Maryland Hospital Global Budget (HGB) 2025 Simulation

Draft Specifications (*Update June 23, 2026*)

Overview

The 2025 simulation estimates Maryland Fiscal Year 2025 (FY25) hospital global budgets (HGB) by first adjusting baselines for hospitals in the top or bottom quartile of Maryland global budget payments relative to standard Medicare pricing (referred to as Adjusted Inpatient and Outpatient Baseline), then calculating simulated CMS-Designed Performance Year (PY1) HGBs.

CMS is adjusting the baseline to reduce disparities among Maryland hospitals with very high or very low base payment rates. **The baseline is not repriced to Fee-for-Service (FFS) rates**. Instead, IPPS and OPPS FFS rates are used as a benchmark to identify hospitals with relatively low vs high rates, compared with other hospitals in the state. CMMI will continue to refine the adjusted baseline methodology with hospitals in advance of Calendar Year 2028[1]. At which point, CMS will finalize the FY26 baseline[2] and the AHEAD CMS HGB methodology will become the driver of future rate changes.

The following specifications detail the methodology used to produce the 2025 simulation spreadsheet titled '*Add Name'.* Data from the following sheets are referenced in the specifications.

- **Base Payment:** Includes data on Maryland Base Rates, IPPS/OPPS Base Rates, and the calculation of the Base HGB Ratio (see Adjusted Baseline Methodology).
- **Quartiles:** Includes data on the calculation of the adjusted baseline for each hospital, including their quartile placement (see Adjusted Baseline Methodology).
- **Hospital Global Budget:** Displays the calculation of the PY1 HGB by applying adjustments to the baseline (see PY1 HGB Methodology).

Note: Additional data tabs are provided in the spreadsheet. Data sources and notes on each of the additional tabs are provided in ***Appendix B.***

Adjusted Baseline Methodology

The Adjusted Inpatient and Outpatient Baseline is calculated in two steps. First, we calculate each hospital's "base HGB ratio," defined as the ratio of total hospital payments under the Maryland HGB methodology—exclusive of add-on payments such as IME, DSH, UCC, or other one-time adjustments (base rate)—to estimated payments under IPPS/OPPS, also exclusive of add-on payments.

Second, hospital base HGB ratios are compared across all eligible hospitals in the state. The total base payment amount is then adjusted upward or downward for hospitals in the highest or lowest quartile. Add-on payments are added back to the inpatient baseline to preserve supplemental payments.

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[1] As stated in 1d and 12.a.i of the AHEAD Model State Agreement

[2] We will use revenue data from Calendar Year 2025 and Calendar Year 2026 on a 50-50 split to calculate FY 2026 estimates.

Hospital Inclusion Criteria

Only regulated revenue facilities are included in the calculation of adjusted baselines. The following hospital types are excluded:

- Rehabilitation only providers[3]
- Psychiatric only providers
- Long-Term Care providers

Freestanding Medical Facilities and Freestanding Emergency Departments do not receive an HGB. Rather, their revenue is combined into their parent acute care facility's HGB.

Step 1: Calculate the Base HGB Ratio – The Ratio of Maryland HGB Revenue to IPPS/OPPS Revenue (*Excluding Add-On Payments)*

To calculate the Adjusted Inpatient and Outpatient Baselines, we first sort all eligible Maryland hospitals into quartiles by their Base HGB ratio, defined as their FY24 Maryland base rate, divided by estimated IPPS and OPPS base rates.

To calculate the Maryland base rate, we sum inpatient and outpatient revenue[4] and then remove add-on payments. Add-on payments include DSH, IME, DME, UCC, and other one-time Maryland specific adjustments. The add-on payment amounts for DSH, IME, DME, and UCC were provided by the Maryland Health Services Cost Review Commission (HSCRC). One-time Maryland specific adjustment data is from Maryland hospital specific rate files. See **Table 1** for more details.

To calculate the estimated IPPS and OPPS base rates we process claims through an IPPS and OPPS grouper to reprice Medicare claims using standard IPPS and OPPS FFS methodology. Then, the inpatient amount receives a case mix adjustment to account for claims coding practices. This is assessed by calculating the average MS-DRG weight per claim in IDR claims, the average MS-DRG weight per claim in the HSCRC data, then calculating the difference in average MS-DRG weight per claim between both. Add-on payments for DSH, IME, and UCC are then removed. IPPS amounts for IME and DSH are estimated using data from the CMS Impact File. UCC amounts are removed by calculating per-claim UCC amounts using the Maryland HGB totals provided by HSCRC and applying them to the number of discharges. See **Table 2** for more details.

$$\textbf{\textit{Base HGB Ratio}} = \frac{(Maryland\ HGB\ -\ Maryland\ Add\ On\ Payments)}{(IPPS\ Estimated\ Payments - IPPS\ Add\ On\ Payments + OPPS\ Estimated\ Payments)}$$

[3] 210064 and 210058 were excluded from the analysis.

[4] Excluding rehabilitation, chronic, and psychiatric claims. These types of claims are not traditionally paid under IPPS and OPPS, but under different pricing mechanisms such as the IRF PPS for rehabilitation, the LTCH PPS for chronic, and the IPF PPS for psychiatric claims.

Where:

***Time Period*:** The focus of the simulation is on Maryland's FY 2024, which is from July 1, 2023 to June, 30 2024.

Maryland HGB: Total Inpatient Revenue for FY24 (*Col C in BasePayment tab)* + Total Outpatient Revenue (*Col AC in BasePayment tab)* for FY24 as detailed in **Table 2**. Rehabilitation, long-term care, and psychiatric services are not included. This amount represents the paid amount on claims in the CMS IDR so includes the Public Payer Differential and sequestration but excludes beneficiary out-of-pocket costs.

Maryland Add-On Payments: Sum of all carveouts in columns S through Z on the *BasePayment tab* as detailed in **Table 2.**

IME, DSH, and DME data are from the Rate Year 2025 ICC Version 5 file produced by HSCRC. To calculate the final IME, DSH, and DME amounts:

- Resident caps are removed
- Amounts are pro-rated to the Medicare percentage
- Amounts are converted from charges to payments by:
    - Removing the public-payer differential (7.95%)[5]
    - Removing the Inpatient Out of Pocket amount (4%)

Two types of UCC amounts are calculated: the UCC percentage that was applied to inpatient rates, and UCC hospital amounts provided by HSCRC that are adjusted proportionally to estimate their impact on IPPS payments. The former UCC is removed prior to calculating the Base HGB Ratio, and the latter UCC is added back after repricing. These amounts are then run through the national analysis to determine their estimated IPPS total. UCC will continue to be evaluated. In baseline year, MD's aggregate UCC payment will be based on existing methodology and distributed according to methodology above. Annual updates to UCC will be based on national methods analogous to CMS FFS UCC calculations.

Note that while these specifications use Maryland programs' values for IME, DSH, DME, and UCC for simulation purposes, the final baseline that forms the 2028 HGB implementation will draw such data from CMS sources such as hospitals' cost reports and the CMS impact file. Therefore, Maryland hospitals should ensure that cost report submissions are fully transitioned by then to ensure accurate data flows into the calculations.

Maryland one-time add-on payments included in the 2024 rate files were reviewed for inclusion. Each hospital's payments were categorized and treated as described in **Table 1. A** comprehensive list of Maryland one-time adjustments and their categorization can be found in **Appendix A**.

[5] This percentage is weighted from two periods: July 2021 through March 2023: 7.7%; and April 2023 through June 2024: 8.7%

Table 1: Maryland One-Time Adjustment Categories

Category	Description	Examples
Remove – Do Not Reprice	Remove from base-rate, then add back in after repricing adjustment.	Generally, Medicaid funding, grants, population health, and capital[6] payments that should be preserved as they fulfill a similar function to Medicare FFS-affiliated programs. For more details on capital see Appendix C.
Reprice	Do not remove from base-rate. Include in repricing.	Items that would normally be considered part of regular payment rates.
Reverse	Remove from base rates but do not add back in to add-on payments.	Items that CMS will not pay for when shifting to the AHEAD HGB CMS Methodology, including quality programs.

IPPS Estimated Payments: Medicare inpatient portion of the HGB repriced to 100% of Medicare rates using IPPS grouper software. For this analysis, revenue data from Calendar Year 2023 and Calendar Year 2024 were used to calculate estimated IPPS payments based on a 50-50 split.

IPPS Add-On Payments: Estimated IPPS payments for IME, DSH, DME, UCC using source data from the CMS Impact File and Innovation and Complexity procedure codes. IME and DSH amounts are based on the DSH and IME factors in the CMS Impact File applied to estimated case-mix adjusted operating and capital amounts.

OPPS Estimated Payments: Medicare outpatient portion of HGB repriced to 100% of Medicare rates using OPPS grouper software. For the purpose of this analysis, revenue data from Calendar Year 2023 and Calendar Year 2024 were used to calculate estimated OPPS payments based on a 50-50 split.

The 'Base Payment' tab includes the following columns.

[6] CMS will review payments for appropriate inclusion. Population health payments must either align to the Hospital's Population Health Accountability Plan (PHAP) or match the criteria for a Service Line Reduction as listed in the V3.1 Financial Specifications. Capital payments will be assessed on a case-by-case basis. For example, capital payments that meet unmet demand may be entirely preserved, while capital payments to compensate for closed facilities will be evaluated separately.

Table 2: 'Base Payment' Tab Column Definitions

Payment Element	Data Source	Column in 'BasePayment' Tab	Calculation Notes
Provider Name	CMS IDR	A	
CCN	CMS IDR	B	
Maryland FY24 HGB – IP	CMS IDR	E	Medicare inpatient paid amount portion of Maryland global budget. Adjusted for the Medicare Performance Adjustment (MPA) and the Public Payer Differential. Excludes Medicare Advantage and Medicare Secondary Payer. Includes sequestration reduction.
Rehabilitation, Long-Term Care, and Psychiatric Services	HSCRC and IDR	F	Rehabilitation, chronic, and psychiatric services that are part of distinct sub-part units will be excluded from the HGB as they are not traditionally paid under IPPS and OPPS, but under different pricing mechanisms such as the IRF PPS for rehabilitation, the LTCH PPS for chronic, and the IPF PPS for psychiatric claims.
Weighted IP Repricing Ratio	CMS CCW	G	Ratio of Maryland inpatient portion of global budget to 100% Medicare FFS rates calculated using IPPS grouper software.
Weighted OP Repricing Ratio	CMS CCW	H	Ratio of Maryland outpatient portion of global budget to 100% Medicare FFS rates calculated using OPPS grouper software.
Case Mix Adjustment	IDR	I	Adjustment to account for under-coding of Medicare inpatient claims, applied to the case mix applicable portion of each claim
Estimated MD FY24 IP HGB Paid at MC 100% FFS	Calculated	J	Calculated as (E-F)/G * (1+I)
IME Operating as a Pct of Paid	CMS Impact File	K	Calculated as IME operating adjustment amount divided by IPPS base rates plus supplemental payments (IME, DSH, UCC).
IME Capital as a Pct of Paid	CMS Impact File	L	Calculated as IME capital adjustment amount divided by IPPS base rates plus supplemental payments (IME, DSH, UCC).
DSH Operating as a Pct of Paid	CMS Impact File	M	Calculated as DSH operating adjustment amount divided by IPPS base rates plus supplemental payments (IME, DSH, UCC).
DSH Capital as a Pct of Paid	CMS Impact File	N	Calculated as DSH capital adjustment amount divided by IPPS base rates plus supplemental payments (IME, DSH, UCC).

Payment Element	Data Source	Column in 'BasePayment' Tab	Calculation Notes
UCC as a Pct of Paid		O	Calculated using a UCC per claim estimate derived from the Maryland HGB UCC amounts provided by HSCRC. The per-claim amount is multiplied by total Medicare Discharges to calculate a UCC total. We then calculate the share of the UCC total out of the total base rate plus supplemental payments (IME, DSH, UCC).
Est. IME Operating	Calculated	P	Calculated as J * K
Est. IME Capital	Calculated	Q	Calculated as J * l
Est. DSH Operating	Calculated	R	Calculated as J * M
Est. DSH Capital	Calculated	S	Calculated as J * N
Est. UCC (MD UCC w/national methodology)	Calculated	T	Calculated as J * O
MD Innovation and Complexity (At IPPS Rates)	CMS IDR	U	MD paid amount on Medicare inpatient claims with procedure codes matching MD Innovation and Complexity policy divided by column D to adjust for MD payment rates.
Estimated Base IP MC FFS Amount	Calculated	V	Calculated as J – SUM(P:U)
IME	ICC File 2024	W	IME Total x Medicare Pct. Resident cap removed. Amounts are converted to charges by: Removing the public-payer differential (7.95%[7]) and Removing the Inpatient Out of Pocket amount (4%)
DSH	ICC File 2024	X	DSH Total x Medicare Pct. Resident cap removed. Amounts are converted to charges by: Removing the public-payer differential (7.95%) and Removing the Inpatient Out of Pocket amount (4%)
DME	ICC File 2024	Y	DME Total x Medicare Pct
Capital Payments	Unique Costs in Maryland Hospital Rates FY 24 File	Z	Capital Payments for Hospital
UCC Payments (within rate)	HSCRC Provided	AA	4.29% baked into inpatient rates

[7] Equal to 75% of the Public Payer Differential of 7.7% from July 2021 through March 2023 plus 25% of the Public Payer Differential of 8.7% from April 2023 to June 2024.

Payment Element	Data Source	Column in 'BasePayment' Tab	Calculation Notes
UCC Payments (from HSCRC pool)	HSCRC Provided	AB	Supplied by HSCRC. This is the net payment amount for UCC.
Innovation & Complexity	CMS IDR	AC	MD paid amount on Medicare inpatient claims with procedure codes matching MD Innovation and Complexity policy.
Maryland One-Time Adjustments	MD Rate Files	AD	Total Approved Revenue Inflated and Adjusted Approved Revenue Inflated (**See Appendix A** for inclusion details)
Medicare Performance Adjustment (MPA)	IDR	AE	
Total MD Add-On Payments (with UCC within IP rate)	Calculated	AF	Calculated as Sum (W, X, Y, Z, AA, AC, AD) This amount will be removed prior to calculating the base HGB ratio
Total MD Add-On Payments (with UCC from HSCRC)	Calculated	AG	Calculated as Sum (W, X, Y, Z, AB, AC, AD+AE) This amount will be added back in after repricing
Total Reversals	Calculated	AH	This is incorporated after repricing
Maryland IP Base Amount	Calculated	AI	Calculated as (E-F) - AF
Maryland FY24 HGB – OP	CMS IDR	AJ	Medicare outpatient paid amount or portion of Maryland global budget. Excludes Medicare Advantage and Medicare Secondary Payer. Adjusted for the Medicare Performance Adjustment (MPA) and the Public Payer Differential. Includes sequestration reduction.
Estimated MD OP FY24 HGB Paid at MC 100% FFS	Calculated	AK	Calculated as AJ / H
IPPS and OPPS Base	Calculated	AL	Calculated as V + AK
MD IP and OP Base	Calculated	AM	Calculated as AI + AJ
MD IP and OP Base Ratio	Calculated	AN	Calculated as (AI + AJ) / (V + AK)
Maryland Current HGB	CMS IDR	AO	Calculated as (E-F) + AJ

Step 2: Quartile Based Adjustments

After calculating the Base HGB ratio in Step 1 (*Col AN in BasePayment tab)*, hospitals are grouped into quartiles based on their payment ratios:

- **Quartile 1** includes hospitals with the highest Base HGB ratios.
- **Quartile 4** includes those with the lowest Base HGB ratios.

The Maryland base payment amount is then adjusted only for hospitals in Quartiles 1 and 4.

Step 2.1: Rank order all eligible Maryland hospitals in descending order by their base HGB ratio. Split the hospitals into four quartiles where quartile 1 is the top 25% of hospitals (those with the highest base

HGB ratios (*col AN in BasePayment tab*) and quartile 4 is the bottom 25% of hospitals (those with the lowest base HGB ratios). Baseline adjustments are only made for hospitals is quartiles 1 and 4.

- E.g., if the base HGB ratio for the top of quartile 2 is 137% of Medicare FFS rates exclusive of add-on payments, the base Maryland HGB is adjusted in step 2.2 down to this level for any hospital in quartile 1.
- E.g., if the base HGB ratio for the bottom of quartile 3 is 115% of Medicare FFS rates exclusive of add-on payments, the base Maryland HGB is adjusted in step 2.2 up to this level for any hospital in quartile 4.

No change is made for hospitals in quartiles 2 and 3, except to remove selected non-baseline items in column H of the quartiles tab. For these hospitals, the final Inpatient and Outpatient base rates are calculated as follows.

$$\boldsymbol{Inpatient\ Base\ Rate}\ (Col\ F\ in\ Hospital\ Global\ Budget\ Tab)$$
$$= Base\ Rate\ (Col\ F\ in\ Quartiles\ Tab)$$
$$\times \left(\frac{Maryland\ FY24\ HGB - IP\ (Col\ E - F\ BasePayment\ Tab)}{\begin{matrix} Maryland\ FY24\ HGB - IP\ \ (Col\ E - F\ BasePayment\ Tab) + \\ Maryland\ FY24\ HGB - OP\ (Col\ AJ\ BasePayment\ Tab) \end{matrix}} \right)$$
$$- Maryland\ Add\ On\ Payment\ Reversals\ (Col\ AH\ in\ BasePayment\ Tab)$$

$$\boldsymbol{Outpatient\ Base\ Rate}\ (Col\ F\ in\ Hospital\ Global\ Budget\ Tab)$$
$$= Base\ Rate\ (Col\ F\ in\ Quartiles\ Tab)$$
$$\times \left(\frac{Maryland\ FY24\ HGB - OP\ (Col\ AJ\ BasePayment\ Tab)}{\begin{matrix} Maryland\ FY24\ HGB - IP\ \ (Col\ E - F\ BasePayment\ Tab) + \\ Maryland\ FY24\ HGB - OP\ (Col\ AJ\ BasePayment\ Tab) \end{matrix}} \right)$$

Step 2.2: For hospitals in quartiles 1 and 4 calculate the ratio of the hospital's base HGB ratio and that of the hospital with the closest ratio not in quartiles 1 or 4. (For quartile 1, the hospital with the highest ratio in quartile 2. For quartile 4, the hospital with the lowest ratio in quartile 3.) (*Col D in 'Quartiles" tab)*

Step 2.3: Calculate the adjusted baseline payment amount as follows (All columns refer to *'Quartiles' tab*:

$$\boldsymbol{Adjusted\ Base}\ (\boldsymbol{Col\ F}) = \frac{(Maryland\ HGB\ (Col\ E) - Maryland\ Add\ On\ Payments\ (Col\ G))}{Difference\ in\ Ratio\ Calculated\ in\ Step\ 2.2\ (Col\ D)}$$

For example, the Maryland base rate for a hospital in quartile 1 with a ratio that is 5% higher than the quartile threshold, is adjusted by dividing that hospital's Maryland base rate by 1.05.

Step 2.4: Calculate the Inpatient and Outpatient Adjusted Base Rate by calculating the ratio of estimated IPPS payments (exclusive of add-on payments) to estimated OPPS payments and vice-versa and then multiplying the ratio by the Adjusted Base Rate. For the Inpatient Base Rate, add-on payments are added back in. (All columns refer to *'Quartiles' tab unless otherwise noted*)

$$\textbf{\textit{Adjusted Inpatient Base Rate}}\ (Col\ F\ in\ Hospital\ Global\ Budget\ Tab)$$
$$= Adjusted\ Base\ (Col\ F\ in\ Quartiles\ Tab)$$
$$\times \left(\frac{Estimated\ IPPS\ Payments\ (Col\ R\ BasePayment\ Tab)}{Estimated\ IPPS\ Payments\ \ (Col\ R\ BasePayment\ Tab) + Estimated\ OPPS\ Payments\ (Col\ AD\ BasePayment\ Tab)} \right)$$
$$+ Maryland\ Add\ On\ Payments\ (Col\ G\ in\ Quartiles\ Tab)$$
$$- Maryland\ Add\ On\ Payment\ Reversals\ (Col\ H\ in\ Quartlies\ Tab)$$

$$\textbf{\textit{Adjusted Outpatient Base Rate}}\ \ (Col\ G\ in\ Hospital\ Global\ Budget\ Tab$$
$$= Adjusted\ Base(Col\ F\ in\ Quartiles\ Tab)$$
$$\times \left(\frac{Estimated\ OPPS\ Payments\ (Col\ AD\ BasePayment\ Tab)}{Estimated\ IPPS\ Payments\ (Col\ R\ BasePayment\ Tab)\ + Estimated\ OPPS\ Payments\ (Col\ AD\ BasePayment\ Tab)} \right)$$

Table 3 provides a sample calculation for four hospitals all with hypothetical base global budgets of $1m. *The example provided does not include a split between inpatient and outpatient.*

Sequestration is then added back to both Adjusted and non-Adjusted Inpatient and Outpatient Base Rates so that it can be removed at the end of the simulated CMS-Designed HGB calculation. In addition, CMS-Designed HGB carveouts and Maryland's Innovation and Complexity are removed. The CMS-Designed HGB carveout will not exceed 15% of statewide spending each year and will target certain high-cost outpatient drugs and services that are applicable to a variety of hospitals[8].

Table 3: Example Quartile Adjustment Calculation

Hospital	Payment Ratio	Quartile	Ratio vs Quartile Comparison Hospital	Adjusted Base MD FY24 HGB	MD Add-On Payments	Adjusted Total FY24 MD HGB
A	2.0	1	= 2 / 1.6 = 1.25	$1m from col. AF *(BasePayment Tab)* / 1.25 = $800k	$300k from col. AA *(BasePayment Tab)*	$800k + $300k = $1.1m
B	1.8	1	= 1.8 / 1.6 = 1.125	$1m from col. AF *(BasePayment Tab)* / 1.125 = $889k	$500k from col. AA *(BasePayment Tab)*	$889k + $500k = $1.389m
C	1.6	2	*No Adjustment*			
D	1.4	2				
E	1.2	3				
F	1.1	3				
G	1.0	4	= 1.0 / 1.1 = 0.91	$1m from col. AF *(BasePayment Tab)* / .91 = $1.1m	$800k from col. AA *(BasePayment Tab)*	$1.1m + $800k = $1.9m
H	0.8	4	= 0.8 / 1.1 = 0.73	$1m from col. AF *(BasePayment Tab)* / .73 = $1.375m	$200k from col. AA *(BasePayment Tab)*	$1.375m + $200k = $1.575m

[8] CMS is developing a list of HCPCS and MS-DRG codes that will be prospectively carved out of HGBs.

PY1 HGB Calculation

HGB adjustments are then applied to the Adjusted Inpatient and Outpatient Baseline.

For this simulation, three adjustments are applied to the Inpatient and Outpatient Base Rates. More information on these adjustments can be found in Version 3.0 of the HGB AHEAD Model Technical Specifications.

- **Annual Payment Adjustment:** The APA adjusts HGB payments to account for changes in Medicare FFS prices between years. These changes include updates to hospital payments per legislative or administrative policy changes. *(For calculation details see Section 2.2.1 of Version 3.0 of the Technical Specifications)*
- **Demographic Adjustment:** The Demographic Adjustment (DA) is designed to adjust HGBs to reflect changes in both the size and medical risk of the population served by the Participant Hospital. *(For calculation details see Section 2.2.2.3 of Version 3.0 of the Technical Specifications)*
- **Social Risk Adjustment**: The Social Risk Adjustment (SRA) is an upside only adjustment to account for hospital-to-hospital differences in social risk of the beneficiary population. *(For calculation details see Section 2.2.3.1 of Version 3.0 of the Technical Specifications)*

Note: While not included in this simulation, additional adjustments will be applied in PY1 for Maryland hospitals. These include the Service Line Adjustment, Market Shift Adjustment, Outlier Adjustment, and the Performance Based Adjustments. The Outlier Adjustment will be included in future simulations; however the others will not be included in the simulations.

Table 4 provides details on the calculation of the HGB, incorporating each adjustment. The table also shares details on the time periods of the data incorporates in the calculation of each adjustment.

Table 4: Hospital Global Budget Simulation Amount

Item	Adjustment	Column(s) in 'Hospital Global Budget Tab' (Inpatient)	Column(s) in 'Hospital Global Budget Tab' (Outpatient)	PY1 Calculation Dates
A	Adjusted Base Rate	F (*See Step 2.4 Adjusted Inpatient Base Rate)*	G (*See Step 2.4 Adjusted Outpatient Base Rate)*	07/2023-06/2024
B	Annual Payment Adjustment	I	J	PY1: 07/2023-06/2024 BY: 07/2024-06/2025
C = A * (1+B)	HGB with APA	K	L	-
D	Demographic Adjustment	M	M	BY2: 07/2022-06/2023 BY3: 07/2023-06/2024
E = C * (1 + D)	HGB with APA & DA	N	O	-
E	Social Risk Adjustment	P	P	BY3: 07/2023-06/2024

Item	Adjustment	Column(s) in 'Hospital Global Budget Tab' (Inpatient)	Column(s) in 'Hospital Global Budget Tab' (Outpatient)	PY1 Calculation Dates
F = D + (D * E)	Total HGB (Before Sequestration)	Q	R	-
G = F * 0.98	Total HGB (After Sequestration)	S	T	-

Appendix A: Categorization of Maryland HGB One-Time Adjustments

Note: List is not inclusive of all one-time adjustments made to specific hospitals.

Remove – Do Not Reprice Remove from base-rates, then add back in after repricing adjustment	**Reprice** Do not remove from base-rate. Include in repricing	**Reverse** Remove from base rates but do not add back in to add-on payments
• DA Fund • HC Fund • FY24 HMH Revenue Shift • Regional Partnership – Behavioral Health Funding • Regional Partnership – Diabetes Funding • Regional Partnership – CY22 Audit Results • NSP 1 • NSP 2 • CRISP Funding • OPH Dereg Market Shift Reconciliation • Maternal and Child Health • Population Health Workforce Support for Disadvantaged Areas • COVID-19 Community Vaccination Funding Program • LTC Partnership Program • Deregulation Adjustment • Reduction for Associated Drug Deregulation • One-Time Deregulation, Revenue Shift, and Hospital Specific Funding • Permanent Hospital Specific Funding • MHCC Fees • Newborn Testing • OB Closure • RP Temp Transition Funding Adj • Set Aside • Shift of Dental Surgery	• Covid Surge Funding • Cyber Attack • Efficiency Reduction Adjustment • FRA Streamlined Funding • FY 2023 Efficiency metric based on stand in efficiency policy • Hospital Funding for AHEAD Participation • Set Aside (Permanent)	• Readmissions Reduction & Disparity Gap • OncoRx One Time[9] • Net Undercharge Adjustment • Net Overcharge Amounts • MHAC • QBR • Advanced CDS-A Funding for RY24 • High-Cost Drugs Advance • FY24 Systems Savings Adjustment • All-Payer Rate Reduction for TCOC Performance • FY23 One-Time Settle Up • Current Year Price Penalty • OP Infusion and Chemo-Therapy Drug Adjustment (Permanent) • HSCRC Fees • FY24 Readmissions and Reduction & Disparity Gap (Prorated) • RRIP Revenue Impact- Shock Trauma/UMROI

[9] This is reversed because amounts are also captured in "OP Infusion and Chemotherapy Drug Adjustment (Permanent)

Appendix B: Data Sources for Source Data Tabs

Data Table	Data Source(s)	Notes
Carveouts	CMS IDR	AHEAD CMS-Designed Hospital Global Budget included Medicare FFS carveouts for sequestration, cancer drugs, and MD innovation & complexity codes.
APA Inpatient Part 1	CMS Impact File	See AHEAD CMS-Designed Hospital Global Budget Technical Specifications section 2.2.1.1
APA Inpatient Part 2	Calculations	See AHEAD CMS-Designed Hospital Global Budget Technical Specifications section 2.2.1.1
APA Outpatient	CMS Impact File	See AHEAD CMS-Designed Hospital Global Budget Technical Specifications section 2.2.1.2
Social Risk Adjustment	CMS IDR	See AHEAD CMS-Designed Hospital Global Budget Technical Specifications section 2.2.3.1
Mergers-Closures	N/A	Research on closed or merged facilities
MD Global Budget	CMS IDR	AHEAD CMS-Designed Hospital Global Budget included Medicare FFS paid amounts
MD IME DSH	ICC File (RY25 ICC v5 (industry).xls)	HSCRC provided file used to calculate IME and DSH
MD Rehab/Psych/Chronic		HSCRC provided file used to identify DPU claims
Percent Medicare	HSCRC Medicare-Payer Share File (Medicare Payer Share.xlsx)	HSCRC provided file that identifies the portion of each hospital's revenue from Medicare FFS.
MD Adjustment Detail	Master Rate Files	HSCRC Rate Order Files. See hospital specific excel file for file name.

Appendix C: Capital Amounts and Calculation Details.

CCN / FMF CCN	ADJ TYPE	Retained Revenue or Capital (All Payer)	PCT MEDI-CARE FFS	PCT OOP (TTL / OP)[10]	PCT MPA (TTL / OP)[11]	Retained Revenue of Capital Adjusted for Medicare FFS	OOP to Remove	MPA to Remove	PPD[12] to Remove	Final Retained Revenue or Capital
210003 / 210055	FMF or FSED	$ 27,582K	12.9%	10.7% / 27.4%	0.8% / 1.0%	$ 3,546K	$ 972K	$ 35K	$ 282K	$ 2,257K
210008	Capital	$ 15,000K	25.0%	18.2% / 26.8%	7.0% / 7.0%	$ 3,750K	$ 682K	$ 262K	$ 298K	$ 2,508K
210012 / 210013	FMF or FSED	$ 27,300K	16.8%	13.3% / 28.6%	2.9% / 3.1%	$ 4,588K	$1,314K	$ 140K	$ 365K	$ 2,769K
210016	Capital	$ 15,391K	34.6%	10.1% / 27.3%	0.4% / 0.5%	$ 5,325K	$ 539K	$ 23K	$ 423K	$ 4,340K
210017	Capital	$ 650K	40.1%	18.8% / 25.7%	0.5% / 0.4%	$ 261K	$ 49K	$ 1K	$ 21K	$ 190K
210022	Capital	$ 11,934K	40.9%	12.1% / 26.5%	0.0% / 0.0%	$ 4,885K	$ 591K	$ 0K	$ 388K	$ 3,905K
210037 / 210010	FMF or FSED	$ 5,834K	20.3%	15.4% / 26.1%	0.5% / 0.6%	$ 1,186K	$ 309K	$ 7K	$ 94K	$ 776K
210044	Capital	$ 2,098K	31.2%	13.6% / 25.2%	3.9% / 4.0%	$ 655K	$ 89K	$ 26K	$ 52K	$ 487K
210049 / 210006	FMF or FSED	$ 4,035K	24.6%	13.5% / 25.7%	4.3% / 4.4%	$ 994K	$ 255K	$ 43K	$ 79K	$ 616K
210057	Capital	$ 9,200K	28.9%	12.0% / 27.9%	3.9% / 4.1%	$ 2,661K	$ 319K	$ 103K	$ 212K	$ 2,028K

[10] Percent of out-of-pocket costs paid by the bene. Total (TTL) is used when Adjustment Type (ADJ TYPE) is Capital. Outpatient (OP) is used when ADJ TYPE is FMF or FSED

[11] Percent of MPA. Total (TTL) is used when Adjustment Type (ADJ TYPE) is Capital. Outpatient (OP) is used when ADJ TYPE is FMF or FSED

[12] Public Payer Differential (7.95%)