Maryland
Hospital Association

February 7, 2018

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 (MHA) 64 member hospitals and health systems, we appreciate the opportunity to comment on the proposed policy changes offered for consideration by Commissioners John Colmers and Jack Keane at the November 2017 public commission meeting.

Background

In September, you asked Commissioners Colmers and Keane to review HSCRC policies and rate-setting methodologies, following the submission of letters supporting the future Enhanced Total Cost of Care Model that also identified the need to address concerns with several HSCRC policies and methodologies. We agree with your view that, as we are about to move forward on the progression of our All-Payer Model, now is a good time to ensure that our current rate-setting methodologies are "reasonable, understandable, predictable, and effective."

MHA's Executive Committee and governing councils have considered these proposals over the past two months. The purpose of this letter is to share with the commission the hospital field's response to a number of the ideas raised by Colmers and Keane, as well as to identify one recommendation for which we believe additional field consideration is needed before providing a final response.

MHA Positions

- **Rate realignment –** Hospitals support rate realignment, but oppose the use of across-the-board adjustments in the update factor to address any resulting impact on Medicare spending per beneficiary that may endanger the ability to meet the terms agreed to with the Centers for Medicare & Medicaid Services (CMS). We instead recommend that the commission request from CMS an increase in the Medicare/Medicaid differential to address this issue. If CMS does not approve such an increase, HSCRC should not realign rates.

- **Readmissions policy changes –** We do not support the proposal to adopt a Medicare-only readmissions reduction incentive program. Over the course of Maryland's

demonstration, clinicians have emphasized the need to continue to focus on reducing readmissions for all patients consistent with our all-payer program. In fact, we believe that CMS has exempted Maryland's program from the national quality-based payment programs specifically because ours is an all-payer program, and it should continue to be so. We also oppose the proposal to adopt an attainment-only readmissions reduction program; improvement incentives should remain a part of this and all other HSCRC quality-based payment programs. While there is no current benchmark to determine whether Maryland's all-payer readmissions rates compare favorably to other states, data indicate that our rates have historically followed similar trends, and this relationship could be used to proxy appropriate all-payer benchmarks. Additionally, we recommend that HSCRC explore the use of similar groups of non-Maryland hospitals to compare to Maryland's hospitals and guide readmissions benchmarking. Using an appropriate comparison group of hospitals would also address concerns about the impact of social and demographic differences in populations. A number of other options could also be explored.

- **Redesign the complications policy –** We agree with the need to redesign the complications policy, including the measures used in the policy. MHA currently has work underway that should allow us to propose a new policy that could be put in place before the start of performance year 2019 (rate year 2021). The field has agreed on the goals and elements of a redesigned complications policy, identified a set of complications to consider, and has begun to model the options. Our timeline calls for modeling and refinement of options over the spring and early summer. We expect our governing councils to approve an option by late summer or early fall that can be recommended to the HSCRC staff by fall, in time for the HSCRC's vetting and public comment process. Implementing a new policy any sooner would be considered retroactive, since performance years are measured by the calendar year. This timeline allows for testing of measures and benchmarking before implementing a payment policy, without making a retroactive change.

- **Medicare Performance Adjustment (MPA) –** We support the implementation of the calendar year 2018 MPA as adopted (and as proposed by Colmers/Keane), and will continue to work with the commission to improve the policy for calendar year 2019.

- **Scaling used in commission policies –** We would support the proposed concept of the use of continuous scaling, including the potential to relax rewards and penalties or create "hold-harmless zones" in the mid-range. For these scaling systems to be "reasonable, understandable, predictable, and effective," they must be set prior to the start of each performance year, so hospitals will know in advance the value of their investments in quality improvement activities.

- **Potentially Avoidable Utilization (PAU)** – Colmers/Keane propose allowing hospitals to recommend to HSCRC hospital-specific programs for reducing avoidable and

unnecessary care. We are concerned about whether HSCRC has the necessary staff resources to review and monitor multiple programs and, in any case, we believe any revised and expanded definition of PAU used in HSCRC all-payer payment programs must employ a uniform, statewide definition of PAU. Additionally, any new measures included in an expanded definition of PAU should be tested and monitored for one year prior to being incorporated into the payment policies, to identify any unintended measurement issues. Furthermore, we believe it is unrealistic to expect this review process to be completed and in place by July 1, 2018. We are committed to working with HSCRC, clinicians, and other stakeholders on the current set of measures to define PAU, as well as other measures that could be included in this policy.

- **Replacing market shift/demographic adjustments with a range of volume adjustments for non-PAU volume changes** – MHA's Executive Committee and policy councils have spent significant time processing this recommendation. While there are strong differences of opinion about how to understand and address market shift and demographic adjustments, MHA believes that establishing a consensus approach to this matter is critical to the success of the next phase of the waiver. We look forward to working urgently with HSCRC staff to address this critical issue.

We trust that you will find this initial response from MHA to be constructive in the continuing dialogue among commissioners about potential modifications to current policies. As always, if you have any questions about the positions raised above, contact me.

Sincerely,

Michael B. Robbins

Michael B. Robbins, Senior Vice President

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