Maryland
Hospital Association

May 21, 2020

Adam Kane
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) rate year 2021 annual payment update. Hospitals acknowledge the efforts of commission staff and the careful consideration of the payment update by the commissioners. We are proud of Maryland's unique rate-setting system and HSCRC staff's actions during this unprecedented time.

Health care affordability is an important policy consideration, but we strongly oppose setting a concrete growth limit. HSCRC should appropriately judge whether the annual revenue increase is reasonable, including comparing the projected outcome to different measures. The contract with the federal government sets an overall limit, and staff recommends a reasonable amount for the commission approval. There is no reason to set a hard threshold to adjust the annual revenue update up or down if Maryland continues to beat its contractual requirements. **The commission should reject this recommendation.**

Exclude the productivity offset for the psychiatric and specialty hospitals. Including the rate year 2021 proposal**,** the update factor for these hospitals has been reduced almost 4% since 2015. Like all health care providers, these hospitals face challenging circumstances. For rate year 2021, they should be granted full inflation.

Eliminate the potentially avoidable utilization (PAU) savings adjustment. Global budgeted revenue (GBR) targets account for all volume, even potentially avoidable utilization. Hospitals have every incentive to eliminate PAU, not only because of GBR, but because PAU is considered in several other methodologies. Maryland's overall Medicare hospital use rates are below the national rates. There is no reason to remove additional dollars from the annual revenue update.

Please see the attachment (pages 3-5, plus exhibits) for further articulation of these points.

We look forward to discussing the update at the May 28 meeting of the Payment Models Work Group and at HSCRC's public meeting June 10, as we continue to work together on behalf of the people and communities we serve.

Sincerely,

Brett McCone, Senior Vice President

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cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
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Stacia Cohen
Sam Malhotra
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director

Enclosure

A new GSP target is not required to adjust the annual payment update

All-payer, per capita hospital spending in Maryland is affordable, and hospitals support HSCRC maintaining affordability. It is not clear why HSCRC staff ask the "commission to task the staff" with setting a new gross state product (GSP) comparison measure, coupled with a concrete policy to adjust the update factor to the measure. This approach would deviate from HSCRC's longstanding approach, that provided we meet our contractual and legal requirements, HSCRC sets reasonable annual payment updates to ensure health care is affordable. Every year, hospitals, health plans, and other stakeholders work with HSCRC staff through a public process to consider all impacts before making an informed recommendation to adjust hospital revenues.

The contract defines affordability to be growth below 3.58% per year, compounded since the 2013 base period. This was the agreed target in the original All-Payer Contract and the subsequent Total Cost of Care Contract. This limit was chosen, and agreed to, because it used a long period to compute the average and the compounded nature allowed for fluctuation up or down each year. Establishing an annual target that does not allow the commissioners to judge reasonableness given the circumstances at the time is not appropriate, for several reasons.

1. **A concrete limit removes HSCRC's flexibility—one of the hallmarks of our system.** HSCRC has always considered targets when making policy. Affordability now is no different. HSCRC might use a variety of measures to determine what is affordable, including GSP, cost inflation, health insurance premiums and other factors. Most important is that staff maintains the ability to recommend what they believe to be appropriate without being tied to an absolute standard.

   HSCRC staff can recommend annual revenue updates that fall below the contractual standard. During the first six years of the model, the HSCRC approved cumulative per capita revenue growth of 21.15%, *before reductions for uncompensated care and pass throughs*, well below the allowable cumulative limit of 27.92%. Net of reductions in uncompensated care and the deficit assessment, HSCRC approved a cumulative increase of 16.63%. During the same period, actual revenue per capita grew just 14.17%. All-payer spending per capita growth is 2.46% below the approved all-payer per capita growth rate. (See Exhibit 1.)

2. **Using GSP to measure annual affordability raises data accuracy concerns.** In fact, the GSP measure in the staff recommendation is GSP per capita. The GSP data reflect Maryland's economic output, a projection from the US Bureau of Economic Analysis. This figure can fluctuate more than 2 percentage points annually. The population is from the Maryland Department of Planning, which is projected using 10-year interval census data and expected trends. Using this type of data to create an annual limit, without using a much longer calculation window or allowing for multiple years of growth, is very problematic.

3. **Maryland's hospital spending is affordable.** As we presented last year and updated this year, figures from the Health Care Cost Institute (HCCI) show Maryland's commercially insured hospital spending per capita to be among the lowest in the nation. According to HCCI, Maryland's inpatient spending per person is the 3rd lowest in the nation and Maryland's outpatient hospital spending per person is the 2nd lowest in the nation. (See Exhibit 2). When non-hospital spending is included, Maryland is 5th lowest. (See Exhibit 3.) From 2013 to 2018, Maryland's inpatient hospital spending per person grew at just above half (54%) of the national

rate and outpatient hospital spending per person grew at just above one-third (36%) of the national rate. (See Exhibit 4.)

4. **Fixing the annual revenue growth to GSP would invariably lead to a one-way door**. If GSP growth exceeded inflation and other adjustments, it is not likely HSCRC staff would recommend, nor would commissioners approve, an amount up to the standard. Other stakeholders would question the need to raise hospital prices beyond the arbitrary figure. Yet establishing a "concrete policy for adjusting the update factor" could easily be used to lower the annual revenue update down to GSP in the name of affordability. This is another reason to support multiple affordability measures and considered judgment by commissioners when deciding the update every year.

5. **Health plan premium growth should be considered, but not linked to a GSP standard.** Hospitals agree, and we've supported this position for several years. HSCRC's effort to understand the relationship between hospital spending and health plan premium growth should not hinge on setting a new GSP target. The first six years of all-payer model spending results demonstrate successful performance.

6. **A revenue update is a much tighter control than a price update.** Maryland's hospitals benefit greatly from our global budgeting and rate setting system. Maryland's hospitals adopted value-based payments and fixed global budgets to reduce potentially avoidable utilization. The global budget—an annual "fixed" amount of revenue—guarantees affordability and stability. HSCRC retaining annual judgment over the fixed amount is paramount in the system.

Health care affordability is of concern to all Marylanders. All Maryland hospitals respect, appreciate, and value this concern. There are multiple ways to measure affordability, and any standard should be considered over a long period. There is no need for HSCRC staff to create a concrete policy for adjusting the update. We may not always agree, but hospitals trust HSCRC staff to recommend and commissioners to approve reasonable revenue updates yearly and over the long term.

Exclude the productivity offset for the psychiatric and specialty hospitals

Like other Maryland hospitals, the two psychiatric hospitals, BrookLane and Sheppard Pratt, and Mt. Washington Pediatric Hospital, are facing financial challenges during the COVID pandemic. Unlike other Maryland hospitals, these hospitals are not subject to fixed revenues under global budgets. However, they will face the same cost inflation.

Historically, the annual payment update, in this case a price update, was reduced by amounts for productivity and other factors. From rate year 2015 through the rate year 2021 proposal, the psychiatric and specialty hospital update was reduced by almost 4%, or approximately 20% of the cumulative amount during that seven-year period. For rate year 2021, we ask HSCRC to forgo any productivity adjustment and give these three hospitals full inflation.

Eliminate the potentially avoidable utilization savings adjustment

No PAU savings adjustment should be taken for rate year 2021. Over the first six years of the Model, Maryland hospitals held hospital spending per capita below the targeted growth rate and substantially below the historical trend. To date, the commission removed almost 2% from hospital revenues as extra

payer savings. Health plans, other payers, and providers other than hospitals are less likely to work on measures to produce savings if their savings are guaranteed in the hospital rate setting system.

HSCRC changed its approach to PAU savings in 2020. We understand HSCRC staff's logic to remove inflation from volumes that are potentially avoidable as an incentive for hospitals to lessen avoidable utilization. Hospitals must and will continue to reduce avoidable utilization. However, Maryland's inpatient Medicare utilization per 1,000 beneficiaries is now below the national average. To achieve this good result, Maryland lowered inpatient admissions that were avoidable, beyond the definition of PAUs.

Taking an explicit reduction for PAU savings is duplicative. Incentives to reduce PAU already are woven into many HSCRC methodologies as either an explicit adjustment or a financial reward for overall improvement. Examples include:

- Reducing age-weighted use rates in the demographic adjustment to reduce PAU incentives
- Financial rewards under the Medicare Performance Adjustment (MPA) for reducing unnecessary Medicare use, including PAU; financial penalties if service use rises relative to the targeted trend
- Providing separate rewards for reducing readmissions, one of the two PAU measures, under the Readmission Reduction Incentive Program (RRIP)

In addition to the foundational reasons, the COVID-19 pandemic is changing care delivery. Hospitals expect very little PAU at the end of rate year 2020 and into rate year 2021 because overall utilization is dramatically lower. Like many HSCRC methodologies, the amount applied prospectively is based on a historical period—in this case, calendar year 2019. Because of the pandemic, hospitals and other health care providers are delivering care in radically different ways, reducing PAU. HSCRC could eliminate the adjustment with the expectation that PAU will be lower, reducing the adjustment in a future period.

EXHIBIT 1:

HSCRC APPROVED GROWTH IS BELOW THE CONTRACT LIMIT

Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage

EXHIBIT 2

MARYLAND SECOND, THIRD LOWEST IN THE U.S.

HOSPITAL, PER PERSON COMMERCIAL SPENDING, BY STATE, 2018

Inpatient

$1,500
$1,300
$1,100
$900
$700
$500

$859

HI AR MD LA MI MS MA IA NC TN UT MT IL OR DC VA KS AL GA NM AZ RI MO KY OK NE CT PA CO WI VT ME WA OH NH NJ ID NV TX MN FL SC IN CA DE NY AK ND WY SD WV

Outpatient

$2,500
$2,000
$1,500
$1,000
$500

$1,055

HI MD DC AR AZ CA AL TN NY NV UT KS MN RI OR NJ FL MA GA MS WA MO LA VA CT MI CO NC IA TX OK NE KY IL PA DE NM MT WI ID ME OH ND SC VT AK WY IN NH SD WV

Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013–2017 and 2014-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage

EXHIBIT 3

MARYLAND AMONG THE LOWEST IN THE U.S.

TOTAL HOSPITAL AND NON-HOSPITAL, PER PERSON COMMERCIAL SPENDING, BY STATE, 2018

2018

$7,500
$6,500
$5,500
$4,500
$3,500
$2,500
$1,500
$500

$5,147

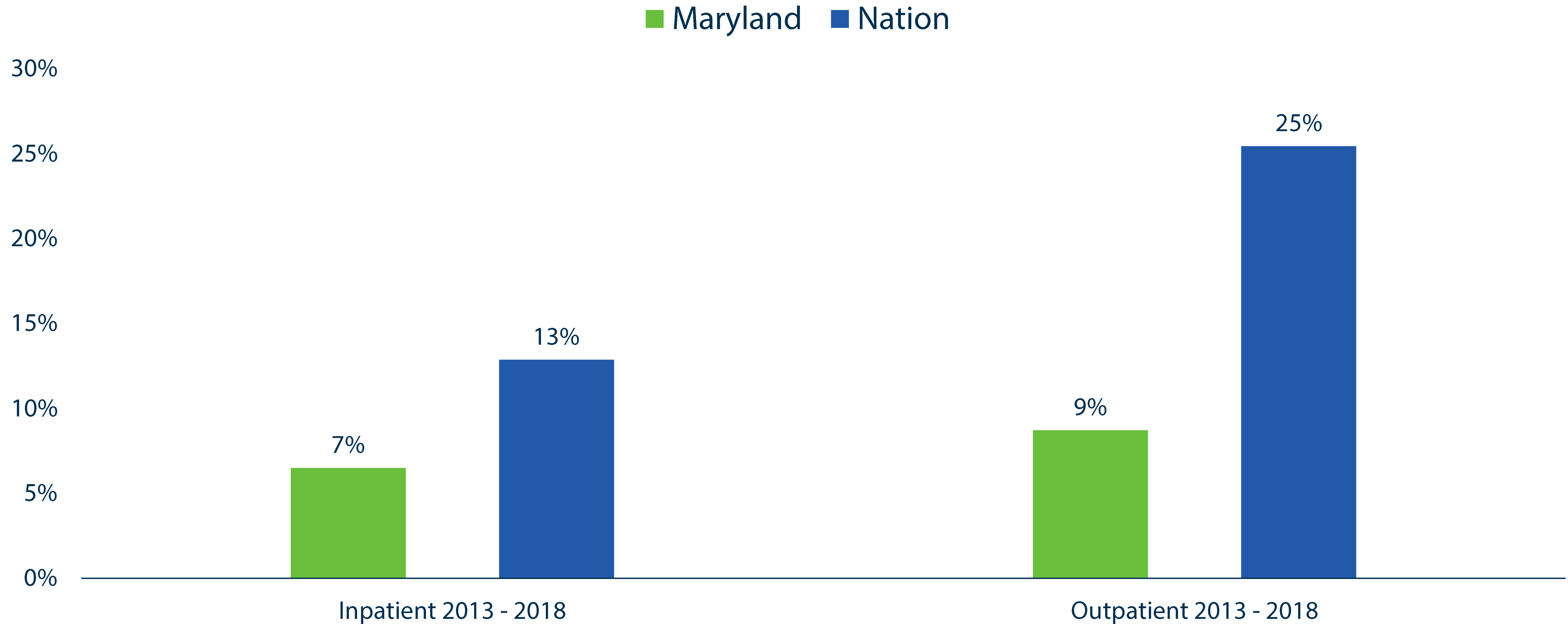
HI AR UT AZ MD KS MI NV AL OR MO MS TN OK NM IA VA CA LA DC MT CO WA NC RI MA IL ME KY FL GA ID NE PA TX VT OH MN DE IN SC CT NJ NY WI ND NH WV WY SD AK

Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013–2017 and 2014-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage

EXHIBIT 4:

MARYLAND HOSPITAL SPENDING GROWTH FAR BELOW THE NATION

HOSPITAL, PER PERSON COMMERCIAL SPENDING GROWTH



Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage