Maryland
Hospital Association

May 22, 2020

Chris Peterson
Principal Deputy Director
Health Services Cost Reivew Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Peterson:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, we thank you for the opportunity to provide feedback on the Episode Quality Improvement Program (EQIP) Request for Information. MHA appreciates the need to create incentives for all providers to align with the goals of the Total Cost of Care Model and further the goals of care transformation. A key component of this alignment is increasing the opportunity for non-hospital providers to move away from fee-for-service models into value-based models. Hospitals recognize that creating more value-based opportunities for non-hospital providers is integral to the success of the Total Cost of Care Model. Developed and deployed with careful consideration, EQIP can achieve this aim.

At the same time, the unprecedented COVID-19 crisis and the impact of the pandemic on the state's health care system necessitate examination—within the context of EQIP and beyond. Our comments therefore fall into three broad categories: EQIP components, timing, and shifting focus due to the COVID-19 pandemic.

1. EQIP Components
We appreciate that the detailed, technical aspects of EQIP have yet to be fully vetted via the stakeholder process and will be deliberated over several months prior to program deployment. The components noted below are threshold considerations that merit immediate attention once the stakeholder process resumes.

Interaction with the Episode Care Improvement Program. New care transformation programs should be tightly aligned with the current hospital Care Redesign Programs, particularly the Episode Care Improvement Program (ECIP). Given the significant functional similarities between EQIP and ECIP, the build out of EQIP should consider the investments and infrastructure as a result of hospitals and health systems' participation in ECIP. Specifically, any bundle available to a non-hospital convener through EQIP should also be available to the hospitals through the ECIP program so that health system conveners can leverage existing infrastructure to engage in expanded value-based models, rather than duplicating efforts under

EQIP. Along the same lines, the savings attribution once inpatient episodes are part of EQIP in future years must also account for hospital and health system investments in value-based care.

Changes in Care Delivery. The proposed EQIP design contains considerable incentives to shift care between and outside of hospital-based settings. These incentives must be thoroughly examined and established in ways that both meet the goals of Total Cost of Care alignment across providers and create balanced, measured shifts in care delivery. For example, patient selection for bundles and risk adjustment of target prices must be designed to minimize cherry-picking for factors such as insurance status or patient acuity. In addition, the implications of the program's ability to shift care between hospitals must be addressed proactively in the development process. This is particularly important because during the COVID-19 crisis hospitals are making difficult decisions around when and how to resume elective procedures and will face uncertainties on this issue for several months.

2. Timing

MHA urges HSCRC to delay the start of EQIP beyond July 2021 to allow time for meaningful analysis of design components and uptake by providers. Hospitals, and other providers, are currently grappling with impacts of COVID-19—the clinical, operational, and financial effects of which will likely be long-lasting.

The pandemic has changed care patterns for all patients. It has also changed the ability to and way in which individuals access care. The health care system's experience with swings in patient acuity and volume must be factored into the foundation of EQIP as a new program—and particularly as calendar year 2020 is used as a baseline for any performance period. While volumes in hospitals are down, including in the emergency department, and ambulatory surgery centers have been shuttered, the acuity of patients admitted through the emergency department is increasing as individuals delay necessary care. MHA plans to analyze the full extent of this phenomenon; anecdotally hospitals are seeing increases in the volumes of patients with ailments from a ruptured appendix to severe heart attack.

Further, non-health system providers already feeling the pinch via lost revenues due to drops in elective procedures and ambulatory care volumes need time to recover. They will not be able to take on the risk contemplated in EQIP within the next year. Downside risk is a key feature of the program, which is important to keep intact to facilitate alignment with the Total Cost of Care Model. A delay in program launch will better position providers to take on risk and allow for adequate time and resources to address other complex considerations.

3. Shifting focus due to COVID-19 crisis

COVID-19 changed the way the health care system can care for patients for the foreseeable future. Hospital staff routinely able to focus on care transformation and population health have been redeployed to address the day-to-day challenges the pandemic poses. As the health care system navigates through this crisis and begins to operate in the "new normal," it is imperative

that stakeholders come together to address the weaknesses that have come to light during this crisis. HSCRC and hospitals should focus on measuring what is most meaningful for patient care within hospitals and across the continuum. To do this, current and potential HSCRC policies and Care Redesign Programs need to be examined for necessity and effectiveness. Performance measures should be modified, with new ones instituted to reflect the needs of patients during this pandemic. Such an evaluation of the current state of play and needed improvements will allow for a strong foundation from which to launch new programs.

Thank you for the opportunity to comment on the EQIP Request for Information. We appreciate HSCRC's consideration of our feedback. We look forward to the continued stakeholder process on the development of EQIP. Please do not hesitate to contact me should you have any questions.

Sincerely,

Maansi K. Raswant

Maansi K. Raswant
Vice President, Policy