

Final Recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2021

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Health Services Cost Review Commission
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PROPOSED COMMISSION ACTION

Staff will be asking the Commission to vote on the final MPA recommendation for RY 2021. The final recommendation remains largely unchanged compared to the draft, with the exception of specifying that Maryland Primary Care Program (MDPCP) care management fees will be excluded from the MPA assessment of total cost of care in the RY2021 policy.

FINAL RECOMMENDATIONS FOR RY 2021 MPA POLICY

- 1) Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
 - a) Use a hierarchy of Maryland Primary Care Program (MDPCP)-actual, Accountable Care Organization (ACO)-like, PCP-like, and Geographic attribution for beneficiary-to-provider attribution
 - b) Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital-affiliated ACOs, hospital employment, and provider referral patterns
 - c) Implement official algorithm result review period
- 2) Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of $\pm 3\%$.
- 3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019. In CY 2019, exclude MDPCP Care Management Fees and Performance-based Incentive Payments, but include Comprehensive Primary Care Payments for Track 2 practices.
- 4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
 - a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
 - b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
- 5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
- 6) Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, obtaining input through continued meetings of the TCOC Work Group.
- 7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
- 8) Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their

performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

INTRODUCTION

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA), with performance beginning in Calendar Year (CY) 2018. The MPA brings direct financial accountability to individual hospitals based on the total cost of care (TCOC) of Medicare fee-for-service (FFS) beneficiaries attributed to them.

MEDICARE PERFORMANCE ADJUSTMENT MECHANICS

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited in the second year, RY 2021, to a positive or negative adjustment of no more than 1.0%), the policy must determine the following: an algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals without double-counting; a methodology for assessing hospitals' TCOC performance based on the beneficiaries and TCOC attributed to them; and a methodology for determining a hospital's MPA based on its TCOC performance.

The HSCRC explored potential changes to the MPA based on extensive feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. This recommendation reflects valuable insights provided by the work group—which has held regular public meetings over the past two years—as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR), and other communications and meetings with stakeholders.

The key objective of the MPA for Year 2 is to further Maryland's progression toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A and B) over time — not only in terms of increased financial accountability, but also increased accountability for care, outcomes, and population health.

Total Cost of Care Attribution Algorithm

For Year 1 of the MPA, a multi-step prospective attribution method assigned beneficiaries and their costs to Maryland hospitals based primarily on beneficiaries' treatment relationship with a primary care provider (PCP) and that PCP's relationship to a hospital. Based on the Total Cost of Care Work Group's input and discussion, as well as initial Year 1 experience, HSCRC staff recommends keeping the main elements of the existing algorithm, but with some reorganization and a few key new elements. This recommendation focuses on explaining the new or changed components. The appendices provide additional detail.

General algorithm organization and provider-to-hospital consistency

In response to Maryland Hospital Association comments, staff has reorganized the structure of the algorithm for the RY 2021 policy to first attribute beneficiaries to providers and then link

providers with hospitals, rather than performing the steps simultaneously. This change ensures that each PCP with attributed beneficiaries will be linked with only one hospital, regardless of how a beneficiary is attributed to that PCP. These beneficiaries are attributed to providers based on their use of primary care services. Beneficiaries that cannot be attributed to a provider through MDPCP-actual, ACO-like or PCP-like are attributed directly to a hospital based on geography (that is, where the beneficiary resides). Providers with attributed beneficiaries are linked to hospitals based on existing provider-hospital relationships.

Beneficiary attribution algorithm changes

Addition of Maryland Primary Care Program (MDPCP)-actual beneficiary attribution.

With the launch of Maryland Primary Care Program (MDPCP) in January 2019, the TCOC Work Group generally supports alignment between the MPA and MDPCP to further align accountability, improve care, and strengthen physician engagement in controlling Medicare TCOC. To align to this important initiative, staff recommends that beneficiaries are first attributed to PCPs in MDPCP-actual. Beneficiaries' relationships with primary care providers are determined through their use of PCP services, as determined in the MDPCP. Beneficiaries not attributed under MDPCP-actual are then assessed for attribution under the ACO-like and, if necessary, PCP-like, and Geographic attribution based on the beneficiary's zip code of residence compared to each hospital's Primary Service Area-Plus (PSAP).

ACO-like beneficiary attribution. Staff recommends no change to the Accountable Care Organization (ACO)-like beneficiary attribution. Under ACO-like, beneficiaries are attributed based on primary care use of clinicians in a hospital-based ACO. Assignment is based on elements of CMS's ACO attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then use of certain specialists if a traditional PCP cannot be identified.

PCP-like beneficiary attribution. Staff recommends changing the name of the "MDPCP-like" portion of the algorithm to "PCP-like," but otherwise recommends no changes to this component. Beneficiaries not assigned to providers through the MDPCP-actual or ACO-like methods will then be considered for attribution to providers based on their use of PCP services, as approved in the Y1 MPA policy.

Geographic attribution. Staff recommends no changes to this component. Any beneficiaries not attributed through MDPCP-actual, ACO-like, or PCP-like components are attributed using the primary service areas listed in each hospital's global budget revenue agreement, and as well as additional zip codes not claimed in any hospital's primary service area (PSA) based on plurality of hospital utilization and drive time. This approach is also referred to as Medicare PSA-Plus or PSAP.

Provider-to-hospital relationships

Year 1 of the MPA included recognizing relationships between ACO providers and hospital-affiliated ACOs, as well as a provider's referral patterns. However, many hospitals expressed strong interest in the MPA accounting for additional relationships. For Year 2 of the MPA,

eligible provider-to-hospital relationships begin with MDPCP provider participation with a hospital-affiliated Care Transformation Organization (CTO), followed by ACO provider participation with an ACO-affiliated hospital. If the provider does not participate with a hospital in these programs, providers may be linked with hospitals based on employment. All remaining providers with attributed beneficiaries will be linked to hospitals based on the referral patterns of their attributed beneficiaries, as described below and in the appendices. Throughout the linkage steps, providers participating in an MDPCP practice will be considered together for the purposes of linkage between providers and hospitals. This ensures that all providers in an MDPCP practice are linked with the same hospital, regardless of the method of linking.

Addition of linkage of MDPCP provider to CTO hospital. Many hospitals are participating in MDPCP as Care Transformation Organizations that help practices provide high-quality care for their beneficiaries. Because of these significant financial investments, staff recommends adding the relationship between MDPCP practices and hospital-affiliated CTOs as the first linkage under the MPA between providers and hospitals. MDPCP practices participating with a hospital-affiliated care transformation organization will be linked with the corresponding hospital, and all attributed beneficiaries for that practice will be attributed to that hospital. All remaining providers and practices will be assessed for linkage through an ACO.

Linkage of ACO provider to ACO hospital. Staff recommends no changes. Remaining providers with attributed beneficiaries not linked under the MDPCP-CTO linkage will be assessed for ACO linkage. Providers participating in an MDPCP practice with a non-hospital affiliated CTO or no CTO will be assessed together as a practice group under this ACO approach. ACO providers participating with a hospital-affiliated ACO will be linked with the corresponding hospital, and all attributed beneficiaries for that provider (regardless of beneficiary attribution method) will be attributed to a hospital. As in the Y1 policy, ACOs with multiple hospitals may designate ACO PCPs to specific ACO hospitals, which will ensure that beneficiaries attributed to those PCPs are attributed to a single hospital; otherwise TCOC will be distributed by Medicare market share (based on federal Medicare FFS hospital payments) of the hospitals in the ACO. All remaining providers and practices will be assessed for linkage based on employment.

Employment linkage. Throughout the past year, some hospital stakeholders have expressed that employment represents one of the strongest links between hospitals and providers. HSCRC staff agree that employment allows for easier coordination and sharing of resources, and therefore should be included in the algorithm, but also believe it is crucial to continue encouraging participation in official payment structures with CMS oversight, such as MDPCP or ACOs. In addition, there is no consistent definition of employment agreed to by all hospitals, and HSCRC will have to rely on voluntary submission of hospital lists that cannot be easily validated. To balance these considerations, HSCRC recommends using employment as a voluntary link between providers and hospitals after the MDPCP and ACO-like linkages. Any providers not linked to hospitals through the CTO or ACO linkages may be linked to hospitals based on voluntary hospital-submitted employment lists. HSCRC will accept the Maryland Hospital Association definition of employment 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. These lists must be submitted to HSCRC by a specified date and represent full-time, fully employed providers with a single hospital/hospital system. Remaining providers participating in an MDPCP practice not linked with hospital-affiliated CTO or ACO will be assessed together as a practice group based on employment.

Referral pattern linkage. Remaining providers will be assigned to the hospital from which that provider's attributed beneficiaries receive the plurality of their care, as in the Y1 MPA policy. Remaining providers participating in an MDPCP practice not linked with hospital-affiliated CTO, ACO, or employment will be assessed together as a practice group based on referral pattern.

Review period

While staff has worked to address some concerns of the TCOC Work Group, no attribution method is perfect. Therefore, staff recommends the implementation of an official algorithm review period. Following the initial running of the attribution algorithm for Year 2, hospitals will have the opportunity to raise concerns about the attribution algorithm output. This period is intended to ensure the attribution algorithm is performing as expected, not as an opportunity to revisit the core elements of the algorithm.

The review period is intended to serve two purposes: (1) identify and correct mechanical errors (e.g., incorrect data submissions); and (2) address specific cases of unintended and misaligned linkages that do not reflect the intent of the MPA policy. For example, in some scenarios, a provider may have significant relationships with more than one hospital. In this case, the hospitals involved may propose to have joint accountability for the total cost of care. In practice, this could result in a portion of the total cost of care attributed to one hospital and the other portion to another hospital. In evaluating any such proposals, HSCRC staff will consider whether the request is reasonable based on the situation and can be implemented into MPA monitoring reports without significant burden. HSCRC staff will work with the TCOC Work Group to determine guidelines associated with review period proposals.

Opportunities for improving linkages/attribution

Consistent with the Commission's Year 1 MPA final recommendation, HSCRC staff have been working with the TCOC Work Group, the Maryland Hospital Association, and other stakeholders to explore merited changes to the attribution, including attributing providers based on existing physician contractual relationships with hospitals or grouping providers in a practice together. With the start of MDPCP, HSCRC is able to group participating providers in MDPCP practices together throughout the linkage process and ensure providers in an MDPCP practice are linked with the same hospital. Data is limited on extending these approaches outside of MDPCP and analyses performed to date have not revealed a consistent approach that can be consistently applied across hospitals. Staff remain committed to exploring these options with the TCOC Work Group and stakeholders.

Performance Assessment

For Rate Year 2021, which is the MPA's second year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2019) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2018) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission, as described in greater detail below. This approach is a year-over-year comparison, based on each hospital's own improvement. In the case that external events impact hospitals' Medicare TCOC (e.g., changes to the differential or reductions to hospital rates), the HSCRC reserves the right to adjust base year performance to capture those changes and better reflect a hospital's improvement.

The attribution of Medicare beneficiaries to hospitals will be performed prospectively. Specifically, beneficiaries' connection to hospitals is determined based on the two Federal fiscal years preceding the performance year, so that hospitals can know in advance the providers for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2019, data for the two years ending September 30, 2018 will be used. For attribution for Base Year 2018, data for the two years ending September 30, 2017 will be used.¹

In response to work group concerns around changes in hospital-attributed populations over time, staff is recommending to add risk adjustment to the year-over-year comparison. This risk adjustment will use Medicare New Enrollee Demographic Risk Score.

The total cost of care for a hospital's beneficiaries attributed through all methods will be summed and divided by the total number of beneficiaries attributed to the hospital through those methods to result in a single total cost of care per capita number. The State's objective is to incentivize hospitals and hospital-based physicians/clinicians to work effectively with community-based physicians/clinicians in order to coordinate care and care transitions, provide effective and efficient care, and focus on high-needs beneficiaries.

This policy for RY2021 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment policy for the MPA requires consideration of a number of complex issues, such as an appropriate attainment benchmark, intrinsic differences between hospital payment rates (such as labor market differences, Graduate Medical Education payments, etc.), and an appropriate risk adjustment methodology. In addition, staff is concerned about alignment and performance on the State's Medicare TCOC financial tests with the federal government, which are improvement-only, if an attainment policy is adopted. Staff acknowledge stakeholder support for an attainment policy that may help mitigate concerns about penalizing hospitals that have reduced total cost of

¹ For Base Year 2018 and Performance Year 2019, the algorithm will rely on 2019 ACO lists, MDPCP lists, and employment lists. As a result, each hospital's TCOC performance as assessed for 2018 as the base year will differ from that calculated for 2018 as the performance year, which is based on 2018 ACO lists.

care and explain some variation in spending growth. However, staff believe further discussion and analyses are necessary to implement a responsible and fair attainment policy. HSCRC staff are actively pursuing new options and methodologies for developing benchmarks and are hopeful these efforts will aid in developing an attainment policy. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan.

TCOC Trend Factor

The MPA for Rate Year 2021, which begins July 2020, will be based on hospital performance on Medicare TCOC per capita in the performance year (CY 2019) compared to its TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2018) TCOC per capita, updated by the TCOC Trend Factor. Final Medicare TCOC data for the State and the nation for calculating the MPA will be available in May 2020.

Consistent with the RY 2020 policy, HSCRC staff proposes that the TCOC Trend Factor for RY 2021 remains set at 0.33% below the national Medicare FFS growth rate. This is the growth rate calculated as necessary to attain the required Medicare TCOC savings by 2023 under the TCOC Model Agreement with the federal government. Even after being approved by the Commission and CMS, however, the TCOC Trend Factor may be adjusted by the Commission and CMS if necessary to meet Medicare financial tests.

Staff recognizes that some stakeholders have expressed interest in fixing a pre-set Trend Factor prior to the start of the performance period. While this would give hospitals the appearance of greater certainty regarding the targets, a pre-set Trend Factor could result in problems if, for example, the Trend Factor was not set aggressively enough. If actual national Medicare growth was substantially lower than the projections on which the pre-set factor was based, hospitals could receive a reward even if the State had an unfavorable year compared to the nation. Such a scenario could cause concerns with model performance requirements, compelling the Commission to adjust the pre-set Trend Factor after the performance period, resulting in dissatisfaction due to changing expectations.

Accounting for Maryland Primary Care Model (MDPCP) Expenditures

The Maryland Primary Care Model is designed to provide additional funding and flexibility to primary care practices to invest in care management, population health, and other high value services. Staff propose gradually incorporating MDPCP expenditures into the MPA performance assessment. For CY19 expenditures included in the RY 2021 policy, staff propose the following:

- Exclude Care Management Fees (CMF) and Performance-based Incentive Payments (PBIP).
- Include Comprehensive Primary Care Payments (CPCP) paid quarterly to Track 2 MDPCP practices (approximately 10% of practices that applied), along with the sum of their reduced fee-for-service revenue

Beginning with the RY 2022 policy, staff intend to include CMF in both the base year and the performance year. Beginning with the RY 2023 policy, staff intend to include PBIP in both the base year and the performance year. Excluding CMF and PBIP payments in CY19 allows hospitals to be held harmless while this new spending is incorporated into the base year comparison for future rate years.

Special Approaches to Increasing Hospital Accountability

The University of Maryland Rehabilitation and Orthopedic Institute (UMROI) provides specialized stroke rehabilitation services along with other rehabilitation services to patients from across Maryland. Recognizing UMROI as a unique state resource and the challenges with operationalizing the MPA for UMROI, the HSCRC recommends piloting an episode-based approach to increase the financial and quality accountability for Medicare beneficiaries receiving services at UMROI.

Hospitals also have the opportunity to collectively address TCOC (e.g., leverage regional partnerships or other regional accountability) by opting to have multiple hospitals treated as a single hospital for MPA purposes. This opportunity was formally shared with hospital CFOs in an HSCRC memo dated March 14, 2018, for the RY 2020 policy. The opportunity is also available for RY 2021. Such a combination of hospitals must be agreed to by all the hospitals, must include a regional component, and serve a purpose that is enhanced by the combination. For example, a small system hospital with a very small attributed TCOC may enter a combination with a large, nearby system hospital. In this case, the combination creates a more stable pool for the small system hospital and acknowledges the hospitals' shared service areas and resources. Another possible scenario is a number of hospitals in a particular county joining in a combination option, where they already share resources and infrastructure. (System affiliation without a geographic area will not be accepted as a combination rationale.) Hospitals should submit their request before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC.

Medicare Performance Adjustment Methodology

For each hospital, its TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine the MPA's scaled rewards and penalties. For RY 2021, the agreement with CMS requires the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue.

The agreement with CMS also requires that the Maximum Performance Threshold (that is, the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained) be set at 3% for RY 2021. Before reaching the RY 2021 Maximum Revenue at Risk of $\pm 1.0\%$, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC). For RY 2021, staff proposes to continue to use the existing RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments; however, staff recognizes that the Commission may choose to add to the programs used for the quality adjustments over time, to increase the alignment between hospitals and other providers to improve coordination, transitions, and effective and efficient care. Both MHAC and RRIP quality programs have maximum penalties of 2% and maximum rewards of 1%. The sum of the hospital's quality adjustments will be multiplied by the scaled adjustment. Regardless of the quality adjustment, the maximum reward and penalty of $\pm 1.0\%$ will not be exceeded. The MPA reward or penalty will be incorporated in the following year through adjusted Medicare hospital payments on Maryland Medicare FFS beneficiaries.

With the maximum $\pm 1.0\%$ Medicare FFS hospital adjustment, staff recommends that the MPA be included in the HSCRC's portfolio of value-based programs and be counted as part of the aggregate revenue at risk for HSCRC quality programs.

Comments on Draft RY2021 MPA Recommendation

HSCRC staff received comments from the Maryland Hospital Association (MHA), Consumer Health First (CHF), MedStar Health, University of Maryland Medical System (UMMS), Johns Hopkins Health System (JHHS), and combined comments from JHHS, UMMS, and MedStar Health.

While there were concerns raised over the risk adjustment approach and requests for additional clarity around MDPCP expenditures, comment letters were generally supportive of the MPA draft recommendation and appreciative of changes made to the attribution algorithm.

Additional Considerations for the Attribution Algorithm

Stakeholders expressed broad appreciation for the enhancements to the attribution algorithm. Staff received a few comments from stakeholder recommending small changes to the attribution algorithm (e.g., using ACO-actual provider attribution instead of ACO-like, and moving employment to be the first step in the provider linkage step of the algorithm). Given the different attribution approaches across ACO models, staff recommends retaining ACO-like as it is, which has broader inclusion of additional provider types and allows attribution to remain prospective. At this time, staff recommends monitoring the performance of the attribution algorithm and will continue to consider changes to the attribution algorithm in future MPA design discussions. Staff also recommends having actual MDPCP attribution precede employment relationships, since MDPCP is focused on improving quality and reducing Medicare TCOC, while employment relationships between physicians and hospitals may not reflect the goals of the model.

Increase Robustness of Risk Adjustment

Both provider and consumer stakeholders expressed a desire for more robust risk adjustment in calculating TCOC performance. The HSCRC agrees that some level of risk adjustment in the

MPA is appropriate, but must be balanced against additional administrative burden and unintended consequences. Differences may be better controlled for in an attainment approach by use of peer groups rather than risk adjustment, for future MPA performance assessment. The HSCRC staff remain concerned about risk adjusting based on a beneficiary's full diagnostic profile in risk adjustment. Including the full diagnostic profile could lead to increased incentives to intensify coding documentation (potentially with differing levels of execution) and overstate the disease burden of the population and adding administrative burden. The State continues to evaluate approaches to incorporate social determinants of health into the MPA policy in a way that incentivizes hospitals to reduce disparities and improve equity. Approaches may include variables such as racial/ethnic identity and the resources available in a patient's community (e.g., area deprivation index (ADI)). Staff plans on adding additional reporting and analytics to monitor trends in health equity and disparities throughout HSCRC programs. To reflect our commitment to equity, staff updated the guiding principles used to inform the design of the MPA to include equity (Appendix 2, Principle 2.1). Staff welcomes additional thoughts from stakeholders on how to incorporate social determinants in a way that fairly holds hospitals accountable for health care outcomes while incentivizing hospitals to improve equity across their populations.

Continued Support of Developing an Attainment Approach

Stakeholders remain very interested in an attainment approach for rewarding performance under the MPA. The HSCRC is currently working with its contractors to develop a statistical approach to construct national hospital peer groups, which is the first step in developing an attainment benchmark. Staff plans on working with the TCOC Work Group to review these results and help develop an overarching attainment approach over the next year.

Other technical suggestions for review in RY 2021

Staff incorporated some additional technical suggestions for Rate Year 2021, such as building in additional financial protections for extremely costly patients. The HSCRC plans to winsorize extreme values at the 99th percentile to provide some insulation to hospitals from expensive but medically necessary cases.

Looking forward: Continued support and interest in stakeholder engagement

Stakeholders expressed the importance of the TCOC Work Group in providing a venue for stakeholders to voice concerns, assess options based on analytic work, and suggest improvements. HSCRC staff agrees and will continue the TCOC Work Group. In November and throughout 2019, the work group will focus on implementation of the RY 2021 policy and potential improvements for the RY 2022 policy. The TCOC Work Group has provided a valuable forum to obtain input from stakeholders and co-create policies that will lead to our collective success.

FINAL RECOMMENDATIONS FOR RY 2021 MPA POLICY

Based on the assessment above, staff recommends the following for RY 2021 (with details as described above).

- 1) Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
 - a) Use a hierarchy of Maryland Primary Care Program (MDPCP)-actual, Accountable Care Organization (ACO)-like, PCP-like, and Primary Service Area-Plus (PSAP) attribution for beneficiary-to-provider attribution
 - b) Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital-affiliated ACOs, hospital employment, and provider referral patterns
 - c) Implement official algorithm result review period
- 2) Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of $\pm 3\%$.
- 3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019. In CY 2019, exclude MDPCP Care Management Fees and Performance-based Incentive Payments, but include Comprehensive Primary Care Payments for Track 2 practices.
- 4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
 - a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
 - b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
- 5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
- 6) Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, obtaining input through continued meetings of the TCOC Workgroup.
- 7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
- 8) Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

List of Abbreviations

AAPM	Advanced Alternative Payment Model
ACO	Accountable Care Organization
CMF	Care Management Fees
CMS	Centers for Medicare & Medicaid Services
CPCP	Comprehensive Primary Care Payments
CTO	Care Transformation Organization
CY	Calendar Year
E&M	Evaluation and Management Codes
ECMAD	Equivalent case-mix adjusted discharge
FFS	Medicare Fee-For-Service
FFY	Federal Fiscal Year
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MHAC	Maryland Hospital-Acquired Conditions Program
MPA	Medicare Performance Adjustment
MDPCP	Maryland Primary Care Program
NPI	National Provider Identification
PBIP	Performance-based Incentive Payments
PCP	Primary Care Provider
PSA	Primary Service Area
RRIP	Readmission Reduction Incentive Program

RY	Rate Year
TCOC	Medicare Total Cost of Care
TIN	Tax Identification Number

APPENDIX I. BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC) is a State agency with unique regulatory authority: for all acute-care hospitals in Maryland, HSCRC sets the amount that each hospital will be reimbursed by all payers. The federal government has granted Maryland the authority for HSCRC to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers.

Since 2014, the State and CMS have operated Maryland's unique all-payer rate-setting system for hospital services to adopt new and innovative policies aimed at reducing per capita hospital expenditures and TCOC spending, while improving health care quality, patient outcomes, and population health. Under this initiative, hospital-level global budgets are established, so that each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of uncompensated care. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

The MPA provides a mechanism to further support aligned efforts of hospitals with other providers. This includes the opportunity for physicians who partner with hospitals under Maryland's Care Redesign Programs (i.e., Hospital Care Improvement Program (HCIP), Complex and Chronic Care Improvement Program (CCIP), and Episode Care Improvement Program (ECIP)) to be eligible for bonuses and increased payment rates under the federal MACRA law.

Although outside the scope of the MPA attribution algorithm and other aspects described in this document, the State also has the flexibility to apply an MPA Efficiency Adjustment to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Efficiency Adjustment. First, the MPA Efficiency Adjustment can permit the flow of Medicare funds to hospitals based on their performance in other programs. For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA Efficiency Adjustment separate from the MPA's adjustment based on the hospital's performance on its attributed population. In addition, the MPA Efficiency Adjustment may also be used to reduce hospital payments if necessary to meet Medicare financial targets that are not approved on an all-payer basis.

APPENDIX II. ASSESSMENT PRINCIPLES

Based on the State’s experience with performance-based payment adjustments, as well as guiding principles for quality payment programs from the HSCRC Performance Measurement Work Group, the TCOC Work Group discussed the following principles for the development of the Medicare Performance Adjustment (MPA):

- 1. The hospital-specific measure for Medicare TCOC should have a broad scope**
 - 1.1. The TCOC measure should, in aggregate, cover all or nearly all Maryland FFS Medicare beneficiaries and their Medicare Part A and B costs.

- 2. The measure should provide clear focus, goals, and incentives for transformation**
 - 2.1. Promote equitable, efficient, high quality and patient-centered delivery of care.
 - 2.2. Emphasize value.
 - 2.3. Promote new investments in care coordination.
 - 2.4. Encourage appropriate utilization and delivery of high quality care.
 - 2.5. The measure should be based on prospective or predictable populations that are “known” to hospitals.

- 3. The measure should build on existing transformation efforts, including on current and future provider relationships already managed by hospitals or their partners.**

- 4. Performance on the measure should reflect hospital and provider efforts to improve TCOC**
 - 4.1. Monitor and minimize fluctuation over time.
 - 4.2. Hospitals should have the ability to track their progress during the performance period and implement initiatives that affect their performance.
 - 4.3. The TCOC measure should reward hospitals for reductions in potentially avoidable utilization (e.g., preventable admissions), as well as for efficient, high-quality care episodes (e.g., 30- to 90-day episodes of care).
 - 4.4. Hospitals recognize the patients attributed to them and their influence on those patients’ costs and outcomes

- 5. Payment adjustments should provide calibrated levels of responsibility and should increase responsibility over time**
 - 5.1. Prospectively determine methodology for determining financial impact and targets.
 - 5.2. Payment adjustments should provide levels of responsibility calibrated to hospitals’ roles and adaptability and revenue at risk that can increase over time, similar to other quality and value-based performance programs.

APPENDIX III. ESTIMATED TIMELINE AND HOSPITAL SUBMISSION

Estimated Timing	Action
December 2018	<ul style="list-style-type: none"> • <i>Required for ACOs:</i> Hospitals provide HSCRC with ACO Participant List for Performance Year 2019 (also used for Base Year 2018) • <i>Voluntary:</i> Hospitals participating in multi-hospital ACOs designate which ACO providers should be linked with which ACO hospital. • <i>Voluntary:</i> Hospitals provide HSCRC with a list of full-time, fully employed providers • <i>Voluntary:</i> Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC
January 2019	<ul style="list-style-type: none"> • Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2018 and Performance Year 2019, and provides hospitals with preliminary provider-attribution lists
February 2019	<ul style="list-style-type: none"> • Official review period for hospitals of 2 weeks following preliminary provider-attribution lists. • HSCRC reruns attribution algorithm for implementation

APPENDIX IV. BENEFICIARY ATTRIBUTION ALGORITHM

Eligible Population: Maryland Medicare Fee-for-Service beneficiaries, defined as Medicare beneficiaries who have at least one month of Part A and Part B enrollment during the previous two years who resided in Maryland or in an out-of-state PSA claimed by a Maryland hospital.

Hierarchy: Maryland Medicare beneficiaries are first assessed for attribution to a hospital through the MDPCP-actual method. Beneficiaries not attributed under MDPCP-actual attribution are then assessed for attribution through the ACO-like attribution. Beneficiaries not attributed under ACO-like attribution are then assessed for attribution through the PCP-like attribution. Those not attributed through the PCP-like attribution are attributed through the Geographic attribution (PSA-Plus). This final step captures all remaining Maryland Medicare beneficiaries, including those with no previous claims experience because they are newly enrolled in Medicare.

Exclusions: Claims associated with categorically excluded conditions are removed prior to attribution assignment. These claims in any setting trigger an episode beginning three days before and extending to 90 days after a hospital stay for such a condition and are excluded from the TCOC as well as from the determination of ACO-like and PCP-like attribution. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

MDPCP-actual beneficiary attribution

The Medicare Performance Adjustment will use the actual attribution used in MDPCP. HSCRC will rely on the actual beneficiaries attributed to MDPCP practices participating in MDPCP as of January of the performance year. Beneficiary attribution in MDPCP is based on primary care services with clinicians participating in MDPCP.

ACO-like beneficiary attribution

After removing the cost and beneficiaries assigned to practices through the MDPCP-actual method, remaining beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all remaining. Beneficiaries are attributed to ACOs based on the use of professional services with ACO clinicians, while clinicians are attached to ACOs if their identifier appears on the ACO's participant list. HSCRC will work with Maryland hospitals and the Maryland Hospital Association to receive lists of ACO providers in the winter of each year to determine ACO participation for that Base Year and the upcoming Performance Year. Any changes to ACO provider lists throughout the year will not be included until the following Performance Year. The hospital-provided ACO lists should be the same list that is submitted to CMS for ACO participation. Hospital affiliation is also identified through ACO participation, and only hospitals affiliated with a Maryland ACO are used for attribution.

Based on the two Federal Fiscal Years preceding the performance period, the logic determines the plurality of allowed charges for primary care services for eligible beneficiaries with at least one visit for a primary care service. If the plurality of charges are to a set of clinicians that are on

a list of ACO providers, the beneficiary is attributed to the corresponding ACO, as is done in the CMS ACO logic. If the plurality of charges are to clinicians that are not on an ACO list, the beneficiary is not attributed to an ACO. PCPs are identified based on specialty. Primary care services are identified by HCPCS codes and measured by allowed charges. If a beneficiary does not have any PCP visit claims, the same logic is performed for clinicians of other specialties. PCP and selected specialties and codes for primary care services are presented below. All beneficiaries that see a specific clinician may not necessarily be attributed to the same ACO or system. Because the ACO-like attribution methodology uses multiple clinicians to determine whether a beneficiary is attributed to an ACO, an additional step is required to determine the specific ACO beneficiary and ACO provider link. The ACO provider with the plurality of services is attributed the ACO beneficiary.

ACO Specialties

Primary Care Providers' specialty codes are sourced from the Medicare Shared Savings Program Guidance, defined as:²

- physicians with a primary specialty of Internal Medicine, General Practice, Geriatric Medicine, Family Practice, or Pediatric Medicine; or
- non-physician primary care providers (Nurse Practitioners, Clinical Nurse Specialists, or Physician Assistants).

Other specialties include Obstetrics/Gynecology, Osteopathy, Sports Medicine, Physical Medicine and Rehabilitation, Cardiology, Psychiatry, Geriatric Psychiatry, Pulmonary Disease, Hematology, Hematology/Oncology, Preventive Medicine, Neuropsychiatry, Neurology, Medical or Gynecological Oncology or Nephrology.

ACO Primary Care Codes

Primary care codes are sourced from the Medicare Shared Savings Program Guidance.³ The codes include new or established patient visits for office or other outpatient services; initial nursing facility care; subsequent nursing facility care; nursing facility discharge services; other nursing facility services; domiciliary, rest home or custodial care; home services; wellness visits; new G code for outpatient hospital claims.

PCP-like beneficiary attribution

After removing the cost and beneficiaries assigned to hospitals through either the MDPCP-actual or the ACO-like method, providers will be attributed beneficiaries based on beneficiary primary care utilization. Assignment of beneficiaries to primary care providers is determined based on the

² <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V6.pdf>

³ See previous.

beneficiaries' use of primary care services as originally proposed in the Maryland Primary Care Program (MDPCP) by the Maryland Department of Health (MDH) to CMMI and adopted in the Y1 MPA policy. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties.

Primary care providers are attributed beneficiaries based on proposed MDPCP logic with minor adjustments. Each Medicare FFS beneficiary with Medicare Part A and Part B is assigned the National Provider Identification (NPI) number of the clinician who billed for the plurality of that beneficiary's office visits during the 24 month period preceding the performance period AND who also billed for a minimum of 25 Total Office Visits by attributed Maryland beneficiaries in the same performance period. If a beneficiary has an equal number of qualifying visits to more than one practice, the provider with the highest cost is used as a tie-breaker. Beneficiaries are attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.

The cost of primary care services must represent 60% of total costs performed by a provider during the most recent 12 months, excluding hospital and emergency department costs. Primary care services are identified by procedure codes from the list appended below. Primary care providers are defined as unique NPIs regardless of practice location and are not aggregated or attributed through practice group or tax identification number (TIN).

PCP-like Eligible Specialties

Traditional Primary Care Providers are defined as providers with a primary specialty of Internal Medicine; General Practice; Geriatric Medicine; Family Practice; Pediatric Medicine; Nurse Practitioner; or Obstetrics/Gynecology. Specialist Primary Care Providers are defined as providers with a primary specialty of Cardiology; Gastroenterology; Psychiatry; Pulmonary Disease; Hematology/Oncology; or Nephrology. These specialties may differ from those used in the MDPCP and ACO-like.

PCP-like Primary Care Codes

Office/Outpatient Visit E&M (99201-99205 99211-99215); Complex Chronic Care Coordination Services (99487-99489); Transitional Care Management Services (99495-99496); Home Care (99341-99350); Welcome to Medicare and Annual Wellness Visits (G0402, G0438, G0439); Chronic Care Management Services (99490); Office Visits (M1A, M1B); Home Visit (M4A); Nursing Home Visit (M4B) BETOS Codes; Specialist Visits (M5B, M5D); Consultations (M6) BETOS Codes; Immunizations/Vaccinations (O1G) BETOS Codes; Other Testing BETOS Codes (T2A Electrocardiograms, T2B Cardiovascular Stress Tests, T2C EKG Monitoring, T2D Other Tests)

Geographic beneficiary attribution

The remaining beneficiaries and their costs will be assigned to hospitals based on Geography, following an algorithm known as PSA-Plus. The Geographic methodology assigns zip codes to hospitals through three steps:

1. Zip codes listed as Primary Service Areas (PSAs) in the hospitals' GBR agreements are assigned to the corresponding hospitals. Costs in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMAD is calculated from Medicare FFS claims for the two Federal fiscal years 2014 and 2015.
2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed 30 minutes' drive time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period for all beneficiaries in that zip code.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

Beneficiaries not assigned based on MDPCP-actual, ACO-like, or PCP-like affiliation who reside in a zip code attributed to multiple hospitals will be included among attributed beneficiaries of each hospital. However, the per capita TCOC for those beneficiaries will be divided among those hospitals based on market share.

APPENDIX V. PROVIDER-TO-HOSPITAL LINKAGE

MDPCP Provider to CTO Hospital Attribution

MDPCP providers will be assessed as a practice for participation with a hospital-affiliated Care Transformation Organization (CTO). All attributed beneficiaries for that practice will be attributed to the affiliated hospital. Maryland hospitals participating with a CTO for the purposes of this method will be determined by the Maryland Department of Health. Any providers not participating with MDPCP are assessed for linkage under ACO approach. Providers participating in an MDPCP practice with a non-hospital affiliated CTO or no CTO will be assessed together as a practice under subsequent steps.

ACO Provider to ACO Hospital Attribution

Remaining providers not linked to a hospital under the MDPCP-CTO linkage will be assessed for ACO linkage. Providers participating with a hospital-affiliated ACO will be linked with the corresponding hospital/system, and all attributed beneficiaries for that provider will be attributed to that hospital/system. ACOs with multiple hospitals (e.g., systems) may designate ACO PCPs to specific ACO hospitals, which will ensure that beneficiaries attributed to those PCPs are attributed to that hospital, if approved by HSCRC. This designation must occur before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC. If ACOs with multiple hospitals do not elect to designate ACO PCP and ACO hospital linkages, TCOC will be distributed by Medicare market share (based on federal Medicare FFS hospital payments) of the hospitals in the ACO. MDPCP practices that are not linked to a hospital under CTO linkage will be assessed together as a group for ACO linkage.

Employed Provider to Hospital Attribution

Any providers not linked to hospitals through the MDPCP or ACO linkages may be linked to hospitals based on voluntary hospital-submitted employment lists. These lists must be submitted to HSCRC by a specified date and represent full-time, fully employed providers with a single hospital/hospital system. MDPCP practices that are not linked to a hospital under CTO or ACO linkage will be assessed together as a group for employment linkage.

Referral Patterns Provider to Hospital Attribution

Under PCP-like, if the provider is not linked to a hospital through MDPCP, ACO, or employment, a provider and the beneficiaries and costs assigned to that provider's NPI are in turn assigned to a hospital based on the number of inpatient and outpatient hospital visits by the provider's attributed beneficiaries. All of the provider's beneficiaries are attributed to the hospital with the greatest number of visits by beneficiaries assigned to that provider. If a provider's beneficiaries have equal visits to more than one hospital, the provider is attributed to the hospital responsible for the greatest total hospital cost. MDPCP practices that are not linked to a hospital under CTO, ACO, or employment linkage will be assessed together as a group for referral pattern linkage. Aside from MDPCP practices, practice group and location do not impact

provider to hospital attribution, nor does the number of practices or TINs to which the provider is affiliated. All beneficiaries attributed to a specific clinician through the PCP-like method will be attributed to a single hospital.