NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendation that will be presented at the September 12, 2018 Public Meeting:

1) Medicare Performance Adjustment for Rate Year 2021

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATION ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE OCTOBER 17, 2018.

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

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555th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 10, 2018

EXECUTIVE SESSION
11:30 a.m.
(The Commission will begin in public session at 11:30 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

1. **Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**

2. **Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on September 12, 2018**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**

   Greater Baltimore Medical Center – 2442N
   Johns Hopkins Health System – 2443A
   Johns Hopkins Health System – 2444A
   Johns Hopkins Health System – 2445A
   Adventist HealthCare – 2446R
   MedStar Health – 2447A
   MedStar Health – 2448A
   Fort Washington Medical Center – 2449N
   University of Maryland Capital Regional Health – 2450R
   Greater Baltimore Medical Center – 2451R

4. **Docket Status – Cases Open**

   2452A – Johns Hopkins Health System
   2453A – MedStar Health
   2454A – MedStar Health
   2455A – Johns Hopkins Health System
   2456A – University of Maryland Medical Center
   2457A – Johns Hopkins Health System

5. **Presentation on Care Redesign Programs**

6. **Final Recommendation on Maximum Revenue Guardrail for Quality Programs for RY 2020**

7. **Draft Recommendation on the Medicare Performance Adjustment for RY 2021**

8. **Policy Update and Discussion**

a. **MDPCP Update**
b. **Workgroups Update**
c. **Commissioner Discussion of Volume and Market Shift**

9. **Hearing and Meeting Schedule**

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF OCTOBER 1, 2018

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2452A	Johns Hopkins Health System	9/6/2018	N/A	N/A	ARM	AP	OPEN
2453A	MedStar Health	9/6/2018	N/A	N/A	ARM	AP	OPEN
2454A	MedStar Health	9/11/2018	N/A	N/A	ARM	DNP	OPEN
2455A	Johns Hopkins Health System	9/25/2018	N/A	N/A	ARM	DNP	OPEN
2456A	University of Maryland Medical Center	9/25/2018	N/A	N/A	ARM	DNP	OPEN
2457A	Johns Hopkins Health System	9/25/2018	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2018**
	*	**FOLIO: 2264**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2454A**

Staff Recommendation

October 10, 2018

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on September 11, 2018 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC to continue to participate in a global arrangement for joint replacements with the National Orthopedic & Spine Alliance for a one year period beginning November 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. ("HRMI"). HRMI will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

There was no activity under this arrangement during its prior approval; however, staff still believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for participation in the alternative method of rate determination for joint replacement services, for a one year period, commencing November 1, 2018. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2265**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2455A**

Staff Recommendation

October 10, 2018

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on September 25, 2018 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. to add additional services to its existing global rate arrangement with Accarent for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services approved February 14, 2018. The System would like to add services related to Eating Disorders and Gall Bladder Surgery to the arrangement effective November 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at

their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After reviewing the Hospital experience data, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's' application to add services related to Eating Disorders and Gall Bladder Surgery to its existing arrangement for an alternative method of rate determination for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services with an effective date for the new services of November 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2018**
MEDICAL CENTER	*	**FOLIO:**	**2266**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2456A**

Staff Recommendation

October 10, 2018

I. INTRODUCTION

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 25, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains that it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the prior year has

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2018.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2267**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2457A**

Staff Recommendation

October 10, 2018

I. INTRODUCTION

On September 25, 2018, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular, pancreas, bariatric surgery and joint procedures with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective November 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the prior year has been

favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint, pancreas, and bariatric surgery procedures for one year beginning November 1, 2018. The Hospitals must file a renewal

x application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Care Redesign Presentation

Staff will present materials at the Commission meeting.

Final Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality Programs for Rate Year 2020

October 10, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
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This document contains the final staff recommendations for updating the Maximum Guardrail Policy for RY 2020.

Table of Contents

LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFY	Federal fiscal year
FY	State fiscal year
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
RY	State rate year
VBP	Value-based purchasing

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) performance-based payment methodologies are important policy tools that provide strong incentives for hospitals to improve their quality performance over time. These performance-based payment programs hold amounts of hospital revenue at-risk directly related to specified performance benchmarks. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into an All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014 and will enter into a Total Cost of Care Model agreement on January 1, 2019. One of the requirements under both agreements is that the proportion of hospital revenue that is held at-risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at-risk under national Medicare quality programs. Given Maryland's programs are fundamentally different from the nation in how revenue adjustments are determined (e.g., most programs have prospective incremental revenue adjustment scales with both rewards and penalties), the at-risk is measured both as potential risk (i.e., highest maximum penalty per program) and realized risk (absolute average of adjustments per program).

The purpose of this report is to make a recommendation for the maximum amount one hospital can be penalized for RY 2020, otherwise known as the maximum revenue guardrail. The recommendations for the maximum penalties and rewards for each quality program are set forth in the individual policies rather than in an aggregate at-risk policy.

BACKGROUND

1. Federal Quality Programs

In developing the recommendation for the maximum revenue guardrail, the staff first analyzed the aggregate revenue at-risk for Maryland's quality-based payment programs compared to the amount at-risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program (HRRP), which reduces payments to inpatient prospective payment system hospitals with excess readmissions.[1]

[1] For more information on the Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

- The Medicare Hospital-Acquired Condition Reduction Program (HACRP), which ranks hospitals according to performance on a list of hospital-acquired conditions and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare Value Based Purchasing (VBP) Program, which adjusts hospitals' payments based on their performance on the following four hospital quality domains: clinical care, patient experience of care, safety, and efficiency.[3]

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The Quality Based Reimbursement (QBR) program employs measures in several domains, including clinical care, patient experience, and safety. Starting in FY 2019, the QBR program revenue adjustments were linked to a preset scale instead of relatively ranking hospitals, which was designed to provide hospitals with more predictable revenue adjustments. Furthermore, the Commission approved a modified full scaling approach to ensure that rewards would only be given out to hospitals that perform well compared to the nation. For additional discussion on the QBR scale, please refer to the RY 2020 QBR policy posted to the HSCRC website.
- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. As with the QBR program, the MHAC program uses a pre-set scale to provide hospitals with the ability to prospectively estimate revenue adjustments. For additional discussion on the MHAC scale, please refer to the RY 2020 policy posted to the HSCRC website.
- The Readmission Reduction Incentive Program (RRIP) establishes a readmissions reduction target, an attainment target, and a scale for rewards/penalties for hospitals. The statewide minimum improvement target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate. For additional discussion on the improvement target, please refer to the RY 2020 policy posted to the HSCRC website.
- In addition to the three programs described above, two additional performance-based payment adjustments are implemented to hospital revenues prospectively as part of the

[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.
[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital-vbp.html.

annual update factor. The Potentially Avoidable Utilization (PAU) Savings Program reduces each hospital's approved revenues prospectively based on revenue associated with avoidable admissions and readmissions. The demographic PAU efficiency adjustment reductions are applied to global budgets to reduce allowed volume growth based on the percentage of revenue associated with PAU for each hospital.

Figure 1 below provides the maximum penalties or rewards for the three CMS and Maryland quality programs for RY/FFY 2019 and RY/FFY 2020. In general, CMS programs relatively rank hospital performance when determining penalties or rewards, whereas Maryland's quality programs use prospectively determined preset scales. For RY 2019 and RY 2020 staff believe that the Maryland quality programs have met or exceeded the national potential risk. Furthermore, staff estimate that through RY 2018 the State has also met or exceeded the national realized risk (FFY 2019 revenue adjustments not yet available). These estimates use the methodology that HSCRC and CMMI agreed upon, but final numbers are pending CMMI review. See Appendix A for additional details on the aggregate at-risk test.

Figure 1. 2018 Maximum Quality Penalties or Rewards for Maryland and The Nation

MD All-Payer	Max Penalty %	Max Reward %	National Medicare	Max Penalty %	Max Reward %
RY/FFY 2019					
MHAC	2.0%	1.0%	HAC	1.0%	N/A
RRIP	2.0%	1.0%	HRRP	3.0%	N/A
QBR	2.0%	1.0%	VBP	2.0%	2.0%
RY/FFY 2020					
MHAC	2.0%	1.0%	HAC	1.0%	N/A
RRIP	2.0%	1.0%	HRRP	3.0%	N/A
QBR	2.0%	2.0%	VBP	2.0%	2.0%

ASSESSMENT

In order to develop the maximum revenue at-risk guardrail for RY 2020 quality programs, HSCRC staff considered CMS relevant policies, conducted analyses, and solicited input from the Performance Measurement Workgroup.[4] During its February meeting, the Performance Measurement Workgroup reviewed data comparing the amount of revenue at-risk in Maryland with the national Medicare programs. Again the RY 2020 aggregate at-risk amounts were approved as part of the actual quality program policies, and this report only presents a recommendation for the maximum revenue guardrail.

[4] For more information on the Performance Measurement Workgroup, see https://hscrc.maryland.gov/Pages/hscrc-workgroup-performance-measurement.aspx

Maximum Revenue at-risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive significant revenue reductions has raised concerns that such penalties may generate unmanageable financial risk. Similar to the risk corridors in other VBP programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. In RY 2017, RY2018, and RY 2019, the hospital maximum penalty guardrail was set at 3.50 percent of total hospital revenue. Staff used the inpatient Medicare aggregate amount at-risk total as the benchmark to calculate the hospital maximum penalty guardrail (e.g. 6 percent * 58 percent revenue attributable to inpatient services). For RY 2020, staff recommend updating the percent of inpatient revenue (dropped from 58 to 57 percent) for calculating the maximum guardrail, which results in a slightly reduced maximum revenue guardrail of 3.40 percent. This maximum revenue guardrail applies to QBR, MHAC, RRIP, and net PAU Savings. Historically, no hospital penalties have reached the maximum revenue guardrail. For reference, in RY 2019 the highest revenue adjustment was a 2.05 percent total revenue reduction (which corresponds to 2.74 percent revenue reduction for inpatient revenue). See Appendix B for by hospital net revenue adjustments across quality programs included in the maximum guardrail calculation.

STAKEHOLDER COMMENTS AND RESPONSES

HSCRC staff received one comment letter from the Maryland Hospital Association that expressed general support for the recommendation to limit the maximum negative revenue adjustment one hospital could receive to 3.4 percent of total hospital revenue. However the letter outlined the following considerations related to the aggregate revenue at-risk and the maximum penalty guardrail for future years:

1. Rethink the magnitude of potential and realized risk on quality programs where Maryland has made significant gains or is outperforming the nation.

2. Include the Medicare Performance Adjustment risk in future calculations of the guardrail and both the potential and realized revenue at risk.

Staff Response:

- ***Staff appreciates MHAs support of this year's policy and would be willing to engage stakeholders to get input on the additional considerations for future years.***
- ***In terms of the revenue at-risk for Maryland quality programs, staff would want to engage stakeholders to discuss reducing revenue at-risk or moving revenue away from programs where Maryland has done well, and focusing the revenue adjustments on areas where improvement is still needed. While staff acknowledge***

that historically the Commission has increased risk in areas of needed improvement (i.e., performance on patient satisfaction surveys), there are concerns about decreasing revenue at risk in other areas and whether gains in improvement will decline. Again, as staff work with stakeholders to develop quality policies over the next few years, these issues should be discussed.

- ***Staff recognizes the additional revenue at-risk for Maryland hospitals under the full 1 percent Medicare Performance Adjustment in RY 2021. For the RY 2021 maximum guardrail policy, staff will engage with stakeholders to consider adding the Medicare Performance Adjustment to the RY 2021 maximum guardrail policy. Among the concerns that may need to be discussed include whether there is any significant impact on other payers by including a payer specific program in aggregate at risk calculations and the max guardrail policy.***

RECOMMENDATION

For RY 2020, the maximum penalty guardrail should be set at 3.40 percent of total hospital revenue.

APPENDIX A. COMPARISON OF AGGREGATE REVENUE AT-RISK FOR MARYLAND QUALITY-BASED PAYMENT PROGRAMS COMPARED TO MEDICARE PROGRAMS

After discussions with CMS, HSCRC staff performed analyses of both "potential" and "realized" revenue at-risk. Potential revenue at-risk refers to the maximum amount of revenue that is at-risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Exhibit 1 compares the potential amount of revenue at-risk in Maryland with the amount at-risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the annual difference.

The top half of Exhibit 1 displays the percentage of potential inpatient revenue at-risk in Maryland for all payers for each of Maryland's quality-based payment programs for RYs 2014 through 2020. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at-risk for quality-based payment programs for FFYs 2014 through 2020. These potential at-risk numbers are the absolute values of the maximum penalty or reward. Due to efforts to align Maryland's quality-based payment programs with the national programs and the increasing emphasis on value-based payment adjustments, Maryland has exceeded the national aggregate maximum at-risk amounts since RY 2016.

Exhibit 1. Potential Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2020

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020
MHAC	2.0%	3.0%	4.0%	3.0%	3.0%	2.0%	2.0%
RRIP			0.5%	2.0%	2.0%	2.0%	2.0%
QBR	0.5%	0.5%	1.0%	2.0%	2.0%	2.0%	2.0%
Subtotal	2.5%	3.5%	5.5%	7.0%	7.0%	6.0%	6.0%
PAU Savings*	0.4%	0.9%	1.4%	4.5%	5.9%	5.8%	*5.8%*
Demographic PAU Efficiency Adjustment*	0.5%	0.9%	1.1%	1.3%	0.5%	0.8%	*0.8%*
MD Aggregate Max. At Risk	3.4%	5.2%	8.0%	12.8%	13.4%	12.6%	12.6%
*Italicized numbers subject to change							

% of National Medicare Inpatient Revenue	FFY2014	FFY2015	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
HAC		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Readmissions	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
VBP	1.3%	1.5%	1.8%	2.0%	2.0%	2.0%	2.0%
Medicare Aggregate Max. At Risk	3.3%	5.5%	5.8%	6.0%	6.0%	6.0%	6.0%
Annual MD-US Difference	0.2%	-0.3%	2.2%	6.8%	7.4%	6.6%	6.6%
*Please note that these numbers are rounded in the table to the 10th decimal and results in some discrepancies compared to calculations done with the table numbers.							

As Maryland's programs moved away from revenue neutral rewards and penalties and toward payment adjustments based on preset payment scales, the actual amounts imposed in quality-based programs differ from the maximum amounts established in the policies and none of the hospitals may be subject to the maximum penalty when the payment adjustments are implemented. On the other hand, the national Medicare programs may make payment adjustments only to the lowest performing hospitals, limiting the reach of the performance-based adjustments. CMMI and HSCRC staff worked on a methodology to compare the total actual payment adjustments by summing the absolute average payment adjustments across all programs, namely aggregate realized at-risk. Maryland is expected to meet or exceed both the potential and realized at-risk amounts of the national Medicare programs but final approval is pending CMMI confirmation. Exhibit 2 provides a comparison of the average adjustment amount between Maryland and national programs. Maryland's overall aggregate average adjustments were 5.25 percent of the total inpatient revenue in RY 2019, compared to 1.33 percent in the national Medicare programs in FFY 2018 (FFY 2019 revenue adjustments in table are estimates based on FFY 2018; if available final policy will include actual FFY 2019 adjustments). While the PAU savings revenue adjustments account for a large proportion of Maryland's higher realized risk, Maryland meets the realized risk requirement even without the PAU savings or demographic PAU efficiency adjustment.

Exhibit 2. Realized Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2019

% of MD All-Payer Inpatient Revenue	**RY 2014**	**RY 2015**	**RY 2016**	**RY 2017**	**RY 2018**	**RY 2019**
MHAC	0.22%	0.11%	0.18%	0.40%	0.50%	0.25%
RRIP			0.15%	0.57%	0.61%	0.58%
QBR	0.11%	0.14%	0.30%	0.26%	0.59%	0.64%
Subtotal	0.34%	0.25%	0.63%	1.23%	1.70%	1.47%
PAU Savings	0.29%	0.64%	0.93%	2.55%	3.05%	3.57%
Demographic PAU Efficiency Adjustment	0.28%	0.33%	0.39%	0.35%	0.22%	0.21%
MD Aggregate Max.At Risk	**0.90%**	**1.22%**	**1.95%**	**4.13%**	**4.97%**	**5.25%**
% of National Medicare Inpatient Revenue	**FFY 2014**	**FFY2015**	**FFY2016**	**FFY2017***	**FFY2018***	**FFY2019***
HAC		0.22%	0.23%	0.24%	0.24%	0.24%
Readmits	0.28%	0.52%	0.51%	0.61%	0.56%	0.56%
VBP	0.20%	0.24%	0.40%	0.51%	0.53%	0.53%
Medicare Aggregate Max. At Risk	**0.47%**	**0.97%**	**1.14%**	**1.36%**	**1.33%**	**1.33%**
Annual MD-US Difference	**0.43%**	**0.25%**	**0.81%**	**2.77%**	**3.63%**	**3.92%**
*The CMS realized risk was calculated by the HSCRC and are subject to CMS validation.						

In summary, staff estimate that Maryland outperformed the national programs in the potential and realized aggregate payment amounts for RY 2019. Maryland hospitals continued to improve their performance in reducing complications and readmissions. However, further reductions in revenue associated with PAU will be important for financial success under the all-payer and Total Cost of Care model. Finally, as additional performance-based revenue adjustments are implemented, such as the Medicare Performance Adjustment for total cost of care, the potential aggregate at-risk amounts for other programs should be evaluated. Staff will continue to discuss the appropriate amounts for performance-based payment programs with the workgroups and other stakeholders.

Appendix B. Consolidated Net Revenue Adjustments for All Quality-Based Payment Programs for Rate Year 2019, by Hospital

HOSP ID	Hospital Name	FY 17 Total Permanent Revenue	FY 17 Permanent Inpatient Revenue	MHAC % Inpatient	RRIP % Inpatient	QBR % Inpatient	PAU Savings % Inpatient	PAU Net Impact % Inpatient	PAU Demographic % Inpatient	Total Impact % Inpatient	Total Impact % Total Revenue
210003	UM-PG	$287,707,710	$215,464,625	0.13%	-0.98%	-1.49%	-2.41%	-0.41%	-0.05%	-2.74%	-2.05%
210004	HOLY CROSS	$489,724,686	$340,412,069	0.24%	-1.63%	-1.08%	-2.57%	-0.25%	-0.03%	-2.72%	-1.89%
210001	MERITUS	$321,955,560	$190,799,459	-0.18%	-1.02%	-1.07%	-3.71%	-0.82%	-0.38%	-3.09%	-1.83%
210062	SOUTHERN MD	$271,260,318	$163,844,003	-0.89%	-0.04%	-1.05%	-4.49%	-0.94%	-0.33%	-2.92%	-1.76%
210022	SUBURBAN	$313,631,832	$197,431,392	-0.04%	-1.18%	-1.23%	-2.61%	-0.34%	-0.20%	-2.79%	-1.76%
210015	FRANKLIN SQ	$522,059,009	$300,623,972	-0.22%	-1.19%	-0.85%	-3.14%	-0.67%	-0.04%	-2.93%	-1.69%
210034	HARBOR	$186,978,444	$112,526,840	0.00%	-1.47%	-0.88%	-3.00%	-0.45%	-0.02%	-2.80%	-1.68%
210033	CARROLL	$225,263,359	$132,801,017	-0.62%	-0.35%	-0.56%	-4.56%	-1.29%	-0.36%	-2.83%	-1.67%
210065	HC GERMAN	$102,303,760	$60,632,167	0.38%	-1.56%	-0.51%	-3.54%	-0.82%	-0.22%	-2.51%	-1.49%
210002	UMMC	$1,399,559,924	$919,253,797	-0.31%	-0.36%	-0.83%	-2.12%	-0.65%	-0.04%	-2.16%	-1.42%
210005	FREDERICK	$338,085,918	$220,972,343	0.07%	-0.06%	-0.89%	-3.50%	-1.21%	-0.41%	-2.09%	-1.37%
210032	UNION OF CECIL	$158,683,870	$66,514,320	0.00%	-1.80%	-0.57%	-4.31%	-0.76%	-0.37%	-3.13%	-1.31%
210024	UNION MEMORIAL	$421,547,476	$235,346,415	-0.71%	0.09%	-0.67%	-3.43%	-0.99%	-0.03%	-2.28%	-1.27%
210018	MS MONTGOMERY	$172,101,071	$77,808,657	0.16%	-0.56%	-1.51%	-4.36%	-0.75%	-0.32%	-2.66%	-1.20%
210029	HOPKINS BAYVIEW	$647,476,458	$357,620,585	0.00%	-0.84%	-0.56%	-3.27%	-0.65%	0.00%	-2.05%	-1.13%
210048	HOWARD	$298,460,107	$183,348,539	-0.62%	-0.11%	-0.45%	-3.39%	-0.64%	-0.36%	-1.82%	-1.12%
210056	GOOD SAMARITAN	$264,597,392	$140,674,848	0.09%	0.28%	-1.10%	-5.21%	-1.05%	0.00%	-1.78%	-0.95%
210010	DORCHESTER	$49,226,292	$26,021,222	0.31%	-0.83%	-0.64%	-3.42%	-0.63%	-0.05%	-1.79%	-0.94%
210019	PRMC	$431,713,670	$241,466,813	0.00%	-0.66%	-0.43%	-3.09%	-0.28%	-0.15%	-1.37%	-0.77%
210016	WASHADVENTIST	$265,729,172	$158,337,604	0.13%	0.28%	-1.12%	-3.03%	-0.57%	-0.14%	-1.28%	-0.76%
210055	UM-LAUREL	$99,871,376	$58,931,276	0.44%	0.35%	-1.61%	-2.98%	-0.47%	-0.14%	-1.28%	-0.76%
210009	JOHNS HOPKINS	$2,352,963,223	$1,378,259,901	0.00%	-0.28%	-0.36%	-2.52%	-0.58%	-0.04%	-1.22%	-0.72%
210051	DOCTORS	$239,227,750	$144,686,192	0.22%	-0.05%	-0.31%	-4.67%	-1.00%	-0.37%	-1.14%	-0.69%
210006	HARFORD	$102,314,327	$48,557,781	0.38%	-0.42%	-0.91%	-5.66%	-0.46%	-0.76%	-1.42%	-0.67%
210027	WESTERN MD	$320,642,519	$171,000,183	-0.44%	0.01%	-0.09%	-3.47%	-0.72%	0.00%	-1.24%	-0.66%

HOSP ID	Hospital Name	FY 17 Total Permanent Revenue	FY 17 Permanent Inpatient Revenue	MHAC % Inpatient	RRIP % Inpatient	QBR % Inpatient	PAU Savings % Inpatient	PAU Net Impact % Inpatient	PAU Demographic % Inpatient	Total Impact % Inpatient	Total Impact % Total Revenue
210011	ST. AGNES	$422,820,202	$237,889,236	0.29%	0.12%	-0.70%	-4.24%	-0.85%	-0.05%	-1.14%	-0.64%
210043	UM-BWMC	$409,703,662	$229,151,792	0.13%	0.38%	-0.92%	-4.20%	-0.67%	-0.46%	-1.07%	-0.60%
210038	UMMC MIDTOWN	$234,227,770	$117,217,727	0.40%	-0.29%	-0.62%	-3.61%	-0.67%	0.00%	-1.18%	-0.59%
210061	AGH	$105,151,502	$37,316,219	0.53%	0.07%	-0.96%	-4.26%	-1.10%	-0.28%	-1.45%	-0.52%
210057	SHADY GROVE	$387,674,359	$231,939,525	0.00%	0.01%	-0.20%	-2.88%	-0.66%	-0.17%	-0.85%	-0.51%
210028	MS ST. MARY	$177,161,733	$76,303,058	0.49%	0.18%	-0.75%	-4.63%	-1.04%	-0.51%	-1.13%	-0.48%
210023	AAMC	$609,013,273	$299,264,995	0.33%	-0.02%	-0.64%	-2.93%	-0.63%	-0.21%	-0.96%	-0.47%
210044	G.B.M.C.	$442,204,396	$225,145,722	-0.71%	0.40%	-0.38%	-2.54%	-0.18%	-0.03%	-0.87%	-0.44%
210012	SINAI	$752,409,746	$398,036,508	-0.31%	1.00%	-0.73%	-2.78%	-0.49%	0.00%	-0.53%	-0.28%
210008	MERCY	$516,410,170	$223,932,822	0.00%	0.21%	-0.18%	-2.08%	-0.45%	-0.02%	-0.42%	-0.18%
210060	FT WASHINGTON	$48,244,588	$19,548,527	0.62%	1.00%	-1.42%	-5.82%	-0.65%	-0.34%	-0.44%	-0.18%
210037	EASTON	$202,561,563	$105,222,295	0.31%	-0.27%	-0.31%	-2.93%	0.01%	-0.19%	-0.26%	-0.13%
210017	GARRETT	$54,328,266	$21,075,334	0.00%	1.00%	-0.73%	-3.41%	-0.54%	-0.30%	-0.27%	-0.10%
210013	BON SECOURS	$115,902,722	$65,798,042	0.00%	0.97%	-0.37%	-3.18%	-0.56%	0.00%	0.04%	0.02%
210035	UM-CHARLES	$148,909,451	$75,199,112	0.38%	0.34%	-0.32%	-4.08%	-0.35%	-0.49%	0.04%	0.02%
210064	LEVINDALE	$58,867,710	$56,105,767	-0.62%	0.85%		-1.25%	-0.16%	-0.16%	0.06%	0.06%
210058	UMROI	$120,638,692	$69,966,359	0.00%	0.22%		-0.12%	-0.11%	0.00%	0.11%	0.06%
210045	MCCREADY	$15,618,329	$3,033,907		0.38%		-6.87%	0.00%	-0.40%	0.38%	0.07%
210049	UM-UCH	$334,751,759	$130,150,364	0.18%	1.00%	-0.04%	-4.62%	-0.85%	-0.47%	0.29%	0.11%
210040	NORTHWEST	$255,493,814	$133,828,758	0.18%	0.89%	-0.07%	-4.96%	-0.78%	-0.11%	0.22%	0.11%
210063	UM ST. JOE	$398,711,781	$237,924,618	0.00%	0.32%	0.12%	-2.17%	-0.23%	-0.08%	0.21%	0.12%
210039	CALVERT	$143,263,199	$63,677,722	0.11%	1.00%	-0.02%	-4.17%	-0.65%	-0.59%	0.44%	0.20%
210030	UM-Chester	$55,473,722	$21,139,936	0.00%	0.62%	0.24%	-5.06%	0.23%	-0.45%	1.09%	0.41%
State	**Statewide**	**$16,292,627,632**	**$9,222,204,362**	**-0.06%**	**-0.21%**	**-0.63%**	**-3.09%**	**-0.61%**	**-0.13%**	**-1.52%**	**-0.86%**

Maryland
Hospital Association

September 18, 2018

Allan Pack
Principal Deputy Director
Director, Population Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Allan:

On behalf of Maryland's 63 hospital and health system members, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality Programs for Rate Year 2020.* We support the draft recommendation to limit the maximum total revenue adjustment for a single hospital's revenue base to 3.4 percent. However, we recommend two additional considerations for future years:

- Rethink the magnitude of potential and realized risk on quality programs where Maryland has made significant gains or is outperforming the nation
- Include the Medicare Performance Adjustment risk in future calculations of the guardrail and both the *potential* and *realized* revenue at risk

As Maryland's hospitals work to manage the total cost of care statewide, they will need to employ new interventions and find new ways to work with care partners. Overzealous improvement targets tied to strong penalties and rewards on measures where hospitals have already made significant progress distract from the work needed to improve care outside hospitals. Rethinking how penalties and rewards are set relative to targets can help ensure the emphasis is on activities that align with total cost of care goals.

The recommendation does not include the 0.5 percent of Medicare revenue at risk under the Medicare Performance Adjustment (MPA) policy. In fiscal 2021, the MPA risk should be included in the maximum guardrail and the calculation of revenue at risk. The MPA risk is clearly additional risk that should be included in the determination of hospitals' risk relative to the nation. Likewise, the guardrail is an important stop-loss mechanism to protect hospitals from overwhelming financial risk and should include the MPA. The guardrail has been in place since fiscal 2017 and is even more important as hospitals take on additional risk under the new Total Cost of Care Model.

We look forward to working with you on these policies.

Sincerely,

Traci La Valle
Vice President

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director

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

October 2018

Health Services Cost Review Commission
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This document contains the draft staff recommendations for updating the Medicare Performance Adjustment (MPA) Policy for RY 2021. Please submit comments on this draft to the Commission by Wednesday, October 17, 2018, via email to hscrc.tcoc@maryland.gov.

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POTENTIAL DRAFT RECOMMENDATIONS FOR RY 2021 MPA POLICY

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

INTRODUCTION

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA) with performance beginning in Calendar Year (CY) 2018. The MPA increases the responsibility on providers by placing hospitals' federal Medicare payments at risk, based on the total cost of care for Medicare fee-for-service (FFS) beneficiaries attributed to a hospital.

MEDICARE PERFORMANCE ADJUSTMENT MECHANICS

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

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

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

Total Cost of Care Attribution Algorithm

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

General algorithm organization and provider-to-hospital consistency

In response to Maryland Hospital Association comments, staff has reorganized the structure of the algorithm for the RY 2021 policy to first attribute beneficiaries to providers and then link providers with hospitals, rather than performing the steps simultaneously. This change ensures that each PCP with attributed beneficiaries will be linked with only one hospital, regardless of how a beneficiary is attributed to that PCP. These beneficiaries are attributed to providers based on their use of primary care services. Beneficiaries that cannot be attributed to a provider through MDPCP-actual, ACO-like or PCP-like are attributed directly to a hospital based on geography (that is, where the beneficiary resides). Providers with attributed beneficiaries are linked to hospitals based on existing provider-hospital relationships.

Beneficiary attribution algorithm changes

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

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

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

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

Provider-to-hospital relationships

Year 1 of the MPA included recognizing relationships between ACO providers and hospital-affiliated ACOs, as well as a provider's referral patterns. However, many hospitals expressed strong interest in the MPA accounting for additional relationships. For Year 2 of the MPA, eligible provider-to-hospital relationships begin with MDPCP provider participation with a hospital-affiliated Care Transformation Organization (CTO), followed by ACO provider participation with an ACO-affiliated hospital. If the provider does not participate with a hospital in these programs, providers may be linked with hospitals based on employment. All remaining providers with attributed beneficiaries will be linked to hospitals based on the referral patterns of their attributed beneficiaries, as described below and in the appendices. Throughout the linkage steps, providers participating in an MDPCP practice will be considered together for the purposes of linkage between providers and hospitals. This ensures that all providers in an MDPCP practice are linked with the same hospital, regardless of the method of linking.

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

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

Employment linkage. Throughout the past year, some hospital stakeholders have expressed that employment represents one of the strongest links between hospitals and providers. HSCRC staff agree that employment allows for easier coordination and sharing of resources, and therefore should be included in the algorithm, but also believe it is crucial to continue encouraging participation in official payment structures with CMS oversight, such as MDPCP or ACOs. In addition, there is no consistent definition of employment agreed to by all hospitals, and HSCRC will have to rely on voluntary submission of hospital lists that cannot be easily validated. To balance these considerations, HSCRC recommends using employment as a voluntary link

between providers and hospitals after the MDPCP and ACO-like linkages. Any providers not linked to hospitals through the CTO or ACO linkages may be linked to hospitals based on voluntary hospital-submitted employment lists. HSCRC will accept the Maryland Hospital Association definition of employment as the eligible providers who will receive a W-2 from the hospital or its parent or subsidiary organization for the calendar year preceding the performance period with full time status. These lists must be submitted to HSCRC by a specified date and represent full-time, fully employed providers with a single hospital/hospital system. Remaining providers participating in an MDPCP practice not linked with hospital-affiliated CTO or ACO will be assessed together as a practice group under employment approach.

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

Review period

While staff has worked to address some concerns of the TCOC Work Group, no attribution method is perfect. Therefore, staff recommends the implementation of an official algorithm review period. Subsequent to the initial running of the attribution algorithm for Year 2, hospitals will have the opportunity to raise concerns about the attribution algorithm output. This period is intended to ensure the attribution algorithm is performing as expected, not as an opportunity to revisit the core elements of the algorithm. The review period is intended to serve two purposes: (1) identify and correct mechanical errors (e.g., incorrect data submissions); and (2) address specific cases of unintended and misaligned linkages that do not reflect the intent of the MPA policy. For example, in some scenarios, a provider may have significant relationships with more than one hospital. In this case, the hospitals involved may propose to have joint accountability for the total cost of care. In practice, this could result in a portion of the total cost of care attributed to one hospital and the other portion to another hospital. In evaluating any such proposals, HSCRC staff will consider whether the request is reasonable based on the situation, can be implemented into MPA monitoring reports without significant burden. HSCRC staff will work with the TCOC Work Group to determine guidelines associated with review period proposals.

Opportunities for improving linkages/attribution

Consistent with the Commission's Year 1 MPA final recommendation, HSCRC staff have been working with the TCOC Work Group, the Maryland Hospital Association, and other stakeholders to explore merited changes to the attribution, including attributing providers based on existing physician contractual relationships with hospitals or grouping providers in a practice together. With the start of MDPCP, HSCRC is able to group providers in MDPCP practices together throughout the linkage process and ensure providers in an MDPCP practice are linked

with the same hospital. Data is limited on extending these approaches outside of MDPCP and analyses performed to date have not revealed a consistent approach that can be consistently applied across hospitals.[1] Staff remain committed to exploring these options with the TCOC Work Group and stakeholders.

Performance Assessment

For Rate Year 2021, which is the MPA's second year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2019) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2018) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission, as described in greater detail below. This approach is a year-over-year comparison, based on each hospital's own improvement. The attribution of Medicare beneficiaries to hospitals will be performed prospectively. Specifically, beneficiaries' connection to hospitals is determined based on the two Federal fiscal years preceding the performance year, so that hospitals can know in advance the providers for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2019, data for the two years ending September 30, 2018 will be used. For attribution for Base Year 2018, data for the two years ending September 30, 2017 will be used.[2]

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

The total costs for a hospital's beneficiaries attributed through all methods will be summed and divided by the total number of beneficiaries attributed to the hospital through those methods to result in a single total cost of care per capita number. 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.

This policy for RY2021 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment

[1] Staff performed extensive analyses of CMS-provided deidentified Tax Identification Numbers (TINs). The source data and staff analysis was shared with the Maryland Hospital Association, and any further insights will be explored.
[2] For Base Year 2018 and Performance Year 2019, the algorithm will rely on 2019 ACO lists, MDPCP lists, and employment lists. As a result, each hospital's TCOC performance as assessed for 2018 as the base year will differ from that calculated for 2018 as the performance year, which is based on 2018 ACO lists.

policy for the MPA requires consideration of a number of complex issues, such as an appropriate attainment benchmark, intrinsic differences between hospital payment rates (such as labor market differences, Graduate Medical Education payments, etc.), and an appropriate risk adjustment methodology. In addition, staff is concerned about alignment and performance on the State's Medicare TCOC financial tests with the federal government, which are improvement-only, if an attainment policy is adopted. Staff acknowledge stakeholder support for an attainment policy that may help mitigate concerns about penalizing hospitals that have reduced total cost of care and explain some variation in spending growth. However, staff believe further discussion and analyses are necessary to implement a responsible and fair attainment policy. HSCRC staff is actively pursuing new options and methodologies for developing benchmarks and are hopeful these efforts will aid in developing an attainment policy. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan.

TCOC Trend Factor

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

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

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

Medicare Performance Adjustment Methodology

For each hospital, its TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine the MPA's scaled rewards and penalties. For RY 2021, the agreement with CMS requires the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue. The 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 agreement with CMS also requires that the Maximum Performance Threshold (that is, the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained) be set at 3% for RY 2021. Before reaching the RY 2021 Maximum Revenue at Risk of ±1.0%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.

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

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

POTENTIAL DRAFT RECOMMENDATIONS FOR RY 2021 MPA POLICY

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

1) Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
   a) Use a hierarchy of Maryland Primary Care Program (MDPCP)-actual, Accountable Care Organization (ACO)-like, PCP-like, and Primary Service Area-Plus (PSAP) attribution for beneficiary-to-provider attribution
   b) Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital-affiliated ACOs, hospital employment, and provider referral patterns
   c) Implement official algorithm result review period
2) Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.

3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019.
4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
   a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
   b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6) Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, obtaining input through continued meetings of the TCOC Workgroup.
7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Continue to work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

List of Abbreviations

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

APPENDIX I. BACKGROUND

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

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

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

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

APPENDIX II. ASSESSMENT PRINCIPLES

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

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

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

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

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

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

APPENDIX III. ESTIMATED TIMELINE AND HOSPITAL SUBMISSION

Estimated Timing	Action
December 2018	• *Required for ACOs:* Hospitals provide HSCRC with ACO Participant List for Performance Year 2019 (also used for Base Year 2018) • *Voluntary*: Hospitals participating in multi-hospital ACOs designate which ACO providers should be linked with which ACO hospital. • *Voluntary:* Hospitals provide HSCRC with a list of full-time, fully employed providers
January 2019	• Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2018 and Performance Year 2019, and provides hospitals with preliminary provider-attribution lists
February 2019	• Official review period for hospitals of 2 weeks following preliminary provider-attribution lists. • HSCRC reruns attribution algorithm for implementation

APPENDIX IV. BENEFICIARY ATTRIBUTION ALGORITHM

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

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

Exclusions: Claims associated with categorically excluded conditions are removed prior to episode assignment. Claims in any setting from an episode beginning three 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 PCP-like attribution. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

MDPCP-actual beneficiary attribution

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

ACO-like beneficiary attribution

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

Based on the two Federal Fiscal Years preceding the performance period, the logic determines the plurality of allowed charges for primary care services for eligible beneficiaries with at least one visit for a primary care service. If the plurality of charges are to a set of clinicians that are on a list of ACO providers, the beneficiary is attributed to the corresponding ACO, as is done in the

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

ACO Specialties

Primary Care Providers are defined as:

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

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

PCP-like beneficiary attribution

After removing the cost and beneficiaries assigned to hospitals through either the MDPCP-actual or the ACO-like method, providers will be attributed beneficiaries based on beneficiary primary care utilization. Assignment of beneficiaries to primary care providers is determined based on the beneficiaries' use of primary care services as originally proposed in the Maryland Primary Care Program (MDPCP) by the Maryland Department of Health (MDH) to CMMI and adopted in the Y1 MPA policy. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties.

Primary care providers are attributed beneficiaries based on proposed MDPCP logic with minor adjustments. Each Medicare FFS beneficiary with Medicare Part A and Part B is assigned the National Provider Identification (NPI) number of the clinician who billed for the plurality of that beneficiary's office visits during the 24 month period preceding the performance period AND

who also billed for a minimum of 25 Total Office Visits by attributed Maryland beneficiaries in the same performance period. If a beneficiary has an equal number of qualifying visits to more than one practice, the provider with the highest cost is used as a tie-breaker. Beneficiaries are attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.

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

PCP-like Eligible Specialties

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

PCP-like Primary Care Codes

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

Geographic beneficiary attribution

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

1. Zip codes listed as Primary Service Areas (PSAs) in the hospitals' GBR agreements are assigned to the corresponding hospitals. Costs in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMAD is calculated from Medicare FFS claims for the two Federal fiscal years preceding the performance period for all beneficiaries in that zip code.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed 30 minutes' drive time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period for all beneficiaries in that zip code.

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

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

APPENDIX V. PROVIDER-TO-HOSPITAL LINKAGE

MDPCP Provider to CTO Hospital attribution

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

ACO Provider to ACO hospital attribution

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

Employed Provider to hospital attribution

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

Referral Patterns Provider to Hospital attribution

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

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

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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Department of Health

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Chairman

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Vice-Chairman

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **October 10, 2018**

RE: **Hearing and Meeting Schedule**

November 14, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
December 12, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.