation to fully fund inflation. Additionally, as economic volatility and contemporary cost pressures, including high and rising energy prices, introduce uncertainty and potential inflationary impacts that may not be captured in current forecasts, MHA recommends staff monitor inflation throughout the year to ensure the inflation allowance is adequate.
- **Prospectively adjust the uncompensated care (UCC) provision in rates by 0.69%.** H.R.1 and other federal policy changes are expected to result in significant Medicaid and Marketplace coverage losses. However, under HSCRC's current policy, increases in UCC in RY 2027 will not be reflected in rates until RY 2029. MHA estimates UCC levels could increase to 4.73% in FY 2027 (a 0.69% increase over FY 2025), based on state-estimated coverage losses due to policies that take effect in CY 2026 alone.
- **Provide an additional 0.30% to support hospital readiness for H.R.1 and AHEAD.** To support statewide efforts to mitigate Medicaid coverage losses under H.R.1, hospitals will need additional resources to identify and enroll Medicaid-eligible patients, help them maintain coverage, and navigate payment processes. Hospitals will also need to make

significant investments to successfully operate under two different sets of payment policies and regulatory systems under AHEAD.

- **Discontinue the productivity adjustment for non-GBR hospitals.** The proposed 0.80% adjustment would leave non-GBR hospitals less equipped to manage cost pressures and could unintentionally limit capacity. The provision of the full inflation allowance (3.37%) will help protect access to specialty care.

The state's favorable Medicare total cost of care (TCOC) savings performance through CY 2025 and recent United States Per Capita Cost (USPCC) trend projections enable HSCRC to provide the funding needed to preserve access to care and address hospital needs while preserving the state's ability to meet its commitments under AHEAD, as further described in *Appendix 1*.

Inflation

MHA supports the proposed inflation increase of 3.37% included in the draft recommendation. This includes a 3.17% core inflation allowance based on S&P Global's estimates from Q4 2025 and a 0.20% correction of historical cumulative underfunding in accordance with the revised "inflation catch-up" policy approved by the Commission last July. A sufficient inflation allowance ensures hospitals can continue to meet the care needs of their communities in an increasingly costly operating environment by helping hospital rates and global budget revenue keep pace with rising labor, supply, and operating costs that are largely outside of their control.

Economic volatility, particularly in energy markets, could place significant pressure on hospital operating costs. Increases in natural gas and electricity prices present a unique challenge for hospitals given their need to keep their doors open and lights on 24/7/365. These costs are especially burdensome for hospitals with aging infrastructure and insufficient capital to upgrade their facilities. Instability in energy markets and large price swings may also have ripple effects for the medical supply chain and transportation, which would place added cost pressure on hospital operations. Given this volatility and considering that regional energy prices have grown at a faster rate than the nation in recent years, it will be important for HSCRC to continue to closely monitor inflation throughout the upcoming year to ensure the allowance included in the update factor is adequate.

Uncompensated Care

The current uncompensated care provision in rates is historically low. While the RY 2027 provision will be updated based on RY 2025 data, the resulting level of rate support will not be aligned with the UCC burden hospitals will face in the upcoming year due to the impacts of H.R.1 and other federal policy changes. In anticipation of a large decrease in UCC due to expanded coverage under the Affordable Care Act, HSCRC modified the policy in 2014, resulting in a prospective decrease in UCC rate support for RY 2015 (see *Appendix 2*).¹ Now, as the state confronts the potential for a sizeable increase in UCC as a result of significant Medicaid and Marketplace coverage losses, HSCRC should take similar action. MHA respectfully urges

¹ As noted in HSCRC's Rate Year 2026 Uncompensated Care Report from November 2025, "In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to avoid carrying over higher UCC amounts".

HSCRC to prospectively adjust the UCC provision in rates by 0.69% in RY 2027, based on an analysis of state-estimated coverage losses due to policy changes that take effect in CY 2026. Without a prospective adjustment, any increase in UCC in RY 2027 would not be reflected in rates until RY 2029 under the current policy, which would place further financial strain on hospitals and threaten their ability to preserve access to essential acute care in the interim.

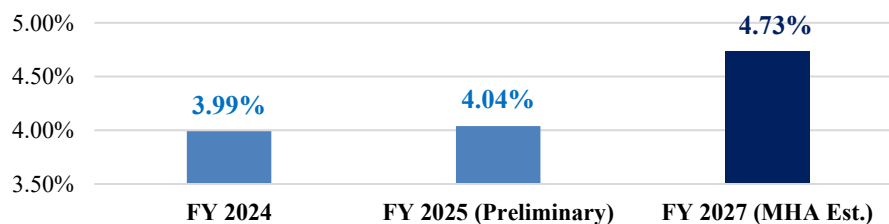
Estimated Medicaid and Marketplace Coverage Losses

Significant reductions in Medicaid enrollment are expected under H.R. 1 as new work requirements, six-month eligibility redeterminations, changes to immigrant eligibility, and other provisions take effect. As many as 130,000 Marylanders could lose Medicaid coverage due to H.R.1, according to the Maryland Department of Health (MDH). Other estimates from the Kaiser Family Foundation (KFF) and the RAND Corporation (180,000 and 230,000, respectively) project even higher coverage losses in Maryland.^{2, 3, 4} At the same time, the expiration of federal enhanced premium tax credits and changes to immigrant eligibility for tax credits for ACA Marketplace plans—two changes that took effect in January 2026—could reduce Maryland Health Connection (MHC) enrollment by 50,000, according to estimates from the Maryland Health Benefit Exchange (MHBE).¹ See *Appendix 3* for a summary of notable policy changes impacting enrollment and a comparison of associated coverage loss estimates.

Prospective Adjustment to UCC Provision in Rates

MHA’s analysis suggests the need for a 0.69% prospective UCC adjustment for RY 2027, which would raise the statewide UCC provision in rates to 4.73% (see *Figure 1*).⁵ This estimate is based on a fraction of the state projected coverage losses, specifically those tied to policy changes that take effect in CY 2026. These include changes to immigrant eligibility for Medicaid coverage and Marketplace tax credits, as well as the expiration of federal enhanced premium tax credits (ePTCs), totaling 65,000 projected coverage losses. The actual increase in UCC could exceed 0.69% if additional coverage losses result from policy changes taking effect in CY 2027 that were not captured in MHA’s analysis.

Figure 1. Statewide UCC Pool, MHA Estimate



Source: RE schedule, FY 2025 + FY 2024 for December hospitals

² Maryland Department of Health and Maryland Health Benefit Exchange January 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

³ Kaiser Family Foundation. August 20, 2025. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State: Allocating CBO’s Estimates of Additional Uninsured People Across the States. Available [here](#).

⁴ RAND. February 26, 2026. State-Level Impacts of Key Medicaid Provisions in the OBBA. Available [here](#).

⁵ MHA calculated the 0.69% projected increase in UCC by multiplying the projected coverage loss of 65,000 by the average cost per uninsured (\$2,380) based on the total amount of UCC in RY 2025 (approx. \$901 million) and the number of uninsured individuals statewide (378,600).

While Medicaid policy changes will not take effect until later this year or in 2027, questions remain about the effectiveness of the mitigation strategies outlined in the draft recommendation. The impacts of Marketplace policy changes, however, are already beginning to emerge.

Recent MHBE data show that 33,000 fewer individuals were enrolled in coverage through Maryland Health Connection (MHC) as of April 2026 compared to the start of the plan year, a 13% decrease compared to the 4% decline in enrollment as of April 2025.^{6, 7} At the same time, those who are enrolling are downgrading coverage, opting for lower-premium bronze plans with up to \$10,000 deductibles. Enrollment in bronze plans as of April 2026 was 7% higher than 2025 levels, whereas enrollment in all other standard metal tiers declined year-over-year: silver (-7%), gold (-16%), and platinum (-39%).⁶ These challenging enrollment trends have occurred despite the availability of state subsidies for plan year 2026 that have lowered monthly premiums by an average of \$95 for nearly seven in 10 MHC consumers. These trends could persist or worsen in plan year 2027 with subsidies that will likely be less generous.⁸

Hospital Readiness for H.R.1 and AHEAD

In preparation for the projected rise in uninsured patients due to H.R.1 Medicaid changes, hospitals will need to make significant operational changes to be ready to support statewide efforts to maximize enrollment in Medicaid. At the same time, hospitals will be making significant investments in staffing, training, and other operational capabilities to prepare for the transition to bifurcated AHEAD policies and programs. MHA urges HSCRC to allocate an additional 0.20% for H.R.1 preparation and 0.10% for AHEAD Model implementation. HSCRC should consider reallocating the Healthcare Outcome Payment Effort (HOPE) funding to support these important statewide priorities.

Under the new coverage environment, hospitals will need to hire additional financial counselors to conduct more extensive Medicaid eligibility screenings, assist with Medicaid applications, assist with more frequent re-enrollment processes, and increase outreach to patients who lose coverage due to procedural or administrative barriers. In addition to expanding front-end capacity, hospitals must strengthen their revenue cycle resources to navigate the new policy changes and coverage landscape. Medicaid eligibility churn, shorter retroactive coverage periods, and more frequent procedural disenrollments are likely to increase denied claims due to coverage lapses or missing documentation. This will create additional administrative burden for hospitals that already dedicate significant resources to securing reimbursement for the care they provide to Medicaid patients.

These coverage disruptions, along with the increased volume of uninsured patients, will not be temporary. Hospitals will need to permanently expand these capabilities to manage these challenges, rather than treat them as short-term response to a policy transition.

⁶ Maryland Health Benefit Exchange. Maryland Health Connection Enrollment Data Dashboard. Available [here](#).

⁷ Enrollment declined by more than 18,000 from March to April, likely due to the expiration of grace periods for non-payment of premiums.

⁸ At MHBE's April Board meeting, the Board approved MHBE staff's preliminary proposal for the parameters for the 2027 state subsidy program. MHBE's Board will be asked to vote on the final proposed parameters in July.

The transition to AHEAD policies and programs is unprecedented and resource intensive for hospitals. For decades, Maryland's unique all-payer global budget revenue system has been built on consistent policies across payers. AHEAD represents a significant departure from that long-standing approach.

Starting in 2028, hospitals will operate under two payment policies and regulatory systems—one for Medicare and another for Medicaid and commercial payers—adding complexity to an already complicated system. As part of their efforts to effectively plan for the transition to this bifurcated system, hospitals will need to allocate significant additional resources to their finance and revenue cycle, clinical operations, quality, and technology workstreams. The AHEAD Model will require hospitals to hire new staff and train existing staff to optimize Medicare cost reporting, transition to a diagnosis-based billing system (i.e., MS-DRG), enhance clinical documentation improvement (CDI), reconfigure systems, and prepare for new payment routines with the Centers for Medicare & Medicaid Services (CMS). Hospitals will also need to assess national quality programs, align systems to manage multiple quality programs by payer, and make investments in productivity management tools and other technology system upgrades, among other planning activities.

Productivity Adjustment

In their draft recommendation, staff propose a 0.80% productivity adjustment to the inflation allowance for non-GBR hospitals. MHA recommends HSCRC discontinue the productivity adjustment and provide specialty hospitals with the full inflation allowance included in the draft recommendation (3.37%). The adjustment is intended to promote cost control and efficiency in operations at non-GBR hospitals. However, it fails to recognize the operational realities of Maryland's specialty hospitals and undermines their ability to preserve access to critical specialty services.

Specialty hospitals play a critical role in Maryland's health care continuum, serving some of the state's most vulnerable populations who cannot safely or effectively be cared for elsewhere. They provide unique inpatient and outpatient behavioral health and pediatric post-acute services to clinically complex patients. This requires specialized nurses, physicians, social workers and other caregivers, often with higher staffing ratios than general acute care hospitals. Given the complexity and highly labor intensive nature of the care they provide, these hospitals cannot be expected to make gains in efficiency without compromising care quality and patient safety.

The productivity adjustment assumes specialty hospitals can and will drive volumes. However, volumes at these hospitals either remain relatively low or are limited by provider and capacity constraints. They do not benefit from the predictability of the GBR system, making them more susceptible to financial challenges due to fluctuations in utilization or operating cost growth. Furthermore, these hospitals face the same cost pressures as their GBR counterparts, including rising energy and staffing costs. However, they are less equipped to absorb these pressures after several years of lower inflation allowances and low reimbursement rates relative to costs. Reinstating the productivity adjustment in RY 2027 would continue this payment inequity. It would also place non-GBR hospitals at a disadvantage in recruiting and retaining the specialized staff required to meet the needs of their patients at a time when they are experiencing clinical workforce shortages.

Conclusion

MHA appreciates the time and effort HSCRC staff have dedicated to the draft recommendation for the RY 2027 update and welcomes the opportunity to work with Commissioners and staff to develop the final recommendation in June. In the coming year, hospitals will need to manage rising input costs due to economic volatility, a higher number of uninsured patients due to federal policy changes, and prepare for AHEAD policies and programs—all while continuing to provide high-quality care to their communities. We ask the Commission to ensure hospitals have sufficient resources for operational readiness and necessary investment in RY 2027, while protecting their long-term financial sustainability.

Thank you for the opportunity to comment on this important matter. If you have any questions, please do not hesitate to contact me.

Sincerely,



Melony G. Griffith
President & CEO

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Cait Cooksey
Jerry Schmith
William Henderson

Appendix 1. Funding Capacity

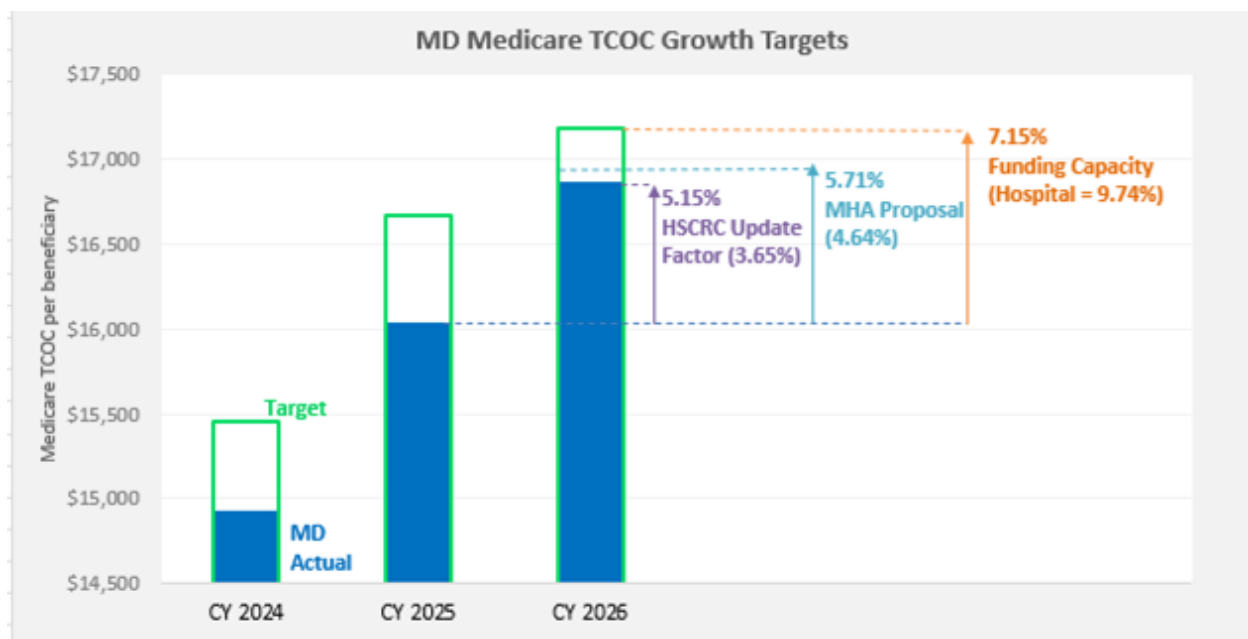
In its draft recommendation, staff present two scenarios for AHEAD target growth rates based on national USPCC trends:

- **Scenario 1:** The 2026 annual target is 4.0 percent, with cumulative growth of 19.0 percent since 2023, based on published USPCC rates.
- **Scenario 2:** Adjusts the national trend by removing duplicate CMS payment adjustments for indirect medical education (IME) and direct graduate medical education (DGME). If these corrections are made, the 2026 annual target increases to 5.3 percent, with cumulative growth of 22.2 percent.

Because AHEAD targets are intended to reflect actual Medicare fee-for-service (FFS) trends as measured by USPCC, MHA believes adjusting the trend for these IME and DGME payments is necessary to ensure a valid and fair comparison of Maryland’s performance to national trends.

Using Scenario 2 targets and incorporating Maryland’s performance in 2024 and 2025, MHA estimates that the maximum allowable total cost of care (TCOC) growth rate for 2026 is 7.15 percent. Assuming non-hospital spending grows at the national projected rate of 5.21 percent, this implies a hospital revenue per beneficiary growth capacity of approximately 9.74 percent (Figure A.1).

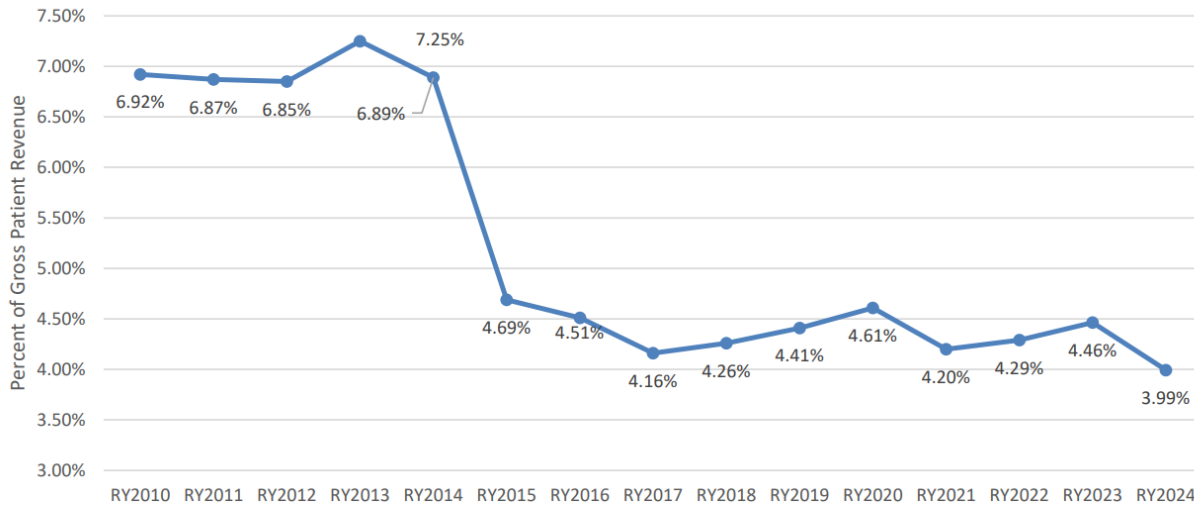
**Figure A.1. Maryland Funding Capacity, MHA Estimate
Based on HSCRC Scenario 2 Modeling Estimates**



MHA proposal (4.64%) includes draft recommendation (3.65%) + UCC (0.69%) + Hospital Readiness (0.30%)

Appendix 2. Uncompensated Care

Actual Statewide UCC in Rates (RY 2010 – RY 2024)



*“Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. **In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts.**”*

Source: HSCRC Rate Year 2026 Uncompensated Care Report, November 3, 2025

Appendix 3. H.R.1 and Other Federal Policy Changes

Table 1. Key Policy Changes, Estimated Coverage Losses, and Impact on RY27 UCC

Provision – <i>Effective Date</i>	State Estimated Coverage Loss	Included in 0.69% Prospective Adj.
<i>Marketplace Policy Changes</i>		
Immigrant Eligibility for Tax Credits – <i>Effective 1/1/26</i> Ends eligibility for Marketplace premium tax credits for lawfully present immigrants under 100% FPL.	20,000	Yes
Enhanced Premium Tax Credits (ePTCs) – <i>Effective 1/1/26</i> Ends federal Affordable Care Act enhanced premium tax credits made available via the American Rescue Plan Act.	30,000	Yes
<i>Medicaid Policy Changes</i>		
Immigrant Eligibility Changes – <i>Effective 10/1/26</i> Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.	15,000	Yes
Work Requirements – <i>Effective 1/1/27*</i> Requires certain expansion adults to complete 80 hrs. per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19-64, with limited exemptions and must be verified through ex-parte processes.	115,000	No
Six-Month Redeterminations – <i>Effective 1/1/27</i> Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver.	--	No
Retroactive Coverage – <i>Effective 1/1/27</i> Reduces retroactive coverage from three months to one month for expansion adults and two months for all other groups.	--	No

* States can request good faith effort extensions through December 31, 2028

Sources: Maryland Department of Health and Maryland Health Benefit Exchange Jan. 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available [here](#). MHBE presentation starts on slide 42, MDH on slide 69.

Table 2. Comparison of Medicaid and Marketplace Coverage Loss Estimates

	MDH/MHBE	KFF	RAND
Medicaid	130,000	180,000 (140,000 – 230,000)	230,000
Marketplace	50,000	30,000	--
Total	180,000	210,000 (160,000 – 260,000)	230,000

Sources: same as above (MDH/MHBE) and footnotes 2 (KFF), and 3 (RAND) on pg. 3