AHEAD Model

Addendum to CMS-Designed Medicare FFS Hospital Global Budget Methodology: Maryland

Version 3.2

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1. Introduction

Maryland (MD) is the only state that currently employs global budgets for hospital payment. MD's use of hospital global budgets (HGB) began in 2014 with the MD All-Payer Model which ran until 2018 when it was replaced by the MD Total Cost of Care (TCOC) model. Because of MD's existing global budget policies and Medicare rate-setting authority (until January 1, 2028), some features of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) HGBs need to be tailored for MD.

As such, this addendum (referred to as 'MD Addendum') identifies which AHEAD HGB policies will differ for MD and then provides detail on the specifications for MD.

1.1 Updates to MD Addendum

Below is a summary of major changes between this version and the June 26, 2026 MD Addendum version:

- **Summary of MD Modifications**. Added Table 1 which summarizes modifications to the National HGB Specifications for MD.
- **MD Hospital-Specific Ratio (HSR)**. Added Section 4 describing the calculation of the HSR which adjusts for the difference between FFS-equivalent payments and the payment levels MD hospitals received in Calendar Year 2026 (CY2026).
- **Baseline Carveouts.** Added Section 5 which notes that carveout methods in MD may deviate from the national methods to conform with the requirements of MD's state participation agreement. Also, carved out services will be reimbursed outside of the HGB on an HSR-adjusted FFS-equivalent basis in MD.
- **Market Shift Adjustment.** Added Section 6 which describes a deviation in the calculation of the Market Shift Allowance for MD. Nationally, the sum of Medicare HGB Payments is defined based on FFS-equivalent payments; however, in MD this amount will be defined as the sum of actual Medicare HGB payments amounts for Participant Hospitals and Medicare FFS payments for Non-Participant Hospitals.
- **Service Line Adjustment (SLA).** Added Section 7 which notes that the methods for valuing SLAs will differ for MD.
- **Outlier Adjustment.** Added Section 8 describing two modifications to the outlier adjustment for MD. First, since MD hospitals' base year payments do not include the outlier adjustment, we will assume that in the baseline MD hospital's outlier share is equal to their share of total Medicare HGB revenue. Second, FFS-equivalent payment amounts will be adjusted by each hospital's HSR when calculating the capital and operating outlier thresholds.
- **Appendix D.** Added a timeline displaying the period of data for each adjustment in each PY.

1.2 Summary of MD Modifications

Table 1 below lists the sections in *Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology v3.2;* henceforth referred to as the '*National HGB*

Specifications.' It also provides an overview of whether and how the policies in each section will differ for MD and identifies where in this MD Addendum hospitals can find the detailed specifications that apply to them. For example, the methods for constructing global budgets for MD will differ from other states. Thus, the table points MD hospitals to Section 2 of this MD Addendum for details. In contrast, the Demographic Adjustment policy for MD will be the same as for other states. Thus, the table points MD hospitals to Section 2.2.2.3 of the *National HGB Specifications*.

CY2026 is the first AHEAD HGB performance year (PY1) for MD. However, in contrast to other participating states that will employ the *National HGB Specifications* in PY1, these methods will not be employed in MD until CY2028 or PY3. To address this MD hospitals should add 2 PYs to timelines detailed in the main body of the *National HGB Specifications*.

Table 1: Applicability of National HGB Specifications for MD

National HGB Specification Section	Criteria Tailored for MD
2.1 Baseline Calculation	
2.1.1. PY1 Baseline Calculation	Not applicable to MD hospitals. See MD Addendum Section 2 below.
2.1.2 Optimizing PY1 Baseline	Not applicable to MD hospitals
2.1.3 Inpatient and Outpatient Baseline Paid Amount	• Not applicable to MD hospitals. See MD Addendum Section 2 below. • While the simulation described in Section 2 below used MD programs' values for IME, DSH, and UCC. CMS will transition to using data from CMS sources such as hospitals' cost reports and the CMS impact file. DGME will be excluded from the HGB. • MD hospitals will receive the Medicare FFS claim-based and passthrough payments listed in *National HGB Specifications* Exhibit D.1 outside of their HGB. according to standard CMS methods except that Participant Hospitals are not eligible for separate payments for services within the global budget for Medicare secondary payer claims.
2.1.4 & 2.1.5 Inpatient and Outpatient Baseline Paid Amount	Carveout method applicable, otherwise not applicable. See MD Addendum Section 5 for MD-specific deviations from the national approach to carveouts.
2.1.6. Payment Floor for CAHs	Will apply to hospitals qualifying as CAHs, though MD currently has none.
2.1.7 Baseline Adjustments	Applicable to MD hospitals, except that baseline calculations for MD will be as described in Section 2 below.
2.1.8 Baseline Estimates	Applicable to MD hospitals
2.2 Annual Trend Update	See subsection notes
2.2.1 Annual Payment Adjustment	• Applicable. Hospital-specific discharges, case mix, IME and DSH are used within the national IPPS and OPPS methods for payment updates. ○ CMS has not finalized policies for transitioning IME, DSH, and UCC related payment updates from MD-specific to national methods.

National HGB Specification Section	Criteria Tailored for MD
	○ MD participation in IPPS quality program adjustments will begin in CY2030 – details for this transition are not final.
2.2.2 Volume-Based Adjustments	See subsection notes
2.2.2.1 Market Shift Adjustment	Applicable with the modification that the Market Shift Allowance is based on the Actual HGB payments for Participant Hospitals. See Section 6 below.
2.2.2.2 Service Line Adjustment	Applicable except MD hospitals will have distinct methods for valuing services. See Section 7 below.
2.2.2.3 Demographic Adjustment	Applicable to MD hospitals.
2.2.2.4 Outlier Adjustment	Applicable to MD hospitals except that in the capital and operating outlier threshold calculations, the Medicare FFS-equivalent payment amounts will be multiplied by the HSR increasing the threshold to reflect the higher Medicare payment rates included in the MD HGBs. See Section 8 below.
2.2.3 AHEAD-Specific Adjustments	See subsection notes
2.2.3.1 Social Risk Adjustment	Applicable to MD hospitals
2.2.3.2 Transformation Incentive Adjustment	MD hospitals are not eligible for the Transformation Incentive Adjustment because they were paid under a global budget prior to the AHEAD model.
2.2.3.3 Adjustments to HGBs Given State Performance on Medicare Fee-for-Service Total Cost of Care Targets	Applicable
2.2.4 Logistical Order of Operations for Annual Trend Updates and AHEAD Specific Adjustments	Applicable
2.3 Performance-Based Adjustment	See subsection notes
2.3.1 Critical Access Hospital Quality Adjustment	MD currently has no CAHs.
2.3.2 Community Improvement Bonus	Applicable to MD hospitals, except that there will be no ramp-up period for the adjustments. MD hospitals will be eligible for up to 0.5% adjustments in PY6 to PY10.
2.3.3 Effectiveness Adjustment	Applicable to MD hospitals, except that there will be no ramp-up period for the adjustments. MD hospitals will be at-risk for up to 2% adjustments in PY4 to PY10.
2.3.4. Total Cost of Care Performance Adjustment	Applicable to MD hospitals.
2.4 Timing and Application of Annual Trend and Performance-Based Adjustments	Not applicable. Timeline in Appendix D will apply to all MD hospitals.
3. Operational	Applicable to MD hospitals

2. Hospital Global Budget Construction

The 2025 simulation estimates MD Fiscal Year 2025 (FY2025) hospital global budgets (HGBs) by adjusting baselines for hospitals in the top or bottom quartile of MD global budget payments relative to standard Medicare pricing (referred to as Adjusted Inpatient and Outpatient Baseline), then calculating simulated CMS-Designed Performance Year 1 (PY1) HGBs.

CMS adjusts the baselines for hospitals in the top and bottom quartile to reduce disparities among MD 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 baseline, and the AHEAD HGB methodology will become the driver of future rate changes.[2]

The following specifications detail the methodology used to produce the FY2025 simulation spreadsheets that were shared with hospitals. Data from the following sheets are referenced in the specifications.

- **Base Payment:** Includes data on MD 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, CMS calculates each hospital's Base HGB Ratio, defined as the ratio of total hospital payments under the MD HGB methodology exclusive of add-on payments such as IME, DSH, UCC, or other one-time adjustments (MD Base Rate) to estimated payments under IPPS/OPPS 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.

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

[2] Per 12b: CMS-Designed Medicare FFS Hospital Global Budget Methodology: Medicare FFS Hospital Global Budgets and Adjustments of the AHEAD Model State Agreement, "CMS will calculate a Participant Hospital's hospital global budget baseline derived from baseline revenue, Medicare Inpatient Prospective System (IPPS) and Medicare Outpatient Prospective System (OPPS) claims data for calendar year 2026 and apply an adjustment factor to PY3 in the form of an annual payment adjustment, as well as other adjustments such as service line adjustments." Should the update factors for 2025 and 2026 exceed the cumulative 2025 and 2026 USPCC trend, CMS will instead either "use a calendar year 2024 baseline revenue amount with an adjustment factor applied to PY3 in the form of an annual payment adjustment" or "implement the alternate baseline option as a pro rata reduction to CY 2026 IPPS and OPPS claims data used in the calculation of the baseline at the individual hospital level."

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

In the 2025 simulation, Freestanding Medical Facilities[4] and Freestanding Emergency Departments do not receive a separate HGB. Rather, their revenue is combined into their parent acute care facility's HGB.

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

To calculate the Adjusted Inpatient and Outpatient Baselines, CMS will sort all eligible MD hospitals into quartiles by their Base HGB Ratio, defined as their FY2024 MD Base Rate, divided by estimated IPPS and OPPS Base Rates.

To calculate the MD Base Rate, CMS will sum inpatient and outpatient revenue[5] and then remove add-on payments. Add-on payments include DSH, IME, DGME, UCC, and other one-time MD specific adjustments. The add-on payment amounts for DSH, IME, DME, and UCC were provided by the MD Health Services Cost Review Commission (HSCRC). One-time MD specific adjustment data is from MD hospital specific rate files. See **Table 2** for more details.

To calculate the estimated IPPS and OPPS Base Rates CMS will 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 calculated as the difference in average MS-DRG weight per claim between claims in IDR and those in the HSCRC data. Add-on payments for DSH, IME, and UCC are then set aside. 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 MD HGB totals provided by HSCRC and applying them to the number of discharges. See **Table 3** for more details.

$$\boldsymbol{MD\ Base\ Rate} = MD\ HGB - MD\ Add\ On\ Payments$$

$$\boldsymbol{Base\ HGB\ Ratio} = \frac{MD\ Base\ Rate}{(IPPS\ Estimated\ Payments - IPPS\ Add\ On\ Payments + OPPS\ Estimated\ Payments)}$$

[3] 210064 and 210058 were excluded from the analysis.
[4] Freestanding medical facilities are eligible for a separate global budget, if requested.
[5] 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 MD's FY2024, which is from July 1, 2023, to June 30, 2024.

MD HGB: Total Inpatient Revenue for FY2024 (*Column C in BasePayment tab*[6]*)* + Total Outpatient Revenue (*Col AC in BasePayment tab*[6]*)* for FY2024 as detailed in Table 3. Rehabilitation, long-term care, and psychiatric services are not included. This amount represents the paid amount on claims in the CMS IDR which includes the Public Payer Differential and sequestration but excludes beneficiary out-of-pocket costs.

MD Add-On Payments: Sum of all carveouts in columns S through Z on the *BasePayment tab*[6] as detailed in Table 3.

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:

- Residents per hospital are identified
- Amounts are pro-rated to the Medicare percentage
- Amounts are converted from charges to payments by:
- Removing the public-payer differential (7.95%)[7]
- Removing the Inpatient Out of Pocket amount (4%)

Two types of UCC amounts are calculated: the UCC percentage that was applied to inpatient and outpatient payments, and UCC hospital net payment amounts provided by HSCRC. 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 MD programs' values for IME, DSH, DME, and UCC for simulation purposes, CMS will transition to drawing such data from CMS sources such as hospitals' cost reports and the CMS impact file.

MD 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 2.** A comprehensive list of MD one-time adjustments and their categorization can be found in **Appendix A**.

[6] This worksheet can be found in the repricing workbooks shared with MD hospitals in June-August 2026.
[7] This percentage is weighted from two periods: July 2021 through March 2023 (7.7%) and April 2023 through June 2024 (8.7%).

Table 2: MD 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[8] 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 *BasePayment tab*[6] includes the following columns.

Table 3: BasePayment Tab Column Definitions[6]

Column in BasePayment Tab	Payment Element	Calculation Notes	Data Source
A	Provider Name		CMS IDR
B	CCN		CMS IDR

[8] 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.

Column in BasePayment Tab	Payment Element	Calculation Notes	Data Source
C	Provider Number ONPI		MD Hospital Rate File
D	Name on Rate Files		MD Hospital Rate File
E	MD FY2024 HGB – IP	Medicare inpatient paid amount portion of MD global budget. Excludes the Public Payer Differential and beneficiary coinsurance. Excludes Medicare Advantage and Medicare Secondary Payer. Includes sequestration reduction.	CMS IDR
F	DPU Amount - Rehabilitation, Long-Term Care, and Psychiatric Services Payments	Medicare inpatient paid amount for rehabilitation, chronic, and psychiatric services that are part of distinct sub-part units. These services 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.	HSCRC and IDR
G	Weighted IP Repricing Ratio	Ratio of MD inpatient portion of global budget to 100% Medicare FFS rates calculated using IPPS grouper software.	CMS CCW
H	Weighted OP Repricing Ratio	Ratio of MD outpatient portion of global budget to 100% Medicare FFS rates calculated using OPPS grouper software.	CMS CCW
I	Case Mix Adjustment	Adjustment to account for potential under-coding of Medicare inpatient claims, applied to the case mix applicable portion of each claim. Calculated as the difference in average MS-DRG weight per claim between claims in IDR and those in the HSCRC data.)	IDR
J	Estimated MD FY2024 IP HGB Paid at MC 100% FFS	Calculated as (E-F)/G * (1+I)	Calculated
K	IME Operating as a Pct of Paid	Calculated as IME operating adjustment amount divided by IPPS Base Rates plus supplemental payments (IME, DSH, UCC).	CMS Impact File

Column in BasePayment Tab	Payment Element	Calculation Notes	Data Source
L	IME Capital as a Pct of Paid	Calculated as IME capital adjustment amount divided by IPPS Base Rates plus supplemental payments (IME, DSH, UCC).	CMS Impact File
M	DSH Operating as a Pct of Paid	Calculated as DSH operating adjustment amount divided by IPPS Base Rates plus supplemental payments (IME, DSH, UCC).	CMS Impact File
N	DSH Capital as a Pct of Paid	Calculated as DSH capital adjustment amount divided by IPPS Base Rates plus supplemental payments (IME, DSH, UCC).	CMS Impact File
O	UCC as a Pct of Paid	Calculated using a UCC per claim estimate derived from the MD 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).	HSCRC
P	Est. IME Operating	Calculated as J * K	Calculated
Q	Est. IME Capital	Calculated as J * L	Calculated
R	Est. DSH Operating	Calculated as J * M	Calculated
S	Est. DSH Capital	Calculated as J * N	Calculated
T	Est. UCC (MD UCC w/national methodology)	Calculated as J * O	Calculated
U	MD Innovation and Complexity (At IPPS Rates)	MD paid amount on Medicare inpatient claims with procedure codes matching MD Innovation and Complexity policy divided by column G to adjust for MD payment rates.	CMS IDR
V	Estimated Base IP MC FFS Amount	Calculated as J – SUM(P:U)	Calculated
W	IME	IME Total x Medicare Pct. Amounts are adjusted by: Removing the public-payer differential (7.95%[9]) and Removing the Inpatient Out of Pocket amount (4%)	ICC File 2024
X	DSH	DSH Total x Medicare Pct. Amounts are adjusted by: Removing the public-payer differential (7.95%) and Removing the Inpatient Out of Pocket amount (4%)	ICC File 2024
Y	DME	DME Total x Medicare Pct	ICC File 2024
Z	Capital Payments	Capital Payments for Hospital	Unique Costs in MD Hospital Rates FY 2024 File
AA	UCC Payments (within rate)	Column E – F + AJ * 4.29% to yield the UCC payment amount baked into inpatient rates	HSCRC Provided

[9] 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.

Column in BasePayment Tab	Payment Element	Calculation Notes	Data Source
AB	UCC Payments (from HSCRC pool)	Supplied by HSCRC. This is the estimated Medicare share of the net payment amount for UCC.	HSCRC Provided
AC	Innovation & Complexity	MD paid amount on Medicare inpatient claims with procedure codes matching MD Innovation and Complexity policy.	CMS IDR
AD	MD One-Time Adjustments	Total Approved Revenue Inflated and Adjusted Approved Revenue Inflated (**See Appendix A** for inclusion details)	MD Rate Files
AE	Medicare Performance Adjustment (MPA)		IDR
AF	Total MD Add-On Payments (with UCC within IP rate)	Calculated as SUM(W, X, Y, Z, AA, AC, AD) This amount will be removed prior to calculating the base HGB ratio	Calculated
AG	Total MD Add-On Payments (with UCC from HSCRC)	Calculated as SUM(W, X, Y, Z, AB, AC, AD,AE) This amount will be added back in after repricing	Calculated
AH	Total Reversals	This is incorporated after repricing	Calculated
AI	MD IP Base Amount	Calculated as (E-F) - AF	Calculated
AJ	MD FY2024 HGB – OP	Medicare outpatient paid amount or portion of MD global budget. Excludes Medicare Advantage and Medicare Secondary Payer. Adjusted for the Medicare Performance Adjustment (MPA) and the Public Payer Differential. Includes sequestration reduction.	CMS IDR
AK	Estimated MD OP FY2024 HGB Paid at MC 100% FFS	Calculated as AJ / H	Calculated
AL	IPPS and OPPS Base	Calculated as V + AK	Calculated
AM	MD IP and OP Base	Calculated as AI + AJ	Calculated
AN	MD IP and OP Base Ratio	Calculated as (AI + AJ) / (V + AK)	Calculated
AO	MD Current HGB	Calculated as (E-F) + AJ	CMS IDR

Step 2: Quartile Based Adjustments

After calculating the Base HGB ratio in Step 1 (*Column AN in BasePayment tab*[6]), 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 MD base payment amount is then adjusted only for hospitals in Quartiles 1 and 4.

Step 2.1: Rank order all eligible MD 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 (*Column AN in BasePayment tab*[6]) 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), in Step 2.2, the base MD HGB is adjusted 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), in Step 2.2, the base MD HGB is adjusted 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.

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

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

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, CMS uses the hospital with the highest ratio in quartile 2. For quartile 4, CMS uses the hospital with the lowest ratio in quartile 3. (*Column D in Quartiles tab)*

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

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

For example, the MD 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 MD 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)

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

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

Table 4 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 MD's Innovation and Complexity are removed.

Table 4: Example Quartile Adjustment Calculation

Hospital	Payment Ratio	Quartile	Ratio vs Quartile Comparison Hospital	Adjusted Base MD FY2024 HGB	MD Add-On Payments	Adjusted Total FY2024 MD HGB
A	2.0	1	= 2 / 1.6 = 1.25	$1M from Column AF *(BasePayment Tab)* / 1.25 = $800K	$300K from Column AA *(BasePayment Tab)*	$800K + $300K = $1.1M
B	1.8	1	= 1.8 / 1.6 = 1.125	$1M from Column AF *(BasePayment Tab)* / 1.125 = $889K	$500K from Column 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 Column AF *(BasePayment Tab)* / .91 = $1.1M	$800K from Column AA *(BasePayment Tab)*	$1.1M + $800K = $1.9M
H	0.8	4	= 0.8 / 1.1 = 0.73	$1M from Column AF *(BasePayment Tab)* / .73 = $1.375M	$200K from Column AA *(BasePayment Tab)*	$1.375M + $200K = $1.575M

3. Simulation Period 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.

- **Annual Payment Adjustment:** The Annual Payment Adjustment (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 National HGB 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 National HGB 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 National HGB Specifications)*

Note: While not included in this simulation, the SLA will be applied in PY3 for MD hospitals who have anticipated or observed service line changes during CY2026 through CY2028.

Table 5 details the calculation of the HGB, incorporating each adjustment. The table also shares details on the time periods of the data incorporated in the calculation of each adjustment.

Table 5: 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
F = D + (D * E)	Total HGB (Before Sequestration)	Q	R	-
G = F * 0.98	Total HGB (After Sequestration)	S	T	-

4. MD Hospital-Specific Ratio

For each MD hospital, CMS will calculate the MD Hospital-Specific Ratio (HSR). The HSR will be used to adjust FFS-equivalent payments to align with the hospital's payment levels in HSCRC's MD HGBs relative to Medicare FFS-equivalent in the CY2026 baseline year[10] after the repricing adjustment detailed above in Section 2. The HSR is equal to the hospital's baseline HGB[11] relative to Medicare FFS-equivalent payments for the same services. The HSR for each hospital may be adjusted in future years at CMS' discretion.

5. Inpatient and Outpatient Carveouts

CMS will carve out highly specialized inpatient DRGS and high-cost outpatient drugs (identified by HCPCS code) from the HGB to preserve the incentive for hospitals to provide high-cost care to high-acuity patients (See *National HGB Specifications* Sections 2.1.4 and 2.1.5). The list of carved out services for MD may deviate from those in national model to conform with the

[10] Or Alternate Baseline Option as detailed in 12.b of the AHEAD Model State Agreement.

[11] The baseline HGB amount includes the quartile based repricing adjustment and any applicable SLAs, but excludes the APA and DA. CMS has not set a final policy for transitioning the baseline medical education and UCC/DSH payments to national methods. Final policies for these payments may affect calculation of the baseline HGB.

requirements of MD's state participation agreement. The carveout will not exceed 15% of in-state, all-payer Acute Care Hospital Revenue each year per the Hospital Participation Requirements detailed in the AHEAD Model State Agreement.[12] Carved out services will be reimbursed outside of the HGB on an HSR-adjusted FFS-equivalent basis in each subsequent PY.

6. Market Shift Adjustment

The MSA adjustment policy in the *National HGB Specifications* (see Section 2.2.2.1) will apply to MD hospitals except for the updates in the excerpt below:

Calculate the MSA Shift Allowance Available for the Hospital-Specific Market Area

The MSA Shift Allowance is the maximum amount of dollars that can shift between Eligible Hospitals in the Hospital-Specific Market Area. For each hospital, it is equal to the sum of actual Medicare payment amounts for services included in the HGB provided to beneficiaries residing in the hospital's Hospital-Specific Market Area's Zip Codes by the hospital itself or by other hospitals whose Hospital-Specific Market Area Overlaps with those Zip Codes, adjusted by the State Growth Benchmark (inpatient and/or outpatient trend) and a Funding Factor of 80 percent.

$$(\boldsymbol{Eq.1})\ \boldsymbol{MSA\ Shift\ Allowance_i} = \sum_{j=1}^{j=n} s_j * State\ Growth\ Benchmark * Funding\ Factor$$

Where,

n = Number of Hospitals is the total number of hospitals with a Hospital-Specific Market Area with Zip Codes that Overlap with the Zip Codes of the Hospital-Specific Market Area of the hospital being analyzed.

s = Sum of Medicare HGB Payments is the sum of actual Medicare HGB payments amounts for Participant Hospitals and Medicare FFS payments for Non-Participant Hospitals for services included in the HGB provided to beneficiaries residing in the Zip Codes for the Hospital-Specific Market Area by all hospitals whose Hospital-Specific Market Area overlaps those Zip Codes.

State Growth Benchmark is the AHEAD state or region wide trend factor applied to the MSA Shift Allowance to recognize growth from one year to the next. The selected State Growth Benchmark is used for the second of two years included in the MSA. For more information, refer to the Total Cost of Care Adjustment (See National HGB Specifications **Section 2.3.4**).

Funding Factor is a multiplier applied to the MSA Shift Allowance to recognize the costs for moving volume from one location to another. The higher the Funding Factor the higher the MSA

[12] Per 8b: Hospital Participation Requirements of the AHEAD Model State Agreement, "For PY1 and PY2, the State must ensure that at least 85 percent of all in-state, all-payer, Acute Care Hospital Revenue for Maryland residents is paid to Participant Hospitals according to the CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology as described in Section 11. For PY3 and each subsequent PY, the State must ensure that at least 85 percent of all in-state, all-payer, Acute Care Hospital Revenue for Maryland residents is paid to Participant Hospitals according to the CMS-Designed Hospital Global Budget Methodology for Medicare FFS, as described in Section 12, and Hospital Global Budgets for Maryland Payers."

Shift Allowance. The MSA's Funding Factor is set at 80 percent to cover the incremental cost of the volume shift between hospitals. CMS may revisit the value of the Funding Factor to balance payment stability against the need to recognize changes in volume.

Calculate the Proportional Shift in FFS and Weights for the Hospital within its Hospital-Specific Market Area

The MSA is determined based on the hospital's year-over-year change in share or proportional shift in FFS-equivalent dollars and weights within its Hospital-Specific Market Area. The proportional shift is calculated for FFS-equivalent dollars and weights separately and is then combined as a 50/50 weighted average between the change in the two proportions. Including both the FFS dollars and the case mix in the MSA recognizes outliers and other payments that are important to hospitals along with weights, which measure the resources used by the hospital to provide certain services.

The FFS Payment Proportional Shift is the change in the hospital's FFS-equivalent dollars, as a proportion of the Total Market Area FFS-equivalent dollars between the two time periods included in the MSA.

$$(\boldsymbol{Eq.2})\ \boldsymbol{FFS\ Payment\ Proportional\ Shift} = \frac{Hospital\ FFS\ Payment_{\ Year2}}{Total\ Market\ Area\ FFS\ Payment_{\ Year2}} - \frac{Hospital\ FFS\ Payment_{\ Year1}}{Total\ Market\ Area\ FFS\ Payment_{\ Year1}}$$

Where,

Hospital FFS Payment = The estimated (for Participant Hospitals) or actual Medicare FFS dollars (for Non-Participant) for hospital services included in the HGB provided by the hospital itself to beneficiaries residing in the Hospital-Specific Market Area Zip Codes.

Total Market Area FFS Payment = The sum of estimated (for Participant) or actual FFS dollars (for non-Participant) for hospital services included in the HGB for beneficiaries residing in the Hospital-Specific Market Area Zip Codes provided by the hospital itself or by other hospitals whose Hospital-Specific Market Areas overlap with those Zip Codes.

The weights proportional shift is the change in the hospital's APC or MS-DRG weights, as a proportion of the Total Market Area's weights between the two time periods.

$$(\boldsymbol{Eq.3})\ \boldsymbol{FFS\ Weights\ Proportional\ Shift} = \frac{Hospital\ Weights_{\ Year2}}{Total\ Market\ Area\ Weights_{\ Year2}} - \frac{Hospital\ Weights_{\ Year1}}{Total\ Market\ Area\ Weights_{\ Year1}}$$

Where,

Hospital Weights = The total weights for Medicare No-Pay or Medicare FFS claims for services provided to beneficiaries residing in the Hospital-Specific Market Area Zip Codes by the hospital

itself. In Medicare payment methodologies, weights are a measure of resource use and are typically multiplied by a conversion factor or base rate to produce a payment amount in dollars. For the global budget, all services including those not normally paid using MS-DRGs or APCs are weighted using MS-DRGs or APCs as described below. As noted above, the MSA is calculated separately for inpatient and outpatient services because they have different weighting systems.

Inpatient services are weighted using the following:

- **MS-DRG Weights:** The MS-DRG system is used to classify inpatient services based on the patient's diagnosis, the severity of the illness, and the procedures performed. Each MS-DRG is assigned a weight that reflects the relative resource use required to treat patients in that group. These are updated annually using historical cost data and adjusted for geographic factors. Although CAHs are not paid using MS-DRGs, CMS assigns MS-DRG weights to these claims that can be used in the MSA. DRG weights are not provided for CAH swing beds services, however these are grouped using IPPS pricing software to assign MS-DRG weights.

Outpatient services are weighted using the following:

- **APC Weights:** APCs are used to group outpatient services into clinically coherent categories with similar resource utilization. Each APC is assigned a weight, which reflects the relative cost of providing a service within that classification. The weight is calculated based on the average cost of all procedures within the APC group, adjusted for geographic cost differences.
- **Weighting for ASP/AWP Drugs:** Part B drug claims paid via Average Sale Price (ASP) or Average Wholesale Price (AWP) are outside of the OPPS APC payment mechanism and these claims are not normally assigned APC weights. ASP/AWP drugs are assigned an APC weight by dividing all APC claim weights by all APC HOPD payments to calculate a scale factor that represents the average Medicare payment per unit of APC weight. ASP/AWP payments on No-Pay or Medicare FFS claims are then multiplied by that scale factor to convert ASP/AWP prices to APC relative values. Drugs paid through ASP/AWP are included except for certain oncology drugs that are carved out of HGBs.

Total Market Area Weights = The sum of hospital weights for services included in the HGB for beneficiaries residing in the Hospital-Specific Market Area Zip Codes provided by the hospital itself or other hospitals whose Hospital-Specific Market Areas include those Zip Codes.

After calculating the FFS Payments Proportional Shift and the Weights Proportional Shift, an overall weighted proportional shift is calculated. The weighting is evenly split 50 percent toward FFS payments and 50 percent toward weights.

$$(\boldsymbol{Eq.4})\ \boldsymbol{Proportional\ Shift} = (FFS\ Payments\ Proportional\ Shift * 50\%) + (FFS\ Weights\ Proportional\ Shift * 50\%)$$

An example of the calculation of the proportional shift in FFS and weights for a hospital within its Hospital-Specific Market Area is provided in **Table 6.a and 6.b**. As shown below, Weights and FFS Payments for Hospital-Specific Market Area hospitals are summed to calculate total MSA weights and dollars for Hospital 1's MSA. The proportional change in volume at other hospitals is not displayed because it is not used to calculate Hospital 1's proportional shift.

Table 6.a: AHEAD MSA Proportional Shift Example for a Single Hospital – Case Weights

Hospital Number	Year 1 Weight (A)	Year 2 Weight (B)	Year 1 Prop of Weight (C) = A/(Sum of A)	Year 2 Prop of Weight (D) =B/(Sum of B)	Shift in Proportion of Weights (E) =D-C
1	200	270	50.0%	56.8%	**+ 6.8%**
2	90	100	x	X	x
3	50	40	x	X	x
4	45	50	x	X	x
5	0	5	x	X	x
6	15	10	x	X	x
Total	400	475			

Table 6.b: AHEAD MSA Proportional Shift Example for a Single Hospital – FFS Payments

Hospital Number	Year 1 HGB Payments (F)	Year 2 HGB Payments (G)	Year 1 FFS Payments (H)	Year 2 FFS Payments (I)	Year 1 Prop of FFS Payments (J) = H/(Sum of H)	Year 2 Prop of FFS Payments (K) =I/(Sum of I)	Shift in Proportion of FFS Payments (L) =I-H
1	$7,750,000	$9,300,000	$5,000,000	$6,000,000	55.6%	59.1%	**3.5%**
2	$2,960,000	$3,108,000	$2,000,000	$2,100,000	x	x	x
3	$1,584,000	$1,232,000	$900,000	$700,000	x	x	x
4	$1,040,000	$1,300,000	$800,000	$1,000,000	x	x	x
5	$0	$105,000	$0	$100,000	x	x	x
6	$489,000	$407,500	$300,000	$250,000	x	x	x
Total	**$13,823,000**	**$15,452,500**	**$9,000,000**	**$10,150,000**			

Convert Proportional Shift in Weights and FFS Payments to MSA Amount

Each Participant Hospital's MSA amount is the weighted proportional shift of FFS payments and weights multiplied by the MSA Shift Allowance.

$$(\boldsymbol{Eq.5})\ \boldsymbol{Hospital\ MSA\ Amount} = Proportional\ Change \times MSA\ Shift\ Allowance$$

Small hospitals, particularly those with rural Hospital-Specific Market Areas, may experience unpredictable downward volume shifts year-over-year that may disproportionately destabilize the fixed nature of prospective HGBs and pose financial risk due to larger than anticipated

reductions to HGBs after accounting for MSA. To provide additional payment stability in HGBs for smaller hospitals, an MSA floor of zero percent is set for hospitals below a threshold of two percent of an AHEAD state's or sub-state region's total Medicare payments, making the MSA upward only. This threshold is assessed and applied annually to each performance year. The MSA floor limits the size of any downward reduction to HGBs that can be applied as the result of the MSA for hospitals where the floor is applicable. For example, a zero percent MSA floor and threshold of two percent means that any hospital with less than a two percent share of total FFS dollars cannot receive a downward adjustment from the MSA.

Table 7 provides an example of an MSA calculation that converts the proportional shift to an MSA adjustment amount for a hospital. The Proportional Shift (Item A) is calculated based on the case mix and FFS payment Proportional Shifts from Table 6.a and 6.b. The Year 2 Total Market Area Payments (Item B) are calculated as the sum of Year 2 HGB Payments from column G in Table 6.b. These Payments exceed the FFS-equivalent payments because the payments to MD hospitals under the HGB generally exceed FFS-equivalent amounts. For this example, the State Growth Benchmark is assumed to be 1.05 and the Funding Factor is 80 percent.

Table 7: AHEAD MSA Proportional Shift Example for a Single Hospital

Item	Variable	Weights (1)	FFS (2)	Total (3)
A	Proportional Shift	6.8%	3.5%	=(A1 * 50%) + (A2 * 50%) = 5.2%
B	Year 2 Total Market Area HGB (for Participant Hospitals) and FFS (for non-Participant Hospitals) Payments	Blank on Purpose	Blank on Purpose	$15,452,500
C	State Growth Benchmark			1.05
D	Funding Factor	Blank on Purpose	Blank on Purpose	80%
E	MSA Shift Allowance			= B3 * C3 * D3 = $15,452,500 * 1.05 * 80% = $12,980,100
F	MSA Amount	Blank on Purpose	Blank on Purpose	= A3 * E3 = 5.2% * $12,980,100 = $674,965

7. Service Line Adjustment

The Service Line Adjustment (SLA) policy in the *National HGB Specifications* (see Section 2.2.2.2) will apply to MD hospitals except that the methods for valuing service line additions and reductions detailed in subsections d.1.2, d.1.3, d.2.2, d.2.6, and d.2.7 of Section 2.2.2.2 may vary from the FFS-equivalent used nationally. In the future, CMS will provide guidance on how the SLA should be valued for MD.

8. Outlier Adjustment

The Outlier Adjustment policy in the *National HGB Specifications* (see Section 2.2.2.4) will apply to MD hospitals with two adjustments. First, since MD hospitals' base year payments do not include the outlier adjustment, we will assume that in the baseline MD hospital's outlier share is equal to their share of total revenue. Second, FFS-equivalent payment amounts will be adjusted by each hospital's HSR when calculating the capital and operating outlier thresholds. This will increase the outlier thresholds to account for the higher Medicare payment levels in MD relative to FFS-equivalent. The excerpt below from the *National HGB Specifications* reflects these adjustments.

Overview

In Medicare FFS, IPPS and OPPS Outlier Adjustments provide additional payment to hospitals to mitigate the financial risk associated with encounters that are unusually expensive and resource intensive. IPPS and OPPS outlier payments serve as a protection mechanism for hospitals, ensuring they can continue to provide high-quality care to patients with exceptional medical needs without jeopardizing their financial stability. Mirroring the IPPS and OPPS outlier policies, the HGB Outlier Adjustment protects Participant Hospitals against changes in the frequency or intensity of outlier cases between PYs. This approach recognizes and compensates Participant Hospitals for treating exceptionally high-cost patients.

The Outlier Adjustment is estimated by applying the IPPS and OPPS outlier policies to no-pay claims submitted for HGB services. When these policies are applied to calculate the operating and capital outlier thresholds for each claim, the Medicare FFS-equivalent payment amounts for the claim are multiplied by the hospital's HSR.

9. Community Improvement Bonus and Effectiveness Adjustment

National HGB Specification Exhibits 42-43 and Exhibit 45-46 do not apply to MD Hospitals. Community Improvement Bonus (CIB) targets for HWR and PQI-90 will be constant from PY6 to PY10 as shown in Table 8 and 9, respectively.

Table 8 CIB Earned for Meeting HWR Improvement Targets in PY6 – PY10 (based on PY4 – PY8 Performance)

CIB Earned (% of HGB Payments)	PY6-PY10
0.00%	0.00%
0.03%	0.10%
0.05%	0.20%
0.08%	0.30%
0.10%	0.40%
0.13%	0.50%

CIB Earned (% of HGB Payments)	PY6-PY10
0.15%	0.60%
0.18%	0.70%
0.20%	0.80%
0.23%	0.90%
0.25%	1.00%

Table 9: CIB Earned for Meeting PQI-90 Improvement Targets in PY6 – PY10 (based on PY4 – PY8 Performance)

CIB Earned (% of HGB Payments)	PY6-PY10
0.00%	0.00%
0.03%	0.50%
0.05%	1.00%
0.08%	1.50%
0.10%	2.00%
0.13%	2.50%
0.15%	3.00%
0.18%	3.50%
0.20%	4.00%
0.23%	4.50%
0.25%	5.00%

Effectiveness Adjustment rates will be constant from PY4-PY10 for all hospital types (Table 10).

Table 10: Effectiveness Adjustment by Performance Year for All MD Hospitals, PY4-PY10 (*All Values Negative*)

Percentile Range								
<20	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-89**	**90-100**
0.00%	0.25%	0.50%	0.75%	1.00%	1.25%	1.50%	1.75%	2.00%

Appendix A: Categorization of MD 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 • FY2024 HMH Revenue Shift • NSP 1 • NSP 2 • CRISP Funding • OPH Deregulation Market Shift Reconciliation • Deregulation Adjustment • Reduction for Associated Drug Deregulation • Permanent Hospital Specific Funding • MHCC Fees • Newborn Testing	• Covid Surge Funding • Cyber Attack • Efficiency Reduction Adjustment • FRA Streamlined Funding • FY2023 Efficiency metric based on stand in efficiency policy • Hospital Funding for AHEAD Participation • Set Aside (Permanent)	• Readmissions Reduction & Disparity Gap • OncoRx One Time[13] • Net Undercharge Adjustment • Net Overcharge Amounts • MHAC • QBR • Advanced CDS-A Funding for RY24 • High-Cost Drugs Advance • FY2024 Systems Savings Adjustment • All-Payer Rate Reduction for TCOC Performance • FY2023 One-Time Settle Up • Current Year Price Penalty • OP Infusion and Chemo-Therapy Drug Adjustment (Permanent) • HSCRC Fees • FY2024 Readmissions and Reduction & Disparity Gap (Prorated) • RRIP Revenue Impact- Shock Trauma/UMROI • Medicaid Budget Assessment • MD Healthcare Coverage Fund • MHCC User Fees • Health Benefit Exchange • FQHC Funding • UCC Fund Reserve • Regional Partnership – Behavioral Health Funding • Regional Partnership – Diabetes Funding • Regional Partnership – CY2022 Audit Results • Maternal and Child Health • Population Health Workforce

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

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
		Support for Disadvantaged Areas • COVID-19 Community Vaccination Funding Program • LTC Partnership Program • One-Time Deregulation, Revenue Shift, and Hospital Specific Funding • OB Closure • RP Temp Transition Funding Adj • Set Aside • Shift of Dental Surgery

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)[14]	PCT MPA (TTL / OP)[15]	Retained Revenue of Capital Adjusted for Medicare FFS	OOP to Remove	MPA to Remove	PPD[16] 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

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

[15] 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

[16] Public Payer Differential (7.95%)

Appendix D: Timing and Application of Annual and Performance-Based Adjustments to the HGB for MD Hospitals

Item	Adjustment	PY 3 (CY2028)	PY4 (CY2029)	PY5 (CY2030)	PY6 (CY2031)	PY7 (CY2032)	PY8 (CY2033)	PY9 (CY2034)	PY10 (CY2035)
A	Base HGB	Base HGB	PY3 HGB w. Annual & DA (Row H)	PY4 HGB w. Annual & DA (Row H)	PY5 HGB w. Annual & DA (Row H)	PY6 HGB w. Annual & DA (Row H)	PY7 HGB w. Annual & DA (Row H)	PY8 HGB w. Annual & DA (Row H)	PY9 HGB w. Annual & DA (Row H)
B	SLA	$ Planned Service Line Changes CY2027 or CY2028	$ Planned Service Line Changes CY2029	$ Planned Service Line Changes CY2030	$ Planned Service Line Changes CY2031	$ Planned Service Line Changes CY2032	$ Planned Service Line Changes CY2033	$ Planned Service Line Changes CY2034	$ Planned Service Line Changes CY2035
C	Market Shift Adjustment (MSA)	NA	CY2027-CY2026	CY2028-CY2027	CY2029-CY2028	CY2030-CY2029	CY2031-CY2030	CY2032-CY2031	CY2033-CY2032
D	Outlier Adjustment	NA	NA	CY2028 CY2027	CY2029-CY2028	CY2030-CY2029	CY2031-CY2030	CY2032-CY2031	CY2033-CY2032
E = A + B + C + D	HGB Adjusted for Volume	PY3 HGB Adj for Volume	PY4 HGB Adj for Volume	PY5 HGB Adj for Volume	PY6 HGB Adj for Volume	PY7 HGB Adj for Volume	PY8 HGB Adj for Volume	PY9 HGB Adj for Volume	PY10 HGB Adj for Volume
F	Annual Payment Adjustment (APA)	CY2028/ CY2026	CY2029/ CY2028	CY2030/ CY2029	CY2031/ CY2030	CY2032/ CY2031	CY2033/ CY2032	CY2034/ CY2033	CY2035/ CY2034
G	Demographic Adjustment (DA)	CY2028/ CY2026	CY2029/ CY2028	CY2030/ CY2029	CY2031/ CY2030	CY2032/ CY2031	CY2033/ CY2032	CY2034/ CY2033	CY2035/ CY2034
H = E * (1 + F) *(1 + G)	HGB with APA & DA	PY3 HGB w/ Annual & DA	PY4 HGB w/ Annual & DA	PY5 HGB w/ Annual & DA	PY6 HGB w/ Annual & DA	PY7 HGB w/ Annual & DA	PY8 HGB w/ Annual & DA	PY9 HGB w/ Annual & DA	PY10 HGB w/ Annual & DA
I	Social Risk Adjustment (SRA)	Up to 2.0% Based on CY2026	Up to 2.0% Based on CY2027	Up to 2.0% Based on CY2028	Up to 2.0% Based on CY2029	Up to 2.0% Based on CY2030	Up to 2.0% Based on CY2031	Up to 2.0% Based on CY2032	Up to 2.0% Based on CY2033
J = H + (H * I)	HGB after Annual Updates	PY3 HGB after Annual Updates	PY4 HGB after Annual Updates	PY5 HGB after Annual Updates	PY6 HGB after Annual Updates	PY7 HGB after Annual Updates	PY8 HGB after Annual Updates	PY9 HGB after Annual Updates	PY10 HGB after Annual Updates

Item	Adjustment	PY 3 (CY2028)	PY4 (CY2029)	PY5 (CY2030)	PY6 (CY2031)	PY7 (CY2032)	PY8 (CY2033)	PY9 (CY2034)	PY10 (CY2035)
K	Effectiveness Adjustment (EA)[17]	NA	NA	Up to (2.00%) Based on CY2028	Up to (2.00%) Based on CY2029	Up to (2.00%) Based on CY2030	Up to (2.00%) Based on CY2031	Up to (2.00%) Based on CY2032	Up to (2.00%) Based on CY2033
L	Community Improvement Bonus (CIB)[18]	NA	NA	NA	Up to 0.50% Based on PY2029/ CY2026	Up to 0.50% Based on PY2030/ CY2026	Up to 0.50% Based on PY2031/ CY2026	Up to 0.50% Based on PY2032/ CY2026	Up to 0.50% Based on PY2033/ CY2026
M	Total Cost of Care Adjustment (TCOC)	NA	NA	NA	Up to 2.0% CY2029/ CY2028	Up to +/- 2.0% CY2030/ CY2029	Up to +/-2.0% CY2031/ CY2030	Up to +/-2.0% CY2032/ CY2031	Up to +/-2.0% CY2033/ CY2032
N	TIA	NA	NA	NA	NA	NA	NA	NA	NA
O = J + (J * K) + (J * L) + (J * M) + (J * N)	HGB with Annual and Performance Adjustments	PY3 HGB w/ Perf. Adj.	PY4 HGB w/ Perf. Adj.	PY5 HGB w/ Perf. Adj.	PY6 HGB w/ Perf. Adj.	PY7 HGB w/ Perf. Adj.	PY8 HGB w/ Perf. Adj.	PY9 HGB w/ Perf. Adj.	PY10 HGB w/ Perf. Adj.
P	Sequestration	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	
Q = O – (O * P)	Final HGB	Final PY3 HGB	Final PY4 HGB	Final PY5 HGB	Final PY6 HGB	Final PY7 HGB	Final PY8 HGB	Final PY9 HGB	Final PY10 HGB
O	Planned SLA Mid-Year Reconciliation	NA	Reconciliation for Service Line Based on PY1 Utilization	Reconciliation for Service Line Based on PY2 Utilization and PY3 Update	NA	NA	NA	NA	NA

[17] The EA uses the quality measures HWR, PQI-90, and EDU.
[18] The CIB uses the quality measures HWR and PQI-90.