Maryland
Hospital Association

Dec. 2, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am commenting on the Health Services Cost Review Commission (HSCRC) 2025 AHEAD preparation funding draft recommendation. We appreciate HSCRC's recognition of the need and opportunity to make health care investments to support patients, hospitals, and communities, but urge faster relief that more directly addresses the cost pressures hospitals are encountering.

As we shared in November, Maryland hospitals and health systems are struggling with rising expenses that have significantly increased since January 2020. The excess savings generated beyond the contractual target under the Total Cost of Care (TCOC) Model provide an opportunity to make robust investments to strengthen acute care across Maryland's communities prior to entry into the AHEAD Model in 2026.

The proposed funding approach would increase rates as of Jan. 1, 2025 by 1.6% on an all-payer basis to lay a foundation for successful implementation of the AHEAD model. Hospitals would hold the revenues collected until directed to specific purposes by HSCRC. Twenty percent of the funds would be directed to the Population Health Trust, and the remaining 80% would go to an Access and Transformation Fund. These dollars would support investments in various health cost and delivery improvement programs to prepare the state for successful performance under AHEAD. The proposal identifies seven areas of potential investment. HSCRC staff would then collaborate with stakeholders and legislators to refine and prioritize allocations before recommending final funding allocations to HSCRC.

While the investment areas proposed under the recommendation are laudable and should be part of a comprehensive effort to strengthen the health care system in our state, MHA urges an approach that releases more funding to enhance hospital readiness and shore up acute care services. This opportunity must prioritize funding hospitals in a timely manner to address the broad-based cost drivers all hospitals are experiencing to varying degrees.

Market experts continue to observe that the operating environment for hospitals and health systems post-pandemic is the most arduous in history. Rising staffing, supply, and drug costs, combined

with challenges in recruitment and retention, increased competition from retail and private equity, insurance denials, and emerging expenses like cybersecurity, AI, and workplace violence prevention have made this downturn exceptionally challenging. Hospitals also continue to confront exorbitant, and continuously rising, costs of essential physician coverage.

Data through the first quarter of calendar year (CY) 2024 show Maryland hospitals continue to fare poorly on key financial metrics as noted here:

- **Operating margin.** The average hospital total operating margin was negative in seven of the last nine quarters, with half or more of Maryland hospitals reporting negative operating margins in most quarters. Maryland lags behind a national sample of nonprofit health care systems tracked by Bank of America.

  For the last five quarters (all quarters available), the national sample outperformed Maryland in operating margin by a cumulative 4.7%. Market experts estimate nonprofit health care providers need about a 3% margin at the health care system level to sustain their missions. Maryland's health care systems average operating margins over the last 11 years were not even half of that (1.6%), including a negative 1.1% in 2023.

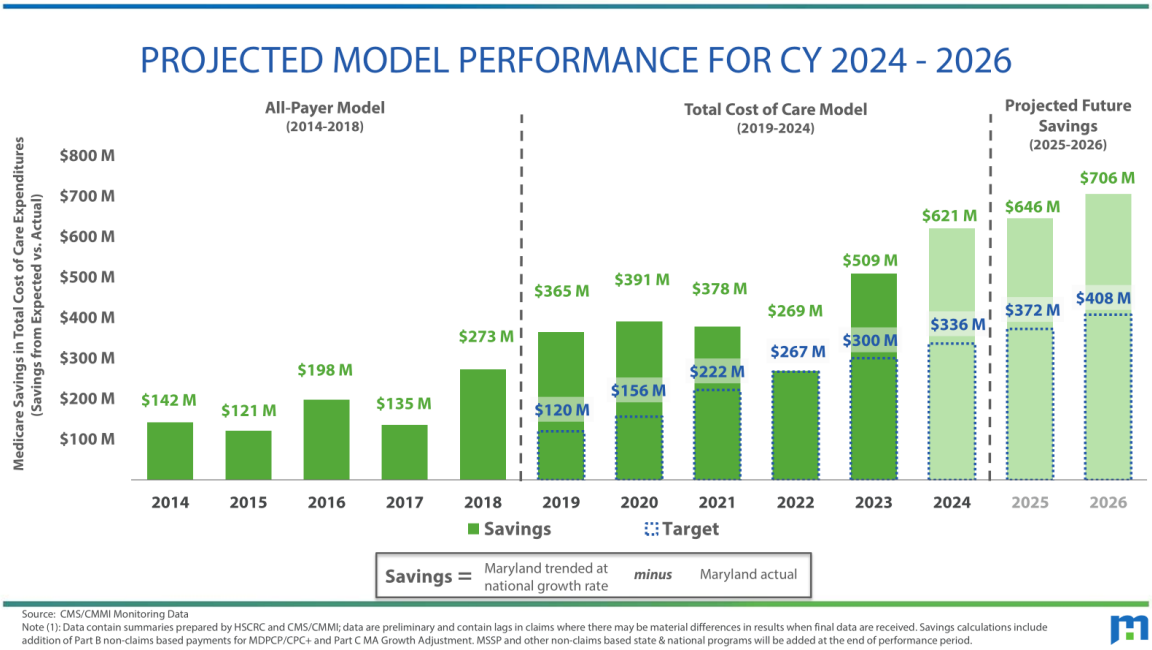
- **Capital Adequacy.** On measures of capital adequacy (cash to debt, debt to capital, capital expenses as a percentage of depreciation, and average age of plant), Maryland hospitals lag behind the nation by an average of almost a full year.

- **Cash Reserves.** Maryland health care systems' cash reserves are below benchmarks when comparing cash reserves to debt—an important credit metric. If health care systems are forced to draw down on cash reserves to cover operating losses, ratings will continue to downgrade leading to lower investment income potential setting up a losing cycle. The state's hospitals could lose access to capital at a time when capital needs are growing.

- **Rating Agency Predictions.** Credit rating agencies predict that cash flow will continue to be pressured in 2025, and operating recovery will be slow. The agencies continue to downgrade three to four times as many ratings as they upgrade nationwide. In Maryland, there were two system downgrades in the last 18 months and two systems with negative rating outlooks.

These financial concerns make hospitals unsustainable in the long term and can be addressed in the short term given the significant amount of excess savings. Hospitals that struggle financially are unable to reinvest in clinical care, recruit and retain talented staff, and invest in patient experience. Financial issues have direct implications on quality and challenge the provision of 24/7 acute care across the state.

The TCOC Model is expected to generate over $600 million in savings by the end of CY 2024—far exceeding the savings targets of $336 million for CY 2024 and $372 million for CY 2025. This also exceeds the AHEAD Model CY 2023 baseline savings of $509 million.



Proposed Funding Relief Plan

Substantial excess savings offer the state an opportunity to invest in and strengthen acute care across every community. The savings can alleviate financial pressures stemming from underfunded costs in the TCOC Model and provide a stable baseline for success under the AHEAD Model.

There is significant room to redirect excess savings to acute care. As shown below, if HSCRC instituted a 2.7% all-payer rate increase from July 1, 2024 through June 30, 2025, it would generate $410 million in all-payer net revenue to hospitals. **This would bring an additional 2.15% in funding for RY 2025.** This rate increase should be implemented for both GBR and non-GBR hospitals to alleviate cost pressures.

IMPACT OF PROPOSED RATE INCREASE FOR HOSPITALS (7/1/24 – 6/30/25)

- $515 million in net revenue after payer discounts and adjustments for uncompensated care (UCC)
- $105 million rebated to Medicaid
- **$410 million in net revenue available for hospitals**
- Impact on Medicare TCOC savings: $171 million reduction in CY 2025

Like the HSCRC proposal, MHA suggests an approach to mitigate the potential impact an acute care funding relief plan may have on other parts of the health care system. MHA's proposal achieves a balance between acute care sustainability, health care access, and health equity with the need to generate savings for payers and promote affordability for patients.

MHA proposes the following elements be incorporated into the funding relief plan:

- To minimize operational complexity, funding should be retroactive to July 1, 2024. Further, hospitals should be allowed to generate revenue from Dec. 1, 2024, through June 30, 2025, to spread the rate increase over the remaining seven months of the fiscal year minimizing financial implications for patients and payers.

- To recognize the challenges facing the state budget, MHA supports rebating Medicaid any portion of the funding that impacts its budget, to hold Medicaid harmless while still providing acute care relief.

Funding Allocation

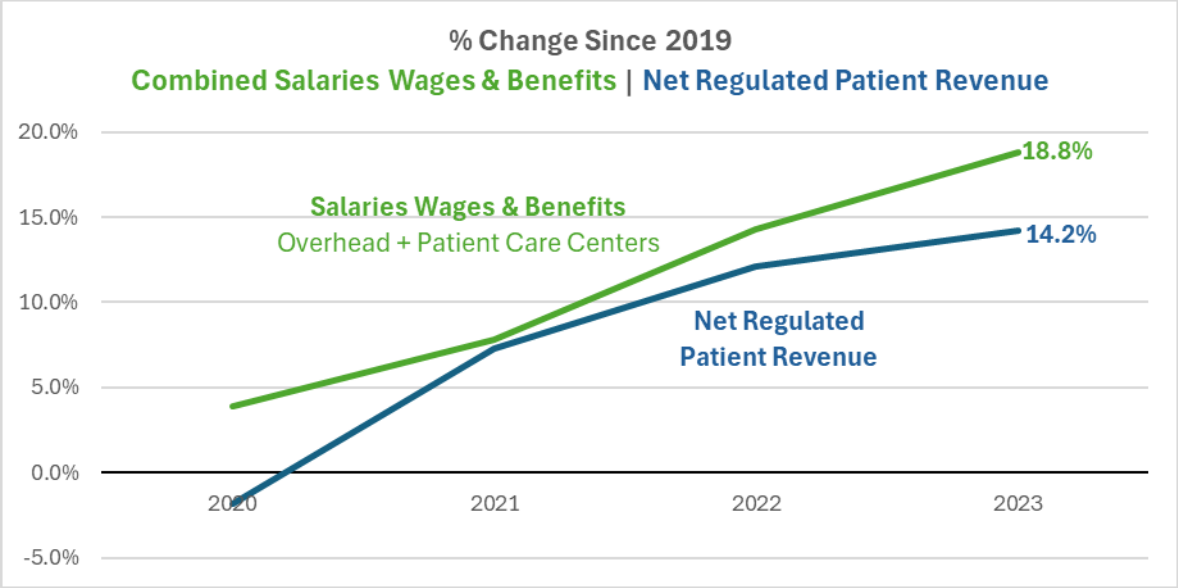
HSCRC should provide permanent funding to address broad-based cost drivers that affect acute care settings across the state to varying degrees. Funding should be allocated to address rising labor costs, routine capital investments, and age-adjusted demographic growth.

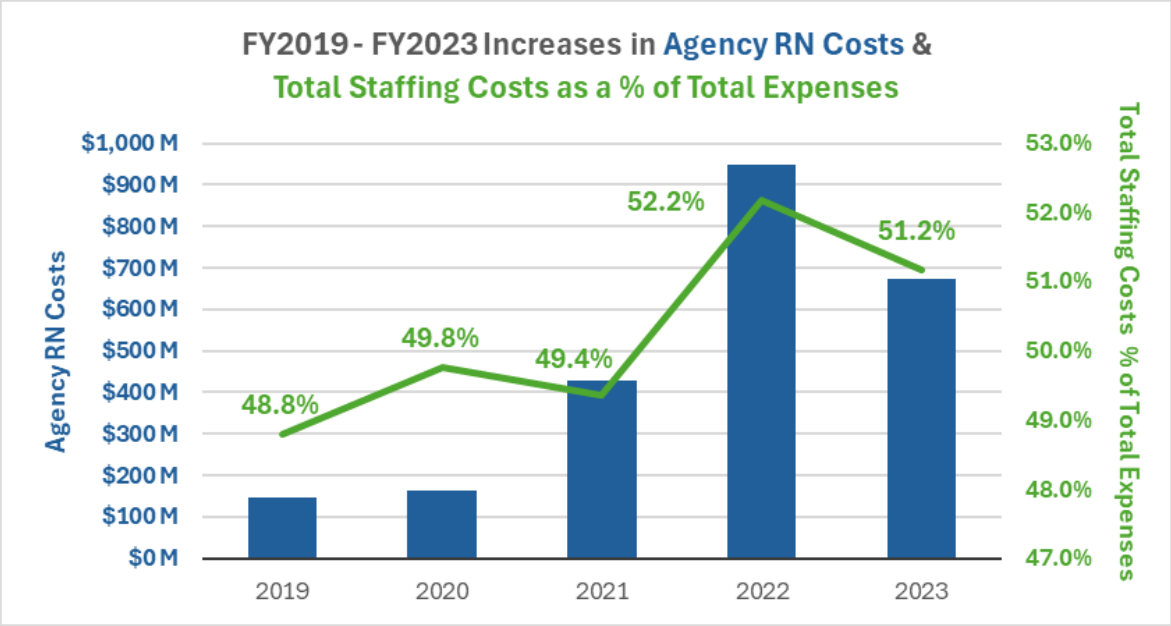
Labor Costs

Labor costs typically account for 60% of a hospital's budget. According to the American Hospital Association, hospitals' labor costs increased by more than $42.5 billion between 2021 and 2023 nationally. Data from the Bureau of Labor Statistics shows that while hourly earnings of health care and social workers are declining (from 7% in 2022 to 3.5% to 4% in 2023 and 2024), labor costs continue to grow faster than inflation. Maryland hospitals continue to contend with worker shortages and difficulty recruiting in clinical and nonclinical areas.

Since the COVID-19 pandemic began, hospitals across the state have seen sharp increases in the cost of labor and have grappled with persistent workforce shortages. There are significant financial losses due to the rising costs of physician coverage for both employed and contracted physicians.

As shown below, labor costs for regulated services have grown significantly since 2019 with the 18.8% growth in labor costs outpacing the 14.2% increase in net regulated patient revenue. Average hourly wage growth has been a substantial cost driver with increases of 5% in 2020, 3.6% in 2021, and 4.1% in 2022—growth rates that are significantly higher than the average wage growth rate of 1.6% for 2013 to 2019. While wage growth moderated in 2023 (0.9%), staffing costs have increased to over 50% of total expenses as the substantial labor cost increases are now a structurally high operational expense. With a 47% increase from 2019 to 2023, agency nurse staffing costs are a big cost driver for hospitals.





Routine Capital

Hospitals have deferred needed routine capital investments due to financial distress over the past several years. As noted above, Maryland hospitals have an older average age of plant than other hospitals nationwide. Continued deferral of these expenses due to insufficient funding from HSCRC places Maryland hospitals further behind their peers and poses long-term risks for patients.

In a recent survey of MHA member hospitals, all respondents reported deferring routine capital purchases over the last three years to mitigate financial risk from operating income uncertainty. These deferred purchases span a wide range of areas, but include routine patient care capital replacement, upgrade, and additional purchases, facility maintenance and renovations, and other

non-patient care purchases, such as for information technology, office equipment, and parking needs. Hospitals also reported having emergency capital expenditures, an indicator of having to defer capital needs until it is unavoidable. Below are examples of Maryland hospital and health system responses from the survey.

- **Health System A** deferred $26 million of $113 million of routine capital expenditures in fiscal year 2023 and $43 million of $122 million in FY 2024.

- **Hospital B** deferred $111 million in capital spending over the last three years. During that period, the hospital spent $1.7 million on emergency capital purchases.

- **Hospital C** deferred $59.5 million in capital expenditures over the past three years due to affordability constraints and the need to prioritize other capital projects related to patient care. The hospital reported spending $11.7 million for emergency capital purchases for needs ranging from the replacement of a CT scanner to facility maintenance needs like replacement ductwork and water mains.

- Citing cash limitations, **Health System D** deferred $384.4 million in capital expenditures over the past three years and spent $116.5 million for emergency capital purchases during this period.

- **Hospital E** deferred $197.4 million in capital expenditures in the last three years, citing financial performance and capital fund limitations. During this time, the hospital spent $17.7 million for emergency capital purchases to address a variety of needs, including elopement prevention, security upgrades, ultrasounds, and renovations of inpatient units.

- **Health System F** deferred $107.3 million in capital purchases in the last three years, citing increased financial instability due to cost pressures driven by insufficient rate support, underfunding, and other factors. The system expended $17.1 million for emergency capital purchases during this period to address a variety of needs, such as medical equipment, ultrasound, and other patient care needs, parking garage and elevator repairs, IT security infrastructure, and other facility needs.

- **Hospital G** has $61 million in deferred capital purchases and $51.6 million in emergency capital purchases during the past three years. The deferred purchases included items for routine patient care as well as facility, new service, and non-patient care capital needs.

- Due to inadequate funding, **Hospital H** deferred $20 million in capital expenditures in the last three years. The hospital reported $2 million in emergency capital purchases during this period on medical equipment, building repairs, air handling units, and facilities renovation.

- **Health System G** reported $333.5 million in deferred routine capital purchases and $108.5 million in emergency capital expenditures in the past three years.

Age-Adjusted Demographic Growth
The demographic adjustment insufficiently accounts for age-adjusted growth. Lowering the adjustment to align with unadjusted state projections for annual population change creates a reduction in growth from 4.25% to 0.25%. A rate increase could address the underfunding of age-adjusted demographic growth—a critical need as Maryland's population ages.

While MHA has highlighted three broad-based cost-drivers, hospitals are also confronting other equally concerning cost pressures including growth in payer denials, cybersecurity, campus security costs, lingering supply chain issues, and other unforeseen costs that are not recoverable under rates like the cost of providing the RSV vaccine to newborns—a new requirement.

A funding solution for these broad-based cost drivers must be implemented quickly. The methodology to allocate funding for these needs should be streamlined and directed to deliver acute care funding relief to hospitals in a manner that is not administratively burdensome to hospitals or HSCRC. The current HSCRC proposal to have hospitals hold revenues collected until receiving direction from HSCRC may present administrative challenges for hospitals and result in delayed acute care funding relief, possibly until the second half of 2025.

Conclusion
The MHA acute care funding relief proposal addresses the variety of cost pressures confronting Maryland hospitals while staying within the bounds of the agreement with the federal government, protecting Medicaid programming, and minimally impacting patient bills and insurance premiums. By curbing the trajectory of savings, HSCRC can provide much-needed acute care financial relief. The funding proposal can and should prioritize hospital readiness and serve as a bridge to AHEAD.

Thank you again for the opportunity to comment on this important issue. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chair
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi