



Maryland
Hospital Association

August 16, 2019

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

Dear Ms. Wunderlich:

On behalf of Maryland's 61-member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed integrated efficiency policy.

MHA supports the proposal to adjust hospital revenues for efficiency.

The Inter-hospital Cost Comparison (ICC) and Total Cost of Care (TCOC) growth are appropriate measures of efficiency. Measuring efficiency in a fixed revenue environment is difficult, and we appreciate the HSCRC staff's approach to balance unit price efficiency with hospital specific, per capita attribution. Global budgets create powerful incentives to reduce utilization, that by design, can lead to price inefficiency. This is an important consideration that requires a thoughtful approach in all HSCRC policies to avoid competing incentives.

The efficiency policy should be revenue neutral on a statewide basis.

If any high cost hospitals' revenues are reduced, the full sum of this reduction should be available to be redistributed within the system. No portion should be withheld. We appreciate the HSCRC staff's consideration that allows low cost outliers to apply for increases and other proposed uses of savings, including capital funding, etc.

The profit strip should not apply when determining high- or low-cost outliers for revenue adjustments but may apply when using the methodology for a full rate application.

In today's TCOC environment, it is impractical to remove only regulated profits from the calculation when hospitals are asked by HSCRC to invest in activities to transform care. Many, if not most, care transformation activities and investments occur in settings not regulated by HSCRC. We appreciate that staff does not regulate professional physician services, the major component of unregulated losses, and we are not advocating that the HSCRC should do so. However, hospitals believe that removing total operating profit – regulated and unregulated – does not violate the HSCRC's statute, particularly as the other efficiency measure, TCOC, includes physician services when determining hospital revenue adjustments. Removing total operating profit gives a much clearer and cleaner picture of actual cost incurred as hospitals move to reduce TCOC.

Policy Goals and Objectives, and Methodology Application

HSCRC should describe clear policy goals and objectives for the efficiency policy. The HSCRC staff's document introduces the measure, but no section clearly articulates the policy's aims.

HSCRC staff propose to use methodology results to withhold the Medicare portion of the annual payment update for those hospitals determined to be high cost. HSCRC staff also propose to use the methodology results to evaluate global budgeted revenue (GBR) enhancement requests. We agree that a single methodology should be used to measure performance that can be applied to revenue adjustments.

While not explicit in the recommendation, MHA expects this methodology would be used in the full rate application process. We note that once the methodology is developed it may be used in several ways to directly or indirectly adjust revenues, and it will likely remain in place for several years. As noted in the ICC Methodology section below, MHA suggests applying adjustments differently in a full rate application, rather than the methodology used to determine outliers.

HSCRC staff should consider the efficiency measure as a threshold to apply a revenue reduction. Historically, hospitals above a certain threshold were identified as high cost hospitals, subject to a spenddown – agreed to by hospital and HSCRC staff. Hospitals appreciate the need to adopt clear policies with stated results. The methodology would still identify high cost outliers with required revenue adjustments but allow hospitals some flexibility to negotiate with staff over terms and amounts. Under this approach, the terms of the agreement should be a public document, reviewed and approved by commissioners at a public meeting.

Hospital revenue reductions from the efficiency measure should be net of other adjustments applied by HSCRC staff. Hospitals are concerned that the efficiency policy could double count revenue reductions previously applied, including deregulation or other GBR adjustments.

ICC and Rate Efficiency Methodology (REM)

The ICC methodology is the first pillar of the efficiency policy. As a reminder, the ICC methodology is largely “fixed.” Hospitals have very little, if any, control over the results because revenues per unit of measure and the adjustment factors are pre-determined.

Hospitals have identified several matters for staff to consider:

Identifying High- and Low-Cost Outliers versus Settling Full Rate Applications

The efficiency measure uses the historical full rate setting approach, establishing a peer group average less profit and productivity, then comparing each hospital’s result to its unadjusted charge per unit. Under the proposed approach, all hospitals appear inefficient because all hospitals appear to receive a revenue reduction. To identify high-and low-cost outliers, hospitals should be compared to the peer group standard using the REM, without adjustments to remove regulated profit or productivity (excess capacity). If the intended goal is to measure price efficiency rather than cost efficiency, profit and productivity should not be removed. These changes should not materially alter the overall results, but profits and productivity should only be applied in a full rate setting.

The full rate application standard, though based on the same framework, should use the ICC and may include adjustments for profit and productivity. The standard to receive additional funding through a full rate application was always more stringent than a hospital efficiency comparison.

Adjustments for Quality Measures

HSCRC staff propose to adjust the methodology for quality performance. Maryland's hospitals are steadfastly committed to raising quality. However, we respectfully request HSCRC staff eliminate this adjustment. There are already ample adjustments for quality in the rate setting system, both direct – readmissions, complications, etc. – and indirect – Medicare Performance Adjustment, etc.

Volume Adjustment

HSCRC staff propose to volume adjust the methodology to reward hospitals that reduced utilization and penalize hospitals that increased utilization. Hospitals generally agree that some adjustment should be made because unit prices are a function of fixed revenues and changing units. Hospitals experiencing a decline in units will appear inefficient if the decline is caused by reductions in avoidable utilization, aligning with GBR and system incentives. Hospitals should receive credit for reducing potentially avoidable utilization (PAU) and there should be no adjustment for general utilization declines. This adjustment is one area where hospitals can affect the ICC results because reducing avoidable utilization will affect the outcome.

This adjustment is applied during the build-up phase of the ICC calculation. The adjustment to recognize PAU must be changed because of MHA's recommended change to measure outliers using the REM and not the ICC.

Productivity Adjustment

Like the profit strip, the productivity adjustment should only apply when using the methodology for a full rate application. Hospitals understand the productivity adjustment will vary by peer group. This adjustment will not apply in MHA's proposed approach to measuring outliers, but because it affects all hospitals in the peer group equally, it should have no impact on any hospital's position.

HSCRC staff recommend an excess capacity adjustment that measures the decline in patient days from 2010 through 2018. Hospital GBRs were constructed using the 2013 base period and negotiated into 2014. Some amount of fixed cost was built into the GBR. If the productivity adjustment measurement period begins in 2010, the methodology will not account for some fixed costs that were included in the initial GBR rate setting.

Peer Groups

HSCRC staff have historically used peer groups to account for unmeasured difference in hospital costs. HSCRC staff are not proposing to evaluate peer groups. We suggest HSCRC assess peer groups because they are an integral part of the core ICC methodology.

Medical Education, Disproportionate Share (DSH) and Other Direct Strips

Hospitals agree it is appropriate to adjust for costs unique to each hospital. The indirect medical education (IME) adjustment was revised during the initial ICC proposal in 2018. MHA and HSCRC staff did not address the IME adjustment during that period. Hospitals note the adjustment was last calculated based on 2015 data.

The revised ICC does not reflect an adjustment for DSH. DSH generally refers to unmeasured cost differences for treating an underserved population, which is different from measuring patient complexity. We appreciate HSCRC staff's conclusion that expanding Medicaid has led to a reduction

in uninsured patients and that comparing case mix adjusted charges for a poor population compared to all other populations did not yield a significant variance. However, many hospitals believe HSCRC staff should continue to study this issue.

The revised labor market adjustor (LMA) splits the state into three categories: Prince George's plus Montgomery counties, all other Maryland, and three outlier hospitals. HSCRC staff previously indicated a desire to use Medicare Wage Index data in the future. MHA supports using Medicare wage data to improve the accuracy of the information. However, as staff pursues this approach, we urge careful consideration of replacing the existing methodology that blends labor markets throughout the state with one that could create "cliffs" by using a defined geographical area.

Total Cost of Care Growth Measure

The second pillar of the efficiency policy measures Medicare TCOC growth – hospital and non-hospital spending per beneficiary – as assigned to a specific hospital. MHA agrees this is an important measure in the efficiency policy because the system incentives are population based.

HSCRC's approach uses the Primary Service Areas-Plus (PSA-P) method to assign beneficiaries to hospitals. We note that this methodology is different than the methodology used to measure the Medicare Performance Adjustment (MPA). We understand HSCRC staff's intent to measure TCOC performance since 2013 and we agree it is not possible using the MPA attribution.

Hospitals acknowledge and agree that any logic attributing beneficiaries to hospitals will be imperfect. Hospital Medicare payments are directly adjusted based on MPA performance. However, we also note that HSCRC staff's statistical analysis reflected a strong correlation between the 2018 MPA results and the 2018 PSA-P. With additional time to review the policy, HSCRC should strive for consistency in its approach to attribution.

Implications for Other HSCRC Policies

Once an efficiency measure is in place, we respectfully ask HSCRC staff to revisit its unit rate compliance policy. Measuring monthly rate compliance and adjusting unit rates, with the process of requesting adjustments outside certain corridors, creates a heavy burden on hospital reimbursement staff, with very little net value. HSCRC staff have previously indicated a willingness to revisit this issue after an efficiency measure has been adopted. We appreciate the need to hold hospitals accountable to revenue targets.

Methodology Validation and Stakeholder Input

MHA recognizes the methodologies and underlying data used to manage the rate setting system have evolved over time. Combining inpatient and outpatient measures, and measuring total cost of care, involve new data sets and unique patient identifiers. One of the hallmarks of Maryland's rate setting system has been the ability to replicate and validate calculations. Allowing unfettered access to patient identifiable data may not be practical, but we would appreciate HSCRC staff's consideration of this important process set. In cases where data can be made available, we urge staff to err on the side of transparency and share the data for all to validate.

Katie Wunderlich
August 16, 2019
Page 5

We strongly encourage HSCRC to maintain an open and transparent process for stakeholders to share feedback on policies, including underlying methodologies. A regular review process will allow all stakeholders to provide feedback to HSCRC staff and will ultimately support the recommendation process.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,



Brett McCone
Senior Vice President, Health Care Payment

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