Maryland
Hospital Association

April 19, 2016

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I am writing to follow up on the commission's April 13 meeting and its discussions about the fiscal year 2017 global budget update. With the midpoint of the five-year all-payer model experiment just two months away, this is a precarious time for hospitals and commissioners alike as we build the strong foundation needed to ensure that the all-payer model is successful and sustainable. I encourage the commission to carefully consider the following facts as the update discussion progresses:

Progress
By all meaningful measures, hospitals are exceeding the targets outlined in the all-payer model agreement and improving health care for Marylanders. In the first two years of the demonstration, cumulative all-payer spending growth is 3.8 percent per capita, far below the 7.3 percent goal; cumulative Medicare savings of $246 million are nearly five times above the target; readmissions rates are well on pace to meet or drop below the national average; and hospital-acquired conditions are down by more than one-third, already surpassing the five-year target. This progress has been made possible because the hard work of care coordination and population health improvement has so far been supported by the commission's funding decisions.

Process
Those who crafted the five-year all-payer experiment contract included a total cost of care guardrail, so that as use of hospital care became more efficient, expenses in non-hospital settings could also be held in check. To date, this guardrail has not been exceeded. Staff, however, have raised concerns about the potential for exceeding this measure. If total cost of care is exceeded, Maryland's contract with the Centers for Medicare & Medicaid Services includes an agreed-upon process: a review period to determine the accuracy of the data (mistakes have occurred in the past), and, if needed, a corrective action plan. The *earliest* that data would be available to determine Maryland's status is the middle of calendar year 2017, a full year from now, as outlined in the contract. A decision now by the commission would be based on estimates that could be favorable or unfavorable to the measure, depending on which data are used. To implement what amounts to a corrective action on July 1, 2016, by limiting hospitals' annual update, would be premature and unnecessary, and undercut the stability needed to ensure the long-term success of our model.

Maturation
As we continue to discuss the global budget update for fiscal year 2017, I hope that you'll keep in mind the extreme difficulty, cost, and effort that it takes to transform a complex, interwoven health care system. By way of comparison, when the state's Total Patient Revenue hospitals started their

new models, they received significantly more funding to invest in care transformation infrastructure, and were given more than four years to demonstrate success in reducing avoidable hospital utilization. Our all-payer model was created as a five-year demonstration for this very reason. Other models, like ACOs and PCMHs, also took years to mature. At just two-and-a-half years old, the new all-payer model needs time to mature as well.

Stability
With barely two years of waiver performance data, this year's update is critical not only because investment is necessary to bolster progress made thus far, but also because withholding available revenue out of concern over the possibility of exceeding the total cost of care guardrail would send a chilling message to stakeholders about the state's commitment to the financial resources needed to sustain the all-payer model. The initial contract makes clear that a viable framework to hold all providers accountable for total cost of care would be developed in the second phase. As it stands, hospitals remain the *only* financially regulated entities in Maryland's health care system and are the only entities at risk for their own performance *and* the performance of all others – physicians, nursing homes, home health agencies and more. Placing the total cost of care burden solely on their backs is akin to placing the burden of an entire bridge on just one support beam – it can't hold the weight. The all-payer experiment is designed to ramp up to a whole-system model that diffuses risk.

Results
In the meantime, stability in the system comes from the annual update that you are now considering. The investments thus far have produced strong results, a willingness by stakeholders to transform business models and care delivery, and unprecedented experimentation on a scale that places Maryland at the forefront of national health care innovation.

Thank you for your consideration, and we look forward to continuing discussion of this important issue.

Sincerely,

Michael B. Robbins
Senior Vice President

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