maryland
health services
cost review commission

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the following topic: **Additional spending or investments for FY 2026**

WRITTEN COMMENTS ON THE QUESTIONS OUTLINED BELOW SHALL BE SUBMITTED TO HSCRC.PAYMENT@MARYLAND.GOV ON OR BEFORE JUNE 27, 2025.

1. **Inflation Corridor**. If the HSCRC were to remove the corridor this year, what should be the approach in future years, if inflation is above or below what is projected? If inflation is overfunded, should the Commission consider not recalibrating when its various savings targets are met?
2. **Risk Adjustment**. The HSCRC announced a process for developing a proposal to risk adjusting the Demographic Adjustment, population growth for a vote in 2025. Questions include:
    a. Should risk assessments be based on national utilization so as to remove TCOC Model impacts?
    b. Should TCOC Model impacts play any role in determining the total available funding provided by the Demographic Adjustment?
    c. If national assessments of utilization reflect incentives to provide services in a Hospital Outpatient Department should the Commission consider additional adjustments to neutralize the lack of site neutral incentives in the national market?
    d. In the event that the Commission cannot incorporate a frequently updated risk adjusted beneficiary count so as to adjust for more than just the aging of the population, should the Commission consider utilizing the growth in Medicare's Hierarchical Condition Categories (HCC's) either for the Medicare only population or extrapolated across the entire Maryland population?
    e. If the Commission elects to change the governor on total funding through the Demographic Adjustment from population growth to risk adjusted population growth, should the Commission also consider changing the allocation methodology, which currently uses age adjusted growth.
    f. The variable cost factor applied to the Demographic Adjustment is currently 100%. Should future modifications to the policy consider using a variable cost factor more in line with other volume policies, i.e., 50%?
    g. Should HSCRC add funding to global budgets in advance of this process. If so, how much and why?
3. **Physician Costs**. It is widely understood that rising physician costs are stressing hospital finances. The HSCRC is working on understanding the nature and extent of

physician costs for hospitals, and there are legal constraints on the Commission's ability to directly reimburse for physician costs.

   a. Are there specific physician costs intrinsic to the operations of the hospital that the HSCRC should consider providing funding for? If so, what physician specialties should be evaluated and under what authority?
   b. Given the complexity of identifying physician subsidies net of professional reimbursements, if the Commission elects to provide additional funding, should the Commission provide an across-the-board increase to hospitals in line with average hospital experience or tailor the adjustment to align with hospital's unique net losses, taking into account things like payer mix and hospital size?
   c. Given the role of payers in addressing physician costs, which are unregulated by HSCRC, how can HSCRC support hospitals while encouraging others to improve their efforts on this challenge?
   d. Can HSCRC support hospitals in addressing physician costs in ways that support value-based care? If so, how?
   e. What other ideas do you have for addressing physician costs?

4. **Surge Funding**. Should the Surge Funding policy become an annual HSCRC policy whereby hospitals are provided funding for volume changes based on their growth in respiratory illness related to RSV, pneumonia, and influenza?
   a. Related to respiratory season, what can reasonably be expected of hospitals in terms of prevention of respiratory disease?
5. **Preparing for AHEAD.** As part of AHEAD model preparation, we believe federal partners may be interested in projects that use the state's unique information technology platform to support cardiovascular disease prevention and access to healthy food.
   a. How can the state data infrastructure be linked to clinical and community programs to advance cardiovascular health in Maryland?
   b. How can the state data infrastructure be tied to community programs to support nutrition and access to healthy food?
   c. How can Maryland leverage CRISP and other data resources to support such efforts – and measure the outcomes?
   d. What other innovative ideas for statewide programs to prevent chronic disease could be included in AHEAD preparations?
6. Are there any other funding areas that have not been considered in the questions above?