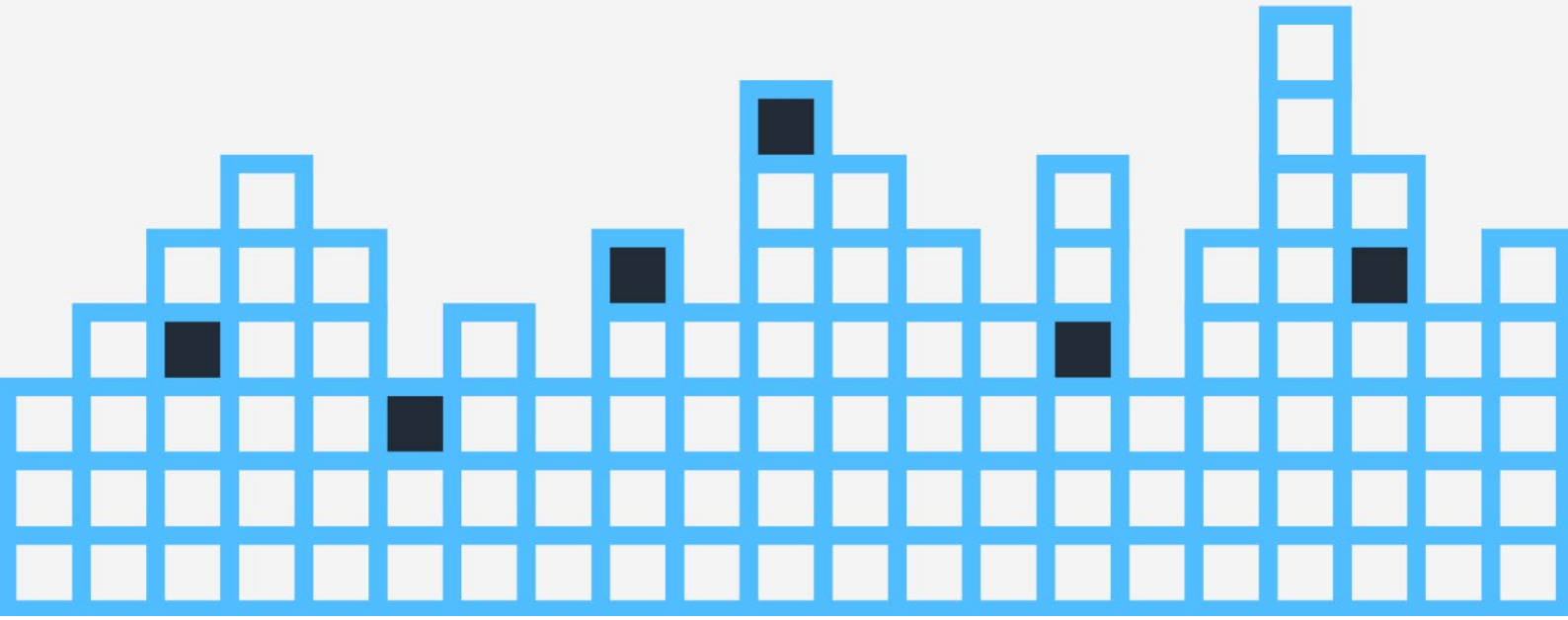

Maryland Outpatient Facility Fee Report – Report on Task 1

October 30, 2025

Commissioned by the Maryland Health Services Cost Review Commission

Charlie Mills, FSA, MAAA

Drew Osborne, FSA, MAAA

Justin St. Andre

Milliman

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Background

The Maryland Health Services Cost Review Commission (HSCRC) engaged Milliman to analyze outpatient facility fees in the state. Chapter 142 of the 2024 Maryland General Assembly directs HSCRC to quantify "the magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers." The engagement includes three analytic tasks which are, briefly:

1. Task 1: summarize the magnitude of outpatient facility fees currently being charged. The analysis must analyze the impact on hospitals, payers, and consumers.
2. Task 2: analyze the impact of up to four "alternative mechanisms" and their impact on Maryland's Total Cost of Care model and related obligations to the federal government.
    a. The alternative mechanisms are rules about outpatient facility fees such as capping or otherwise limiting outpatient facility fees and which may include different definitions of which services constitute outpatient facility fees. The mechanisms are not defined in the engagement.
3. Task 3: model the impact of the alternative mechanisms on the Medicare, Medicaid, and commercial insurance markets, including how they would affect consumer out-of-pocket costs.

This report covers Task 1, which is historical and focused on hospitals, payers, and consumers. For the purpose of this report, "allowed" is the total amount collectable by hospitals, "patient cost" is the amount due by patients, and the remainder is the amount due by payers such as health plans and the Medicare program. Our analysis does not separate out the portion of allowed that is uncollectable by hospitals. Bad debt and charity care may be expanded upon in a future report.[1]

Results

Exhibits 1 and 3 summarize Maryland residents' patient cost sharing for medical services performed in calendar year (CY) 2023. Patient cost sharing is shown by type of service and insurance market or line of business (LOB) and is represented in two ways:

1) **Patient cost sharing as percentage of the allowed cost.** This is also referred to as the effective patient coinsurance percentage. We measure allowed cost as the claim line level allowed payments due to providers, including the primary insurer, the patient, and any secondary sources of coverage.
2) **Percentage of claims with cost sharing.** This is the count of services with patient cost sharing divided by the total number of services delivered.

Exhibits 2 and 4 show the allowed and patient cost sharing dollar volumes in millions.

The exhibits show allowed and cost sharing for each medical service category, with detail for outpatient facility. Exhibits 1 and 2 define outpatient clinic visits using HSCRC rate centers. Exhibits 3 and 4 focus on services identified by MedPAC as often performed outside a facility setting.

[1] More information about Maryland's process for accounting for bad debt and charity care can be found at: https://hscrc.maryland.gov/Pages/UCC.aspx

As shown in these exhibits, our analysis found:

1. The cost sharing percentage for outpatient clinic visit services varied from an average of 5% in the commercial large group fully insured LOB to 23% in Medicare fee-for-service (FFS) in Exhibit 1, using HSCRC rate centers. For most lines of business, the outpatient clinic services cost sharing percentage is similar to the overall cost sharing percentage for all medical care. Exhibit 3, using MedPAC's definition of often non-facility services, shows comparable but slightly higher cost sharing for most lines of business.
2. Outpatient clinic visit services identified using HSCRC rate center codes accounted for 1.7% of total medical expenditure and a similar proportion of patient cost sharing. The services that can be performed in a non-hospital settings based on MedPAC's definition account for 5.3% of total medical expenditure, about three times the HSCRC rate center clinical visits. Said another way, MedPAC's definition suggests services beyond clinic visits can be performed in a non-hospital setting.
3. In Exhibit 1, the percentage of outpatient clinic visit claim lines with cost sharing varied from 30% in the commercial large group fully insured LOB to 99% in Medicare FFS, since outpatient services typically have 20% cost sharing under Medicare Part B[2]. Exhibit 3 shows similar results.

All exhibits are limited to medical services and do not include prescription drug cost information.

The Medicare FFS cost sharing reported does not include the impact of Medicare Supplement plans. Medicare Supplement plans wrap around Medicare FFS and cover all or a portion of the patient cost sharing, and it is common for Medicare FFS beneficiaries purchase such a plan. Accordingly, the actual cost sharing paid by Medicare FFS members will be lower in aggregate than the amounts reflected here (but these individuals also incur a premium for the supplemental plan that is not reflected in these results either).

The Exhibits do not show results for Maryland Medicaid patients because these patients generally pay little or no cost sharing.

Methodology and Assumptions

This analysis is based on medical claims incurred in calendar year 2023 from the following data sources:

1. Maryland All-Payer Claims Database (APCD): Used for the Medicare Advantage, individual, commercial small group, and commercial large group fully insured markets.
2. Milliman Consolidated Health Cost Guidelines Sources Database (CHSD): Used for the commercial large group self-insured market.
3. CMS 5 Percent Limited Data Set: Used for the Medicare fee-for-service (FFS) market. Because these data reflect 5 percent of the total, the amounts are grossed up by a factor of

[2] For more information on Medicare cost sharing, please see: https://www.medicare.gov/basics/costs/medicare-costs

20 to estimate the total Medicare FFS market. The impact of Medicare Supplement plans on patient cost is not considered in our analysis.

The APCD data covers the entirety of the lines of business listed above, except that it does not contain federal employees and employees covered by ERISA (e.g., self-insured plans), and a small number of data contributors were excluded for not meeting the data quality requirements of this analysis[3]. The CHSD dataset is a contributor dataset and unlike the APCD does not contain data from all carriers in Maryland. The HSCRC will adjust total volume to account for data not in the APCD and CHSD datasets. Service categories are assigned using both the Milliman's Health Cost Guidelines Grouper (HCG Grouper)[4] and lists of HCPCS to define the HSCRC clinic "rate centers" or the list of HCPCS that MedPAC has identified as services that can be performed outside a facility setting. The HCG Grouper first identifies a claim as inpatient, outpatient, or professional. After this initial split, claims categories are refined. Within the outpatient category:

1. *Outpatient clinic* services are defined by the HSCRC clinic "rate center", each of which is composed of a list of HCPCS codes provided by the HSCRC to Milliman on July 24, 2025. Rate centers are service categories used by the HSCRC to analyze hospital claims data.
2. MedPAC identified services are based on publicly available information from MedPAC[5].
3. The other categories use the HCG Grouper outpatient benefit categories, rolled up to a small number of broad outpatient categories for display.

Outpatient services are not restricted to certain types of facilities in our analysis, even though the HSCRC does not have authority over all types of facilities that can bill for outpatient services. Based on nationwide averages of Medicare data, we believe the HSCRC would have authority over the overwhelming majority, over 85% of total outpatient facility expenditures. Most outpatient services are performed at short-term acute hospitals and units within those hospitals, including special hospital types such as critical access hospitals. Services that are classified in our exhibits as outpatient that would be outside of the HSCRC's authority include dialysis centers, outpatient skilled nursing facilities (SNF), federally qualified health centers, rural health centers, and others. Commercial and Medicaid may have a higher or lower percentage of services at facilities the HSCRC oversees, but we expect hospitals that the HSCRC has authority over to be the overwhelming majority in those lines of business as well.

The service categories presented in the exhibits are mutually exclusive, meaning a claim line can only be assigned to a single category. This analysis presents average cost sharing. Cost sharing for an individual will differ, sometimes substantially, from these averages. Additionally, covered services may vary by line of business and plan.

[3] Exclusions were made at the contributor level. Eight of the twenty-six contributors were excluded but only comprise about 3% of total allowed charges. 95% of the exclusions are due to a single contributor whose largest line of business had negative patient payments in aggregate

[4] For more information, please see: https://www.milliman.com/en/products/health-cost-guidelines-grouper

[5] Medicare Payment Advisory Commission. (2023, June). *Aligning fee-for-service payment rates across ambulatory settings* (Chapter 8, *Report to the Congress: Medicare and the Health Care Delivery System*). https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

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This analysis is based on historical claims costs. Adjustments for incurred but not reported claim costs, provider risk sharing and incentives, or other financial arrangements outside of the claims data are not reflected in this report.

Prescription drug (e.g., retail pharmacy) claims are excluded from this analysis.

Definitions

Allowed or Allowed Claims: The total amount of fee-for-service payments for covered medical services including the amount that the plan pays, the patient pays, and any other payer pays for covered services. Charity care, provider bonus, capitation, and risk sharing payments are not included. No adjustments are made for bad debt.

APCD: Maryland's All Payer Claims Database.

CHSD: Milliman's Consolidated Health Cost Guidelines (HCGs) Sources Database (CHSD): A comprehensive, longitudinal, health care experience database containing detailed enrollment and medical claims data.

HCPCS: Healthcare Common Procedure Coding System, a reporting code used in medical claims coding.

Outpatient facility services: Are identified based on the presence of certain revenue codes or based on the provider type (e.g., ambulatory surgical center). Outpatient facility services are categorized primarily based on the revenue codes and Healthcare Common Procedure Coding System (HCPCS) or Common Procedure Terminology (CPT) codes.

Outpatient facility fee: A fee billed by a hospital when a patient receives services from the hospital. Outpatient clinic fees are a subset of outpatient facility fees for hospital-based outpatient clinic services. Outpatient facility fees are separate from and in addition to any professional fees. For example, a patient visiting an outpatient clinic may receive multiple bills: (1) outpatient clinic fees and (2) one or more professional fees.

Patient cost: The total amount of payments for covered medical services that that the patient pays, such as copays, coinsurance, and deductible.

Data Reliance and Variability of Results

This report and the accompanying exhibits have been prepared for the Maryland HSCRC. This information is intended solely for educational purposes and presents information of a general nature. It is not intended to guide or determine any specific individual situation and persons should consult qualified professionals before taking specific actions. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work.

In performing our analysis, we relied on data and other information provided to us by the Centers for Medicare and Medicaid Services (CMS) and our data partners. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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We have also relied on the data and other information provided by the Maryland HSCRC for this analysis. We have performed a limited review of this data and other information and checked for reasonableness and consistency. While we excluded a limited set of Maryland APCD data contributors, we have not found material defects in the data or information used. If there are material defects in the included data or other information, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Drew Osborne and Charlie Mills are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

List of Attachments

The attached exhibits detail CY2023 outpatient facility costs and patient cost sharing for Maryland residents.

Exhibit 1: CY2023 Cost Sharing Rates by LOB and Claim Category using HSCRC Rate centers

Exhibit 2: CY2023 Costs by LOB and Claim Category using HSCRC Rate centers

Exhibit 3: CY2023 Cost Sharing Rates by LOB and Claim Category using MedPAC Codes

Exhibit 4: CY2023 Costs by LOB and Claim Category using MedPAC Codes

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Charlie Mills
charlie.mills@milliman.com

Drew Osborne
drew.osborne@milliman.com

Justin St. Andre
justin.standre@milliman.com

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Exhibit 1
Maryland HSCRC
CY2023 Cost Sharing Rates by LOB and Claim Category
Using HSCRC rate center codes to define outpatient clinic

Category	Allowed Distribution Across All APCD LOBs	Medicare Advantage (APCD)	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD)	Medicare FFS (5% LDS)
		Patient Cost / Allowed					
Inpatient	22.9%	4%	7%	4%	2%	2%	5%
Skilled Nursing Facility	1.1%	4%	2%	2%	2%	5%	17%
Outpatient Surgery	8.1%	7%	11%	8%	2%	5%	21%
Ambulatory Surgical Center	2.2%	11%	26%	22%	7%	12%	20%
Outpatient Clinic	**1.7%**	**9%**	**20%**	**19%**	**5%**	**9%**	**23%**
Outpatient Radiology	1.7%	7%	16%	16%	5%	8%	22%
Outpatient Other	13.7%	6%	17%	20%	6%	11%	19%
Professional	44.7%	9%	17%	25%	12%	14%	20%
Ancillary	3.9%	13%	19%	23%	7%	8%	10%
Total Medical	100.0%	7%	14%	18%	8%	10%	14%
		% Claims with Patient Costs					
Inpatient	22.9%	76%	70%	78%	45%	51%	71%
Skilled Nursing Facility	1.1%	45%	27%	36%	33%	28%	66%
Outpatient Surgery	8.1%	71%	83%	84%	43%	49%	100%
Ambulatory Surgical Center	2.2%	65%	85%	84%	44%	48%	99%
Outpatient Clinic	**1.7%**	**57%**	**63%**	**65%**	**30%**	**43%**	**99%**
Outpatient Radiology	1.7%	63%	69%	68%	30%	50%	99%
Outpatient Other	13.7%	59%	50%	62%	42%	49%	80%
Professional	44.7%	53%	53%	65%	50%	53%	79%
Ancillary	3.9%	47%	59%	67%	32%	35%	41%
Total Medical	100.0%	53%	53%	66%	48%	52%	76%
		Allowed Claims, Member Months, and Allowed PMPM					
Allowed Distribution in APCD		23%	11%	10%	59%		
Allowed Volume ($Millions) (1)		$2,034	$1,051	$875	$4,705	$2,569	$13,480
Member Months		2,207,400	2,716,673	2,324,864	11,781,899	6,020,778	8,648,700
Unique Lives		208,747	300,670	242,904	1,136,804	577,119	790,240
Allowed PMPM		$921.58	$386.90	$376.33	$399.37	$426.64	$1,558.62

(1) 5% sample volume multiplied by 20 to estimate full Medicare FFS volume.

Exhibit 2
Maryland HSCRC
CY2023 Costs by LOB and Claim Category
Using HSCRC rate center codes to define outpatient clinic

Category	Allowed Distribution Across All APCD LOBs	Medicare Advantage (APCD)	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD)	Medicare FFS (5% LDS)
Member Months		2,207,400	2,716,673	2,324,864	11,781,899	6,020,778	8,648,700
		Patient Cost					
Inpatient	22.9%	$28,680,148	$16,826,300	$6,349,284	$14,472,296	$13,681,263	$229,992,261
Skilled Nursing Facility	1.1%	$3,226,511	$66,197	$21,001	$332,407	$279,786	$145,279,452
Outpatient Surgery	8.1%	$10,518,897	$9,002,487	$6,105,093	$8,076,762	$12,383,530	$80,894,224
Ambulatory Surgical Center	2.2%	$3,211,003	$5,381,678	$4,795,600	$9,241,933	$6,448,218	$40,807,363
Outpatient Clinic	**1.7%**	**$2,176,623**	**$3,315,206**	**$2,750,577**	**$4,063,551**	**$4,680,176**	**$36,720,830**
Outpatient Radiology	1.7%	$2,184,259	$2,593,433	$2,254,438	$4,200,912	$4,807,638	$55,786,698
Outpatient Other	13.7%	$20,889,661	$26,886,649	$19,772,663	$36,982,560	$36,947,917	$365,596,523
Professional	44.7%	$51,643,549	$81,415,042	$112,732,030	$278,787,865	$168,837,572	$805,878,494
Ancillary	3.9%	$11,704,097	$6,853,594	$6,117,522	$12,223,963	$7,580,736	$129,108,933
Total Medical	100.0%	$134,234,749	$152,340,586	$160,898,208	$368,382,248	$255,646,835	$1,890,064,778
		Allowed					
Inpatient	22.9%	$729,613,265	$240,865,461	$160,511,424	$850,322,499	$555,462,774	$4,495,307,403
Skilled Nursing Facility	1.1%	$73,145,868	$3,210,047	$953,615	$20,971,897	$5,734,777	$841,534,325
Outpatient Surgery	8.1%	$143,336,063	$80,384,745	$77,012,936	$400,176,537	$239,569,612	$381,999,054
Ambulatory Surgical Center	2.2%	$28,422,932	$20,510,961	$21,776,864	$123,821,602	$53,335,823	$202,831,212
Outpatient Clinic	**1.7%**	**$25,464,154**	**$16,420,814**	**$14,595,534**	**$86,539,896**	**$51,248,571**	**$163,139,442**
Outpatient Radiology	1.7%	$29,183,926	$16,680,171	$14,330,095	$90,261,949	$57,209,216	$252,390,234
Outpatient Other	13.7%	$346,680,855	$156,115,109	$101,206,016	$584,097,711	$346,460,522	$1,908,931,851
Professional	44.7%	$568,034,805	$481,635,371	$457,962,279	$2,364,388,461	$1,165,856,596	$3,967,023,346
Ancillary	3.9%	$90,413,104	$35,247,996	$26,563,985	$184,764,876	$93,810,723	$1,266,862,043
Total Medical	100.0%	$2,034,294,972	$1,051,070,675	$874,912,749	$4,705,345,429	$2,568,688,613	$13,480,018,908

(1) 5% sample volume multiplied by 20 to estimate full Medicare FFS volume.

Exhibit 3
Maryland HSCRC
CY2023 Cost Sharing Rates by LOB and Claim Category
Using MedPAC list of services that can be performed outside a facility setting

Category	Allowed Distribution Across All APCD LOBs	Medicare Advantage (APCD)	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD)	Medicare FFS (5% LDS)
		Patient Cost / Allowed					
Inpatient	22.9%	4%	7%	4%	2%	2%	5%
Skilled Nursing Facility	1.1%	4%	2%	2%	2%	5%	17%
Outpatient Surgery	7.2%	7%	10%	7%	2%	5%	21%
Ambulatory Surgical Center	1.4%	9%	20%	16%	6%	10%	20%
MedPAC Identified Services	**5.3%**	**9%**	**28%**	**25%**	**7%**	**11%**	**21%**
Outpatient Radiology	1.2%	6%	11%	11%	3%	5%	22%
Outpatient Other	12.3%	6%	16%	18%	6%	11%	19%
Professional	44.7%	9%	17%	25%	12%	14%	20%
Ancillary	3.9%	13%	19%	23%	7%	8%	10%
Total Medical	100.0%	7%	14%	18%	8%	10%	14%
		% Claims with Patient Costs					
Inpatient	22.9%	76%	70%	78%	45%	51%	71%
Skilled Nursing Facility	1.1%	45%	27%	36%	33%	28%	66%
Outpatient Surgery	7.2%	73%	83%	85%	45%	51%	100%
Ambulatory Surgical Center	1.4%	64%	78%	81%	43%	46%	99%
MedPAC Identified Services	**5.3%**	**60%**	**68%**	**64%**	**32%**	**44%**	**96%**
Outpatient Radiology	1.2%	64%	63%	64%	26%	45%	100%
Outpatient Other	12.3%	59%	50%	66%	42%	51%	81%
Professional	44.7%	53%	53%	65%	50%	53%	79%
Ancillary	3.9%	47%	59%	67%	32%	35%	41%
Total Medical	100.0%	53%	53%	66%	48%	52%	76%
		Allowed Claims, Member Months, and Allowed PMPM					
Allowed Distribution in APCD		23%	11%	10%	59%		
Allowed Volume ($Millions) (1)		$2,034	$1,051	$875	$4,705	$2,569	$13,480
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Unique Lives		208,747	300,670	242,904	1,136,804	577,119	790,240
Allowed PMPM		$921.58	$386.90	$376.33	$399.37	$426.64	$1,558.62

(1) 5% sample volume multiplied by 20 to estimate full Medicare FFS volume.

Exhibit 4
Maryland HSCRC
CY2023 Costs by LOB and Claim Category
Using MedPAC list of services that can be performed outside a facility setting

Category	Allowed Distribution Across All APCD LOBs	Medicare Advantage (APCD)	Individual (APCD)	Commercial Small Group (APCD)	Commercial Large Group Fully Insured (APCD)	Commercial Large Group Self Insured (CHSD)	Medicare FFS (5% LDS)
Member Months		2,207,400	2,716,673	2,324,864	11,781,899	6,020,778	8,648,700
		Patient Cost					
Inpatient	22.9%	$28,680,148	$16,826,300	$6,349,284	$14,472,296	$13,681,263	$229,992,261
Skilled Nursing Facility	1.1%	$3,226,511	$66,197	$21,001	$332,407	$279,786	$145,279,452
Outpatient Surgery	7.2%	$8,839,369	$7,296,285	$4,715,008	$5,963,476	$10,281,927	$63,742,095
Ambulatory Surgical Center	1.4%	$1,183,280	$2,732,403	$2,407,608	$4,692,008	$3,625,417	$21,108,558
MedPAC Identified Services	**5.3%**	**$8,163,970**	**$13,288,001**	**$11,118,272**	**$18,665,612**	**$17,046,910**	**$109,916,956**
Outpatient Radiology	1.2%	$1,509,521	$1,383,209	$1,079,637	$1,904,511	$1,930,827	$36,028,692
Outpatient Other	12.3%	$19,284,304	$22,479,555	$16,357,847	$31,340,111	$32,382,398	$349,009,337
Professional	44.7%	$51,643,549	$81,415,042	$112,732,030	$278,787,865	$168,837,572	$805,878,494
Ancillary	3.9%	$11,704,097	$6,853,594	$6,117,522	$12,223,963	$7,580,736	$129,108,933
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Skilled Nursing Facility	1.1%	$73,145,868	$3,210,047	$953,615	$20,971,897	$5,734,777	$841,534,325
Outpatient Surgery	7.2%	$127,237,438	$72,686,596	$69,711,660	$358,183,320	$214,705,348	$303,518,926
Ambulatory Surgical Center	1.4%	$13,912,573	$13,838,639	$14,652,355	$79,275,403	$35,821,160	$106,451,255
MedPAC Identified Services	**5.3%**	**$92,520,039**	**$46,799,395**	**$44,993,860**	**$271,885,129**	**$154,939,222**	**$527,618,660**
Outpatient Radiology	1.2%	$23,998,623	$12,640,243	$10,170,236	$59,520,542	$36,862,137	$166,205,015
Outpatient Other	12.3%	$315,419,256	$144,146,928	$89,393,333	$516,033,302	$305,495,876	$1,805,497,936
Professional	44.7%	$568,034,805	$481,635,371	$457,962,279	$2,364,388,461	$1,165,856,596	$3,967,023,346
Ancillary	3.9%	$90,413,104	$35,247,996	$26,563,985	$184,764,876	$93,810,723	$1,266,862,043
Total Medical	100.0%	$2,034,294,972	$1,051,070,675	$874,912,749	$4,705,345,429	$2,568,688,613	$13,480,018,908

(1) 5% sample volume multiplied by 20 to estimate full Medicare FFS volume.