maryland
health services
cost review commission

Demographic Adjustment Stakeholder Comments

December 18 2025

Summary of Public Comments

Topics	MHA	UMMS	JHHS	Frederick Health	Adventist	CareFirst	HME
Fund Age Adjusted Population growth	✓	✓	✓	✓	✓	✓	✓
Use SG2 to Fund Projected Future Utilization Growth	✓	✓		✓			
Incorporate National Demand Modifier	✓	✓	✓	✓	✓		✓
Continue Including Volume Variable Funding in DA	✓	✓	✓	✓	✓		
AHEAD Alignment & Other comments	✓	✓	✓		✓		

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

Introduction – Factors Driving Hospital Demand

- The Demographic Adjustment is intended to reflect factors that impact demand for hospitals services (as opposed to price). These factors can be broadly categorized in 3 buckets:
  - The size of the population served
  - The age of the population served
  - Changes in technology, clinical practices and population health (aside from aging)
- Historically, for various reasons, the HSCRC has only considered the first item (age is used to distribute funding but does not change the total amount provided).
- There has been considerable concern that the failure to acknowledge age has resulted in systematic underfunding. During this process the HSCRC demonstrated that excluding the impact of aging has not resulted in systematic underfunding as it has been offset by the third factor. This is consistent with evidence from national data sets, and many commenters acknowledged this in their comment letters.

Introduction – The Future of the Demographic Adjustment

- Having ruled out existing underfunding, the discussion has moved to the appropriate future funding formula. There are three potential options:
  A. Continue the current practice of assuming that age will be offset by other changes in demand
  B. Add a factor for age and other considerations based on average historical experience (past is prologue)
  C. Building into the future process a dynamic estimate of changing hospital demand (considering clinical risk and other demand drivers).
- While experience of the model to date has shown that approach A is adequate Staff have proposed moving to option B to acknowledge the various drivers of population demand.
- A few commenters argued for returning to Approach A while others argued for either (1) revising the estimate derived for Approach B or moving for Approach C.
- Staff have not changed their proposal based on the comments because:
  - They believe the data supports a small incremental increase beyond population growth
  - They do not believe the proposed revisions to approach B were an improvement
  - They believe that the added complexity of moving to Approach C is not merited given the limitations on available data and the subjectivity involved in any projection approach
- The following slides address the comments in more detail.

Fund Age Adjusted Population Growth Comments

Overall Summary: Many Stakeholders strongly support fully funding age-adjusted population growth, averaging about 0.65% annually, stating that the current methodology underfunds aging-related utilization. They also argue that the Demographic Adjustment serves as the sole means to finance anticipated increases in utilization driven by an aging population. In contrast, CareFirst and HME oppose additional funding, citing efficiency gains, technology improvements, and sufficient current funding.

Staff Response: ***Staff did not conduct new analysis on the age adjusted growth statistic cited in the comments supporting this approach. This value was specifically designed to distribute population funding, not to function as a governor for statewide funding.***

As has been discussed in both the Volume Workgroup and the November Commission meeting, the age-adjusted growth statistic in the Demographic Adjustment is inappropriate for two reasons: it fails to account for year-over-year growth, thus missing broader secular trends, and it only considers one factor (aging) that affects changes to hospital utilization.

Instead, Staff analyses for this Workgroup engagement have focused on the proposed approaches that more comprehensively account for aging and other important factors that impact population-level risk. The slides that have been presented before on this topic are included in an appendix.

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	CareFirst	HME

See appendix for comment details.

Use SG2 to Fund Projected Future Utilization Growth Comments

Overall Summary: Stakeholders broadly cited independent forecasts like Sg2 showing 4.5% inpatient and 17.4% outpatient growth from 2025–2035, supporting a higher national demand modifier (0.52%–0.64% annually) versus the proposed 0.10%. They emphasize the need for prospective forecasts to ensure hospitals are adequately resourced in 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment.

Staff Response: ***Staff thanks stakeholders for providing an alternative to the 0.1% national demand modifier statistic outlined in the Demographic Adjustment Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration.***

However, staff is concerned that the proposal is not viable for the following reasons:

1. ***Proprietary Data: The specifics of the Sg2 forecast are proprietary and not available to non-hospital entities, making external vetting difficult.***
2. ***2. Variability: Sg2's annual ten-year forecasts exhibit significant variation (as shown in the accompanying table). This suggests the statistic may not be sufficiently reliable or predictable to serve as a volume governor in a capitated model.***
3. ***Double Counting: The Sg2 forecast includes base population growth, which is already incorporated into the Demographic Adjustment calculation. Using the Sg2 forecast unmodified would result in double counting. If population growth is removed from the Sg2 statistic, the resulting negative growth is a figure whose veracity staff questions (See next slides for schedule).***

Summary of Annual SG2 Report Projections

SG2 Report Year	Forecast Period	Population	IP Discharges 10-Year Growth	OP Visits 10-Year Growth
2021	2019 - 2029	NA	-1%	14%
2022	2022 - 2032	13%	8%	16%
2023	2023 - 2033	10%	2%	16%
2024	2024 - 2034	13%	3%	17%
2025	2025 - 2035	14%	5%	18%

Comments were received from:	MHA	UMMS	Frederick Health

See appendix for comment details.

MHA SG2 Proposal

Staff was able to replicate the calculations behind MHA's proposed 0.64% national modifier using the SG2 report

	A	B	C = sum (A x B)	D	E = C - D	F = E / 10
Age Cohort	**Sg2 National Growth 2025-35**	**Cohort Weight**	**Weighted Total National Growth**	**Site Neutral Discount**	**10 Year Total (2025-35)**	**1 Year Total (National Modifier)**
Adult IP	4.5%	59.0%				
Adult OP	17.4%	31.0%				
Ped IP	-2.0%	5.0%				
Ped OP	8.0%	5.0%				
Weighted Total			**8.35%**	**1.90%**	**6.45%**	**0.64%**

Components of SG2 Proposal

Sg2 national utilization growth accounts for the following:

- Population 
- Aging & Other Demographic Changes 
- Economy & Consumerism 
- Epidemiology & Sociocultural Changes 
- Innovation & Technology 
- Systems of Care 

The financial impact of population growth is already built into the **Update Factor**. Giving additional credit to population growth through the national demand modifier would mean this growth is being **accounted for twice**.

If population growth is stripped out of MHA's calculation, the national modifier would be -0.01%

	A	B	C = A - B
Age Cohort	Sg2 National Growth 2025-35	National Population Growth 2025-35	Sg2 National Growth 2025-35 Excl. Pop
Adult IP	4.5%	7.7%	-3.2%
Adult OP	17.4%	7.7%	9.7%
Ped IP	-2.0%	-3.7%	1.7%
Ped OP	8.0%	-3.7%	11.7%

- National population growth projections were obtained from **Claritas Spotlight.**
- Sg2 National Growth Excl. Pop. accounts for all factors identified in the Sg2 report other than population growth.
- The values from Column C in the top table flowed through the MHA calculation in the bottom table to determine the national modifier without the impacts of population growth.

	C (from Above)	D	E = sum (C x D)	F	G = E - F	H = G / 10
Age Cohort	Sg2 National Growth 2025-35 Excl. Pop.	Cohort Weight	Weighted Total National Growth	Site Neutral Discount	10 Year Total (2025-35)	1 Year Total (National Modifier)
Adult IP	-3.2%	59.0%				
Adult OP	9.7%	31.0%				
Ped IP	1.7%	5.0%				
Ped OP	11.7%	5.0%				
Weighted Total			**1.79%**	**1.90%**	**-0.11%**	**-0.01%**

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Incorporate National Demand Modifier Comments

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative. Some highlight national all-payer data and suggest incorporating a national demand modifier to more explicitly account for Medicaid, which based on stakeholder modelling would result in a 0.28% national modifier versus staff's proposal of 0.1%.

Staff Response: ***Staff again thanks stakeholders for providing an alternative to the 0.1% national demand modifier statistic outlined in the Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration. However, staff does not believe there is a basis for changing the approach used:***

- ***Staff's approach relies on claims data while the proposed approach relies on Medicare cost report data, there is significant research into the challenges of cost report data (see box) and Staff believes the claims-based approach is preferable.***
- ***Staff believes the answers are effectively the "same" given the level of precision feasible in deriving these estimates. For example, using a different source of population estimates changes the outcomes of the stakeholder modeling from 0.28%* to 0.19% or 0.23% (depending on the method used, see next slide). Staff believes the relatively narrow range of the various estimate should provide comfort and that using the claims-based estimate as the point estimate is preferable.***

Examples of literature on the challenges of cost report data:

1. The Medicare Cost Report and the limits of hospital accountability: improving financial accounting data - highlights the general issue of cost reports not being audited
2. Hospitals in Some States Under Report Medicaid Discharge Counts in Cost Report Data - shows the disconnect in claims-based discharges and those in cost reports (within Medicaid)
3. Statewide Hospital Discharge Data: Collection, Use, Limitations, and Improvements - in 28 studies using discharge data, only 7 used cost reports, and all of those 7 supplemented with another source (typically HCUP).

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	HME

** Staff were unable to replicate the commenter calculation of 0.28% but assume it uses a credible source of population data.*
See appendix for comment details.

Incorporate National Demand Modifier Comments cont.

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative. Some highlight national all-payer data and suggest incorporating a national demand modifier to more explicitly account for Medicaid, which based on stakeholder modelling would result in a 0.28% national modifier versus staff's proposal of 0.1%.

Algebra	Variable	US Population	US wo Maryland Population	Notes
A	2013 Population	316,128,839	310,240,464	https://data.census.gov/table?q=United+States&g=010XX00US&y=2023
B	NASHP 2013 Adjusted Patient Discharges	64,298,340	63,183,885	https://tool.nashp.org/
C=B/A*1000	2013 Adjusted Discharges Per 1000 Population	203.4	203.7	
D	2023 Population	334,914,896	328,722,456	https://data.census.gov/table?q=United+States&g=010XX00US&y=2023
E	NASHP 2023 Adjusted Discharges	70,737,422	69,764,234	https://tool.nashp.org/
F=E/D*1000	2023 Adjusted Discharges Per 1000 Population	211.2	212.2	
G=F/C-1	2013-2023 % Growth in National Discharges Per 1000	3.84%	4.21%	
H	Conservative Site Neutral Discount	1.90%	1.90%	Staff Recommendation based on Medpac Report: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf
I=G-H	Potential National Demand Modifier Over 10 Years	1.94%	2.31%	
J=I/10	Potential National Demand Modifier 1 Year	0.19%	0.23%	In line with staff proposal but utilizes conservative site neutral opportunity and is reliant on national cost report data

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	HME

See appendix for comment details.

Continue Including Volume Variable Funding in DA Comments

Overall Summary: Stakeholders urge HSCRC to continue to apply Demographic Adjustments to all revenues until the scope of services carved out of Global Budgets is fully established.

Staff Response: ***Staff have some serious concerns regarding the current request.***

We believe that applying Maryland population growth projections to volumes evaluated under a fee-for-service methodology is double counting since fee-for-service reimbursement automatically includes demographic driven volume growth, particularly when non-Maryland populations are being considered, i.e., out-of-state volumes.

Staff could not find an analogous adjustment in a fee-for-service context and could not identify a clear policy rationale for this approach.

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist

See appendix for comment details.

AHEAD Alignment & Other comments

Overall Summary: Stakeholders suggest that the Demographic Adjustment should be aligned with AHEAD methodologies when applicable. Other recommendations include support in postponing HCC risk score application, utilizing variable cost factors, evaluating alternative sources for population data, and incorporating regional variation in Demographic Adjustment.

Staff Response: ***Staff agree that the Demographic Adjustment should align with AHEAD methodologies to the furthest extent possible. To achieve this alignment, staff have taken the following actions:***

1. Advanced a total risk adjustment
2. Not recommended incorporating a variable cost factor.
3. Signaled that future Demographic Adjustments should utilize more sophisticated risk adjustment for Medicare and non-Medicare HGB's.

Moving forward, staff will work with stakeholders to ensure that approaches analogous to the Medicare HGB Demographic Adjustment are utilized and that population funding is clearly delineated between Medicare and non-Medicare global budgets.

If authorized, staff will explore alternative sources for population data in a future year, which could potentially better address regional variation in population growth. However, staff notes that the gold standard for population growth estimates is the U.S. Census Bureau. Claritas, the proprietary dataset the Commission currently uses to distribute population funding, relies on the Census Bureau for all of its estimates but uses a zip code level, which already accounts for regional variation at a granular level.

Comments were received from:	MHA	UMMS	JHHS	Adventist

See appendix for comment details.

Appendix –Concerns with Age Adjusted Growth Detailed Stakeholder Comments & Sg2 Analysis Details

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Many factors impact hospital utilization and costs

While the statewide population growth **doesn't account for all factors** impacting hospital utilization and the costs to treat patients, it has served as a **reasonable governor** for determining the statewide funding to be provided under a per capita Model.

Other Factors Impacting Hospital Utilization & Costs to Treat Patients

Population Aging[1]

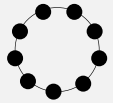
Use Rates

Acuity

Shifts in Care Settings

Innovation & Technology

Socioeconomic Factors



Other Factors

This workgroup will explore if there is a more nuanced governor available to account for aging and other factors that **might offset or increase the effect of aging**. Will necessitate **national assessments** because Maryland utilization patterns reflect TCOC Model impacts.

Note (1): Population aging is used to determine the distribution of Demographic Adjustment funding. Other factors listed above are not directly considered in the Demographic Adjustment Methodology.

Use of Age Cost Weights in Demographic Adjustment

Age cost weights are used in the Demographic Adjustment to reflect the **differential costs** of treating patients in different age cohorts. Population growth in more expensive cohorts will result in more funding than population growth in less expensive cohorts.

Example Calculation – FY2026 Data:

Age Cohort	Actual Per Capita Revenue	Age Cost Weight
0 – 4	$2,224	0.69
5 – 14	499	0.16
15 – 44	1,873	0.58
45 – 54	2,708	0.84
55 – 64	4,320	1.35
65 – 74	6,583	2.05
75 – 84	9,235	2.88
85+	10,381	3.23
Total	$3,212	1.00

A

B

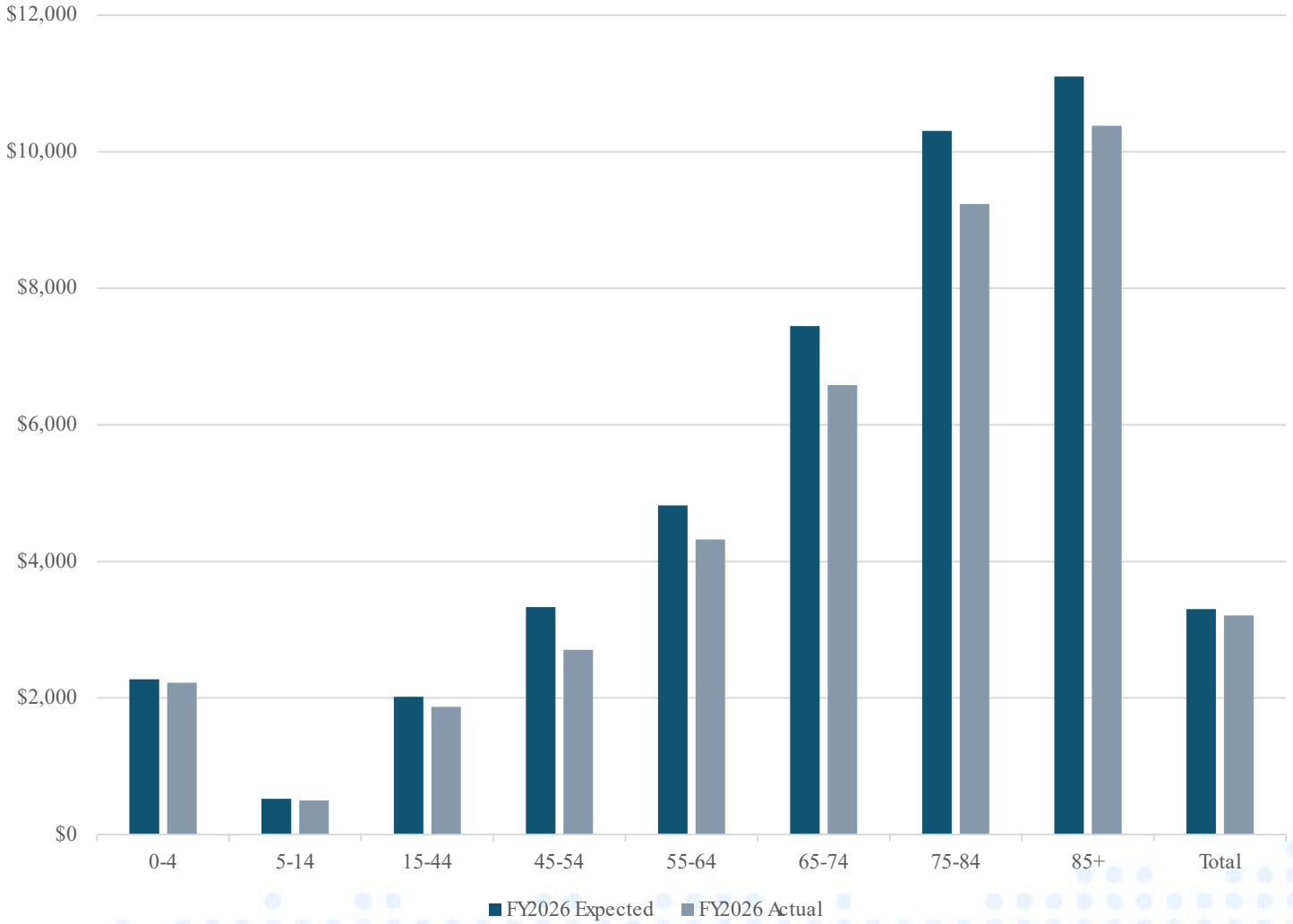
C

A — Cost weights are **calculated for each age cohort** by dividing the age cohort revenue per capita by statewide overall revenue per capita.

B — The **older age cohorts** receive the **largest cost weights** given their increased utilization and need for more intensive services.

C — Statewide the **average revenue per capita** was $3,212. This receives a cost weight of 1.00.

Inflation-adjusted per capita costs have declined for all age cohorts



- FY2026 expected is calculated as FY2015 actual revenue per capita trended forward with 10 years of inflation to FY2026 dollars. This value represents funding per capita with **no underlying change in costs** of treating patients vs. the FY2015 baseline.
- For all age cohorts, FY2026 actual revenue is less than FY2026 expected, meaning **across the board, per capita costs have declined** (after adjusting for inflation).
- Using age cost weights to fund aging in the Demographic Adjustment would ignore these **secular declines in revenue per capita.**

Illustrative Example

Last Year's Test

A professor gives a test and the class average is 50 percent.

As a result, the professor applies a 20 percent curve to bring the class average to 70 percent.

This is reasonable as it brings the class average to a C.

This Year's Test

The professor gives the same test the next year and the class average is 90 percent.

It would be unreasonable for the professor to apply the same 20 percent curve from last year, as something changed year over year that resulted in better performance.

Its possible that the class is smarter, the material was taught differently, or something else caused the variation in performance, but regardless the 20 percent curve should not be applied.

What This Means in the Context of Age Cost Weights:

You can't just take a "fix" from one specific year (like the "aging bonus" or the "20-point curve") and apply it forever. The situation changes every year. Using age cost weights to fund aging through the Demographic Adjustment would be flawed because it **permanently bakes in an assumption about costs**, ignoring data that shows spending across all age cohorts is decreasing. A **more sophisticated approach** would be needed that would account for secular declines in cost, PAU, and other factors.

Fund Age Adjusted Population Growth Comments

Overall Summary: Many Stakeholders strongly support fully funding age-adjusted population growth, averaging about 0.65% annually, stating that the current methodology underfunds aging-related utilization. They also argue that the Demographic Adjustment serves as the sole means to finance anticipated increases in utilization driven by an aging population. In contrast, CareFirst and HME oppose additional funding, citing efficiency gains, technology improvements, and sufficient current funding.

Organization	Summary of Comments
MHA	MHA recommends HSCRC to fully fund estimated age-adjusted population growth and supported an adjustment of 0.65% to account for average annual amount of age adjusted growth between 2020–2024 as the current methodology insufficiently accounts for age-adjusted population growth. They believe discounting this statistic for efficiency is unnecessary since existing PAU scaling and other policy levers with GBR adjustments already promote efficiency.
UMMS	UMMS emphasizes that the Demographic Adjustment methodology should be risk-adjusted to account for aging and socioeconomic factors and proposed an age-adjustment factor, which has averaged 0.65% above pure population growth annually since 2020, serves as a relatively appropriate risk adjustor.
JHHS	JHHS stresses that the current Demographic Adjustment methodology insufficiently accounts for age-adjusted population growth, as it effectively caps adjustments at unadjusted population growth projections. They argue that since global budgets are not case-mix adjusted, the Demographic Adjustment is the only mechanism to fund expected utilization growth due to aging. JHHS supports fully funding estimated age-adjusted growth in the interim and is open to a more comprehensive risk adjustment approach in the future.
Adventist	Adventist highlights that age-adjusted population growth has exceeded total population growth by about 0.65% annually and argues that the Demographic Adjustment should fully fund this growth to reflect increasing acuity and resource intensity. They caution that underfunding risks access constraints, especially in aging markets, and emphasize that Demographic Adjustments under AHEAD are intended to account for both population size and medical risk and encourage HSCRC to explore incorporating additional non-age-related demographic and social risk factors—such as sex, race, and socioeconomic status.
Frederick Health	Frederick Health states that the current methodology caps Demographic Adjustments at unadjusted population growth, leaving a significant gap between age-adjusted growth and the scaled adjustment provided. Since this adjustment is the only mechanism for revenue tied to aging-related utilization, they strongly support fully funding estimated age-adjusted growth in the interim while broader refinements are developed.
CareFirst	CareFirst believe additional funding for age-adjusted growth is not currently needed because improvements in technology, population health, and care transformation have reduced reliance on hospital services.
HME	HME opposes the provision of additional funding due to aging as they feel Maryland hospitals are sufficiently funded to respond to the state's aging population.

Use SG2 to Fund Projected Future Utilization Growth Comments

Overall Summary: Stakeholders broadly cited independent forecasts like Sg2 showing 4.5% inpatient and 17.4% outpatient growth from 2025 - 2035, supporting a higher national demand modifier (0.52%-0.64% annually) versus the proposed 0.10%. They emphasize the need for prospective forecasts to ensure hospitals are adequately resourced in 2026, thereby closing the gap between age-adjusted growth and the scaled Demographic Adjustment.

Organization	Summary of Comments
MHA	MHA questions HSCRC's reliance on historical trends without projecting future utilization, noting that other forecasts e.g., Sg2 predict significantly higher growth, 4.5% inpatient and 17.4% outpatient from 2025–2035. MHA estimates total growth of 8.3% over the decade and recommends applying a 0.64% annual national demand modifier, rather than the 0.10% proposed, starting with RY 2026 to ensure hospitals are adequately resourced.
UMMS	UMMS strongly recommends using prospective forecasts rather than retrospective data and cited Kaufman Hall Consulting's (earlier Sg2) 2025 Impact of Change Forecast which states 4.5% inpatient growth and 17.4% outpatient growth from 2025–2035. Equivalent to 8.3% total growth or 0.83% annually, UMMS supports applying a 0.64% annual national demand modifier.
Frederick Health	Frederick Health notes that the draft recommendation relies on historical trends without projecting future utilization, despite Frederick County's expected significant demographic growth, especially among those over 75. They point to independent forecasts like Sg2, which project much higher inpatient and outpatient growth, and agree with MHA that applying these projections would justify a national demand modifier closer to 0.52% annually, rather than the proposed 0.10% in RY 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment in current FY26 rates.

Incorporate National Demand Modifier Comments

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative and urging forward-looking demand estimates. Some highlight national all-payer data and suggest incorporating a national demand modifier to account for Medicaid.

Organization	Summary of Comments
MHA	MHA raises concerns that HSCRC understates demographic impacts and overstates practice pattern changes. They question if the Medicare Advantage adjustment is necessary given Maryland's low enrollment and non inclusion of Medicaid, which saw a dramatic increase in enrollment during the evaluation period due to the Affordable Care Act. Also, MHA have conducted an analysis of all-payer data and suggested National demand modifier should account for Medicaid, which would increase it to 0.28%.
UMMS	UMMS believe HSCRC's retrospective analysis (2013–2023) fails to account for future expectations in terms of both expected demand and total risk. It assumes a 3% national growth rate for the next decade, which is too conservative.
JHHS	JHHS believes the current Demographic Adjustment Policy's reliance on historical growth to set prospective adjustments is problematic because use-rate growth reflects more than demographics. They suggest reconsidering whether future adjustments should be based on historical trends or incorporate actual forward-looking utilization growth estimates for greater accuracy.
Frederick Health	Frederick Health appreciates HSCRC's empirical approach but raises concerns that the analysis understates demographic impacts and overstates practice pattern changes. They question the appropriateness of Medicare Advantage adjustments given Maryland's lower enrollment and note the omission of Medicaid data, which saw significant growth. Additionally, MHA's review of national all-payer data indicates higher utilization growth than HSCRC estimates, supporting the need for a larger national demand modifier.
Adventist	Adventist suggested using quality and access indicators alongside utilization metrics to ensure lower use rates are not achieved at the expense of care quality. They explained that to fully assess whether lower use reflects healthier populations versus constrained access, complementary outcome and throughput indicators should be reviewed in tandem, for example, diabetes prevalence or control, obesity and BMI trends, ambulatory care–sensitive condition rates, ED wait and boarding times, and mortality.
HME	HME cites HSCRC's analysis showing age-adjusted hospital utilization in Maryland decreased by 10%, with outpatient utilization declining even more. They note that global budgets have increased during this period, meaning hospitals have been funded based on outdated utilization patterns. This supports their position that additional demographic funding is unnecessary.

Continue Including Volume Variable Funding in DA Comments

Overall Summary: Stakeholders urge HSCRC to continue to apply Demographic Adjustments to all revenues until the scope of services carved out of Global Budgets is fully established.

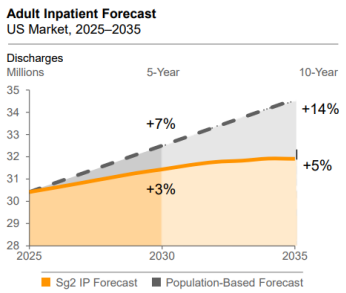
Organization	Summary of Comments
MHA	MHA urges HSCRC to maintain the policy of applying Demographic Adjustments to all revenues.
JHHS	JHHS supports continuing to apply the Demographic Adjustment to all revenues.
Frederick Health	Frederick Health support MHA's request to maintain the policy of applying Demographic Adjustments to all revenues to ensure hospitals are adequately resourced for community needs.
UMMS	UMMS suggests not to discontinue the application of the Demographic Adjustment to volumes that are not part of population-based payments until the definition and methodology treatment of those volumes are known and evaluated on these terms.
Adventist	Adventist does not support moving forward with any carveouts until additional workgroup discussion and analysis occur. Adventist explains that the extent of volumes to be carved out of population-based payments remains under development.

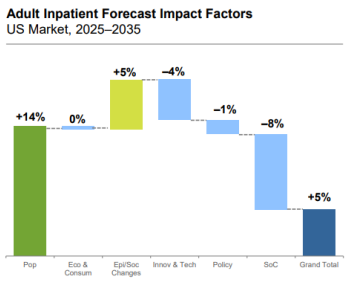
AHEAD Alignment & Other comments

Overall Summary: Stakeholders suggest that the Demographic Adjustment should be aligned with AHEAD methodologies when applicable. Other recommendations include support in postponing HCC risk score application, utilizing variable cost factors, evaluating alternative sources for population data, and incorporating regional variation in Demographic Adjustment.

Organization	Summary of Comments
MHA	MHA recommends that any Demographic Adjustment changes for 2026–2027 be reassessed before CMS takes over Medicare global budgets in 2028 to ensure utilization needs of the changing population. They also urge HSCRC to consider implications of any changes in Demographic Adjustments policy as part of broader discussions about additional exclusions from hospital global budgets under AHEAD.
JHHS	JHHS emphasizes that as Maryland transitions to the AHEAD model, Demographic Adjustment policies must align with future requirements. They recommend reevaluating any changes for 2026–2027, before CMS assumes Medicare global budgets in 2028 to ensure adequacy.
Adventist	Adventist supports postponing HCC risk score application until AHEAD implementation, agrees with staff not to apply a variable cost factor, as it would complicate methodology and distort funding balance, warns that demographic change varies by region, with some markets facing capacity constraints and urges exploring alternative data sources for age-adjusted estimates, presenting ranges or sensitivity analyses to account for uncertainty and strengthen methodology.
UMMS	UMMS suggests establishing the steps and timeline for reviewing potential changes to the Demographic Adjustment Methodology after CMS assumes responsibility for Medicare population under AHEAD.

Methodology for calculating total projected growth based on Sg2 “Impact Factors”





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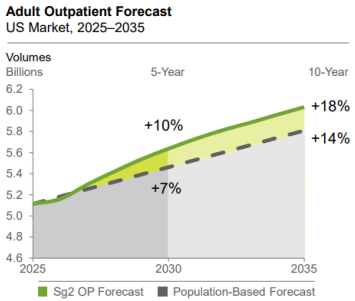

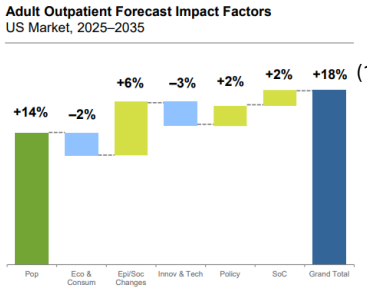

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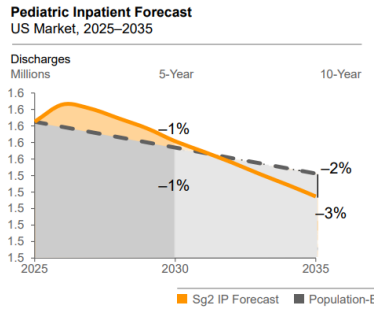

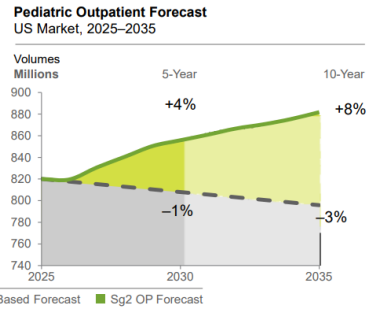

Sg2 IP Forecast Population-Based Forecast Sg2 OP Forecast

Site of Service	Years	Source	SG2 Population + Other Demographic Impacts	SG2 “Impact” Factors	Projected 10-Year Growth
Inpatient	**2025-2035**	**SG2 US 18+**	**14.0%**	**-9.5%**	**4.5%**
Inpatient	2025-2035	Spotlight MD 18+	10.2%		0.7%

Site of Service	Years	Source	SG2 Population + Other Demographic Impacts	SG2 “Impact” Factors	Projected 10-Year Growth
Outpatient	**2025-2035**	**SG2 US 18+**	**14.0%**	**3.4%**	**17.4%**
Outpatient	2025-2035	Spotlight MD 18+	10.2%		13.6%

Site of Service	Years	SG2 Population + Other Demographic Impacts	SG2 Population + Other Demographic Impacts	SG2 “Other” Impact	Projected 10-Year Growth
Inpatient	**2025-2035**	**SG2 US 0-17**	**-3.0%**	**1.0%**	**-2.0%**
Inpatient	2025-2035	Spotlight MD 0-17	-4.0%		-3%
Outpatient	**2025-2035**	**SG2 US 0-17**	**-3.0%**	**11%**	**8.0%**
Outpatient	2025-2035	Spotlight MD 0-17	-4.0%		7%

Note: The “Projected 10-year Growth” column is the first step in both National and MD Calculations on slides 7 and 8.

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Policy Correction Related to FMF Conversions & PAU Volume

December 18, 2025

Funding PAU Shifts related to FMF Conversions

Overview of PAU in Market Shift Policy

- Since the inception of the Maryland Model, the Market Shift Policy has not recognized or funded shifts in Potentially Avoidable Utilization (PAU) because the Commission did not want to:
  - Disincentivize hospitals from reducing readmissions and preventable admissions.
  - Reward hospitals that were unsuccessful in reducing PAU volume.

Potential Exception to this Rule: FMF Conversions

- When **acute-care hospitals convert to Freestanding Medical Facilities (FMFs)**, inpatient PAU volumes automatically shift to other acute care hospitals because FMFs provide only outpatient and emergency care.
- Some of these PAU cases represent necessary care, especially when volumes move after a closure and the new facility has not yet had the opportunity to intervene with the patient population.

Staff has acknowledged transfers of PAU volume during a facility closures or conversion in the past, and moving forward staff will **apply this same logic universally** to all hospitals when a facility converts or closes.

Staff is currently reviewing FMF conversions retrospectively and intends to **provide funding for historical PAU shifts**, where appropriate. Staff has completed the analysis for Laurel and plans to move to Harford next.

High-Level Approach for Funding Calculation

The funding approach will generally follow the **Market Shift Methodology**, applied to PAU volumes only, in the year of the FMF conversion.

Calculation Steps

1. Isolate the **PAU service line** in Market Shift data.
2. In the year of the FMF conversion, identify the jurisdictions (zip codes or counties) that experienced a **decline in YoY PAU volume from the converting facility**.
3. Identify hospitals that experienced **corresponding increases** in PAU volume from the jurisdictions defined in step 2.
4. Apply the inpatient medical **variable cost factor of 57 percent** to the average cost per ECMAD for these volumes to calculate the MSA.
5. Apply **inflation** to the calculated MSA to reflect current year dollars.
6. **Adjust** the amount as needed, based on any prior funding provided to the hospital in connection to the closure.

Preliminary Results from Laurel Analysis

Staff plans to apply the following adjustments to hospitals' Global Budgets related to the 2019 Laurel FMF conversion:

Hospital	PAU Revenue Adjustment
UMMS- Laurel	$ (6,750,583)
Adventist- White Oak	1,477,028
Luminis- Doctors	993,279
JHH- Howard County	858,774
UMMS- Capital Region	812,097
JHH- Johns Hopkins	752,773
UMMS- UMMC	364,743
Trinity - Holy Cross	305,377
Luminis- Anne Arundel	253,978
UMMS- BWMC	238,981
Adventist- Shady Grove	217,828
JHH- Suburban	151,393
MedStar- Southern MD	143,399
MedStar- Montgomery	129,811
Other Hospitals <$100k	708,910
Total Net Adjustment	**$ 657,789**

Note (1): Adventist White Oak calculation based on annualized data from 2019 Q4 since White Oak opened in Q4.
Note (2): Other hospitals includes 30 hospitals with adjustments ranging from $50 to $84,395.