



March 30, 2026

The Honorable Heather Bagnall
Chair, House Health Committee
Room 240, House Office Building
Annapolis, MD 21401

RE: Senate Bill 515 – Health Services Cost Review Commission – Health Facilities – Jurisdiction and Rate Setting – Letter of Information

Dear Chair Bagnall and Committee Members:

The Health Services Cost Review Commission (HSCRC) respectfully submits this Letter of Information for Senate Bill (SB) 515, “Health Services Cost Review Commission – Health Facilities – Jurisdiction and Rate Setting.”

Background

Hospital staffing and clinician payment models have shifted substantially since the inception of the Maryland Model in 2014. Historically, clinicians worked primarily in physician-owned independent or group practices; however, increasingly clinicians are employed by hospitals, health systems, or practices with non-physician owners, such as private equity groups. This shift has fundamentally changed the structure of clinician compensation and created new challenges for the hospital industry that are compounded by flat or declining reimbursement for clinician services relative to inflation. This is particularly notable within Medicare, a major payer for most hospitals.

Current Efforts to Address Physician Costs

Recognizing these pressures, HSCRC has made efforts to consider, and where possible provide support for, these pressures within the hospital global budget revenue (GBR) rate-setting process. For example, policies such as Revenue for Reform allow hospitals to retain a portion of savings attained under the Model, recognizing that some portion of that revenue will subsidize costs, such as physician staffing. The Revenue for Reform policy specifically carves out a Physician Spending Safe Harbor which allows hospitals to include spending on primary care, mental health providers, and dental providers in a Health Professional Shortage Area or a Medically Underserved Area.

In addition, in collaboration with the hospital field, HSCRC has prioritized understanding the full scope and impact of physician costs and revenue within hospitals as part of a

broader effort to modernize hospital annual reporting. This analysis includes assessing currently available data, identifying data that are still needed, and considering potential policy or regulatory opportunities.

Stemming from this effort and working with all Maryland hospitals, HSCRC has conducted and reported on two data pilot projects that have produced foundational information about the volume of clinicians working within hospitals, the types of employment and contractual arrangements that govern physician services, and broad information about the costs and revenues associated with physician employment and costs. Data gathered through this process revealed that unregulated physician losses totaled approximately \$517 million in fiscal year (FY) 2016 and grew to \$1.14 billion in FY 2025. Over the same time period, through the HSCRC's GBR rate-setting process, rate increases to hospital regulated margins have largely offset reported unregulated physician losses, increasing by \$490 million, from \$1.21 billion in FY 2016 to \$1.70 billion in FY 2025.

The pilot process also revealed significant additional questions, and highlighted areas in need of further study, including but not limited to the need to clearly define physician services necessary for regulated services, identifying and understanding indirect/support staff costs associated with physician services, and ensuring consistent reporting of key data across hospitals and health systems. In its December 2025 Commission meeting, HSCRC put out a call for public comments, which resulted in submissions from a wide array of stakeholders including hospitals, hospital systems, and payers from across the state.

Comments received were reviewed during the January 2026 meeting, revealing areas of consensus as well as disagreement within the healthcare sector. As part of the January discussion, Commissioners identified significant additional considerations, including the need to:

- Establish clear definitions;
- Identify appropriate outcome measures and quality metrics;
- Establish methodologies to ensure accountability and transparency;
- Understand the full scope of the supports that are currently in place; and
- Define, within those parameters, supports that may be needed going forward.

Most recently, HSCRC prepared and presented a report on data provided for calendar year (CY) 2025 at the March 2026 Commission meeting. The findings from this process continue to inform the agency's next steps.

Healthcare Investments in the Context of the AHEAD Model

Maryland's success in the AHEAD Model requires multi-agency and cross-sector collaboration to a greater extent than the previous All-Payer and Total Cost of Care Models. The goals of the model extend beyond managing costs to include ensuring equitable and affordable access to healthcare for all Marylanders, and investing in population health improvements. Under the auspices of the multi-agency Regulatory Working Group, HSCRC, MHCC and MIA—in collaboration with the Maryland Department of Health and the Maryland Health Benefit Exchange—have partnered to advance several initiatives to position the State for success under AHEAD. Each initiative, as well as others to be determined, requires identification of a funding source. This becomes extremely poignant in the face of decreasing federal funding for healthcare and in a tight budgetary environment.

Any policy decision impacting health care funding must carefully balance the needs, potential impacts, and considerations across the full spectrum of healthcare service delivery, as funding in one area necessarily reduces the resources available in other critical areas. In addition, consideration of physician costs within hospital rates could translate into upward pressures on the state budget (*i.e.*, through Medicaid and the State Health Employee Plan) as well as to consumers (*i.e.*, through increased insurance premiums and co-pays).

The joint efforts of State agencies and Maryland hospitals, as outlined above, have clearly demonstrated that policy action in this area must be carefully structured to avoid significant unintended impacts, including destabilization within and across insurance markets, increased pressure towards health system consolidation, and negative impacts on clinician employment and the viability of independent physician practices.

HSCRC appreciates the opportunity to provide the Committee with information about the context, background, and potential impact of SB515. If the Committee or members have any questions, or if we can provide you with any further information, please do not hesitate to contact us at jon.kromm@maryland.gov.

Sincerely,



Jon Kromm
Executive Director