Maryland
Hospital Association

April 29, 2022

Willem Daniel
Deputy Director of Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: New Requirements for Hospital-Led Care Redesign Programs in Maryland

Dear Mr. Daniel,

At the March 18 HSCRC Care Transformation Initiatives (CTI) Steering Committee meeting, you shared results from a recent survey to better understand the use of fraud and abuse waivers by hospital participants to engage care partners through care redesign programs (CRPs). You then said Commission staff intend to recommend that the Centers for Medicare and Medicaid Innovation (CMMI) establish more stringent requirements for the Episode Care Improvement Program (ECIP) and a higher bar to create future tracks.

That conclusion is very disappointing, and we strongly urge the Commission to reconsider. At a time when Maryland's hospitals will be held to increasingly ambitious financial, quality and transformation tests, our hospitals need access to every tool available for success.

First, HSCRC ought to engage a legal expert to advise on the necessity of the fraud and abuse waivers to implement engagement strategies. Then, HSCRC staff ought to present your recommendations to commissioners at public meetings, first as draft, then as final.

To the first point, HSCRC relied upon hospitals' and health systems' counsels when establishing the CRP track; the protection afforded by the various fraud and abuse waivers was viewed as crucial. The Commission should not draw conclusions about the necessity of these waivers without having expert legal opinion on the value of the non-monetary renumeration provided under ECIP at the individual participant level.

To the second point, the direction of existing and future CRP tracks has major ramifications for the implementation and outcomes of the Total Cost of Care Model. It is customary for HSCRC commissioners to opine on such matters.

MHA recommends HSCRC continue ECIP as currently constructed and allow flexibility to pilot new hospital-led tracks.

In the remainder of this letter, we offer details on the utility of fraud and abuse waivers not captured by the survey and provide suggestions for how participation should be evaluated.

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It is too early to draw conclusions about the utility of fraud and abuse waivers

As noted during the March meeting, HSCRC based its recommendations on discrepant survey results. Fifteen responses were received, but with identities unknown, staff have no way of knowing whether the sample size reflects a fair statewide representation.

HSCRC makes its conclusions based on two contradictory insights: 1) most providers do not offer resources only to ECIP certified care partners; and 2) most hospitals find the waivers to be "critical" to offer care transformation resources.

We again caution against drawing any conclusions that the care transformation resources do not require waivers without consulting legal counsel.

The value of CRPs is not limited to incentive payments

HSCRC shared CMMI's expectation that hospitals should either provide incentive payments or "more than a nominal amount of care management staff, etc."[1] to care partners under CRPs. It is important to note the genesis of CRPs, to allow hospital-led models available in other states, that align with Maryland's Model, to grow locally. **In national programs, where Maryland historically has been excluded, incentive payments are not required, and the federal government recognizes that provision of non-monetary resources is appropriate.**

Blanket waivers give hospitals the ability to readily extend services to their care partners without needing to evaluate each specific use case. Examples of non-monetary renumeration include:

- Transitional nurse navigators assist skilled nursing facility (SNF) and hospice partners
- Nurse practitioners embed in post-acute care sites and monitor patient compliance to a congestive heart failure pathway, better enabling rapid discharge and follow up
- Patient data are shared to help improve care coordination; includes data platforms that allow for real-time monitoring of patients, and daily sharing of quality data to drive continuous improvement processes.

As stated, before making any changes, HSCRC should get an expert legal opinion on the status of the ability for hospitals to provide these incentives without the waivers.

ECIP has helped hospitals and care partners align on shared health outcomes, particularly for post-acute providers. In 2019, 67% of enrolled hospitals partnered with SNFs, and 60% partnered with home health.[2] Other HSCRC policies do not promote the kind of alignment necessary to be successful under the model. For example, the Episodes Quality Improvement Program (EQIP), which follows a similar structure to ECIP, offers a smaller subset of episodes

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[1] March 18th Care Transformation Meeting Powerpoint
[2] Rachel Machta et. al. "Evaluation of the Maryland Total Cost of Care Model: Implementation Report" *Mathematica* (2021). Accessed April 25, 2022. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-implementation-report

(15 vs. 23) and less opportunity to enhance relationships with post-acute partners. **MHA supports continued maturation of EQIP and believes ECIP should have a similar level of support from HSCRC.**

Additional factors limit hospitals' ability to provide incentive payments

The payment mechanism for ECIP creates another barrier. Since savings flow through the Medicare Performance Adjustment, hospitals facing negative adjustments, despite savings under ECIP, are prevented from receiving payments for downstream providers.

As noted on the call, hospitals need to realize savings to have anything to share. This is not unlike what has been observed in the Medicare Shared Savings Program and other value-based programs. **Maryland's hospitals should not have to leap a higher bar than hospitals nationally.**

Several factors may impact participation and should be evaluated

While ECIP uptake in the first performance year was 15 hospitals, participation has grown steadily. In 2022, ECIP has 24 participating hospitals, which is more than double the minimum number of participants HSCRC has arbitrarily made necessary to establish future CRP tracks.

During the COVID pandemic, hospital operations staff were pulled away from normal duties to fulfill support roles. Despite this disruption, program uptake did not falter**. We recommend HSCRC re-evaluate participation at a future date if enrollment declines substantially.**

We also ask HSCRC to consider how its policy development schedule impacts participation in various programs. While HSCRC continues to develop new policies to drive success, hospital staff capacity to work on implementing existing programs is already limited. New policies may drive down participation at a time when CMMI and its evaluator expect participation to rise. **HSCRC should look for opportunities to evaluate and refine existing programs like ECIP that include additional stakeholder input beyond a survey.**

Thank you for your openness to better understand the value of care redesign programs and the waivers they offer. As the state continues to pioneer care transformation under the Maryland Model, avenues must exist to engage non-hospital care partners. Please do not hesitate to contact me to discuss any of the issues raised in this letter.

Sincerely,

Nicole Stallings
Chief External Affairs Officer