maryland
health services
cost review commission

Payment Model Workgroup

May 29, 2025

Draft Recommendations

For Global Revenues:

- Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.
- Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.
- Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than percentage growth rates, thus improving the accuracy and better reflecting actual population changes.
- To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.
- Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.36 percent for inflation and apply a productivity offset of 0.80 percent for a total update of 2.56 percent.

STAKEHOLDERS' COMMENTS

Comment Letters Received

Letters were received from:

1. Sheppard Pratt
2. Mount Washington Pediatrics
3. The Maryland Hospital Association
4. University of Maryland Hospitals
5. Adventist Health
6. Luminis Health
7. Frederick Health
8. Johns Hopkins Health System
9. Lifebridge Health
10. MedStar Health
11. CareFirst

Comments generally focused on 7 areas:

1. Provide Additional Inflation
2. Fully fund Age-Adjusted Demographic Growth
3. Pass on Medicaid Deficit Assessment to Payers
4. UCC Fund Revision
5. Reinvestment of Excess Medicare Savings
6. Integrated Efficiency Policy Modification
7. Suspend Productivity Adjustment for non-GBR hospitals

1. RY2026 Update Factor Comments: Address Inflation Pressures

- The Maryland Hospital Association and its member hospitals requested that the Commission consider funding additional inflation funding. Hospitals suggested that the 3.36% outlook for Q1 provided through S&P was likely to be conservative and the actual inflation value would come in higher. Hospitals requested an additional 0.67%, which was calculated by the average relative difference of funded versus actual inflation for RY23 and RY24. One hospital system, requested the 0.52% that is the current calculated underfunding as calculated through the inflation catch up methodology.

1. RY2026 Update Factor Comments: Address Inflation Pressures

HSCRC Response: As part of the RY 2025 Approved Update Factor Recommendation an inflation catch-up methodology was adopted. This methodology aims to:

- *Consider historical overfunding allowances*
- *Allow for two-sided risk*
- *Utilize multi-year solutions to ensure savings tests are met*
- *Establish formulaic methods that are predictable to hospitals and payers*
- *All additional inflation values still need to be considered against required savings*

The current calculation of the catch-up methodology indicates an 'unfunded' inflation rate of -0.52%. This figure does not activate the 1% guardrail threshold, meaning no additional inflation funding is provided for Maryland hospitals at this time, per policy. Should actual inflation exceed the funded inflation for Rate Year 2026 (RY26), the catch-up methodology will automatically adjust to account for any variance, triggering additional inflation support if the 1% guardrail is breached.

It's important to note that the 1% guardrail was established as an acceptable tolerance level, reflecting historical inflation funding patterns since 2013. Additionally, hospitals have not provided supporting evidence suggesting a significant deviation between actual and funded inflation rates.

1. RY2026 Update Factor Comments: Address Inflation Pressures

Max Tolerance =	1.00%					1.00%							
HSCRC Scenario/Table 1 - Inflation Resolved after First	Historical											Projected	
Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.35%	3.24%	3.36%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.71%	3.24%	3.36%
Actual Inflation Correction												1.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	-0.35%	1.00%	0.00%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.51%)	-0.52%	-0.52%
Guardrail/Tolerance **(A)**											1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.52%)	(0.52%)	**(0.52%)**
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)								**1% for stub period**		1.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.35%	4.24%	3.36%

2. RY2026 Update Factor Comments: Fully Fund Age Adjusted Demographic Growth

- The Maryland Hospital Association and its member hospitals requested that the Commission go beyond the proposed 0.76% correction and fully fund age-adjusted demographic growth. They stated that the current adjustment does not reflect the true cost of serving an aging population. MHA estimated that 2.6% in age-adjusted growth from 2020 to 2024, or roughly 0.65% per year, remains unfunded and recommended including this amount in the update.

HSCRC Response: Staff propose moving forward with recommending an additional 0.76 percent to reflect revised historical data from the Maryland Department of Planning. Staff also propose that RY 2026 and future demographic adjustments be reconciled to cumulative population count from 2020 through the most recent year.

In addition to the aforementioned policy correction, hospitals have requested additional funding related to a proposed revision of the demographic policy, specifically concerning updates to age and risk adjustment calculations. Staff are committed to continued collaboration with hospitals and other stakeholders to revise this policy and will work over the coming months to review and align it with the implementation of the AHEAD Model. It is important to note that this process involves a fundamental change to the underlying methodology, not merely a revision related to source data or calculation errors. Therefore, it is essential that this process is conducted through a thorough stakeholder engagement process.

3. RY 2026 Update Factor Comments: Pass on Medicaid Deficit Assessment Increase to Payers

- The Maryland Hospital Association and its member hospitals requested that hospitals not be required to directly remit any portion of the $150-million increase to the Medicaid Deficit Assessment, citing financial vulnerability.

HSCRC Response: The Maryland Legislature has approved a $150 million increase to the Medicaid Deficit Assessment, bringing the total amount to be collected in Rate Year (RY) 2026 to approximately $444 million. Given the magnitude of this increase, staff believe it would be inequitable to pass the entire burden onto payers and patients.

Staff propose a hospital-payer split consistent with the historical allocation used in RY 2015, which was 14.5% for hospitals and 85.5% for payers. Applying this split would result in an additional $8 million in hospital costs statewide, representing 0.04% of revenue. Staff propose transitioning to a percentage-based allocation model (14.5% hospitals & 85.5% payers). This approach aims to enhance predictability and ensure a fair distribution of costs between hospitals and payers, aligning with the principles of equity and transparency.

4. RY 2026 Update Factor Comments: UCC Fund Revision

- The Maryland Hospital Association and all member hospitals supported the proposed correction to the uncompensated care (UCC) fund calculations for RY2023 to RY2025. They agreed with providing additional funding to hospitals and health systems that were underfunded, while holding harmless those that were overfunded. MedStar requested clarification on how the UCC correction will be implemented, specifically whether it will be applied as a one-time rate adjustment in RY2026.

HSCRC Response: Staff appreciates the hospital support and understanding regarding the need for policy corrections when errors occur. In effort to ensure that undue burden is not placed on hospitals when corrections need to be made, staff is proposing holding hospitals harmless who were overfunded based on this policy correction. If approved by the Commission, HSCRC staff will implement this policy correction as a one-time adjustment in RY 2026, not as an increase to mark up.

5. RY 2026 Reinvestment of Medicare Savings Above Target

- The Maryland Hospital Association, along with several hospitals including UMMS, LifeBridge, and MedStar, noted the state's estimated $795 million in CY 2024 Medicare Total Cost of Care savings and identified it as an opportunity to support hospital funding. LifeBridge and MedStar more directly urged the Commission to reinvest a portion of the surplus and cited the role hospitals played in generating the savings and the need to stabilize operations in preparation for the AHEAD model. The MHA cited several hospital cost pressures in their comment letter. These cost pressures included:
  - Expected Impact on Tariffs
  - Potential Funding Cuts to Medicaid
  - Increase in Payer Denials
  - Rising Physician & Other Staffing Costs
  - Medical Liability Costs
  - Cybersecurity and Campus Security

5. RY 2026 Reinvestment of Medicare Savings Above Target

HSCRC Response: Staff modeled four different scenarios to project the CY 2025 guardrail position. In all four modeled scenarios, Maryland is expected to achieve the savings target for CY 2025 with varying degrees of cushion. However, it is important to note that the guardrail can not be above the nation by 1 percent in any year or above the nation by any percent in two consecutive years. The guardrail position in CY 2024 was below the nation, so Maryland will only trigger the guardrail if growth is more than 1 percent above the Nation. In two of the scenarios modeled, Maryland exceeds the guardrail by more than 1 percent. In another scenario, the estimated guardrail is 0.8 percent above the nation, 0.2 percent away from tripping the guardrail.

The HSCRC received a large number of comments regarding potential rate increases above the formulaic update factor methodology. At this time, Staff are not making recommendations related to reinvestment of savings above target and above the formulaic adjustments outlined in this presentation. However, Staff are working with Commissioners to assess options outlined in comments and other feedback.

6. RY 2026 Integrated Efficiency Policy Modification

- The Maryland Hospital Association, along with JHHS and MedStar, specifically supported the recommended modification to the Integrated Efficiency Policy. They agreed with limiting penalties to hospitals in the fourth quartile that are also identified as ICC outliers and supported the use of a historical standard deviation. Medstar also encouraged convening a stakeholder workgroup to collaborate on additional revisions to the policy and related methodologies. LifeBridge Health requested the suspension of Integrated Efficiency policy penalties in RY 2026, citing uncertainty of Maryland's Medicare Waiver and projected statewide savings targets.

HSCRC Response: Staff appreciate the broad support provided by stakeholders to limit the downside risk of the Integrated Efficiency policy to hospitals in the fourth quartile that also are worse than one standard deviation from average performance in the ICC.

Staff generally agree with Medstar that the Commission should every 3-5 years review existing policies to assess their efficacy and amend them if necessary. Staff would note though the Integrated Efficiency policy has gone through revisions approximately every two years since its original inception in 2020 (implementation in 2022), and there are also several other policies that stakeholders would like staff to review/amend, most notably the marketshift policy and the demographic adjustment policy.

Staff do not agree with Lifebridge Health's request to suspend the implementation of the Integrated Efficiency policy, as the proposed modification further ensures that the policy only identifies outliers. Additionally, the federal government has noted in its AHEAD methodology specifications that it aims to use global budgets to make greater investments in population health, and uncertainty regarding the future of the Maryland Model does not eliminate the Commission's obligation to ensure that hospital costs are reasonable and hospital rates are reasonably related to charges, both of are accomplished by the ongoing application of the Integrated Efficiency policy.

7. RY 2026 Suspend Productivity Adjustment for non-GBR Hospitals

- The Maryland Hospital Association and its member hospitals are requesting the suspension of the productivity adjustments for non- GBR hospitals. The proposed -0.80% would lower the non-GBR hospitals with an update of 2.56%
- The Maryland Hospital Association states that 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. Applying a lower inflation factor to non-GBR hospitals at this time could create unnecessary financial strain.

7. RY 2026 Suspend Productivity Adjustment for non-GBR hospitals

Draft Recommendation Inflation Breakdown: Specialty Hospitals	
Inflation	**3.36%**
Productivity Adjustment	**-0.80%**
Additional Inflation Support	**0.00%**
Gross Inflation Allowance	**2.56%**

HSCRC Response: Staff followed the formulaic approach in the development of the draft recommendation by applying the productivity adjustment of -0.80% is in line with the proposed IPPS rule for FFY 26. The productivity adjustment is a tool that aligns Medicare payment updates with broader economic productivity trends, promoting cost control and efficiency in hospital operations. A productivity adjustment is applied to hospitals under both IPPS and IPF PPS. HSCRC staff do not set Medicare rates for non-GBR hospitals. The proposed update is included for non-governmental payers. HSCRC staff understand that non-GBR hospitals are facing similar cost pressures to GBR hospitals. Staff are reviewing several analyses in response to this request to waive the productivity adjustment which include:

- *Volume Changes & Changes in Service levels - both experience and case mix adjusted*
- *Compensation per FTE: Reported vs. Inflated*

Are there other analyses that Staff should be considering?

8. Payer and Other Stakeholder Comments

- Carefirst opposed the draft recommendation, stating that hospitals have already received more than $541 million in additional funding through recent Commission actions, including RSV surge support, margin enhancements, and inflation catch-up adjustments. They argued that these increases have prioritized hospital revenue over consumer affordability and warned that such an approach is not sustainable.
- CareFirst further noted that all modeled update scenarios exceeded Medicare guardrail thresholds and expressed concern that this continued trend could put the State's Model at risk.

HSCRC Response: Staff appreciate CareFirst's concern and commitment to protecting consumers and patients in Maryland. 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 other stakeholder comment letters. We understand the importance of considering both savings and guardrail positions related to our Model performance.

8. Payer and Other Stakeholder Comments

HSCRC staff received comment relating to “systemic and complex policy errors that have led to multi-year underfunding. We are deeply concerned that the continued layering of increasingly complex methodologies—without the ability to consistently execute them in a timely and accurate manner—risks the long-term viability of the Model. We encourage the Commission to prioritize simplification and external, independent replication of policy results to ensure the Model’s long-term sustainability.”

HSCRC Response: Staff would like to emphasize our commitment to a thorough and inclusive stakeholder engagement process. This approach ensures adequate time for making substantive changes and improvements that meaningfully inform decision-making. Such processes often span several months and involve extensive data sharing and dialogue with Maryland hospitals and other stakeholders.

To support this collaborative effort, it is imperative that the HSCRC receives timely and accurate hospital data. This data is essential for informing the work and analyses under review, enabling the development of policies that reflect the collective input and needs of all parties involved. Requests for data resubmission, data submission errors, and other data corrections that need to be made hinder the integrity of results. To date in FY 2025, staff have approved approximately 15 requests for extensions or data resubmissions. Oftentimes, this results in staff’s inability to run timely or correct methodologies that informs policy making on a statewide basis.

8. Other Stakeholder Comments

One comment received related to the reconciliation of the set aside funding. The Commission approved $31.7 million of permanent hospital funding in the RY 2025 update factor through the set-aside, only $10.8 million of this was distributed to hospitals permanently per the reconciliation in Appendix I. MedStar seeks clarification around this $20.9 million difference and how staff are accounting for this in the RY 2026 update factor.

HSCRC Response: While the historical distribution of set aside funding has been concentrated on permanent funding, the allotment has always been a mix of both permanent and one-time funding, i.e., there is no guarantee that the funding will be permanent or one-time. In RY 2025, due to the process by which set aside funding was distributed, a large portion was provided as one-time funding for financial hardship, as seen in Appendix I. HSCRC removed the permanent portion of this funding from the total set aside allotment and the remainder was included in the removal of extraordinary one-time adjustments as described in Table 5 of the recommendation. Based on MedStar's commentary, staff have revised the extent of one-time set aside funding that will be reversed in RY 2026. This small correction is reflected in the following tables.

Update Factor Discussion

Table 2: Update Factor Schedule

Balanced Update Model for RY 2026					
Components of Revenue Change Link to Hospital Cost Drivers /Performance			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 3.7% for Wages and Salaries)			3.34%	$748.9	$247.1
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.36%**	**$753.9**	**$248.8**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$33.9	-$11.2
- Grant Funding RY26: RP for Behavioral Health			0.04%	$9.7	$3.2
- Care Transformation			0.13%	$30.0	$9.9
Total Care Coordination/Population Health	**B**		**0.03%**	**-$24.2**	**-$8.0**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.74%	$166.0	$54.8
- RY2026 Revision to Prior Year Estimates			0.76%	$170.5	$56.3
Total Adjustment for Volume	**C**		**1.50%**	**$336.5**	**$111.1**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.20%	$44.9	$14.8
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.20%	$44.9	$14.8
- Reversal of one-time adjustments for drugs	G		-0.05%	-$11.2	-$3.7
- Capital Funding & Estimated Increase for Full Rate Applications	H		0.13%	$28.6	$9.4
- UCC Fund Revision	I		0.30%	$67.2	$22.2
Net Other Adjustments	**J =**	**Sum of D thru I**	**0.78%**	**$174.3**	**$35.3**
Quality and PAU Savings					
- PAU Redistribution	K		-0.03%	-$6.73	-$2.2
- Reversal of prior year quality incentives -QBR, MHAC, Readmissions	L		-0.16%	-$34.9	-$11.5
- Current Year Quality Incentives	M =		-0.06%	-$13.8	-$4.5
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.4**	**-$18.3**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.42%**	**$1,185.1**	**$368.9**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.64%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	Q		-0.44%	-$98.7	-$32.6
- Deficit Assessment	R =		0.70%	$158.0	$52.1
Net decreases	**S =**	Q + R	**0.26%**	**$59.2**	**$19.5**
Total Update First Half of Rate Year 26					
Revenue growth, net of offsets	**T =**	O + S	**5.68%**	**$1,274.4**	**$388.5**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.90%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**V =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**W =**	T + V	**5.68%**	**$1,274.4**	**$420.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.90%**		

Revenue Scenarios

Table 5: CY 2025 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2024		10,772,404,416
Actual Revenue July - December 2024		11,019,304,349
Actual Revenue CY 2024		21,791,708,765
Step 1:		
Approved GBR RY 2025		22,436,402,668
Actual Revenue 7/1/24-12/31/24		11,019,304,349
Approved Revenue 1/1/25-6/30/25		11,417,098,319
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/25-6/30/25	**A**	**11,417,098,319**
Expected Revenue Growth 1/1/25-6/30/25		**5.98%**
Step 2:		
Final Approved GBR RY 2025		22,436,402,668
Reversal of Extraordinary One-Times		-181,511,599
Final Adjusted GBR Base for RY 2025		22,254,891,069
Projected Approved GBR RY 2026		23,518,962,716
Permanent Update RY 2026		5.68%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,607,440,332
Projected RY26 Increase over RY25		6.08%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,764,845,077**
Expected Revenue Growth 7/1/25- 12/31/25		**6.77%**
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,181,943,396**
Increase over CY 2024 Revenue		**6.38%**
Per Capita Increase over CY 2024		**5.60%**

CY 25 Guardrail Scenario 1: 2024 Trended forward at 2017 - 2019 Trend

Table 6a: TCOC Estimate (Scenario 1, 2017 to 2019 Base)

Scenario 1 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,421	$13,886	Predicted Variance
YOY Growth	5.3%	3.9%	1.4% Over
Estimated CY 2025 Savings Run Rate			$641.9 M

CY 25 Guardrail Scenario 2: 2024 Trended forward at 2015 - 2019 Trend

Table 6b: TCOC Estimate (Scenario 2, 2015 to 2019 Base)

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,343	$13,746	Predicted Variance
YOY Growth	4.8%	2.9%	1.9% Over
Estimated CY 2025 Savings Run Rate			$569.0 M

CY 25 Guardrail Scenario 3: 2024 Trended forward at 2022 - 2024 Trend

Table 6c: TCOC Estimate (Scenario 3, 2022 to 2024 Base)

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,508	$14,141	Predicted Variance
YOY Growth	5.9%	5.8%	0.1% Over
Estimated CY 2025 Savings Run Rate			$814.2 M

CY 25 Guardrail Scenario 4: 2024 Trended forward using USPCC projections

Table 6d: TCOC Estimate (Scenario 4, USPCC Base)

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,647	$13,365	
2025	$15,500	$14,033	Predicted Variance
YOY Growth	5.8%	5.0%	0.8% Over
Estimated CY 2025 Savings Run Rate			$722.2M

Scenario 4 is based on the United States Per Capita Cost (USPCC) data published by CMS.

USPCC trend information can be found here: https://www.cms.gov/files/document/2026-announcement.pdf

Draft Recommendations

For Global Revenues:

- Provide all hospitals with gross inflation increase of 3.36 percent. Additionally, allocate 0.02 percent of this total inflation allowance based on each hospital's proportion of drug costs to total costs.

- Provide an overall increase of 5.68 percent for revenue (including a net increase to uncompensated care) and 4.90 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

- Require hospitals to report on their improvement targets and outcomes as part of their high value care plans aimed at reducing statewide potentially avoidable utilization. Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the RY 2026 rate orders.

- Adopt the revisions outlined in this recommendation for the Demographic Adjustment to incorporate updated population data from the Maryland Department of Planning, including a census restatement and a revised net migration estimate that together add over 41,000 lives. These changes include reconciling the RY 2026 and future Demographic Adjustments to cumulative population counts rather than percentage growth rates, thus improving the accuracy and better reflecting actual population changes.

- To address Uncompensated Care (UCC) underpayments from RY 2023 to RY 2025, staff propose a one-year settlement for adversely impacted hospitals on a per-system basis, similar to the CARES reconciliation approach, with a total proposed impact of $67.2 million (0.30 percent), funded first through the UCC fund balance and then a statewide UCC rate markup if needed.

- Modify the Integrated Efficiency policy by establishing a new threshold by which hospitals will not be penalized in Integrated Efficiency: 3rd quartile or better OR better than one historical standard deviation (6.41 percent) from Average Interhospital Cost Comparison Performance.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.36 percent for inflation and apply a productivity offset of 0.80 percent for a total update of 2.56 percent.