STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 28, 2012

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2012 Joint Chairmen's Report, Page 67-68, M00Q01.01 – Report on Medicare Waiver and Approved Hospital Financial Targets

Dear Chairmen Kasemeyer and Conway:

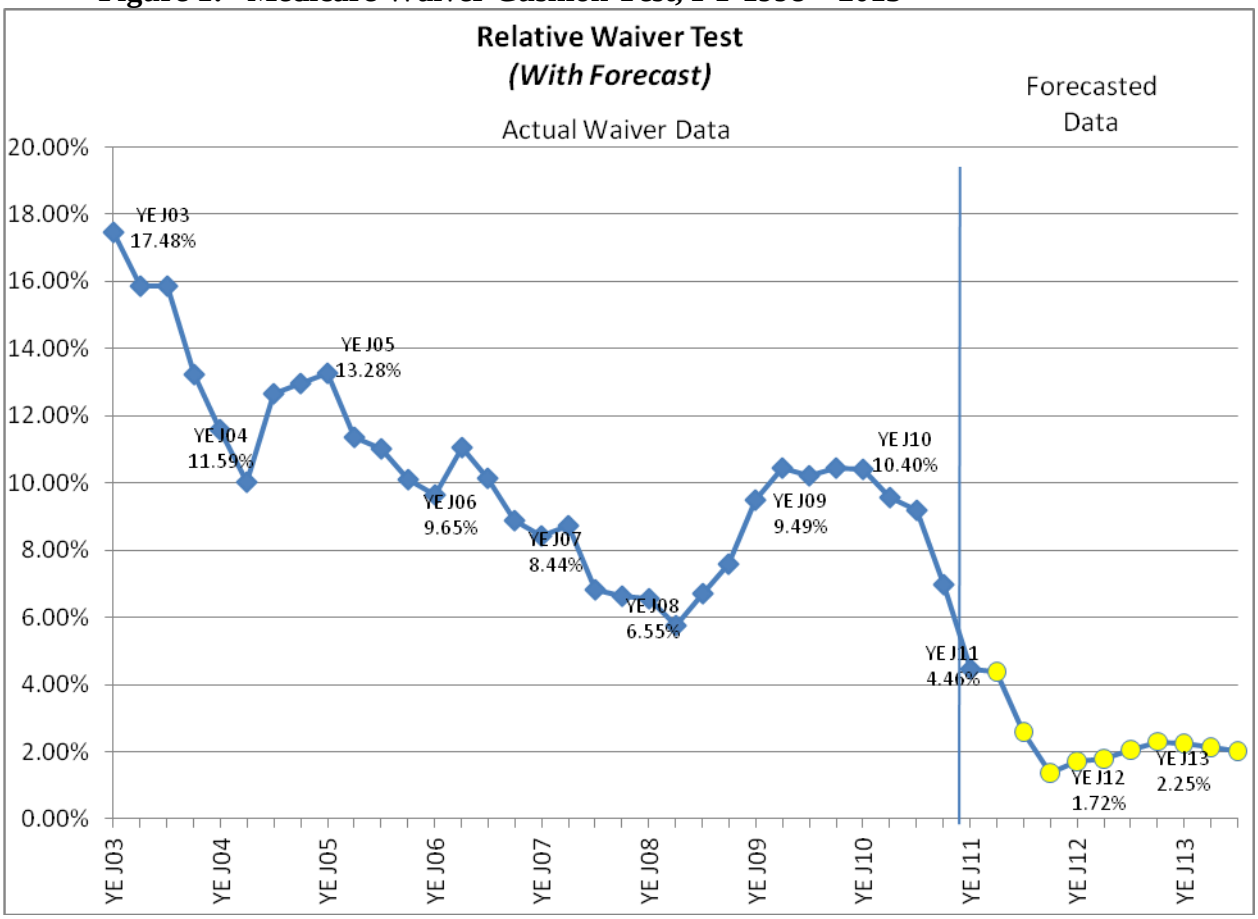
In accordance with pages 67 and 68 of the 2012 Joint Chairmen's Report, the Department of Health and Mental Hygiene (the Department) submits this report on the State's Medicare waiver and approved hospital financial targets. The committees had requested that the Department, in consultation with the Health Services Cost Review Commission (HSCRC), report on (1) the specific impact that any proposed fiscal year (FY) 2012 and 2013 budget actions have, or will have, on the waiver cushion or HSCRC-approved hospital financial targets, and (2) the cumulative impact that the hospital Medicaid budget funding assessment has had on the waiver cushion or HSCRC-approved hospital financial targets.

Maryland's Hospital All-Payer System: Federal Terms and Conditions

Maryland maintains a unique "all-payer" hospital system, in which hospital rates are regulated by the HSCRC, and these regulated rates must be paid by all payers including Medicare, Medicaid, and commercial carriers. Federal legislation authorizes the inclusion of Medicare payments in this hospital-rate regulated system. Because Medicare complies with the rates set by the HSCRC, as opposed to those established nationally, Maryland must meet certain terms and conditions. The most important condition is that the HSCRC must ensure that the rate of growth for Medicare inpatient payments per case in Maryland must be no greater than the national rate of growth for Medicare inpatient payments per case. This is a cumulative growth test, which goes back to the base year 1981.

The HSCRC monitors Maryland's performance using the "waiver relative cushion" test. The waiver relative cushion test looks specifically at how much Medicare inpatient per case charges could increase in Maryland if national Medicare inpatient per case charges did not grow at all. Figure 1 shows that the waiver cushion has been eroding over recent years.

Figure 1: Medicare Waiver Cushion Test, FY 1998 – 2013



Source: The Health Services Cost Review Commission

What is Contributing to the Erosion of the Waiver Cushion?

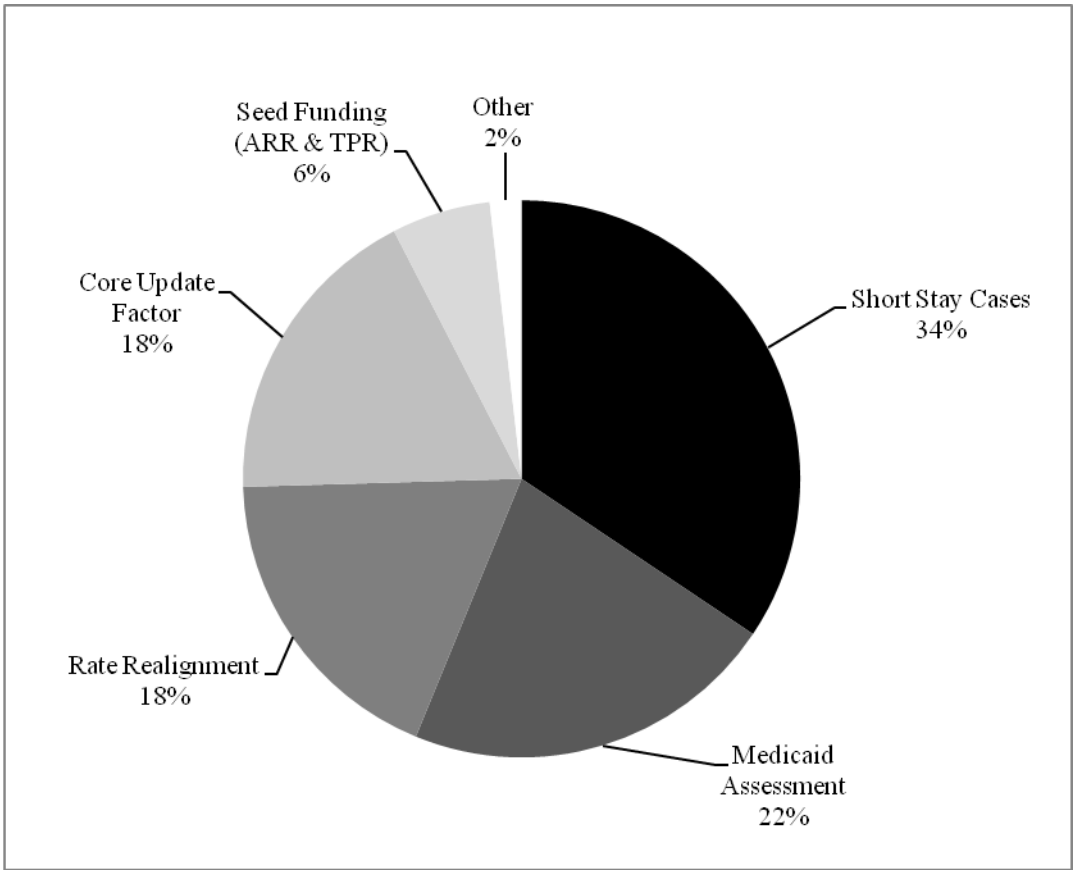
Of specific interest to the legislature has been the effect on the waiver cushion caused by the increase in a hospital assessment that was included in the state budget as passed and enacted for both FYs 2012 and 2013. This uniform assessment replaces state general funds in helping to finance the Medicaid program, which has seen significant cost increases primarily due to enrollment growth.[1] In each of FYs 2012 and 2013, the benefit to the state general fund, by financing Medicaid partially through revenues generated by the increase in the hospital assessment rather than general revenues was $389 million, although the amount assessed was actually $333 million, since the HSCRC decided to have the hospitals pay the difference -- $56 million – directly to the State. These assessments are built into all overall hospital rates, which are paid by all payers. While the assessment is one factor that contributes to the erosion of the waiver cushion, the increase in the assessment is not the sole factor contributing to the erosion, nor even the major factor. The analysis from the HSCRC and Department demonstrates that this is not the case.

[1] Report on Medicaid Financing and Cost Drivers to the Maryland General Assembly, The Department of Health and Mental Hygiene, December 2011.

In preparing for its annual update factor decision in June of 2012, the HSCRC analyzed the factors contributing to the increase in inpatient charges for the year ending February 2012. According to HSCRC hospital data at the time, the inpatient charge per case grew by 8.69 percent for the year ending February 2012, which is a figure that far exceeds the 4.3 percent increase budgeted during HSCRC's rate update factor discussions. However, more recent data show that the charge per case increase from September 2011 to September 2012 is significantly less at 3.47 percent.

As shown in Figure 2 below, in June of 2012, the HSCRC identified a number of factors contributing to the increase. These factors include the policy on short stay cases (34 percent), the Medicaid assessment (22 percent), a core rate update factor that covers inflation (18 percent), rate realignment that has resulted in increased inpatient revenues (18 percent), and seed funding for the Admission-Readmission Revenue (ARR) and Total Patient Revenue (TPR) programs (6 percent). It is also worth noting that further improvements in efficiency in the delivery of services can reduce costs and reduce the pressure on the waiver test.

Figure 2: Factors Contributing to Charge per Case Growth, Year Ending February 2012



Source: Health Services Cost Review Commission, May 2, 2012.

As noted, the largest single contributor to the erosion in the past two years has been the policy change on short stays. Specifically, the HSCRC removed the one-day stays from the charge per case methodology. These short stays tend to be lower acuity cases, which are less expensive. Therefore, including short stays in the charge per case methodology reduces the overall average. Similarly, removing them from the charge per case methodology, as HSCRC did in FY2011, has the effect of making the remaining cases more expensive on average. The HSCRC is considering altering the one day stay policy to ensure that it does not negatively impact on the waiver test and rates in general.

Based on this information, the hospital assessment is neither the single contributor, nor is it the largest contributor, to the growth in the charge per case. Rather, the answer is more complex and requires an examination of other factors, including those beyond Maryland's control. For example, because the waiver cushion is a function of how Maryland compares to the rest of the country, the tools that the federal government uses to constrain national Medicare spending also affects the waiver cushion.

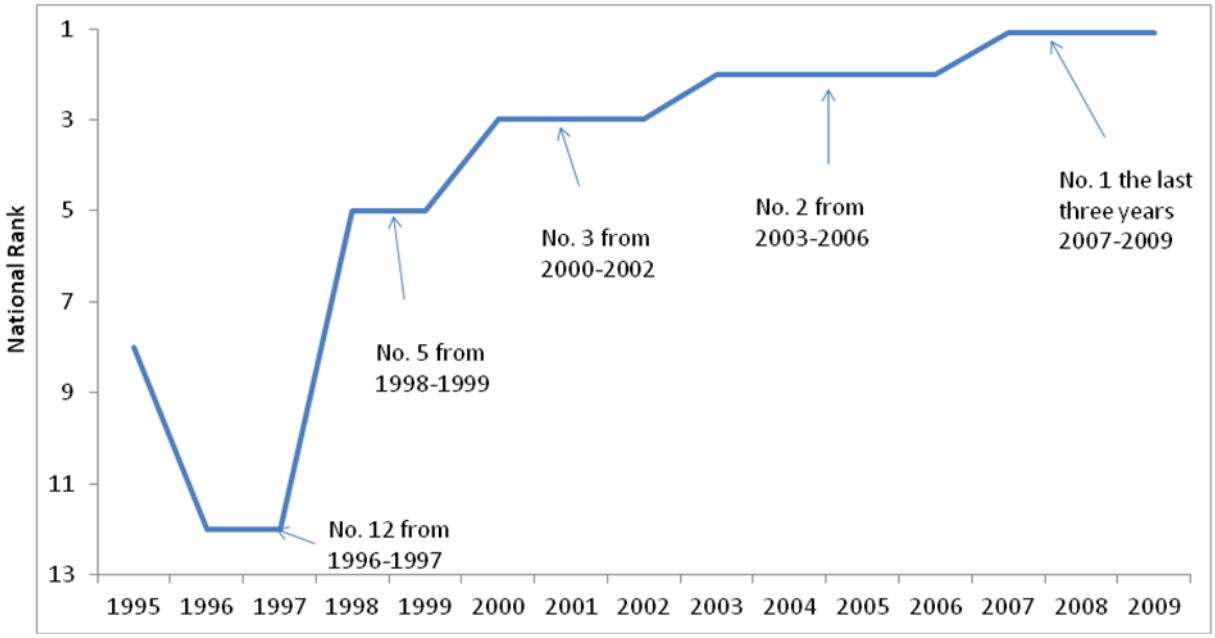
The federal government is not static in managing Medicare expenditures. It has been implementing a number of initiatives aimed at lowering inpatient costs. For example, in 2008 Medicare stopped paying hospitals for additional costs associated with preventable medical errors. Also, under the Affordable Care Act, Medicare was granted statutory authority to reduce payments to hospitals that have excess readmission rates. On October 1, 2012, Medicare began to reduce payments for readmission rates associated with the certain conditions, namely acute myocardial infarction, heart failure, and pneumonia. Medicare anticipates extending its readmission policy to other conditions as well.

While the HSCRC has implemented a similar policy with its ARR program, there are key differences from the federal government's approach to Medicare. First, the ARR program is not operating at all HSCRC regulated hospitals. Second, the ARR program does not reduce a hospital's operating revenue; instead, the hospitals are permitted to retain any savings in the short-term from this program. Nonetheless, over time, a successful ARR program can reduce costs and be designed to provide savings to all payers.

Under the "all-payer" waiver, Maryland is not required to implement the policies the federal government generally applies to Medicare. In order to be exempt from the national policies, however, Maryland must demonstrate that its programs meet or exceed the federal program in terms of cost savings and outcomes. But as the cost spending in other states is cut drastically by Medicare through its cost reduction strategies, more pressure is placed on Maryland to achieve similar savings or see further erosion of the cushion in the waiver test.

Beyond these recent developments, Maryland has ranked among the top three highest cost states in Medicare hospital spending per capita for the past ten years for which data is available, and the highest state the past three years (2007-2009) (see Figure 3). Maryland rose to the highest cost state prior to the imposition of the increase in the hospital assessment, which occurred in FY 2012. While such national comparisons are difficult since Maryland includes costs in the all payer system that are either not included or reflected differently in the Medicare system (uncompensated care, graduate medical education, etc.), those differences in payment methods have existed throughout the ten year period. In short, Medicare's aggressive cost reduction policies make it difficult for Maryland to maintain a lower growth rate for inpatient per case charges, which results in further deterioration of the waiver cushion. The HSCRC has begun to take action to mollify this effect by considering changes to its ARR policy.

Figure 3: Maryland's Rank Among States in Per Capita Medicare Hospital Spending



Source: Kaiser Family Foundation. State Health Facts. Medicare Spending Per Enrollee by State of Residence by Service Type, 1995-2009.

When costs per equivalent inpatient admission (including inpatient and outpatient costs) are reviewed on an all-payer basis, Maryland has been at or below the national average. One of the primary goals of the all-payer system is to reduce costs and cost growth to all payers. Under this system, hospitals do not have the ability to cost shift losses from reduced payment by public payers (Medicare and Medicaid) on to private payers.

How Has the Assessment Impacted Hospital's Financial Targets?

The HSCRC does not build the entire Medicaid cost containment amount into an assessment. Rather, the hospitals are required to directly pay a portion of the cost containment amount to Medicaid. In FY 2011, the hospitals were required to pay roughly $28 million directly, while $80 million was built into an assessment that was passed along to payers in the form of a rate increase. And in FYs 2012 and 2013, the hospitals were required to pay roughly $56 million directly, while $333 million was built into an assessment. The $56 million direct payment and $333 million together account for the total cost containment amount budgeted for the assessment.

The hospitals report audited profit information to the HSCRC annually. Based on this information, even with a direct payment of $28 million to the Medicaid program, Maryland hospitals, in aggregate, reported a total operating profit margin in FY 2011 of 3.52 percent (and 6.23 percent excess or total profit margin). Unaudited data reported for FY 2012 show a total operating profit margin of 1.91 percent (and total profit margin at 4.17 percent).

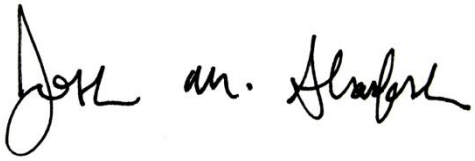
Modernizing the All-Payer System

The Department and HSCRC understand that simply removing the Medicaid assessment does not remove the need to modernize the terms and conditions of the all-payer hospital system. As with the HSCRC's TPR program, payment reforms are no longer focused exclusively on an individual inpatient stay, but rather on the entire care provided in the hospital setting. This includes both inpatient and outpatient settings as well as possibly other settings. The TPR program provides certain hospitals, primarily those in rural areas, with a global budget for all inpatient and outpatient care. One result of the TPR is that low-intensity cases are moving from the hospital to more appropriate settings. In turn, the remaining cases are likely to be more expensive, which increases the charge per case and causes the waiver cushion to further deteriorate. Put simply, as the rate of deterioration continues to increase, Maryland will find it more difficult to meet the current waiver test through efforts such as these new payment reforms.

The Center for Medicare and Medicaid Services' Innovation Center provides opportunities to states. The opportunities are to seek grant funds that test various payment reforms. The Department and HSCRC are working closely together on a plan to modernize the all-payer system and intend to share its proposal shortly with the Innovation Center. The Department will keep stakeholders and the General Assembly informed of these discussions as they move forward. In the meantime, the HSCRC is continuing to implement actions to address this pressing problem in the short term.

I hope this information is helpful. If you have any questions or need additional information on this subject, please do not hesitate to contact Marie Grant, Director of Governmental Affairs, at (410) 767-6480.

Sincerely,



Joshua M. Sharfstein, M.D.
Secretary

cc: Chuck Milligan
Tricia Roddy
Audrey Parham-Stewart
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