Maryland
Hospital Association

October 30, 2026

William Henderson
Interim Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) evaluation of whether financial assistance is required to maintain the viability of Medicare Advantage (MA) plans and whether to adjust hospital rates to provide such assistance, as required by the Budget Reconciliation and Financing Act (BRFA) of 2026.

MHA recognizes the importance of maintaining a viable and competitive Medicare Advantage market to preserve coverage options and access to care for Maryland Medicare beneficiaries. However, financial assistance to MA plans should not come at the expense of hospital financial stability or Marylanders' access to essential hospital services. Before considering any additional financial assistance, the state should first evaluate the impact of HSCRC's Medicare Advantage Partnership (MAP) funding program and the multi-agency Regulatory Working Group's newly established Medicare Advantage Stabilization program set to take effect in January.

MHA offers the following comments for HSCRC's consideration.

Evaluate the Impact of Former and Current Medicare Advantage Funding Initiatives, Including the New Stabilization Program, Before Considering Additional Assistance

Maryland has already acted to provide substantial financial support to Medicare Advantage plans, including $63.5 million in grants through the MAP funding program that operated in fiscal year (FY) 2021 and FY 2022, as well as the newly established MA Stabilization program. Beginning in calendar year (CY) 2027, qualifying MA plans will receive an additional 11.55% discount on hospital rates, with the program estimated to provide approximately $150 million in annual subsidies.[1] Given the magnitude of these investments, MHA encourages HSCRC to evaluate the impact of the programs before considering additional financial assistance. We recommend that this evaluation examine the extent to which the MAP and MA Stabilization programs improved plan financial performance, supported continued plan participation, preserved beneficiary access to MA coverage, and contributed to long-term market stability. It should also consider whether plans are making progress toward financial sustainability without

[1] Regulatory Working Group Cost-Shifting and MA Stabilization Policy (approved by Governor), available here

ongoing subsidies and whether the financial assistance is producing measurable benefits for Maryland Medicare beneficiaries.

Providing additional financial assistance in CY 2026 would present practical implementation challenges, particularly given the limited time remaining in the year and the prior issuance of hospital rate orders. Moreover, the MA Stabilization program is not scheduled to take effect until January 2027, leaving the state without an opportunity to assess its impact before considering further intervention. For this reason, MHA recommends that the Commission defer consideration of additional hospital rate-funded assistance until the effectiveness of the existing funding efforts can be meaningfully assessed.

Financial Assistance to Medicare Advantage Plans Must be Targeted, Temporary, and Subject to Meaningful Accountability

Any financial assistance is provided under the program must have clear eligibility criteria, defined limitations on funding, and meaningful accountability measures to ensure that support to plans produces measurable benefits for Marylanders. As noted in MHA's Dec. 2, 2025 comments regarding the MA Stabilization program, financial assistance to MA plans should serve as a temporary intervention rather than an ongoing source of financial support. Any additional assistance should be time-limited, subject to an annual funding cap, and accompanied by clearly defined criteria for reducing or discounting support. To support this aim, participating plans should be required to demonstrate financial need and submit detailed plans outlining how they intend to achieve long-term financial stability without continued support.

Financial assistance should be contingent on meaningful commitments from MA plans to improve beneficiary access to care, quality of care, and population health. Eligibility should be conditioned on compliance with reasonable utilization review standards given the significant rise in medical necessity denials by MA plans in recent years, contributing to delays in patient care and administrative burdens for hospitals. Plans receiving support should be required to meet established benchmarks for medical necessity determinations, timely prior authorization decisions, access to meaningful peer-to-peer review, and reductions in inappropriate claims denials. Delays in prior authorization for post-acute services is a particular area of challenge for MA plans and contributes to prolonged hospital stays despite patients being ready for discharge. Timely approvals would support efforts to reduce prolonged hospital stays and emergency department throughput challenges. Reasonable utilization review practices are necessary to maintain and increase beneficiary participation in MA plans. Regular reporting on these measures would help the state assess whether financial assistance is accompanied by meaningful improvements in plan performance and accountability.

Protect Hospital Financial Stability and Address Unintended Hospital Revenue Impacts

MHA appreciates the multi-agency Regulatory Working Group's efforts to structure the MA Stabilization program to be revenue neutral for hospitals. However, as described in HSCRC's Oct. 9, 2026 memorandum regarding CY 2027 subsides, hospitals bear the financial risk of changes in payer mix after the public payer differential for qualifying MA plans is established. Specifically, any changes in MA enrollment or plan participation could cause the total value of

hospital rate discounts to exceed initial projections, potentially resulting in unintended reductions in hospital revenue.[2] For example, HSCRC notes that a five-percentage point increase in the MA share of Medicare revenue, and a 10-point increase in the qualified MA plan share of Medicare revenue could result in about $28 million in lost hospital revenue statewide.[3] These risks warrant particular attention given the significant financial pressures facing Maryland hospitals and health systems, including anticipated coverage losses due to H.R.1 and other federal policies and the forthcoming transition to the AHEAD Model.

MHA therefore appreciates HSCRC's commitment to monitoring the financial impacts of the MA Stabilization program. The state should establish a transparent and timely process to identify and reconcile these differences. This would protect hospitals from bearing the burden of higher-than-expected program costs due to factors outside of their control, including increases in MA enrollment and plan participation. More broadly, any assistance to MA plans should include explicit safeguards to protect hospital revenue and ensure that efforts to stabilize the MA market do not compromise hospitals' ability to preserve access to essential services.

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MHA appreciates the state's consideration of opportunities to stabilize the Medicare Advantage market to ensure continued access to coverage options for Medicare beneficiaries. Given the substantial financial assistance already committed through the MA Stabilization program, it is important to evaluate the effectiveness of that intervention before considering additional support.

Thank you for your consideration of these comments and your continued collaboration with Maryland hospitals and health systems. Please do not hesitate to reach out with any questions.

Sincerely,

Patrick D. Carlson
Vice President, Care Transformation & Finance

cc: Kevin Sexton, Chair
Jonathan Blum
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Dr. Benjamin Stallings

[2] Oct. 9, 2026 HSCRC Memo: Medicare Advantage Stabilization Differential Estimate (CY 2027), available here
[3] HSCRC also modeled greater increases in the MA share and qualified MA plan share of Medicare revenue, which would result in statewide hospital revenue reductions of approx. $61 million and $143 million, respectively.