maryland
health services
cost review commission

Revised Final Recommendation for the Update Factors for Rate Year 2022

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P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
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

Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2022. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

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

At this time, the staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

(a) Provide an overall increase of 2.44 percent for revenue (including a net increase to uncompensated care) and 2.43 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. This recognizes an additional 0.20 percent for salary and malpractice cost pressures. Staff does not believe this should be the normal policy. However, as hospitals continue to grapple with the effects of the pandemic, staff feels the request is not unrealistic.

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.

Additionally, Staff recommends that the adjustment to consider the reconciliation of CARES Provider Relief Funds and HSCRC support for RY 2020 be included in the midyear target (as described in (e) below).

(b) Provide all hospitals a base inflation increase of 2.34 percent and allocate 0.23 percent of the total inflation allowance based on each hospital's proportion of drug cost to the total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high-cost drugs.

(c) Reduce the Demographic and Population adjustment from 0.16 percent, that was included in the Draft Recommendation, to 0.01 percent based on the Maryland Department of Planning

estimate.

(d) Increase the set aside to 0.25 percent by redistributing the decrease of 0.15 percent from the Demographic and Population reduction to the set aside for unforeseen adjustments. Commissioners requested a reconciliation of the set a side for RY 20 and RY 21

(e) Adjust rates effective July 1, 2021, over a 6 month window, to implement the reconciliation of CARES Provider Relief Funds (PRF) and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

- For hospitals where the sum of actual charges and PRF Funding is less than their fiscal year 2020 approved Global Budget Revenue, the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
- For hospitals where the sum of actual charges and PRF Funding is greater than their fiscal year 2020 approved Global Budget Revenue the adjustment would subtract from the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of this recommendation) from their July 1, 2021 rate order.
- Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined above to maintain financial stability for hospitals, given that the COVID pandemic continues to have an impact on health care delivery in RY 2021.

(f) Initiate full rate reviews on all Maryland MedStar hospitals.

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

(a) Provide an overall update of 2.57 percent for inflation. This includes an additional 0.20 percent to gross inflation to help alleviate labor and cost pressures experienced by hospitals.

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

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19

response in the development of the update factor. As in all of 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 still keeping the increase in hospital costs affordable for all payers.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland has already met the 5 year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to develop the RY 2022 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) 2022 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2022, HSCRC staff is proposing an update of 2.43 percent per capita for global budget revenues and an update of 2.57 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 2021 market basket growth estimate with a capital growth estimate. For RY 2022, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2021 market basket growth of 2.50 percent with 8.80 percent of the capital growth estimate of 1.00 percent, calculating the gross blended amount as a 2.37 percent inflation adjustment. The First Quarter 2021 market basket is updated and remains consistent with Fourth Quarter 2020 market basket growth. In addition to a base inflation amount of 2.37 percent, staff is recommending adding an additional 0.20 percent to help alleviate the labor and cost pressures hospitals are facing as a result of the COVID-19 pandemic. The 0.20 percent was derived by taking half of the estimated savings from CY 2020 of approximately 0.40 percent. Staff believes 0.20 appropriate because hospitals represent approximately 50 percent of the total cost of care.

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 2.57 percent, this includes the additional 0.20 percent staff is proposing for GBR hospital to help with labor and cost pressures. The pandemic's effect on hospitals resulted 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 Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.57%	2.57%
Productivity Adjustment		SUSPENDED
Proposed Update	2.57%	2.57%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

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

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 2.36 percent and per capita growth of 2.35 percent for RY 2022. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 2.44 percent with a corresponding per capita growth of 2.43 percent for RY 2022.

In order to measure the proposed update against financial tests, which are performed on Calendar Year results, staff need to 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 2022 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 2022			
Components of Revenue Change Link to Hosptial Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 1.45% for wages and compensation)			2.14%
- Outpatient Oncology Drugs			0.23%
- Savings from CY 2020 (.40%*6/12)			**0.20%**
Gross Inflation Allowance	**A**		**2.57%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.33%
- Regional Partnership Grant Funding RY22			0.14%
Total Care Coordination/Population Health	**B**		**-0.19%**
Adjustment for Volume			
-Demographic /Population			0.01%
Total Adjustment for Volume	**C**		**0.01%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.25%
- Low Efficiency Outliers	E		-0.10%
- Complexity & Innovation	G		0.10%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.21%**
Quality and PAU Savings			
-PAU Savings	J		-0.24%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.11%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.24%**
Total Update First Half of Rate Year 22			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**2.36%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+0.01%)	**2.35%**
Adjustments in Second Half of Rate Year 22			
-Oncology Drug Adjustment	P		0.00%
-Future Adjustment	Q		0.00%
Total Adjustments in Second Half of Rate Year 22	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 22			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**2.36%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+0.01%)	**2.35%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.08%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**0.08%**
Total Update First Half of Rate Year 22			
Revenue growth, net of offsets	**X =**	N + W	**2.44%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+0.01%)	**2.43%**
Total Update Full Rate Year 22			
Revenue growth, net of offsets	**Z =**	S + W	**2.44%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+0.01%)	**2.43%**

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

HSCRC staff accounted for a number of 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 2.37 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2021 market basket growth of 2.50 percent with 8.80 percent of the capital growth index change of 1.00 percent. The adjustment for inflation includes 1.45 percent for wage and compensation. In addition to a base inflation amount of 2.37 percent, staff is recommending adding an additional 0.20 percent to help alleviate the labor and cost pressures hospitals are facing as a result of the COVID-19 pandemic. The 0.20 percent was derived by taking half of the estimated savings from CY 2020 of approximately 0.40 percent. Staff believes 0.20 is appropriate because hospitals represent approximately 50 percent of the total cost of care. Staff does not intend to make this a normal inclusion in our decision making, however, believe it is appropriate given the extraordinary circumstances the industry is facing. A portion of the 2.57 inflation allowance (0.23 percent) will be allocated to hospitals in order to more accurately provide revenues for increases in outpatient oncology and infusion drugs. This drug cost adjustment is further discussed below.

- **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 drug.

  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 2022 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. Data from the most recent period support a continued reduction in price trend, however, 2020 trends are likely distorted due to the COVID crisis so at this time staff is recommending no further reduction and continued use of a 6 percent trend for Rate Year 2022.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2021 hospital revenues. These programs include: Long Term Care Grants, Medicare Advantage Program Grant Funding, Regional Partnership Funding for Behavioral Health, Regional Partnership Funding for Diabetes Prevention and Management. 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 2021 of -0.33 percent. Regional Partnership funding for Behavioral Health and Diabetes Prevention and Management is part of a 5 year program. Included in this adjustment is funding for the proposed Maternal Child Health initiatives, approved by the Commission at the May 2021 Commission meeting. RY 2022 funding is expected to be approximately 0.14 percent.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2021 is 0.01 percent. For RY 2022, the staff is proposing to use the value of the Department of Planning CY 2021 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. The amount under review for RY22 as determined by the Integrated Efficiency policy is approximately $19.9 million or a -0.10 percent reduction from the update[1]. This withhold is subject to revisions based on updated data and Commission approval.

- **Set-Aside for Unforeseen Adjustments:** The set-aside for RY22 will be 0.25 percent. This amount was determined by the 0.10 percent reduction outlined in the Integrated Efficiency policy. In addition, Staff recommends redistributing the 0.15 percent from the demographic adjustment to the set-aside. Staff will reconcile the spending of the annual set-aside for RY20 and RY21. The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen circumstances that may occur at hospitals.
- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits

[1] These figures may change due to the release of the Final Integrated Efficiency policy. Staff does not believe the impact will be significant.

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, and 2020. Based on this analysis, staff concluded that the historical average growth rate was 0.39 percent, which equates to a combined state impact of 0.10 percent for the RY 2022 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2022 PAU savings adjustment is calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU performance. RY 2022 PAU savings adjustment represents the change between RY 2021 and RY 2022. Previous years of PAU savings adjustments are not reversed out.
- **Quality Scaling Adjustments:** HSCRC staff and hospital stakeholders expressed concerns about using CY 2020 data for the RY 2022 hospital quality pay-for-performance programs due to the COVID-19 public health emergency and data reliability and validity concerns. These pay-for-performance programs include: Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR). HSCRC staff proposed to CMMI that the State should be allowed to re-use RY 2021 revenue adjustments and apply these adjustments for RY 2022. This request was approved by CMMI. For this reason you will see the reversal and new inputs for RY 2022 quality programs net to 0 in Table 2.

  Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing program will not be included in the federal RY 2022 payment program due to data validity concerns. Since this program is the analog to the QBR program, staff may revise its recommendation to align with federal guidance. Any modifications to Quality revenue adjustments will be effectuated in January rate orders, as the final IPPS rule will not be promulgated until after the start of the State fiscal year. Similarly, the IPPS rule outlined measure suppression policies for the Hospital-Acquired Condition Reduction Program (HACRP) and the Hospital Readmissions Reduction Program (HRRP), which are the analogs for the MHAC and RRIP, respectively. As such, staff will potentially modify revenue adjustments for MHAC and RRIP in the January rate orders to align with the final IPPS rule.

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 2022 will be 0.08 percent. The amount in rates was 4.41 percent in RY 2021, and the proposed amount for RY

2022 is 4.49 percent, an increase of 0.08 percent.

- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2022, and as a result, this line item is 0.00 percent.

Additional Revenue Variables

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

PAU Savings Updated Methodology

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

For RY 2022, the incremental amount of statewide PAU Savings reductions is determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2022 PAU savings reduction of -0.22 percent statewide, or $39,662,473[2]. Hospital performance on avoidable admissions per capita and sending readmissions estimated revenue determines each hospital's share of the statewide reduction.

Table 3

Statewide PAU Reduction	Formula	Value
RY 2021 Total Estimated Permanent Revenue*	A	$17,981,594,280
RY 2022 Inflation Factor**	B	2.15%
CY 2019 Total Experienced PAU $	C	$1,844,766,206
RY 2022 Proposed Revenue Adjustment $	D = B*C	-$39,662,473
RY 2022 Proposed Revenue Adjustment %	E = D/A	-0.22057%
RY 2022 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.22%**
RY 2022 Adjusted Proposed Revenue Adjustment $	G = F*A	**-$39,559,507**
Total PAU %	H	10.43%
Total PAU $	I = A*H	$1,875,811,224
Required Percent Reduction PAU	J = G/I	-2.11%

*Does not include revenue from Grace, UM-Laurel, or freestanding EDs.

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

[2] Actual PAU differs slightly (-0.02%) from what is shown in Table 2 based on updated Department of Planning data that impacts the demographic adjustment.

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 in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

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

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine the total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2020 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $156 million for performance year two (CY 2020). Final CY 2020 data is in the process of being reconciled and approved with CMS and will be released at a later date. Similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Due to the ongoing COVID-19 pandemic and the uncertainty and volatility of the current landscape, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails. Actual revenue resulting from RY 2021 updates affect the CY 2021 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2021 to assist in

estimating the impact of the recommended update factor together with the projected RY 2021 results. The overall increase from the bottom of this table is used in Table 5.

Table 4

Estimated Position on Medicare Test		
		Scenario A: Based on Last Year Acutal
Actual Revenue CY 2020		17,663,547,233
CARES Act $'s Adjustment		-
Adjusted Bases		17,663,547,233
Step 1:		
Approved GBR RY 2021		19,091,716,940
Actual Revenue 7/1/20-12/31/20		9,337,804,834
Approved Revenue 1/1/21-6/30/21	**A**	**9,753,912,106**
Step 2:		
Approved GBR RY 2021		19,091,716,940
Reverse One Time Extrodinary Adjustments:		
Extraordinary Price Variance in RY2021		(96,867,601)
Adjusted GBR RY 2021		18,994,849,339
Projected Approved GBR RY 2022		19,458,015,349
Permanent Update RY 2022		2.44%
Adjusted Change from GBR RY 2021		1.92%
Step 3:		
Estimated Revenue 7/1/21-12/31/21 (after 49.73% & seasonality)		9,676,471,033
CARES Act $ Payback		(51,000,000)
FY21 Undercharge in First Half of CY21		(200,000,000)
Projected Revenue 7/1/21-12/30/21	**B**	**9,425,471,033**
Step 4:		
Estimated Revenue CY 2021	**A+B**	**19,179,383,139**
Increase over CY 2020 Revenue		8.58%
Growth Used in Alternative Guardrail Scenario		
Increase over CY2020 Revenue w/o pop growth		8.58%

Steps to explain Table 4 are described as below:

The table begins with actual revenue for CY 2020.

Step 1: The table uses global revenue for RY 2021 and actual revenue for the last six months for CY 2020 to calculate the projected revenue for the first six months of CY 2021 (i.e. the last six months of RY 2021).

Step 2: This step begins with the approved revenue for RY 2021 and reverses out the price variance from RY 2021 that was a result of the RY 2020 undercharge from the COVID-19 pandemic. The result is an adjusted RY 2021 GBR. The proposed update of 2.23 percent, as shown in Table 2, is then applied to the adjusted RY 2021 GBR amount to calculate the projected revenue for RY 2022.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2022 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2022. Additionally, staff applied the reconciliation of CARES PRF and HSCRC-support accrued in RY 2020 (as described in this report), as well as the estimated RY21 undercharge from the first half of CY 2021.

Step 4: This step shows the resulting estimated revenue for CY 2021 and then calculates the increase over actual CY 2020 Revenue. There are two increases shown in this section. The first one, 8.58 percent, is the estimated increase over CY 2020 revenue using the update of 2.44 percent. The second increase of 8.58 percent is the estimated increase over CY 2020 revenue using an update of 2.43 percent, which is the update without a volume adjustment included. These amounts are the same based on the low demographic amount of 0.01 percent. The 8.58 percent is used to estimate CY 2021 hospital spending per capita for Maryland in our guardrail calculation, which is explained later in this policy.

Previous updates utilized Medicare fee-for-service growth estimates from the CMS Office of the Actuary. Due to the variability in the estimates from actual performance, staff moved to using actual national Medicare fee-for-service total cost of care growth from the previous calendar year in the RY 2020 update factor policy. Total Cost of Care growth for the nation showed a significant decline in CY 2020, due to the COVID-19 pandemic. Staff did not feel that using a negative growth rate to measure our guardrail was an appropriate proxy to predict future trends. As a result, staff created an alternative guardrail approach to be used in the RY 2022 update factor policy to determine and project Maryland's CY 2021 guardrail position. Of note, staff do intend to revisit using actual national total cost of care growth from the previous year in future policy decisions.

Staff's approach to project the CY 2021 guardrail position utilized Medicare fee-for-service per capita data for Maryland and the nation. To project CY 2021 growth in the nation, staff calculated the average trend from 2017 to 2019 and trended 2019 data forward two years so as to remove the confounding of COVID-19 pandemic in CY 2020. This was calculated in four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) and added together to calculate a total per capita estimate. Staff used the same approach to estimate non-hospital part A and B for Maryland. To estimate CY 2021 hospital growth, staff

applied the CY 2020 growth of 8.58 percent, shown in Table 4, to CY 2020 growth because global budget revenues are a known data element. The Maryland hospital growth estimate takes into account available hospital specific factors and the estimated RY 2021 undercharge settlement. Table 5 below shows the results of this analysis. Using this approach, Maryland is projected to be equal to the nation in CY 2021. This analysis assumes that Medicare growth equals All-Payer growth and does not include any prediction for pent-up demand or change in healthcare utilization patterns that may occur due the COVID-19 pandemic.

Table 5

MARYLAND	Hospital		Non-Hospital		
	Part A	Part B	Part A	Part B	Total
2017 Actual			$1,344	$4,074	$11,727
2019 Actual			$1,308	$4,625	$12,376
			-1.30%	6.60%	
2020 Actual	$4,198	$2,080			$11,916
2021 Projected	$4,559	$2,258	$1,274	$5,252	$13,343
					11.97%

US	Hospital		Non-Hospital		
	Part A	Part B	Part A	Part B	Total
2017 Actual	$3,400	$1,545	$1,526	$3,700	$10,172
2019 Actual	$3,512	$1,770	$1,548	$4,154	$10,984
	1.60%	7.00%	0.70%	6.00%	
2020 Actual					$10,618
2021 Projected	$3,628	$2,028	$1,570	$4,664	$11,889
					11.97%

Update Factor - CY 2020 Revenue Growth

8.58% Applied to CY 2020 Actual Hospital Spending (Taken from Table 4)

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. The purpose of this modeling is to ensure that healthcare remains affordable in the State. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GSP numbers available (CY17-CY20). The 3-year CAGR calculation shows a per capita amount of 3.17 percent. Staff then compared that number to the 3 year CAGR for Hospital Acute Charges using (CY18-CY21). Staff was able to estimate CY 2021 charges using the proposed RY 2022 update factor. The CAGR for hospital charge growth equated to 3.35 percent. Staff believes using a 3-year comparison of GSP to hospital charges provides a more accurate assessment of affordability. The chart below shows this comparison.

Table 6

3 Year CAGR				
GSP		Hospital Charges		Variance
2017-2020	3.17%	3.35%	2018-2021	0.19%

Medicare's Proposed National Rate Update for FFY 2022

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 27, 2021. In the proposed rule, CMS would increase rates by approximately 2.80 percent which includes a market basket increase of 2.50 percent, a productivity reduction of -0.20 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2021 and will not go into effect until October 1, 2021. This also does not take into account volume changes.

Reconciliation of CARES Provider Relief Fund and HSCRC-support

During the COVID crisis, hospitals have faced unprecedented challenges both in meeting the acute needs of COVID patients and in handling significant volume declines due to economic shutdowns and other ramifications of the COVID crisis.

In fulfilling its mandate to ensure adequate funding to Maryland hospitals, the Health Services Cost Review Commission (HSCRC) made a number of policy accommodations to ensure hospitals remained financially stable during the crisis. Subsequent to HSCRC actions, the Federal Government also provided significant funding to all healthcare providers nationwide and hospitals were a major beneficiary of this funding. As the HSCRC has noted previously, it will take federal funding into account when setting a hospital's Global Budget Revenue (GBR) for FY 2022. This is in line with the Commission's mandate to consider all sources of funding when setting hospital rates.

The simultaneous provision of these dual sources of funding requires the HSCRC to set a hospital's GBR appropriately to avoid an overlap that would result in payers paying twice. For the current year, the resolution of an overlap is a key component in evaluating Maryland's ability to comply with the total cost of care guardrails under the Maryland Total Cost of Care Model. At this point it appears that Medicare spending growth in Maryland for CY 2021 may exceed that of the nation. Therefore, staff is incorporating this policy within this Update Factor Recommendation, which is the primary vehicle for monitoring and helping assure compliance with these federal tests.

Background & Timeline

On March 19, 2020, the HSCRC issued a notice to hospitals that leveraged Maryland's unique rate setting model to provide two financial accommodations in relation to the crisis. Specifically, the memo stated:

1. "The HSCRC will permit hospitals to increase rate corridors up to the 10 percent threshold or by an additional 5 percentage points from their current charging position, whichever is greater"
2. "To further accommodate any GBR revenue that may not be able to be billed in FY 2020 due to fluctuating volumes over the final quarter, HSCRC staff will suspend undercharge penalties and

allow hospitals to recoup those undercharges over the 12 months of FY 2021 as a one-time adjustment."

The first of these provisions provided immediate practical relief, to the extent feasible, given a desire to avoid excess charge increases to patients and providers and the second guaranteed hospitals 100% of their GBR over the long term, consistent with the revenue stability that is intended under a fixed revenue model.

On April 10, 2020, the Federal Government passed the CARES Act, which established the Provider Relief Fund which appropriated $178 billion for hospitals and other healthcare providers nationwide. This money was distributed over the next 9 months on various bases. Based on reporting received from the Federal Government the HSCRC believes Maryland regulated hospitals have received $1.262 Billion from all allocations made by the Federal Government through December 31, 2020.

Recognizing that the State and Federal funding commitments were likely to overlap, on April 23rd the HSCRC issued notice to hospitals that "We will consider all available funding from these federal programs before determining eligibility for additional GBR funding to cover preparedness costs and lost revenue/undercharges". This guidance was reinforced in a memo dated July 28th, 2020, that noted undercharges would be recovered net of CARES PRF Funds.

On April 30, 2020, the Commission approved the Final Recommendation on COVID Surge Funding (the COVID Surge Policy, available here Final Recommendation on COVID Surge Funding). Under the policy, hospitals were eligible for additional funding to the extent COVID cases caused hospital volumes to exceed those established in a hospital's GBR. This policy was effective March 1, 2020, until it was suspended by the Commission effective June 30, 2020, as COVID cases declined. No payments were due under this policy for this period. It was then re-instituted as of November 1, 2021 and is currently in effect. Amounts due to hospitals are calculated over the entire period the policy is active and therefore will not be available until the Commission elects to suspend the policy.

On May 8, 2020, the Commission issued a memo expanding the corridor relief for inpatient only, patient care rate centers to 20 percent. This expansion was considered at the request of hospitals and is consistent with, but more generous than, Medicare's policy under the Inpatient Prospective Patient System which included a 20 percent increase in reimbursement for entire Medicare inpatient COVID cases.

As of June 30, 2020, for the completed fiscal year, actual hospital charges were $17.432 Billion versus an FY2020 final statewide GBR of $18.373 Billion - an undercharge of $941 Million. The HSCRC estimates that had the two COVID corridor expansions not been provided, the undercharge would have been $285 Million larger for FY 2020 (i.e. payers paid an additional $285 Million in Q4 of 2020 than they would have had to if a fee-for-service system had been in place).

Effective January 1, 2021, the HSCRC provided approximately $97 Million of funding to selected hospitals who had an undercharge, after considering PRF funds, for FY 2020 consistent with the Commission's original commitment to fund the FY 2020 undercharges. This amount was added such that recovery will occur in the first 6 months of the calendar year. These amounts were intended as preliminary relief to hospitals

with an undercharge and will be revised based on this recommendation in July 1, 2021 rate orders.

Considerations not Addressed in this Approach

In order to simplify the issues involved in this recommendation, the HSCRC is choosing not to consider two items:

1. Undercharge amounts are all calculated based on charges without consideration to the differential adjustments received by most payers, which reduce the amount actually paid to hospitals. This is appropriate when considering policy-related amounts within the Maryland system as any recovery of undercharges in future periods would also be subject to the same differential. However, when considering undercharges versus external funding such as PRF funding it creates a slight mismatch as a hospital loses only approximately $0.95 cents per $1.00 of charges, but a hospital receives 100% of relevant PRF funds. Staff elected not to adjust this phenomenon in order to simplify the calculations but would note that it means hospitals' financial positions are likely slightly more favorable than discussed in this recommendation and exhibits.
2. The only COVID-specific funding source staff considered in this recommendation is the PRF funding. Hospitals are able to receive temporary and permanent funding support through a number of other programs such as FEMA and the Medicare Advanced Payment Program. Staff did not consider these programs because the amounts are uncertain, relatively immaterial, and, in some cases, require repayment (i.e. only provide liquidity support).

Final Recommendation and Public Comment

In the February 2021 Commission meeting, staff recommended that the Commission resolve the overlap between PRF Funds and HSCRC rate relief for the 18 months ended December 31, 2020, by counting the PRF funds towards a hospital's GBR and then adjusting, effective July 1, 2021, any resulting over or under charge (the Draft PRF Recommendation). Further detail on this proposal can be found in the Commission materials for the February 10th meeting.

Nine Public Comment letters were received and are appended to the end of this recommendation. Four letters were supportive of the Draft PRF Recommendation (Johns Hopkins Health System, JLMcGee Consulting, CareFirst, and Leni Preston). Four letters (MedStar, Holy Cross Health, Tidal Health, and Adventist HealthCare) argued that the Commission delay any action and raised a number of other technical issues with the Draft PRF Recommendation which will be addressed throughout this document and one letter (University of Maryland Medical System) supported an alternative approach described in the February Commission meeting, discussed further below, as well as argued that any settlement should be done at a hospital rather than system level. The Draft PRF Recommendation and the alternative approach were both described as being settled at a system level, i.e. combining the results of all hospitals in a system before determining the outcome. After receiving additional information and stakeholder comment, staff made the decision to include the reconciliation of PRF funds in the RY 2022 Update Factor as described in

this report.

Definition of Allocated PRF Funds

Draft PRF Recommendation Allocation Approach and Comment Letters

HHS distributed PRF payments to providers over the course of Calendar Year 2020 in multiple phases and on multiple bases with different organizations eligible for different distributions (a full timeline can be found here: PRF Timeline). Hospitals were not the only recipient of funds, and other organizations such as physician practices received funding; however, the HSCRC is only responsible for setting rates for Maryland's regulated hospitals. Therefore, to reconcile GBR funding and PRF funding, it is necessary to determine how much PRF funding is relevant to the regulated hospital.

In the Draft PRF Recommendation, staff proposed the following process to identify the relevant funding.

(1) Capture the funding provided to the regulated hospital entity under the PRF[3]
(2) Allocate that funding between regulated and unregulated portions of the regulated entity based on the revenue reported in the 2019 Annual Filing for the hospital
(3) Count only the regulated allocation in assessing overlap with GBR Funding

The process after this allocation only considers funding provided to the regulated hospital entity; the unregulated portion of PRF is excluded from further calculation. Staff notes this process excludes any funding received by the unregulated providers within the regulated entity. In other words, within the regulated entity, funding provided to the regulated provider is allocated to unregulated providers but the reverse is not true. This approach, which likely understates the regulated allocation, is necessary because the HSCRC has no way to identify the providers within the unregulated reporting.

The industry raised several issues regarding this approach:

1. Varying methods of reporting result in the revenue reported for unregulated business in the annual filing being significantly depressed for some hospitals.
2. Varying corporate structures between hospitals impact the degree to which their unregulated business is reported in the HSCRC Annual Filing or within a corporate entity not subject to annual filing requirements.
3. Federal guidance permits entities to move PRF funds between entities which commenters interpreted to mean that the allocation of funds used in this settlement should be at the total discretion of the hospital.

[3] Staff is now working with CMS and have obtained an authoritative list of funding under item (1) and expect to be able to maintain that data with CMS as additional funding is received or funding is returned. This report will be used in determining any settlements and is reflected in the data in Appendix A. To date no Maryland hospital has returned funding to the Federal Government.

4. That only accounting for PRF funds and only allocating from regulated to unregulated results in an overly favorable outcome to hospitals.

The HSCRC has limited reporting on entities outside the regulated entity and it is not feasible to use that reporting to allocate PRF funds. However, to be responsive to this issue, and the issue raised in item 1 above, staff is recommending a revised allocation approach as described below under.

The logical extension of item 3 is that the HSCRC cannot consider any PRF Funds for a hospital system because the hospital system could choose to allocate all the funds to another entity. Under such an approach, Maryland rate payers would be 100% responsible for shortfalls under the GBR. Moreover, this policy presents equity concerns for small, independent Maryland hospitals who do not have out-of-state sister entities or extensive unregulated operations to potentially redistribute PRF funds.

Further staff does not believe that this was the intent of the Federal guidelines. The HSCRC's authority allows the Commission to consider all sources of funding in assessing the viability of the regulated entities. Finally, the HSCRC is using the allocation approach outlined below to estimate the amount of PRF Funds relevant to setting regulated Maryland rates; it does not preclude the health system from using the PRF funds amongst its other entities.

Definition of Allocated PRF Funds

Allocated PRF Funds shall be calculated as follows:

(1) Capture the funding provided to the regulated hospital entity under the PRF as reported to the HSCRC by CMS.
(2) Allocate that funding between regulated and unregulated portions of the regulated entity based on (1) the percentage of revenue reported in the 2019 Annual Filing for the hospital and (2) the percentage of statewide revenue for the same period.
(3) Use only the smaller of the two regulated allocations in the step above in assessing overlap with GBR funding.

Staff believes that using the more favorable hospital-specific and Statewide regulated/unregulated split is a reasonable and equitable way to address the first two industry concerns noted in the prior section. The Allocated PRF Funds would be recalculated should a hospital return PRF Funding to the Federal Government in the future, but the imputed percentage that allocated funds are based on would remain the same.

Staff acknowledges the commenters' concerns that the original and the revised approach to this allocation will tend to result in a favorable allocation for hospitals. However, staff believe a bias towards more generous funding to hospitals is appropriate in the crisis given the lack of information to allow a more

rigorous calculation.

Settlement Period

Current Recommendation

Industry raised several concerns about the 18-month settlement period proposed in the Draft PRF Recommendation, specifically:

1. GBRs are typically settled on a fiscal year basis and the HSCRC expressly waived the interim target for FY21, thus calculating that settlement through this window would be technically problematic.
2. The COVID crisis is ongoing.
3. The PRF allowed for spending and lost revenue through June 30, 2021.

In recognition of these concerns, this final recommendation addresses only FY20. In the approach outlined below, staff considers all Allocated PRF Funds in assessing FY20 outcomes. However, since the new approach does not offset Allocated PRF funds beyond those needed for FY20 relief, it does not preclude the use of these funds in FY21 and therefore is not in conflict with the Federal program timing.

Recommended Settlement Approach

Overall Approach

For hospitals where Allocated PRF Funds do not cover the hospitals' actual GBR undercharge, this Recommendation has not changed. The hospital will still be permitted to recover the undercharge and any incremental net COVID expenses and funding under the COVID surge policy.

Given industry concerns over the HSCRC recovering PRF dollars that could be used by a health system for another entity, staff has revised the recommended approach for hospitals who's Allocated PRF Funds exceed their FY20 undercharge. Whereas previously, the HSCRC would reduce on a one-time basis FY21 GBRs equivalent to how much a hospital's FY20 GBR was exceeded by hospital charges and Allocated PRF Funds, the proposed revision limits recoveries to the lessor of the relief provided by the Commission or the amount of extra funding. Staff believes this is consistent with the HSCRC mandate which is to consider all sources of funding in assessing hospital financial conditions.

In addition, the staff is recommending that the calculation be resolved at a hospital level, although a system may choose to make any resulting adjustments across the system, at their discretion, subject to staff approval.

The specific calculation would be as follows:

1. If the sum of FY20 Actual Charges and Allocated PRF Funds exceed the FY20 GBR, remove from the hospital's future rates the lessor of:

The amount of COVID Relief provided by the Commission.

a. The amount by which actual FY20 Actual Charges + Allocated PRF Funds exceed FY20 GBR.

2. If the sum of FY20 Actual Charges and Allocated PRF Funds is less than the FY20 GBR, add to the rates the amount of such shortfall.

For this calculation:

- COVID Relief Provided by the Commission is defined as the greater of zero and the sum of the following:
  - I. Actual Q4 FY2020 (which coincides with the start of the pandemic) charges less FY2020 rate order rates X Actual Q4 2020 Volumes X 1 plus Corridor relief percentage granted prior to COVID.
  - II. COVID Surge Funding, for any period where the Surge Policy was in effect, which has been completed at the time the settlement is determined.
  - III. Net incremental COVID expenses for FY20 as defined by staff.
- Actual Charges are the charges reported by the hospital in their financial reports.
- FY20 GBR is the final GBR as of June 30, 2020. FY20 rates are the rates calculated from that GBR.

This approach is the same as the alternative approach described in the February 2020 Commission meeting except that (a) it is limited to FY20, (b) it is at a hospital level, (c) the Allocated PRF Funds calculation has been revised as described above and (d) the COVID Surge Funding and Net Excess COVID expenses are included as COVID relief. Staff changed the handling of the items (d) because they believe that the Commission should not provide extra funding for these items to the extent that the System has remaining PRF Funding.

Appendix A contains a calculation by a hospital of the amounts due to or from each hospital under this recommendation based on currently available data and before consideration of the COVID Surge Policy or net incremental COVID expense. This estimate shows a net statewide increase of $46 million in rates to be applied on July 1, 2021. However, since $97 million of preliminary relief was granted on January 1, 2021 rate orders the actual year over year impact will be $51 million of recovery, which will be implemented over the last 6 months of the calendar year (as shown in Table 4). Note the amounts referenced above and in Appendix A are included for informational purposes and are not intended to reflect final settlement amounts which will be updated for the yet-to-be-determined information.

Timing

The rate adjustments described above would be calculated based on the available information and applied in the July 1, 2021, rate orders for recovery during the first 6 months of FY21. To the extent that the amounts subsequently change because, for example, the hospital returns PRF Funding to the Federal Government or additional expense information becomes available, additional adjustments will be made in future rate orders.

Other considerations

Staff believes this Recommendation addresses most of the comments raised in the comment letters received. Comments not addressed include:

The pandemic crisis is ongoing and funds should not be removed now: Funds are being removed effective July 1, 2021, staff is assuming that the crisis will be substantially mitigated at this point. If this is not the case the Commission could delay these adjustments.

Statute and GBR Agreements do not allow the HSCRC to treat PRF payments as revenue for hospital services as with other sources such as fundraising, state and local grants: Staff believe the statute allows consideration of all revenue sources in evaluating financial condition.

Burden of COVID in a specific service area was extreme and conflicting guidance and lack of recognition for the burden of treatment will force reassessment of resources dedicated to care transformation under the TCOC model: While staff acknowledges the burden of treatment and the enormous efforts hospitals have made, staff also notes that almost all care transformation requirements on hospitals have been delayed and that, given the large amount of funding available, Maryland hospitals both individually and collectively are in no weaker financial position now than they were before the crisis. Therefore, Staff sees no reason for the industry to change its approach to the long-term crisis of keeping healthcare affordable for all Marylanders.

Staff should follow the HHS approach of quantifying and funding incremental expenses at a detail level and considering the entire system rather than relying on net impact on the annual filings: Based on a preliminary review of Annual Filings, staff believes that hospitals realized cost savings due to reduced volumes that generally offset incremental expenses. While staff does not have access to system-level costs at the same level of detail, the assumption is that the same dynamic is true. Staff does not believe that Maryland rate payers should reimburse hospitals for added COVID expenses without realizing the benefit of lower costs in other areas, given that the hospital's revenue base is guaranteed regardless of volume. Staff will be reviewing hospitals individually and allowing for expense recovery for hospitals that bore an expense burden disproportionate to their cost reductions.

Future rate offsets should not be implemented because (1) such future reductions may not be counted for the purpose of justifying CARES funding and (2) that the HHS terms that hospitals sign to receive CARES money referencing lost revenues and expenses "other sources are obligated to reimburse" prevent the HSCRC from revising rates beyond any COVID specific corridor expansions: Given the cap on HSCRC recoveries in this final recommendation is limited to COVID relief provided by the Commission, staff believes the scenario described in 1 is no longer relevant. In addition, staff notes, under this Recommendation, should the Federal Government recover funds from a hospital the hospital's calculated settlement would be adjusted and the hospital would be entitled to recover funds

through the HSCRC based on the adjusted settlement. Staff does not believe the "other sources are obligated to reimburse" clause in HHS guidance refers to the HSCRC since the HSCRC is not a payer and does not reimburse any provider. To the contrary in Maryland, the HSCRC determines what payers are obligated to reimburse, and therefore it is impossible for the HSCRC to be in conflict with this clause.

Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2022 update. HSCRC staff received and reviewed comments from Maryland Hospital Association (MHA), Johns Hopkins Health Systems (JHHS), University of Maryland Medical System (UMMS,) LifeBridge Health, Luminis Health, MedStar Health, and CareFirst. Stakeholders expressed concern over the following aspects of the draft recommendation:

Table 7

	Increase Inflation to Supplement Increasing Labor and Cost Pressures	Increase Demographic Adjustment	Eliminate Productivity Adjustment for Hospital not on GBRs	Reconsideration of CARES ACT PRF Reconciliation
MHA	X	X	X	
JHHS	X			
UMMS	X	X		
LifeBridge Health	X			
Luminis Health	X	X		
MedStar Health				X
CareFirst	expressed support for staff's methodologies in generating savings under the TCOC Model, CARES settlement, PAU adjustment, demographic adjustment, and maintaining affordability.			

Comment: Increase Inflation to Supplement Increased Labor and Cost Pressures

MHA: *Requested that core inflation be raised by 50 basis points. Maryland hospitals are facing real and significant cost inflation that is outpacing next year's proposed allowance. As reflected in their attachments, the most recent data indicate 2021 cost per adjusted patient day growing 3.4% over 2020, or 1% above HSCRC's measure of RY 2022 inflation. We respectfully ask the Commission to raise the annual core inflation factor from 2.37% to 2.87%; 50 basis points is half of the running cost variance.*

JHHS: *Stated that they believe that other components also need to be considered this year in light of the current economy. JHHS has seen dramatic increases in the cost of agency labor in recent months and believe that these increased costs will continue for the foreseeable future. Under the fixed revenue model of GBR, it becomes increasingly difficult to deal with these unanticipated cost pressures without some level of incremental rate authority. They respectfully requested that the HSCRC take these rising costs into consideration in the approval of the FY 2022 Update Factor by adding additional funding to help cover these increases.*

UMMS: *UMMS respectfully requested the HSCRC consider the MHA proposal to increase the FY 2022 inflation by 0.50%. It is unclear if the incremental staffing and contract labor cost increases will continue into FY 2023. As such, UMMS would be supportive of the HSCRC evaluating the need for the continuation of the 0.50% increase into FY 2023.*

LifeBridge Health: *Consistent with a multitude of media outlet reports indicating a rapid and new escalation in inflation with prices for consumer goods and services increasing 0.8% in April, captured in the first quarter inflation index currently being utilized to develop the recommendation of 2.14%.*

Luminis Health: *Luminis Health has experienced abnormally high personnel, contracted labor, and supply and drug costs over the past year. Pre-COVID inflation rates on fixed and variable costs for Luminis Health hovered at 4.1% year over year (FY2018-FY2020). However, during FY2021 our hospitals experienced inflation rates of 5.6%, which were driven by contracted labor (48% increase over FY2020) coupled with pharmaceutical and supply costs, which increased 17% and 10% over FY2020, respectively.*

Staff Response: Staff acknowledges the difficulties hospital's have faced during the COVID-19 pandemic. It is our goal, when developing the update, to ensure the increase is fair and reasonable for the consumers in the State while maintaining the goals of the Model. Staff appreciates the work that has been done, around the State, to meet Model tests for 2020. In light of indications from hospitals that they have faced added clinical wage pressure as they emerge from the COVID crisis, staff is recommending an increase in the inflation update of 0.20 percent in recognition of the special circumstances. Staff has previously committed to reviewing 2021 expenses and providing additional funding for COVID-driven cost outliers, if the Commission elects to provide this additional inflation that will be considered an offset to any additional one-time funding that might otherwise have been provided for 2021. For this reason, we recommend adding 0.20 percent to inflation which results in a gross inflation amount of 2.57 percent. The recommended update for RY 2022 increases as a result of these changes to 2.44 percent. The guardrail position for CY21 is estimated to be equal to the Nation which staff believes is consistent with Model tests.

Comment: Increase the Demographic Adjustment

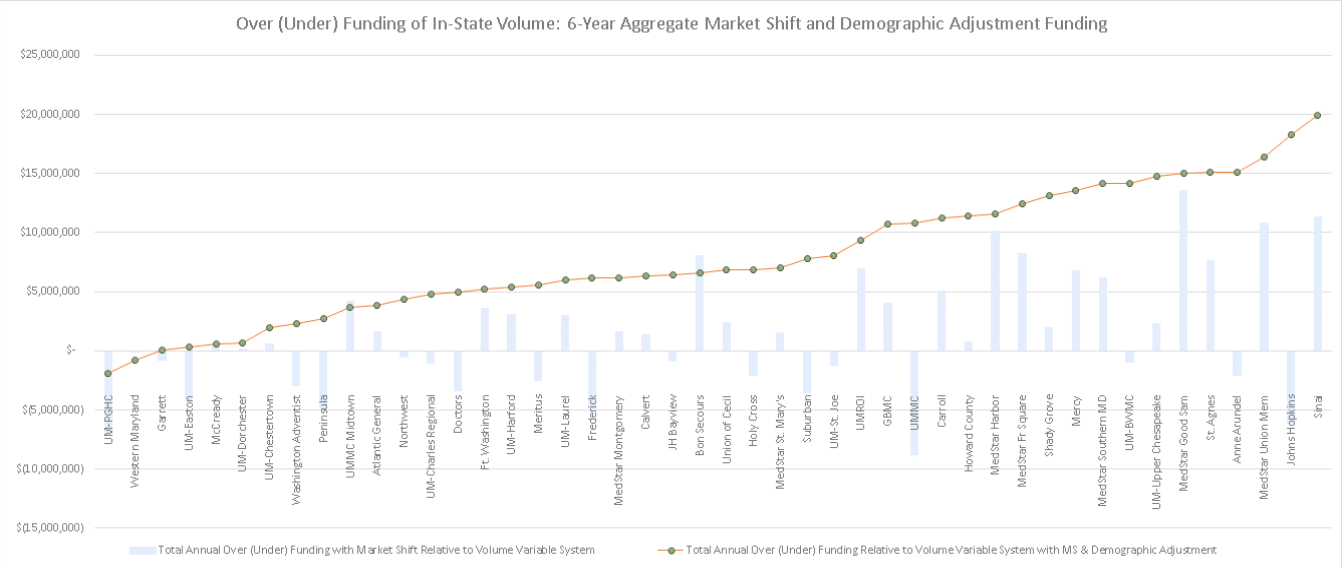
MHA: *Requested inclusion of 16 basis points for age-weighted population growth, allowing a basic demographic adjustment. Under a capped revenue system, including a fair amount for service growth – beyond which hospitals are at risk – is a core tenet. Age-weighting alone would yield 0.59% growth, which the staff proposal has scaled back to projected overall growth of 0.01%. Adding 15 basis points is one-fourth of the 0.59% age-weighted growth; this is equal to the prior year's allowance.*

UMMS: *Expressed its ongoing concern regarding the continued diminishment of the annual demographic adjustment and the significant variances that exist between the MD Department of Planning and CLARITAS population estimates each year. UMMS supports MHA's recommendation to fully evaluate the demographic adjustment methodology and sources as new census population data become available over the next year.*

Luminis Health: *Requested using an age-weighted demographic adjustment to reflect the higher costs of an aging population. They are confident that with these adjustments, we will continue to meet the Medicare Total Cost of Care target. Our success to date reflects the commitment of all Maryland hospitals to meet and exceed this g*oal.

Staff Response: The goal of the Demographic Adjustment is to provide all-payer funding for anticipated growth in line with the growth in the total Maryland population. While staff does provide age adjusted growth to individual hospitals in order to differentiate hospitals that serve an older population and thus expect higher utilization rates, the HSCRC has always scaled the statewide Demographic Adjustment back to total population growth because a) the Medicare TCOC test is a per capita test, not an age adjusted per capita test and b) the funding thus far from the Demographic Adjustment and the Market Shift methodology have provided nearly all hospitals at least a 50% variable cost factor for changes in utilization.

Table 8



Given the success of the HSCRC volume methodologies, staff does not recommend departing from the current methodology of pegging the Demographic Adjustment to the Maryland Department of Planning statewide projections, especially as unnecessary, additional funding for age adjusted growth will likely result in price increases that will jeopardize the Commission's ability to adhere to the TCOC guardrail tests. However, staff recommends redistributing the 0.15 percent to the set aside for unforeseen adjustments, increasing the set aside to 0.25 percent.

Comment: Eliminate Productivity Adjustment for Non-GBR hospitals

MHA: *We support HSCRC staff's proposal to suspend the productivity adjustment for psychiatric and specialty hospitals.*

Staff Response: In addition to suspending the productivity adjustment for psychiatric hospitals and Mt. Washington Pediatrics staff also recommends increasing core inflation by 0.20 percent to help alleviate the labor and cost pressures that hospitals across the State are facing. This change increases the inflation for hospitals not on global budgets to 2.57 percent.

Comment: Reconsideration of CARES Act PRF Reconciliation

MedStar: *MedStar Health continues to be extremely concerned with the HSCRC's proposed "reconciliation" of CARES Act Provider Relief Fund support. Specifically, MedStar makes 3 major points:*

1. *"The HSCRC's proposal is contrary to the Federal CARES Act and in excess of the HSCRC's proper authority."*
2. *"The HSCRC's proposal is contrary to sound healthcare policy."*
3. *"The HSCRC relies on a flawed methodology in calculating the impact of the corridor relief granted to Maryland hospitals."*

Staff Response: Only MedStar raised concerns on this issue. Staff's responses are as follows:

1. *"The HSCRC's proposal is contrary to the Federal CARES Act and in excess of the HSCRC's proper authority."*

Staff does not agree with this comment. The HSCRC is simply taking into account available federal funding in setting its Maryland rates, which is consistent with the Commission's statutory mandate, and which is consistent with the Commission's multiple notifications to hospitals that it would do so in providing the extraordinary relief of a GBR "guarantee" even before any federal funding was given. Staff is not dictating how hospitals use that funding. The HSCRC's proposed approach places Maryland hospitals in a position analogous to that of fee-for-service hospitals in all other states and then evaluates federal funding in this context when determining Maryland funding. Staff believes this approach is consistent with federal policy and also fair to Maryland's rate payers who should not be asked to shoulder more of the burden than payers in other states simply because of Maryland's unique system that assures hospitals of its ability to meet all their reasonable financial requirements.

2. *"The HSCRC's proposal is contrary to sound healthcare policy."*

Staff interprets MedStar's comments to mean that because the proposed approach is not 100% volume-based it is not sound policy. Staff notes: (1) that Maryland hospitals have operated in, and benefitted from, a fixed revenue system since 2013;, (2) that federal CARES funding uses a similar approach whereby total potential funding is based on attaining pre-COVID revenue and, therefore, hospitals that lost less volume (i.e., less lost revenue) are entitled to retain less funding, all else being equal; and (3) that under the draft recommendation, after considering allocated federal funds, MedStar is in the top 3 systems in the State both in total funding as a % of GBR, and dollars of funding received above the GBR. While Staff commends MedStar for their efforts during the pandemic,, Staff believes that the proposed recommendation reasonably compensates them for those efforts.

3. *"The HSCRC relies on a flawed methodology in calculating the impact of the corridor relief granted to Maryland hospitals."*

MedStar does not describe their specific concern in the public comment letter. Staff is responding based on an assumption about their concern derived from other conversations in which they have objected to Staff's approach to calculating COVID Relief specific to the Drug and Supply Cost Centers. Staff agrees that the methodology used to determine COVID Relief for Drugs and Supplies was a change from the HSCRC's

typical approach to these centers. However, as the circumstances during the period were clearly not typical, Staff believes that the methodology applied in determining the amount of COVID Relief in Drugs and Supplies was justified. Staff also notes that it was consistent with the Global Budget Agreements signed by all hospitals. Most importantly, Staff believes it was a reasonable approach to protect consumers from excessive rate increases during the pandemic, in contrast to rate increases that would be permissible under MedStar's preferred approach. Furthermore, no other hospital has raised any concerns with this methodology even though it was applied precisely the same way across all hospitals under a GBR arrangement.

Based on the concern that Maryland payers and consumers may have been charged unreasonably high rates by MedStar hospitals during the pandemic, Commissioners approved an amendment to the final recommendation, which directs staff to open full rate reviews on all Maryland MedStar hospitals.

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 2022 update factors.

(a) Provide an overall increase of 2.44 percent for revenue (including a net increase to uncompensated care) and 2.43 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. This recognizes an additional 0.20 percent for salary and malpractice pressures. Staff does not believe this should be the normal policy. However, as hospitals continue to grapple with the effects of the pandemic, staff feels the request is not unrealistic.

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.

Additionally, Staff recommends that the adjustment to consider the reconciliation of CARES Provider Relief Funds and HSCRC support for RY 2020 be included in the midyear target (as described in e) below).

(b) Provide all hospitals a base inflation increase of 2.34 percent and allocate 0.23 percent of the total inflation allowance based on each hospital's proportion of drug cost to the total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high-cost drugs.

(c) Reduce the Demographic and Population adjustment from 0.16 percent, that was included in the Draft Recommendation, to 0.01 percent based on the Maryland Department of Planning estimate.

(d) Increase the set aside to 0.25 percent by redistributing the decrease of 0.15 percent from the Demographic and Population reduction to the set aside for unforeseen adjustments. Commissioners requested a reconciliation of the set a side for RY 20 and RY 21.

(e) Adjust rates effective July 1, 2021, over a 6 month window, to implement the reconciliation of CARES Provider Relief Funds (PRF) and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

- For hospitals where the sum of actual charges and PRF Funding is less than their fiscal year 2020 approved Global Budget Revenue the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
- For hospitals where the sum of actual charges and PRF Funding is greater than their fiscal year 2020 approved Global Budget Revenue the adjustment would subtract from the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of this recommendation) from their July 1, 2021 rate order.
- Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined above to maintain financial stability for hospitals, given that the COVID pandemic continues to have an impact on health care delivery in RY 2021.

((f) Initiate full rate reviews on all Maryland MedStar hospitals.

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

a) Provide an overall update of 2.57 percent for inflation. This includes an additional 0.20 percent to gross inflation to help alleviate labor and cost pressures experienced by hospitals.

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

Appendix A:

Note: Amounts do not reflect rate relief granted January 1, 2021, so actual July 1, 2021 adjustment will be net of that relief

Hospital Name	FY20 Final GBR (Under) Over Charge	Allocated PRF Funds	(Under) Over Charge Position with Allocated PRF Funds	Q4 Charges w Pre-COVID Corridor	Actual Q4 Charges	Commission Granted COVID Relief - Revenue Shortfall	Other Commission Granted Relief (1)	Total Commission Granted Relief	Rate (Incr) Decr Implemented July 1, 2021
	A	B	C = A + B	D	E	F = E - D	G	H = G + F	Min of (Max(H or $0) or C)
Meritus Medical Center	($33,436,603)	$8,355,099	($25,081,504)	$73,851,370	$78,753,600	$4,902,230	TBD	$4,902,230	($25,081,504)
UMMC	($80,031,647)	$97,006,111	$16,974,464	$395,521,529	$424,077,896	$28,556,367	TBD	$28,556,367	$16,974,464
Prince George	($10,810,786)	$68,969,587	$58,158,821	$83,328,719	$80,215,622	($3,113,098)	TBD	($3,113,098)	$0
Holy Cross	($23,017,050)	$51,133,098	$28,116,048	$114,189,306	$117,988,836	$3,799,530	TBD	$3,799,530	$3,799,530
Frederick Memorial	($17,354,453)	$17,395,122	$40,669	$73,710,515	$78,375,833	$4,665,318	TBD	$4,665,318	$40,669
UM Harford Memorial	($12,587,225)	$2,433,790	($10,153,435)	$19,447,784	$18,518,473	($929,312)	TBD	($929,312)	($10,153,435)
Mercy	($39,411,366)	$9,314,239	($30,097,126)	$110,806,440	$123,258,229	$12,451,789	TBD	$12,451,789	($30,097,126)
Johns Hopkins	($160,141,265)	$116,728,681	($43,412,584)	$514,860,904	$545,472,395	$30,611,491	TBD	$30,611,491	($43,412,584)
UM Shore Medical Dorchester	($9,325,434)	$15,423,184	$6,097,750	$6,904,722	$7,318,969	$414,246	TBD	$414,246	$414,246
St. Agnes	($30,562,445)	$34,580,325	$4,017,880	$82,473,795	$89,101,985	$6,628,190	TBD	$6,628,190	$4,017,880
Sinai	($32,916,550)	$29,965,351	($2,951,199)	$171,384,858	$194,385,139	$23,000,281	TBD	$23,000,281	($2,951,199)
Bon Secours	($2,626,367)	$10,312,859	$7,686,492	$7,915,008	$10,061,487	$2,146,478	TBD	$2,146,478	$2,146,478
MedStar Franklin Square Medica	($331,551)	$24,494,340	$24,162,789	$129,610,920	$151,967,561	$22,356,641	TBD	$22,356,641	$22,356,641
Washington Adventist	($4,126,333)	$59,063,362	$54,937,030	$80,389,189	$76,278,484	($4,110,705)	TBD	($4,110,705)	$0
Garrett County Memorial	($4,776,096)	$9,543,311	$4,767,215	$13,422,904	$12,101,658	($1,321,246)	TBD	($1,321,246)	$0
MedStar Montgomery Medical Cen	$362,566	$21,193,888	$21,556,454	$38,445,260	$42,614,628	$4,169,368	TBD	$4,169,368	$4,169,368
Peninsula Regional Med Cen	($21,666,823)	$26,319,555	$4,652,732	$101,422,841	$106,402,444	$4,979,603	TBD	$4,979,603	$4,652,732
Suburban	($28,351,528)	$31,095,740	$2,744,212	$61,378,548	$66,873,028	$5,494,480	TBD	$5,494,480	$2,744,212
Anne Arundel Med Cen	($38,452,368)	$42,551,034	$4,098,666	$129,374,389	$139,182,105	$9,807,716	TBD	$9,807,716	$4,098,666
MedStar Union Mem Hospital	($1,598,073)	$24,946,521	$23,348,448	$76,082,221	$107,704,432	$31,622,211	TBD	$31,622,211	$23,348,448
Western Maryland Regional Medi	($8,586,321)	$14,158,753	$5,572,432	$78,302,942	$81,555,744	$3,252,803	TBD	$3,252,803	$3,252,803
MedStar St. Mary	$482,675	$10,097,457	$10,580,132	$42,924,295	$49,747,037	$6,822,742	TBD	$6,822,742	$6,822,742
Hopkins BayviewMedical	($59,743,931)	$52,384,438	($7,359,493)	$125,956,648	$134,837,910	$8,881,263	TBD	$8,881,263	($7,359,493)
UM Shore Medical Chestertown	($13,168,085)	$6,021,315	($7,146,771)	$8,025,810	$8,295,531	$269,721	TBD	$269,721	($7,146,771)
Union Hospital Cecil County	($10,521,647)	$7,276,337	($3,245,309)	$33,959,857	$37,786,245	$3,826,388	TBD	$3,826,388	($3,245,309)
Carroll Hospital Center	($11,410,909)	$11,595,391	$184,482	$47,652,464	$51,084,737	$3,432,273	TBD	$3,432,273	$184,482
MedStar Harbor Hospital	($10,384,160)	$19,543,543	$9,159,383	$35,340,556	$38,599,086	$3,258,530	TBD	$3,258,530	$3,258,530
UM Charles Regional	($10,060,006)	$12,201,627	$2,141,622	$35,865,408	$32,963,785	($2,901,623)	TBD	($2,901,623)	$0
UM Shore Medical Easton	$626,210	$0	$626,210	$47,840,408	$50,210,549	$2,370,141	TBD	$2,370,141	$626,210
UMMC Midtown Campus	($15,405,321)	$21,038,797	$5,633,477	$44,550,287	$46,351,086	$1,800,799	TBD	$1,800,799	$1,800,799
Calvert Health	($2,294,938)	$7,241,356	$4,946,418	$38,249,519	$39,635,767	$1,386,248	TBD	$1,386,248	$1,386,248
Northwest	($16,789,476)	$20,474,502	$3,685,026	$54,206,526	$61,368,989	$7,162,463	TBD	$7,162,463	$3,685,026
UM BWMC	($30,926,741)	$28,137,939	($2,788,802)	$83,575,572	$95,413,477	$11,837,905	TBD	$11,837,905	($2,788,802)
G.B.M.C.	($28,502,629)	$15,383,066	($13,119,563)	$96,837,840	$106,343,289	$9,505,450	TBD	$9,505,450	($13,119,563)
McCready	($374,572)	$0	($374,572)	$989,509	$938,421	($51,088)	TBD	($51,088)	($374,572)
Howard County General	($19,993,336)	$25,166,150	$5,172,814	$62,978,539	$69,665,693	$6,687,154	TBD	$6,687,154	$5,172,814
UM Upper Chesapeake	($26,179,241)	$26,025,879	($153,362)	$66,933,329	$65,877,501	($1,055,828)	TBD	($1,055,828)	($153,362)
Doctors Community Hosp	($15,946,682)	$28,097,966	$12,151,284	$49,042,184	$58,851,158	$9,808,974	TBD	$9,808,974	$9,808,974
Laurel Regional	($2,955,247)	$0	($2,955,247)	$4,876,506	$4,336,559	($539,947)	TBD	($539,947)	($2,955,247)
Ft. Washington	($2,858,785)	$5,518,096	$2,659,311	$11,432,974	$11,375,237	($57,737)	TBD	($57,737)	$0
Atlantic General	($9,605,883)	$8,684,566	($921,317)	$21,840,286	$21,661,783	($178,503)	TBD	($178,503)	($921,317)
Medstar Southern Maryland Hosp	($6,796,561)	$34,276,660	$27,480,098	$55,206,999	$65,068,799	$9,861,800	TBD	$9,861,800	$9,861,800
UM St. Joseph Medical Center	($34,712,587)	$17,576,410	($17,136,177)	$70,028,786	$73,750,063	$3,721,277	TBD	$3,721,277	($17,136,177)
Holy Cross Germantown Hospital	($405,000)	$0	($405,000)	$28,057,747	$28,339,724	$281,977	TBD	$281,977	($405,000)
Germantown Emergency Center	($1,588,210)	$0	($1,588,210)	$2,223,063	$2,434,335	$211,272	TBD	$211,272	($1,588,210)
Queen Anne Emergency Ctr	($374,616)	$0	($374,616)	$2,052,700	$1,955,383	($97,317)	TBD	($97,317)	($374,616)
Bowie Emergency Center	($2,306,134)	$0	($2,306,134)	$3,271,252	$3,125,556	($145,696)	TBD	($145,696)	($2,306,134)
UM Rehab Ortho Inst	($15,895,008)	$2,163,142	($13,731,866)	$18,925,234	$21,653,905	$2,728,671	TBD	$2,728,671	($13,731,866)
MedStar Good Samaritan Hospita	($6,954,734)	$25,435,925	$18,481,190	$55,075,079	$62,185,451	$7,110,372	TBD	$7,110,372	$7,110,372
Levindale	($3,206,520)	$2,930,138	($276,381)	$13,090,688	$14,333,766	$1,243,078	TBD	$1,243,078	($276,381)
Shady Grove Adventist	($23,290,976)	$20,328,796	($2,962,180)	$105,303,291	$102,533,975	($2,769,316)	TBD	($2,769,316)	($2,962,180)
Total	($941,290,744)	$1,122,583,446	$181,292,701	$3,629,137,521	$3,912,933,346	$283,795,825		$283,795,825	($46,806,714)

1. Includes (1) incremental net FY20 COVID-related expenses to be assessed by Staff and (2) COVID Surge Funding, for any period where the Surge Policy was in effect, which has been completed at the time the settlement is determined.

Appendix B: Public Comment Letters Re: Reconciliation of CARES Provider Relief Fund and HSCRC-support

Staff received the below comment letters regarding the Draft CARES Fund Reconciliation that was presented at the February 2021 Commission meeting.

JLMcGee Consulting

Leni Preston, Independent Consumer Voice on Health Policy

Adventist HealthCare

University of Maryland Medical System

Holy Cross Health

CareFirst

Johns Hopkins Health System

MedStar Health

Tidal Health

JLMcGee Consulting

James L. McGee, MBA, CEBS
6408 Redwing Rd.
Bethesda, MD 20817
(301) 320-6105 (LL)
(202) 256-9594 (mob)
Jim@JamesLMcGee.com

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

February 24, 2021

RE: CARES Funding Policy Update

Dear Chairman Kane:

Thank you for allowing me this opportunity to offer comments on the draft CARES Funding Policy update. I am recently retired as the Executive Director of the Transit Employees Health & Welfare Fund and the newly formed Transit Employees Retiree Health Plan. However, I am still engaged for some limited consulting. The funds are governed by boards of trustees representing the management of the Washington Metropolitan Area Transit Authority and ATU Local 689.

At the June 2020 Commission meeting I submitted comments on the update factor. Much of this letter will echo those comments which seem sadly prescient in hindsight. In that letter I wrote:

> "I would like to see a clear plan that anticipates the possibility that the combination of hospital revenue from payers and additional federal and/or state COVID-19 relief funds might exceed hospital expenses. If so, how will that additional revenue flow back to private payers?"

These are still perilous times; and not just for the hospital industry and their fearless employees who have worked tirelessly to keep themselves and the public alive and safe. Over 1,000 Metro employees have lost time due to contracting COVID. Four have died. Many have those hospitals and those employees to thank for their continued health and even their lives.

During the past year, we have seen workplaces altered and far too many shuttered. Our economy, perhaps even our way of life, may be permanently altered. Throughout this, the unique hospital rate setting experiment in Maryland has allowed Maryland hospitals a degree of stability that is surely the envy of hospitals throughout the country.

But something that makes any crisis more tolerable is the idea of shared sacrifice. That is not a phrase that has been associated with this pandemic, but it is a value that is part of the Maryland rate setting experiment. I feel that the staff proposal on CARES funding is fair to the hospitals and to the publics they serve and shares our sacrifice equitably.

I urge the Commissioners to accept the staff CARES funding policy update.

Sincerely

James L. McGee, CEBS

JLMcGee Consulting

James L. McGee, MBA, CEBS
6408 Redwing Rd.
Bethesda, MD 20817
(301) 320-6105 (LL)
(202) 256-9594 (mob)
Jim@JamesLMcGee.com

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I urge the Commissioners to accept the staff CARES funding policy update.

Sincerely

James L. McGee, CEBS

Leni Preston
Independent Consumer Voice on Health Policy
Email: lenipreston@verizon.net Cell: 301.351.9381

24 February 2021

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

RE: CARES funding policy option

Dear Chairman Kane:

I appreciate the opportunity to comment on the draft CARES funding policy option. I do so as the former chair of the Board of Directors of Consumer Health First and as a current and former member of several HSCRC workgroups, including the Consumer-Standing Advisory Committee.

I wish to echo the points made in the comments submitted by Jim McGee and reinforce his emphasis on the need for "shared sacrifice." To achieve that, with funding from the CARES Act, it is important that those dollars be factored into the reconciliation process with hospital rate setting.

Therefore, I urge you to accept the recommendation of the HSCRC staff. This is the only fair and equitable approach that will ensure that, in the end, consumers do not end up paying more than their fair share.

Thank you for taking these comments into consideration as you deliberate this important issue.

Sincerely,

Leni Preston

Adventist HealthCare

March 11, 2021

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

Dear Chairman Kane,

On behalf of Adventist HealthCare, thank you for the opportunity to provide comments on the HSCRC's CARES Funding Policy Update presented at the February 10, 2020 meeting of the Health Services Cost Review Commission.

Timing:

In the February 10, 2021 presentation, the staff states the "intent is to provide ***final*** guidance for the 18 months ended 12/31/20 shortly so hospitals can have certainty moving forward." We believe that it is premature to issue final guidance as the pandemic, our response as well as the distribution and justification of use of the Provider Relief Funds is still on-going. To date, we estimate that HHS has allocated just under $130B of the $178B of available funding including amounts for Phase 3 General Distributions which began in mid-December of 2020 and will continue into the first months of 2021. This leaves an additional $48B that may be allocated to providers between now and June 30, 2021. Additionally, in a 10/28/2020 FAQ, HHS states that "Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if on June 30, 2021, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately." Even with receipts thus far which are not complete, providers have through June 30, 2021 to demonstrate the use of these funds consistent with U.S. Department of Health and Human Services (HHS) Terms and Conditions.

Due to the incomplete financial picture that is currently available which will be complicated by ultimately crossing multiple rate years, we believe it would be difficult for the HSCRC staff to develop a fully informed final policy proposal at this time.

In addition to the timing considerations, we believe that there are inconsistencies between the proposed HSCRC policy and HHS application of CARES funds that may lead to unintended negative financial consequences for Maryland Hospitals.

Revenue and Expense considerations:

The HHS guidelines clearly state that the "Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund." While we recognize there is information the HSCRC staff has not yet had the opportunity to collect and analyze, we are concerned that the Policy update presented on February 10, 2020 meeting, may not have represented a full picture to the Commissioners that hospitals and health systems are experiencing related to both revenue ***and*** expense. We feel that it is important to make the Commissioners aware that there are significant COVID related expenses that were not presented and looking at undercharges compared to the amount of CARES Act money received alone does not present a full picture of the financial impact of COVID on an organization. It is critical to understand hospitals and health systems which have experienced higher COVID related volumes may have received more CARES funding, while not experiencing as much of an undercharge as other organizations, but those organizations are also likely experiencing greater expenses related to COVID which were not presented in the policy update.

Organizational Structure and Use of Funds:

While we understand the HSCRC only has jurisdiction over hospital rate setting, the pandemic has impacted all areas of the care delivery system and health systems have experienced lost revenues and expenses beyond Acute Care hospitals, while also needing to quickly deploy resources in unprecedented ways. HHS and Congress have recognized the need for health systems to have flexibility in allocating both the General Distribution and Targeted funds received. As such, the Consolidated Appropriations Act, 2021, permits that "For any reimbursement by the Secretary from the Provider Relief Fund to an eligible health care provider that is a subsidiary of a parent organization, the parent organization may, allocate (through transfers or otherwise) all or any portion of such reimbursement among the subsidiary eligible health care providers of the parent organization, including reimbursements referred to by the Secretary as 'Targeted Distribution'' payments, among subsidiary eligible health care providers of the parent organization…."

The HSCRC staff propose the use of the FY 2019 RE Schedules to determine a regulated apportionment to use in a calculation to determine "Net Over/(Under) Funding." We believe this could be potentially flawed for a couple of reasons. First the HSCRC's Annual Filing may not represent an organization or health system in its entirety. Most, if not all, health systems have patient care related subsidiaries that are not reflected on one of its Annual Filings. Because of the flexibility that HHS

allows health systems in the allocation for use of funds, we believe that this inconsistency could create a situation where the funds have been used and reported to HHS differently than how the HSCRC is evaluating the funds for application in rate setting and inadvertently disadvantage Maryland hospitals. It is important to note that providers are required by HHS to provide detailed reporting justifying the use of the funds and that reporting is subject to a Single Audit conducted under 45 CFR Part 75. We recommend the HSCRC use the reports and the organization's reported use and allocation of funds as submitted to HHS, which are already subject to audit and significant anti-fraud monitoring.

Offsets to Future Rates:

In its Funding policy update, the HSCRC Staff indicate amounts of HHS funds received in excess of its GBR undercharge (FY 2020 plus the first 6 months of FY 2021) plus the impact of COVID on expenses for the same period, be treated as "over-funding" and therefore be subject to a future rate reduction. We believe this view is flawed for a couple of important reasons:

First, it would be inappropriate to assume the 18-month period is complete. As mentioned earlier, the funds have not been fully distributed by HHS and the period for which a provider can justify the use of funds has not been completed, regardless of when the funds were received during the pandemic. Providers are recognizing HHS funds as revenue as they can demonstrate lost revenues or COVID expenses consistent with HHS guidelines, which may mean many organizations have a portion of total receipts recorded as a liability on their balance sheets. If a provider does not have lost revenues or expenses to justify the use of those funds, it will be required to return those funds to HHS. If between December 31, 2020 and June 30, 2021, the provider experiences further lost revenues and/or COVID related expenses, additional funds may be released into income to cover those amounts. The HSCRC staff's proposal does not appear to take into consideration the amounts received are intended by HHS to go through June 30, 2021 nor does it acknowledge providers will be required to return funds not used consistent with HHS guidelines.

Second, we believe an approach which offsets future rates would unduly harm Maryland hospitals and may violate HHS terms and conditions. HHS guidelines "require that recipients be able to demonstrate lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources *or that other sources are obligated to reimburse*, exceed total payments from the Relief Fund." It is our interpretation that by reducing future rates to offset the "over-funding" as determined by the HSCRC, beyond any extraordinary corridor expansions granted in order to retain HHS funds as additional "lost revenue" would violate this requirement by reducing the amount that "other sources are obligated to reimburse." We believe reducing rates for a reason and amount which is outside of normal policy would in effect be reducing the payers, both governmental and commercial, obligation to reimburse. Additionally, we strongly believe that even if rate reductions were permissible to justify lost revenue, reducing future rates beyond the June 30, 2021 time frame

would preclude hospitals from claiming that lost revenue as the current guidelines stipulate in the notice of reporting requirements on the Provider Relief Fund website, funds must be expended no later than June 30, 2021. For these reasons, we do not believe the HSCRC is able to consider CARES Act receipts in excess of lost revenues and increased expenses as reported to HHS as an "overcharge" and subsequently reduce future rates.

We appreciate the opportunity to provide comment and we fully support the need for a well thought out policy on the use of Provider Relief Funds within the context of the Maryland system. The impacts of the pandemic are still on-going and extremely fluid and there are still outstanding and complex factors which need to be considered in the HSCRC's CARES Funding Policy. For the reasons outlined above, we respectfully request the HSCRC staff delay its final policy decision until further clarification and analysis can be conducted to ensure the HSCRC policy is consistent with HHS requirements and guidance, and we welcome further discussion with Commissioners and Commission staff regarding the complexities of the HHS terms and conditions for receipt and use of the Provider Relief Funds.

Sincerely,

Kristen Pulio
SVP, Chief Revenue Officer
Adventist HealthCare, Inc.

cc: Terry Forde, President & CEO, Adventist HealthCare, Inc.
James Lee, EVP & CFO, Adventist HealthCare, Inc.
Katie Wunderlich, HSCRC Executive Director
Joseph Antos, Ph.D, HSCRC Vice Chairman
Victoria W. Bayless, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner
James Elliott, M.D. HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829
www.umms.org
410-328-2331 | 410-328-1931 FAX

Mohan Suntha, MD, MBA
President and Chief Executive Officer

March 11, 2021

RE: Fiscal Year 2020 and 2021 HSCRC Undercharge Settlement Approach
Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

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") proposed action related to the Department of Health and Human Services ("HHS") CARES Act Funding.

Since the pandemic began, the HSCRC has assisted Maryland hospitals in their response to this unique emergency. As an academic medical system, UMMS has been duly focused on providing care in our local communities as well as supporting the State in its efforts to respond on statewide level. We appreciate working closely with the HSCRC throughout the pandemic to develop solutions to issues never before contemplated.

UMMS agrees that the proposed action to include CARES Act funding in the settlement process is a necessary component in reconciling the financial impact of the pandemic to Maryland hospitals and UMMS supports the general framework of the settlement calculation which also considers Global Budget Revenue (GBR) undercharges, operating expenses and recognition of physician losses.

UMMS would like to offer the following specific comments on certain aspects of this proposed action.

Settlement and Identification of HSCRC's View of "Overfunding"
UMMS is concerned with the overlapping nature of the Staff's approach to identifying "overfunding" versus HHS requirements to attest to and reconcile CARES Act funding. The HHS attestation and reconciliation process will also evaluate potential overfunding but will use a different approach to identifying COVID expense. This difference in methodologies will likely create disparities between the HSCRC and the HHS conclusions.

At the onset of the pandemic, the HSCRC provided a critically important stabilizing mechanism by allowing hospitals to expand rate corridors beyond the normal five percent. With the benefit of the support received through the CARES Act, it is possible that some of that funding was

ultimately not required by every hospital. To the extent that such charging support was ultimately not needed, we believe the HSCRC should take back those specific funds provided by the Commission to support hospitals to respond to COVID such as the revenue generated by the expanded corridors and that the principles and policies that govern GBR should remain in place.

Multi-Year Approach to Reconciling

The current proposed action aims at considering regulated revenues, operating expenses and CARES Act funding through the 24 month period ending June 30, 2021. We agree with this multi-year approach and we support a preliminary reconciliation through April 2021 for July 1, 2021 implementation.

Settlement Approach - System vs. Individual Hospital

HSCRC Staff intends to calculate the reconciliation at a health system level. All Maryland hospitals have unique GBRs and corresponding unit rates established on the basis of individual hospital cost structures. We believe this to be an important and key principle of our rate setting system. As such, we are concerned that deviating from a hospital-specific approach in this reconciliation will potentially set an unintended precedent for future commingling of GBR within a system. For consistency and equity, whether a stand-alone hospital or a hospital within a health system, we believe the reconciliation should be done on a hospital-specific basis.

Method to Allocate CARES Act Funding to Unregulated Services

The Staff's recognition of the need to support physician losses when considering the utilization of CARES Act funding is a welcome addition to the settlement process. We appreciate the Staff evaluating modified approaches to using the Schedule RE as presented at the March 5 HSCRC Payment Models work group and we are supportive of an approach that considers the potential differences in hospital reporting as well as recognizing hospital specific issues. Alternative 2 appears to be a more equitable option, but we emphasize the need for the HSCRC to continue to provide hospitals the opportunity to bring forth hospital specific issues.

Thank you for the opportunity to provide feedback. We appreciate the HSCRC's ongoing recognition of the significant financial implications COVID has created for hospitals. If you have any questions, please do not hesitate to contact me.

Sincerely,

Mohan Suntha, MD
University of Maryland Medical System
President and Chief Financial Officer

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, MD
Sam Malhotra
Katie Wunderlich, Executive Director
William Henderson, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Michelle Lee, UMMS Chief Financial Officer
Alicia Cunningham, UMMS SVP Finance

HOLY CROSS HEALTH

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

March 11, 2021

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

Dear Mr. Kane,

On behalf of Holy Cross Health, we appreciate the opportunity to comment on the CARES funding policy presented at the HSCRC's February 10, 2021 public meeting.

The COVID-19 pandemic has placed unprecedented challenges upon our healthcare delivery system and has required significant investment in critical resources to meet the care demands of our community. While our Global Budget System provided the essential backstop that allowed Maryland hospitals to sustain a revenue base despite dramatic patient volume fluctuations, it was the addition of federal Provider Relief Funds which kept Holy Cross Health financially stable while we worked to support, expand and reinforce our front line facilities, access points, and care teams in meeting the overwhelming demands generated by the pandemic. The essential funding allowed us to recruit additional front-line care givers, many of whom were agency labor and came at a premium cost throughout the pandemic, in some cases amounting to almost double the standard full-time staffing rates, while uplifting and retaining our front-line teams. It also allowed us to provide essential PPE, obtain critical resources and supplies, pivot to new methods of care and communication when families and visitors were unable to be present, and provide new and essential care for our at risk community member who are uninsured and underinsured.

In accepting Provider Relief Funds, Holy Cross Health is now obligated to meet the specific terms and conditions as outlined in the Post-Payment Notice of Reporting Requirements issued by HHS, dated January 15, 2021. This guidance describes how funds are expected to be used and states *"funding will reimburse the recipient for only health care related expenses or lost revenue attributable to Coronavirus and will not reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse"*. With this condition of acceptance, it is important the HSCRC's approach consider and incorporate essential elements of the HHS guidance in forming its recommended policy. The HSCRC's current proposal references the use of Provider Relief Funds to cover only lost revenue (GBR undercharges) but does not consider the incredible cost burden experienced by those hospitals who managed significant levels of COVID-19 surge cases. Our service area of Montgomery and Prince Georges Counties were the first hit by the pandemic and Holy Cross was the first in the region to respond. Additionally, as you know, our region was hardest hit by the pandemic and includes 1/3 of the State's uninsured and underinsured population, many of whom reside in the hardest hit zip codes. Holy Cross' immediate action to respond and expanded our resources to meet the needs came at a very high cost. Conflicting polices/guidance on how funds can be utilized and the lack of recognition for the tremendous costs burden fails to recognize these efforts and hospitals that have given so much will be forced to reassess and, potentially scale back, vital resources and investments made to support the transformation of care delivery under the Total Cost of Care model.

In addition, each Provider Relief Fund recipient is required to comply with specific reporting requirements as specified by HHS. If recipients are unable to sufficiently substantiate the use of the funds and document their utilization through prescribed reporting requirements, then the recipient is obligated to pay back any unjustified

funding to HHS. Hospitals were also permitted to redistribute Provider Relief Funds amongst their affiliated facilities to offset COVID-19 costs and lost revenue not otherwise covered by Provider Relief Funds or other sources. Neither of these unique elements have been considered in the current proposed HSCRC policy. The Hospitals' reporting requirements to HHS should be the basis upon which the HSCRC validates costs associated with COVID-19 and allow for the distribution of funding amongst their affiliated facilities. If any residual Provider Relief Funds remain, then the Hospital is obligated to send that funding back to HHS.

It will also be important to consider the timing in recognizing Provider Relief funding as we are still incurring costs to support the fight against COVID-19. With the burnout experienced by our exhausted caregivers, the impact of the pandemic is still being felt across our hospitals' cost structures. Provider Relief Funds were intended to support costs incurred throughout the pandemic and HHS has stated that if recipients do not expend Provider Relief Funds in full by the end of the calendar year 2020, they will have an additional six months in which to use the remaining amounts. Adjusting for these federal funds in advance of this time period is premature and ongoing costs incurred to address our community's needs must also be considered in the policy development. The full impact of the pandemic is still evolving and must be considered when developing this policy.

This is a complex issue and one that requires distinction between our GBR system and federal funding. We urge the Commission to carefully consider all aspects when finalizing their approach and distributing ongoing guidance.

Thank you for this opportunity to offer our comments on this policy and welcome the opportunity to participate in further discussion in its development.

Sincerely,

Norvell "Van" Coots, M.D.
President and CEO

Anne D. Gillis
Chief Financial Officer

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

Maria Harris Tildon
Executive Vice President
Public Policy & Government Affairs

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-505-2855

February 24, 2021

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

Dear Chairman Kane:

CareFirst appreciates the opportunity to comment on the "CARES Funding Policy Update." We recognize that hospitals and other providers continue to go above and beyond to take care of the community and we applaud actions by the HSCRC to support them in doing so. We support the Draft Recommendation as proposed.

HSCRC has been clear from the beginning that it is their intent for hospitals to utilize accountable federal support before rate dollars, and we understand that in order to maintain rate integrity, settle-ups should occur as close as possible to the Fiscal Years in which federal CARES support was provided. Therefore, we believe that staff's approach to begin the reconciliation now and make appropriate adjustments as more information and data are available is prudent.

We understand the policy's attempt to reconcile funding provided to hospitals for COVID-related expenses and lost revenue. Staff is required to consider all sources of revenue and is looking to avoid double payment by considering the expanded rate corridors utilized as well as CARES funding from the federal government. While the Staff's proposal could have been more conservative by considering other non-rate support received by hospitals, we understand Staff's decision to focus on CARES federal funding as it is both the largest and most trackable portion of non-rate support.

While this is a complex topic, it is clear Staff has heard the desire from the industry to simplify its policy approaches. Not only did Staff narrow its efforts to a scope of just COVID rate corridor expansion and CARES federal funding, Staff also proposed a standardized, logical approach to identifying regulated CARES funding. We understand hospitals and health systems were provided funding from the federal government to cover both regulated and unregulated operations and there was no assignment of those dollars upfront. Since it would require sophisticated, consistent cost accounting across the industry to identify all COVID-related expenses as either regulated or unregulated, Staff took an understandably simple approach that can be replicated in future reconciliations without added administrative burden on hospitals. We support Staff's use of historical revenue splits between regulated and unregulated as a means for determining the regulated portion of CARES funding.

During a period in which many hospitals across the country struggled financially, as patient volume plummeted, Maryland's hospitals were fortunate to have the flexibility and stability of the rate-setting system to ensure their financial statements remained healthy. Rather than waiting for the federal government to intervene, HSCRC acted quickly and expanded rate corridors early

on, leading to little interruption in either hospital's top-line revenue or cash position. Appropriately, this policy attempts to settle-up the few instances where HSCRC and the federal government's combined support overestimated the actual impact COVID-19 had on hospitals during the 18-month period ending December 31, 2020.

It is important to remember that hospitals' revenues represent expenses to the community. Many other businesses and individuals struggled financially during 2020. We have seen firsthand the impact COVID has had on our members and accounts and made many accommodations for our members and communities, including lengthened grace periods for premium payments, premium credits, waived co-payments for COVID-19 testing and treatment, waived co-payments for telehealth during the initial months of the pandemic, procurement of PPE for community providers, and extensive community support, to name just a few. It is important to ensure that duplicative rate dollars for CARES Act support are quickly reconciled, in order to prevent any further burden on businesses, individuals, municipalities, and others who are paying the bills for hospital services in the State.

The policy proposed by Staff removes the estimated $284 million overfunding from rates and appropriately shares the savings with the public. In addition to the fully insured members we serve, more than half of CareFirst's members are under administrative services only plans, meaning that CareFirst administers the benefits, but the account holds the risk and pays the bill. Therefore, reduced hospital rates would directly benefit employers that have suffered economic pressures brought on by the pandemic.

Again, we thank you for this opportunity to share our support and thoughts regarding the "CARES Funding Policy Update." We understand there will still be industry participation in the discussion around identification of COVID-related expenditures and which hospitals were disproportionately affected. We look forward to continued collaboration as this evolves.

Sincerely,

Maria Harris Tildon

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

JOHNS HOPKINS
MEDICINE

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

March 10, 2021

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the HSCRC CARES Funding Policy. JHHS generally supports the staff's position for the treatment of the CARES Funds within the HSCRC Rate Setting System. The policy has been thoughtfully developed and provides a fair and reasonable approach to the treatment of the funds. Developing a policy around the CARES Funding is critical in protecting the Maryland Model.

JHHS supports the principle that any hospital undercharges that the HSCRC allowed to flow from FY 20 into FY 21 rates should be offset for CARES Funds received from the Federal Government (HHS). This is consistent with the HSCRC position articulated in March 2020. While the HHS distribution of the CARES Funds and the HSCRCs treatment of those funds are related, they are two separate issues. We believe that the HSCRC has the authority to adjust hospital rates in a fair and equitable manner and also has the authority to consider other sources of funding that a hospital may receive. During these unprecedented times, the HSCRC adjusted their charging policies to allow hospitals to recover incremental revenues in FY 20, without penalty, to help assure adequate cash flow at the beginning of the pandemic. The flexibility that the HSCRC allowed in the rate setting system allowed for a higher level of financial stability than other hospitals across the country experienced. It is also important to acknowledge that these are one-time funds and will not impact a hospitals permanent rate structure moving forward.

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

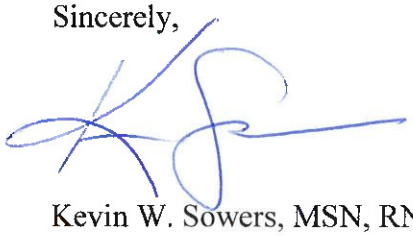
Katie Wunderlich
CARES Funds Policy
March 10, 2021

JHHS does believe that the adjustments made to rates should be done at the individual hospital level as that is how the CARES Funds were distributed. The GBR system operates at an individual hospital level and making adjustment at the system level could set a precedent for allowing movements of GBR dollars across hospitals within a system for other reasons. We believe that assuring that the rates a hospital charges are reasonably related to the underlying cost structures of that hospital are an important tenant of the HSCRC rate setting system.

We also realize that the settlement of the CARES Funds within the rate setting system will be a multi-year issue. As we are still in the midst of the Public Health Emergency, we understand that there could be additional funds distributed by HHS and that COVID expenses at the hospitals will also need to be considered. We appreciate the staff's consideration of these factors in the development and final settlement of any CARES Funds within the rate setting system.

JHHS appreciates the opportunity to comment on the CARES Funding Policy. We also commend the staff for their thoughtful work on developing a policy that balances the individual hospital impact with the overall performance of the state while taking into consideration the goals of the All-Payer Model and the Total Cost of Care Model.

Sincerely,



Kevin W. Sowers, MSN, RN, FAAN
President, Johns Hopkins Health System
EVP, Johns Hopkins Medicine

MedStar Health

10980 Grantchester Way
8th Floor
Columbia, MD 21044
410-772-6927 PHONE
410-772-6954 FAX
MedStarHealth.org

Susan K. Nelson
Executive Vice President and
Chief Financial Officer

February 24, 2021

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

Dear Chairman Kane:

On behalf of MedStar Health, Inc. and our subsidiary Maryland hospitals, we are providing comments on the CARES Funding Policy Update Presentation presented by the Health Services Cost Review Commission (HSCRC) Staff on February 10, 2021. We understand at this time this is not a draft policy to be voted on by HSCRC Commissioners and that it is stated in the presentation that the expectation is "to finalize approach in the March Meeting." We feel it is imperative to provide MedStar's position on the approach presented.

The presentation's approach is flawed for the following reasons:

1. **It is premature to evaluate Provider Relief Fund (PRF) payments received by hospitals and health systems before the U.S. Department of Health & Human Services (HHS) has finalized guidance on use of PRF payments and health systems have determined how to use the funds and whether they will need to return payments to HHS.** The pandemic is ongoing, and it is too early to draw conclusions on the status of PRF funding received by the health systems. Current HHS guidance indicates that PRF recipients must use their payments by June 30, 2021, and recipients must return to HHS any unused payments as of that date, although it is possible this deadline could be extended. Importantly, HHS expects health systems to allocate PRF payments across different care providers within the same system in order to coordinate its COVID-19 response, and many health systems have not yet made final decisions as to how payments will be allocated. Therefore, the proposed HSCRC approach is backwards - the HSCRC should wait <u>until after</u>, not before, any final determination of how those federal funds are allocated and used. Also troubling is that the proposed approach relies on incomplete funding data that is in flux and will continue to be updated. Most critically, every Maryland hospital is continuing to deal with the effects of the ongoing pandemic, including the high costs of labor and supplies, additional testing supplies, costs necessary to maintain the additional bed capacity, and the establishment of vaccination clinics. Given that the financial impact of the pandemic on hospitals and health systems is continuing, it would not be appropriate to take away financial resources needed to continue pandemic response efforts.

2. **The proposed approach would thwart the purpose of the PRF and take away the federal benefit that Congress and HHS intended for hospitals and health systems.** Congress and HHS intended for PRF payments to provide hospitals and health care providers with extraordinary relief to respond to an unprecedented, global public health

emergency. PRF payments are intended to reimburse health care related costs attributable to COVID-19 and/or to be a backstop against lost revenues due to the COVID-19 pandemic. The federal government has recognized that this will be a multi-year effort that will require accountability in complying with federal requirements but also flexibility with the changing nature of the pandemic. Therefore, the HSCRC should not make its own policy of characterizing PRF funding in a way that is inconsistent with the purposes for which PRF funds have been allocated under federal law. The HSCRC proposed approach would effectively take away financial resources from hospitals and health systems, essentially undoing the federal relief afforded by Congress.

3. **HSCRC does not have authority to treat PRF payments as revenue for hospital services that is subject to the GBR Agreements.** The HSCRC authorizing statutes and regulations, as well as the GBR Agreements, do not support the inclusion of the extraordinary federal relief provided under PRF as part of regulated revenue. To do so would suggest that other types of funding, including FEMA grants, state and local grants, research grants and even fundraising dollars, should also be considered part of revenues subject to HSCRC regulation. Consistent with its proper regulatory authority, the HSCRC cannot include these funding sources as part of revenue for inpatient and outpatient hospital services.

We would welcome a chance to discuss these points with you and other Commissioners given both the significance and complexity surrounding this topic.

Sincerely,

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

cc: Kenneth A. Samet, FACHE, President & CEO, MedStar Health, Inc.
Katie Wunderlich, HSCRC Executive Director
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayless, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner

TidalHealth™

Executive Office

100 East Carroll Street
Salisbury, MD 21801

410-543-7111

March 12, 2021

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

Dear Chairman Kane:

On behalf of TidalHealth we appreciate the opportunity to comment on Health Care Services Cost Review Commission (HSCRC) proposed action on U.S. Department of Health and Human Services (HHS) CARES Act funding and, specifically, the Provider Relief Fund (PRF) Payments.

1) HSCRC should not supersede HHS guidance and allowable uses.

HHS is the CARES funding grantor, and hospitals must follow HHS rules, terms, and conditions. The HSCRC proposal considers how hospitals *received* funding from HHS. However, HHS allows health systems to *use* funding broadly among their entities to coordinate their COVID response. This includes use of alternative sites and expanded outpatient and virtual access to health services. HSCRC should not ignore HHS guidance for these necessary and allowable uses.

The authority of the HSCRC is in question when considering granted funds outside of established regulation. It is alarming to consider where this action may lead to when considering alternative sources of funds such as investment income, state funding, grants, and foundation donations, etc. We have witnessed firsthand HSCRC staff indicate a willingness to consider or be influenced by these types of revenue streams and implement policy changes outside the purview of established regulation. The pace and direction of change is causing greater and greater concern and should be evaluated.

2) It is premature to determine the course of action.

The pandemic has not ended. Hospital volumes and COVID-related expenses are volatile and may not settle to normal until the end of calendar year 2022, if not later. Any hospital revenue adjustments should reflect the complete and full impact when the pandemic has passed. A $1.9T package was recently approved and may likely convolute the picture even further for rural hospitals. We should be maximizing federal support as these funds are not counted in the total cost of care calculations.

Maryland's hospitals appreciate the Total Cost of Care Model ("Model") guardrails and the need to manage the system within those borders. Projecting total state Medicare spending growth relative to the nation is not feasible with any degree of accuracy.

Given the unknown effect of financial support, service use, and ongoing COVID impact, we would suggest that the HSCRC work with the Centers for Medicare & Medicaid Services (CMS) to evaluate Maryland's performance during the pandemic over a multi-year period. The funding adjustments made by HSCRC and HHS are non-recurring, while the Model is designed to demonstrate savings over a longer period.

3) HSCRC rate action should be limited to the support HSCRC provided.

HSCRC supported hospitals in several ways, including guaranteeing global budget undercharge carry-forward, price corridor expansion, surge funding, and yet to be determined, expenses. If the HSCRC is compelled to adjust already distributed funds, future HSCRC rate adjustments should not exceed amounts placed in rates.

*****

Thank you again for allowing comments to contribute to this determination. If you have any questions, please feel free to contact me.

Sincerely,

Steven Leonard, PhD, MBA, FACHE
CEO/President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

Appendix C: Public Comment Letters Re: RY 2022 Update Factor Recommendation

Staff received the below comment letters regarding the Draft Update Factor Recommendation for RY 2022 that was presented at the May 2021 Commission meeting.

The Maryland Hospital Association

Johns Hopkins Health System

University of Maryland Health System

LifeBridge Health

Luminis Health

MedStar Health

CareFirst

Maryland
Hospital Association

May 19, 2021

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 appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) rate year (RY) 2022 annual payment update. Hospitals acknowledge the careful consideration commissioners and staff are putting into determining the payment update.

MHA members strongly urge the Commission to adjust the proposed rate update to account for the unprecedented and permanent inflation that is straining hospitals and health systems. We offer three recommendations.

1) Raise core inflation by 50 basis points. Maryland hospitals are facing real and significant cost inflation that is outpacing next year's proposed allowance. As reflected in the attachment, the most recent data indicate 2021 cost per adjusted patient day growing 3.4% over 2020, or 1% above HSCRC's measure of RY 2022 inflation. We respectfully ask the Commission to raise the annual core inflation factor from 2.37% to 2.87%; 50 basis points is half of the running cost variance.

2) Include 16 basis points for age-weighted population growth, allowing a basic demographic adjustment. Under a capped revenue system, including a fair amount for service growth – beyond which hospitals are at risk – is a core tenet. Age-weighting alone would yield 0.59% growth, which the staff proposal has scaled back to projected overall growth of 0.1%. Adding 15 basis points is one-fourth of the 0.59% age-weighted growth; this is equal to the prior year's allowance.

3) Suspend the productivity adjustment for psychiatric and specialty hospitals. We support HSCRC staff's proposal to suspend the productivity adjustment for psychiatric and specialty hospitals.

Please see the attachment (pages 3-5, plus exhibits) for further articulation of these points.

We state this position fully conscious of the Medicare guardrail. We firmly believe the guardrail will not be breached even with these changes. In any case, the palpable and lasting effects of the COVID-19 pandemic make the upward adjustments entirely justifiable if Marylanders are to continue to enjoy a robust hospital system.

MHA and our members appreciate your openness to input from the hospital field and we especially thank HSCRC for your understanding and remedial action during the unprecedented times brought on by COVID-19.

We look forward to discussing the update at the May 25 meeting of the Payment Models Work Group and at HSCRC's public meeting June 9, as we continue to work together on behalf of the people and communities we serve.

Sincerely,

Brett McCone
Senior Vice President

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

Enclosure

SUPPLEMENT TO COMMENTS ON RY 2022 PAYMENT UPDATE

Hospital Cost Inflation Will Outpace IHS Markit's Hospital Market Basket

All-payer, per capita hospital spending in Maryland is affordable. Hospitals face tremendous cost pressures that are not of their own making. Though some immediate COVID-19 cost pressures were relieved by federal provider relief funds and HSCRC action, **the RY 2022 figure does not reflect true, *permanent* cost growth** that will endure after the pandemic subsides.

- **Cost per equivalent inpatient day,** reflecting net expenses, **grew 3.4%** for the eight months ending February 2021 compared to the twelve months ending June 2020.
    - This is **more than 1% above projected rate year 2022 inflation** of 2.37%, 0.63% above 2.77% granted in 2021, and 1.3 % above IHS revised 2021 inflation figure of 2.09%
    - Cost per equivalent inpatient day for the same period **grew 9.0%** from the eight months ending February 2020 in rate year 2021
- If 2021 cost growth is **1% above future inflation**, even if half of the excess cannot be justified, **0.50% is reasonable.**
- Included in our next expense growth is a sharp increase in contract labor cost. Data gathered from Maryland hospitals reflect:
    - 2021 annualized **contract labor costs of $486 million**
    - **92% jump** from $250 million in 2020
    - **129% explosion** from $210 million in 2019. The increase from **2020 to 2021 is more than 1.2% of statewide hospital revenue**.
- As the labor market tightens, salaries and wages are rising. Hospitals are experiencing high levels of retirement, burn out and new nursing staff turnover requiring much higher base salaries.
- Mandates and voluntary actions to raise starting wages to $15 per hour, especially in non-hospital services, are forcing higher hourly wages for clinical and other support staff.
- According to Qualivis data for traveling nurse demand, Maryland is the 7th highest in nursing demand.

When federal provider relief funds and HSCRC actions conclude, **margins will significantly decline as cost pressures remain**. The statewide, unaudited hospital margin for the eight months ending February 2021 was 4.7%. This is largely thanks to HSCRC and federal interventions, combined with hospitals extraordinary cost management efforts. Excluding other operating revenue that reflects provider relief funds, net patient service margin was -4.3%. Cost pressures will not abate in 2022 as the temporary supports conclude.

IHS Markit's 2022 inflation figure of 2.37% is inconsistent with the stark cost increases faced by Maryland hospitals. During the period 2014-2019, the "actual" market basket inflation was. 2.1%, measured a year or two after the initial release. We analyzed HSCRC annual filing data for the same period and **calculated weighted cost per unit of volume growth to be 2.65%.** This is a conservative estimate. When we account for allowance for indirect cost it **rises to 3.35%**.

IHS projects hospital malpractice expense to grow 1.8%. This may be valid as a national average, but it is much lower than what we see in Maryland. **Maryland's malpractice costs rose 59%** from 2014 to 2019. (2020 data are not yet available)

It has been several years since HSCRC reviewed the underlying inflation calculations. We strongly support a new review to thoroughly analyze the inputs to projected inflation.

Add 0.15% for Age-Weighted Population Growth

We appreciate the constraints of the Total Cost of Care Model, including the per capita growth limit. Due to the aging of the population, age-weighted growth, including a reduction for potentially avoidable utilization, is projected to be 0.59%. This amount is then scaled to 0.01% overall population growth as projected by the Maryland Department of Planning. Medicare beneficiaries, however, will grow by more than this figure. The annual payment update is uniform across *all* payers. So, if the Medicare population increases 0.59%, implicit per capita Medicare growth *must* be lower than the average.

We welcome an assessment of the population growth data. The Maryland Department of Planning uses U.S. Census Bureau data where data are recorded only once every ten years.

Medicare Guardrail Considerations

HSCRC staff agree that Maryland and national spending per beneficiary growth for 2021 is not accurately predictable due to COVID-19. Despite the pandemic, Maryland must consider our Medicare Total Cost of Care guardrail when determining a reasonable 2022 payment update. The following points support a common goal – appropriately constraining per capita Medicare spending – yet allow for the extraordinary nature of the COVID-19 pandemic.

1. We encourage HSCRC and the Center for Medicare & Medicaid Innovation (CMMI) to take a **long view of the Model and savings targets.** Maryland's rate setting system provided the unique opportunity to stabilize rates during the COVID-19 pandemic. This will result in a two- to three-year volatile period as year-over-year global budgets reflect both under- and over-charges. The Model was designed to test per capita incentives over a *longer* period.
    - The attached slides reflect favorable Maryland performance when compared to a multi-year average of spending per beneficiary, in every year except 2017.

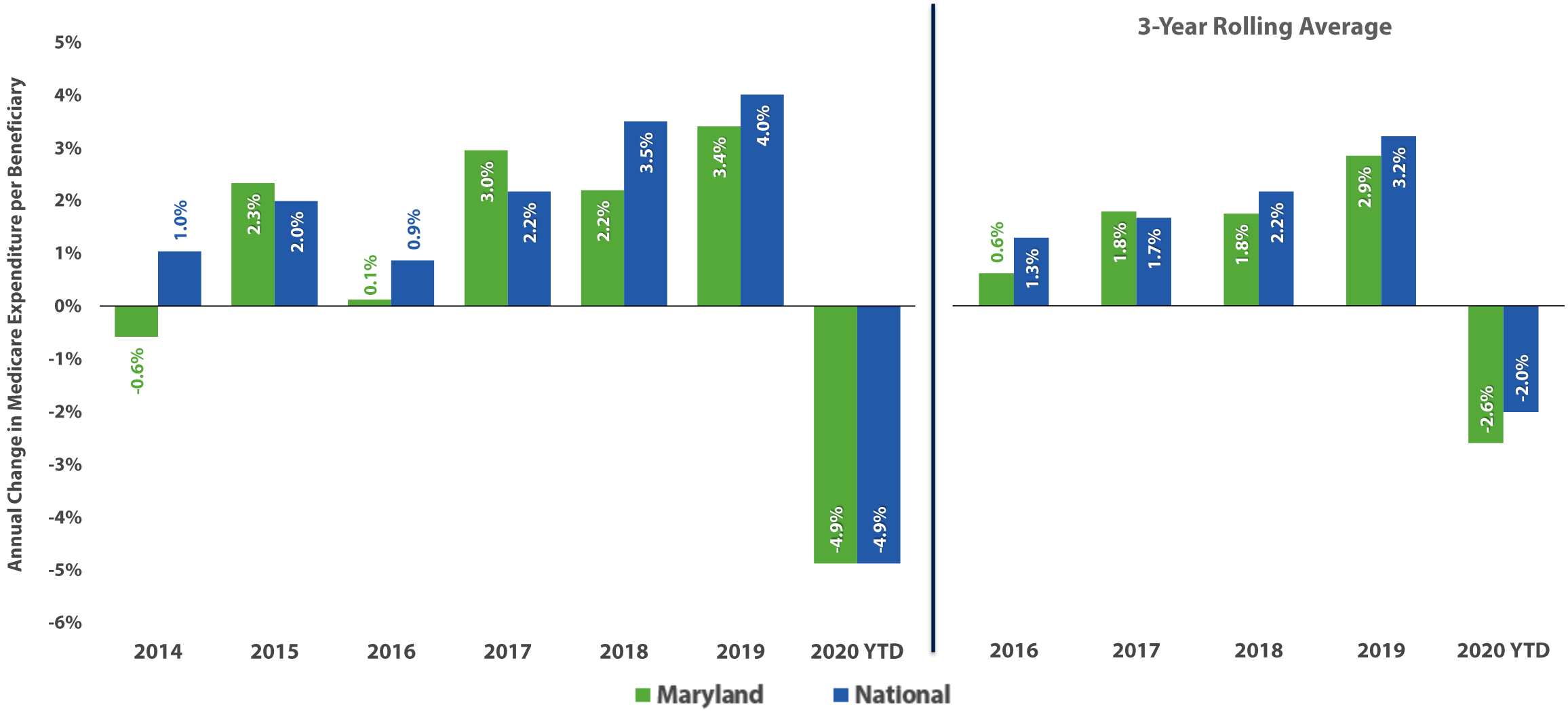
2. Like HSCRC's view of hospital financial performance, CMMI should **look at 2020 and 2021 combined.** Because Maryland's total cost of care growth was below the nation in 2020, the agreement allows for 2021 total cost of care to grow up to 1% more than the national rate. Like the rest of the country, Maryland's hospitals focused on delivering the highest quality of care and protecting lives during the pandemic, not on generating savings. Yet Maryland did produce a small amount of total cost of care savings in 2020. This amount should be allowed to serve as a cushion for calendar year 2021 growth.

3. The contract requires HSCRC to consider total cost of care, not just hospital costs, when setting hospital rates. However, **non-hospital providers absorb no financial risk** as a result of the annual constraint. In 2020, Maryland's hospital spending per Medicare beneficiary declined 3%, while the nation declined 5.2%. Because the hospital base in Maryland did not decline as fast as the nation, we fully expect hospital spending to grow below the national rate in 2021. In the face of rising inflation under a capped system, Maryland hospitals should not bear the entire risk for non-hospital growth during this unique period.

4. The year-over-year guardrails govern only Medicare spend per beneficiary. Maryland has consistently delivered all-payer hospital savings per capita. If HSCRC is concerned about the Medicare guardrail, an option would be to implement the Medicare Performance Adjustment Savings Component and **deliver direct savings to Medicare** in the form of lower payments.

5. **CMS's Inpatient Prospective Payment System (IPPS) proposed rule provides for inpatient price growth of 2.8%,** including one-time adjustments. CMMI should avoid short term volatility. However, proposed inpatient *price* growth, even if volumes do not rise, is greater than total Medicare *revenue* growth in Maryland.

ANNUAL CHANGE IN MEDICARE SPENDING PER BENEFICIARY



Source: CMS monitoring data
Note: Data contain summaries prepared by HSCRC based on data summaries provided by the federal government; data are preliminary and contain lags in claims and there may be material differences in results when final data are received

Ed Beranek
Vice President of Revenue Management and Reimbursement
3910 Keswick Road
South Building / 4th Floor
Suite S-4200D
Baltimore, MD 21211
443-997-0631/FAX 443-997-0622
Jberane1@jhmi.edu

May 19, 2021

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

Dear Ms. Wunderlich:

On behalf of the Johns Hopkins Health System (JHHS) and our 4 Maryland hospitals, we appreciate the opportunity to comment on the commission's Draft Recommendation for the Update Factors for Rate Year 2022.

JHHS supports a healthy Rate Year 2022 update factor that will help hospitals afford continued investments in population health as well as the supporting the financial challenges hospitals are facing in the current economy.

The staff recommendation follows the historic process for calculating the update factor balancing underlying inflation, changes in population, other individual hospital adjustments with the overall projected performance on the waiver test. We believe that other components also need to be considered this year in light of the current economy. JHHS has seen dramatic increases in the cost of agency labor in recent months and believe that these increased costs will continue for the foreseeable future. Under the fixed revenue model of GBR, it becomes increasingly difficult to deal with these unanticipated cost pressures without some level of incremental rate authority. We respectfully request that the HSCRC take these rising costs into consideration in the approval of the FY 2022 Update Factor by adding additional funding to help cover these increases.

Thank you again for your consideration of this issue. If you have any questions, please feel free to contact me.

Sincerely,

Ed Beranek

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

UNIVERSITY of MARYLAND MEDICAL SYSTEM

900 Elkridge Landing Road
4th Floor East
Linthicum Heights, Maryland 21090
www.umms.org

Finance Shared Services

May 19, 2021

Re: Draft Recommendation for the Update Factor for Rate Year 2022

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

Dear Katie:

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 2022.

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

An additional inflation amount should be provided to fund incremental labor cost increases

UMMS strongly supports MHA's proposal to provide an incremental 0.50% inflation provision. Hospitals will continue to experience incremental expenses in FY 2022 due to the COVID pandemic. As outlined in MHA's letter, hospitals are experiencing large increases in contract labor for nursing and other clinical staff due to shortages in permanent employees. Increased staffing ratios and supply and drug cost for COVID patients have also created cost pressures. Although these costs are expected to be lower in FY 2022 compared to FY 2021, UMMS hospitals are projecting contract labor expense in FY 2022 to be 45% higher than FY 2019 and FY 2020. Similarly, UMMS is projecting salaries to be significantly higher (after removing the impact of inflation) than pre-COVID salary expense due to increased staffing ratios for COVID patients and higher base rates. Based upon UMMS FY 2022 cost projections, the 0.50% increase will not fully cover the incremental contract labor, salary, supply and drug cost, however, it will provide much needed relief.

CARES Act funding has provided much needed support in FY 2021, but the elimination of this funding and an inflation provision that represents 'business as usual', while hospitals continue to experience new incremental costs is creating significant budget constraints that exceed a normal year. The annual reduction in Global Insights inflation of 0.24% for PAUs also continues to create difficulty for hospitals to fund annual merit increases, market adjustments and other normal inflationary cost. The combined impact of these items, plus a demographic adjustment of just .01% also stand to support this request.

UMMS respectfully requests the HSCRC consider the MHA proposal to increase the FY 2022 inflation by 0.50%. It is unclear if the incremental staffing and contract labor cost increases will continue into FY 2023. As such, we would be supportive of the HSCRC evaluating the need for the continuation of the 0.50% increase into FY 2023.

We urge the Commission to consider the following points when evaluating the requested inflation increase:

- TCOC savings have significantly exceeded Medicare Savings targets since the inception of the model. The additional amount requested for inflation would only have a minor impact to the aggregate savings amounts.
- Maryland has not exceeded the national growth rate in the current term of the TCOC agreement. Even if the incremental inflation requested in FY 2022 caused the TCOC growth rate in Maryland to exceed the nation, it would not cause a triggering event.
- Per capita growth, per Table 2 is expected to be 2.07%, well below the 3.58% all payer growth ceiling

Demographic Adjustment should be revisited with the release of 2020 Census data

UMMS would like to express our ongoing concern regarding the continued diminishment of the annual demographic adjustment and the significant variances that exist between the MD Department of Planning and CLARITAS population estimates each year. UMMS supports MHA's recommendation to fully evaluate the demographic adjustment methodology and sources as new census population data become available over the next year.

Innovation Policy funding levels are appropriate

UMMS fully supports additional funding for innovation and complexity at University of Maryland Medical Center (UMMC) and Johns Hopkins Hospital (JHH). Each year, new treatments and therapies emerge from the research laboratories of Academic Medical Centers (AMCs) that have the potential to significantly improve survivability and the quality of life for people with diseases that were previously considered untreatable. During the COVID emergency, the AMCs saw a slight decline in volume due to the pause placed on elective procedures. During the early part of FY 2021, however, the AMCs are experiencing significant increases in

these medically complex cases, which is now surpassing the decline experienced in the prior year. We fully support the 0.10% funding allocated to the AMC hospitals by the commission staff for RY 2022.

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

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc:

Adam Kane, Chairman	Sam Malhotra
Joseph Antos, PhD, Vice Chairman	Katie Wunderlich, Executive Director
Victoria W. Bayless	William Henderson, Principal Deputy Director
Stacia Cohen, RN	Jerry Schmith, Principal Deputy Director
John M. Colmers	Mohan Suntha, MD, MBA, UMMS Chief Executive Officer
James N. Elliott, MD	Michelle Lee, UMMS Chief Financial Officer

LIFEBRIDGE HEALTH

May 19, 2021

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

Dear Katie –

On behalf of the LifeBridge Health System and its five member hospitals (Sinai, Northwest, Carroll, Grace and Levindale), thank you for the opportunity to comment of the rate year 2022 annual update factor recommendation.

Similar to previous years, Staff has outlined a comprehensive and balanced approach to evaluating the annual update that considers the overarching goals of the Maryland model and staying within the guardrails of the national total cost of care growth rate. At the same time, we do want to draw attention to the continuing circumstances and environment we are operating in and offer that it fairly suggests consideration of an increase to the core inflation recommendation of 2.14% (excluding the high-cost drug add-on).

Specifically, hospitals most significant cost component of labor resources (both employed and through use of contracted agency) has escalated dramatically in just the past several months. At LifeBridge we were already in the process of implementing market and equity-based compensation increases for nurses and other recruitment sensitive categories such as central sterile and surgical technicians. At the same time LifeBridge had accelerated its decision of bringing all employees to the standard living-wage of $15/hour, which we are considering increasing further still. Consistent with a multitude of media outlet reports indicating a rapid and new escalation in inflation with prices for consumer goods and services increasing 0.8% in April, we believe the increases in labor outlined above have rapidly emerged and are not adequately captured in the first quarter inflation index currently being utilized to develop the recommendation of 2.14%.

LifeBridge is extremely appreciative of the HHS CARES Act Provider Relief Funds and the expanded corridor and surge policies enacted by the HSCRC to support stable and sustainable operations for delivering care during the pandemic. It has has allowed us to retain staffing, absorb the unevenness of volatile volume patterns, obtain necessary PPE and continue uninterrupted numerous population health and total-cost-of-care initiatives we've been working-on for some time now. Nonetheless, the CARES funds being recorded in the current year and likely to have been fully recorded by year-end, will no longer offset the longer-term inflationary pressures currently being experienced and expected to continue throughout rate year 2022.

In summary, we believe the inflationary cost pressures that LifeBridge and other hospitals are now experiencing, particularly with respect to labor market demands, have not been fully captured and reflected in the current update recommendation and warrant consideration of the core inflation factor being increased for rate year 2022.

As always, should you wish to discuss this issue in greater detail, please do not hesitate to reach-out to us directly.

Sincerely,

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

CC: Adam Kane, Esq.
HSCRC Chairman

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000 | luminishealth.org

May 19, 2021

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

Dear Chairman Kane,

On behalf of Luminis Health, thank you for the opportunity to comment on the draft RY2022 Update Factor recommendation. We appreciate the Staff's thoughtful analysis and the Commission's support of hospitals as we manage through the COVID-19 crisis.

As we continue to battle the consequences of the COVID-19 pandemic, we are concerned that the inflation adjustment recommended in the policy doesn't keep pace with the most recent Maryland hospital experience. Similar to that of other health systems regionally and nationally, Luminis Health has experienced abnormally high personnel, contracted labor, and supply and drug costs over the past year. Pre-COVID inflation rates on fixed and variable costs for Luminis Health hovered at 4.1% year over year (FY2018-FY2020). However, during FY2021 our hospitals experienced inflation rates of 5.6%, which were driven by contracted labor (48% increase over FY2020) coupled with pharmaceutical and supply costs, which increased 17% and 10% over FY2020, respectively.

These resources are necessary to provide safe, high-quality care to the communities we serve. Moreover, in order to invest in important care initiatives such as population health, SIHIS, and behavioral health, the update factor for RY2022 should align with the cost pressures experienced during the height of the COVID-19 pandemic.

Additionally, we recommend using an age-weighted demographic adjustment to reflect the higher costs of an aging population. We are confident that with these adjustments, we will continue to meet the Medicare Total Cost of Care target. Our success to date reflects the commitment of all Maryland hospitals to meet and exceed this goal.

Thank you again for the opportunity to provide comments as we continue our effort to transform our care delivery system.

Sincerely,

Sherry B. Perkins, Ph.D., RN, FAAN
President, Anne Arundel Medical Center

Deneen Richmond, MHA, RN
President, Doctors Community Medical Center

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
James Elliott, M.D.
John M. Colmers
Stacia Cohen, RN, MBA
Sam Malhorta
Katie Wunderlich, Executive Director
Jerry Schmith, Prinicipal Deputy Director

MedStar Health

10980 Grantchester Way
8th Floor
Columbia, MD 21044
410-772-6927 PHONE
410-772-6954 FAX
MedStarHealth.org

Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 19, 2021

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

Dear Chairman Kane,

On behalf of MedStar Health, Inc. and our subsidiary Maryland hospitals, we are providing comments on the Draft Recommendation on the Update Factors for Rate Year 2022 presented by the Health Services Cost Review Commission ("HSCRC") Staff on May 12, 2021. MedStar Health continues to be extremely concerned with the HSCRC's proposed "reconciliation" of CARES Act Provider Relief Fund support, as it would inappropriately strip MedStar Health hospitals of CARES Act funding granted by the federal government and redistribute those funds for the benefit of the Maryland waiver "system." The HSCRC's proposal goes beyond the HSCRC's authority under federal and state law. It also undermines the important policy goal of promoting innovation and advances in the provision of healthcare services.

In earlier meetings and discussions, the HSCRC appeared to recognize that it lacks authority to regulate federal CARES Act funding and had indicated that it would focus on appropriate rate-setting methodologies specific to HSCRC-provided relief. But despite those statements, the fundamental problem with the HSCRC's proposal has not changed. Under the most recent version of its proposal, the HSCRC is still seeking to require MedStar Health and other hospitals to "use allocated regulated CARES funding" not as the federal government directs, but rather based on the priorities and according to the direction of the HSCRC.

1. The HSCRC's proposal is contrary to the federal CARES Act and in excess of the HSCRC's proper authority.

The HSCRC's proposed policy is contrary to and undermines the objectives of the federal CARES Act. Congress enacted the CARES Act and appropriated billions of dollars for the Provider Relief Fund in response to an unprecedented global public health emergency. Moreover, in implementing the federal CARES Act, the Secretary of Health and Human Services has issued detailed guidance concerning eligibility, terms and conditions, and reporting requirements. Hospital systems that receive federal CARES Act funding are required to account for the funds they have received, and they are not entitled to additional federal funding beyond what the federal government permits under the program.

The federal funding provided under the CARES Act was not appropriated by Congress as a general fund for hospital services. Nor has Congress granted state regulators authority to determine how CARES funds may be used. Instead, the funds are designed to reimburse eligible healthcare providers for expenses and lost revenues attributable to COVID-19. The funds thus operate much like other federal emergency grants. Indeed, Congress created the Provider Relief Fund—or, more formally, the "Public Health and Social Service Emergency Fund"—to respond to public health emergencies. That is why the Provider Relief Fund seeks not only to help providers that are struggling financially, but also to bolster the capacity of the entire health care system's infrastructure for managing a national emergency. Importantly, the federal government recognized that health care systems have discretion to allocate Provider Relief Fund within the systems' provider network in order to best respond to the COVID-19 pandemic. In other words, under the federal CARES Act, it is the health care providers themselves (and not state or local agencies) that determine the specific allocations and uses of Provider Relief Fund dollars to combat COVID-19.

Not surprisingly, the funds provided by Congress under the Provider Relief Fund are subject to strict federal oversight to ensure that they are properly used in furtherance of federal policies and for the purposes for which Congress appropriated them. The CARES Act requires that recipients demonstrate lost revenues and expenses attributable to COVID-19, *excluding* expenses and losses reimbursed from other sources. Any Provider Relief Fund monies that are not fully expended on expenses and revenues attributable to COVID-19 at the end of the final reporting period must be returned to HHS. Moreover, recipients who receive one or more payments exceeding $10,000 in the aggregate are required to report on their use of federal funds as part of a post-payment reporting process. In addition, recipients who receive more than $750,000 in federal funds, including payments under the Provider Relief Fund and other federal financial assistance, are subject to outside auditing requirements. To ensure that providers who benefit from Provider Relief Fund payments do not obtain improper recoveries, the providers are also required to report their other COVID-19-related assistance, including from Treasury, the Small Business Administration, the Paycheck Protection Program, FEMA, CARES Act testing activities, and business insurance. All recipients are subject to audit by government authorities to ensure they meet all applicable terms and conditions.

By redirecting federal funds for the benefit of the Maryland waiver "system," the HSCRC's proposal second guesses the careful federal judgments of Congress and federal regulators and conflicts with the intended purpose and requirements of federal law. In purporting to "reconcile" CARES Act funds, the HSCRC is effectively seeking to give more federal funding to hospitals that under federal law are not entitled to more funds, while stripping federal funding from hospitals (such as MedStar Health) that under federal law are entitled to use the funds for the purposes that federal law permits. In addition, the HSCRC is seeking to direct how federal CARES Act funds should be used, requiring that the funds not be used as intended under federal law, but rather that the funds be redistributed to other Maryland hospitals for the benefit of the Maryland system.

The HSCRC has no authority to substitute its general redistributive goals for Congress's specific, emergency-related objectives. Specifically, the HSCRC has never identified any authority under either federal or state law that permits it to regulate CARES Act funds. While the HSCRC has authority to regulate charges for hospital services, the funding provided by Congress through the Provider Relief Fund is not a payment for hospital services. The CARES Act did

include other provisions that temporarily increased Medicare reimbursement, allowed deferred payments of social security taxes, and expanded the Medicare Accelerated and Advance Payment Program. Separate from these other forms of federal assistance, Congress provided financial support under the CARES Act Provider Relief Fund, which is conceptually similar to grants and other forms of support the federal government has provided in other contexts to stabilize systems and mitigate harms in times of crisis. These funds were not provided by Congress to pay for services, but rather to backstop the nation's healthcare providers as they incurred additional healthcare-related expenses and lost revenues attributable to the COVID-19 pandemic. In short, these federal funds are not subject to regulation by the HSCRC.

2. The HSCRC's proposal is contrary to sound healthcare policy.

The HSCRC's proposal to redistribute CARES Act funds is premised on a misunderstanding of MedStar Health's performance under its GBR Agreement for FY20. The HSCRC acknowledges that MedStar Health experienced an undercharge at approved rates for the services provided in FY20. To the extent that MedStar Health's undercharge was smaller than other providers in Maryland, this was due to its extraordinary efforts to respond to the pandemic and its long-term strategic investment in innovative approaches to ensure that it could continue to provide essential services to patients. These efforts meant that MedStar Health hospitals were able to recover volumes at a faster pace after the first "surge" while managing higher patient acuity levels and continuing to treat COVID-19 patients, as depicted in the attached **Exhibits A and B**.

As part of its efforts to improve services, MedStar Health deployed its distributed care delivery network—its "One MedStar" approach—to achieve efficiencies across its system, implement uniform policies and procedures, enhance capacity for treating patients, and improve care provided to patients. During the COVID-19 pandemic, MedStar was able to leverage this care-delivery model to meet the pandemic's many challenges. For example:

- Innovations to better load balance patients. MedStar Health's distributed care delivery network allowed MedStar Health to quickly allocate resources and expertise based on need, which meant that MedStar Health was able to successfully load balance patients across its system and thereby avoided the high rates of diverted patients that certain other systems experienced during COVID-19 surges. In particular, MedStar Health established a MedStar Transfer Office, managed by senior clinical leaders, which oversaw twice daily assessments with representatives from all 10 MedStar Health hospitals to evaluate current and anticipated bed status across the system, including examining intensive care, intermediate care, medical-surgical, emergency department, and other specialty bed types. This system-wide process allowed MedStar Health to manage patient flow and maintain capacity at each of its locations while not overwhelming any individual site of care and ensuring that it was prepared to manage any surge of patients at one or more hospitals. This resulted in MedStar Health achieving lower patient diversion rates compared to certain other systems in the region, as shown in the attached **Exhibit C**. Indeed, a similar transfer process was later implemented by the Maryland Institute of Emergency Medical Services Systems as the model for load balancing ICU beds across the entire State of Maryland.

Using these same innovations, MedStar Health successfully managed its scarce resources, including ventilators. Rather than moving ventilators between hospitals, MedStar Health developed a new standard of care to safely move patients to available ventilators in locations across its system. MedStar Health's approach was similar to high-performing health care systems across the country.

- Improved telehealth services. Even before the pandemic, MedStar Health was using telehealth and other connected care models to improve access, coordinate care, and optimize utilization of services. As part of its response to COVID-19, MedStar Health exponentially increased telehealth capacity across its entire system. That included rolling out telehealth for scheduled office visits to more than 4,000 providers in a few weeks' time and expanding acute telehealth consultations to all of its emergency departments and urgent care locations. Between mid-March 2020 and 2021, MedStar Health delivered more than 772,750 telehealth video sessions and 173,880 audio sessions across its entire system.

  To further care for the community and to manage the threat of COVID-19, beginning in March 2020 MedStar Health waived all fees for its MedStar eVisit on-demand urgent care video visit platform, offering free access 24 hours a day, seven days a week, to online MedStar Health providers. Maryland residents have since received 49,850 zero-cost visits on the eVisit platform for general acute care management, COVID-19 focused care, and navigation to in-person testing and other services.

  By dramatically increasing its capacity for telehealth, MedStar Health was not only able to treat more patients efficiently during the management of the COVID-19 pandemic but also to speed the pace of an overall systematic transformation in how it delivers care, providing the right care, at the right time, and in the right setting. MedStar Health has been nationally recognized for its innovations in telehealth during the COVID-19 pandemic and, in particular, for its "proven success using telehealth to improve population needs and close inequities in care." Becker's Hospital Review, *Celebrating healthcare organizations who made a considerable impact in their communities through virtual care* (May 7, 2021).

- Innovations in integrating and enhancing care. MedStar Health deployed its distributed care delivery network to provide more efficient care across the region. For example, MedStar Health used its urgent care and ambulatory care network to manage outpatient COVID-19 testing and triaging, which allowed MedStar Health hospitals to focus on treating very sick patients (both COVID-19 and non-COVID-19 patients). MedStar Health also activated an EHR algorithm to identify COVID-19 patients that could potentially be transferred to palliative care. Similarly, MedStar Health leveraged its inpatient rehabilitation hospital and home health agency to safely move more COVID-19 patients out of hospitals and into post-acute care settings, so it could expand its care of COVID-19 patients.

These advances and innovations contributed to MedStar Health's ability to navigate through the multiple COVID-19 surges while recovering its non-COVID-19 care volumes. In fact, over the past year, MedStar Health has treated approximately 1 in 4 COVID-19 inpatients in the Maryland/D.C. region. For these extraordinary efforts to continue serving patients and delivering

better value at lower cost, MedStar Health's efforts should be encouraged, not penalized through the inappropriate redistribution of federal CARES Act dollars.

3. The HSCRC relies on a flawed methodology in calculating the impact of corridor relief granted to Maryland hospitals.

The HSCRC's proposal incorporates a calculation of COVID-19 corridor relief, but the methodology used by the HSCRC staff is flawed. Specifically, the HSCRC staff utilized a measurement of corridor relief that is inconsistent with the HSCRC's approved policy to measure unit rate compliance under the Global Budget Revenue model. An appropriate reconciliation of COVID-19 relief would entail an evaluation of the data over the entire period of the pandemic. MedStar Health would welcome continued discussions with the HSCRC on an appropriate reconciliation of COVID-19 relief.

For all of these reasons, we strongly urge the HSCRC to reconsider its reconciliation of CARES Act Provider Relief Fund and HSCRC-support included within the latest Draft Recommendation on the Update Factor for FY2022.

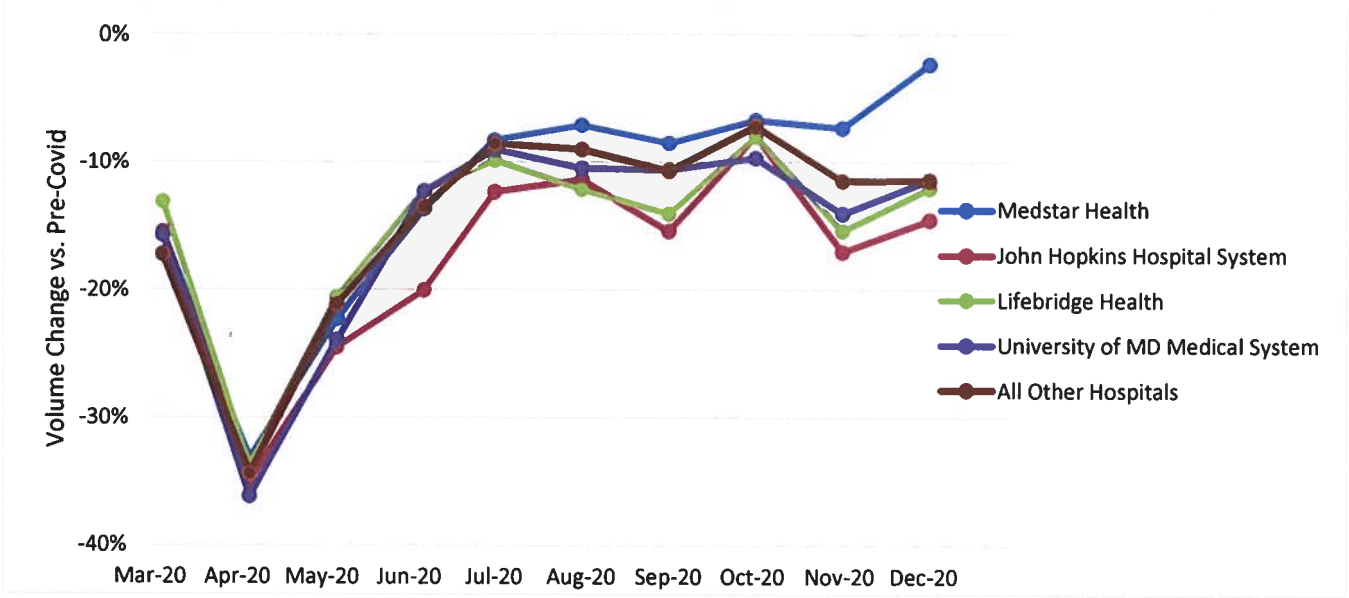
Sincerely,

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

cc: Kenneth A. Samet, FACHE, President & CEO, MedStar Health, Inc.
Katie Wunderlich, HSCRC Executive Director
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayless, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner

EXHIBIT A

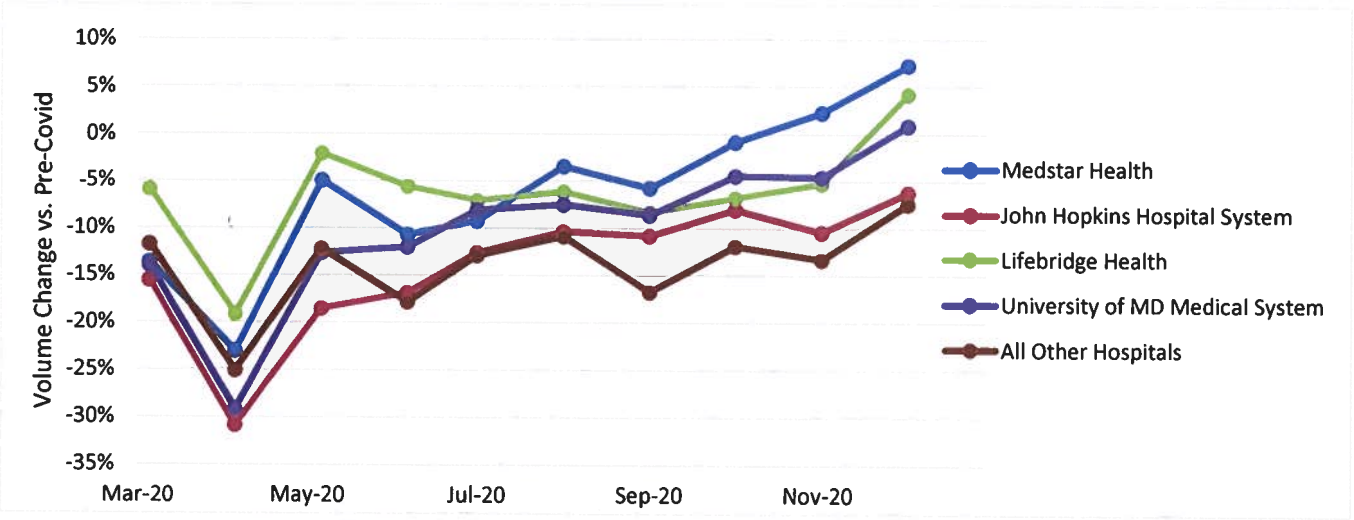
Change in Admissions and Observation across Maryland Systems



Source: Sinai Report which contains information on 23 of 46 Hospitals in the State.
MedStar includes all MD hospitals

EXHIBIT B

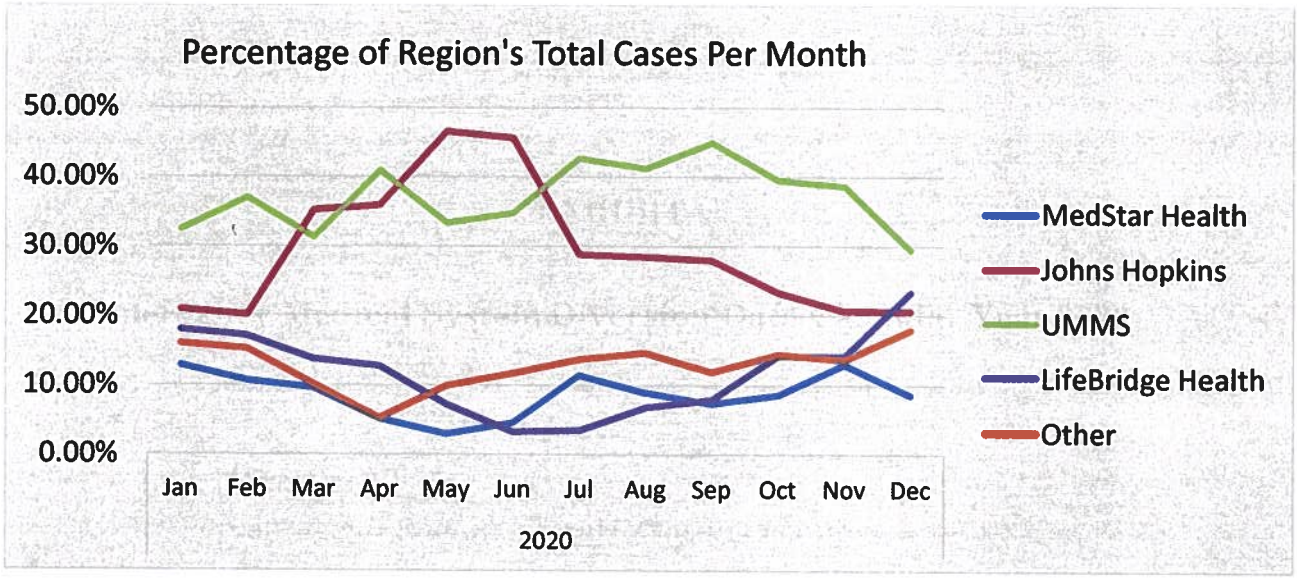
Change in Patient Days across Maryland Systems



Source: Sinai Report which contains information on 23 of 46 Hospitals in the State.
MedStar includes all MD hospitals

EXHIBIT C

Emergency Medical System Diversion Data Calendar Year 2020



Source: Maryland Institute of Emergency Medical Services System "MIEMSS" website

Maria Harris Tildon
Executive Vice President
Public Policy & Government Affairs

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-505-2855

May 19, 2021

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

Dear Mr. Kane:

Thank you for the opportunity to provide CareFirst BlueCross BlueShield's comments on the "Draft Recommendation for the Update Factor for Rate Year 2022" which will be applied to hospital rates effective July 1, 2021.

Due to various volume fluctuations and policy changes over the past nearly year and a half, HSCRC Staff encountered new challenges in setting the update factor for FY 2022. We commend Staff for working through these issues and presenting an overall balanced approach to the RY 2022 update factor. We also appreciate the valiant efforts of hospitals and health care professionals in playing a major role in bringing Maryland, we hope, to the brink of navigating through the COVID-19 pandemic.

We have consistently supported a formulaic approach to the annual update factor, and we appreciate that Staff, despite an unusual year, stuck with their principled calculation which promotes predictability, transparency, and objectivity in the process. We believe the results presented in the Draft Recommendation of 2.23% revenue growth and 2.07% per capita growth in FY 2022 represent reasonable magnitudes and are not overly conservative. While the recommendation demonstrates that this update actually drives an increase in hospital spending in CY2021 of 8.38%, we understand much of this is driven by CY2020's decline in utilization.

We find the Staff's approach and result prudent and reasonable, and below, we offer our perspective on several points within the recommendation:

1. **Update Factor as a Savings Lever –** In recent years, the Commission has concentrated their efforts to achieve system savings through the annual update factor. To achieve success toward this goal, the Commission will need to take a reasonably conservative approach each year when addressing the update factor, since it has been described as the primary savings lever within the system. System savings can be used to allow payers and purchasers of care to share in the return on investment from infrastructure costs that have been included in rates, and updated, since the inception of the All-Payer Model in 2014. We recognize and appreciate the need for hospitals to have sufficient revenue to provide necessary hospital services and invest in improving population health across the State. This requires a delicate balance which, given other factors included in this recommendation (such as the CARES settlement), we believe Staff has achieved for FY 2022.

2. **Favorable CARES Settlement –** while we support the settlement approach to CARES funding, the methodology is relatively favorable for hospitals, as (1) it only considers funding received through the CARES Act, excluding other potential sources of support made available to hospitals from the federal, state, and local governments, such as FEMA support, and the American Rescue Plan Act of 2021; (2) it limits recoupment of funds to what was charged through COVID corridor expansion; and (3) it allows hospitals to use the more favorable of an individual hospital's regulated to unregulated ratio OR the statewide ratio to allocate CARES funding to regulated services.

3. **Guaranteed FY2021 GBR** – if the Commission guarantees FY 2021 GBRs, as was done for FY 2020, hospitals will likely be able to recover residual undercharges in FY 2022 which will increase revenue over the proposed update. If this occurs, while hospitals may be entitled to these revenues, it will impact charge growth in that year. It remains to be seen whether this will be necessary or how much may be shifted from FY 2021 to FY 2022.

4. **Potentially Avoidable Utilization (PAU) Adjustment –** we continue to support the PAU adjustment, which removes inflation on PAU volume remaining in the hospital. We are encouraged that over the past year staff has endeavored to expand the scope of PAU to prevention indicators for pediatrics, and eventually potentially avoidable emergency department visits. We also look forward to working with the Commission to further broaden the scope of PAU in the future. As for the update factor, it makes intuitive sense to discontinue inflation on the avoidable utilization that remains in the hospital.

5. **Affordability and Guardrail Tests –** we continue to believe a savings estimate vs. Medicare as well as an affordability comparison to State GDP are appropriate steps to take in considering the reasonableness of the result produced by the update factor formula. We understand this year's savings estimate had to be calculated differently given the differences between Maryland and the nation. We support Staff's plan to revert to using actual national total cost of care growth from the previous year in future policy decisions. The alternative approach taken this year appears reasonable given the circumstances and yields marginal anticipated savings with the proposed update.

6. **Demographic Adjustment** – finally, we continue to support Staff's demographic and population growth adjustment, which annually is driven by the Department of Planning's year-over-year growth estimate. We understand this has historically been used in conjunction with the market shift adjustment to achieve a 50% variable cost factor for changes in utilization. We consider this part of the formulaic calculation that has been developed and adhered to by Staff in recent years and we understand Staff has validated that hospitals have been more than adequately funded for volume changes under this methodology.

Overall, our comments above demonstrate that the update factor incorporates several elements that are favorable for hospitals (guaranteed revenues in FY2020 and FY2021 and favorable CARES settlement policy), yet still manages to land in a reasonable place generating anticipated savings. Staff has presented in various public meetings and workgroups on the financial condition of hospitals, demonstrating the GBR and the HSCRC's rate accommodations throughout the pandemic have enabled them to maintain both strong balance sheets and income statements. We understand the pandemic continues and so too do its associated costs; however, we believe hospitals are well positioned entering FY2022 with the proposed update.

Thank you again for this opportunity to comment on the Draft Update Factor Recommendation and we thank Staff for expediting necessary policy change and pivoting on policy, as necessary, in recognition of

the unprecedented need for health care services during the pandemic. We appreciate the efforts of Staff to ensure savings and affordability for Marylanders and we look forward to working with you to that end.

Sincerely,

Maria Harris Tildon

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