

MEMORANDUM

To: Hospitals
Medicare Advantage Plans

From: William Henderson, Acting Executive Director

Date: October 9, 2026

Re: Medicare Advantage Stabilization Differential Estimate (CY 2027)

Kevin J. Sexton
Chair

Jonathan Blum, MPP

Ricardo R. Johnson

David N. Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD

Benjamin Z. Stallings II MD

Background

Medicare Advantage (MA) enrollment in Maryland is consistently lower compared to the nation—a recent analysis indicates that 51 percent of Medicare beneficiaries nationally, while 25 percent of Maryland beneficiaries are enrolled in MA plans.¹ Accordingly, a September 2025 directive issued by Governor Moore required the State to explore options to stabilize the MA market in Maryland, with the aim of aligning the goals of the AHEAD Model and the MA market to improve access to MA for older adults and dual-eligibles in Maryland.

The ensuing policy recommendation—approved by the Governor in December 2025 and at the January 2026 meeting of the Health Services Cost Review Commission (HSCRC)—will adjust the public payer differential to generate reduced hospital costs for MA plans that meet a set of qualifying criteria.² The policy will go into effect in January 2027, with an estimated total differential of 19.19 percent for qualifying plans and 8.64 percent for non-qualifying plans. This represents an illustrative calculation, using older data. The HSCRC will share the final figure once

William Henderson
Acting Executive Director

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

¹ <https://www.chartis.com/insights/medicare-advantage-market-growth-slows-amid-intensified-headwinds#:~:text=51%25%20of%20the%20country%27s%20Medicare,67.9%20million%20Medicare%20Eligible%20Individuals.>

² The full policy recommendation, as approved by the Governor, can be found here: https://hscrc.maryland.gov/Documents/AHEAD/Multi-Agency%20RWG_Cost-Shifting%20and%20MA_Policy%20Recommendation_FINAL%20%281%29.pdf.

data are available for the first half of calendar year (CY) 2026. Qualified plans for CY 2027 were identified and informed in February 2026.

Preliminary Modeling Estimates

The estimated differential was calculated using:

- January-to-June revenue estimates from preliminary, pre-carve out, fiscal year (FY) 2027 Global Budget Revenues (GBRs); and
- Actual FY 2025 gross revenue by payer as reported by hospitals on Schedule PDA in their Annual Cost Report.

To estimate the split of revenue between Medicare Advantage Qualifying Plans (MA QP) and Medicare Advantage Non-Qualifying Plans (MA non-QP), staff calculated an estimated split by hospital using FY 2025 case mix data based on the staff's current understanding of the likely MA QP share for each Medicare Advantage plan. The final number will be calculated using actual data on MA QPs for a more recent period, as discussed below.

The approved recommendation set a discount for Qualifying Plans at 11.55 percent of paid amounts, which translates to 10.66 percent of charges, while being revenue-neutral for Medicare Fee-for-Service (FFS) and MA non-QPs. To achieve this, staff calculated an effective differential of 11.49 percent for MA QPs and 0.94 percent for MA non-QPs. If this were the final notification, these are the amounts by which relevant plans could increase their differential, effective January 1, 2027. Under this estimate, the new total differentials (including the current differential of 7.7 percent) would be 19.19 percent and 8.64 percent, respectively, for MA QPs and MA non-QPs.

Medicare FFS will be offset via the Medicare Performance Adjustment (MPA). Current modeling estimates show matching cost increases to Medicaid, commercial and other payers of one percent.

FY 2027 and FY 2028 Implementation

Staff will update the modeling with final FY 2027 revenue estimates and actual revenue from hospitals' FY 2026 Schedule PDA (in which hospitals report revenue separately for MA QPs and MA non-QPs). Staff will release the final results later this year. The results from this modeling will be the amount of discount that MA QPs are allowed to take.

The new offset for the discount will be added in the January 2027 rate files. Staff is implementing the offset as a one-time adjustment due to the complexities associated with issuing rate orders with two effective dates, especially in regard to monitoring and measuring rates and GBR compliance. Staff believes this simple approach is the best path forward for FY 2027.

Preliminary sensitivity analysis indicates that variance between the one-time adjustment and the actual discount applied will not be material; consequently, no formal reconciliation is planned. However, staff will monitor the results and consider a true-up if significant discrepancies arise.

For FY 2028, staff will implement the adjustment via a change to the mark up calculation, using a revised differential for MA QPs (and MA non-QPs) based on updated estimates for CY 2027 MA enrollment.

Modeling and Sensitivity Tests

Staff recognizes that once the differential and offset are determined, hospitals are at risk for any changes in payer mix, and there may be slight variations in CY 2027 MA QP enrollment from baseline estimates. Therefore, in addition to baseline estimates, staff modeled three scenarios and will provide them via an Excel file to the industry. Note the impacts of any estimation error, as described below, would only be experienced for six months, since staff intends to make an updated adjustment using more recent data on July 1, 2027. Also, while staff has modeled the impact of increasing shares, hospitals would experience a benefit if shares were to decline.

Scenario 1: Increased Medicare Advantage (MA) Share

The first scenario that staff modeled was to determine the impact on hospitals assuming that the MA share of Medicare Revenue increased above estimates used to set the differential. **In this scenario, staff assumed that the split between MA QP and MA non-QP revenue remains unchanged from baseline estimates.**

Table 1: Scenario 1 Impact on Net Revenue with Sensitivity Tests

	Statewide Average Impact on Net Revenue	Value for Least- Impacted Hospital	Value for Most- Impacted Hospital	Increase (Decrease) - Medicaid	Increase (Decrease) - Commercial/ Other
Base Estimate (26.4% Share)	0.00%	0.00%	0.01%	1.02%	1.02%
5-Point Increase to MA Share	(0.11%)	(0.05%)	(0.18%)	1.02%	1.02%
20-Point Increase to MA Share	(0.44%)	(0.19%)	(0.73%)	1.02%	1.02%
40-Point Increase to MA Share	(0.89%)	(0.37%)	(1.45%)	1.02%	1.02%

As seen in Table 1, assuming a five-point increase to the MA share of total Medicare revenue, hospitals would lose approximately \$12 million statewide. Large increases in the MA share above baseline estimates have the potential for more material impacts.

Scenario 2: Increased Medicare Advantage (MA) Qualify Plan (QP) Share

The second scenario that staff modeled was to determine the impact on hospitals assuming that the MA QP share of MA revenue increased above estimates used to set the differential. **In this scenario, staff assumed that the total share of MA revenue remains unchanged from baseline estimates.**

Table 2: Scenario 2 Impact on Net Revenue with Sensitivity Tests

	Statewide Average Impact on Net Revenue	Value for Least- Impacted Hospital	Value for Most- Impacted Hospital	Increase (Decrease) - Medicaid	Increase (Decrease) - Commercial/ Other
Baseline Estimate (46.4% Share)	0.00%	0.00%	0.01%	1.02%	1.02%
55% Share	(0.11%)	(0.02%)	(0.20%)	1.02%	1.02%
65% Share	(0.23%)	(0.05%)	(0.43%)	1.02%	1.02%
80% Share	(0.41%)	(0.08%)	(0.78%)	1.02%	1.02%

As seen in Table 2, assuming an increase of MA QP revenue to 55 percent of the total MA revenue, hospitals would lose approximately \$12 million. It should be noted that in the third sensitivity test (assuming an 80-percent share of MA QP revenue), the statewide share is slightly below 80 percent (78.8 percent), as some hospitals already had a high percent of MA QP revenue and thus their MA QP revenue increase was capped at 100 percent of their MA revenue.

Scenario 3: Increased Medicare Advantage (MA) Qualify Plan (QP) Share

The third scenario that staff modeled was to determine the impact on hospitals assuming that some variation of both Scenario 1 and Scenario 2 occurred at the same time. **This scenario assumes that both the MA QP share of Medicare Advantage revenue and the Medicare Advantage share of Medicare Revenue increased above estimates used to set the differential.**

Table 3: Scenario 3 Impact on Net Revenue with Sensitivity Tests

	Statewide Average Impact on Net Revenue	Value for Least- Impacted Hospital	Value for Most- Impacted Hospital	Increase (Decrease) - Medicaid	Increase (Decrease) - Commercial/ Other
Baseline Estimate	0.00%	0.00%	0.01%	1.02%	1.02%
Sensitivity Test 1	(0.26%)	(0.12%)	(0.37%)	1.02%	1.02%
Sensitivity Test 2	(0.57%)	(0.26%)	(0.81%)	1.02%	1.02%
Sensitivity Test 3	(1.33%)	(0.61%)	(1.95%)	1.02%	1.02%

In Table 3, Sensitivity Test 1 assumes that the MA share of Medicare revenue increased by five points while the MA QP share increased by 10 points. Under this scenario, hospitals would lose approximately \$28 million. Sensitivity Test 2 assumes that the MA share of Medicare Revenue increased by 10 points while the MA QP share increased by 20 points. Sensitivity Test 3 assumes that the MA share of Medicare Revenue increased by 20 points while the MA QP share increased by 40 points.

Modeling File

As stated above, staff will be sending with this memo an Excel file containing the modeling for the baseline estimates and three scenarios. Staff recognizes that some of the information contained in the baseline estimates is preliminary and will update in future iterations of the modeling.

Each tab contains one of the aforementioned estimates/scenarios. The baseline estimates contain a build-up of the GBR and the impact of adjusting each differential (MA QP and MA non-QP) and the MPA. The expectation is that the adjustments should be revenue neutral to hospitals; however, there is some noise in the rounding allowing for an immaterial increase to hospitals statewide (approximately \$229,556).

Next Steps

Stakeholders are welcome to share comments with the HSCRC, particularly regarding the proposed true-up approach. Otherwise, HSCRC will finalize the differentials effective January 2027 once the relevant data are available, likely in early December 2026.