Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.03 Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, are submitting our comment letter on COMAR 10.37.03 – Types and Classes of Charges Which Cannot be Changed Without Prior Commission Approval. We believe that there is a need to align this regulation with related Health Services Cost Review Commission (HSCRC) policies, Global Budget Revenue (GBR) agreements, and informal HSCRC staff guidance.

Background
Historically, the HSCRC established charge compliance rules in COMAR through the authority in its enabling statutes. Health General 19-219 provides broad authority for the HSCRC to set rates based on reasonable costs.

> Health General 19-219
> (b) Power to approve rate or amount of revenue. --
> (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate or amount of revenue that a facility sets or requests.
> (2) A facility shall:
> (i) Charge for services only at a rate set in accordance with this subtitle

The HSCRC implements hospital charging standards, corridors and penalties in COMAR 10.37.03.

> 10.37.03.01 – Change in Rates: A hospital may not increase any existing rate or charge of any class or type or impose any new rate or charge of any class or type without the approval of the Commission, except for those changes specifically excepted by regulation or order of the Commission.

10.37.03.05 – Overcharges and Undercharges:

A. For purposes of this regulation, the following definitions apply:

(1) "Overcharge" means any charge for a hospital service under the jurisdiction of the Commission that is in excess of its approved rate.

(2) "Undercharge" means any charge for a hospital service under the jurisdiction of the Commission that is less than its approved rate.

B. When any hospital overcharges by more than the allowed corridors, as defined in §G of this regulation, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

C. When any hospital overcharges less than the allowed corridor, as defined in §G of this regulation, that overcharge shall be reduced from prospectively approved rates at the actual amount of overcharge plus appropriate interest.

D. When any hospital undercharges more than 2 percent in obstetrics, nursery, labor and delivery, clinic, emergency room, pediatrics, or intensive care units, that undercharge may not be recovered in prospective periods.

E. When any hospital undercharges less than 2 percent in the patient service centers listed in §D of this regulation, that undercharge shall be added to prospectively approved rates at the actual amount of undercharges.

F. When a hospital undercharges beyond the allowed corridors, as defined in this section, the amount of undercharge in excess of the corridors less 40 percent shall be added to prospectively approved rates. These allowed undercharge corridors are defined as follows:

(1) Patient care areas, when the unit of service is a patient day, not listed in §D of this regulation ----- 3 percent;

(2) Admissions center ---------- 3 percent;

(3) Ancillary service areas and ambulatory service areas not listed in §D of this regulation ---------- 5 percent.

G. Overcharge Corridors and Pricing for Medical/Surgical Supplies and Drugs.

(1) The allowed overcharge corridors are defined as follows:

(a) Daily patient care areas, ambulatory service areas, and admissions center ---------- 2 percent;

(b) Labor and delivery room ---------- 3 percent;

(c) Renal dialysis ---------- 5 percent;

(d) Ancillary service areas other than labor and delivery room and renal dialysis ---------- 3 percent.

(2) There are no price corridors for medical/surgical supplies and drugs.

H. Notwithstanding this regulation, if any hospital's net overcharges are more than 1 percent of the hospital's total approved revenue, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

I. In cases when a flagrant disregard of approved rates is found, the Commission may require direct repayment of overcharges and penalties to those patients who were overcharged.

J. The Commission may assess penalties as described in this regulation, for rates approved effective July 1, 1978.

As reflected in 10.37.03, this regulation is outdated and should be modernized. In addition to conflicting with unit rate compliance language in the GBR agreement and informal HSCRC staff guidance, this regulation does not reflect the GBR target compliance corridors, the GBR interim (six month) compliance requirements and the applicable penalties for non-compliance with the GBR target.

Historically, HSCRC staff measured unit rate compliance both at year end, and on an interim or "rolling" basis for a specific period. For interim compliance, hospitals could be penalized if they were outside of the allowable corridors for more than three consecutive months. (Prior to three months, interim compliance was measured on a six month basis.) HSCRC *monitored* unit rate compliance on a monthly basis, but did not impose penalties unless the hospital was out of compliance for more than three consecutive months.

All-Payer Demonstration Model

Since implementing global budgets, including Total Patient Revenue (TPR), Maryland's hospitals have been required to comply with an overall GBR "cap" by adjusting unit prices relative to underlying service use. The fundamental incentive of a global budget is to establish a predetermined revenue cap to encourage hospitals to reduce unnecessary or avoidable service use.

Under the current All-Payer Demonstration Model (Waiver), several statutes grant the HSCRC specific authority to implement global budgets and underlying charge structures to support global budgets.

Health General 19-207(b)(9) grants HSCRC the authority to enact global budgets.

> Health General 19-207
> (b) General duties. -- In addition to the duties set forth elsewhere in this subtitle, the Commission shall:
>> (9) Beginning October 1, 2014, and, subject to item (10)(ii) of this subsection, every 6 months thereafter, submit to the Governor, the Secretary, and, subject to § 2-1246 of the State Government Article, the General Assembly an update on the status of the State's compliance with the provisions of Maryland's all-payer model contract, including:
>>> (iii) Actions approved and considered by the Commission to promote alternative methods of rate determination and payment of an experimental nature, as authorized under § 19-219(c)(2) of this subtitle.

Beyond establishing the HSCRC's broad rate setting authority, Health General 19-219 authorizes compliance with the terms and conditions of Maryland's all-payer model, and establishes alternate methods of rate determination, including global budgets.

> Health General 19-219
> (b) Power to approve rate or amount of revenue.

> (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate or amount of revenue that a facility sets or requests.
> (2) A facility shall:
> > (i) Charge for services only at a rate set in accordance with this subtitle; and (c) Consistent with Maryland's all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation, and notwithstanding any other provision of this subtitle, the Commission may:
> > > (1) Establish hospital rate levels and rate increases in the aggregate or on a hospital-specific basis; and
> > > (2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all-payer model contract.

Health General 19-212 specifies establishing global budgets and associated limits.

> Health General 19-212
> (6) Develop guidelines for the establishment of global budgets for each facility under Maryland's all-payer model contract, including guidelines to prevent facilities from taking actions to meet a budget that the Commission determines would have adverse consequences for recipients or purchasers of services;
> (7) Receive confirmation from Commission staff that facility global budget agreements, as they are developed, are consistent with the guidelines; and
> (8) After review by the Commission for compliance with the guidelines, post each executed global budget agreement on the Commission's Web site

To implement appropriate unit rate charge compliance, the HSCRC included language in its GBR agreement and subsequent addendums.

> GBR agreement and addendums
> V. Compliance
> > B. Unit Rate Flexibility
> > The hospital be expected to monitor and its unit charges on an ongoing basis to ensure that it operates within the Annual Regulated Revenue that is approved by the HSCRC under the GBR model… The HSCRC will relax the unit rate compliance corridors that is general applies to hospitals. *(Presumably from COMAR regulations?)* Specifically, the Hospital will be permitted to charge at a level up to five percent (5 percent) above (or below) the approved individual unit rates without penalty. This limit may be extended to ten percent (10 percent) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations in COMAR 10.37.03.05.

On March 20, 2015, HSCRC staff sent a memorandum on unit rate compliance to hospital Chief Financial Officers.

The memorandum clarified that:

- Supporting documentation should be supplied for any request to expand unit rate corridors to +/- 10 percent.
- Interim penalties for three consecutive months' unit rate non-compliance, sometimes referred to as the rolling month penalties, *are not being imposed*
- Unit rate compliance will be measured for the full rate year. However, compliance is measured by staff monthly, and any large shifts among centers will be addressed.

Recent Interpretation, Considerations and Recommendations
As reflected above, while the statutes provide the HSCRC authority to implement global budgets and appropriate limits, COMAR, GBR agreements and staff policies are inconsistent. The GBR agreement refers to penalties under COMAR 10.37.03.05. However, the enabling statues appear to give deference to the GBR agreements to measure unit rate compliance and impose penalties for non-compliance.

There are several considerations that we believe require clear guidance and alignment between COMAR, the GBR addendum and HSCRC staff policy. Recent Commission rate setting practices and the calculation of underlying unit rates are included in these considerations.

1) **Use of most current period volume to set unit rates** – Historically, HSCRC staff used the most recent prior period rate center units to set underlying unit rates. For example, July 1 unit rates were calculated using actual, unadjusted 12 months of rate center volume for the period ending June 30. Since the inception of GBR, HSCRC staff use rate year 2013 units, adjusted for market shift and other across the board volume changes. The 2013 volumes are realigned, but not updated, using the most recent period actual data. Using the 2013 volumes disconnects the GBR cap and actual unit rate charging from unit rate compliance. As volumes increase or decrease, hospitals adjust prices to achieve the GBR cap. In many hospitals, unit rate volumes have changed significantly from 2013 to the most recent period, beyond the price corridors. Using older volumes – even with adjustments and realigned on new experience – will result in an unofficial spenddown if hospitals cannot recover their allowed global budget.

   HSCRC staff stated that use of the 2013 GBR base period unit rate volume would remain in place until an efficiency measure is developed. HSCRC recently proposed its Inter-hospital Cost Comparison (ICC) methodology, therefore it is time to "rebase" unit rate volumes to the appropriate current period, and continue to rebase in each annual rate order. Rebasing unit rate volume will create less pressure on unit rate compliance corridors as unit rates will be much closer to actual charging practices. This step alone may mitigate the need for several recommendations because hospital rates will agree to the GBR, causing most hospitals to be within the current allowable corridors.

2) **Consecutive month rate compliance** – The March 20, 2015 addendum specifies that interim or "rolling" compliance penalties are not being imposed. At MHA's August 10 Financial Technical Work Group, HSCRC staff informed the field that interim compliance penalties may be imposed if a hospital beyond its approved corridor in *any* single month. This seems to contrast with the March 20, 2015 guidance. The GBR addendum states that charges beyond the corridors may be subject to penalties, but the addendum does not specify what time period will be used for measurement.

3) **Supply and drug price compliance** – Under GBR, HSCRC staff measure supply and drug price compliance on a *revenue* basis, not a unit rate basis. Charging for supplies and drugs is very different than charging a typically unit rate. For a typical unit rate, the hospital can "fix" the price of the unit and charge accordingly. Unit pricing can be "fixed" in the face of seasonality or change in service mix. Hospitals use hundreds and thousands of supplies every day, many with different prices, making it difficult to charge within +/- 5 percent, or even +/- 10 percent of approved revenue on a monthly basis. Increases or decreases in supply and drug use will lead to hospitals needing to change mark-ups to meet a fixed revenue target. This can be the result of seasonality, or, a change in the mix of surgical and non-surgical cases, etc.

4) **Unit rate corridors to achieve GBR compliance** – As reflected in GBR agreements, hospitals may vary unit rate charge up to +/- 5 percent without permission, and may vary unit rate charges up to +/- 10 percent with HSCRC staff permission.

   An increase to +/- 10 percent is only valid for a specified period and must be accompanied by an "acceptable" explanation and supporting documentation. Hospital staff and HSCRC staff may engage in a lengthy exchange of correspondence before an agreement is reached, challenging the ability to achieve compliance on a timely basis. This practice also places a heavy administrative burden on HSCRC staff and on Maryland's hospitals, diverting resources that could be used to transform care delivery under the All-Payer Model.

   There is no standard process, documentation or explanation that HSCRC staff prescribes to grant corridor increases. Therefore, it is difficult to predict what information the HSCRC staff will want to support the request.

   A global budget system has one true incentive – the hospital receives a fixed level of revenue, even when it reduces avoidable utilization. Artificially limiting unit rate corridors stifles the incentive to reduce avoidable utilization beyond a certain point. We are aware that other factors, market shift, etc., may cause changes in hospital volume and may require a corresponding adjustment to the GBR cap. These other factors should complement, not supersede, the ability to raise and lower rates to achieve GBR compliance.

In certain cases, the HSCRC requires, recommends or otherwise allows hospitals to tier certain unit rates. For example, in a January 18, 2012 memorandum, the HSCRC mandated that hospitals established a tiered charging structure for supplies and drugs. Informally, it is recommended that hospitals tier the Same Day Surgery (SDS) rate to differentiate charges for the amount of post-surgical recovery time required, and tier the Clinic (CL) rate to differentiate the resources used by different types of clinics. Hospitals are also allowed to tier their 100 percent inpatient "room and board" rates to reflect utilization differences during the stay. Tiering of these rates, supplies and drugs in particular, require corresponding compliance flexibility as long as the hospital maintains annual, unit rate price compliance, and overall GBR compliance.

5) **Unit rate compliance early in the rate year** – The hospital field appreciates the HSCRC's best efforts to issue rate orders in a timely manner, and hospitals attempt to project the subsequent year's rates for compliance. However, until a final rate order is received, hospitals are supposed to comply with the most recently issued rate order, which may be the prior year's order. If hospitals must comply with the prior year's order to achieve "monthly" compliance, then a final rate order is issued a month or two into the new rate year, unit rate compliance problems may arise because rates are realigned and rate factors are updated. This also challenges the ability to increase or decrease rates in tandem since realignment may affect individual rates differently.

   For a variety of reasons, several rate orders may be issued until a rate order is final. If hospitals are expected to comply with the final rate order for the month of July, unit rate corridor increases may need to be approved on a retroactive basis. Hospitals also have difficulty moving all rates in tandem if the final rate order varies from the preliminary rate orders.

6) **Mid-year rate adjustments and December 31 GBR compliance** – In recent years, HSCRC staff have implemented rate January 1 rate adjustments, in the middle of the rate year. In several cases, these mid-year adjustments were effective for the entire rate year, requiring hospitals to increase or reduce charges in the compressed period from January through June. Though both GBR and unit rates are adjusted, the compressed period can make it more difficult for hospitals to effectively raise or lower prices to achieve compliance.

   HSCRC staff have also required hospitals to comply with a six-month GBR target for the period July 1 through December 31. In order to achieve GBR compliance with the six month target, hospitals may need to raise or lower unit rates in this compressed period. To do so, hospitals often submit urgent requests to expand corridors, increasing the administrative burden on hospitals and HSCRC staff.

On behalf of the hospital field, MHA respectfully requests that HSCRC staff consider the following actions:

1) Update COMAR 10.37.03 to repeal sections D through F
2) Update COMAR 10.37.03 to include the following subsections:
    a. "Annual rate orders shall reflect the actual, unadjusted unit rate volume for the preceding twelve month period ending June 30 to set unit rates."
    b. "Unit rate compliance shall be measured on an annual, rate year basis for the purpose of enforcing unit rate penalties. An annual price corridor, the amount a hospital may charge above or below the established rate without penalty, shall be proposed by HSCRC staff and approved by the Commission. The annual price corridor may be changed with Commission approval. The current staff policy shall be reflected in the hospital's GBR agreement with the Commission. The price corridors shall be consistently applied across all hospitals."
    c. "GBR cap compliance shall be measured on an annual, rate year basis for the purpose of enforcing penalties. An annual price corridor, the amount a hospital may charge above or below the established rate without penalty, shall be proposed by HSCRC staff and approved by the Commission. The annual price corridor may be changed with Commission approval. The current staff policy shall be reflected in the hospital's GBR agreement with the Commission. The price corridors shall be consistently applied across all hospital."
        i. "Should Maryland's performance under the All-Payer Model be measured on a period different than the HSCRC rate year, HSCRC staff may impose interim GBR compliance targets and penalties, upon HSCRC staff recommendation and Commission approval."
    d. "HSCRC staff shall monitor unit rate compliance on an interim basis. Price corridors and penalties for non-compliance may be established by the Commission on an interim basis, if approved by the Commission."
3) The HSCRC staff should recommend a rate compliance policy to enforce the principles established in regulation. The policy should be reviewed and approved by the Commission in a public meeting, with the opportunity for public comment. Maryland's hospital's recommend the following be included in this proposed rate compliance policy:
    a. The existing GBR price corridors, penalties and compliance methodology, established by the HSCRC in GBR agreements, should be reflected in the proposed policy.
    b. The *annual* price compliance corridors for unit rate centers, except supplies and drugs, shall be +/- 5 percent, with the opportunity to request a +/- 10 percent *annual* corridor. HSCRC policies should be appropriately flexible to achieve GBR compliance. Maryland's hospitals should provide HSCRC staff sufficient lead time when requesting annual corridor changes, and the HSCRC staff should respond to the requests in a timely manner. Improving timeliness will allow appropriate management of corridors during the year and reduce potential price fluctuations.

c. If the HSCRC chooses to establish interim, unit rate price compliance corridors, the interim unit rate price corridors shall be *twice* the allowable annual corridors. The allowable annual corridors include approval by the commission to increase the corridor from +/- 5 percent to +/- 10 percent, and thus the interim corridors would reflect two times the annual, from +/- 10 percent to +/- 20 percent.
d. Should the HSCRC choose to establish price corridors on an interim basis, HSCRC staff should specify which rate order the hospital should comply with during the early part of the rate year. HSCRC staff should have flexibility to allow the hospital to charge to a projected set of unit rates, rather than the prior year rate order, if agreed to by the hospital and HSCRC.
e. Supply and drug revenue compliance *should not be measured on an interim basis* since the current measure is based on monthly revenue, subject to seasonality and sudden price changes. Measuring supply and drug revenue compliance on an interim basis often results in significant and sharp changes in supply and drug charges because of the underlying utilization. Supply and drug revenue compliance should be measured annually, with price corridors established at +/- 20 percent, allowing for greater flexibility needed for these unique charge structures. HSCRC staff and hospitals should evaluate alternative methods of supply and drug compliance, and, supply and drug revenue realignment as part of the annual rate order process.

4) Hospital should only prove the need to achieve GBR compliance as the reason to approve price corridor changes. The lone exception should be hospital disclosure of a moving a service or services unregulated setting. Hospital members have been asked to prove that unit price adjustments to achieve GBR compliance did not result from temporary market shifts or other matters that ultimately affect the GBR. This should not be required because the HSCRC has a market shift policy and other policies in place to adjust GBR revenues appropriately. Though the market shift adjustments reflect a six month lag, hospital GBR revenues will ultimately be adjusted appropriately by the HSCRC's methodology.
5) Mid-year rate adjustments should be limited to changes from Commission actions that occur during the year. Routine policy adjustments should be placed in rates July 1. The HSCRC's market shift adjustment is the lone exception as it is applied bi-annually to reflect changing market conditions.
6) HSCRC staff and hospitals should review rate realignment, including supplies and drugs, in the annual rate as certain rate centers have not been realigned in several years. The rate realignment methodology review should include how overhead costs are assigned to rate centers and how these costs are currently adjusted.
7) Changes to rate compliance regulations and Commission rate compliance policies should be clearly communicated to the Centers for Medicare and Medicaid Services (CMS) and their representatives responsible for analyzing the Maryland model.
8) HSCRC staff should provide clear, written guidance on rate compliance during the current fiscal year, fiscal year 2018, including a formal position on interim, unit rate compliance.

Thank you for your consideration of these important matters. MHA and Maryland's hospitals look forward to working with HSCRC staff to address these considerations. Should you have any questions, please call (410) 540-5060, or email bmccone@mhaonline.org. We are happy to discuss these issues in more detail at MHA's Technical Work Group or at a meeting of the HSCRC staff's request.

Sincerely,

Brett McCone
Vice President