Maryland
Hospital Association

November 5, 2020

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

Dear Chairman Kane:

On behalf of Maryland's 61 member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed integrated efficiency policy.

Inflation withholds should apply on or after July 1, 2021.
We agree with HSCRC staff's conclusion that the policy should apply to hospitals that are clearly outliers so as not to counteract utilization management incentives. We respectfully ask HSCRC to apply inflation withholds no sooner than July 1, 2021. We understand HSCRC postponed its planned July 1, 2020 implementation as a result of COVID-19. Hospitals continue to face significant financial uncertainty due to the pandemic, largely because of anticipated final guidance on federal relief funds, reporting COVID expenses in January 2021, and impact of relief funds and expenses on rates.

In addition to COVID uncertainty, one-half of the efficiency policy is based on HSCRC's proposed benchmarking of commercial and Medicare spending per beneficiary. HSCRC has been creating the methodology for some time. However, the formal release of information did not occur until August, and many hospitals have not had adequate opportunity to give attention to review and validate the information while addressing other financial challenges during the pandemic. Implementing inflation withholds on or after July 1, 2021 will allow hospitals adequate time to consider the benchmarking methodology.

HSCRC also plans to review peer groups, including for Johns Hopkins Hospital and University of Maryland Medical Center, along with resident counts in graduate medical education adjustments. Changes to these factors may alter the results. These tasks are slated to be complete in January 2021. A July 1, 2021 or later implementation date would allow for these changes.

If adopted, HSCRC should set unit rates under global budgets using the most recent volumes.
We respectfully ask HSCRC staff to set annual unit rates using volumes from the most recent 12-month period preceding the rate order. Measuring monthly rate compliance and adjusting unit rates, with the process of requesting adjustments outside certain corridors, imposes a heavy burden on hospital reimbursement staff, with very little net value. We appreciate the need to hold hospitals accountable to revenue targets, and the efficiency policy will lessen allowable revenues for outlier hospitals. Connecting unit rates to GBRs will reduce the burden on HSCRC staff and hospitals.

The efficiency policy should be revenue neutral statewide.
We agree that if revenues are reduced for high-cost hospitals (as HSCRC defines such), the full sum of this reduction should be available to be redistributed within the system. None should be withheld. We appreciate HSCRC staff's consideration that allows low-cost outliers to apply for increases and other proposed uses of savings, including capital funding, etc.

HSCRC's intent to credit investments is appropriate. Judging which hospital investments align with the Total Cost of Care Model is concerning.
One of HSCRC's long term policy considerations is to "quantify investments…in unregulated settings…in line with the incentives of the Total Cost of Care Model." A byproduct would be to credit hospitals in the ICC evaluation for retained revenues. The intent is appropriate because Maryland's Total Cost of Care Model holds the state accountable for more than just hospital spending. HSCRC enforces accountability via the efficiency adjustment and the annual payment update by accounting for total spending growth.

However, hospitals have serious concerns about HSCRC staff judging which hospital investments are worthwhile. As the regulator, the commission should set broad goals and targets that satisfy our Model agreement and meet the triple aim. Hospitals should be accountable to achieve both state and hospital specific targets. Hospitals need latitude to choose and to demonstrate their investments. Some may fail, but that is acceptable within the parameters of the Model.

This policy consideration should be removed from the efficiency policy and become the subject of strategic conversations between HSCRC commissioners and staff and the hospital field, before determining a course of action.

Adjustments may be required if applying the policy in full rate applications.
The efficiency methodology will be used in the full-rate application process. When the methodology is developed, it will likely remain in place for several years. As the full-rate application methodology is proposed, MHA will comment on efficiency policy calculations in a full-rate application and how it may differ from annual inflation adjustments.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

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