

COUNCIL ON FINANCIAL POLICY



Maryland
Hospital Association

June 3, 2025



Maryland
Hospital Association

COUNCIL ON FINANCIAL POLICY

Tuesday, June 3, 2025, 1-3 p.m.
VIRTUAL

AGENDA

1 p.m.	Welcome and Consideration of Meeting Minutes	Mohan Suntha, M.D., Chair
1:03	Meeting Objectives	Tequila Terry, SVP, Care Transformation & Finance
1:10	Annual Payment Update for RY 2026 <ul style="list-style-type: none">HSCRC Recommendation Recap / Payment Models Workgroup	Patrick Carlson, Vice President, Care Transformation & Finance
1:40	Volume Policy Update <ul style="list-style-type: none">Update on HSCRC Work on Demographic and Market Shift Policies	Adam Kellermann, Director, Health Care Payment
2	Payer Denials & Accountability <ul style="list-style-type: none">MHA Survey ResultsHSCRC Data Collection on DenialsMIA Workgroup on Adverse DecisionsProposed MIA Health Insurance Commission or Advisory BoardMedicaid Payer Relations Task Force	Patrick Carlson Adam Kellermann Brian Burkhalter, Assistant Vice President, Health Care Analytics
2:30	AHEAD Model Update	Tequila Terry
2:55	Recap and Action Items	Tequila Terry
3 p.m.	Adjourn	Dr. Mohan Suntha



Maryland
Hospital Association

COUNCIL ON FINANCIAL POLICY

Membership Roster
Fiscal Year 2025

Mohan Suntha, M.D., Chair

President & Chief Executive Officer
University of Maryland Medical System
Baltimore

Ed Beranek

Vice President, Revenue Management and
Reimbursement
The Johns Hopkins Hospital & Health System
Baltimore

Amy Boothe

Vice President, Finance and Operations
Garrett Regional Medical Center
Oakland

Emily Briton

MedStar Montgomery Medical Center
President
Olney

Joshua A. Campbell, MBA, FHFMA

Vice President, Finance & Reimbursement
GBMC Healthcare, Inc.
Baltimore

Alicia Cunningham

Senior Vice President, Corporate Finance and
Revenue Advisory Services
University of Maryland Medical System
Baltimore

Justin C. Deibel

Executive Vice President & Chief Financial
Officer
Mercy Medical Center
Baltimore

Katie Eckert, CPA*

Senior Vice President, Strategic Operations
Adventist HealthCare
Gaithersburg

Stephanie Gary

Vice President, Finance and Chief Financial
Officer
TidalHealth
Salisbury

Carolyn Heithaus

Vice President, Finance & Chief Financial
Officer
Calvert Health Medical Center
Prince Frederick

Hannah Jacobs

Senior Vice President & Chief Financial
Officer
Frederick Health
Frederick

James A. Kanuch

Chief Financial Officer & Vice President
Atlantic General Hospital
Berlin

Julie Keese

Vice President and Chief Financial Officer
Holy Cross Health
Silver Spring

David Krajewski

Executive Vice President and Chief Financial
Officer
LifeBridge Health
Baltimore

Mitch Lomax

Chief Financial Officer
Ascension Saint Agnes
Baltimore

Susan K. Nelson

Executive Vice President and Chief Financial
Officer
MedStar Health
Columbia

Amber Ruble

Chief Financial Officer
UPMC Western Maryland
Cumberland

Kelly Savoca

Vice President and Chief Financial Officer
Sheppard Pratt Health System
Towson

Stephanie Schnittger

Luminis Health
Chief Financial Officer
Annapolis

Thomas J. Senker

President, MedStar Good Samaritan Hospital
& MedStar Union Memorial Hospital
Baltimore

Mario Voli

Vice President, Finance
ChristianaCare, Union Hospital
Elkton



Maryland
Hospital Association

COUNCIL ON FINANCIAL POLICY

Wednesday, April 30, 2025, 1 p.m. - 3 p.m.

MINUTES

ATTENDANCE

Members	Present	Absent
Mohan Suntha, M.D., Chair	X	
Ed Beranek		X
Amy Boothe	X	
Emily Briton		X
Joshua Campbell	X	
Alicia Cunningham	X	
Justin C. Deibel	X	
Katie Eckert	X	
Stephanie Gary	X	
Carolyn Heithaus		X
Hannah Jacobs	X	
Jim Kanuch	X	
Julie Keese	X	
David Krajewski		X
Mitch Lomax	X	
Susan Nelson	X	
Amber Ruble	X	
Kelly Savoca	X	
Stephanie Schnittger		X
Thomas J. Senker	X	
Mario Voli	X	

Guests

Rebecca Ford, Dr. David Maine, Mike Myers, Scott Perrin, Zach Pietsch, Laura Russell, Kathy Talbot, David White, Mike Wood

Attending MHA Staff

Patrick Carlson, Melony G. Griffith, Adam Kellermann, Anene Onyeabo, Tequila Terry, Chastity Veasley, Emily Way, Kashay Webb, Amanda Wright

CALL TO ORDER AND APPROVAL OF MINUTES

Dr. Mohan Suntha called the meeting to order at 1 p.m. The minutes from the March 18, 2025 meeting were approved as written.

RY 2026 Annual Payment Update

Outcome

Council members agreed with MHA's advocacy strategy for the RY 2026 Annual Payment Update. There was strong support to exclude the Medicaid Deficit Assessment from calculations of net benefit to hospitals. Members agreed that MHA's messaging should clarify the disconnect between the proposed 5.63% update and the true financial impact, accounting for excluded components and passthrough obligations. The group affirmed MHA's four advocacy priorities and encouraged MHA to continue engaging directly with HSCRC commissioners to reinforce these positions and advocate for a fairer, more sustainable update.

Main Points of Discussion

- At the April 29 Payment Models Workgroup, HSCRC staff proposed a 0.76% demographic adjustment correction to reflect updated population growth based on U.S. Census data. This would be in addition to the existing 0.74% demographic adjustment based on the Maryland Department of Planning's growth estimates.
- MHA supports a more robust demographic adjustment and advocated for a prospective inflation increase to account for cost volatility faced by hospitals
- HSCRC staff proposed a prospective correction to address uncompensated care (UCC) funding errors from FY 2021-FY 2023. Hospitals that were underfunded would receive a positive adjustment, while those that were overfunded would be held harmless. For health systems, the adjustment may be blended to reflect systemwide funding discrepancies.
- Staff also shared projections showing over \$800 million in Medicare TCOC savings for CY 2024, along with several guardrail test scenarios
- Staff intend to apply a -0.80% productivity cut to the inflation update for non-GBR hospitals, resulting in a proposed inflation adjustment of 2.56%. MHA urged HSCRC to continue to suspend this cut due to persistent financial strain across the field.
- Members noted that HSCRC's proposed 5.63% annual payment update overstates the actual benefit to hospitals, as it includes components that do not generate net new revenue
- Several adjustments and one-time funding sources are excluded from the 5.63% figure, including the reversal of FY 2025 set-aside funds, the reversal of FY 2025 surge funding, and the second half of the mid-year inflation increase. Members emphasized the importance of quantifying these items to reflect the true net financial impact.
- Members also highlighted that the proposed update includes a 0.7% increase to fund the Medicaid Deficit Assessment, which is a passthrough to Medicaid and does not support hospital bottom lines. Members recommended excluding this amount from MHA's update request.



Maryland Hospital Association

- Questions were raised about whether additional unfunded policies, such as the delayed implementation of new volume methodologies and the recently passed technology assessment, were factored into the staff's update calculations
- MHA reported that while HSCRC staff appear hesitant to deviate from formulaic methodologies, commissioners have shown openness and agreed to meet with MHA to review the rationale for a more comprehensive update
- Members agreed that advocacy efforts should focus on the ongoing financial burden from overachievement of Medicare savings, continued underfunding of demographic growth, and volatility in cost trends
- Members supported refining messaging to the Board to provide an “apples-to-apples” comparison between HSCRC’s proposal and MHA’s ask, clearly excluding the Medicaid Deficit Assessment and other components that do not translate into retained hospital funding
- Clear counterarguments should be developed to anticipated staff positions, particularly in response to proposals to delay or backload adjustments

MHA Next Steps

- MHA will send a one-pager to council members, comparing the staff proposal to the MHA ask, excluding the Medicaid Deficit Assessment from the hospital contribution
- MHA will follow up with commissioners to continue advocacy on inflation and demographic adjustment funding, Medicaid Deficit Assessment, and productivity adjustment

Member Action

- Review MHA’s forthcoming one-pager summarizing funding components and confirm support for the proposed approach

Volume Policy: Demographic Trending Analysis

Outcome

MHA relayed HSCRC staff’s perspective on aging-related hospital utilization and shared an analysis developed in response to feedback. Council members broadly supported MHA’s approach to demonstrating the link between aging populations and higher hospital utilization, emphasizing the need for stronger data and policy arguments to advance demographic funding reforms. Members affirmed the importance of continuing this analysis and offered several suggestions to strengthen the evidence base. On volume policies more generally, members expressed interest in ongoing engagement as HSCRC considers revisions to the variable cost factor and broader volume policy refinements.

Main Points of Discussion

Demographic Adjustment

- HSCRC staff have questioned the extent to which an aging population drives increased hospital utilization, citing technological advancements that may offset costs.



Maryland Hospital Association

- MHA presented a new analysis showing that counties with growing 60+ populations experienced higher unrecognized ECMAD growth not captured by the Market Shift Policy
- When county-level data were apportioned to hospitals using CY 2023 ECMAD shares, the correlation between aging and utilization remained evident at the hospital level
- Members were asked for feedback on how MHA might refine or expand the analysis to build a stronger case for long-term reforms to the demographic adjustment
- Suggestions included compiling national literature to link aging with cost growth, duplicating AHEAD Model HCC analysis, and documenting technical errors in the volume scorecard to elevate concerns to HSCRC staff and commissioners.

Volume Policies

- HSCRC is reviewing literature and working with consultants to revise the Market Shift Policy's 50% variable cost factor (VCF), with a potential new policy effective July 2025. Staff indicated a preference for maintaining the 50% VCF for medical services and increasing it to 60% for surgical services
- John Colmers is developing a non-binding recommendation for a longer-term framework on volume policy reform

MHA Next Steps

- MHA will continue enhancing its aging-utilization analysis and explore additional methodologies to support the case for demographic adjustment reform
- MHA will compile member-reported issues with the volume scorecard and consider how best to share those with HSCRC staff and commissioners
- A more detailed discussion on HSCRC's evolving volume policy framework will be brought to the Council on Financial Policy at a future meeting

Member Action

- Send MHA any discrepancies, technical errors, or concerns identified in the volume scorecard
- Share additional ideas or resources (e.g., national studies or analytic methods) to strengthen the aging-utilization policy case

Proposal to Modify Integrated Efficiency Policy

Outcome

Council members expressed general support for HSCRC's proposed modification to the Integrated Efficiency Policy. The revision was viewed as a step in the right direction, particularly in limiting penalties for hospitals with efficiency scores just outside of the third quartile. While the revised threshold and protection measures were well received, members raised concerns about expanding penalties to the third quartile and suggested exploring alternative methodologies to better account for performance variation.

Main Points of Discussion



Maryland
Hospital Association

- At the April 2 Payment Models Work Group meeting, HSCRC staff introduced a proposed modification to the Integrated Efficiency Policy and requested feedback from stakeholders ahead of a potential Commission vote in the coming weeks
- The revised policy would create a new threshold where hospitals would not be penalized if they either (1) fall within the third quartile or better or (2) perform better than one historical standard deviation from the average ICC (Interhospital Cost Comparison) performance
- Under this approach, the number of penalized hospitals may decrease compared to the current policy, which applies penalties based solely on ordinal ranking
- HSCRC is also considering expanding negative scaling to include hospitals in the third quartile, although low-volume protections would remain intact
- Council members generally supported the revision, particularly the move toward incorporating standard deviation thresholds, which may better reflect true performance differences
- Concerns were raised about the potential for expanding penalties to the third quartile without sufficient justification or demonstrated performance gaps
- Some members suggested replacing quartile-based cutoffs with percentage-based or fixed-threshold approaches to avoid penalizing hospitals due to compressed performance distributions
- There was interest in reviewing earlier policy documentation to assess whether standard deviation-based approaches were previously considered and to evaluate their historical applicability
- MHA noted that HSCRC staff have not received substantial field feedback to date but appear poised to move forward with the proposal
- Multiple Council members expressed that the revision is a meaningful improvement, though additional refinement of the ICC methodology is still needed
- Members emphasized the importance of addressing both high-cost outliers and low-cost hospitals, suggesting that mechanisms beyond full-rate applications may be needed to appropriately incentivize improvement

MHA Next Steps

- MHA will relay Council feedback to HSCRC, confirming general support for the revised methodology and raising member concerns about third quartile penalties
- MHA will review prior policy records to evaluate the feasibility of a fixed standard deviation or percentage-based approach

Member Action

- Share any supporting documentation or past analysis related to performance threshold methodologies (e.g., standard deviation or percentile-based models)

AHEAD Model Status Update

Outcome



Council members engaged in a forward-looking discussion about the implications for Maryland's transition to the AHEAD Model. The conversation raised early priorities and process considerations for upcoming negotiations. Members emphasized the need for real-time updates and flexible engagement as details emerge. MHA will use this input to shape its role in the state's planning efforts and ensure hospital perspectives are reflected throughout the negotiation process.

Main Points of Discussion

- CMMI released a public statement confirming that Maryland's TCOC Model will end in 2025 to allow for transition to the AHEAD Model in 2026
- While the state is still expected to join AHEAD, a new phase of negotiations is underway, and significant changes to the Model structure may occur. The Maryland Secretary of Health will lead the state's discussions with CMMI.
- MHA is involved in the planning process for negotiations and will share emerging updates as more information becomes available
- Members emphasized that given the fluidity of the situation, MHA should keep the Council closely informed, even if it requires ad hoc meetings between regularly scheduled Council on Financial Policy meetings
- There was interest in comparing the financial specifications of AHEAD Model versions 2.0 and 3.0 with Maryland's existing methodology to better anticipate potential shifts

MHA Next Steps

- MHA will continue participating in the state's negotiation planning and monitor emerging guidance from CMMI
- Additional updates will be shared with Council members as new details become available, including through special briefings as needed

Member Action

- Submit any questions or concerns you would like MHA to elevate during the AHEAD Model negotiations

Topic

Annual Payment Update for Rate Year 2026

Objective

To update the Council on Financial Policy on the status of the RY 2026 annual payment update and gather feedback on MHA's advocacy strategy to secure additional funding support for hospitals

Discussion
Question

- Is there a preference on the advocacy strategy MHA should pursue to secure additional APU funding support?
- Are there messages MHA should elevate in upcoming conversations with HSCRC Commissioners and in its testimony at the June 11 public meeting?

Under their draft recommendation for the Rate Year 2026 annual payment update, Health Services Cost Review Commission (HSCRC) staff propose a 3.36% gross inflation allowance for all hospitals, a 2.56% inflation update for non-GBR specialty hospitals after application of a -0.80% productivity adjustment, and 5.68% revenue growth (4.9% per-capita revenue growth) over rate year 2025 for GBR hospitals. Their draft recommendation includes 1.06% revenue growth for technical corrections to the demographic adjustment and uncompensated care calculations from prior rate years.

MHA Comment Letter on Draft Recommendation

On May 21, MHA submitted a [comment letter](#) on behalf of the field highlighting the need for a robust annual payment update given the financial conditions of Maryland hospitals and health systems and the significant cost pressures and uncertainty they face. MHA requested that HSCRC (1) provide an adjustment to address unprecedented inflationary cost pressures, (2) fully fund age-adjusted demographic growth, (3) pass through the \$150-million increase in the Medicaid Deficit Assessment to payers, and (4) suspend implementation of the productivity adjustment for non-GBR specialty hospitals. The comment letter encourages the Commission to look at the substantial excess Medicare TCOC savings generated by the state over the Model as an opportunity to provide a more robust annual payment update.

HSCRC Responses to Stakeholder Feedback on Draft Recommendation

HSCRC staff responded to feedback from stakeholders on their draft recommendation at the May 29 Payment Models Work Group meeting. Staff shared that while they received many requests from stakeholders for a more robust update, they adhered to the formulaic approach and any rate adjustments beyond what was proposed will be determined by Commissioners.

Potential Alternative Positions

In response to feedback from HSCRC staff, MHA is considering modified positions to secure additional funding in the annual payment update including:

- Funding for age-adjusted demographic growth, but with an HSCRC evaluation of the impact of this increased funding on unrecognized volume growth
- A few options for additional funding support including:
 - Option 1: 0.67% adjustment, based on the average relative difference between inflation forecasts and actuals in RY 2023 and RY 2024 (MHA's current request)
 - Option 2: Suspension of the 1% guardrail for underfunded inflation adopted last year and funding for the current cumulative underfunding (0.52%)
 - Option 3: 0.35% adjustment, based on the relative difference between inflation forecasts and actuals in RY 2024

MHA Health Care Payment Work Group members support continuing to push for age-adjusted demographic funding and either Option 1 or Option 2 to get additional funding for inflation. Work group members also advised that MHA's engagement should focus on approaches that we believe resonate best with Commissioners.

Next Steps

HSCRC is expected to release their final recommendation on June 4. MHA has engaged directly with HSCRC staff and Commissioners regarding the annual payment update over the past several weeks and will provide testimony at the June 11 Commission meeting, at which time HSCRC staff will present publicly—and commissioners will vote on—their final recommendation.

Prepared by: Patrick Carlson, Vice President, Care Transformation & Finance

Attachments:

- PowerPoint presentation
- MHA comment letter

ANNUAL PAYMENT UPDATE FOR RY 2026



DRAFT RECOMMENDATION

HSCRC's [Staff Recommendation for the RY 2026 Annual Payment Update](#) includes:

- 3.36% gross inflation allowance for all hospitals
 - Non-GBR hospitals: inflation update of 2.56% after applying a -0.80% productivity adjustment
- **5.68% revenue growth** and **4.9% per-capita revenue growth** for **GBR hospitals**
 - 1.5% demographic adjustment, including 0.76% in technical corrections from prior rate years
 - 0.30% adjustment to address an uncompensated care (UCC) funding error from FY21-FY23
 - 0.70% adjustment to account for the \$150-million increase in the Medicaid Deficit Assessment, of which MHA understands hospitals will only be responsible for ~ \$8M
- Proposed modification to the integrated efficiency policy intended to ensure only hospitals with outlier Inter-Hospital Cost Comparison (ICC) performance are penalized, of which Health Care Payment Work Group and CFP members were supportive

MHA'S REQUESTS

- 1** A **0.65% adjustment for age-adjusted demographic growth**, which represents the average annual amount of unfunded age-adjusted population growth from 2020 to 2024 after the proposed demographic growth correction
- 2** A **0.67% adjustment to inflation to account for economic volatility**, based on the average relative difference between inflation forecasts (the basis for the funding amount) and actuals from RY 2023 and RY 2024
- 3** **Pass through the full amount of the increase in the Medicaid Deficit Assessment (\$150 million) to payers**
- 4** **Continue suspension of the productivity adjustment for non-GBR hospitals**

1.32% revenue growth on top of what HSCRC staff have proposed

The comment letter MHA submitted on behalf of the field highlights these requests

HSCRC RESPONSES

Re: Inflation Support: The current unfunded inflation rate is -0.52%, below the 1% guardrail threshold. If actual inflation exceeds the funded inflation rate for RY 2026 and cumulative unfunded exceeds the 1% guardrail, additional inflation support will be provided.

Re: Age-Adjusted Growth: Staff will collaborate with stakeholders to revise this policy and will work over the coming months to review and align it with the implementation of AHEAD. This involves a fundamental change to the methodology, so a stakeholder engagement process is required.

Re: Medicaid Deficit Assessment Pass-Through: Given the magnitude of the increase (\$150 million), it would be inequitable to pass the entire burden onto payers and patients.

Re: Productivity Adjustment: The adjustment is in line with the proposed IPPS rule for FFY 26. Staff understand non-GBR hospitals are facing similar cost pressures to GBR hospitals. Staff are reviewing analyses (volumes changes and changes in service lines, compensation per FTE) in response to requests to waive the adjustment and are open to stakeholder feedback on what analyses to consider.

HSCRC RESPONSES

Re: UCC Fund Revision: If approved by the Commission, HSCRC staff will implement this policy as a one-time adjustment in RY 2026, not as an increase to mark up.

Re: Excess Savings: “At this time, **Staff are not making recommendations related to reinvestment of savings above target and above the formulaic adjustments...** However, Staff are working with Commissioners to assess options outlined in comments and other feedback”.

Re: CareFirst’s Comments: “Staff are committed to ensuring that the recommended balance update considers hospitals, payers, and patients that receive care in the State of Maryland. For this reason, **Staff do not recommend revising the draft policy to amend for any of the concerns outlined in the other stakeholder comment letters.** We understand the importance of considering both savings and guardrail positions related to our Model performance.

PAYMENT MODELS WORKGROUP

Staff intend to adhere to the formulaic approach for determining the update

Any rate adjustments beyond what has been proposed in staff's draft recommendation will be determined by Commissioners

Staff may be entertaining continued suspension of the productivity adjustment for non-GBR hospitals

The final recommendation will be released tomorrow, June 4

POTENTIAL MODIFIED POSITION OPTIONS

Potential Modified Positions

- Demographic adjustment
 - 0.65% adjustment for age-adjusted growth **with an HSCRC evaluation**
- Additional inflation support
 - *Option 1*: Continue to push for **0.67%** adjustment (avg. relative diff., RY23-24)
 - *Option 2*: Seek suspension of 1% underfunded guardrail and **0.52%** adjustment*
 - *Option 3*: Push for **0.35%** adjustment (relative diff, RY24)

Health Care Payment Work Group Feedback

- Support for continued push for age-adjusted demographic funding
- Support for either Option 1 or 2 in an effort to get additional inflation funding
- Focus of future engagement should be on approaches that resonate best with Commissioners

* Based on HSCRC's calculation of underfunding, included in draft recommendation and 5/29 Payment Models Workgroup meeting

DISCUSSION

- Is there a preference on the advocacy strategy MHA should pursue to secure additional APU funding support?
- Are there messages MHA should elevate in upcoming conversations with HSCRC Commissioners and in its testimony at the June 11 Public Meeting?
 - CareFirst has raised consumer affordability as a concern in opposing efforts to increase the APU—are there impactful points to make to mitigate concerns about the cost impact on consumers?

ANNUAL PAYMENT UPDATE FOR RY 2026

Appendix



Approach Discussed with CFP on 4/30 Updated Based on HSCRC Draft Recommendation

HSCRC Core Update Factor Elements	
Revenue growth, net of offsets	5.68% (A)
Per capita revenue growth	4.90%
MHA Requests for Additional Funding	
Prospective adjustment for inflation	+ 0.67% (B)
Funding for age-adjusted demographic growth	+ 0.65% (C)
Total funding request (B + C)	+ 1.32% (D)
Total Update with MHA Requests for Additional Funding	
Revenue growth, net of offsets (A + D)	7.00% (E)
Per capita revenue growth	6.21%

Update proposed under HSCRC Draft Recommendation.

Inclusive of 1.06% in corrections related to demographic growth (0.76%) and uncompensated care (0.30%) funding.

After Backing Out \$150M Increase in the Medicaid Deficit Assessment

Medicaid Deficit Assessment Increase - 0.70% (F)

Revenue growth, net of offsets (E + F)	6.25%
Per capita revenue growth	5.47%

Per CFP's request. Intended to isolate the portion of the proposed update that directly benefits hospitals and health systems.

RY 2025 Update (for comparison)

Revenue growth, net of offsets = 4.80%

Per capita revenue growth = 4.53%



PROPOSED UPDATE FOR RY 2026

HSCRC staff presented their [Draft Recommendation for the Rate Year 2026 Annual Payment Update](#) to Commissioners on May 14. It includes:

- 3.36% gross inflation allowance for all hospitals
 - Non-GBR hospitals: inflation update of 2.56% after applying a -0.80% productivity adjustment
- **5.68% revenue growth** and **4.90% per-capita revenue growth** for **GBR hospitals**
 - RY 2025 (for comparison): 4.80% revenue growth and 4.53% per-capita revenue growth
 - Revenue growth figures represent a 0.05% increase over what was presented to CFP on 4/30 due to increase in the allowance for “Care Transformation” funding

Note: Inflation and revenue growth figures may be different in the Final Recommendation presented to Commissioners for approval at the June 11, 2025 HSCRC Public Meeting

DEMOGRAPHIC ADJUSTMENT

Staff propose a **1.5% demographic adjustment** for RY 2026

- **0.74%** based on the Maryland Department of Planning's most recent overall population growth estimate, per standard demographic adjustment policy
- [*New in RY 2026*] **an additional 0.76%** based on population growth not accounted for in prior rate years' annual payment update due to:
 - A Census restatement and revised net migration estimate: ~ 41k additional lives
 - Reconciling the demographic adjustment to cumulative population counts vs. percentage growth rate to improve accuracy/ reflect actual population changes: ~ 6k additional lives
 - Staff propose revising this policy for RY 2026 and future years

UNCOMPENSATED CARE CORRECTION

Staff propose a **0.30% adjustment to address a UCC funding error**

- Due to an HSCRC calculation error, 27 hospitals were underfunded, and 16 hospitals were overfunded for uncompensated care between FY21 – FY23
 - Under the proposal, hospitals that benefited (were overfunded) will be held harmless
 - Adversely impacted (underfunded) hospitals will receive a positive adjustment; for system hospitals, the adjustment may be reduced if affiliated hospitals were overfunded
 - HSCRC staff shared an Excel file showing the impact to each hospital in an email to hospital CFOs and casemix liaisons titled “Financial Methodology Outputs” on May 2

OTHER ITEMS OF INTEREST

- Staff propose a **0.70%** adjustment in RY 2026 to account for the legislature-approved \$150 million increase in the **Medicaid Deficit Assessment**
 - MHA understands that hospitals would be responsible for \$64.4M (14.5% of the total deficit amount: \$444.8 million) in RY 2026: ~ \$8 million more than in RY 2025 (\$56.4 million)
- As proposed, a **-0.80% Productivity Adjustment** would be applied to the inflation update for non-GBR hospitals, bringing the inflation update to 2.56%
 - Staff communicated that they are still working to determine if this is a reasonable adjustment and expressed interest in speaking with specialty hospitals on that point
- Staff recommend a **modification to the Integrated Efficiency policy** to ensure only hospitals with outlier Inter-Hospital Cost Comparison (ICC) performance are penalized, of which Health Care Payment Work Group and CFP members were supportive



Maryland
Hospital Association

May 21, 2025

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 Health Services Cost Review Commission (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2026. MHA appreciates the time your dedicated staff took to ensure a fair and reasonable update as well as their collaboration with stakeholders over the past several months on this important issue.

After reviewing staff's draft recommendation, MHA respectfully requests consideration of an additional 1.32% revenue growth (0.65% for age-adjusted demographic growth and 0.67% for a prospective inflationary increase), a full pass through of the increase in the Medicaid Deficit Assessment to payers, and suspension of the productivity adjustment for non-GBR hospitals, as described in greater detail below.

Maryland hospitals and health systems are navigating uncharted waters. Challenging financial conditions and unprecedented cost pressures related to tariffs, potential cuts to Medicaid funding, rising insurer denials, and increasing physician costs challenge their stability at a time when they can least afford it. Ensuring hospitals and health systems have sufficient resources for operational readiness and necessary investment in care transformation is more important than ever and will support the state's transition to the new phase of the Maryland Model.

MHA and its members appreciate HSCRC's actions to address hospital needs in RY 2025 through additional funding for underfunded inflation, one-time set-aside, and respiratory surge funding. Even with these efforts, Maryland hospitals are facing serious financial pressures, with many of them operating in the red. This is not sustainable, and additional support is needed.

Recognizing the update proposed under the draft recommendation is relatively high, a significant portion (0.70%) is attributable to the legislatively-mandated \$150-million increase to the Medicaid Deficit Assessment, from which hospitals and health systems do not directly financially benefit. In addition, 1.06% of the update represents technical corrections to the demographic adjustment and uncompensated care calculations from prior rate years. As a result, the proposed update (5.68% revenue growth over RY 2025) overstates the level of financial benefit to hospitals and health systems to address contemporary funding needs in RY 2026.

MHA believes the substantial excess Medicare Total Cost of Care (TCOC) savings generated currently and over the course of the Model offers an opportunity—and existing levers within the global budget methodology including the demographic adjustment and inflation update, a vehicle—to provide hospitals and health systems with the additional, immediate funding relief needed to address the contemporary cost pressures they face and ensure their stability during the Model transition.

MHA Request for an Adjusted Annual Payment Update

We offer the following proposals for the final recommendation in June:

- **Provide an adjustment to address unprecedented inflationary cost pressures.** S&P Global Insights' Q1 2025 cost tables estimate inflation of 3.36% for RY 2026. However, forecasts have been consistently conservative in the post-COVID era. The average relative difference between forecasts and actuals for RY 2023 and RY 2024 was 0.67%.
- **Fully fund age-adjusted demographic growth.** Over the last four years (2020-2024) and after accounting for a proposed correction in the staff recommendation, HSCRC will have funded 1.39% of overall population growth, with 2.6% of age-adjusted population growth over the same period having gone unfunded (average of 0.65% per year).
- **Pass through the increase in the Medicaid Deficit Assessment to payers.** Given hospitals' financial vulnerability, MHA asks that hospitals not be required to directly remit any portion of the \$150-million increase to the Medicaid Deficit Assessment.
- **Suspend implementation of the productivity adjustment for non-GBR hospitals.** The proposed 0.80% productivity adjustment would significantly reduce the inflation update for non-GBR hospitals. However, specialty hospitals face the same inflationary cost pressures as acute care hospitals and continue to experience low volumes.

Financial Conditions of Maryland Hospitals

Maryland hospitals and health systems continue to confront significant financial challenges. Data show Maryland hospitals and systems fare poorly on key measures of financial stability:

- **Operating margins:** The average operating margin across Maryland systems as of the end of Q3 of 2024 (the most recent quarter for which national data is available) was 0.3%, well below the average among a Bank of America sample of 150 nonprofit systems nationwide of 1.5% and even further below the industry benchmark for sustainable positive operating margins of 3%. Six Maryland systems had negative operating margins in CY 2024, twice as many as at the start of the Total Cost of Care Model and three times as many as at the start of the All-Payer Model.
- **Debt and capital adequacy:** Maryland hospitals and health systems lag behind the nation on key measures of debt and capital adequacy (debt to capital, capital expenses as a percentage of depreciation, and average age of plant). Many hospitals and health

systems also have deferred capital investments, which can impact patient care, due to resource constraints and financial uncertainty at a time when capital needs are growing.

- **Cash reserves:** While liquidity levels are sound overall, several Maryland systems have fewer than 150 days cash on hand, and cash reserves are well below national benchmarks when comparing cash reserves to debt—an important credit metric. If health care systems are forced to draw down on these limited cash reserves to cover their operating losses, their ratings may continue to be downgraded, and hospitals may lose their ability to invest in needed capital.
- **System ratings:** Staff noted at the April Commission meeting that, in their estimation, “no hospitals are facing immediate solvency questions.” Solvency is a low bar for measuring financial sustainability, and rating outlooks for Maryland systems are stable at best. As of the date of this letter, three systems have negative rating outlooks, and no systems have positive rating outlooks.

When hospitals face financial challenges, they cannot reinvest in clinical care, attract and keep skilled staff, or improve the patient experience. These limitations directly affect care quality and threaten the ability to provide round-the-clock acute care statewide. Furthermore, these challenges threaten the financial stability of hospitals at a time when they can least afford it given the unprecedented cost pressures they face.

Significant Cost Pressures Maryland Hospitals Face

Maryland hospitals are navigating an unprecedented combination of cost pressures and unfunded mandates that are not fully accounted for in the state’s current rate-setting methodologies. From inflation and potential tariff-driven supply cost increases to rising uncompensated care and new population health mandates, these challenges are creating sustained financial strain across the field. Despite clear evidence of growing operating expenses, recent annual updates have fallen short of addressing the financial realities hospitals face every day.

As a result, hospitals are increasingly forced to absorb the costs of inflation and comply with new regulatory and care delivery mandates without corresponding rate support. This growing disconnect between actual costs and available funding is eroding already-thin margins, forcing delays in needed investments, and threatening hospitals’ ability to deliver high-quality, accessible care. Without timely and adequate relief, these pressures risk undermining the very foundation of Maryland’s hospital infrastructure.

Given the scope and severity of these issues, a meaningful and appropriately scaled Rate Year 2026 annual payment update is essential. The Commission has the opportunity to take decisive action to preserve hospital financial stability, protect access to care, and enable hospitals to meet the state’s evolving health system goals.

Impact of Expanded Tariffs on Hospitals

Recent federal trade policy changes, including expanded tariffs on medical devices, pharmaceuticals, and supplies, have introduced external inflationary pressures that will likely

further burden hospitals. Tariffs on these critical goods could further disrupt patient care and increase hospital expenses. Hospitals rely heavily on a global supply chain, and tariffs on goods could potentially crowd out funds for other needs.

As of March 2025, the United States faced over 270 active drug shortages, and nearly 70% of medical devices were sourced exclusively from overseas manufacturers. Tariffs applied to these products could increase procurement costs, disrupt supply chains, and create volatility in budgeting for essential clinical resources. These costs, which are entirely outside of hospital control, could contribute to inflation above historic annual updates. Ongoing federal tariff activity is an exogenous cost driver that could further strain hospital finances and must be considered as part of the RY 2026 inflation adjustment.

Potential Funding Cuts to Medicaid

Hospitals remain vulnerable to potential changes in federal Medicaid funding. Any reduction in federal support would shift a significant financial burden onto states and providers and erode hospital revenue. Hospitals cannot trim expenses to offset such a loss. Given that 1.6 million Marylanders rely on Medicaid, hospitals would be required to absorb an increase in uncompensated care, particularly in emergency and inpatient settings.

The state's all-payer system could provide some mitigation, but that alone is insufficient to address the magnitude of the risk. As such, the Commission should account for the possibility of federal funding changes when evaluating upcoming financial needs.

Increase in Payer Denials

Hospitals are experiencing a sharp and unsustainable rise in claims denials from insurers, which reduces payment for care already delivered and places increasing strain on revenue cycles and operational resources. Between FY 2013 and FY 2024, denied hospital claims in Maryland more than tripled to \$1.39 billion. Many of these denials stem from administrative policy changes or automated algorithms, rather than clinical judgment, resulting in delayed reimbursements, lost revenue, and heightened administrative burden. This trend directly erodes hospital revenue, and we urge the Commission to recognize payer denials as a growing systemic risk and factor in their financial impact.

Rising Physician and Other Staffing Costs

Labor expenses, making up approximately 56% of total hospital costs, have surged in recent years due to persistent workforce shortages and the need to offer competitive wages to attract and retain staff. This adds significantly to the financial pressures hospitals face. One of the most critical and growing drivers of labor cost is physician coverage. To ensure continuous access to critical services such as emergency care, anesthesia, and intensive care, hospitals continue to absorb substantial physician-related expenses.

Unlike many states, Maryland hospitals operate under global budgets that generally exclude physician professional fees from hospital rate payments. As a result, hospitals remain financially responsible for securing and subsidizing this essential coverage, especially in high-demand

specialties where staffing is limited and costs are escalating. Rising physician compensation, market competition, and recruitment challenges have embedded these expenditures into hospital operating budgets without a clear path for rate recovery. Because hospitals cannot simply increase charges under a global budget, physician deficits directly erode regulated margins, diverting resources away from core operations.

Currently, there is no mechanism to fully account for these mounting structural costs. As physician costs continue to climb, the ability of hospitals to maintain 24/7 access to critical services is increasingly at risk. Essential physician coverage is a foundational cost of care delivery, and the Rate Year 2026 update should reflect the reality of this financial burden.

Medical Professional Liability Costs

Medical professional liability insurance premiums continue to rise. National trends in litigation, jury awards, and insurance market volatility are driving higher premiums. The cost per malpractice claim in Maryland is significantly higher than in most other states and has been steadily rising in recent years. The increasing frequency of large claims in Maryland has reduced access to commercial insurance protection, as several insurance providers have left the market while the rest have reduced participation, leaving Maryland healthcare systems to bear the cost. Liability costs are largely fixed and unavoidable, yet they reduce available operating funds. According to a Willis Towers Watson analysis of claims as of March 2025, liability claims have cost Maryland healthcare organizations an estimated \$4.5 billion over the past decade. As financial margins tighten, hospitals will have limited capacity to absorb additional liability expenses without adjustments to their base rates.

Cybersecurity and Campus Security

Physical and digital security has become an operational imperative for Maryland hospitals. Maryland hospitals today must invest heavily in security measures, both cyber and physical, to safeguard patients, data, and staff. These investments have become indispensable in response to rising threats, but they impose significant costs that are not directly reimbursed within global budgets.

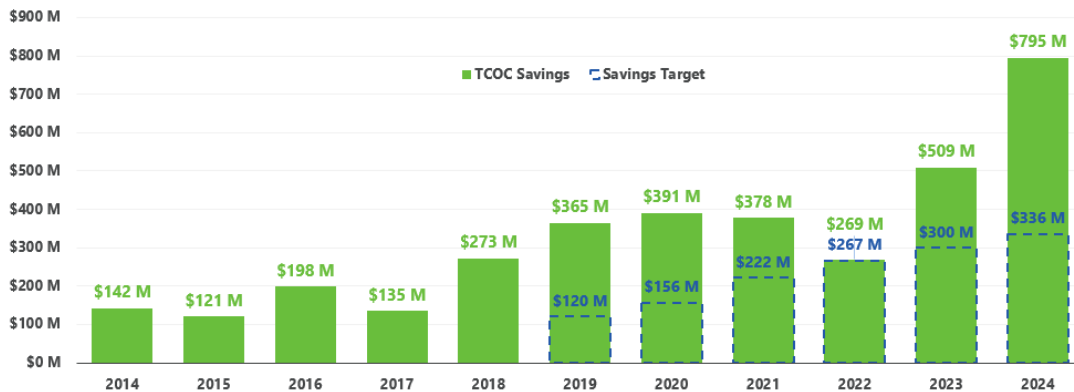
Cyberattacks targeting hospitals are growing in frequency and severity, with substantial consequences ranging from operational shutdowns to legal settlements. At the same time, rising threats of violence on hospital campuses have prompted increased investment in physical security infrastructure, such as surveillance systems, panic alerts, and trained security personnel. These measures are crucial for protecting health care workers and patients, but carry a financial cost, often substantial capital investments up front and higher operating costs for staffing and technology maintenance.

For Maryland's rate-regulated hospitals, the rising spend on security is largely unrecovered through current payment structures. The Commission should acknowledge cybersecurity and violence prevention as essential health care investments in today's environment. Ensuring hospitals have the funding to keep up with these investments is an important part of maintaining overall hospital viability.

Excess Medicare Total Cost of Care Savings

According to HSCRC, the state is on track to generate an estimated \$795 million in cumulative Medicare TCOC savings through CY 2024, \$460 million more than the year-end target of \$336 million (Figure 1). Over the course of the Model, savings have been driven by significant reductions in hospital expenditures—between the start of the All-Payer Model (2014) and 2024, the state generated \$1.02 billion in cumulative hospital savings and \$354 million in non-hospital dissavings—yet they have accrued to the benefit of payers, not hospitals and health systems.

Figure 1. Medicare Total Cost of Care Savings (2014-2024)



HSCRC staff modeled three scenarios based on historic spending trends to project the CY 2025 savings and guardrail position using the recommended update factor: two that rely on pre-COVID trends (2015 to 2019 and 2017 to 2019) and one on a more contemporary trend (2022 to 2024). The third scenario, which is based on more recent national trend experience (2022 to 2024) and is a better predictor of future performance supports a robust update for RY 2026. In fact, the estimated savings run rate for this scenario is \$810 million, more than twice the CY 2025 savings target of \$372 million. Furthermore, MHA’s analysis suggests that even after accounting for full funding of age-adjusted demographic growth (with an inclusion of an estimated additional 0.65%) and an additional 0.67% adjustment for inflation, the third scenario would still generate savings (\$731 million) well above the CY 2025 target and year-over-year Medicare TCOC growth less than 1% above the nation (Table 1).

Table 1. TCOC Estimate (Scenario 3, 2022 to 2024 Base) with MHA’s Requests

Scenario 3 Guardrail Projections			
	Maryland	U.S.	
2024	\$14,647	\$13,365	
2025	\$15,603	\$14,141	Predicted Variance
YOY Growth	6.5%	5.8%	0.7% Over
Estimated CY 2025 Savings Run Rate			\$731 M

Staff also modeled a fourth scenario using the United States Per Capita Cost (USPCC) trend to project the CY 2025 savings and guardrail position. MHA encourages HSCRC to not draw any conclusions about the amount of room for additional hospital revenue growth (or lack thereof) from the USPCC trend given it is not yet clear how USPCC data will be used in the CY 2026 target setting under the AHEAD Model, which staff acknowledged in the draft recommendation.

Finally, MHA recognizes that only the first half of RY 2026 falls within CY 2025. Therefore, HSCRC must also consider CY 2026 savings requirements under the AHEAD Model when determining the update factor. Importantly, as staff noted, all four of the aforementioned scenarios are expected to generate savings in excess of the estimated CY 2026 AHEAD target.

Prospective Adjustment for Inflation

MHA and our member hospitals and health systems are concerned that the proposed inflation update in the draft recommendation of 3.36% will not sufficiently address the exceptional cost pressures hospitals and health systems are facing. We respectfully urge HSCRC to consider providing a 0.67% prospective adjustment to inflation to account for anticipated economic volatility.

S&P Global Insights' inflation forecasts have been consistently conservative in recent years (Table 2). The average relative difference between inflation forecasts and actuals for RY 2023 and RY 2024 was 0.67%. When including RY 2022, the average relative difference over the prior three rate years (2022-2024) is even greater: 1.15%. Though the accuracy of the forecast has improved from year to year, an imprecise forecast for RY 2026 is likely given the high degree of uncertainty in the health care and economic landscapes.

Table 2. Inflation Forecasts vs. Actuals (2022-2024)

	Forecast (HSCRC Funded)	Actual Inflation	Relative Difference
RY 2022	2.57%	4.79%	2.12%
RY 2023	4.06%	5.09%	0.98%
RY 2024	3.35%	3.71%	0.35%
<i>Average Relative Difference (RY 2022, RY 2023, and RY 2024)</i>			1.15%
<i>Average Relative Difference (RY 2023, RY 2024)</i>			0.67%

It is important to note that the S&P Global Insights Q1 2025 forecast, the basis for the proposed update, relies on assumptions that may not fully account for the impact of federal policies and tariffs. MHA requests that HSCRC include in its final recommendation the most recent inflation forecasts available at that time and include an additional prospective adjustment to address the economic volatility and associated cost pressures not accounted for due to conservative forecasting.

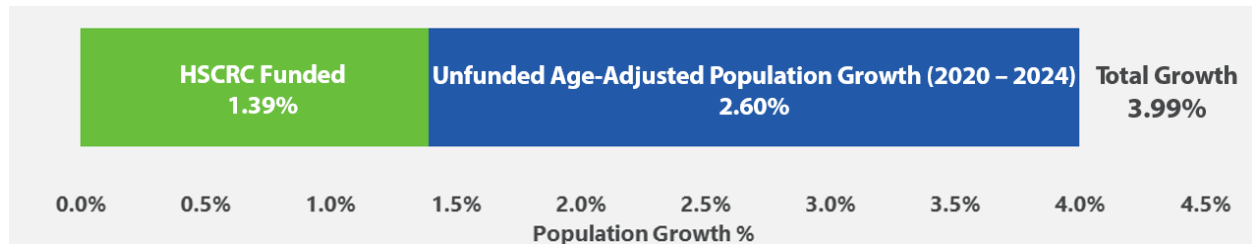
Recognizing the Commission adopted a policy last year that provides a mechanism to address historic over- and underfunding of inflation, hospitals and health systems cannot afford to wait until next July or later for a retrospective adjustment. An adjustment now—rather than relying on a conservative forecast—would better reflect the extraordinary challenges hospitals are facing.

Age-Adjusted Demographic Growth Funding

The draft recommendation includes a proposed 0.76% adjustment for volume to account for revised historical data and population growth estimates from the Maryland Department of Planning. This is a welcomed and important adjustment. It should be noted, however, that this adjustment represents a correction of historic underfunding for demographic growth and is funding that should have been incorporated in prior updates. This correction does not address the underlying underfunding of age-adjusted demographic growth.

The demographic adjustment policy is intended to provide funding increases or decreases to account for anticipated changes in hospital volumes associated with age-adjusted population changes. However, according to data shared by staff at the April 29 Payment Models Workgroup Meeting, an estimated 2.60% in age-adjusted population growth has gone unfunded over the last four years (2020 to 2024), or an average of 0.65% per year (Figure 2). ***This estimate of unfunded age-adjusted demographic growth accounts for the proposed correction. When excluding this proposed correction, the level of underfunding is even higher at 3.63% over the four-year period, an average underfunding of 0.91% each year.***

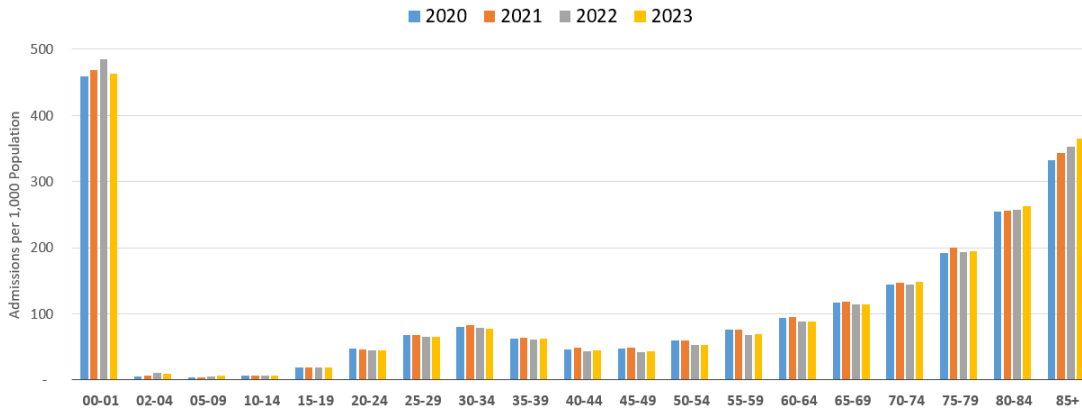
Figure 2. Unfunded Age-Adjusted Population Growth (2020-2024)



Maryland’s population has aged in recent years and is expected to continue aging between now and 2030. The correlation between this aging population and increased utilization of hospital services is clear. Case mix data from 2020 to 2023 shows that there were more inpatient admissions and outpatient visits among the 60 to 64 age cohort and older age cohorts (65 and older) than any younger age cohorts. Generally, the older the patient, the more likely they are to have been admitted to a hospital or visited an outpatient department (Figure 3 and Figure 4).

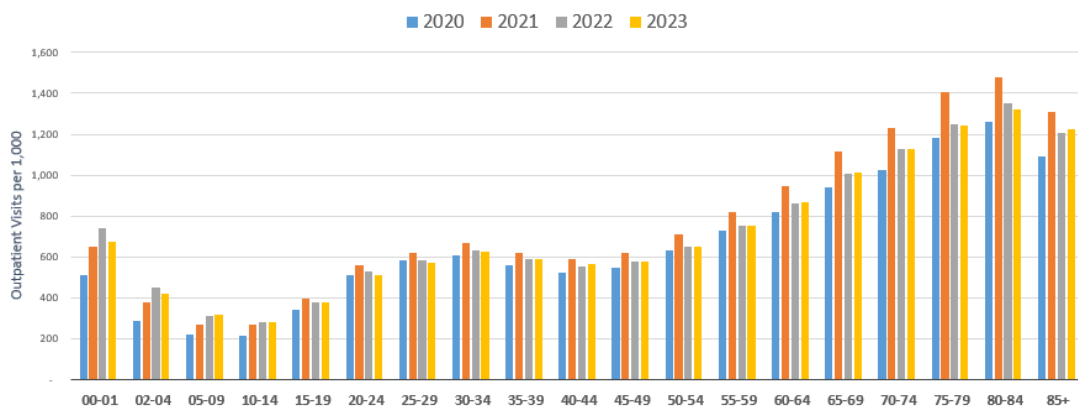
Additionally, MHA analyzed population growth by age cohort and unrecognized growth in Equivalent Case-Mix Adjusted Discharges (ECMADs) not attributable to market shifts between 2022 and 2023 using Department of Planning and case mix data (Figure 5). The data show that, generally, counties that experienced the largest growth in age cohorts 60 to 79 and 80 and older tend to have the highest amount of unrecognized ECMAD growth.

Figure 3. Maryland Inpatient Admissions per 1,000 by Age Category (2020-2023)



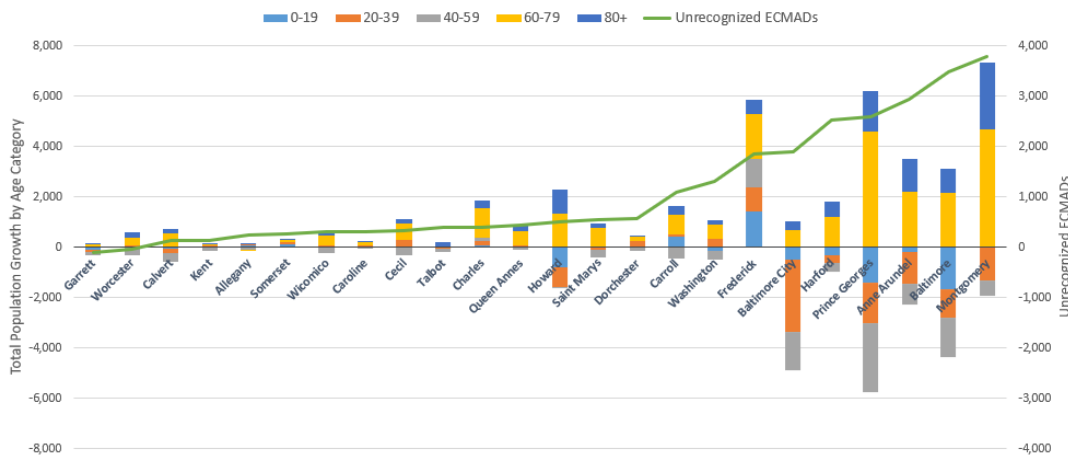
Source: Maryland Department of Planning Data and HSCRC Case Mix Data

Figure 4. Maryland Outpatient Visits per 1,000 by Age Category (2020-2023)



Source: Maryland Department of Planning Data and HSCRC Case Mix Data

Figure 5. YOY Population Change vs. Unrecognized ECMAD Growth (2023 v 2022)



Source: Maryland Department of Planning Data and HSCRC Case Mix Data; Unrecognized ECMADs include PAU Volume

We ask that HSCRC provide full funding for estimated age-adjusted demographic growth, in addition to funding for overall population growth, this year and going forward. HSCRC should include in the update an additional 0.65%, which represents the average annual amount of unfunded age-adjusted population growth over the measurement period. This request is consistent with the intent of the demographic adjustment policy.

MHA appreciates HSCRC's interest in collaborating with the field to identify potential refinements to its volume policies, including the demographic adjustment. While we understand the desire to conduct a more comprehensive assessment of the volume policies, hospitals cannot afford to wait for long-term refinements. Funding for age-adjusted demographic growth presents an opportunity to more accurately fund volume changes associated with population growth in the near-term while broader policy changes are considered.

Medicaid Deficit Assessment

The Maryland General Assembly approved a \$150-million increase to the Medicaid Deficit Assessment for FY 2026 as part of the Budget Reconciliation and Financing Act (BRFA) of 2025 to help cover the increasing cost of the Medicaid program. In light of the financial vulnerability of hospitals and health systems, we respectfully ask that HSCRC pass through the full amount of the increase to the Medicaid Deficit Assessment to payers.

Productivity Adjustment

MHA urges the Commission to continue suspension of the productivity adjustment for non-GBR hospitals in Rate Year 2026. The proposed -0.80% adjustment would lower the inflation update for these hospitals to 2.56%, despite the fact that they are experiencing the same inflationary pressures and contemporary cost drivers as their GBR counterparts. In particular, non-GBR hospitals are confronting challenges with recruitment, retention, and increased compensation of physicians and other staff, which may impact their ability to meet the demand for the specialty services they provide. Moreover, the size of this downward adjustment is at the upper range of productivity adjustments that have been applied in previous years. Applying a lower inflation factor to non-GBR hospitals at this time could create unnecessary financial strain and limit their ability to meet rising costs while maintaining access to high-quality care. Considering the significant and shared challenges across all hospitals, we believe it is important that the annual update be applied equitably and in a manner that supports stability across the full hospital field.

Integrated Efficiency Policy Proposal

MHA supports the recommended modification to the integrated efficiency policy. As staff noted, all hospitals in the fourth quartile of overall efficiency ranking are subject to negative scaling of the update factor or participation in the revenue for reform program under the current policy, regardless of their performance variance from hospitals in the third quartile. The proposed policy modification ensures that hospitals in the fourth quartile are only subject to penalties if they have outlier Inter-Hospital Cost Comparison (ICC) performance. MHA also supports the proposal to use a historical standard deviation, as opposed to a standard deviation that changes over time as the distribution of hospital performance narrows, to identify outlier hospitals.

UCC Fund Revision

MHA supports the proposed correction to the uncompensated care (UCC) fund calculations for RY 2023 to RY 2025. In particular, MHA supports the recommendation to allocate additional funding to hospitals and health systems that were underfunded for UCC and to hold harmless those that were overfunded. As staff note, many of the hospitals that were overfunded are rural and safety net hospitals, and it's important to protect these hospitals from any negative policy adjustment that may jeopardize their ability to care for the vulnerable populations they serve.

Conclusion

MHA sincerely appreciates the time and effort staff have dedicated to the draft recommendation for the RY 2026 update and welcomes the opportunity to work with Commissioners and staff to develop the final recommendation in June. Rate Year 2026 will bring an extraordinary amount of change to Maryland's health care system due to volatility stemming from federal policies coupled with the implementation of a new phase of the Maryland Model. Given these unprecedented circumstances, the Commission has the opportunity to stabilize Maryland's acute care infrastructure to ensure hospitals and health systems can maintain their important mission. We urge the Commission to support both the near-term and long-term financial stability of Maryland hospitals.

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

Sincerely,



Melony G. Griffith
President & CEO

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

Topic

Volume Policy Update

Objective

To update the Council on Financial Policy on HSCRC's work related to the demographic adjustment and market shift adjustment policies

Demographic Adjustment

MHA and HSCRC have explored changes to the demographic adjustment methodology to more accurately fund age-adjusted population growth. HSCRC staff acknowledged that changing the demographic adjustment is the most pressing but difficult policy change. At the April 30 Council on Financial Policy meeting, MHA described how HSCRC's and the field's perspectives on the demographic adjustment policy differ and how MHA responded to arguments from staff related to the volume scorecard, the timing of policy changes, and the relationship between the aging population and increased utilization of health care services.

At the May 14 HSCRC meeting, staff shared that they are working on a recommended policy change that accounts for age-adjusted growth, which they hope to put forth for consideration by Commissioners later this year. Staff clarified at the May 29 Payment Models Work Group meeting that while they plan to make a policy recommendation this year, the revised policy would likely not be implemented until the Rate Year 2027 annual payment update.

Market Shift Adjustment

MHA engaged in discussions with HSCRC over the past several months about policy changes that more accurately fund volume changes due to market shifts. MHA proposed an approach supported by the Health Care Payment Work Group and CFP that would recognize a greater share of overall costs as variable by evaluating costs on a service line basis. At the same time, HSCRC have been working with a consultant on an alternative to the current methodology, which funds volume growth at a flat 50% variable cost factor (VCF).

While specifics on HSCRC's proposed approach are still unknown, MHA believes they may consider keeping medical service lines at 50% and increasing surgical service lines to 60%, as well as applying these changes consistently across all volume-related policies, including deregulation. MHA understands that HSCRC staff will reconvene a work group in July or earlier to discuss this proposed approach.

John Colmers Analysis

Separate from these near-term efforts related to the demographic and market shift adjustments, John Colmers is developing non-binding recommendations regarding HSCRC's volume policies, though the timeline for his recommendations is unclear.

Prepared by: Patrick Carlson, Vice President, Care Transformation & Finance

Attachment: PowerPoint presentation

VOLUME POLICY UPDATE



DEMOGRAPHIC ADJUSTMENT

- MHA and HSCRC explored methodology changes to fund **age-adjusted growth**; HSCRC staff acknowledged that changing the demographic adjustment is the most pressing, but difficult policy change

Staff Argument	MHA Response
The volume scorecard suggests that hospitals have been overfunded for volume growth over the course of the TCOC model	The volume scorecard has not been validated and therefore should not be used to evaluate the accuracy of/potential changes to policies; each volume policy should stand on its own merit
Now may not be the best time to refine the methodology given the transition to the AHEAD Model, which includes risk adjustment	A short-term fix can be implemented while a more refined, long-term methodology change using risk adjustment is contemplated
We have not seen evidence to suggest that an aging population correlates with increased utilization	Preliminary analysis shows unrecognized market shift growth in areas with an aging population

At the May Commission meeting, HSCRC staff shared that while older populations utilize more hospital services than younger populations, there have been overall secular declines in volume (inpatient utilization per capita) that would also need to be accounted for under a revised methodology

MARKET SHIFT

- Current methodology funds volume growth at a flat 50% variable cost factor (VCF)
- Members of the Health Care Payment Work Group and CFP support an approach that recognizes a greater share of overall costs as variable by evaluating costs on a service line basis
- Staff raised questions about MHA's proposed approach; MHA provided preliminary response to staff based on feedback from members of the Health Care Payment Work Group
- HSCRC staff are working with a consultant on an alternative to the flat 50% VCF
- While definitive specifics on the HSCRC staff proposal are not yet known, there are indications that HSCRC staff may be considering:
 - Keeping medical service lines at 50% and changing surgical service lines to 60%; and
 - If these VCFs are established for the market shift policy, proposing application of the same VCFs across all volume policies, including deregulation

WHERE THINGS STAND

- **Demographic adjustment:** HSCRC staff are working on a recommended policy change that accounts for age-adjusted growth, which they hope to put forth for consideration by Commissioners later this year
- **Market shift adjustment:** HSCRC staff are reconvening a work group to discuss staff's proposed revision to the market shift in July 2025 or sooner.
- **Colmers analysis:** Separate from these efforts, John Colmers is developing non-binding recommendations regarding HSCRC's volume policies, though the timeline for his recommendations is unclear

VOLUME POLICY UPDATE

Appendix



DEMOGRAPHIC TRENDING ANALYSIS

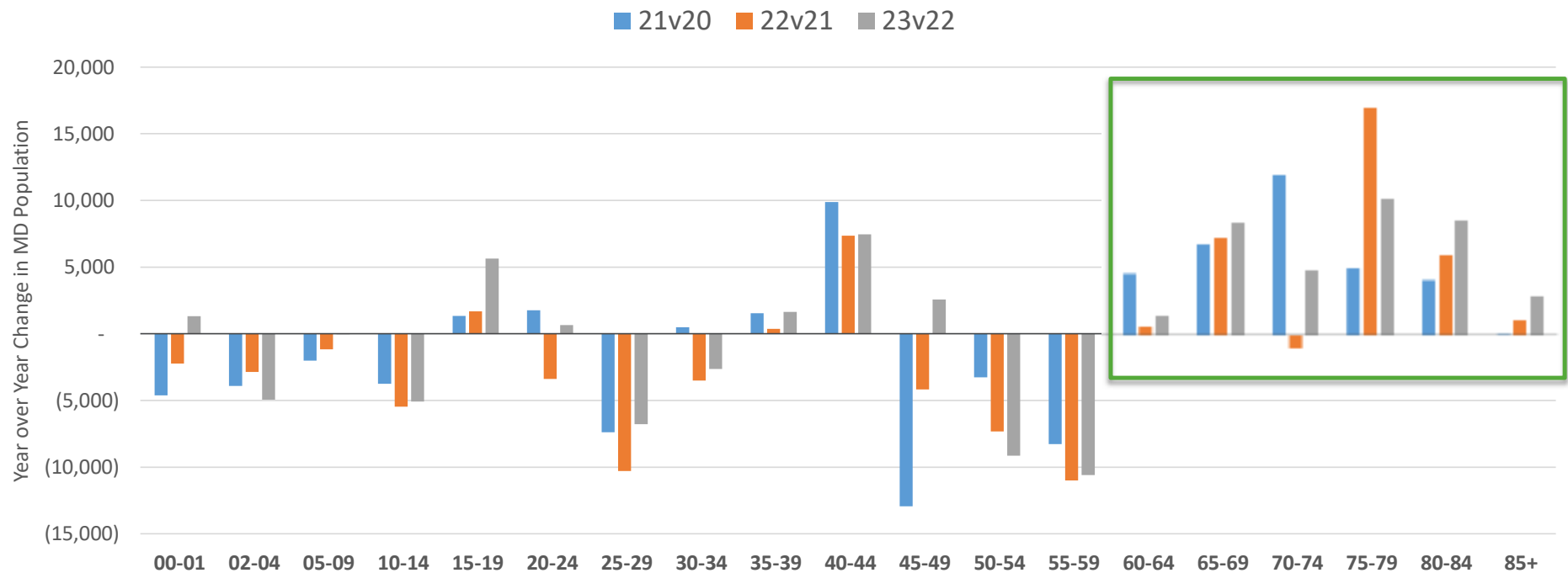
Background: HSCRC staff raised during the April 2 Payment Models WG Meeting that they do not believe/have not seen evidence to suggest an aging population correlates with higher utilization

Question: Does an aging population have higher hospital utilization?

- The Maryland Department of Planning provides population estimates by age for every county in Maryland. By comparing this to our case mix data, we can calculate utilization by age bucket including:
 - Inpatient Admissions per 1,000
 - Inpatient Days per 1,000
 - Outpatient Visits per 1,000
- These trends can also be compared to population shifts over time and assessed against unrecognized volume growth within the Market Shift Adjustment

MARYLAND IS CONSISTENTLY SEEING A RISE IN POPULATION OVER 60+

Year over Year Change in Maryland Population by Age

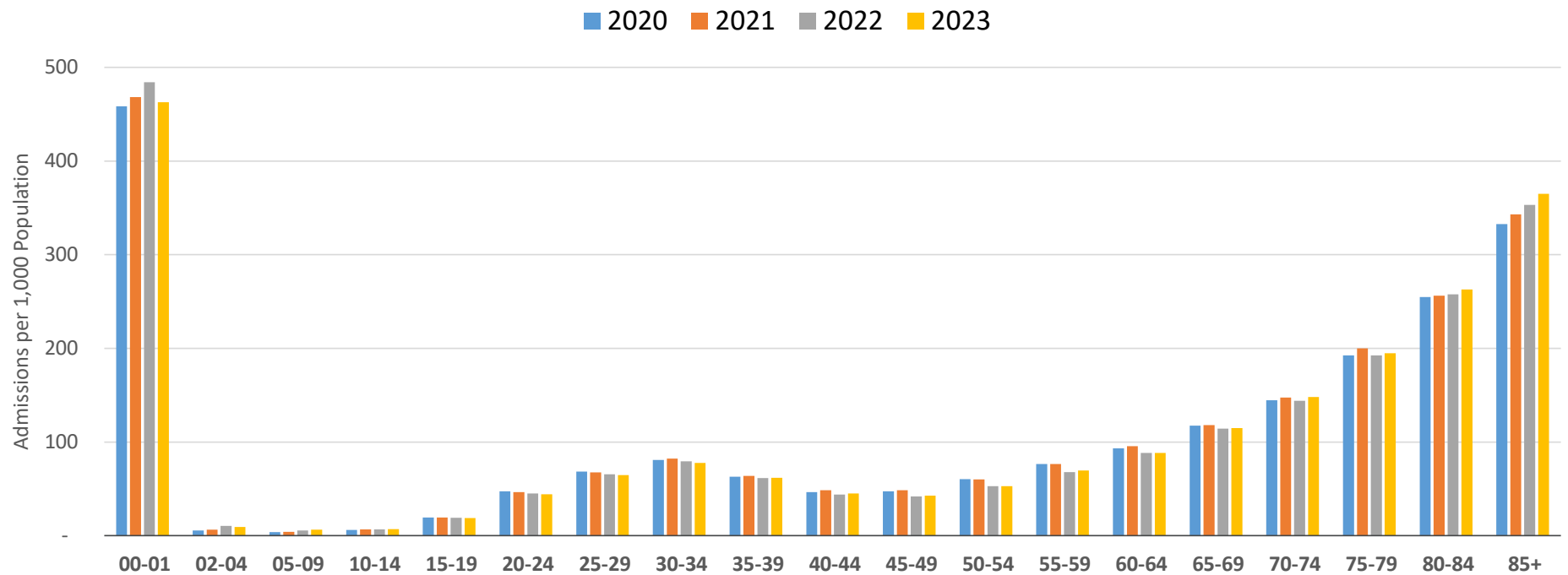


Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



INPATIENT ADMISSIONS PER 1,000 POPULATION

Maryland Admissions per 1,000 by Age Category

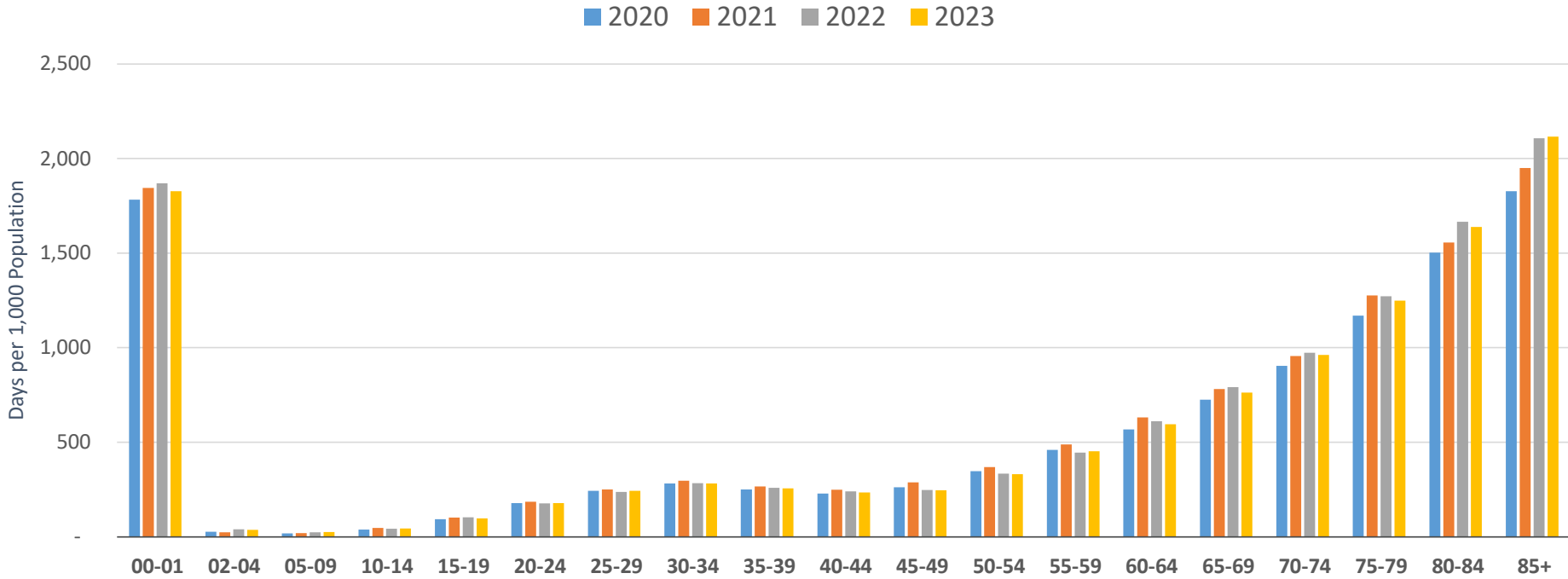


Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



INPATIENT DAYS PER 1,000 POPULATION

Maryland Inpatient Days per 1,000 by Age Category

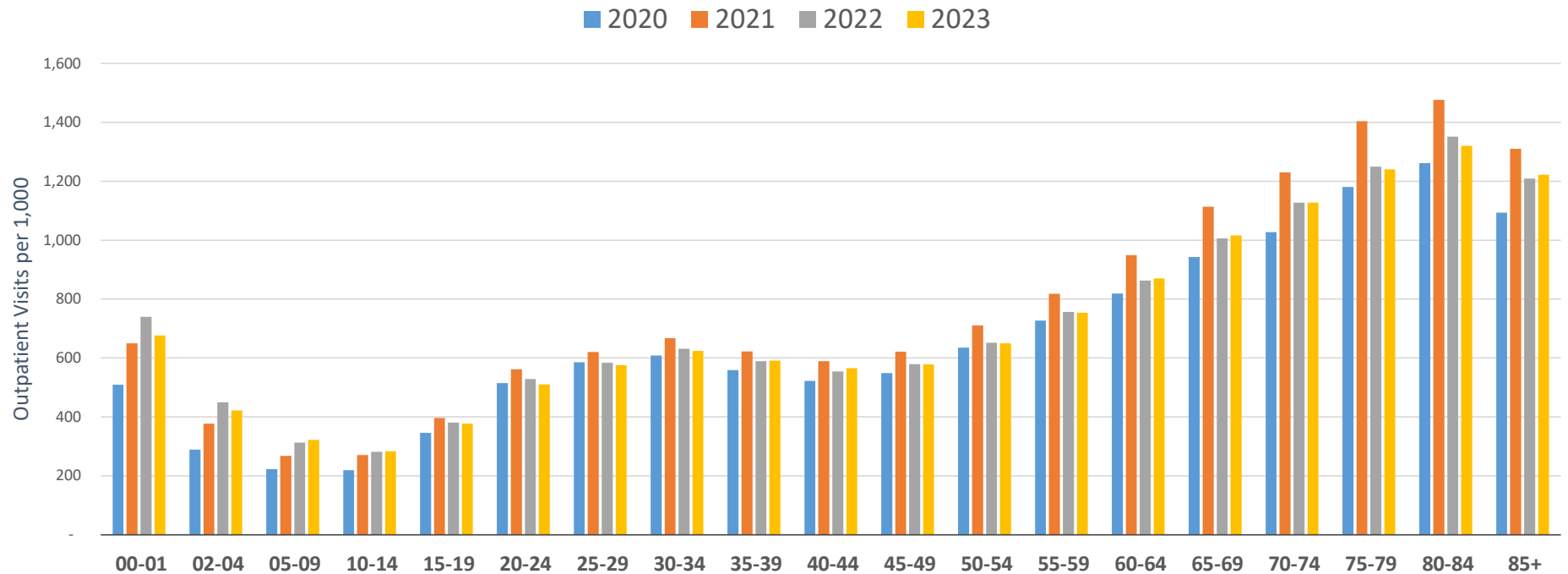


Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



OUTPATIENT VISITS PER 1,000 POPULATION

OP Visits per 1,000 by Age Category

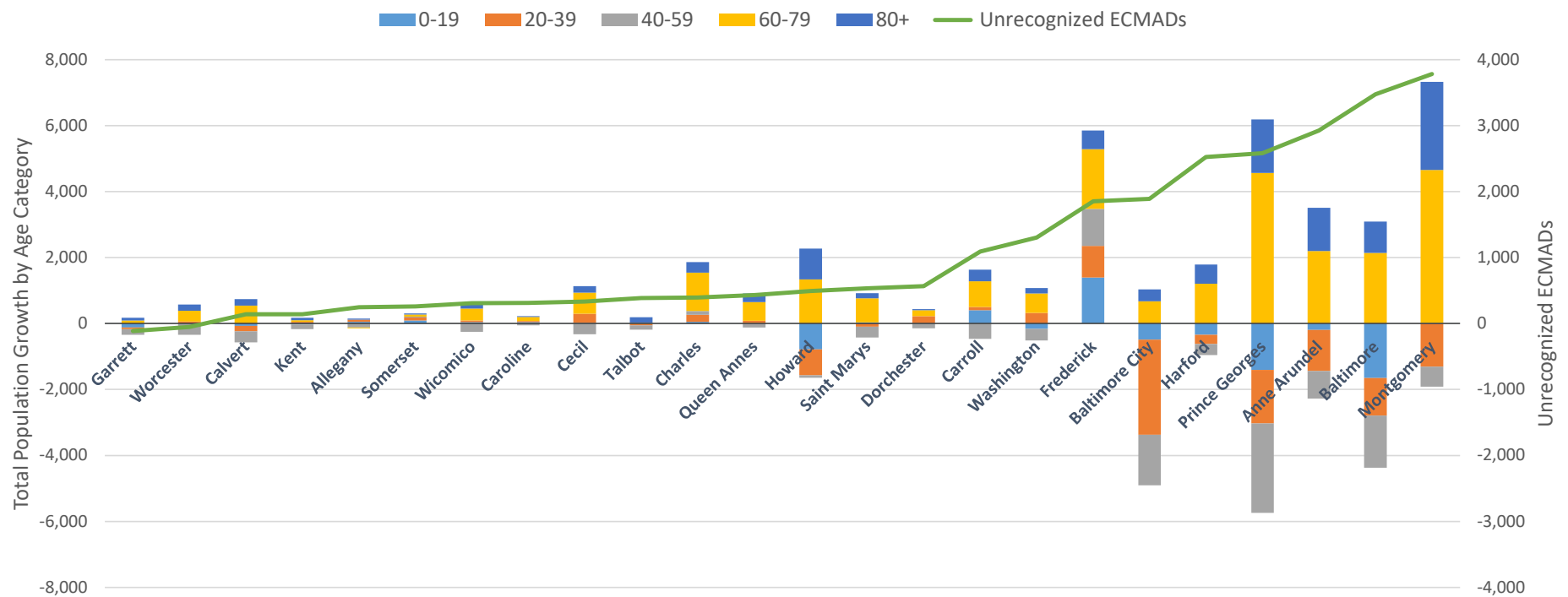


Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



COUNTIES WITH THE HIGHEST UNRECOGNIZED ECMAD GROWTH HAVE AN INCREASING POPULATION 60+

Year over Year Population Change vs Unrecognized ECMAD Growth (2023 v 2022)

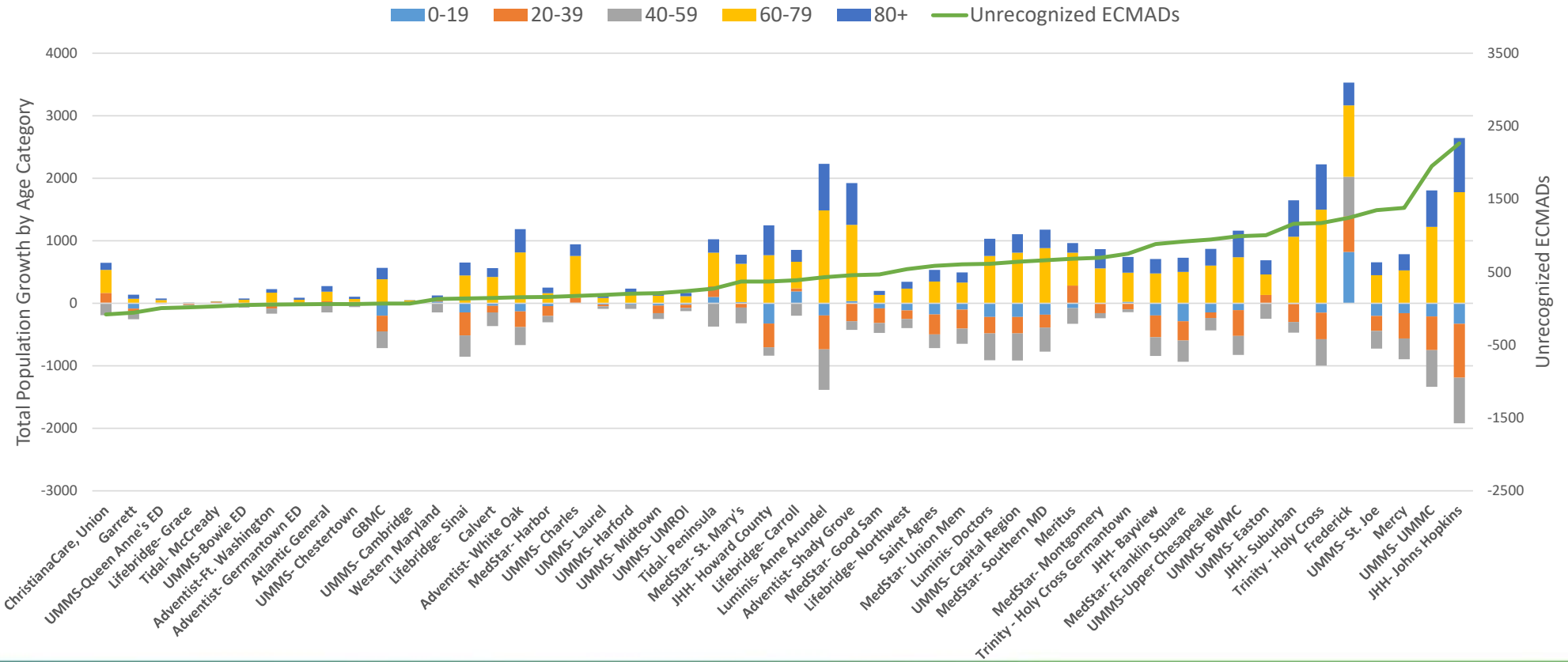


Note: Unrecognized ECAMDs include PAU Volume

Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



HOSPITALS WITH THE HIGHEST UNRECOGNIZED ECMAD GROWTH HAVE AN INCREASING POPULATION 60+



Note: Unrecognized ECAMDs include PAU Volume

Source: Maryland Department of Planning Data - https://planning.maryland.gov/MSDC/Pages/pop_estimate/InterCensalPopEst-AGR.aspx and HSCRC Case Mix Data



Topic

Payer Denials and Accountability

Objective

To gather member input on key pain points for advocacy, and to explore potential policy solutions and accountability strategies to guide MHA's payer strategy and engagement with state partners.

Discussion
Questions

1. What pain points related to payer denials should we raise with MIA and Maryland Medicaid?
2. Are there particular policy options that we should explore and consider advocating for?

Background: MHA Payer Denials Survey

In December 2024, MHA surveyed MHA Technical Work Group members to analyze payer denial trends from FY 2019 to FY 2024. MHA's analysis showed that payer denials have increased substantially since 2013, with a notable acceleration in recent years:

- From FY 2013 to FY 2024, the total dollar value of denied claims more than tripled to \$1.39 billion
- In just the past three years, emergency department service denials rose by 116%, with a 117% increase in the dollar value of denials
- In FY 2024, 13.2% of inpatient cases were denied, marking a six-year high
- Denied cases as a percentage of total outpatient services increased from 10.2% in FY 2019 to 11.4% in FY 2024, with commercial payer outpatient denials rising from 8.5% to 12.5%
- For commercial plans, denials for emergency department services jumped from 6.1% to 15.2%
- Medically necessary denials increased 232.5% for Medicare Advantage and 79.1% for commercial plans, with Medicaid MCO denial rates remaining high.

Recent Developments and Policy Response

MHA initiated efforts to better understand and address the rising burden of payer denials. Recent work has focused on conducting targeted analyses, raising awareness, and engaging stakeholders to identify solutions and promote accountability.

HSCRC Insurance Denials Technical Workgroup

In April, HSCRC staff presented the final patient-level denials reporting template to the MHA Technical Work Group. During the discussion, the group identified the need for better visibility into concurrent (peer-to-peer) denials and standardized reporting approaches. A new HSCRC Insurance Denials Technical Workgroup was created in response and will refine the reporting process to collect actionable data to understand the true impact of denials on hospitals.

Legislative Action – Senate Bill 776 / House Bill 995 of 2025

MHA supported legislation that established a state work group to study the rise in adverse determinations. The group includes legislators, agencies, MHA, and hospital representatives, and will make recommendations to improve state reporting on adverse decisions, including specified standard definitions, methods, and processes

Proposal: Health Insurance Advisory Commission or Board

MHA raised concerns about payer denials, the lack of clarity and transparency in carrier rate requests and premium rates, escalating out-of-pocket costs for consumers, and inadequate provider networks that limit access to care. At MHA's urging, legislative leaders requested that MIA establish a standing Health Insurance Advisory Board or Commission to ensure ongoing stakeholder engagement and oversight of commercial health plan design and management practices.

Medicaid Payer Relations Task Force

On May 7, MHA convened the Medicaid Payer Relations Task Force with Maryland Medicaid to directly address denials and related issues. MHA members expressed that the forum has value but that there are ongoing unaddressed operational concerns, including the need for timely responses from Maryland Medicaid staff, stronger MCO accountability, updated technology systems, and streamlined processes.

Additional policy priorities were highlighted, including third-party liability, ED auto-pay list-related denials, and audit processes utilized by an MCO vendor of concern. MHA is exploring more regular meetings with Medicaid to ensure continued engagement and accountability.

MHA is seeking Council on Financial Policy input on potential policy solutions or levers to pursue and opportunities to strengthen accountability and transparency in payer practices.

Prepared by: Patrick Carlson, Vice President, Care Transformation & Finance

Attachment: PowerPoint presentation

PAYER DENIALS & ACCOUNTABILITY

MHA Survey Results



THE CHALLENGE OF PAYER DENIALS

Denials on the Rise

- Payer denials have grown substantially since 2013
- Growth in denials has accelerated in recent years
- Denied cases have increased steeply in the emergency department and outpatient settings
- AI is contributing to increased denials

Harmful Impact to Patients & Providers

- Denials can cause delays for patients in receiving necessary care
- Higher out-of-pocket costs resulting from claim denials can cause patients to defer receiving care
- Denied and delayed payment of claims is contributing to financial pressures on hospitals and operational uncertainty
- Valuable staff and clinical resources diverted to fight inappropriate claim denials

The Need for More Payer Accountability

- Maryland needs a system for reviewing payer denials that refines data disclosures and ensures data integrity, enhances payer denial transparency, and reduces denial rates while examining factors that contribute to excessive denial rates, such as the use of AI in claims review and prior-authorization requirements

DENIAL CASES: KEY OBSERVATIONS

- 13.2% of inpatient cases were denied in FY 2024–this is the highest level in six years
- Over a six-year period (FY 2019 to FY 2024):
 - Denied cases as a percentage of total outpatient cases increased from 9.3% to 10.5%
 - Specifically for commercial payers, this percentage increased from 4.2% to 9.5%
 - For commercial payers, denied cases as a percent of emergency department cases more than doubled

DENIALS TRENDS FOR MEDICAL NECESSITY

Change in # of Medical Necessity Denials

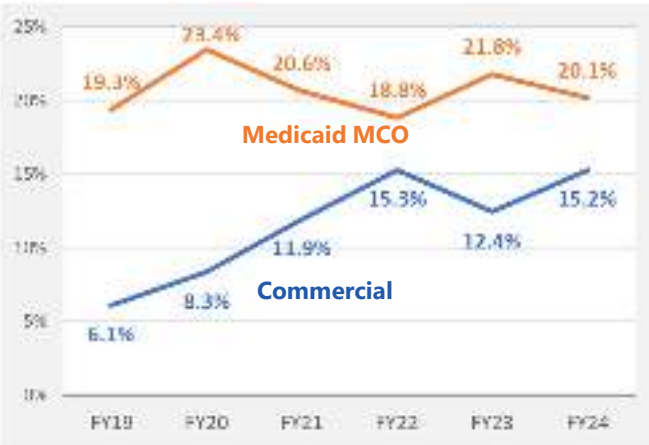
FY 2019 to FY 2024

Medicare Advantage	232.5%
Commercial	79.1%
Medicaid MCO	-5.7%
Medicaid FFS	-7.1%
Medicare FFS	-31.6%

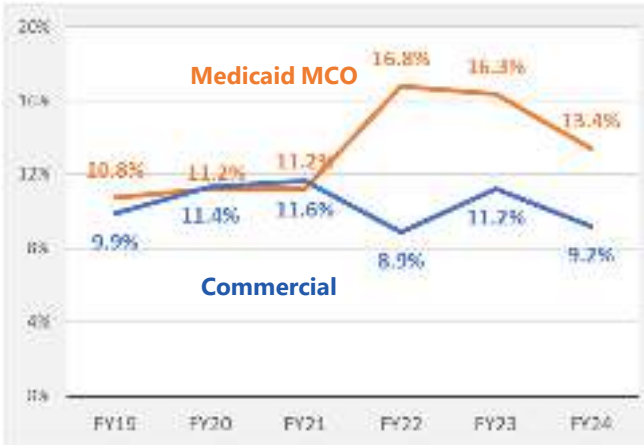
PERCENT OF CLAIMS WITH DENIALS

COMMERCIAL AND MEDICAID MCO

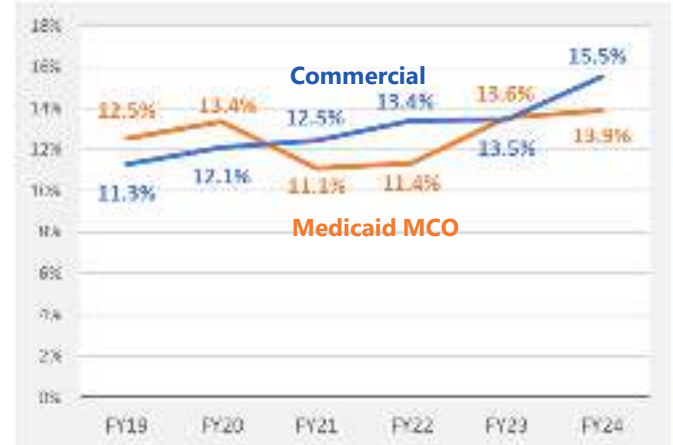
Percent of ED Claims with a Denial



Percent of OP Claims with a Denial



Percent of IP Claims with a Denial



COMMERCIAL TRENDS BY DENIAL REASON

% Change in # of Denials by Denial Reason

FY 2019 to FY 2024 | MD's Five Largest Commercial Payors

Commercial Payor	Total	Medical Necessity	No Pre-Authorization	Untimely Filing	Other
Aetna Healthplans	+22%	+39%	-16%	-30%	+62%
CareFirst	+25%	+136%	-13%	-1%	+114%
Cigna	+160%	+235%	+82%	+1%	+502%
Kaiser Permanente	+57%	+350%	-8%	+43%	+203%
United Healthcare	+174%	+424%	-9%	+90%	+360%

"Other" category includes Patient Eligibility, Duplicate Claim/Service, Coding Errors, Missing Information and all other denial reasons



COMMERCIAL TRENDS BY PATIENT SETTING

% Change in # of Denials by Patient Setting

FY 2019 to FY 2024 | MD's Five Largest Commercial Payors

Commercial Payor	Total	Emergency Department	Inpatient Services	Outpatient Services (Non-ED)
Aetna Healthplans	+22%	+126%	-6%	+2%
CareFirst	+25%	+143%	+51%	+7%
Cigna	+160%	+296%	+97%	+133%
Kaiser Permanente	+57%	+124%	+234%	+7%
United Healthcare	+174%	+627%	+99%	+93%



MEDICAID TRENDS BY DENIAL REASON

% Change in # of Denials by Denial Reason

FY 2019 to FY 2024 | MD's Six Largest Medicaid Payors

Commercial Payor	Total	Medical Necessity	No Pre-Authorization	Untimely Filing	Other
Amerigroup Community Care	-28%	-30%	-26%	-28%	-25%
CareFirst	+14%	-26%	+55%	+52%	+237%
Jai Medical Group	-47%	-54%	-9%	-29%	-49%
Medstar Family Choice	-38%	-73%	+67%	+169%	-53%
Priority Partners	-24%	-10%	-50%	+56%	-25%
United Healthcare	+6%	+47%	-23%	+136%	-36%

"Other" category includes Patient Eligibility, Duplicate Claim/Service, Coding Errors, Missing Information and all other denial reasons



MEDICAID TRENDS BY PATIENT SETTING

% Change in # of Denials by Patient Setting

FY 2019 to FY 2024 | MD's Six Largest Medicaid Payors

Medicaid Payor	Total	Emergency Department	Inpatient Services	Outpatient Services (Non-ED)
Amerigroup Community Care	-28%	-35%	-46%	-2%
CareFirst	+14%	-19%	+107%	+104%
Jai Medical Group	-47%	-51%	-20%	-37%
Medstar Family Choice	-38%	-71%	+128%	+35%
Priority Partners	-24%	-26%	+12%	-28%
United Healthcare	+6%	+39%	-35%	-18%

KEY TAKEAWAYS

- Total dollars of denials has more than tripled since 2013
- **Medicaid** claims are being denied at the **highest rate**
- **Commercial** claims have seen the **largest increase** in denials
 - Especially for Medical Necessity denials
 - Especially in the Emergency Department
 - United and Cigna have seen the steepest increases

PAYER DENIALS & ACCOUNTABILITY

HSCRC Patient-Level Denials Data
Collection



HSCRC DATA COLLECTION ON DENIALS

- HSCRC finalized its patient-level denials reporting template and presented it to the MHA Technical Work Group in April
 - The goal is to collect actionable data to understand the true impact of denials on hospitals
- The discussion surfaced broader issues, including burdensome denials management and limited visibility into concurrent (peer-to-peer) denials, not captured through traditional claims data
- The group supported forming a dedicated work group to focus on concurrent denials and standardizing reporting
 - The new HSCRC Insurance Denials Technical Workgroup, which met for the first time earlier today, will be working to refine reporting approaches
- HSCRC will determine a feasible submission time period, tentatively aiming for December 2025/January 2026

PAYER DENIALS & ACCOUNTABILITY

MIA Workgroup on Adverse
Decisions



NEW WORKGROUP ON ADVERSE DECISIONS

(SENATE BILL 776/HOUSE BILL 995 OF 2025)

- Legislation passed establishing new Workgroup to Study the Rise in Adverse Decisions in the State Health Care System
- Scope of work:
 - Review existing state adverse decision reporting requirements for all health payers
 - Make recommendations to improve state reporting on adverse decisions, including specified standard definitions, methods, and processes
 - Develop strategies for, and make recommendations to reduce, the number of adverse decisions
 - Develop recommendations for legislation to address the rise in adverse decisions and standardize state reporting requirements regarding adverse decisions across all payers
- Report due: Dec. 1, 2025
- Membership includes legislators, state agency representatives, and 13 other members, including MHA and two hospital representatives (one large hospital system; one community hospital)

PAYER DENIALS & ACCOUNTABILITY

Proposed MIA Health Insurance Advisory
Commission or Board



CALL FOR ONGOING OVERSIGHT OF HEALTH INSURANCE PRACTICES

- Work groups convened by MIA or other state agencies have historically helped address urgent issues in health coverage and payment but are often short-term and narrowly focused
- MHA has raised concerns about payer denials, the lack of clarity and transparency in carrier rate requests and premium rates, escalating out-of-pocket costs for consumers, and inadequate provider networks that limit access to care
- At MHA's urging, legislative leaders requested that MIA establish a standing Health Insurance Advisory Board or Commission to ensure ongoing stakeholder engagement and oversight of commercial health plan design and management practices

PROPOSAL: HEALTH INSURANCE ADVISORY COMMISSION OR BOARD

Includes seven to nine members

Consists of representatives of carriers, hospitals and other health care providers, consumers, employers, and other key stakeholders

The group could meet, at least quarterly, to review, advise, and direct action on matters relating to carriers and health insurance products subject to the MIA's authority

PURPOSE OF NEW OVERSIGHT BODY

1. Advance access to affordable health coverage
2. Enhance transparency and public access to information on carrier operations and products
3. Protect consumers from excessive premium rates and cost-sharing requirements, inadequate provider networks, and other plan design features that are arbitrary, capricious, unfair, or discriminatory
4. Review and improve utilization review standards to ensure access to and reimbursement of medically appropriate services and reduce the administrative burden on patients and health care providers
5. Develop, evaluate, and support adoption of emerging payment models that ensure access to high-quality, patient-centered health care services

PAYER DENIALS & ACCOUNTABILITY

Medicaid Payer Relations Task Force



MHA MEDICAID PAYER RELATIONS TASK FORCE

- MHA convened the Medicaid Payer Relations Task Force with Maryland Medicaid on May 7 to address challenges with payer denials and other issues
 - Participation included leaders from multiple offices, such as Medical Benefits Management, Long Term Services, Eligibility, Provider Services, and Finance
- Members valued the forum but stressed the need for structural improvements, including timely responses, operational improvements, technology modernization, and stronger MCO accountability and oversight
- Members also raised priority issues, including third-party liability, ED auto pay, and a problematic MCO vendor audit process
- MHA will continue working with Maryland Medicaid and is exploring more frequent meetings to support ongoing dialogue and issue resolution

MHA MEDICAID PAYER RELATIONS TASK FORCE

- MHA requested feedback from certain task force members on priority problem areas, specifically the top three denial challenges for both Medicaid FFS and Medicaid MCOs
- Additional feedback will be received from members at the June meeting of the MHA Technical Work Group

DISCUSSION

- What other pain points related to payer denials should we be raising in future discussions with MIA and Maryland Medicaid?
- Are there particular policy options that we should explore and consider advancing?

Topic

AHEAD Model Update

Objective

To provide an update on the AHEAD Model negotiation process

Discussion
Questions

1. What questions do Council members have about the AHEAD Model negotiation process?
2. Are there additional federal or state advocacy strategies MHA should explore to mitigate the financial risk of a transition to Medicare PPS?
3. Are there additional services MHA could provide to its member hospitals to ease a transition to Medicare PPS?

The new Center for Medicare & Medicaid Innovation (CMMI) leadership is renegotiating the AHEAD Model agreement with Maryland. Gov. Wes Moore appointed Maryland Department of Health Secretary, Dr. Meena Seshamani to lead the negotiations. Following initial meetings, state officials laid out two potential future direction options. In both options, Maryland would no longer have authority to set hospital rates for Medicare.

State officials have asked the hospital field for input on the future direction option that is most viable. To assist in identifying a field consensus position about the progression of the Maryland Model, MHA convened a Future Direction Planning Subgroup of the Health Care Payment Work Group to develop guiding principles and a recommendation of the hospital field's "must-haves."

The group met twice in May to provide input on the two options proposed by state officials and to consider other possible future direction options from the hospital field. While the group did not come to a consensus recommendation on specific model designs for the future direction, there was agreement on principles and key goals for this new round of AHEAD Model negotiations. The group also identified important considerations related to Medicare enhanced funding, cost shifting, and transition planning time. The goal of this discussion will be to discuss the feedback from the Future Direction Planning Subgroup and the MHA Board of Trustees.

Additionally, in the event the Model progression negotiations between Maryland and CMMI do not result in options supported by the hospital field, Council members will be asked to consider contingency options for federal and state advocacy strategies and member support services that MHA should pursue to mitigate financial risk of a transition to the Medicare PPS.

Prepared by: Tequila Terry, Senior Vice President, Care Transformation & Finance

Attachment: PowerPoint presentation

AHEAD MODEL: UPDATE ON NEGOTIATIONS



NEGOTIATIONS WITH CMS

- Earlier in the year, state officials indicated that the new CMMI leadership was interested in renegotiating the AHEAD Model Agreement. They noted federal concerns including:
 - Perception that the Maryland Model is too costly to federal taxpayers
 - Concerns related to Maryland rate setting
- Governor Moore appointed Maryland Department of Health Secretary, Dr. Meena Seshamani to lead the negotiations with CMMI
- Informal groups brought together by the Governor's office have been meeting to discuss the negotiation strategy and provide input on how the state should engage with CMS
- Groups weigh in on a variety of considerations for the negotiation, including:
 - Strategic Approach
 - Political Engagement
 - Communication/ Messaging
 - Technical Policies

FUTURE DIRECTION PLANNING SUBGROUP

Option 1



State Direction 1
"AHEAD National
Model"

Option 2



State Direction 2
"State-Based All-
Payer HGB"

Option 3



Hospital Field
Designed
"Tailored Option"

Option 4



Discontinuation
of the Model
with Orderly
Transition to PPS



HOSPITAL FIELD GUIDING PRINCIPLES

1. **Financial Sustainability** – Ensure hospitals remain solvent while meeting savings targets
2. **Operational Feasibility** – Avoid strategies that are overly complex to implement or maintain
3. **Preservation of Access** – Safeguard essential services; re-evaluate excess capacity and the CON process to reduce barriers to timely service expansion
4. **Reasonable Medicare Savings Expectations** – Consider two savings perspectives:
 - TCOC Savings Target - Maintain required level of Medicare savings in current AHEAD State agreement (HGB baselines must be reasonable - Retain RY2026 APU in the base or the most current period)
 - Magnitude of Enhanced Medicare Funding Reduction
5. **Participation and GBR Design Flexibility** – A one-size-fits-all model may not work; tailor by hospital type, growing markets, or other cohort
6. **Allow flexibility for services excluded from HGBs**
7. **Predictability and Stability** – Avoid burdensome annual negotiations across payers
8. **All-Payer Nature of System** – Retain Maryland’s ability to align across payers where feasible

NEGOTIATION GOALS & FUTURE POLICY NEEDS

- **Medicare Enhanced Payments** - It is critical to maintain the Medicare rates in any future direction proposed.
- **Cost Shifting** - If there is a reduction in Maryland's enhanced Medicare rates (and possibly Medicaid), the decrease must be offset by commercial payers.
- **GBR Policies** - GBR policies of the future – whether state or federally defined -- must address a variety of historical issues across the state.
- **Transition Period Policy** – Hospitals need a minimum of 3-5 years to transition to the Medicare PPS system.
- **Clarity on Foundational Questions and Key Details** – Among other unknowns, clarity is needed on:
 - Confirmation of continued Medicare enhanced payments in the short-term (CY2026), mid-term (CY2027), and long term (CY2028 and beyond)
 - Plan for waiver modifications to preserve payment of HSCRC rates for GBR excluded services
 - How Medicare savings will be achieved under the proposed GBR structure with fixed bi-weekly payments (e.g., how will savings accrue from non-hospital providers)
 - Key details on how baseline budgets are formed (e.g., based on gross revenue/charges vs. net revenue/payments)

NEW AHEAD MODEL FOCUS

- State officials indicated that a new component of the negotiations has been focused on requiring AHEAD Model participating states to implement strategies to foster “Choice & Competition”

Choice

- Create more transparency in cost and quality to shift health care decision making to individuals

Competition

- Enable competitive market forces and add incentives to innovate to raise quality and drive down prices

PPS TRANSITION PLANNING

- MHA continues to assess a potential transition to the Medicare Prospective Payment System (PPS) for the hospital field
- To better understand the implications of a PPS transition, MHA engaged hospital leaders to:
 - Identify anticipated operational impacts
 - Understand staffing, training, and infrastructure needs
 - Uncover financial risks and mitigation strategies
 - Gather input on what MHA should advocate for in preparation
- MHA also developed a set of proposed federal and state advocacy strategies and transition support services for member hospitals

**Federal Advocacy
Strategies**

**State Advocacy
Strategies**

**Member Transition
Support**

PROPOSED ADVOCACY OPPORTUNITIES

Federal Advocacy

Address Federal Regulations

- Represent the hospital field's perspective on changes that will be needed to federal regulations that account for the elimination of rate setting in Maryland
- Interpret regulations that now become applicable to Maryland

Engage Congressional Leaders

- Engage key federal partners to clarify changes in strategy and support hospital field efforts

Engage HHS, CMS, CMMI

- Engage agency staff and leadership to shape the future model based on hospital preferences

PROPOSED ADVOCACY OPPORTUNITIES

State Advocacy

Reduce Administrative Burden

- Moratorium on new administrative requirements for hospitals
- Canceling efficiency policies and suspension of negative volume adjustments

Increase Planning Time

- Advocate for 1-year extension of the TCOC Model and longer transition period

Mitigate Financial Risk

- Waive financial penalties for GBR overage, quality penalties
- Establish rules for financial support from the state and/or payers to support hospital transition (e.g., cash advances, maintaining Medicaid/commercial rates, requirements for maintaining commercial rate setting)
- Require commercial payers to accept all hospitals in their networks during the transition period
- Funding support for uncompensated care
- Lower the percentage of revenue under GBR during transition
- Enable strategies that enable financially sustainable consolidation

Address State Legislation & Regulations

- Represent the hospital field in legislative and regulatory clean up to reflect the elimination of Medicare rate setting

PROPOSED TRANSITION SUPPORT

Field Preparation

Provide Training

- Provide training on nuances of PPS (e.g., webinars/learning systems)

Identify Legal Issues

- Assess legal strategy to continue rate setting payments if state legal authority is in question

Analyze Policy Impacts

- Assess the effects of changes on existing state policies and communicate regularly
- Identify AHEAD 3.0 and PPS requirements to ensure hospitals plan for changes needed

NEXT STEPS

- MHA will:
 - Continue to engage with state officials on key strategic and technical policy considerations for the AHEAD Model negotiations
 - Continue developing contingency strategies for Model termination
 - Finalize the legal analysis of Model termination implications
 - Develop federal and state advocacy strategies
 - Identify member support
 - Provide updates on negotiations in several member forums including our work groups, councils, all member meetings, and Board meetings

DISCUSSION

- What questions do Council members have about the AHEAD Model negotiation process?
- Are there additional federal or state advocacy strategies MHA should explore to mitigate the financial risk of a transition to Medicare PPS?
- Are there additional services MHA could provide to its member hospitals to ease a transition to Medicare PPS?



Maryland
Hospital Association

MHA's Office
6820 Deerpath Road
Elkridge, MD 21075