Maryland
Hospital Association

October 9, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am providing feedback on Health Services Cost Review Commission (HSCRC) staff questions related to Medicare Performance Adjustment (MPA) and Care Transformation Initiative (CTI) policies.

Our member hospitals and health systems are concerned about certain aspects of each of the programs, particularly their ability to measure the effectiveness of actual clinical interventions of the hospitals and their capacity to positively drive care delivery transformation.

Medicare Performance Adjustment

Align MPA Results with Total Cost of Care (TCOC) Savings Calculation

The hospital field continues to be concerned about the disconnect between MPA results and the Medicare savings being generated, which are far more than the contractual target. From a policy perspective, these two measurements should be synonymous or at least significantly aligned. The most recent results demonstrate the opposite.

In calendar year (CY) 2023, Maryland exceeded the Medicare savings contractual target by over $190 million. During this same period, HSCRC data show Maryland hospitals incurred a statewide penalty in the MPA of about $24 million. MPA generated over $64 million in penalties since CY 2018, while the state continues to overperform against the savings target.

Eliminate Required Savings in MPA

Maryland hospitals are required to produce a certain level of TCOC savings when compared to the national growth rate with certain adjustments as part of MPA policy—regardless of the savings being generated under the Model. For example, the FY 2026 MPA policy includes a benchmark 0.4% below the nation, which equates to $40 million of incremental Model savings for CY 2024. This requirement is unnecessary if the state is generating savings above the savings target and perpetuates an ongoing disconnect between the savings target and MPA. These

required savings should be eliminated, and other mechanisms such as the annual payment update should be utilized to ensure that Maryland achieves Model savings.

Application of Final Rule to MPA Results

The Centers for Medicare and Medicaid Services (CMS) issued a final rule on Sept. 27, "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023*."* The final rule was in response to a significant increase in DME payments related to fraudulent catheter billings.

The final rule specifically states that "[g]iven the scope of the Significant, Anomalous, and Highly Suspect (SAHS) billing activity, there is a high likelihood that, absent CMS action, shared savings and losses calculations for PY 2023, and for future performance years where CY 2023 is a benchmark year, would be significantly impacted for Accountable Care Organizations (ACO). Under these circumstances, some ACOs are likely to experience adverse impacts (for example, lower or no shared savings or higher shared losses) while other ACOs would experience windfall gains (for example, higher shared savings or lower or no shared losses)."

The extent of fraud is not equal across hospitals, therefore the MPA for CY 2023 should be recalculated to exclude the two CPT codes (A4352 and A4353) identified in the final rule as they likely impacted Maryland hospitals' results under MPA policy.

Add Non-Claims Based Payments to MPA Scoring

MHA supports the addition of non-claims-based payments to MPA scoring as this brings the methodology into closer alignment with how the annual savings target is calculated.

Revise Attribution Methodology

MPA's previous attribution methodology more closely aligned the clinical relationships between providers and payers by prioritizing attribution based on primary care (defined as being part of an ACO or, later, Care Transformation Organization), physician employment, or a plurality of primary care services. The transition to a geographic-only attribution diminished the closer clinical link of the previous methodology.

MHA supports allowing hospitals to voluntarily choose to link beneficiaries to the hospital's MPA using panel-based CTIs or other mechanisms.

Care Transformation Initiatives

MHA understands that CTI policy intends to measure hospitals' clinical interventions and the corresponding reductions or increases in TCOC. However, implementation has been challenging due to the varying capacities to achieve substantial savings, including sufficient savings to meet the statewide offset requirement.

MHA encourages HSCRC to continue advocating with CMS for authorization to implement the CTI buy-out methodology. A CTI buy-out methodology would encourage robust hospital participation and promote better alignment between hospital clinical interventions and TCOC accountability.

Stop Loss

MHA supports a stop-loss provision for CTI policy to add a degree of protection for Maryland hospitals depending on the magnitude of the statewide savings pool. MHA recommends HSCRC, in partnership with the hospital field, develop a standardized methodology that can be applied annually based on prior years' results to determine the appropriate stop-loss level.

Stop Gain

MHA understands the rationale for a stop-gain limit but is concerned that such a limit could diminish the incentives for maximum TCOC reductions. MHA wants to consider limiting coding increases that could occur year-over-year, like in the Medicare Shared Savings Program. In these other value-based programs, coding is only allowed to increase a certain amount year-over-year to ensure savings are due to clinical interventions that lead to TCOC savings rather than a singular focus on coding and documentation.

Adjust Dollars Subject to the Offset

MHA acknowledges that the potential to reduce TCOC varies among hospitals, as reflected in HSCRC's current benchmarking methodology. MHA supports HSCRC factoring in these regional differences when allocating the statewide savings offset across hospitals. Areas with lower TCOC reduction opportunities will likely have more challenges generating sufficient savings for their share of the statewide pool. At the same time, areas with larger TCOC reduction opportunities may have regional dynamics that will make it more challenging to realize savings through care transformation efforts, such as by having a higher burden of social determinants of health, lower access to primary care, and lower average income. MHA requests that HSCRC consider whether the offset methodology should account for these equity considerations.

Conclusion

MHA appreciates the opportunity to comment on these important topics. We continue to believe that policies need to align across programs and not provide conflicting answers on hospital performance. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick D. Carlson
Vice President, Healthcare Payment