Maryland
Hospital Association

April 24, 2020

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

Dear Mr. Kane:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation on COVID-19 Surge Funding.

Maryland hospitals support HSCRC's approach to increase rate year 2020 or 2021 global budget revenue (GBR) limits if COVID cases cause the hospital to exceed GBR. We agree HSCRC should use standardized charges at approved rates for the calculation. As reflected in the recommendation, we assume this to mean the number of units in each rate center multiplied by the approved unit rate for that center. Special consideration may be needed for supplies and drugs because these are cost-based revenue centers.

We will continue to work with HSCRC staff on other COVID-19 impacts like the rate year 2020 volume trough and expected undercharge to be addressed in rate year 2021.

Thank you for your help during this public health emergency. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
Willem Daniel, HSCRC
John M. Colmers
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Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Kane:

We are going through an unprecedented time and we want to start by thanking you, the commissioners, the HSCRC Staff, and the entire hospital industry for your collective efforts to ensure the best care for our members and all Marylanders during this time. We recognize that complex policy decisions need to be made amidst this pandemic and we appreciate the collaborative, transparent approach you've taken to this point.

As you're aware, we've made several policy decisions of our own lately. While many of our policy changes have been to help members through this crisis, we're also making changes to support our partners in the provider community. We launched a provider support program through which we are accelerating payments for hospitals and practices. In addition, we adjusted utilization management policies to reduce provider administrative burdens and relaxed authorization requirements for hospital admissions, surgeries, and hospital transports. We're honoring prior authorizations for elective surgeries for a period of up to 12 months, contingent on member eligibility. Finally, we've expanded telemedicine services, providing an alternative revenue stream for some practices.

I write to provide CareFirst's comments on the HSCRC Staff's "Draft Recommendation on COVID Surge Funding." Given the volatility of volumes over the course of the last month and potentially the next few months, it's important for all stakeholders to understand how this will impact Maryland's Global Budgeted Revenue (GBR). While other states continue to see revenue that moves in line with volumes, we are uniquely positioned to smooth the impact of this pandemic on the financials of stakeholders in the Maryland hospital space.

Generally, we are supportive of the Staff recommendation to (1) modify hospitals' FY2020 and FY2021 GBR to include additional revenue if COVID cases cause the hospital to exceed its GBR; and (2) add amounts related to COVID cases that exceed a hospital's original GBR

as one-time adjustments. We appreciate the Staff's foresight in noting their desire to prevent double-payment and consideration of emergency grant funds in conjunction with undercharge carryovers and incremental COVID revenue. We also appreciate the Staff taking some of our early input into consideration. Utilizing approved unit rates, or standardized charges, to calculate COVID case revenue is a simple approach that does not require waiting for reliable case weights to become available.

Our remaining comments focus on the complex dynamics involved with transformation costs, various funding sources, and timing.

HSCRC Staff should clearly state the purpose of rate funding on COVID cases. Ordinarily, it is assumed that approved rates cover hospital costs that are 50% fixed and 50% variable in nature. This is the basis for assumptions in several HSCRC policies, namely the market shift adjustment and the deregulation methodology. HSCRC should state whether this assumption carries into the unit rates applied to COVID cases. Understanding that hospitals continue to incur expenses related to transformation, including increased capital expansion, equipment, supply, and labor costs, the 50% fixed portion may be assumed to increase on this particular volume. Based on Staff analysis on industry spending, HSCRC Staff should develop a position on variability so that hospitals have a clear understanding of which portion of the COVID revenue is designated for transformation costs. If HSCRC deems these cases to be 60% fixed/40% variable, for example, hospitals could appeal that split on a case-by-case basis.

As hospitals collect support from multiple funding sources, there should be a process to ensure funding streams are not duplicated. This underscores the importance of the previous point regarding clear purposes of HSCRC rate funding. As the federal government supplies hospitals with funding through the Coronavirus Aid, Relief, and Economic Security Act (CARES) and Federal Emergency Management Agency (FEMA), while the State works simultaneously to provide hospitals with funding through MHHEFA bonds and/or other State and local government support, and the HSCRC works to provide hospitals with funding through this COVID Surge Funding policy, it will be important to understand what each of these funding streams is intended to cover. Which funding stream is intended to cover lost revenue because of the ceased elective procedures, and is that being offset against the corridor expansion and/or the undercharge carryover? Which funding stream is intended to cover the costs associated with transition and surge readiness ramp-up capabilities, and is that being offset against the 50-60% fixed portion of the approved unit rates applied to COVID cases? HSCRC Staff should consider collecting detailed reports from hospitals displaying the funds they've received, their incurred transformation costs, and lost revenue during this time.

HSCRC Staff should have flexibility regarding timing on the back end of this policy. We support the timing considerations the Staff has proposed as factors that might end this policy: end of the State of Emergency, resumption of elective surgeries, and/or a determination by the HSCRC. There are several reasons the State of Emergency could be lifted before hospitals see this type of volume dissipate. Similarly, the Governor could leave the State of Emergency in place for a period beyond when COVID cases dissipate and

elective procedures return to hospitals. HSCRC Staff should monitor the volume of COVID cases and other types of cases, as well as the burdens placed on hospital staff. HSCRC Staff should develop a plan for how they will track this and ultimately determine that this COVID Surge Policy is no longer necessary.

Thank you again for this opportunity to comment on the COVID Surge Policy. We support the goals of the policy and understand the need for HSCRC intervention during this crisis. We appreciate the efforts of all involved in controlling and minimizing the impact of the current coronavirus pandemic. Consistent with the changes we've made that are described above, we will continue to monitor the impact of COVID-19 and play our role to support our provider partners in the community.

Sincerely,

Maria Harris Tildon

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