



Maryland
Hospital Association

November 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's (HSCRC) Draft Recommendation for Demographic Adjustment Refinement. We appreciate staff's recognition of the limitations in the existing demographic adjustment methodology and consideration of policy changes to better account for the impacts of aging on utilization.

Maryland's population is aging and, at the same time, becoming more complex with an increased burden of chronic disease. This population will have a greater need for hospital services and the demographic adjustment must be responsive to this need. In response to feedback from MHA and other stakeholders that the methodology needs to provide additional funding to account for age-adjusted demographic growth, staff are proposing a 0.10% "national demand modifier". However, the draft recommendation also proposes discontinuing application of the demographic adjustment to volumes subject to volume variable methodologies. **The combined effect of these proposed changes is a net reduction to the statewide RY 2026 demographic adjustment from 1.51% to 1.47%** at a time when the state's population is aging and it is critically important to ensure hospitals have sufficient resources to meet the growing needs of their communities.

We offer the following comments for consideration by HSCRC.

Age-Adjusted Population Growth

The current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by effectively capping the statewide adjustment at the Department of Planning's projections for unadjusted population growth. A well-designed demographic adjustment is essential to ensure that hospitals are resourced to care for patients in need of a greater level of health care services. Global budget revenue is not adjusted for case mix and the demographic adjustment is the only population-based adjustment that provides additional revenue for expected utilization growth due to population growth and aging. While we recognize there are risk factors other than age that impact utilization and are supportive of a more comprehensive risk adjustment approach in the future to better align with CMS's methodology for Medicare hospital global budgets, HSCRC should fully fund estimated age-adjusted growth while longer-term policy refinements are being developed. For this reason, MHA has supported

an adjustment of 0.65% to account for the average annual amount of age-adjusted growth between 2020 and 2024. Discounting this statistic to account for expected efficiencies in care delivery is unnecessary given the current methodology already includes a potentially avoidable utilization (PAU) scaling factor, and HSCRC deploys several other policy levers and GBR adjustments to drive efficiency.

Analysis of Historical Utilization Trends

MHA appreciates the empirical approach in the draft recommendation to evaluate the extent to which the current demographic adjustment accounts for utilization changes due to aging. The actuarial analysis that serves as the foundation of the draft recommendation is novel, effectively attributing historical utilization trends to two factors (demographic changes and changing practice patterns) and calculating the national age-adjusted utilization growth rate using Maryland's demographics. However, based on a preliminary assessment, **MHA is concerned that the analysis understates the impact of demographic changes on utilization and overstates the impact of changes in practice patterns.**

The analysis in the draft recommendation concludes that had Maryland followed the same utilization patterns as other states but experienced its own demographic changes, total hospital utilization would have increased by 4.4% from 2013 to 2023. After accounting for favorable selection into Medicare Advantage (MA) plans, this estimate drops to just 3%. We question the magnitude of this adjustment and whether an MA adjustment is necessary given the state's significantly lower MA enrollment rate compared to the nation. At a minimum, this adjustment must be appropriately weighted to reflect differences in enrollment. In addition, this analysis relies on a sample of Medicare and commercial data, but does not include Medicaid, which saw a dramatic increase in enrollment during the evaluation period due to the Affordable Care Act. An MHA analysis of all-payer data from the National Academy for State Health Policy's (NASHP) Hospital Cost Tool shows non-Maryland national adjusted discharge per capita growth of 4.7% between 2013 and 2023, suggesting there is national utilization growth not accounted for in HSCRC's analysis.¹ If the same discount for site neutral incentives were applied to this 4.7% figure instead of the 3% estimate, the resulting national demand modifier would be substantially higher at 2.8% over a decade or .28% annually instead of .10% annually.

Projections of Future Utilization Trends

Furthermore, MHA questions the analytical focus on national historical utilization trends without an accompanying projection of future utilization trends. The draft recommendation applies a modest adjustment for national demand that relies on a key assumption that the historical utilization trends from 2013 to 2023 observed in their analysis will continue over the next decade. **While the HSCRC analysis does not project future utilization trends, other projections of future national utilization trends differ significantly from the historical trends HSCRC observed in their analysis.** HSCRC's analysis found that national inpatient utilization declined by 5%, and outpatient utilization increased by 12% from 2013 to 2023 when accounting for utilization pattern and demographic composition changes. In comparison, Sg2, a Vizient company, projects 4.5% growth in inpatient volumes and 17.4% growth in outpatient

¹ National Academy for State Health Policy (NASHP). Hospital Cost Tool. Available [here](#).

volumes nationally between 2025 and 2035 after accounting for changes in the population and other factors that impact utilization including innovation and technology and policy, among others.² Using their estimates of inpatient and outpatient utilization, MHA estimates total utilization growth of 8.3% over the decade.³ If the same discount for site neutral incentives were applied to this figure instead of the 3% estimate, the resulting national demand modifier would be substantially higher at 6.4% over a decade or 0.64% annually, in comparison to the 1% or .10% adjustment included in the draft recommendation. **Given the importance of ensuring hospitals are sufficiently resourced to meet the needs of the communities they serve, MHA urges HSCRC to consider, at a minimum, applying a 0.64% national demand modifier to the demographic adjustment, starting with the RY 2026 policy.**

Any changes to the demographic adjustment implemented for 2026 and 2027, including the level of the national demand modifier, should be reevaluated before CMS assumes responsibility for Medicare hospital global budgets in 2028 to ensure the methodology is sufficiently accounting for the utilization needs of the changing population. MHA also urges HSCRC to keep in place the long-standing policy to apply the demographic adjustment to all revenues and consider the implications of a potential change to this policy as part of broader discussions about additional exclusions from hospital global budgets under AHEAD.

Thank you for the opportunity to comment on these important policy changes. We look forward to continuing to work together on HSCRC policy development in the coming months. If you have any questions, please do not hesitate to contact me.

Sincerely,



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cc: Dr. Joshua Sharfstein, Chair
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² Sg2 2025 Impact of Change Forecast Highlights. Available [here](#).

³ Sg2's projected utilization for adult and pediatric separately. To estimate total utilization growth, MHA calculated a weighted growth rate using adult and pediatric populations and charge ratios of inpatient and outpatient charges.