

# **The Health Services Cost Review Commission's Report on Unregulated Space in Hospital Operating Suites Pilot Project**

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## Executive Summary

During Maryland's 2019 Legislative Session, the House Health and Government Operations Committee (HGO) passed House Bill 940 (HB 940), *Unregulated Space in Hospital Operating Suites Pilot Project – Study*. Although the bill passed through both the House and the Senate Finance Committee, the bill ultimately failed when a last minute floor amendment regarding a separate issue was added. Given that the bill would have passed had the amendment not been added, HGO Chairwoman Shane E. Pendergrass sent a letter to the Health Service Cost Review Commission (the Commission) requesting that the Commission fulfill the mandates of House Bill 940.

In response to this request, the Commission met with stakeholders from across the healthcare system to begin developing a voluntary pilot program to be tested in regulated hospital operating rooms. The Commission also reviewed considerations for further action. This work is detailed in the following report.

## Background

HB 940 required the Commission, in conjunction with the Maryland Health Care Commission, hospitals, providers, payers, and other relevant stakeholders, to study the feasibility and desirability of allowing for an unregulated space in a hospital operating room as a pilot project. HB 940 mandated that the study include an examination of:

- The availability of operating room space for elective, self-paying patients that ensures safe and appropriate care for patients at higher risk or who need a higher level of immediate post-surgical care;
- The Commission's current authority within the current regulated structure to accomplish differential pricing for services covered by payers and the use of unregulated services;
- Factors related to the mixing of regulated and unregulated space at a hospital, which may include: 1) implications for all public, commercial, and independent payers of health care services; 2) transparency for and parity of access by consumers to health care services; 3) implications for hospital capital funding and capacity planning needs and 4) appropriate adjustments to a hospital's global budget revenue target for deregulating a hospital operating room suite and opportunities to offer unregulated operating room space for services that are not covered by insurers;
- The number of hospital participants in the pilot project that would be financially responsible in the context of the all-payer model contract;

- The implications of the pilot project on quality of care and how the quality of the services provided under the pilot project will be ensured;
- Possible criteria and standards for hospital participation in the pilot project; and
- Any other implications of the pilot project that should be considered before moving forward, including any cost-shifting that could result from the pilot project, the all-payer aspect of the all-payer model, and any impact on the Total Cost of Care Waiver.

The Commission was required to report back to the legislature by June 30, 2020 with this information.

## Development of Strategy

In order to fulfill the requirements of HB 940, the Commission carried out a comprehensive review of options in conjunction with stakeholders from across the healthcare system, including representatives from the Maryland Health Care Commission, payers, hospitals, provider groups, and others. Engagement from all stakeholders is critically important to ensure that any proposed alternative models would be utilized by the healthcare community.

## Stakeholder Engagement Process

The Commission has held two public meetings to incorporate feedback from stakeholders, including members of the public. These meetings were held on July 31, 2019 and February 25, 2020. Between these meetings, the Commission met and worked with stakeholders to carry out analyses of potential options for the pilot program.

Workgroup discussion centered on a growing public concern with the high cost of minor surgery performed at regulated hospitals compared to the cost of surgery performed at unregulated Ambulatory Surgery Centers (ASCs). At the same time, hospitals noted their concern about the current utilization and cost shift trends for minor surgical procedures at regulated hospitals. Due to the higher hospital cost structure (e.g., overhead, requirement to fund Uncompensated Care, etc.) and the fact that ASCs have more efficient cost structures and lower fixed costs, hospitals have difficulty competing with ASCs. Hospitals cannot lower prices to ASC levels with the current minor surgery options and ASCs are increasingly expanding in Maryland, which adds to hospital concerns over competition. Without action, patients would have less access to hospital-based services, which are subject to more rigorous quality requirements than ASCs and have a greater capacity to treat higher-risk patients. In addition, because commercial payers are shifting minor surgery volumes to unregulated settings (ASCs), public payers are paying disproportionately for regulated hospital services, which have higher rates.

## Guiding Principles

The Commission developed a list of guiding standards with stakeholders to ensure its approach addressed a broad range of needs. The Commission believes the program it has started to develop incorporates each of the following principles:

- **Lower cost to public** – Any proposal should ease concerns over price disparities between regulated and unregulated minor surgeries
- **Reduce total cost of care** – Proposal should aim to reduce the Total Cost of Care and not incentivize increased utilization
- **Establish Site Neutrality** – Any model should enable hospitals to charge reasonable rates that are comparable to ASC prices
- **Ensure access to care for all** – Consideration should be given to the all-payer nature of regulated settings, which enhances access to high-quality care for all Marylanders, including higher-risk patients
- **Utilize existing capacities** – Model should aim to utilize existing capacity so as not to drive unnecessary duplication of capital in unregulated space
- **Ensure high quality of care** – Model proposal should consider the need to be close in proximity to hospital ICU services or specialized technologies for certain services; any services rendered in the regulated hospital setting are also subject to rigorous state- and national- level quality programs

## Analysis of Healthcare Landscape

Commission staff performed an analysis of claims data to understand the delivery of Outpatient Facility and Ambulatory surgery in Maryland and how hospital pricing for services compares to ASC pricing in Maryland. By splitting Maryland commercial claims data into major and minor surgery, the Commission identified a large gap between hospital and ASC prices for minor surgery. More specifically, the Commission found that the commercial ASC price for minor surgery was 40% of the hospital price, and the commercial ASC price for major surgery was 67% of the hospital price. While the Commission used commercial data for its analysis, a similar analysis could be done for Medicare and the Commission believes it would show similar results. The Commission used the data on minor surgeries in its pilot program modeling.

## Option 1: Pilot Program for Repricing Minor Surgery

The Commission has started to develop a pilot program that was originally going to be offered to all hospitals for voluntary participation in FY 2021. Hospitals that partook in the program would

have been able to reprice minor surgery at 40% of current hospital outpatient pricing so that hospital pricing was comparable to the ASC level. These hospitals would have had their global budget revenues (GBRs) reduced by 25% on eligible minor surgery revenue. The Commission would have reviewed the success of the program at the end of RY 2021 and considered continuing or ending it based on performance.

This option brings many potential benefits for Marylanders and hospitals. For Marylanders, it brings immediate cost relief for those seeking care in a hospital setting, it preserves access to hospital care, maintains quality, and caps utilization due to the incentives for value or volume in the hospital setting and not the ASC setting. In addition, the approach would not only produce immediate TCOC savings by reducing the GBRs of participating hospitals and lowering utilization, but it would also create longer-term savings by encouraging use of existing, regulated space instead of duplication of capital in unregulated settings. The program would also ensure enhanced transparency in pricing. Services at the hospital are subject to state and federal regulations requiring hospitals to both make their prices publicly available in several locations and also, upon request, provide patients with an estimate of the charges for services received. Finally, for carriers, it minimizes cost shifts onto public payers and will reduce overall costs.

However, at the same time, the Commission planned to monitor the success of the pilot program based on several considerations. As this is a new initiative that has not been carried out in a setting like Maryland's, the Commission would have monitored the results of the program to examine whether the program's cost structure was suitable for regulated settings. Hospitals are used to a different business model than ASCs and other providers, which contributes to why hospitals often have higher prices. For this reason, the Commission would have watched the extent to which hospitals were able to succeed financially by adapting to this different business model. Finally, hospitals had reacted differently to the concept of the pilot program because they believe it will affect individual hospitals in distinct ways. The Commission would have carefully monitored how the pilot program affected hospitals in varying ways.

## **Option 2: Partial Deregulation**

The Commission considered the feasibility of partial deregulation of hospital space based on time blocks, OR rooms/suites, or surgical procedures. This option would require the Commission, legislators, and possibly other stakeholders to amend the Commission's jurisdiction over outpatient services. Currently, the Commission's jurisdiction over outpatient hospital services is limited to outpatient services provided "at the hospital" (Health-General § 19-201). In addition, Code of Maryland Regulations (COMAR) 10.37.10.07-1 states that the term "at the hospital" means "a service provided in a building on the campus of a hospital in which hospital services are provided," and that "A service at the hospital is: (1) Presumed to be an outpatient service; and (2) Subject to rate regulation." This language mandates that hospital operating room services, including those provided to elective, self-paying patients, are regulated. Mixing of

unregulated and regulated space is often confusing for patients and regulators under this framework so is highly discouraged.

Exemptions for certain time blocks, rooms/suites, or procedures would require extensive changes. These changes include:

- The Commission approving changes to COMAR regulations, implementing a new method of determining global budgets and billing for services and, and re-examining quality measures and adjusting charity care policies (for unregulated procedures);
- The State applying to the Centers for Medicare & Medicaid Services (CMS) for a change to Maryland's all-payer system contract;
- State legislators amending the existing Statute, Health-General § 19-201, to reflect the changes outlined above; and
- Hospitals redesigning operational/staffing strategies to adjust to a different approach to care delivery.

These changes, particularly the fact that the State would most likely have to renegotiate substantial parts of its all-payer agreement with CMS, would threaten the State's Medicare waiver.

## **COVID-19 Considerations**

The workgroup convened by the Commission to develop this strategy preferred Option 1 (repricing minor surgeries) to Option 2 (partial deregulation) given the relative ease in implementing Option 1 compared to Option 2. An informal poll conducted in February 2020 suggested hospitals were willing to participate in a pilot as early as July 1, 2020. Commission staffers were therefore planning to present the full findings of the workgroup process and the pilot program in the June public Commission meeting so that the pilot program could be implemented in RY 2021 (begins July 1, 2020).

However, due to the unforeseen COVID-19 pandemic, the Commission has had to delay the original timeline indefinitely. Commissioners and Commission staff have been focused on addressing the healthcare system's COVID needs, so resources have not been available to finalize a recommendation. Furthermore, COVID-19 has affected hospital finances and procedures for the foreseeable future in a way that may impact hospital interest in a new pilot

program that requires hospital resource investment. For these reasons, the Commission has not taken formal action to implement either Option 1 or Option 2 to date.

## Next Steps

Due to the uncertain nature of the virus, the Commission is hesitant to include a specific timeline for the strategy outlined in this report going forward. As outlined previously, any further action on Option 2 is dependent on a broader effort to redesign Maryland's healthcare payment system. Next steps for Option 1 will require a re-evaluation of hospital interest once the effects of COVID-19 become clearer and hospitals are more stable. The Commission intends to develop a plan for implementation and will continue to solicit information from all stakeholders through additional workgroup meetings. Additional considerations for implementation include further discussions on quality reporting, defining terms such as "minor" and "major" surgery, and clarifying program evaluation models.