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March 17, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: Senate Bill 917 – Health Care Facilities – Health Services Cost Review Commission – User Fee Assessment – Letter of Support

Dear Chair Kelley and Committee Members:

The Health Services Cost Review Commission (HSCRC or Commission) would like to thank you for considering Senate Bill (SB 917) titled, “Health Care Facilities - Health Services Cost Review Commission - User Fee Assessment,” and requests that the Committee favorably move this important legislation. SB 917 supports the ongoing and sustainable operation of the HSCRC by changing the methodology for calculating the Commission’s user fee assessment cap.

SB 917 proposes to change the cap on the user fee assessment under Health General 19-213(c)(1) from a flat $16 million per year to the greater of 0.1% of budgeted, regulated gross hospital revenue or the largest amount of the cap for a fiscal year in the prior five fiscal years. The Commission’s operating budget is fully funded by the assessments that are subject to this cap and are subject to annual budget oversight by the Maryland General Assembly through the annual budget process. The proposed change in the user fee cap is necessary to sustain HSCRC’s work over the long term, while holding the agency to a controlled rate of growth that is directly tied to the industry that the Commission regulates.

The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare. HSCRC’s vision is to enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.

This Request is Timely

HSCRC’s user fee cap was last adjusted in Fiscal Year (FY) 18. In the past, this cap has been revised every three to four years.[1] It will be five years since the last change in the user fee cap if the cap is adjusted for FY 23.

HSCRC’s Expertise Supports the Success of the Maryland Health Model

The HSCRC establishes rates for all hospital services and helps direct the State’s innovative efforts to transform the delivery system and achieve goals under the Maryland Health Model. The Maryland Health Model includes the Total Cost of Care (TCOC) Model agreement with the federal Centers for Medicare and Medicaid Services (CMS) and the State’s long standing all-payer hospital rate-setting system. The Maryland Health Model benefits the State in many ways, including investment in primary care and population health, healthcare cost containment and transparency for Maryland consumers, equitable funding of Uncompensated Care, and support for state healthcare infrastructure.

[1] The user fee cap was revised in the following years: FY 2018 - CH 23 (2017); FY 2015 - CH 263 (2018)l FY 2012 - CH582 (2011); and FY 2008 - CH628 (2007).

HSCRC's expert staff and analytic resources are key to the success of the Maryland Health Model.

Under the TCOC Model, which started in 2019, HSCRC is responsible for creating innovative programs to encourage hospitals to partner with non-hospital providers to improve healthcare cost and quality and partner with community organizations to improve population health and health equity. This is an expansion of the scope of the Commission's responsibilities, which, for most of the past 50 years, has focused solely on financing the care that occurs at hospitals. In order to coordinate delivery system innovations and to facilitate engagement of hospitals, non-hospital providers, population health experts, and other leaders across the State to achieve the goals of the TCOC Model, the HSCRC has required additional highly-skilled staff and contractual resources. The Commission is meeting these responsibilities through additional employees/PINs and by contracting with individuals and firms with the necessary expertise. Passage of SB 917 would allow HSCRC to continue to meet these increasing needs for policy development, implementation, research, analysis, and auditing. HSCRC is also partially funding the Maryland Primary Care Program (MDPCP) program management office in the Maryland Department of Health. MDPCP is a component of the TCOC Model. HSCRC has also taken a lead role in developing and implementing the Statewide Integrated Health Improvement Strategy (SIHIS), which sets population health goals for the State.

HSCRC Supports Research and Analysis Requested by the Legislature

In addition, in recent years, the Commission has received an increasing number of legislative assignments (see Appendix 1 for a full list of legislative assignments over the last six years). These include new regulatory and audit responsibilities over topics like facility fees and medical debt, conducting research to complete reports in areas such as financial assistance and hospital profits, and convening workgroups related to behavioral health and community benefits. These responsibilities take both staff and contractor resources. Passage of SB 917 would help HSCRC continue to conduct high quality research and analysis in response to legislative requests.

The Methodology Change ties HSCRC's Budget to Regulated Industry

HSCRC expects that the "0.1%" provision (rather than the "5-year" provision) in SB 917 would apply in most, if not all, years (see Appendix 2 for the projected user fee cap assuming HSCRC applied an assessment of 0.1% of hospital gross revenues). This approach to calculating the fee cap would tie HSCRC's operational budget to the growth rate of the revenue of the industry that HSCRC regulates. It aligns with other assessments in HSCRC's statute that are based on a percent of hospital revenues. Maryland is required, under the TCOC Model agreement with CMS, to control the total cost of Medicare in Maryland, including hospital costs. This ensures that there is continued federal and state pressure on HSCRC to control hospital cost growth, and thus the Commission's own fee cap. Under this approach, the Commission expects the cap to grow at no more than 4% per year.

If hospital revenues decrease, the proposed legislative language would allow HSCRC to apply a fee cap that is equal to the highest fee cap in the past five years. A situation like the COVID-19 pandemic might trigger this provision for a single year. However, HSCRC doesn't expect a situation to occur where this provision is used for more than one year in a row. If hospitals experience sustained significant decreases in revenue, this provision temporarily protects HSCRC's operating budget, giving HSCRC and the legislature time to determine the best path forward for determining the Commission's fee cap under such changed circumstances.

Additional Background on User Fee Assessment and Cap

Under law, the assessments that fund HSCRC's operating expenditures are paid by hospitals. However, HSCRC builds these assessments into hospital rates, so that hospital revenue increases by the amount of the assessment. Thus, the assessments are paid, indirectly, by the State's healthcare payers (including Medicare, Medicaid, and commercial insurers). It is important to note that the Commission is not required to collect the full amount of the fee cap in any year. Historically, there have been a number of years when the Commission has assessed less than the full cap amount. The user fee cap is not the only limitation on user assessments in law. HSCRC is also constrained

by the annual appropriation[2] and provisions of law that ensure that the assessment is only used to address the direct costs of HSCRC's regulatory and statutory duties.

Risk of Disinvestment

A fully resourced Commission is essential to long-term success of the Maryland Health Model and continued delivery system transformation. On the other hand, an under-resourced Commission would pose a long term risk to the Model, impacting recruitment and retention of quality staff and minimizing system delivery design projects that support the Model. HSCRC's FY 21 expenditures ($18.9M) and FY 22 projected expenditures ($18.2) exceeded the existing $16 million fee cap. HSCRC has funded these expenditures through carry over funds. At the end of FY 22, HSCRC expects to only have $500K in carry over funds. For FY 22 and FY 23, HSCRC has created lean budgets, cutting contracts, deferring projects to future years, minimizing training funds, and providing minimal funding for planning sessions for the Commissioners due to the insufficiency of the current cap to cover routine expenses. SB 917 would allow HSCRC to maintain the capacity to develop key policies that ensure the Maryland Health Model continues to bring key benefits to constituents across the State.

The Commission urges a favorable report on SB 917. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at me at katie.wunderlich@maryland.gov or Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Katie Wunderlich
Executive Director

[2] Specifically, the assessment "may not exceed the Special Fund appropriation for the Commission by more than 20%".

Appendix 1: Legislative Tasks 2016 to 2021

Table 1: JCR Required Reports by year, HSCRC named in report description.

Year	Report Topic
2016	Report on the status of hospital partnerships with community behavioral health providers.
2017	Report on emergency department overcrowding.
2018	N/A
2019	Report on the Maryland Primary Care Program impact on behavioral health services. Report on projected operating expenses for the Maryland Primary Care Program and funding sources. Report on Medicaid cost-saving and growth rate targets and quality goals. Report (lead by MIEMSS) providing an update on Emergency Department Overcrowding.
2020	Evaluation of the impact of HSCRC led program on Medicaid dual eligible enrollees. Study of hospital medical liability market and impact on the Total Cost of Care. Evaluating the Maryland Primary Care Program Report on policy tools to constrain excessive hospital profits. Analysis of the impact of hospital financial assistance policy options on uncompensated care and costs to payers
2021	Evaluation of Hospital at Home Model Evaluation of the MDPCP Program Analysis of Hospital Provision of Reduced-Cost Care and Collection Procedures Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland

Table 2: Tasks Required by Legislation

Year	Legislation requiring implementation by HSCRC	Summary of Commission Tasks	Level of HSCRC Resources Required
2016	Ch. 321: Termination of Maryland Health Insurance Plan, Transfer of Senior Prescription Drug Assistance Program, and Funding for State Reinsurance Program	Ended authority to make assessments to support the Maryland Health Insurance Plan	Low
2017	Ch. 23: Budget Reconciliation and Financing Act of 2017	Increased the administrative charge paid by HSCRC to MDH from 18% of salaries to 30.5% of salaries. Increased fee cap from $12 million to $16 million.	N/A- Increased agency revenue

2018	Ch. 10: Budget Reconciliation and Financing Act of 2018	The Maryland Department of Health and the Health Services Cost Review Commission shall develop 5–year and 10–year Medicaid–specific cost savings targets, which shall include a reduction in total hospital costs, total cost–of–care, and quality measures.	Moderate
2019	Ch. 6: Mandated Reports and Statutory Commissions, Councils, and Committees –Revisions Ch. 19: University of Maryland Medical System Corporation – Board of Directors, Ethics, and Audits	Required submission of information on the State's compliance with the All-Payer Model contract as part of an existing annual report. Deleted a requirement for an obsolete report. HSCRC must collect disclosures of financial interests from UMMS board members, make such reports available to the public on the web, and submit a summary of each statement to the legislature.	Moderate

2020	Ch. 365: Health Facilities – Hospitals – Disclosure of Outpatient Facility Fees (Facility Fee Right–to–Know Act)	Established process, with the Health Education Advocacy Unit of the Maryland Attorney General's Office (HEAU), for resolving complaints. HSCRC must collect a list of hospital-based, outpatient rate regulated services from hospitals, post those lists on the HSCRC website, and provide the lists to MIA and HEAU.	High
	Ch. 402: Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants – Administration and Funding	Participate in a workgroup.	
	Ch. 436: Hospitals Health Services Cost Review Commission – Community Benefits – Reporting	Convene a workgroup and adopt regulations that establish a standard reporting format. Submit reports on the community benefit reporting process and annual community benefits.	
	Ch. 470 Hospitals – Financial Assistance Policies and Bill Collections	Updated special audit procedures to reflect requirements of the bill. Each year, HSCRC must collect each hospital's financial assistance policy and an annual report on that policy and post that information on the web. The Commission must submit an annual financial assistance report. The Commission established a process and email address for complaints. HSCRC was also required to submit a one-time report modeling the impact of certain proposed policies on uncompensated care in the state.	
	Ch. 490: Hospitals – Changes in Status – Hospital Employee Retraining and Placement	HSCRC established a new annual remittance from hospitals to fund hospital employee retraining and coordinated with the Department of Labor on the submission of fee and other requirements of the law.	
	Ch. 505: Health Services Cost Review Commission – Duties and Reports – Revision	Consolidated HSCRC annual reporting requirements to the Governor and the Legislature.	
2021	Ch. 71: Preserve Telehealth Access Act of 2021	Consult with the Maryland Health Care Commission on a report on Telehealth.	High
	Ch. 770: Health Facilities – Hospitals – Medical Debt Protection	Update regulations on financial assistance and medical debt policies to reflect the change in law. Collect reports on debt collection from hospitals and post those reports on the web. Develop payment policy guidelines. Complete a report on the impact of potential policies on uncompensated care.	

Appendix 2: Projected User Fee Cap Using “0.1%” provision

Table 3: Projected User Fee Cap Set at 0.1% Budgeted Hospital Gross Revenues, FY 23 – FY 27

Fiscal Year	Projected User Fee Cap set at 0.1% budgeted hospital gross revenues
2023	$19,687,559
2024	$20,291,510
2025	$20,913,988
2026	$21,555,562
2027	$22,216,817

SB 917- HSCRC User Fee- Letter of Information.pdf
Uploaded by: Erin Dorrien
Position: INFO

Maryland
Hospital Association

March 17, 2022

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Information- Senate Bill 917- Health Services Cost Review Commission - User Fee Assessment

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 917. The Health Services Cost Review Commission (HSCRC) oversees rate regulation for Maryland's hospitals and health systems and promotes the success of our unique Total Cost of Care Model (Model) agreement with the federal government.

HSCRC's assessment cap at present is $16 million per year and only applies to hospitals.

The legislation guarantees perpetual growth in the assessment cap by allowing HSCRC to assess the *greater of* 0.1% of gross patient revenue of Maryland hospitals for the immediately preceding fiscal year *or* the highest cap amount assessed in the five prior fiscal years. This creates a situation where the HSCRC assessment on hospitals can grow, even when hospital revenue is falling and without consent of the General Assembly. This would give the HSCRC unique authority as a state agency to raise fees automatically.

Hospital revenues change as a function of several factors, including hospital sector cost inflation, net impact of quality performance, technological advances, and volume growth, some of which is associated with the growth and aging of the population. Not all these factors might logically apply when determining the user fee limit. HSCRC has wide jurisdiction when determining how much hospital revenues can grow, which would impact its user fee allowance under this bill.

We understand and appreciate the complexity of HSCRC's job and its need for additional resources to take on new policy domains. We also value HSCRC's championing of Maryland's engagement in the Model to the federal government. The Commission needs an appropriate annual budget. It is unclear how their responsibilities expand with increases in hospital revenue. The House of Delegates added an amendment to sunset the automatic growth factor after three years. This seems prudent given the novel approach to HSCRC's assessment authority and the changes to the General Assembly's budgeting powers likely to start next year.

We hope you find this information helpful as you deliberate on SB 917.

For more information please contact:
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