Maryland
Hospital Association

February 23, 2023

James Elliott, M.D.
Commissioner, Health Services Cost Review Commission
Chair, HSCRC Physician Engagement & Alignment Work Group
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Elliott:

On behalf of Maryland's 60 hospitals and health systems, we appreciate the opportunity to provide input on physician engagement and alignment as the state plans for progression of the Total Cost of Care Model (Model) beyond 2026. Partnerships among hospitals, health systems, community providers, and partners are integral to improve health outcomes for patients in the most appropriate care settings at lower costs.

During the Feb. 2 Physician Engagement & Alignment Work Group meeting, stakeholders discussed opportunities to enhance two care redesign programs (CRP): the Episodes of Quality Improvement Program (EQIP) and Maryland Primary Care Program (MDPCP). MHA agrees with suggestions raised during the meeting, including enhancing the ability of specialists to participate in bundled payments through additional waivers and flexibilities. For both programs, MHA supports continued alignment across payers and the ability to choose clinical quality metrics from a pool of options.

Health systems and providers have experienced data challenges with EQIP that significantly impact physician engagement. During the first performance year, performance data was not available to providers until late October. The lack of timely data has unfortunately reduced provider interest in continued program participation. MHA recommends exploring opportunities with the state and Centers for Medicare & Medicaid Services (CMS) to improve timely data release.

MHA offers potential modifications to EQIP episodes:

1. Explore longer episode lengths for chronic and preventive episodes. Episodes that focus on chronic conditions may benefit from multi-year episode periods, which present the opportunity to prevent high-cost procedures over time and realize the long-term effects of innovative interventions.
2. Explore methods to control for supply and drug costs for certain episodes. For some episodes, such as oncology, drug and supply costs may determine up to 40% of episode

costs, limiting the ability to control total cost of care. The ability to control for such costs should be considered as the program develops.

We support the Maryland Department of Health's (MDH) plans to request medication cost-sharing waivers through MDPCP. MHA recommends the state advocate for the following to enhance participation:

1. Maintain track two of the program, which is set to sunset in 2025. Track two provides an avenue for new practices to enter the program and build infrastructure to achieve advanced primary care before subjecting them to substantial downside risk.
2. Recognize the importance of care transformation organizations (CTOs) as the program evolves. As of 2021, 24 CTOs participated in the program, with 78% of practices electing to receive CTO support to meet program care transformation requirements.[1]
3. Request for CMS to provide monthly claims files instead of quarterly. This would allow for more real-time data analysis, leading to better physician engagement.
4. Continue to expand acceptable uses for Health Equity Advancement Resource and Transformation (HEART) payments. The innovative payment has received national attention and is critical to the state and the Center for Medicare & Medicaid Innovation's (CMMI) health equity focus.

Work Group members also discussed the need for more state support to administer and expand CRPs. MHA recommends exploring contract revisions to address the issue. Current language identifies the state as responsible for CRP administration. It further lists the Health Services Cost Review Commission (HSCRC) as the responsible agency for submitting CRP track proposals and amendments. More flexibility may be required to enable state contracted entities to administer CRPs. Such an alternative could benefit the programs by bringing in dedicated subject matter experts familiar with implementing care transformation programs and value-based arrangements.

The Episodes of Care Improvement Program (ECIP) is a CRP that garners participation from post-acute providers. The HSCRC Post-Acute and Long-Term Care Work Group is assessing opportunities to enhance hospital and post-acute partnerships. Any forthcoming recommendations should be evaluated to inform potential enhancements to ECIP.

The Statewide Integrated Health Improvement Strategy (SIHIS) sets targets for the Care Transformation Initiative (CTI) program and CRP participation. As reported at the Feb. 21 Consumer Engagement Work Group meeting, Maryland is not meeting these goals. Yet, data has not been shared, and commissioners have not discussed the targets. In February, HSCRC staff reported final CTI performance will not be available until April. HSCRC should work with the state and stakeholders to understand performance drivers and whether revisions to SIHIS goals should be considered.

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[1] 2021 Maryland Primary Care Program Report, *Maryland Department of Health,* health.maryland.gov/mdpcp/Documents/2021%20Annual%20Report.pdf.

Finally, we recommend reassessing how quality provider (QP) threshold scores are calculated for Maryland providers enrolled in CRPs. The continued ability to receive incentive payments will only enhance physician engagement in these programs. Under federal MACRA law, qualifying QPs will receive a 3.5% alternative payment model (APM) incentive bonus for performance year 2023.[2] For performance years 2024 and beyond, QPs will receive an increased physician fee schedule update based on the QP conversion factor. Previously, threshold scores in Maryland were based on the provider's percentage of payments through an advanced APM, or through the percentage of patients through an advanced APM. Since CMS designated the state as an APM under the Model, the QP determination should be modified so providers who receive 50% of their patients from Maryland Medicare beneficiaries or have 35% of Maryland Medicare patients are determined QPs.

The numerator of the QP threshold score is based on a clinician's linkage to the hospital based on Medicare Performance Adjustment (MPA) attribution and whether a beneficiary had an encounter at the hospital.[3] Since the MPA attribution methodology changed in 2023, HSCRC should evaluate whether the calculation needs to be changed.

Thank you for the opportunity to comment on opportunities to enhance physician engagement and alignment as the Model advances beyond 2026. We look forward to discussing our recommendations in future work group meetings and forums.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: William Henderson, HSCRC

[2] Advanced Alternative Payment Models, *Centers for Medicare & Medicaid Services*, qpp.cms.gov/apms/advanced-apms.
[3] July 25, 2018 Total Cost of Care Work Group PowerPoint Presentation, *Health Services Cost Review Commission.*