Maryland
Hospital Association

August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-5522-P, Medicare Program; CY 2018 Updates to the Quality Payment Program, June 30, 2017

Dear Ms. Verma,

On behalf of our 64 member hospitals and health systems, the Maryland Hospital Association appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule updating the physician quality payment program: to continue most calendar year 2017 policies governing advanced alternative payment models (APMs) into calendar year 2018.

Maryland's hospitals request the following:

- That lower financial risk thresholds be waived for practices that are part of organizations with 50 or more qualified clinicians that participate in medical home models authorized under Sec 1115A
- That nominal risk standards apply to practices in the Maryland Primary Care Program
- That special consideration be given to Maryland's hospitals and physician providers due to the amount of risk they are taking on

Background

Mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the quality payment program began on January 1, 2017, and includes two tracks – the default Merit-based Incentive Payment System, and an option for clinicians participating in certain APMs.

Throughout Maryland, providers are actively engaged in the Medicare Shared Savings Program, including participation in the Merit-based Incentive Payment System. MHA supports the goals of CMS to promote quality and reduce unnecessary utilization for Medicare beneficiaries, as these are prominent goals in our All-Payer Model Agreement with CMS.

In 2016, CMS finalized a relaxed financial risk standard to allow qualified medical home models to operate as advanced APMs without requiring significant downside risk. However, CMS plans to limit the relaxed standard, beginning in 2018, to APM entities owned and operated by organizations with 50 or fewer clinicians. The only existing model thus far to qualify for the

relaxed standard is the CPC+ model, which began Round 1 on January 1, 2017. CMS now proposes to exempt from the 50-clinician limitation those CPC+ practices enrolled in Round 1.

Rationale for Requests

Lower Nominal Risk Threshold and Impact on Maryland Primary Care Program

Lower nominal risk thresholds should be waived for practices that are part of organizations with 50 or more qualified clinicians that participate in medical home models authorized under Sec 1115A for two key reasons.

First, a larger organization is not necessarily better positioned to take on risk. Many complex factors determine an organization's readiness for financial risk, and each starts in a different place. If clinicians are striving to achieve CMS' care transformation goals by participating in one of the agency's advanced APMs, those clinicians should receive credit for their efforts, regardless of whether they partner with a larger organization.

Second, the proposal would be disruptive to Maryland's progression that is currently being negotiated with CMS to establish a Total Cost of Care Model beginning in January 2019. The state is working with CMS to develop a Maryland Primary Care Program (MDPCP) modeled on the Comprehensive Primary Care Plus Program, expected to launch in summer 2018. Maryland's health care providers have been actively engaged in the development of the program, recognizing that a comprehensive primary care medical home program is essential to meet the requirements of the Total Cost of Care Model and achieve the Triple Aim for Marylanders. The proposed rule would disrupt a uniform framework and arbitrarily divide physician groups into different categories, resulting in misaligned incentives among providers and a negative impact on participation in the MDPCP.

The lower financial risk standard and nominal amount standards should apply to all practices in the MDPCP, given the larger context of the Maryland All-Payer Model. Application of these risk standards in this way is not without precedent. CMS has already elected to allow them to be applied in Round 1 of the CPC Plus program. MACRA's explicit discussion of medical homes gives CMS unique latitude to tailor financial risk and nominal amount standards for Medical Home Models that fall below an amount considered sufficient to be "more than nominal" in the context of other types of APMs. MHA encourages CMS to apply that latitude to practices owned by parent organizations with more than 50 eligible clinicians and to MDPCP participants.

Maryland Providers Already Assume Significant Risk

As noted in our December 19, 2016, comment letter to CMS, we believe the Maryland All-Payer Model already meets the risk requirements for the Advanced APM criteria. The State is working with CMS to finalize an approach to assign hospital-specific responsibility for Medicare total cost of care, including physician services, in hospital global budgets. This approach must be done in a way that acknowledges the amount of risk inherent in the Maryland All-Payer Model and provides flexibility to account for investments in Accountable Care Organizations, clinical integration and other alignment approaches. Incorporating this responsibility into the All-Payer

Model and engaging physicians in Accountable Care Organizations, the newly approved Care Redesign Programs and the MDPCP will align efforts of physicians with the goals of the All-Payer Model and give Maryland physicians a pathway to participate in the care delivery transformation CMS envisions.

We appreciate CMS' consideration of the unique risk Maryland's providers have taken on to determine the implications of this proposed rule on the MDPCP and the All-Payer Model Agreement. Thank you again for the opportunity to provide input on the proposed rule.

Sincerely,

Nicole Stallings
Vice President
Maryland Hospital Association