Maryland
Hospital Association

February 3, 2025

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 writing in response to the Health Services Cost Review Commission's (HSCRC) call for public comment on needed policy changes and investments to maximize Maryland's success as the state transitions to the AHEAD Model. We appreciate HSCRC's recognition that this is an opportune time to examine existing policies and implement changes to strengthen the Maryland Model.

The transition from the Total Cost of Care (TCOC) Model to the AHEAD Model brings us to an important moment in our ongoing effort to improve the health and wellbeing of Marylanders. Since the inception of the Maryland Model, Maryland hospitals have led the way in driving innovation through health care payment reform. Over the course of the All-Payer Model and the TCOC Model, hospitals generated $4.6 billion in Medicare savings through high-quality, efficient care delivery. Our hospitals reduced disparities in unplanned readmissions, preventable admissions, and timely follow-up both by race and for areas with challenging socio-economic conditions.

The AHEAD Model aims to build on this legacy with an even greater focus on population health and health equity and provides new opportunities to improve the health of all Marylanders. Hospitals will play a critical role in leading local interventions that focus on identifying populations that are most at risk for poor outcomes and developing targeted interventions that improve health. Our hospitals will also lead in the effort to improve health equity with each creating health equity plans that will demonstrate how equity is actively incorporated in hospital operations, strategies, and services. AHEAD includes important opportunities for hospitals to partner with other care providers across the care spectrum and, rightly, includes a focus on expanding access to primary care.

MHA Priorities

To be successful under AHEAD, hospitals must be financially healthy and sufficiently resourced to meet the baseline acute care needs of patients, invest in care transformation and population health, and make needed capital investments. ***The hospital field identified three top concerns***

that need to be addressed to support our mission of advancing health care and the health of all Marylanders: (1) policies to support the financial health of hospitals and access to care, (2) rising costs for essential physician coverage, and (3) payer denials and accountability.

Policies to Support the Financial Health of Hospitals and Access to Care

As we have highlighted over the past few months, Maryland hospitals and health systems have experienced challenging financial conditions since January 2020 as expenses have risen significantly. Maryland hospital system operating margins have been under pressure. In most quarters in the last three years, half or more of the systems have reported negative operating margins. Margins remain low with an average of just 0.3% in the third quarter of 2024, and margins lag when compared with other systems in the nation. Market experts estimate that nonprofit systems generally need a margin of 3% to sustain their missions. Since 2023, Maryland hospital systems have only reached this level once, and the average of the last 11 years was substantially lower at 1.6%.

Our hospital systems lag on other important financial performance measures as well. Due to operational uncertainty, hospitals deferred needed capital investments. In 2023, the average age-of-plant for Maryland hospitals was 13.2 years vs. 12.3 years nationally. Maryland hospital systems are below national benchmarks when comparing cash reserves to debt. Maryland also lags its peers in days cash on hand, an important liquidity measure. Labor and other cost pressures have been a challenge. From 2019 to 2023, labor costs grew by nearly 19%, outpacing the 14.2% increase in net regulated patient revenue. Staffing costs have increased to over 50% of total expenses, and the substantial labor cost increases are now a structurally high operating expense. Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Low reimbursements do not cover the costs of these essential medical staff, and these losses have grown by 55% for all specialties in recent years.

When evaluating the financial health of hospital systems, one must look at the full spectrum of financial indicators. Credit ratings are just one measure of financial stability. Operating margins are a central metric, and when considering margins, the focus must be at a system level. The Maryland Model is a total-cost-of care model. When appropriate, hospitals are supposed to shift services to lower cost unregulated and non-hospital settings and enhance integration of care across the care continuum, including through investments outside of the hospital walls to enhance primary care, post-acute care, community care, and population health. Because our focus is on improving care in settings across the continuum of care, our financial measures must focus on hospital system level performance that includes margins on hospital and non-hospital services. An exclusive focus on regulated margins fails to account for these important aims. And there are hospital costs, like essential physician services, that are not covered under rates. Without considering total hospital system financial performance, one misses large cost drivers and loss leaders for hospitals. HSCRC must embrace a broader focus on a wholistic set of financial metrics to obtain a complete and honest picture of hospital sustainability.

The financial challenges of our hospitals have occurred when hospitals have been generating Medicare TCOC savings substantially more than what is required under the Total Cost of Care Model. For 2024, Maryland is on track to achieve more than $600 million in savings for

Medicare—well above the contractual target of $336 million. The estimated savings are well above the baseline for the start of AHEAD and the first-year target under the new model agreement where we must generate an estimated additional $16 million in savings above the baseline. Over the course of the TCOC Model, Maryland has generated more $1.1 billion in excess Medicare TCOC savings. The Maryland Model and HSCRC policies must achieve a balance of hospital sustainability, health access, and health equity with cost savings for payers and affordability for patients. The generation of substantial excess savings at time when hospitals have struggled is a sign of a Model that is out of balance. HSCRC policies and actions are not keeping up with the costs hospitals incur for providing care in their communities. This is leaving hospitals resource constrained at a time when hospitals need to be strengthened to perform successfully under the AHEAD Model beginning in 2026.

HSCRC policies and actions must enable hospitals to be financially sustainable and provide greater access to care in their communities. Changes to key policies must be made this year to better fund volume growth and shifts, inflationary and other cost pressures, and capital needs.

Needed Improvements to Volume Policies

It is imperative that volume policies ensure that hospitals receive adequate funding services. Changes are needed to the market shift policy and demographic adjustment so that they more precisely account for and sufficiently fund volume changes.

Market Shift

The existing policy governing market shifts funds volume changes at a 50% variable cost factor (VCF). MHA urges adoption of a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. MHA recommends an approach that would use the annual filing to calculate VCF percentages by rate center, apply the calculated rate center-specific VCFs to service line/rate center charges, and then calculate service line-specific VCFs to apply statewide. An optimal approach would capture as variable costs direct expenses and direct patient care overhead costs, resulting in an appropriately higher calculated average VCF. An exception could be considered for outpatient psychiatric services, a service line with relatively high fixed costs—a higher VCF could support growth and greater access to these services.

MHA also recommends modifying the geographic definitions used under the market shift methodology. The current methodology, which generally tracks shifts by ZIP code with exceptions for certain service lines that are under a county level approach, does not sufficiently capture shifts, and broader geographic definitions would improve the methodology. The change to a county or regional approach would be simpler than the existing methodology, result in a higher effective VCF, and potentially benefit hospitals experiencing unfunded volume growth. The county-level approach is used under the national AHEAD methodology, and the potential benefit to volume-growing hospitals may support efforts to address access challenges.

Demographic Adjustment

Maryland's population is aging and becoming more complex. By 2030, nearly 20% of our population is projected to be 65 or older—this is up from just 12% in 2010 and 16% in 2020. Our state is also confronting an increased burden of chronic disease. The number of individuals with three or more chronic conditions is projected to increase. The percentage of our population with prediabetes is projected to reach nearly 30%, and the percentage of our population with diabetes will reach more than 15%. Projected figures are even higher for seniors, with 51% having prediabetes and 26% with diabetes. Our aging population with more chronic conditions will have a higher need for health care services, and the demographic adjustment must be responsive to this need.

The current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by lowering the adjustment so that it aligns with unadjusted state projections for annual population change. The methodology, which discounts potentially avoidable utilization (PAU) and age-adjusted growth by a per capita scaling factor, underfunds use-rate growth to achieve the contractual all-payer revenue limit. This approach acts as an additional constraint on growth beyond the PAU adjustment, unduly limits hospital resources, and exacerbates access challenges. For Rate Year (RY) 2025, the scaling factor reduced the adjustment from 4.25% to 0.25%. The cumulative impact of the underfunded growth has been substantial. From RY 2016 through RY 2025, the methodology has resulted in a cumulative underfunding of demographic growth by $7.4 billion.

MHA urges changing the methodology to discontinue the scaling factor so hospitals can receive more funding for use-rate growth. This change needs to be implemented in time to support growth in rate year 2025. MHA can support a two-pronged effort to (1) implement a more straightforward, implementable, modification to the age-adjusted approach for funding demographic growth in the near term, and (2) develop a more refined risk adjustment approach in the long term. The status quo is not sustainable, and imminent HSCRC action is needed.

Inflationary and Other Cost Pressures

In the post-COVID years, hospitals have been contending with inflationary cost pressures, and HSCRC policies have not provided sufficient funding to address these challenges. As noted above, staffing costs have been a significant cost driver and are now a structurally high operating expense. A reasonable annual payment update for Rate Year 2026 is essential to address the challenges and support hospital financial stability and access to care with the beginning of AHEAD.

Preliminary estimates have core inflation for Rate Year 2025 ending higher than projected (3.42% vs. 3.24%). The annual payment update for RY 2025 included an additional 1% for historic underfunding of inflation, an action that provided important support for our hospitals. But under HSCRC's methodology for calculating cumulative inflation over- or underfunding, hospitals are currently underfunded by a percentage that would fall within the inflation tolerance corridor of ±1%. The current methodology would yield no additional inflationary support allocated for RY 2026.

MHA urges changing the methodology so that annual update funding for Rate Year 2026 keeps pace with core inflationary pressures and includes additional support to address underfunded inflation. This could include narrowing inflation tolerance corridors that would yield an inflation catch up for the upcoming rate year.

Deferred Routine Capital Needs

As we highlighted in December, 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. HSCRC must revise policies so that hospitals have additional resources to address deferred capital needs. Hospitals need to address these needs to meet patients' baseline acute care needs. Facility renovation, routine equipment replacement, and investment in new technology play an important role in enhancing patient experience. Improvement in HCAHPs and quality scores depends on the ability of hospitals to make these needed investments.

Rising Costs for Essential Physician Coverage

Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Hospitals require sufficient medical staff to perform the basic functions of providing care to patients, and the losses attributable to physician employment or contractual arrangements—termed physician subsidies—are largely unavoidable.

Low physician reimbursement from payers and an increase in private equity acquisitions of physician practices are driving up contractual costs to provide adequate coverage for the hospital. In 2017, the average private physician payment rate was 104% of Medicare, one of the lowest in the nation, and physician subsidies are on the rise. A growing number of hospitals are citing increased physician subsidies, specifically in the hospital- based specialties of anesthesia and radiology, when requesting rate increases. The entry of private equity into the physician market is a challenge. When private equity enters the market, physician costs increase, particularly in instances when a single firm controls more than 30% of the market.

A survey of MHA member hospitals found that in the last seven to 10 years, expenses and net losses for physician services have grown, particularly for certain specialties.[1] For all specialties,

[1] Survey base years differ due to respondent data availability.

losses have grown by 55% over the period. Increases were significant for a variety of specialties, including anesthesiology, hospitalists, and emergency medicine.

The current global budget and rate structure does not enable hospitals to cover the costs for these physician services that are essential to run a hospital. HSCRC must adopt a funding mechanism that enables hospitals to recover in rates expenditures for physician services that are not fully reimbursed by payers.

Payer Denials and Accountability

Maryland hospitals are confronting a significant challenge with payer denials. Denied cases have grown substantially since 2013, and this growth has accelerated in recent years. In particular, denied cases are increasing steeply in the emergency department and outpatient settings. Artificial intelligence (AI) claims analyzer technology has been contributing significantly to the increase.

From fiscal 2013 through 2024, the total dollar value of denials has more than tripled to $1.39 billion. In the last three years, denials by commercial payers have spiked, and denials for emergency department services, in particular, have risen 116%, and the dollar amount of denials up 117%. In fiscal year 2014, 13.2% of inpatient cases were denied—the highest level in six years. From fiscal 2019 through 2024, denied cases as a percentage of total outpatient services increased from 10.2% to 11.4%. Commercial payers were responsible for the largest percentage increase in outpatient denials with the percentage increasing from 8.5% to 12.5% of the total. And for commercial payers, denied cases for emergency department services increased from 6.1% to 15.2%. There has been a noteworthy increase in medically necessary denials for Medicare Advantage (232.5%) and commercial plans (79.1%). The overall denial rate for Medicaid managed care organizations has also been high over the last six years.

Denials can cause delays for patients receiving necessary care, and higher out-of-pocket costs resulting from claim denials can cause patients to defer care. Denied and delayed payment of claims is contributing to financial pressures on hospitals and operational uncertainty. Valuable staff and clinical resources are diverted to fight inappropriate claim denials.

We need a system for reviewing payer denials that refines data disclosures and ensures data integrity, enhances payer denial transparency, and reduces denial rates while examining factors that contribute to excessive denial rates, such as the use of AI in claims review and prior-authorization requirements. HSCRC can play an important role in supporting the collection and analysis of information on claim denials. MHA urges HSCRC to pursue policy development and levers that may address wrongful denials.

HSCRC Call for Input Categories

Regarding the specific areas of inquiry on which HSCRC has requested public input—high-value care, access to care, and other cross-cutting policies—MHA offers the following comments.

High Value Care

Ensuring that patients receive the right care at the right time and in the right setting is an important objective. MHA encourages language that reflects a focus on medical necessity, rather than terminology like "high value care" that may inadvertently suggest certain services lack value. A more precise framework for evaluating care appropriateness that centers on medical necessity will help hospitals provide high-quality, patient-centered care that best meets the needs of our communities.

MHA and our members recognize the importance of delivering high-quality, patient-centered care and offer the following considerations to ensure a framework that effectively supports hospitals in meeting these objectives:

- **Benchmarking Population Health Performance**: To measure progress toward high-quality, patient-centered care, there must be robust benchmarking of Maryland's population health performance. This should include an evaluation of how the state's policies under the TCOC Model have contributed to improved patient outcomes and care delivery. Establishing clear benchmarks in advance of the AHEAD Model will allow hospitals to track improvements and identify areas for further enhancement.

- **Program Funding Flexibility**: Sustainable, flexible funding mechanisms are essential to enable hospitals to launch, sustain, and scale chronic care management and population health initiatives. Providing financial support that can be adapted to evolving needs will help ensure that Maryland hospitals can continue their efforts to improve health outcomes while managing costs effectively.

- **CRISP Enhancements**: Real-time data analytics and reporting improvements through CRISP are necessary to align hospital efforts with statewide population health objectives. Investing in enhancements to data availability and usability will strengthen decision-making and allow for proactive interventions that improve patient care.

- **Increased Collaboration:** A stronger partnership among hospitals, physicians, and HSCRC is needed to refine policies and ensure alignment with the goals of the TCOC Model. Encouraging a collaborative approach to policy development and implementation will enhance the effectiveness of high-quality, patient-centered care strategies across the state.

- **Workforce Stability**: Maryland's physician workforce is essential to delivering high-quality, patient-centered care. Efforts to strengthen physician recruitment, retention, and reimbursement alignment with TCOC objectives must be prioritized to ensure stable and sustainable care delivery, particularly in underserved communities.

- **Person-Centered Care for Chronic Disease Management and Reduction of Inappropriate ED Use**: High-quality, patient-centered care should be rooted in person-centered strategies that prioritize patient engagement, self-management support, and

coordination of care. Focusing on person-centered approaches could improve chronic disease management and lead to better long-term health outcomes. Policies changes should be considered to influence patient behavior and lower inappropriate emergency department use.

Improving Access to Care

A framework for improving access to care should ensure that all Marylanders receive timely and necessary health care services. Establishing a clear, comprehensive framework for evaluating and supporting access to care is essential to ensure that Maryland hospitals can continue to meet the needs of the communities they serve. Central to any strategy to improve access to care is to embrace a focus on MHA's priorities shared above. This includes implementing policies to support the financial health of hospitals to ensure that our hospitals are resourced to meet patients' baseline acute care needs. It also includes improving volume policies to sufficiently fund demographic growth and market shifts. As HSCRC develops measures and policies to promote equitable, high-quality access to care statewide, we appreciate the opportunity to share additional key considerations from the hospital field:

Key Considerations for an Access-to-Care Framework:

1. **Establishing High-Level Measures:**
   To effectively support improved access, HSCRC should implement standardized, broadly applicable metrics that provide a comprehensive view of health care availability and utilization. These measures should account for differences such as geographic variations, workforce capacity, and patient acuity to ensure meaningful statewide assessment and prioritization of funding.

2. **Hospital Effectiveness in Access to Care:**
   A robust access framework should consider multiple factors that impact a hospital's ability to meet patient needs. Specifically, evaluations should include:

- The complexity and volume of patients served, including growing populations of older adults and patients with chronic conditions requiring specialized care.
- The availability of non-hospital health care resources, such as behavioral health services, post-acute care options, and primary care providers, which directly influence hospital capacity and patient throughput.
- The rising costs associated with recruiting and retaining both contracted and employed providers, particularly in regions with health care workforce shortages.

3. **Addressing Policy Barriers to Access through PAU Funding:**
   Current policies related to Potentially Avoidable Utilization (PAU) funding may be overly restrictive and could inadvertently limit hospitals' ability to improve access to care. For example, the market shift policy does not account for PAU. MHA encourages HSCRC to reevaluate these policies to ensure they promote, rather than hinder, access to high-quality care.

While long-term strategies are necessary to create sustainable access-to-care solutions, immediate interventions are also critical to addressing the urgent challenges hospitals face. In particular, refinements to the demographic adjustment and volume policies must be prioritized, as these directly impact hospitals' ability to respond to changes in patient populations and care demand. Hospitals must be equipped with policies that reflect real-time shifts in demographics and service utilization, allowing them to adapt and maintain high-quality care for their communities. Without these key adjustments, hospitals may struggle to manage increasing patient complexity and volume, undermining broader access-to-care goals.

Cross-Cutting Policies

We appreciate HSCRC's proactive approach in soliciting feedback on cross-cutting policy areas for 2025. We welcome the opportunity to share the field's perspectives on hospital-based physician costs, facility conversions, and consideration of services that should be excluded under the state's global budget framework:

Policy Changes to Address Costs for Hospital-Based Physicians

Hospitals depend on a stable and well-supported physician workforce to provide high-quality patient care 24/7/365. However, increasing physician costs present a challenge within the current reimbursement framework. As we discussed above, MHA urges HSCRC to recognize physician costs as an essential acute care hospital expense and to provide a means for hospitals to cover these in payment policies. HSCRC action should be part of a broader effort to evaluate Maryland's physician reimbursement levels compared to other states and address existing disparities that may affect physician recruitment and retention.

Conversion of Facilities to Freestanding Medical Facilities or Other Lower Acuity Providers

The question of facility conversion is complex and requires careful consideration of health care access, community needs, and financial sustainability. MHA members have a range of perspectives on HSCRC's role in these discussions but emphasize the following principles:

- Any policy approach should be guided by a data-driven process to assess the appropriate inpatient bed capacity needed across jurisdictions in the intermediate and long term.
- The hospital field supports preserving hospital and health system autonomy in making facility conversion decisions to ensure transitions align with community health care needs and financial sustainability.
- Future discussions should explore incentives that encourage hospitals to convert more freestanding medical facilities to increase capacity and access.

Percentage of Revenue Under Global Budgets

Members provided diverse feedback on which services should be excluded from the Global Budget Revenue model. Among the services mentioned, obstetric care, hospital-at-home, and

advanced diagnostic imaging (e.g., MRI) were highlighted as areas that may benefit from a more flexible reimbursement model.

Conclusion

The MHA vision for today and for the future is to have healthy hospitals and healthy communities. This is an important moment for the Maryland Model as we transition to the AHEAD Model. Our hospitals will be central in the effort to improve health quality, health equity, and population health. They must be empowered and resourced to meet the challenge of caring for Marylanders who are aging and have increasingly complex health needs. HSCRC must act swiftly to adopt and implement policies that will support hospital sustainability and enable our hospitals to meet baseline patient needs, invest in care transformation and population health, and make needed capital investments.

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

Sincerely,

Melony G. Griffith
President & CEO

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