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Payment Model Workgroup

April 29,2025

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Payment Models Meeting Agenda

April 29, 2025
1:00 pm – 3:00 pm
Health Services Cost Review Commission

I	Demographic Assessment Modeling
II	UCC Policy Application Correction
III	RY 2026 Update Factor Overview
IV	Projected Savings and Guardrail Test Scenarios
V	Annual Filing Modernization
VI	RSV Funding Update
VII	Adjournment

Demographic Assessment Modeling

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Demographic Adjustment Overview

Purpose

- Designed to **adjust for hospital volume changes due to population changes**, without allowing for increases in hospital volume due to potentially avoidable utilization (PAU).
- Generally **provides additional funding to the system** because population is growing - serves as **governor** to total new volume funding.

Adjustment is relative to current Maryland experience only, so no overall secular changes are accounted for

How it Works

Uses ZIP code population projections by age cohort to apportion anticipated hospital volume growth, allocated by a hospital's market share so that hospitals gaining market share will gain more demographic adjustment

Methodology

1. **Base population estimates** attributed by hospital's share of volume in a given ZIP code and age cohort
2. **Age adjusted population growth rates** are calculated by ZIP code and age cohort, adjusted for Statewide age costs
3. **Hospital-specific age adjusted population growth** is calculated by multiplying hospital-specific base population by age-adjusted population growth rates, using ZIP codes and adjusted by age cohort
4. **Age Adjusted Growth Scaled to Population Growth** incorporates adjustments for potentially avoidable utilization and a scaling adjustment to ensure the Demographic Adjustment is not more than population growth - no variable cost factor is applied

Demographic Adjustment Example

The calculation is performed across all of Maryland's zip codes and for 8 age cohorts so age cost weights can be applied.

Final age-adjusted growth is discounted by potentially avoidable utilization and an adjustment to ensure statewide growth equals population growth.

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific PAU Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
		STEP 1a			Step1b		Step2a		Step2b		Step 3		Step 4		
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L) /sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	$2,335				401	1.3%	14%	1.08%	0.54%

Scaling adjustment to get to population growth

Annual average discount across Model (RY14-RY22) = ~0.60%

Max = 0.95% in RY 2017

RY 2025 Demographic Adjustment Improvements

- Demographic Adjustment has a disconnect between:
  - Claritas data that is used to allocate population growth and
  - Planning data that is used as governor for statewide total population allotment
  - Ex: RY 2026 DA uses CY 2025 Claritas growth & July 2024 Planning growth
- Both Claritas and Planning recast prior year estimates (sometimes with material impact)

- Because of the disconnected time periods AND reestimation of prior years periods, the Commission missed the 2020 “census catch up”

- To ensure this did not happen again staff elected in RY 2025 to lock in 2020 as the base for Claritas
  - Age-adjusted growth is therefore projected across multiple years, e.g., RY 2026 DA calculates age adjusted growth from CY 2020-CY 2025
  - The governor on statewide population growth is still the year over year growth from Planning, e.g., RY 2026 DA calculates population growth from 7/1/23-7/1/24
  - To ensure that hospitals are not advantaged/disadvantaged by this method, each year the DA deducts out from the age adjusted growth statistic growth provided subsequent to 2020 from prior year DA’s, e.g., the RY 2026 DA will deduct out 2020-2023 growth from the RY23,24,& 25 DA’s
  - Comparisons between age adjusted growth and population growth in a given DA is thus flawed because one is a multi-year statistic and one is a year over year statistic

RY 2026 Demographic Adjustment Improvements

Currently in Rates					
		Department of Planning Annual Release		Provided Via DA	
	Base/Performance	Base Year	Performance Year	YOY Growth #	YOY Growth %
2020 Census		6,177,224			
RY 2023 & RY 2024 DA	2021-2022			-22,968	
RY 2025 DA	2022-2023	6,164,660	6,180,225	15,565	0.25%
RY 2026 DA	2023-2024	6,217,062	6,263,220	46,158	0.74%
			Total	38,755	

Latest Projections for All Years					
		Department of Planning Annual Release		Provided Via DA	
	Base/Performance	Base Year	Performance Year	YOY Growth #	YOY Growth %
2020 Census		6,177,224	~~6,181,629~~	4,405	0.07%
RY 2023 DA	2020-2021	6,181,629	6,179,403	-2,226	-0.04%
RY 2024 DA	2021-2022	6,179,403	6,192,440	13,037	0.21%
RY 2025 DA	2022-2023	6,192,440	6,217,062	24,622	0.40%
RY 2026 DA	2023-2024	6,217,062	6,263,220	46,158	0.74%
			Total Growth from Census	85,996	
				RY 2026 Rebasing Inputs	**Comments**
			Census Restatement	4,405	*Bancroft Hall Annapolis*
			2023 Base Restatement	36,809	*Net Migration Methodology Change*
				41,214	

- Staff did not intend to reconcile changes to prior year Planning estimates until 2030; however, staff is considering addressing this because:
  - Planning revised the 2020 census, not just growth since the census
  - Planning's changes to growth since the census are very material

RY 2026 Demographic Adjustment Improvements cont.

- Demographic Adjustment has historically reconciled to the percentage population growth provided by Planning, not the population count
  - Because hospitals are different sizes, this resulted in a final population allocation that did not sum to the actual change in the population number
- To correct for Planning's new estimates and for the inherent imprecision of reconciling to a percentage change versus population count, staff are putting forward for consideration that the RY 2026 DA (and subsequent DA's) reconcile to the cumulative Planning estimate from 2020 to most recent year population count

For Update Factor			Comments
RY 2026 Standard Policy	0.74%	46,158	
RY 2026 Restatement	0.76%	47,241	*41k is due to restatement from prior slide, 5k is due to RY24 DA reconciling to % vs population count*
RY 2026 Total	1.50%	93,399	

How to Interpret Gap in Planning Population Growth & Claritas Age Adjusted Growth

- If Staff's recommendation is followed, the RY 2026 DA will reflect the following:
  - Claritas Age-Adjusted Growth from 2020-2025 for purposes of allocating population growth
  - Planning Population Growth from 7/1/23-7/1/24 PLUS reestimation of growth from 2020-7/1/23
- This method ensures total population provided post census is equivalent to current Planning estimate for 2020-7/1/24 of 85,996
  - Discrepancy of 171 lives is due to historical scaling method that provides Levindale average of Sinai and Northwest % change

- Comparing 2020-2024 Population Growth under this method to 2020-2024 Age Adjusted Growth for Claritas (apples to apples), suggests that the RY 2026 DA is discounting age adjusted growth by 0.65% per year

- In line with historical discounts that occurred from RY14-RY22 when age adjusted growth was assessed on a year over year basis.

	Population #	Effective Age Adjusted Growth % Provided	Population as % of Census	Annual Reduction in Rates by Not Providing Age Adjusted Growth
RY 2024 DA	(22,968)			
RY2025 DA	15,565			
RY 2026 DA	93,228			
Cumulative Population Growth Provided 2020-2024	*85,825*		*1.39%*	
2020-2025 Age& PAU Adjusted Growth	*308,348*	*27.83%*	*4.99%*	
2020-2024 Age & PAU Adjusted Growth (Calculated)	*246,678*	*34.79%*	*3.99%*	*0.65%*

UCC Policy Application Correction

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FY21 - FY23 UCC Regression Error

- UCC fund calculation involves a 50/50 blend of UCC Actuals AND Predicted UCC using a logistic regression
- The logistic regression determines the probability of UCC using payer type, area deprivation index (ADI) and site of service variables **at the patient level**
  - If an ADI variable is not available, the hospital specific average ADI is used
- From FY21 - FY23, the ADI variable changed and was not properly captured in the calculation, which resulted in **hospital ADI averages** in all instances
- Due to this error, there were incorrect coefficients and misapplication of erroneous coefficients
  - Generally, the error adversely affected hospitals with lower than average ADI scores, i.e., those hospitals with wealthier patient populations
  - Statewide UCC was not affected because the policy is redistributive

The smaller the ventile the more affluent the patient (ranges from 0-100 in units of 5)

	Payer Status	Site of Service	ADI (Ventiles)	Hosp Avg ADI	UCC Probability
Patient 1 (known ADI)	Commercial	ED	90	22.33	
Patient 2 (unknown ADI)	Commercial	ED	NA	22.33	
Correct UCC Methodology for Patient 1	Commercial	ED	90	90	0.53
Correct UCC Methodology for Patient 2	Commercial	ED	NA	22.33	0.27
Incorrect Application for Patient 1	Commercial	ED	90	22.33	0.18
Incorrect Application for Patient 2	Commercial	ED	NA	22.33	0.18

UCC Fund Revision Impact

- Statewide, UCC was funded correctly; however, given the incorrect development and application of coefficients, distribution via the UCC pool was flawed
- Net impact for adversely affected hospitals across 3 years (FY21 - FY23)
  - Individual hospital basis = ~$102M
    - FY21: ~$32.4M
    - FY22: ~$34.9M
    - FY23: ~$34.5M
  - Hospital system basis = ~$67.2M
    - FY21: ~$20.7M
    - FY22: ~$22.9M
    - FY23: ~$23.8M

Net Impact by Hospital

Hospital Name	FY 2021 UCC Fund Variance ($)	FY 2022 UCC Fund Variance ($)	FY 2023 UCC Fund Variance ($)	All 3 Years Combined UCC Fund Variance ($)
Hospital A	$ 3,802,748	$ 4,157,835	$ 4,152,431	$ 12,113,014
Hospital B	$ 2,722,957	$ 2,961,088	$ 3,019,974	$ 8,704,019
Hospital C	$ 2,906,755	$ 2,980,186	$ 2,805,972	$ 8,692,913
Hospital D	$ 2,278,676	$ 2,671,794	$ 2,738,515	$ 7,688,985
Hospital E	$ 2,020,144	$ 2,178,800	$ 2,173,166	$ 6,372,110
Hospital F	$ 1,654,739	$ 1,668,928	$ 1,690,614	$ 5,014,281
Hospital G	$ 1,653,060	$ 1,658,421	$ 1,591,318	$ 4,902,799
Hospital H	$ 1,503,734	$ 1,628,230	$ 1,513,892	$ 4,645,856
Hospital I	$ 1,191,023	$ 1,245,405	$ 1,429,672	$ 3,866,099
Hospital J	$ 1,235,391	$ 1,247,686	$ 1,320,740	$ 3,803,816
Hospital K	$ 1,123,935	$ 1,251,149	$ 1,235,831	$ 3,610,914
Hospital L	$ 1,089,614	$ 1,176,184	$ 1,129,888	$ 3,395,686
Hospital M	$ 1,086,859	$ 1,087,699	$ 1,104,429	$ 3,278,987
Hospital N	$ 987,940	$ 1,096,381	$ 1,084,063	$ 3,168,384
Hospital O	$ 1,012,775	$ 1,116,328	$ 1,026,917	$ 3,156,019
Hospital P	$ 894,552	$ 1,071,017	$ 1,013,726	$ 2,979,295
Hospital Q	$ 910,904	$ 1,021,195	$ 1,026,786	$ 2,958,884
Hospital R	$ 881,259	$ 988,615	$ 1,035,297	$ 2,905,171
Hospital S	$ 916,191	$ 971,934	$ 1,002,425	$ 2,890,550
Hospital T	$ 765,292	$ 849,722	$ 840,266	$ 2,455,281
Hospital U	$ 705,497	$ 742,137	$ 755,323	$ 2,202,958
Hospital V	$ 322,397	$ 315,037	$ 296,099	$ 933,534
Hospital V	$ 277,242	$ 247,271	$ 234,745	$ 759,257
Hospital X	$ 170,662	$ 238,789	$ 225,945	$ 635,397
Hospital Y	$ 142,968	$ 137,461		$ 280,429
Hospital Z	$ 83,582	$ 95,655	$ 75,943	$ 255,181
Hospital AA	$ 34,267	$ 85,544	$ 21,946	$ 141,757
Subtotal (All Underpayments from the fund)	$ 32,375,161	$ 34,896,900	$ 34,545,923	$ 101,811,576
Hospital AB	$ (40,322)	$ 6,408	$ (12,132)	$ (46,046)
Hospital AC	$ (162,861)	$ (268,917)		$ (431,778)
Hospital AD	$ (849,297)	$ (980,307)	$ (1,132,494)	$ (2,962,098)
Hospital AE	$ (1,368,479)	$ (1,309,502)	$ (1,302,793)	$ (3,980,774)
Hospital AF	$ (1,230,900)	$ (1,381,789)	$ (1,470,796)	$ (4,083,485)
Hospital AG	$ (1,410,546)	$ (1,706,735)	$ (1,634,697)	$ (4,751,977)
Hospital AH	$ (1,481,972)	$ (1,663,969)	$ (1,862,723)	$ (5,008,664)
Hospital AI	$ (1,650,355)	$ (1,646,981)	$ (1,948,333)	$ (5,245,669)
Hospital AJ	$ (1,548,889)	$ (1,939,456)	$ (1,826,017)	$ (5,314,363)
Hospital AK	$ (1,987,214)	$ (2,135,444)	$ (1,932,492)	$ (6,055,150)
Hospital AL	$ (1,949,344)	$ (2,333,605)	$ (2,696,104)	$ (6,979,053)
Hospital AM	$ (2,282,668)	$ (2,456,363)	$ (2,242,142)	$ (6,981,173)
Hospital AN	$ (2,612,473)	$ (3,264,251)	$ (3,179,084)	$ (9,055,808)
Hospital AO	$ (4,066,261)	$ (3,672,869)	$ (3,029,684)	$ (10,768,814)
Hospital AP	$ (3,469,921)	$ (3,611,973)	$ (3,833,749)	$ (10,915,643)
Hospital AQ	$ (6,263,658)	$ (6,524,741)	$ (6,442,682)	$ (19,231,081)
Subtotal (All underpayments into the fund)	$ (32,375,161)	$ (34,896,900)	$ (34,545,923)	$ (101,811,576)
Grand Total	$ (0)	$ (0)	$ 0	$ -

- 27 hospitals were adversely impacted
- 16 hospitals benefitted
- Impact of error was very consistent by year for hospitals

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Net Impact by Hospital System

Hospital System	FY 2021 UCC Fund Variance ($)	FY 2022 UCC Fund Variance ($)	FY 2023 UCC Fund Variance ($)	All 3 Years Combined UCC Fund Variance ($)
Health System A	$ 4,713,652	$ 5,179,030	$ 5,179,216	$ **15,071,898**
Health System B	$ 4,549,088	$ 4,904,355	$ 4,829,966	$ **14,283,409**
Health System C	$ 3,824,893	$ 4,612,109	$ 4,622,614	$ **13,059,616**
Health System D	$ 3,612,252	$ 3,722,323	$ 3,561,295	$ **10,895,871**
Health System E	$ 1,653,060	$ 1,658,421	$ 1,591,318	$ **4,902,799**
Health System F	$ 1,235,391	$ 1,247,686	$ 1,320,740	$ **3,803,816**
Health System G	$ 881,259	$ 988,615	$ 1,035,297	$ **2,905,171**
Health System H	$ (207,356)	$ 371,440	$ 1,411,243	$ **1,575,327**
Health System I	$ 277,242	$ 247,271	$ 234,745	$ **759,257**
Subtotal (All Underpayments from the fund)	$ 20,746,836	$ 22,937,659	$ 23,786,434	$ **67,257,165**
Health System J	$ (40,322)	$ 6,408	$ (12,132)	$ **(46,046)**
Health System K	$ (849,297)	$ (980,307)	$ (1,132,494)	$ **(2,962,098)**
Health System L	$ (828,219)	$ (1,160,362)	$ (1,569,728)	$ **(3,558,309)**
Health System M	$ (1,230,900)	$ (1,381,789)	$ (1,470,796)	$ **(4,083,485)**
Health System N	$ (1,650,355)	$ (1,646,981)	$ (1,948,333)	$ **(5,245,669)**
Health System O	$ (2,282,668)	$ (2,456,363)	$ (2,242,142)	$ **(6,981,173)**
Health System P	$ (3,469,921)	$ (3,611,973)	$ (3,833,749)	$ **(10,915,643)**
Health System Q	$ (3,924,140)	$ (5,175,143)	$ (5,134,377)	$ **(14,233,660)**
Health System R	$ (6,263,658)	$ (6,524,741)	$ (6,442,682)	$ **(19,231,081)**
Subtotal (All Underpayments into the fund)	$ (20,746,836)	$ (22,937,659)	$ (23,786,434)	$ **(67,257,165)**
Grand Total	$ (0)	$ (0)	$ 0	$ (0)

2 larger systems primarily drive the delta between the hospital and system payback approach

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Possible Solutions

	Budget Neutral or Hold Harmless	System or Hospital	Duration of time	Funding
Option 1 (Ensure Intended Policy Result)	Ensure budget neutrality by offsetting funding corrections by the same amount of revenue that was incorrectly provided to hospitals	Implement on a hospital basis, as that is the unit of measurement for the UCC policy	Settle over one year to remedy methodology error expediently OR settle over time (e.g. 3 years) to mitigate rate impact by accounting for "credit" in UCC pool	Increase statewide UCC markup in rates to recognize funding AND/OR Utilize available fund balance in UCC Fund
Option 2 (Account for Adverse Impact)	Hold hospitals harmless by not clawing back funding from institutions that were overfunded through the methodology error	Take into account the net effect to hospital systems to mitigate the clawback from hospitals that were overfunded		
Staff Recommendation	Hold hospitals harmless, as they tended to be rural and safety net hospitals. Clawback would be disruptive as hospitals may generally assume that UCC policy is being implemented pro forma.	Utilize system approach to mitigate rate impact, as was done with CARES reconciliations	Settle over one year to reduce complexity and because rate impact is mitigated by system approach. Utilize 3 years if hospitals are not held harmless	Use UCC Fund first to mitigate rate impact but leave 1 month balance and then use rate support

RY 2026 Update Factor Review

TABLE 2

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 4.0% for Wages and Salaries)			3.32%	$744.4	$245.6
- Additional Inflation Support			0.00%	$0.0	$0.0
- Outpatient Oncology Drugs			0.02%	$5.0	$1.6
Gross Inflation Allowance	**A**		**3.34%**	**$749.4**	**$247.3**
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			0.09%	$20.0	$6.6
Total Care Coordination/Population Health	**B**		**-0.02%**	**-$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**	**0.48%**	**$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%	-$14.1	-$4.6
Net Quality and PAU Savings	**N =**	**Sum of K thru M**	**-0.25%**	**-$55.6**	**-$18.4**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**5.05%**	**$1,180.4**	**$367.3**
Per Capita	**P =**	(1+O)/(1+0.74%)	**4.28%**		
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	**5.31%**	**$1,192.4**	**$386.9**
Per Capita Revenue Growth	**U =**	(1+T)/(1+0.74%)	**4.54%**		
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	**5.31%**	**$1,192.4**	**$393.5**
Per Capita Revenue Growth	**X =**	(1+W)/(1+0.74%)	**4.54%**		

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Revenue Scenarios

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		-150,893,207
Final Adjusted GBR Base for RY 2025		22,285,509,461
Projected Approved GBR RY 2026		23,472,129,668
Permanent Update RY 2026		5.32%
Miscellaneous Revenue Adjustments for RY 2026 (one-time)		88,477,616
Projected Approved GBR RY 2026 w Misc Adj		23,560,607,284
Projected RY26 Increase over RY25		5.72%
Step 3:		
Permanent AHEAD Preparation Funding		50,000,000
Estimated Revenue 7/1/25-12/31/25 (after 49.73% & seasonality)	**B**	**11,741,555,002**
Expected Revenue Growth 7/1/25- 12/31/25		***6.55%***
Step 4:		
Estimated Revenue CY 2025	**A+B**	**23,158,653,321**
Increase over CY 2025 Revenue		**6.27%**
Per Capita Increase over CY 2025		**5.49%**

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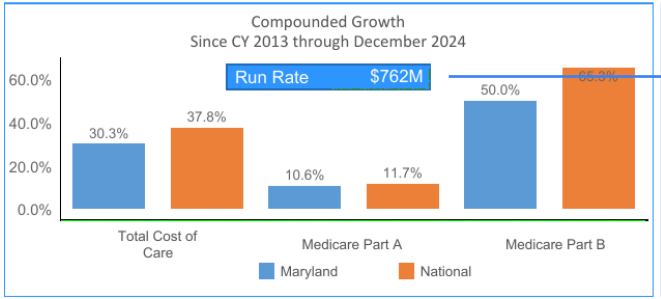
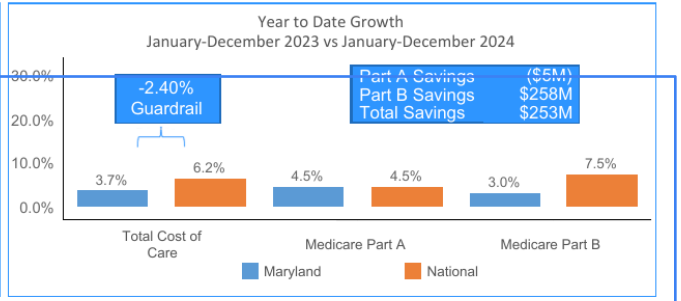
Update Factor Recommendation for Non-Global Budget Revenue Hospitals

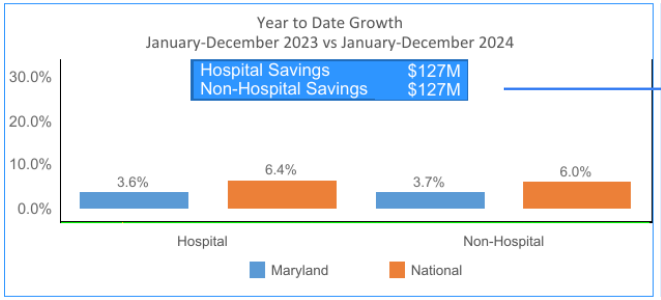
	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.34%
Productivity Adjustment	-0.80%
Proposed Update	2.54%

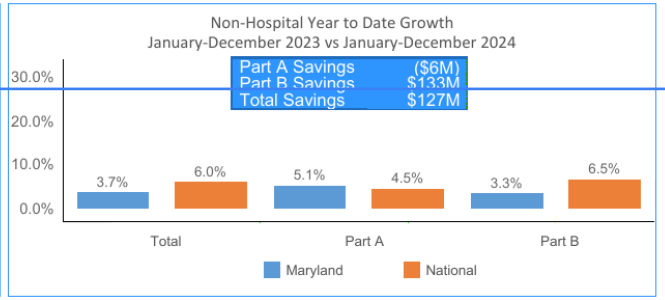
Projected Savings, Guardrail Test Scenarios, and GSP

Current 2024 Projections









Estimated savings of $762 M based on 2 months run out. Open items:

- One more month run out and tie into CMS, likely +/-0$
- Part C, likely +~$30 M
- NCBP other than MDPCP = to 2023, +/- $30 M (?)

Non-hospital contributes significant savings in 2024

A negative number in parentheses represents dissavings

MC FFS Guardrail Tests - Proposed Scenarios

- All scenarios uses HSCRC revenue projection for Part A and Part B MD Hospital
- Dropped pre-pandemic baselines (but not trend references)
- For MD Non-Hospital and US Hospital and Non-Hospital

Scenario 1: 2024 Trended forward at 2017 - 2019 Trend

Scenario 2: 2024 Trended forward at 2015 - 2019 Trend

Scenario 3: 2024 Trended forward at 2022 - 2024 Trend

Scenario 4: 2024 Trended forward at 2023 - 2024 Trend *(to be dropped)*

OACT/USPCC

Amounts shown on the following slides are not final. Staff are still refining non-claims based payments and consideration of impact of the differential on Medicare payments. Staff expect the impact of these adjustments to result minor changes to the outcomes.

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

Scenario 1 Guardrail Projections			
	Maryland	US	
2024	$14,519	$13,144	
2025	$15,283	$13,664	Predicted Variance
YOY Growth	5.3%	4.0%	1.3%
Estimated CY 2025 Savings Run Rate			$670.0 M

Positive value above 1% = TCOC guardrail failure

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

Scenario 2 Guardrail Projections			
	Maryland	US	
2024	$14,519	$13,144	
2025	$15,206	$13,524	Predicted Variance
YOY Growth	4.7%	2.9%	1.8%
Estimated CY 2025 Savings Run Rate			$597.0 M

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

Scenario 3 Guardrail Projections			
	Maryland	US	
2024	$14,519	$13,144	
2025	$15,349	$13,907	Predicted Variance
YOY Growth	5.7%	5.8%	0.01%
Estimated CY 2025 Savings Run Rate			$838.0 M

CY 25 Guardrail Scenario 4: 2024 Trended forward at 2023 - 2024 Trend

Scenario 4 Guardrail Projections			
	Maryland	US	
2024	$14,519	$13,144	
2025	$15,235	$13.971	Predicted Variance
YOY Growth	4.9%	6.3%	-1.4%
Estimated CY 2025 Savings Run Rate			$983.0 M

Non-Hospital Trends

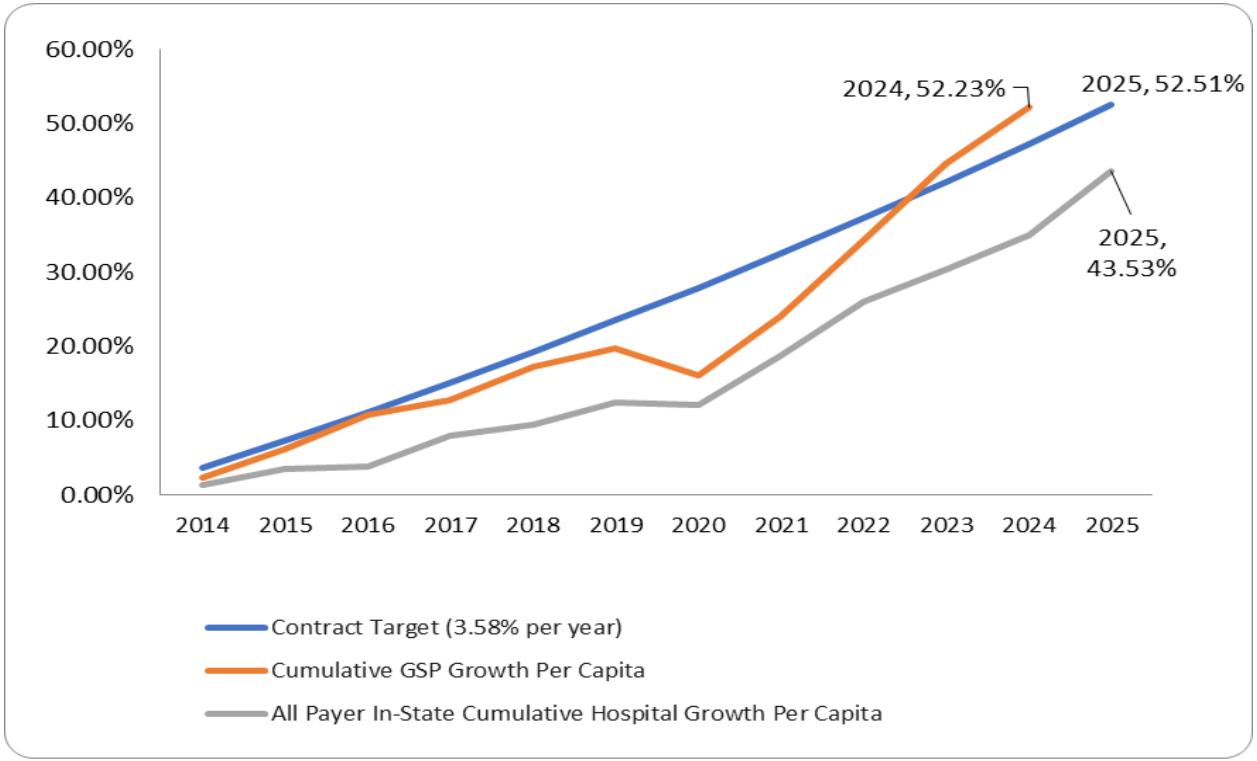
Year	Maryland	Nation	MD (Lower) Higher
2013			
2014	0.0%	0.9%	-0.9%
2015	3.2%	2.0%	1.2%
2016	1.2%	-0.2%	1.4%
2017	3.0%	1.5%	1.5%
2018	4.5%	3.8%	0.6%
2019	5.1%	4.5%	0.7%
2020			
2021			
2022	2.4%	2.3%	0.1%
2023	7.0%	6.4%	0.6%
2024	3.7%	6.0%	-2.3%

MD versus National 2024 Non-Hospital trends are significantly out of line with historic norms. Therefore, Staff is planning to drop scenario 4. 2024 trends are represented in Scenario 3 but only at 50% weight.

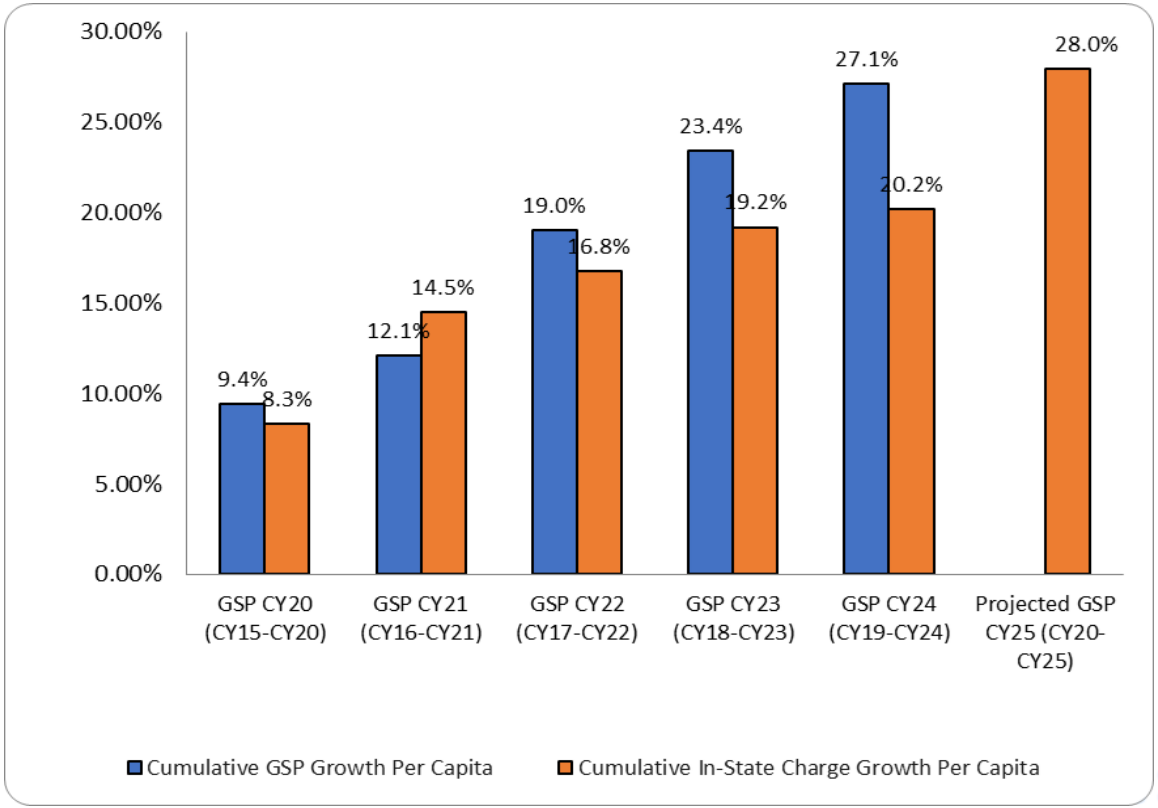
OACT/USPCC

- Staff is waiting on OACT for projections
- AHEAD uses USPCC projections
  - *https://www.cms.gov/files/document/2026-announcement.pdf*
  - *See Table II-2 Current Year values*
  - USPCC is not apples-to-apples with MD TCOC measurement
  - Staff is reviewing to refine comparison
- Preliminary Estimates
  - USPCC FFS non-ESRD for CY 2025 is 5% split 3.6% on Part A and 5.9% on Part B.
  - Yields blended trend of 5.0% and savings estimate of $730 M (guardrail = 0.9%)
  - USPCC estimate was 3.5% for CY 2024 versus 7.2% actual

All Payer Growth compared to GSP



Rolling 5 year Growth Comparisons



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Annual Filing Modernization – *Information & Updates*

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Information & Updates

01 eF2

- Development has been finished
- Currently testing
- Go live planned for July 1
- Hospital training planned for August
  - Planning 2 to 3 interactive sessions which will be recorded and posted

02 Clinical Cost Schedule

- Will be fully implemented in FY25 annual filing
- For FY25 only
  - Due 165 days after the end of hospitals' fiscal year*
- For FY26
  - Due 120 days after FY end

**For FY25 only, the HSCRC is granting a 45-day extension for the submission of the Clinician Cost Schedule to accommodate potential constraints during the transition to eF2.*

Annual Filing Modernization – *Allocation Methodology Proposed Changes*

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Changes to Allocation Methodology - Overview

The HSCRC has opted for minimal, more technical correction-type changes at this time to avoid disruption to the fall Annual Filing submission. Additional details on following pages.

1	2	3	4	5
Management Pool	***Plant Operations***	***Data Processing***	***Drugs and Supplies***	***Population Health***
				
• Standardize ambulatory definition	• No changes to allocation methodology	• Considers cyber security • Standardizing methodology used to allocate	• No changes	• Consider how to track and manage related costs

Management Pool – Schedule J

Overview

1. The Management Pool – Schedule J – is made up of the following overhead departments:
   - Hospital Administration
   - Nursing Administration
   - Patient Accounting
   - Fiscal Accounting
   - Medical Records
2. The Management Pool is allocated based on accumulated costs and split between IP, OP and Ambulatory based on revenue.
3. Clarification of the definition of “Ambulatory” is needed as it is not consistently defined or reported across hospitals.

Proposed Changes / Notes

1. No material changes proposed in calculation.
2. Update Hospital Administration definition
3. Define Ambulatory as:
   - Clinic (including 340b clinic)
   - Oncology Clinic
   - OR Clinic
   - Same Day Surgery
   - Emergency Room
   - Trauma
   - Observation
   - Psych Day / Night

Source of Ambulatory Classification*	# Responses Received
Clinic and day hospital visits are ambulatory; IPs taken for testing (EKGs, etc.) are OP	1
Departments with a visit count	5
Historical mapping	5
Section 500, schedule V2	2
HSCRC chart of accounts definitions	2
Budget manual	1
Section 200 chart of accounts	4

* *Data derived from responses received in survey submitted by Maryland hospitals in March 2025.*

Management Pool – Schedule J

Classification of Ambulatory Costs

As reported by hospitals in AFM Survey submitted in March 2025

	ER		CL		OBS		Psych Day/Night		SDS	
Ambulatory	4	8%	8	15%	5	10%	19	37%	29	56%
Ambulatory/OP	1	2%	0	0%	0	0%	0	0%	1	2%
Ambulatory/IP	36	69%	36	69%	12	23%	2	4%	11	21%
Ambulatory/IP/OP	0	0%	0	0%	1	2%	0	0%	0	0%
OP/IP	2	4%	0	0%	24	46%	0	0%	0	0%
OP	2	4%	3	6%	2	4%	2	4%	2	4%
IP	0	0%	1	2%	1	2%	1	2%	0	0%
Blank	7	13%	4	8%	7	13%	28	54%	9	17%
	52	100%	52	100%	52	100%	52	100%	52	100%

Management Pool – Schedule J

Change in Standard Rates from Standardized/Expanded 'Ambulatory' Definition

Service Type	FY24 Revenue Impact	% of FY24 Revenue
Daily Hospital Services*	$4,848,996	0.09%
Ambulatory Services	($30,646,696)	(1.07%)
Ancillary Services	$29,542,976	0.23%
Statewide	**$3,745,275**	**0.02%**

** Includes Admissions Rate Center*

Management Pool – Schedule J

Change in Standard Rates from Standardized/Expanded 'Ambulatory' Definition

System	FY24 Revenue Impact	% of FY24 Revenue
System A	$2,542,125	0.05%
System B	$748,671	0.03%
System C	$292,839	0.05%
System D	$115,787	0.01%
System E	$71,669	0.00%
System F	$14,288	0.00%
System G	($74,787)	(0.01%)
System H	($92,466)	(0.01%)
Non-System	$127,150	0.00%
Statewide	**$3,745,275**	**0.02%**

Plant Operations

Overview

1. Plant operations allocations are based upon square footage.

Proposed Changes / Notes

1. No changes proposed to allocation methodology.
2. Propose hospital attestation that square footage has been reviewed at least every 3 years.

Data Processing – OADP Schedule

Overview

1. Existing methodology allows each hospital to choose the allocation methodology used.

OADP Allocation Methodology *		
Actual Worked	2	4%
Service Tickets	2	4%
FTEs	13	25%
Other	11	21%
Dollars Spent	24	46%
	52	100%

Proposed Changes / Notes

1. The definition of data processing is being updated and will be reflected in the revised Manual.
2. Recommend standardizing allocation methodology based up on FTEs.
3. Based on survey only 25% of hospitals are currently using FTEs most are using dollars spent (46%).
4. Unable to model impact of proposed changes

* *Data derived from responses received in survey submitted by Maryland hospitals in March 2025.*

Population Health

Overview

1. Inconsistency in what costs are included in Pop Health allocation methodologies across Maryland* (standard methodology needed).

Proposed Changes / Notes

1. Recommend addition of new population health cost center beginning in FY27
2. Recommending to standardize allocation methodology (similar to how we allocate hospital admin) and departments included in the allocation
3. More information will be forthcoming

* *Data derived from responses received in survey submitted by Maryland hospitals in March 2025.*

RSV Funding Update

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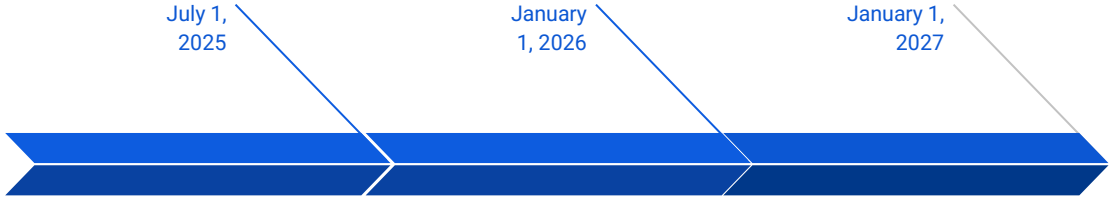
RSV Funding

- As additional support Staff will stand up reporting for RSV immunization for infants, thus allowing the Commission to provide volume variable funding based on this reporting.
- This will be treated as a one-time adjustment
- Beginning July 1, 2025 hospital casemix data submissions will include an RSV flag

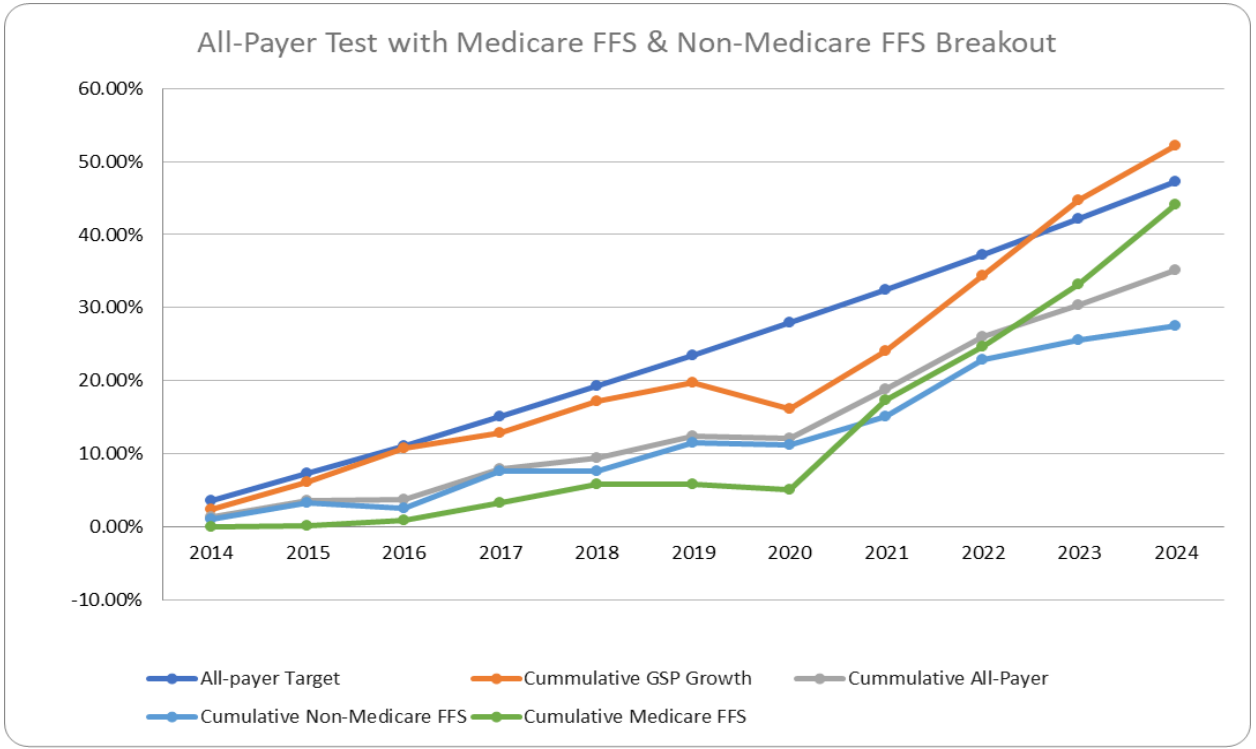


Considerations:

- Confirmation of Cost of Vaccine
- Discount the count based on payments for vaccine made outside of rates (e.g exploration/consideration of how Medicaid pays for this vaccine.)

Appendix

All Payer Growth with Medicare FFS & Non-Medicare FFS Breakout



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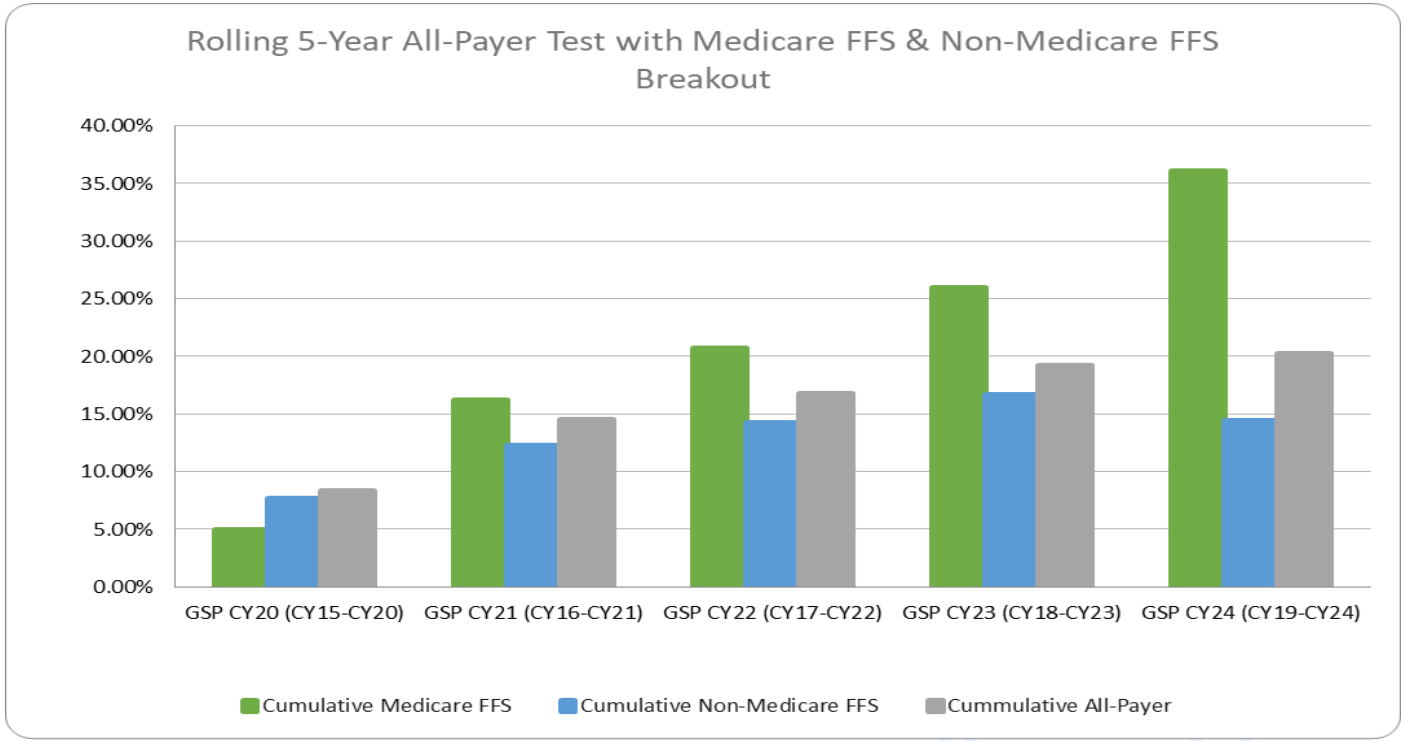
Rolling 5 Year Growth with Breakouts



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