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Final Recommendation for the Update Factors for Rate Year 2023

June 8, 2022

This recommendation was approved by the Commission on June 8, 2022.

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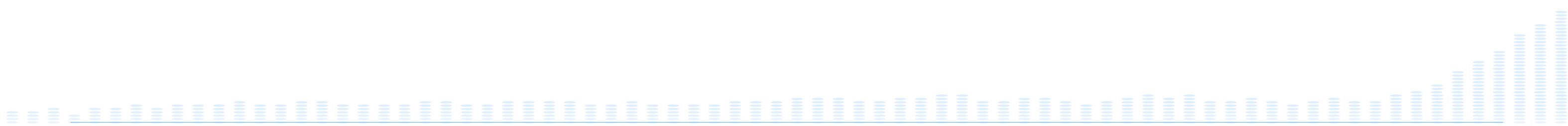


List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
MPA-SC	Medicare Performance Adjustment - Saving Component
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 3.38 percent per capita, a revenue increase of 3.25 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.66 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics. The updates for GBR hospitals and specialty hospitals include an additional 0.40 percent for inflation catch up.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2023. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.	The annual update factor contains the growth of costs for all payers and also reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Summary

The following report includes the final recommendation for the Update Factor for Rate Year (RY) 2023. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis continues to create significant uncertainty and will likely drive large, short, and long-term changes in the healthcare industry. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability and slowing the growth of healthcare costs.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022.

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland has already

met the 5-year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to develop the RY 2023 annual update is outlined in this report, as well as staff's estimates on calendar year Model tests.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2023 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2023, HSCRC staff is proposing an update of 3.38 percent per capita for global budget revenues and an update of 4.06 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's First Quarter 2022 market basket growth estimate with a capital growth estimate. For RY 2023, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth estimate of 2.20 percent, calculating the gross blended amount as a 3.66 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 3.66 percent. The pandemic's effect on hospitals continues to result in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years. After review of inflation over the course of the pandemic from RY 2020 - RY 2022, staff have determined that hospitals have been underfunded by approximately 0.40 percentage points. That amount has been added to the inflation amount outlined in Table 1 below. Table 3 outlines this inflation catch up in more detail.

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66%	3.66%
Inflation Catch-Up	0.40%	0.40%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	4.06%	4.06%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.68 percent and per capita growth of 3.81 percent for RY 2023. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.25 percent with a corresponding per capita growth of 3.38 percent for RY 2023.

To measure the proposed update against financial tests, which are performed on Calendar Year results, staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2023 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for RY 2023			
Components of Revenue Change Link to Hospital Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 4.80% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
- Inflation Catch Up			0.40%
Gross Inflation Allowance	**A**		**4.06%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.68%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.81%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.68%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.81%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**3.25%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**3.38%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**3.25%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**3.38%**

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.66 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth index change of 2.20 percent. The adjustment for inflation includes 3.90 percent for wages and compensation. A portion of the 3.66 inflation allowance (0.02 percent) will be allocated to hospitals to more accurately provide revenues for increases in outpatient oncology and infusion drugs . This drug cost adjustment is further discussed below. After further evaluation of inflation during the course of the pandemic, hospitals have been underfunded for RY 2020-RY2022 by approximately 0.40 percent. The details of this calculation can be reviewed in Table 3 below.

Table 3

	RY 2020	RY 2021	RY 2022	Cumulative Growth
Funded Inflation	2.96%	2.77%	2.57%	8.53%
Actual Inflation	2.31%	2.01%	4.42%	8.98%
	0.65%	0.76%	-1.85%	-0.40%

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2023 continues this practice. While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and

the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Staff reviewed trends from 2018 to 2021 and determined that price and mix trends remain well below prior years. Therefore, staff is proposing a 1 percent drug inflation factor for RY 2023, which calculates to 0.02 percent that will be earmarked for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2022 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2022 of -0.22 percent. RY 2023 funding is expected to be approximately 0.20 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2022 is -0.12 percent. For RY 2023 the staff is proposing to use the value of the Department of Planning CY 2022 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. Due to the confounding impact that the COVID-19 pandemic has had on data, staff will not implement an efficiency policy effective July 1, 2022, but is assessing if a mid-year efficiency policy that addresses COVID concerns could be utilized in January 2023.

- **Set-Aside for Unforeseen Adjustments:** Staff recommends 0.10 percent set-aside to use for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits

dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018, 2019, 2020, and 2021. Based on this analysis, staff concluded that the historical average growth rate was 0.54 percent, which equates to a combined state impact of 0.14 percent for the RY 2023 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2023 PAU savings adjustment, of -0.32 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2021 PAU performance
- **Quality Scaling Adjustments:** These pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR).

  Over the past several months, staff have worked with the Performance Measurement Workgroup to assess potential modifications to the underlying measurements and methodologies for the RY 2023 pay-for-performance programs due to the confounding effects of the COVID public health emergency. While many workgroup members supported staff's guiding principle to adjust or not adjust for COVID in a uniform fashion across the three core quality programs, other workgroup members remain concerned about the overall deterioration in revenue adjustments relative to RY 2022.

  Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing programs will not be included in the federal RY 2023 payment program due to data validity concerns. Specifically, the proposed rule may make the Hospital Value-Based Purchasing (HVBP) program and the Hospital Acquired Conditions Reduction Program (HACRP) revenue neutral for federal RY 2023. These programs are analogous to the QBR and MHAC programs, respectively.

  Given the uncertainty of the federal programs, which are the basis for the required at-risk in programs in Maryland, staff are recommending that Quality programs in the RY 2023 Update Factor remain to be determined and that any adjustments determined through further engagement of the Performance Measurement Workgroup be implemented in January rate orders. Depending on the final IPPS rule, which will not be promulgated until after the start of the State fiscal year, staff may revise its recommendations to align with federal guidance. Similarly, if the final IPPS rule recommends any changes to the Hospital Readmissions Reduction Program (HRRP), which is the analog for RRIP, staff will potentially modify revenue adjustments for this program as well.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2023 will be -0.43 percent. The amount in rates was 4.65 percent in RY 2022, and the proposed amount for RY 2023 is 4.22 percent, a decrease of -0.43 percent.
- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2023, and as a result, this line item is 0.00 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2023, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This will result in a RY 2023 PAU savings reduction of -0.32 percent statewide, or $60,153,549. Hospital performance on avoidable admissions per capita and 30 day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4

Statewide PAU Reduction	Formula	Value
RY 2022 Total Estimated Permanent Revenue*	A	$18,797,984,034
RY 2023 Inflation Factor**	B	3.52%
CY 2019 Total Experienced PAU $	C	$1,719,724,282
RY 2023 Proposed Revenue Adjustment $	D = B*C	-$60,534,295
RY 2023 Proposed Revenue Adjustment %	E = D/A	-0.32203%
RY 2023 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.32%**
RY 2023 Adjusted Proposed Revenue Adjustment $	G = F*A	**-$60,153,549**
Total PAU %	H	9.77%
Total PAU $	I = A*H	$1,835,962,632
Required Percent Reduction PAU	J = G/I	-3.28%

*Does not include revenue from McCready, or freestanding EDs.

** Inflation factor is subject to revisions related to updated data and Commission approval

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the Model to generate $300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2021 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $222 million for performance year three (CY 2021). However, while the State has favorable savings for CY 2021, guardrail performance when compared to the nation is expected to be unfavorable, with Maryland growing faster than the nation in 2021. Final CY 2021 data is in the process of being reconciled and approved with CMS and will be released at a later date, but staff anticipate that the State will miss the guardrail target by greater than 0.5 percent. Similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used to estimate national trend. However due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails in RY 2022. For RY 2023 staff is

using a similar approach as the prior year trend is, once again, not likely to be an accurate reflection of future trends.

Actual revenue resulting from RY 2022 updates affect the CY 2022 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2022 to assist in estimating the impact of the recommended update factor together with the projected RY 2023 results. The overall increase from the bottom of this table is used in Tables 6a-6c.

Table 5

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(125,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**10,011,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraordinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		20,081,373,781
Permanent Update RY 2023		3.25%
Adjusted Change from GBR RY 2022		2.26%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,986,467,181
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,983,716,261**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,995,385,313**
Increase over CY 2021 Revenue		5.51%

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2021.

Step 1: The table uses global revenue for RY 2022 and actual revenue for the last six months for CY 2021 to calculate the projected revenue for the first six months of CY 2022 (i.e., the last six months of RY

2022). Hospitals currently project they will not be able to charge all of RY 2022 revenue by the end of the Rate Year, the estimated shortfall is $125 million (the RY 2022 Undercharge). The RY 2022 Undercharge is either (a) forfeited as penalties or (b) deferred and added to revenue as a catch-up in the first half of CY 2023, or some combination of the two, with the actual result varying by hospital. Under either scenario it does not impact CY 2022 revenue and is therefore subtracted in Step 1.

Step 2: This step begins with the approved revenue for RY 2022 and reverses out the extraordinary one-time adjustments from RY 2022 that were a result of the COVID-19 pandemic. These one-times include: RY 2020 GBR settle up, RY 2021 price variance, COVID surge funding, and RY 2023 advanced inflation funding. The result is an adjusted RY 2022 GBR. The proposed update of 3.25 percent, as shown in Table 2, is then applied to the adjusted RY 2022 GBR amount to calculate the projected revenue for RY 2023.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2023 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2023. Additionally, staff applied the RY 2023 Advanced Inflation payback and release of the remaining RY 2021 undercharge to determine the projected revenue for the final six months of the calendar year.

Step 4: This step shows the resulting estimated revenue for CY 2022 and then calculates the increase over actual CY 2021 Revenue. The CY 2022 increase based on this year's recommended update is 5.51 percent. The 5.51 percent is used to estimate CY 2022 hospital spending per capita for Maryland in our guardrail calculation, which is explained next in this policy.

Consistent with prior commitments, staff are reviewing an additional wave of Covid surge funding for RY22 and expense funding for RY20 and RY21. At this time, it is not recommended that any funding be added in July. Staff will work with stakeholders to refine the methodology for the COVID wave that occurred in RY 2022. Any additional funding would be implemented at a later date and will consider the impact on calendar year guardrail tests.

Staff modeled three different scenarios to project the CY 2022 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2022 growth of 5.51 percent, shown in Table 5 to Maryland hospital spending per capita from 2021. The Maryland hospital growth estimate takes into account available hospital specific factors, such as the estimated RY 2022 Undercharge, remaining RY 2021 undercharge release and advanced inflation payback. Tables 6a-6c below show the results of these analyses. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2021 as the base. This is a similar trend that staff used to predict 2021 growth, with an updated base.

Table 6a

Scenario 1 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,742	$11,974	Predicted Variance
YOY Growth	4.99%	3.88%	1.12%

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2021 as the base. This is the most conservative estimate of the three scenarios. Staff added this scenario because the trend used in Scenario 1 proved to be higher than actual trend in CY 2021 and resulted in an overestimate of national growth. Utilizing a longer period to establish the "typical" trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b

Scenario 2 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,696	$11,850	Predicted Variance
YOY Growth	4.64%	2.80%	1.84%

Scenario 3, shown in Table 6c, utilizes the 2022 projection as published by the Office of the Actuary which is predicted to be 7.10 percent for 2022. The non-hospital portion of Maryland estimate utilizes the OACT growth prediction of 7.1 percent. The draft recommendation used a national growth estimate of 5 percent. Staff derived that amount by using figures provided in the National Health Estimate (NHE) tables. The 5 percent matched OACT figures for CY 2023. After further review and discussion with OACT, 7.1 percent is the best growth estimate to use for CY 2022. . Hospital and non-hospital is not broken out in the updates provided to staff. Staff believes 7.1 percent is the best estimate to use, but have some concerns that this may be too low of a growth to use for Maryland non-hospital because Maryland has historically trended higher than the nation. There is considerable variation among staff's three national trend forecasts - high (7.10 percent) and low (2.8 percent). This illustrates considerable uncertainty about how health care costs

will "bounce back" as the healthcare market incorporates the COVID-19 pandemic window into the future patterns of care.[1]

Table 6c

Scenario 3 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,927	$12,345	Predicted Variance
YOY Growth	6.41%	7.10%	-0.69%

In addition to modeling the CY 2022 guardrail position, staff also modeled estimated savings under each scenario. The savings target for CY 2022 is $267 million. Achieving an annual run rate of $267 million in CY 2022 is crucial as we move to the next phase of Model negotiations because this year will serve as the basis for the federal government's evaluation of the Model. Tables 7a-7c below highlight our annual savings or dissavings and anticipated 2022 run rate under each scenario.

Scenario 1 and Scenario 2 estimate that Maryland would miss the savings target for CY 2022, while under Scenario 3 Maryland would achieve the target. This range of outcomes illustrates the considerable uncertainty in the national projections. Staff want to note that there are significant negative consequences to missing the savings target in CY 2022.

Of note, the final line item in Table 7a and Table 7b estimate CY2022 savings if we applied the MPA-SC (Medicare Performance Adjustment - Savings Component) to the Medicare portion of the remaining undercharge that will be released in July rate orders. Staff believe that invoking this option would be a path of last resort. In addition, staff believes that the only revenue that would be appropriate to have this applied to would be one-time revenue adjustments, as application to permanent revenue would undercut the all-payer nature of the Model.

[1] During the workgroup process around this recommendation hospital stakeholders suggested using the US Per Capita Cost trends used to project Medicare Advantage increases. This methodology estimates a much higher 9 percent growth for the nation for CY 2022. Staff have concerns about differing from the national estimate that is provided by OACT, which the HSCRC has used as a reference in past years, given that these are projections and there is considerable uncertainty regarding the likely bounce back. As discussed above the approach used in Scenario 1 proved to be an overestimate in CY 2021.

Table 7a

Scenario 1 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$110 M
2022 Savings (Run Rate)	$228 M
2022 Savings with One-Time Revenue Adjustments Removed	$263 M

Table 7b

Scenario 2 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$192 M
2022 Savings (Run Rate)	$146 M
2022 Savings with One-Time Revenue Adjustments Removed	$181 M

Table 7c

Scenario 3 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Savings	$72 M
2022 Savings (Run Rate)	$410 M

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. The purpose of this modeling is to ensure that healthcare remains affordable in the State. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GSP numbers available (CY18-CY21). The 3-year CAGR calculation shows a per capita amount of 2.22 percent. Staff then compared that number to the 3-year CAGR for Hospital Acute Charges using (CY18-CY22). Staff was able to estimate CY 2022 charges using the proposed RY 2023 update factor. The CAGR for hospital charge growth equated to 3.59 percent. Staff also calculated a 5-year CAGR calculation, shown in Table 8b. The difference between 5 years of Gross State Product and Hospital Acute charges show a variance of 0.69 percent. The charts below show these comparisons. While unfavorable, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the

Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution. Moreover, given the unprecedented increases in inflation over the past year that have yet to prove temporal, staff do not believe it is prudent to use prior affordability assessments as a hard cap on global budget revenue allotments in RY 2023.

Table 8a

GSP (2018 - 2021)	Hospital Charges (2019-2022)	Variance
2.22%	3.77%	1.55%

Table 8b

GSP (2016 - 2021)	Hospital Charges (2017-2022)	Variance
2.52%	3.21%	0.69%

Medicare's Proposed National Rate Update for FFY 2023

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 18, 2022. In the proposed rule, CMS would increase rates by approximately 3.20 percent which includes a market basket increase of 3.10 percent, a productivity reduction of -0.40 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2022 and will not go into effect until October 1, 2022. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Inflation Reconciliation Proposal

Staff's draft recommendation of the update factor utilized a lower national growth projection. The final recommendation utilizes an updated growth projection for CY 2022. After further review of inflation funding, staff determined that hospitals have been underfunded over the course of the pandemic by approximately 0.40 percent. As a result of these two changes, staff has updated the recommendation to include an additional 0.40 percent for inflation reconciliation to be added on July 1, 2022. At this time staff do not recommend providing any additional inflation beyond the 0.40 percent in this rate year, as it would not be tied to any methodological approach. Staff are committed to continuing to monitor inflation and review Maryland growth compared to the nation for the remainder of the calendar year. In addition, now that this type of adjustment has been incorporated into the process, Staff recommend the Commission consider this retroactive evaluation every year and apply an adjustment to current year inflation if the variation is material, regardless of the direction of the adjustment

The annual update factor relies on an estimate of the inflation for the future period being funded. As a result, the approved Update Factor could over- or under-fund inflation for a given period versus the actual experience for that period.

The Commission has not historically adjusted for this because amounts are often small and adjusting inflation for prior estimation error would add additional complexity to the update factor process, it is likely that under- and over-estimates will cancel out over time, and the Commission's mandate is to provide financial stability and not a margin guarantee. Therefore, it is not necessary to exactly fund inflation in every period, as hospitals can bear some risk for variations between funding and inflation.

Hospital stakeholders have argued that because the inflation estimate used in the RY 2022 update factor was a significant underestimate of actual inflation the Commission should depart from historic practice and provide additional inflation, a "catch-up", in RY 2023, in order to fund full inflation on a permanent basis.

The Commission and staff have been watching inflation and wage and labor cost pressures carefully. In response to concerns raised by the hospital field around rising labor costs, the Commission advanced a one-time increase of $100 million in January 2022, and accelerated the release of prior year undercharges. Additionally, the Governor also made available $30 million to hospitals to support unusually high workforce costs. Finally, an additional $50 million is anticipated to be awarded from the State to hospitals in RY 2023 to further cover workforce demands that have sustained through the year. While these are one-time adjustments to hospital rates, they do provide financial support to hospitals in the short term until more is understood about the permanency of those labor cost increases.

While staff acknowledge that the shortfall of permanent inflation for RY 2022 was much more significant than the variance in prior years, staff are not recommending the Commission reverse historic practice and adopt a catch-up adjustment greater than .40 percent as of July 1, 2022, because of the availability of extraordinary one-time funding available to hospitals in RY 2022 as mentioned above, pressure on the Medicare guardrail and savings tests documented above, as well as uncertainty surrounding national growth trends.

Instead, staff recommend that the Commission direct staff to convene a stakeholder workgroup and report back to the Commission in November 2022 on (a) a policy for addressing differences between actual and estimated inflation in future update factors within the parameters outlined below (or that such a policy is not required) and (b) a recommendation to the Commission for a reconciliation inflation adjustment for experience through RY 2022 to be applied to hospital rates on January 1, 2023, consistent with the policy developed under item (c), and with the State's savings position and other factors considered in the typical annual update factor process. Staff's bias is that such an adjustment is appropriate but the feasibility of providing such adjustment and the size of the adjustment will depend on the State's savings position, national growth rates and the policy parameters described for the general policy and that by waiting for January 1, 2023, to apply any adjustment the Commission will have better information on these factors.

The possible parameters for the general policy described in (a) above are:

1. That any policy is two-sided and would apply to both over and underestimates of inflation
2. That any policy looks at cumulative inflation over or under funding since 2013, including consideration of the impact of the PAU inflation adjustment, the infrastructure funding and other permanent funding adjustments as applicable
3. That any policy would have a materiality provision such that an adjustment would only apply when the cumulative under or overfunding of inflation reached a specified threshold (e.g., 0.75 percent)

Stakeholder Comments

In a series of meetings beginning in early CY 2022, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2023 update.

MHA submitted a proposal that outlined the requested increase of their members. The following hospitals also submitted comment letters in support of MHA's letter: Luminis Health, University of Maryland Medical System, Johns Hopkins Health System, Holy Cross Health, MedStar Health, Acension St. Agnes, and Sheppard Pratt. MHA's request in their official comment letter did not differ from their request from their comments during Payment Models. Comments are outlined below with staff's response in italics:

1. Fund IHS Market's RY2023 cost inflation, expected to be at least 3.58%
   Staff agree and have updated our tables and projections to include the release of the First Quarter Book from Global Insights. The inflation amount of 3.66 percent is reflected in this recommendation.
2. Make the $100 million advance funding permanent, requiring no repayment
   Staff does not agree. This advance was always intended and communicated that it was to be paid back. In addition, hospitals have received $80 million from the Governor over the last two fiscal years. The advance amount of $100M was not based on any specific inflation information. Staff have proposed an adjustment based on an analysis of historic inflation data and staff does not believe making a temporary, stopgap, advance permanent is appropriate in lieu of or in addition to an inflation adjustment based on a reasonable methodology.
3. Modify the savings adjustment for potentially avoidable utilization (PAU): A) Set rewards and penalties around a base of 0 percent, measuring year-over-year change; B) Set a statewide average benchmark as hold harmless floor, and apply adjustments to hospitals that exceed the benchmark; and C) Use a national benchmark to set a PAU savings target
   Staff believe that the proposal has merit since global budgets already have an incentive to reduce PAU and PAU inflation cannot theoretically be defunded in perpetuity without adversely affecting core inflation for non-PAU services. However, this assertion rests on the notion that hospitals, primarily due to the incentives of the global budgets, have successfully eliminated almost all avoidable utilization, even independent of the current definition of PAU (30 day readmissions and acute exacerbations of chronic conditions). To date, no data has been provided to suggest that Maryland has grossly surpassed current national performance on current definitions of PAU or other definitions not yet reflected in payment policy (excess imaging, canonical examples of low value care - knee arthroscopy for individuals with osteoarthritis, etc). Therefore, to discontinue the

PAU savings adjustment, especially in a year where TCOC guardrails and savings are a concern, does not seem prudent, but staff defer to the judgment of the Commission.

4. Limit the projected reduction in uncompensated care funding
Staff do not agree. The uncompensated care policy has historically relied on a retrospective statistic of uncompensated care to determine funding. This approach has provided higher than anticipated levels of uncompensated care as the Affordable Care Act and other factors, e.g. lower unemployment, steadily reduced charity care and bad debts. Thus, staff do not believe it is appropriate to stray from policy in this year purely based on the assertion that uncompensated care will increase due to sunsetting federal stimulus payments. Furthermore, staff believe that the large decline in UCC levels may be due to changing practice patterns that result in an increased utilization of telemedicine, urgent care centers, and other alternatives to emergency room care. As such, staff do not support this request because UCC levels may not rebound.
5. Monitor inflation and Model performance for six months and adjust rates effective January 1, 2023, if conditions permit.
Staff are committed to working with a workgroup to determine if any additional funding will be appropriate on January 1. Our proposal is outlined in this recommendation, but staff would note additional inflation in RY 2023 is unlikely since the Final Recommendation outlines an additional .40 percent increase to recognize recent underfunding of actual inflation.

In addition to the request outlined above, MHA proposed using a much higher national growth estimate when trending forward 2022. These growth rates of 9 percent were mentioned earlier in this recommendation. *Staff do not believe it is appropriate to stray away from the OACT for the national growth projection and the internal projection approaches based on recent trends used in prior years. Office of Actuary projections are projected for Fee-for-Service. The USPCC projections cited by MHA are used in projection MA (Medicare Advantage) increases. In addition, staff have had conversations with the Office of the Actuary to determine the most appropriate source to use when determining projected cost growth for the following year. It was determined through those conversations that the growth projections provided by the Office of the Actuary for the President's Budget are the most appropriate projections to use.*

Medicaid provided comments that supported staff's draft recommendation for three main reasons:

1. Maryland can't risk becoming subject to a corrective action plan for failing to meet the TCOC Model Guardrail test.
Staff agrees. In the penultimate year of this demonstration it is incredibly important to ensure that the update remains within the bounds of projected calendar year growth. Staff has worked hard during this process to determine the appropriate national growth projection and will not recommend an update that does not provide some cushion.
2. Medicaid does not agree with MHA's comment that the $100 million inflation advance should be made permanent and should not be paid back.
Staff agrees.
3. Medicaid served as a safety net during the pandemic, absorbing an increase of 20 percent increase in coverage and agrees that the UCC adjustment is appropriate.
Staff agrees.

CareFirst agreed with staff's draft recommendation, but had several concerns, which are outlined below.

1. CareFirst noted that any increase as a result of the Update Factor gets passed on to employers. In addition, they expressed concern that mid-year rate increases can't be accounted for in MA and MCO plans.
   Staff recognizes the concerns it may place on payers by having mid year rate increases. We understand that RY21 was a significant increase at mid-year and do try to limit such increases. Staff have revised our proposal to provide a fixed increase as of July 1, thereby significantly reducing the likelihood of providing additional inflation in January.
2. CareFirst expressed concern that two of the guardrail/run rate scenarios that staff created project Maryland to grow faster than the Nation, explicitly stating concerns over staff's non-hospital projection. It was also noted that the undercharge assumption may not carry forward to June. It was urged that staff pressure test these assumptions prior to finalizing the recommendation.
   Staff created over 10 different guardrail and savings scenarios while evaluating potential guardrail positions. The three that were presented were the most realistic outcomes based on extensive review of data and past trends. The biggest obstacle to overcome each Update Factor season is projecting what will happen with national growth. Staff have had conversations with the Office of the Actuary to determine the most appropriate growth estimate and determined that the projections from the President's Budget are the best estimate. In addition, staff recognize that there are a number of factors that impact this year's update, including the projected FY 2021 undercharge. Staff are releasing the final recommendation with updated undercharge projections with data through April 2021.
3. CareFirst noted that staff's 'affordability' test comparing three years of hospital charge growth to a three-year GSP trend yields unfavorable results. The impact of which gets passed on to employers and health plans.
   As noted above, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the RY 2023 update factors.

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix A: Reconciliation of Set Aside for RY 21 and RY 22

As part of the RY 2022 recommendation, Commissioners requested that staff provide a reconciliation of previous years set aside funding. Below is an overview of this request for RY 21 and RY 22.

Distribution of Set Aside for RY 2021			
RY 2021 GBR Revenue		$19,105,021,605	
Set Aside %		0.25%	
Set Aside $		$47,762,554	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Mercy	$15,000,000	0.08%	Integrated Efficiency
Suburban	$11,933,939	0.06%	Integrated Efficiency/Capital
Shock Trauma	$2,564,524	0.01%	Shock Trauma Standby
Anne Arundel	$5,270,679	0.03%	Cardiac Program Funding
Statewide	$13,291,872	0.07%	Statewide Vaccination Adj.
Total	$48,061,024	0.25%	

Distribution of Set Aside for RY 2022			
RY 2022 GBR Revenue		$19,638,102,984	
Set Aside %		0.25%	
Set Aside $		$49,095,257	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**

Fort Washington	$6,253,680	0.03%	Integrated Efficiency
Howard County	$12,500,000	0.06%	Integrated Efficiency
Holy Cross	$8,704,705	0.04%	Integrated Efficiency
Anne Arundel	$1,364,501	0.01%	Cardiac Program Funding
Garrett	$2,072,192	0.01%	New Services: LIT, Pain Mgmt, Pop Heath.
Dorchester	$3,400,000	0.02%	Integrated Efficiency
Sinai	$5,500,000	0.03%	Integrated Efficiency (one-time)
PRMC	9,300,179	0.05%	Population Health, Behavioral Health, & Integrated Efficiency
Total	$49,095,257	0.25%	

Maryland
Hospital Association

May 18, 2022

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

Dear Chairman Kane:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we offer our comments on the Health Services Cost Review Commission's (HSCRC) July 1, 2022 annual payment update draft recommendation. MHA appreciates HSCRC's support during the past two years and our collaboration to secure Maryland's Total Cost of Care Model.

We are eager to join with the Commission in devising a fair annual payment update for rate year (RY) 2023. MHA's April 22 position paper respectfully asked HSCRC to:

1) Fund IHS Markit's RY2023 cost inflation, now 3.66%
2) Make the $100 million advance funding permanent and not require repayment
3) Modify the savings adjustment for potentially avoidable utilization
4) Limit the projected reduction in uncompensated care funding
5) Monitor inflation and Model performance for six months and raise rates January 1, 2023

As has become abundantly clear in recent months, Maryland hospitals today face extraordinary financial challenges. They have a profound need for an adequate rate update. And yet, **the difference between our request and staff's recommendation is just 0.86%**. Small as that figure is, it will truly help hospitals that are struggling both to keep core operations going and to invest in advancing the health of their communities.

We understand that the Commission must balance hospitals' intensifying financial pressures against the Medicare spending growth constraints in calendar year (CY) 2022. In that regard, we ask HSCRC to use the most up-to-date source available for national Medicare total cost of care growth comparisons. HSCRC staff and MHA both are relying upon numbers produced by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary. Staff's reference number is from National Health Expenditures (NHE) estimates that CMS actuaries calculated using data from 2019. However, in April, using data from 2021, CMS projected national Medicare fee-for-service spending growth for CY 2022 that is nearly double the NHE estimate.

Even if one were to apply a conservative adjustment to the freshest figure, **there is ample room for HSCRC to grant MHA's request without any risk of breaching the guardrail.**

Supporting information that supplements our April 22 paper is attached.

These extraordinary times call for extraordinary measures. HSCRC staff's draft recommendation adheres to the traditional approach. Other than adjusting for Medicare's actions on quality policy, it relies on mostly retrospective measures that do not capture the massive cost growth happening right now.

Even if the Commission accepts MHA's proposal, the situation at present is so volatile that **we must also ask you to commit to raise rates further in January 2023** if (a) Maryland's CY2022 performance on the guardrail test is favorable and (b) cumulative 2022-23 actual inflation proves to be at least 0.75% above the inflation the Commission provides for July 1.

What the hospital field is asking of the Commission is fair and reasonable. It will balance hospitals' needs for adequate revenue with the state's need—which hospitals support emphatically—to stay within Model contract parameters.

MHA and all our members sincerely appreciate the HSCRC's partnership as we continue to work together on behalf of the people and communities we serve.

Sincerely,

Bob Atlas
President & CEO

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

Information and Supporting Rationale

A. HSCRC's Medicare Guardrail Estimate Is Too Conservative

We make our requests fully knowing that Maryland's CY 2022 Medicare growth presents a challenge. MHA agrees that HSCRC should use a CMS source to project national Medicare total cost of care growth. In our position paper, MHA cited the Medicare fee-for-service per capita spending growth in CMS's 2023 Medicare Advantage (MA) final rate notice as the appropriate comparison.[1] The rate notice uses newer data than the National Health Expenditure (NHE) report HSCRC staff have cited.

In the 2023 rate notice, CMS's Office of the Actuary (OACT) projected 9.4% CY 2022 growth in Medicare Part A and Part B spending per beneficiary. MHA has confirmed with OACT that the MA rate notice fee-for-service projections reflect claims experience through September 30, 2021, and cash activity through December 31, 2021.[2] OACT also confirmed that their NHE estimates used the 2021 Medicare Trustees Report which reflects data only through 2019.

HSCRC's draft recommendation repeatedly cites the Medicare guardrail as the reason HSCRC cannot fund additional inflation—or, to state it more precisely, to fund inflation that the Commission did not fund fully in RY2022.

MHA has applied conservative assumptions to OACT's 9.4% figure to produce an adjusted growth rate projection of 7.1%. Even this lower figure allows room for MHA's July 1 requests.

Maryland's Model contract sets limits on growth of Medicare spending per beneficiary. The contract also has a combined all-payer annual hospital spending per capita growth limit of 3.58% compounded. Since 2013, all-payer hospital spending per capita has grown 15.14%, less than 2% per year, and less than half the limit of 32.50%. If HSCRC is concerned about CY2022 Medicare growth, it should implement the Medicare Performance Adjustment - Savings Component and **deliver direct savings to Medicare** in the form of lower payments.

B. Fund RY2023 Inflation; Make $100 Million Advance Permanent; Boost Rates January 1

1) Inflation continues to mount. In our position paper, Maryland hospitals strongly urged the Commission to raise the proposed rate update to account for the unprecedented and permanent inflation that is straining hospitals and health systems. We appreciate that HSCRC has proposed to fully fund market basket inflation of 3.66%. This is helpful step toward a stable future.

RY2022 inflation is now 4.42%, fully 1.85 percentage points or 72% higher than HSCRC's RY2022 factor of 2.57%. Adding the 0.5% advance to 2.57% would bring that factor to 3.07%,

[1] Though this is CMS's annual revision in Medicare managed care capitation rates, tables II-2 and II-3 project fee-for-service growth, used by CMS to project service use in capitation rate development.
[2] https://www.cms.gov/files/document/narrative-supporting-2023-growth-rate.pdf, pp. 1-2

still 1.35 percentage points and 43% below measured RY2022 inflation. Making the 0.5% permanent does not add new money to the system, it simply avoids the payback. Put another way, making this amount permanent fills slightly more than one-fourth of the last year's inflation shortfall. This is a balanced and reasonable request.

In granting the $100 million advance, commissioners expected RY2023 inflation to soar, allowing HSCRC to cover the advance. The 3.66% forecast is significant, though it is muted since RY2023 inflation is now projected *off a much higher RY2022 base*. Making 0.5% permanent partially offsets this difference.

MHA generally agrees with HSCRC's approach to raising rates January 1, and HSCRC should only adjust for extreme differences. We ask HSCRC to commit to boosting rates January 2023 if the following criteria are met.

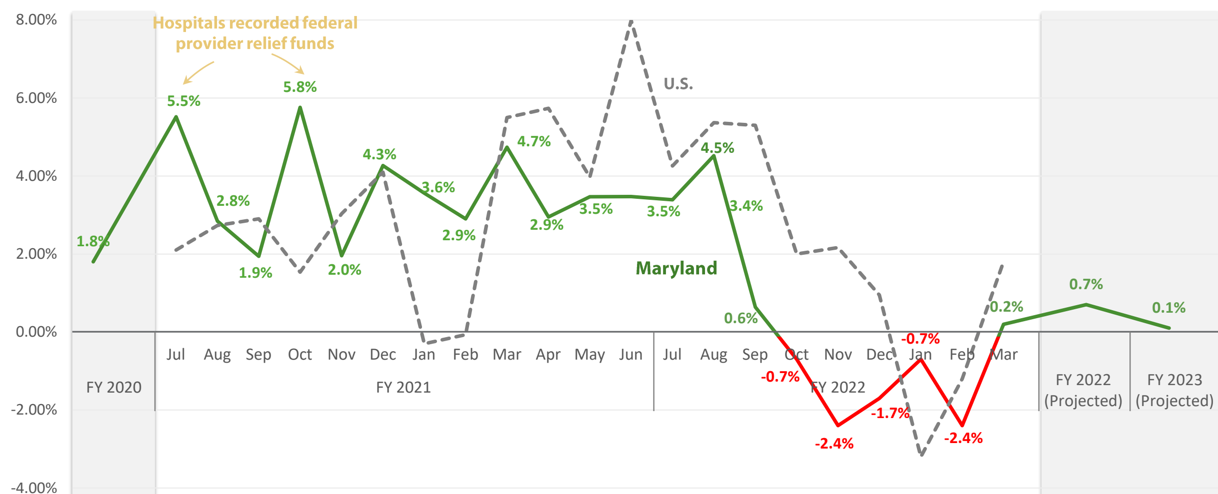
a) Maryland's CY2022 Model performance is favorable, and

b) Actual cumulative 2022-23 inflation proves to be at least 0.75% above the level provided.

MHA and member hospitals will participate in any work group HSCRC may use to discuss this is issue. We ask that commissioners receive regular reports in the second half of CY2022, and we welcome the opportunity to discuss this matter with commissioners at any point prior to January 1.

2) Hospital margins remain weak as cost pressures grow; margins would be even lower without one-time support. As shown in the chart below, the median hospital operating margin in March 2022 was a scant 0.2%, after five straight months of operating losses.

Hospital Operating Margins



More important, the financial pain continues. MHA has polled members and found Maryland hospitals are projecting median year-end RY2022 margin of just 0.7% and their RY2023 budgets will yield a mere 0.1% operating margin. These figures are well below both recent years' performance and the HSCRC's targeted operating margin of 2.75%.

Maryland's rate setting system continues to afford hospitals a degree of financial stability. We are grateful that HSCRC, combined with significant federal relief funds, served as shock absorbers in during 2020 and 2021. RY2022 figures reflect at least $200 million of one-time inflows, including prior year undercharges and the remnants of federal relief. With costs unchanged, absent these one-time infusions, CYTD 2022 financial performance would be much worse. In effect, the help hospitals got in the last two years masks the need for permanent inflation support.

For example, hospitals in one health system are projected to finish the twelve months ending June 2022 with a $6 million net income, a slightly positive operating margin of 0.7%. Excluding federal relief funds that were exhausted earlier in the year, the hospitals would combine to lose $25 million, a nearly 3% operating loss.

New data from national consultants Kaufman Hall, McKinsey and Premier, Inc. support the need for permanent revenue solutions as labor costs continue to rise.

- Kaufman Hall's May 2022 Flash Report shows hospital labor costs have jumped 30% nationally since 2019.[3]
- McKinsey's May 11 report shares its survey results, with 29% of responding nurses indicating they are likely to leave their patient care role.[4] By 2025, McKinsey projects a nationwide nursing shortage of 200,000 to 450,000 nurses.
- Premier, Inc's data shows a real increase in hospital labor wages of 16.5% in the end of 2020, remarkably consistent with MHA's labor survey showing nursing and nursing assistant rates climbing 16% to 18%.[5]

3) The labor market continues to constrain hospital services. The staffing crisis is very real, and it threatens hospitals' ability to operate services at normal capacity to serve our patients. Some recent service impact examples include:

- Despite heroic efforts, many hospitals have had to temporarily close inpatient beds when staff were not available. As a result, emergency department throughput is thwarted, extending wait times and causing service delays.

[3] https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf
[4] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top
[5] https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending

- Several hospitals have been forced to scale back operating room availability, impacting the community.
- One hospital has had to reassign staff from outpatient services focused on population health—like wound care, cardiopulmonary rehabilitation, and even behavioral health—to fill core, beside acute services.

Maryland hospitals are committed to Model goals of improving population health and transforming care. However, as shown in the examples and in many other stories, hospitals are forced to focus on keeping up core mission capabilities while eyeing the future.

C. Mitigating the RY2023 Uncompensated Care (UCC) Impact

Our April 22 position paper gave a detailed rationale to lessen the 0.43% UCC impact. MHA proposes to reduce the estimated impact by half, sharing the cash implications evenly between hospitals and insurers.

HSCRC's UCC policy self-adjusts over time. However, in certain instances, HSCRC has prospectively lowered UCC for expected savings. Though HSCRC did not initially reduce UCC funding when coverage expanded under the Affordable Care Act (ACA), it prospectively reduced funding in year 2, as UCC began to fall from 7% to 4.5% of statewide revenues.

As of this writing, 2023 hospital write-off data are not available to model 2023 UCC policy options. MHA's proposal to offset the UCC reduction by half still lowers payments by 0.22%. After assessing 2022 actual results, this adjustment can be removed in the future.

D. Potentially Avoidable Utilization (PAU) Savings Adjustment

HSCRC staff acknowledges that MHA's PAU savings proposal has merit. MHA agrees and is committed to work with HSCRC staff to explore different options to reimagine the policy. An empirically based approach would compare Maryland's performance to targets using national benchmarks. Should Maryland exceed the benchmark, the negative policy impact should be reduced.

DEPARTMENT OF HEALTH

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

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

May 17, 2022

Chairman Kane,

On behalf of the Medicaid program at the Maryland Department of Health (the Department), I am writing to communicate the Department's full support of the Health Services Cost Review Commission's (HSCRC) staff recommendation for the rate year (RY) 2023 rate update factor. Our full support centers around three key points.

First, Maryland cannot risk becoming subject to a corrective action plan for failing to meet the Total Cost of Care (TCOC) Model's guardrail tests as it prepares to enter negotiations with the Center for Medicare and Medicare Innovation (CMMI). The growth guardrail test requires Maryland not to grow faster than the national Medicare rate. Maryland exceeded the national Medicare growth guardrail in calendar year (CY) 2021. If Maryland exceeds the national rate of growth in CY 2022, the state will be subject to a corrective action plan under the TCOC Model. Current projections predict another unfavorable performance for CY 2022 for the Medicare growth test, as well as for achieving the savings target of $267 million. Based on the staff's analysis, the proposed rate increase for RY 2023 provides the best assurance that Maryland meets these tests.

Staff analyses on the health of the hospitals' financial condition showed generous operating and profit margins in 2021. Absent approval of the staff recommendation as currently written, CMMI is likely to ask why Maryland was not able to achieve the growth and savings targets and why these monies should not be used to achieve CY 2022 targets. The pandemic affected all states; Maryland is not unique in its struggles with the pandemic and should be able to meet the national Medicare growth rate test.

Second, in addition to other positive adjustments, the Maryland Hospital Association (MHA) has proposed making permanent the one-time, $100 million inflation advance provided in January 2022. This is contrary to the HSCRC's agreement that the

$100 million would be repaid. MHA has stated that if these positive adjustments cause Maryland to fail its savings or guardrail tests, the Medicare Performance Adjustment can be used to adjust Medicare rates on the backend to bring the state into compliance. This is a direct 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 or on the backend. The same adjustment to Medicare must be made to Medicaid. Additionally, this deviation from all-payer rates does not align with the central tenet of the Total Cost of Care Model.

Third, in its testimony during the presentation of the draft recommendation, MHA asserted that the Medicaid redetermination process after the federal public health emergency ends necessitates an upward adjustment to uncompensated care. Maryland Medicaid now provides insurance coverage to over 1.7 million Maryland residents. Before the pandemic, Maryland Medicaid covered roughly 1.4 million. Maryland Medicaid served as the safety net during the pandemic, absorbing an over 20-percent increase in insurance coverage. The 0.20-percentage-point increase in uncompensated care for RY 2021 cited a slowing of the decrease in the uninsured population. Based on the extraordinary growth in Medicaid coverage, the FY 2021 increase was not necessary and should be adjusted downward as the staff recommends.

The Department has been closely following analyses that predict the federal public health emergency may extend past the 2022 midterm elections. If these predictions are accurate, Maryland Medicaid will not start redeterminations until early 2023. Once initiated, redeterminations will occur over a 12-month period. The staff's downward adjustment is appropriate at this time and should be reviewed again next year.

Thank you again for the opportunity to provide comments. If you have additional questions, please do not hesitate to contact me or Tricia Roddy, Deputy Medicaid Director.

Sincerely,

Steven R. Schuh
Deputy Secretary for Health Care Financing and
Director of Medicaid

David Schwartz
Vice President
Public Policy & Federal Affairs

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-7433

May 18, 2022

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

Dear Chairman Kane:

CareFirst BlueCross BlueShield (CareFirst) appreciates this opportunity to comment on the Draft Recommendation for the Update Factor for Rate Year 2023. We recognize the Staff is balancing significant competing priorities including (1) funding cost inflation in global budgets to accommodate hospitals' exposure to labor pressures, (2) recognizing the healthcare affordability crisis faced by Maryland residents and employers amidst a challenging economic environment, and (3) meeting a required Total Cost of Care (TCOC) Model Medicare savings test and guardrail on which the state performed poorly in 2021.

CareFirst sympathizes greatly with the hospital industry as they navigate the nursing shortage that has been exacerbated by the pandemic. We recognize the impact this has had on financials and operations, and we are committed to being a part of solving this problem at its root cause in collaboration with the state, HSCRC, and hospitals. We have already been working on this issue in all three of our jurisdictions. In Maryland, we testified in support of two bills this past legislative session. The first establishes a Commission to Study the Health Care Workforce Crisis in Maryland, which will collect and analyze data to identify both short and long-term solutions that address root causes. The second establishes the Maryland Loan Assistance Repayment program for Nurses and Nursing workers. In Washington, DC, we recently sponsored, and our Chief Executive Officer moderated, the DC Chamber's Health Policy forum, which focused on the future of DC's healthcare workforce as well as solutioning for capacity and pipeline challenges. In Virginia, CareFirst actively engages with and currently chairs the advisory board for the Governor's Health Science Academy at Alexandria City High School, which is focused on graduating students into three healthcare paths.

We are prioritizing this issue and will continue devoting people and resources toward solving its root causes. **We do not believe permanent hospital rate enhancement is a solution** to the core problem, and we urge HSCRC to consider who that would impact.

Impact on Maryland Residents, Employers, and Plans

Two-thirds of CareFirst's Maryland business is covered by self-insured plans, meaning that as healthcare costs rise, employers feel it directly since they take full risk for the cost of their employees' care. Many of these businesses are already dealing with significant price inflation in gas, housing, and food and beverage costs. Healthcare costs are usually employers' second

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largest expense, and they are increasingly searching for relief in a number of ways, including (1) engaging companies to assist employees in finding efficient care alternatives, (2) seeking point solutions that promise to impact particular conditions, and/or (3) relying on provider profiling to

identify lower cost, high performing providers.

Recently, significant mid-year adjustments were applied to Maryland hospitals' rates, including rate corridor expansions, GBR additions of prior year undercharges, and an advance on inflation earlier this year. These mid-year adjustments have direct impacts on Maryland residents with benefit plans that apply coinsurance in the hospital setting. At CareFirst, roughly 43% of Maryland-based individual members are in plans with inpatient coinsurance.

These mid-year increases also cannot be accounted for by Medicare Advantage (MA) plans, which lock rates with bids submitted in June for the upcoming year, or by Medicaid Managed Care Organizations (MCOs), which lock rates in September. We know HSCRC is aware MA plans in Maryland are already underfunded by the national payment methodology that does not contemplate the impact of Maryland's all-payer rate-setting.

For these reasons, **we have concerns about Staff's recommendation to develop a new policy to adjust inflation in January** if the gap between funded and actual inflation surpasses a determined threshold.

Medicare Guardrail Projections

CareFirst took note of two assumptions in Staff's projection of guardrail and savings test performance that inherently adopt risk. The first is the expectation in the guardrail projection scenarios that Maryland's non-hospital spending growth trajectory will equal that of the nation. Given Maryland has a history of non-hospital spending growth outpacing the nation, it seems an average of Maryland-specific non-hospital spending growth over a reasonable recent period would be a more realistic expectation.

The second risk is the assumption the undercharge of $178 million through December 2021 will carry forward to June 2022. It is possible hospitals will charge at the top of their allowable rate corridors in the final quarter of the year to eliminate or reduce undercharges at year-end. In fact, it was reported by Staff at the May HSCRC public meeting this figure has already reduced to $150 million.

Both assumptions could be significantly underestimating Maryland's TCOC growth in Calendar Year 2022, which the industry and HSCRC need clarity on to understand how the recommended update factor positions the state on the guardrail test. **We urge Staff to pressure-test and adjust these assumptions before making a final recommendation**.

Affordability

Finally, Staff recently built into the update factor process an affordability analysis of their projected update. The 2020 Final Recommendation for the Medicare Performance Adjustment Framework stated that one of the principles for setting the update factor should be that "hospital spending growth continues to grow less than the Gross State Product." Despite this principle, this year's Staff recommendation yields an unfavorable result in that hospital charge growth exceeds the three-year GSP trend. This is indicative of how Maryland residents and employers are being impacted, which is troubling in a state with a unique model focused controlling health care cost growth.

Conclusion

We understand and agree with the need to fund cost inflation at Maryland's hospitals, but we believe a few critical items need to be addressed between the draft and final update factor recommendations.

1. We believe **a closer look at Maryland's non-hospital spending growth and undercharge position is necessary** to solidify the TCOC growth projections and understand the state's guardrail positioning.
2. If by funding cost inflation, the recommendation still projects tripping guardrails in 2022, we believe **there needs to be a plan to identify where savings will come from** outside of the update factor to ensure Maryland meets the TCOC Model's savings test requirements.
3. Staff should **reconsider its recommendation to develop a process for adjusting inflation in January** given the unbudgeted impact on employers and health plans.

Thank you again for the opportunity to comment today. We look forward to continuing collaborative discussions with Staff and the industry as this draft progresses toward a final recommendation.

Sincerely,

David Schwartz

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen, R.N.
Maulik Joshi, DrPH
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

10980 Grantchester Way
Columbia, MD 21044
410-772-6500 PHONE
410-715-3754 FAX
medstarhealth.org

May 18, 2022

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

Dear Chairman Kane:

On behalf of MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital, and MedStar Union Memorial Hospital, we write to support the hospital field's July 1, rate request.

Throughout the pandemic Maryland hospitals have supported our communities and partnered with the state and the HSCRC to rise to the challenge to expand access to care, increase testing and distribute the vaccine to deliver on our mission to save lives, and we were glad to do it.

Now more than two years since the pandemic began, the impacts of this extended crisis on the healthcare workforce across the country and in the state of Maryland are greater than we could have imagined. The accumulation of months of stress has led to burnout and a higher number of nurses leaving the acute care setting or the profession. As a result, nursing turnover and vacancy rates have increased after each surge and our nursing vacancy rate is now more than 2.5 times higher than it was prior to the pandemic. To respond to the increased demand for nurses, we have adjusted wages, instituted special pay programs to encourage nurses to take additional shifts, and increased our utilization of agency nurses. Agency rates remain high based on the increased demand. Since not enough nurses are available, we have increased recruitment of patient care technicians and medical assistants to supplement the nurse staffing to continue to deliver safe and appropriate patient care. This increased demand has in turn driven up the market compensation for medical assistants, patient care technicians, respiratory therapists, and other clinical positions. These market forces have resulted in an increase in FY22 YTD personnel costs per adjusted admission of more than 30% when compared to FY19.

Cost increases extend beyond personnel with supply chain challenges, and other inflationary pressures. These expense increases have been significantly detrimental to hospital finances and have resulted in operating losses in our Maryland hospital operations. The expense pressure and inflationary increases are projected to continue in FY23. In addition, pandemic disruptions have created other operations challenges. Below are the some of the additional specific operational challenges that we are facing:

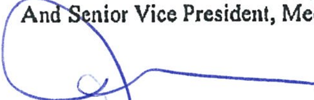
- Increase in food, drug, supplies, and delivery/freight costs
- Delays in receiving supplies and equipment causing increases in repair costs while waiting for new items
- Increase in behavioral health patients that require 1:1 attention and additional resources
- Delays in placement of patients due to Post Acute staffing challenges
- Reduction in Baltimore jobs program funding for peer recovery coaches and community health workers

While the health care industry's requested FY23 rate update will not fully alleviate these unavoidable cost increases, it is greatly needed as part of the solution. Thank you for your consideration of this request and please reach out should you have any questions.

Sincerely,

Brad S. Chambers
Senior Vice President & Chief Operating Officer, Baltimore Region, MedStar Health
President, MedStar Good Samaritan Hospital
President, MedStar Union Memorial Hospital

Stuart M. Levine, MD
President, MedStar Franklin Square Medical Center
And Senior Vice President, MedStar Health



Jill Donaldson, FACHE
President, MedStar Harbor Hospital
And Senior Vice President, MedStar Health

T.J. Senker, FACHE
President, MedStar Montgomery Medical Center and
Senior Vice President, MedStar Health

Stephen T. Michaels, MD, FACHE
President, MedStar Southern Maryland Hospital Center and
Senior Vice President, MedStar Health

Mimi Novello, MD, MBA, FACEP
President and Chief Medical Officer,
MedStar St. Mary's Hospital and
Senior Vice President, MedStar Health

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

May 18, 2022

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

Dear Chairman Kane:

On behalf the Johns Hopkins Health System (JHHS) and our four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the payment update. JHHS supports the hospital industry's position. As noted by JHHS President Kevin Sowers during the May Commission meeting, many hospitals are facing unprecedented challenges. In his testimony, Mr. Sowers specifically spoke to financial and staffing pressures as well as actions our hospitals are taking to reduce costs.

JHHS greatly appreciates the actions taken by the HSCRC and state and federal governments to support hospitals throughout the COVID pandemic. However, this relief was generally "one-time" funding and with its discontinuation, many Maryland hospitals are struggling. At JHHS, three of our four Maryland hospitals are projecting a negative operating margin. The financial situation is severe enough that two of the JHHS Maryland hospitals will have to borrow money to meet cash flow needs.

Staffing and nursing agency spend is one of the biggest contributors to financial challenges. Healthcare, and in particular, hospital care, is a 24/7 operation with specific staffing needs. Hospitals that operate at capacity have no option but to take immediate action to stabilize the workforce. The expected nursing agency spend for our four Maryland hospitals over fiscal 2022 and 2023 is $469 million. In addition, JHHS invested $56 million in salary adjustments to recruit and retain all staff at our Maryland hospitals.

The health care and workforce landscape are forever altered by the COVID pandemic. Care models must be redesigned – but this is a long-term strategy. JHHS, and our four Maryland hospitals, have taken immediate action to address cost pressures through $210 million in

performance improvement actions. However, even in light of these actions and the proposed update, three of our Maryland hospitals are still facing negative operating margins.

JHHS recognizes that the HSCRC must balance the targets of the Total Cost of Care Agreement with the needs of the industry. We appreciate the sensitives to both the guardrails and the overall savings target. However, if the savings target is of such significant concern, there are actions the state can take to both support hospitals and protect the target. Hospital rates include 3-4% for items that are passed through the hospital rate structures and do not drop to the bottom line. **Reduction or elimination of some or all of these pass throughs would improve the performance against the guardrail.**

JHHS also recognizes that hospitals across the country are facing similar challenges and these cost pressures are not unique to Maryland, however we have tolerated modest margins in the past with the knowledge that Maryland's rate setting system offers a safety net in difficult times.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. We greatly appreciate the HSCRC's transparent process in the development and approval of the payment update. JHHS supports the payment update proposal by MHA and the hospital field, however if this proposal cannot be accepted due to the Agreement constraints, other actions can be taken to stabilize hospitals experiencing the greatest cost pressures.

Sincerely,

Ed Beranek

Ed Beranek
Vice President of Revenue Management and Reimbursement
Johns Hopkins Health System

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

Sheppard Pratt

Harsh K. Trivedi, MD, MBA
President & Chief Executive Officer

May 18, 2022

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

Dear Chairman Kane:

On behalf of Sheppard Pratt, I write to support the hospital field's July 1, rate request.

Sheppard Pratt has a projected loss of ($12.1m) through the end of Fiscal Year 2022. This includes one-time HHS funding of $1m and additional one-time support through the state to maintain capacity. While we continue to manage COVID outbreaks on our inpatient units, the primary challenge in this current year is due to workforce shortages impacting Sheppard Pratt. Sheppard Pratt has had to rely on costly staffing agencies due to high turnover. Nursing agency expenses alone are a staggering $13.2m to the organization and over a 300% increase from prior year.

Based on our inability to staff programming, we have been forced to take several hospital beds offline for a portion of the year. In addition, we have five Day Hospital and Intensive Outpatient programs closed due to staff shortages as well as five at significantly reduced capacity. These program closures have the potential to impact Emergency Departments and other psychiatric inpatient units due to lack of other inpatient and outpatient services.

Sheppard Pratt is working to address staffing shortages by increasing compensation for existing staff and new nurses. To retain and recruit, we are increasing compensation by 20% in some cases. In addition, overtime is incredibly high with overtime labor accounting for 10% of all labor hours which is causing staff burnout. Sheppard Pratt is considering reductions to other mission-driven services to attempt to manage the operating losses.

Thank you for your consideration. Please call me with any questions.

Sincerely,

Harsh Trivedi, MD, MBA

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

6501 N. Charles Street, Baltimore, MD 21204 • PHONE: 410.938.3401 • FAX: 410.938.3450 • htrivedi@sheppardpratt.org

HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
HolyCrossHealth.org

May 18, 2022

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

Dear Mr. Kane,

On behalf of Holy Cross Health, I am writing in support of the proposed July 1, 2022 rate request submitted by the Maryland Hospital Association on behalf of Maryland hospitals.

As you are aware, the past two years have posed a variety of significant and escalating challenges as Maryland hospitals continue to fight the impact of COVID-19 on the health of our community and our own financial wellbeing. The financial impact is severe as costs have risen exponentially driven by skyrocketing inflation and unprecedented spikes in labor availability and cost. Hospitals, including both within the Holy Cross Health system, are facing substantial operating income declines and overall losses. Through April 2022, Holy Cross Health has reported a financial loss of $4.3 million. This loss would have been $7.6 million YTD April 2022 were it not for $3.3 million of provider relief funds. Those one-time funds only lessened our losses and will not support our ongoing needs. This performance is a dramatic decline from our FY21 operating income of $49.2 million which also included substantial support from provider relief funds (PRF) totaling $31.3 million. If we remove the PRF from our FY21 operating income, our financial performance would have been much lower at $17.1 million. Comparing this year over year financial performance after eliminating the one-time PRF funding, our operating income is projected to decline by $24.7 million. The FY 2021 operating performance of $17.1 million, while positive, leaves little opportunity for reinvestment in focus areas that support lowering the total cost of care and ensuring access and efficiency of and in operations. With the continued challenges facing us on the labor front and rising inflation pressures, we are projecting a continued loss in FY23 totaling $10.0 million despite implementing initiatives to curb costs in all areas throughout our system. FY 2022 losses and even further loss in FY 2023 are crippling to Holy Cross Health and jeopardizes our position as an exceptional high quality, low cost, efficient and accessible provider of community-based hospital services.

Throughout the pandemic years, Holy Cross Hospital and Holy Cross Germantown Hospital both grew in comparison to the market at large and to hospitals in the region. Individuals who neglected care during the pandemic are seeking innovative treatments in our hospitals, while those who had emergent needs, including women needing a care partner for their birthing plans never stopped coming through our doors. We have remained open and have not delayed or deferred service offerings. The very real challenge to our operating performance today is driven by the dramatic increase in labor costs and supply chain cost escalations. A prominent driver of labor costs is the overall growth in compensation rates for nurses and essential clinical resources. At the height of the pandemic, meeting the needs of the community required us to pay two to three times market rate for nursing and ancillary caregivers. With high burnout and enticing financial opportunities presented, a significant number of our clinical colleagues have left Holy Cross Health to take positions with the contract agencies who offering premium dollars to fill market vacancies. While this significant turnover continues to

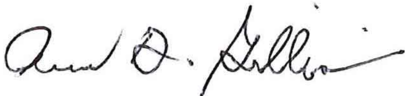
occur and premium dollars are spent on labor, Holy Cross built retention programs that offer bonus pay, wage adjustments and supportive benefits. Many colleagues have taken advantage of these offerings, but too few to impact the overall deficit caused by the significant wage increases necessary for us to remain competitive in the market.

Holy Cross Health has taken significant action to address attract and fill vacancies while implementing initiatives to retain current colleagues. We reviewed market compensation and instituted substantial adjustments multiple times this fiscal year and are continuing to review and adjust rates as necessary to address turnover and attract new colleagues. We implemented a retention program for those positions that are particularly difficult to recruit and established an in-house agency to offer a flexible work option for those seeking non-benefit-eligible positions. We are working closely with local colleges to effectively recruit and transition new nurse graduates into vacancies within our organization and providing the essential support to allow for their successful transition. We are also exploring the recruitment of foreign trained nurses to supplement our recruitment needs long term and exploring alternate staffing models to provide greater support for our front-line care givers and allow our nursing teams to work at the top of their licenses. These initiatives are essential for addressing our labor challenges but the growth in costs is creating a significant drain in our operating performance. Labor costs now comprise 60% of our net operating revenue compared to 52% in prior year and our overall compensation rates have risen over 14% from prior year.

The lack of recognition for the tremendous costs burden fails to recognize hospitals that have given so much and is forcing us to reassess and, potentially scale back, vital resources and investments made to support the transformation of care delivery under the Total Cost of Care model.

The challenges we are facing today are unprecedented and requires careful consideration as we look to continue the high-quality, accessible and efficient care that leads to improvement in and lowering of the total cost of care. Thank you for this opportunity to share the challenges we are facing in managing through these turbulent times and we appreciate your consideration of these challenges as you deliberate the update factor.

Sincerely,



Anne D. Gillis
Chief Financial Officer

Cc: Joseph Antos, Ph.D., Vice Chairman
James N. Elliott, M.D.
Sam Malhotra
Stacia Cohen, R.N.
Norvell "Van" Coots, M.D, Pres and CEO, Holy Cross Health
Maulik Joshi, DrPH
Victoria W. Bayless
Katie Wunderlich, Executive Director

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

May 16, 2022

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

Dear Chairman Kane:

I write to support the hospital field's July 1 rate request on behalf of Luminis Health.

Luminis Health recorded an operating margin loss of $48.6M vs. a budgeted margin loss of $1.4M for the nine months ending March 31, 2022. The projected full fiscal year 2022 operating margin is a loss of $58.9M vs. a budgeted loss of $4.9M. The projected operating margin loss of $58.9M represents an operating margin of (5.2%) vs. a budgeted margin of (0.4%), significantly below FY21 and FY20 operating margins of 2.0% and 0.6%, respectively. Additionally, as we continue to lose non-recurring revenue streams, such as CARES funding ($7M received in FY22), labor shortages coupled with premium agency rates, and supply chain disruptions, we are budgeting an operating margin loss of $18M. The budgeted operating margin loss of $18M represents an operating margin of (1.5%).

As with most health systems across the nation, staffing challenges have impacted the level and quality of services across Luminis Health. Emergency room diversions have remained elevated year over year, resulting from reduced staffing, and have been a driver in poor throughput and the inability to open additional inpatients beds. Additionally, the downstream effect of lower inpatient beds has also negatively impacted Luminis Health's operating room capacity. The nursing staff has also taken on duties in other departments, specifically tasks customarily performed by Respiratory Therapy and Phlebotomy. Medical length of stay has increased year over year, partially due to the increased number of inexperienced and agency staff. There has been a significant increase of inductions on hold in Labor and Delivery because of staffing issues. Maintaining adequate levels of scarce clinical talent has made focusing on and funding population health, community health, and care transformation investments problematic.

In September 2021, driven by the challenges faced by workforce competition, Luminis Health received Board approval to invest $29M in employee wage and benefits optimization programs. The investments included but were not limited to nursing retention bonuses, salary market adjustments, the implementation of a $17/hour living wage across the enterprise, and an R.N. college loan repayment program. Luminis Health has also experienced higher than average contract labor costs. Contract labor hourly rates have risen from $72 in FY19 to $174 in October 2021 (a 142% increase) and are still rising. Moreover, contract labor expense has grown from $23.3M in FY20 to $38.1M in FY21 and is projected to exceed $70.0M in FY22.

We hope you consider the wage pressures and the impact on care quality and delivery across the Maryland health systems in the July 1 rate order.

I appreciate your consideration. Please call me with any questions.

Sincerely,

Kevin L. Smith
Chief Financial Officer

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

Ascension Saint Agnes

May 18, 2022

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

Dear Chairman Kane,

On behalf of Ascension Saint Agnes Hospital, I write to support the hospital field's July 1st rate request.

Ascension Saint Agnes is experiencing unprecedented staffing challenges, wage pressures and rising costs for supplies and services. For the period July through the end of April 2022, Ascension Saint Agnes has an operating margin of 0.0% and projects an operating margin for fiscal 2022 year end of 0.7%. Commission action in January including approval of the 0.5% midyear advance funding and expansion of unit rate corridors has been critical for Ascension Saint Agnes to respond to rapidly increasing cost inflation and wage pressure in fiscal year 2022. For fiscal year 2023, Ascension Saint Agnes is projecting 0.35% operating margin. The erosion from fiscal year 2022 is driven primarily by rising labor costs and lower regulated revenue due to lower unit rate corridors. Ascension Saint Agnes has experienced a year-over-year increase in salary and wages per equivalent discharge and supply expense per equivalent discharge of 11.6% and 5.4%, respectively. Commission action to approve the hospital field's July 1st rate request will provide much needed financial support to respond to the rising costs.

Staffing shortages at Ascension Saint Agnes are leading to significant throughput issues in the emergency department, critical care, and med/surg nursing units. Emergency department red and yellow alerts (a good indicator of emergency department crowding) is currently running 390% over pre-pandemic levels for the ten months ending April 2022. Emergency department overcrowding is causing increased wait times, delays in treatment, delays in recognizing serious

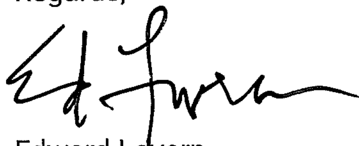
Ascension Saint Agnes
900 S. Caton Avenue
Baltimore, MD 21229
667-234-3114

medical issues, increased ambulance wait times and increased violence towards staff members due to the long wait time.

Ascension Saint Agnes has taken significant action over the past year to access the workforce and respond to the rapidly rising cost of labor. Ascension Saint Agnes currently has a nursing vacancy rate of 30% and a voluntary turnover rate of 25%. Contract labor and temporary staffing costs for the ten months ended April 2022 have increased $19.2m (532% increase) over the same 10-month period last year. An increase in contract labor and temporary staffing utilization means loss of permanent staff which causes inconsistencies in care teams and inconsistent adherence to policies and procedures including initiatives to improve quality and patient experience. To stabilize its workforce in response to the higher contract labor and temporary staffing utilization, Ascension Saint Agnes has invested $10.9m into permanent wage increases (representing a 6.3% increase in non-physician salary expense) to attract and retain employed personnel.

Thank you for your consideration. Please call me with any questions.

Regards,



Edward Lovern
President & CEO

cc: Katie Wunderlich, Executive Director
Joseph Antos, Ph.D.
Maulik Joshi, Dr.P.H.
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

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

CORPORATE OFFICE

May 18, 2022

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2023 Update Factor

Dear Katie:

On behalf of the entire University of Maryland Medical System, including all of our employees, and especially our care givers, we appreciate the extraordinary efforts of the HSCRC in providing the entire industry with resources and numerous flexibilities that have allowed us to continue to provide the world class care that we are so committed to delivering to our patients and communities.

Now as we begin to move forward in a COVID-modified environment, we are facing unprecedented labor shortages and cost inflation pressures. Some of these pressures are likely temporary, however, it is unclear about how long they will persist. In other areas, particularly regarding structural labor rates, we have had to make numerous permanent increases to our wages and benefit design.

As you are aware, the US economy is experiencing the largest increase in inflation in recent memory. Inflation is rising at rates last experienced with the oil crisis of the 1970s. Much recent debate has centered around the likely persistence of this inflationary trend – is it temporary or will it persist?

It is well documented that forecasts often lag turning points in economic activity. During a period of rising inflation, status quo models often miss the factors contributing to growth and continue to forecast increases well below those experienced for some time into the future. For Maryland hospitals, the implication is that costs would continue to rise well beyond the allowed increases based on the annual update factor.

The purpose of this letter is to discuss the adequacy of the preliminary update to rates proposed by the HSCRC staff, based on the current edition of the Medicare Market basket and the IHS Markit model for Rate Year 2023.

Cost Pressures at the University of Maryland Medical System

This general rise in prices is exerting operational and financial pressures on hospitals. While prices for all items are rising, the rising cost of labor is most impactful as there has been a fundamental shift in the labor market creating staffing shortages and permanent pressure on wages. These labor market changes necessitated swift action and UMMS moved quickly to make investments into our workforce including both one-time investments such as retention bonuses and over $68 million in permanent wage increases. The financial consequences of these investments are exacerbated by increases in the cost of agency staff needed to fill vacancies in critical clinical positions. In FY 2022 UMMS is projected to spend over $200 million in agency costs, more than four times the amount budgeted. Agency employees cost substantially more than employed staff. While the use of agency employees reflects a temporary circumstance in the hospital labor market, the situation is not necessarily short term. The impact of the lingering effects of the pandemic, workforce investments, one-time and permanent, and the unprecedented agency cost, is a FY 2022 projected breakeven operating margin which is far below annual budget goals.

Adding to this higher permanent FY 2022 cost, UMMS is expecting continued and increasing cost pressure in FY 2023 due to growth in inflation and the need for additional workforce investments. The FY 2023 budget includes the continuation of higher than normal agency usage, although lower than FY 2022, and the need for additional permanent wage and salary increases. To mitigate the impact of both FY 2022 and FY 2023 budgeted cost growth, UMMS is implementing $125 million in cost reductions through performance improvement initiatives - $50 million in agency cost and $75 million in other cost savings through such initiatives as a nursing care model changes and overall productivity improvements. In addition to targeting cost reductions, UMMS is also deferring programmatic investments, replacement of capital and equipment, and spending initiatives for innovative patient care delivery. Despite performance improvement initiatives and deferred spending, UMMS is budgeting an operating margin significantly lower than targeted margins needed to fund capital.

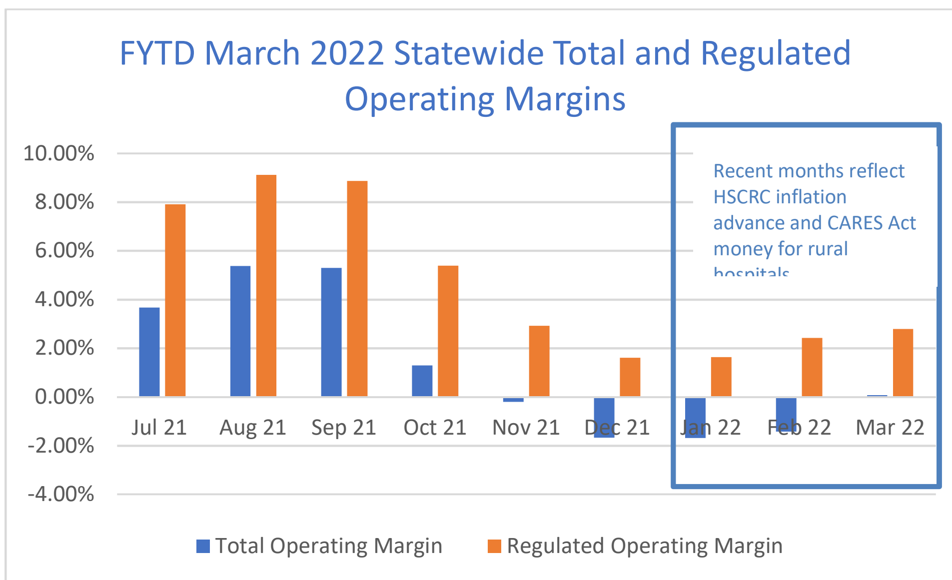
Industry Effects of Underfunding in FY2022

In addition to the prospective pressures of current inflation, the HSCRC update factor for Fiscal Year 2022 was well below actual inflation and is a compounding factor in the pressures UMMS is experiencing on its operating margins.

- For FY 2022, the approved update factor was 2.44% while actual inflation is projected at 3.9% by IHS Market forecast of the CMS market basket. Given the recent experience with the growth of the price indexes mentioned above, this gap could continue to increase.
    - Of specific concern is the CMS market basket assumptions regarding growth in labor costs. The market basket uses the Employment Cost Index, which is forecast for FY 2022 at 4.1%. This is

expected to rise to 5.4% in the next projection. However, alternative measures such as BLS's Average Hourly Earnings for hospital workers is rising at 7.8% and expected to peak at 9.7% in 2022. This rapid growth is echoed by a newly released Kaufman Hall report that estimates that labor costs for hospitals have risen by more than one-third since the onset of the pandemic.

- The results of this underfunding manifests itself in declining margins in preliminary data for FY 2022 to date. Regulated margins fell from 8.86% in September 2021 to 1.60% in December 2021 and total operating margins declined to a loss of 1.70% in December. Regulated operating margins have started to improve with the $100 million in advanced funding approved by the Commission and total operating margins are currently at breakeven. The results are shown in the chart below:



Per the recent HSCRC staff analysis, cumulatively, the annual update factor had overfunded inflation for the industry in the aggregate by 0.5 percentage points prior to FY 2022, but the 2022 underfunding clearly dwarfs that previous experience and is an outlier in forecast errors for recent years. Given the magnitude of the underfunding, it is not surprising that hospital margins have dropped precipitously.

The $100 million advance on the FY 2023 update factor increase appears to have stabilized the decline, as shown in the graph above. However, this advance of one-time money that is scheduled for recoupment is unlikely to offer sustained relief for long given that inflation numbers have continued to rise at an increasing rate:

- The Bureau of Economic Analysis (BEA) announced the PCE Index for March 2022 grew at 6.6% on an annual basis, which continued to increase over the 6.3% reported for the previous month. This increase in the rate of price growth suggests that the current price pressures have not yet peaked.
- According to BLS, producer prices for final demand increased 11.0% from April 2021 to April 2022. The Increase has been 10.0% the previous month.

- The Consumer Price Index rose 8.3% from April 2021 to April 2022, following a 12-month increase of 8.5% in March 2022.
- Medicare actuaries forecast that Medicare per capita costs will rise 9.4% in 2022.

Demonstration Model Considerations

The State has committed to $300 million in annual savings to Medicare Part A and B by the end of 2023 as a condition of the TCOC Model. To date, the State has exceeded the savings target, but the staff announced that position has eroded in recent months. Hospitals were running below the national growth rate, but non-hospital costs were growing faster than the national rate of growth.

Additionally, the guardrail position for CY 2021 over the same time the previous year was positive, which indicates as second consecutive year of growth beyond the national average. The anomalous conditions related to the pandemic have made comparisons to the national performance problematic. Clearly, the HSCRC has a difficult task to manage the system's performance under the Demonstration Model with providing sufficient revenue for hospitals to cover the rising costs of providing patient care. UMMS is fully committed to the success of the Demonstration Model and only asks that the HSCRC consider the extreme operating pressures that the industry is currently trying the manage.

A Proposal for the FY 2023 Update Factor

Given the new information regarding the cumulative savings erosion and the fact that inflationary pressures appear to be still increasing, UMMS would propose an update factor that recognizes both realities of Demonstration Model performance and labor cost pressures.

The current adjustment for inflation included in the staff's preliminary balanced update model for FY 2023 currently stands at 3.66% but given the fact that the IHS forecast has undershot recent forecasts for inflation (as have most forecasting models for the current fiscal year), updated models may show higher market basket forecasts.

1. We ask that the Commission consider alternative forecasts for expected fee-for-service Medicare per beneficiary growth in FY 2023. Given the CMS actuary's forecast of 9.4% per beneficiary fee-for-service growth for the Medicare Advantage update, the projection in the staff recommendation may be excessively conservative. While it is necessary to balance the needs of patients, payers, and providers, the financial pressures from volatile and rising input prices layered on top of an emerging post-pandemic environment have placed considerable stress on hospitals and health systems. It is necessary to substantially cover expected cost increases if the hospital system is to continue to meet the demands placed upon it by patients and policymakers.
2. We request that hospitals get some relief from the underestimate of inflation for FY 2022. We ask that the HSCRC forgive the payback of the $100 million advance from FY 2023 rates and keep this revenue as part of the permanent rate base. This approach effectively provides .50% of permanent funding for FY 2022 underfunded inflation. While this approach does not fully cover the

underestimate of FY 2022 inflation, this effort to relieve hospitals is balanced with the need to meet the state's commitments under the Demonstration Model. We would also request the HSCRC reevaluate the remaining underfunded FY2022 inflation for inclusion in rates as early as January 1, 2023 or at a future date dependent upon positive performance to the Total Cost Care savings target.

3. To avoid a repeat of FY 2022's underfunding in FY 2023, we suggest an update factor that recognizes full funding of expected inflation for FY 2023. This may require a reassessment at midyear to understand where cost growth stands in January 2023, given the volatility of the current economic environment.

Summary

While this proposed structure does not make hospitals whole with respect to rising costs, it offers a more realistic structure to cover cost pressures while balancing the State's commitments to expected performance under the Demonstration Model. We recognize this is a very difficult decision with numerous countervailing pressures. Maintaining a strong hospital industry given the stresses of the past two years must be a priority of any Demonstration Model as we work to care for the citizens of Maryland while bending the cost growth curve. We appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Mohan Suntha, MD, MBA

President and CEO
University of Maryland Medical System

cc: Adam Kane, Esq. Chairman
Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, M.D.
Maulik Joshi, DrPH
Stacia Cohen, RN, MBA
Sam Malhotra
Jerry Schmith, Principal Deputy Director
Michelle Lee, UMMS, CFO
Alicia Cunningham, UMMS, SVP