Maryland
Hospital Association

November 28, 2022

Adam Kane
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane:

The Maryland Hospital Association (MHA) and our 60 member hospitals and health systems appreciate the opportunity to participate in finding ways to improve our Total Cost of Care Model savings performance.

We applaud the Commission for invoking the exogenous factors clause in the contract with the federal government to gain relief with respect to calendar year (CY) 2022 performance. The COVID-19 pandemic and its after-effects have disrupted health care operations massively, imposing new permanent costs and forcing constraints on vital delivery capacity.

Hospitals also appreciate that Maryland needs to act seriously to get back on track toward meeting contractual targets, notwithstanding the fact that the savings shortfall is driven mainly by lower-than-projected national Medicare spending, not excessive spending in Maryland.

A sound corrective action plan must do three things: (1) improve Model performance where it matters most, in the Medicare segment; (2) equitably share the financial burden among the major stakeholders; and (3) ensure that hospitals are funded adequately to meet patients' needs, and to continue to invest in population health improvement efforts.

As reflected in the staff's November draft recommendation, Maryland is targeting $100 million of CY 2023 savings, incremental to the $160 million CY 2022 run rate. The hospital field agrees with parts of the Commission staff's proposal. We do, though, differ on other aspects of the plan because, when taken together, they do not satisfy the three crucial criteria.

Our recommendations are summarized below. These positions are supported by data and analysis presented in the addendum.

1. **Support the staff's proposal to raise the public payer differential 1% and to secure state support of $50 million.** Maryland's Model benefits multiple stakeholders. All stakeholders—hospitals, private payers, and the state—should contribute equitably to improving our performance. In contrast to our hospitals, insurers' finances and the state's finances are more than sound. Reduced demand for care and hefty premium increases have boosted health insurers' profits and reserves. And the state's finances are vigorous thanks to federal relief dollars and unbudgeted surpluses.

2. **Remove the proposed all-payer rate reduction of 0.4%.** The problem with the Model right now is a Medicare problem, not an all-payer problem. Maryland remains well within our all-payer, per capita spending limit. Our Medicare spending is as predicted. The Medicare savings shortfall is primarily the result of utilization nationally not matching up to the Medicare actuary's own forecast.

   Regardless of the now-observed softening of national Medicare cost growth, HSCRC was correct to add 0.4% for rate year (RY) 2023 inflation. If the Commission retracts the 0.4%, cost inflation for just this one year will be underfunded by 1.16%. That equates to a shortfall of hundreds of millions of dollars hospitals need to care for Maryland patients.

3. **Count the expected traditional Medicare Performance Adjustment (MPA) savings from 2022 performance.** The MPA makes each hospital accountable to deliver total cost of care savings. Because Maryland's total cost of care performance in CY 2022 was poor, almost all hospitals face a financial penalty. The financial adjustments are directly linked to performance results, therefore ought to count toward the savings. If Maryland's performance improves, penalties will ease, and if not, they will continue to be assessed.

4. **Use the MPA – Savings Component (MPA-SC) to deliver the balance of savings.** The MPA-SC tool was purpose-built for situations where Medicare savings are off track. When deployed, it properly limits savings to Medicare without shifting the burden to other payers. Hospitals' payments fall and Medicare gets its savings.

   And please be reminded that there was strong consensus from the hospital field to share a $25 million reduction, with 75% based on the HSCRC's efficiency policy and 25% shared evenly among all hospitals according to their revenues. We ask that HSCRC defer to field consensus for any recommended reduction, consistent with HSCRC's history.

As we write this letter, Maryland is facing a surge of pediatric respiratory illnesses, rising influenza among vulnerable groups, persistent COVID hospitalizations, and unprecedented demand for behavioral health services. Demand is spiking and other care sources—from pediatric practitioners to community behavioral health providers to nursing facilities—are unable to withstand the onslaught. All while costs are climbing rapidly and vacant positions go unfilled. Our hospitals face a crunch. We ask you and all commissioners to take that into account.

Sincerely,

Bob Atlas
President & CEO

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Maulik Joshi, Dr.Ph.
James Elliott, M.D.
Stacia Cohen
Sam Malhotra
Katie Wunderlich, Executive Director

Addendum – Support for Maryland Hospital Association's Recommended Action

MHA's recommended approach produces the savings HSCRC is aiming for and satisfies the three key criteria. Moreover, our proposal emphasizes incremental action because the current national trend appears anomalous. National spending could take a different turn in 2023 and 2024, so the Commission should monitor movements and act accordingly if conditions warrant.

Our rationale is outlined below. The first two sections explain why HSCRC should be cautious in adjusting payments, the third outlines MHA's proposal for shared accountability, the fourth describes the inflation funding shortfall and supports avoiding an all-payer rate reduction, and the final section offers evidence of Maryland hospitals' unfavorable financial performance.

1) **Global budgeted revenue incentives and Model limits.** Global budgets trade steady growth for revenue limits that allow for reasonable price and service growth. Managing utilization relative to the nation has been disrupted compared to historical norms during this unique period.

2) **COVID-related one-time adjustments must settle.** HSCRC provided reasonable, if not conservative, *permanent* update factors throughout the pandemic. Additional one-time impacts will be reversed by the end of 2022, giving HSCRC a better understanding of actual performance in early 2023.

3) **Shared accountability.** Comparing HSCRC's draft recommendation with MHA's proposed alternative shows the disproportionate impact on hospitals. Commercial payers and the State have adequate resources to contribute comparable amounts.

4) **HSCRC permanent hospital rate funding is conservative.** When judging Maryland's Model performance, 2022 and 2023 rate increases were moderate, and largely formulaic. While HSCRC added 40 basis points to 2023 inflation when deciding the update, new data show inflation still underfunded by 80 basis points.

5) **Hospital financial performance is unfavorable and is likely to remain so.** In fiscal 2022, more than half of Maryland hospitals' operating expenses were higher than revenues. Including non-hospital services in hospital-based health systems, the average operating margin was -0.3% with a 15% decline in cash.

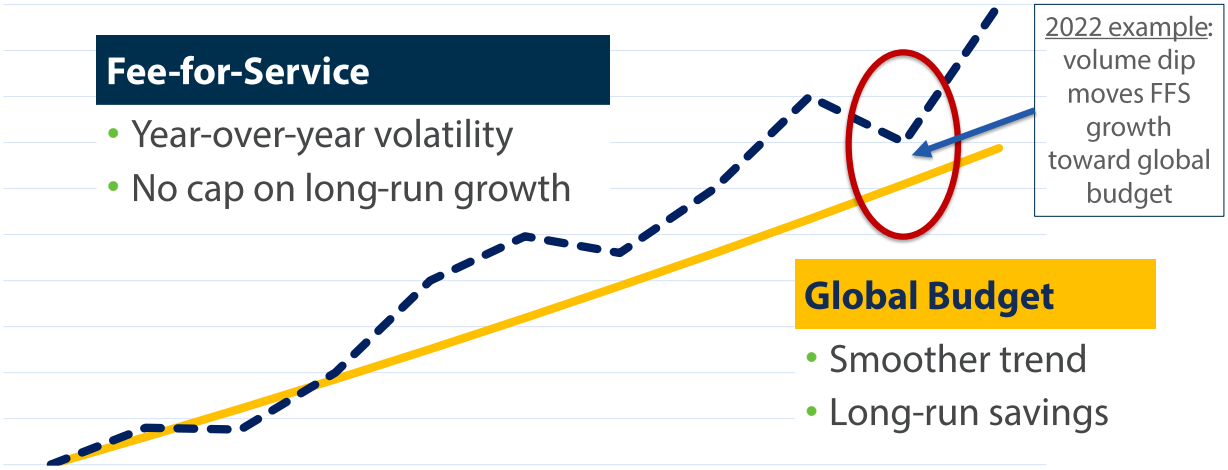
1. Global Budgeted Revenue Incentives and Model Limits

Maryland's historic waiver program capped growth of price per hospital admission. In 2014 the All-Payer Model introduced global budgeted revenue that capped growth of spending on hospital services. In 2019 the Total Cost of Care Model added risk on hospitals for spending beyond the hospital. So today, our hospitals live with not only fixed revenues but also risk for costs of services they mostly do not control. Then, in 2020, the COVID-19 pandemic caused massive disruption, the effects of which continue to reverberate to this day both in Maryland and across the United States.

Maryland's Model was designed to deliver income stability for hospitals and cost savings for payers over the long term. The Model introduced an all-payer hospital spending growth limit of 3.58%, plus reasonable Medicare hospital and total spending limits. Hospital revenues were meant to grow at a reasonable pace with hard revenue limits enforced by the annual payment update. In contrast, prior to the Model's launch, with no limits placed on hospital volume growth, *per capita hospital spending grew 6.78% each year for 10 straight years*.

Figure 1 below illustrates global budgets compared to fee-for-service payment. Under global budgets, hospital revenues are regulated to grow steadily. Both prices and utilization are, in effect, capped. In contrast, under a fee-for-service system, even if prices are regulated, the absence of sufficient incentives to limit the volume of services means spending is more volatile and will tend to rise more over time.

Figure 1: Illustration of GBR versus Fee-for-Service



Under fee-for-service outside of Maryland, spending may fall when utilization falls, but as the evidence shows, utilization in aggregate almost always rises. However, 2022 was extraordinary. Utilization dropped across the nation. This phenomenon only occurred because the COVID-19 pandemic and its aftershocks dramatically altered both the supply of and demand for health care.

In 2021, the Center for Medicare & Medicaid Innovation (CMMI) touted the Maryland Model as one of only six demonstration projects to produce savings, out of 50 that were evaluated since 2010. In absolute dollar terms Maryland ranked #1. Evidence shows that Maryland can, and does, limit cost growth. From 2014 through 2021, cumulative total cost of care growth was more than 3% below the nation with $378 million in annual Medicare savings – well ahead of that year's $222 million interim target. Only the peculiarities of this one year changed this trajectory.

Year to date savings *have* declined significantly. The national trendline dipped while Maryland maintained our steady pace. But national hospital volumes will not be suppressed for long. Our own state's experience tells us that delays in routine care have left people with more serious health conditions, resulting in the need for more care at higher intensity. Once the national pattern resumes, Maryland will be back on track to produce savings.

2. COVID Related One-Time Adjustments Must Settle

HSCRC made several one-time adjustments to help hospitals absorb the financial shocks of the pandemic in 2020 and 2021. To understand our true performance, one must quantify the effects of reversing those adjustments. These adjustments include the 2022 $100 million advance, rate year (RY) 2021 undercharge support of $215 million, additional COVID surge funding, and the actual differences in undercharges and overcharges in 2021 and 2022. Reversing all COVID-related one-time adjustments will improve savings by $80 million.

Adding that amount to HSCRC staff's projected year-end 2022 savings of $80 million gives a 2023 baseline savings run rate of $160 million.

HSCRC is targeting $100 million in additional savings, meant to recover half of an estimated $200 million difference between Maryland's 2022 target and our projected result. We also know that Maryland is only one side of the savings measure. Given the instability of the national market and the need to shore up hospital finances, we urge HSCRC and CMMI to acknowledge that a $100 million improvement may not completely close the 2023 performance gap. The agencies should again look to the exogenous factors clause in the contract for 2023.

3. Shared Accountability

MHA respects HSCRC's determination to act promptly. Though the burden of corrective action must be borne equitably by all stakeholders: hospitals, commercial insurers, and the state. As shown in Figure 2 below, however, the impact of staff's recommendation fails that test.

Figure 2: HSCRC Draft Recommendation
($ in millions)

		Contribution, in (), or Offset				
	Medicare Savings	Hospitals	Commercial Payers	State	*Medicaid*	*State*
Reduce hosp. portion of Medicaid assessment - $50m	$ -	$ 50		$ (50)	*$*	*(50)*
Raise Medicare Differential - **1%**	26	-	(50)	16	*16*	*-*
All-Payer Rate Reduction - **0.40%**	27	(80)	32	16	*16*	*-*
MPA - Savings Component - balance	50	(50)	-	-	*-*	*-*
Total	**$ 102**	**$ (80)**	**$ (18)**	**$ (18)**	*$ 32*	*$ (50)*
MPA - Traditional - 1/2 Year, 2023 only	20	(20)	-	-	*-*	*-*
Readmissions Savings	5	(5)				
Grand Total	**$ 127**	**$ (105)**	**$ (18)**	**$ (18)**	*$ 32*	*$ (50)*

Overwhelming burden borne by hospitals

Notes:
Impacts from HSCRC staff recommendation or consistently scaled. Total does not equate by payer because other payers are excluded.
Medicare, Medicaid and Commercial payer impacts per HSCRC staff recommendation figures
Traditional MPA is $40m, assumes 1/2 year impact in 2022.

Figure 3 shows MHA's alternative for producing $100 million in Medicare savings in a way that passes the shared accountability test. Our explanation follows.

Figure 3: MHA Alternative Sharing the Burden Equally Among Stakeholders
($ in millions)

	Medicare Savings	Contribution, in (), or Offset: Hospitals	Commercial Payers	State	*Medicaid*	*State*
State direct funding - $50m	$ -	$ 50		$ (50)		*$ (50)*
Raise Medicare Differential ~ **0.65%**	17	-	(33)	11	*11*	*-*
All-Payer Rate Reduction - **0.0%**	-	-	-	-	*-*	*-*
MPA - Traditional - 1/2 Year, 2023 only	20	(20)	-	-	*-*	*-*
MPA - Savings Component - balance	63	(63)	-	-	*-*	*-*
Total	**$ 100**	**$ (33)**	**$ (33)**	**$ (39)**	*$ 11*	*$ (50)*

Burden shared equitably by all three Model stakeholders

Notes:
Impacts from HSCRC staff recommendation or consistently scaled. Total does not equate by payer because other payers are excluded.
Medicare, Medicaid and Commercial payer impacts per HSCRC staff recommendation figures
Traditional MPA is $40m, assumes 1/2 year impact in 2022.

a) Raising the Public Payer Differential

MHA does not take lightly the all-payer nature of the Model, recognizing that Maryland has only changed the differential once in the past 40 years. However, COVID was an unprecedented event that requires all stakeholders to support corrective action.

Commercial payers benefit greatly from all-payer rate setting. According to the Health Care Cost Institute, Maryland commercial payers enjoy the lowest hospital outpatient costs and the second lowest inpatient hospital costs. If Maryland's commercial insurance payments were moved to the national median, *commercial hospital spending in Maryland would jump $2.3 billion*, including $680 million inpatient and $1.6 billion outpatient. Increasing the differential by 65 basis points will cost commercial payers just $33 million.

The language below from Section 8.b.ii.1. of the Model contract allows Maryland to use the differential if all-payer hospital spending per capita is less than the limit, which is the case now.

1. Beginning in Model Year (MY)1 for implementation in MY2, the State may submit to CMS a request to change the Public Payer Differential calculated by the State under any of the following circumstances:

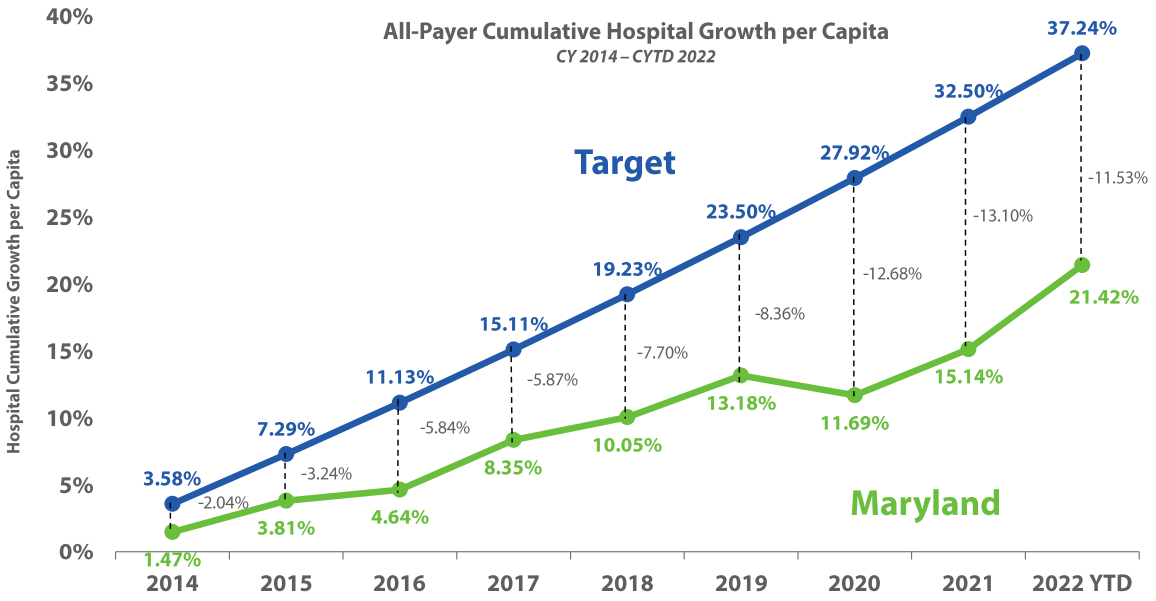
    a. To enable the State to meet the Annual Savings Target for the subsequent Model Year, provided that hospital expenditures for the current Model Year are less than the All-Payer Revenue Limit calculated by the State in accordance with Section 6.f and Appendix B of this Agreement for that Model Year.

Earlier contract drafts included a "Medicare Payment Savings Adjustment," designed to allow Medicare to directly reduce hospital payments if Maryland's all-payer hospital performance was favorable and Medicare performance was unfavorable. Ultimately, that section was deleted because CMMI agreed that we could use the Medicare Performance Adjustment – Savings

Component (MPA-SC) to achieve Medicare savings, or the State could request a change in the differential should today's exact circumstance occur.

The contract sets the annual all-payer revenue limit as 3.58% compounded growth from the 2013 base period. Figure 4 shows Maryland's performance to be well below the 2022 limit. The 2020 to 2022 results are not surprising as the COVID-19 pandemic curtailed hospital service use, resulting in lower aggregate spending on hospital services.

Figure 4: Maryland's All-Payer Growth Limit and Actual Performance



Commensurately, commercial health insurers are seeing lower medical expense ratios and enjoying very favorable financial results. Figure 5 shows most large insurers have seen large profits in both 2021 and 2022, with most growing their profits this year.

Figure 5: Health Insurers' Net Income Increases

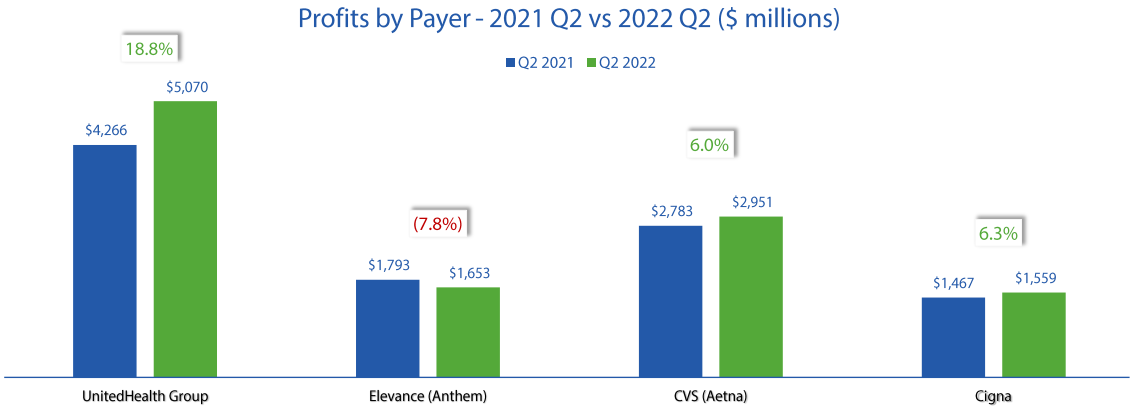
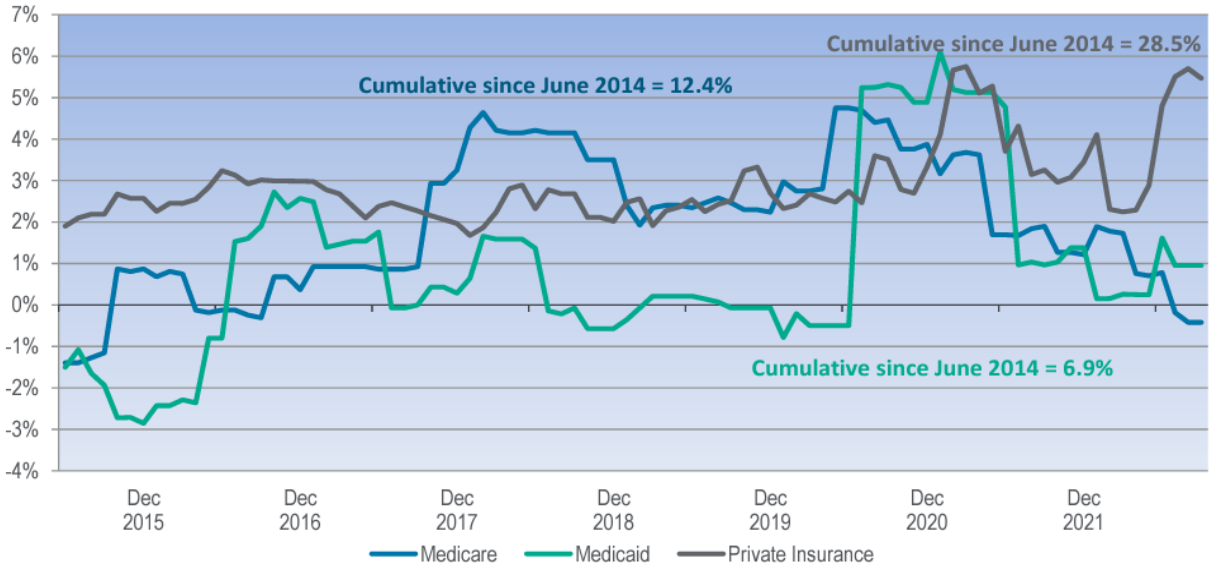


Figure 6 shows private insurance hospital prices rising 28.5% nationally since 2014, more than double the rate of Medicare and for than four times Medicaid. The sharpest increase occurs after December 2021 as hospitals outside of Maryland shift higher prices to private insurance.

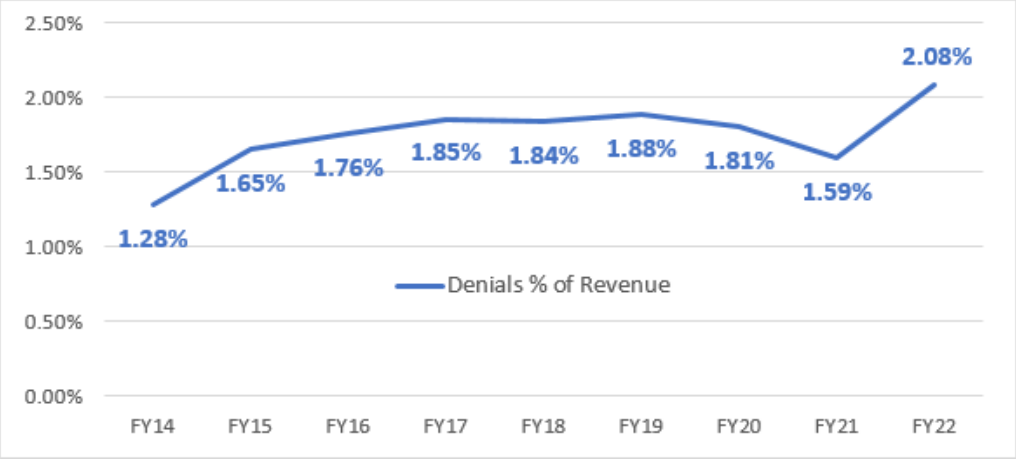
Figure 6: Year-over-Year Change in Hospital Price Growth, by Payer



Source: Altarum, "Health Sector Economic Indicators – Price Brief," October 21, 2022 (Exhibit 8)
https://altarum.org/sites/default/files/uploaded-publication-files/HSEI-Price-Brief_October_2022.pdf

Additionally, as Figure 7 shows, there has been a sharp uptick in hospital claim denials by insurers. This change cannot be driven by hospitals suddenly submitting claims for services that aren't medically justified. Rather, by increasing denials, insurers boost their profits directly at the expense of hospitals.

Figure 7: Hospital Denials as a Percent of Revenue



Source: HSCRC 2022 Annual Filings (29 out of 45 hospitals reporting)

b) State Support

We support HSCRC's intent to secure an equitable contribution from the state. The state reaps economic benefits from the Model, both by keeping commercial hospital payments well below the national average and not having to use state funds to own or subsidize safety net hospitals.

There are two paths. Either the State could reduce by $50 million the hospital portion of the Medicaid deficit assessment, as reflected in the staff's recommendation, or the state could deliver $50 million directly to hospitals as pandemic-related funding.

In fiscal year 2023, the state budgeted for federal Medicaid matching funds to drop because the enhanced match is due to expire at the end of the public health emergency (PHE). Yet the PHE will remain in place at least until April 2023, so the state is reaping this line-item surplus.

The Medicaid budget surplus and federal ARPA came to Maryland because of the COVID-19 pandemic. The pandemic and its aftershocks caused our unfavorable Model performance. It therefore stands to reason that the state can use those funds to make this contribution to stabilize performance. Plus, the state's cost is partly offset by increasing the public payer differential.

c) Medicare Savings – Count Traditional Medicare Performance Adjustment (MPA) and use MPA Savings Component (MPA-SC)

Combined with raising the differential and securing state funding, HSCRC need not reduce all-payer rates. We showed in Figure 4 that Maryland hospitals are delivering more all-payer hospitals savings than required. Counting the traditional MPA results toward our savings target, then using the MPA-SC, is the appropriate way to address any remaining Medicare shortfall.

The contractually required MPA enforces hospital accountability for total cost of care growth. Revenue adjustments are made by comparing each hospital's performance to a national growth rate. Maryland grew faster than the nation in 2022 and because the traditional MPA adjustment has already been approved, the results will be realized.

Annualizing year-to-date 2022 traditional MPA performance projects $45 million in Medicare payment reductions, a $35 million increase from 2021. Half of this amount will affect RY 2023, and another half will be reflected in RY 2024. (One half of this amount is reflected as $20 million in figures 2 and 3, consistent with HSCRC's draft recommendation.) While this amount has not traditionally been "permanent," should Maryland's unfavorable performance continue, unfavorable MPA results will persist.

After accounting for $20 million in traditional MPA savings, the balance of Medicare savings—after raising the public payer differential and securing state funding—should be secured via the MPA-SC.

Using MHA's formulation, an additional $63 million of statewide Medicare savings is required from the MPA-SC. This amount nets to a statewide increment of $13 million after accounting for $50 million in state support to hospitals.

4. HSCRC Permanent Hospital Rate Funding Is Conservative

HSCRC should not reverse 0.4% of permanent inflation funding, regardless of the national Medicare projection. HSCRC did not deliver hospitals a permanent windfall in the last two years. Rather, because of recent cost spikes, HSCRC has underfunded inflation since the beginning of the pandemic and the beginning of the Model. To take back funding undermines a core principle when revenue growth is limited under global budgets.

RY 2022 and RY 2023 Permanent Inflation

In RY 2022, HSCRC funded 2.57% inflation, adding 20 basis points to known inflation at the time, HSCRC projected RY 2022 permanent revenue growth of 2.44% after accounting for other adjustments. In RY 2023, HSCRC provided 4.06% inflation, adding 40 basis points to known inflation at the time, and estimated permanent hospital revenue growth of 3.38%. The underlying permanent inflation and projected revenue growth seemed reasonable if not conservative.

At the time of the RY 2023 annual update, MHA urged HSCRC to consider CMS Office of the Actuary projection of 2022 national spending growth of 7.1%. Obviously, that projection did not prove accurate, and our savings shortfall ensued. However, regardless of the comparison figure, HSCRC's allowances for inflation still fell short of actual inflation.

Newer measures of inflation reveal how short. IHS Markit's 3rd Quarter 2022 release puts RY 2022 inflation at 4.79% and RY 2023 inflation at 4.80%. Both figures are expected to grow with the next release. Had HSCRC not added 20 basis points in 2021 and 40 basis points in 2023, funded inflation would be even further below actual.

Figure 8: Funded vs Actual Inflation, RY2022-RY2023, COVID-19 Pandemic Period (2020-2023), and New Model Period (2014 – 2023)

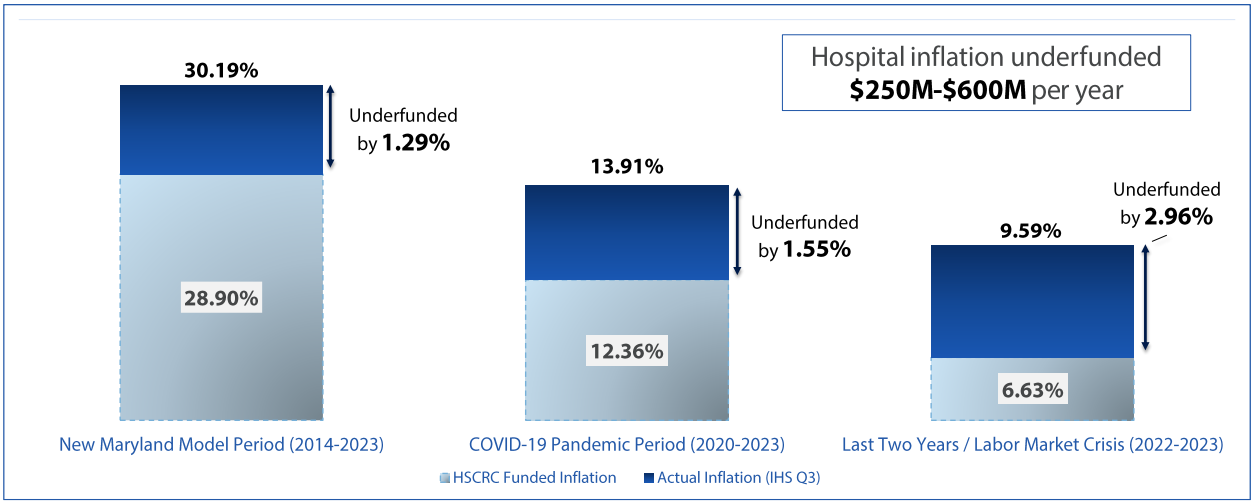


Figure 8 above reflects cumulative cost inflation for three different periods: RY2022-RY2023, COVID-19 pandemic period (2020-2023) and the New Model Period (2014-2023). In any frame, hospital inflation is prospectively underfunded between $250 million and $600 million. Were

these figures to include both infrastructure funding and potentially avoidable utilization offsets, *hospitals would be prospectively underfunded by more than $700 million per year* through 2023.

After seeing higher inflation in hospitals' costs of production earlier this year, CMS adopted MedPAC's recommendation to give higher inflation allowances in Medicare's prospective payment systems. Should inflation continue to climb, Medicare can boost its update in 2023.

What is more, hospitals outside of Maryland will seek significant price hikes from commercial payers to compensate for insufficient funding of inflation by public payers (Figure 6).

5. The Dire Financial Condition of Maryland Hospitals

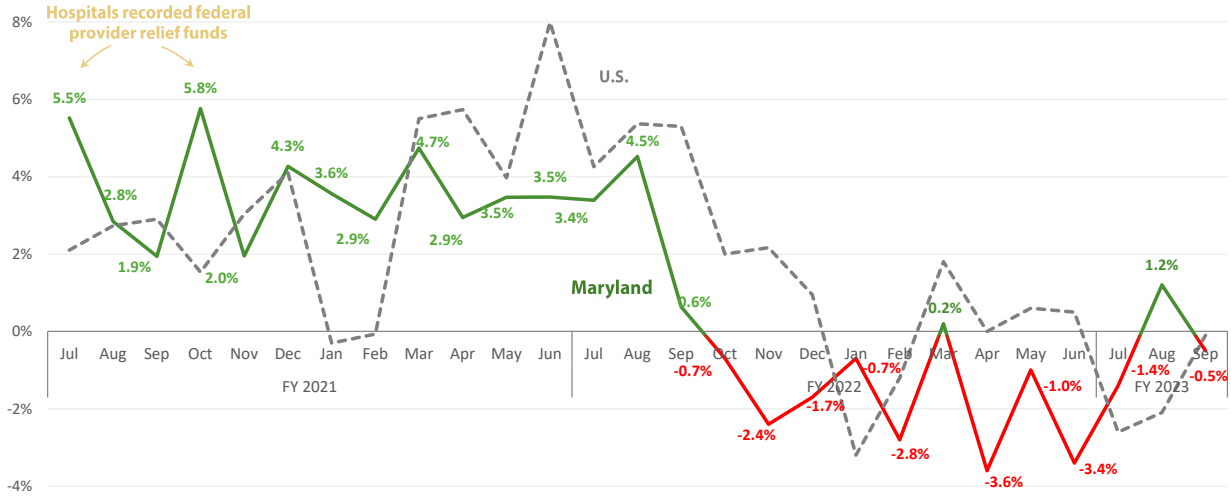
By law, HSCRC has a dual mission: to promote health care cost containment for consumers and their insurers *and* to support hospitals' financial viability. Recent financial performance of our hospitals suggests HSCRC revisit a core provision in Health General 19-212 (2) –

> [The commission shall] concern itself with solutions if a [hospital] facility does not have enough resources.

Like others across the country, Maryland hospitals are facing their worst financial crisis in decades. Huge increases in input costs—labor especially—have severely depressed operating margins. Cash and investments have receded as hospitals cover steep operating losses. Hospitals cannot continue to deplete their fund balances and they can only cut expenses so much before patients' access to care is diminished.

Our hospitals' operating margins were well below the nation in fiscal year 2022. And whereas margins were negative for U.S. hospitals two months of the year, Maryland operating margins remained negative for eight of the twelve months.

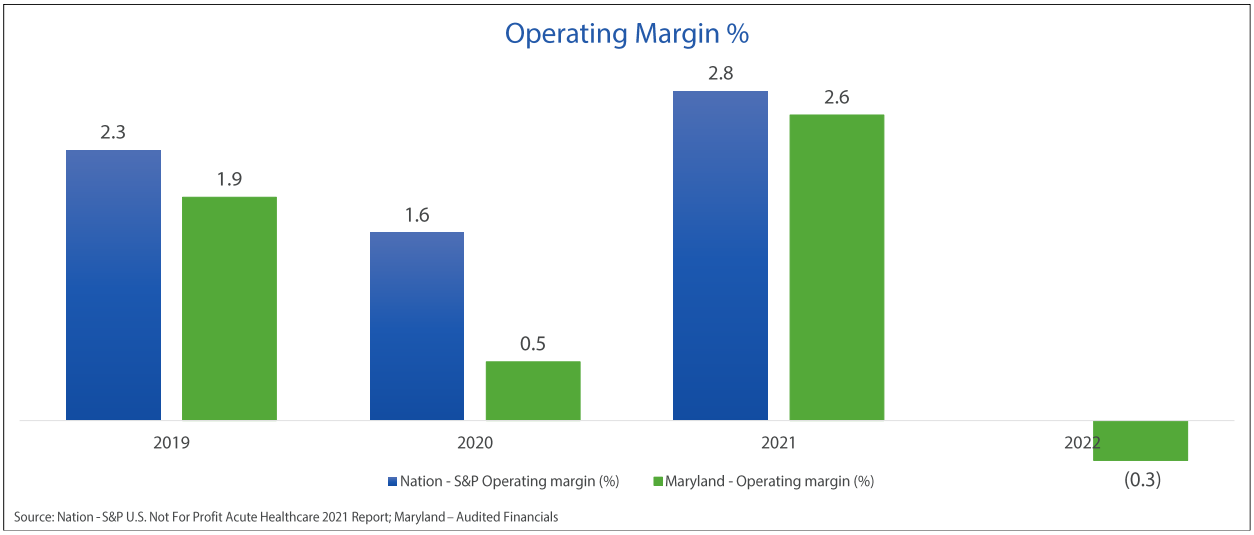
Figure 9: Maryland and National Hospital Margins



Sources: Maryland, HSCRC monthly reports. Nation, Kaufman Hall Flash Report.

Health system audited financial data for 2022, including non-hospital services, show a median loss of 0.3%, the worst in four years, while days cash on hand has fallen by 15%. As reflected in Figure 10, Maryland's health system margins are consistently below rating agency medians.

Figure 10: Maryland and National Health System Median Operating Margins



American Hospital Association (AHA) data in Figure 11 show Maryland's margins much lower than the nation for years. Historically, this difference was understood and accepted because of Maryland's rate setting system and HSCRC's mandate to support hospitals. Over time, operating margins remained steady in Maryland compared to the nation. In 2019, the U.S. had its second-highest operating margin in 16 years, while Maryland's average margin was about half the U.S., 3.62% compared to 7.13%. While margins everywhere fell in 2020 (the latest year for which AHA has data), Maryland margins remained well below the nation, 3.81% compared to 5.52%.

Figure 11: Maryland and US Operating Margins 2005-2022

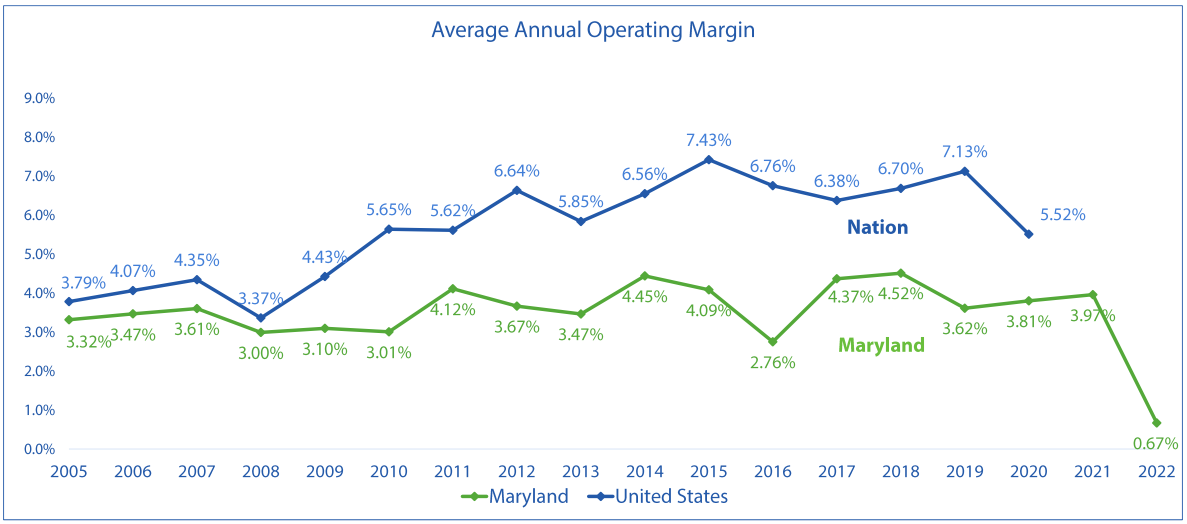


Figure 12 reflects *all-payer*, hospital net revenue and expenses per unit and per capita, explaining how Maryland hospitals reduced avoidable utilization to limit spending growth. When hospitals were placed on GBRs, net revenues and expenses per capita were below the nation, 6.8% less and 3.6% less, respectively. As of 2020, they are much further below the nation, 18.25% less and 15.6% less.

Figure 12: Net Revenue, Expenses per Unit, per Capita; Select Utilization Measures

	MARYLAND	NATION	VARIANCE	%
Total Net Revenue				
per EIPA	$ 10,517	$ 9,994	523	5%
per EIPD	$ 1,931	$ 1,769	162	9%
per capita (per 1000 population)	$ 2,965	$ 3,624	(659)	(18%)
Total Expenses				
per EIPA	$ 10,020	$ 9,226	794	9%
per EIPD	$ 1,839	$ 1,633	206	13%
per capita (per 1000 population)	$ 2,825	$ 3,346	(521)	(16%)
Community Health Indicators				
IP Admissions /1000	84.0	95.3	(11)	(12%)
IP Days /1000	457.5	538.2	(81)	(15%)
OP Visits /1000	1,322.8	2,176.6	(854)	(39%)
ED Visits /1000	308.9	374.1	(65)	(17%)

At the same time, we acknowledge that price per unit—per adjusted admission and per adjusted patient day—have grown. Expense per equivalent inpatient admission (EIPA) went from 0.4% below the nation to 8.6% above the nation. Expense per inpatient day (EIPD) changed from 20.3% above the nation in 2010 to 12.6% in 2020. This is exactly what the Model provides for: following the incentives to contain service growth and create savings per beneficiary.

Community health indicators support this notion as well. Prior to 2013, Maryland ranked higher than the U.S. on inpatient admissions and emergency department visits per 1,000 beneficiaries. The state has been below the nation on every metric reported since 2014, with consistent improvement. In 2020, Maryland was 11.8% below the nation on inpatient admissions, 15% below on inpatient days, 39.2% below on outpatient visits, and 17.4% below on ED visits.