



Maryland  
Hospital Association

December 9, 2020

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

Dear Chairman Kane:

On behalf of Maryland's 60 member hospitals and health systems, the Maryland Hospital Association appreciates the opportunity to comment on the proposed full rate application policies.

**A reasonable operating margin should be included during the “build-up” in the Inter-hospital Cost Comparison (ICC).**

We respectfully ask HSCRC to include a reasonable operating margin when setting hospital rates in a full rate application during ICC's “build-up” phase. This departure from historic policy is required for two important reasons.

First, the overarching goal of the Total Cost of Care Model and global budgets for regulated hospital services is to reduce avoidable hospital utilization. Historically, HSCRC regulated prices, not revenue. When determining fair prices, 100% of regulated profit was removed from a hospital's cost base with the implicit understanding hospitals would retain marginal income from marginal volume growth. Beginning in 2014, volume growth incentives were replaced by lowering avoidable use to generate savings. Absent marginal volume growth, a small, reasonable margin must be included in the hospital's revenue base.

Second, Maryland's Model has strong incentives to invest in services beyond those regulated by HSCRC. Hospitals must invest in population health initiatives, extensive care coordination, and services in the community. These activities are crucial to the success of the Model but are not regulated by HSCRC as hospital services. Removing all regulated profit in rate setting would render hospitals unable to reinvest in services beyond hospital walls and thus sustain both hospital savings and total cost of care savings.

**Consider including hospital-specific total cost of care growth performance.**

The full rate application methodology algorithm includes a small provision in the total cost of care comparison algorithm to address growth performance. Given the uncertainty of comparing service area spend per capita in benchmarking methodology (see below), HSCRC might consider expanding the inclusion of growth performance. Comparing spending per capita in different service areas is difficult without applying multiple adjustment factors to address different conditions. Comparing spending growth per capita assigned to a hospital, provided the assignment or service area is unchanged from the base, could be a more stable option.

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**The benchmarking methodology needs further assessment.**

In December 2019, HSCRC staff proposed their benchmarking methodology—comparing Maryland hospitals' spend per Medicare beneficiary and spend per commercial enrollee—to hospital-specific service areas outside of Maryland. We appreciate HSCRC staff's intent to measure total spending per capita because it is a key incentive of the Model. We pledge to work with the staff as the COVID 19 surge concludes to review and refine the methodology.

The benchmarking logic is proposed in the efficiency policy, the full rate application policy, and the MPA. Though it is very technical, the decision to compare spending attributed to Maryland hospitals with non-Maryland hospitals is major policy step. Historically, core methodologies of this magnitude would be vetted before the commission.

The ability to replicate methods and calculations, from start to finish, has always been a cornerstone of Maryland's rate setting system. HSCRC staff have made the peer group comparison calculations available for hospitals but hospitals have not easily been able to assess potential alternative comparisons. We are still understanding whether the same underlying Medicare data are publicly available for the most recent time period. The commercial benchmarking data is proprietary and much be purchased.

Maryland's market for hospital services is very different than the nation—Medicare and Medicaid pay the actual cost of hospital care and are not subsidized by commercial insurance. Understanding these differences is important with a methodology of this magnitude. Differences in Medicare Part A or Part B only beneficiaries, Medicare Advantage penetration, commercial insurance negotiating clout, and the baseline differences in Medicare payments all factor into hospital positions.

Thank you again for your careful consideration of these matters. Maryland hospitals appreciate being able to work directly with HSCRC staff to shape hospital payment policies. If you have any questions, please contact me.

Sincerely,



Brett McCone

Senior Vice President, Health Care Payment

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