Maryland
Hospital Association

September 20, 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 47 acute care hospitals, we appreciate the opportunity to comment on HSCRC's Medicare Performance Adjustment policy. The policy brings accountability for Medicare total cost of care, previously only measured statewide, to the individual hospital. This requires attributing all Maryland beneficiaries to an individual hospital or system. All other providers that have entered into Medicare demonstrations with the federal government have attributed beneficiaries to a physician who has agreed to be part of an Accountable Care Organization (ACO) or other demonstration entity. The Medicare Performance Adjustment is the first policy to base payment on the efficacy of a hospital's care for its entire Medicare population – a policy that goes beyond global budgets and fully aligns an individual hospital's Medicare total cost of care risk with the statewide risk under the enhanced model demonstration. HSCRC is proposing an attribution approach which would first attribute beneficiaries to physicians and then link the physicians to a hospital or system. This approach supports the view, which we share, that physician partnerships are fundamental to managing and controlling total cost of care.

The Medicare total cost of care attribution brings the accountability to individual hospitals and health systems for the statewide Medicare total cost of care. As a result, the attribution approach is a necessary methodology that could be used in other policies, such as: a mechanism to reduce hospital budgets more broadly, if the state was in danger of exceeding a savings target; an "efficiency" component of a full rate review process or determination of eligibility to access capital funds; a "denominator" in a population health measure. Measurement of spending per beneficiary is aligned with the current demonstration and the proposed enhanced model, unlike previous measures of spending per discharge which can create an incentive for volume growth. However, because many details have not been scrutinized or tested, we caution the commission against using the Medicare total cost of care per beneficiary measurement in other policies and placing additional revenue at risk without further discussion of the implications.

While the Medicare Performance Adjustment 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 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), it is also important to recognize that the methodology is untested. The development process has been thoughtful and collaborative, but the timing required to implement

in calendar 2018 does not allow for testing and validation before implementation. As such, we recommend that the commission continue to work with the hospital field to refine, test and modify the policy over the coming year.

The method of attributing beneficiaries to individual hospitals or systems should match, as closely as possible, the mechanisms by which hospitals can manage care delivery and influence total cost of care. Hospitals have invested significant resources in arrangements with physicians and other providers to manage Medicare total cost of care, including ACOs, and physician practice ownership and management arrangements. Although participation in those arrangements may change over time, attributing beneficiaries to hospitals based on existing arrangements should be the first step of an attribution methodology. The commission has also proposed a methodology that links a physician and their attributed beneficiaries to a hospital based on where the plurality of the physician's patients are admitted. This model attributes based on actual practice patterns instead of formal agreements to work together. As expected, the two attribution approaches overlap, but are not identical. This approach also has merit, but only if a hospital is provided information on the physicians linked to their hospital and driving their total cost of care. Knowing which physicians are linked to the hospital, whether the physician refers primarily to one hospitals or a handful of hospitals in a region, and the risk profile of their associated beneficiaries, provides the hospital with the opportunity to reinforce regional partnerships and influence care patterns and total cost of care.

We would like to continue working with the commission staff on the following issues, incorporating as many as possible into a calendar 2018 performance year (fiscal 2020 adjustment) policy as possible, and carrying the remaining issues forward to adopt as part of the calendar 2019/fiscal 2021 policy.

1. **Reduce Risk on Other Quality Policies**
   The revenue at risk in the Medicare Performance Adjustment should offset a portion of the risk in the Quality-Based Reimbursement program, as Maryland now has a corollary to the national Medicare spending per beneficiary measure.

2. **Operational Issues**
   Maryland's hospitals are taking on risk for the entire Medicare population in Maryland. Managing therefore requires identification and engagement of beneficiaries who are most at risk. In accordance with federal and state privacy laws and requirements, hospitals and physicians are eligible to receive data on beneficiaries with whom they have existing relationships. It remains unclear how much access hospitals will have to information that allows them to adequately manage the total cost of care and associated financial risk. While this issue is manageable for year one, we look forward to working with the commission to ensure appropriate access to information.

3. **Risk Adjustment**
   The pool of beneficiaries attributed to each hospital will have different risk profiles. Although measuring the annual change in spending per beneficiary mitigates some of the volatility in

using unadjusted data, adjusting for beneficiaries' age, gender and comorbidities will explain some variation in spending growth. Hierarchical Condition Categories are widely used by Medicare for risk adjustment and need to be evaluated along with simpler demographic models.

4. **Methodology Validation**
   - Over the coming year, the hospital field will need to validate the HSCRC methodology, including exclusions, programming, and other details.
   - We would recommend that HSCRC continue the Total Cost of Care Work Group to focus on issues that are unaddressed in the first year, and that may be discovered as the policy is implemented.
   - Consideration may need to be given for hospitals with fewer than 5,000 attributed beneficiaries. Medicare requires a minimum of 5,000 beneficiaries in an ACO's risk pool, and it is not yet clear what impact a smaller risk pool has on certain Maryland hospitals.

5. **Improvement Only or Attainment and Improvement**
   For the first year, the HSCRC is considering an individual hospital's annual change compared to the prior year. However, improvement-only assumes that all hospitals have the same opportunity to reduce spending in their beneficiary pools. Differences in base period spending per beneficiary may impact the relative opportunity in the same way that hospitals with lower base period readmission rates were disadvantaged by an improvement-only methodology. Risk adjustment will help address the differences in opportunity for improvement; however, a policy that recognizes attainment or improvement can address concerns about penalizing hospitals that have reduced total cost of care.

We appreciate the commission's consideration of our feedback and the opportunity to continue working with the HSCRC. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle, Vice President

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