Maryland
Hospital Association

November 5, 2020

Adam Kane
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of Maryland's 61 member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed revisions to its Medicare Performance Adjustment (MPA) policy.

MHA respectfully recommends the following positions:

- **Maintain the hierarchical attribution rather than geographical**
- **Adopt the proposed target of national growth less 0.5%**
- **Forgo hospital-specific growth targets based on the benchmarking performance, at least until the following year**
- **Adopt proposed 2019 base period**
- **Retain existing scaling of rewards and penalties**
- **Adopt proposed Care Transformation Initiative (CTI) adjustments to the MPA**
- **Reject proposed Maryland Primary Care Program (MDPCP) supplemental adjustment**

Maintain the hierarchical attribution.
MHA recommends HSCRC continue using the hierarchical attribution to preserve direct clinical linkage to hospital accountability. Last year, we asked HSCRC staff to review the attribution methodology due to concerns over its stability. Following its review, HSCRC concluded a geographical attribution is no better or worse, statistically, than the hierarchical attribution, albeit simpler to administer.

While we appreciate a simpler approach, moving to a geographic attribution removes clinical links among patients, physicians, and hospitals. There is no one right way to attribute lives in this model. We are searching for the optimal way. Following extensive discussion with hospitals across the state, there is consensus that maintaining clinical linkage is more important that gaining a slightly greater degree of stability. In future, perhaps other refinements may be discovered that will more closely mirror the actual clinical ties between patients/beneficiaries and hospitals and their affiliated providers.

Adopt national growth less 0.5% as the targeted growth rate.
MHA supports the proposed target of national growth less 0.5%. This is a slight increase from the target in the first two years of national growth less 0.33%. Provided the scaling is retained, this

increase is reasonable. We also thank the staff for removing the earlier proposal of setting a future growth rate target in the MPA. We look forward to working with HSCRC to address this important matter.

Forgo hospital-specific growth targets using the benchmarking methodology, at least until CY2021.
We appreciate HSCRC staff's proposal to differentiate hospital growth targets using absolute performance versus a national peer group. Hospitals support an attainment measure. However, MHA recommends that HSCRC wait at least a year to adopt the measure to allow hospitals to review, understand, and validate HSCRC benchmarking methodology for this purpose.

We appreciate HSCRC staff's detailed work to introduce the benchmarking methodology. Hospitals have not had time to assess the methodology. The proposal would reallocate funding around the targeted growth rate, and it therefore should be revenue neutral. When policy results are revenue neutral, and thus not impactful to payers, we respectfully ask HSCRC to defer to the field's position.

Adopt the proposal to fix the base period as 2019.
MHA supports HSCRC's proposal to use 2019 as the fixed base period, updated by national growth. This proposal improves stability in the measure and allows hospitals showing strong performance in any year to retain that savings to apply in a future period.

Retain the existing scaling of rewards and penalties.
MHA supports maintaining the existing scaling of rewards and penalties, including the limit of 1% of Medicare revenue at risk (plus or minus).

Adopt the proposed CTI adjustments to the MPA.
MHA supports the proposed adjustments that will mitigate unfavorable MPA results by participating in care transformation initiatives (CTI). HSCRC allows hospitals to focus on their own efforts to reduce total cost of care through CTI participation. The proposal creates another incentive to grow CTI participation and helps mitigate the financial impact of any instability in the MPA adjustment.

Reject the proposed Maryland Primary Care Program (MDPCP) supplemental adjustment.
We ask the commission to reject the proposed MDPCP supplement adjustment that places hospitals at risk for care management fees (CMF). There are multiple reasons:

- The added risk double counts risks against the hospital borne in GBR, MPA, and other policies.
- Care Transformation Organizations (CTOs) must perform specified services not done by hospitals in the normal course and that are too expensive for one practice to supply on their own (e.g., pharmacist and nutrition counseling, referrals to social services, community health workers). Care management fees do not cover the full expense of these services.
- Hospitals' global budgets cannot cover every non-billable activity. HSCRC's MPA, efficiency and rate corridor policies already evaluate and limit GBR savings that can be repurposed for interventions outside the hospital.
- Hospitals are reaching out to small, independent practices that otherwise would not be engaged in the Model. This is a key point for Model alignment. Hospitals will be less

likely to invest in scalable programs like MDPCP with a timeline that is too short to determine success.

- The proposed policy lacks sufficient risk adjustment needed account for socioeconomic differences or dual-eligible populations.
- CTOs that not aligned with hospitals face no risk of any kind for health care costs, yet they receive same care management fees that hospital-affiliated CTOs do.
- MDPCP practices unaligned with CTOs get to keep all their CMF dollars even if they drive up health care costs.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

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