Final Recommendation for the Medicare Performance Adjustment Framework

October 16, 2019

Health Services Cost Review Commission
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SUMMARY

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

POLICY NAMING

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

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

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

RECOMMENDATIONS FOR THE RY2020 MPA FRAMEWORK POLICY

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

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

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

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

INTRODUCTION

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

BACKGROUND

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

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

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

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

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

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

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

THE MPA-RC IN ACTION: REWARDING CARE TRANSFORMATION INITIATIVES

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

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

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

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

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

Incentives to Participate in Care Transformation

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

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

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

Table 1. Example MPA Reconciliation Component for 2020

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

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

Supporting CTIs

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

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

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

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

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

THE MPA-SC IN ACTION: ACHIEVING TCOC SAVINGS REQUIREMENTS

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

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

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

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

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

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

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

Calculating the MPA Savings Component to Achieve Required Medicare Savings

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

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

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

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

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

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

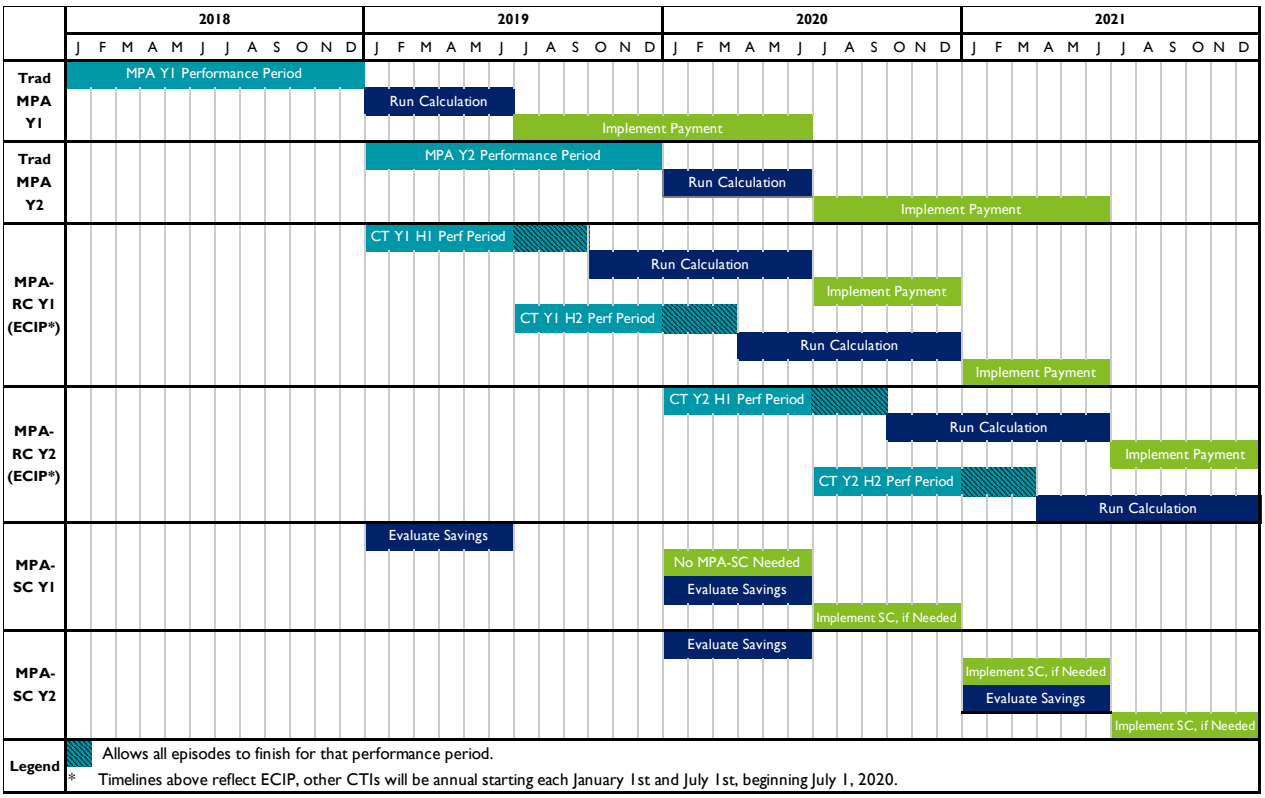
1. Once a full calendar year of Medicare data are available (including 3 months for claims run out) staff will be able to update Run Rate projections. Staff will then recommend an MPA-SC for the first six months of the next calendar year based on the current Medicare TCOC Run Rate; and

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

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

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

Figure 1: Timing of the MPA Framework and Traditional MPA



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

RECOMMENDATION FOR RY 2020 MPA FRAMEWORK POLICY

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

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

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

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

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

Hypothetical Participating Hospital:

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

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

Hypothetical Non-Participating Hospital:

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

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

APPENDIX 2: CARE TRANSFORMATION INITIATIVE (CTI) METHODOLOGY

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

Part 1: Identifying the Target Population

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

Part 2: Constructing the Episode

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

Part 3: Setting the Target Price

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

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

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

Part 4: Calculating the Reconciliation Payment

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

Maryland
Hospital Association

September 18, 2019

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

On behalf of Maryland's 61-member hospitals and health systems, the Maryland Hospital Association appreciates the opportunity to comment on the commission's proposed Medicare Performance Adjustment (MPA) framework.

MHA supports the proposed MPA Savings Component (MPA-SC)
Maryland's hospitals support establishing the MPA-SC. In our March 2019 comment letter, we supported the originally proposed MPA Efficiency Component. As stated by several commissioners, adopting the MPA-SC will decouple the Medicare savings required under Maryland's Total Cost of Care (TCOC) contract from the annual update factor. The update factor should contribute to sustainable growth for all stakeholders—not set growth limits to achieve Medicare-only savings. The MPA Efficiency Component is a useful tool, available through the contract, which should serve as a safety valve if Medicare TCOC savings targets are not met in future years.

We agree with HSCRC staff's conclusion that the MPA-SC is not needed in 2020 because of Maryland's performance under the Medicare total cost of care guardrail. The latest figures reflect $291 million in total cost of care savings—close to achieving our targeted savings. In March, we noted that hospital leaders understood MPA-SC could be used to meet *annual* Medicare savings targets—and that it could also be used to *increase* payments to hospitals in the event of favorable performance. The commission should not increase Medicare payments in 2020 but ought to consider using the MPA-SC to increase Medicare payments if favorable performance continues.

MHA supports the intent of recognizing savings from care transformation initiatives (CTI), but it is premature to finalize a mechanism to adjust Medicare payments
The MPA Reconciliation Component (MPA-RC) would establish a methodology to reward hospitals for demonstrated Medicare savings from CTI. As proposed, the policy would increase Medicare payments for hospital-specific CTI savings and offset the total amount of savings proportionately across all Medicare hospital payments. Hospitals appreciate the importance of showing how we are changing care to produce per capita savings under the contract. We appreciate the commission staff's efforts to date and the proposed timing of future payment adjustments.

Hospitals agree we need to measure program savings, including CTI beyond the formal care redesign programs. Because the proposed MPA-RC affects hospital payments, we urge HSCRC staff to be deliberate in measuring CTI savings. We respectfully request that HSCRC staff **bring a separate CTI recommendation to the commissioners** before approving a methodology that would affect Medicare payment levels, even though the proposed impacts are several years away. This recommendation should include details on measuring CTI, accounting for costs associated with CTI, and rationale for how the HSCRC will prioritize the policy. For example, the traditional MPA places hospitals at risk for an entire attributed population, and the proposed MPA-RC would directly adjust payments for a subset of hospital interventions.

Hospitals have raised important considerations around the proposed measurement of CTI:

- The proposed CTI measurement period does not begin until July 2020, and therefore will not recognize previously achieved savings by high-return programs
- Consistent measurement of CTI savings among hospitals, given that hospitals may submit different types of programs
- The ability to isolate the impact of a single CTI using claims data that may not reflect socio-economic factors that drive service use
- Measurement of spending per beneficiary by comparing an intervention population to a control (non-intervention) population, rather than measuring a base versus current period change in payments through claims data
- Prioritizing CTI for data programming that could omit demonstrated, hospital specific savings, at the expense of funding total savings.

We appreciate that HSCRC staff is open to hospital feedback and working closely with stakeholders to address hospital considerations. The MPA-RC is an important policy to demonstrate how Maryland's hospitals are delivering care better. The CTI policy details are the foundation of the MPA-RC.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
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September 18, 2019

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini:

The purpose of this letter is to provide CareFirst's comments on the HSCRC Staff's "Draft Recommendation for the Medicare Performance Adjustment Framework."

CareFirst supports the Staff's draft recommendation and its 2 key components:

1. **The MPA-RC (reconciliation component).** We believe this is a reasonable revenue neutral approach to encourage hospitals to participate in the Care Transformation Initiatives (CTIs) where hospitals will be allowed to retain up to 100% of their Medicare Total Cost of Care (TCOC) savings originating from their sponsored CTIs. Under the TCOC model, it is critical for all hospitals to participate in programs designed to improve population health and we support the Staff's efforts in developing a policy to both encourage and reward hospitals for their participation.

2. **The MPA-SC (savings component).** As we have noted in previous correspondence, CareFirst had reservations regarding decoupling savings and allowing Medicare a direct payment offset. The Staff has addressed these concerns during this year's Update Factor process by incorporating conservative Update target limits. As a result, we support using this component as a mechanism to achieve TCOC model savings.

We anticipate we will have additional comments and questions as we participate in further work group discussions regarding the CTI program. In particular, we hope to gain a better understanding of how Staff will determine whether a hospital-initiated CTI has indeed generated TCOC savings and the calculations supporting these savings.

For instance, how would staff calculate the savings realized by one hospital establishing a clinic to treat diabetes patients? Such a program, while potentially effective in improving population health, will likely take many years to yield measurable results and it will likely be challenging to attribute these savings to a particular clinic. Or, if the HSCRC staff determined that a hospital participating in the Episode Care Improvement Program (ECIP) successfully reduced its Medicare cost per episode, relative to its pre-established per episode benchmark, how will Staff ensure that such savings were not offset by an increase in the number of episodes performed?

Thank you for this opportunity to comment on the MPA Framework policy. We look forward to working with Staff and the hospital industry to address these and other questions as we more fully develop the Care Transformation Initiative (CTI) program. We support this effort as it ultimately helps to encourage hospitals' more direct participation in improving the population health of the communities they serve.

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Sincerely,

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

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JOHNS HOPKINS
MEDICINE

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

September 18, 2019

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for the Maryland Performance Adjustment (MPA) Framework. JHHS strongly supports the intent of the MPA Framework, which is to incentivize hospitals to develop Care Transformation Initiatives (CTIs) and reduce costs, as well as achieve the Medicare Total Cost of Care (TCOC) savings required under Maryland's TCOC Model. JHHS does however, have questions regarding some of details outlined in the draft recommendation and seek clarification as the policy moves forward. Before moving forward with the MPA Framework, it is critical that additional clarity be gained as to how this complex policy, with its many components, will be operationalized.

The MPA Framework

The MPA Framework, as detailed in the draft recommendation, aims to ensure that the required $330 million in cumulative savings are achieved through the MPA Savings Component (MPA-SC), while also rewarding hospitals for care transformation efforts through the MPA Reconciliation Component (MPA-RC).

Additionally, HSCRC staff, at various public meetings, have also described the MPA Framework as an opportunity to gain a better understanding of each hospital's efforts and success at reducing TCOC while also establishing an inventory of programs and initiatives that are effective at transforming care. Another principle outlined by staff is the ability to identify "free-rider" hospitals who may have limited efforts in care transformation but have benefited from the successful efforts of other hospitals.

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Katie Wunderlich
Response to MPA Framework
September 18, 2019

JHHS supports the principles and aims outlined in the MPA Framework and believe these principles lay an appropriate foundation for achieving savings and capturing successful transformation efforts. Before the Commission approves the MPA Framework, it is our hope that additional clarity can be developed around the MPA-SC and MPA-RC.

MPA-SC

The MPA-SC will ensure that the statewide Medicare savings targets are met by prospectively reducing hospitals Medicare payments. This process will replace the 0.5% "savings cushion" included in the update factor that has historically been used to achieve the required Medicare savings under the All-Payer Model. The MPA-SC aims to reduce hospitals' uncertainty about their Medicare revenues and increase transparency in the rate-setting process. These are worthy aims that should continue to serve as the foundation to all policies established by the HSCRC.

The current policy to unilaterally reduce each hospitals Medicare payments in order to achieve Medicare savings may have the unintended consequences of disproportionately impacting hospitals serving a higher proportion of Medicare. However, if the MPA-SC is implemented in conjunction with other policies that reward hospitals for being efficient, then perhaps this concern can be mitigated. We hope that should the MPA-SC move forward, that other policies are implemented that either reward hospitals for being efficient, or recognizes the disproportionate burden some hospitals experience in serving a Medicare patient population with more complex medical and social issues.

JHHS greatly appreciates the conservative approach the HSCRC has taken in the execution of the MPA-SC. Due to the Medicare savings achieved to date under the Model, the HSCRC did not deduct the MPA-SC from hospitals Medicare payments for January to June 2020. JHHS hopes that the HSCRC continues to exercise this same conservative approach towards the MPA-SC moving forward. Balancing the need to achieve savings, while not unnecessarily constraining hospitals' ability to invest in care transformation is critical to the long-term success of the TCOC Model.

MPA-RC

The MPA-RC aims to recognize the efforts made by hospitals to transform care and improve TCOC that may be outside the structured programs established under the Care Redesign Program. JHHS recognizes that the MPA-RC was designed in light of requests from the hospital industry to recognize transformation efforts and we applaud the Commissioners and staff for incorporating hospital input into policy development. Continued dialogue between all stakeholders will hopefully result in a solid MPA Framework policy. Staff's recommendation to delay CTI implementation until July 1, 2020 reflects the need for further policy development under the CTI proposal.

Katie Wunderlich
Response to MPA Framework
September 18, 2019

Methodology

The current methodology to calculate savings is unclear. The draft recommendation notes that hospitals "that do not participate or have less successful CTIs will pay an increasing share of the required TCOC savings." The policy is clear that hospitals that are successful in achieving savings through CTI will be "funded" by hospitals that are not successful or choose not to participate, however, currently there is no description of what benchmarks will be used to define success if all hospitals demonstrate some level of savings. How will the HSCRC determine the threshold for "less successful CTIs" or hospitals? We appreciate the examples provided by staff in the draft recommendation and public meetings, however these examples rely on the logic of non-participating hospitals, which will likely not be the reality. Additional and more diverse examples of how the policy will be implemented would be greatly appreciated.

The CTI methodology as proposed monitors an entire population eligible for CTI, without any determination or measure of whether patients actually received the intervention. This will likely not capture an accurate measure of the success of a CTI. Staff should consider whether CTIs will be prioritized on highest overall savings or highest per capita savings.

JHHS recognizes that there are advantages and disadvantages to the various approaches to analyze savings. The "intent to treat" analysis permits the assessment of potential cost savings for a population regardless of the intervention or set of interventions deployed. However this approach is limited in the ability to assess the effectiveness of an intervention. Staff should give additional consideration to the utilization of other methods of analysis such as a "difference in differences" approach which will offer insight as to which interventions have the biggest impact. Details around exclusion and outcomes criteria should also be discussed with the CTI Steering Committee. Consideration should be given to how patient deaths be addressed under the analysis as well as whether there will be criteria to ensure that CTIs are improving patient care, rather than simply reducing costs.

Considering the uncertainty and complexity around the CTI methodology, perhaps the HSCRC should consider monitoring performance under the CTI for a defined period of time before actually tying hospital performance to financial penalties and rewards. This would allow for adjustments to the MPA-RC, without improperly impacting the financial performance of any hospitals.

Baseline

Staff have indicated that hospitals can identify the baseline period between 2016 and present for measurement of a successful CTI. JHHS greatly appreciates the flexibility of the HSCRC to allow hospitals to identify a baseline period, however there are some very successful care transformation efforts have been implemented well in advance of what would be captured with

a 2016 baseline period. Would the HSCRC consider allowing for a baseline measurement prior to 2016?

Thematic Areas

The September 6 Care Transformation Steering Committee spent significant time detailing the potential thematic areas for CTIs. Currently it is not clear whether hospitals will be limited to submitting CTIs related only to the thematic areas or whether any worthy program should be pursued as a CTI. The thematic categories may be distracting from hospital efforts to address the needs of defined population. We recommend that instead of focusing on categories or themes of interventions, hospitals should be permitted to focus on population segments, such as patients with congestive heart failure with three or more hospital admissions.

Medicare Population

Staff have indicated that the CTI process is currently intended for the Medicare fee-for-service population only, but that other payers will be included as data becomes available. While the All-Payer Model has evolved into the TCOC Model, the foundation for Maryland's Model is still an all-payer approach. Care transformation is best pursued through a payer agnostic approach. JHHS hopes that CTI participation from other payers will be included in the near future.

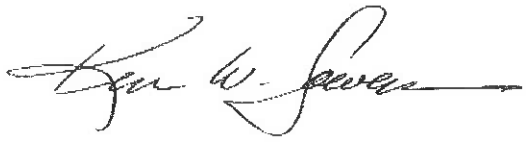
Population Health

Staff have been clear in their description of the MPA Framework and CTIs that this process is not intended to account for all population health investments, and that there will be development of other policies that will more accurately address population health. JHHS appreciates that the current CTI policy is intended to be a mechanism to measure the "short-term" impact of transformation efforts, however the assessment of true transformation will likely need a longitudinal view that evaluates savings over many years, perhaps even decades. JHHS looks forward to collaborating with the HSCRC in the development of future population health intervention policies. As noted in the draft recommendation, "the State committed to transforming care in a valuable and sustainable way." Valuable and sustainable transformation cannot be captured in six month or yearlong snap shots. The success of the TCOC Model in truly improving care for patients and populations is contingent on the ability to measure progress over an extended period of time.

Thank you for the efforts of the Commissioners and staff in the continued development of policies that contribute to the future success of the Total Cost of Care Model. We look forward to continued evolution of the MPA Framework. JHHS recommends that the MPA Framework be brought to the Commissioners for formal approval at a future Commission meeting. The MPA Framework is one of many HSCRC policies that are being developed by staff. It is critical that Commissioners and hospitals have a clear understanding of not only each individual policy, but also how all of these policies relate to overall hospital operations and

reimbursement. A formal approval process will result in greater transparency and stakeholder participation. JHHS welcomes continued collaboration with Maryland hospitals and the HSCRC to improve the MPA Framework.

Sincerely,



Kevin W. Sowers, M.S.N., R.N., F.A.A.N
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
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September 18, 2019

Chris Peterson
Principle Deputy Director, Payment Reform and Provider Alignment
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Peterson:

On behalf of Anne Arundel Medical Center (AAMC), thank you for the opportunity to comment on the draft recommendation for the Medicare Performance Adjustment (MPA) Framework. We appreciate the Staff's commitment to meeting the goals of the Total Cost of Care Model and engaging hospitals in care transformation activities.

We support the use of a Medicare-only Savings Component as needed to meet the goals of the Total Cost of Care Model. Decoupling this tool from the Update Factor allows for continued hospital sustainability and investments in population health. We agree with the Staff's decision to not use the adjustment in rate year 2020, since Maryland hospitals have achieved substantial savings to date and are well positioned to meet the Model savings target.

We support the use of Care Transformation Initiatives (CTIs) to reward hospitals for their successful interventions. As the collection and measurement of CTIs evolve, we ask the Staff:

1. Consider establishing Savings Component guardrails to protect hospitals from massive adjustments to offset the uncapped Reconciliation Component adjustments
2. Provide transparent and timely communication so hospitals can appropriately budget for potential Reconciliation Component or Savings Component adjustments
3. Expand CTI measurement to include additional payer types and encourage interventions for all patients
4. Explore methodologies to capture initiatives that require a longer time period to realize savings
5. Ensure Staff capacity to provide timely support for the measuring and monitoring of CTIs

Thank you again for the opportunity to comment. Please let us know if we can be of assistance to you.

Sincerely,

Maulik Joshi, DrPH
Executive Vice President of Integrated Care Delivery &
Chief Operating Officer

Bob Reilly
Chief Financial Officer

Cc: Victoria Bayless, President & Chief Executive Officer, AAMC
Nelson Sabatini, Chairman, HSCRC
Katie Wunderlich, Executive Director, HSCRC

UNIVERSITY of MARYLAND MEDICAL SYSTEM

September 18, 2019

Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

The University of Maryland Medical System (UMMS) appreciates the Health Services Cost Review Commission's (HSCRC) desire to determine the impact of hospital population health investments through the MPA Framework Policy. Understanding the impact of hospital population health investments is important and will allow hospitals to learn from the successes of others.

As such, UMMS is supportive of the premise of the MPA Framework Policy, but is concerned with the premature adoption of a payment methodology. UMMS has several concerns about the methodology and suggests that HSCRC implement the methodology to quantify the impact of the CTIs but delay the implementation of the payment policy.

Currently, several HSCRC payment methodologies exist to reward or penalize hospitals for Medicare total cost of care performance including RRIP, MHAC, PAUs, MPA-Traditional, and the MPA reconciliation component (MPA-RC) will create additional overlap between HSCRC policies. To avoid any potential unintended consequences, HSCRC should thoroughly analyze the extent of this overlap and ensure alignment where possible.

The proposed payment methodology also presents operational challenges that may inhibit adequately capturing the broader range of population health management activities that hospitals deliver. As outlined in the draft policy, hospitals are only eligible to receive reconciliation payments for CTIs that have a triggering event identifiable via claims data. This limitation is problematic because patient enrollment into any given care intervention relies on clinical decision points that are difficult to quantify through individual claims. Thus, the "true" enrolled population will not be reflected by HSCRC's current methodology, which will result in skewed measurements of actual cost savings. Additionally, interventions that address social determinants of health or target total population health rather than individualized interventions will not be recognized since they cannot be linked to claims data. UMMS recommends that the HSCRC explore additional methodologies that will more accurately capture the true population enrolled. This will lead to greater understanding of the population health investments necessary to address the multitude of factors that lead to unnecessary healthcare utilization and higher costs.

UMMS is concerned with HSCRC's proposal to offset savings. Hospitals that have Medicare populations with more complex needs or are implementing new initiatives may not be successful in generating savings immediately but will still be funding rewards at other hospitals. UMMS remains concerned that hospitals not participating in population health management activities will have offset payments similar to hospitals that are participating.

In addition, given the industry interest and investment in the success of quantifying the savings based on CTIs, we would encourage the HSCRC to allow for more extensive comment and discussion on appropriate thematic groupings, triggering events and episode durations prior to issuing a staff recommendation.

Thank you for the opportunity to provide comments on the draft MPA Framework Policy. If you have any questions or concerns regarding the considerations outlined, please contact me.

Sincerely,

Alicia Cunningham
SVP, Corporate Finance and Revenue Advisory Services
University of Maryland Medical System
920 Elkridge Landing Road, Linthicum, MD 21090

Cc: Nelson Sabatini, Chairmen
HSCRC Commissioners
John Ashworth, UMMS CEO
Michelle Lee, UMMS CFO

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September 18, 2019

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich: Katie

Comments - Draft Recommendation for Medicare Performance Adjustment Framework - Presented to HSCRC Commission 9-11-19

Incorporating hospital determined Care Transformation Initiative (CTI) into the Medicare Adjustment Performance Framework is innovative and substantive.

Regarding Figure 1 (page 9): Timing of MPA Framework and Traditional MPA
While the MPA timing is guided by the run rate calculations and hospital revenue cycles, CTI implementation coordination is complex and can require a run-in or ramp-up period. Major interventions can need a multi-month ramp-up.[1] In short, selected CTIs may not match up with the suggested timing.

Identifying a baseline beneficiary cohort and accumulating a sufficient number of intervention beneficiaries requires time and effort to assure reasonable cohort homogeneity. This homogeneity is necessary to detect a difference post intervention. Also, secular trends need identification and adjustment. There will be additional complexities should the CTI involve more than one hospital.

The Commission - desires "Qualifying CTIs" (page 9) to be shared with other hospitals. This, in turn, will require intervention fidelity, i.e., the CTI intervention is sufficiently detailed so that other hospitals can replicate the intervention. Fidelity is best defined in the ramp-up period before intervention initiation.

CTIs are a valuable addition to the MPA process. Implementation flexibility will yield dividends in the coming months and years.

Thank you,

Dale

Dale N. Schumacher
President, Rockburn Institute

cc: Willem Daniel

[1] Berkowitz SA, Parashuram S, Rowan K, et al. Association of Care Coordination Model With Health Care Costs and Utilization: The Johns Hopkins Community Health Partnership (J-CHIP). JAMA Netw Open. 2018 Nov 2;1(7):e184273. doi: 10.1001/jamanetworkopen.2018.4273.

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