

Maryland Hospital Association Rate Year 2023 Annual Payment Update Position Paper Addendum April 22, 2022

Since delivering our position paper to the Health Services Cost Review Commission on March 29, MHA has examined new information about projected cost inflation, national Medicare spending growth and other factors. This paper presents the Association's fresh perspectives.

Our Association's governing body understands that the Commission must consider not just hospitals' intensifying financial pressures but also the Medicare spending growth constraints in the Model contract. Calendar year (CY) 2022 is a crucial year for Model measurement, so Maryland must be judicious. Accordingly, and in respect of HSCRC's feedback, MHA has tempered our rate update proposition.

MHA and all members of the Association sincerely appreciate HSCRC's support during the past two years and our long-running collaboration to secure Maryland's unique Total Cost of Care Model for years to come. We are eager to join with the Commission in devising a fair annual payment update for rate year (RY) 2023.

Maryland hospital leaders continue to see extraordinary cost growth in every corner of their operations, and they can see no reversal of the trend on the horizon. What our hospitals are experiencing is borne out in our monthly experience, and in figures published by federal agencies, whether the 8.5% jump in the Consumer Price Index or the Medicare actuaries' forecast that Medicare per capita costs will rise 9.4% in 2022.

February 2022 reflects the fifth straight month that Maryland's median hospital operating margin was negative. This is fueled by wage rates that are 15% higher than the previous year, coupled with nearly \$100 million of contract labor spending in February alone. Appendix 1 gives detail of the mounting financial pressure on Maryland's hospitals.

MHA'S RATE YEAR 2023 REQUEST AND MODEL TEST CONSIDERATIONS

Balancing the hospital field's RY2023 needs with Model limits, we ask the following:

- 1. Fund IHS Markit's RY2023 cost inflation, expected to be at least 3.58%**
- 2. Make the \$100 million advance funding permanent, requiring no repayment**
- 3. Modify the savings adjustment for potentially avoidable utilization**
- 4. Limit the projected reduction in uncompensated care funding**

5. Monitor inflation and Model performance for six months and adjust rates effective January 1, 2023, if conditions permit

Exhibit 1 summarizes MHA’s request and reflects a moderate, 3.42% increase to permanent revenue. Ignoring one-time adjustments, RY2023 allowable revenues grow only 2.92% over RY2022 because the \$100 million we are asking to be made permanent is already in the base.

Exhibit 1: Summary of MHA Request

Category	MHA Proposal	Note
2023 Base Inflation	3.58%	Currently expected increase; raise if IHS April/May forecast update is higher
Make 2022 \$100m advanced funding permanent	0.50%	Advance not to be paid back; equivalent amount put into rates
Subtotal	4.08%	
PAU savings offset	-0.14%	Alternative to standard method
Quality policies	-0.26%	Net 2022 & 2023; subject to COVID adjustment
Other (net)	-0.05%	
Uncompensated Care (UCC)	-0.22%	Smaller prospective reduction; uptick in UCC foreseen
Total	3.42%	

Our rationale and supporting analysis for each request are presented on the following pages. We also highlight new Medicare spending growth projections from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary. Those figures are higher than previously reported. That ought to leave plenty of headroom for an annual payment update that truly reflects the severe cost growth Maryland hospitals are experiencing.

Furthermore, we concur with HSCRC staff’s position stated in the March 30 Payment Models Work Group, to use the Medicare Performance Adjustment – Savings Component (MPA-SC), if needed to mitigate the volatility of one-time adjustments on hospital revenues.

RATE REQUEST COMPONENTS

- 1. Fund IHS Markit's RY2023 cost inflation, expected to be at least 3.58%**
- 2. Make the \$100 million advance permanent, requiring no repayment**

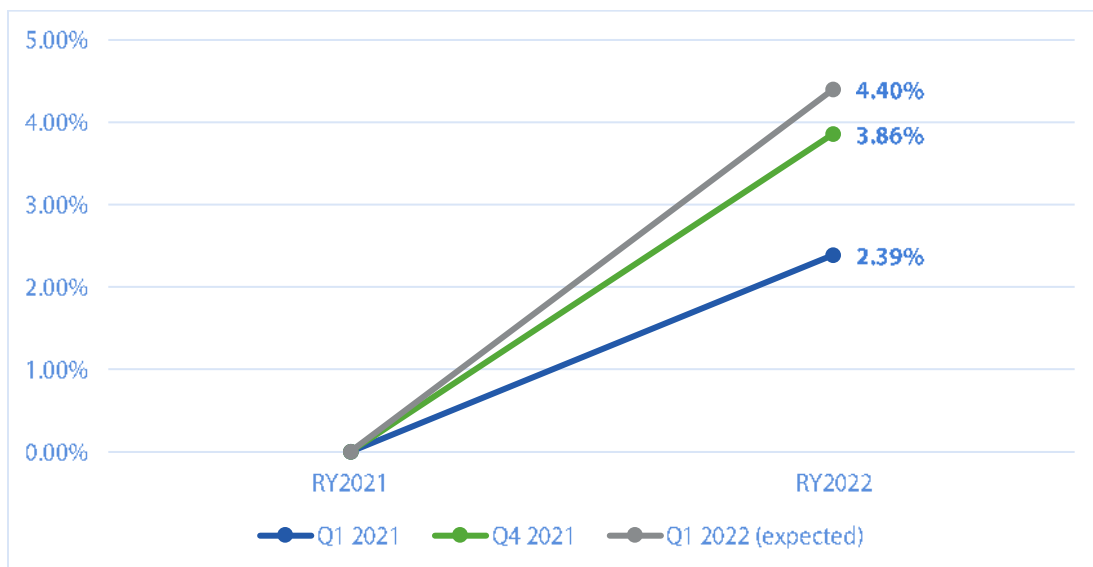
IHS Markit’s 4th Quarter 2021 release projected RY2023 inflation of 3.08%. Following RY2022’s pattern of increases, we expect the RY2023 inflation figure to rise when IHS issues its next forecast in the next two weeks. MHA assumes the figure will grow to 3.58%. A rise of this magnitude, or higher, was signaled in CMS’s April 18 notice that Medicare will boost Inpatient

Prospective Payment System (IPPS) rates 3.2% next year, not the 2.5% CMS floated previously. Whatever the exact number will be, we ask HSCRC to fully fund RY2023 inflation.

MHA earlier asked for hospitals to be caught up fully on 2022 inflation. In response, HSCRC gave hospitals \$100 million in 2022, equal to approximately 0.5% of statewide revenues. As projected 2022 inflation continues to spiral upward, we ask HSCRC to lock this in as a permanent adjustment.

A challenge to the RY2023 figure is the sharp rise in the 2022 base. As the RY2022 base rises, IHS may predict a smaller *percentage* increase in inflation. Exhibit 2 compares the RY2022 projected amount using the 1st quarter 2021 inflation factor (2.39%),¹ the 4th quarter release (3.86%), and the expected 1st quarter 2022 release (4.4%).

Exhibit 2: RY2022 Market Basket Inflation



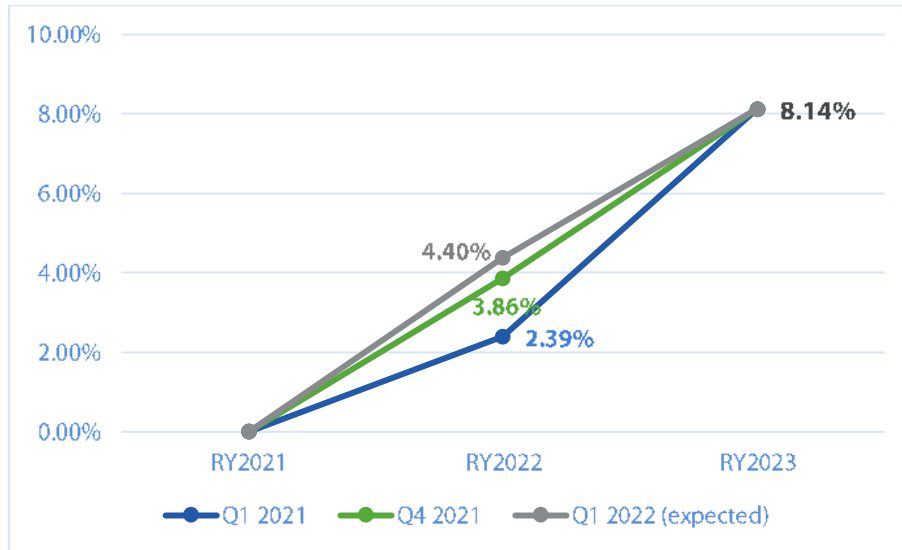
Extrapolating the impact to 2023, Exhibit 3 below shows expected two-year inflation of 8.14%.² When the 2022 base is revised upward by two full percentage points, to achieve the same cumulative growth, *RY2023 inflation would grow 4.12% from the Q4 2021 projection, and 5.61% from the Q1 2021 projection.* The latter being a full two percentage points above the now expected growth of 3.58%.

Exhibit 3 reveals that, as the 2022 base rises, the trend line into 2023 flattens compared to that higher base.

¹ This compares only the raw IHS CMS Market Basket figures to demonstrate inflation growth. HSCRC added a 0.2% permanent adjustment and the 0.5% advance to the 2022 figure.

² Assumes an increase of 0.54% in 2022 and 0.5% in 2023.

Exhibit 3: RY2023 Cumulative Inflation



The main driver of hospital cost growth continues to be labor. The CMS Market Basket uses the Bureau of Labor Statistics (BLS) Employment Cost Index (ECI) for hospitals to project wage inflation. The ECI for RY2022 is now 4.1%. This is expected to rise to 5.4% in the next projection. With labor costs representing 42% of the market basket, 2022 inflation would grow by 0.5%, to 4.4%.

BLS's Average Hourly Earnings for hospital workers is a better measure of what hospitals are feeling in real time since it captures the true cost of wage pressures, including expanded overtime, premium pay, and higher pay for additional shifts.³ In our previous paper, we showed BLS's Average Hourly Earnings (AHE) for hospital workers rising 7.8% for the same period. This figure is now *expected to soar to 9.7%* in 2022.

Separately, national data show hospital expenses continuing to soar. Premier, Inc. reports that hospitals' labor rates jumped 16.6% in the last five quarters and those costs show no signs of slowing. Kaufman Hall reports that for the first two months of 2022, expense per adjusted discharge is up 10.4% and labor expense per discharge up 15.3%, compared to the same period in 2021. Compared to 2020, both labor and total expense per adjusted discharge have risen more than 30%.

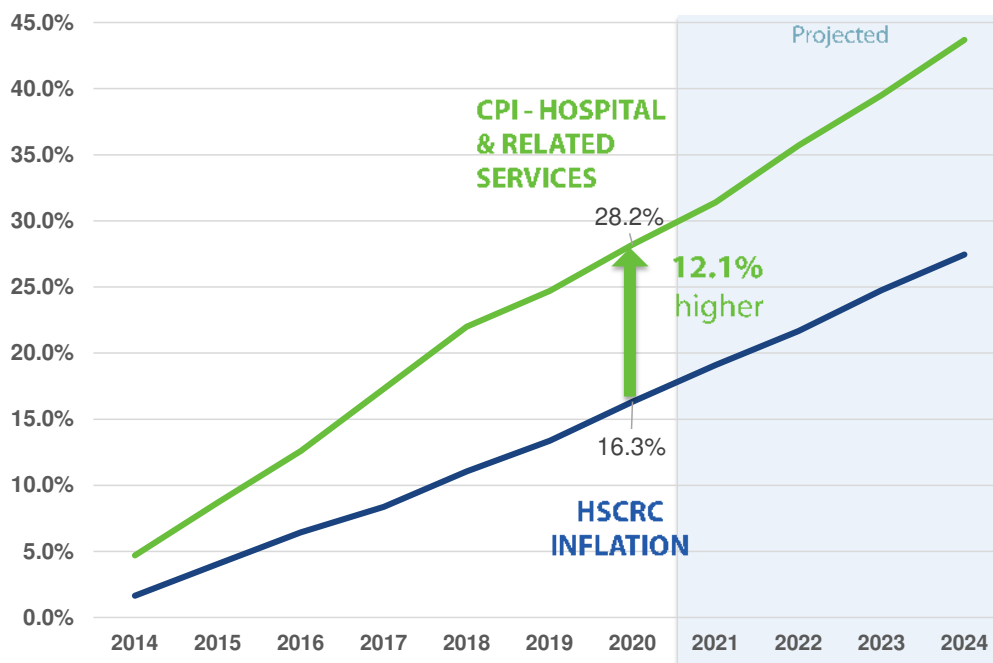
At the March 30 Payment Models Work Group, HSCRC compared the Consumer Price Index (CPI) – Hospital & Related Services to the ECI – Hospitals to show that price inflation through 2021 was commensurate with hospital employment costs.

³ BLS Handbook of Methods, Chapter 2. Employment, Hours, and Earnings from the Establishment Survey, p. 3 <https://www.bls.gov/opub/hom/pdf/ces-20110307.pdf>

We offer three considerations. First, the chart reflects data through the quarter ending December 2021. That quarter ended when the sharp wage cost increase had just begun. Second, the CPI – Hospital & Related Services is a lagging indicator of cost pressures because it measures the change in hospital prices paid by insurers and patients out-of-pocket. As costs grow, hospital prices, particularly for private payers, will eventually catch up. Third, as shown in Exhibit 4 below, the CPI – Hospital & Related Services has far outpaced increases HSCRC has granted since the beginning of our new agreement with CMS.

Had Maryland hospitals’ revenues risen with national hospital price growth, they would be 12.1% higher in 2020 alone. The gap would widen in the future.

Exhibit 4: CPI – Hospital & Related Services vs. HSCRC Hospital Inflation



For more detailed information on the financial pressures facing hospitals, please see Appendix 1.

3. Modify the PAU Savings Adjustment

We asserted in our earlier paper that the PAU savings adjustment should not apply in 2023, because today’s hospital utilization is driven by effects of the COVID pandemic, for both COVID and non-COVID patients. Avoidable utilization has been all but squeezed out.

We do, though, appreciate that HSCRC customarily applies a distinct incentive to further reduce utilization of services deemed potentially avoidable. However, when the differentiator is applied to a baseline reduction, the incentive is overwhelmed by the reduction itself.

Under the global revenue budget, hospitals can gain by reducing *any* service use, whether or not it is PAU. The PAU savings adjustment adds an extra incentive for PAU only. But there is no parallel *increase* if non-PAU service use is reduced. Hospitals understand the GBR to be an all-encompassing incentive, generating savings if use falls and dissavings if use increases.

If PAU and non-PAU service use both fall by 10% from one year to the next, hospital rates are lowered in the first year, and *then lowered again* in the second year, by only a slightly smaller amount. The only way to avoid a PAU penalty is to have zero PAU. That is not feasible. (See Appendix 2 for illustration.)

Understanding that HSCRC wants to preserve a separate incentive to encourage hospitals to reduce PAU, we offer three potential alternative courses of action:

Option 1: Set rewards and penalties around a base of 0%, measuring year-over-year change

In this option, the GBR incentive is undisturbed, yet hospitals have the opportunity to earn a small reward, or face a small penalty, relative to their prior PAU performance.

Option 2: Set a statewide average benchmark as a hold harmless floor, and apply adjustments to hospitals that exceed the benchmark

Here, a hospital that keeps PAU below a certain level is held harmless for performing better than the state average. As with the existing policy, hospitals above the average would face a small penalty. In this alternative, if the calculated PAU adjustment is -0.28% and the statewide average is the benchmark, we assume that the PAU impact would be -0.14%.⁴

Option 3: Use a national benchmark to set a PAU savings target

In this option, HSCRC could use a national benchmark combining the underlying readmissions and Prevention Quality Indicators (PQI) measures to set an improvement target, an attainment target, or a combination of both.

Each option requires more analysis. MHA will work with HSCRC to assess RY2023 alternatives.

4. Limit the Reduction in Uncompensated Care (UCC) Funding

HSCRC's workpapers show that statewide UCC fell 0.43% in RY2021, and RY2023 rates will reflect this adjustment. We ask HSCRC to lessen this reduction by half, as hospitals expect uncompensated care will rise in RY2023.

⁴ -0.14% is the estimate applied in Exhibit 1.

Consistent with prior years, HSCRC accounts for the change in UCC funding when projecting hospital revenue growth. UCC funding is meant to ebb and flow with actual experience, though a portion of each hospital's UCC is determined by a predictive regression model. The HSCRC's UCC policy sets total UCC funding using the most recently available performance. For RY2023, total UCC is set using RY2021's experience.

The RY2021 reduction was likely a combination of two factors, both associated with COVID-19. First, during the pandemic, the Health Resources and Services Administration (HRSA) used new federal appropriations to cover COVID testing, treatment, and vaccination costs for uninsured patients. Maryland hospitals, like other hospitals, accessed the pool during the pandemic. We estimate that 0.1% to 0.5% of hospital revenue was paid by HRSA. That spending would have otherwise been charity care. The HRSA funding is now ended.

Second, a general change in hospital utilization during the pandemic likely led to the decline in uncompensated care. As care patterns return to normal in 2022 and 2023, we expect the mix to normalize, raising UCC somewhat.

5. Monitor Inflation and Model Performance, and Adjust Rates January 1, 2023

After four decades of low inflation and facing the constraints of the Model contract in CY2022, MHA appreciates why HSCRC would adopt a conservative posture. Yet we have demonstrated that extraordinary inflation in hospitals' costs is very real, just as it is across the U.S. economy.

If Maryland's Model performance remains favorable and RY2023 inflation continues to rise, HSCRC should add to rates at the midpoint of the rate year. To augment rates mid-year would be entirely suitable considering the extraordinary volatility now seen in the health care industry and across all sectors of the economy.

MEDICARE MODEL GUARDRAIL

Maryland's Medicare guardrail is a spending measure, not a price measure. As we showed in our March 29 paper, between 2013 and 2019, Medicare *spending* grew nearly twice the rate of the combined Medicare inpatient and outpatient prospective payment system (PPS) *price* hikes.

Data that CMS released in early April show that the Medicare actuaries predict *Medicare-fee-for-service (FFS) spending will grow 9.4% in CY2022.*⁵

⁵ Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. <https://www.cms.gov/files/document/2023-announcement.pdf>

Broken down, CMS foresees 9.3% growth in Part A FFS spending per beneficiary and 9.52% growth in Part B.⁶ One must infer that CMS expects Medicare volumes and service intensity to continue their upward rebound from the COVID pandemic

Exhibit 5 shows Maryland’s projected CY2022 growth, using HSCRC’s approach to price level the RY2023 permanent update plus significant one-time adjustments.⁷ The Maryland growth projections use HSCRC’s March 30 Payment Models Work Group figures and MHA’s position reflected in Exhibit 1.⁸ CY2022 growth is above the permanent update because of CY2021 undercharges and the net effects of one-time adjustments.

Reflected in Exhibit 5, CY2022 national Medicare FFS forecasted growth is significantly higher than the historic trend.

Exhibit 5: CY2022 Projected MD vs. National Growth

		Projected National Growth Scenarios, Compared to Maryland							
	MD CY2022 Projected Growth	2017 - MD Over 2019 / (Under)		2015 - MD Over 2019 / (Under)		MD Over FFS / (Under)		MD Over / FFS Projected; (Under)	
		Trend	National	Trend	National	Projected	National	Conservative	National
HSCRC - Mar. 30	5.1%	4.0%	1.1%	2.9%	2.1%	9.4%	-3.9%	7.2%	-2.0%
MHA Request	6.1%	4.0%	2.0%	2.9%	3.1%	9.4%	-3.0%	7.2%	-1.0%

Like HSCRC’s difference statistic comparing all-payer growth to Medicare growth, MHA projected a conservative growth scenario. One year ago, CMS predicted CY2021 Medicare FFS per capita spending growth of 11.71%. Now, CMS estimates CY2021 growth of 10.44%. Data presented at HSCRC’s April meeting show a national Medicare growth of 9.1% in 2021.

The difference between the projected 11.71% and the official CMS growth rate of 9.1% is 22.2%. Applying this factor, the conservative projection limits national growth to 7.2%. Even in the conservative approach, Maryland’s CY2022 spending, when applying MHA’s proposed update factor, is still 1.0% below the limit

In addition to revisiting the annual payment update at the mid-year mark, if needed, HSCRC can use the MPA-SC to *directly adjust* Medicare payments for volatile, one-time swings.

⁶ Though a per-beneficiary per-month calculation, beginning with Table II-7, the MA rate notice provides data to calculate the FFS change, within instructions on Page 24.

⁷ MHA adjusted the projected CY2022 growth from HSCRC’s figures to reflect no payback of the \$100 million advance, and also spread the balance of recovering RY2021 undercharges overall all of RY2023, rather than the first six months.

⁸ Maryland’s growth uses HSCRC’s methodology to adjust the RY2023 update to CY2022 revenue growth. MHA applied the historic trends to Maryland’s non-hospital growth in each scenario. When comparing to the growth rates extracted from the MA rate notice, MHA used the 2017 to 2019 historic trend for non-hospital growth.

From HSCRC's March 30 workpapers, the balance of the RY2021 undercharge is \$96 million. Assuming Medicare is 35% of the statewide payer mix, applying the MPA-SC saves Medicare approximately \$33.6 million of this recovery, or approximately 0.4% of Medicare charges.

BALANCE IS ATTAINABLE

Maryland hospitals value the HSCRC's stewardship of the Model. We, too, want CY2022 to be a very successful year. Success will be enjoyed if Maryland both passes the Model test and protects the viability of hospitals so they can continue to meet their patients' and their communities' needs.

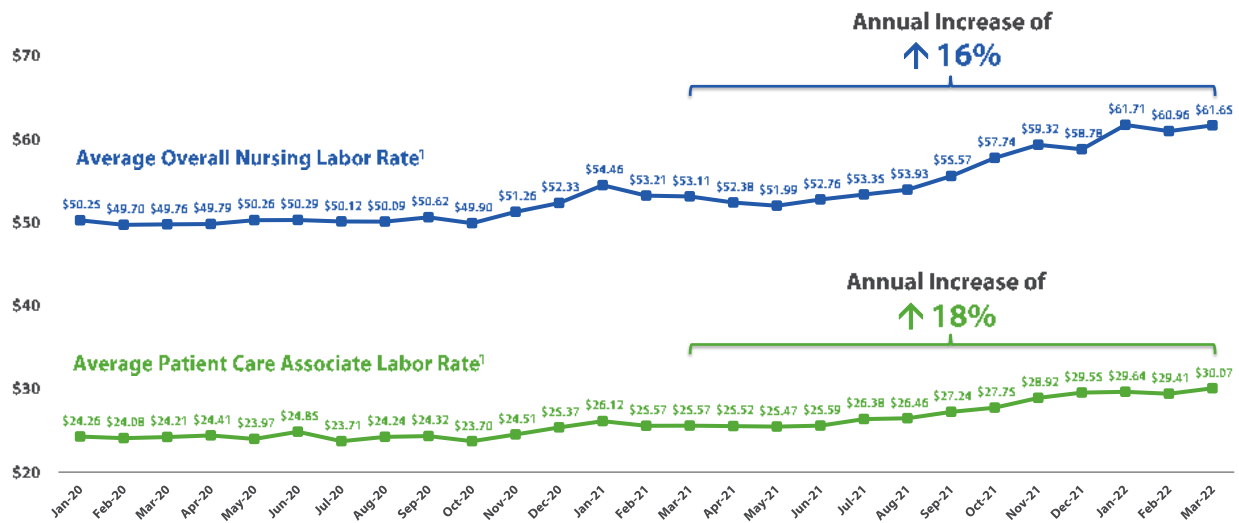
The hospital field's RY2023 rate update request, coupled with a mutual commitment to adjust rates mid-year based upon new inflation data and monitoring of guardrail performance, is fair and reasonable.

APPENDIX 1: HOSPITAL FINANCIAL PRESSURES

In this appendix we supplement the basic presentation of facts with additional detail on hospitals' financial challenges.

We begin with labor costs, the biggest component of hospitals' spending. Exhibit 6 shows the rise in nurse and patient care associate (nurse assistant) hourly wages. From March 2021 to March 2022, the average nursing wage jumped 16%, from \$53.11 to \$61.65, and the average patient care associate wage leaped 18% from \$25.57 to \$30.07.

Exhibit 6: Average Nurse and Nurse Assistant Wage Rates⁹



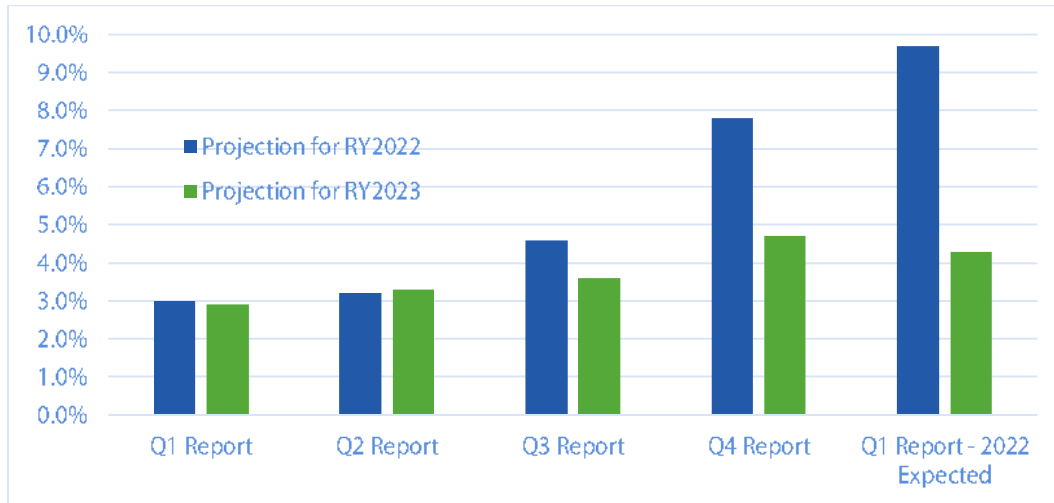
These are permanent wage increases that will not be reversed.

Funding wage growth above 15% for the largest components of the hospital workforce is a daunting challenge. These data correlate with the most recently available national labor statics data.

As noted above, national Average Hourly Earnings for hospital workers, beyond just nurses and nursing assistants, is now projected to grow 9.7% for the twelve months ending June 2022. The change in the projected trend for RY2022 and RY2023 is reflected in Exhibit 7. To incur 9.7% growth for the full twelve months, growth rates have accelerated substantially in the latter part of 2021, continuing into 2022.

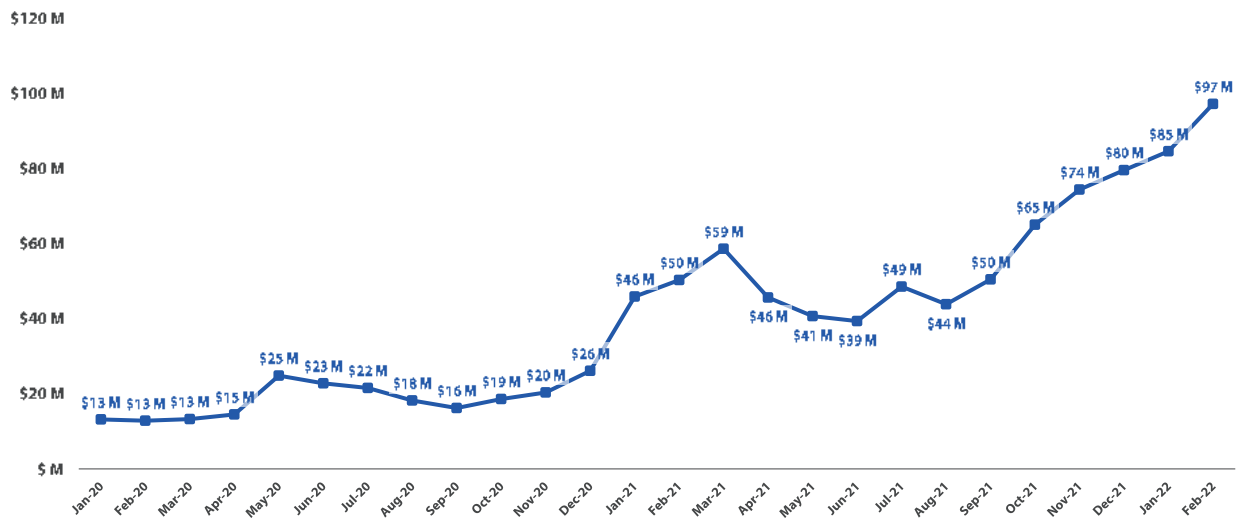
⁹ MHA's monthly hospital labor cost survey.

Exhibit 7: Average Hospital Workers' Hourly Earnings – Shifts in IHS Projections¹⁰



Hospitals must continue to boost wages to retain and attract employees because contract labor costs show no signs of slowing. Exhibit 8 shows the average monthly spend on contract labor costs. In February alone, hospitals spent nearly \$100 million on contract labor – close to double the spend at the same time last year and 650% higher than the pre-pandemic period.

Exhibit 8: Maryland Hospitals' Monthly Contract Labor Expenses¹¹



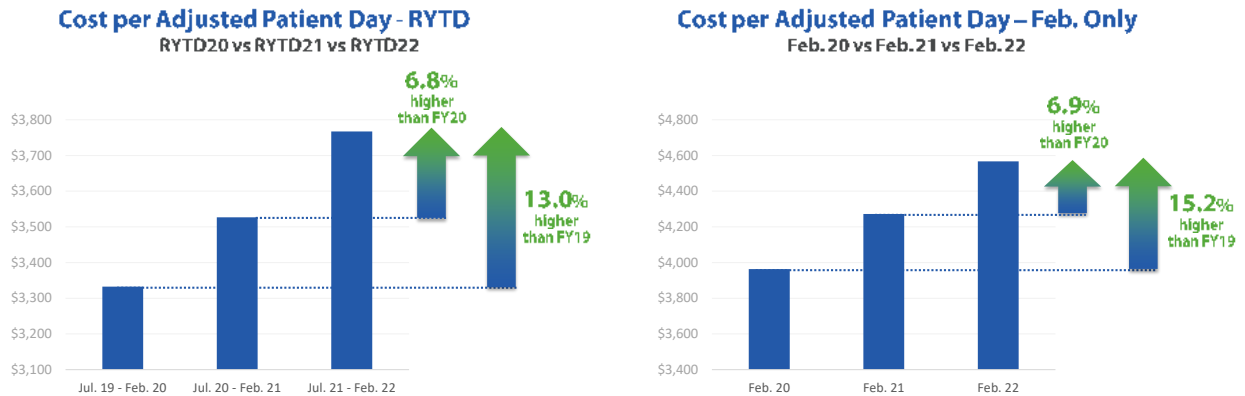
Should this pattern continue, Maryland's hospitals will incur nearly \$1 billion in contract labor costs during RY2022 alone.

¹⁰ The expect 2023 project reflects MHA's concern that higher 2022 growth is tempering the 2023 inflation projection. 14.4% cumulative 2022 – 2023 growth is expected in the Q1 2022 release, up from 12.8% in the Q4 2021 release.

¹¹ MHA's monthly Labor Cost Survey

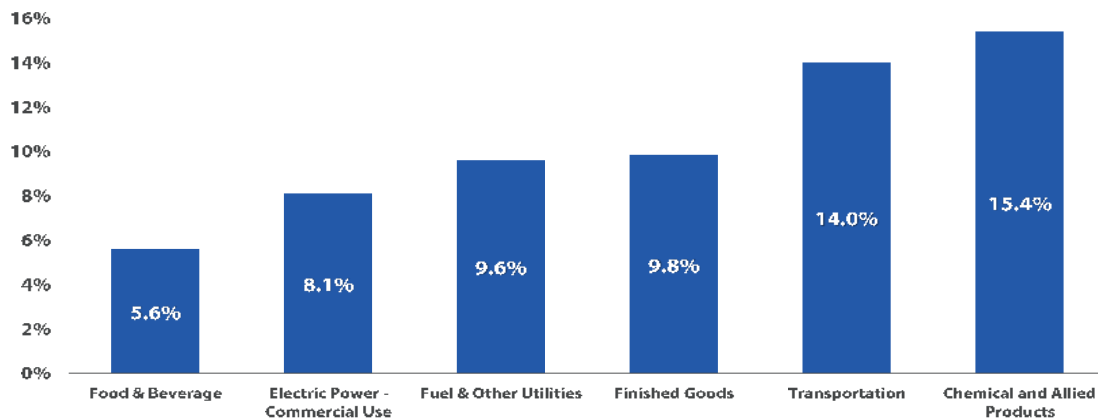
As presented in our original position paper, all hospitals costs, beyond just labor, continue to grow at rates not seen in recent memory. Updated with February data, Exhibit 9 shows cost per unit for the eight months ending February 2020, February 2021 and February 2022, and for the month of February in each year. Over the two years, hospital costs per adjusted inpatient day grew 13.0% for the eight month period, and 15.2% from February 2020 to February 2022. Comparing 2022 to 2021, hospital cost per unit grew nearly 7% for the eight month period and the month of February compared to the prior year.

Exhibit 9: Growth in Maryland Hospital Cost per Unit



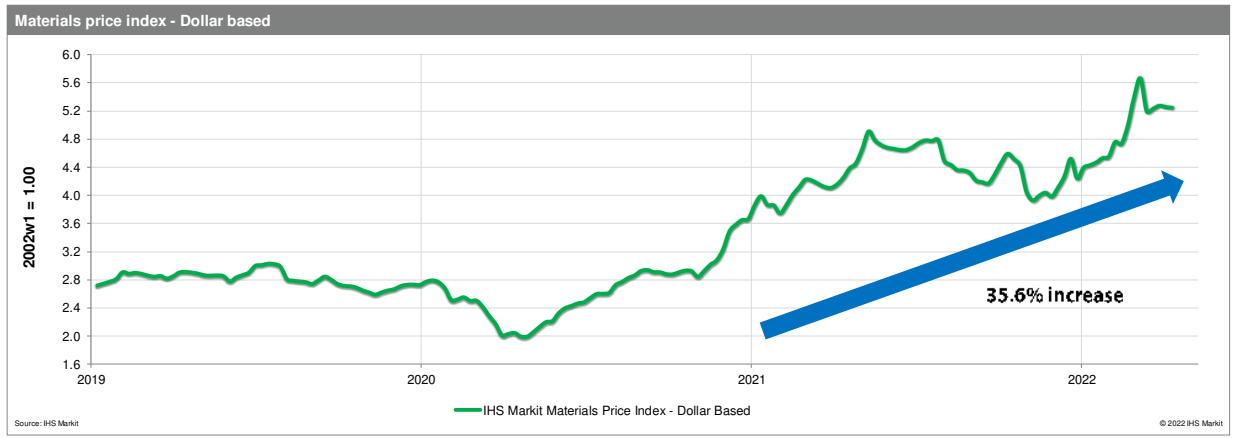
In addition to labor costs, hospitals are facing the same cost pressures as other sectors. Exhibit 10 displays IHS’s projected annual cost growth through June 2022 for selected commodities. Hospitals consume these items in very large quantities. Knowing that costs spiked even more in February and March, *these figures are likely understated.*

Exhibit 10: Projected Cost Growth, Selected Goods, June 2022 over June 2021



Beyond operating costs, building materials and other costs that affect capital spending are shown in Exhibit 11: IHS’s Materials Price Index. The index is up 35.6% since January 2021. Like all other market segments, this has, and will continue to raise capital spending costs at the same time hospitals must address substantial operating concerns.

Exhibit 11: IHS's Materials Price Index¹²



The results of these sharp cost increases are hitting hospitals' bottom lines, even with additional supports provided by HSCRC. Exhibit 12 shows Maryland hospitals median margins, by month, in RY2022. The median loss of 2.4% for February 2022 is now the fifth straight month that the median hospital margin was negative.

Exhibit 12: Median Maryland Hospital Operating Margin

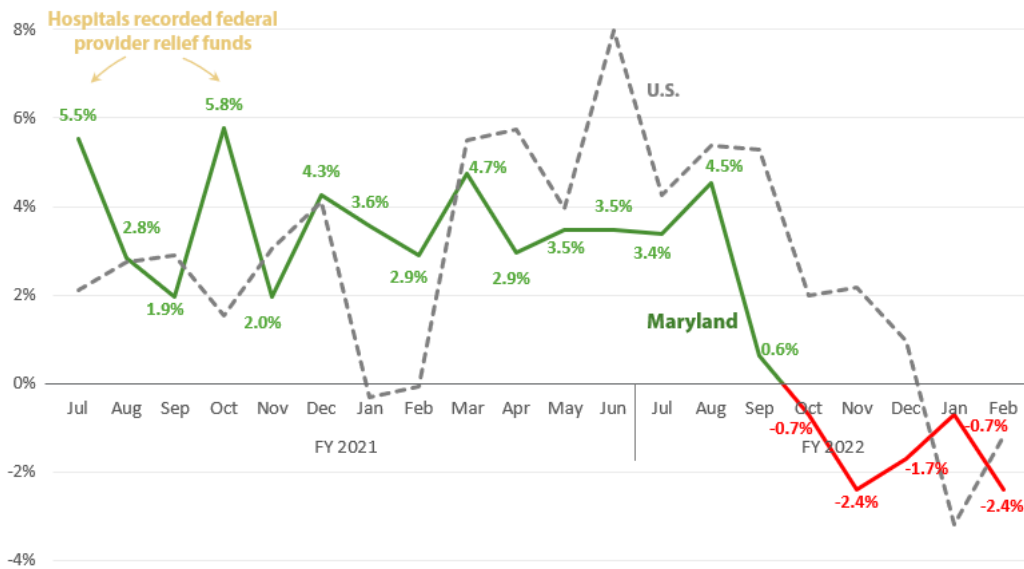
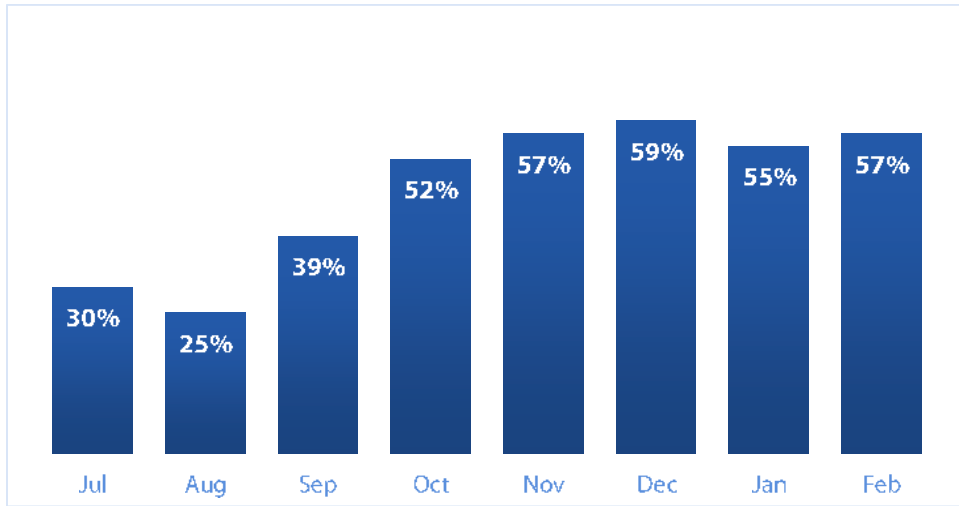


Exhibit 13 indicates the percentage of Maryland hospitals seeing negative operating margins in each month of RY2022. In February alone, 25 hospitals reported negative operating margins; 10 of those hospitals posted double digit losses.

¹²IHS Markit, April 19 release.

Exhibit 13: Percentage of Maryland Hospitals with Negative Operating Margins in RY2022



APPENDIX 2: PAU SAVINGS ADJUSTMENT EXAMPLE

The chart below assumes revenues grow by 2.8% in Year 1 and Year 2. Year 1 total volume is 100 with 90 non-PAU and 10 PAU. In year 2, service use is reduced by 10%, spread evenly between PAU (81) and non PAU (9). Following HSCRC's usual policy of not providing inflation on PAU, in this case 2.8%, the PAU savings adjustment is -0.28% in Year 1, and -0.25% in Year 2. While this is a 0.03% improvement to the reduction, *the reduction is still 0.25%*.

In theory, the hospital retains 10% savings from reducing all service use, the big GBR incentive. Yet the hospital still faces a 0.25% penalty, even though the hospital reduced PAU at the same rate as non-PAU. There is no need to offset a functioning incentive.

PAU Impact Example

