maryland
health services
cost review commission

The Maryland Model and Hospital Responses to the COVID-19 Pandemic

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

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Summary

The report, drafted in response to a request in the 2022 Joint Chairmen's Report (JCR), provides background information on the Maryland Health Model, an analysis of financial challenges faced by hospitals due to the COVID-19 pandemic, a description of State and Federal responses to these financial challenges, and a description of actions taken by the Maryland Health Care Commission and the Maryland Department of Health to increase hospital bed capacity during the COVID-19 pandemic.

The Health Services Cost Review Commission (HSCRC) analyzed the financial challenges faced by hospitals due to the COVID-19 pandemic. The following three impacts of the pandemic contributed to these financial challenges:

1. The number of patients visiting the hospital decreased as potential patients were required or chose to forgo inpatient and outpatient hospital visits, resulting in a significant loss of revenue for the hospitals.
2. How the change in the mix of different types of patients in hospitals, with an increase in COVID-19 patients (a patient-type that was unexpected before the pandemic) and a decrease in other patients, interacted with the HSCRC-regulated rates and GBRs.
3. The added costs of preparing for COVID-19 patient spikes through the expansion of hospital capacity and the acquisition of special supplies, including personal protective equipment (PPE).

The State of Maryland and the Federal Government took action to ensure financial stability for hospitals during the COVID-19 pandemic. These actions included direct funding from the State and Federal Governments. In addition, HSCRC adopted the following three policies which provided adjustments to the global budgets which apply to acute care hospitals in Maryland:

1. Global Budget Guarantee, which allowed hospitals that did not have enough patient volume to meet their annual global budget to increase charges and/or roll over expected revenue in the next year.
2. COVID Surge Funding, which provided additional funding for hospitals whose volume of patients exceeded the expected volume used to calculate the hospital's Global Budget Revenue (GBR) due to COVID-19 patients.
3. COVID Expense Adjustment, which was designed to support hospitals facing high expenses and reduced margins due to the pandemic.

These policies were successful in supporting hospitals financially during fiscal years 2020 and 2021[1]. HSCRC was able to implement these policies in part due to the Total Cost of Care Model Agreement with the Centers for Medicare and Medicaid Services (CMS).

Finally, the report provides information on the successful efforts taken by the Maryland Health Care Commission and the Maryland Department of Health to increase hospital bed capacity during the pandemic, in addition to ongoing efforts led by the Maryland Department of Health to ensure sufficient health system capacity for future surges.

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[1] This report will not address 2022 as the period was not complete in time to analyze for this report.

Introduction

The 2022 Joint Chairmen's Report (JCR) directed the Health Services Cost Review Commission (HSCRC) to provide an overview of how the unique Maryland Health Model impacted the State and the State's hospitals during the COVID-19 pandemic. Specifically, the JCR included the following language:

> Maryland has long been a unique state in terms of hospital financing and regulations. During the COVID-19 pandemic, this system was able to provide financial stability and relief to the State's hospitals. The committees are interested in how the State's model impacted the State and State's hospitals in terms of stability and operations during the pandemic when compared with other hospitals in the nation during this crisis. Further, the committees are interested in the costs associated with the pandemic: both in terms of the treatment of COVID-19 hospitalizations by payor; and the indirect costs incurred in hospital operations during this period. This cost discussion should also include information on additional funding received by the hospital outside of the model that were considered in rate setting, such as the provider relief fund, and include the extent to which additional funding received by the hospitals have assisted with hospital staffing and salaries during this period. Further, the report should discuss the jurisdictional distribution of these additional, non rate-related funds, as well as the rate-related funding. Additionally, the committees are interested in the financial performance of the hospital industry in fiscal 2022 and any liabilities that the State's current hospital financing stability has presented to the ongoing success of the State's model agreement, the Total Cost of Care model. Further, the report should address the challenges faced during the pandemic due to a lack of surge capacity existing in the State's hospitals prior to the pandemic, any lessons learned during the initial response COVID-19 pandemic, and how those lessons will be applied for future surge planning. The committees request that the Health Services Cost Review Commission… submit a report addressing these areas.

This report provides background information on the Maryland Health Model, including the Total Cost of Care (TCOC) Model Agreement with Centers for Medicare and Medicaid Services (CMS) and the HSCRC's hospital rate setting authority; a description of the financial challenges faced by hospitals due to the COVID-19 pandemic and the accommodations made by the HSCRC to offset these challenges; and the overall impact of the pandemic on hospitals' financial stability. The report also discusses how these factors impacted costs to health care payers (including Medicare, Medicaid, commercial insurers, and individual patients). The report discusses the challenges created for the State's performance under the Total Cost of Care Model by the combination of the COVID-19 pandemic and the State's funding model. Finally, the report provides information on the efforts taken by the Maryland Health Care Commission and the Maryland Department of Health to increase hospital bed capacity during the pandemic, in addition to ongoing efforts to ensure sufficient health system capacity for future surges.

Maryland Health Model Background

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth under the unique Maryland Health Model. The Maryland Health Model is built upon two major components, the Total Cost of Care Model Agreement with the federal government and Maryland's long-standing all-payer hospital rate setting system. The Health Services Cost Review Commission (HSCRC) helps develop the State's innovative efforts to transform the delivery system and achieve goals under the Model.[2] The Maryland Health Model—

- Incentivizes better health outcomes through pay-for-performance programs, linking quality and payment.
- Guarantees equitable funding for uncompensated care, ensuring that low-income individuals have access to care at all hospitals.
- Creates a stable and predictable revenue system for hospitals, a benefit of the Model that has been particularly important in the pandemic.
- Uses savings generated from reduced hospital utilization to fund investments in social determinants of health and population health; and
- Provides support for pioneering state healthcare infrastructure and subject matter expertise on health care financing and reform.

Achieving the goals of the Model is a collaborative effort between the State, hospitals, non-hospital providers, payers, and a broad spectrum of community partners, all working together to create long-term health improvements and cost savings for Marylanders.

The Total Cost of Care (TCOC) Model Agreement

The TCOC Model, which began in January 2019, aims to enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders. The TCOC Model builds on the success of the All-Payer Model, which ran from 2014 through 2018. The TCOC Model is an agreement between the State of Maryland and the Federal Centers for Medicare and Medicaid Services.

Under the TCOC Model, acute care hospitals are subject to global budgets, expanded hospital quality requirements, and other incentives and requirements to control costs. In addition, the Model incentivizes hospital and non-hospital providers to engage in care transformation and partnerships across settings of care, including investment in primary care through the Maryland Primary Care Program (MDPCP). The

[2] The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high quality healthcare through hospital global budgets and innovative efforts to transform the delivery system.

TCOC Model also includes substantial investment in population health initiatives focused on diabetes, opioid use, and maternal and child health.

Each year, Maryland must achieve six performance targets under the TCOC Model:

- **Annual Medicare Total Cost of Care Savings Target**: By 2023, Maryland must achieve $300 million in annual savings.
- **Guardrail Test:** Maryland must not exceed national Medicare spending per-beneficiary growth rate by more than 1% in any year and/or exceed that growth rate by any amount for two years in a row.
- **All-Payer Hospital Revenue Growth Per Capita:** Maryland must keep all-payer hospital revenue growth equal to or below 3.58% per capita annually.
- **Readmissions Reductions for Medicare:** Maryland's readmission rates must be equal to or better than National and prior Maryland Medicare readmissions rates.
- **All-Payer Reductions in Hospital- Acquired Conditions:** Maryland's performance on a measure of all-payer potentially preventable conditions must be equal to or better than previous Maryland performance on that measure.
- **Hospital Revenue under Population-Based Payment Methodology:** Maryland must have at least 95% of hospital revenue under a population-based payment methodology (i.e., global budget revenue) over the course of the Model.

In 2019 and 2020, Maryland met or exceeded these performance requirements. In 2021, Maryland met all targets except for the readmissions target. HSCRC has requested a waiver of that requirement for 2021 from CMS based on exogenous factors (i.e. the COVID-19 pandemic).

Maryland's all-payer hospital rate setting system

Since the 1970s, HSCRC has set rates for hospital services in the State of Maryland. In 2014, HSCRC adopted hospital global budget revenues (GBRs), which gives each acute care hospital an annual budget based on the population the hospital serves, rather than paying for each service the hospital provides. The global budget revenue system rewards efficiency, supports population health, and helps achieve better health care, better outcomes, and lower costs for Marylanders. Hospitals are encouraged to develop strategies that help keep patients healthy, including:

- improving care coordination and discharge planning to make sure patients leave the hospital with the right medications and care plan to avoid readmissions;
- coordinating with primary care doctors to help manage chronic conditions; and
- reducing inefficient and unnecessary care, which increases costs and puts patients at risk for harm.

The goal of this payment system is for patients to receive the right amount of care in the right setting so that they can be healthier and allow hospitals to focus on treating the sickest patients.

HSCRC sets an annual revenue target (GBR) for each hospital by taking into account inflation, changes in population, the hospital's performance on quality and efficiency metrics, and other factors. Each hospital is expected to meet their annual global budget revenue by charging rates that, in total, equal the GBR.

Hospital Financial Challenges during the COVID-19 Pandemic

Hospitals across the nation experienced financial challenges resulting from the COVID-19 pandemic, including lost revenue from reduced patient volumes, the cost of caring for patients with an entirely new disease, and additional overhead and supply costs. These challenges are described below.

Loss of Revenue from Decreased Patient Volume

In the Spring of 2020, hospitals across the country experienced severe declines in patient volumes. These volume declines were due to patients delaying care for non-COVID medical conditions and to a State public health order that prohibited "elective and non-urgent medical procedures" between March 24, 2020 and May 6, 2020.[3]

Figures 1 and 2 show Maryland hospital volumes from February to August 2020 as a percentage of pre-pandemic levels from the prior year. This shows how volumes precipitously declined at the onset of the pandemic before recovering once the first wave passed and prohibitions on elective procedures were lifted.[4] Outpatient volumes (Figure 2) show particularly significant declines.

For context, peak COVID-19 hospitalizations due to the first wave of COVID-19 occurred on May 5, 2020, with more than 1,700 COVID-19 patients in hospitals in the State (see Figure 3). During this first wave, COVID-19 patients never exceeded 28% of daily hospitalizations and all hospitalizations stayed below 85% of hospitals' staffed capacity.[5]

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[3] https://governor.maryland.gov/wp-content/uploads/2020/03/03.23.2020-Sec-Neall-Healthcare-Matters-Order.pdf; https://governor.maryland.gov/2020/05/06/governor-hogan-announces-resumption-of-elective-medical-procedures-broadening-of-outdoor-activities-under-stay-at-home-order/. Hospitals were also ordered to reduce or suspend elective procedures in other stages of the pandemic, if needed, to meet the needs of responding to COVID-19 and other urgent care patients. According to the Maryland Hospital Association, during the Omicron surge at the end of 2021, 15 hospitals in Maryland operated under crisis standards of care, which may have included delaying these procedures.

[4] The first COVID-19 wave lasted from March 2020-July 2020.

[5] https://coronavirus.maryland.gov/

Figure 1: Inpatient Volumes as a % of Same Month 2019 Levels, February to August 2020.[6]

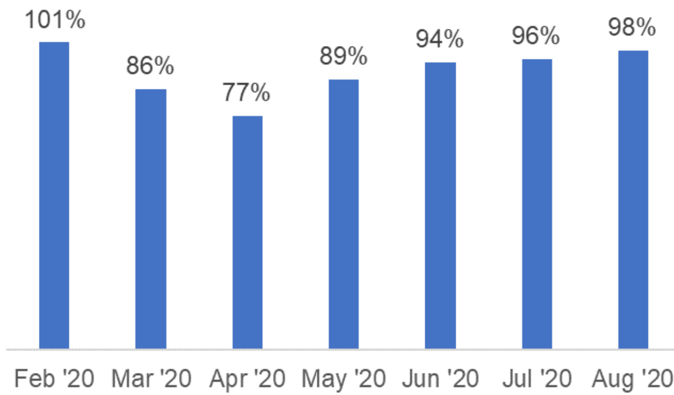
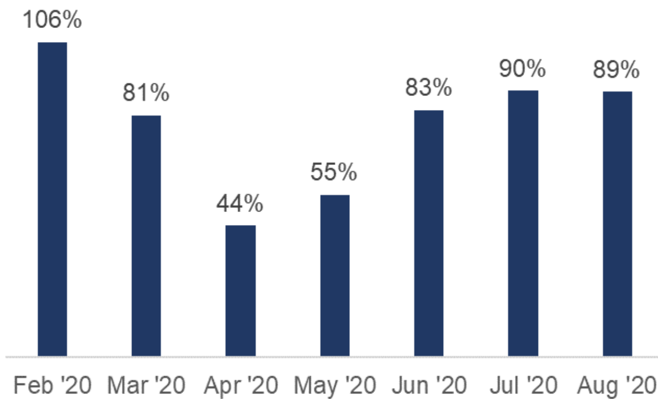


Figure 2: Outpatient Volumes as a % of Same Month 2019 Levels, February to August 2020.[7]



[6] HSCRC Monthly Volume reports.

[7] HSCRC Monthly Volume reports. Emergency Department (ED) volumes are excluded from Figure 2, as the data for ED volumes is not comparable over this time period because of a change in the unit scale used to measure ED volume that was implemented in June 2019. The HSCRC estimates outpatient declines would be somewhat larger if ED volumes were included.

Figure 3: Daily number of hospitalized patients by COVID-19 and ICU or acute care status, March through August 2020.[8]

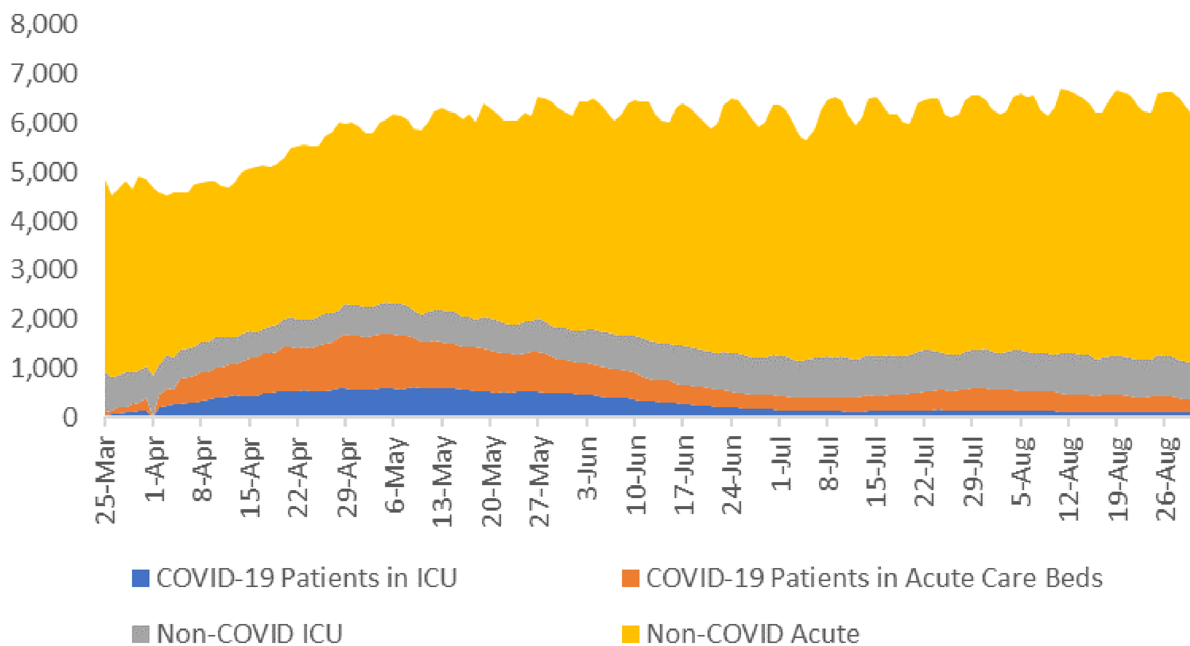
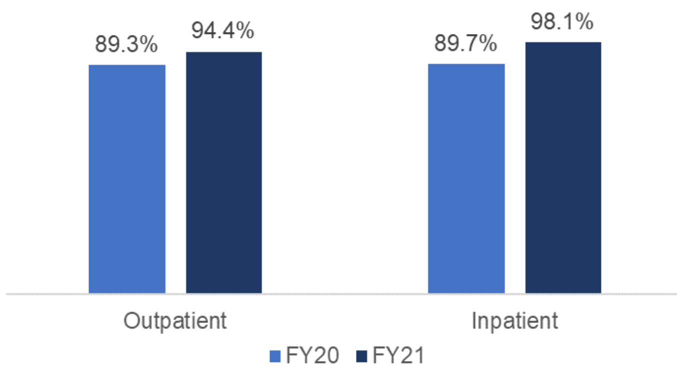


Figure 4: FY 2020 and FY2021 Annual Volume as a % of 2019 pre-pandemic levels.



[8] A version of this graph is available for all dates on https://coronavirus.maryland.gov/.

COVID-19 Patients, Rates, and GBRs

The second financial challenge for hospitals during the COVID-19 pandemic was the unexpected increase of a new patient type (i.e. COVID-19 patients) and the direct cost of caring for these unique patients.

HSCRC set the rates for the services at a granular level, i.e., per patient day, laboratory test, imaging test etc. HSCRC rates for each service are developed to align with the costs involved in providing the service. Services provided to COVID-19 patients use these same rates and therefore reflect the cost of the services provided (although the suite of services used is different, as it is for every unique patient type). However, the total annual amount billed using HSCRC rates is subject to the limitations of the hospital's overall global budget for revenue. Thus, hospitals were appropriately reimbursed for services provided to COVID-19 patients as long as the hospital did not hit the GBR limit. For much of the pandemic, this limitation was not a concern because direct care for COVID-19 patients was a small minority of total hospital spending. For example, for Maryland's Medicare Fee for Service (FFS) population in Calendar Year (CY) 2020 and Calendar Year 2021, COVID-19 patients accounted for 5.7% and 4.7% of total hospital spending, respectively.[9] In addition, for much of the pandemic, the drop in volume in non-COVID patients suppressed the total revenue of most hospitals, offsetting the increase in revenue from COVID-19 patients.

However, as non-COVID volumes returned later in the pandemic, hospitals could become underfunded if the rates associated with their non-COVID patient volume, combined with the rates for the unexpected COVID-19 patient volume, exceeded their GBR. HSCRC calculated that, in FY 2021, hospitals statewide lost $48 million of COVID patient revenue due to volume that exceeded the GBR. Hospitals did not lose any funding in FY 2020. The HSCRC developed a COVID Surge Funding Policy to address this potential issue. This policy is described later in this report.

In summary, the direct cost of caring for COVID patients was not the major financial challenge of the pandemic because (a) hospitals were reimbursed for COVID patients based on the services they needed, (b) COVID patients represented a small share of total hospital spending, and (c) the HSCRC's COVID Surge policy mitigated the potential financial impact when COVID volumes were sufficient to exceed the hospital's GBR.

Additional Overhead and Direct Costs

Hospitals incurred unexpected overhead and direct costs as a result of the COVID-19 Pandemic.[10] Specific overhead and direct cost areas experienced significant increases. The "Hospital Administration" category in hospital financial reports to HSCRC captures much of the unusual cost growth in the pandemic. This

[9] HSCRC calculation based on Maryland Medicare FFS claims in Medicare's Chronic Conditions Warehouse.

[10] This discussion includes costs that are not direct costs for COVID-19 patient care. These costs generally fit into overhead cost categories.

category of expenses increased by 19% from FY 2020 to FY 2021. Examples of these costs include the cost of preparing additional space in anticipation of a surge in patients, additional costs to retain and reward staff working under pandemic conditions, and buying supplies like personal protective equipment in quantities and at prices beyond normal levels. These added costs were offset, however, by savings in other areas. These savings were driven by volume declines and hospital cost management strategies.

Figure 5: HSCRC-Regulated Hospital Overhead Costs, 2014 to 2021, in Billions[11]

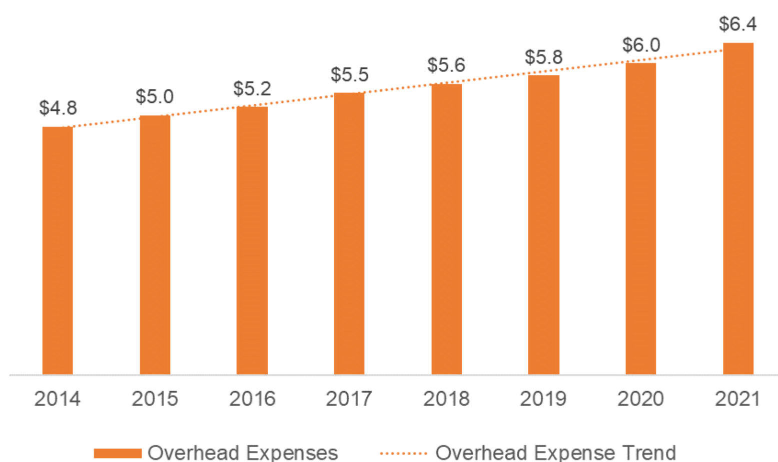


Figure 5 depicts overhead cost by year from 2014 when GBRs began. Historically, overhead costs have generally grown in line with inflation. 2021 cost growth was slightly above the average trend but the year over year (YOY) administrative cost growth during the COVID-19 pandemic was within the normal range in the long-term context.[12]

Mitigating Hospital Financial Challenges

HSCRC and the Federal Government took action to provide financial support to hospitals during the COVID-19 pandemic to ensure that hospitals had the resources to meet the challenges described above. These government actions include Federal and State funding for hospitals and three HSCRC policies which adjusted normal GBR and rate setting rules: (1) a Global Budget Guarantee, (2) COVID Surge Funding, and (3) a COVID Expense Adjustment. These actions are discussed in detail below.

[11]HSCRC Annual Filings. Costs include both Schedule C and Schedule UA from those filings. Schedule C represents mostly salary driven overhead such as administration and patient accounting while Schedule UA represents mostly non-salary overhead such as depreciation, malpractice, and interest.

[12] HSCRC fiscal years 2020 and 2021 data. Final Fiscal Year (FY) 2022 financial reports are not yet available.

Federal and State Funding for Hospitals and GBRs

Hospitals received direct funding from the Federal and State Government in response to the pandemic. In order to control hospital rates in the State, HSCRC took some of the federal funding into account in setting GBRs for the hospitals.

Throughout the COVID-19 pandemic the Federal Government provided direct funding to hospitals through the Coronavirus Aid, Relief, and Economic Security Act (CARES), the American Rescue Plan Act (ARPA) (received both directly from the Federal government and via the State) and FEMA funds. The Federal Government also provided hospitals with reimbursement adjustments under Medicare.

The most significant source of federal funding for hospitals was the Provider Relief Fund (PRF) under the CARES Act. This intervention provided direct payments to hospitals and other health care providers to offset lost revenue resulting from declines in patient volumes and the added costs for overhead and COVID-19 patient care.[13] Maryland hospitals were fully eligible for this program and to date have received $1.321 billion from the PRF. Approximately $20 million of these funds went to Maryland hospitals that are not subject to GBRs (psychiatric hospitals and Maryland's only children's hospital) and the remainder ($1.301 billion) was provided to hospitals subject to GBR.

For the hospitals subject to GBR, HSCRC decided to take some of the PRF funds into account in rate setting decisions. This lowered the burden on health care payers in Maryland (Medicare, Medicaid, commercial insurance, and individual patients) by reducing the amount that the payers would otherwise have funded through rates. Including PRF funds in HSCRC rate setting was complex for a number of reasons:

- PRF funds were awarded at a hospital entity level. However, HSCRC's rate setting authority does not apply to the whole hospital entity, but only to certain hospital services.[14] Therefore, some of the PRF funding could be interpreted as "belonging" to services that are not regulated by the HSCRC.
- The Federal government allowed entities to move PRF funds that were used in one health entity to another entity in the same health system. This means that a hospital system could move PRF funds from an HSCRC-regulated entity to an entity that is not subject to HSCRC rate-setting.
- The PRF funding was provided in multiple tranches. The timing of these awards and the periods for which it was intended to be used did not always align with the time periods used by HSCRC to assess Global Budget funding.
- The Federal government used various methodologies to allocate PRF funds to specific hospitals. These methodologies were set on a national basis using national data sets. The resulting funding

[13] The HSCRC notes that the Federal government's conceptual approach to offsetting lost revenues was a "global budget" type approach that calculated amounts due as the difference between actual revenue and historic or hospital budget revenue, rather than estimating the specific volume drop and pricing it on a FFS basis.

[14] The scope of HSCRC's authority is specified in Part 2 of Subtitle 2 of Title 19, Health General, Maryland Code.

did not always allocate money among Maryland hospitals in a way that was consistent with how the HSCRC measured the relative financial impact of the pandemic on each Maryland hospital.

After working with the hospital industry to understand PRF funding, the HSCRC ultimately considered $1.112 billion of the $1.301 billion provided to hospital entities in Maryland to be relevant to FY 2020 and FY2021 hospital global budgets. This $1.112 billion was considered in the HSCRC's rate setting decisions as discussed in the next section. The remaining balance ($189 million) was either allocated to services that are not regulated by HSCRC ($150 million) or will be considered for FY 2022 ($38 million).

In addition to the PRF, hospitals received funding from a number of other federal sources, including funding from the American Rescue Plan Act (ARPA) and FEMA. Some of the ARPA funding was paid directly to hospitals by the federal government. The State also allocated some ARPA money to hospitals. The HSCRC did not consider the ARPA or FEMA funds in setting hospital rates in FY 2020 or FY 2021. HSCRC did consider the $80 million dollars in ARPA funds allocated by the State to hospitals as a factor in setting FY 2022 and FY 2023 hospital rates.

With respect to Medicare reimbursement adjustments, the Federal Government suspended the application of a 2% Medicare payment reduction that otherwise would have applied for the period of May 1, 2020, through March 31, 2022, on a nationwide basis.[15] This adjustment in Medicare reimbursement applied in Maryland and benefited Maryland Hospitals.[16]

Global Budget Guarantee

At the start of the COVID-19 pandemic the HSCRC provided a Global Budget guarantee for hospitals. The guarantee had two components, 1) corridor relief and 2) carryover of undercharges. These policies are described below.

Corridor Relief

HSCRC allowed hospitals to raise hospital rates higher than what is normally permitted during the end of FY 2020 and the beginning of FY 2021. This policy is generally known as "corridor relief". HSCRC normally allows hospitals to adjust their rates +/- 5% per service in order to meet the annual global budget revenue set by HSCRC. Because of the drop in patient volume during the COVID-19 pandemic, the +/- 5% corridor for rate adjustments was insufficient to make up for the lost revenue that hospitals were experiencing from

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[15] "Congress waived the automatic 2% reduction in Medicare payments required under budget rules (i.e., sequestration) between May 1, 2020 and March 31, 2022, delayed until 2023 a separate 4% reduction in Medicare payments that would otherwise have been triggered in 2022 under PAYGO rules, and increased physician payments by 3% for 2022 under the Medicare Physician Fee Schedule (PFS) payments to mitigate scheduled budget neutral cuts." https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/

[16] A national 20% increase in Medicare reimbursement for COVID-19 patients did not apply in Maryland because of the federal government's waiver of national Medicare rate setting rules for Maryland, which gives HSCRC the authority to set Medicare hospital rates, a component of Maryland's all-payer hospital rate setting system which has been in place since the 1970's. As noted below, HSCRC provided other forms of financial relief for hospitals.

reduced volume. While the corridor relief policy was in effect, HSCRC permitted hospitals to increase rate corridors to 20% above approved rate order unit rates for rate centers that provided 100% inpatient patient care, and to 10%above approved rate order unit rates for all other rate centers.[17] The corridor relief policy allowed hospitals to adjust rates to increase revenue (subject to the limit of the hospital's annual GBR) to help the hospital maintain financial liquidity.[18] The corridor was set at +20% to balance the policy goals of protecting hospital liquidity while limiting price increases on payers in Maryland. For some hospitals, the corridor relief was not sufficient to generate revenue equal to the hospital's GBR. However, HSCRC felt that the 20% limit on rate increases, combined with the limit of the GBR, was important to protect consumers by limiting price growth.

Carryover of Undercharges

As noted above, some hospitals were unable to charge rates equal to their GBR in FY 2020 and FY 2021, even with the corridor relief. For these hospitals, the difference between the amount the hospital earned in the year and the hospital's GBR is referred to as an "undercharge".

Normally HSCRC expects hospitals to generate revenue to meet their annual GBR. Hospitals with undercharges do not have an opportunity to recoup that "lost" revenue. In addition, if the undercharge was more than 0.5% of the GBR, the hospital would be subject to a financial penalty in addition to the amount of the lost revenue.

Under HSCRC's COVID-19 policies, HSCRC allowed hospitals to carry forward the amount of undercharged revenue in a year to the next year, increasing their GBR by the amount of the prior year's undercharge. The purpose of this policy was to provide hospitals with financial stability while spreading out the rate increases from lost patient volume over time (rather than allowing larger corridor relief in a year), so that the rate increases would be smaller than if the hospitals were trying to meet the GBR in a single year. In effect, the system gave hospitals a promise of future payment.

Hospitals could afford to accept this promise of future revenue because of the financial stability generated by the GBR system over time, which provided hospitals with revenue to invest in the market. As of June 30, 2019, the Maryland-based health systems who own the vast majority of Maryland hospitals had

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[17] Select hospitals already had HSCRC-approved corridor relief in excess of 5% prior to the pandemic. For these hospitals the cap for non-inpatient rate centers was their current level plus 5%.

[18] The GBR system is a form of capitation. Under most capitation approaches, the recipient of the capitation is paid per beneficiary regardless of the specific service utilization in any period. Under GBRs, rates are set on a capitation basis but paid on a service basis. Under this system, the amount paid for any specific service is immaterial to a payer, who cares only about the total cost, which is limited by the GBR. The amount for any specific service is very material to the individual who has a cost share. This interplay between GBRs and consumer out-of-pocket costs exists under HSCRC's rate-setting system under normal circumstances, and is managed, in part, through the rate corridors. In a period of dramatic patient volume declines, such as the COVID-19 pandemic, HSCRC does not consider it appropriate to raise rates to fully offset the volume loss as it would result in unconscionable charges to the individual. This structure limits the Commission's ability to mitigate the revenue shortfall, but helps to protect consumers.

approximately $11.3 billion in cash and investments on hand.[19] Thus, these systems were well positioned to maintain operations despite the financial impact of the COVID-19 pandemic.

Federal Funds Offset

At the time the HSCRC adopted the policy to guarantee hospital GBRs, it was not clear what, if any, federal assistance would be provided to hospitals. Once federal funding was provided to hospitals, HSCRC elected to offset a portion of the PRF funds received by hospitals against the hospitals' GBRs. This effectively reduced hospital rates, so that payers in Maryland (including consumers) were responsible for a smaller share of the GBR. HSCRC's goal in this policy was to put Marylanders in a roughly analogous position to what occurred in other States, which had no global budget guarantee policy, in terms of the impact of PRF relief on hospital financial health.

Figure 6 (below) provides a summary of the funding HSCRC provided to hospitals and the federal offsets that HSCRC applied to GBRs. Column A shows the total shortfall versus the GBR as described above. Columns B and C show the amounts provided to hospitals under HSCRC's policies allowing corridor relief and the carryforward of undercharges in order to guarantee GBR. Column E shows the federal amounts that were offset against the GBR by HSCRC. The federal amounts in column E are less than the full amount of PRF funds provided to hospital systems in Maryland (the $1.112B referenced above) as there are mismatches at a hospital level between the amounts granted by the Federal government and the amount required for the federal funds offset as calculated by the HSCRC. When the Federal relief exceeded the HSCRC-calculated need, the hospital retained that revenue.

Figure 6: Corridor Relief, Carryover of Undercharges, and Federal Offsets, FYs 2020 and 2021

Period	A. Total GBR Shortfall Calculated as described above	B. Additional Corridor Relief	C. Undercharge Carryforward funded by HSCRC	D. Net HSCRC Funding Beyond Normal Rates (=B+C)	E. Federal Funds Considered as an Offset to GBR	F. Unfunded GBR Shortfall (=A - D - E)
FY 2020	$1,225 M	$284 M	$188 M	$472 M	$753 M	$0
FY 2021	$510 M	$250 M	$83 M	$333 M	$177 M	$0
Combined	$1,735 M	$534 M	$271 M	$805 M	$930 M	$0

[19]Audited Health System financials submitted to the HSCRC. Amount reflects cash and short and long-term investments excluding those with donor or other restrictions but including board-designated funds. Health systems whose operations are primarily outside Maryland are excluded to avoid counting reserves that are not applicable to Maryland hospitals.

HSCRC COVID Surge Funding

In addition to the Global Budget Guarantee policy described above, in the Spring of 2020 the HSCRC adopted the COVID Surge Funding Policy. This policy specified the circumstances under which a hospital could receive reimbursement for patient volumes that exceeded the volumes predicted in their GBR. Under normal circumstances, a hospital is not allowed to charge more than their GBR in a year and is subject to lost revenue and a penalty if such charges occur. This is meant to incentivize hospitals to control patient volumes. As described above, the HSCRC viewed the COVID-19 pandemic as an exception to the general rule that hospitals should not be allowed to increase funding through increasing volumes. If, in a surge, volumes increased more than the GBR predicted, HSCRC determined that the hospital should be reimbursed for that cost and not be penalized for exceeding GBR. While many hospitals experienced drops in patient volumes during the pandemic, some hospitals had periods of time when combined non-COVID patient volume and COVID-19 patient volume exceeded expected levels of services outlined in a hospital's rate order from HSCRC. Under the COVID Surge funding policy hospitals were due $48 million for FY 2021, of which $16 million was offset against Federal Funds and the remainder paid to hospitals. No amounts were due for FY 2020 as decreases in patient volume in other service lines more than offset COVID volumes.

HSCRC COVID Cost Adjustment

As noted earlier in this report, the COVID-19 pandemic increased hospital administrative costs. The HSCRC is planning to review these costs by looking at FY 2020, FY 2021, and FY 2022 on a combined basis.[20] The HSCRC is evaluating these costs in the context of savings in other areas, other sources of hospital revenue, and the long-term financial stability enjoyed by Maryland hospitals under Maryland's rate-setting system. The HSCRC is developing a three-part test that considers cost growth as well as overall impact on hospital margins. This test determines whether (1) hospital expense growth has outstripped HSCRC-approved revenue growth, (2) operating margins have dropped by an abnormal amount during the COVID pandemic, and (3) a hospital's margins were low in comparison to other Maryland hospitals. The data analysis completed to date suggests that in FY2020 and FY2021, most hospitals did experience expense growth that has outstripped their HSCRC-regulated revenue growth; however, their respective operating margins for HSCRC-regulated services did not experience abnormal decreases, primarily due to funding for other sources. Therefore, the HSCRC expects reimbursement for 2020 and 2021 under the final COVID Cost Adjustment policy to be minimal and limited to a few hospitals with outlier experiences.

[20] Final Fiscal Year (FY) 2022 financial reports are not yet available.

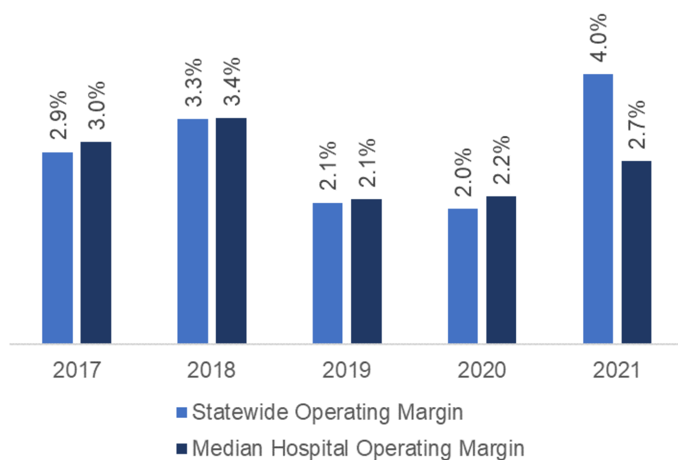
Impact of the COVID-19 Pandemic on Hospital Financial Stability

Due to Federal and State mitigations, hospital finances remained steady during FY 2020 and FY 2021.

Figure 8 (next page) summarizes the various hospital revenue sources and revenue losses related to the COVID-19 pandemic for FY 2020 and FY 2021. During this period, funding exceeded losses primarily because the hospitals that received greater Federal funding than the HSCRC-calculated need were able to retain that funding for use in other entities.

Hospital financial results for FY2020 and FY2021 were well within historical norms. Figure 7 compares FY2020 and FY2021 margins to the prior three pre-pandemic years. While 2020 is a little low, 2021 is higher resulting in overall margins well within historic ranges. Based on these figures, HSCRC has concluded that increased costs were covered by the various sources of reimbursement.

Figure 7: Hospital Operating Margins[21], FY2017 to FY2021



[21] Source: HSCRC calculation from hospital Annual Filings, amounts reflect both HSCRC-regulated and unregulated business of HSCRC-regulated entities. Margins for HSCRC-regulated business only show similar consistency across time.

Figure 8: Recap of COVID-related Hospital Funding Sources and Uses for FY 2020 and FY 2021

Item	Amount
Revenue Losses/Cost Increases	
Volume Driven Revenue Shortfall	$1,735 M
COVID Volumes beyond GBR	$48 M
Net COVID Expenses	TBD but minimal expected
Total	$1,783 M
Funding Sources	
Federal PRF	$1,221 M
HSCRC Global Budget Guarantee provided through Corridor Relief and GBR carryforward	$805 M
HSCRC COVID Surge Policy	$32 M
HSCRC Covid Expense Adjustment	TBD but minimal expected
State ARPA Funds	To be considered in FY 2022
Other Federal Sources	Not quantified
Total	$2,058 M

In addition to stable operating margins, hospitals also enjoyed strong non-operating margins in 2020 and 2021 due to investment returns. Among the Maryland-based health systems that own the vast majority of Maryland hospitals, total cash and investments increased from $11.3 billion on June 30, 2019, to $13.9 billion[22] as of June 30, 2021 (excluding cash from Medicare payment advances). Thus, Maryland hospitals' financial stability has not been negatively impacted by the COVID-19 pandemic through FY 2021.

Cost of COVID-19 Hospitalization by Payer

Generally, due to Maryland's all-payer system, the rates for hospitals in Maryland are higher than other parts of the country for Medicare and Medicaid and lower for private insurance and self-pay patients. The relative rates for different payer types in Maryland were not significantly impacted by the COVID-19 pandemic. This section describes the impact on each insurance type: Medicare, Medicaid, commercial insurance, and self-pay/uninsured individuals. As noted above, the Corridor Relief Policy increased rates for all payers by up to 20% while it was in effect. The Surge policy allowed hospitals to charge for volume that otherwise would have been prohibited due to the GBRs, increasing costs to payers. At the same time, many hospitals had reductions in patient volumes, which resulted in undercharges, reducing costs to payers in the year the undercharge was incurred. HSCRC's policy allowing for the carryover of undercharges does mean that rates increased in the periods following the undercharge. However, the net carryforward amount of $271 million[23] is only 1.4% of total annual hospital charges of approximately $19 billion per year, and therefore will have a minimal impact on rates paid by any single business or consumer.[24] HSCRC used some federal funds and plans to use State direct funds to offset rate increases resulting from these policies to decrease the burden on payers.

Nationally, Medicare raised its standard rates by 20% for COVID-19 patients. This increase did not apply in Maryland. In Maryland, the Corridor Relief Policy discussed above likely had about the same impact on Maryland hospitals but on an all-payer basis and across all inpatient services, not just services provided to COVID-19 patients.

For Medicaid, since hospital payment policy in Maryland doesn't exist outside the HSCRC, there is not a counterfactual to compare actual experience against. Per-service costs for Maryland Medicaid will have increased due to the additional funding provided to hospitals, but it is impossible to say whether these increases exceeded what the State might have done in the absence of the Total Cost of Care model.

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[22] Audited Health System financials submitted to the HSCRC. Amount reflects cash and short and long-term investments excluding those with donor or other restrictions but including board-designated funds. Health systems whose operations are primarily outside Maryland are excluded to avoid counting reserves that are not applicable to Maryland hospitals.

[23] From Figure 5, column C.

[24] In practice the $271 M was spread over multiple future years further diluting the impact on costs in any one year.

Pre-pandemic rates paid by commercial insurance (and ultimately funded through premiums by businesses and individuals) in Maryland were some of the lowest in the nation.[25] Analysis by the HSCRC found that Maryland's private insurance costs per unit of inpatient service were 25% below the private insurance costs per unit in similar areas in the rest of the country in 2018.[26] It is theoretically possible that the Corridor Relief policy permitted during the COVID-19 pandemic may have eroded this advantage as commercial payers elsewhere would not have been obliged to increase their rates as they would under this policy in Maryland. The HSCRC does not have the national data to evaluate the impact of this policy on commercial insurers in Maryland relative to the nation during the pandemic at this time. However, the extra payments that resulted from the Corridor Relief policy are small compared to the total costs of commercial insurers in Maryland. Thus, HSCRC expects that Maryland's commercial insurance costs remained lower than commercial insurance costs in comparable areas in other states, despite the Commission's COVID-19 policies for hospital charges.

Research published by FAIR Health, an independent not-for-profit aggregator of insurance claims data, found Maryland in the lowest quintile in the Nation for COVID-19 complex inpatient, non-complex inpatient, and outpatient charge amounts.[27] Because all-payers, including self-pay patients, pay the same amount for hospital services in Maryland, this means that self-pay patients in Maryland faced relatively low charges for COVID-19 treatments compared to patients in other states.

Total Cost of Care Model Challenges

Generally, the Total Cost Care Model performed well during the COVID-19 pandemic. The performance of the Model can be viewed through two lenses: its success in managing Maryland healthcare costs while maintaining a stable hospital industry, and its success in achieving the goals set by CMS.

Impact on Maryland Hospitals and Consumers

The long-term stability of the Model meant Maryland's hospitals, even in rural areas, entered the COVID-19 pandemic in a strong financial position. In April 2020, HSCRC responded quickly to provide short-term flexibilities through the GBR system to guarantee hospital revenues, to provide financial support for hospitals facing COVID-19 costs and major losses in patient volumes.

Federal CARES Act funding provided a national safety net for hospitals similar to that provided by HSCRC's policies in Maryland. This Federal funding lessened the need for State funding. The Federal and State

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[25] See for example figure 3 in: https://www.milliman.com/-/media/milliman/pdfs/2021-articles/7-1-21-commercial-reimbursement-benchmarking.ashx

[26] Source: Overall Summary of Results CY 2018 8-24.xls available at: https://hscrc.maryland.gov/Documents/August%202020%20Benchmarking%20Materials%2011-10.zip

[27] https://www.fairhealth.org/states-by-the-numbers/covid19-heatmap

actions to mitigate the financial challenges faced by hospitals were effective as Maryland's hospitals were in a stronger financial position at the end of FY 2021 than they were at the end of FY 2019.[28]

The hospital rates paid by Maryland insurers and consumers remained competitive with national averages. HSCRC's policy of offsetting federal funds against future hospital GBRs acted to control charges faced both by payers and consumers.

Impact on TCOC Model Goals

The COVID-19 pandemic had the potential to affect the State's performance under the Total Cost of Care Model. The State must meet annual performance targets and also has broad reform goals related to care transformation and behavioral health.

Maryland must demonstrate to CMS, on an annual basis, that the State has generated Medicare savings compared to the nation. Under a GBR system, hospital revenue is not directly sensitive to patient volumes like it is under a fee-for-service (FFS) system, where hospitals are paid by the volume of services they provide. Therefore, in a period of low volumes such as the pandemic, a GBR-based model, like the TCOC Model, will always struggle to outperform a FFS model in terms of per-capita cost growth. HSCRC's adoption of the GBR Guarantee policy during the COVD-19 pandemic risked hurting the State's performance on the annual Medicare Total Cost of Care Savings Target under the Model. However, much of the funding to maintain the GBR guarantee came from outside the systems in the form of PRF funds, which are not counted in the Medicare savings target. Offsetting GBRs with PRF funds allowed HSCRC to maintain the GBR Guarantee while lessening the risk that the State would fail the annual Medicare savings target under the Model. In addition, Maryland was well ahead of the savings goals prior to the pandemic. Maryland succeeded in meeting the annual Medicare savings target in calendar year (CY) 2020 and CY 2021.

Maryland is also subject to an annual limit on the growth in Medicare spending per beneficiary, compared to the Nation. This is referred to as the "guardrail" test. Maryland must not exceed the national Medicare spending per-beneficiary growth rate by more than 1% in any year and/or exceed that growth rate by any amount for two years in a row. In CY 2020, the State's TCOC per-beneficiary growth rate was 0.5 percentage points below the national. However, in CY 21, Maryland's TCOC per-beneficiary growth rate was 0.6 percentage points above the National growth rate. If Maryland exceeds the national growth rate again in CY 2022, the State will need to implement a corrective action plan under the Model agreement with CMS. HSCRC staff continue to monitor this data and will have a clearer understanding of Maryland's likely performance in CY 2022 later in the year.

[28] Hospitals are facing additional challenges in FY 2022 related to inflation and workforce availability and cost. This report does not address these issues.

Perhaps the most significant challenge to the TCOC model created by the pandemic is the damage to the collective efforts of the hospital industry, payers, and the State to implement programs under the Model that transform care delivery and improve population health, such as the Statewide Integrated Health Improvement Strategy (SIHIS). Providers and State agencies responsible for the public health response to the pandemic needed to focus on such efforts, which resulted in temporary delays in developing, implementing, and improving these programs. The HSCRC is working closely with the industry and other stakeholders to regain momentum to meet TCOC model goals in the years to come.

Surge Response and Future Plans

Hospital capacity in Maryland is influenced by many factors, including finances, regulations related to Certificate of Need (CON) and licensure, workforce availability, and business decisions made by hospitals. From a regulatory perspective, many State entities, including the Governor's Office, the Maryland Department of Emergency Management, the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), HSCRC, and others worked together to develop and implement plans related to hospital capacity in response to the COVID-19 pandemic.

In fiscal year 2019, approximately 9,400 acute care hospital beds were licensed in Maryland.[29] Licensed bed capacity for acute care hospitals in the State of Maryland is dynamic and is calculated annually. Total licensed acute care bed capacity is established for each fiscal year at 140% of the hospital's average daily census, using the average daily census of acute care patients for each hospital for the 12-month period ending with the first quarter of the prior year.[30] In March 2020, in anticipation of a COVID-19-related increase in demand for hospital services, general acute hospitals in Maryland followed orders from the Governor and the Maryland Department of Health to reduce inpatient census by postponing elective procedures, implementing policies to safely shorten the length of stay of patients who could be cared for in other settings, and otherwise discharge patients to other care settings as quickly as possible. This created capacity in hospitals to meet the needs of COVID-19 patients within the existing licensure rules.

In general, while operationally challenged, it is not accurate to portray Maryland hospitals as lacking surge capacity capability when the pandemic arrived. In the years prior to the COVID-19 pandemic, general acute hospitals in Maryland reported to MHCC that the physical bed capacity in their facilities exceeded the amount of beds that were licensed by 1,500 to 2,000 beds. This capacity was in addition to the capacity built into the licensed bed calculation which assumes an average annual occupancy rate of 71%. Thus, hospitals had capacity that could be brought online in an emergency like the COVID-19 pandemic without

[29] Licensed Acute Care Beds by Hospital and Service: Maryland, FY 2019, MHCC, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/FY2019_Tables_Bed_Designation.pdf

[30] Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2018, MHCC, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Annual_Rpt_Hosp_Services_FY2018.pdf

taking extraordinary measures (such as creating new temporary hospital space off-site of existing hospital campuses).

MHCC and MDH, in conformance with the State of Emergency declaration from the Governor, also tailored existing emergency authorization policies to approve temporary bed additions. Beginning in March 2020, MHCC began issuing emergency Certificates of Need under existing regulations in response to the COVID-19 pandemic state of emergency to allow for the addition of hospital beds throughout the State.[31] The MDH, which licenses hospital beds, also began granting emergency approvals to put existing surge capacity into use. In all, MHCC and MDH granted 40+ emergency CONs and MDH authorizations. Most of these CONs and MDH authorizations were issued to hospitals for projects aimed at creating additional bed capacity for infected patients or for relocating low-acuity non-COVID-19 patients to new beds to free up better equipped and monitored bed capacity for infected patients. Emergency CONs were typically issued within 24 hours by MHCC's Executive Director and later confirmed by the Commission. For some hospitals, emergency authorizations were used to add modular bed capacity or field hospital beds to meet the short-term needs of particular service areas. HSCRC's response to the need for surge capacity during the COVID-19 pandemic focused on providing financial stability to hospitals in the State during the pandemic, as described earlier in this report.

MHCC and MDH also authorized three alternate care site hospitals. In 2020, Maryland was fortunate in having two intact recently retired general hospitals located in the suburbs of the District of Columbia; the former UM Laurel Regional Hospital, functioning only as a freestanding medical facility in early 2020, and the former AHC Washington Adventist Hospital in Takoma Park, which had functioned as a general hospital until late 2019. These hospitals were authorized as alternate care site (ACS) hospitals. The Laurel facility was utilized through early 2022 and the Takoma Park facility was used into the summer of 2022. At peak census, the Takoma Park and Laurel ACS hospitals cared for over 300 patients, so they played a critical role in the state's response. MHCC and MDH approved a third ACS hospital at the Baltimore Convention Center. This latter facility was not used for inpatient care to any significant extent, but was an important site for COVID testing in Baltimore City.

By July 1, 2020, hospitals in Maryland had been authorized to set up and staff 12,423 total acute care beds, adding over 3,000 beds to the total licensed bed capacity of 9,400 in place prior to the pandemic. A smaller number of additional emergency CONs were issued in FY 2021. In a significant number of cases, hospitals were able to manage during pandemic-related surges without needing to implement expansion projects approved through emergency approvals, i.e., through use of their normally-licensed bed capacity. Patient

[31] The Maryland Health Care Commission (MHCC) regulates certain types of health care facility capital projects based on a set of regulations referred to as the State Health Plan (SHP). The State Health plan sets standards for the review of applications for a Certificate of Need (CON). Health facilities must apply to MHCC for CONs for the following types of projects: establishing a health care facility; relocating and replacing a health care facility; adding certain services; hospital capital projects requiring an expenditure that exceeds an established threshold; and adding physical beds or operating rooms at certain types of health care facilities.

demand for non-COVID treatment dropped during the pandemic which helped hospitals meet the needs of COVID-19 patients during this period. However, the challenges confronted by the state's hospitals were not uniform. Some hospitals were severely pressed for space and staffing, particularly in the Capital region, but extreme operating conditions were generally of short duration during pandemic peaks. For these hospitals, the additions to normal licensed bed capacity were vital. MHCC and MDH's use of emergency CON and licensure authorities prevented any prolonged periods during which hospitals lacked physical facility capacity to handle patient census. Staffing additional bed capacity is a more difficult and costly issue confronting hospitals than the creation of additional bed space.

At the request of the Secretary of Health, emergency CONs were extended through the Spring of 2022 after the Maryland State of Emergency was lifted. MHCC has since reauthorized the emergency CONs for hospitals that have used that capacity during pandemic surges through April of 2023. At this time, the emergency CONs function as pre-approved contingency plans for future surges rather than implemented projects. Since the significant Omicron surge of the most recent winter months (2021-22), the levels of COVID-19 hospitalization have been manageable within normal hospital licensed bed capacity.

In 2022, the Secretary of Health convened a work group to develop a hospital surge capacity plan premised on the absence of the ACS hospitals in the future.[32] A plan to have surge bed capacity in a constant state of readiness at designated hospitals throughout the State, with the capacity tailored to the projected needs of a region, is in the early stages of implementation. The objective is to have the capability to handle future surges at a regional level without the need to activate new hospital sites (which is expensive and dependent on the availability of appropriate sites) and without the need to empty hospitals of non-pandemic-related patients. Reducing census of non-pandemic-related patients has a severe financial impact on hospitals and can have a negative impact on the health of affected patients. Adequate physical bed capacity will be provided through a combination of designated surge hospitals that can quickly activate additional bed capacity, supplemented with implementation of other efforts (e.g., modular ICU deployment) to provide incremental additions of bed capacity. Other components of the plan focus on the need to have surge capacity for supplies, equipment, and clinical staff to meet the needs of future emergencies. HSCRC can provide financial support for any future surge through the same tools that were used to support hospitals in 2020 and 2021.

Conclusion

Hospitals around the nation faced a number of financial challenges during the COVID-19 pandemic, including reduced patient volumes and increased costs for overhead, supplies (like PPE), and workers. The

[32] The Laurel ACS is in "hibernation" at present. UMMS, the owner of the Laurel campus, plans to demolish the hospital after a new freestanding medical facility, currently under construction adjacent to the existing facility, is completed in early 2023. The Takoma Park site could be available in the short term for future use, but a less expensive alternative is preferable. The Takoma Park campus is also planned for redevelopment by an adjoining University.

Maryland Health Model provided Maryland with a unique set of tools to respond to the financial strain that hospitals experienced as a result of the pandemic. HSCRC used its authority over hospital rates and global budgets to stabilize hospital revenue and allow hospitals to focus on providing necessary care to both COVID-19 positive and non-COVID patients in 2020 and 2021. In addition, the Federal and State government provided direct funding to hospitals. These policies complemented the work by MDH and MHCC to increase hospital bed capacity through emergency licensure of existing physical beds in hospitals, standing up alternative care sites, and other projects. MDH is leading efforts to ensure that the Maryland health system stands ready to respond to future public health emergencies through the development of a plan that addresses hospital bed capacity, supplies, equipment, and clinical staff.