Maryland
Hospital Association

August 20, 2021

Jerry Schmith
Principal Deputy Director, Revenue and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Schmith:

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 stakeholder input on HSCRC's Global Budgeted Revenue (GBR) agreement. Thank you for the opportunity to comment on the proposed revisions. We pledge to work deliberately and thoughtfully with you to address our considerations.

The agreement reflects HSCRC's financial constraints and performance standards that hospitals are required to follow. HSCRC initiated the GBR agreement as a replacement for its Charge-per-Case agreement when global budgets were established. HSCRC amended the GBR agreement several times to specify additional considerations during the past several years.

The Proposed Revisions Open the Agreement Between HSCRC and Hospitals
HSCRC is updating the agreement to address important unit rate compliance considerations, beginning in rate year 2022. While the goal is simple, the extensive revisions prompted hospitals to review the agreements in detail, including several reviews by legal counsel. We appreciate HSCRC's desire to memorialize new specifications for rate year 2022, which began July 1. However, because the proposed language changes are extensive, HSCRC should please take the time needed to address all considerations, including those raised by hospitals. **We respectfully request at least an additional 30 days to address these matters, with at least one additional HSCRC working group meeting.**

The document is an agreement between HSCRC and hospitals. The proposed revisions reference HSCRC policy inputs that "may be updated from time-to-time." As this is a formal multi-party agreement, we respectfully ask HSCRC to describe a process to update those policies. Given the Aug. 20 comment deadline, MHA and the hospital field are poised to work with HSCRC to develop this language, including minimum notice, stakeholder input via work groups, comment periods, and changes that require or do not require commissioner approval.

Update COMAR and HSCRC Policy to Agree with GBR Agreement
MHA understands the GBR agreement was implemented to establish GBR and unit rate compliance rules. The proposed language states the GBR agreement supersedes compliance requirements in COMAR 10.37.03.05 that references unit rates set before the advent of the All-Payer Model and the Total Cost of Care Model. HSCRC's statutory authority was updated to allow HSCRC to manage compliance via the GBR agreement. HSCRC previously issued a memo establishing GBR and unit rate compliance requirements. MHA recommends that as part of the review, HSCRC compare three sources—the GBR

agreement, the compliance policy memo, and COMAR—then update COMAR to reflect the final compliance rules.

Measure Unit Rate Compliance Annually, Allowing for Expanded Corridors in Each Month
The GBR agreement does not explicitly state that unit rate compliance is measured annually or that annual compliance is weighted by the allowed monthly changes. Hospitals may change rates +/-5% without permission, and up to +/-10%, or potentially higher, with HSCRC's approval. HSCRC should consider including a simple example of weighted unit rate compliance to clarify its intent. (Six months of +5% plus six months of +10% = annual corridor of +7.5%.)

In addition to the weighted calculation, we ask HSCRC to consider language to recognize legitimate actions for hospitals to comply with unit rates as they manage GBR. Hospitals must request and receive approval for expanded corridors. This process can be delayed, requiring further increases or decreases in rates, over a shorter period, to manage GBR compliance.

HSCRC staff make a good faith effort to distribute rate orders close to July 1, the beginning of the rate year. In some cases, receipt of the rate order can affect unit rate compliance as hospitals drive toward GBR compliance. We know that HSCRC staff willingly work with hospitals to address this issue. We appreciate HSCRC considering options to address any timing concerns.

Define "Substantially" in New Supply and Drug Charge Compliance Proposal
The proposed revision states staff will evaluate "substantial" changes in the supply and drug charge-to-cost ratios. However, the proposed agreement does not specify what a substantial change would be. Because cost is the "volume" for supplies and drugs, hospitals could be penalized inadvertently for efficiently controlling supply and drug expenses.

Outlays for supplies and drugs are a function of both unit input cost and usage and have long been treated differently under HSCRC rules. For this provision to be effective, we suggest HSCRC review overall rate realignment based on underlying costs, and that stakeholders discuss and recommend a definition of a substantial change in charge-to-cost ratios.

Use the Most Recent 12-Month Volumes to Calculate Unit Rates
Thank you for proposing to rebase unit rates using 2019 volumes. Consistent with our previous comment letters, unit rates should continue to be calculated using the most recent 12-month volume period. If not annually, at least periodically. HSCRC implemented its efficiency policy to adjust global budgets. Adjusting to the most recent volume period will allow hospitals to more accurately adjust unit prices to achieve GBR compliance. MHA recognizes that this consideration may need to be adjusted for COVID-19 impacts.

Remove Monthly Written Report Requirement and Periodic Population Health Plan
The proposed agreement requires hospitals to submit a monthly written report on GBR compliance, and, to submit a periodic plan for Population Health Improvement and reductions on Potentially Avoidable Utilization. While this language is not new, MHA recommends it be removed because it is not practical and not consistently submitted.

Hospitals file monthly revenue and expense data to monitor compliance and must seek HSCRC's approval, with justification, before raising or lowering unit rates outside of the corridor. Maryland is already working to address population health and avoidable utilization considerations under the Statewide Integrated Health Improvement Strategy (SIHIS), Care Transformation Initiatives (CTIs) and the

proposed Revenue for Reform policy. These actions should give HSCRC adequate population health and avoidable utilization information without requiring a periodic plan.

Remove Medicare Access and CHIP Reauthorization Act (MACRA) Section
The MACRA section is not needed in the GBR agreement. Hospitals are subject to the Medicare Performance Adjustment (MPA) that adjusts hospitals' rates based on total Medicare spending per beneficiary attributed to each hospital. The MPA is referenced in an earlier section of the GBR agreement.

Notice and Comment Period for Change Should Be Extended
We appreciate HSCRC's extension for comments until Aug. 20. GBR agreement changes were initially discussed at the July 30 Payment Model Work Group and materials we received a day prior. HSCRC originally asked for comments by Aug. 6, with the expectation that HSCRC would distribute the revised agreements by mid-August. Once distributed, hospital CEOs have 10 days to sign and return the agreements. If followed, this timeline moves from concept to implementation—including expected stakeholder feedback—in less than 30 days. That is too short a time frame for this significant a policy change, especially when hospital leaders' energies are once again being sapped by a COVID surge.

Thank you for your considering our feedback on the GBR agreement. If you have any questions, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Katie Wunderlich, Executive Director
Cait Cooksey, HSCRC