Maryland
Hospital Association

June 21, 2023

Adam Kane
Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chair Kane:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the draft rate year (RY) 2024 Integrated Efficiency Policy recommendation, including other planned Health Services Cost Review Commission (HSCRC) analyses. Hospitals must be able to seek permanent rate relief from HSCRC, and the efficiency policy is important to lift the full rate application moratorium in RY 2024. Consistent with MHA's work group comments, HSCRC should assess all policies, including the efficiency policy, relative to our system's aims to create a more predictable and stable policy environment.

Lifting the Full Rate Application Moratorium to Provide Permanent Rate Relief

We understand HSCRC staff's reasoning for proposing full rate application settlements as one-time adjustments, yet we are concerned about the impact on future policy making. Hospitals eligible for permanent rate relief may be reluctant to make permanent decisions, like raising nursing wages, if ongoing dollars are not guaranteed. At the same time, hospitals should be free to use HSCRC's proposed approach to receive one-time funding, with a 2025 settle-up, provided they may still seek permanent rate relief.

HSCRC's full or permanent rate application moratorium ends July 1. After then HSCRC cannot prevent hospitals from seeking permanent rate relief through a full rate application. If HSCRC wants to delay permanent rate adjustments because volumes are not stable, then it must follow its rule making process and propose to extend the moratorium via regulation, which MHA does not support.

HSCRC also set aside 0.40% in the Annual Update Factor to settle full rate applications. This set aside was applied instead of potentially funding permanent inflation, increasing other amounts, or creating system savings—implying the monies ultimately will be permanent.

The proposal to apply full rate applications as one-time adjustments is inconsistent with the policy and other HSCRC rate adjustments. HSCRC staff cite falling profitability as the basis to permanently reestablish a productivity adjustment. Yet falling profitability occurred during the same period HSCRC cites as a concern. A portion of this period will affect permanent market

shift adjustments. While Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTI) are not permanent revenue base adjustments, the same data were used to adjust annual hospital revenues.

The efficiency policy may be revised in 2024, changing any settle-up beyond volume alone. Traditionally, HSCRC has not retrospectively applied changes to its methodologies to settle full rate applications. The Commission should maintain the practice of setting policies prospectively, unless errors are identified, as in the case of the demographic adjustment.

The Productivity Adjustment Should Not be Reinstated

From HSCRC staff's 2021 recommendation, the productivity adjustment was suspended to account for Total Cost of Care (TCOC) Model (Model) investments outside of regulated hospital business. Prior to suspension, HSCRC staff recommended using the productivity adjustment as a *temporary measure* until additional reporting could provide a better understanding of physician costs intrinsic to the operations of acute care facilities and population health investments. HSCRC plans to recognize certain population health investments in the buyout provision, and HSCRC staff plan to revise the RY 2024 annual filings to better understand physician costs. Reinstituting the productivity adjustment has the unintended consequence of requiring already efficient hospitals to become *even more efficient* to fund these costs.

At the April 12 HSCRC public meeting, commissioners directed staff to evaluate a measure for operational efficiency. The proposed approach is based on historical operating margins and a blanket 2% adjustment. It does not address the intent of commissioners' request to ensure both cost and price efficiency are evaluated as utilization declines.

The proposed measure does not account for reasonable margins in a global budget revenue (GBR) system. Hospital margins have eroded compared to pre-pandemic years. Regulated expenses rose during this period, primarily driven by agency costs and permanent salary adjustments. Whereas pre-COVID operating margins were offset by unregulated costs, erosion has occurred in all margins (see appendix). The data also shows that all other hospital costs declined despite inflation, showing *improved cost efficiency*.

Any further consideration of operational and administrative efficiency should occur only after a financial conditions assessment, understanding Maryland's position relative to the nation. If a measure is adopted, it should be well studied, as there is no rationale for the historical 2% adjustment.

With Proper Evaluation, Adopt a New Total Cost of Care Measurement Approach

HSCRC staff's recommendation to move to a Medicare Performance Adjustment (MPA)-like approach for both Medicare and commercial TCOC performance is appropriate, as there are concerns about the existing benchmarking methodology and national peer group comparisons. However, certain concerns about the MPA remain, including:

- Overlapping TCOC risk across HSCRC payment policies
- MPA's geographic attribution, which fails to recognize hospital efforts to manage TCOC

Although no methodology is perfect, the previous physician-linked methodology better captures hospital care transformation. The MPA approach for Medicare—in place since 2021—is more vetted. The commercial analog approach is only based on a 2018-2019 data period and is untested. For this reason, MHA supports a phased-in approach.

Implement Full Rate Application Algorithm, but Allow Population Health Investments

We support the revised algorithm for full rate application rewards and penalties, as it recognizes both total cost of care performance and improvement. We suggest modifying the full rate application to include population health investments as phase II adjustments. If HSCRC staff apply the logic for inefficient hospital "buy out," then applications should follow suit. For example, an inefficient hospital making primary care investments in a medically underserved or health professional shortage area would have the costs considered in their revenue base. Such investments would not be recognized for efficient hospitals, creating inequities across policies.

Expand Revenue for Reform Spending for Community Needs and Behavioral Health

We appreciate staff broadening the physician spending category to align with primary care specialties and provider types included in the Maryland Primary Care Program. At the April 18 HSCRC Efficiency Work Group meeting, staff stated they would recommend broadening the community needs spending category to include costs that are recorded in the hospital but are community facing, like care navigation costs beyond traditional discharge planning. We suggest making this explicit in the final recommendation. We also recommend adding spending on behavioral health, which is a key concern of the Maryland Department of Health.

Long-Term Policy Considerations

MHA applauds the Commission for reviewing the policy in an iterative manner and looks forward to participating in the long-term work group, anticipated to begin in summer 2023. Based on field input, MHA suggests HSCRC:

- Address overlap of TCOC risk among HSCRC payment policies
- Review hospital-based physician costs
- Re-evaluate peer group comparisons
- Explore alternatives to the disproportionate share hospital (DSH) adjustment
- Determine if using equivalent case mix adjusted discharges to calculate permanent revenue in the Inter-hospital Cost Comparison is appropriate in a population-based payment system

We appreciate HSCRC's commitment to refining the policy and look forward to future engagement. If you have any questions about the recommendations outlined in this letter, please do not hesitate to contact me.

Sincerely,

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Senior Vice President, Health Care Payment

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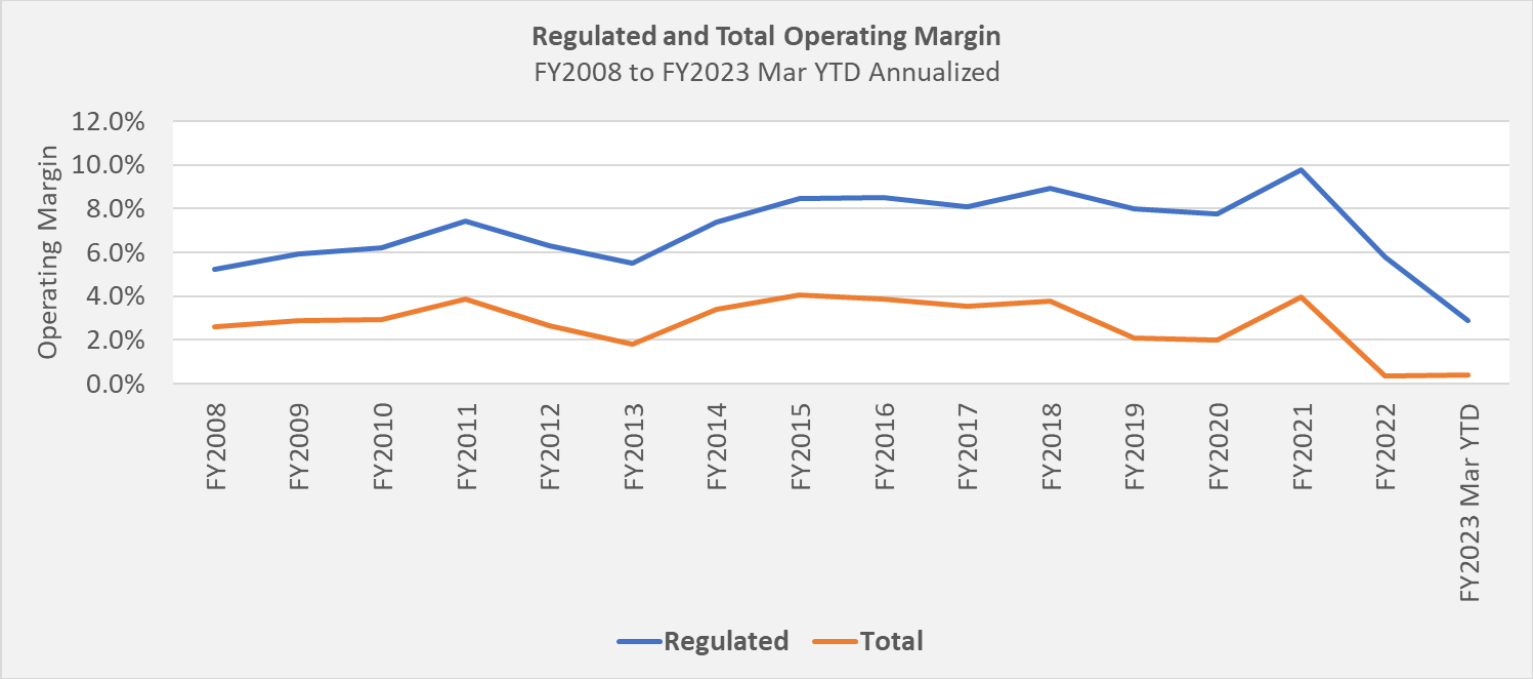
Appendix I – Operating Margin Trends



Unregulated Subsidy (as Percent of Total Net Operating Revenue)	
FY2008-FY2013	-2.9%
FY2014-FY2017	-3.8%
FY2018-FY2022	-4.7%