Maryland
Hospital Association

May 11, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Revenue for Reform proposal

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the Commission's interest in ensuring that hospitals meet the population health aims of the Maryland Model.

On May 6, MHA's Executive Committee, our governing body, discussed the Revenue for Reform proposal and concluded **we must ask the Commission to suspend any further action on the policy and join with hospital field leaders to find a workable approach to meet the laudable aims we all share**. We appreciate that HSCRC will discuss this matter at an upcoming public meeting. Hospital leaders will join MHA staff to speak to the proposed policy.

There are two main reasons for this conclusion. First, after two years of battling the pandemic, and notwithstanding much-appreciated financial relief delivered by both the Commission and the federal government, Maryland hospitals face real and increasingly severe cost pressures just to deliver core services. Most hospitals are seeing losses in the current fiscal year, and they expect losses to continue next year. That will be true even if the Commission accepts our proposal for the annual payment update and especially if the Commission adheres to the staff's draft update recommendation.

There are no resources to spare; in fact, many hospitals are right now making tough choices about cutting essential functions. And yet, they all continue to do right by their communities.

As a result, MHA's Executive Committee strongly disagrees with HSCRC's expectation that hospitals must give other entities 50% of their retained revenues – or 1% of revenue for those hospitals having no retained revenues – to perform community health work. The Association does accept the short-term approach to "safe harbor" expenses from the efficiency policy.

Second, hospital field leaders find that the proposed Revenue for Reform policy uses a definition of population health investment that makes artificial distinctions between multiple activities meant to keep people healthy and reduce their needs for acute care. The Commission staff's characterization of some efforts as acceptable for safe harbor treatment and other equally valuable efforts as ineligible does not square with real world practice. It would not be appropriate for the Commission to enforce this distinction through official policy, especially by insisting that hospitals give money to independent entities that are not accountable to perform

according to the goals of the Total Cost of Care Model. There is abundant evidence of hospital direct service costs that are essential to improving community health and avoiding utilization.

The rest of this letter sets forth the hospital field's position and our rationale. We present:

1. MHA's view of the policy approach
2. Recommendations on applying a safe harbor in the efficiency policy in year 1 and year 2
3. Our position on the spending threshold requirements, beyond the second year

1. Policy Approach

HSCRC's proposed Revenue for Reform policy has multiple aims. Among these are to remove or redistribute revenues retained in the system and to encourage hospitals to invest in community health. The Association acknowledges the value of addressing retained revenues. MHA also is confident that *existing* Total Cost of Care Model provisions and HSCRC policies already give hospitals ample incentive to invest in community health.

Our comments below correspond to the two stages of the proposed policy: first, application of the safe harbor / buyout provision in the first two years under the efficiency policy; second, the requirement that hospitals spend the greater of 50% of retained revenues or 1% of total revenues after year two.

2. Safe Harbor in the Efficiency Policy

MHA endorses HSCRC's plan to create a safe harbor in the efficiency policy, allowing hospitals to "buy out" of a rate reduction. The efficiency policy effectively moves some revenues from less efficient to more efficient hospitals. That is its primary tool to address retained revenues built up under global budgeted revenue (GBR). We appreciate staff's balanced approach to address retained revenues while trying not to undermine the GBR incentive.

At the same time, HSCRC must recognize population health investments each hospital makes by following patients in the community and promoting the health of people who have not used the hospital recently, or ever. These investments differ markedly from conventional discharge planning and other expenses related to hospital encounters. Examples of hospital costs that support the community are included in the appendix.

3. Spending Threshold Beyond Year 2

Hospitals know they must invest to make people healthier to avoid use of both hospital services and other preventable care. Hospitals use many and varied effective approaches, beyond standard hospital functions, to meet the distinct needs of their populations and to fill gaps left by public health agencies and community-based organizations. Efforts include community care case management, targeted primary and specialty physician care, and community partnerships.

Most hospitals do give money to community-based organizations – where they exist and have competencies hospitals lack – to advance the health of catchment area residents. While such donations can yield important benefits, the outcomes do not always align with the drivers of hospital service use, the most expensive part of the health care system.

If hospitals are mandated to steer half of retained revenues, or 1% of total revenues, exclusively to community-based entities, it will crowd out real, sustainable hospital investments that work.

Hospital field leaders are not alone in seeing this. In the General Assembly's 2020 session a bill was proposed with the same goal as HSCRC's, to direct a greater portion of hospital spending toward identified community health needs. That bill was amended specifically to remove this requirement. Legislators readily recognized that, much as hospital community health needs assessments help identify focus areas, government should not dictate specific partnerships or spending. They acknowledged community needs and institutional capabilities vary.

Though HSCRC's efficiency policy is the primary tool to address retained revenues, it is just one of many policy levers. Rather than create a new incentive, one that would require new spending to meet the threshold even as hospital margins decline, HSCRC should evaluate and fine tune all policies that remove or redistribute revenue. These include Care Transformation Initiatives, market shift, unit rate corridors, deregulation of services, and other hospital-specific adjustments.

To be clear, Maryland hospitals are deeply committed to work toward improving the health of the population. We are no less determined to do this than the Commission, the state, and the federal sponsors of the Total Cost of Care Model. And hospitals are the most accountable of all.

As one example, at its meeting last week, our Executive Committee determined that MHA will launch a robust maternal morbidity improvement initiative using Association funds. This effort will target racial health disparities and there will be a high degree of hospital accountability. One focus of this work will be upstream, community-based, pre-natal interventions to reduce risks for new mothers and newborns.

We appreciate HSCRC considering our comments and we look forward to discussing these matters in work groups and formal public proceedings. Public discussion with commissioners is crucial to explore how to use all available policy levers to best effect.

Should you have any questions, please contact me.

Sincerely,

Bob Atlas
President & CEO

Cc: Adam Kane, Esq., Chairman
Willem Daniel, Deputy Director

Appendix: Case Examples

Illustrative Program Investments and Case Studies

The examples below demonstrate how hospital resources, and related expenses, are integrated into community-based care delivery beyond conventional hospital interventions. These are the types of investments that should be included in the safe harbor.

Hospitals partner with local health departments, community and faith-based organizations, physicians, and others to promote better health and well-being of the people in their catchment areas. Many times, the first opportunity to engage an individual patient is at the hospital. But as these examples show, hospitals continue following people well beyond the encounter and well beyond the readmission time window.

These are real examples that demonstrate staff roles and functions, impacts of the interventions, and the time spent in the community connecting patients to wrap-around supports.

Program Level Investment Example

The Care Transitions Teams provide eligible patients transitional support from one setting or level of care to another. Patients who have or are experiencing the following may qualify for help from the Care Transitions Team:

- Extensive medication needs
- Complex diagnoses
- Multiple social barriers

The Care Transitions Team supports patients in many ways:

- Provides education to ensure patients have the tools they need to prevent or self-manage chronic disease(s)
- Connects patients to needed community resources
- Conducts follow-up calls and home visits (CHW) when needed
- Medication therapy management
- All team members are available to meet with the patient outside of the hospital, at the patient's health care providers' appointments, and during social services interactions

Impact

The Care Transitions Team has shown success improving patient medication compliance, making connections to primary care and specialty providers, enrolling eligible individuals in long-term care management, improving quality of life, pre/post labs, and reducing cost of care. The results below speak to the impact of the program.

6 Month Pre/Post Utilization Outcomes
(n=57)

	Total Charges	Emergency	Observation	Inpatient	Readmission
Pre	$2,037,948	59	42	91	20
Post	$1,015,653	35	16	33	6
Difference	**$1,022,295**	**24**	**26**	**58**	**14**

Six month estimated cost savings[1]: **$435, 808**

Patient Case Examples

Patient Case Example 1

A 71-year-old man, "Mr. Davis," comes to the emergency department after falling at home shortly after he's released from the hospital. While the emergency medical team must stabilize Mr. Davis and make sure his laminectomy (a surgery where part of the vertebrae is removed to release pressure on the spinal nerves) is not affected, they also need to check the patient's numerous comorbidities. These costs are normal, core hospital operating expenses.

Mr. Davis has hypertension, acid reflux, type 2 diabetes, high cholesterol, uncontrolled blood pressure, and obesity. The patient also reports "sharp, severe headaches that wake me up." And he has a long list of medications.

The emergency team hands Mr. Davis off to the hospital's care transitions team. They break down barriers so he can care for himself. The team then collaborates with his primary care physician to conduct comprehensive medication therapy management, which includes a plan for ongoing monitoring. Motivational interviewing techniques encourage him to make some lifestyle changes and educate him about his multiple conditions. The team determines the patient qualifies for long-term outpatient support and makes appropriate referrals, ensuring a guided hand off.

When Mr. Davis was first introduced to the care transitions team, he had an average blood pressure reading of 181/101 mmHg, and A1C level of 7.4%. Six months after he first presented to the ED, his blood pressure had dropped to 128/80 mmHg, and his A1C level to 6%. This substantial drop would not have been possible without the many interventions and connections created by the hospital's care transition team.

[1] Based on FY19 Direct Expense/Total Charge ratio:
Emergency services: 35.1%
Med/Surg Acute: $48.9%
Definitive Observation: 34.7%
Med/Surg Intensive Care: 66.9%

Interventions Beyond the Hospital	Results
• Education • Medication management • Coordination with primary care physician • Connection with long-term outpatient assistance • Lifestyle modification support	Blood pressure 181/101, down to 128/80 A1C of 7.4%, down to 6%

Patient Case Example 2

A 68-year-old woman, "Ms. Smith," arrives in the ED because she doesn't have any ostomy bags, which collect waste from the body. Ms. Smith was referred to ED Transitional Nurse Navigator (TNN), who also referred her to the senior triage team for case management.

After meeting with Ms. Smith, her case manager learns many things not clear from her chart. Ms. Smith did *not* have the following when she came to the ED:

- A working phone
- Income or bank account
- Stable housing (she was facing eviction)
- Insurance card for Medicaid
- Medicare
- State ID
- Social Security Card
- PCP/proper medications
- Transportation
- DME company to provide necessary ostomy supplies

Interventions Beyond Hospital Activities	Results
• Referred to ED TNN and senior triage • Collaboration to determine medical care plan • Transportation to essential doctor appointments • Referral to get needed medical care supplies • Mental health resources for severe depression • Assistance with accessing follow-up medical care • Support entering assisted living	• Phone with service monthly • Income - Social security applied for and received, has new card • Bank account set up in client's name, working on financial assistance through rep payee program • Medicare A and B with QMB in place to cover part B monthly payment, received card • Medicaid still in place, received card • Medication management in place (Alarming pill box) • Moved into an ALF (New home visiting PCP) • State ID - Still in progress

Hospital staff learned Ms. Smith's late husband was a veteran. Hospital caregivers helped her get a copy of her late husband's death certificate, which will allow her to apply for VA benefits she can use to pay for assisted living. Hospital staff helped her get Social Security benefits, set up a working phone, and assisted her with medication reconciliation.