Final Recommendation for the Medicare Performance Adjustment (MPA) for Rate Year 2020

November 13, 2017

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 2020. The final recommendation differs from the draft recommendation in two important ways. First, while the draft recommendation left open for discussion the possibility of using either a pre-set scale or a prospectively set methodology, the final recommendation from staff is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national Medicare growth rate. Second, the final recommendation places greater emphasis of the importance of monitoring the MPA and sharing information with hospitals for RY 2020, and of assessing potential changes to the MPA for the RY2021 policy.

Final Recommendations for RY 2020 MPA Policy

1) Implement the Medicare Performance Adjustment, based on HSCRC calculations.
2) Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like, and PSAP attribution.
3) Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%.
4) Include the MPA as part of the aggregate revenue at-risk under HSCRC quality programs.
5) Set the TCOC benchmark as each hospital's TCOC from 2017, updated with a Trend Factor of 0.33% below the national Medicare growth rate for CY 2018.
6) Continue to evaluate the MPA throughout the year and consider enhancements for a Year 2 MPA policy, 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) 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
CMS	Centers for Medicare & Medicaid Services
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
PCP	Primary Care Provider
PSA	Primary Service Area
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
TCOC	Medicare Total Cost of Care

INTRODUCTION

The State of Maryland is leading an effort to transform its health care system by increasing the emphasis on patient-centered care, improving population health, and lowering health care costs. To achieve these goals, the State of Maryland worked closely with hospitals and the Center for Medicare & Medicaid Innovation (CMMI) at the federal Centers for Medicare & Medicaid Services (CMS) to develop the Maryland All-Payer Model, which was implemented in 2014. The State, in partnership with providers, payers, and consumers, has made significant progress in this statewide modernization effort. Under the State's existing All-Payer Model, Maryland hospitals participate in a global hospital payment system with both individual and shared responsibility for limiting cost growth, including Medicare's total cost of care (TCOC).

This document outlines how Maryland hospitals would assume increasing responsibility for limiting the growth in TCOC for Medicare Fee-for-Service (FFS) beneficiaries, working together with other providers, over time, beginning with performance in Calendar Year (CY) 2018. To incorporate this additional responsibility, Maryland will utilize a value-based payment adjustment, referred to as a Medicare Performance Adjustment (MPA). The MPA will place hospitals' federal Medicare payments at risk, based on the total cost of care for Medicare beneficiaries attributed to a hospital.

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.

Beginning in 2014, the State and CMS entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. Under this new initiative, hospital-level global budgets were 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.

In December 2016, Maryland submitted a "Progression Plan" to CMS describing its goals and plans for an Enhanced TCOC All-Payer Model, under which the State will expand the Model's focus to incorporate the entire continuum of care. As part of this progression, the MPA is based on a TCOC measure, constructed by attributing all Maryland Medicare beneficiaries with Part A

and Part B FFS coverage to one or more hospitals. Their Medicare TCOC will include costs in both hospital and non-hospital settings. To incentivize increased focus on TCOC growth, the MPA would make a percentage adjustment to hospitals' federal Medicare payments. For its initial year (Performance Year 2018, affecting hospital payments from Medicare in Rate Year (RY) 2020), the MPA will be based on per capita TCOC spending for the beneficiaries attributed to a given hospital. (In future years, the MPA may also be formulated so that hospitals would share in statewide Medicare TCOC performance.)

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited in the first year to a positive or negative adjustment of no more than 0.5%), the policy must determine the following:

- An algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals;
- 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 remainder of this document describes the recommendation for calculating the MPA for RY 2020, based on extensive feedback from the industry and other stakeholders through the Total Cost of Care Work Group and other meetings.

As with all of Maryland's value-based payment programs, HSCRC may modify this approach over time, based on experience, ongoing analyses, and input from stakeholders. The State's intent is to gradually increase the Maryland health care delivery system's responsibility for TCOC.

The key objective of the MPA for Year 1 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.

To provide a mechanism to support aligned efforts by physicians/clinicians practicing at the hospital as well as those working in community settings, we are seeking to allow physicians/clinicians participating in Care Redesign Programs (e.g., Hospital Care Improvement Program (HCIP) and Complex and Chronic Care Improvement Program (CCIP)) to be eligible for bonuses and increased rates under the federal MACRA law.

ASSESSMENT

The HSCRC worked extensively with a stakeholder group, the Total Cost of Care Work Group, on the technical specifications to determine a hospital-specific measure of Medicare FFS TCOC. This recommendation reflects valuable insights provided by the work group—which has held regular public meetings over the past year—as well as analyses by HSCRC contractors LD

Consulting and Mathematica Policy Research (MPR) and other communications and meetings with health system stakeholders.

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 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.

Total Cost of Care Attribution Algorithm

Based on the Total Cost of Care Work Group's input and discussion, the staff developed a multi-step prospective attribution method. The method will assign 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 a formal Accountable Care Organization (ACO) relationship or through the PCPs' hospital referral patterns. (See Appendix I for estimated timeline of algorithm assignment and ACO list submission.)

The TCOC Attribution Algorithm uses the following hierarchy (each method of attribution is explained more fully below): (1) ACO-like attribution; (2) Maryland Primary Care Program (MDPCP)-like attribution; and (3) Geographic attribution. This approach is intended to recognize that hospitals can most easily identify and influence the quality and costs of patients who use them and their affiliated providers, while ensuring that responsibility for other beneficiaries is equitably assigned. 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. Through aligned efforts with both independent and affiliated physicians/clinicians, Maryland aims to provide better care while limiting the growth in total cost of care.

The total costs for a hospital's beneficiaries attributed through the ACO-like method, MDPCP-like method, and Geographic method 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.

$$Hospital\ Medicare\ TCOC\ per\ Capita = \frac{TCOC_{ACOlike} + TCOC_{MDPCPlike} + TCOC_{Geo}}{Benes_{ACOlike} + Benes_{MDPCPlike} + Benes_{Geo}}$$

ACO-like attribution

The ACO-like attribution enables hospitals that have already agreed to be accountable for beneficiaries in their ACO to build on those relationships. This step in the attribution is relevant for Maryland hospitals participating in the Medicare Shared Savings Program or Medicare Next Generation ACO Program. Assignment is based on elements of ACO attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then specialist use if a PCP cannot be identified. Beneficiaries are assigned to ACOs according to their use of participating providers (Appendix II). Beneficiaries affiliated with the ACO are then attributed to hospitals affiliated with that ACO. (If an ACO does not have a Maryland hospital as a participant, it is not included in the algorithm.) Based on 2016 Medicare spending of beneficiaries modeled in the attribution algorithm, beneficiaries attributed through the ACO-like portion of the algorithm account for 29% of Maryland Medicare beneficiaries and 31% of the statewide Medicare TCOC.

HSCRC will rely on CMS-provided lists of ACO providers in November of each year to determine ACO participation for that Base Year and the upcoming Performance Year (Appendix

I). Any changes to ACO provider lists throughout the year will not be included until the following Performance Year.

For ACOs with more than one hospital participating, the beneficiaries and their TCOC will be distributed in one of two ways. As outlined in the draft recommendation, the default approach is that beneficiaries will be distributed proportionally according to each participating hospital's Medicare market share. However, if the ACO's participating hospitals elect to designate their ACO PCPs to specific ACO hospitals, beneficiaries attributed to those PCPs will be attributed to the specific ACO hospital connected with that PCP, if approved by HSCRC. It is important to note that the ACO logic attributes beneficiaries to an ACO based on primary care use, but does not automatically attribute beneficiaries to specific PCPs. HSCRC will work with the TCOC Work Group and interested hospitals to determine an approach for attributing ACO beneficiaries to ACO PCPs.

Maryland Primary Care Program-like Attribution

Beneficiaries not assigned to hospitals through the ACO-like method will then be considered for attribution to hospitals based on beneficiaries' use of primary care providers and those providers' treatment relationships with hospitals. Beneficiaries' relationships with primary care providers are determined through their use of PCP services, as proposed in the MDPCP. Each provider is assigned to the hospital from which that provider's patients receive the plurality of their care. Primary care providers are defined by unique NPIs, regardless of practice location, and are not aggregated or attributed through practice group or TIN (Appendix II).

The method is similar to that by which beneficiaries are assigned to ACO providers; however, as with the ACO-like attribution, the MDPCP-like attribution can differ from the program on which it is based, if doing so more successfully aligns with the MPA principles laid out above. For example, although CMS ultimately decided that the MDPCP could not include any specialists, it was the general consensus of staff, TCOC WG members, and industry to permit the inclusion of certain specialists (if no other PCP was flagged and other criteria were met) in the MDPCP-like part of the MPA attribution algorithm (Appendix II). Based on 2016 Medicare spending of beneficiaries modeled in the attribution algorithm, beneficiaries attributed through the MDPCP-like portion of the algorithm account for 42% of Maryland Medicare beneficiaries and 52% of the statewide Medicare TCOC.

Geographic Attribution

The remaining beneficiaries and their TCOC — or the "residual of the residual" — will be assigned to hospitals based on geography. The Geographic methodology assigns zip codes 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. This approach is also referred to as PSA-Plus or PSAP (Appendix II). Based on 2016 Medicare spending of beneficiaries modeled in the

attribution algorithm, beneficiaries attributed through the Geographic portion of the algorithm account for 29% of Maryland Medicare beneficiaries and 16% of the statewide Medicare TCOC.

Assessment Methods

Multiple options for assigning beneficiaries and their costs to hospitals were explored with the TCOC Work Group over the past several months. In developing this staff recommendation, HSCRC staff evaluated the methods selected for attribution based on the degree to which they conform to the principles laid out above. In particular, the following metrics were used to assess each option. Results for the final selected attribution algorithm are included below each metric.

Scope: Measured by the share of Medicare TCOC and beneficiaries attributed statewide.
- 100% of Maryland Medicare beneficiaries are attributed under the recommended approach.

Incentives: Measured by the share of Medicare TCOC and beneficiaries uniquely attributed to hospitals, in total and by hospital
- 75% of beneficiaries, with 92% of TCOC, are uniquely attributed to a system/hospital under the recommended approach. Beneficiaries are assigned to multiple systems/hospitals only if multiple systems/hospitals have claimed the same PSA.

Relation to existing efforts: Promoted by adopting existing ACO and primary-care arrangements, and measured by the extent to which these arrangements are reflected in the attribution.
- Combined, ACO-like and PCM-like yield attribution to hospitals of 71% of beneficiaries and 83% of TCOC under the recommended approach.

Hospital efforts reflected: The stability of attribution resulting from proposed methods to ensure that hospital efforts are reflected, measured as the share attributed to the same provider, hospital, and system (as applicable) in consecutive years.
- 87% of beneficiaries attributed to same system/hospital between 2015 and 2016 under the recommended approach (excluding beneficiaries who during those two years were newly enrolled, died, or otherwise were not in both years of data, with whose inclusion this number would be 82%).

Calibrated responsibility: Measured as the association of hospitals' Medicare revenue with the Medicare TCOC to which they were assigned responsibility, and the impact of current and proposed future payment adjustments on hospitals' revenues.
- 0.5% maximum revenue at risk for Y1 under the recommended approach.

These numbers reflect specific design choices, reflected in this recommendation, purposely designed to optimize the algorithm's first-year performance under the above measures. For example, 87% of beneficiaries were attributed to same system/hospital between 2015 and 2016 under the recommended approach for several reasons, including:

- Annual attribution is based on two years of data;
- Attribution is fixed prospectively, with changes during the Performance Year in physicians'/clinicians' participation in ACOs or beneficiaries' intrastate moves, for example, not altering attribution; and
- The combination of all three components of the algorithm (i.e., ACO-like, MDPCP-like and Geography) ensures greater year-over-year consistency than any one component.

Performance Assessment

For Rate Year 2020, which is the MPA's first year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2018) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2017) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission, as described in greater detail below. Thus, for Rate Year 2020, performance will be assessed based on each hospital's own 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 beneficiaries for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2018, data for the two years ending September 30, 2017 will be used. For attribution for Base Year 2017, data for the two years ending September 30, 2016 will be used.

TCOC Trend Factor

The Final TCOC Trend Factor must be approved and determined by the Commission and approved by CMS before the MPA is applied, beginning July 1, 2019. Final TCOC data for the State and the nation are available in the May following the end of a calendar rear. For RY 2020, this means that CY 2018 performance data will be available in May 2019, and the MPA would be applied in July 2019.

HSCRC staff proposed that the TCOC Trend Factor should be set in reference to national Medicare FFS growth. However, some stakeholders 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.

Although staff is concerned about balancing the needs for a prospective and predictable target, staff is recommending to prospectively set the methodology for the TCOC Trend Factor, but not to pre-set the specific target for the first performance year. The Final Recommendation is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national growth rate, which is what is currently calculated as necessary to attain the required Medicare TCOC savings by 2023 under the Enhanced TCOC Model.

Staff understands hospital concerns with this approach and will provide periodic updates and national projections to aid hospitals in their progress. The Commission may consider revisiting the use of a pre-set target in future years of the MPA as the Commission becomes more comfortable with performance under the Model.

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 2020, the agreement with CMS requires the maximum penalty be set at 0.5% and the maximum reward at 0.5% of hospital federal Medicare revenue. The expectation is that the potential penalties and rewards will increase over time, as hospitals adapt to the new policy and desirable modifications are indicated, developed, and implemented.

The draft 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 2% for RY 2020. Before reaching the RY 2020 Maximum Revenue at Risk of ±0.5%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-quarter of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the draft agreement with CMS requires that a quality adjustment be applied. For RY 2020, the staff proposes to use the existing measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC) to determine these quality adjustments; however, staff recognizes that the Commission may choose to revise 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 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 (Appendix II). Regardless of the quality adjustment, the maximum reward and penalty of ±0.5% will not be exceeded.

With the maximum ±0.5% 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. Staff will examine the impact of including the MPA in aggregate revenue-at-risk from both Medicare and All-Payer perspectives.

MPA Implementation

Based on the hospital-specific MPA percentages calculated by HSCRC for Performance Year 2018, CMS can implement the MPA as an adjustment to hospitals' federal Medicare payments in Rate Year 2020. CMS continues to affirm its ability to implement the MPA based on its application of similar Medicare payment adjustments in other models (e.g., Next Generation ACOs, Comprehensive Primary Care Plus (CPC+)).

HSCRC staff intends to work with CMS and CRISP to provide hospitals with information so they can more effectively engage in care coordination and care improvement activities, assess their performance, and better manage TCOC in alignment with physicians/clinicians for beneficiaries attributed to them under the MPA. This information may include, as appropriate and consistent with federal and state privacy laws and requirements:

- List of PCPs whose beneficiaries are attributed to a hospital under the attribution algorithm
- List of beneficiaries attributed to a hospital under the attribution algorithm
- Reports of performance on the TCOC for each hospital relative to the attributed population during the performance year

Comments on Proposed MPA Algorithm and Recommendation

HSCRC staff received comments from the Maryland Hospital Association (MHA), Anne Arundel Medical Center (AAMC), Johns Hopkins Health System (JHHS), and the University of Maryland Medical System (UMMS), as well as oral feedback in the last Commission meeting from CareFirst and MHA. While there were concerns raised over the attribution approach, comment letters were generally supportive of the MPA draft recommendation, but raised numerous issues that staff plans to explore with the TCOC Work Group for improving the MPA and its algorithm for RY 2021. Staff recognizes that there are advantages and disadvantages of any attribution approach; however, staff believes it is important to operate the MPA and to make adjustments to the approach based on learning from initial operations. Therefore, staff continues to recommend implementation in alignment with the State's draft agreement with CMS.

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 2018, the work group will focus on implementation of the RY 2020 policy and potential improvements for the RY 2021 policy. Stakeholders must lead the effort of transformation in the State for it to be successful, and staff believes that the TCOC Work Group has provided a valuable forum to obtain input from stakeholders, as reflected in this recommendation. The staff is interested in inviting additional participation in the TCOC Work

Group. For example, staff welcomes the expertise that CareFirst brings in focusing on high-needs beneficiaries and serving them and in operating one of the largest PCMH models for commercial beneficiaries in the nation.

Implementation

To be successful in TCOC performance, stakeholders noted the need to identify and engage beneficiaries who are most at risk. To address these concerns, HSCRC is actively working to provide data and reporting to hospitals. Through the Care Redesign Amendment, CMS will make data available for care redesign efforts through the participation agreement, subject to applicable requirements for data use. Hospitals can use this data to focus their efforts in coordination, care management resources, and efficiency. In addition, HSCRC staff have provided hospitals with lists of PCPs and with counts of beneficiaries attributed to hospitals under the ACO-like and MDPCP-like portions of the algorithm if the MPA had been in place for Performance Year 2016. These lists, including near term updates to the lists, can help hospitals identify physicians/clinicians with whom they should work to improve coordination and transitions of care. CRISP is working with hospitals and with HSCRC to produce reports that can assist hospitals in monitoring their performance under the MPA. With the TCOC Work Group, staff will also monitor data for any unintended consequences of MPA implementation.

Revenue at Risk

HSCRC staff agrees with the stakeholders that the revenue at risk under the MPA is included as part of the revenue at risk in HSCRC quality programs. The specific effects on the other quality measures will be addressed by the Commission when the broader set of RY 2020 quality policies are considered.

Benchmark/Trend Factor

Stakeholders acknowledged staff concerns about the accuracy of predicting a trend factor ahead of time, but supported the development of a pre-set trend factor prior to the start of the performance period. Based on prior experiences with pre-set factors, as under the Quality-Based Reimbursement (QBR) adjustment, HSCRC staff believes that it is preferable to align the MPA's TCOC Trend Factor with the State's goal of beating national Medicare TCOC growth by a certain percentage. However, staff is willing to consider a pre-set trend factor for future years, subject to Commissioners' review. In the meantime, HSCRC will provide national Medicare growth estimates less a savings requirement and actual growth throughout the year to help hospitals monitor their progress.

Performance assessment

Multiple stakeholders advocated for a policy that recognizes both attainment and improvement, which can address concerns about penalizing hospitals that have reduced total cost of care and explain some variation in spending growth. HSCRC staff recognizes the potential value of adding attainment to the assessment of TCOC under the MPA. However, staff recommends that the TCOC Work Group considers how to introduce attainment for the RY 2021 policy, due to the number of complicated issues to analyze, such as:

- Defining the attainment benchmark(s). (Options for benchmarks could include the lowest adjusted quartile of TCOC among Maryland hospitals, comparisons to best quartile of national benchmarks with peer groupings, among others.)
- When making comparisons across hospitals, adjusting for TCOC differences over which a hospital has little or no control. (Options could include adjustments for the population's health risks, dually-eligible status, demographic factors, as well as adjustments for other factors affecting cross-hospital TCOC comparisons, such as Graduate Medical Education payments and labor market differences.)
- Applying the appropriate blend of attainment versus improvement. (Options could include adjusting the MPA's TCOC Trend Factor based on performance on attainment, taking the better of improvement or attainment, or assigning shares of revenue at risk for attainment versus improvement.)

Interaction of MPA with Care Redesign Programs
In addition to comment letters and feedback from the Commission, staff also received a concern for the record and approval vote by proxy by one of the Commissioners. While the Commissioner approved the recommendation, he noted the importance of devoting adequate attention and resources to the oversight of the Care Redesign Programs and their relationship to the MPA. Specifically, the CRISP administrative functions and the HSCRC oversight functions should ensure that physician protections in the Care Redesign Programs are enforced, including appropriate payment of incentives under the care partner agreements, adequate investigation and resolution of physician complaints, and appropriate functioning of hospital Care Redesign committees.

Staff agrees that oversight is an important part of ensuring care partner confidence in Care Redesign participation. As part of its oversight functions, HSCRC staff will ensure that hospitals are fulfilling the obligations to which they agreed according to their CMS- and HSCRC- approved HCIP and CCIP Implementation Protocols. These Implementation Protocols specify the conditions of payment under which hospitals will make incentive payments to participating care partners. The HCIP Implementation Protocol requires hospitals to specify the measures being used to determine that conditions of payment were met, as well as how the hospital will work with the third-party administrator contracted by CRISP to ensure that incentive payments are distributed accurately. For HCIP, incentive dollars come from reduced utilization, which translates into cost reductions or savings. While payments are contingent on performance of the conditions of payment, if savings are not achieved, payments are not made to physicians. The CCIP Implementation Protocol similarly requires hospitals to specify how completion of required interventions will be tracked, as well as additional information (if applicable) on the percentage of savings that will be shared with care partners and the process for distributing incentive payments, including how the payment will be issued and documented.

In addition to HSCRC's role, each participating hospital is required to establish a CRP Committee to oversee the operation of the Care Redesign Program in the hospital. With some exceptions for previously existing committees, at least half of the hospital's CRP Committee members must be eligible care partners, who can also help assure that incentive payments are

made in accordance to the hospital's Implementation Protocol. In their Implementation Protocols, each hospital provides information on the membership of its CRP Committee and how the CRP Committee will provide oversight, guidance, and management to the Care Redesign Program.

Each hospital participating in Care Redesign is required to submit a CRP report on a quarterly basis to CRISP, the HSCRC, and CMS. The reports must conform to the HSCRC's HCIP and CCIP reporting templates, which collect information on the activities of the CRP Committee and incentive payments by physician, among other topics. The HSCRC will aggregate information from the quarterly hospital-level CRP reports to submit a semiannual State-level monitoring report to CMS. The State-level monitoring reports will include information on CRP Committee activities and the amounts of incentive payments made to each care partner.

The CRISP Executive Committee created a Care Redesign Committee as a temporary advisory body to provide input to the CRISP Board on the implementation of the HCIP and CCIP programs. The three-member Care Redesign Committee comprises representatives from the CRISP Executive Committee, MedChi, and MHA and meets approximately every two weeks.

Other technical suggestions for review in RY 2021
Staff has incorporated some of the technical suggestions for Rate Year 2020, such as allowing ACOs to designate ACO physicians to specific ACO hospitals. The TCOC Work Group will explore the additional suggestions for Rate Year 2021, including attributing providers based on existing physician contractual relationships with hospitals or based on the plurality of weighted utilization measures instead of visits. Other issues raised that the TCOC Workgroup and staff plan to explore next year include modifications to the quality adjustment, a multi-year measurement approach, TCOC exclusions or adjustments based on type of spending, the relationship between actual and attributed TCOC, and the possibility of an all-geographic approach for some areas of the State. Staff looks forward to gaining insights on this issue from hospitals and clinicians for determining a potential RY 2021 policy.

RECOMMENDATIONS

Based on the assessment above, staff recommends the following for RY 2020 (with details as described above). The final recommendation differs from the draft recommendation in two important ways. First, while the draft recommendation left open for discussion the possibility of using either a pre-set scale or a prospectively set methodology, the final recommendation from staff is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national Medicare growth rate. Second, the final recommendation places greater emphasis of the importance of monitoring the MPA and sharing information with hospitals for RY 2020, and of assessing potential changes to the MPA for the RY2021 policy.

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APPENDIX I. ESTIMATED ALGORITHM TIMELINE

Estimated Timing	Action
Oct-Nov 2017	CMS* provides HSCRC with ACO Participant List for Performance Year 2018 (also used for Base Year 2017)
Nov-Dec 2017	HSCRC runs attribution algorithm for Base Year 2017 and Performance Year 2018, and provides hospitals and CMS with attribution lists
January 2018	Performance Year begins

*Subject to change, dates as noted in https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Participant-List-Agreement.pdf

APPENDIX II. TCOC 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 and no months of HMO enrollment or enrollment in Part A or Part B alone, 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 ACO-like method. Beneficiaries not attributed under ACO-like attribution (the first residual) are then assessed for attribution through the MDPCP-like attribution. Those not attributed through the MDPCP-like attribution (residual of the residual) 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 episode assignment. Claims in any setting from an episode beginning 3-days before and extending to 90-days after a hospital stay for such a condition are excluded from the TCOC and from the determination of ACO-like and PCM-like affiliation. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

ACO-like Attribution

All beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all. However, only ACOs with participating Maryland hospitals in the Medicare Shared Savings Program (MSSP) or Next Generation ACOs will be attributed beneficiaries through this method. 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 rely on CMS-provided lists of ACO providers in November 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. Hospital affiliation is also identified through ACO participation, and only hospitals affiliated with a Maryland ACO are used for attribution.

Beneficiary-to-ACO 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.

Provider-to-ACO attribution

Clinicians will be considered ACO providers if their National Provider Identification (NPI) number is included on an ACO list provided by CMMI and a Maryland hospital participates in that ACO.

ACO-to-Hospital attribution

Maryland hospitals participating in an ACO for the purposes of this method will be defined as hospitals listed on the Participant List of an ACO domiciled in Maryland. All beneficiaries and costs for beneficiaries of ACOs with a participating Maryland hospital will be attributed to that hospital. For ACOs with more than one hospital, beneficiaries and their TCOC will be attributed through one of two approaches. The default approach will be to distribute TCOC by Medicare market share (based on federal Medicare FFS hospital payments) of the hospitals in the ACO. However, if an ACO elects to designate ACO PCPs to specific ACO hospitals, beneficiaries attributed to those PCPs will be attributed to the specific ACO hospital connected with that PCP, 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.

ACO Specialties

Primary Care Providers are defined as physicians with a primary specialty of Internal Medicine; General Practice; Geriatric Medicine; Family Practice; Pediatric Medicine, or non-physician primary care providers - Nurse Practitioners, Clinical Nurse Specialists, or Physician Assistant. Other specialties include Obstetrics/Gynecology; Osteopathy; Sports Medicine; Physical Medicine and Rehabilitation; Cardiology; Psychiatry; Geriatric Psychiatry; Pulmonary Disease; Hematology; Hematology/Oncology; Preventive Medicine; Neuropsychiatry; Medical or Gynecological Oncology or Nephrology.

ACO Primary Care Codes

Domiciliary, rest home or custodial care

- CPT 99324 – 99337

- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

Domiciliary, rest home or custodial care

- CPT 99324 – 99337

- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

MDPCP-like Attribution

After removing the cost and beneficiaries assigned to hospitals through the ACO-like method, hospitals will be assigned beneficiaries based on beneficiaries' primary care providers (identified based on primary care utilization) and hospitals used by the beneficiaries of those providers over the two Federal fiscal year period preceding the performance period. Assignment of beneficiaries to primary care providers is determined based on the 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. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties if the beneficiary has chosen that clinician to provide primary care. Each clinician is assigned to a hospital based on the hospital most used by the clinician's beneficiaries. All beneficiaries attributed to a clinician through the MDPCP-like method will be attributed to the same hospital.

Beneficiary-to-Provider attribution

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. Clinicians enrolled in the Next Generation ACO Model, ACO Investment Model, or Advanced Payment ACO Model; or any other program or model that includes a shared savings opportunity with Medicare FFS initiative are excluded. Primary care providers are defined as unique NPIs regardless of practice location and are not aggregated or attributed through practice group or TIN. (Unlike in the MDPCP, in the methodology used in the MPA attribution, there is no requirement on practice size. The MDPCP requires a practice to have a minimum of 150 Medicare beneficiaries.)

Provider-to-Hospital attribution

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. 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.

MDPCP 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.

MDPCP 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 Attribution

The remaining beneficiaries and their costs will be assigned to hospitals based on Geography, following an algorithm known as PSA-Plus. Geography is determined on the basis of all Medicare TCOC for all Maryland Medicare beneficiaries, not only those left in this step of the attribution. The Geographic methodology assigns zip codes to hospitals through three steps:

1. Costs and beneficiaries in 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 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.

Beneficiaries not assigned based on ACO-Like or MDPCP-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.