Maryland
Hospital Association

May 14, 2020

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we offer our comments on the Health Services Cost Review Commission's (HSCRC) proposed Guidance on Addressing Likely Rate Year 2020 (RY2020) Undercharges presented at the April 30 public meeting.

Maryland's hospitals are thankful for HSCRC's assistance during this tremendously challenging period. We are fortunate to have a strong partnership with HSCRC staff and we appreciate the collaborative environment of our unique system. As HSCRC plans to address the likely RY2020 undercharges and related matters, here are **four suggested principles** for HSCRC to consider before offering final guidance:

1. Grant additional rate corridor relief based on each hospital's unique circumstances, including relevant financial considerations, not just liquidity
2. Account for the CARES Act and other federal funding, with some limits
3. Retain the foundational global budgeted revenue (GBR) incentive to avoid unnecessary utilization by adjusting prices
4. Recover the RY2020 undercharge, with reasonable rates, over the shortest possible period

These principles address more than just expanding rate corridors. The largest and most unpredictable consideration is RY2021 hospital service use. Should volumes return to, or increase beyond RY2020 levels, the undercharge can be recovered with less corridor relief. Additionally, RY2021 volume patterns will certainly be unequal among hospitals.

1. Grant Additional Rate Corridor Relief Based on Each Hospital's Unique Circumstances
MHA supports the goal of clear policy guidance. We historically urged HSCRC to use this approach. In a normal environment, a more rigid policy structure is acceptable, if not preferable, so all stakeholders know the rules and every matter is not adjudicated case by case by HSCRC staff or the commission. However, because the steep financial impacts affect more than just revenues, we suggest HSCRC be flexible in its approach.

MHA does not agree with the threshold to dip below 75 days' cash-on-hand before a hospital could seek additional corridor relief. We agree HSCRC should analyze each hospital's financial position, including balance sheet measures. Each hospital's balance sheet is the result of decision making over the life of the organization, and it is important to view it through that lens. The financial market's view of HSCRC and Maryland's hospitals are also important. Both HSCRC and hospitals have spoken to bond rating agencies and investors. HSCRC said it will allow hospitals to recover the unfunded undercharge. This is an important signal to the financial markets that HSCRC is a stabilizing force providing a firm foundation.

HSCRC is rightfully concerned that hospitals have enough cash to operate and to meet liquidity requirements for bond holders. The types of short-term investments vary and disposal of investments in the current market may not be the best strategy. Bond covenants require hospitals to maintain certain levels of debt service coverage that are impacted by margin. It is important to understand and account for this ratio, and the consequences to the hospital should a hospital fail a bond covenant. As HSCRC plans to discuss this in a work group, hospitals will gladly discuss appropriate metrics with HSCRC staff and will share perspectives from bond holders about these metrics.

2. Account for the CARES Act and Other Federal Funding, With Some Limits
MHA is grateful Maryland hospitals received the same level of federal support as hospitals in other states. We agree Maryland should leverage the CARES Act and other federal funding before raising prices, and HSCRC stated its intention to account for federal dollars before waiving undercharge penalties.

We ask HSCRC to adjust any CARES funding offset by the portion of unregulated hospital entity business, and, by certain impacts on net revenues as a result of federal mandates. About 16% of the hospital business reported on schedule RE in the annual filing is unregulated. U.S. Department of Health and Human Services funding delivered to hospitals did not distinguish between regulated and unregulated services. It is fair and reasonable to exclude this portion from consideration.

In addition to this percentage, hospitals are precluded from billing and collecting the patient's share of certain encounters during the state of emergency. MHA asks HSCRC to exclude any net revenue impact if the payer does not cover the patient's share and the hospital is otherwise prohibited from billing the patient's share. These provisions are required by the federal government and affect revenues after HSCRC sets gross charge levels.

3. Retain the GBR Incentive
The Maryland model expects hospitals to reduce avoidable utilization. This is a foundational agreement—one that prevents continued volume growth and encourages efficient service use. Hospitals have flexibility, with permission, to raise prices up to 10%. Before the pandemic, some hospitals received approval to do so. Even if utilization returns to pre-pandemic levels, hospitals

that were approved for upper end corridor relief could be limited by a 10% threshold in RY2021. Hospitals that effectively controlled service use would be penalized for their proper actions. HSCRC may need to approve pricing above 10% in these situations.

4. Recover the Undercharge, With Reasonable Rates, in the Shortest Period
HSCRC historically limited "banked" or owed revenue in the system to prevent future liabilities. When the charge per case system was implemented more than 20 years ago, a main consideration was the unsustainability of banked revenue from the prior methodology. HSCRC specifically adopted a 100% penalty on any undercharge more than 2% below GBR to prevent the same issue from arising.

MHA appreciates the need for price sensitivity during the state of emergency. It is appropriate to spread the undercharge impact into RY2021. Hospitals believe the highest priority is to completely recover the residual undercharge, no matter the time frame. Provided measures are favorable, we support accomplishing this recovery by the end of RY2021. Doing so would limit uncertainty, provide needed cash flow as hospitals draw down advances, and eliminate any future system liability.

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We appreciate HSCRC's considerations of these important matters. Relative to global budgets, the final impact will be determined by actual volume and the relative prices needed to recover the undercharge. Federal funding is an important consideration and one that is not yet fully known.

Thank you again for your help during this public health emergency. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Jerry Schmith, HSCRC
Allan Pack, HSCRC
William Henderson, HSCRC
Willem Daniel, HSCRC