Maryland
Hospital Association

November 8, 2017

Chris L. Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chris:

On behalf of Maryland's 64 hospital and health system members, we appreciate the continuing opportunity to comment on the Health Services Cost Review Commission's Medicare Performance Adjustment (MPA) policy. The MPA policy is an important component of Maryland's progress toward the enhanced model and a requirement to qualify Maryland's hospitals as Advanced Alternative Payment Models (AAPM) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA.) We understand that attributing all Medicare beneficiaries is a key component of the guidance provided by the Centers for Medicare & Medicaid Services for such a methodology to be approved as an AAPM. We do ask, however, that if the MPA is not approved for MACRA purposes, the commission scale back the attribution methodology and not attribute all beneficiaries in an effort to better align with hospitals' existing efforts to control total cost of care.

As we noted in our September 20 letter, while the development process has been thoughtful and collaborative, the timing for calendar 2018 does not allow for adequate testing and validation before implementation. The recommendation reflects an approach to attribution supported by the hospital field and is our best suggestion based on the information that we have been provided and the required mandate to attribute all Medicare beneficiaries to hospitals. As we begin to more deeply understand how the methodology aligns with the mechanisms that hospitals already have in place to manage care delivery and influence total cost of care, modifications in the attribution methodology will likely be needed. It is not clear whether there is sufficient time to evaluate the impact of potential attribution modifications in time for calendar 2018, or what additional types of data could be given to hospitals to validate the methodology. Given these challenges and the need to complete this work, we recommend that the commission revisit the ability to directly link primary care physicians to hospitals where there is an existing relationship, such as owned practices and care redesign providers, as is done with Accountable Care Organization physicians. With further analysis, additional recommendations may come forward.

At last month's meeting, commissioners considered whether to set the performance benchmark prior to the performance period, or closer to when the payment adjustment is applied. The hospital field prefers that the performance benchmark be set at the start of the performance period so there is a clear target to which performance can be managed. Although national data would be available

after the performance period, thus allowing better calibration of the Maryland performance target, the commission has other mechanisms by which it can adjust the Maryland revenue growth as additional data becomes available. Also important to target setting will be to take into consideration the additional spending in Maryland as a result of the Maryland primary care program. This additional spending is anticipated to lower total cost of care over the longer term, but may increase spending initially. Recognition of this investment is expected to be recognized within the total cost of care model and should likewise be recognized in setting the MPA performance benchmark.

We appreciate the commission's consideration of our feedback and look forward to continuing to work with staff to refine, test and modify the policy over the coming year. There are a number of items the field would like to discuss, among them, refining the attribution methodology, incorporating a recognition of hospitals that attain a low total cost of care, risk adjustment, and a number of operational considerations.

Sincerely,

Traci La Valle, Vice President

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
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