Maryland
Hospital Association

October 30, 2026

Abid Khan
Director, Division of Multi-Payer Models
State and Population Health Group (SPHG)
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Version 3.2 AHEAD Model Medicare FFS Hospital Global Budget Financial Specifications and Maryland Hospital Global Budget 2025 Simulation Draft Specifications

Dear Mr. Khan,

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to provide input on version 3.2 of the AHEAD Model Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget (HGB) Methodology and Maryland HGB 2025 Simulation Draft Specifications released on Sept. 1.

Maryland hospitals are committed to improving the health and well-being of the communities they serve and advancing the goals of the AHEAD Model. A well-designed Medicare hospital global budget methodology that supports hospital financial stability and continued access to high-quality care is essential to these efforts. With this in mind, MHA offers the following comments and questions for consideration by CMMI as it works to finalize the specifications for Performance Year 3 (2028) before Jan. 15.

Given that some elements of the methodology remain under development, we encourage CMMI to provide, upon stakeholder request, additional opportunities for review and comment in the coming months to the extent practicable. It is important that hospitals can request and provide input on components of the methodology that have not been finalized, as well as any items that emerge once the final specifications, updated modeling, and preliminary HGB calculations are released. Hospitals are working diligently to evaluate the methodology and maintaining flexibility for their continued engagement is critical to supporting a successful transition to Medicare HGBs in 2028.

National Medicare HGB Specifications (Version 3.2)

Market Shift, Effectiveness, and Total Cost of Care Adjustments Modeling: MHA would appreciate CMMI sharing modeling of the market shift, effectiveness, and total cost of care adjustments based on data from a historical period. Such modeling would support hospitals' understanding of the respective methodologies and, for the market shift, the potential magnitude of adjustments for shifts in volume. Modeling of the market shift adjustment methodology could

include information on hospital-specific and overlapping market areas, as well as the small hospitals that may be eligible for the market shift adjustment floor based on their share of the state's total Medicare payments.

Baseline Carveouts: Clarification is needed regarding the anticipated timeline to release the complete lists of DRGs and HCPCS codes that will be excluded from hospital global budgets in CY 2028. CMMI indicates that it will monitor its carveout policy for high-cost, high-acuity inpatient services on an ongoing basis and "may, in exceptional circumstances, modify the policy during a Performance Year" (Section 2.1.4.a). Additional information is needed regarding the circumstances that may necessitate a mid-year update and how a mid-year change would be operationalized (e.g., implications for future bi-weekly HGB payments). We would also appreciate clarification regarding whether similar mid-year changes would be considered to the high-cost drug carveout policy described in Section 2.1.5.a. as it will be important to ensure that any new-to-market high-cost drugs that meet the specified criteria for carveouts can be excluded from hospital global budgets in a timely manner. Finally, we would urge CMMI to exercise caution when considering the removal of certain services and drugs from the list of carveouts mid-year as such changes could create operational and financial disruptions for hospitals and undermine the predictability and stability of global budgets.

Service Line Adjustments: According to the specifications, hospitals must submit service line adjustment requests no later than Sept. 1 for those adjustments to apply to the following year's HGBs, and mid-year requests will generally not be considered. It will be important to ensure hospitals can request mid-year adjustments to account for significant, unforeseen changes that may warrant immediate adjustments or, at a minimum, mid-year consideration of adjustments effective the following year to support operational planning. In addition, we ask CMMI to consider establishing a streamlined service line adjustment approval process to reduce administrative burden, improve predictability, and support access to care. This could include identifying specific services and volume thresholds for expedited approval (e.g., behavioral health services with demonstrated barriers to access), establishing automatic approval for adjustments below a specified percentage of a hospital's HGB, and a standardized form that hospitals can use to submit service line adjustment requests and associated information. We recommend the service line adjustment policy be designed to incentivize hospitals to provide services in lower-cost settings whenever possible. This includes the administration of high-cost drugs excluded from HGB that can be provided in an outpatient community setting. MHA asks CMMI to consider expanding the policy to incentivize such shifts by allowing hospitals to request service line adjustments for high-cost drugs and receive a percentage of the estimated savings as legacy revenue funding in their HGB, and ensure that the approach to these adjustments is reflected in the final specifications.

CMS National Quality Program Adjustments: The description of the inpatient baseline paid amount calculation (Section 2.1.4b) references quality adjustments that will serve as the basis for certain Medicare FFS payment factors within the calculation, including the Hospital Readmissions Reduction Program (HRRP), Value Based Purchasing Program (VBP), and Hospital Acquired Conditions Reduction Program (HACRP). As payment adjustments for these programs are made on a federal fiscal year schedule, clarification is needed as to how this

payment adjustment schedule will be operationalized within the calendar year-based HGB payment structure of the AHEAD Model.

Community Improvement Bonus (CIB): Measuring performance on the two community health improvement focused quality measures (Hybrid eHWR and PQI-90) relative to each hospital's historic performance over a fixed base period may present limited opportunities for high-performing hospitals to demonstrate further improvement. MHA recommends CMMI consider a methodology that evaluates the better of performance improvement or attainment, rather than only utilizing an improvement approach. Under this approach, hospitals demonstrating performance improvement or attaining their performance goal will receive the CIB. Additionally, we recommend applying the CIB to HGBs beginning in PY3. An earlier start would support hospitals' continued investment in community health improvement initiatives by providing resources to sustain and accelerate progress toward Model goals and long-term success.

Medicare Cost Reporting and Payments Outside of Claims: Section 3.5 notes that additional guidance on Medicare hospital cost reporting is available in the Hospital Participation Agreement. However, this information is not included in the current version of Hospital Participation Agreement for Maryland hospitals. Additional details regarding cost reporting are needed, including how CMMI will communicate any expected cost reporting changes relevant to hospitals receiving HGB payments on an ongoing basis as well as clarification on how CMMI will use Medicare hospital cost report data and CMS impact files reported on a fiscal year basis to construct calendar year hospital global budgets.

Data Sources (Appendix B): MHA respectfully requests that CMMI define the data period(s) for each of the data sources included in Appendix B and the accompanying calculations for each performance year, to the extent possible. For example, it would help to understand the specific data period and DRG/APC versions that will be used to determine the case weights for the Market Shift Adjustment starting in PY4 (CY 2029) and the data periods that will be used to update the case weights in future years. We would also appreciate additional detail on the data periods used to evaluate changes in Medicare FFS enrollment for the purpose of calculating the Demographic Adjustment for each PY.

Other Items: We would appreciate CMMI sharing the methodology used to calculate national Community Deprivation Index (CDI) scores as part of the Social Risk Adjustment, if possible, as well as additional information on the payment approach for New Technology Add-On Payments.

Maryland Addendum to National Medicare HGB Specifications (Version 3.2)

Updated Simulations and Methodology: The addendum describes the methodology used to construct Fiscal Year 2025 (FY 2025) Medicare FFS hospital global budget simulations for Maryland hospitals, largely based on data from FY 2024 and includes only baseline and annual updates. MHA requests clarification regarding CMMI's anticipated timeline for releasing revised simulations based on more recent data, providing a full assessment of the CMMI methodology with simulations of market shift and AHEAD performance adjustments, and updating the addendum to reflect the methodology (and data periods) that will be used to calculate Maryland hospitals' CY 2028 (PY3) Medicare hospital global budgets.

Statewide Savings Adjustment: The AHEAD Model Maryland State Agreement (12.b.iii) includes a savings adjustment to the HGB to ensure the state meets its Medicare FFS TCOC targets and an upward adjustment to be applied in a subsequent year if TCOC savings exceed statewide TCOC targets each year. The calculation methodology for determining statewide performance is included in Appendix A of the State Agreement. MHA requests a detailed description of how and when statewide performance will be calculated, including which versions of the United States Per Capita Cost (USPCC) estimates will be used when calculating savings targets, including for CY 2027, and how adjustments will be applied to each HGB in CY 2028 and subsequent years to reflect statewide performance.

Transition to National Program Values for Add-On and Pass-Through Payments: The Addendum states that the simulations use Maryland program values for IME, DSH, DME, and UCC, but that CMMI plans to transition to use of its own data sources, including hospital cost reports and the CMMI impact file. MHA requests details on the transition timeline and the specific data periods CMMI will use to calculate CY 2028 HGBs. Hospitals also need to understand differences between Maryland and CMMI data values and how CMMI will reconcile material discrepancies. It will be important for CMMI to receive stakeholder input in determining how to establish add-on payment values; for example, GME funding is a critical issue for several hospitals and newer programs, in particular, should have an opportunity to establish an appropriate funding base and resident cap. In addition, MHA requests additional information on how CMS will adjust pass-through payments, such as payments for bad debt, DME, nurse and allied health education, and organ acquisition costs as listed in the national specifications Appendix D.

Inpatient Prospective Payment System (IPPS) Quality Program Adjustments: As stated in Table 1 of the Addendum, Maryland's participation in the IPPS quality program adjustments will begin in CY 2030; however, the Addendum also notes that details regarding this transition have not yet been finalized. MHA requests additional details on the approach for the transition as this will introduce overlapping performance periods for HSCRC-administered quality programs and the CMS-administered quality programs and there are operational questions on how adjustments will implemented with the transition to Medicare HGBs with HSCRC-administered adjustments occurring on a State fiscal year basis and AHEAD functioning on a calendar year basis. Details are also sought on the range of IPPS quality programs that will apply to Maryland hospitals during the transition years, such as the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. Specificity on these transition details will help hospitals assess financial and operational impacts and align their quality improvement efforts accordingly.

In addition, MHA encourages CMS to work through the Center for Clinical Standards and Quality (CCSQ) to establish educational resources, technical assistance, and an engagement approach for Maryland hospitals as they transition to the national IPPS quality programs. Unlike hospitals in other states, Maryland hospitals have historically operated outside many CMS quality program structures and therefore have not benefited from the same level of CCSQ-led education, benchmarking resources, technical support, and engagement opportunities. As Maryland transitions to these programs, hospitals will require guidance on program requirements, data submission and validation processes, performance feedback reports, and

payment adjustment methodologies. MHA further requests the establishment of formal pathways for Maryland hospitals to engage with CCSQ on data questions, quality reporting concerns, measure specifications, and program implementation issues. Ensuring Maryland hospitals have access to CCSQ resources, education, and supports tailored to their unique needs will be critical to a successful transition.

Categorization of Maryland HGB One-Time Adjustments: Appendix A provides a list of Maryland-specific adjustments and a description of how they will be accounted for in HGB base rates. Certain adjustments are categorized as being "reversed" (removed from base rates and excluded from add-on payments) whereas others are being "removed" (removed from base rates and added back after repricing). MHA requests an updated version of Appendix A that will be used for CY 2028 HGB calculations and a description of rationale for including historical adjustments.

Distinct Part Unit (DPU) Services: Additional clarity is needed regarding the treatment of DPU services under the Medicare HGB methodology and the options available to Maryland hospitals related to these services. During the October 20 office hours meeting, CMMI described options to convert these services to DPUs or keep them under HGBs. MHA requests clarification on whether hospitals will have the option to retain DPU-related services within their HGBs rather than having the associated revenue carved out. Maryland hospitals have a long history of providing these services as standard acute care services under HGBs, and establishing DPUs may present significant operational and administrative challenges. Maryland hospitals should have the option of retaining these services within their HGBs at Maryland rate levels, at least for a transition period.

CMMI should provide hospital-level modeling of the financial implications of each option as soon as possible, allowing hospitals sufficient time to review the results and make informed decisions. This modeling should help hospitals assess the extent to which establishing a psychiatric DPU may change DSH payments given psychiatric units often serve a relatively high proportion of Medicaid patients. It will be important for CMMI to provide additional information on how claims associated with DPUs will be identified and classified in the Integrated Data Repository (IDR) in the baseline and future data periods for hospitals to implement changes in their workflows as they asses full implications.

CMMI should also clarify whether revenue associated with DPU services reimbursed under the Medicare prospective payment system outside of HGBs would be considered as excluded services when determining compliance with the requirement in Section 8.b of the State Agreement that 85% of all in-state, all payer, acute care hospital revenue is paid to participant hospitals under the HGB methodology. MHA recommends aligning the classification of DPU revenues as ineligible for HGB's with the national methodology, which would exclude DPU-related revenues from the calculation of participation requirement for Maryland.

Finally, we ask that CMMI offer flexibility in allowing hospitals to submit the CMS-855A forms beyond the February 1, 2027 deadline for Performance Year 3 (2028) and confirm that hospitals will have the ability to change their DPU status in future performance years.

Case Mix Adjustment: MHA appreciates CMMI's diligent work in accounting for historical differences in payment, and coding practices in Maryland to create fair baseline estimates for CMS HGBs. To account for coding differences, CMMI calculated an estimate of under coding in Medicare claims using HSCRC claims. However, adjustments are applied in a two-sided manner, which penalizes hospitals with better coding practices for Medicare claims. MHA requests that the case mix adjustment be applied to only have a positive impact when calculating baseline ratios as the goal of the adjustment is to account for under coding of Medicare claims. In addition, the Case Mix Adjustment formula listed in Column J of *Table 3* is different from the formula included in the FY 2025 simulation file ((E-F)/G * (1-I)).

Outlier Adjustment: The Addendum notes that CMMI will assume hospitals' outlier share is equal to their "share of total Medicare HGB revenue" in the baseline given Maryland hospitals' base year payments do not include the outlier adjustment. CMMI should clarify how it intends to determine each hospital's share of total Medicare HGB revenue for this purpose.

Sequestration: We ask CMMI to clarify how sequestration is accounted for when calculating HGBs and Medicare FFS equivalent payments; specifically, whether sequestration is applied consistently in every stage of HGB calculations including baseline estimates, one-time adjustments, or only applied once in the calculation of final HGB amounts.

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Thank you for the opportunity to provide feedback. For any questions or responses that CMMI would like to provide in writing, please reach out to Sule Gerovich, MHA Senior Vice President, Health Care Analytics, at sgerovich@mhaonline.org.

Thank you for the continued partnership.

Sincerely,



Melony G. Griffith
President & CEO
Maryland Hospital Association