maryland
health services
cost review commission

Payment Model Workgroup

July 9, 2026

Final Recommendations Presented on June 10, 2026

For Global Revenues:

(a) Provide all hospitals with a gross inflationary increase of 3.37 percent, including an additional 0.20 percent to support revenue needs based on historical underfunding of inflation, and 0.06 percent allocated based on each hospital's proportion of drug costs.

(b) Provide an overall increase of 4.07 percent for revenue (including a net increase to uncompensated care) and 3.95 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.

(c) **DRAFT RECOMMENDATION:** Provide additional funding related to uncompensated care to the Maryland Health Benefit Exchange Fund of 0.4 percent to support reinsurance and subsidies for marketplace enrollees and 0.1 percent to increase the reserve held in the HSCRC's Uncompensated Care Fund to be released as additional uncompensated care emerges. This element is a draft recommendation and the 0.5 percent will be removed from the update factor if the final recommendation is not approved subsequently.

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

(a) Provide an overall update of 3.17 percent for inflation and additional inflation of 0.20, for a total update of 3.37 percent. Suspend the productivity adjustment for RY 2027.

Stakeholder Comments

UCC Comment Letters Received

Letters were received from:

1. Maryland Hospital Association (MHA)
2. Robert Laughlin
3. Maryland Citizens' Health Initiative (MCHI)
4. Lutheran Office of Public Policy in Maryland
5. CareFirst BlueCross BlueShield
6. Mid-Atlantic Association of Community Health Centers (MACHC)
7. Johns Hopkins Health System (JHHS)
8. Unitarian Universalist Legislative Ministry of Maryland (UULM-MD)
9. Luminis Health
10. 1199 SEIU
11. Maryland Health Benefit Exchange (MHBE)
12. Maryland Insurance Administration (MIA)
13. University of Maryland Medical System (UMMS)
14. Health Care for the Homeless (HCH)
15. Maryland Community Health System (MCHS)
16. Adventist HealthCare
17. Kaiser Permanente
18. Maryland Association of County Health Officers (MACHO)

Comments generally focused on 7 areas:

1. Adequacy of the proposed 0.10% UCC Fund Reserve Increase.
2. Support MHBE funding to preserve Marketplace coverage.
3. Allocation of the Proposed 0.50% UCC Adjustment.
4. Directing uncompensated care funding to FQHCs.
5. MHBE Pass-Through Funding.
6. Prospective hospital uncompensated care funding.
7. Monitor uncompensated care trends.

1. Adequacy of the Proposed 0.10% UCC Fund Reserve Increase

- MHA, UMMS, Luminis Health, and Adventist HealthCare stated that the proposed 0.10% increase to the UCC Fund Reserve is insufficient to address anticipated increases in uncompensated care associated with Marketplace and Medicaid coverage losses. JHHS supported the proposed 0.10% increase and recommended that reserve releases or reconciliations be based on audited hospital financial statements. Adventist HealthCare also requested clarification regarding the methodology for allocating reserve funding among hospitals and the timing of distributions.

HSCRC Response: Staff believe that the 0.10% is appropriate increase to the reserves. Staff will monitor UCC throughout the year using unaudited data and base reserve releases on unaudited data. This decision is based on timeliness of data. Reconciliations will be reviewed and determined based on audited data. Any release of these reserves will not occur before January 2027. Staff will communicate with industry on future distribution calculations. As noted in the Update Factor Recommendation, staff believe most Medicaid coverage reductions will occur in FY 2028.

2. Support MHBE funding to preserve Marketplace coverage

- MHBE/MIA, MCHI, UULM-MD, the Lutheran Office of Public Policy in Maryland, Maryland Episcopal Public Network, 1199SEIU, Robert Laughlin, and Kaiser Permanente supported directing funding to the Maryland Health Benefit Exchange (MHBE) to strengthen the State Reinsurance Program and State Subsidy Program. Commenters stated that preserving Marketplace coverage would maintain affordability, reduce coverage losses, improve access to preventive and primary care, stabilize premiums, and reduce uncompensated care. Kaiser Permanente stated that reinsurance and other marketplace subsidies are valuable tools to lower premiums, increase enrollment, and stabilize the market by mitigating the impact of high-risk claims. Hospital stakeholders generally supported the goal of preserving Marketplace coverage but stated that additional prospective hospital uncompensated care funding would likely remain necessary while requesting clarification regarding implementation of the proposed MHBE funding strategy.

HSCRC Response: Staff appreciate the support of the recommendation to fund reinsurance and subsidies through MHBE. This will be input as one-time funding for RY 2027, and will be evaluated for continued funding as part of the RY 2028 Update Factor.

3. Allocation of the Proposed 0.50% UCC Adjustment

- CareFirst recommended directing the full 0.50% adjustment to the Maryland Health Benefit Exchange to support reinsurance and Marketplace subsidies rather than reserving funding for prospective hospital uncompensated care. CareFirst stated that investing upstream in maintaining insurance coverage would benefit both patients and hospitals by reducing future uncompensated care, whereas prospectively funding hospital uncompensated care primarily addresses downstream financial impacts. Similarly, Kaiser Permanente stated that directing funding to reinsurance represents an upstream intervention that keeps more individuals covered and reduces coverage losses, rather than relying solely on uncompensated care funding. In contrast, hospital commenters generally supported maintaining additional prospective hospital funding to address anticipated uncompensated care associated with federal coverage losses.

HSCRC Response: Staff appreciate the comments made by payers supporting the entire allocation being directed to MHBE. However, at this time, Staff believe it is appropriate to direct some level of funding to the UCC fund to help mitigate any future coverage concerns that may not be addressed through support to the marketplace plans.

4. Directing Uncompensated Care Funding to Federally Qualified Health Centers (FQHC)

- MACHC, MCHS, Health Care for the Homeless (HCH), and 1199 SEIU supported directing a recurring portion of uncompensated care funding to Federally Qualified Health Centers (FQHCs). Commenters argued that FQHCs provide primary and preventive care regardless of insurance status and that additional investment would expand capacity, reduce avoidable emergency department visits and hospitalizations, improve health outcomes, and reduce overall uncompensated care. Several commenters emphasized that anticipated Marketplace and Medicaid coverage losses would substantially increase uncompensated care delivered by FQHCs and recommended dedicating a recurring funding source to support these providers. MCHI also emphasized ensuring that FQHCs have sufficient resources to provide essential care and reduce unnecessary emergency department visits for individuals who remain uninsured.

HSCRC Response: Staff value the comments we received relating to FQHCs. The final recommendation reflects $25 million (approx. 0.10%) directed to funding for FQHCs. Staff acknowledge that these centers play an important role in ensuring that individuals receive primary and preventative care regardless of insurance status. This funding will be input as one-time funding in RY 2027, and will be evaluated for continued funding as part of the RY 2028 Update Factor.

5. MHBE Pass-Through Funding

- MHA, JHHS, Luminis Health, and Adventist HealthCare supported preserving Marketplace coverage through the MHBE but requested additional clarification regarding implementation of the proposed funding strategy. Commenters requested additional information regarding the allocation of funding between reinsurance and state subsidies, funding methodology, implementation timelines, expected impacts on Marketplace enrollment and premiums, and evaluation of program effectiveness. JHHS also requested clarification regarding the legal authority for the proposal, governance and accountability for MHBE pass-through funding, reconciliation and reporting of funds, and the treatment of funds collected but not ultimately expended. Luminis Health recommended using hospital-specific collection rates rather than mark-up rates for any MHBE pass-through funding.

HSCRC Response: Staff will allocate the MHBE funding by proportioning the funding proportionate to revenue or another decided upon criteria. This funding will be marked up and placed in rates as a one-time assessment. Clarification on how payments should be made to MHBE will follow pending Commission decision on recommendation. Staff will work with MHBE on a report out on evaluating program effectiveness as part of continued funding in FY 2028. Unused funds will be carried over to future periods and considered in the evaluation of future funding needs.

The HSCRC has statutory authority to establish reasonable rates, implement alternative payment methodologies, promote hospital financial stability, and address hospital uncompensated care within the scope of its statutory responsibilities. Under this authority, the HSCRC may establish hospital revenue adjustments that support the state funding component of Maryland's 1332 waiver.

The MHBE is responsible for governance, financial accountability, and the disposition of unexpected funds. A forthcoming MOU amongst the participating state agencies will delineate each agency's role and responsibilities, promoting accountability while formalizing a clear governance framework for implementation and administration of the 1332 waiver.

6. Prospective Hospital Uncompensated Care Funding

- MHA, UMMS, Luminis Health, and Adventist HealthCare requested that HSCRC prospectively recognize anticipated increases in hospital uncompensated care associated with H.R.1 by providing an approximately 0.66% adjustment to the uncompensated care provision in rates for RY 2027. UMMS reiterated its previously submitted 0.69% request while expressing support for MHA's recommendation. Commenters stated that hospitals are already experiencing increased self-pay patients, bad debt, collection costs, and uncompensated care, while the current UCC methodology would not recognize these impacts until future rate years. MHA, UMMS, and Luminis Health also recommended reconciling prospective funding to actual experience once data becomes available.

HSCRC Response: At this time, staff believe the approach described in the RY2027 Update Factor recommendation is the appropriate path forward.

7. Monitor Uncompensated Care Trends

- MHA, UMMS, and CareFirst recommended that HSCRC continue monitoring uncompensated care throughout the rate year and incorporate emerging experience into Maryland's existing uncompensated care policy. Commenters recommended monitoring Marketplace enrollment, Medicaid enrollment, payer mix, emergency department utilization, and uncompensated care levels to determine whether additional policy action becomes necessary as federal coverage changes are implemented.

HSCRC Response:Staff agree and are committed to continued monitoring of UCC throughout the year.

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 3.10% for Wages and Salaries)			3.11%	$746.5	$246.3
- Additional Inflation Support			0.20%	$48.1	$15.9
- Outpatient Oncology Drugs			0.06%	$15.2	$5.0
Gross Inflation Allowance	**A**		**3.37%**	**$809.8**	**$267.2**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.15%	-$36.9	-$12.2
- Grant Funding RY27			0.02%	$3.7	$1.2
- HOPE			0.21%	$50.0	$16.5
- CTI Transition			0.20%	$48.7	$16.1
Total Care Coordination/Population Health	**B**		**0.27%**	**$65.5**	**$21.6**
Adjustment for Volume					
- Demographic /Population Standard Policy			0.12%	$28.8	$9.5
- Demographic Policy Refinement - RY2026 Incremental Change			0.03%	$7.9	$2.6
Total Adjustment for Volume	**C**		**0.15%**	**$36.7**	**$12.1**
Financial Methodologies & Other Adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.40%	$96.1	$31.7
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		0.16%	$37.5	$12.4
- Full Rate Application & Capital Funding	G		0.07%	$16.2	$5.3
- Reversal of one-time adjustments for drugs	H		-0.06%	-$14.7	-$4.9
- Reversal of Surge Funding (RY24-RY25 in RY26 rates)	I		-0.81%	-$194.3	-$64.1
- RY26 Respiratory Surge Funding Estimate (9 month)	J		0.19%	$44.7	$14.7
- RY25 New Volume Policies	K		0.06%	$14.7	$4.8
- AHEAD ReadinessFunding (Commissioner Amendment)	L		0.21%	$50.0	$16.5
- Individual Market Stabilization	M		0.52%	$125.0	$41.3
Net Other Adjustments	**N =**	**Sum of D thru M**	**0.73%**	**$175.1**	**$57.8**
Quality and PAU Savings					
- PAU Redistribution	O		-0.02%	-$5.5	-$1.8
- Reversal of prior year quality incentives	P		0.04%	$9.7	$3.2
- Current Year Quality Incentives	Q		-0.06%	-$15.0	-$5.0
Net Quality and PAU Savings	**R =**	**Sum of O thru Q**	**-0.04%**	**-$10.7**	**-$3.5**
Total Update First Half of Rate Year					
	S =	Sum of A + B + C + N+ R	**4.48%**	**$1,076.4**	**$355.2**
	T =	(1+S/(1+0.12%)	**4.35%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
- Uncompensated care, net of differential	U		0.12%	$29.8	$9.8
- Deficit Assessment	V		-0.20%	-$47.6	-$15.7
	W =	**Sum of S thru T**	**-0.07%**	**-$17.8**	**-$5.9**
Total Update First Half of Rate Year 27					
Revenue growth, net of offsets	**X =**	S + W	**4.41%**	**$1,058.6**	**$349.3**
Per Capita Revenue Growth	**Y =**	(1+X)/(1+0.12%)	**4.28%**		
Adjustments in Second Half of Rate Year					
- Medicare Advantage Stabilization*			0.00%	$0.0	$0.0
Total Adjustments Second Half of Rate Year	**Z =**		**0.00%**	**$0.0**	**$0.0**
Total Update Full Rate Year					
	AA =	X + Z	**4.41%**	**$1,058.6**	**$349.3**
	AB =	(1+AA)/(1+0.12%)	**4.28%**		

*MA Stabilization has a revenue neutral impact on proposed increase to revenues, staff are adding this for awareness due to the adjustment being new in CY27.

Revised Update Factor Inclusive of the following:

- $50 million for AHEAD Readiness Funding
  - Commissioner Amendment 6/10/26 Commission Meeting
- $125 million Market Stabilization
  - $100 million - MHBE
  - $25 million - FQHCs (NEW)
- $25 million UCC Fund Reserve Increase
- 4.41% Revenue Growth
  - Minimal Impact on Tests associated with Model

Final Recommendations

1. $100 million to the Maryland Health Benefit HSCRC Exchange (MHBE) special fund to provide funds for reinsurance and Maryland premium subsidies.
2. $50M for advance funding to the UCC fund for coverage losses that Maryland cannot mitigate such as loss of coverage due to immigration status. This would be divided into 2 buckets:
    a. $25 million for Federally Qualified Health Centers (FQHCs) and local health departments to provide primary care to avoid hospital utilization
    b. $25 million to increase the reserves in the Uncompensated Care Fund