



Maryland
Hospital Association

December 15, 2021

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 (MHA) 60 member hospitals and health systems, we appreciate the Health Services Cost Review Commission (HSCRC) for considering our feedback on the proposed Revenue for Reform recommendation.

MHA's Understanding of Policy Application

As proposed, Revenue for Reform would accomplish three things beyond the HSCRC's existing efficiency policy:

- 1) It would create a "safe harbor" in each hospital's revenue base by subtracting certain expenses that meet HSCRC criteria, lowering the revenue per unit comparison. (This is like a tax deduction that would lower income before comparing to others.)
- 2) The budgeted expenses identified would alter the results the HSCRC's efficiency policy, beginning with its application in rate year 2023.
- 3) In the future, HSCRC would establish a statewide Inter-hospital Cost Comparison (ICC) standard. Beginning in rate year 2025, it will adjust all hospitals to a percentage of the ICC standard, if they are not below the percentage. This would replace the annual update revenue offset for the lower quartile hospitals in the efficiency policy. MHA understands the proposal to be a one-sided, downward adjustment.

Hospitals Request Delay in Approving Revenue for Reform Policy Until Details Are Complete

MHA sincerely appreciates the HSCRC's intent for hospitals to invest even more in population health by safe harboring those investments.

However, MHA respectfully asks **HSCRC to delay the proposed policy** until the population health investment definitions have been well vetted, the ICC standard is justified and established, and stakeholders have had ample time to assess the policy. If this is the HSCRC's priority, then HSCRC should establish a working group solely focused on this task over the next twelve months.

HSCRC's efficiency policy has already been approved, and will remain in place, allowing HSCRC to adjust revenues from low efficiency outliers. Our reasoning is outlined below.

1. **The commission should not adopt the ICC standard methodology until policy details are final.** MHA strongly disagrees with the commission approving policies before addressing important and substantive details. Once the policy is approved, the commission no longer needs to consider input from the field. HSCRC should first establish a working group and craft recommendations.
2. **To give commissioners perspective on financial adjustments, MHA asks HSCRC to quantify hospital-specific financial risk, intended and actual, before approving the final policy.** Hospitals face a myriad of financial adjustments because of existing HSCRC policies, many of which have not yet matured. A list of policies that apply financial risks are included in Appendix A.

As an example, HSCRC staff and hospitals, *during the COVID-19 public health emergency*, created and finalized the HSCRC's Care Transformation Initiative (CTI) policy. This policy was designed to quantify hospital investments, built upon less favorable performers paying more favorable performers. Because we have not yet completed the first year, hospitals do not know the magnitude of the risk, but they expect it to be significant. This policy was specifically designed to create financial incentives around care transformation.

3. **Further refine population health spending investments before policy application.** As clarified by staff, the Revenue for Reform policy is intended to quantify *how hospitals are investing* retained global budgeted revenue (GBR) savings, *not how hospitals earned* the retained GBR savings. Determining investments allowed will require a much longer process, with clinical and population health experts, to establish the appropriate criteria.
 - a. MHA sincerely appreciates HSCRC staff's effort to create boundaries. MHA staff acknowledge that hospitals want what may seem contradictory during the development process but really is not—both flexibility and specificity.
 - b. The proposal only recognizes community health investments as a strategy to lower total cost of care. Yet, investments not classified as community health have had a significant impact on the surrounding community while reducing overall costs. Hospitals have made large scale investments in case management to improve care transitions programs, which extend beyond the walls of the hospital so that patients' health needs can be fulfilled in the communities they reside.
 - c. In other instances, the proposal could conflict with each hospital's Community Health Needs Assessment. An example would be if a hospital and its community partners identified lung diseases as a top priority due to say, localized heavy air pollution. Subsidizing pulmonologists due to a shortage of providers in the community would not, though, qualify under Revenue for Reform.

- d. Other options might include aligning spending with the Statewide Integrated Health Improvement Strategy or focusing on a handful of common initiatives.
- 4. Allow hospitals in the bottom quartile to negotiate financial adjustments, considering their unique population health investments.** Historically, HSCRC used a comparison to *identify* hospitals as candidates for rate reductions. Once a hospital was identified, the hospital and HSCRC negotiated the magnitude of any adjustments, considering unique circumstances.
- a. In its efficiency policy, HSCRC is requiring highly efficient hospitals to first justify additional funding through a rate request. If HSCRC will judge requests to boost revenues for efficient hospitals, the same logic should apply to inefficient hospitals.
 - b. Rather than HSCRC passing judgment on care transformation investments across the state, hospitals in the top and bottom quartiles can demonstrate their investments to the commission.
- 5. The policy may have unintended consequences.** HSCRC assumes that hospitals will invest more in population health because the safe harbor serves as an incentive to do so. However, the ICC standard measures revenue per unit. If hospitals face risk of receiving a GBR reduction, hospitals could de-emphasize better managing volume if the expenses required to achieve savings are too large. Simply put, if this incentive outweighs the global budget or other incentives, it may conflict with model goals.

Consider Accountable Care Organizations. They effectively reduced utilization. However, better health outcomes were elusive at first. The same is true for population health efforts. The proposal will move hospitals to an average while redistributing revenue on a neutral basis. Existing HSCRC policies with similar structures make it difficult for hospitals to get out of the penalty zone in subsequent years.

Thank you for considering MHA's comments, which reflect the hospital field's consensus views. Please reach out to me with any questions.

Sincerely,



Brett McCone
Senior Vice President, Health Care Payment

cc: Joseph Antos, Ph.D., Vice Chairman	Stacia Cohen
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Appendix: Existing Financial Incentives Under HSCRC Policies

Policy	Effective Date	All-Payer vs. Medicare Only	Revenue Impact
Global Budget Revenue & Unit Price Corridors	2014	All-Payer	Fixed, with decrease if volumes reduce beyond the unit price corridor
Market Shift Adjustment	2015	All-Payer	Increase & Decrease
Revenue Adjustments for Shifts from Regulated to Unregulated	2014	All-Payer	Decrease
Traditional Medicare Performance Adjustment (MPA)	2019	Medicare	Increase & Decrease
MDPCP Supplemental Adjustment to MPA <i>(to be phased out after 2021)</i>	2021	Medicare	Increase & Decrease
Care Transformation Initiatives (CTIs)	2021	Medicare	Increase & Decrease
Integrated Efficiency Policy – Cost per Unit	2005	All-Payer	Decrease to bottom quartile; Hospitals in top quartile and request an increase
Quality Based Reimbursement Program (QBR)	2009	All-Payer	Increase & Decrease
Readmission Reduction Incentive Program (RRIP)	2016	All-Payer	Increase & Decrease
Maryland Hospital Acquired Conditions (MHAC)	2011	All-Payer	Increase & Decrease
Potentially Avoidable Utilization (PAU) Savings	2017	All-Payer	Decrease