maryland
health services
cost review commission

Payment Model Workgroup

April 1, 2026

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Payment Models Meeting Agenda

April 1, 2026
11:00 am – 1:00 pm
Health Services Cost Review Commission

I.	Inflation Discussion
II.	Update Model Review
III	GSP Estimated Impact
IV	High Cost Drug Trend
V	Impact of HR1 Changes on UCC
VI	Medicare Advantage Differential Change for January 1, 2027
VII	Adjourn

Inflation Discussion

Inflation Comparison

Global Insights

Medicare payment updates for hospitals are based on hospital market baskets developed by CMS and S&P Global which measure:

- Labor Costs (wages, benefits)
- Medical Supplies
- Pharmaceuticals
- Utilities
- Equipment
- Insurance
- Other hospital-specific expenses

Bureau of Labor Statistics

BLS produces broad economy-wide measures including: Consumer Price Indexes (CPI), Producer Price Index (PPI), Employment Cost Index (ECI).

CPI Reflects:

- Groceries
- Gas
- Rent
- Clothing
- Retail Services

Hospitals spend on clinical labor, medical supplies, capital equipment, professional services, and malpractice. These costs are completely different from CPIs.

Why CMS Uses Forecasting Firms

Under the Social Security Act §1886, CMS must update hospital payment rates using a hospital "market basket" (an input price index reflecting hospital costs) rather than a consumer price index (CPI). However, the statute does not explicitly forbid all consumer indexes; instead, it directs the Secretary to construct an index based on hospital input prices.

As a result, CMS constructs IPPS and OPPS Hospital Market Baskets, which are weighted indexes based on hospital cost reports.

CMS needs:

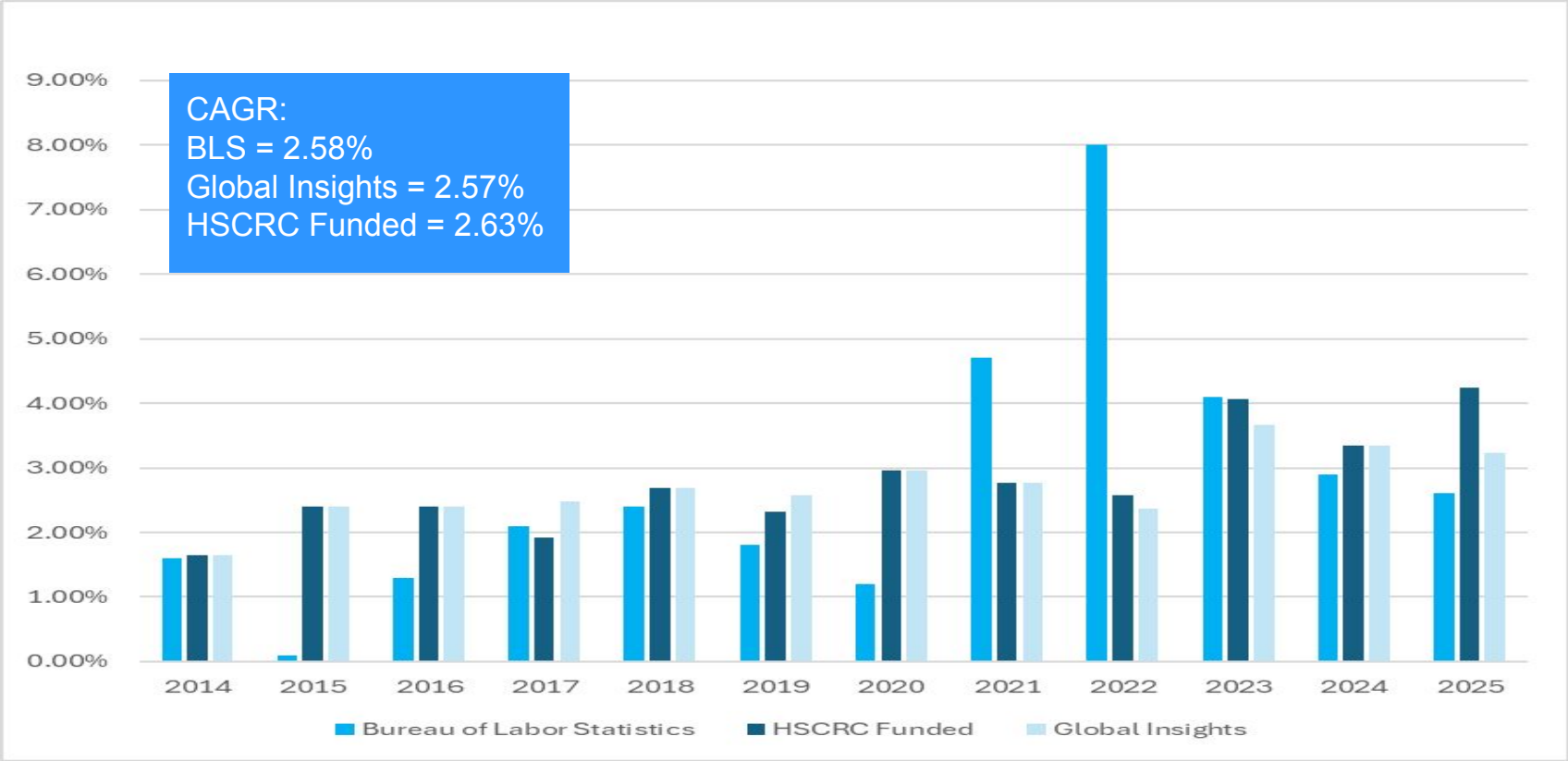
- Historical data
- Current trend data
- multi-year forecasts
- quarterly revisions
- forecasted wage growth, energy prices, and pharmaceutical cost growth
- macro assumptions related to GDP and productivity.

Global Insights provides:

- Forward-looking modeling
- sector-specific projections
- consistent macroeconomic baselines

BLS does not publish projection data or hospital specific cost forecasts

Inflation Comparison



Update Factor

TABLE 2

Balanced Update Model for RY 2027					
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)			3.03%	$727.6	$240.1
- Additional Inflation Support			0.20%	$48.1	$15.9
- Outpatient Oncology Drugs			0.06%	$15.2	$5.0
Gross Inflation Allowance	**A**		**3.29%**	**$790.9**	**$261.0**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.17%	-$41.9	-$13.8
- Grant Funding RY27			0.00%	$0.0	$0.0
- HOPE			0.21%	$50.0	$16.5
Total Care Coordination/Population Health	**B**		**0.03%**	**-$41.9**	**-$13.8**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.00%	$0.0	$0.0
- Demographic Policy Refinement - RY2026 Incremental Change			-0.04%	-$9.6	-$3.2
Total Adjustment for Volume	**C**		**-0.04%**	**-$9.6**	**-$3.2**
Financial Methodologies & Other Adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.00%	$0.0	$0.0
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.18%	$42.7	$14.1
- Reversal of one-time adjustments for drugs	G		-0.07%	-$16.7	-$5.5
- Estimated Increase for Full Rate Applications & Capital Funding	H		0.00%	$0.0	$0.0
- RY26 Respiratory Surge Funding Estimate	J		0.00%	$0.0	$0.0
Net Other Adjustments	**K =**	**Sum of D thru J**	**0.11%**	**$25.9**	**$8.6**
Quality and PAU Savings					
1 - PAU Redistribution	L		0.00%	$0.00	$0.0
- Reversal of prior year quality incentives	M		0.05%	$11.1	$3.6
- Current Year Quality Incentives	N =		0.00%	$0.0	$0.0
Net Quality and PAU Savings	**O =**	**Sum of L thru N**	**0.05%**	**$11.1**	**$3.6**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**P =**	Sum of A + B + C + K + O	**3.44%**	**$776.4**	**$256.2**
Per Capita	**Q =**	(1+P)/(1+0.00%)	**3.44%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	R		0.01%	$2.4	$0.8
- Deficit Assessment	S		-0.20%	-$47.6	-$15.7
- Medicare Advantage Stabilization	**T**		0.00%	$0.0	$0.0
Net decreases	**U=**	S + R + T	**-0.19%**	**-$45.2**	**-$14.9**
Total Update First Half of Rate Year 27					
Revenue growth, net of offsets	**V=**	P + U	**3.25%**	**$781.2**	**$241.3**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.00%)	**3.25%**		
Adjustments in Second Half of Rate Year					
- Hold for Future Adjustment			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**X =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
Revenue growth, net of offsets	**Y =**	V + X	**3.25%**	**$781.2**	**$257.8**
Per Capita Revenue Growth	**Z =**	(1+V)/(1+0.00%)	**3.25%**		

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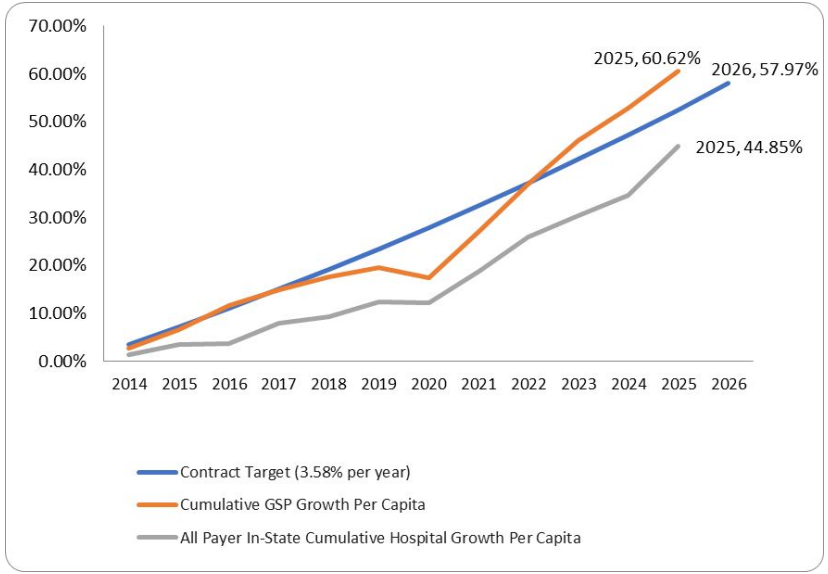
Estimated Review of Revenue Calendar Year Update

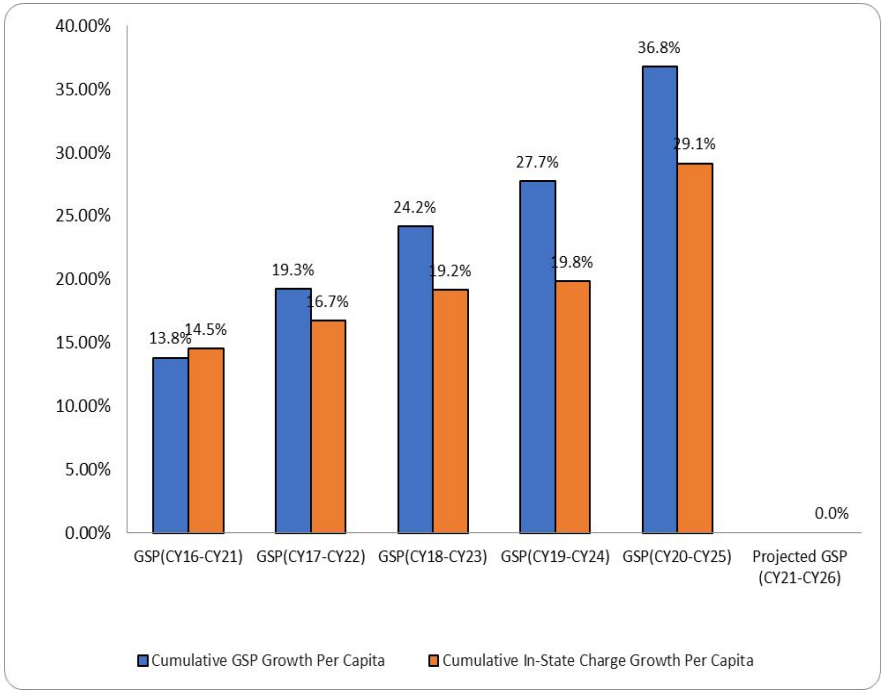
Estimated Position on Medicare Test		
Actual Revenue January - June 2025		11,469,777,117
Actual Revenue July - December 2025		11,856,400,853
Actual Revenue CY 2025		23,326,177,970
Step 1:		
Approved GBR RY 2026		24,039,557,189
Actual Revenue 7/1/25-12/31/25		11,856,400,853
Approved Revenue 1/1/26-6/30/26		12,183,156,336
Projected FY25 GBR Compliance		0
Anticipated Revenue 1/1/26-6/30/26	**A**	**12,183,156,336**
Expected Revenue Growth 1/1/26-6/30/26		**6.22%**
Step 2:		
Final Approved GBR RY 2026		24,039,557,189
Reversal of Extraordinary One-Times		0
Final Adjusted GBR Base for RY 2026		24,039,557,189
Projected Approved GBR RY 2027		24,820,772,473
Permanent Update RY 2027		3.25%
Miscellaneous Revenue Adjustments for RY 2027 (one-time)		0
Projected Approved GBR RY 2027 w Misc Adj		24,820,772,473
Projected RY27 Increase over RY26		3.25%
Step 3:		
Estimated Revenue 7/1/26-12/31/26 (after 49.73% & seasonality)	**B**	**12,343,370,151**
Expected Revenue Growth 7/1/26- 12/31/26		**4.11%**
Step 4:		
Estimated Revenue CY 2026	**A+B**	**24,526,526,487**
Increase over CY 2025 Revenue		**5.15%**
Per Capita Increase over CY 2025		**5.15%**

GSP Estimated Impact

All Payer Test Graphic



Rolling 5-Year GSP Test



High-Cost Drug Spending

Drug Funding in Update Factor

- Effective with FY24 Drug policy was changed to provide 100% reimbursement of changes in drug cost
- Because all volume changes are now funded at current prices, inflation is only needed for “pure price”, that is the price change of each drug at its base year volume (See appendix for example).
- Staff analyze the “pure price” by comparing price changes while holding volume constant at base year mix.
    - Impact of volume shares switching between 340-B and non-340-B is removed as not reflective of underlying trends.

CDS-A Drug Trend, Actual Statewide Experience

- Table shows components of drug trend. Volume and mix-driven price trend is addressed via CDS-A adjustment.
- FY25 price trends grew slightly
- 4 year rolling pure price trend = 1.8% compared to 1.2% last year. HSCRC is proposing to include 3% in the update factor for all hospitals based on longer term trends and current year growth.
- HSCRC reviewed academic specific trends and price trends were similar.

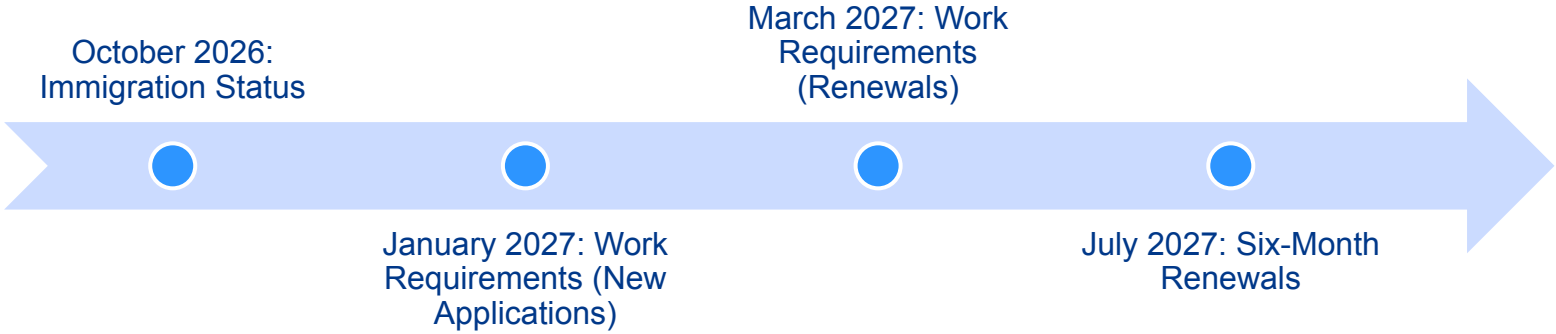
	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25
Pure Price	5.6%	-0.5%	0.4%	1.6%	3.8%	2.6%	-2.9%	4.1%
340-B Switching	-6.1%	-0.2%	-0.7%	0.1%	-2.3%	0.3%	-1.1%	0.4%
Volume	-12.5%	8.0%	7.2%	3.7%	3.9%	6.6%	4.2%	6.1%
Mix-Driven Price	18.3%	-3.7%	-5.3%	-1.3%	-2.0%	0.8%	1.3%	2.5%
Total	3.0%	3.3%	2.5%	4.1%	3.3%	10.5%	1.3%	12.7%

Estimated Impact of HR1 Changes on UCC

Medicaid Eligibility Changes

Medicaid Eligibility Provisions under House Resolution 1 (HR 1):

- **Immigration**: Certain immigrants are no longer eligible for Medicaid (refugees, asylees, immigrants granted parole for at least one year, certain victims of abuse and trafficking)—does not impact pregnant individuals or children. *(Effective Oct. 2026; related coverage losses Oct. 2026)*
- **Work Requirements (Jan. 2027)**: States must implement work requirements as a condition of Medicaid eligibility for ACA expansion adults aged 19-64. *(Effective Jan. 2027; related coverage losses start Jan. 2027 for new applications and Mar. 2027 for renewals)*
- **Six-Month Renewals**: States must conduct eligibility determinations for ACA expansion adults aged 19-64 once every six months (vs. the current requirement of annual). *(Effective Jan. 2027; related coverage losses start Jul. 2027)*



Work Requirements

Individuals seeking care at hospitals may qualify for either an exemption to work requirements (*i.e.,* full Medicaid coverage) or for coverage for their hospital stay (*i.e.,* Hospital Presumptive Eligibility).

Exemptions to Work Requirements	Medical Frailty

• Parents/caretakers of young children or individuals with disabilities
• Medically-frail individuals
• Incarcerated or recently-released from incarceration
• Pregnant or postpartum individuals
• Participating in a substance use disorder (SUD) program
• Entitled to Medicare Part A or enrolled in Medicare Part B
• Former foster youth under age 26
• American Indians and Alaska Natives
• Veterans with disabilities
• Individuals subject to SNAP work requirements or meeting TANF work requirements
• Optional "short-term hardship" exemptions:
  • Recent acute care or travel for medically-complex and necessary care
  • County emergency or disaster
  • High county-level employment
	HR 1 indicates that medical frailty should include at least five potential categories of conditions:
	1) Blindness or disability
	2) Substance use disorders
	3) Disabling mental disorders
	4) Physical, intellectual or developmental disability
	5) Serious or complex medical conditions
	States can accept self-attestation for medical frailty status.

Impact of HR 1 on Medicaid Uncompensated Care in FY 2027

Immigration-Related Losses

- Not eligible for HPE
- Inpatient and emergency department (ED) services will be covered by Emergency Medicaid Services.

Analysis will account for the rollout of eligibility changes as displayed on the earlier timeline.

ACA Expansion Losses

Disenrollments due to non-compliance with work requirements, versus disenrollment due procedural reasons, *e.g.,* not submitting paperwork, will be mixed.

- Inpatient: Uncompensated care will be near-zero, as inpatient stays create an exemption from work requirements.
- ED: A significant portion of those disenrolled should have coverage for ED visits:
  - Procedural disenrollments will re-qualify for full Medicaid coverage.
  - Approximately half of disenrollments due to work requirements will qualify through HPE.
- Outpatient: Procedural disenrollments will re-qualify for full Medicaid coverage.

Estimated Impact of HR 1 on Medicaid Uncompensated Care in FY 2027

HR 1 Impacts on Hospital UCC–Summary by Impacted Population

	FY2027 Low End (in millions)			FY2027 High End (in mllions)		
	Immigrant	ACA Expansion	Total	Immigrant	ACA Expansion	Total
Total Individuals Impacted by Coverage Losses	**15,000**	**12,200**	**27,200**	**15,000**	**24,400**	**39,400**
Gross $ Impact of Coverage Losses	$ 38.8	$ 10.0	$ 48.8	$ 38.8	$20.0	$ 58.8
Emergency Medicaid & Re-Enrollment Offset	(29.8)	(7.8)	(37.6)	(29.8)	(15.6)	(45.4)
HPE Offset	-	(0.5)	(0.5)	-	(1.0)	(1.0)
Net Impact of Coverage Losses on Hospital UCC	**$ 9.0**	**$ 1.7**	**$ 10.7**	**$ 9.0**	**$ 3.4**	**$ 12.4**

Note: Assumptions are based on guidance available as of March 17, 2026; the impact of HR1-related eligibility policy is constantly evolving. These estimates should therefore be considered independently of other analyses, for the sole purpose of informing the hospital uncompensated care policy for FY 2027.

Spending in each category is based on average Medicaid spending in the relevant population.

Estimated Impact of HR 1 on Medicaid Uncompensated Care in FY 2027

HR 1 Impacts on Hospital UCC–Summary by Visit Type

	FY2027 Low End (in millions)				FY2027 High End (in millions)			
	IP Hospital	OP ED	OP Non-ED	Total	IP Hospital	OP ED	OP Non-ED	Total
Total Individuals Impacted by Coverage Losses				**27,200**				**39,400**
Gross $ Impact of Coverage Losses	$ 27.6	$ 9.8	$ 11.4	$ 48.8	$ 33.3	$ 11.8	$ 13.7	$ 58.8
Emergency Medicaid & Re-Enrollment Offset	(27.6)	(8.8)	(1.2)	(37.6)	(33.3)	(9.8)	(2.3)	(45.4)
HPE Offset	-	(0.5)	-	(0.5)	-	(1.0)	-	(1.0)
Net Impact of Coverage Losses on Hospital UCC	**$ -**	**$ 0.5**	**$ 10.2**	**$ 10.7**	**$ -**	**$ 1.0**	**$ 11.4**	**$ 12.4**

Note: Assumptions are based on guidance available as of March 17, 2026; the impact of HR1-related eligibility policy is constantly evolving. These estimates should therefore be considered independently of other analyses, for the sole purpose of informing the hospital uncompensated care policy for FY 2027.

Spending in each category is based on average Medicaid spending in the relevant population.

Impact of HR 1 on Medicaid Uncompensated Care in FY 2028

- CMS guidance on HR 1 implementation is still rolling out, and state Medicaid agencies must interpret how the guidance applies to their individual programs.
- At this point, too many undefined variables in the modeling to develop a reliable estimate of the impact on uncompensated care in FY 2028.
- HSCRC staff are working closely with the Maryland Medicaid program and the Hilltop Institute to develop a stronger understanding of the FY 2028 impact, including at a hospital level.

Medicare Advantage Differential Change for January 1, 2027

Medicare Advantage Stabilization Framework

- Designate Qualified Plans:
  - At least 50 percent of Medicare Advantage (MA) beneficiaries in the relevant H-contract reside in Maryland
  - At least 5,000 beneficiaries or 20 percent of MA beneficiaries residing in Maryland in that H-contract reside in eight jurisdictions*
  - Have a star rating of at least 3.5 (2028 plan year data release)
- Starting with FY 2026 update factor, award Qualified Plans an additional 11.55 percent in rate relief, effective CY 2027
- CY 2027 will be offset by both Medicaid and commercial rates; CY 2028 and beyond, just commercial
- HSCRC staff may pursue a fund structure in future years to simplify the rate relief process.

* Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington, Wicomico

Medicare Advantage Stabilization: Qualifying Plans

- Three companies preliminarily qualified;* one company was granted a waiver; two companies didn't qualify; two companies with multiple H-contracts were split.
- All plans received a memo with a list of qualified plans on February 20th.
- HSCRC will build the policy into the FY 2027 update factor and provide additional guidance over the summer.
- Rate relief will be effective on January 1, 2027

Qualifying Plans

- Alterwood Advantage
- CareFirst
- Health Care Service Corporation (1 of 2)
- Kaiser Permanente
- UnitedHealth Group (1 of 7)

Non-Qualifying Plans Granted a Waiver

- Hopkins Health Advantage

Non-Qualifying Plans

- Aetna
- Health Care Service Corporation (1 of 2)
- Humana
- UnitedHealth Group (6 of 7)

* Based on plan-submitted data. MIA will validate against CMS data once available in April.

Qualified Plan Enrollment (January 2026)

Parent Company	Contract	Legal Entity	Contract Enrollment
UnitedHealth Group, Inc.	H7464	UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC.	15,115
Kaiser Foundation Health Plan, Inc.	H2172	KAISER FDTN HLTH PLAN OF THE MID-ATLANTIC STATES	72,019
Johns Hopkins Healthcare, LLC	H1225	HOPKINS HEALTH ADVANTAGE, INC.	7,547
	H3890	HOPKINS HEALTH ADVANTAGE, INC.	6,574
Health Care Service Corporation	H2108	BRAVO HEALTH MID-ATLANTIC, INC.	10,282
CareFirst, Inc.	H7379	CAREFIRST ADVANTAGE PPO, INC.	41,542
	H8854	CAREFIRST ADVANTAGE DSNP, INC.	8,044
LifeBridge Health, Inc.	H9306	ALTERWOOD ADVANTAGE, INC.	11,857
		Total	**172,980**
		Total MA Enrollment	**241,064**
		MA-Enrolled Beneficiaries in Qualified Plans	**71.8%**

Source: January 2026 enrollment data as submitted by MA plans to the Maryland Insurance Administration

Steps for Calculating the Discount

1. Use FY 2025 Annual Filing Schedule PDA (Payer Differential) to pull total global budget by payer.
   - PDA has total MA values but not by plan contract level.
   - Case-mix uses initial payer(s) and plan but not final payer(s) or contract level.
   - Staff will update the PDA for FY 2026 to add reporting for qualifying MA plans.
   - Preliminary indications assume hospitals can build MA legal entity names (based on H-contract) into their systems and could split the PDA between qualified and non-qualified plans.
2. (Only for initial estimates) Multiply MA in PDA by share according to case-mix that goes to the qualified plans to create estimate of total revenue that will qualify for the discount.
3. Multiply by the discount (11.55 + 7.7 = 19.25) to create the amount to build back in as mark-up.
4. Determine how much of the mark-up goes to Medicare FFS (for CY 2027 only) or one of the qualified MA plans, then increase the mark-up again to offset those amounts.
5. Establish an MPA adjustment to offset the mark-up for Medicare FFS (for CY 2027 only).

Mark-Up Challenges

- Generally, the cost of the differential is offset via the mark-up.
- In this case, due to the limited enrollment that qualifies and the fact that it could change during the year, there is more uncertainty in the amount of discount being provided, particularly at a hospital level.
- If a hospital's exposure is less than anticipated, the estimated mark-up will exceed the discount and vice-versa.
- Conversely, the MA plan may not receive the expected discount, and Medicare FFS may be impacted, if the mark-up over or under reimburses hospitals versus the amount of discount provided.
- The HSCRC is evaluating options in response to these risks and favors an approach using a prospective revenue adjustment.

Options for Applying the Discount

Principle: Discount will be effective on January 1, 2027.

Base Approach: Prospective Revenue

- Build in one-time revenue on January 1, 2027 instead of changing the mark-up mid-year.
- Starting July 1, 2027 adjust the rate orders and increase the mark-up, based on available data.

Options for Reconciliation

- Option 1) Include a retrospective reconciliation between the initial adjustment and the actual experience; repeat this process annually thereafter.
- Option 2) Do not reconcile the initial adjustment based on the actual experience.
- Option 3) Set a threshold that would trigger reconciliation if the initial adjustment and the actual experience exceeds a certain amount.

Considerations for Reconciliation

- Determine whether the reconciliation of the mark-up should be reflected in an updated differential.
- If not, plans may experience a small amount of risk of not receiving the full amount of rate relief.

Example Medicare Advantage Calculation Impact

January 1, 2027 Example	Total	Qualifying MA Plans
Policy Discount as a % of Net Cost (A)		11.55%
Initial Incremental Differential on Gross (B= A x .923)		10.66%
Starting Global Budget (C)	$540.4	$17.1
Mark-up to offset differential to Qualifying MA Plans and hold Medicare FFS harmless, will vary by hospital (D)*	$3.2	$0.1
Final Differential to Qualified MA Plan adjusting for mark up (E)*		11.22%
New Global Budget (F= C + D)	$543.6	$17.2
Final Qualifying Plan Differential (G=E+7.7%)		18.92%
Differential Received, Net of Mark Up Increase (H = F * G – D)		$3.1
Total Effective Differential (I = H/C)		18.36%
Incremental Discount (J = I – 7.7%)		10.66%

There is estimation risk in this program. In this example, without true up, an increase in qualifying plan MA share from expected of ~3.2% of GBR to actual of ~3.7% would create an ~$300k loss for the hospital. Or a gain if it moved in the opposite direction.

In setting the mark up the qualifying MA plan share of GBR will be estimated, given the volatility in qualifying plan Medicare Advantage beneficiaries there is a greater of risk actuals departing from estimated at a hospital level versus the historic differential.

As lost revenue under the differential is sensitive to the number of claims submitted, but mark up is not, a hospital gains or loses if actual differential frequency is different than anticipated. Historically, there has not been an adjustment for that, but the variation could be bigger in this situation.

As net savings to the plan is sensitive to the amount of mark up, if the mark up is trued up it also translates into a change in the differential.

* Calculation to be provided separately.

Open Items

- MIA will share beneficiary counts from CMS to validate the plan-reported data already provided (April); HSCRC will update its modeling.
- HSCRC will update the annual filing template for FY 2026 to include reporting for qualifying MA plans, *i.e.*, on Schedule PDA.
- If Option 3 is selected, HSCRC will propose a threshold for reconciliation.