maryland
health services
cost review commission

Surge Funding Stakeholder Comments

December 2025

Summary of Public Comments

Topics	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	HME	JHHS	CareFirst	MedStar
Use of Full-Year Data for Funding Calculations	✓	✓	✓	✓	✓	✓	✓		✓
Methodology for Calculating Surge Funding	✓	✓	✓	✓	✓		✓		✓
Length of Stay Incentives				✓	✓		✓	✓	
Timing and Process for Funding Adjustments			✓		✓			✓	✓
Alignment with Broader Policy Initiatives			✓	✓			✓		

- Staff received comment letters from nine stakeholders regarding the Draft Recommendation on Surge Funding
- The comments from stakeholders can be broadly categorized into five areas of concern.

Use of Full-Year Data for Funding Calculations Comments

Overall Summary: Stakeholders broadly support using a full 12 months of data to calculate surge funding, emphasizing that funding should reflect actual, demonstrated need and not be constrained by arbitrary caps. HME expresses concern about increased consumer costs if funding is expanded

Staff Response: ***Staff agrees with utilizing a full 12 months of data in alignment with all other HSCRC volume methodologies, which assess volume changes across an entire year. Global Budget Revenue (GBR) volumes are budgeted prospectively and are intended to account for 12 months of actual experience, including seasonal fluctuations in demand. Therefore, assessments regarding volume surges should also be conducted on a 12-month basis to avoid arbitrary budget caps and to account for all available resources provided through a global budget.***

Adjusting GBRs based on the inadequacy of prospective budgeted volumes—considering the totality of the global budget rather than a subset or season—is consistent with the foundational language of the GBR contracts.

The impact of providing additional surge funding to consumers is minimal. As demonstrated by various staff analyses, this funding is necessary to support additional volumes not initially accounted for in hospital budgeted GBRs, particularly given the rise in respiratory-related conditions.

Comments were received from:	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	HME	MedStar	JHHS

See appendix for comment details.

Pro Forma Impact of Surge Funding on Per Diem Charges

The potential incremental surge funding being discussed **does not have a material impact on costs**. Staff estimates that providing $24M in incremental Surge Funding would **increase average charges per patient day by $8 or 0.1%.** Providing $64M in incremental Surge Funding would result in a **$21 or 0.3% increase**

		$100M Funding Option [1]	$125M Funding Option [2]	$165M Funding Option [3]	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY2025 Actual Total Hosptal harges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
FY2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY2025 Actual Charges per Patient Day	$	7,414	7,414	7,414	F = D / E
FY2025 Charges + Incremental Surge	$	23,018,649,505	23,043,108,425	23,082,908,030	G = D + C
FY2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY2025 Charges + Surge per Patient Day	$	7,414	7,422	7,435	H = G / E
% Variance from Baseline			0.1%	0.3%	

Source: HSCRC Experience Data

[1] $100M 9-month amount currently in rates using 33% ECMADs and 66% patient days
[2] $125M RY25 12-month evaluation using 66% ECMADs and 33% patient days
[3] $165M RY25 12-month evaluation using 33% ECMADs and 66% patient days

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Pro Forma Impact of Surge Funding on Commercial Premiums

Similarly, the potential additional Surge Funding would be expected to **increase commercial insurance premiums by 0.0% to 0.1%** if all of the costs were passed on to consumers.

		$100M Funding Option	$125M Funding Option	$165M Funding Option	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY2025 Actual Total Hospital Charges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
Incremental Surge Funding as a % of Charges		0.0%	0.1%	0.3%	E = C / D
Hospital Spend as a % of Total Healthcare Spend	$	37%	37%	37%	F
Expected Impact of Surge Funding on Commercial Premiums		**0.0%**	**0.0%**	**0.1%**	G = E * F

Sources:
HSCRC Experience Data
Hospital Spend as a % of Total per Maryland Insurance Administration (MIA)

Methodology for Calculating Surge Funding (ECMADs vs. Patient Days) Comments

Overall Summary: Stakeholders generally support shifting toward a higher weight for ECMADs in the methodology, while maintaining some degree of blending with patient days. The most common proposal is a 33% ECMADs/66% patient days weighting for future years, with some advocating for a predominantly ECMAD-based approach to avoid unintended incentives related to length of stay or a 100% patient day approach given the nature of the surge cases. Some stakeholders also recommend having a transition period if there is a shift in methodology.

Staff Response: ***The current weighting methodology—66% patient days and 33% ECMADs—was established as a placeholder during last year's respiratory surges. At that time, the Commission expressed a desire to deemphasize patient days to avoid relying on antiquated volume statistics for global budget adjustments. Consequently, staff were directed during the July 2025 public meeting to analyze more appropriate weighting options.***

Staff conducted various analyses to estimate the degree to which surge situations account for LOS increases and based on those findings, staff recommend a revised methodology of 66% ECMADs and 33% patient days. This approach more fully utilizes ECMADs to avoid unintended consequences, such as inpatient length-of-stay exacerbation, while acknowledging that ECMADs may not capture all patient days associated with peak flu season case profiles.

Given that RY 2026 revenue adjustments have already been issued under the original weighting, Staff and stakeholders agree that the current methodology should remain in place for the remainder of RY 2026. Staff defer to the Commission on whether the additional $64M should be funded in the current fiscal year or accounted for in the RY 2027 Update Factor.

Moving forward, staff recommend adopting the new weighting for RY 2027 surge funding and beyond, with full funding to occur in the following fiscal year.

66% ECMAD 33% Patient Days	33% ECMAD 66% Patient Days	50% ECMAD 50% Patient Days	0% ECMAD 100% Patient Days
▪ **Staff Recommendation** ▪ LifeBridge ▪ Adventist	▪ JHHS ▪ Luminis[1] ▪ MedStar ▪ MHA ▪ UMMS	▪ Luminis[1]	▪ Luminis[1]

Comments were received from:	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	JHHS	MedStar

See appendix for comment details.

[1] Luminis supports the 100% patient day methodology or a 50/50 blended methodology, but at a minimum requests maintaining the 33% ECMAD/66% patient day split.

Length of Stay Incentives Comments

Overall Summary: Several stakeholders cautioned against implementing a separate IP LOS incentive policy, stating that such a policy could penalize hospitals for factors beyond their control. They recommend monitoring the length of stay rather than introducing independent incentives and favor approaches that minimize unintended consequences. If an IP LOS policy were to be implemented, stakeholders believe it should be done as a separate recommendation and allow for extensive workgroup and stakeholder engagement. Other stakeholders were supportive of the development of a LOS policy.

Staff Response: ***While the IP LOS Incentive Policy and the Surge Funding Policy are being developed independently, staff believe it is important to highlight the significant interaction between the two.***

There is a concern that providing surge funding may inadvertently disincentivize hospitals from managing length of stay (LOS) efficiently, which could negatively impact quality outcomes such as ED wait times and patient satisfaction. Currently, approximately 50% of surge funding for RY 2025 is allocated to hospitals with IP LOS levels exceeding national norms.

Staff acknowledge that hospitals cannot control every factor impacting LOS and that longer stays are sometimes necessary for optimal health outcomes. However, the overall growth in IP LOS is a concern that warrants further investigation. Notably, while admission volumes have declined over the course of the Model, patient days have remained relatively constant despite stable acuity levels (see next slide).

Key areas identified for improvement include; post-acute care discharges, behavioral health placements, the impact of prior authorization, and general throughput efficiency

Given the concern over the Surge Funding Policy's potential to worsen IP LOS, staff is considering two additional recommendations for workgroup discussion

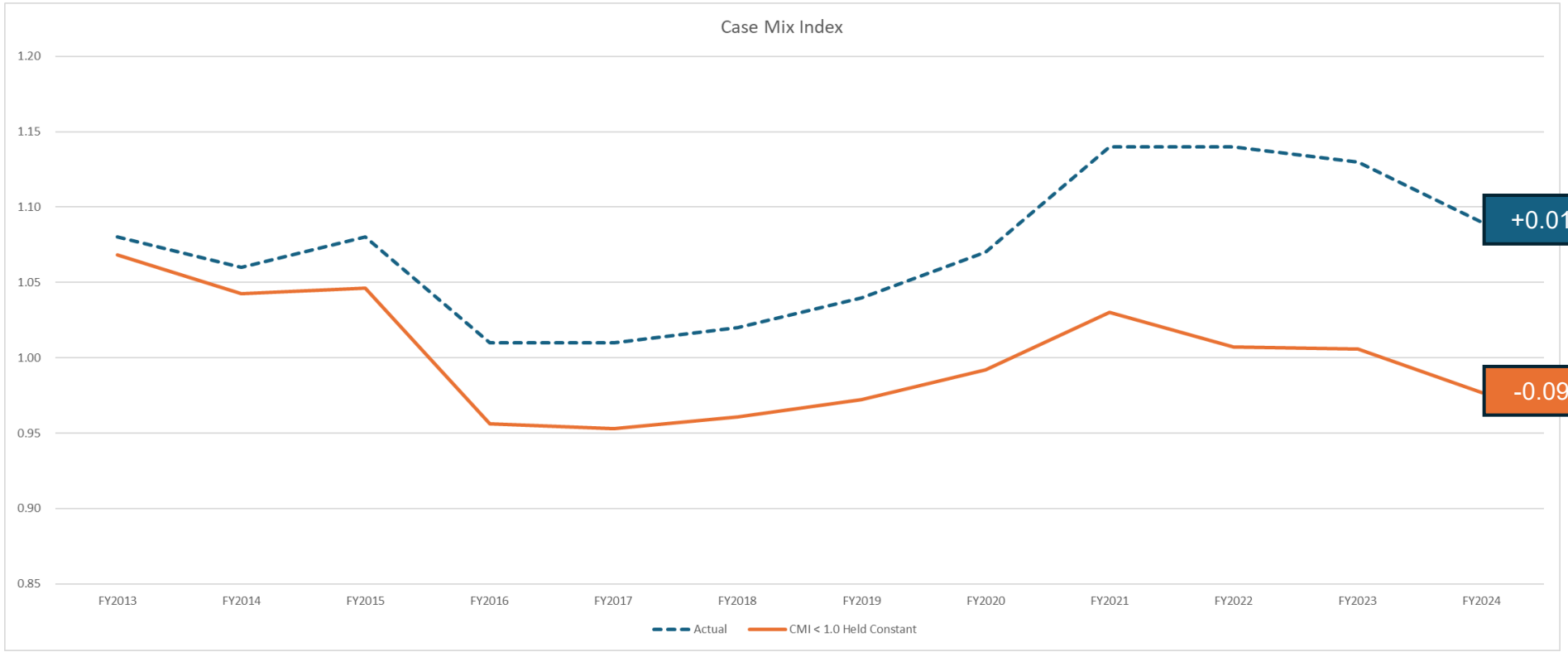
- ***If an IP LOS incentive is not established by June 30th, the surge policy be suspended until an IP LOS incentive is approved; alternatively,***
- ***If an IP LOS incentive is not established by June 30th, the Surge policy will be amended to only account for case growth (100% ECMAD evaluation)***

Comments were received from:	MHA	UMMS	JHHS	CareFirst

See appendix for comment details.

Adjusted CMI Trend

While actual statewide Case Mix Index has increased slightly, Staff's analysis suggests that the **shift of low-acuity cases** out of the IP setting is a larger driver of the increase than a more complex and older population.



- The **dotted blue line** represents actual statewide Case Mix Index, based on APR DRGs, calculated using the HSCRC data tapes.
- From FY2013 to FY2024, **actual CMI increased by 0.01**.

- The **orange line** represents the CMI if all DRGs with a CMI < 1.0 and a decline in admissions from FY2013 are held constant at FY2013 levels.
- This -0.09 indicates the **change in CMI if the shifts of low acuity cases to other settings had not occurred**.

Timing and Process for Funding Adjustments Comments

Overall Summary: Stakeholders generally support timely and transparent adjustment processes. There is broad support for using prospective estimates with reconciliation based on full-year data to ensure funding reflects actual experience and supports hospital needs. Many advocate for implementing incremental funding in January rate orders and providing surge funding in the same year rather than delaying to future rate years. CareFirst notes general concerns about the policy development process and recommendations for a more thoughtful and inclusive approach.

Staff Response: ***Staff understands the necessity of making resources available to hospitals so that they can continue to provide high quality care to patients. The intent of the surge policy is to provide hospitals with funding for additional costs incurred due to volume surges in the prior year. Delaying funding until July will be inconsistent with the intent of the policy. Staff already has the full 12-month amount necessary to fund surge, reconciling this amount in January is in keeping with the intent of the surge policy.***

While Staff defers to Commissioners, Staff is putting forward the following for workgroup discussion

RY 2026 Incremental Surge Funding	Timing & Process for Funding	Comments
$24M or $64M	***January RY 2026***	Provides all funding for volume surges in the prior year within the next year as intended by the Surge Funding Policy
	July RY 2027	Not an off-cycle adjustment as funding is handled in concert with the update factor ensuring total affordability considerations
		Con: First time the HSCRC has purposefully delayed an adjustment when the data is available

Comments were received from:	Adventist HealthCare	UMMS	MedStar	CareFirst

See appendix for comment details.

Alignment with Broader Policy Initiatives Comments

Overall Summary: Stakeholders stress the importance of aligning surge funding policies with broader initiatives and caution against adding complexity during transitions.

Staff Response: ***Staff agree that the Surge Funding policy should align with broader initiatives and not add complexities as we the transition to the AHEAD model***

Moving forward Staff will work with stakeholders to ensure that approaches under the Medicare and Non-Medicare HGBs are promoted. Medicare's risk adjustment policies address some of this risk but it may also be a consideration CMS has not fully addressed and will need to be raised with them

Comments were received from:	Adventist HealthCare	MHA	JHHS

See appendix for comment details.

Appendix - Detailed Stakeholder Comments

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Use of Full-Year Data for Funding Calculations Comments

Overall Summary: Stakeholders broadly support using a full 12 months of data to calculate surge funding, emphasizing that funding should reflect actual, demonstrated need and not be constrained by arbitrary caps. Equity considerations, such as payer mix and support for hospitals serving vulnerable populations, are highlighted as essential. HME expresses concern about increased consumer costs if funding is expanded.

Organization	Summary of Comments
LifeBridge Health	LifeBridge endorses revising surge funding to reflect 12 months of volume experience, noting the full-year analysis shows greater respiratory case growth than the initial 9 months
Luminis Health	Luminis supports recognizing surge volume growth for the entire 12-month period, calling the 9-month cap arbitrary
Adventist HealthCare	Adventist recommends funding based on a full 12 months of actual experience, with reconciliation in January rate orders. They also urge that funding reflect full actuarial estimates and equity considerations for hospitals serving vulnerable populations
MHA	MHA urges updating funding to reflect the full year of RY2025 data, not just the first nine months/ They also stress funding should match resource needs and not be arbitrarily capped
HME	HME opposes increasing surge funding if global budgets already sufficiently fund higher volumes, warning about rising consumer costs and advocating for robust analysis before retrospective increases. HME also requests that the HSCRC clarify how funding adjustments will impact consumer costs
UMMS	UMMS strongly urges amending the funding cap to reflect a full 12 months of respiratory surge volume, stating that partial-year caps intentionally underfund necessary care and create inconsistency. UMMS also advocates for providing the full $164.6 million based on a 12-month evaluation period
MedStar	MedStar strongly supports using 12 months of data for FY2025, urges HSCRC not to deviate from this precedent, and recommends implementing the full $164M in funding
JHHS	Supports the full rate year allotment ($164.6M) based on 12 months of data, and urges amending/removing the cap for RY2026 to avoid underfunding care

Methodology for Calculating Surge Funding (ECMADs vs. Patient Days) Comments

Overall Summary: Stakeholders generally support shifting toward an ECMAD-based methodology, with some recommending a blend with patient days. The most common proposal is a 66% ECMADs/33% patient days weighting for future years, with some advocating for a 50/50 blend or a predominantly ECMAD-based approach to avoid unintended incentives related to length of stay. Some stakeholders also recommend having a transition period if there is a shift in methodology.

Organization	Summary of Comments
LifeBridge Health	Life Bridge supports a shift to a predominantly ECMAD-based approach, aligning with other HSCRC methodologies and avoiding incentives related to length of stay
Luminis Health	Luminis suggests a 50/50 blend of patient days and ECMADs for future periods rather than 66% patient days/33% ECMADs based on the HSCRC mixed results of which calculation is more predictive of added resources
Adventist HealthCare	Adventist supports 66% ECMADs/33% patient days weighting starting in Rate Year 2027, stating that it promotes consistency and supports statewide efforts to improve length-of-stay performance
MHA	MHA urges to keep using the existing methodology of assigning 2/3 weight to patient days and 1/3 to ECMADs and suggests the change methodology should be considered only in RY2027 and rate years there after
UMMS	UMMS believes the Staff analysis does not justify change to the 66% patient days and 33% ECMAD funding logic and is merited at this time
JHHS	JHHS suggests on having a transition period if there is shift of weighting in methodology approach from 66% patient days and 33% ECMAD evaluation
MedStar	MedStar endorses using the existing approved methodology for FY2026, with changes considered only for FY2027 and beyond

Length of Stay Incentives Comments

Overall Summary: Stakeholders caution against policies that incentivize longer hospital stays or penalize hospitals for factors beyond their control. They recommend monitoring the length of stay rather than introducing independent incentives and favor approaches that minimize unintended consequences. Some recommend having an independent ALOS incentive and call for public input, strong safeguards, and incentives to improve throughput, coordination, and ED wait times.

Organization	Summary of Comments
MHA	MHA opposes independent incentives for length of stay because inpatient length of stay is driven by clinical needs and some factors outside hospitals' control, such as caring for complex and aging patients, payer delays, workforce shortages, etc. MHA also has concerns related to the inpatient length of stay incentive proposal, stating that the data being utilized does not capture shifts in patient acuity
UMMS	UMMS recommends that the adoption of an independent Average Length of Stay (ALOS) incentive be evaluated separately, not as part of the surge funding policy
JHHS	JHHS suggests to thoughtfully weight the LOS impacts before inclusion and check the policy for possible penalization of hospitalization for providing care to respiratory patients that may have longer LOS
CareFirst	CareFirst supports an independent inpatient length-of-stay (LOS) policy, urges robust public input and comment periods, and expects that with proper incentives and quality safeguards it will improve throughput, system coordination, and ED wait times

Timing and Process for Funding Adjustments Comments

Overall Summary: Stakeholders generally support timely and transparent adjustment processes. There is broad support for using prospective estimates with reconciliation based on full-year data to ensure funding reflects actual experience and supports hospital needs. Many advocate for implementing incremental funding in January rate orders and providing surge funding in the same year rather than delaying to future rate years. CareFirst notes general concerns about the policy development process and recommendations for a more thoughtful and inclusive approach.

Organization	Summary of Comments
Adventist HealthCare	Adventist recommends a prospective estimate in July, with reconciliation in January based on full-year data to ensure funding reflects actual experience and supports hospital needs
UMMS	UMMS urges providing surge funding in RY2026 by implementing the incremental $64.2 million in hospitals' January 2026 rate orders, aligning funding with the full-year evaluation period
MedStar	MedStar suggests to provide hospital with the surge funding in FY26 and not delayed until future rate years
CareFirst	CareFirst critiques the development of this policy, stating that the recommendation was rushed and fundamentally flawed

Alignment with Broader Policy Initiatives Comments

Overall Summary: Stakeholders stress the importance of aligning surge funding policies with broader initiatives, such as the AHEAD model and national CMS programs, and caution against adding complexity during transitions. JHHS suggests the policy may be unnecessary and recommends having a comprehensive review of whether other volume policies in place are working as expected.

Organization	Summary of Comments
MHA	MHA emphasizes alignment with AHEAD and national programs
Adventist HealthCare	Adventist values collaborative engagement and alignment with broader policy initiatives
JHHS	JHHS believes this policy may be unnecessary if age-adjusted demographic and market-shift policies work, and urges a comprehensive review of volume policies before the CMMI AHEAD transition

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Updates to Select Volume Realignment Policy Implementation

December 2025

Select Volume Realignment - Final Approved Policy

At the December Public Meeting, Commissioners voted to approve the Select Volume Realignment Policy:

1. From January 1, 2026 through June 30, 2027, remove, for select hospitals, KP volumes and revenues evaluated in the Market Shift Policy from Global Budget Revenues. A variable cost factor will be employed. Select hospitals are defined as follows:
    - Greater than 5 percent of total Kaiser revenue statewide, regardless of Kaiser GBR share.
    - Greater than $5M in annual charges and greater than 2 percent of global budget revenue.
    - Specialty hospitals and hospitals where >96.85 percent of Kaiser charges have an EMG rate center charge are excluded.

2. Allow removed KP volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates. A variable cost factor will be employed.

3. On July 1, 2027, build back into Global Budgets removed KP volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026 through December 31, 2026.

4. Apply retrospective adjustments (both permanent and one-time) if hospitals can verify that Kaiser volumes were replaced with other volumes that are currently unsupported by Demographic, Market Shift, or related adjustments.

Concerns with real-time implementation of VCF

Staff has determined that applying a VCF to Kaiser volumes in real-time would have **two unintended consequences**:

Different Rates for Different Payers

Applying a VCF to Kaiser charges during realignment would result in hospitals needing to charge Kaiser patients a different rate from other patients.

(See slide 4)

Overfunding of Volume

The application of a VCF may also result in overfunding of volume for certain payers and potentially across the system depending on how the fixed costs associated with treating Kaiser patients were handled.

(See slide 5)

Different Rates for Different Payers

Removing Kaiser revenue from GBR and reimbursing actual Kaiser volume in real time at a 59% would result in **different rates for different payers**. This is not aligned with the goals of the TCOC Model or the Select Volume Realignment Policy and would create unnecessary burden on hospitals.

For example, if a hospital's average charge per ECMAD after removing Kaiser volume from its GBR is $15,000, **charges for non-Kaiser patients** would be $15,000 but **charges for Kaiser patients** would be $8,850 due to the application of the 59% VCF.

	Kaiser	Non-Kaiser
Average Charge per ECMAD post-Kaiser Removal	$15,000	$15,000
VCF for Kaiser Volume	59%	N/A
Charge per ECMAD during Realignment	**$8,850**	**$15,000**

Overfunding of Volume

Removing Kaiser revenue from GBR and reimbursing actual Kaiser volume in real time at a 59% would cause the **system to be overfunded**.

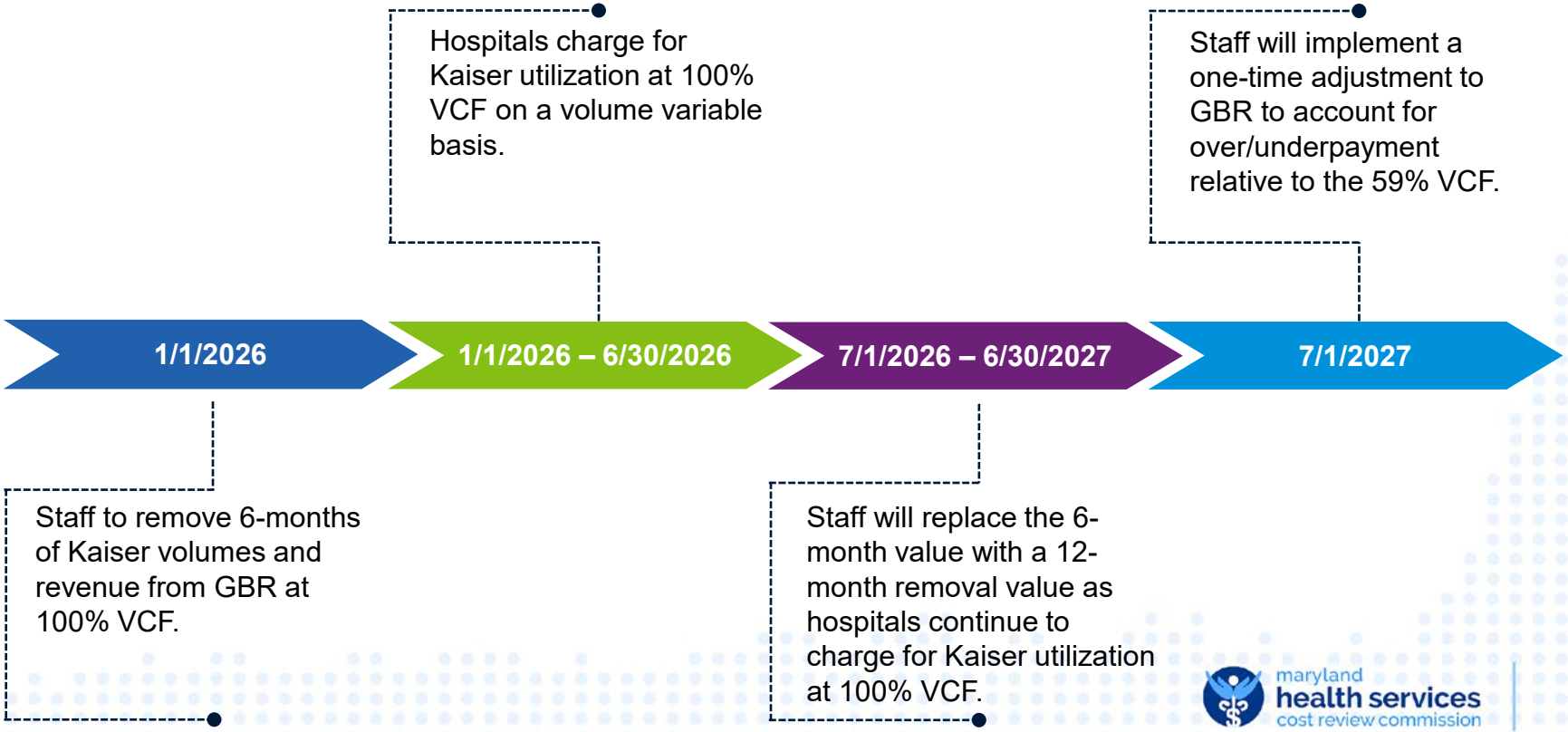
Applying a 59% VCF to removed Kaiser volume would shift the fixed costs associated with treating Kaiser patients to non-Kaiser payers. As an example:

Average Charge per ECMAD pre-Kaiser Removal	$15,000
VCF for Kaiser Volume Removal	59%
Charge per ECMAD Removed from GBR	$8,850
Fixed Costs per ECMAD Remaining in GBR	**$6,150**

These fixed costs would remain in the non-Kaiser GBR and be charged to other payers, resulting in **overfunding for the non-Kaiser cases** seen in the hospital during the realignment period. Alternatively, if rates were held constant for all payers it would generate systemwide overfunding.

Proposed Approach

To avoid the issues identified in the previous slides, Staff proposes the **following approach**, which is in alignment with the nature of the approved recommendation.



Reconciliation to 59% VCF in FY2028

To reconcile over/underpayment relative to a 59% VCF for the FY2028 Rate Order, Staff will perform the following:

1. Evaluate the **total shift in Kaiser volume** experienced during the realignment period.
2. Determine the **appropriate level of funding** associated with the realigned Kaiser volume, if a **59% VCF** had been applied.
3. Compare actual Kaiser volume funding provided through volume variable reimbursement at **100% VCF** to the appropriate level of funding from step 2.
4. If needed, implement a **one-time adjustment** to reconcile the difference between actual funding and appropriate funding at the 59% VCF.

Staff will also use experience data to monitor **overall compliance**.