CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

July 15, 2022

Katie Wunderlich
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Maryland's Performance on the Total Cost of Care Requirements, CY2021

Dear Ms. Wunderlich:

This letter is intended to inform the Health Services Cost Review Commission (HSCRC) and the State of Maryland (the State) that the Centers for Medicare & Medicaid Services (CMS) has reviewed the State's performance on the annual requirements specified in sections 6 and 8 of the Maryland Total Cost of Care Model (the Model) State Agreement (the Agreement) and determined that the State has met five of the six requirements and did not meet the Readmissions Reductions for Medicare requirement. The Nation performed better than Maryland on the Medicare 30-day unadjusted all-cause, all-site hospital readmission rate by 0.23 percentage points.

Under section 12.d.i.3 and 12.d.i.4 of the Agreement, if CMS determines that the State has not improved quality or failed to demonstrate that the State's hospital and value-based payment program achieves or surpasses the measured results in terms of patient outcomes and cost savings in relation to the national program of equivalent, the result could qualify as an Other Event. CMS may pursue corrective action as described in section 12.d.ii, including requiring the State to submit a formal Corrective Action Plan (CAP) or termination of the HVBP, HAC, or HRRP Medicare payment waivers.

Additionally, under section 12.c.i.3 of the Agreement, if CMS determines that the quality of care provided to Medicare, Medicaid, or CHIP beneficiaries has deteriorated, CMS may purse corrective actions for Triggering Events in accordance with section 12.c.ii of the Agreement. Consistent with section 12.a of the Agreement, CMS has used its discretion to allow the State to submit additional data and analyses to demonstrate that an Exogenous Factor caused the State to fail the Readmissions Reductions for Medicare requirement, in whole or in part. The decision to pursue corrective action will be dependent on CMS' review of the additional data submitted by the State; data submission requirements are reaffirmed in section five (5) of this letter. CMS has determined that all other performance requirements have been satisfactorily met for calendar year (CY) 2021 (Model Year 3).

For details on the State's reported performance, see attachments "*1a. Financial - TCOC Monitoring Presentation- May 2022_FINAL for CMMI.pdf*", "*2a. Quality - Complication and Readmission Monitoring for CMMI CY 2021.pdf*", "*3a. VBR - CY 2021 - Drug Reimbursement & Compliance Memo FINAL.pdf*" and "*4. All Payer Revenue Limit Test MY3TCOC-CY21.pdf*".

1. **Annual Medicare Savings (Section 6.c)**

The State is required to produce annual savings in Maryland Medicare TCOC per Beneficiary of $222 million for Model Year (MY) 3 (CY 2021). In accordance with the Methodology defined in Section 6.b and Appendix C of the State Agreement, CMS has calculated the annual Medicare TCOC savings per Maryland Medicare Beneficiary to be $378.1 million for CY 2021. Consistent with section 6.b.i, of the Agreement, the State earned $234.6 million in excess of the savings target in MY2 (2020), thus one half, or $117.3 million, in Medicare savings has been carried over from MY2 and added to the calculated annual Medicare TCOC savings per Maryland Medicare Beneficiary of $378.1 million for MY3 (CY 2021). The State earned a total saving amount of $495.3 million in MY3; CMS considers this requirement of the Model met. For validation details, see attachment "*TCOC Hospital Savings NCBP CY 2021 2022.06.14.xlsx*", 2021 TCOC Savings NCBP tab.

2. TCOC Guardrail (Section 6.e)

The State must not exceed National Medicare TCOC per beneficiary spending growth by more than one percent for any given Model Year and must not exceed the National Medicare TCOC per beneficiary spending growth by any amount for two or more consecutive Model Years. The State's TCOC per beneficiary growth rate was 0.6 percentage points above the National growth rate in CY 2021. In CY20 the State's TCOC per beneficiary growth rate was 0.5 percentage points below the National growth rate, therefore CY21 was the first year the State exceeded the National Medicare TCOC per beneficiary growth rate by any amount, thus CMS considers this requirement of the Model met. In accordance with section 12.d.i.2 of the Agreement, if in CY22 the State exceeds the National Medicare TCOC per beneficiary spending growth by any amount CMS could consider this an Other Event and pursue corrective action. For validation details, see attachment "*TCOC Hospital Savings NCBP CY 2021 2022.06.14.xlsx*", TCOC Growth NCBP tab.

3. All-Payer Revenue Limit (Section 6.f)

Maryland's all-payer regulated gross patient service revenue must be less than or equal to the maximum revenue that Regulated Maryland Hospitals may earn in that Model Year from All Payers. In accordance with the Methodology defined in Appendix B.II of the State Agreement, CMS has calculated the State's all-payer regulated gross patient service revenue for CY 2021 to be $1.71 billion below the maximum revenue amount; therefore, CMS considers this requirement of the Model met. CMS reaffirms that the State met this requirement in MY1 (2019) and MY2 (2020). For validation details, see attachment "*All Payer Revenue Growth and Savings CY 2021 2022.04.20.xlsx*", All-Payer Ceiling Savings tab.

4. All-Payer Quality Improvement Reductions in Potentially Preventable Conditions under the Maryland's Hospital Acquired Condition Program (Section 8.d.1-3)

The State must maintain improvements seen under the All-Payer Model by not exceeding the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC) in a given Model Year. The HSCRC reported All-Payer PPC performance for CY 2021 yielded a 0.13 percentage point reduction in the All-Payer PPC rate compared with CY 2018 performance. Based on the State's report, CMS considers this requirement of the Model met for CY 2021.

5. Readmissions Reductions for Medicare (Section 8.d. 1-3)

The State must maintain the improvements achieved under the All-Payer Model on the aggregate

Medicare 30-day unadjusted all-cause, all-site hospital readmission rate for Medicare FFS beneficiaries such that regulated Maryland Hospitals have achieved equal to or less than the national Readmission Rate for Medicare FFS beneficiaries at the end of Model Year 3. CMS has reviewed the State's calculation and concludes that State's CY 2021 Readmission Rate of 15.64 percent is above the national CY 2021 Readmission Rate of 15.41 percent; therefore, CMS has determined that the State did not meet this requirement.

CMS expects the State to dedicate a section of the Federal Fiscal Year (FFY) 2023 Quality Waivers Exemption Request Memo to demonstrate that an Exogenous Factor caused the State to fail the Readmissions Reductions for Medicare requirement, in whole or in part. This section should include (1) a brief description of the situation and request for Exogenous Factors (2) relevant background information (3) a qualitative and quantitative assessment of how the exogenous factors impacted the State's ability to meet the Readmissions Reductions for Medicare requirement and (4) the State's assessment conclusions and other performance exceptions that CMS should consider; supporting data should be included with the State's submission of the FFY 2023 Quality Waivers Exemption Request. CMS' decision to pursue corrective action will rely heavily of the quantitative components of the assessment. CMS will include a decision whether or not to pursue corrective action with our response to the State's Quality Waivers Exemption request for FFY 2023. Improvements in quality are fundamental to the overall success of the Model and CMS encourages the State to continue to prioritize opportunities to improve hospital quality performance. For validation details, see attachment "*Medicare Readmissions CY 2021 2022.04.20.xlsx*", YoY Readmissions Data tab.

6. Hospital Revenue Population Based Payment (Section 8.a.)

The State is required to facilitate the movement of Regulated Revenue for Maryland residents into Population-Based Payment. Section 8.a.ii requires that at least 95 percent of all Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology. The HSCRC has reported 97.97 percent of Regulated Revenues are under Maryland's 'Rate Setting System' for CY 2021, which CMS has approved as meeting the definition of a Population-Based Payment. Based on the State's report, CMS considers this requirement of the Model met for CY 2021.

In summary, CMS has determined that the State has met or exceeded the annual requirements of the Maryland Total Cost of Care Model for the third Model Year of the Model (CY 2021), with the exception of the Readmissions Reductions for Medicare requirement. CMS will determine whether to pursue corrective action per our review of the State's Exogenous Factor request and accompanying data in the upcoming FFY 2023 Quality Waivers Exemption Request. CMS appreciates the State's commitment to achieve the annual performance requirements of the Model and looks forward to our continued partnership.

Sincerely,

Janelle Gingold
Deputy Director
State Innovation Group
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services

Attachments:
1. 1a. Financial - TCOC Monitoring Presentation- May 2022_FINAL for CMMI.pdf
2. 2a. Quality - Complication and Readmission Monitoring for CMMI CY 2021.pdf
3. 3a. VBR - CY 2021 - Drug Reimbursement & Compliance Memo FINAL.pdf
4. All Payer Revenue Limit Test MY3TCOC-CY21.pdf
5. TCOC Hospital Savings NCBP CY 2021 2022.06.14.xlsx
6. All-Payer Revenue Growth and Savings CY 2021 2022.04.20.xlsx
7. Medicare Readmissions CY 2021 2022.04.20.xlsx