maryland health services cost review commission

Final Recommendation for the Update Factors for Rate Year 2024

June 14, 2023

This document reflects the Final Recommendation on the Update Factors for FY 2024 as ultimately approved by the Commission on June 14, 2023.

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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
GSP	Gross State Product
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 3.75 percent per capita, a revenue increase of 3.58 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.35 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2024. 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. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and 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.

Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2024. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. One notable exception is that staff had to account for the one-time actions taken during the December 2022 Commission meeting to improve total cost of care performance in Calendar Year (CY) 2023. Thus, in the modeling of TCOC savings in this recommendation staff accounted for the December 2022 actions of a $40 million one-time all-payer rate reduction, a temporary increase of 1 percent to the governmental payer discount (known as the differential) and an increase to the Medicare Performance Adjustment Savings

Component (MPA SC) of $64 million, which reduces Medicare reimbursement levels (not rates). Reductions to hospital payments were partially offset by a $50 million reduction to the Medicaid Deficit Assessment - a hospital provider tax that supports the Maryland Medicaid program.

All analyses herein do not contemplate TCOC savings in 2024, as the various financial tests that are considered in determining the reasonableness of the Update Factor are always predicated on the current calendar year and projecting two-year growth for national total cost of care and Maryland non-hospital providers would likely be inaccurate. Nevertheless, it should be noted that any calculated savings rates in CY 2023, when measured on a permanent go forward basis, are overstated,[1] because the one time actions taken in the December 2022 Commission meeting will be reversed in CY 2024 - the lone exception is the increase to the differential which will remain in rates for the entirety of RY 2024 and then eliminated in the second half of the calendar year.

Staff recognizes that the ripple effect of the COVID-19 crisis, workforce shortage and subsequent high rates of inflation continue to create significant uncertainty in the healthcare industry, which is why the Commission elected to implement one-time and mostly Medicare specific TCOC improvement actions during the December Commission meeting. Staff will 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. Specifically, Staff believes that the Commissioners should consider revising the annual inflation allotment provided in the RY 2024 Update Factor recommendation to align with the Medicare Inpatient and Outpatient Prospective Payment System rule when the final Medicare payment increases are known. Additionally, if Maryland's TCOC performance should worsen or not meet expectations compared to the nation, the Commission should consider ways to ensure that Maryland meets its CY 2023 contractual obligations by implementing an all-payer reduction and/or requesting to increase the MPA SC later in the year. Additionally, Staff believe the Commissioners should consider endorsing a workgroup to develop and assess financial condition benchmarks that will help inform future actions the Commission may take to stabilize the Maryland hospital market.

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 for consumers and purchasers of hospital services, as well as meeting all of the State's contractual obligations with the federal government.

Staff requests that Commissioners consider the following final recommendations:

[1] Staff estimates that the reversal of the one-time TCOC improvement actions that were approved in the December 2022 Commission meeting will likely yield an additional dissavings of ~1% or ~$100 million.

For Global Revenues:

a. Provide all hospitals with a base inflation increase of 3.35 percent.
b. Provide an overall increase of 3.58 percent for revenue (including a net increase to uncompensated care) and 3.75 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.
c. Convene a workgroup to establish benchmarks and methods for a Financial Condition Assessment that will, at a minimum, evaluate operating margins, cash position, debt coverage ratios, and capital investments.

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

a. Provide an overall update of 3.35 percent for inflation.
b. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

As a result of action taken by the Commission at its public meeting of June 14, 2023, the Commission approved this Staff Final Recommendation with the following amendment: *1) Use CY 2021 base period to provide an additional .97% in population growth and offset that increase with a .11% reduction via the PAU Shared Savings Program 2) A similar population reconciliation should take place following the 2030 census.*

The impact of this change increases the revenue on line AA in Table 2 to 4.32 percent. As a result, our updated savings estimate for CY 2023 under the most conservative approach is $312 million. This revised savings estimate is inclusive of an anticipated savings allotment of $40 million for the addition of non-claims-based payments.

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 continued long-term impact that COVID-19 is having on the healthcare industry 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 CY2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland exceeded the 5-year total cost of care savings requirement under the Total Cost of Care Agreement in 2021, but this performance stalled in 2022, i.e. there was a deterioration of the annual run rate in CY 2022 below that which was achieved at the end of CY 2021. While the Commission did take significant actions in December of 2022 to ensure that the State meets the total cost of care savings run rate of $300 million in 2023, progress must be sustained through CY 2023, as the savings requirement is not a cumulative test and 2023 will be the last year the current Model is evaluated.

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 developing the RY 2024 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) 2024 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2024, HSCRC staff is proposing an update of 3.75 percent per capita for global budget revenues and an update of 3.35 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 2023 market basket growth estimate with a capital growth estimate. For RY 2024, HSCRC Staff combined 91.20 percent of Global Insight's First Quarter 2023 market basket growth of 3.40 percent with 8.80 percent of the capital growth estimate of 2.80 percent, calculating the gross blended amount as a 3.35 percent inflation adjustment.

Consideration of Hospital Financial Conditions

Hospital industry representatives have raised concerns over hospital financial performance in several forums. Staff recognize that Fiscal Years 2022 and 2023 have been more financially challenging for hospitals than prior years and that several hospitals are challenged to meet their system debt service coverage ratios. As noted in the Hospital Financial Condition Report released in May, hospital regulated margins for Fiscal Year 2022 were 6.46 percent, down from 9.70 percent in Fiscal Year 2021. While total operating margins (including unregulated business) were 0.77 percent, down from 4.01 percent over the same time window. Unaudited data received by the HSCRC shows that year-to-date Fiscal 2023 margins through February have declined further to 2.93 percent regulated margins and 0.35 percent total operating margins. However, staff notes that unaudited results may change based on final year submissions and final audit allocations.

This recommendation does not include any specific accommodations for these results beyond recommending that the Commission work with stakeholders to develop a more comprehensive financial condition assessment. While Staff acknowledges the deterioration of the margin during FY 22 and 23, at this time, Staff is not recommending any special accommodations given the fact that overall hospital

balance sheets remain well above levels seen prior to the beginning of the GBR system in 2014 and have followed a period of many years of strong margin. Furthermore, statewide average regulated margins remain positive, meaning that any extra funding would effectively be directed at unregulated operations, over which the Commission has no regulatory authority and limited ability to evaluate appropriateness (although Staff acknowledge some of these costs may be inherent in operating a hospital). A more thoughtful approach is needed to consider covering additional costs needed to run a hospital. Individual hospitals with more significant financial challenges can and have been taking advantage of the various avenues to appeal for specific relief.

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 3.35 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.

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.35%	3.35%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	3.35%	3.35%

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, including achieving $300 million in annual Medicare savings by the end of CY 2023;
- 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 3.58 percent and per capita growth of 3.75 percent for RY 2024.

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 2024 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 2024			
Components of Revenue Change Link to Hospital Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 4.80% for Wages and Salaries)			3.35%
- Outpatient Oncology Drugs			0.00%
Gross Inflation Allowance	**A**		**3.35%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY24			0.19%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			0.39%
-Drug Population/Utilization			0.00%
Total Adjustment for Volume	**C**		**0.39%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		0.00%
- RY 2022 Surge Funding	F		0.20%
- Complexity & Innovation	G		0.10%
-Reversal of one-time adjustments for drugs	H		-0.04%
-Capital Funding & Estimated Increase for Full Rate Applications	I		0.41%
Net Other Adjustments	**J=**	**Sum of D thru I**	**0.77%**
Quality and PAU Savings			
-PAU Savings	K		-0.38%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	L		-0.32%
-Current Year Quality Incentives	M =		-0.25%
Net Quality and PAU Savings	**N =**	**Sum of K thru L**	**-0.95%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**O =**	Sum of A + B + C + J + N	**3.53%**
Per Capita First Half of Rate Year (July - December)	**P=**	(1+O)/(1-0.16%)	**3.70%**
Adjustments in Second Half of Rate Year 24			
-Oncology Drug Adjustment	Q		0.00%
-Current Year Quality Incentives	R		0.00%
Total Adjustments in Second Half of Rate Year 24	**S =**	Q+ R	**0.00%**
Total Update Full Fiscal Year 24			
Net increase attributable to hospital for Rate Year	**T =**	O + S	**3.53%**
Per Capita Fiscal Year	**U =**	(1+T)/(1-0.16%)	**3.70%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	V		0.05%
-Deficit Assessment	W		0.00%
Net decreases	**X =**	V + W	**0.05%**
Total Update First Half of Rate Year 24			
Revenue growth, net of offsets	**Y =**	O + X	**3.58%**
Per Capita Revenue Growth First Half of Rate Year	**Z =**	(1+Y)/(1-0.16%)	**3.75%**
Total Update Full Rate Year 24			
Revenue growth, net of offsets	**AA =**	T + X	**3.58%**
Per Capita Fiscal Year	**BB =**	(1+Z)/(1-0.16%)	**3.75%**

As a result of action taken by the Commission at its public meeting of June 14, 2023, the Commission approved this Staff Final Recommendation with the following amendment: *1) Use CY 2021 base period to provide an additional .97% in population growth and offset that increase with a .11%*

reduction via the PAU Shared Savings Program 2) A similar population reconciliation should take place following the 2030 census.

The impact of this change increases the revenue on line AA in Table 2 to 4.32 percent. As a result, our updated savings estimate for CY 2023 under the most conservative approach is $312 million. This revised savings estimate is inclusive of an anticipated savings allotment of $40 million for the addition of non-claims-based payments.

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 3.35 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2023 market basket growth of 3.40 percent with 8.80 percent of the capital growth index change of 2.80 percent. The adjustment for inflation includes 4.80 percent for wage and compensation.

- **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 2024 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 and then again with a lowering to 1 percent for RY 2023. This year Staff reviewed trends from 2018 to 2022 and determined that price and mix have been minimal over the recent period. Therefore, Staff is proposing a 0 percent drug inflation factor for RY 2024 for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2023 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 2023 of -0.22 percent. RY 2024 funding is expected to be approximately 0.19 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 RY 2024 is -0.16 percent; however, as noted by staff in Payment Model Workgroup Meetings and in Commission meetings, the projected population declines are relative to a revised July 1, 2020 base in which the Department of Planning accounted for the ten year forecasting error that was identified in the 2010-2020 census. Specifically, in the RY 2023 Demographic Adjustment, the Department of Planning revised the base upwards by 1.93 percent, an increase of 116,283 lives, and then projected a population decline of -0.12 percent from that revised base. The Commission only reflected the decline of -0.12 percent in the RY 2023 Demographic Adjustment, thereby reducing global budgets for 27 hospitals by approximately $79 million. In light of the revision to the census, Staff is recommending that the Commissioners a) reverse the population declines that were scored for 27 hospitals in RY 2023 b) implement a 0 percent RY 2024 Demographic Adjustment for all hospitals in lieu of the Department of Planning projection of -0.16 percent and c) consider expediting the review process to provide additional demographic funding in hospital rates for the population growth that was not accounted for from 2010-2020.

- **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 or potentially for reinvestment through the proposed Revenue for Reform policy. Staff is simultaneously recommending modifications to the Integrated Efficiency policy in the June Commission meeting, and as such will not reflect potential adjustments related to Integrated Efficiency Policy in the Final Update Factor Recommendation. Staff does note, however, that if the Commission were to approve the Integrated Efficiency policy in the July Commission meeting, TCOC savings in CY 2023 would improve by a range of approximately $8 million.

- **Set-Aside for Unforeseen Adjustments:** The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Staff is recommending 0.10 percent for RY 2024.

- **FY2022 Surge Funding:** A policy (COVID-19 Surge Policy) was adopted by the Commission in April 2020 under which hospitals would be reimbursed for COVID-19 cases that exceeded their GBR during designated periods. Two periods were designated eligible for this funding, one coinciding with the onset of the COVID-19 crisis in the spring and summer of 2020 and one during the winter of that year, ending in early 2021. With the severe spike of COVID-19 cases in the winter of 21/22 the Commission expressed a commitment to evaluate a similar approach for FY 2022, upon completion of the fiscal year and after modifying the policy to take into consideration the different circumstances in FY2022. Consideration of this policy was delayed due to the Medicare savings challenges during CY 2022, but Staff is now proposing an approach to meet this commitment. The outcome of that approach is a 0.20 percent overall impact as shown in this update factor. Details of the specific approach can be found in Appendix A of this document. Staff recommends this adjustment be the last special adjustment for COVID for both prior and future periods, except in the event of a major recurrence of the crisis.

- **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, 2021, and 2022. Based on this analysis, staff concluded that the historical average growth rate was 0.38 percent, which equates to a combined state impact of 0.10 percent for the RY 2024 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2024 PAU savings adjustment, of -0.38 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2022 PAU performance.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement program (QBR). Despite the suspension of payment incentives and modifications for COVID in RY 2022 and RY 2023, in RY 2024 all three quality programs will be implemented. Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The January QBR adjustments may also include changes to the preset revenue adjustment scale to reflect reduced performance standards in line with lower scores nationally, as approved in the RY 2024 final policy. The current revenue adjustments across the three programs is -0.25 percent (with preliminary QBR). The Update Factor recommendation also reflects the reversal of prior year Quality adjustments, which in RY 2023 were higher than historical adjustments at 0.32 percent, as the only incentives that were put in place were the RRIP, inclusive of the Disparity Gap Incentive.

- **Capital Funding and Estimated Increase for Full Rate Applications:** The Greater Baltimore Medical Center (GBMC) received an approved Certificate of Need (CON) in August 2020 to construct an expansion of the main lobby. This project is estimated to increase the budget by 0.01 percent, or $2 million, in RY2024**.**

  Preliminary modeling indicates that efficient hospitals may be entitled to approximately $80 million through the Full Rate Application Policy. This value is subject to change based on quality assurance reviews of Inter-hospital Cost Comparison (ICC) methodology and the Marketshift Policy, which has an effect on the final revenues evaluated in the ICC. Additionally, the values may

also change based on Commission consideration of proposed revisions to the Full Rate Application policy, which will be released as a Draft Recommendation in the June Commission meeting.

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 2024 will be 0.05 percent. The amount in rates was 4.22 percent in RY 2023, and the proposed amount for RY 2024 is 4.27 percent, an increase of 0.05 percent.
- **Deficit Assessment:** In line with the Commission's Total Cost of Care improvement actions taken in December 2022, the legislature proposed a $50 million decrease to the Deficit Assessment; however, the Commission indicated during its deliberations in December 2022, that any reduction should be attributable to hospital profits and thus has no impact on hospital charges. 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 RY 2020, 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 2024, 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 3). This will result in a RY 2024 permanent PAU savings reduction of -0.39 percent statewide, or $76,384,056 (this value does not include revenue from McCready or freestanding EDs). 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 3

Statewide PAU Reduction	Formula	Value
RY 2023 Total Estimated Permanent Revenue	A	$19,585,655,296
RY 2024 Inflation Factor*	B	3.74%
CY 2022 Total Experienced PAU $	C	$2,066,535,838
RY 2024 Proposed Revenue Adjustment $	D = B*C	-$77,288,440
RY 2024 Proposed Revenue Adjustment %	E = D/A	-0.39462%
RY 2024 Adjusted Proposed Revenue Adjustment %**	F = ROUND(E)	**-0.390000%**
RY 2024 Adjusted Proposed Revenue Adjustment $ **	G = F*A	**-$76,384,056**
Total PAU %	H	10.44%
Total PAU $	I = A*H	$2,044,485,050
Required Percent Reduction PAU	J = G/I	-3.74%

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

**Does not include revenue from McCready, or freestanding EDs, thus the reduction on a statewide basis is equal to -0.38%..

Change in Differential

In December 2022 the Commission voted, and CMMI subsequently approved, an increase of 1 percent to the public payer differential, from 7.7 percent to 8.7 percent, effective April 1, 2023. This increase was implemented for the remainder of RY 2023 and the duration of RY 2024. While the overall impact to hospitals will be revenue neutral, hospital markups, rates, and GBRs will be adjusted to account for a lower public payer payment. The adjustments will be hospital specific, as they are based on the percentage of services attributable to public payers.

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 the end of CY 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. In CY 2022, the annual TCOC run rate in Maryland deteriorated from a high of $379 million. Current estimates put the CY 2022 annual TCOC run rate between $219-$259 million, which is below the required run rate of $267 million. While the Commission did take significant actions in December of 2022 to ensure that the State meets the total cost of care savings run rate of $300 million in 2023, progress must be sustained through CY2023, as the savings requirement is not a cumulative test and 2023 will be the last year the current Model is evaluated.

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 as the stand-in 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 for RY 2023. For RY 2024 Staff are using a combination of these approaches. Scenario 3 represents the prior year trend test used prior to the pandemic; the other 3 scenarios are similar to those used in the more recent periods.

Actual revenue resulting from RY 2024 updates affect the CY 2023 results. As a result, Staff must convert the recommended RY 2024 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2023 to assist in estimating the impact of the recommended update factor together with the projected RY 2024 results. The overall increase from the bottom of this table is used in Tables 5a-5d.

Table 4.

Estimated Position on Medicare Test		
Actual Revenue January - June 2022		10,053,288,206
Actual Revenue July-December 2022		9,932,049,353
Actual Revenue CY 2022		19,984,015,293
Step 1:		
Approved Blended GBR RY 2023		20,185,681,779
Actual Revenue 7/1/22-12/31/22		9,932,049,353
Approved Revenue 1/1/23-6/30/23		10,253,632,426
Projected FY23 Undercharge		-12,292,753
Anticipated Revenue 1/1/23-6/30/23	**A**	**10,241,339,673**
Expected Revenue Growth 1/1/23-6/30/23		***1.87%***
Step 2:		
Final Approved GBR RY 2023		20,293,387,021
Reverse One Time Extraordinary Adjustments:		
Final Adjusted GBR RY 2023		20,293,387,021
Projected Approved GBR RY 2024		21,019,936,050
Permanent Update RY 2024		3.58%
Adjusted Change from GBR RY 2023		3.58%
Step 3:		
Estimated Revenue 7/1/23-12/31/23 (after 49.73% & seasonality)		10,453,214,198
Projected Revenue 7/1/23-12/31/23	**B**	**10,453,214,198**
Expected Revenue Growth 7/1/23 - 12/31/23		***5.25%***
Step 4:		
Estimated Revenue CY 2023	**A+B**	**20,694,553,870**
Increase over CY 2022 Revenue		**3.56%**
Per Capita Increase over CY 2022		**3.72%**

Steps to explain Table 4 are described as below:

The table begins with actual revenue for CY 2022.

- Step 1: The approved blended GBR for RY 2023 is $20,185,681,779. This blends the approved budgeted revenues from rate orders effective beginning July, March, and April. It is necessary to account for anticipated charges in the first six months of CY 2023. Hospitals currently project they will not be able to charge all of RY 2023 revenue by the end of the Rate Year, the estimated shortfall is $12.3 million (the RY 2023 undercharge).

- Step 2: The final approved GBR for RY 2023 is $20,293,387,021 which includes the change in differential. This step applies the proposed update of 3.58 percent, as shown in Table 2, to the adjusted RY 2023 GBR amount to calculate the projected revenue for RY 2024.

- Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2024 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2024.

- Step 4: This step shows the resulting estimated revenue for CY 2023 and then calculates the increase over actual CY 2022 Revenue. The CY 2023 increase based on this year's recommended update is 3.56 percent. The 3.56 percent is used to estimate CY2023 hospital spending per capita for Maryland in our guardrail policy, which is explained in the next policy.

Staff modeled four different scenarios to project the CY 2023 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 2023 growth of 3.56 percent, shown in Table 4 to Maryland hospital spending per capita from 2022. In addition, the temporary mitigation adopted by the Commission in December 2022 for CY2023 discussed above has been added to the Guardrail Scenario tests. Some aspects of these interventions are included in Table 4 because they directly impact all-payer charges, while others that manifest through other mechanisms, such as the differential and the MPA Savings Component, are not. The incremental impact of the interventions that is not reflected in Table 4 is a 1.13 percent reduction in per capita costs, this incremental savings is reflected in the tables below. The net impact of these temporary interventions is approximately 1 percent. As these interventions all terminate on either December 31, 2023, or June 30, 2024, this 1 percent of savings will need to be replaced by permanent savings in order for the State to meet CY2024 savings goals. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 5a, 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 2022 as the base.

Table 5a

Scenario 1 Guardrail Projections			
	Maryland	US	
2022	$13,652	$11,887	
2023	$14,015	$12,358	Predicted Variance
YOY Growth	2.66%	3.96%	-1.31%
Estimated CY2023 Savings Run Rate (assuming CY22 = $219 M)			$365 M

Scenario 2, shown in Table 5b, 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 2022 as the base. This is the most conservative estimate of the four scenarios as average national trends for that period were low. 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 5b

Scenario 2 Guardrail Projections			
	Maryland	US	
2022	$13,652	$11,887	
2023	$13,944	$12,226	Predicted Variance
YOY Growth	2.14%	2.86%	-0.72%
Estimated CY2023 Savings Run Rate (assuming CY22 = $219 M)			$295 M

Scenario 3, shown in Table 5c, 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 3 takes the trend from the prior period (2021-2022) and trends the data forward using 2022 as the base. Staff added this scenario assuming that the post-pandemic trend of 2021 over 2022 reflects the go forward trend. This approach is consistent with the pre-pandemic approach of using the prior year trend to guide current year savings targets. This approach results in a slightly higher estimate of national trends and slightly larger projected savings than Scenario 2.

Table 5c

Scenario 3 Guardrail Projections			
	Maryland	US	
2022	$13,652	$11,887	
2023	$13,884	$12,189	Predicted Variance
YOY Growth	1.70%	2.55%	-0.84%
Estimated CY2023 Savings Run Rate (assuming CY22 = $219 M)			$300 M

Scenario 4, shown in Table 5d, 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 4 takes the average trend from 2015 - 2019 and trends the data forward using 2019 as the base. The trend used is the same as Scenario 2 but it is applied to a 2019 base rather than 2022, which eliminates the impact of the pandemic on total cost of care. As the overall impact of the pandemic years was to lower total costs this scenario results in a higher projection for 2023 total cost of care. While the pandemic could be viewed as a temporary disruption rather than a permanent change to total cost of care patterns, Staff's review of the data so far does not show a rebound to pre-pandemic patterns of care. This rebound may still occur but assuming it will occur in CY2023 is likely an optimistic assumption.

Table 5d

Scenario 4 Guardrail Projections			
	Maryland	US	
2022	$13,652	$11,887	
2023	$13,985	$12,318	Predicted Variance
YOY Growth	2.44%	3.63%	-1.19%
Estimated CY2023 Savings Run Rate (assuming CY22 = $219 M)			$360M

In addition to modeling the CY 2023 guardrail position, Staff also modeled estimated savings under each scenario; these are shown in each table above. The savings target for CY 2023 is $300 million. Achieving an annual run rate of $300 million in CY2023 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.

In three of the four scenarios above, Maryland is set to achieve the savings target for CY 2023 with varying degrees of cushion. In the most conservative scenario, the savings target is closely achieved with a $5 million dollar shortfall. Therefore, this recommendation proposes funding inflation as reported by Global Insights for RY 2024 but does not provide additional funding based on higher prior inflation or anticipated future inflation.

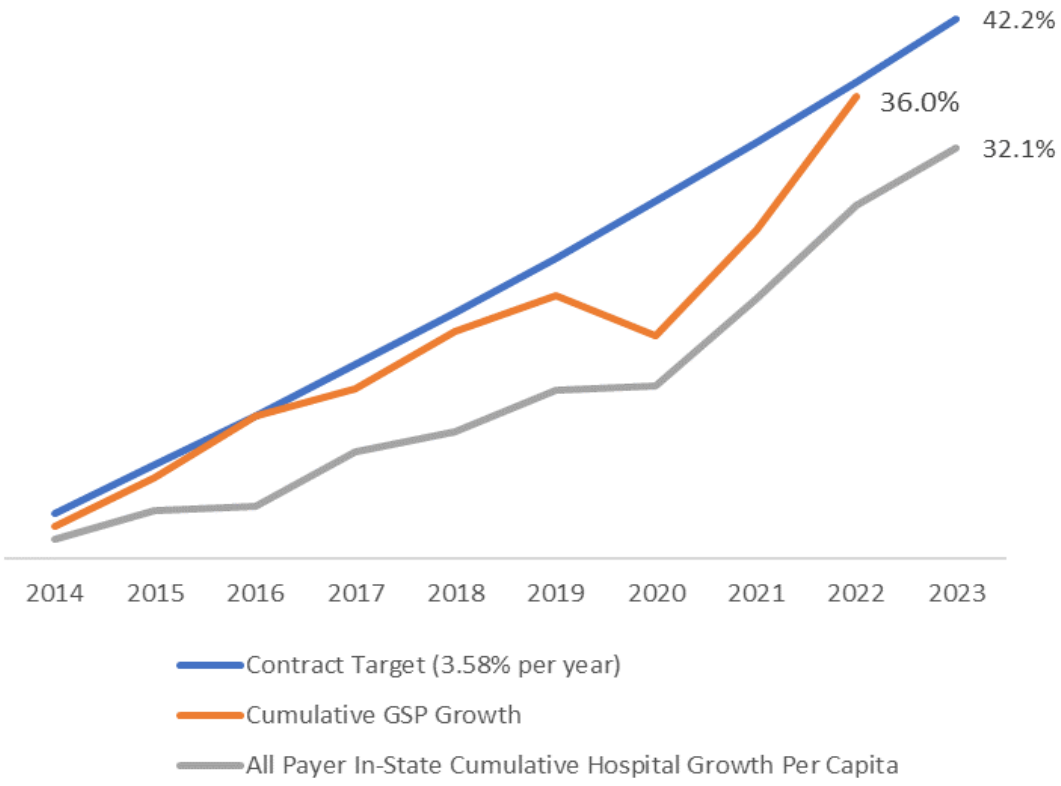
All-Payer Affordability

Under the Total Cost of Care Contract all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). As shown in Figure 1 the cumulative value of this target through CY2023 is 42.2 percent. Actual all-payer in-state hospital charge growth through CY2022 is 27.6[2] percent, inflating this to 2023 using the recommended update factor on a per capita basis yields 32.1 percent. This means that Maryland is approximately 10 percentage points below this target, as seen in Figure 1. Staff also notes that through CY2022 all-payer in-state hospital

[2] All GSP and charge growth figures in this section use an estimate of Maryland population that does not reflect the increase resulting from the correction of the forecasting error discussed in the "Adjustments for Volume section". This correction was omitted because it is not yet reflected in the all-payer test submitted to CMS. Correcting this value will improve Maryland's performance on the All-Payer test by approximately 1%. It will not change relative performance on the other GSP tests because the same population value is used in calculating both GSP and in-state acute hospital charges per capita.

charges are not just well below the all-payer target but also below the actual cumulative GSP growth through 2022 of 36.0 percent, which is an indication of the savings generated by the Model that accrue to all payers and consumers.

Figure 1. Affordability Scorecard – Cumulative GSP Test with CY 2023 Projection



Staff also compared the all-payer in-state hospital charges to economic growth in Maryland as measured by the GSP for the most recent 5 years. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose Staff believes it is not sufficient to only look at the cumulative test embedded in the Total Cost of Care Contract. Therefore, Staff calculated the cumulative growth for five years using the most updated State GSP numbers available (CY18-CY22). The 5-year calculation shows a cumulative per capita growth of 20.1 percent. Staff then compared that number to the 5-year cumulative growth in in-state acute hospital charges using (CY19-CY23). Staff was able to estimate CY 2023 charges using the proposed RY 2023 update factor. The cumulative growth for in-state hospital charges also equated to 20.1 percent, meaning the recommended update factor would keep the cumulative in-state hospital charge growth equal to the GSP growth over a 5-year window.

Medicare's Proposed National Rate Update for FFY 2024

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 11, 2023. In the proposed rule, CMS would increase rates by approximately 2.80 percent which includes a market basket increase of 3.00 percent, and a productivity reduction of -0.20 percent. This proposed increase will not be finalized until August 2023 and will not go into effect until October 1, 2023. 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. As noted above, Staff believes that one way to be responsive to the uncertain TCOC national performance is to make a revision to the annual inflation allotment provided in the RY 2024 Update Factor recommendation to align with the Medicare Inpatient and Outpatient Prospective Payment System rule when the final Medicare payment increases are known.

Stakeholder Comments

Beginning in early CY 2023, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed update for RY 2024. Comments generally focused on 6 areas: unfunded inflation, unfunded population growth, modifying the QBR scaling program, financial condition assessment, All-Payer hospital test and TCOC savings test, and market shift and surge policy concerns.

MHA submitted a proposal outlining the increase requested for its member hospitals. In addition to MHA's letter, the following hospitals submitted comments: Luminis Health, University of Maryland Medical System, Johns Hopkins Health System, Holy Cross Health, MedStar Health, Tidal Health, Frederick Health and Ascension St. Agnes. The request and comments outlined by MHA and echoed by member hospitals are outlined below with staff's response in italics.

1. All hospitals requested that the Commission fund appropriate revenues to cover operating costs, boosting the annual payment update by 1.15% to recognize recent, extraordinary inflation growth.

    a) Tidal Health requested that additional inflation funding should be scaled and targeted to efficient hospitals by either a) shifting a portion of this amount to the set aside to target and allow for a larger distribution to efficient hospitals or b) scaling the full 1.15% to apply more inflation to efficient hospitals and less inflation to hospitals with retained revenue.

    b) Johns Hopkins did note their belief that hospitals should not receive inflation on retained revenues citing that areas of the state with the largest retained revenues could not prove they were engaging in meaningful population health strategies.

c) University of Maryland requested that full inflation is funded, but that it should not be provided on retained revenues prior to CY 2019.

HSCRC Staff Response: There is no policy basis for going back in time to fund inflation in line with historical over/underfunding. From RY 2014 to RY 2021, the Commission cumulatively overfunded inflation by 1.97% and never considered reconciling it to actual inflation. The same principle should apply for both underfunding and overfunding.

Staff would additionally note that the Commission already has the Integrated Efficiency policy as its main tool to scale inflation based on efficiency and TCOC effectiveness (both of which will reflect excessive retained revenue that does not yield positive TCOC outcomes).

2. Almost all hospitals requested that the Commission apply the full demographic adjustment correction, adding 1.36% back on July 1 and work with HSCRC staff to validate population underfunding and related calculations.
    a) Hopkins noted that it supported the staff's phased-in approach to handling the Demographic Adjustment.
    b) Tidal Health stated that if the full demographic makeup would not be funded in RY24, that inflation should be scaled based on efficiency.
    c) Frederick requested that the demographic adjustment be funded equitably to ensure that the fastest growing counties are adequately supported.

HSCRC Staff response: Staff's recommendation already accounts for 0.39% of the 1.36% requested. This funding reverses negative adjustments that were implemented in RY 2023; thus, hospitals in the fastest growing counties of the State (and received positive adjustments in RY 2023) are better off than other hospitals. While there is a policy rationale for the remainder of the request (0.97%), as the Model always intended to fund full population growth in lieu of funding volume through volume variable methodologies, the Commission must first a) weigh this request against the spending limits imposed by the all-payer hospital test AND TCOC test and b) develop a revised methodology to establish the scope of the catch up and how to distribute it.

Staff believe its current estimation of the census catch up is reasonable, but it has yet to hear feedback from stakeholders or Commissioners on the proposal. While CY 2022 final performance is still to be confirmed by CMMI, staff believe that the inclusion of national population-based non-claims based payments will improve the annual run rate by a magnitude of up to $40 million. If indeed there is an increase in the final calculated run rate, staff believe that the release of some of the demographic catch up would not on its own jeopardize the CY 2023 TCOC test.

	Population Count	% of RY 2022 Funded Population
Census Catchup	116,877	1.93%
Less 30%	(35,063)	-0.58%
Less Pop Growth Provided Since RY 2023	(15,161)	-0.25%
Less RY 2024 DOP Cumulative Reduction Credit	(8,019)	-0.13%
Potential Remaining HSCRC Census Catchup	58,634	0.97%

Should stakeholders and Commissioners agree that a census catchup of 0.97% is warranted (or some other amount), staff believe a few additional considerations should be taken into account to effectuate that proposal.

1) *Staff believe strongly that the funding should be distributed by the Demographic Adjustment methodology and not some new allocation method, e.g., efficiency, as that would conflate and potentially duplicate revenue adjustments*
2) *To ensure that hospitals that missed population growth funding in the last decade receive that funding, the base year before the census catch up needs to be locked (i.e. CY 2021 Claritas base); projected population growth from that base will be distributed based on the current casemix adjusted market share*
3) *Any census catch up has to be offset by increased PAU Shared Savings reductions in line with the GBR contracts (section IV. B. 2. g)*
4) *A policy rider must be established to ensure a similar catch up is accounted for in the 2030 census (in either direction)*

As a result of the comments staff received in support of funding the full demographic adjustment catch up, staff modeled our savings with the 0.97 percent population catchup and the offsetting Potentially Avoidable Utilization reduction of 0.11 percent under the most conservative approach, i.e. the scenario that yielded $295 million, slightly less than the $300 million required under the contract. In this modeling, staff additionally noted the likely revision to the CY 2022 run rate due to the federal government's accounting of larger than anticipated non-claims payments. Although this value is not yet finalized, staff are noting the

likely revision of up to $40 million more in additional savings, because it could provide the necessary room to fund the entire census catchup of 0.97 percent.

Scenario 2 Guardrail Projections with full demographic catch up			
	Maryland	US	
2022	$13,652	$11,887	
2023	$14,123	$12,226	Predicted Variance
YOY Growth	3.45%	2.86%	0.60%
Estimated CY2023 Savings Run Rate (assuming CY22 = $219 M)			$272 M*
Additional Savings Allotment based on updated NCBP payments			$40 M
Updated Estimated CY2023 Savings Run Rate			$312

Although staff did not provide a savings run rate under each of its 4 scenarios, each one was modeled and yielded a consistent reduction to the Estimated CY2023 Run Rate of approximately $22 million. Thus, based on estimated growth rates for Maryland and the Nation (inclusive of the full census catchup, the offsetting PAU reduction, and the $40 million revision to the CY 2022 run rate), the State will likely meet its CY 2023 Savings target under the four staff scenarios.

3. Reset quality payment policy scaling, supported by national performance, reducing the 2024 offset by an estimated 0.15%, consistent with HSCRC's Performance Measurement Work Group discussion.

HSCRC Staff response: This will be reviewed at a later date and settled when final data is available. The implementation will occur in the January rate files and future adjudication on this item will be processed through the Performance Measurement Work Group.

4.MHA requested that the Commission complete a full financial condition assessment of Maryland hospitals and set appropriate financial targets to balance revenue growth with sustainability. MHA recommends this review be conducted by an independent consultant or with significant input from independent voices, including rating agencies, banks, and other financial experts.

HSCRC Staff response: Staff agree that this should be taken up in the next fiscal year in line with the staff recommendation on this topic. Staff also welcomes the idea that independent subject matter experts be included in the evaluation.

5. MHA noted that data show Maryland's all-payer hospital and total spending per capita growth remain below national growth and the contract limits. As such, the HSCRC should adequately fund hospital costs to ensure long-term success. MHA further noted that Maryland's Medicare Total Cost of Care spend is projected to grow only 2.51%. If the nation grows at least 3.50%, we will achieve the savings target.

HSCRC Staff response: Staff strongly agree that the Maryland Model has made healthcare more affordable in Maryland while at the same time creating greater financial stability than what hospitals experienced prior to the All-Payer Model (and certainly relative to the nation in the current period). This is evidenced by all-payer hospital growth that is less than State GSP growth coupled with improved financial positions relative to 2013, albeit with recent signs of worsening financial conditions.

Staff would further note that prior to the pandemic, the nation from 2015 to 2019 only grew faster than 3.50% in one year (2019 over 2018). That said, staff agree that the long-term success of the Model is predicated on funding hospital costs adequately, and thus will continue to work with the industry to identify opportunities for improving hospitals' current financial condition.

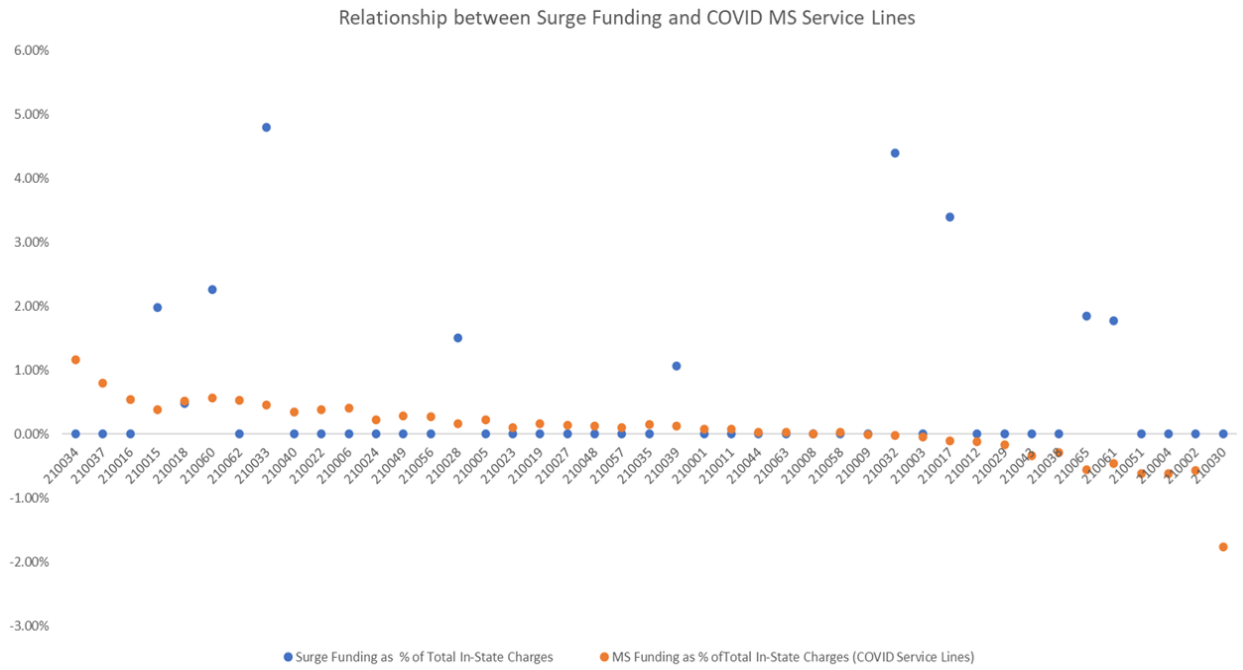
6. UMMS noted the overlap of the Surge Funding policy with Market Shift should be eliminated as the calendar year 2022 vs calendar 2019 Market Shift adjustment is implemented. The proposed surge funding policy evaluates volume growth in FY 2022, which includes quarters 1 and 2 of calendar year 2022. Both the surge and market shift policies, as proposed, would include volume funding for the Omicron surge, which occurred during quarter 1 and quarter 2 calendar year 2022. The Omicron surge was a one-time event resulting in increased volume and should therefore be funded on a one-time basis. The calendar year 2022 Market Shift is a permanent adjustment and as proposed, includes the COVID influenced service lines. It is inappropriate to fund the volume increase in two different policies and on a permanent basis when as we have seen with calendar year 2023, there have been no further surges in COVID hospital volume.

HSCRC Staff response: Staff share UMMS concern that there could be overlap between surge funding and market shift for Covid influence service lines; however, there appears to be limited relationship between the two revenue adjustments. Staff isolated the COVID influenced service lines in the CY 2022 marketshift and found limited relationship between surge funding provided and marketshift adjustments.

- *To remove scale, denoted all adjustments against total in-state charges*
- *In several cases, hospitals with no surge funding received marketshift adjustments (among them the three largest MS adjustments in terms of % of in-state revenue)*

- *In several other cases, hospitals with no marketshift adjustment received surge funding.*

Figure 2



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 2024 update factors.

For Global Revenues:

a. Provide all hospitals with a base inflation increase of 3.35 percent.
b. Provide an overall increase of 3.58 percent for revenue (including a net change to uncompensated care) and 3.75 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.

c. Convene a workgroup to establish benchmarks and methods for a Financial Condition Assessment that will, at a minimum, evaluate operating margins, cash position, debt coverage ratios, and capital investment.

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

a. Provide an overall update of 3.35 percent inflation.
b. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

As a result of action taken by the Commission at its public meeting of June 14, 2023, the Commission approved this Staff Final Recommendation with the following amendment: *1) Use CY 2021 base period to provide an additional .97% in population growth and offset that increase with a .11% reduction via the PAU Shared Savings Program 2) A similar population reconciliation should take place following the 2030 census.*

The impact of this change increases the revenue on line AA in Table 2 to 4.32 percent. As a result, our updated savings estimate for CY 2023 under the most conservative approach is $312 million. This revised savings estimate is inclusive of an anticipated savings allotment of $40 million for the addition of non-claims-based payments.

Appendix A: FY2022 Surge Funding Methodology

Under the original COVID surge policy (in place for FY2020 and FY2021), funding was set equal to the greater of:

1. $0
2. COVID Standardized Charge - (GBR - Non-COVID Standardized Charge)

   Where Standardized Charges are equal to the relevant volume times the rate on the hospital's final issued rate order.

The FY2022 funding starts with this approach and then adds three refinements.

1. COVID cases are limited to those which either had (1) a primary diagnosis of COVID-19 or (2) a primary diagnosis of Sepsis (A41.48) and a non-primary COVID diagnosis. Previously, any case with a COVID diagnosis was considered a COVID case and considered for funding. The change was made as Staff felt that, as the crisis progressed and routine volumes returned to hospitals, there was a much greater prevalence of cases which would reflect a COVID diagnosis, but which were primarily care that was already funded under the GBR. By focusing on COVID primary and Sepsis cases, the policy is focused on hospitals experiencing a spike in COVID volumes. This is consistent with the direction outlined to HSCRC Commissioners in January 2022.

2. The amount awarded under the approach is further capped at the amount by which the hospital's COVID Standardized Charges exceeded the statewide average share of COVID Standardized Charges for FY2022 (2.3%). Staff added this element as, during FY2022, all hospitals faced some degree of COVID cases. Limiting the incremental funding to those with above state average experience focuses the funding on hospitals with differential COVID experience rather than those with heavy, non-COVID volume (as the GBR is not generally a volume funded approach). This limitation becomes particularly relevant given the State's position on the Medicare savings test (and resulting limited funds) and is consistent with the direction previously outlined to HSCRC Commissioners in January 2022.

3. Standard rates were calculated using FY2021 rates on the hospital's final issued rate order trended forward based on the change in total GBR from FY2021 to FY2022. This was done to remove the impact of volume rebasing reflected in FY2022 rates with reduced capacity in the GBR.

Staff intends for these to be the only adjustments made to the previously existing COVID Surge policy methodology. Staff does not intend to further offset these amounts for other funding sources (e.g. PRF dollars).

Appendix B: Reconciliation of Set Aside for RY 22 and RY23

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%	

Distribution of Set Aside for RY 2023			
RY 2023 GBR Revenue		$20,185,681,779	
Set Aside %		0.10%	
Set Aside $		$20,185,682	
Hospital	Set Aside $ Value	Set Aside %	Reason
Garrett	$3,677,333	0.02%	RY22 Integrated Efficiency, CDS-A underfunding, & OOS volume growth
Christiana Care, Union of Cecil	$1,356,937	0.01%	OOS volume growth
Holy Cross Germantown	$2,958,467	0.01%	OOS volume growth, FY22 surge funding, & OB malpractice
Total	$7,992,737	0.04%	
Remaining	$12,192,945	0.06%	

TidalHealth™

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May 9, 2023

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

Dear Commissioner Kane:

Over the next few months, there are several very important staff recommendations that are being brought forward for vote. We hope that as these recommendations are discussed a strong consideration is made to build policy incentives that reward efficient low-cost providers. We also hope that strong consideration is made to appropriately remove and reallocate revenue from inefficient hospitals that have retained revenue since the implementation of the Global Budget Revenue System.

Being proposed right now is the Draft Staff Recommendation related to the FY24 Update Factor. We hope the Commission and the Commission Staff would build in a scaled approach to the Final Update Factor Recommendation. This is one step that could begin to bridge the significant gap that currently exists and has grown significantly between low-cost and high-cost providers. This approach has been deployed in the past and should be re-introduced. We would recommend a quartile approach that provides at the least a 1.0% spread to the base inflation adjustment for FY24. This would mean overall inflation of 3.16% would provide top quartile (high cost) hospitals 2.16%, and bottom quartile (low cost) hospitals 4.16%. This would not rectify the issue, but we believe would be a step in the right direction.

We know that all hospitals are experiencing significant financial burden. However, we would argue that inefficient hospitals have more opportunity to reduce that burden through overhead reductions.

Thank you for strong consideration of this request, and feel free to reach out should you have any questions.

Sincerely,

Stephanie Gary
Chief Financial Officer

cc: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Principal Deputy Director
HSCRC Commissioners

Ascension
Saint Agnes

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

May 22, 2023

Dear Ms. Wunderlich,

I am writing today on behalf of Ascension Saint Agnes to provide comments on the recommendation by the staff of the Health Services Cost Review Commission (HSCRC) regarding the Fiscal Year 2024 rate update. I appreciate the work that the HSCRC staff has put into developing the recommendation, including soliciting feedback from the hospital field.

Ascension Saint Agnes, like the rest of our colleagues in Maryland, continue to face unprecedented financial challenges. Hospital operating margins have deteriorated significantly, with hospitals around the country laying off parts of their workforce, reducing or eliminating services, and contemplating closures of entire facilities. One of the strengths of the Maryland model historically has been that it provided for predictable and reasonable reimbursement to promote more equitable access to care, regardless of payer. With the financial strain that Maryland's hospitals find themselves under, continuing to maintain the current level of services may prove to be untenable, an outcome that none of us wants to see.

While we understand the State's savings target obligations under the Total Cost of Care (TCOC) Agreement with the Center for Medicare and Medicaid Innovation (CMMI), Ascension Saint Agnes would encourage the HSCRC to provide additional financial relief to Maryland's hospitals. Appropriately correcting the demographic adjustment and increasing the rate update to reflect inflation more accurately would serve to place Maryland's hospitals in a stronger financial position and prevent the possibility of reductions in services.

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900 S. Caton Avenue
Baltimore, MD 21229
667.234.6000

Ascension Saint Agnes also firmly believes that any rate update should be equitably applied based on existing methodologies such as the efficiency methodology that have been fully vetted and discussed by the industry.

Thank you for the opportunity to comment on the FY 2024 rate update.

Sincerely,

Beau Higginbotham
Interim CEO

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Stacia Cohen, R.N.
Sam Maholtra

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

May 22, 2023

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

Dear Ms. Wunderlich,

Thank you for allowing Luminis Health to provide written comments on the draft staff recommendation for the Fiscal Year 2024 annual rate update. We appreciate the time and effort that the Health Services Cost Review Commission (HSCRC) has put into the process, including several discussions with the industry.

Luminis Health continues to be concerned with the HSCRC's conservative approach to the annual rate update. Although we recognize the State's contractual obligations to achieve specific savings targets each year, given the improved TCOC performance and the actions already taken by the HSCRC to generate an additional $125M savings in CY2023, we are requesting that the HSCRC fund unfunded inflation to address the unprecedented inflationary pressures and deteriorating financial positions of Maryland's hospitals. Luminis Health supports the Maryland Hospital Association's position on the annual rate update and believes it is a reasonable approach that balances achieving needed savings while providing additional revenue beyond the staff recommendation.

Luminis Health was also disappointed that the staff recommendation does not entirely correct for age-adjusted population growth forecasting error. Moreover, accurately and appropriately accounting for population growth, and adjusting revenue accordingly, is a foundational pillar of the system. Combined with the underfunding of inflation, this decision does not promote predictability and exacerbates an already challenging environment.

We would encourage the HSCRC to revisit the staff recommendation and make adjustments to fund Maryland's hospitals appropriately.

Sincerely,

Kevin L. Smith
Chief Financial Officer

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
James Elliott, M.D.
Maulik Joshi, Dr. P.H.
Sam Malholtra

Charlene MacDonald
Senior Vice President
Chief Government Affairs Officer

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-5207
Charlene.MacDonald@carefirst.com

May 24, 2023

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

Dear Chairman Kane:

CareFirst BlueCross BlueShield ("CareFirst") is grateful for the opportunity to comment on the proposed update factor for Rate Year 2024. We remain committed to working with the HSCRC to further its vision. As the HSCRC contemplates rate updates for the industry, it must prioritize retention of the Model that has served the State so well for the last 50 years, even against the backdrop of a global pandemic. During the COVID-19 pandemic, hospitals faced unprecedented uncertainty, labor shortages, and other challenges, leading to turbulent financial conditions. However, thanks to the flexibility and support the waiver offers, Maryland ranked 6th nationally among states for COVID-19 health system performance. While Maryland hospitals saw the same reduction in patient volumes as their peers in other states, the HSCRC swiftly intervened and ensured the financial stability of essential healthcare services.

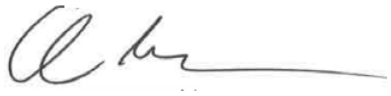
To ensure Marylanders and hospitals continue to benefit from the flexibility and stability provided by this Model, we must prioritize the long-term viability of the waiver. However, we recognize the inherent challenge of updating payment rates in such a way that both provides hospitals the financial support they need and ensures the state meets its $300 million savings target. We appreciate and encourage the HSCRC's collaboration with stakeholders from a variety of industries, offering an opportunity for all key voices in the healthcare delivery system to work together to best serve the people of Maryland. The future of our great experiment is at a crossroads, and it is evident that CMMI's evaluation will focus heavily on the Model's 2023 savings target performance. Thus, as the Commission contemplates the update factor for RY2024, it is imperative that Model performance remains the top priority.

While we applaud the Model's population-based methodology and believe any miscalculations should be corrected, corrections that come at the expense of the waiver's long-term viability would be irresponsible. It is not only possible, but advisable, to honor both our commitment to the methodology and to the Model itself by phasing in the demographic adjustment over several years, thereby mitigating the burden on a single year's savings test performance. This is more crucial now than ever as CMS considers the waiver's future and places its performance under the microscope.

Much like the rest of the economy, hospitals were forced to contend with high inflation in 2023, a significant burden that we agree must be properly addressed. CareFirst fully supports the HSCRC's work to balance the long-term solvency of the Model with the importance of equipping hospitals to care for their communities. As such, we support the Staff's recommendation to fund core inflation and reserve 0.4% for full rate applications to be evaluated, which they project would put the State at approximately the $300 million target. For the good of the Model and the Marylanders it serves, any changes to the update factor must not trip the savings target guardrails without a plan in place to recover the foregone savings in full. We must keep Marylanders' best interests at the center of every decision we make.

Thank you again for the opportunity to comment on this important matter. We look forward to our continued partnership with hospitals, the HSCRC, and CMMI to transform health care. Together, we can ensure the waiver's long-term viability and best serve the people of Maryland.

Sincerely,



Charlene MacDonald

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701
240-566-3300

May 24, 2023

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

Dear Chairman Kane,

Compensating hospitals for inflation and population growth are foundational tenets of the Maryland Model. I am writing to ask for the Health Services Cost Commission's (HSCRC) support of the Maryland Hospital Association's (MHA) draft recommendation for the Fiscal Year 2024 annual rate update as well as the following be considered:

- Fully fund the proposed incremental inflation allowance of 1.15%. As the MHA letter correctly states, Maryland's hospitals continue to face challenging financial circumstances due to escalating labor pressures and inflation. This has resulted in significant underfunding of inflation over the past several years. Given the improved Total Cost of Care (TCOC) performance and the actions already taken by the HSCRC to generate an additional $125M in savings in CY2023, we are requesting that the HSCRC fund unfunded inflation of 1.15% to stabilize the hospital's financial position.

- Fully fund the demographic correction. The recommendation by the staff to not fully correct for the demographic forecasting error which has significantly underfunded age-adjusted population growth that negatively impacts the hospital industry, further compounds these challenges and is inherently out of line with a basic tenet of our reimbursement system. We would encourage the HSCRC to revisit this decision in the final recommendation.

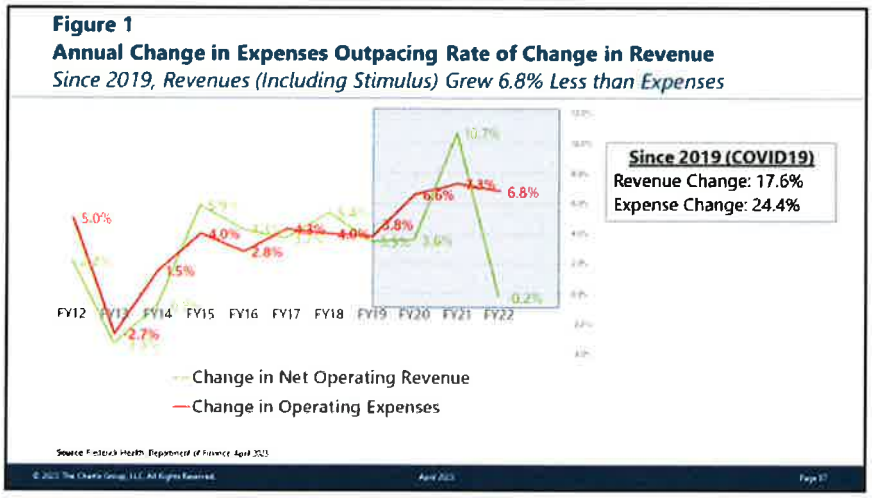
- Equitably fund FY24 demographic adjustment for growing counties. Frederick County is the fastest-growing county in Maryland. These funds are critical to ensure adequate support is provided. **As currently recommended by staff, the fastest-growing county in the state would receive $0 for incremental demographic growth revenue in FY24.**

- Adjust quality-based reimbursement (QBR) to account for national performance, -0.42%. We feel the National performance standards should be equal for Maryland hospitals.

Understanding Frederick Health's Position

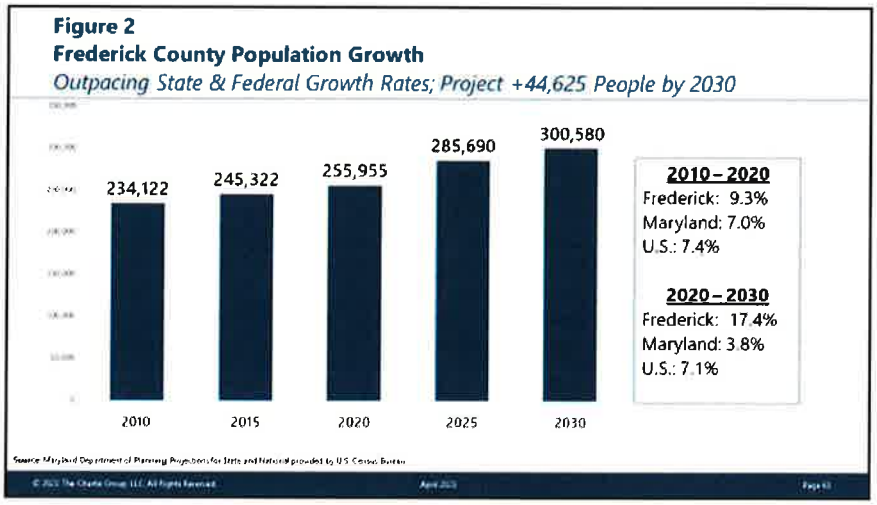
1. Frederick Health's Economic Sustainability is Challenged Without Funding for Population Growth and Inflation. Frederick Health is the sole hospital provider for Frederick County. Its economic sustainability is critical to ensure timely access to care. For illustrative purposes, **Frederick Health is the third busiest Emergency Department in Maryland caring for nearly 80,000 visits annually.** Without funding to account for inflation and population growth, which is fueling increased operating costs and service demand, Frederick Health may be required to reduce services that are important for the community's health and achieve a reduction in the total cost of care. Frederick Health has already been forced to reduce 5% of our workforce and delay and/or modify capital projects that would have increased access to care for those living in outlying parts of Frederick County.

Frederick Health's economic sustainability is challenged in part due to the lack of reimbursement for inflation-based increases in operating expenses while service demand associated with robust population growth has increased. Frederick Health has had a consistent negative operating income since November 2022 (15 months). In FY22, Frederick Health's operating margin was negative at 4.2%. The operating margin year-to-date FY23 (March 31) has remained unchanged from FY22, negative 4%. Before 2019, the HSCRC reimbursement models were consistent with actual operating expenses *(Figure 1)*. Alternatively, between 2019 and 2022, **reimbursements have not kept pace with inflation and increased service demands by nearly $100 million**.



2. Inflationary Costs Increased Beyond Traditional Expectations (Labor, Supplies, and Pharmaceuticals). The increase in general inflation between 2019 and 2022 was roughly $40 million. Another roughly $20 million was required to ensure adequate staffing to ensure safe care delivery. Between 2019 and 2022, labor costs nationally increased by 25% (McKinsey & Co, 2022). Like other hospitals, Frederick Health responded by increasing wages to ensure patient safety was maintained.

3. Increased Demand Associated with Robust Population Growth. Frederick County has the highest population growth in Maryland (Maryland Matters, 2022). Between 2010 and 2020, Frederick County's population increased by 9.3% (roughly 22,000 people), which was greater than the Maryland and United States growth rate, 7.0% and 7.4%, respectively *(Figure 2)*. **Between 2020 and 2030, an estimated incremental 45,000 (17.4%)** are projected to reside in Frederick County. During the same period, the Maryland and United States projected growth rates are 3.8% and 7.1%, respectively. Any policy that does not recognize and fund this growth **annually** and **consistently** is inherently at odds with a basic principle of our reimbursement system.



Furthermore, Frederick Health recognizes the need to address the question of retained savings as we move into the next phase of the model. We encourage hospital collaboration with the HSCRC over the summer to assess the impact of retained savings on the goals of the TCOC model and global budgeted revenue incentives and to consider how retained savings will be handled in the future within the context of the other policies under the model.

Frederick Health would like to encourage, consistent with MHA's position, a more robust annual rate update to address inflation growth, unfunded inflation, and unfunded demographic growth. We believe that this measured approach will provide much-needed relief while still adhering to the savings goals of the model. Without this relief, we may need to take action of reducing services similar to what has occurred nationally.

Thank you again for the opportunity to comment.

Sincerely,

Thomas Kleinhanzl
President & Chief Executive Officer

cc: Joseph Antos, Ph.D., Vice Chairman
Katie Wunderlich, Executive Director, HSCRC
Laura Herrera Scott, MD, Secretary of Health
Victoria W. Bayless
Maulik Joshi, Dr. P.H.
James Elliot, M.D.
Sam Maholtra
Brett McCone, SVP, Maryland Hospital Association
Hannah Jacobs, Chief Financial Officer, Frederick Health

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

May 24, 2023

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

Dear Chairman Kane,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the FY24 payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Demographic adjustment

JHHS is in agreement with the staff's recommendation regarding the demographic adjustment. We believe that it is important, in a population health-based system/model to ensure that demographic changes are appropriately funded. JHHS thanks the HSCRC for their commitment to resolve any additional funding the Commission should provide to account for the ten-year forecasting error that occurred in the preceding decade and making sure hospitals are fully funded for demographic changes moving forward. We look forward to participating in those discussions and methodology development.

Lack of alignment with the purpose of the update factor

JHHS is concerned with the proposed recommendation, as it is not consistent with the purpose of the update factor as stated by the HSCRC, nor the goals of the Maryland Model. According to the draft recommendation, the purpose of the update factor is to "provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable within the State of Maryland[1]." The recommendation as currently proposed is inconsistent with the purpose of the update factor.

[1] Health Services Cost Review Commission. (May 10, 2023). *Draft Recommendation for the Update Factors for RY 2024.*

733 North Broadway, MRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, ksowers4@jhmi.edu

Generally, the update factor is applied evenly across all hospitals regardless of volume and capacity. Hospitals with low volume or retained revenue receive inflation beyond their operational needs. These hospitals receive inflation and funding for volumes, patients, and costs that do not currently exist.

Some stakeholders and staff believe inflation should be distributed evenly because retained revenues should be dedicated to population health investments. However, there are no data or outcomes to support that these investments have been made with retained revenues. Certain Baltimore City hospitals have the highest representation of retained revenue, yet represent some of the greatest health disparities in the state. Analysis of Baltimore City multi-visit patients indicates that 33,895 high utilizers[2] in Baltimore City represented 21% of unique patients from the city, and represented 57% of total hospital charges; this population generated $1.2B of the $2.2B of total hospital charges, with the most common chronic conditions being hypertension, chronic kidney disease, and mental health diagnoses, among others. Zip code analyses of Baltimore City demonstrate that the highest concentration of high utilizers and multi-visit patients can be found in zip codes that surround hospitals with retained revenues. There is no evidence that hospitals with retained revenue are engaged in meaningful population and community health strategies and investments.

This issue has compounded over time, and must be resolved over a number of years in order to stabilize the model. Fully inflating retained revenue for the period of 2014 through 2019 has contributed over $140M in excess cost to the Maryland Model, however applying a 50% variable cost factor would reduce the excess amount to $70M.

Impact on affordability for patients

Furthermore, the overfunding of inflation at hospitals with low volumes and retained revenues impacts affordability for patients who seek care at those hospitals; patient bills are inflated to ensure the hospital can then meet its global budget revenue (GBR). JHHS urges the HSCRC to continue to prioritize affordability for patients, and to consider the impact of this recommendation as proposed.

Funding of inflation

While historically this process may have worked well for the industry, hospitals are currently operating in extraordinary circumstances with unprecedented nursing and staffing costs due to COVID-19 and its ongoing impact. It is critical for hospitals providing medically necessary care to be appropriately funded for the previous two years. JHHS urges the HSCRC to provide further support to hospitals in these extraordinary circumstances. The HSCRC has expressed legitimate concerns that there must be a conservative approach to the update factor due to the need to achieve our model savings targets. However, there is sufficient capacity to provide a reasonable update factor that fully funds inflation for hospitals that are providing medically necessary care if strategies are pursued to address retained revenue.

Lack of alignment with the goals of the Maryland Model

[2] Defined as 3+ inpatient/emergency department/observation visits within the year; based on FY21 analysis

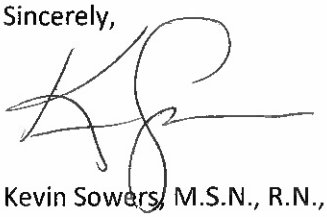
As proposed, the recommendation reflects the fundamental concerns that JHHS has repeatedly expressed regarding the direction and goals of the Maryland Model. As designed by CMMI, the model is intended to be a population health model in which targeted population health investments lead to improved health outcomes and reduced hospital utilization in certain diseases or communities, while controlling for cost and quality. However, as JHHS has previously noted, the model currently rewards any and all volume reduction, regardless of how this reduction was achieved. Hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and the repeated application of inflation to retained revenues only serves to further the distortions that currently exist in the model.

Recommendations

Given the economic climate and the challenges currently faced by the healthcare industry, JHHS believes a more nuanced and balanced approach to the update factor is required. For the reasons outlined above, hospitals should not receive inflation on retained revenue, as this is funding volumes that do not exist. Additionally, because the hospital industry remains unstable and uncertain in the aftermath of the COVID-19 pandemic, retained revenue should be assessed for pre-COVID model performance years (2014-2019). JHHS believes that these recommendations will allow the HSCRC, the State, and the healthcare industry at large to further align with the total cost of care goals.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update, and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,



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

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra

MedStar Health

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P 410-772-6500
MedStarHealth.org

May 24, 2023

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 field's July 1, annual update rate request.

During the pandemic, Maryland Hospitals partnered with the state and the HSCRC to manage through the public health crisis and meet the healthcare needs of the citizens of Maryland, and we were glad to do it. Now more than three years since the pandemic began, Maryland hospitals are faced with a different crisis, a financial crisis.

In the aftermath of the pandemic, hospitals in Maryland & nationwide are coping with significant changes to their expense structures. During Fiscal Year 2022, hospitals were forced to take action as the impact of labor shortages, sky high agency rates and hyper-inflation began to take a toll on hospital finances. Extraordinary pay increases and other special pay programs were implemented to deal with workforce shortages and maintain healthcare services. Now, in Fiscal Year 2023, the full impact of these actions is being realized. Hospital costs have increased significantly, and permanently. In fact, MedStar's Fiscal Year 2023 annual operating expenses are projected to grow by approximately 15% when compared to Fiscal Year 2020. For that same period, the statewide median for operating expenses is projected to rise by nearly 20%.

In the Maryland system, with a fixed revenue base, it is incumbent on hospitals to control expenses and the HSCRC to fund inflation. Unfortunately, the impact of the pandemic has been an increase to expenses in a way that was never anticipated and was unavoidable and uncontrollable. Meanwhile, it is estimated for Fiscal Year 2022 and 2023 alone, inflation funding in GBR has fallen short of actual inflation by a total of 3%. A 3% gap in inflation funding is a permanent, on-going shortfall that places tremendous pressure on hospital operating margins. With operating margins at or below zero since early in Fiscal Year 2022, hospitals have been forced to use financial reserves to cover operating losses. The continued use of financial reserves for these purposes is not a sustainable solution. While the industry's requested FY24 rate update does not fully fund the inflation funding gap, it is greatly needed as part of the solution.

As we look to the future and the next phase of the Maryland model, alignment of policies, incentives and methodologies will be critical to our success. We look forward to continuing to partner with the HSCRC as we prepare to build upon the achievements of the Maryland system.

MedStar Health and its member hospitals appreciate the HSCRC staff's work on the update factor and the open conversations with the field throughout the process. 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, FACP
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

Thomas 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

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
Victoria W. Bayless
James Elliott, M.D.
Sam Malhotra

Maryland
Hospital Association

May 24, 2023

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, 2023 annual payment update draft recommendation. MHA appreciates your support of the hospital field and collaboration on a fair annual payment update for rate year (RY) 2024.

We offer the following positions that align with and expand on the MHA March 22 position paper and reflect current data and considerations.

1) Fund appropriate revenues to cover operating costs, boosting the annual payment update by 1.15% to recognize recent, extraordinary inflation growth.

2) Apply the full demographic adjustment correct, adding 1.36% back on July 1. Work with HSCRC staff to validate population underfunding and related calculations.

3) Reset quality payment policy scaling, supported by national performance, reducing the 2024 offset by an estimated 0.15%, consistent with HSCRC's Performance Measurement Work Group discussion.

4) Complete a full financial condition assessment of Maryland hospitals and set appropriate financial targets to balance revenue growth with sustainability. MHA recommends this review be conducted by an independent consultant or with significant input from independent voices, including rating agencies, banks and other financial experts.

Maryland hospitals are facing extraordinary financial challenges. The median hospital operating margin has been hovering at or below zero for the last 18 months. As outlined in the MHA March position paper, labor, supplies, drugs and other costs remain stubbornly high. Higher costs for physician coverage in parts of the state—critical to operating hospital services—are now acute for anesthesiology, radiology, and other specialties.

HSCRC has a mission to support financially sustainable hospitals. These extraordinary times require you, the Commissioners, and the staff to think differently and activate the levers at your disposal—such as inflation and population growth which are collectively at least 2% below what is needed.

The 2023 Medicare total cost of care savings target is $300 million. There is ample room for HSCRC to grant this request without risking the 2023 savings target as noted by these insights:

1. MHA 2023 projected Medicare hospital revenue growth—including 1.15% inflation recovery and 0.15% quality scaling, plus January 1 HSCRC actions—is 2.22%. Including a conservative estimate for non-hospital growth, Maryland's Medicare Total Cost of Care spend is projected to grow only 2.51%. If the nation grows at least 3.50%, we will achieve the savings target.

2. Data show Maryland's *all-payer* hospital and total spending per capita growth remain below national growth and the contract limits. HSCRC should adequately fund hospital costs to ensure long-term success.

3. In addition to favorable all-payer performance, Maryland has accumulated more than $2.2 billion in cumulative Medicare savings beginning in 2014. As we strive for the target, it is unwise to pick the most conservative growth alternative relative to hospital financial condition when additional savings are not required.

Supporting information that supplements this letter and the MHA March position paper is attached.

MHA and the 60 hospitals providing acute care and more to communities across the state sincerely appreciate your partnership. On behalf of all hospitals and health systems in the State of Maryland, we ask HSCRC to honor this RY 2024 request.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Maulik Joshi
James Elliott, M.D.
Sam Malhotra

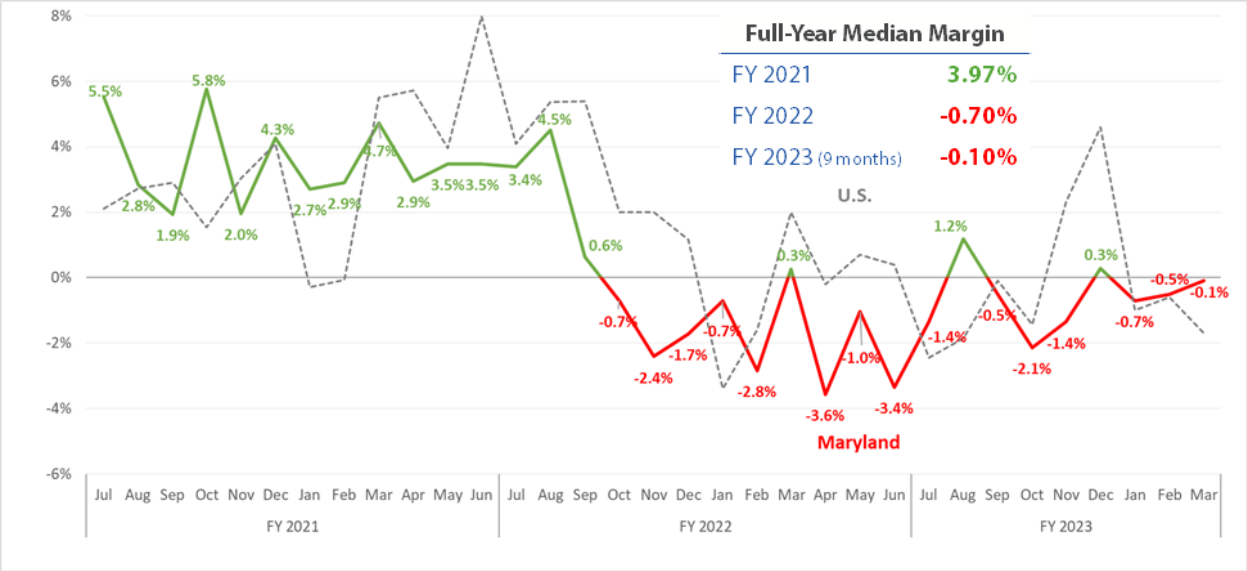
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Allan Pack, Principal Deputy Director
William Henderson, Principal Deputy Director

Information and Supporting Rationale

A. Adequate Revenue is Needed to Cover Costs and Improve Financial Performance

1) Maryland hospitals' financial performance is severely strained, yet it is well below national operating revenue and expense per capita. Operating margins remain depressed as hospitals struggle with rising inflation for the reasons listed in the MHA position paper. Figure 1 reflects hospital monthly and annual operating margins through March 2023, showing that more than half of Maryland hospitals' revenues are below expenses.

Figure 1: Maryland and National Monthly Margins, with Annual Summary[1]



In 2022 actual inflation exceeded funded inflation by 86%, and nearly 50% including both 2022 and 2023. We agree with HSCRC staff that prospective inflation should not be adjusted every year. These are not small variances found in ordinary years. The inflation variance for 2022 and 2023 is more than 3%, equivalent to about $600 million in funding. This request is empirically based on overall the inflation gap of 1.15%, triggered by the extraordinary difference. This amount is not likely to keep up with rising costs but would provide some financial steadiness.

As noted last year, Maryland's rate setting system, combined with federal relief, afforded hospitals a degree of financial stability during 2020 and 2021. Calendar year 2022 figures reflect at least $200 million of one-time inflows, which have been reversed and reduced even further in CY 2023. MHA seeks permanent, structural relief.

[1] Sources: Maryland, HSCRC monthly reporting. National, KaufmanHall Monthly Flash Report.

HSCRC must consider the impending impacts of negative margins. On May 10, S&P Global Rates released a new report, *Not-For-Profit Acute Health Care State Snapshot: Maryland.*[2] The first headline reads, "Global Budget is Strained After Years of Stability." S&P concludes that HSCRC has historically provided predictability and stability, particularly through COVID. However, they acknowledge revenue growth could be stagnant, "**weaking operating performance and cash flow, which could lead us to lower ratings or revise outlooks to negative**.*"*

As noted by many market experts, hospitals entered this cycle with generally strong liquidity positions, providing a short-term cushion to absorb weak operating performance while recovery is underway. However, **cash positions are volatile and don't substitute for sustainable operating performance**. Without sustainable cash flow, hospitals' cash positions erode and the cost of capital rises, leading to an inability to sufficiently invest in programs and facilities and eventually to closures of necessary but unsustainable programs.

HSCRC presented data showing Maryland's cash position above historical values from 10 and 20 years ago, but rating agencies and markets do not use these standards and cash reserves to cushion the recovery period are already being whittled away.

Market experts believe this cycle of industry challenges is worse and more intractable than prior ones, with no obvious path to stabilization. Rating downgrades and even defaults have accelerated, particularly in the last 6-8 months, with no sign of abatement.

Cash cushions remain sound but are only an effective bulwark against negative operations if negative performance is expected to be temporary. The current cycle, featuring stubbornly high inflation, is occurring simultaneously with the rising cost of capital and weaker investment markets. The combination has already eaten into reserves, which could erode further as the cycle continues.

Operating revenues, one of the major inputs to determine net income, is within the HSCRC's control. Raising the update so that hospitals have revenue to cover costs is paramount to long-term success and sustainability.

2) **HSCRC should correct the demographic adjustment in full, July 1, 2023.** MHA thanks HSCRC staff and commissioners for recognizing the magnitude of the population underestimate and for working speedily to correct the methodology. MHA appreciates the HSCRC's first step in revising its demographic adjustment to reflect corrected population growth estimates. As discussed at the May meeting, a per capita system should, at bare minimum, fund age-weighted population growth and cost inflation. We agree that the funding should be restored as quickly as possible and recommend applying the full demographic adjustment catchup of 1.36% on July 1,

[2] https://www.spglobal.com/ratings/en/research/articles/230510-not-for-profit-acute-health-care-state-snapshot-maryland-12727684

2023. This includes 0.39% to reverse 2023 offsets and 0.97% to restore the full amount. We pledge to work with HSCRC staff to validate its underfunding analysis and related calculations.

B. With MHA's Request, Maryland Will Meet the Model Target

HSCRC's draft recommendation repeatedly cites the 2023 Medicare $300 million total cost of care savings target as the reason HSCRC added funding to the system—revenues to cover costs for both inflation and population growth—the two core pillars of a per capita system. HSCRC extrapolated trends showed Maryland's savings falling to $80 million in 2022, which proved to be untrue. According to data presented at the HSCRC May public meeting, **Maryland will end 2022 with $219 million of savings, *before* considering corrective actions applied January 1.** Applying MHA's requested update and including this corrective action, Maryland's CY 2023 Medicare hospital spending will grow just 2.22% over CY 2022. This estimate removes any counter arguments about affordability, especially in a period of hyperinflation.

Figure 2 – CY2023 Hospital Revenue Growth

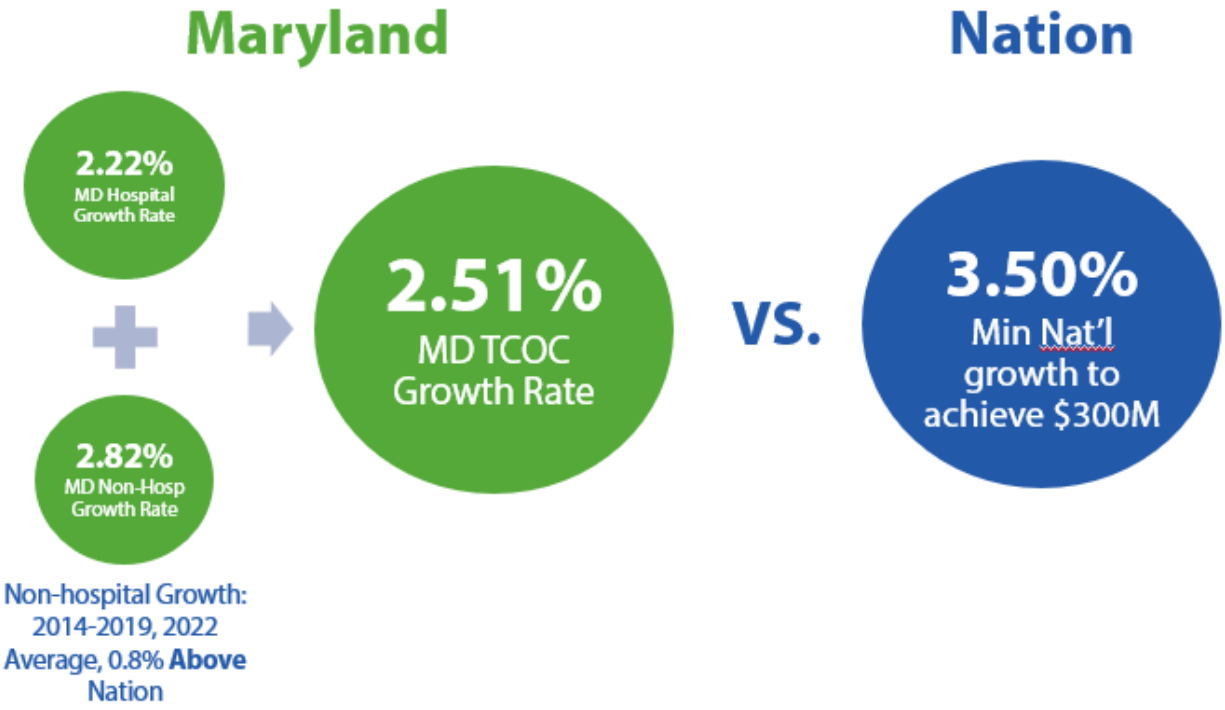
Calendar Year 2023 Hospital Revenue Growth Projections	
Jan-June Growth (RY2023)	1.67%
Jul-Dec Growth (RY2024)	7.12%
CY 2023 over CY 2022 All-Payer Growth	**4.38%**
Less Approved Actions Affecting Medicare:	
MPA-SC Reduction	(1.10%)
Differential Savings	(0.86%)
Subtotal:	(1.96%)
Traditional MPA	(0.19%)
CY 2023 Projected Medicare Hospital Growth	**2.22%**

5.42% RY 2024 Update, compared to actual Jul-Dec 2022 revenue

% of Total Medicare Hospital Payments

Coupled with a reasonable estimate for non-hospital payment growth of 2.8%, if the nation grows at or above 3.50% (less than half of last year's assumption) Maryland will make the $300 million target. The latest KaufmanHall figures show national discharges for March 2023 rising 7% over March 2022, suggesting that national volumes are rebounding, supporting our minimum national growth assumption. Figure 3 reflects these inputs.

Figure 3: CY2023 Projected Maryland Total Cost of Care Growth, Minimum National Growth to Equal $300 Million Required Savings



We appreciate HSCRC staff's approach of using different assumptions to present a range of outcomes. In today's financial climate, HSCRC should not simply pick the most conservative outcome to ensure we meet the Medicare target. To achieve Maryland's aims of reducing disparities and improving population health, hospitals need adequate revenues to ensure they can meet community needs.

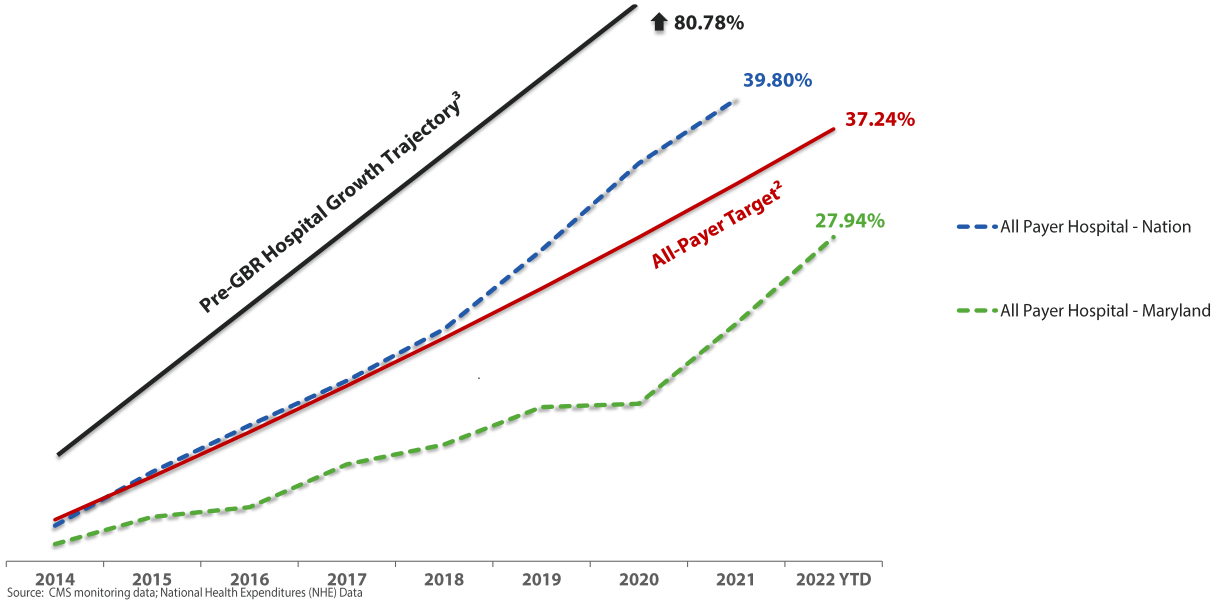
Since 2014, Maryland produced additive Medicare total cost of care savings of $2.2 billion, likely aided by the underfunding of population growth as reflected above. From 2019 to 2021 alone, cumulative savings were more than $600 million above the interim targets of $1.1 billion.

C. All-Payer, Per Capita Spending Performance Demonstrates Maryland's Affordability

If all-payer growth is favorable, HSCRC should consider levers beyond Medicare growth to provide a more robust update. As show in Figure 4 below, Maryland's growth in all-payer hospital spending per capita is 9.3 percentage points below the contractually allowed limit and 11.86 percentage points below the nation.[3] These data confirm hospital spending growth is not rising faster than the nation.

[3] Data from National Health Expenditures (NHE) and the federal Bureau of Labor Statistics (BLS) are cited in several charts. Though data lag, they consistently show Maryland performing favorably.

Figure 4: Maryland and U.S. All-Payer Hospital Spending per Capita; Model Target and Pre-Model Performance



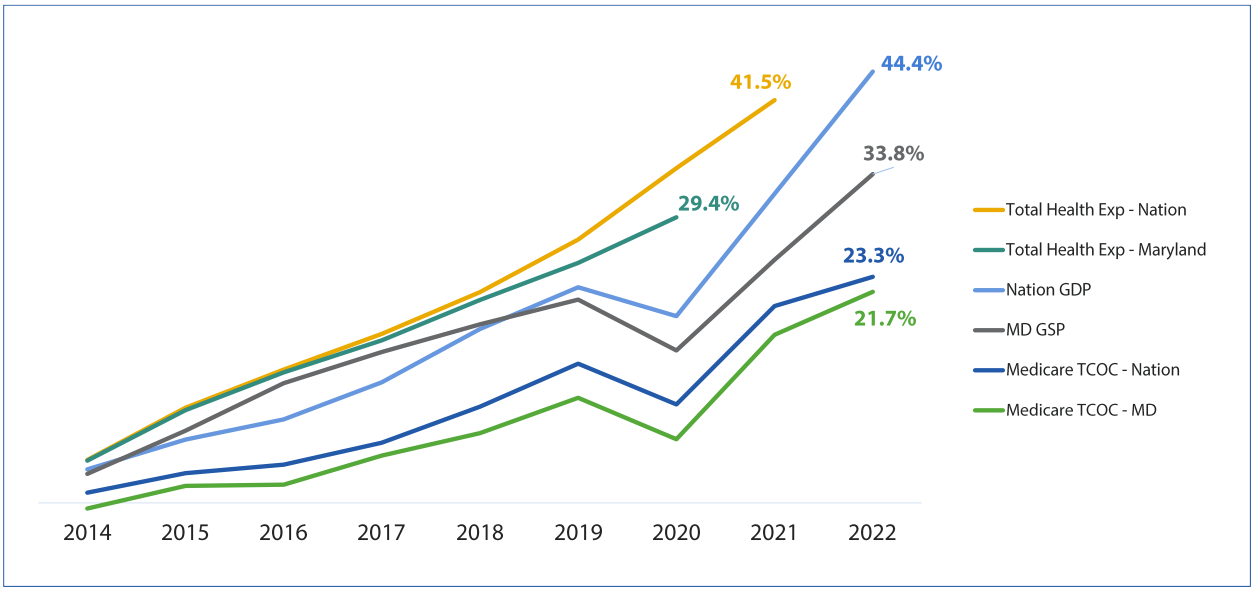
Source: CMS monitoring data; National Health Expenditures (NHE) Data

Note 1: NHE per capita growth at U.S. Population. Reconciles to within 0.05% when Maryland's payer mix is applied to the National per capita growth rate
Note 2: Compounded annual all-payer growth target of 3.58% per contract agreement
Note 3: Compounded annual hospital growth of 6.8%

Moving to a per-capita revenue system and the agreed upon target created an unprecedented bend in the hospital cost curve. As HSCRC considers the annual payment update and an overall desire to meet Medicare targets, take into account hospital savings provided to all-purchasers built into the Model from day one.

While figure 4 can be viewed as hospital only expenses, figure 5 below reflects both all-payer total cost of care growth from National Health Expenditures (NHE) data, and Medicare total cost of care growth from the Model data. NHE does not have all-payer data for the most recent years, yet Maryland remains more than 11 percentage points below the nation when comparing 2020 to 2021. The chart also references Medicare data, below the all-payer growth, and both Maryland and U.S. growth in gross domestic (state) product.

Figure 5: Maryland and U.S., All-Payer and Medicare, Total Cost of Care Growth



Finally, figure 6 notes national hospital price growth for Medicare, Medicaid and commercial insurance. Commercial price growth has nearly doubled Medicare growth during the GBR period. Since 2021, commercial insurance hospital prices grew more than three times faster than Medicare and seven times faster than Medicaid.

Figure 6: National Hospital Price Growth, GBR Period 2014 – Present

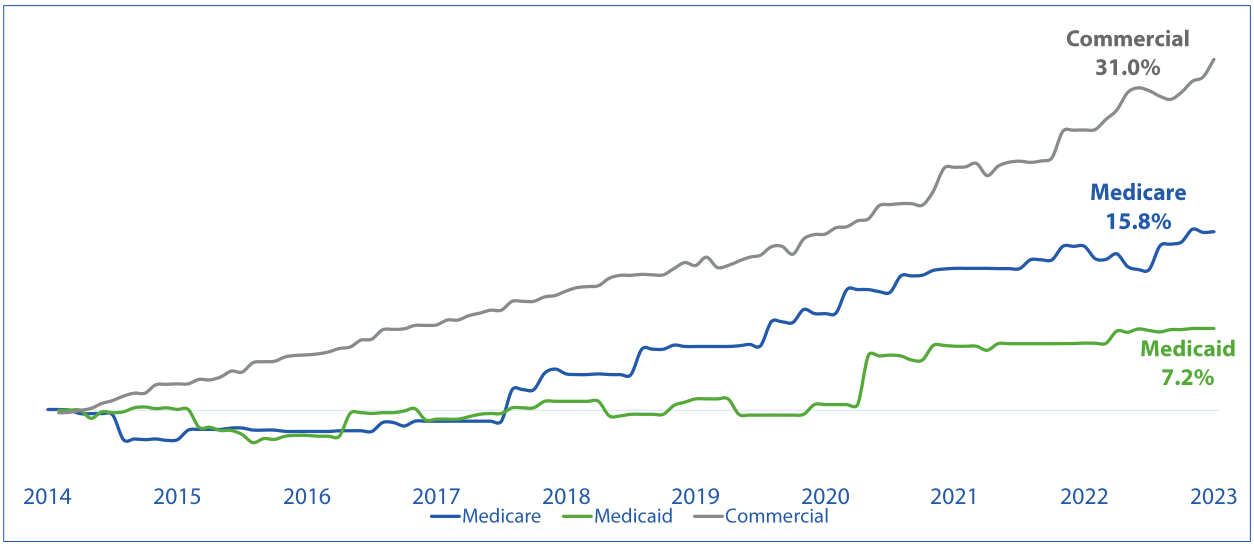


Figure 7: National Hospital Price Growth, 2021 - Present

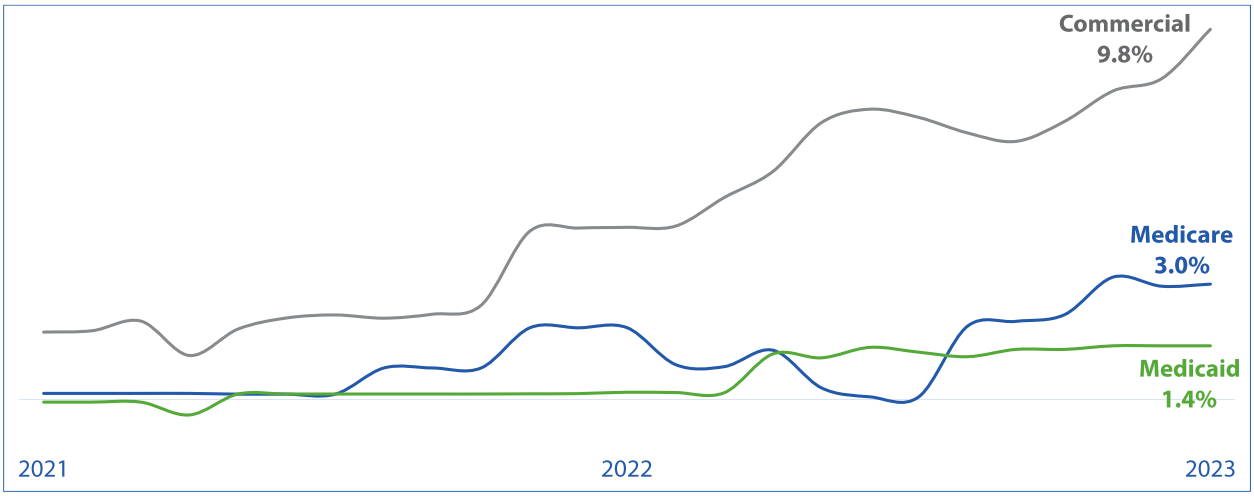
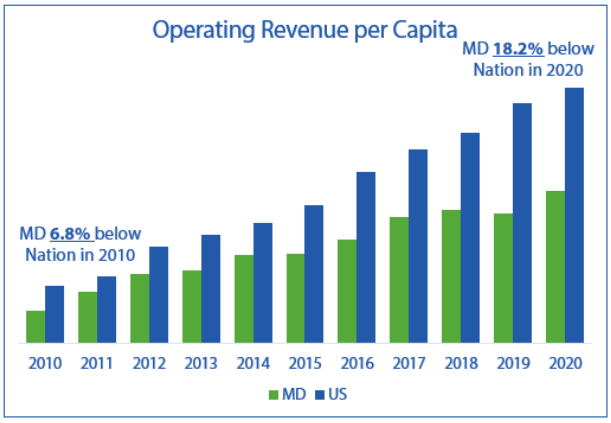
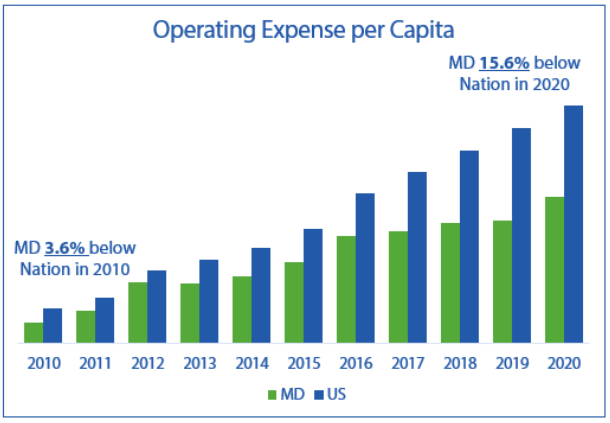


Figure 8 compares statewide Maryland hospitals' operating revenue and expense per capita to the nation using the most recent American Hospital Association (AHA) Annual Survey data. These data were used by HSCRC as a benchmark for cost efficiency for many years.

Figure 8: Maryland and U.S. Hospital Operating Revenue, Operating Expense per Capita





Data show Maryland is 18.2% below the nation in hospital net operating revenue per capita and 15.6% below the nation in operating expense per capita, showing Maryland hospitals are relatively efficient using the same construct as the Model per capita incentive.

The breadth and depth of these data reveal that hospital care in Maryland is affordable compared to the nation. Importantly, they are measured on a per capita basis which is the foundation of Maryland's unique Model.

D. Reset the QBR Scale

The HSCRC should adjust the FY 2024 Quality Based Reimbursement (QBR) payment scale to align with recent national performance. The intention of the QBR policy and other HSCRC quality policies is to calibrate incentives similar to national performance.

In December 2016, HSCRC approved a retrospective adjustment to the FY 2017 QBR payment scale because it determined the scale approved at the start of the year rewarded many hospitals "despite relatively poor performance" [relative to the nation]. Commissioners removed $37 million in retrospective changes to FY 2017 adjustments, moving from a $27 million statewide reward to a $10 million penalty. At the same time, HSCRC staff proposed setting the Maryland payment scale based on national performance so Maryland hospitals would be rewarded for performance better than the national average and penalized for performance below the nation.

Typically, the national distribution is stable. However, Maryland and national scores fell during COVID and in the post-COVID recovery. The most recent data show national median scores on these measures at 33%. This is 8 basis points below Maryland's 41% score. The third quartile of national performance is 41%, meaning that Maryland hospitals would need to be in the top quartile to begin earning rewards.

Resetting Maryland's FY 2024 QBR payment scale to align with national performance would reflect a cut point of 33%, with the maximum rewards threshold remaining at 80%. This scale results in net statewide penalties of $61 million instead of $90 million, reducing the statewide impact by 0.15%. MHA's modeling supports this impact and has been shared separately with HSCRC staff.

TidalHealth™

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May 24, 2023

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

Dear Mr. Kane,

Tidal Health appreciates the opportunity to comment on the Health Services Cost Review Commission's ("HSCRC") draft staff recommendation for the Fiscal Year 2024 Update Factor. The HSCRC has the important opportunity to consider changes to the staff recommendation to fully account for inflation and population growth, as well as **to provide funding that is equitable amongst hospitals**. Both are critically important, and we hope commissioners will strongly consider the following changes to the staff recommendation:

(1) Inflation

We support MHA's request to provide additional funding to the industry to account for underfunded inflation; **We believe this additional inflation funding should be targeted to support efficient hospitals** Therefore, We strongly support either 1) reduction of this amount to .75% and shifting of .45% to increase amount set aside for full rate applications thereby targeting/allocating more dollars to efficient hospitals or 2) Scaling the 1.15% to apply more to efficient hospitals and less towards hospitals with retained revenue (we submitted a letter on May 9, 2024 outlining the approach and justification to scale).

(2) Population Growth

We support MHA's request to fund the full amount of demographic adjustment catchup, adding 1.36% back on July 1. **If this is not going to be fully funded, we believe the HSCRC recommendation as written needs to be changed so that funding is equitable by evenly distributing to the hospitals**. At the April HSCRC Meeting, you had requested HSCRC staff to reconvene and find an equitable solution. The current recommendation we believe is not equitable amongst hospitals.

It is important to note that our recommendations are guided by a strong belief that there is inherent inequity within the Maryland model. This inequity is driven by retained revenue and inefficient hospitals where volume has fallen, but the resources for those facilities has not been adequately redistributed amongst more efficient hospitals and in our case those that provide efficient tertiary services where our volume has grown. While we respect the original guiding principles of the model allowing hospitals to retain revenue in the case of successful population

health efforts, on-going cumulative dollars embedded in inefficient hospital costs and charges to consumers has caused major inequities and does not provide the necessary funds to support the communities we serve.

Thank you again for the opportunity to comment and I am available should you have any questions.

Sincerely,

Steven E. Leonard, Ph.D., MBA, FACHE
President/CEO

cc: Joseph Antos, Ph.D., Vice Chairman
Katie Wunderlich, Executive Director, HSCRC
Laura Herrera Scott, M.D., Secretary of Health
Victoria W. Bayless
Stacia Cohen, R.N.
Maulik Joshi, Dr. P.H.
James Elliot, M.D.
Sam Malhotra
Brett McCone, SVP, Maryland Hospital Association
Stephanie Gary, Vice President and Chief Financial Officer, TidalHealth, Inc.

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CORPORATE OFFICE

May 24, 2023

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2024 Update Factor

Dear Adam:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2024.

We appreciate the time spent by Commission Staff in developing and vetting this proposal with the industry. We would like to address specific adjustments proposed in the balanced Update and offer our support of the points outlined in MHA's comment letter.

Current Hospital Financial Conditions

Inflationary pressure continues to exert operational and financial stress on hospitals. While prices continue to be high, the unprecedented cost of labor is most impactful as the fundamental shift in the labor market created ongoing staffing shortages and permanent pressure on wages. The financial consequences of investments in our workforce are exacerbated by increases in the cost of agency staff needed to fill vacancies in critical clinical positions.

Like the rest of the industry, UMMS is experiencing unprecedented erosion in financial performance that risks preventing us from appropriately investing in routine capital, clinical programs, and needed investments in labor in this exacerbated market. While we continue to be focused on performance improvement and expense reductions, we will need additional rate support to stabilize operating performance in fiscal year 2024.

Provide Unfunded Inflation in Rates, Accounting for Distortions that Exist in the System

In fiscal year 2021 and 2022, hospitals have been underfunded on inflation by more than 3% during a period when costs have grown at near historical levels. UMMS recognizes the importance of achieving the Medicare savings targets established in the Maryland demonstration model. We believe, however, it is important hospitals have financial stability as the state is negotiating the next phase of Demonstration Model. As the Commission considers its decision on the Annual Update, we ask the Commission to consider the overall fundamental success of the Model, CMMI's support of the Model, and the $2.2 billion of cumulative savings since fiscal year 2014.

UMMS believes that, just as across-the-board suppression of the annual update factor is not a solution for achieving statewide TCOC savings targets, decisions to address extraordinary circumstances when they arise should not be handled through uniform adjustments without considering hospital capacity and retained revenue. We believe that accounting for distortions in funding decisions is the most appropriate way to ensure equitable application across hospitals. These distortions include: retained revenue (particularly prior to the COVID-19 pandemic), excess capacity, the need for payment policies to address different hospital geographies and situations (AMC, rural), among others. We understand that these are complex issues that will take time to work through, however we feel that effort is necessary to ensure the long-term success of the model, especially as the Model enters its next phase of the Model.

The HSCRC must begin to address the matter of retained revenue in the system to ensure the ongoing success of the Model. We are proposing the HSCRC withhold fiscal year 2024 inflation on retained revenue that was incurred prior to the COVID-19 pandemic (2014-2019). Until we have at least twelve months of normalized volume experience, distortions in volume since the onset of COVID-19 should be excluded from this measurement of retained revenue.

Correct the Full Amount of Demographic Error in FY 2024

Commission Staff have recently identified a 10-year forecasting error in the annual demographic adjustment. The 2020 census demonstrated a significantly larger growth in population than estimated by both Claritas and the MD Department of Planning. Commission staff have recognized this disparity and are proposing to reverse negatives applied during FY 2023 in the FY 2024 update. We agree with this proposed action. It does not,

however, address the significant underfunding of the demographic adjustment since the inception of GBR, which is estimated at 0.97% or $191M statewide (after adjusting for pre-GBR time periods and the FY 2023 reversal of negatives). UMMS urges the Commission to swiftly correct the error in full effective July 1, 2023 to recognize the larger population being served by hospitals.

Market Shift Funding for COVID Service Lines Should be Excluded from the Methodology

The overlap of the Surge Funding policy with Market Shift should be eliminated as the calendar year 2022 vs calendar 2019 Market Shift adjustment is implemented. The proposed surge funding policy evaluates volume growth in FY 2022, which includes quarter 1 and 2 of calendar year 2022. Both the surge and market shift policies, as proposed, would include volume funding for the Omicron surge, which occurred during quarter 1 and quarter 2 calendar year 2022. The Omicron surge was a one-time event resulting in increased volume and should therefore be funded on a one-time basis. The calendar year 2022 Market Shift is a permanent adjustment and as proposed, includes the COVID influenced service lines. It is inappropriate to fund the volume increase in two different policies and on a permanent basis when as we have seen with calendar year 2023, there have been no further surges in COVID hospital volume.

Adjust the QBR Policy Cut Point to Align with National Performance

CMMI and the Commission have acknowledged that COVID does significantly affect performance in the Quality programs, as evidenced by their suspension during the peak of the pandemic. Additionally, final Staff Recommendations for all Quality Programs (MHAC, RRIP and QBR) include statements that allow the Commission to retroactively evaluate each program for COVID influences and adjust the programs as needed. For QBR, we agree that the payment scale be adjusted to account for significant COVID distortions. As previously discussed, hospitals have had to use temporary labor to ensure patients continue to receive care during the nursing crisis. Hospitals have significantly less influence over these temporary staff to ensure that all established quality protocols are followed. We therefore support MHA's proposal to adjust the QBR payment scale, specifically by adjusting the cut point, which would reduce the statewide QBR penalty by 0.15%.

UMMS Update Factor Request for Consideration

UMMS urges the Commission to consider the following modifications to the update factor proposal:

1. Provide full inflation for hospitals for FY 2024, currently 3.35%, disallowing inflation on retained revenue prior to calendar year 2019.
2. Release full amount of remaining demographic error (0.97%) on July 1.
3. Provide the 1.15% in historical update factor shortfall to fund unprecedented inflation growth.
4. Exclude COVID influenced service lines in calendar 2022 vs. calendar year 2019 market shift calculation.
5. Adjust QBR cut point to 33% to align with national performance.

Thank you for the opportunity to provide feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,

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

cc: Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, MD
Maulik Joshi, Dr. P.H.
Sam Malhotra
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Allan Pack, Principal Deputy Director
William Henderson, Principal Deputy Director
Michelle Lee, UMMS, CFO
Alicia Cunningham, UMMS, SVP

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

May 25, 2023

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

Chairman Kane:

On behalf of the Maryland Department of Health (MDH), I am writing to communicate the Department's support of the Health Services Cost Review Commission's (HSCRC) staff recommendation for the rate year (RY) 2024 rate update factor, with a caveat about examining demographic factors for the previous 10 years.

As we saw in RY 2023, the Commission had to implement a multi-pronged approach to returning dollars to Medicare for missing savings targets under the Total Cost of Care agreement. A conservative approach to estimating the Medicare national trends and setting an appropriate update factor will help ensure the state meets our savings targets. Moreover, this will allow us to maintain the integrity of the "all payer" nature of the Total Cost of Care Model and setting hospital rates.

In light of the new State of Maryland population estimates provided by the Department of Planning, we support the HSCRC staff recommendation to reverse past negative population adjustments to hospital rates from RY 2023, a one-time adjustment totaling approximately $80M. However, we do have a concern about the proposal in the staff recommendation to form a workgroup on a recommendation looking specifically at the Maryland Department of Planning's forecasting estimates over the previous 10 years and the suggestion that any misses in the estimates could be accounted for in rate updates for RY 2024. We are concerned that this proposal would examine one input factor to hospital rate updates without considering other estimates and misses that could impact the update factor, including retained revenue. We are in support of the one year adjustment and correction moving forward. Further, we support staff's recommendation related to the adjustment of gross inflation for RY24 and do not support any additional inflation adjustments for previous years.

The Department looks forward to working closely with the Commission to preserve and evolve the Total Cost of Care waiver in order to ensure continued investments in primary care, improving population health statewide, and advancing health equity.

Thank you again for the opportunity to provide comments. If you have additional questions, please do not hesitate to contact me.

Sincerely,

Laura Herrera Scott, MD, MPH, Secretary
Maryland Department of Health

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

May 31, 2023

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

Subject: Inquiry on Update Factor and Graduate Medical Education (GME) in Maryland

Dear Chairman Kane,

As a representative of the MedChi Resident Section, I am writing to discuss a matter of great significance that directly affects the equitable compensation of residents and the funding of Graduate Medical Education (GME) programs in our state. Specifically, I would like to address the transparency and effectiveness of the update factor with regard to GME funding mechanisms employed in Maryland.

Undoubtedly, Maryland stands apart from other states by financing residents and graduate medical education through a rate-setting approach. While this methodology has facilitated the provision of essential resources, it is crucial that we ensure the citizens have transparency with regard to funding and residents are justly compensated for their services. As a Hopkins resident I recently received an out of cycle inflation index, as well as our normal yearly upgrade. While our pay is still low given our debt load, Hopkins is trying to treat us fairly, is this being done with all the other programs?

To this end, I kindly request your assistance in addressing the following inquiries:

Update Factor and Resident Compensation: Is there comprehensive data available regarding the annual increases provided by the update factor that is applied to GME? I am interested in understanding how these adjustments directly impact the compensation received by residents or the GME programs.

Comprehensive Information on GME Funding: In our pursuit of transparency and accountability, it is imperative to have access to comprehensive information on GME funding in Maryland. I kindly request any relevant reports or documentation that outlines the allocation of funds, the sources of these funds, and any applicable guidelines governing their disbursement. Such information will enable us to assess the efficacy of our current investment in GME and identify potential areas for improvement. When the State moved to GME funding through global budgets has it continued to study the number of residency slots to make sure they have increased as payments to systems who have residents increased?

Regular Reports on Value for Investments: Given the substantial investments made in GME, it is vital to establish mechanisms that continuously evaluate the value generated from these expenditures. Does the HSCRC receive regular reports that provide an overview of the outcomes, achievements, and benefits derived from the GME programs funded in Maryland. This information will assist us in further enhancing the quality and effectiveness of our investments, ultimately benefiting the residents and the overall healthcare system.

Mr. Kane, I am confident that by addressing these inquiries, we can work together to create a more transparent and accountable system that supports the well-being of our residents and bolsters the quality of healthcare in Maryland. I would like to express my sincere gratitude for your attention to this matter and your commitment to improving the healthcare landscape in our state.

Please do not hesitate to reach out to me if you require any additional information or clarification on the matters raised in this letter. I eagerly await your response and look forward to the opportunity to collaborate on these crucial issues.

Thank you for your time and consideration.

Sincerely,

Karen Dionesotes

Karen Dionesotes
Chair of MedChi Residents Section

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

June 1, 2023

The Honorable Adam Kane and HSCRC Commissioners

Health services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

Re: Comments regarding Update Factor

Dear Mr. Kane,

I hope this letter finds you well. I am writing to express MedChi, the Maryland State Medical Society's support for finding a reasonable compromise to move the update factor in a positive direction. Everyone is aware that many Maryland businesses, including hospitals, are facing financial challenges related to inflation and workforce shortages. These issues have implications for Maryland's Total Cost of Care (TCOC) Model and the financial stability of Maryland hospitals. I believe it is essential to consider the following points when evaluating the inflation update and its impact on hospitals.

Hospitals are currently facing significant financial challenges and are under increasing financial strain: The healthcare industry is undergoing substantial financial pressures, stemming from rising costs, declining non-regulated reimbursements, and the ever-growing demand for healthcare services. These challenges pose a threat to the financial stability of hospitals, compromising their ability to deliver quality care and invest in vital resources and infrastructure.

Balancing hospital financial stability with the TCOC model: While recognizing and prioritizing the need to meet the TCOC Model targets, it is also crucial to prioritize hospital financial stability within the TCOC Model. The decisions made should factor in the implications on hospitals' finances and consider the long-term sustainability of the healthcare system. Striking a balance between cost control and maintaining hospitals' viability is of utmost importance. MedChi believes it is especially important to pay close attention to the needs of our world class academic hospitals as they make these decisions.

Avoiding across-the-board application of the update factor without considering significant distortions in the Model: The Health Services Cost Commission (HSCRC) should refrain from uniformly applying the update factor across all hospitals without considering notable distortions in the model. One such distortion is the impact of retained revenue, which can significantly affect hospitals' financial situation. Ignoring these distortions can lead to unfair financial implications for hospitals, potentially hampering their operations and the care provided to patients.

Correcting demographic errors and fair fund distribution: It is imperative for the HSCRC to address any demographic errors that may impact the allocation of funds to hospitals. Accurate distribution of funds ensures that hospitals receive appropriate financial support based on their patient demographics and

needs. By rectifying these errors and implementing fair fund distribution practices, we can maintain equity among hospitals and bolster their financial stability.

I urge you to carefully consider these points when making decisions and policy updates within the HSCRC. By factoring in the financial challenges faced by hospitals and ensuring fairness in the distribution of funds, we can work together to support the financial stability of our healthcare institutions and maintain the provision of quality care to our communities.

Thank you for your attention to this matter. I would greatly appreciate the opportunity to discuss these concerns further and explore potential solutions that would benefit both hospitals and the healthcare system as a whole. Please let me know if you would be available for a meeting or conversation.

Sincerely,

Gene M. Ransom III

CEO MedChi, The Maryland State Medical Society