Maryland
Hospital Association

October 18, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson:

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we appreciate the opportunity to comment on the proposed Medicare Performance Adjustment (MPA) and Care Transformation Initiative (CTI) changes—to raise the MPA risk reward from 1% to 2%, and limit downside CTI risk to 3%.

Support Mitigating MPA Risk If Combined with CTI Buy Out

As a condition of a per capita hospital payment system and under the contract agreement, a mechanism must be in place to measure Total Cost of Care Model (TCOC) performance with appropriate financial incentives. However, since the MPA was effectuated, hospital TCOC performance has been layered into additional HSCRC payment policies, including Care Transformation Initiatives (CTI) and the efficiency policy.

We support the HSCRC proposal to mitigate MPA risk by the same amount the hospital is at risk for under the CTI policy. HSCRC should further consider the MPA-like impact of the Medicare TCOC measure in the efficiency policy. For example, HSCRC could compare the efficiency rankings with and without the MPA TCOC. If a hospital's position is negatively impacted, then this level of risk should not overlap with MPA.

Hospital acceptance of HSCRC's proposal to boost the MPA risk and reward to 2% is contingent on implementing the CTI buy-out. This ensures the combined risks from different policies do not place an undue burden on hospitals, which are already navigating a complex landscape of changing payment models and care delivery transformation.

Payment policies are most effective when hospitals can affect the outcome. We remain concerned that strict geographic attribution does not capture hospital initiatives to transform care delivery. Under this approach, hospitals have limited opportunity to impact their attributed beneficiaries through treatment relationships, such as the Maryland Primary Care Program (MDPCP), Episode Quality Improvement Program (EQIP) affiliated providers, or hospital care transformation activities. HSCRC should review the attribution method as both risk and rewards increase.

Support Limiting CTI Downside Risk with Additional Cap Analysis

MHA supports limiting the downside risk under CTI. This approach aligns with establishing a maximum risk threshold for hospital quality payment programs. Rate year 2024 is the first year where financial adjustments were implemented, and HSCRC staff acknowledge it is difficult to predict results because of the lack of claims run out needed to measure performance.

While MHA supports capping downside risk, we ask HSCRC to evaluate the 3% cap, including potential formulaic alternatives to set the threshold. It is imperative to understand the methodology behind this percentage. At 3%, the cap only limits risk to one or two hospitals. As outlined below, a larger quantitative risk assessment of all policies is needed.

Measuring performance during 2022, including the COVID-19 surge, raises concerns. Assessing the CTI risk cap should include a thorough examination of how the unprecedented circumstances during COVID might have impacted the results and understand the consequent implications for future performance years. Given the profound disruptions faced during this period, it is crucial to ask whether the proposed risk cap is appropriate in the post-pandemic landscape.

MHA believes in the merit of a risk ceiling but stresses the need to assess all relevant factors when establishing the limit.

Quantify Financial Risk in All Policies

MHA respectfully requests that HSCRC quantify the risk and reward of all value-based payment policies, or those that adjust, or potentially adjust, a hospital's all-payer rates or Medicare payments, based on total cost of care performance.

- What is the maximum amount of risk/reward and what is the average realized risk/reward in each policy?
- Where applicable, calculate how certain policies overlap or conflict, and whether these interactions compound the overall effect.

As Maryland's TCOC Model has evolved, hospitals must navigate a variety of payment incentives—all designed to enhance the precision of rate setting or improve the accuracy of performance. Understanding the budgetary impact of each policy and the combined impact of all policies is required, particularly before new policies are applied.

We appreciate your attention to this matter and are happy to discuss our recommendations. Please contact me with any questions.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

Cc: Jon Kromm, Executive Director
Allan Pack, Principal Deputy Director

Adventist HealthCare

October 18, 2023

Mr. William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson,

Adventist Healthcare appreciates the opportunity to provide comment on the proposed changes to the Medicare Performance Adjustment (MPA) and Care Transformation Initiative (CTI) policies. We appreciate HSCRC Staff's efforts to date on these complex policies and look forward to collaborating with Staff on refinements.

AHC supports focusing risk on populations with whom hospitals have a treatment relationship with.

Adventist HealthCare is aligned with HSCRC and CMS' desires to reduce Total Cost of Care (TCOC) but we are concerned about raising the revenue at risk on MPA to 2% considering limitations on the ability to influence our attributed population. For our three hospitals, Adventist HealthCare interfaces with only 14% of the total attributed lives through MPA, either through our robust Care Transformation Organization or treatment relationships through our hospitals. Adventist HealthCare supports the proposed CTI buy out that recognizes hospital's ability to have more impact on patients in treatment relationships.

However, Adventist HealthCare has significant concerns with the nascent CTI payment policy and recommends further study and refinement which is detailed out in the attached detailed assessment of the CTI programs submitted to Executive Director Katie Wunderlich in June of 2023.

Adventist HealthCare appreciates Staff's stop-loss modification to the policy as it addresses one of our top concerns with CTI however, we would recommend that a comprehensive policy risk assessment be considered in setting the CTI loss cap.

Maryland hospitals participate in at-risk revenue arrangements across multiple HSCRC payment policies. Adventist HealthCare recommends a standard risk framework to assess comprehensive risk across all these policies when contemplating new risk thresholds. Additionally, comprehensive risk under GBR should be benchmarked to comparative risk under IPPS/OPPS reimbursement methodologies as incremental risk in Maryland is a core tenant of the Model. However, comprehensive

risk should be explicitly reviewed to ensure that hospitals are not taking on too much risk too fast and jeopardizing sustainable financial operations.

Given the risk portfolio already in place for Maryland hospitals, Adventist supports a CTI downside risk less than 3%.

Given the challenges of the Year 1 CTI payment policy as documented in Adventist HealthCare's enclosed CTI comment letter, Adventist HealthCare does not think it is appropriate to solely use the Year 1 policy results in setting the stop-loss risk. Specifically, there were unique challenges due to the COVID global pandemic for the measurement period used to set the recommended 3%.

In the absence of a standard methodology to assign risk across policies, risk could be set at a lower threshold, such as 1% and incrementally increased as the CTI payment policy matures, and a standard risk framework is established. Adventist HealthCare appreciates that CMS will require equal and offsetting risk under CTI to accept a CTI buy-out provision in conjunction with MPA and supports the minimum CTI risk necessary to secure a buy-out provision as the CTI policy is refined and matures.

Conclusion

Adventist Healthcare appreciates the significant efforts to date on these policies and understands the importance within the Maryland Model policy framework. Adventist Healthcare appreciates the opportunity to collaborate with HSCRC staff and would welcome a meeting to discuss further.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Vice President, Reimbursement and Strategic Analytics
Adventist HealthCare

cc: Jon Kromm, Executive Director
Allan Pack, Principal Deputy Director

Enclosures: Adventist Health Care 6/21/23 CTI comment letter

October 24, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTIs). JHHS's comments are outlined below.

1. Given the challenge of timeliness of data due to claims run out, JHHS agrees that it is difficult for hospitals to predict or adjust performance based on data. JHHS supports the recommendation to limit downside risk. A maximum liability threshold will support the longer-term stability of the program.
2. Under the current policy, hospitals with sizable Medicare revenues must generate significant numbers of episodes in their CTIs in order to hit the minimum savings rate and, therefore, perform well in the program. Further, any CTI savings are offset by a statewide MPA cut, which is also calculated based on a hospital's share of statewide Medicare revenue. The linkage of these policies to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital.
3. JHHS encourages the HSCRC to apply learnings from evaluation of the first year of the program, and consider narrowing the thematic areas of the program and/or revise selection criteria to assist hospitals with program planning and guidance on future investments in population health.
4. Given the overlap with other policies, JHHS recommends that the HSCRC conduct an analysis to determine if payments are duplicated by the CTI process with other pay for performance programs.
5. A hospital's ability to influence the MPA remains unseen at this time. Therefore, JHHS believes the MPA risk should not be increased until there is further data and clarity on this issue.

JHHS appreciates the HSCRC's consideration of the above comments related to the MPA and CTIs, and looks forward to continued participation and collaboration on these programs.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management & Reimbursement
Johns Hopkins Health System

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

Comments submitted by UMMS 10/23:

Overall, UMMS supports the establishment of a consistent and stable MPA that accurately reflects TCOC changes/improvements on a macro level and which is compatible with other policies (CTIs, ECIP, EQIP, etc.). On specific points for PY24

- The industry has invested a significant amount of effort into attribution in recent years, and we concur that a geographical approach is the most suitable framework to align with theory of change for a population health model.
    - Given a geographic model, UMMS strongly requests the HSCRC make full population CCLF claims available for attributed populations and/or provides access to Milliman ACO Insights as demoed. The hMetrix tool proposed requires too much development internally and we should leverage the industry expertise of Milliman.
- The HSCRC should evaluate benchmarking and targets for MPA to ensure certain geographies and populations are not disadvantaged/advantaged by using a risk adjustment + national trend model (recognizing that targets are individual to each hospital/pop)
    - Comparable models, such as CMS' MSSP, incorporate more MSA matching/regional methodology to compare growth rates, ensuring alignment with Maryland's evolving experience as well as the nation's. As we continue to develop a population model and our populations should match.
    - Adjusting trend to benchmark/track to more distinct geographic/population areas nationally, or evaluating a true-up
    - Exploring re-basing for differential COVID experiences

- **Medicare Performance Adjustment (MPA) Risk Cap Increase:** The proposed 2% cap necessitates an achievement of a TCOC savings rate 6% better than the national average to maximize value, or 6% worse to incur the full penalty. Given the minimum savings requirements of other programs (CTIs for instance) and the scale of the MPA population, this TCOC savings rate appears exceptionally high. While we support revenue at risk for TCOC change, does this increase effectively allow us to be rewarded/[penalized for changes on a population of this scale?
    - An example of scale:
        - St. Joseph's Medical Center was attributed 23,600 beneficiaries in MPA Y5 Performance. Under the proposed cap increase, SJMC would have to average a 6% savings rate across this population in order to maximize reward.
        - Conversely, St. Joseph's Medical Center participated in PY1 of the CTI program where Minimum Savings Rates (MSRs) are scaled more appropriately:
            - A transitional care program with 1,165 episodes required a 2% savings rate
            - A primary care program with 11,000 episodes required a 1.5% savings rate
- The Population health adjustment and calculation method require further scrutiny from the industry, **specifically medical economics and TCOC experts**. Modeling and impact analyses have not been available to date.

- **Care Transformation Initiative (CTI) Buyout and Risk Cap:** UMMS supports a CTI buyout and a CTI risk cap:
    - We maintain that the buyout approach is the most appropriate course of action. We agree with the Commission that CTIs are more tailored to our specific efforts to enhance population health, rather than being primarily macro-focused to demonstrate results within the broader context.
    - Regarding the CTI Risk Cap, UMMS is in support of capping the risk of this policy to protect from unpredictable and larger-than-expected penalties. However, we need to know more about the calculations involved as this proposed methodology was not thoroughly explained in the 9/27 Workgroup.
        - Our assumptions given context-clues in the 9/27 workgroup is that the 3% cap would be applied to the statewide value for Medicare Revenue (in CTP reports this variable is called "MPA $'s").
            - Given this assumption, in PY1 this 3% cap would be applied to $4,539,791,422, equating to a Statewide Offset cap of $136,193,742 (~$10m higher than the experience PY1 Statewide Offset)