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Medicare Performance Adjustment

Final Recommendation

December 2021

This document contains the final staff recommendations for the CY 2022 Medicare Performance Adjustment.

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Final Recommendations For CY 2022 MPA Policy

Staff recommend the following revisions to the MPA policy for calendar year 2022 (CY2022):

1. Replace the existing multi-step MPA attribution with geographic attribution, with an additional attribution layer for Academic Medical Centers for calendar year 2022.

2. Maintain the other aspects of the MPA with the following exceptions:

    a. Modify the Supplemental MPA attribution to be based on HSCRC's MDPCP-like attribution;

    b. Add additional attribution for beneficiaries participating in the Episode Quality Improvement Program (EQIP)

Staff recommend revising the existing MPA attribution in order to align beneficiaries with hospitals based on their geographic service area, rather than on the hierarchical, multi-step attribution method that has been used in the past based on primary care networks in MDPCP and other programs. In addition to the complexity, the multi-step attribution algorithm is volatile and unpredictable, meaning that a significant number of beneficiaries are attributed to different hospitals in successive years. This inhibits a hospital's ability to target interventions at the beneficiaries who will remain attributed to that hospital and are located in their service area.

Staff believe a change to the attribution based on geography will simplify the MPA and allow hospitals to focus on CTI and other programs that better match the hospital's clinical strategies. This will also ensure that hospital resources are deployed and invested in the hospital's immediate geographic area. With the exception of the attribution algorithm, Staff recommend maintaining the majority of the MPA policy, as finalized by the Commission in December of 2020. The MPA policy has changed frequently, resulting in uncertainty about future MPA rewards, targets, and expectations. Staff recommend maintaining the existing structure of the MPA, with the changes recommended here, for CY2022 and CY2023 – barring any changes required by CMMI. Finally, in line with the Commission and CMMI's focus on increasing the importance of health equity, population health, and quality measures within all programs, during 2022 Staff will work with stakeholders to assess the measures and share of risk related to quality under the MPA and implement agreed upon changes in an update to this policy for CY2023. Any modification to the quality measures included will leverage measures being utilized in other programs, including SIHIS.

The following discussion provides rationale and detail or each of these recommendations.

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare Beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2022 and makes important improvements to the reward calculation methodology, and adds additional hospital flexibility through Care Transformation Initiatives.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by the CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Overview of the MPA Policy

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (i.e. 1 percent of Medicare fee-for-service revenue).

The MPA includes two "components": a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and

applied to the amount that Medicare pays the hospitals. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Traditional Component

Currently, the HSCRC assigns patients to hospitals using a hierarchical algorithm. First, beneficiaries are attributed based on participation in the Maryland Primary Care Program (MDPCP). Second, beneficiaries are attributed under an ACO-like attribution where HSCRC replicates CMS's attribution for the Medicare Shared Savings Program (SSP) ACOs and physicians voluntarily identified by hospitals as employed by their system. Third, any beneficiary not attributed based on the prior two attribution approaches could be attributed under a referral relationship where HSCRC assigned physicians to hospitals based on where the plurality of their patients' hospitalizations occurred and then attributed any beneficiary who received a plurality of their primary care services from the physician to that hospital. Finally, any beneficiary not attributed under the previous approaches would be attributed to a hospital based on the hospital's geographic service area.

The MPA then penalized or rewarded hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national. Beginning in 2021, the HSCRC has scaled the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographics elsewhere in the national. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below.

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D)

Example Calculation of MPA Targets

Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. the rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. The amount of

revenue at risk under the MPA policy is capped at 1% of the hospital's Medicare revenue. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 1%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.30%
Hospital B	$11,846	$11,941	0.80%	-0.30%
Hospital C	$11,792	$11,556	-2.00%	0.70%
Hospital D	$11,800	$12,154	3.00%	-1.00%
Hospital E	$11,294	$11,859	5.00%	-1.00%

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 Conditions (MHAC). Staff recommends continuing the current policy of using the RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments. Under the existing approach the reward or penalty before the quality adjustment is multiplied by 1 + the quality adjustment. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded.

In line with the Commission and CMMI's focus on increasing the importance of health equity, population health, and quality measures within all programs, during 2022 Staff will work with stakeholders to assess the measures and share of risk related to quality under the MPA and implement agreed upon changes in an update to this policy for CY2023. Any modification to the quality measures included in the MPA adjustment will use measures being utilized in other programs, including SIHIS.

Efficiency Component

The MPA includes additional rewards and penalties for hospitals that reduce the TCOC through care redesign program, include the Episode Care Improvement Program (ECIP), the Care Transformation Initiatives (CTI), and the Maryland Primary Care Program (MDPCP). The HSCRC increases the MPA reward or penalty based on the success of these programs. The HSCRC developed the Efficiency Component because the Traditional MPA was not targeted well enough to reward a hospital for a specific target population. A hospital would only be rewarded for a successful care redesign effort under the Traditional Component of the MPA, if every beneficiary included in the effort was attributed to the hospital and if the impact of the program was not washed out by the impact on other beneficiaries who were also attributed to the hospital. Historically, the Traditional MPA has not been well aligned with individual hospital care redesign efforts which necessitated the development of the Efficiency Component.

Attribution Issues

In November 2019, the Commission directed staff to explore potential changes to the MPA based on feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. Based on this review, Staff concluded that the multi-step attribution method has both strengths and weaknesses. Attribution based on primary care visits aligns with clinical relationships that, presumably, have significant influence over the TCOC of the attributed beneficiaries. However, the multi-step attribution method is complex. Hospitals and staff spend a significant amount of time and energy analyzing the MPA attribution and its complexity has led to questions about whether a hospital's performance is due to the hospital's efforts or due to the eccentricities of the attribution algorithm.

Staff compared the current attribution algorithm with simpler attribution methods, namely those based solely on geographic relationships. Geographic attribution performed just as well on a variety of measures as the current attribution algorithm, except for Academic Medical Centers (AMCs). Based on this analysis, Staff recommended modifying the MPA attribution to use a purely geographic attribution with an adjustment for AMCs. However, the industry's comments to the Draft Recommendation emphasized that geographic attribution would lose an important clinical link between the patients seen by the hospital's physician networks and the patients attributed to the hospitals. During the workgroup process, numerous hospitals recommended that HSCRC analyze whether moving to geographic attribution would result in a more tenuous relationship between the hospital and its attributed patients. Staff analyzed the number of attributed beneficiaries that receive services from the hospital that they are attributed to and found that a similar proportion of beneficiaries received services from the hospital under both the existing attribution and the geographic attribution.

Staff analyzed the impact of moving to the geographic attribution by measuring the percentage of beneficiaries who are attributed to the hospital and who also receive services from that hospital. Under the existing attribution 12.8 percent of attributed beneficiaries receive a service from the hospital that they are attributed too. Under the geographic attribution, 14.2 percent of attributed beneficiaries receive a service from the hospital they are attributed to. This indicates that the geographic attribution captures the clinical relationship between the hospitals and their attributed beneficiaries.

While staff recognize the importance of a clinical relationship between the hospitals and their attributed beneficiaries, staff does not believe that the Traditional MPA component accurately encompass hospital's clinical relationships for two reasons: 1) the MPA attribution is required to attribute 95 percent of all Maryland beneficiaries to some hospital and therefore each hospital will receive a significant number of non-clinically attributed beneficiaries; and 2) the MPA is a one-size fits all attribution that does not allow for the specifics of individual hospital's clinical strategies. Therefore, while a portion of the hospital's MPA performance represents the impact of the hospital's clinical networks on the total cost of care and a portion of the hospital's MPA results are driven by the MPA attribution algorithm. Untangling the two effects is difficult and takes significant time and effort.

The HSCRC developed the CTI policy in order better capture the impact of hospitals' clinical strategies on the total cost of care. Hospitals may tailor the CTI to their own clinical programs and thus can more precisely target the attribution logic to their own clinical strategies. Additionally, the CTI measures the impact of the hospital's interventions at the programmatic level and does not have the confounding impact of other beneficiaries attributed to the hospital to ensure that 95 percent of all Medicare beneficiaries are attributed to some hospitals. Staff therefore believe that the CTI will more accurately attribute beneficiaries and be a more valid measure of the direct clinical impact that hospitals have on the total cost of care.

MPA Final Recommendations

Staff recommend three changes to the MPA for CY2022: 1) revise the attribution algorithm to be aligned with the hospital's service area, with an adjustment for AMCs; 2) revise the attribution approach in the MDPCP supplemental adjustment; and 3) add an efficiency component for the EQIP program. Once those changes are made, Staff recommends maintaining the MPA for CY2022 and CY2023 in order to create as much stability for hospitals as possible.

Revised Attribution

Staff recommend replacing the current 'tiered attribution' approach to the MPA with a purely geographic approach. The geographic attribution algorithm will be unchanged from the geographic tier in the current

MPA algorithm. Under this approach beneficiaries and their costs will be assigned to hospitals based on their residency. Zip codes are assigned to hospitals based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. Zip codes not contained in a hospital's PSA are assigned to the hospital with the greatest share of hospital use in that zip code, or, if that hospital is not sufficiently nearby, to the nearest hospital. Specifically, each zip code is assigned to hospitals through three steps:

1. Costs and beneficiaries in zip codes listed as a hospital's Primary Service Areas (PSAs). Staff will work with industry to rationalize the existing definition of PSAs over the next 6 months so that during 2022 the PSAs will reflect a systematic approach to defining service areas. 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 preceding the performance period.

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.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

4. Using an alternative attribution approach for the AMCs, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also have a geographic based attribution.

Some zip codes are included in multiple hospitals' PSA. Beneficiaries that reside in those zip codes will be attributed to each hospital; however, the TCOC for those beneficiaries will be divided among those hospitals based the hospitals' market share within those zip codes.

Supplemental MDPCP Accountability

In 2021, the Commission directed staff to increase the accountability for managing the TCOC in the MDPCP. Therefore, HSCRC added a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. Staff recommended measuring the hospital's performance based on the beneficiaries attributed to the hospital by CMMI. The purpose of this policy was to hold hospitals accountable for the beneficiaries included the MDPCP program.

However, hospitals joined the MDPCP program at different times. Since a hospital is not attributed any beneficiaries until they join the program, there is no consistent baseline of attributed beneficiaries for hospitals in MDPCP. Consequently, it is impossible to compare hospitals relative performance. Therefore,

Staff recommend using the HSCRC's MDPCP-like attribution to create a consistent baseline of beneficiaries in order to determine the hospitals relative performance. This change would also apply to the CY21 calculation.

Efficiency Component for the EQIP Program

Currently, the Maryland TCOC Model holds hospitals accountable for managing the total cost of care even though they are not responsible for nonhospital costs. In order to increase the accountability held by nonhospital providers, Staff developed EQIP – an episode-based program – that pays nonhospital providers for reducing the cost of episodes of care that they provide. EQIP providers are paid a share of the savings that they create. In order to pay the providers, the savings for the program first have to be paid to a hospital through the MPA. The HSCRC will increase the MPA for the administering hospital and then that hospital will pay the providers through the EQIP program.

The University of Maryland Medical Center (UMMC) volunteered to be the administering entity for the EQIP program. Therefore, Staff recommend increasing the UMMC's MPA adjustment by an amount equal to the savings earned by the EQIP providers. Furthermore, the EQIP beneficiaries will be attributed to UMMC. This will ensure that the EQIP providers meet the threshold for being a Qualified Practitioner under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). These beneficiaries will not be considered in calculating the Traditional MPA.

Stakeholder Responses and Feedback

Comment letters were submitted by the Maryland Hospital Association (MHA), the Johns Hopkins Health System (JHHS), the University of Maryland Health System (UMMS), and Medstar Health.

JHHS and UMMS were supportive of the move towards geographic attribution. Both noted that geographic attribution is not perfect, particularly in rural areas. However, they recognized that geographic attribution would reduce beneficiaries churn and other undesirable characteristics of the MPA and therefore supported moving to geographic attribution. Both JHHS and UMMS were supportive of the alternative attribution for the Academic Medical Centers. Medstar Health was not supportive of using geographic attribution because hospitals would be attributed beneficiaries with whom they do not have an established clinical relationship. Staff do not agree with the Medstar comment because hospitals are currently attributed beneficiaries with whom they have no clinical relationship under the geographic tier of the existing algorithm; moving to a purely geographic algorithm will not substantially change the number of beneficiaries with whom the hospital does not have a clinical relationship. Therefore, Staff continue to believe that simplifying the attribution algorithm will result in a more stable and understandable policy.

Medstar Health also recommended that the State limit delay the application for new CTIs so that hospitals can better understand their financial risk under the CTI. Staff intend to allow hospitals to apply for new CTIs that begin in July of 2022 and annually thereafter. Staff believe that hospitals should be allowed to modify and create new CTI on an annual basis, since the purpose of that program is to give hospitals flexibility to tailor their Medicare attributed population to their clinical interventions.

Staff submitted the State's MPA proposal to CMMI in November of 2021. CMMI approved the move to geographic attribution and other aspects of the proposal but did not approve the 'CTI Buyout', which would lower the traditional MPA penalty based on the number of CTI attributed beneficiaries the hospital receives. CMMI believes that the traditional MPA is an important policy for holding hospitals accountable for managing the total cost of care of Maryland beneficiaries. Staff do not agree with CMMI and continue to believe that the CTI is a better policy for holding hospitals accountable for managing the total cost of care. However, the magnitude of the traditional MPA penalties have been relatively limited and therefore Staff believe that the impact of eliminating the CTI buyout is relatively limited.

CMMI also encouraged the State to develop additional quality measures for the MPA. Staff believe that hospitals can do more to manage population health in line with the State's Integrated Health Improvement Strategy (SIHIS) and plan to develop additional quality measures over the upcoming year. However, Staff believes that quality measures should be all-payer in nature and therefore Staff recommend incorporating those measures into existing quality programs or develop a new population health quality program, rather than developing new measures specifically for the MPA. Staff will work to convince CMMI that quality measures should be all-payer in nature and not developed specifically for the Medicare population.

The MHA agreed with Staff's disappointment that CMMI did not approve the CTI Buyout. Additionally, the MHA agreed that quality measures should be developed on an all-payer basis. The MHA did suggest that Staff conduct and assessment of the revenue at risk under the Commission' various quality programs. Staff will work with stakeholders to assess the different quality programs over the next several workgroup meetings.