August 17, 2022

Willem Daniel
Deputy Director, Payment Reform & Stakeholder Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Daniel,

Thank you for sharing the Health Services Cost Review Commission's plans to modify quality adjustments in the Medicare Performance Adjustment (MPA) policy. MHA encourages HSCRC to continue to process the proposed population health measure with the Payment Models and Performance Measures Work Group before linking it to financial incentives.

Our members also seek to better understand the quality measure weighting before taking a formal position and we ask HSCRC to review that at the next Total Cost of Care Work Group meeting and give participants the opportunity to provide feedback.

Below we offer several specific suggestions regarding the policy adjustments.

Explain the proposed weighting of the population health measure
Hospitals understand HSCRC is responding to the Centers for Medicare & Medicaid Services' (CMS) aims to measure hospital-specific accountability for quality and Statewide Integrated Health Improvement Strategy (SIHIS) performance. HSCRC calculations show the quality adjustment but do not show how staff weighted each measure: 2% for the Readmissions Reduction Improvement Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) Program and 4% for the population health measure.

Adjust the quality measures only after reviewing and aligning HSCRC policies
MHA accepts that, to satisfy CMS's expectations, there needs to be more hospital accountability for quality and population health performance. Our members and governing groups are, however, concerned that HSCRC would layer on additional policies and measures without first carefully reviewing all current policies and the interactions among them and any new policies. During the recent discussion on staff's proposed Revenue for Reform policy, MHA and commissioners agreed policies need to be better aligned.

Start reporting, monitor performance. and validate the measure before activating accountability
HSCRC staff said a hospital-level measure would be selected when the ad hoc Population Health Work Group convened. Then, you intend to measure performance in 2023 and adjust MPA rewards and penalties based on that year's performance. To implement a novel, untested measure so swiftly is out of step with longstanding HSCRC and CMS practices. Before imposing real consequences on the affected entities, regulators are expected to employ technical experts to assess the validity and reliability of measures and to judge whether there are unintended biases in measures. CMS and HSCRC have always monitored any new measure for a minimum of one year. None of these steps are in HSCRC's timeline. Rushing forward to reward and penalize hospitals without adequate testing risks making inappropriate adjustments to hospitals' global budgets.

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MHA supports HSCRC's intention to start with process measures hospitals can reasonably influence, like elevated HbA1c levels in people who are overweight and initiation of the Diabetes Prevention Program (DPP) in people who are eligible.

It is also important to carefully consider the denominator to which each hospital will be held accountable. The hospital field does not support holding a hospital accountable for screening or DPP enrollment across a geographic service area. Since much of this screening and referral happens in the ambulatory space, concerns about hospitals' overlapping service areas are magnified. Hospitals' affiliated practices may be far from the primary service area of the hospital. Similarly, with virtual DPP, a person may participate in a DPP program offered by a hospital well outside the primary service area of their closest hospital.

As noted during the Population Health Work Group meetings, there are important concerns about the preliminary measures. Incomplete data is available for screening of elevated HbA1c. Enrollment of individuals in DPP is problematic because not all hospitals bill for it. And, because not all hospitals received funding for diabetes programs through the regional partnership catalyst grants, some hospitals are better resourced to offer the service.

MHA welcomes the opportunity to address these concerns through our Performance Measurement and Payment Models work groups. HSCRC should not incorporate the measure into MPA without first receiving a recommendation from the work groups and at least one year of monitoring.

Thank you for the opportunity to comment and raise discussion topics for the Total Cost of Care Work Group regarding the MPA quality adjustment. We look forward to continued discussions to help implement the population health measure and gain a better understanding of the recommended weighting. If you have any questions regarding our suggestions, we welcome the opportunity to discuss.

Sincerely,

Traci LaValle

Senior Vice President, Quality and Health Improvement

CC: William Henderson, Principal Deputy Director, Medical Economics and Data Analytics
Geoff Dougherty, Deputy Director, Population Based Methodologies, Analytics and Modeling