Maryland
Hospital Association

April 14, 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 the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to provide additional feedback on physician engagement and alignment to inform the state's progression planning for the Total Cost of Care Model (Model) beyond 2026.

We maintain the recommendations in our Feb. 23 comment letter (attached). Since then, the Maryland Primary Care Program (MDPCP) Advisory Group shared future priorities, Health Services Cost Review Commission (HSCRC) staff released a draft work group report, and members presented ideas for new care redesign tracks. Today, we offer recommendations on these items.

Maryland Primary Care Program (MDPCP) Future Priorities
MHA is part of the Maryland Health Care Commission (MHCC) MDPCP Advisory Committee. MHCC requested feedback on future MDPCP priorities following the March 28 meeting. Our recommendations are attached.

Draft Work Group Report

- Priorities for Model Negotiation with the Centers for Medicare and Medicaid Services (CMS)

Additional recommendations:

1. As proposed for the Episode Quality Improvement Program (EQIP), MDPCP practices should be eligible to create a pooled entity, which would enable risk sharing among smaller practices.
2. As the state identifies new areas of opportunity to engage physician partners, it should be able to acquire additional fraud and abuse waivers as it currently does for new care redesign tracks.

- Priorities for State Model Leadership

Additional Recommendations:

1. The work group discussed flexibility to engage physicians that cannot participate in episodic based models, such as anesthesiologists. This recommendation should be added to the work group report.
2. The state should work to ease administrative burden, where possible, such as alignment on quality metrics among payers and programs.

Newly Proposed Care Redesign Tracks

- Global Budget Concept for Emergency Physicians in Maryland

MHA supports including emergency physicians as part of the Global Budget Revenue (GBR) 2.0 model HSCRC's Total Cost of Care Work Group is discussing. MHA supports this model, which allows voluntary hospital and provider participation. We support expanding this model to payers beyond Medicare in future years. MHA is awaiting draft contract language from HSCRC staff before offering additional recommendations.

We support emergency physicians' participation in the GBR 2.0 framework, yet we offer these considerations that will influence program design and implementation:

1. Hospital-based physicians receive professional payments on a fee-for-service basis. Movement to a GBR model will require new funding to pay for these services. MHA believes hospitals and providers would share accountability for certain outcomes and savings.
2. Many emergency room physician payment arrangements include an income guarantee to manage volume fluctuations. It is unclear how the payment structure is different from GBR structure if income is guaranteed and would incentivize physicians differently.
3. Many hospitals contract physicians to staff their emergency departments (EDs). These contracted employees often work for national staffing agencies. The program should be designed so it does not disincentivize staffing agencies from entering contracts with Maryland hospitals, and thus, exaggerating ED staffing issues.
4. Avoidable ED utilization is a suggested quality measure. Many factors influence avoidable utilization and are not entirely within the hospital or physician's control. MHA suggests focusing on measures care partners can reasonably influence.

- Additional Models

MHA agrees opportunities to include additional provider types not already included in state care redesign programs should be explored. Suggestions to engage hospital-based physicians,

create a critical primary care program, and a value-based drug cost program were presented at the March 30 and April 13 work group meetings. Unfortunately, details regarding the concept design remain largely unknown, and MHA does not have enough information to opine on these suggestions. We request to join the ad-hoc work group to discuss provider integration in a GBR model.

- Behavioral Health

CareFirst is launching a new behavioral health medical specialty home. It is our understanding the program would apply to CareFirst beneficiaries. MHA recommends maintaining flexibility within our future contract to pilot and expand successful programs to additional payers.

We appreciate the opportunity to comment on additional work group member proposals and the draft work group report. If you have any questions about the recommendations outlined in our letter, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: William Henderson, HSCRC

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.*

MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Maryland Primary Care Program (MDPCP) Advisory Council

Priorities for the Future of the MDPCP Maryland Hospital Association Recommendations

Instructions

This document provides a list of draft top priorities and potential modifications for the future of the MDPCP. *Please add your feedback related to Considerations, Recommendations, and Comments for each category directly within the table. The completed table should be submitted via email to the* MDPCP Program Management Office (PMO) at mdh.pcmodel@maryland.gov *by* ***Friday April 7th***. Council feedback will inform the MDPCP PMO's recommendations to the Health Services Cost Review Commission for the Progression Plan.

CATEGORY	ELEMENT
1. SPENDING LEVEL/ INVESTMENT	• Enhanced primary care investment sufficient to address medical, behavioral, and social needs of patients (include additional health equity dollars) that ensures sustainability ○ ***Considerations***: Currently, funds can only be used for a Health Equity Advancement Resource and Transformation (HEART) designated beneficiary. This does not align with methods practices use to identify patients with needs. Patients are not differentiated by insurer or payment type. ○ ***Recommendations***: MHA supports expanded uses of HEART payments.

CATEGORY	ELEMENT
	○ ***Comments***: Investments in primary care to address medical, behavioral, and social needs of patients aligns with the Centers for Medicare & Medicaid Innovation's (CMMI) focus on health equity and Maryland Hospital Association (MHA) priorities. It is unclear how the investment level would differ from the current program design and MHA requests more detailed information before opining on this matter.
2. PAYMENTS	• Hybrid model of payment = FFS + Simplified, unified population-based payment to fully support comprehensive, team-based primary care with flexibility on payment uses ○ Provide practices the financial resources to address social needs, either through a specific equity-focused funding stream or within a unified MDPCP payment ○ ***Considerations***: ○ ***Recommendations***: MHA supports consolidation of payments, where possible, to reduce the administrative burden on practices. Payment flexibility will better allow providers to address social needs to improve outcomes for patients. It is also important to add some type of accountability for the payments intended to mitigate the non-medical barriers to better health. As part of quality metrics, the program should assess practices' progress towards equitable outcomes. ○ ***Comments***:
3. FINANCIAL RISK	• Not requiring downside risk on the core primary care payments that fund operations and the basics of advanced primary care (health equity/BHI/care management) • Limited level of risk on some of the additional MDPCP payments (e.g., after certain level of investment is achieved)/At-risk performance incentive payment • Risk should be shared by larger entities or pooled across the State/ region/ Care Transformation Organizations (CTOs) • Risk should be voluntary and/or voluntary for smaller practices

CATEGORY	ELEMENT
	○ ***Considerations***: Introducing downside risk was a key component in negotiating continuation of the program with the CMMI. Suggesting a different method of sharing risk among practices may be more feasible, as recommended below. ○ ***Recommendations***: MHA supports the modified approach discussed at the last Advisory Council meeting, which would propose pooling of risk among practices. ○ ***Comments***:
4. PAYER ALIGNMENT	• Multi-payer alignment on payments, quality measures and data to reduce administrative burden and make care more efficient ○ ***Considerations***: ○ ***Recommendations***: MHA supports payer alignment, which will garner more participation in the program, reduce reporting burden on practices, and facilitate better outcomes. ○ ***Comments***:

CATEGORY	ELEMENT
5. PARTICIPATION AND ELIGIBILITY	• Maintain entry level Track 1 for initial starters and Track 2 • Allow for additional application periods for new practices to join with more flexible requirements on attribution and specialty eligibility. ○ ***Considerations***: A Statewide Integrated Health Improvement Strategy (SIHIS) goal is to increase the number of providers participating in advanced payment models. MDPCP is one of three avenues to meet this goal. 45% of practices in the state are enrolled in MDPCP, indicating more room for opportunity. 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. ○ ***Recommendations***: Maintain track two of the program, which is set to sunset in 2025. MHA also recommends maintaining open enrollment to allow new practices to join. ○ ***Comments***:

CATEGORY	ELEMENT
6. PERFORMANCE MEASUREMENT	• Responsibility for core set of clinical quality measures and utilization, with limited weight on Total Cost of Care measure • Simple, easily captured, meaningful performance data on measures that matter, with sufficient financial incentives adjusted for health equity o ***Considerations***: o ***Recommendations***: MHA supports the ability to choose clinical quality metrics from a pool of options and introducing an equity component. Assessing equity could include stratifying measures by demographic groups or requiring practices to assess performance on guidance concordant care by demographic groups. o ***Comments***:
7. POLICY AND STATE LEADERSHIP	• Additional shifting of policymaking and operations from CMMI to the State regarding quality measures, payment methodology, enrollment eligibility, operations, and data o ***Considerations***: o ***Recommendations***: MHA agrees that the state should have administrative authority to operate the program and set policies within the contract authority provided by CMMI. o ***Comments***:

CATEGORY	ELEMENT
8. CTOS	• CTOs participation with guardrails and modifications to enhance care transformation support, effectiveness, and accountability ○ ***Considerations***: Care Transformation Organizations (CTO) play an important role in ensuring program success, especially for smaller practices, who benefit from a shared pool of resources. As of 2021, 24 CTOs participated in the program, with 78% of practices electing to receive CTO support to meet program care transformation requirements. ○ ***Recommendations***: Continue CTO participation in the program. ○ ***Comments***: