Final Recommendation for the Medicare Performance Adjustment Framework

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SUMMARY

The following report includes a recommendation for an approach under which the Commission will use the MPA Framework to ensure that the State meets the Medicare savings targets in the Total Cost of Care (TCOC) Model Agreement, while also incentivizing hospitals to engage in Care Transformation Initiatives (CTIs). In order to accomplish these goals, the recommendation includes the potential use of both a positive Medicare Performance Adjustment (MPA) to reward hospitals that produce total cost of care savings through CTIs and negative MPA to (1) achieve the required Medicare savings under the TCOC Model and (2) offset the positive payments related to CTIs. The recommendation is updated from the Draft Recommendation dated March 13, 2019 to clarify the link between the MPA Framework and CTIs, further highlight the mechanics of the MPA Framework with other Commission policies including the Update Factor policy, and remove the proposed MPA reduction for RY2020 given the State's current Medicare Savings Run Rate.

POLICY NAMING

This recommendation for the MPA Framework replaces the prior recommendation which referred to the MPA Efficiency adjustment. For clarity, the Commission is no longer using the term MPA efficiency or MPA Efficiency Component. Instead this policy will be referred to as the MPA Framework and within this framework there will be two components which will allow adjustments to Medicare rates:

- The MPA Reconciliation Component (MPA-RC): to be used to encourage Care Transformation Initiatives
- The MPA Savings Component (MPA-SC): to be used to help the State achieve its savings benchmarks by reducing hospital Medicare payments

The original Medicare Performance Adjustment policy will be referred to at the Traditional MPA. The Traditional MPA is not governed by this policy.

RECOMMENDATIONS FOR THE RY2020 MPA FRAMEWORK POLICY

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.

2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. No savings "cushion" will be provided to achieve Medicare savings, instead, the MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

INTRODUCTION

The Medicare Performance Adjustment Framework policy is designed to incentivize hospitals to engage with partners in Care Transformation Initiatives (CTIs) with a goal to reduce the Medicare TCOC across all care settings while ensuring that the State meets its Medicare savings targets in the TCOC Model Agreement.

BACKGROUND

The Maryland All-Payer Model ended on December 31, 2018, after the State successfully met or exceeded its obligations to the federal government. To meet its financial savings obligation, the State targeted an annual growth rate for hospitals' Global Budget Revenue (GBR) to $330 M of cumulative savings to Medicare. By limiting the growth of hospital GBRs, this savings approach created benefits to all payers. By allowing hospitals to keep savings associated with hospital utilization reductions, hospitals were encouraged to engage in care transformation activities and reduce unnecessary utilization. Combined, the All-Payer Model generated savings for all payers, improved quality of care, and incentivized the creation and expansion of successful care transformation programs.

The Maryland TCOC Model replaced the All-Payer Model in January 2019. Under the TCOC Model, the State committed to reach an annual Medicare total cost of care savings rate of $300 million by 2023, inclusive of non-hospital costs. The new Model provides a flexible Medicare payment adjustment mechanism. The MPA Framework policy articulates an approach to using this new tool, which incentivizes hospitals to develop CTIs and reduce costs, as well as achieve the Medicare TCOC Savings. The CTI program, which started in 2019, rewards quantifiable care innovation that hospitals have invested in under the Model.

In short, the MPA Framework will allow hospitals to keep savings they produce from non-hospital costs through reconciliation payments (the MPA-RC). This is similar to the way that the GBR allows hospitals to keep hospital utilization savings. In addition, the MPA Framework can prospectively reduce hospital Medicare payments in order to meet the TCOC Medicare savings requirements, if required (the MPA-SC). Combined, the components of this policy will create savings to Medicare and incentivize the creation of successful CTIs that reduce the total cost of care in an intelligent fashion.

A New Tool: The Medicare Performance Adjustment and the MPA Framework

The TCOC Model Agreement (Section 8.c,i,6) allows the State to apply an adjustment to hospital payments in order to reward or penalize hospitals based on their success at controlling Medicare total cost of care. The adjustment is effectuated through a change to the amount paid by the Centers for Medicare & Medicaid Services (CMS), to hospitals after a claim has been received by the Medicare Administrative Contractor (MAC). The State calculates the amount and passes that amount to CMS, which then reduces all claims paid to the hospital by the indicated percentage. This adjustment is additive with other adjustments, like the sequestration adjustment, and is applied by CMS prior to paying a claim. The change does not go into hospital HSCRC rates, does not affect hospitals' GBR calculations, and is not reflected in rate orders.

The TCOC Model Agreement also has a "traditional" MPA component (described in Section 8.c.i.5), which creates a TCOC per capita benchmark by attributing beneficiaries to hospitals and then rewarding or penalizing hospitals based on their performance around that benchmark (Traditional MPA).

A hospital's "net" adjustment is the sum of the Traditional, Reconciliation, and Savings Components. To begin, the State proposes adjusting hospital MPAs semi-annually, though has the authority from CMS to make changes as frequently as quarterly.

THE MPA-RC IN ACTION: REWARDING CARE TRANSFORMATION INITIATIVES

Under the TCOC Model, in addition to producing savings to Medicare, the State committed to transforming care in a valuable and sustainable way. In order to demonstrate the continued value of the Maryland Model to CMS, the State must demonstrate care transformation across the entire delivery system and not simply reduce hospital unit costs. This approach is especially important as non-hospital costs are included in the Medicare TCOC test. Thus, developing a care transformation approach that also addresses non-hospital costs is necessary to ensure that the burden of producing TCOC savings is shared by the entire delivery system.

Currently, hospital GBRs do not capture utilization savings that occur outside of their GBR. While a hospital's success at reducing total cost of care helps the State meet the Medicare TCOC financial test the success of those initiatives do not benefit the hospitals themselves. Thus, without the MPA-RC there is relatively little incentive for hospitals to develop CTIs that target the total cost of care.

In order to strengthen hospital incentives for CTIs across care settings and partners, staff recommend the following principles:

1. Hospitals should keep the savings from their CTIs up to 100% to the extent feasible
2. Incentives should be structured to reward participation in CTIs and penalize non-participation
3. New and Existing CTIs that transform care across the entire delivery system should be supported

The MPA-RC is the mechanism by which CTI reconciliation payments are made to participating hospitals. For additional care transformation efforts, staff will use the MPA-RC as a vehicle for achieving principles 1 and 2.

Incentives to Participate in Care Transformation

Incentives to participate in CTIs in the non-hospital setting are critical to Maryland's success. Incentive payments made based on CTIs will allow hospitals to keep the total cost of care savings they produce outside their GBR. For example, if a hospital produces $5 million in savings under the Episode Care Improvement Program (ECIP, discussed later in this recommendation), they will receive a $5 million incentive payment. However, if the MPA-RC is only used to pay out hospitals for ECIP success it will produce limited net savings (since the payments will offset the savings achieved). Therefore, the payments specific to a hospital will be offset with a pro-rata reduction to all hospitals, based on total Medicare payments so that net savings to Medicare still exist but the hospitals that achieved the savings receive the greatest benefit.

Including offsets to incentive payments from CTIs within the MPA Framework has two implications. First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being

penalized for their non-participation. An example of the MPA Reconciliation Component is shown in Table 1.

Table 1. Example MPA Reconciliation Component for 2020

	Hospital Experience Savings (Costs)		Medicare Experience (Savings) Costs
	Participating Hospitals (represent 33% of total Medicare Payments)	Non-Participating Hospitals (represent 67% of total Medicare Payments)	Savings to Medicare
Non-Hospital Care Transformation savings achieved			($6M)
Reward payments to participating hospitals	$6M	$0M	$6M
Offset of reward payment	($2M)	($4M)	($6M)
Net Savings	**$4M**	**($4M)**	**($6M)**

Allowing hospitals to capture the savings they produce through care transformation creates an additional incentive for hospitals to participate in CTIs. As some hospitals begin to succeed in care transformation, the MPA Reconciliation Component offset on all hospitals will increase. Hospitals that do not participate or have less successful CTIs will pay an increasing share of the required TCOC savings. Through this tradeoff, this policy will equally apply pressure for care transformation investment and prioritization. See Appendix 1 for a detailed example of how the MPA-RC will be applied to hospitals participating in CTIs.

Supporting CTIs

Because hospital's best path to earn back reductions made through the MPA-RC will be by addressing total cost of care costs through care transformation the staff recommend continuing to develop additional opportunities for hospitals to achieve and quantify total cost of care saving that will be eligible for offsets as discussed for above.

Under the GBR, hospitals have been engaging in care transformation but their efforts have not been systematically assessed. The CTI program was designed to quantify care innovation that hospitals have invested in under the Model to reduce non-hospital costs and achieve the Medicare TCOC Savings. Initiatives must have defined interventions and a trigger to identify a population based on claims data. The trigger can be limited in a way to restrict the population to those most likely to be impacted and should include an intervention window. With this information, HSCRC can measure the impact on TCOC once intervention effects are be observable. Appendix 2 provides additional details on the methodological steps used to assess CTIs. Staff will issue a detailed User Guide covering more information on the savings calculation.

In addition to the CTI, the Care Redesign Program (CRP), which began in 2017, was in part developed to create a new tool to improve alignment between hospitals and non-hospital providers. The CRP allows

hospitals to make incentive payments to non-hospital providers that participate in care transformation. The CRP began with two tracks, the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). While some savings from these tracks may accrue to Medicare, these tracks were primarily designed to align non-hospital providers with initiatives that produce savings within the hospital setting covered under the GBR.

At the start of 2019, the State implemented the first CTI, the Episode Care Improvement Program (ECIP). ECIP is a CRP track that is based on CMS's Bundled Payment for Care Improvement Advanced (BPCI-A) model and rewards hospitals for post-acute care savings produced through better care management within 23 clinical inpatient episodes of care. If hospitals reduce the post-acute care costs in an episode by more than 3%, they earn a "reconciliation" payment on their Medicare hospital payments equal to the post-acute care savings generated beyond the 3% CMS Savings Discount. The MPA-RC provides a vehicle for making these payments. Because the Commission is offsetting CTI payments using the MPA-RC, staff recommend removing the 3% CMS Savings Discount within the ECIP reconciliation payments. ECIP has limitations — most prominently, it only covers 23 inpatient episodes and does not account for other initiatives and programs that hospitals may have already created to reduce the total cost of care.

THE MPA-SC IN ACTION: ACHIEVING TCOC SAVINGS REQUIREMENTS

Under the previous All-Payer Model, the State included a "savings cushion" in the Update Factor Policy to ensure that the Medicare hospital costs grew less than national hospital costs. The savings cushion amount was set to ensure that the State produced the required $330 million in cumulative five-year hospital Medicare savings required by the All-Payer Model. Under this approach savings targeted for Medicare were also applied to other payers.

The MPA-SC allows the Commission to further refine its Medicare savings approach with regards to the Update Factor Policy. Staff recommends the following principles in setting the annual Update Factor policy:

1. The Update Factor should ensure that the growth rate of Medicare total cost of care in Maryland grows less than national care growth
2. The Update Factor should ensure that hospital spending growth continues to grow less than the Gross State Product (GSP)
3. Remove the 0.5% savings cushion historically used to achieve the required Medicare savings

Importantly, as the TCOC Model's main financial test is now assessed on the basis of the total cost of care, rather than just hospital spending, the Update Factor will need to ensure that excess non-hospital growth in Maryland is offset by slower growth in hospital costs.

Staff view these principles on the Update Factor as consistent with the Commission's approach under the All-Payer Model. By continuing to constrain hospital spending, savings will be generated for all payers and health care costs will be constrained for Maryland citizens while hospitals will be allowed to keep the savings generated through reduced hospital utilization.

The TCOC Model also includes additional financial guardrails to ensure sustainable growth in health care expenditures. First, Medicare TCOC growth in Maryland cannot exceed the national growth rate by more than 1 percentage point in any given year. Second, Medicare TCOC growth in Maryland cannot exceed

national growth in any two consecutive years. By following the Update Factor principles above, the State should ensure that the growth rate of Medicare TCOC in Maryland remains less than national.

Calculating the MPA Savings Component to Achieve Required Medicare Savings

Under the agreement with CMS, the State committed to produce an annual total cost of care savings of $300 million by 2023. Prior to 2023, the State must meet incremental savings targets. The MPA-SC will be used on a prospective basis, as needed, to achieve these targets in place of the adjustment to the Update Factor used previously.

Based on current savings, HSCRC proposes that no Savings Component will be deducted from hospitals' Medicare payments for January to June 2020. There will be another assessment for the second half of the year in early 2020, but application of the MPA-SC is not anticipated.

Staff considered different options for allocating the MPA-SC to individual hospitals and supports a simple approach of allocating the MPA-SC to hospitals based on their share of statewide Medicare hospital payments. The Medicare Savings part of the MPA Savings Component could then be applied as the same flat percentage adjustment across all Maryland hospitals. For an example of how the MPA-SC will be applied to hospital Medicare payments, please see Appendix 1.

Operations of the MPA Savings Component and Interactions with other Commission Policies

Staff intend to calculate savings run rates during the spring of each year to coincide with the annual Update Factor development and leverage existing stakeholder engagement forums (the Payment Models Work Group and the Total Cost of Care Work Group) to evaluate the need for a payment reduction. Staff believe that announcing both the MPA-SC savings reduction and the annual Update Factor simultaneously will reduce hospitals' uncertainty about their Medicare revenues during the upcoming rate year and increase transparency in the HSCRC rate-setting process.

Because the Medicare TCOC savings are assessed on a calendar year basis and the Update Factor operates on a fiscal year basis, estimating the incremental savings to target with the MPA Savings Component will require projecting, during the spring, the following calendar year's total cost of care run rate (see figure). In order to reduce the uncertainty associated with run-rate projections, as opposed to actuals, staff recommends a two-step process for setting the MPA-SC:

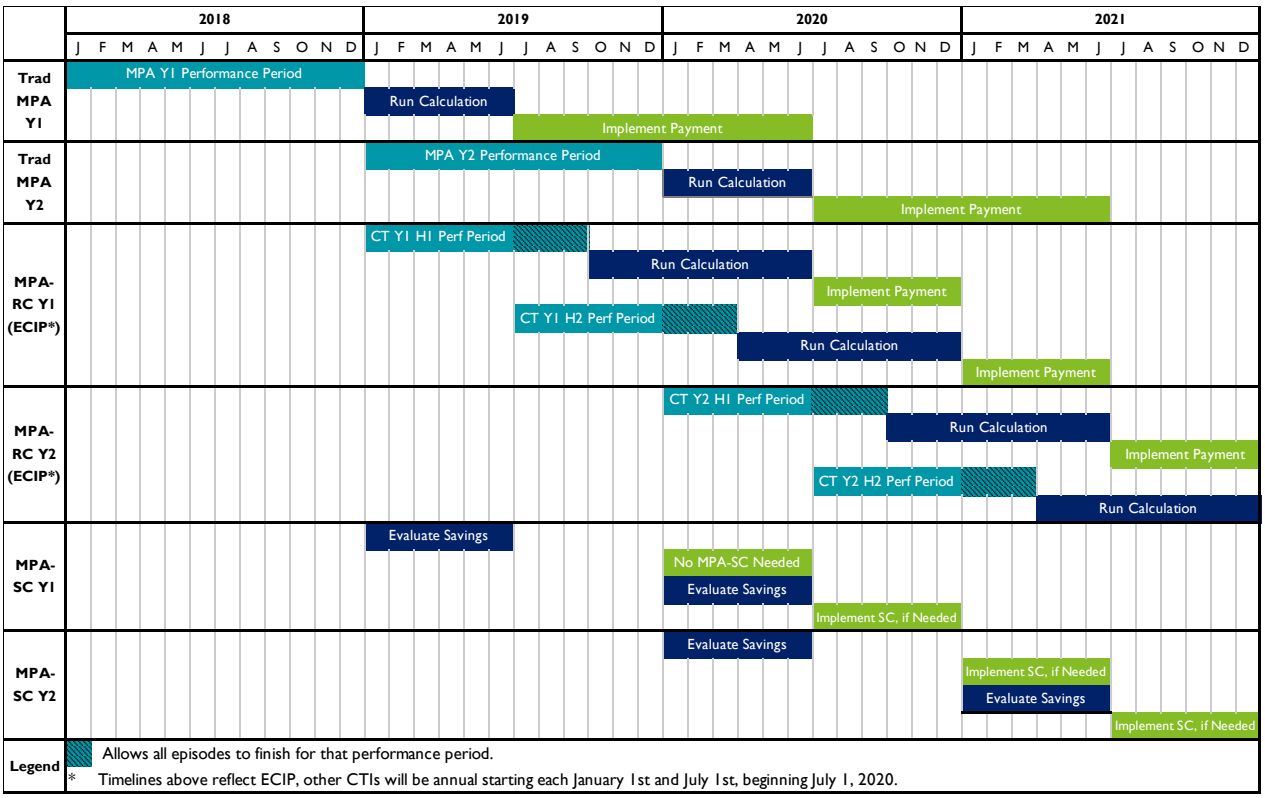
1. Once a full calendar year of Medicare data are available (including 3 months for claims run out) staff will be able to update Run Rate projections. Staff will then recommend an MPA-SC for the first six months of the next calendar year based on the current Medicare TCOC Run Rate; and

2. In the following spring, staff will recommend an update to the MPA-SC for the second six month period of that calendar year.

3. Should an MPA-SC adjustment related to achieving the savings target be determined to be necessary, the Commission will adopt specific policies specifying the adjustment amount.

Figure 1 shows the timing of the MPA Framework components in comparison to the timing of the Traditional MPA.

Figure 1: Timing of the MPA Framework and Traditional MPA



Staff considered either forecasting the total cost of care run rate for an annual MPA-SC or waiting until the end of the calendar year to set the MPA-SC using the actual run rate. However, both of these alternatives would have increased hospitals' uncertainty when estimating Medicare revenues through the annual Update Factor policy. Setting the MPA-SC in the spring of the preceding calendar year and then updating it in the spring of the current calendar year means that June 30 fiscal year hospitals will have insight into the MPA-SC for the entire next fiscal year during their budget process.

RECOMMENDATION FOR RY 2020 MPA FRAMEWORK POLICY

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2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. No savings "cushion" will be provided to achieve Medicare savings, instead, the MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

APPENDIX 1: EXAMPLE OF MPA FRAMEWORK'S IMPACT ON A HOSPITAL PARTICIPATING AND NOT PARTICIPATING IN CARE TRANSFORMATION

Hypothetical Participating Hospital:

- Hospital represents 5% of total MC hospital payments in the state
- Hospital has achieved a Traditional MPA reward of 1%
- Hospital is participating in CTIs and achieved $5M of savings out of a statewide total of $30 M
- The Commission has adopted a policy implementing incremental savings of $10M through the MPA-SC to ensure the State meets savings targets

Expected annual Medicare hospital payments		$500M
Traditional MPA: Yields +1% adjustment		$5.0M
MPA Framework Adjustment Allocation:		
MPA-SC Calculation: Allocation of Savings Share = 5% of $10M	-$0.5M	
MPA-RC: Positive Reconciliation Payment through CTIs	+5.0M	
MPA- RC: Allocation from Offset of statewide CTI payments = 5% of $30 M	-1.5M	
Total MPA Framework		$3.0M
Result: Hospital A Medicare payments		$508M

Hypothetical Non-Participating Hospital:

- Hospital represents 5% of total MC hospital payments in the state
- Hospital has achieved a Traditional MPA reward of 1%
- Hospital is not participating in CTIs and did not contribute to the statewide total of $30 M
- The Commission has adopted a policy implementing incremental savings of $10M through the MPA-SC to ensure the State meets savings targets

Expected annual Medicare hospital payments		$500M
Traditional MPA: Yields +1% adjustment		$5.0M
MPA Framework Adjustment Allocation:		
MPA-SC Calculation: Allocation of Savings Share = 5% of $10M	-$0.5M	
MPA-RC: Positive Reconciliation Payment through CTIs	$0.0M	
MPA-RC: Allocation from Offset of statewide CTI payments = 5% of $30 M	-$1.5M	
Total MPA Framework		-$2.0M
Result: Hospital B Medicare payments		$503M

APPENDIX 2: CARE TRANSFORMATION INITIATIVE (CTI) METHODOLOGY

The following section walks through the high-level methodology to identify a CTI's target population, construct the episode, set the target price, and calculate the reconciliation payment.

Part 1: Identifying the Target Population

Medicare claims data (Parts A and B) will be used to develop triggers that identify participants eligible for an intervention. This Intent-to-Treat analysis avoids only measuring those actually receiving the intervention, providing a way to avoid methodological limitations like selection bias. The trigger can include any combination of claims data elements - procedures received, hospital or ED admittance, diagnosed condition, basic patient demographic information, geographic residency, and select hospital(s) or provider(s) (NPI, TIN, etc.) delivering a service. Each CTI also identifies their intervention window (15, 30, 60, 90, 180, etc. days) in which the total cost of care will be measured.

Part 2: Constructing the Episode

Depending on the episode, certain methods will be applied to ensure validity and consistency. First, items such as blood clotting factors and technology pass-through payments, along with beneficiaries receiving ESRD services or with a hospital stay lasting 60 days or more will be omitted from all episodes. When a beneficiary dies, they can also be excluded from the episode. Definitional overlap between similar CTIs will be avoided by changing population definitions, however, up to 15% of overlap will be tolerated for meaningfully different CTIs. If the overlap is greater than 15%, a beneficiary is assigned based on which trigger occurred first. Finally, if claims span beyond the episode period the claims will be prorated.

Part 3: Setting the Target Price

Using the episode generated by Parts 1 and 2, the HSCRC will determine the target price. All payments assigned during the episode period will be summed to calculate the total episode spending. To determine the target spending for the Performance Period:

- The Base Period spending will be adjusted forward using the HSCRC update factor for inpatient and outpatient stays, the weighted average of anesthesia and physician update factors for the Physician Fee Schedule, and a ratio algorithm or the Medicare Economic Index (MEI) for other settings of care;
- Spending will be winsorized to limit extreme values at the 1st and 99th percentiles;
- Adjustments will be made for patient case mix using established mechanisms such as HCCs, APR-DRGs, Demographics, and Long-Term Institutional characteristics;

Episodes are then attributed to hospitals in the Baseline and Performance Periods, looking at the billing participant. Finally, the target price will be converted into a per episode amount, taking the adjusted base period spending and dividing by the number of episodes within the base period. For CTIs with small populations, the HSCRC will run a power calculation on the CTI population to set a savings threshold.

Part 4: Calculating the Reconciliation Payment

With the target price and episode specifications, the HSCRC will determine the per episode costs in the Performance Period (divide the adjusted total cost of care for the Performance Period by the number of episodes) and compare them to the target price. The positive difference between the Performance Period per episode costs and the target price will be multiplied by the number of Performance Period episodes to develop the final Reconciliation Payment amount.