Maryland
Hospital Association

October 30, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am providing feedback on the Health Services Cost Review Commission (HSCRC) draft recommendation for deregulation, repatriation, and out-of-state (OOS) volume policies. We appreciate the staff's review and refinement of volume policies along with the work group engagement for input from the field.

To support the Maryland Model, the ability of our hospitals to meet the health care needs of patients and community members, and the financial health of hospitals, volume policies must provide hospitals with adequate funding. HSCRC volume methodologies should more precisely account for and fund volume changes and identify and fund costs that are variable versus fixed. Though the draft recommendation on volume policies incorporates elements recommended by MHA members in work groups over the past few months, there are elements that remain unaddressed. We encourage the Commission to continue to implement needed changes.

Implementation of Adjustments

In the draft, deregulation, repatriation, and OOS adjustments would be implemented at the next rate issuance, on a one-time basis with a permanent adjustment made the following year if the same change is confirmed. This is a fair approach that recognizes volume changes may be temporary. The proposal rightfully allows hospitals to provide additional information to contest an HSCRC finding in this process.

All adjustments would be subject to a materiality threshold. MHA supports the proposal to adopt a larger threshold for deregulation, expatriation, or a negative OOS adjustment. The proposed threshold—requiring a downward change of more than 3% of global budget revenue (GBR) or of the associated service line—is sound policy, recognizing that volume changes may be small or temporary while allowing greater funding predictability and financial stability for hospitals. The proposal would implement a materiality threshold for repatriation and positive OOS changes so that an adjustment would occur if it exceeds 1% of GBR or of the associated service line.

While MHA supports this lower threshold, we encourage adopting a 0.5% threshold to more accurately capture volume shifts under the policy.

The policy would still require planned deregulation to be reported. If the deregulation methodology indicates potential deregulation that varies from what is planned by more than 10%, HSCRC may consider revising the deregulation. MHA supports this approach. Deregulation may occur due to action by payers or physicians outside of hospitals' control. The threshold and staff discretion to administer the policy recognize this dynamic and the inherent difficulty of quantifying precisely the extent of deregulation.

Repatriation

Regarding the proposed methodology for repatriation, MHA identified the following issues to be addressed:

- *Interaction with Deregulation.* Hospitals may face double penalties under both policies. MHA requests excluding Equivalent Case-Mix Adjusted Discharges (ECMAD) accounted for under deregulation from the unrecognized ECMADs under the repatriation policy.

- *Distorted Results from Extrapolation to All Payers.* Use of extrapolation from Medicare fee-for-service (FFS) data to all payers can distort results under the methodology, specifically when there is a low Medicare fee-for-service (FFS) percentage. We recommend removing or using alternative methods to assess repatriation for service lines with low Medicare FFS percentages.

- *Medicare FFS Default.* A significant percentage (nearly half) of the procedure categories lack an appropriate Medicare FFS percentage and use a default percentage of 100%. This caps repatriation growth and potential funding at the Medicare growth level. MHA recommends defaulting to a different percentage or calculating the Medicare FFS percentage at the non-county-specific service line level where a percentage may be derived.

- *Services Addressed in Other Policies.* CDS-A and innovation service lines are addressed already in their stand-alone policies and should be excluded from the repatriation analysis.

Volume Scorecard

The draft recommendation includes a request for "codification" of a volume scorecard that would provide a "complete accounting of all volume adjustments that occurred over the course of the All-Payer and [Total Cost of Care] models." The proposal would not have the scorecard serve as a methodology but would have it used to allow future policymakers to assess the need for potential revisions to HSCRC volume policies. Members have raised concerns about the results of the scorecard given that it has not been validated. MHA urges against any HSCRC "codification" or other formalization of the scorecard. . HSCRC should consider retaining an independent third-party to validate the approach before using the scorecard to evaluate the over and underfunding of volume and whether modification is needed to methodologies for funding volume changes.

Unresolved Matters

The draft recommendation addresses policies governing OOS, deregulation, and repatriation volume changes. However, improvements are needed to existing policies governing the funding of other types of volume changes.

Market Shift Methodology

The existing policy governing market shifts needs important, unaddressed updates. The methodology needs to fund variable and fixed costs more precisely. Current methodology funds volume change at a 50% variable cost factor (VCF). MHA favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. In work group discussions, HSCRC staff offered analyses that support an overall 50% VCF. However, a preliminary service line analysis by MHA shows adoption of a higher overall VCF for inpatient and outpatient services is required, with drugs and supplies appropriately funded at a 100% VCF.

Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. Broader geographic definitions (e.g., county level) could improve the methodology. MHA urges HSCRC to change to the market shift methodology to allow potentially avoidable utilization (PAU) to flow through the underlying service line. Hospitals should get funded for PAU when this is from a market shift. If a hospital provides care that could not be avoided through better planning, prevention, or care coordination efforts by that hospital, it should be fully funded for providing that care under the policy.

MHA respectfully requests that HSCRC continue to work with the field to develop and make improvements to the market shift methodology.

Demographic Adjustment

The current methodology for demographic adjustments insufficiently accounts for age-adjusted growth. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment from 4.25% to 0.25%. This substantially underfunds age-adjusted demographic growth at a time when the state has higher utilization with an aging population.

Conclusion

MHA appreciates the opportunity to comment on volume policy changes. Volume policies must do a better job accounting for and funding volume changes. Hospitals seek a balance to keep communities healthy. While the focus of the draft recommendation is on deregulation, repatriation, and OOS adjustments, we urge you to also consider the other volume policies, including market shift and demographic adjustment, that need improvement.

Sincerely,

Patrick D. Carlson
Vice President, Health Care Payment

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