maryland
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cost review commission

603rd Meeting of the Health Services Cost Review Commission
February 8, 2023

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

EXECUTIVE SESSION
11:00 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

4. Discussion of Tidal Health's Petition for Declaratory Ruling - Authority General Provisions Article, §3-305(7)

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 11, 2023

2. Docket Status – Cases Closed

3. Docket Status – Cases Open
   2603R - Luminis Anne Arundel Medical Center
   2608R - Shady Grove Adventist Medical Center

4. Traditional MPA - CY 2023 Performance - Final Recommendation

5. Emergency Department Challenges and Strategies

6. Analysis of Utilization Trends under the TCOC Model

7. Policy Update
   a. Model Monitoring
   b. Legislative Update
   c. Analysis of Hospital Funding in Rural and High Poverty Areas

8. Hearing and Meeting Schedule

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF JANUARY 30, 2023

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2603R	Luminis Anne Arundel Medical Center	7/22/2022	FULL	KW	OPEN
2608R	Shady Grove Adventist Medical Center	7/18/2022	CAPITAL	GS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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Medicare Performance Adjustment

Final Recommendation

February 8, 2023

This document contains the final staff recommendations for the CY 2023 Medicare Performance Adjustment.

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Recommendations For CY 2023 MPA Policy

Staff recommend the following incremental revisions to the Medicare Performance Adjustment (MPA) policy for calendar year 2023 (CY2023) to align with State and federal policy directives:

1. Formalize the geographical attribution algorithm;
2. Remove the Supplemental Maryland Primary Care Program adjustment; and
3. Increase the amount of revenue at risk by increasing the weight of the MPA quality adjustment.

In 2021, Staff completed a major policy review of the MPA. As a result of the review, the Commission revised the attribution algorithm and the methodology for calculating the rewards / penalties under the MPA. During the review, stakeholders emphasized that the MPA policy had changed numerous times and stressed the need for consistency in the future. Correspondingly, Staff recommend keeping the majority of the MPA unchanged. However, Staff are recommending the minor changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2023 and makes incremental improvements to the current policy.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

TCOC and the benchmark.		rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.		

Overview of the MPA Policy

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of the large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (1 percent of Medicare fee-for-service revenue).

The MPA includes two "components": a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Traditional Component

Currently, the HSCRC assigns patients to hospitals based on their geographic residence. In CY22, the Commission assigned patients to hospitals based on the hospital's Primary Service Areas (PSAs) as designated in the original hospital GBR agreements. However, based on industry feedback, Staff proposed to move towards a geographic algorithmic PSA Definition. For CY 2023, Staff recommends using the revised geographic attribution algorithm going forward, as described below.

1. Hospitals are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30 minute drive-time from the hospital's PSA.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

4. An alternative attribution approach for the AMCs will be used, consistent with that approved for CY2022, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also be assigned all zip codes for Baltimore City for their geographic attribution.[1]

The MPA then penalizes or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scales the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. This approach and calculation are the same as was used in CY2022. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below.

[1] Additionally, Staff recommend dropping the University of Maryland Rehabilitation and Orthopedic Institute (UMROI) from the MPA. Traditionally, UMROI has been grouped with the University of Maryland Medical Center or given a special attribution. Staff do not believe that either of these approaches work well, given the unique patient mix seen by UMROI.

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D)

Example Calculation of MPA Targets

Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. The rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. The amount of revenue at risk under the MPA policy is capped at 1% of the hospital's Medicare fee-for-service revenue. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 1%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.30%
Hospital B	$11,846	$11,941	0.80%	-0.30%
Hospital C	$11,792	$11,556	-2.00%	0.70%
Hospital D	$11,800	$12,154	3.00%	-1.00%
Hospital E	$11,294	$11,859	5.00%	-1.00%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes. Revisions to the quality adjustment for CY 2023 are outlined below.

Efficiency Component

The MPA includes additional rewards and penalties for hospitals that reduce the TCOC through care redesign programs, including the Episode Care Improvement Program (ECIP), the Care Transformation Initiatives (CTI), and the Maryland Primary Care Program (MDPCP). The HSCRC increases the MPA reward or penalty based on the success of these programs. The HSCRC developed the Efficiency Component because the Traditional MPA was not targeted well enough to reward a hospital for a specific target population. A hospital would only be rewarded for a successful care redesign effort under the Traditional Component of the MPA, if every beneficiary included in the effort was attributed to the hospital and if the impact of the program was not washed out by the impact on other beneficiaries who were also attributed to the hospital. Historically, the Traditional MPA has not been well aligned with individual hospital care redesign efforts which necessitated the development of the Efficiency Component.

Public Comments

Staff received public comments on the draft CY 2023 MPA proposal from the Maryland Hospital Association (MHA), MedStar Health, Luminis Health, and TidalHealth. The Maryland Hospital Association, MedStar Health, and Luminis Health were supportive of removing the MDPCP Supplemental Adjustment and generally supportive of using the geographic attribution in the MPA for CY 23, although all three indicated that geographic attribution was not a perfect attribution algorithm and suggested that staff and the industry continue to investigate potential improvements in the attribution algorithm. Staff agree that geographic attribution is not perfect; however, Staff believe that the attribution algorithm is the best of the algorithms investigated by the TCOC Workgroup. Namely, the geographic attribution has three major advantages: it is

simple, it is predictable, and it is consistent. Staff will continue to investigate alternative attribution algorithms but expect to maintain the geographic attribution for the foreseeable future.

MHA, MedStar Health, Luminis Health, each indicated support for deferring the inclusion of the population health measures for future years and have suggested alternatives to the proposed ED Diabetes Screening Measure. Staff note that CMMI have approved the MPA without the inclusion of the population health measure in CY 23 but have expressed their expectation that the State include these measures in CY 24. Staff anticipate using the remainder of CY 23 to finalize the population health measures prior to CY 24.

TidalHealth expressed a concern regarding the TCOC benchmarking methodology that is used in the MPA and other HSCRC policies. First, TidalHealth believes that the TCOC benchmarks are flawed because they do not incorporate the CMS hospital wage index that is used to set IPPS rates nationally; second, TidalHealth believes that the benchmarks are flawed because they do not incorporate an adjustment for health outcomes. Staff do not agree with either objection. Regarding the first concern, the CMS hospital wage index is widely acknowledged to be inaccurate for Maryland hospitals.[2] Matching inaccurate Maryland numbers to accurate national numbers would produce inaccurate results. Instead, Staff used median income to measure a hospital's labor costs, which addresses the concern raised by TidalHealth without the data integrity issues of the CMS hospital wage index. Staff also tested other measures of wage costs and did not find a material difference[3]. Regarding the second concern, the benchmarks were designed to measure the relative level of costs in Maryland and demographically similar regions in the rest of the country. The benchmarks were not designed to determine the level of spending necessary to achieve a certain level of health outcomes. While the latter question is academically interesting and may be pertinent to other HSCRC policy goals, the State is required to meet the savings target in the Maryland Total Cost of Care Model Agreement, which is accomplished in part through the MPA. The MPA uses the benchmarks to determine which Maryland hospitals have relatively high per capita spending and thus most need to reduce costs in order to meet the statewide savings target in a manner proportional to their opportunity. The implementation of the differential targets is gradual and limited by the 1% revenue at risk and therefore does not result in a substantially greater hardship for hospitals with high per capita TCOC.. The HSCRC has other policies (PAU, MHAC, RRIP) that financially support hospitals which improve quality.

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[2] See for instance: Committee on Geographic Adjustment Factors in Medicare Payment, Board on Health Care Services, Institute of Medicine. Geographic Adjustment in Medicare Payment: Phase I: Improving Accuracy. Second edition. Edited by M. Edmunds and F.A. Sloan. Washington, DC: National Academies Press, 2011. Available at https://www.ncbi.nlm.nih.gov/books/NBK190074/.
And see the discussion in the Congressional Research Service. "Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages." March 3, 2021. Available at https://crsreports.congress.gov/product/pdf/R/R46702.

[3] See Staff memo on additional testing of benchmarks at:
https://hscrc.maryland.gov/Documents/Memo%20on%20Additional%20Benchmarking%20Considerations-2-4-22%20FINAL.pdf

MPA Final Recommendations

Staff recommends three changes to the MPA for CY2023: 1) formalize the revision of the geographic attribution algorithm as described above; 2) eliminate the Supplemental MDPCP Adjustment; and 3) increase the weight placed on quality measures. Once those changes are made, Staff recommends maintaining the MPA for CY2023 and CY2024, in order to create as much stability for hospitals as possible.

Revised Attribution

In CY22, the Commission moved to a geographic attribution algorithm to assign beneficiaries to hospitals under the MPA (in addition to a separate attribution tier for the state's two Academic Medical Centers). Geographic attribution was based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. During a review of the MPA Policy in CY21, Staff and the industry concluded that the PSAs in the GBR had become dated and the industry suggested adopting a more algorithmic approach. The CY 2022 Recommendation directed the Staff to develop a standardized approach to assigning zip codes to hospitals. Staff recommend that hospitals should be assigned the zip codes that constitute 60% of the hospital's volumes, as determined by ranking each zip code from largest volume to least and assigning the zip codes to the hospitals until 60% of the hospital's volume has been attributed. Further specifics of the approach are described above.

Supplemental MDPCP Accountability

In 2021, the Commission directed Staff to increase the accountability for managing the TCOC in the MDPCP since the MDPCP program itself did not include direct TCOC risk. Therefore, HSCRC added a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. The MCPCP supplemental adjustment rewards / penalizes hospitals for the relative success of their MDPCP programs. However, in CY 2022, CMS announced a Track 3 of MDPCP for CY 2023 that includes direct TCOC risk. Therefore, the Supplemental MDPCP Adjustment is redundant. Staff recommend eliminating the MDPCP Supplemental Adjustment.

Increased Quality Adjustment

In its approval of the CY 2022 MPA, CMMI indicated that they would like to see an increase to the revenue at risk in the MPA and a greater focus on population health. Currently, the MPA quality adjustment is equal to the sum of the hospitals Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program. The percentage for the two quality programs is summed and multiplied by the amount that the hospital is above or below the MPA target. That is, the MPA adjustment is equal to the TCOC result x 1/3[4] x (1+ RRIP + MHAC Reward/Penalty). Since the RRIP and the MHAC

[4] The TCOC results is the % by which the hospital exceeds or falls short of target to a maximum of 3%. The fraction of 1/3rd is applied to translate the result into a maximum penalty of ±1%.

programs have a maximum revenue at risk of 2%, at this point the maximum adjustment is ±1.04%. Finally, the MPA is capped at 1% reducing the final maximum to ±1.00%. Since the cap occurs after the application of the quality adjustment, a hospital already at the limits of the financial adjustment may have no additional impact from their quality adjustment.

In order to meet CMMI's request to increase the revenue at risk, Staff recommend applying the 1% revenue at risk cap earlier in the calculation and doubling the weight of the quality adjustment. Therefore, the calculation would be TCOC results x 1/3 (capped at 1% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty)). This will modestly increase the maximum adjustment to ±108%, or ±1.08% of the hospital's Medicare revenue as opposed to 1.00% under the current approach.

Finally, Staff recommend including a population health quality measure in the MPA, once approved by CMS and the Commission. Staff have been working on an all-payer measure for diabetes screening with the Performance Measurement Workgroup for monitoring purposes in CY 2023. Staff have proposed measuring the rates of diabetes screening but deferring any adjustment on payment rates until the following year. Staff are also considering potential alternative monitoring measures. In CY 2024, once that measure, or an alternative population quality health measure, is fully developed and incorporated into our quality programs, Staff recommends including that measure into the MPA Quality Adjustment with a weight of 4%. The MPA adjustment would be TCOC results x 1/3 (capped at 1% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + population health quality measure)). This will increase the maximum adjustment to 1.16% of the hospital's Medicare revenue and reflect the dual desire to increase revenue at risk and incorporate additional SIHIS-related population health quality measures into Maryland's hospital quality program.

December 21, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Commission's proposed Medicare Performance Adjustment (MPA) policy for 2023. MHA generally supports the draft recommendation. Below is our feedback on each component.

Attribution

MHA supports using a formula to assign beneficiaries to hospitals under the geographic attribution. However, we remain concerned that strict geographic attribution does not capture hospital initiatives to transform care delivery. MHA is disappointed the Centers for Medicare & Medicaid Services (CMS) only approved the Care Transformation Initiative (CTI) buyout for calendar year (CY) 2021. The buyout mitigates removing the physician-based methodology. Due to claims run-out, the financial impact of CTIs is still largely unknown. MHA encourages HSCRC to share CTI data as soon as practicable to understand revenue adjustments and possible overlapping incentives.

HSCRC plans to use a different attribution methodology for academic medical centers since the geographic approach does not reflect tertiary care service use patterns. HSCRC should share impact modeling prior to the final recommendation.

Removing MDPCP Supplemental Adjustment

MHA supports removing the Maryland Primary Care Program (MDPCP) supplemental adjustment. MDPCP Track 3 features downside risk for both physician practices and hospital Care Transformation Organizations beginning in CY 2023. The MDPCP supplemental adjustment in MPA would duplicate this provision.

Population Health Adjustment

MHA applauds HSCRC staff and CMS for not implementing a CY 2023 population health measure because a workable measure is not final. The population health measure should be

removed from the 2023 final MPA recommendation and revisited when the measure and details are proposed.

In our November letter, MHA expressed serious concerns with HSCRC's proposal to screen hospital emergency department (ED) patients for diabetes. While additional screening is valuable to identify previously undiagnosed diabetes, there is significant potential for added cost of care without the added benefit of getting individuals into a regular system of care to manage diabetes. Hospital ED clinicians are already overburdened, and their urgent work would be disrupted if they were required to add this procedure.

Instead, MHA urges HSCRC to adopt **hemoglobin A1C control in hospitals' affiliated practices** as the population health performance measure in HSCRC payment policy. Screening is much better suited to ambulatory care settings.

We appreciate your time and attention to this important matter. Should you have any questions please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
James N. Elliott, M.D.
Maulik Joshi, Dr.P.H.
Willem Daniel, Deputy Director, Payment Reform and Stakeholder Alignment

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December 22, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the MedStar Maryland hospitals, we appreciate the opportunity to provide comments on the HSCRC's proposed Medicare Performance Adjustment (MPA) Policy for calendar year 2023.

Attribution Adjustment
MedStar Health commends the HSCRC's recognition that the primary service areas defined in hospital global budget agreements are an outdated methodology for attribution. While MedStar Health supports a change to the currently outdated attribution methodology, we remain concerned about the pitfalls of a strictly geographic-based attribution, particularly in metropolitan areas where there are overlaps. We believe the Commission and the industry at-large should continue its efforts in pursuit of more refined attribution methodologies that appropriately align hospital resources with the communities they serve.

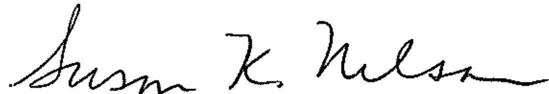
Removing the MDPCP Supplement Adjustment
MedStar Health concurs with the Maryland Hospital Association's position in support of removing the Maryland Primary Care Program (MDPCP) supplemental adjustment.

Population Health Adjustment and ED Diabetes Screening
MedStar Health supports deferring the inclusion of a population health measure into the MPA policy beyond CY2023. Any proposal to include population health measures should first be studied within appropriate HSCRC workgroups prior to inclusion in any draft or final policy recommendation. MedStar Health recognizes and appreciates the importance of population health and believes future policy recommendations deserve careful time and attention.

In a letter to Mr. Allan Pack, dated December 2, 2022, MedStar Health joined with Johns Hopkins Health System and University of Maryland Medical System to express concerns with the proposed ED Diabetes Screening Program, which we believe would cause delays in patient care, as well as add costs and erode patient trust in our healthcare system. As discussed in this letter, MedStar Health supports the alternate approach of offering testing for **hemoglobin A1C levels** on patients being admitted to the hospital. Further information on the collective position of MedStar Health, Johns Hopkins Health System and University of Maryland Medical System on the topic of diabetes screening is contained within the aforementioned letter dated December 2, 2022.

Thank you for the opportunity to provide comments.

Sincerely,



Susan K. Nelson
Executive Vice President and Chief Financial Officer
MedStar Health, Inc.

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
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James N. Elliott, M.D.
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December 27, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

TidalHealth Peninsula Regional appreciates the opportunity to provide comments on the Medicare Performance Adjustment draft recommendation. This draft recommendation proposes relatively minor modifications to the geographic attribution methodology along the elimination of the MDPCP adjustment and with minimal changes to the revenue at risk in response to Innovation Center requirements. These changes are minimal and appear to offer little disruption to the current structure of the MPA methodology.

Our specific concern with this draft MPA proposal is with an issue that was not addressed by the draft recommendation. Our concern is the role that continues to be played by the Total Cost of Care (TCOC) benchmarks in in the MPA methodology. As we have noted in a variety of forums, the Medicare TCOC benchmarks have serious shortcomings. From a strategic standpoint, these benchmarks fail to establish equitable outcomes for the state's rural communities by imposing upon Maryland financial standards that reflects the poor financial performance of rural hospitals nationally. From a technical standpoint, the benchmarks fail to account for the type of adjustments routinely made in the Commission's usual methodologies in establishing financial standards, such as a direct wage adjustment. Furthermore, the benchmarks ignore the consistently poor health outcomes in the counties used to construct these standards. The HSCRC scales the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographic areas elsewhere in the nation. For hospitals which are expensive relative to their peers as established by this methodology, they bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to peers under this methodology bear proportionally less of the burden. To the degree that these benchmarks are erroneous, however, their use misallocates resources within the state in contradiction to the goals of the TCOC Model.

These issues require attention as the benchmarks continue to be used in other Commission methodologies as well. We believe it is urgent to address this issue, given the multiple methodologies in which the benchmarks have been used. We appreciate the opportunity to provide these comments, and we urge expedited consideration of this important issue. Please contact me if you have any questions.

Sincerely,

Steve Leonard, PhD, MBA, FACHE
President/CEO, TidalHealth

Luminis Health

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Annapolis, Md. 21401
LuminisHealth.org

December 28, 2022

Adam Kane, Esq., Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane and Ms. Wunderlich,

On behalf of Luminis Health, the purpose of this letter is to provide commentary in response to the Draft CY2023 Medicare Performance Adjustor (MPA) Policy presented at the December 14, 2022, Commission meeting.

Luminis Health supports refining the geographic attribution with a formulaic approach; however, we still have concerns with a strict geographic attribution. A strict attribution methodology does not accurately capture hospital-specific initiatives to improve population health. The CTI buyout mitigated the shift to a geographic attribution from a physician-based methodology; however, CMS only approved the buyout for CY2021. Luminis requests that the HSCRC share CTI results with the industry as soon as it is available and evaluate any overlap with other Commission policies.

Luminis supports eliminating the Maryland Primary Care Program (MDPCP) supplemental adjustment. Including the downside risk in MDPCP Track 3 beginning in CY2023 addresses any unfavorable performance by participating practices; therefore, the continuation of the MDCPC supplemental adjustment would be duplicative.

The draft staff recommendation includes a provision incorporating population health quality measures into the CY2023 MPA policy, pending approval by CMS and the Commission. Luminis requests that population health quality measures be removed and that the CY2023 MPA policy be revisited once the population health quality measures are approved. This will ensure that the policy can be evaluated based on final measures.

Thank you for the opportunity to provide commentary on the draft CY2023 MPA policy. If you have any questions, please do not hesitate to contact me.

Sincerely,

Kevin Smith
Chief Financial Officer
Luminis Health

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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CENTER FOR MEDICARE AND MEDICAID INNOVATION

January 18, 2023

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

RE: Medicare Performance Adjustment Proposal for PY2023

The purpose of this letter is to inform the Health Services Cost Review Commission (HSCRC) and the State of Maryland that the HSCRC's Medicare Performance Adjustment (MPA) Proposal for Performance Year (PY) 2023 submitted to the Centers for Medicare & Medicaid Services on December 19, 2022 has been approved. CMS finds the MPA Proposal satisfies all requirements in accordance with Section 8.c of the Maryland Total Cost of Care Model State Agreement and has provided additional feedback below.

In reference to the Savings Component section of the MPA Proposal, the State is requesting to implement a savings reduction of $64 million across all regulated hospitals for CY2023 using the MPA to make up for a portion of the anticipated CY 2022 Medicare savings shortfall, effective February 1, 2023. CMS has reviewed this request and approves the proposed savings reduction of $64 million; however, CMS does not have sufficient time to implement the updates effective February 1, 2023. As a result, CMS will implement the Savings Component MPA updates effective March 1, 2023. **CMS requests that the HSCRC provide an updated MPA adjustment file by February 1, 2023 to reflect the new effective date of March 1, 2023.**

Additionally, it is CMS's understanding, based on the supplemental materials included with the MPA proposal, that the State is requesting to eliminate the MDPCP Supplemental Adjustment. CMS approves this request as the MDPCP Supplemental Adjustment was expected to continue until MDPCP incorporated downside risk, which was accomplished with the implementation of Track 3 on January 1,2023.

As stated in the MPA PY 2022 CMS response letter issued October 10,2021, CMS expects the State to increase the revenue at risk (± 1%) under the traditional MPA in 2024. CMS appreciates HSCRC's continued effort to improve quality of care using the MPA as a tool to incentivize continued improvement, and approve the modest increases to maximum revenue at risk in PY 2023 to allow quality measures to have a greater impact. However, CMS believes that increased financial risk tied to quality measures is key to driving improvement, and we strongly encourage Maryland to consider further increasing the level of risk associated with quality programs in PY 2024. Additionally, we look forward to the inclusion of population health measures as a component of the MPA in PY 2024. CMS will heavily weigh a further increase of the maximum revenue at risk and the inclusion of population health measures when considering the MPA Proposal for 2024.

Sincerely,

Tequila Terry
Director, State Population Health Group
Center for Medicare and Medicaid Innovation

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Director
Revenue & Regulation Compliance

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: February 8, 2023

RE: Hearing and Meeting Schedule

March 8, 2023 To be determined - HSCRC Offices/GoTo Webinar

April 12, 2023 To be determined - HSCRC Offices/GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.