Final Recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2022

November 13, 2019

Health Services Cost Review Commission
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This document contains the final staff recommendation for changes to the MPA Policy for Rate Year 2022, ready for Commission discussion and vote.

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LIST OF ABBREVIATIONS

AAPM	Advanced Alternative Payment Model
ACO	Accountable Care Organization
CMF	Care Management Fees
CMS	Centers for Medicare & Medicaid Services
CPCP	Comprehensive Primary Care Payments
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
PBIP	Performance-based Incentive Payments
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

FINAL RECOMMENDATIONS FOR RY 2022 MPA POLICY

1) Continue measuring Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships. Implement only minor changes from the RY 2021 approach.
2) Maintain 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 CY 2019, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2020. Exclude MDPCP Performance-based Incentive Payments and Care Management Fees, but include Comprehensive Primary Care Payments for Track 2 practices in both the base and performance period.
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) Focus TCOC Work Group on more comprehensive review of the MPA policy for Rate Year 2023 (Performance in calendar year 2021), including but not limited to revisiting the fundamental attribution method, coordinating with the CTI process, adding attainment with benchmarking, and considering changes to amount at risk.
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.

Changes from MPA RY 2022 Draft Recommendation:

The incorporation of MDPCP expenditures in the MPA has been amended in the recommendations and section, "Accounting for Maryland Primary Care Program (MDPCP) Expenditures", to continue excluding Care Management Fees from both the base and performance period in MPA RY 2022, rather than including these fees as stated in the Draft Recommendation.

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 brings direct financial accountability to individual hospitals based on the total cost of care (TCOC) of Medicare fee-for-service (FFS) beneficiaries attributed to them. This policy addresses updates for Rate Year 2022. Staff are proposing limited changes in this policy because of many other areas of change at the HSCRC (Efficiency Policy, Capital Policy, MPA Framework, etc.) and a desire to allow a longer term view of performance by minimizing attribution changes.

Throughout this policy, the periods involved will be referred to as follows:

- Year 1: Rate Year 2020, Performance Year 2018, Base Year 2017
- Year 2: Rate Year 2021, Performance Year 2019, Base Year 2018
- Year 3: Rate Year 2022, Performance Year 2020, Base Year 2019

MEDICARE PERFORMANCE ADJUSTMENT MECHANICS

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited beginning in Year Two 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 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 three years—as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR), and other communications and meetings with stakeholders.

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 Year 1 and 2 experience, HSCRC staff recommends keeping the main elements of the existing algorithm for Year 3, with some minor adjustments. A separate technical guide will be released by HSCRC staff describing the attribution algorithm for Year 3 and updates from the Year 2 Policy. The proposed updates make small changes to the way low volume physicians are handled and implement the treatment of all

employed providers of a hospital as a single group within the attribution (as opposed to individuals).

Review period

Staff will continue to implement an official algorithm review period, as in Year 2. As the initial running of the attribution algorithm for Year 3 is completed, 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 and 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.

Performance Assessment

For Year 3, hospital performance on Medicare TCOC per capita in the performance year (CY 2020) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2019) TCOC per capita, updated by (1) a TCOC Trend Factor determined by the Commission, as described in greater detail below and (2) adjusted for changes in the hospital's risk score over time. This approach is a year-over-year comparison, based on each hospital's own improvement. In the case that external events impact hospitals' Medicare TCOC (e.g., changes to the differential or reductions to hospital rates), the HSCRC reserves the right to adjust base year performance to capture those changes and better reflect a hospital's improvement.

The attribution of Medicare beneficiaries to hospitals will continue to 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 2020, data for the two years ending September 30, 2019 will be

used. For attribution for Base Year 2019, data for the two years ending September 30, 2018 will be used.[1]

The risk adjustment methodology based on Medicare New Enrollee Demographics Risk Score adopted in the Year 2 policy will continue to be used in Year 3.

This policy for RY 2022 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment 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. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan to assess future policy changes.

TCOC Trend Factor

The MPA for Year 3, which begins July 2021, will be based on hospital performance on Medicare TCOC per capita in the performance year (CY 2020) compared to its TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2019) 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 2021.

Consistent with the RY 2020 and 2021 policy, HSCRC staff proposes that the TCOC Trend Factor for RY 2022 remains set at 0.33% below the national Medicare FFS growth rate. 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.

Accounting for Maryland Primary Care Program (MDPCP) Expenditures

The Maryland Primary Care Program is designed to provide additional funding, flexibility, and tools to primary care practices to invest in care management, population health, and other high value services. In the Year 2 recommendation the Commission approved gradually incorporating MDPCP expenditures into the MPA performance assessment. Under this approach, MDPCP Care Management Fees were to be added to both the base and performance period in Year 3. However, the Commission is now expecting a much larger change in these fees between 2019 and 2020 and does not wish this change to impact measured hospital performance. Therefore, staff propose the following for Year 3:

- Include Comprehensive Primary Care Payments (CPCP) paid quarterly to Track 2 MDPCP practices, along with the sum of their reduced fee-for-service revenue

[1] For Base Year 2019 and Performance Year 2020, the algorithm will rely on 2020 ACO lists, MDPCP lists, and employment lists. As a result, each hospital's TCOC performance as assessed for 2019 as the base year will differ from that calculated for 2019 as the performance year, which is based on 2019 ACO lists.

- Exclude Care Management Fees (CMF)
- Exclude Performance-based Incentive Payments (PBIP)

Beginning with the Year 4 (RY 2023) policy, staff intend to include both CMF and PBIP in both the base year and the performance year.

Special Approaches to Increasing Hospital Accountability

The University of Maryland Rehabilitation and Orthopedic Institute (UMROI) provides specialized stroke rehabilitation services along with other rehabilitation services to patients from across Maryland. Recognizing UMROI as a unique State resource and the challenges with operationalizing the MPA for UMROI, the HSCRC piloted an episode-based approach to increase the financial and quality accountability for Medicare beneficiaries receiving services at UMROI in CY 2019. This pilot will continue in CY 2020 with any changes implemented during next year's policy review.

Once again, hospitals also have the opportunity to collectively address TCOC by opting to have multiple hospitals treated as a single hospital for MPA purposes. Such a combination of hospitals must be agreed to by all the hospitals, must include a regional component, and serve a purpose that is enhanced by the combination. Hospitals should submit their request before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC.

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 Year 3, 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. However, the HSCRC will be reviewing the reward/penalty maximum in the MPA next year, as CMS has indicated interest in increasing the amount at risk.

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 Year 3. Before reaching the Year 3 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 Conditions (MHAC). For Year 3, 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. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded. The MPA reward or penalty will be incorporated in the following year through adjusted Medicare hospital payments on Maryland Medicare FFS beneficiaries.

With the maximum ±1.0% Medicare FFS hospital adjustment, staff continues to recommend 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.

FINAL RECOMMENDATIONS FOR RY 2022 MPA POLICY

Based on the assessment above, staff recommends the following for RY 2022 (with details as described above).

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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 Framework to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Framework. First, the MPA Framework can permit the flow of Medicare funds to hospitals based on their performance in other programs (the MPA Reconciliation Component (MPA-RC)). For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA-RC separate from the MPA's adjustment based on the hospital's performance on its attributed population. In addition, the MPA Framework may also be used to reduce hospital payments if necessary to meet Medicare financial targets that are not approved on an all-payer basis (the MPA Savings Component (MPA-SC)).

APPENDIX II. ESTIMATED TIMELINE AND HOSPITAL SUBMISSION

Estimated Timing	Action
December 2019	• *Required for ACOs:* Hospitals provide HSCRC with ACO Participant List for Performance Year 2020 (also used for Base Year 2019) • *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 • *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC
January 2020	• Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2019 and Performance Year 2020, and provides hospitals with preliminary provider-attribution lists
February 2020	• Official review period for hospitals of 2 weeks following preliminary provider-attribution lists • HSCRC reruns attribution algorithm for implementation