



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

November 23, 2022

Mr. Adam Kane, Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of the Maryland Medicaid Administration of the Maryland Department of Health (the Department), I appreciate the opportunity to comment on the ongoing dialogue surrounding Maryland's Total Cost of Care Model (TCOC Model), including the current recommendations developed by Health Services Cost Review Commission (HSCRC) staff for the Commission's consideration, which are as follows:

- (i) **An all-payer rate adjustment** effectuated through hospital rate orders, *i.e.*, reversal of 0.40% provided in rate year (RY) 2023 Update Factor.
- (ii) **Medicare-only payment reductions** effectuated through the Medicare Performance Adjustment (MPA) Savings Component.
- (iii) **Public-payer rate reductions** through an increase to the Public Payer Differential for the duration of fiscal years (FY) 2023 and 2024, which would require Center for Medicare and Medicaid Innovation (CMMI) approval.
- (iv) **A state contribution through the Medicaid Deficit Assessment** or through additional grant dollars, which would require approval by the General Assembly and/or the Department of Budget and Management, respectively.

The Department appreciates that the Commission staff has outlined a broad-based solution to address the Medicare savings shortfall and is pleased to provide the following comments on staff recommendations (ii) and (iv).

MPA Savings Component

The staff recommendation suggests the application of the MPA Savings Component to adjust Medicare rates on the backend (i.e., outside of charges), thereby bringing the state into compliance with the savings targets. As communicated in our comment letter on the RY 2023 staff recommendation dated May 17, 2022, we believe this recommendation would be a violation of the Medicaid Upper Payment Limit test. Federal rules do not permit Medicaid to pay more than Medicare. This test is applied whether the adjustment to rates occurs upfront (i.e., when establishing and setting charges) or on the backend. The same adjustment to Medicare would need to be made to Medicaid. We believe this deviation from all-payer rates would not align with a central tenet of the Total Cost of Care Model.

Additionally, the Department encourages staff to work with CMMI to consider total cost of care guardrails for Medicaid. In conversations regarding Medicaid alignment with the Maryland Primary Care Program, CMMI shared that a goal for Medicaid primary care alignment would be to shift dollars from hospitals to primary care. This can be only achieved if Medicaid receives at least the same level of hospital savings as Medicare. This would require the MPA Savings Component adjustment to apply to Medicaid hospital services as well.

The Department understands the challenges of trying to project national Medicare spending. This uncertainty necessitates building a level of conservatism into the rate updates each year.

Medicaid Deficit Assessment (MDA)

As you know, any reduction in the MDA would need to be approved by the General Assembly. As noted in our last testimony, the vast majority of states use assessments as a way to bring more federal dollars into their states. The assessment monies used as the state share for Medicaid expenditures allow states to receive a federal match. For Maryland, this federal matching rate is around 60 percent. Accordingly, a reduction of the MDA by \$50 million would total more than \$125 million in lost Medicaid dollars.

We promised at the last Commission meeting to provide an overview of the hospital assessments across other states (see attached). According to a 2022 analysis by the Kaiser Family Foundation, 44 states (including the District of Columbia) have a hospital provider tax.¹ At less than 3.5 percent of net patient revenue, Maryland's hospital provider tax (i.e., the Medicaid Deficit Assessment) is not an outlier compared with other states.

¹ Kaiser Family Foundation "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023."
<https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-provider-rates-and-taxes/>

Please note that the MDA is currently \$295,825,000. Since its peak at \$412,455,978 in fiscal year (FY) 2014, the successive decreases in the MDA, combined with the elimination of the MHIP Assessment and decreases in uncompensated care, have generated cumulative savings in excess of \$1.3 billion since that time.

Lastly, although the TCOC Model's Medicare savings fall \$187 million short of the target, the staff recommendations only total \$100 million. The Department would like to point out the likelihood that, absent additional and palatable interventions, this conversation may need to be revisited as part of the Rate Year 2024 update-factor development.

Please contact me with any questions via phone at 410-767-5809 or via email at tricia.rodny@maryland.gov.

Sincerely,

A handwritten signature in blue ink that reads "Tricia Roddy". The signature is written in a cursive, flowing style.

Tricia Roddy
Deputy Medicaid Director

Enclosure

CC: Katie Wunderlich
Marc Nicole
Steven Schuh
Laura Goodman

Overview of Hospital Assessments

Provider Group Subject to Tax: Hospitals		
State	In Place in FY2022	Size of tax as a percentage of net patient revenue (as of July 1, 2022)
AK	0	
AL	1	>5.5%
AR	1	≤3.5%
AZ	1	5.01% - 5.5%
CA	1	≤3.5%
CO	1	>5.5%
CT	1	>5.5%
DC	1	≤3.5%
DE	0	
FL	1	≤3.5%
GA	1	≤3.5%
HI	1	≤3.5%
IA	1	≤3.5%
ID	1	≤3.5%
IL	1	4.01% - 5%
IN	1	4.01% - 5%
KS	1	≤3.5%
KY	1	≤3.5%
LA	1	≤3.5%
MA	1	≤3.5%
MD	1	≤3.5%
ME	1	≤3.5%
MI	1	3.51% - 4%
MN	1	3.51% - 4%
MO	1	5.01% - 5.5%
MS	1	≤3.5%
MT	1	≤3.5%
NC	1	≤3.5%
ND	0	
NE	0	
NH	1	5.01% - 5.5%
NJ	1	≤3.5%
NM	0	
NV	0	
NY	1	4.01% - 5%
OH	1	3.51% - 4%
OK	1	≤3.5%
OR	1	>5.5%
PA	1	≤3.5%
RI	1	5.01% - 5.5%
SC	1	≤3.5%
SD	0	
TN	1	4.01% - 5%

2021 data used for AR & GA

Source: Kaiser Family Foundation "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023" <https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-provider-rates-and-taxes/>

TX	1	>5.5%
UT	1	≤3.5%
VA	1	>5.5%
VT	1	>5.5%
WA	1	≤3.5%
WI	1	≤3.5%
WV	1	≤3.5%
WY	1	≤3.5%



Charlene MacDonald
Senior Vice President,
Chief Government Affairs Officer

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-5207

December 1, 2022

Dear Chairman Kane:

Thank you for the opportunity to comment on the “Draft Recommendation on Adjustments to Maryland’s Total Cost of Care (TCOC) Performance.”

CareFirst believes in Maryland’s all-payer system and the Total Cost of Care Model (the Model)’s underlying principles to drive innovation, reduce health care expenditures and advance access to high-quality, equitable, affordable healthcare for Marylanders. As noted in the agreement, the Model tests “whether State-wide health care delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare total cost of care.”¹ CareFirst is proud to join stakeholders across the healthcare system in supporting this innovative approach to promoting cost containment, affordability, and quality in Maryland.

We recognize the value our hospital partners provide to Marylanders, the financial pressure the industry is facing, and the fact that hospitals assume responsibility for the industry’s total cost of care performance since their rates are the only lever the Health Services Cost Review Commission (HSCRC) can pull. HSCRC has already taken many steps to address these financial pressures, including guaranteeing undercharges for two years, expanding unit rate corridors, advancing \$100M in January, and providing an incremental 0.4 percent in the update factor. CareFirst and all other payers have been paying the approved rates resulting from these HSCRC measures, which aimed to ensure the financial stability of hospitals through a period of unprecedented uncertainty. Now, as we emerge from this public health crisis, we must not abandon our commitment to care transformation, improved outcomes, and controlled cost growth that spurred Maryland’s innovative approach to hospital payment policy.

We recognize the difficulty Maryland’s 2021 and 2022 year-to-date Model performance presents, especially against the backdrop of challenging economic circumstances for individuals and businesses. We understand there are several contributing factors to this performance. Given the value of the Model for Marylanders, it will be important to make appropriate adjustments that demonstrate the State’s commitment to the Center for Medicare and Medicaid Innovation (CMMI) as a partner.

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1
2. “Inflation signals unrest ahead for health care”; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

As the HSCRC contemplates adjustments, it is important to recognize the current macro state of economics and healthcare financing to ensure the model continues to meet its intended goals. National healthcare spending continues to rise as we all confront record inflation growth and continue to deal with lingering impacts of the COVID-19 pandemic. Deloitte's 2022 Pulse Survey of US Consumers showed that 28 percent of consumers feel less prepared to pay for unexpected medical costs than they did last year². Deloitte notes health insurance prices in September 2022 were up nearly 30 percent from a year ago which is outpacing the rate of inflation growth of roughly 8 percent². With overall costs rising, it is more important than ever for the model to drive care transformation to support improved health outcomes and ultimately lower costs.

HSCRC Staff has recommended adjustments that, if implemented, would drive \$102 million in Medicare savings in 2023. This would be achieved through a combination of all-payer hospital rate reductions, Medicare-only rate reductions with a corresponding elimination of the hospital component of the Medicaid Deficit Assessment paid to the State of Maryland, and an increase in the public payer differential.

Maryland has relied on hospital savings to meet Model requirements since global budgets were established. HSCRC Staff recently released data to the Total Cost of Care workgroup demonstrating that during the period 2013-2019, Maryland averaged \$39 million in annual savings relative to Medicare's national rate of growth. However, in a reversal of prior years' trends, comparing the first six months of 2022 to the same period in 2021, Maryland Medicare hospital spend has grown by \$144 million more than the nation, representing 77 percent of Maryland's excess cost. When Staff looked deeper at inpatient trends in Maryland, they found that the primary driver of Maryland's excess inpatient cost was cost per day, not an increase in admissions or case mix. There have been attempts to frame this as a Medicare-only issue that we all should be working to solve, but CareFirst's members, other commercial members, Medicaid, and Medicare beneficiaries have all been subject to the same all-payer rates driving this cost per day, making it clear this is not just a Medicare issue. Thus, we support the Staff's first step in their proposal of an all-payer rate reduction, acknowledging this is an all-payer system.

However, we are deeply troubled by Staff's recommendation to increase the public payer differential by one percent, shifting \$50 million in public payer spending to individuals and businesses holding commercial insurance. This would yield \$26 million in "savings" for Medicare Fee-for-Service, but would fail to address underlying issues with respect to utilization and cost growth.

- **Lack of policy basis or empirical evidence** – The public payer differential has a long history in Maryland and is in place for 2 reasons: (1) to account for prompt payment, which applies to all payers; and (2) to account for public payer business practices, which avert bad debt. In 2018, HSCRC approved a historic adjustment to the public payer differential. At the time, Staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on changes in bad debt percentages by payers and was intended to correct for market dynamics. In this recommendation, the HSCRC also included the following conditions:

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1

2. "Inflation signals unrest ahead for health care"; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

“...The success of the Model is dependent on improving care, reducing avoidable utilization, and providing efficient and effective care. To this end, the Commission should not use changes to the differential to meet TCOC savings performance requirements.”

“...It is the intent of the Commission to make a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract to correct for cost inequities within the system and to avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.”

The draft recommendation violates these conditions that were approved by HSCRC to avoid this scenario. There is no evidence that market dynamics have changed between payers nor any rationale for the one percent increase. The public payer differential, which has a foundational purpose, is inappropriately being used as a vehicle to plug the remainder of required Medicare savings. Approval of this recommendation would call into question the integrity of the Model and the State’s commitment to an all-payer system.

- **Precedent setting** – The Model’s savings requirements are in place to hold the State accountable for driving care transformation, lower cost growth, and improved outcomes. If HSCRC chooses to use a cost shift to meet these savings targets, it sets the precedent that when the Model’s performance is in question, the public payer differential can serve as a backstop. This is not why the differential is in place and we advise against setting that precedent.
- **Implications at CMMI** – The apparent purpose of the public payer differential in this proposal is to artificially improve its performance for one payer. The Model specifically references “avoiding shifting costs” with regard to the public payer differential. The intent of the Model is to drive improved population health and true transformation of the delivery system, not to shift costs away from Medicare to other payers and consumers. We already know how CMMI will react to this – HSCRC put forward a proposal to CMMI that would have used the payer differential to help solve the Medicare Advantage benchmark problems faced by Maryland. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We would caution the HSCRC against ignoring that history.

During the discussion at HSCRC’s November public meeting, HSCRC Staff responded to concerns about the public payer differential adjustment proposal by noting that it was intended to be temporary, ending in fiscal year 2024. CareFirst opposes this proposal even though it is temporary, because of the principles laid out above, not its material or immaterial impact on our business. Notwithstanding, it is unclear how the HSCRC expects to be able to reverse the adjustment in 2024 without shifting cost onto Medicare, presenting some of the same guardrail and savings challenges we face today. In its history, HSCRC has made several temporary adjustments that have become permanent, namely the artificial rate realignment of 25% of

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1

2. “Inflation signals unrest ahead for health care”; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

inpatient costs to outpatient rate centers, which shifted costs from Medicare to commercial payers, and the continued use of the Medicaid Deficit Assessment, which was initially used to temporarily take fiscal pressure off the State budget during the previous economic downturn.

CareFirst always appreciates the unique opportunity we have in Maryland to partner with the HSCRC and hospitals to advance the principles and intent of our Model. As HSCRC identifies appropriate adjustments to address Maryland's current Model performance, we simply encourage adherence to the fundamental tenets of this system. Thank you for the opportunity to comment on this important issue.

Sincerely,

A handwritten signature in black ink, appearing to read 'Charlene MacDonald', followed by a horizontal line.

Charlene MacDonald

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1
2. "Inflation signals unrest ahead for health care"; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

November 21, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich,

Thank you for the opportunity to provide responses to the Health Services Cost Review Commission's (HSCRC) request for input regarding proposed actions considering the State's current performance on the Total Cost of Care (TCOC) Agreement with the Centers for Medicare and Medicaid Services (CMS). TidalHealth appreciates the HSCRC's efforts to consider comments from the hospital industry on how best to address this issue.

As we noted in our earlier comments on potential actions, TidalHealth supports a limited adjustment beginning in January 2023. In determining the magnitude of the recovery, the HSCRC needs to balance various competing factors, including the following:

- The recovery needs to be of a sufficient size to demonstrate to CMS that the State, and by extension Maryland's hospitals, is taking its obligations seriously under the TCOC Agreement.
- Since the final performance for CY 2022 will not be known until mid CY 2023, the recovery needs to be based on the best data available, including by considering a wide range of potential projections, so as not to cause significant revenue swings if a subsequent correction is needed on July 1, 2023.
- Although a correction is needed based on the most recent performance data, Maryland's hospitals, similar to national peers, are experiencing unprecedented financial pressures. While Maryland cannot be an island unto itself, the rate setting system was specifically established to ensure solvency for efficient and effective hospitals.

TidalHealth supports a long-term plan based on existing policies with certain modifications to create a more targeted approach than may be able to be developed with the limited time before January 1, 2023. While the Commission is appropriately developing a corrective response to the state's current performance under the Model agreement, it is likely that both the Maryland healthcare industry and healthcare nationally have yet to reach a steady state in the pandemic's aftermath. This fact suggests that the state's current underperformance may not persist to the degree documented in current data and that policy corrections should be applied with caution to avoid undue financial hardship to hospitals that could result from an overcorrection.

TidalHealth is supportive of the all-payer nature of the rate setting system and believes that it has been a foundational success over the past several decades. By establishing certain quality programs such as the Readmissions Reduction Incentive Program (RRIP) as all-payer, providers are able to focus holistically on clinical delivery approaches that are in the best interests of the patients, regardless of payer. This type of approach has set Maryland apart from other regulatory models and value-based programs nationally, which are typically more fragmented and lack the cohesiveness of the all-payer system.

In that spirit, TidalHealth supports the staff's proposal to remove the 0.4% increase in the update factor that was provided for Fiscal Year 2023. We view this reduction as a prudent step toward realigning the state's per beneficiary total cost of care with national trends. We note, however, that this is an all-payer response to a fundamentally Medicare policy issue. Because this increase was intended to address the shortfalls in revenue that Maryland hospitals are experiencing in the face of rising inflation, we ask that the Commission make this change a temporary adjustment with the intention of restoring this revenue to the rate base as the system stabilizes. Inflation represents a permanent increase in our costs, and a permanent rate reduction will cause continued financial stress in the face of rising costs across the board.

Although TidalHealth supports the all-payer system, we believe that a temporary Medicare-only action is also warranted in this situation. The TCOC Agreement with CMS is based on achieving Medicare savings, not all-payer savings. Since the State is currently failing this Medicare-only test while continuing to meet the all payor per capita growth rate, any action that recovers funds on an all-payer basis is unnecessary and only adds to the financial distress of the hospitals.

By applying the recovery on an all-payer basis, the savings will accrue to commercial insurers who already receive significant financial benefit from the all-payer rate setting system, paying less for hospital services than their peers in other states. If an all-payer recovery is implemented, the HSCRC should work with their colleagues at the Maryland Insurance Administration to ensure that these savings are passed along to premium payers, e.g. consumers, and not solely increase the financial margins of the insurers. The staff's proposal to increase the payer differential on a temporary basis is a fair suggestion to directly address the issue of commercial payer engagement during this policy response.

Moreover, TidalHealth supports a thoughtful and targeted approach to any Medicare-only recovery rather than an across-the-board reduction. Although TidalHealth has concerns regarding the current Integrated Efficiency Policy (including in its use of the TCOC benchmarks as currently designed), the basic premise of providing additional funding for low cost and price efficient hospitals while taking money away from higher cost and price inefficient hospitals is sound policy. The HSCRC should apply this same premise to any recovery, rather than implementing an across-the-board reduction that doesn't distinguish between inefficient and efficient hospitals and is inconsistent with HSCRC's stated policy goals.

TidalHealth believes that any rate adjustments in January should be based on the goals of existing HSCRC policies while we – the hospital industry and HSCRC – work towards a longer-term solution that could be implemented in July. TidalHealth offers the following suggestions for areas of discussion and opportunity, to be considered now and as a longer-term policy is developed:

- **Modifications to the current Integrated Efficiency Policy.** The current policy includes a TCOC calculation that is based on information that substantially misrepresents reality, that unfairly penalizes rural areas of the state, and that runs counter to the HSCRC's and CMS's goal of

improving health outcomes while achieving health equity. For example, we believe that the selection of benchmark counties was based on a limited set of matching criteria that failed to adequately consider social determinants of health and, more importantly, lacked any analysis of desired health outcomes. Using these benchmark counties lowers the TCOC benchmarks for Maryland rural hospitals, thereby placing them at risk of losing money – money that is needed to fulfil their statutory mandate of improving the health of their communities. We also believe that the failure to adjust for price differences across geographies—most critically by ignoring the Medicare hospital wage index, which is used to directly adjust Medicare hospital payments under the IPPS and OPPIs, as well as the payments for several other non-hospital providers—was arbitrary and capricious. This fatal flaw compounds the problematic redistribution of revenue from rural counties to affluent areas, further increasing inequities in the Maryland healthcare system, all in direct contravention of our Model’s goals. We plan to continue to evaluate our legal options to challenge the existing TCOC benchmark methodology. While we intend to submit a more detailed proposal as part of discussions regarding the longer-term plan, we ask that the Commission remove the problematic TCOC benchmarks from any solution that is implemented on January 1, 2023. We propose replacing the use of the benchmarks in the Integrated Efficiency Policy with a TCOC growth calculation measure instead.

- **Excess capacity and retained revenue.** TidalHealth believes that the HSCRC’s current position on this issue needs to be revisited. By not addressing excess capacity and locking fixed revenue in increasingly price inefficient hospitals, the current HSCRC position:
 - Increases costs for patients receiving services at these facilities;
 - Reduces funding for needed investments at hospitals still providing needed clinical services; and
 - Provides a perverse incentive for hospitals to eliminate services, regardless of the needs of the communities that they serve.

TidalHealth does not agree with the premise that addressing retained revenue will provide a disincentive for hospitals to continue to reduce utilization. A policy could be developed that allows for the retention of these funds for a defined period of time, with an expectation that they would be used for specific purposes and reduced in a thoughtful way over time to reflect the reduced level of service that the hospital is providing. This premise is already reflected in the conversion of acute care hospitals to Freestanding Medical Facilities (FMF). The HSCRC reduced funding for FMFs because they were providing fewer services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

- **Review of existing assessments and add-ons in rates.** Over time, the HSCRC has included many assessments and add-ons in rates for things like the Medicaid deficit assessment, Graduate Medical Education, and Catalyst Regional Partnerships. While each of these on their own potentially has merit or meets a pressing need, they collectively add cost to the system, negatively impacts our performance under the TCOC Agreement, and can make otherwise price inefficient hospitals appear to be more efficient. As part of the longer-term process, the HSCRC and industry should examine each of these assessments and add-ons to determine if they are still appropriate, both in their policy goals and magnitude. The proposed reduction in the state’s deficit assessment that has existed for several years is a promising beginning to that process.

Thank you again for the opportunity to provide feedback to the HSCRC on this important issue. The leadership of TidalHealth will make itself available should you or your staff have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Steve Leonard", written in a cursive style.

Steve Leonard



15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

For information, contact:
Matthew Celentano, Executive Director

November 28, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Public Payer Differential Adjustment

Dear Ms. Wunderlich:

On behalf of the League of Life and Health Insurers of Maryland, Inc. (League), thank you for the opportunity to provide comments on the public payer differential adjustment. The League is the state trade association representing life and health insurance companies in Maryland. On behalf of the five carriers in the state's commercial market (Cigna, CareFirst Blue Cross Blue Shield, CVS/Aetna, Kaiser Permanente, and UnitedHealthcare), who provide coverage to millions of Marylanders, the League appreciates the opportunity to comment and express our concerns with proposed adjustment to the differential.

League members are very supportive of the proposed overall goals of the Total Cost of Care Model (Model), but are very concerned about the current public payer differential adjustment discussion. The HSCRC's proposal to increase the differential 1% will just shift the cost from public payers to the commercial market and ultimately Maryland consumers in higher premiums.

Unfortunately we are not currently seeing the promise of the cost savings through outcome improvements in the Model, and the discussion departs from that objective by asking commercial carriers and their members to fund the Model's Medicare savings target, rather than driving true transformation of the delivery system. The proposal represents rate manipulation and will ultimately just be a pass through to individuals, employers, and the employees they are trying to cover. Not only does the proposal hurt these stakeholders, but it's a bad precedent as Maryland and the Center for Medicare and Medicaid Innovation (CMMI) try to realize the goals of the Model.

The League of Life and Health Insurers of Maryland, Inc.
15 School Street, Annapolis, MD 21401
410-269-1554
www.leaguemaryland.com

In addition to the above concerns, we are concerned about the damage the proposal could do to Maryland's relationship with CMMI. In 2021, the HSCRC put forward a proposal to CMMI that would have used the payer differential to generate savings for Medicare Advantage plans, with the goal of increasing choice, enhanced benefit offerings, and competition that could be offered through a stronger MA market. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We are concerned that this proposal could jeopardize the waiver – if the HSCRC relies on a payer differential adjustment to meet the savings target, and CMMI rejects that approach, the State will have lost valuable time to explore other options to achieve \$300 million in savings by the end of 2023.

Lastly, the current proposal is in direct conflict with past HSCRC approved policies. In 2018, the HSCRC approved a historic adjustment to the public payer differential. At the time, Commission staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on the changes in bad debt percentages by payers due to increasing levels of uncompensated care. As part of that recommendation, the HSCRC stated that the change was being made for equity purposes and "the Commission should not use changes to the differential to meet TCOC savings performance requirements." Furthermore, it noted that the HSCRC should "avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model." HSCRC staff have not provided analysis or policy justification for this proposal. Thus, it is clear the public payer differential is being used as a vehicle to inappropriately shift costs between payers in an all-payer system.

Thank you, again for the opportunity to provide this feedback on the public payer differential adjustment. Should you have any questions, please do not hesitate to contact me. We are happy to continue the discussion and find solutions that attain the needed financial stability.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal line extending from the end of the signature.

Matthew Celentano
Executive Director
The League of Life and Health Insurers of Maryland, Inc.

October 7, 2022

Ms. Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie,

On behalf of the members of the Maryland State Medical Society (MedChi), I am writing to provide feedback to the Health Services Cost Review Commission (HSCRC) regarding its recent request for information on potential actions to be taken to address the expected shortfall of the State of Maryland under the Total Cost of Care (TCOC) Agreement with the Centers for Medicare and Medicaid Services (CMS).

As part of any action to address the expected shortfall, I would encourage the HSCRC to advocate for highlighting the exogenous factors provision in the TCOC Agreement in its discussions with CMS. These are unprecedented times that we are living through, with volumes remaining relatively flat nationally and CMS' own actuaries being off in their projections – used by HSCRC staff as part of the annual rate update for Maryland's hospitals – by several percentage points.

If CMS is unwilling to recognize the exogenous factors that have led to our current situation, then MedChi supports the position of the Maryland Hospital Association that a modest rate adjustment is needed January 1, 2023, to demonstrate the State's commitment to the success of the TCOC Agreement. MedChi believes that the adjustment should be viewed as an incremental step while a full assessment to better understand the magnitude of the issue is completed, allowing for a more comprehensive and longer-term solution to be implemented July 1, 2023.

In developing a longer-term solution, MedChi strongly advocates for the HSCRC to revisit the issue of excess capacity and retained revenue. By not addressing these issues in a comprehensive way, the current HSCRC position has the unfortunate consequence of increasing costs for patients receiving care at these facilities. It also limits the amount of funding available for needed clinical services and provides a perverse incentive for hospitals to eliminate services, regardless of the needs of the communities that they serve.

MedChi does not agree that removing retained revenue from the global budgets will necessarily provide a disincentive for hospitals to continue to reduce utilization. A complementary policy could be developed that allows a hospital to keep some of these funds, with the expectation that they would be used for specific purposes and reduced in a thoughtful way over time to reflect the reduced level of service that the hospital is providing. This policy premise is already reflected in HSCRC's position on the conversion of acute care hospitals to Freestanding Medical Facilities (FMF). In approving these new types of facilities, the HSCRC removed funding from the historic global budgets because they were providing less services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

It is in this spirit that MedChi continues to raise concerns about the lack of action by the HSCRC regarding the full rate review for Medstar Health. If the HSCRC had acted on the full rate review as approved by the Commissioners, it may have been able to identify significant savings and set a precedent by which future policies regarding retained revenue could be based. In the absence of the HSCRC acting on the full rate review, it has limited the policy tools available to it and ensured that funds that could be better spent on patient care are instead trapped in increasingly price inefficient facilities.

In its deliberations to identify potential solutions, MedChi strongly encourages the HSCRC to not remove any funding or make changes to two critical programs for the future success of the TCOC Agreement – the Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPCP). MedChi strongly supports and agrees with the separate letter sent by the management of the Maryland Primary Care Program. EQIP and MDPCP are strongly supported by the MedChi membership, align community practitioners with the hospitals, and have the potential to accelerate and deliver upon the savings requirements of the TCOC Agreement.

Thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in blue ink that reads "Gene M. Ransom III". The signature is written in a cursive style with a horizontal line at the end.

Gene Ransom
CEO
MedChi, The Maryland State Medical Society

cc: Adam Kane, Chairman, HSCRC
Joseph Antos, Vice Chairman, HSCRC
Tori Bayless, Commission, HSCRC
Stacia Cohen, Commissioner, HSCRC
James Elliot, Commissioner, HSCRC
Maulik Joshi, Commissioner, HSCRC
Sam Maholtra, Commissioner, HSCRC



November 28, 2022

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for adjusting for excessive Total Cost of Care (TCOC) growth in CY2022. JHHS appreciates the balanced approach that the Health Services Cost Review Commission (HSCRC) has taken with the draft recommendation. The approach leverages support for adjustments across all stakeholders that benefit from the Maryland Model, including hospitals, commercial payors and the state of Maryland. While JHHS is generally supportive of the HSCRC's draft recommendation, specific comments and concerns are noted below.

Staff recommends an all-payer rate reduction of 0.40% that will be taken from the January rate orders across the board

JHHS, and the majority of the hospital industry, supports a targeted approach to rate reductions, rather than across the board. The hospital industry developed a consensus position, recommending a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This approach was proposed by Maryland Hospital Association (MHA) at the October meeting, and most of the Maryland hospitals supported this approach. Reducing rates based on the efficiency policy accounts for the fact that some hospitals are better positioned to sustain rate reductions than others. Less efficient hospitals have retained revenue and the industry recognizes that 75% of the rate reduction should come from inefficient hospitals and 25% from the remainder. JHHS would encourage the HSCRC to reconsider this aspect of the recommendation and instead honor the industry consensus to achieve the reductions in a targeted way, utilizing the HSCRC approved efficiency policy. We strongly encourage staff to adhere to existing policies. To change policy stances in response to a correction period causes us to pause in trying to understand the purpose of a policy that has been used in the past, but is now not considered by staff to be "accurate" or "relevant" to help address the issues before us. Constant policy changes that are not properly vetted with the industry undermines the stability of the Maryland Model.

We would also encourage the HSCRC to alter the all-payer rate reduction when the state is failing the Medicare targets – there is only a need reduce Medicare costs in Maryland in order to achieve compliance. The hospital industry is facing unprecedented labor and supply costs, with operating margins deteriorating significantly. Implementing an all-payer rate reduction will worsen hospital financial conditions, resulting in difficult decisions about staffing and services for some hospitals, while providing minimal targeted savings to address the Medicare issue directly. There is no need to reduce rates to all payers, particularly when commercial payers already receive the benefit of reduced hospital costs.

Staff recommends requesting an increase to the Public Payer Differential of 1% for the remainder of FY 2023 and the duration of FY 2024, contingent upon approval of the Center for Medicare and Medicaid Innovation (CMMI)

JHHS strongly supports using the differential as a temporary tool to reduce Medicare costs in Maryland. Insurers are the biggest benefactor of Maryland's all-payer system, resulting in hospitals costs to commercial payers that are on average 25% less than the nation. Expecting all stakeholders to contribute to corrective actions sends a strong message to state and federal policy makers, recognizing that success and failure of the Maryland model requires support, commitment, and sacrifice from all parties. Additionally, as more charity care and bad debt is associated with insured patients being enrolled in high-deductible health plans, revisiting and revising the differential may be sound public policy.

Staff recommends implementation of the Medicare Performance Adjustment Savings Component of \$50 million

JHHS strongly supports using the Medicare Performance Adjustment Savings Component (MPA-SC) as a policy to bring Maryland cost growth in line with the nation. As noted earlier, JHHS believes that any reduction to hospital rates should be Medicare-only, and implemented based on the integrated efficiency policy, not across the board. The MPA-SC was developed and approved as a methodology to achieve the Medicare savings target if needed. The policy should be implemented now and used to mitigate across the board and all-payer reductions.

Additionally, given that there are various factors still in flux that will impact final model performance, JHHS believes the HSCRC should be cautious not to overcorrect with the adjustments under consideration. Of note, the actions inherent in the July 1, 2022 rate adjustments are not yet included in the data, and will have an impact on the state's final performance.

Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by \$50 million, contingent upon approval by the State Legislature

JHHS also supports this recommendation. Similar to the differential position, reducing the Medicaid Deficit Assessment demonstrates a multi-stakeholder commitment to protecting and preserving the Maryland Model, where all parties benefit. The staff recommendation notes that any

reduction to the Deficit Assessment is contingent upon approval by the State Legislature. However, a reduction to the remittance portion of the Deficit Assessment likely does not require any action by the Legislature. The laws governing the Medicaid Deficit Assessment were last revised by Chapter 16 of the Acts of 2019. The language currently states, “for fiscal year 2021 and each fiscal year thereafter, the budgeted Medicaid Deficit Assessment shall be \$294,825,000.” There is no reference in current law to a remittance portion, which is currently \$56 million. In fact, any requirement for a remittance portion of the Medicaid Deficit Assessment was removed from law after 2016. In reviewing the law as it is currently written, the HSCRC and the Maryland Department of Health have the authority to abandon the remittance portion of the Medicaid Deficit Assessment so long as the total assessment remains as \$294,825,000.

We appreciate concerns from the Maryland Medicaid program around long-term implications of this policy. However, the recommendation is a one-time only action, and is certainly justifiable when hospitals are experiencing unprecedented financial struggles and the Maryland Medicaid program is experiencing unprecedented financial surplus due to funds through the public health emergency.

Taking Corrective Actions Without Addressing Underlying Issues with the Model is Problematic

In addition to pursuing corrective action and as JHHS noted in our previous comment letter on potential corrective action, we also encourage the HSCRC and the industry to pursue a thoughtful evaluation of the policies within the TCOC Model that are improving patient care and those that are not. We must address the systemic problems within the Maryland Model and the Global Budget Revenue (GBR).

To this end, JHHS must reiterate our concerns around the issue of retained revenue and the need for a rational population-based and clinical needs approach to right-sizing bed capacity, especially in Baltimore City where the population has experienced a decline. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services:

- Recent Vizient and Sg2 data show that nationally, staffed beds at community hospitals declined by 3%, while Maryland has experienced a 17% decline in staffed beds at community hospitals. Simultaneously, AMC beds have grown 9% nationally, while in Maryland, AMC staffed beds remain stagnant.
- Nationally, community hospitals are shrinking; the revenue from these hospitals is being shifted to the hospitals that provide medically necessary care for those patients. However, in Maryland, this shrinkage is accelerated, while most of the revenue remains with the hospitals closing beds.
- Additionally, the population of Baltimore City is shrinking; the Baltimore City population was 576,498 in 2021, a 7.2% decrease from the population of 620,942 in 2010. As community hospitals are operating at a fraction of their fixed capacity and are projected

to see fewer inpatients over time, it is clear that their long-term role in the care continuum is changing.

- The Maryland Model should support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas. The model should not protect and insulate hospitals from bed declines that are either deliberate or the result of population shifts.
- The HSCRC should investigate and explore potential regulatory opportunities regarding length of stay (LOS). The current regulatory environment in Maryland has resulted in challenges related to getting patients admitted into long-term care facilities, which in turn increases LOS, particularly for complex patients.
- The HSCRC should also explore regulatory opportunities related to skilled nursing facilities (SNFs). Due to low Medicare Advantage penetration in Maryland, there is very little utilization management, resulting in more SNF bed days in Maryland compared to the nation. This becomes a crucial consideration as we evaluate total cost of care performance compared to the nation.

In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that – instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care, hindering progress on the benchmark, and limiting investments at hospitals still providing needed care to the community.

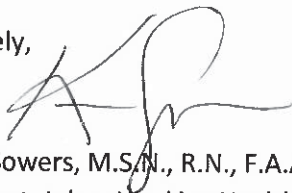
JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions, improved health, and addressing the underlying social determinants of health (SDOH). There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Locking retained revenue in facilities that no longer provide clinical care will also greatly limit the state's ability to invest in the types of transformative strategies that CMMI is expecting, namely housing and SDOH-focused interventions.

JHHS believes that corrective action needs to be pursued in order support the long-term viability of the Maryland Model. However, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS would

encourage the HSCRC to begin work in January to realign the existing incentives within the Model, with the goal of implementing a comprehensive approach that addresses the underlying challenges of the current Model and places Maryland on a stronger path to success.

JHHS appreciates the opportunity to comment on the draft recommendation and longer-term policy corrections that may be required of the State and the industry.

Sincerely,

A handwritten signature in black ink, appearing to be 'KS', written over a horizontal line.

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich

Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

November 28, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
750 E. Pratt Street
Baltimore, MD 21202

RE: Draft Recommendations for Adjustments to the Total Cost of Care Model

Dear Ms. Wunderlich:

Thank you for the opportunity to provide comments on the draft recommendations for adjustments to the Maryland Medicare Total Cost of Care Model. As the largest integrated health care delivery system in the United States,¹ [Kaiser Permanente's approach to care](#) shares similarities with the Maryland Model – a focus on care coordination, quality improvement, and population health, with aligned financial incentives.

From that perspective, we uniquely appreciate the promise of the Total Cost of Care Model to ensure access to high quality, equitable, and affordable care for all Marylanders. Nevertheless, we are concerned about the Commission's proposal to increase the public payer differential by one percent, shifting costs from public payers to commercial payers and ultimately to the members that they serve. Specifically, our concerns are as follows:

- **The proposal does not reflect true savings.** This approach undermines the central objective of the Total Cost of Care Model, which is health system transformation. The Model is based on the premise that better care coordination and quality will improve patients' health while generating cost savings to hospitals and ultimately consumers. The proposal under consideration departs from that objective by asking commercial carriers and their members to fund the Model's Medicare savings target, rather than driving true transformation of the delivery system.
- **CMMI has previously rejected cost-shifting proposals.** In 2021, the HSCRC put forward a proposal to CMMI that would have used the payer differential to generate savings for Medicare Advantage plans, with the goal of increasing choice, enhanced benefit offerings, and competition that could be offered through a stronger MA market. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We are concerned that this proposal could jeopardize the waiver – if the HSCRC relies on a payer differential adjustment to meet the savings target, and CMMI

¹ Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

rejects that approach, the State will have lost valuable time to explore other options to achieve \$300 million in savings by the end of 2023.

- **The proposal conflicts with the HSCRC’s past positions.** In 2018, the HSCRC approved a historic adjustment to the public payer differential. At the time, Commission staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on the changes in bad debt percentages by payers due to increasing levels of uncompensated care. As part of that recommendation, the HSCRC stated that the change was being made for equity purposes and “the Commission should not use changes to the differential to meet TCOC savings performance requirements.” Furthermore, it noted that the Commission should “avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.”

We appreciate that the COVID-19 pandemic has put tremendous financial pressure on hospitals and are open to discussion about additional actions that could be taken to achieve financial stability. Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

A handwritten signature in dark ink that reads "Allison Taylor". The signature is written in a cursive, flowing style.

Allison Taylor
Director of Government Relations
Kaiser Permanente



250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

November 28, 2022

RE: UMMS Comments Regarding the HSCRC November 9 Draft Staff Recommendation on Adjustments to the Maryland Medicare TCOC Performance

Adam Kane, Esq., Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane and Ms. Wunderlich:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, We appreciate the opportunity to state our position regarding the HSCRC's November 9 Draft Staff Recommendation on Adjustments to the Maryland Medicare TCOC Performance.

The Maryland Total Cost of Care (TCOC) Model is enormously beneficial to providers, commercial payers, and, most importantly, the citizens of Maryland. UMMS is a strong proponent of the Maryland Model and recognizes the serious nature of the Model performance. It is critical that stakeholders come together in the effort to tackle the shared task of improving Model performance and respond collectively. As such, we continue to strongly support the industry's position that any corrective action plan should share the financial burden among stakeholders and provide adequate funding toward hospital operations that support long-term per capita savings and population health improvement goals.

Maryland hospital's financial condition has greatly deteriorated and UMMS is also experiencing declining financial results as we have experienced operating losses through fiscal year to date October 2022. We urge the HSCRC to consider the industry's position when determining a final decision. With this in mind, our comments regarding the Recommendation are below.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM
University of Maryland Medical Center • University of Maryland Medical Center Midtown Campus •
University of Maryland Rehabilitation and Orthopaedic Institute • University of Maryland Baltimore Washington Medical Center •
University of Maryland Shore Regional Health – University of Maryland Shore Medical Center at Easton -
University of Maryland Shore Medical Center at Chestertown - University of Maryland Shore Medical Center at Dorchester –
University of Maryland Shore Emergency Center at Queenstown •
University of Maryland Charles Regional Medical Center • University of Maryland St. Joseph Medical Center •
University of Maryland Upper Chesapeake Health System – University of Maryland Upper Chesapeake Medical Center -
University of Maryland Harford Memorial Hospital •
University of Maryland Capital Region Health – University of Maryland Bowie Health Center –
University of Maryland Laurel Medical Center – University of Maryland Prince George's Hospital Center •
Mt. Washington Pediatric Hospital

UMMS Supports Raising the Public Payer Differential by 1% and Pursuing \$50M in State Support

All stakeholders benefit from the Maryland Model and should share accountability more equitably to ensure the Model's success. Raising the payer differential and securing state funding ensures that hospitals do not carry the full burden of the corrective action. Maryland hospitals are delivering significant savings to all-payers. Raising the payer differential is a reasonable approach to ensuring payer participation in securing the future of the Model.

Additionally, reducing the Medicaid Deficit Assessment to hospitals represents another important opportunity for shared accountability. We urge the HSCRC to pursue this avenue with the State and to investigate the potential avoidance of Legislature action.

The 0.4% All- Payer Rate Reduction Should be Replaced with a Medicare-only MPA-SC Adjustment

UMMS strongly disagrees with the proposed 0.40% all-payer reduction and believes it should be eliminated. The state's current performance is not driven by hospital volume or price growth, but rather a slowing in the growth rate of the nation. Since all stakeholders in the state benefit from the model, the majority of the financial burden must not be borne by hospitals, but rather shared across all stakeholders. As indicated earlier, hospitals are facing significant financial challenges and implementing an all payer reduction of 0.40% would place a disproportionate financial burden on hospitals, when a smaller, more directed adjustment could be made in the MPA-SC.

Savings from the Traditional Medicare Performance Adjustment Should be Counted

The traditional Medicare Performance Adjustment (MPA) already measures change in TCOC performance from CY 2019 to CY 2022 versus the nation. As statewide performance has eroded, the overall MPA adjustment for the state is expected to be a significant reduction to hospital payments, potentially as high as \$45 million. Excluding this amount from any corrective action would result in providing more savings to Medicare than is required.

Medicare Performance Adjustment Savings Component Should Be Used for the Remaining Required Savings

Using the MPA-SC both limits the financial burden to hospitals by providing direct savings to Medicare and avoids shifting any further financial burden to other payers via other mechanisms. Using the MPA-SC protects the all-payer model given the need to ensure Medicare savings and avoids providing rate reductions to other payers that already achieve savings from the Model.

As stated in our October letter, we are supportive of distributing a small portion of the correction across-the-board, while distributing the majority of the MPA-SC according to the existing efficiency policy.

UMMS believes it is necessary to evaluate existing policies as part of a broader process to address the appropriate distribution of resources within our capped system. In our October letter, we provided remarks on this matter and continue to support those comments. Importantly, UMMS serves a broad, diverse set of communities in Maryland. Policies must account for the differential resources required to serve the unique circumstances of academic medical centers, sole community providers and providers with safety net functions. Working together to develop policies that create clear, direct incentives around all of these issues will be key to the long-term sustainability of our Model.

UMMS appreciates the opportunity to provide comments on the Draft Staff Recommendation and we look forward to continuing discussions with the Commission on policy topics.

Sincerely,



Mohan Suntha, MD, MBA
President and CEO
University of Maryland Medical System

Cc: Joseph Antos, PH.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen
James Elliott, M.D.

Maulik Joshi
Sam Maholtra
Michelle Lee, CPA CFO
Alicia Cunningham



November 28, 2022

Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie –

Thank you for continuing to allow Maryland hospitals to offer comments and suggestions on how an adjustment to Global Budget Revenues in response to Maryland's current performance on Total-Cost-of-Care (TCOC) might be applied at an individual hospital basis.

LifeBridge Health understands the Health Services Cost Review Commission position to possibly allocate the reductions to revenue using a combination of overall regulated revenue and performance on an efficiency measure – either ICC ranking, MPA performance or a hybrid of both. As we noted previously, we continue to remain supportive of the MHA proposal to allocate a \$25 million Medicare adjustment using a 25% proportioned reduction and 75% efficiency policy measure, but maintain concerns about the sole use of the ICC for larger overall revenue reductions given some of the unique issues highlighted in our October 6th comment letter and included below again for reference.

- The current Interhospital Cost Comparison (“ICC”) utilizes outdated volumes (FY2019) and more current volumes remained distorted due to the impact of COVID.
- The HSCRC has placed a moratorium on Full Rate Applications due to concerns with the validity of the Integrated Efficiency Methodology
- The Total Cost of Care attainment methodology does not adequately address health disparities and needs further refinement.
- LifeBridge continues to question whether the disproportionate share methodology adequately accounts for the costs in urban settings after the elimination of long-standing peer groups.
- The medical education resident adjustment needs to be evaluated to ensure that credit for non-academic hospitals is appropriate

CARE BRAVELY

2401 W. Belvedere Ave., Baltimore, MD 21215-5216 • lifebridgehealth.org

While we raise concerns with what we see as issues which might contribute to making the ICC a difficult method to use to apportion statewide revenue reductions, we remain both supportive of the Commission's goal of taking actions designed to stabilize TCOC performance and committed to the long-term success of Maryland waiver model.

Sincerely,

David Krajewski (signed MDM)

David Krajewski

Executive Vice President and Chief Financial Officer – LifeBridge Health
& President – LifeBridge Health Partners

Michael D. Myers

Michael D. Myers

Vice President Regulatory Reporting and Reimbursement, LifeBridge Health
& CFO Carroll Hospital

MidAtlantic BUSINESS GROUP ON HEALTH

November 28, 2022

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Executive Director

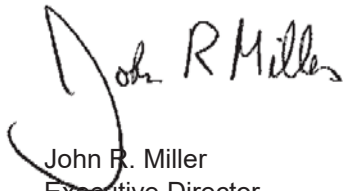
Dear HSCRC Leadership Team,

This letter is regarding the public payer differential change being considered by HSCRC. However, I'd first like to take this opportunity to express appreciation and support for the Maryland Total Cost of Care program. Over the years, the MidAtlantic Business Group on Health has sought to educate commercial healthcare purchasers (employers) on the unique situation that exists in Maryland. In fact, the Maryland TCOC approach aligns very well with what employers are driving for all over the country.

I have recently learned that HSCRC is considering a recommendation to increase the public payer differential by one percent. Of course, this will shift spending from public payers to commercial insurers (and indirectly to fully insured employers), self-insured employers, and ultimately workers.

Certainly, hospitals face economic pressures. However, shifting the responsibility for meeting these challenges to commercial purchasers of healthcare seems counter to the spirit and intention of the Maryland waiver. Many employers (including not-for-profit employers) are also facing economic pressures, as are their employees. I urge HSCRC to keep this conversation open, and to continue to find and consider options to avoid setting this precedent.

Very few non-healthcare employers are aware of HSCRC's existence, much less the details of HSCRC's calculations, and are thus unlikely to weigh in on this situation. Thanks for this opportunity to represent an employer's viewpoint.



John R. Miller
Executive Director
MidAtlantic Business Group on Health

November 28, 2022

Adam Kane, Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane and Ms. Wunderlich:

On behalf of the MedStar Maryland hospitals, we appreciate the opportunity to provide comments on the HSRC staff's Draft Recommendation on Adjustments to Maryland Medicare Total Cost Of Care (TCOC) Performance dated November 9, 2022.

We support the goal of overcoming the Maryland Model's immediate challenges created by pandemic driven volatility. Although hospitals continue to face unprecedented financial challenges as a direct result of the volatility of the COVID-19 pandemic, MedStar Health appreciates the need to improve the TCOC Model performance ensuring the longevity of our unique and valued reimbursement system which benefits all participants: patients, payors and hospitals alike. To that end, **MedStar Health supports the approach laid out in the Maryland Hospital Association's (MHA) comment letter which emphasizes a Medicare-focused reduction that is shared equitably across hospitals, payors and the state.**

Maryland's Model performance was running favorable to target prior to the pandemic and the current challenges meeting the guardrails are a direct impact of this unprecedented pandemic. Given this unique situation, we support HSCRC and the State activating the built-in flexibilities in the Model contract including:

- Invoking the exogenous factors clause
- Raising the public payor differential

To date, hospitals have shouldered a significant and disproportionate load of the financial burden associated with this once in a lifetime pandemic. National nursing shortages have placed hospitals in a precarious position. Workforce shortages and inflationary pressures have driven costs up significantly and macro-economic conditions have resulted in erosion of cash reserves for the health care industry. Nursing vacancy rates in the Mid-Atlantic are higher than the nationwide industry average highlighting the critical challenges associated with staffing. Further

underfunding inflation and/or disproportionately negatively impacting hospitals will further stress all Maryland hospitals' ability to remain competitive on a national level in attracting the necessary clinical resources to care for Maryland residents. **It is imperative that any solution does not further exacerbate the current underfunded inflationary crisis faced by hospitals.**

There have been large fluctuations in hospital volumes and healthcare needs since the pandemic began. Historical information is likely to look much different than current and future state. As we move forward, policy changes undoubtedly will be necessary; however, decisions made on historic data may not reflect current realities and could jeopardize delivery of healthcare services. As a result, HSCRC's historical disciplined approach will be even more critical in making future policy changes.

In closing, we ask that the HSCRC balance the need for action with stability and predictability, which have been hallmarks of the Maryland Model.

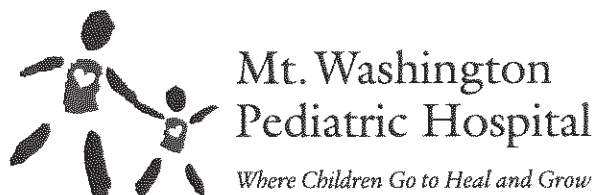
Thank you for the opportunity to provide comments.

Sincerely,



Susan K. Nelson
Executive Vice President and Chief Financial Officer
MedStar Health, Inc.

cc: Joseph Antos, PhD
Victoria W. Bayless
Stacia Cohen, RN, MBA
James Elliott, M.D.
Maulik Joshi, DrPH
Sam Malhotra
Kenneth A. Samet, President & CEO, MedStar Health



Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

December 7, 2022

Jerry Schmith
Principal Deputy Director, Revenue and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Mt. Washington Pediatric Hospital – Comments Regarding TCOC Performance and Potential Corrective Action Steps

Dear Jerry:

This letter is to provide commentary to the Health Services Cost Review Commission ("The HSCRC") in response to the request at the September Public Session for input on potential corrective action steps that may be required if the State does not meet the financial targets required by the Maryland Total Cost of Care Model.

As proposed, the HSCRC would reduce all-payer rates, in an effort to improve Model performance in the Medicare segment. However, as a children's hospital, MWPH has virtually no Medicare revenue. In FY21 and FY22, total gross regulated Medicare revenue at MWPH averaged about \$24,000, or 0.03% of total revenue.

At the same time, a rate reduction of 0.4% would cost the hospital approximately \$250,000 in a year when we are struggling financially due to low volumes/revenue related to staffing shortages.

MWPH is unlike most acute care hospitals in the State, is not on a Global Budget Revenue reimbursement arrangement. It is our request that the HSCRC note the impact of these proposed changes and consider the exclusion of MWPH from the proposed corrective actions.

Sincerely,

Mary Miller, Chief Financial Officer MWPH

cc: Derrek Myers, Director, UMMS
Alicia Cunningham, SVP, UMMS

Accredited by The Joint Commission
and by Commission on Accreditation
of Rehabilitation Facilities

mwph.org

Mt. Washington Pediatric Hospital
1708 West Rogers Avenue
Baltimore, Maryland 21209
410-578-8600

Dennis Phelps, HSCRC
Cait Cooksey, HSCRC

**Mt. Washington Pediatric Hospital
at UM Capital Region Medical Center**
901 North Harry S. Truman Drive,
8th Floor, Largo, Maryland 20774
240-677-1800 (inpatient)
240-677-1850 (outpatient)



Ascension Saint Agnes

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

November 28, 2022

Dear Ms. Wunderlich,

I am writing on behalf of Ascension Saint Agnes to provide feedback to the Health Services Cost Review Commission (HSCRC) on the draft recommendation on adjustments to Maryland's Medicare Total Cost of Care (TCOC) Performance.

The HSCRC staff has proposed a series of reductions to increase Maryland's Medicare savings by a total of \$102 million beginning January 1, 2023. These reductions include:

- All-Payer Rate adjustment effectuated through hospital rate orders (reversal of 0.40% provided in RY 2023 Update Factor)
- Medicare-only payment reductions effectuated through the Medicare Performance Adjustment Savings Component
- Public Payer rate reductions through an increase to the Public Payer Differential for the duration of FY 2023 and 2024
- State contribution through Medicaid Deficit Assessment or additional grant dollars

Ascension Saint Agnes appreciates the comprehensive approach that the HSCRC staff has proposed, including leveraging other policy options such as reducing the Medicaid Deficit Assessment, but we remain concerned about any reductions that are unnecessarily broad-based and not directly targeted to providing savings to Medicare. While we agree in the all-payer nature of the TCOC Model and believe that it should be a central tenet of any customary actions adopted by the HSCRC, our current situation is an outlier largely caused by circumstances outside of Maryland's control, including relying upon actuarial estimates provided by the Centers for Medicare and Medicaid Services (CMS) that proved to be largely inaccurate. The goal of any

reductions should be to balance between taking proactive steps to restore some of Maryland's savings under the model while not overly removing needed revenue from hospital rates while we are still struggling with ongoing staffing and other inflationary issues.

Ascension Saint Agnes also supports a targeted approach to any reductions based on the Integrated Efficiency Policy. An across-the-board reduction that doesn't distinguish between inefficient and efficient hospitals is inconsistent with the HSCRC's stated policy goals. Any actions taken by the HSCRC to improve Maryland's current TCOC performance should be consistent with existing policies that distinguish performance amongst hospitals and distribute rewards and penalties accordingly.

Thank you again for the opportunity to provide feedback to the HSCRC on this important issue.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ed Lovern", written in a cursive style.

Ed Lovern
President and CEO

UPMC Western Maryland

12400 Willowbrook Road
Cumberland, MD 21502
240-964-7000

November 28, 2022

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

Dear Mr. Kane,

I am writing on behalf of UPMC Western Maryland (UPMC Western Maryland) to share our feedback regarding the draft recommendation on adjustments to Maryland's Medicare Total Cost of Care (TCOC) performance recently presented at the November 9th meeting of the Health Services Cost Review Commission (HSCRC).

The HSCRC staff proposed a series of actions to increase Maryland's Medicare savings by a total of \$102 million beginning January 1, 2023, to address the current projections and Maryland's anticipated shortfall in meeting the TCOC Model's compound savings target for Calendar Year 2022. These actions include:

- All-payer rate adjustment effectuated through hospital rate orders (reversal of 0.40% provided in RY 2023 Update Factor)
- Medicare-only payment reductions effectuated through the Medicare Performance Adjustment Savings Component
- Public payer rate reductions through an increase to the public payer differential for the duration of FY 2023 and 2024
- State contribution through the Medicaid Deficit Assessment or additional grant dollars

UPMC Western Maryland appreciates the HSCRC's interest in hearing directly from the hospital field regarding these potential actions. We acknowledge the necessity of acting in January to demonstrate Maryland's commitment to the TCOC Model, including the need to achieve the agreed upon savings over time, but we encourage the HSCRC to be thoughtful in its approach and not overcorrect which will result in undue harm for the industry that is already struggling. UPMC Western Maryland, like our colleagues across the state, continues to struggle with increased labor expenses and other inflationary pressures that are limiting our ability to invest in needed clinical and community programs that are critical in this rural area of the state.

Since the State is currently failing this Medicare-only test while continuing to meet the all payor per capita growth rate, any action that recovers funds on an all-payer basis is unnecessary and only adds to the financial distress of the hospitals. We encourage the HSCRC to utilize the Medicare Performance Adjustment Savings component to target the adjustment to Medicare only.

UPMC Western Maryland

12400 Willowbrook Road
Cumberland, MD 21502
240-964-7000

UPMC Western Maryland understands the desire to target the rate reduction, however concerns remain with the TCOC methodology which is part of both the MPA and Integrated Efficiency Methodology. As stated previously, we believe the TCOC benchmarking methodology is biased against rural providers in areas with poor socio-economic factors. If a targeted approach is utilized, we feel it should be based on price efficiency only to address retained revenue which has resulted in higher hospital prices.

Thank you for your time and attention to our feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,



Amber Ruble
Chief Financial Officer

CC: Katie Wunderlich, Executive Director
Joseph Antos, Ph. D.
Victoria Bayless
Stacia Cohen, RN, MBA
Maulik Joshi, DrPH
James N. Elliott, M.D.
Sam Malhotra



November 30, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

RE: Draft Recommendations for Adjustments to the Total Cost of Care Model

Dear Ms. Wunderlich:

My name is Jon Frank, and I am a senior legislative consultant for the Maryland Association of Health Underwriters (MAHU). On behalf of MAHU, I am writing to offer comments on the referenced recommendations.

MAHU is a trade association of several hundred licensed health insurance brokers, agents and consultants who represent a substantial portion of small and medium-sized businesses in Maryland that offer health benefit plans among other employee benefits. A critical role for MAHU members is to identify cost-effective coverage options for employees of their business clients including advice on subjects such as cost-sharing, tax-deductible options for employees, and other methods of addressing the cost of health insurance.

The rapid growth of inflationary factors across our broad economy has affected health care services as well, including the cost of health insurance. In fact, although the small employer health insurance market in Maryland has enjoyed stable enrollment for a number of years, for the first time in recent memory it is experiencing double digit rate increases due to inflation. Small employers are especially sensitive to such increases.

Another factor driving costs are recent changes in the individual health insurance market. On MAHU's behalf, I participated in a study conducted by the Maryland Health Benefit Exchange this year on the subject of proposed subsidies in the small group market, a change originally proposed in Senate Bill 632. That study was overtaken by events at the federal level with new, additional subsidies adopted in the individual health insurance market. As a result, potential subsidies in Maryland small group have been put on hold, pending the expiration of these new individual subsidies several years from now. Nevertheless, these subsidies place additional pressure on employers who are considering whether to keep their small group health plans or simply send employees to the individual market (or no market at all).

To this dual effect of general inflationary pressures and the new individual market subsidies, the HSCRC now proposes an additional rule change increasing the public payer differential that will add some tens of millions of dollars in higher costs. The policy argument in favor of this rule change has not, to our knowledge, been presented. Instead, the reason seems to be simply to address a savings shortfall that, in the opinion of the Commission, should be filled in this manner. We respectfully disagree.

We are aware that the Commission, in approving a previous adjustment to the public payer differential in 2018, engaged in a detailed analysis to demonstrate the reason for the change. That adjustment, in simple terms, was

based on changes in bad debt percentages resulting from higher levels of uncompensated care. The Commission also stated at that time that it "should not use changes to the differential to meet TCOC savings performance requirements." The logic of that statement also applies today.

MAHU appreciates the opportunity to offer comments on the draft recommendations under consideration by the Commission. We hope that you find our comments to be constructive.

Very truly yours,

A handwritten signature in blue ink that reads "Jon Frank". The signature is fluid and cursive, with a long horizontal stroke extending from the end.

Jon Frank

cc: Bryson Popham
Nancy Colaianne