Maryland
Hospital Association

October 15, 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 Budget Revenue (GBR) agreement. Thank you for responding to our Aug. 20 comment letter. As requested, this letter reflects MHA's feedback to your responses presented Sept. 10.

Proposed Corridors for Supplies and Drugs
Under GBR, hospitals historically managed to a revenue target for supplies (MSS) or drugs (CDS) over the 12-month period of GBR compliance. Ultimately, hospitals aim to be within the approved MSS and CDS price corridor, applied to rate order revenue, at rate year end. HSCRC is contemplating a charge-to-cost measure to account for revenue changes as a function of cost.

Hospitals propose the following, with justification below:

- The rate year end revenue corridor for MSS and CDS revenue should be fixed at +/-15%
- Allow a +/- 60% year-end corridor from the rate order charge-to-cost ratio. If the beginning charge-to-cost ratio is 2.0, at year end, the hospital's charge-to-cost ratio could be within 0.8 to 3.2
- HSCRC might compare monthly MSS and CDS charge-to-cost ratios to +/- 60%. However, hospitals do not support establishing rate penalties for a single month given the retrospective nature of MSS and CDS expense reporting compared to billed charges
- HSCRC should evaluate hospital performance compared to the year-end revenue corridor before assessing charge-to-cost ratios

MSS and CDS charge-to-cost ratios will fluctuate throughout the year because MSS and CDS are the only centers that use cost as the basis for volume. Hospitals set MSS and CDS markups based on their best estimate of the utilization that will occur in that month. Monthly invoice costs are not final until *after* the month has been closed. Hospitals will charge expected revenue using current month MSS and CDS use, along with historical experience as guideposts, but *they will not know actual invoice costs* until the month is closed. This could cause charge-to-cost ratios to vary. Monthly supply and drug expenses vary for a variety of reasons—cost savings, rebates, incentives, inventory adjustments, etc.—and these adjustments will not be known or applied in the concurrent month.

The chart below reflects the *average* of the maximum and minimum hospitals deviated from their average charge-to-cost ratio during the year. For example, even before the pandemic, in 2019, hospitals lowered the MSS ratio by an average of 33% *at least one month* during the year and raised the MSS ratio by an

average of 66% in at least one month. In 2020, before the pandemic, the average hospital ranged from -30% to +42%. The maximum increased to a high of +90% when the April-June 2020 period is included. Rate year 2021 ranged from -37% to +61%.

	2019		YTD March 2020		2020 (Total)		2021	
Center	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**
MSS	-33%	66%	-30%	42%	-43%	90%	-37%	61%
CDS	-35%	58%	-36%	67%	-43%	112%	-47%	115%

In assessing the standard deviation of charge-to-cost ratios from 2019 to 2021, most hospitals had a single month with charge-to-cost ratios of more than two standard deviations from the average, yet only two hospitals had two months with charge-to-cost ratios beyond two standard deviations. The same is true for drugs, except only three hospitals exceeded two standard deviations—all in rate year 2020.

Hospitals are trying to maintain GBR compliance and are managing rates collectively, including MSS and CDS to achieve that result. If hospitals must continue to measure MSS and CDS revenue corridors—supply or drug rate or revenue divided by 12 months—charge-to-cost ratios will change as hospitals attempt to stay within the revenue corridor. The chart below reflects an example using the same assumptions from above. In this example, the hospital cost decreases from $10,000 to $8,000, or 20%. The hospital would mark up cost by a factor of 2.5—a 25% increase from the beginning of the year ratio—to maintain revenue compliance.

	Cost	**Charge-to-Cost**	**Revenue**
Year beginning (rate order)	$10,000	2.0	$20,000
Year end	$8,000	2.5	$20,000
Change	-20%	25%	0%

An alternative would be to remove MSS and CDS revenue targets altogether. However, HSCRC may need to address its overall unit price corridor if a hospital reached its charge-to-cost ratio compliance limit and *did not* reach its revenue limit. In this case, the remaining revenue authority under GBR must be made up by raising prices in other rate centers, likely room-and-board centers, which would affect Maryland's Total Cost of Care performance.

We ask HSCRC to review historical and year-to-date data to test the reasonableness of this corridor. If current experience is significantly different than this proposal, we respectfully ask HSCRC be open to reconsidering this proposal after analyzing the actual data. We also ask that changes to MSS and CDS become effective Jan. 1, 2022, rather than retroactive to July 1. Hospitals must still achieve overall GBR compliance, limiting total system revenue.

Rebase Volumes to Calculate Unit Rates Every Three Years

Thank you for rebasing 2021 unit rates using 2019 volumes. While the hospital field believes unit rates should continue to be calculated using the most recent 12-month volume period, we appreciate HSCRC will consider periodically updating the volume base. MHA recommends HSCRC rebase volumes every three years.

Remove Written Requirements and COMAR Updates
MHA agrees with HSCRC staff's proposal to remove references to the Medicare Access and CHIP Reauthorization Act (MACRA), and to remove requirements for written reports on GBR compliance and population health. We agree with HSCRC's long-term goal to revise COMAR to align with the GBR agreement.

Measuring Unit Rate Compliance
We agree with HSCRC staff's proposal to include language about annual price compliance weighting. The GBR agreement sets forth the general unit rate price compliance guardrails. HSCRC might consider issuing technical guidance outside of the GBR agreement to address specific issues with unit price compliance.

Thank you for your considering MHA's feedback. Please reach out to me with any questions.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Katie Wunderlich, Executive Director
Cait Cooksey, Deputy Director