Maryland
Hospital Association

September 6, 2018

Chris L. Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chris:

On behalf of Maryland's 63 hospital and health system members, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Medicare Performance Adjustment (MPA) policy.

The MPA policy is an important element of Maryland's efforts to manage and measure Medicare total cost of care (TCOC), a key metric of the Maryland TCOC model. The hospital field supports the intent and purpose of the MPA policy to begin to align physician – and other primary care provider – incentives with hospital incentives and to bring TCOC accountability to a hospital-specific level. The policy for year one was a step in the right direction. Adjustments to the year two policy will help Maryland's hospitals and the state recognize greater opportunities for success.

Our recommendations aim to harmonize the interaction between the attribution methodology and the arrangements hospitals already have in place with physicians. Because the physician's relationship with the beneficiary is key to managing health outcomes and cost, a hospital's connection to the physician is the most important mechanism to influence total cost of care.

Our recommendations are in three areas, summarized below. More details follow.

Leverage Existing Relationships to Improve Attribution: Expand the types of physician-hospital relationships that directly link hospitals to physician practices, to take maximum advantage of existing relationships and investments. Include physician employment, hospital-based Care Transformation Organizations (CTOs) under the Maryland Primary Care Program, and other relationships, such as Clinically Integrated Networks (CINs).

Add Risk Adjustment and Attainment: Include a robust risk adjustment and recognition of attainment of a target, not just improvement from current performance. A hospital's opportunity to reduce per capita TCOC is influenced by its population's characteristics, disease burden and baseline hospital use rates.

Opportunity to Review and Modify: Even with improvements to the attribution logic in year two, unintended results may occur. At the start of the performance period, allow hospitals a brief period to review and revise the linkage of physicians to hospitals before finalizing the beneficiary attribution. At the end of the performance period, analyze actual beneficiary utilization and physician referral patterns compared to anticipated trends. If the analysis reveals unexpected trends or results, the HSCRC could decide whether further action is needed. The year-end analysis would also inform future policy decisions.

Recommendation Details

Leverage Existing Relationships to Improve Attribution
Expand the ways providers can be directly linked to hospitals to include employment and participation in a hospital's CTO as part of the initial attribution stage. Clinically Integrated Networks are another way to directly link hospitals to the physicians they work with. Rename this stage "Direct Link."

In the first attribution stage, as is currently done with Accountable Care Organizations (ACOs), a hospital's or health system's entire complement of employed physicians should be linked to the hospital or system and beneficiaries attributed to the entire complement of employed physicians. In the Maryland Primary Care Program, enrollment in the program is at the practice level, not individual physician level. Therefore, the state will be able to attribute beneficiaries to the practices in hospital-based CTOs and link the entire practice to the hospital.

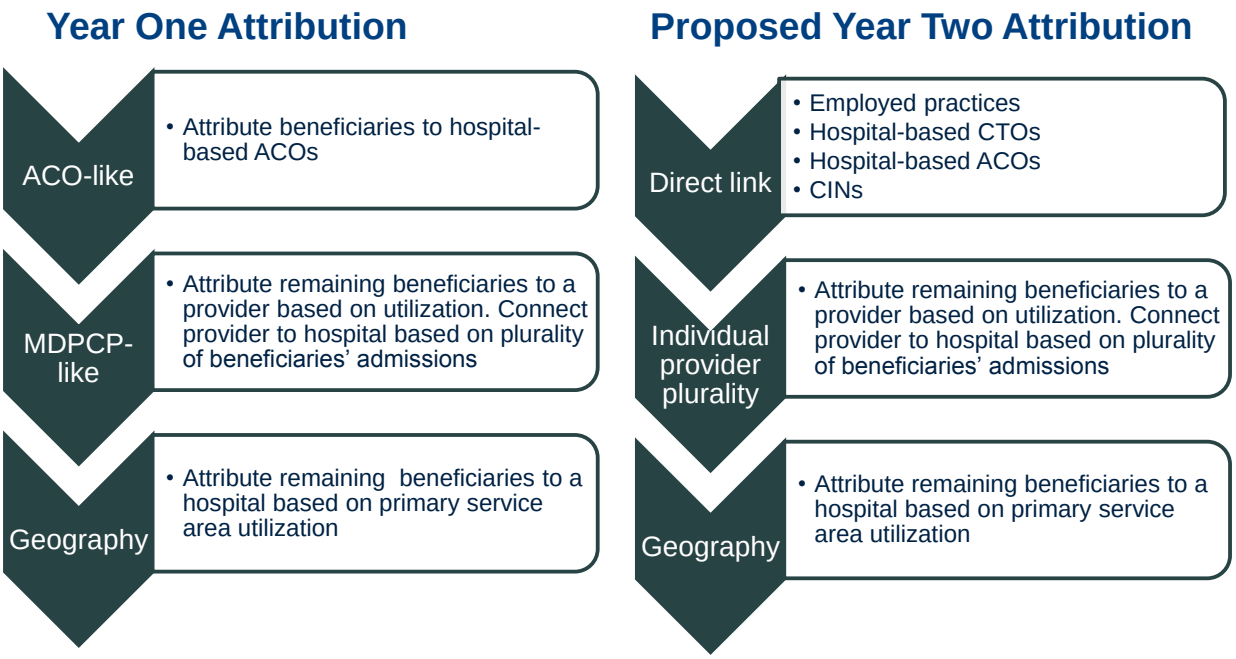
Physicians who are not linked to a hospital by employment, hospital-based CTO, or hospital-based ACO can be linked to a hospital through a hospital's CIN. However, because there is no clear way to identify which physicians are grouped together in practices, the linkage to the hospital and the attribution of beneficiaries will be by individual physician for those who are part of a CIN.

Physicians who participate in a formal arrangement with more than one hospital (e.g., a CTO and ACO) should be attributed in the order specified (employed, CTO, ACO, CIN). Individual adjustments to the physician linkages to improve alignment could be made as needed during the review period at the start of the performance period (details provided later in this letter).

A hospital may choose to provide a list of employed physicians to the HSCRC for linkage in this first stage. Employment should be defined as the eligible providers who will receive a W-2 from the hospital or its parent or subsidiary organization for the calendar year preceding the performance period with full time status. The hospital would also be required to attest that the reported providers worked full time. The HSCRC could address any concerns about the accuracy of this reporting through its annual Special Audit. If more than one hospital reports a provider as employed, the HSCRC could ask the involved hospitals to work out the discrepancy, and if the result is unsatisfactory, exclude the provider from linking to either hospital via employment.
In the second attribution stage, physicians and beneficiaries who have not been attributed would be eligible for attribution as they are under the year one policy. To avoid linking physicians to

more than one hospital, only physicians who have not been linked to a hospital in stage one would be eligible. Otherwise, there should be no changes to the methodology. In the year one policy, this stage is called MDPCP-like. Re-name this stage "Individual Provider Plurality" to highlight that attribution in this stage occurs based on beneficiary utilization of individual providers. Also, since attribution to CTOs would be included in stage one, it could be confusing to again reference MDPCP in the second stage.

The graphic below compares the year one attribution with our year two recommendations.



Add Risk Adjustment and Attainment

Robust risk adjustment and an attainment option are critical components currently absent from the MPA policy. Risk adjustment acknowledges the disparate and unique conditions of the various populations hospitals serve. The lack of an attainment target can result in unwarranted penalties for early high performers. Hospitals with a relatively low TCOC per beneficiary in the early years of the MPA policy will have more difficulty demonstrating continuous improvement compared to those that started with more opportunity to improve. While we recognize that HSCRC believes additional analyses to inform attainment benchmarks is needed, it is important to resolve this issue as soon as possible.

A robust risk adjustment method for the MPA would have the following characteristics:

- Recognition of individual patients' chronic conditions and demographic characteristics
- Ability of risk scores to change over time, reflecting the changing health status and demographics of a population

- A proven record as a reliable methodology

The full Hierarchical Condition Category (HCC) system used by the Centers for Medicare & Medicaid Services to risk adjust ACOs and Medicare Advantage is an example of a method that meets all the criteria. It or other methodologies should be implemented in year two.

Opportunity to Review and Modify
Although these recommendations seek to improve the attribution of providers and beneficiaries to hospitals, there will be instances where the methodology doesn't work as intended. It will be beneficial to allow hospitals to review and make modifications to the provider attribution at the start of each performance period. During this interval, HSCRC should make the modifications as requested, provided that the following conditions are met:

- A physician is added to the hospital's attribution to improve alignment. One example is adding a physician in a group practice where all other physicians in that practice are attributed to the hospital, so that the practice is consolidated at one hospital. Another is reassigning physicians who are in one hospital's ACO and a different hospital's CTO. A hospital would not be permitted to remove a physician simply based on an expectation of unfavorable performance.
- The hospital taking on the physician(s) and the hospital releasing the physician(s) agree that the change should be made.

We appreciate the opportunities HSCRC staff have provided to collaborate on the MPA methodology and policy implementation. We offer these recommendations in the same spirit of collaboration and respectfully ask HSCRC staff to address our comments in the staff recommendation. We look forward to continue working with you to test and improve the policy over the coming year.

Sincerely,

Traci La Valle
Vice President

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