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DATE: October 24, 2018

TO: Rivka Friedman, Center for Medicare & Medicaid Innovation (CMMI)

FROM: Chris Peterson, Principal Deputy Director

RE: Maryland's understanding of QP Threshold Test for CRP Care Partners

The All-Payer Model includes the voluntary Care Redesign Program (CRP), which allows participant hospitals to enter into arrangements with certain nonhospital providers and suppliers, referred to as Care Partners, who support the participant hospital's efforts under the All-Payer Model. These Care Partners may receive incentive payments from the participant hospital in exchange for performing care redesign interventions.

CMS has informed the State that the Maryland All-Payer Model is an Advanced Alternative Payment Model (APM). Eligible Clinicians that participate in an Advanced APM are eligible to receive the 5 percent APM Incentive Payment if they meet a threshold level of participation in the APM, making them Qualifying APM Participants, or QPs. The Threshold Score assesses the proportion of their payments and/or patients that are part of the APM. Care Partners participate in the All-Payer Model through the CRP and can potentially earn the APM Incentive Payment. This memo outlines the State's understanding regarding how the QP Threshold Test will be conducted.

A. Overview of QP Determination

To determine whether an Eligible Clinician is a QP under the Maryland All-Payer Model, CMS will calculate (1) a payment amount Threshold Score and (2) a patient count Threshold Score, to determine whether a hospital's Care Partner has achieved QP status. CMS will apply the more advantageous QP status to the Eligible Clinicians in the APM Entity.

To be considered a QP in 2018, a Care Partner that is an Eligible Clinician must receive 25 percent of their Part B professional payments for services provided to a beneficiary attributed to the hospital with which they have a Care Partner Arrangement, or 20 percent of their beneficiaries must have been attributed to the hospital with which they have a Care Partner Arrangement.

B. Identification of potential QPs Participating in the Maryland All-Payer Model

CMS will assess any Eligible Clinician (i.e., all physicians or other practitioners as defined in Section 1842(b)(18)(C) of the Social Security Act) who is included on a Care Partner List submitted to CMS by a hospital participating in the CRP. This list constitutes an "Affiliated Practitioner List," as defined in 42 CFR § 414.1305, because:

1. *All acute care hospitals in the State of Maryland are APM Entities*. The Maryland All-Payer Model is authorized by Section 1115A of the Social Security Act and is thus an Alternative Payment Model (APM). All acute care hospitals in the State of Maryland are subject to rate regulation by the Health Services Cost Review Commission (HSCRC) and are APM Entities, as they participate in the All-Payer Model through State law under Title 19 of the Health General Article of the Annotated Code of Maryland.

2. *The hospitals' Care Partners are Affiliated Practitioners.* The CRP allows hospitals to enter into a CRP Arrangement with nonhospital providers (Care Partners) and make incentive payments to those Care Partners. A CRP Arrangement is a contractual relationship with an APM Entity that commits the Care Partner to help reduce costs and improve quality consistent with the goals of the Maryland All-Payer Model. The CRP Arrangement makes Care Partners an Affiliated Practitioner of the hospital.

According to 42 CFR §414.1425(a)(2), CMS will assess the Eligible Clinicians included on the Affiliated Practitioner List when there are no there are no Eligible Clinicians on the Participation List. Participants in the Maryland All-Payer Model are hospitals and thus no Eligible Clinicians are included on the Participation List for the Maryland All-Payer Model. Following 42 CFR §414.1425(b)(2), CMS will assess all Affiliated Practitioners individually, rather than in a group.

C. Identification of Attributed and Attribution Eligible Beneficiaries.

CMS will identify the "attribution-eligible beneficiaries" using the alternative sixth criterion from the definition of an attribution-eligible beneficiary in 42 CFR §414.1305. This criterion is applicable for Advanced APMs that does not "base attribution on evaluation and management services and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP Performance Period."

The alternative definition of attribution-eligible beneficiaries is necessary because the Maryland All-Payer Model attributes beneficiaries to hospitals based on inpatient and emergency department services, not professional services.

Based on prior discussions with CMS, the State's understanding of the QP Threshold Test with respect to CRP Care Partners will consist of the following steps:

a. Identify attribution-eligible beneficiaries.

Under the All-Payer Model, the APM Entity does not include any Eligible Clinicians. Instead, CMS has agreed that attribution-eligible beneficiaries are those beneficiaries who have received any Part B professional services (claim type codes 40, 71, and 72) from the Eligible Clinician on the Affiliated Practitioner List. Since CMS will assess Affiliated Practitioners individually, and not in a group, the attribution-eligible beneficiaries will be determined individually for each Eligible Clinician on the Affiliated Practitioner List.

b. Identify beneficiaries attributed to CRP Hospitals.

Attributed beneficiaries are those beneficiaries assigned to an APM Entity under the terms of the APM. Under the Maryland All-Payer Model, CMS attributes beneficiaries to hospitals using a "touch" methodology to demonstrate a treatment relationship and determine payments for hospital services under model. In addition, the State attributes beneficiaries to hospitals to monitor and adjust each hospital's Medicare payments under the All-Payer Model Agreement using the CMS-approved Medicare Performance Adjustment (MPA). The union of these two groups of beneficiaries represents those attributed to a CRP hospital:

1. *MPA-attributed beneficiaries*. The State will compile a list of beneficiaries that were attributed to each hospital using a State-designed, CMS-approved MPA attribution algorithm, as described in Amendment 2 of the Maryland All-Payer Model; and
2. *Touch-attributed beneficiaries.* CMS will compile the list of beneficiaries that have received a service from the hospital (Part A or Part B, inpatient or outpatient).

CMS has agreed that the State will provide the list of MPA-attributed beneficiaries.[1] CMS will produce the final list of attribution-eligible beneficiaries by combining the lists of MPA-attributed beneficiaries and touch-attributed beneficiaries.

D. QP Threshold Test

CMS will determine whether an Eligible Clinician is a QP by calculating a Payment Threshold Score and the Patient Threshold Score. If either score exceeds the threshold, that Eligible Clinician will be considered a QP. An Eligible Clinician will not be required to meet both thresholds to be considered a QP.

a. Calculate Payment Threshold Scores.

CMS will calculate the numerator of the Payment Threshold Score as the aggregate of all payments for Medicare Part B covered professional services furnished by Affiliated Practitioner in the Advanced APM Entity to attributed beneficiaries during the QP determination period.

[1] On August 30, 2018, the State provided to CMMI the list of MPA-attributed beneficiaries to each hospital, in a table named MPA_BENE_MASTER_QPP placed it in the CCW environment at U:\DUA_027496_Shared\QPP\. This represents all de-identified bene ids attributed to a given hospital facility for 2018 performance year. Enrollment through July of 2018 used was the latest available.

CMS will calculate the denominator for the Payment Threshold Score as the aggregate of all Medicare Part B claims for covered professional services furnished by the Affiliated Practitioner to attribution-eligible beneficiaries during the QP determination period.

Thus the Payment Threshold Score is equal to the following:

$$\frac{\$ \text{ for claim types } 40,71, \text{and } 72 \text{ recieved by the Eligible Clinician for MPA \& Touch attributed beneficaries}}{\text{All } \$ \text{ for claim types } 40, 71, \text{and } 72 \text{ recieved by the Eligible Clinician}}$$

As the Affiliated Practitioner List identifies patients by their NPI, CMS will evaluate the Threshold Score as identified by the NPI only and will not use a TIN/NPI combination. CMS will exclude any payment adjustments for MIPS, PQRS, and other payments in calculating the Threshold Score. CMS will not include any shared savings or financial risk payment in the calculation of the Threshold Score. Supplemental payments that are not included in the Physician Fee Schedule and are made at the NPI level will be included.

b. Calculate Patient Threshold Scores.

The numerator for the Patient Threshold Score will be the number of unique beneficiaries who were attributed to the hospital by either the MPA-attribution or the touch-attribution *and* whom the Affiliated Practitioner received payment for Part B covered professional service.

The denominator of the Patient Threshold Score will be the number of unique attribution-eligible beneficiaries for whom the Affiliated Practitioner received payment for Part B covered professional service.

Thus the Patient Threshold Score is equal to the following:

$$\frac{\text{\# of MPA \& Touch attributed beneficaires given a type } 40, 71, \text{or } 72 \text{ service by the Eligible Clinician}}{\text{\# of all beneficaries given a type } 40, 71, \text{or } 72 \text{ service by the Eligible Clinician}}$$

E. Timing of the QP Determination

CMS will assess the Eligible Clinicians that were included on the Affiliated Practitioner List on August 31. All claims with a date of service between July 1, 2018 and August 31, 2018 will be included in the threshold test.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE AND MEDICAID INNOVATION

TO: Chris Peterson, Principal Deputy Director HSCRC

DATE: November 2, 2018

RE: Response to QP Threshold Test for CRP Care Partners

This memorandum is in response to a memorandum from HSCRC to CMS dated October 24, 2018 entitled 'Maryland's Understanding of QP Threshold Test for CRP Care Partners.' HSCRC raised five points for clarification. CMMI's responses to each of those five points are provided below.

A. Overview of QP Determination. CMS agrees with HSCRC's understanding that to be to be considered a QP in 2018, a Care Partner that is an Eligible Clinician must receive 25 percent of their Part B professional payments for services provided to a beneficiary attributed to the hospital with which they have a Care Partner Arrangement, or 20 percent of their beneficiaries must have been attributed to the hospital with which they have a Care Partner Arrangement.

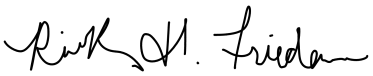
B. Identification of potential QPs Participating in the Maryland All-Payer Model. CMS agrees with HSCRC's understand that Participants in the Maryland All-Payer Model are all acute care hospitals in Maryland and thus no Eligible Clinicians are included on the Participation List for the Maryland All-Payer Model. Following 42 CFR §414.1425(b)(2), which specifies that CMS will assess the Eligible Clinicians included on the Affiliated Practitioner List when there are no there are no Eligible Clinicians on the Participation List, CMS will assess Care Partners who are Affiliated Practitioners individually, rather than as a group.

C. Identification of Attributed and Attribution Eligible Beneficiaries. CMS agrees with HSCRC's understanding of the definitions of Attributed and Attribution Eligible beneficiaries. Attribution Eligible beneficiaries are those beneficiaries who have received any Part B professional services (claim type codes 40, 71, and 72) from the Eligible Clinician on the Affiliated Practitioner List. Attributed beneficiaries are those beneficiaries attributed to Maryland hospitals, which are the APM Entities, and are the union of "MPA-attributed beneficiaries" and "touch-attributed beneficiaries" as those terms are defined in HSCRC's memo.

D. QP Threshold Test. CMS agrees with HSCRC's understanding that CMS will determine whether an Eligible Clinician is a QP by calculating a Payment Threshold Score and a Patient Threshold Score. An Eligible Clinician must only meet one threshold to be considered a QP. As the Affiliated Practitioner List identifies patients by their NPI, CMS will evaluated the Threshold Score as identified by the NPI only and will not use a TIN/NPI combination. The calculation of the Threshold Scores will occur as laid out in the HSCRC's memo.

E. Timing of the QP Determination. CMS agrees with HSCRC's understanding that CMS will assess the Eligible Clinicians included on the Affiliated Practitioner List on August 31 and that all claims with a date of service between July 1, 2018 and August 31, 2018 will be included in the threshold test.

Sincerely,



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