Health Services Cost Review Commission
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**544th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION**
**October 11, 2017**

**EXECUTIVE SESSION**
**9:30 a.m.**
**(The Commission will begin in public session at 9:30 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 Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

3. **Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**

**PUBLIC SESSION**
**1:00 p.m.**

1. **Review of the Minutes from the Public Meeting and Executive Session on September 13, 2017**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   **2395A – Johns Hopkins Health System**
   **2396A – Johns Hopkins Health System**
   **2397A – Johns Hopkins Health System**

5. **Docket Status – Cases Open**
   **2398N – University of Maryland Midtown Campus**
   **2399A – Priority Partners**
   **2400A – University of Maryland Medical Center**
   **2401A – MedStar Health**
   **2402A – MedStar Medicare Choice**
   **2403A – MedStar Family Choice**
   **2404A – Johns Hopkins Health System**

6. **Presentation by Johns Hopkins Hospital**

7. **Draft Recommendation on Updates to the Inter-hospital Cost Comparison Methodology**

8. **Draft Recommendation on the Medicare Performance Adjustment**

9. **Update on Future Direction for RY 2020 and Enhanced Model Quality Programs**

## 10. Hearing and Meeting Schedule

# Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

# Monitoring Maryland Performance
# Financial Data

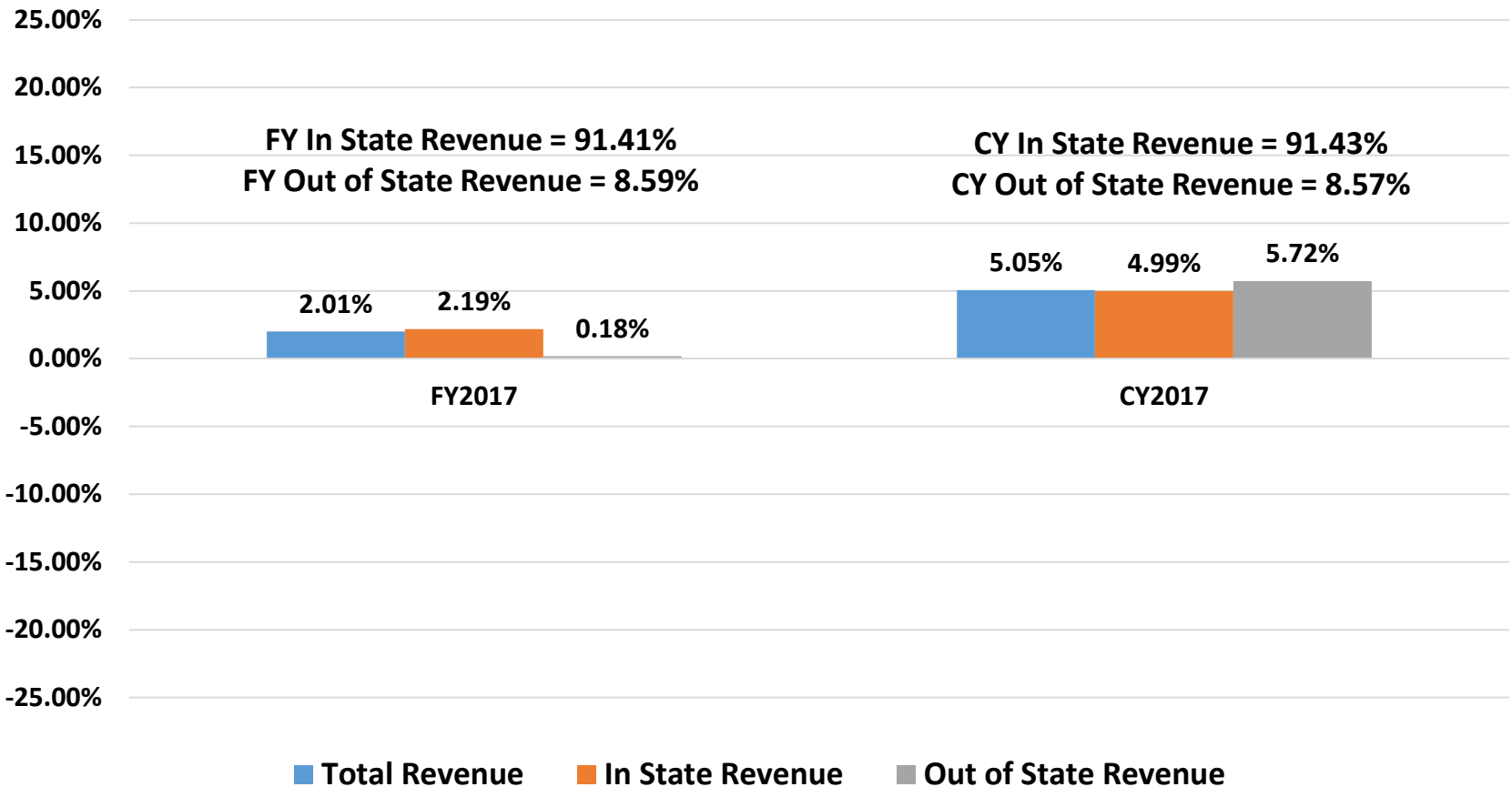
Year End through June 2017 with Experience Corrections

Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: September 27, 2017

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2014 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A and Part B beneficiary counts have been revised from January 2014 forward. Part A changed very slightly and Part B is more noticeably changed. The slides reflecting the change in beneficiary counts have been denoted by an asterisk (*).

# Gross All Payer Revenue Growth

FY 2017(Jul 2016-June 2017 over Jul 2015-June 2016) and CY 2017 (Jan-June 2017 over Jan-June 2016)




**The State's Fiscal Year begins July 1**



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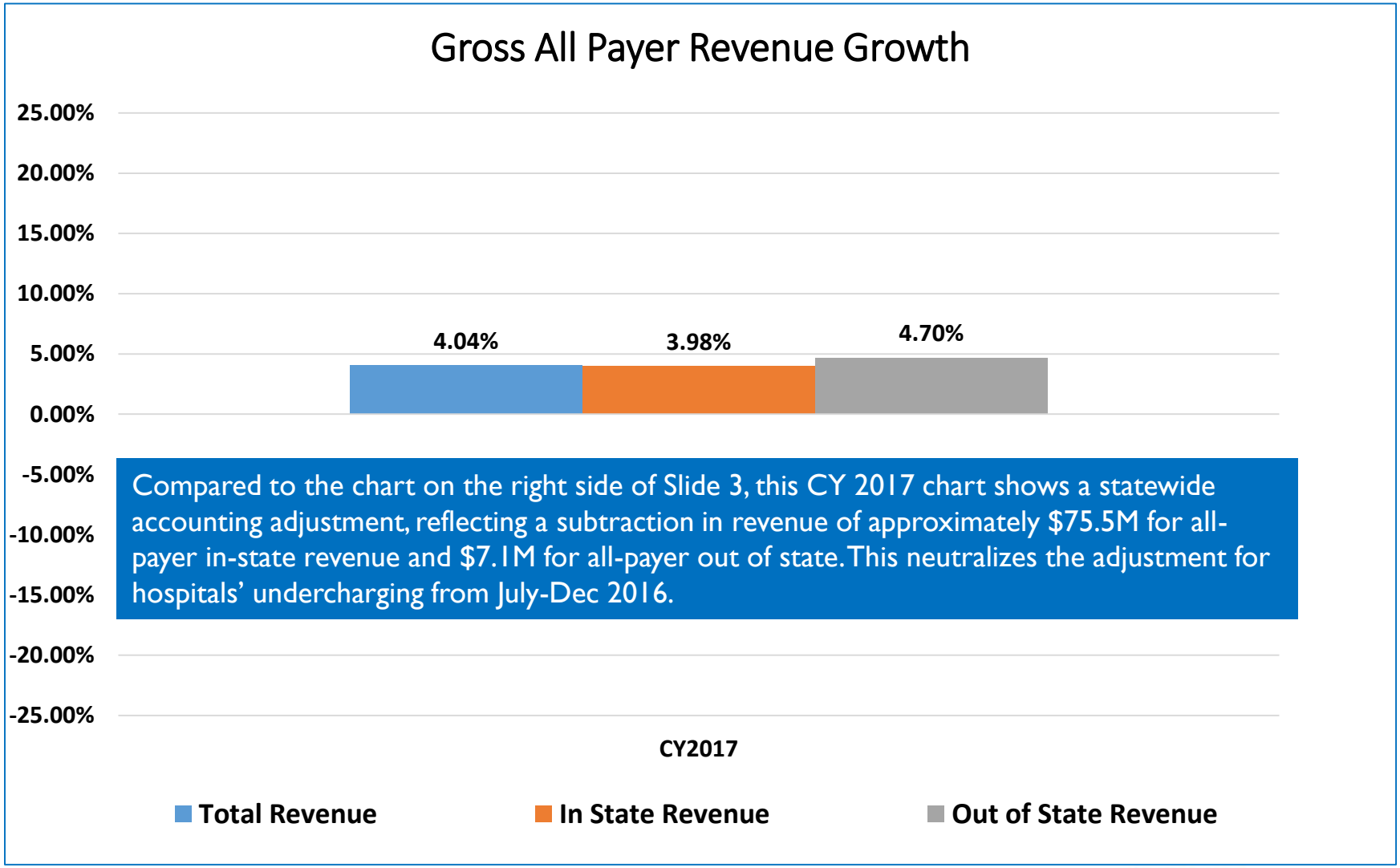
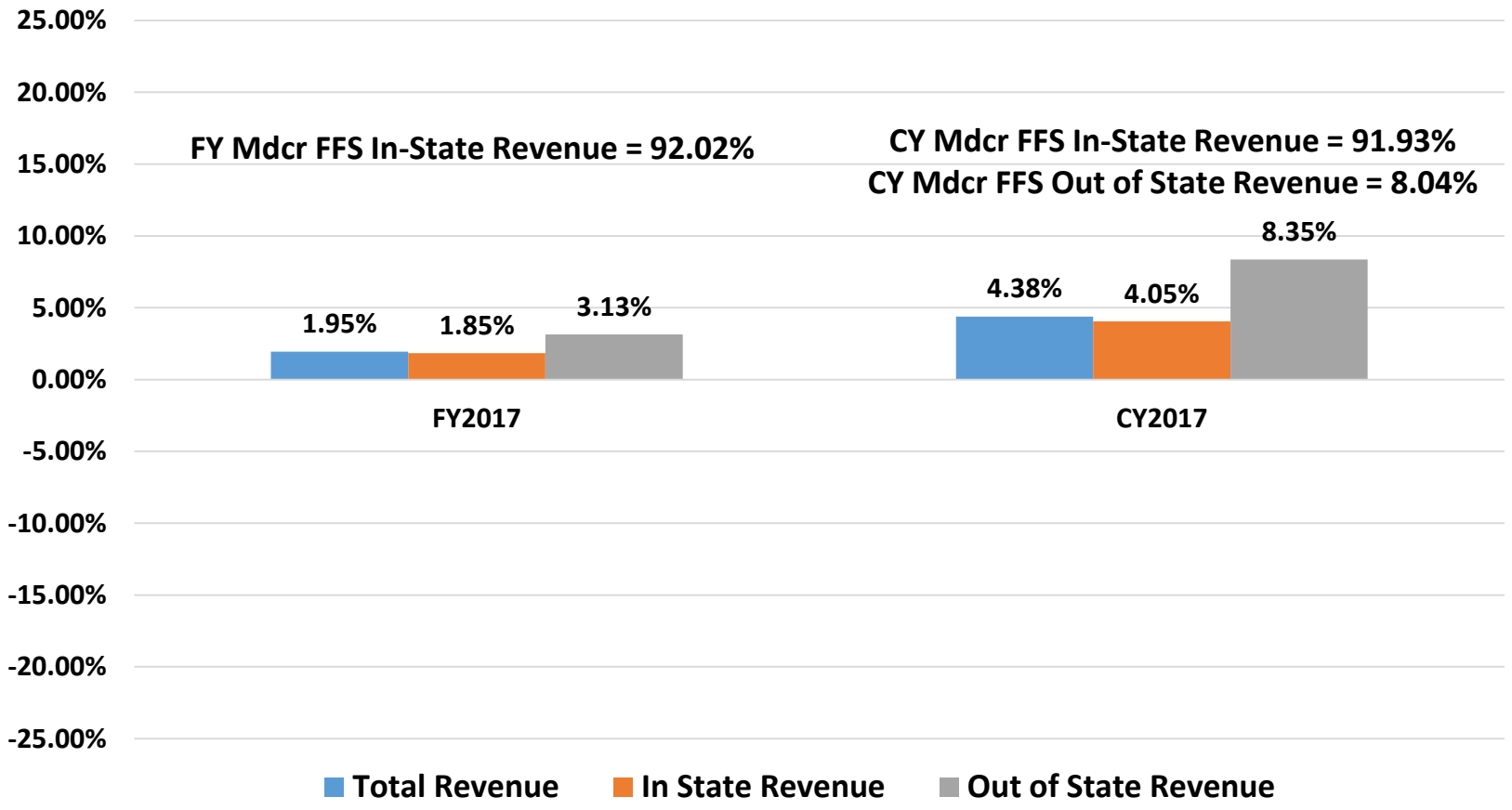
# Statewide Adjustment in CY17 for CY16 Undercharge




Compared to the chart on the right side of Slide 3, this CY 2017 chart shows a statewide accounting adjustment, reflecting a subtraction in revenue of approximately $75.5M for all-payer in-state revenue and $7.1M for all-payer out of state. This neutralizes the adjustment for hospitals' undercharging from July-Dec 2016.

# Gross Medicare Fee for Service Revenue Growth

FY 2017 (Jul 2016 - June 2017 over Jul 2015-June 2016) and CY 2016 (Jan-June 2017 over Jan-June 2016)




**The State's Fiscal Year begins July 1**



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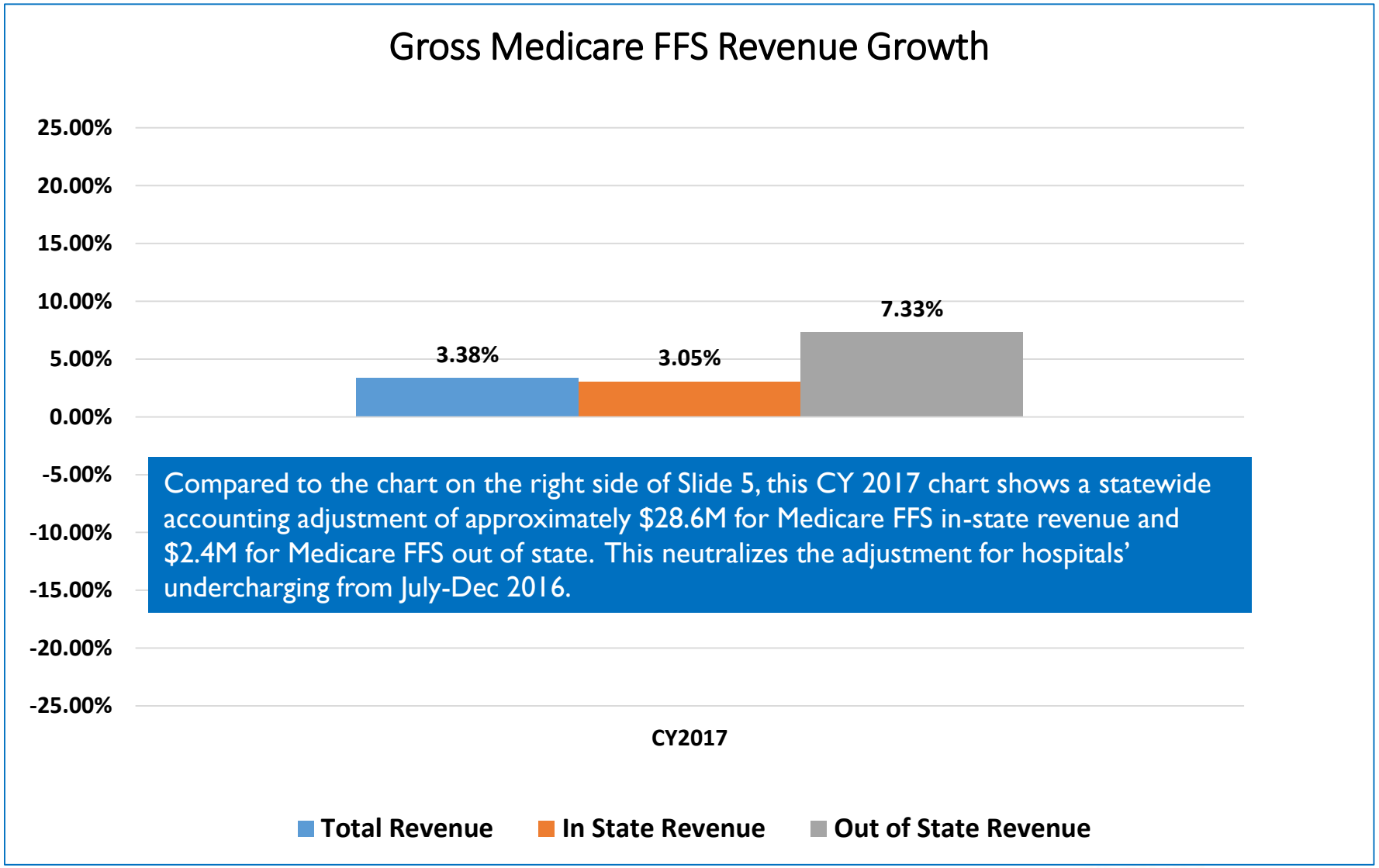
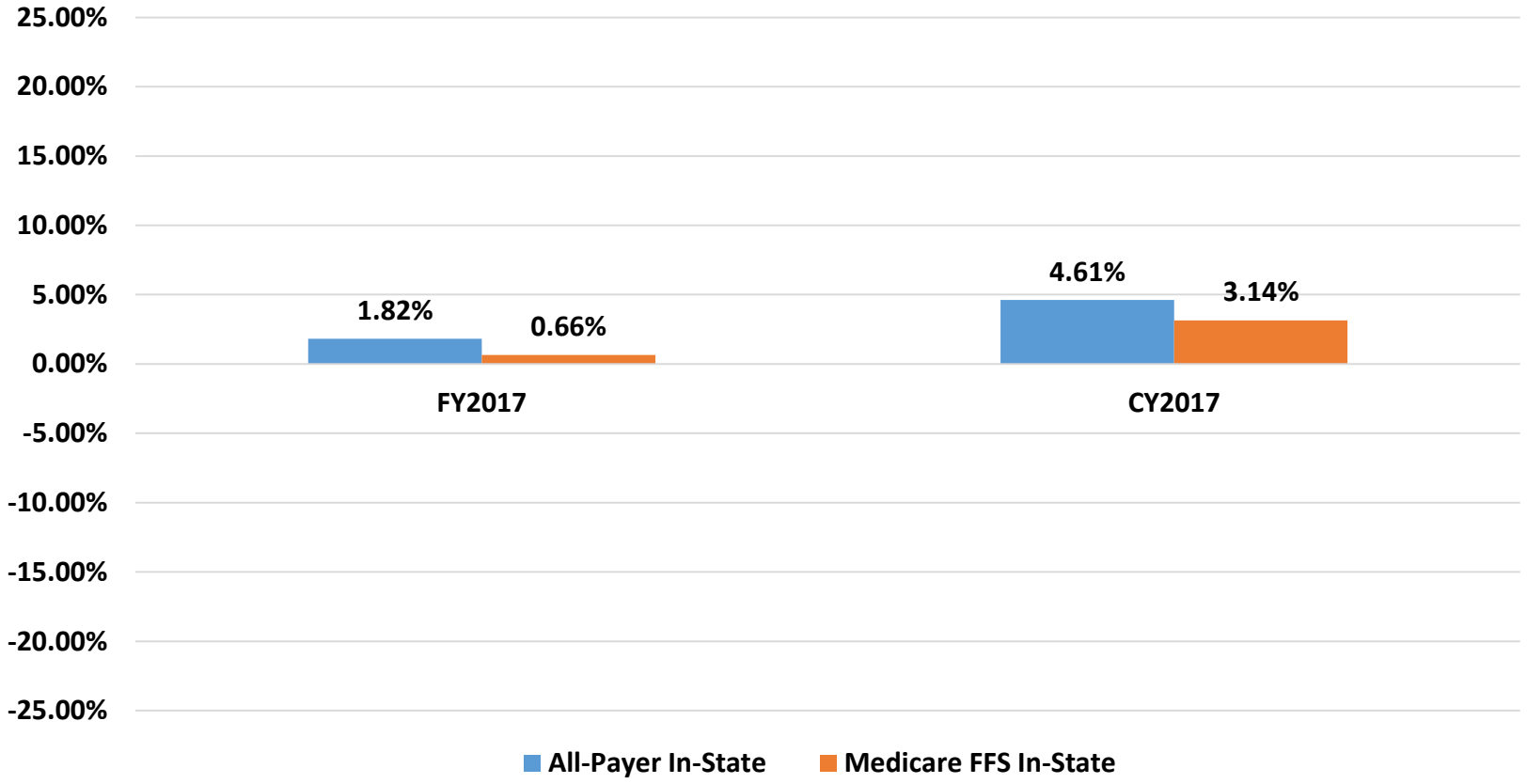
# Statewide Adjustment in CY17 for CY16 Undercharge




Compared to the chart on the right side of Slide 5, this CY 2017 chart shows a statewide accounting adjustment of approximately $28.6M for Medicare FFS in-state revenue and $2.4M for Medicare FFS out of state. This neutralizes the adjustment for hospitals' undercharging from July-Dec 2016.

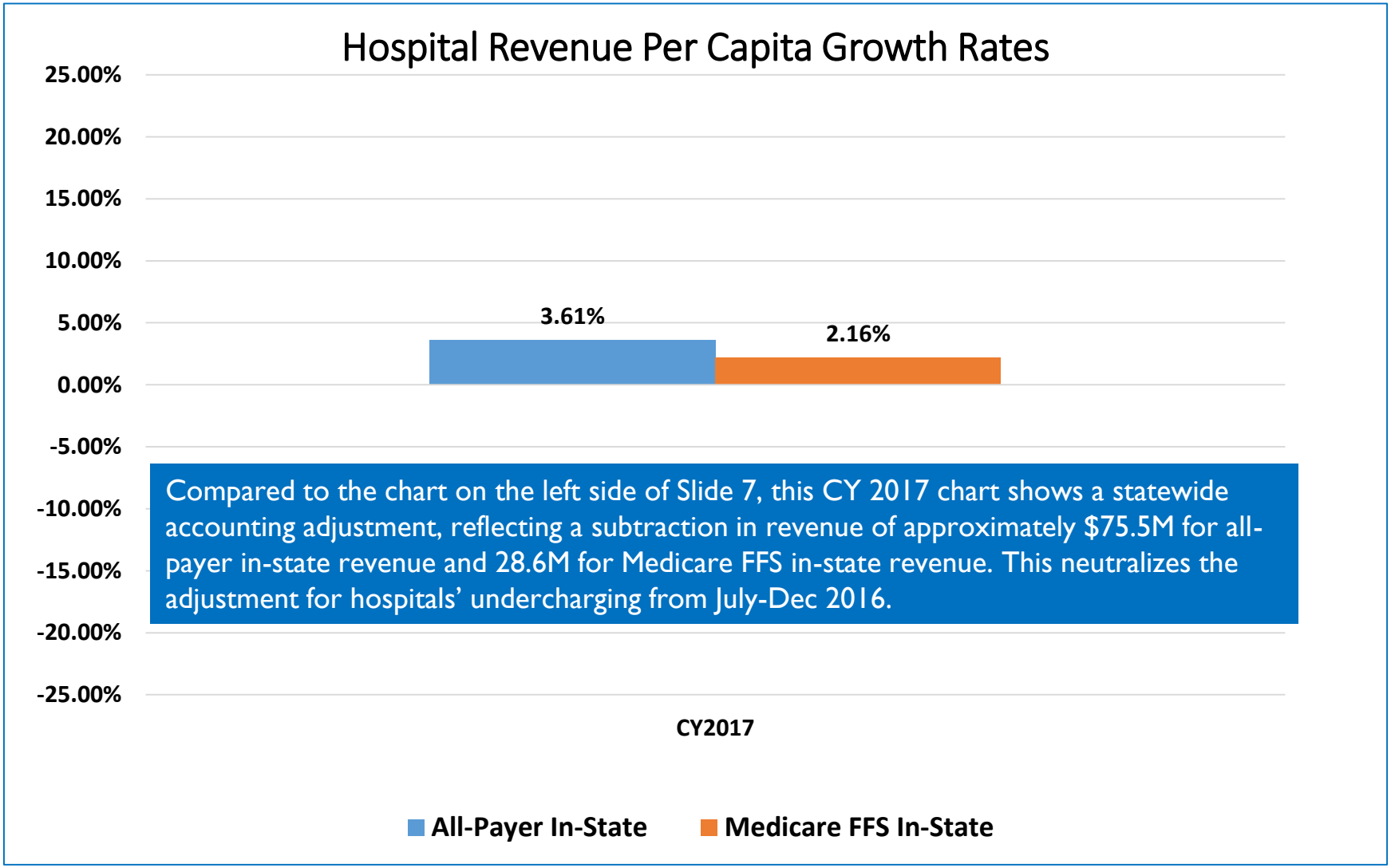
# Hospital Revenue Per Capita Growth Rates *

FY 2017 (Jul 2016 – June 2017 over Jul 2015 – June 2016) and CY 2017 (Jan-June 2017 over Jan-June 2016)




**The State's Fiscal Year begins July 1**

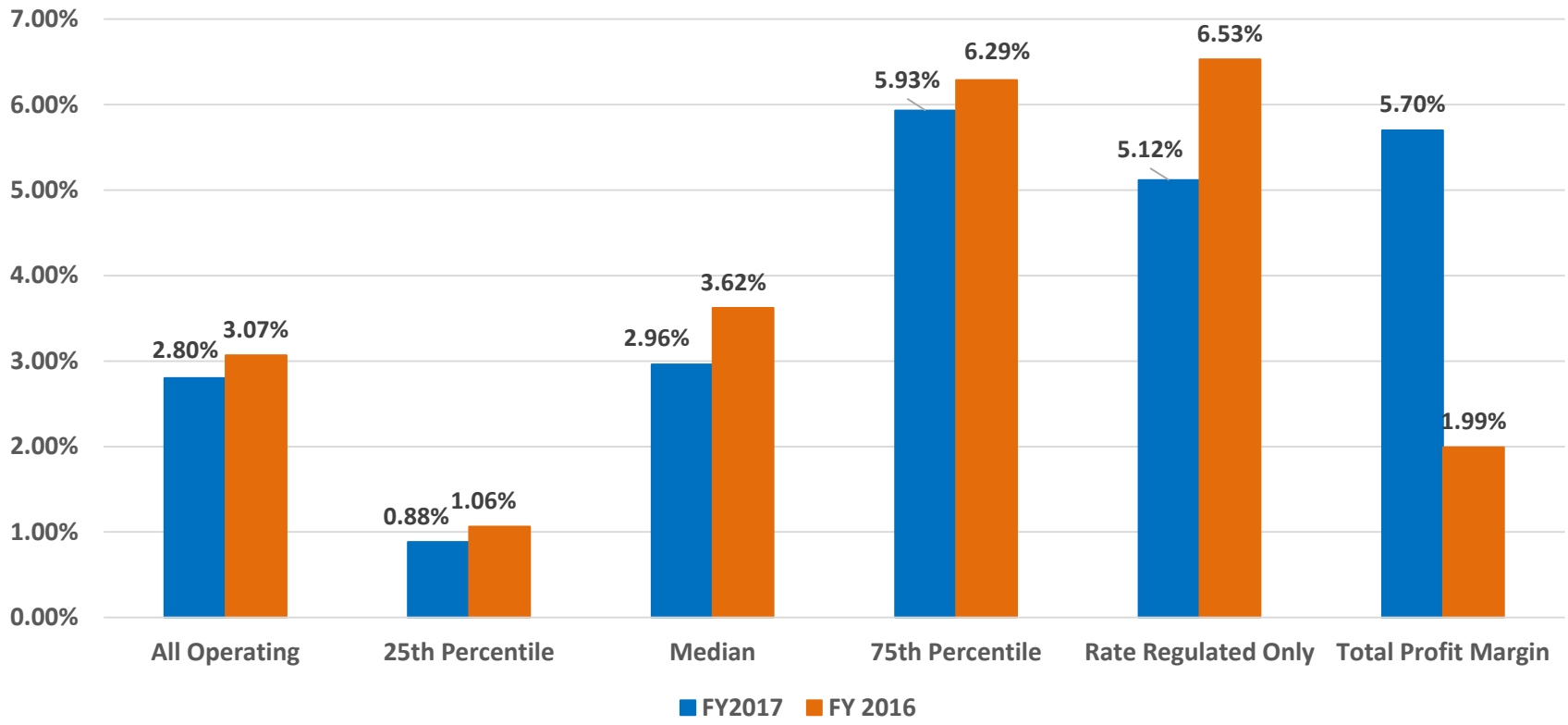
# Statewide Adjustment in CY17 for CY16 Undercharge




Compared to the chart on the left side of Slide 7, this CY 2017 chart shows a statewide accounting adjustment, reflecting a subtraction in revenue of approximately $75.5M for all-payer in-state revenue and 28.6M for Medicare FFS in-state revenue. This neutralizes the adjustment for hospitals' undercharging from July-Dec 2016.

# Operating and Total Profits

Fiscal Year 2017 (Jul 2016-June 2017) Compared to Same Period in Fiscal Year 2016 (Jul 2015 - June 2016)

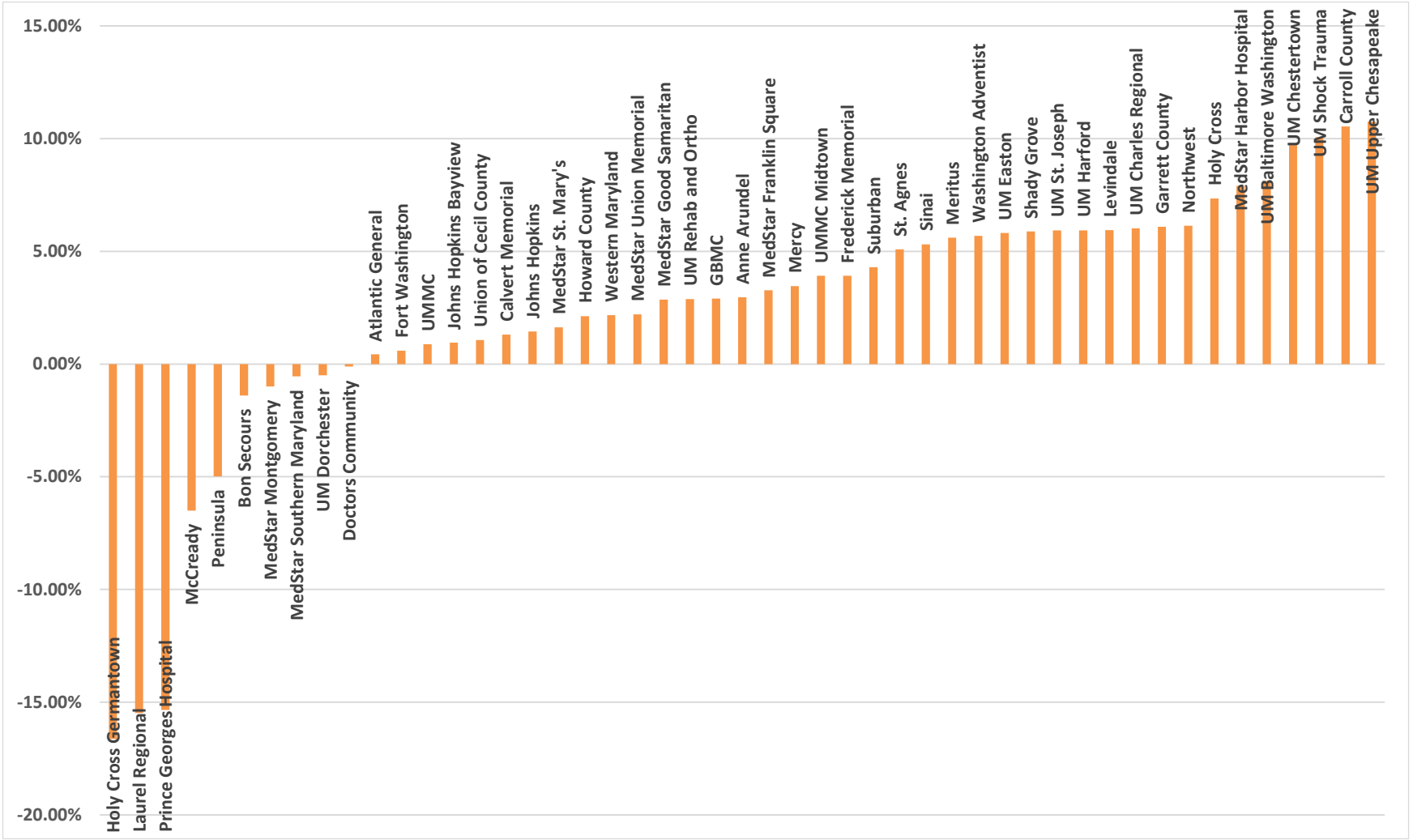



**FY 2017 unaudited hospital operating profits to date show a decrease of .27 percentage point in total profits compared to the same period in FY 2016. Rate regulated profits for FY 2017 have decreased by 1.41 percentage points compared to the same period in FY 2016.**

**FY 2017 hospital total profit margin (includes income from investments) to date shows an increase of 3.71 percentage points.**

# Total Operating Profits by Hospital

Fiscal Year 2017 (Jul 2016-June 2017)



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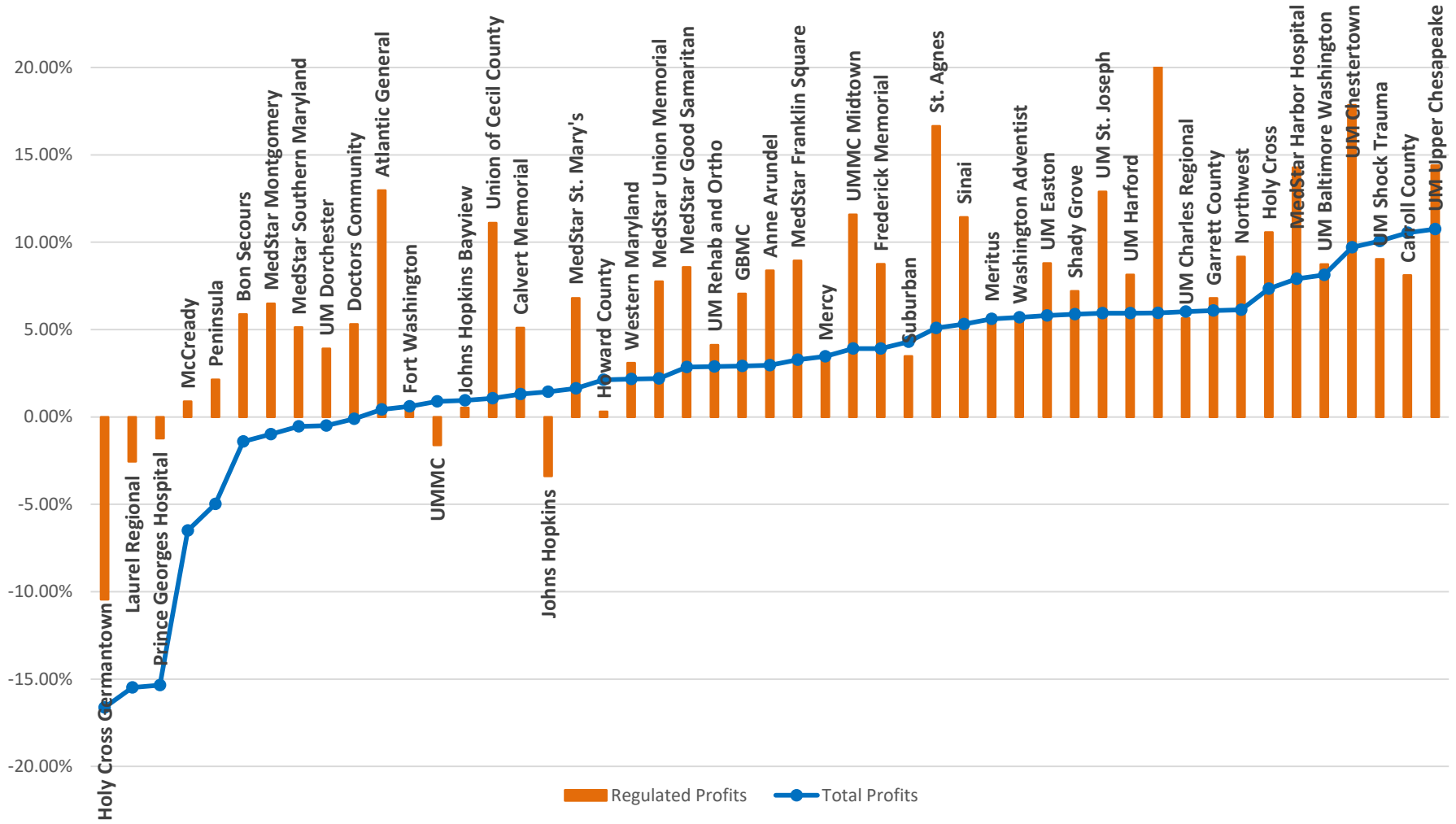
# Regulated and Total Operating Profits

Fiscal Year 2017 (Jul 2016 – June 2017)

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# Monitoring Maryland Performance Financial/Utilization Data

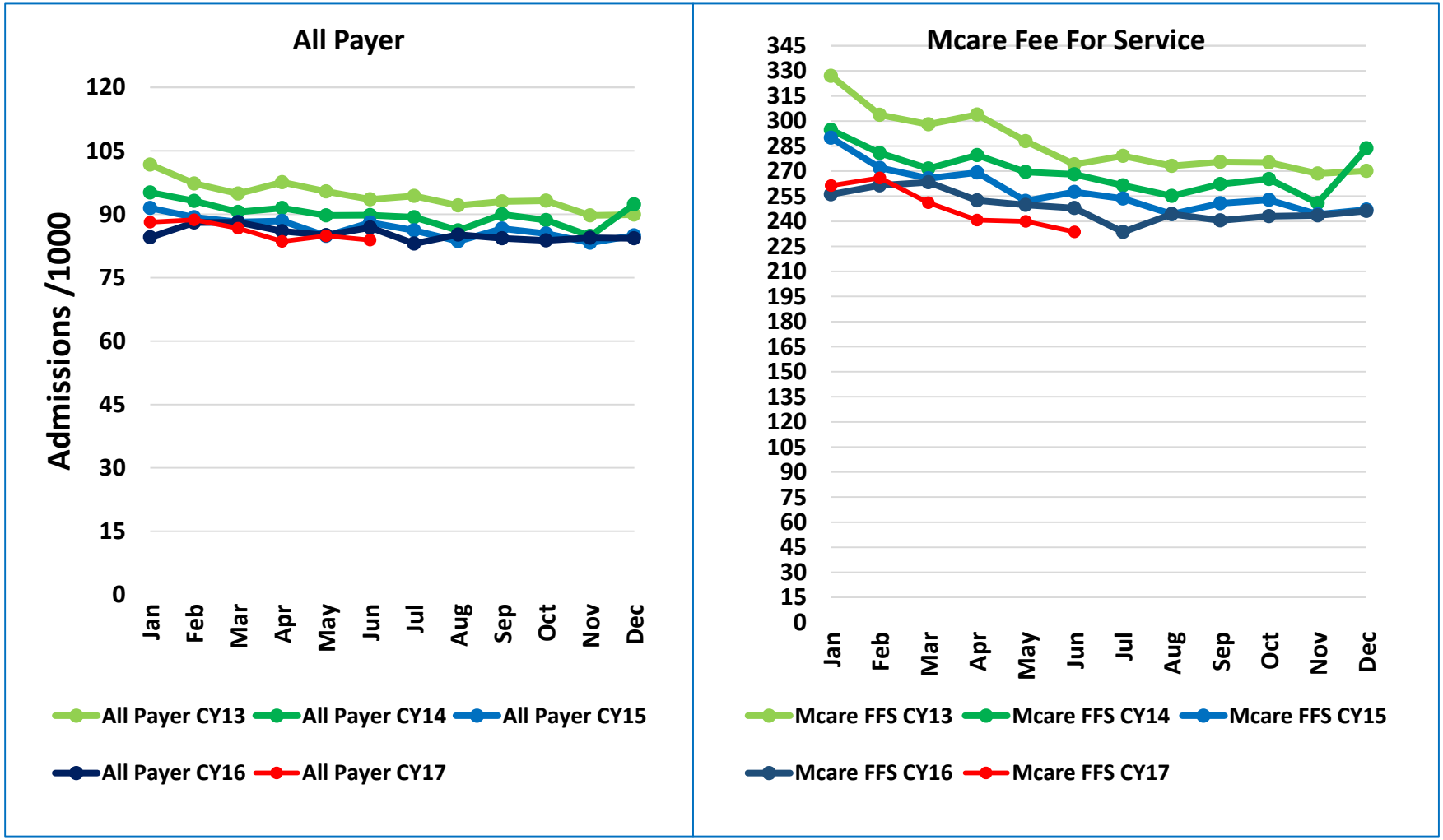
## Fiscal Year End Data through June 2017 after Experience Corrections

Source: Hospital Monthly Volume and Revenue Data

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2014 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A and Part B beneficiary counts have been revised from January 2014 forward. Part A changed very slightly and Part B is more noticeably changed. The slides reflecting the change in beneficiary counts have been denoted by an asterisk (*).

# Annual Trends for ADK Annualized*

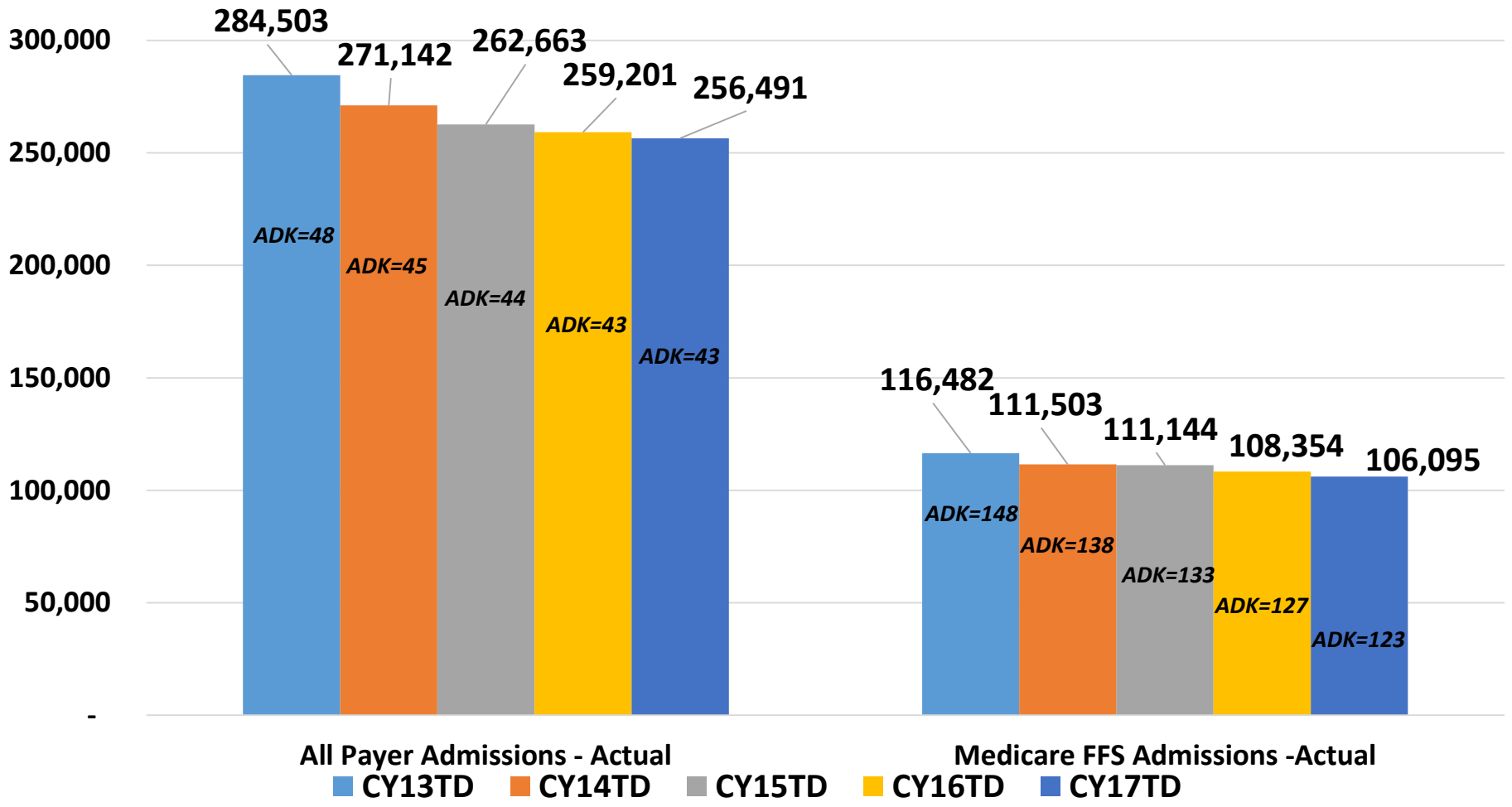
Medicare Fee For Service and All Payer (CY 2013 through CY 2017 June)




**Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.**

# Actual Admissions by Calendar YTD June*

(CY 2013 through CY 2017)




**Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.**

# Change in Admissions by Calendar YTD June*

(CY 2013 through CY 2017)

**Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.70%**
**Change in All Payer Admissions CYTD14 vs. CYTD15 = -3.13%**
**Change in All Payer Admissions CYTD15 vs. CYTD16 = -1.32%**
**Change in All Payer Admissions CYTD16 vs. CYTD17 = -1.05%**

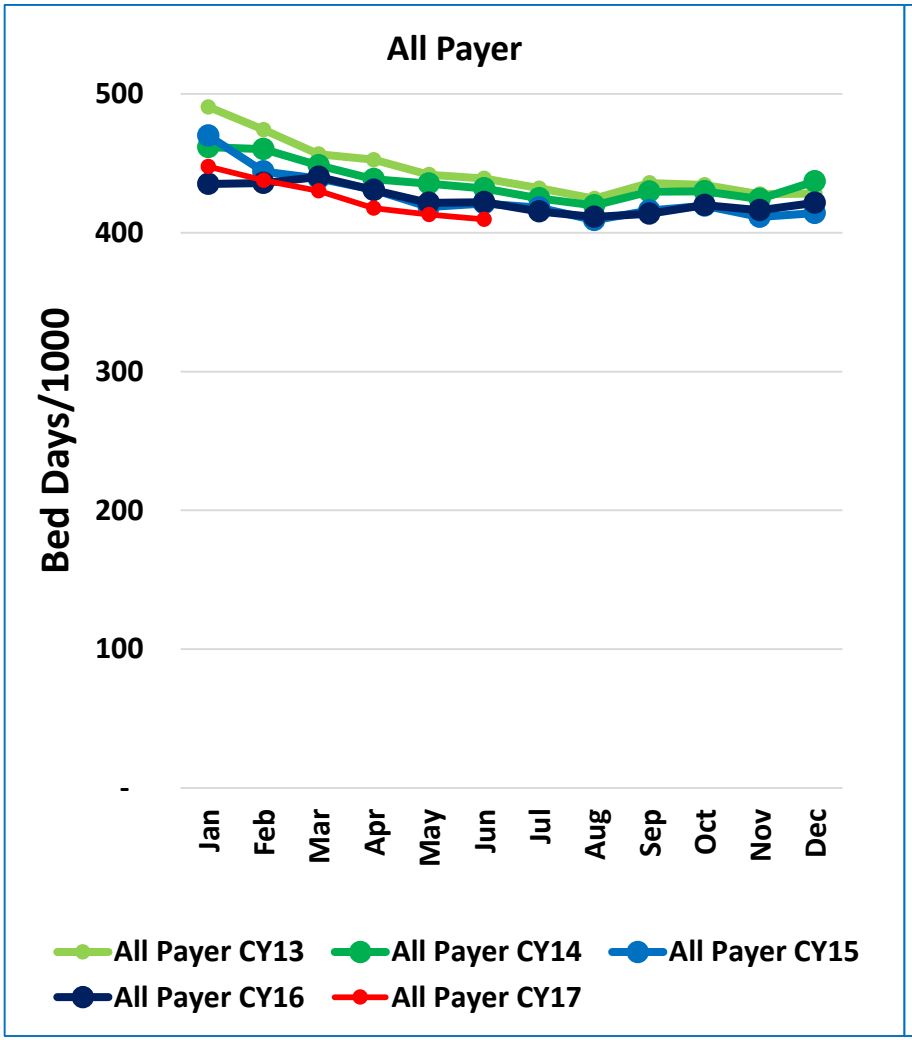
**Change in ADK CYTD 13 vs. CYTD 14 = -5.27%**
**Change in ADK CYTD 14 vs. CYTD 15 = -3.57%**
**Change in ADK CYTD 15 vs. CYTD 16 = -1.67%**
**Change in ADK CYTD 16 vs. CYTD 17 = -1.05%**

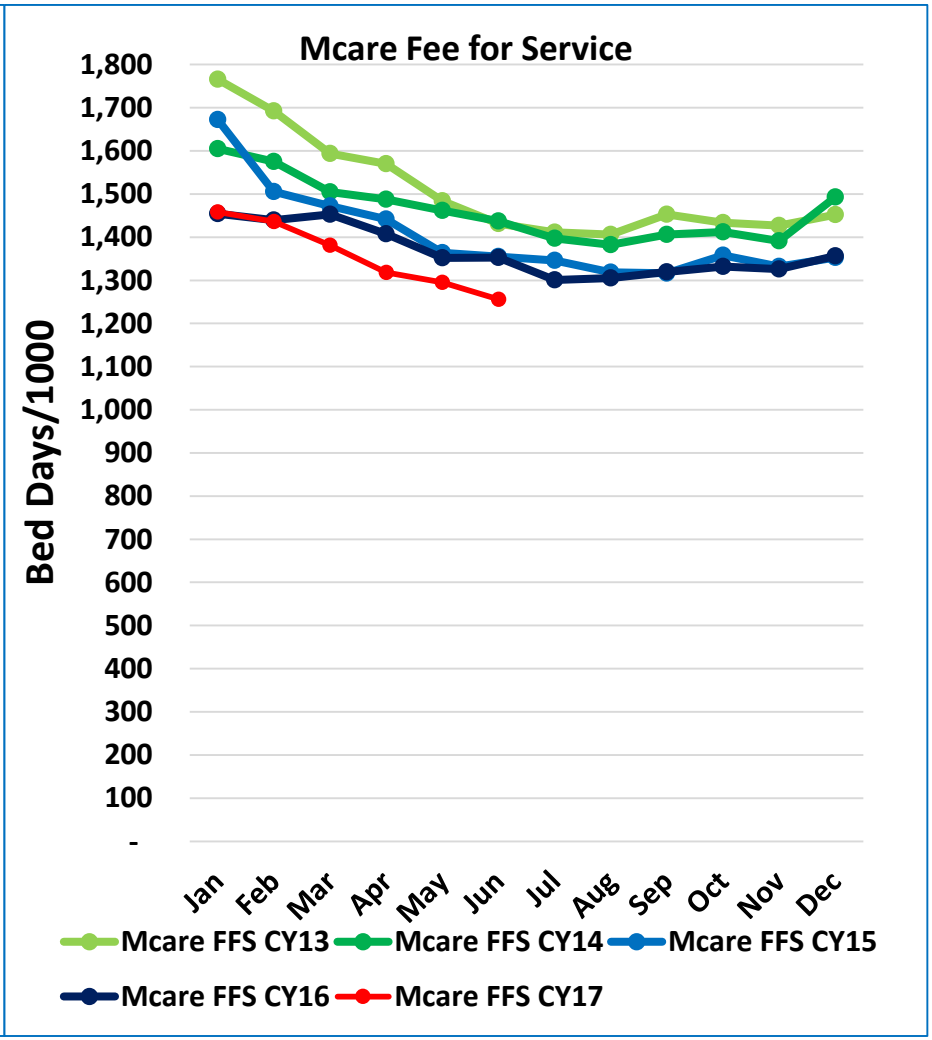
**Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -4.27%**
**Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = -0.32%**
**Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -2.51%**
**Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -2.08%**

**Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -7.28%**
**Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -3.46%**
**Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -4.16%**
**Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -3.10%**

# Annual Trends for BDK Annualized*

Medicare Fee For Service and All Payer (CY 2013 through CY 2017 June)




**Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.**



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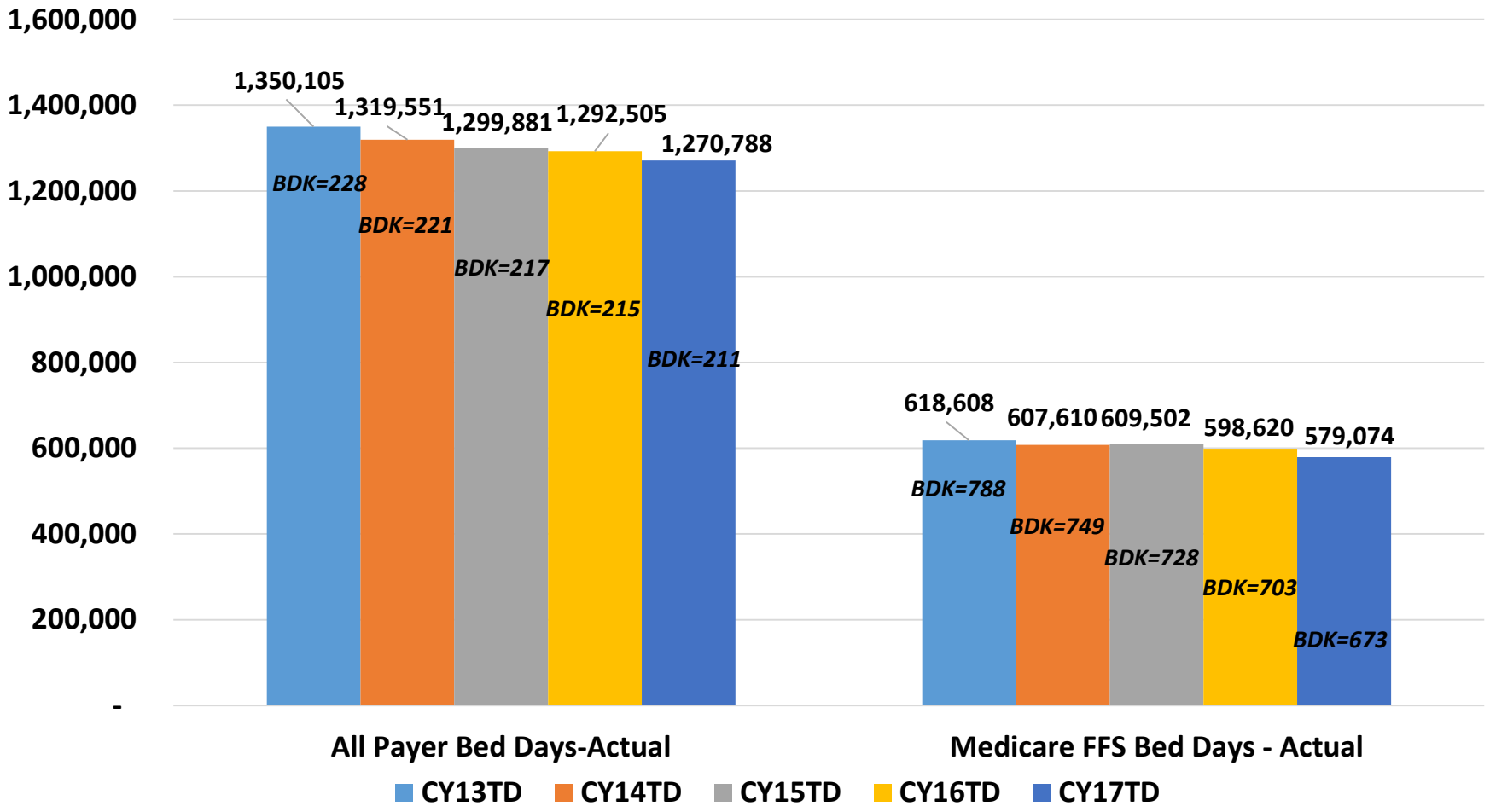
# Actual Bed Days by Calendar YTD June*

(CY 2013 through CY 2017)




Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.



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# Change in Bed Days by Calendar YTD June*

(CY 2013 through CY 2017)

**Change in All Payer Bed Days CYTD13 vs. CYTD14 = -2.26%**
**Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.49%**
**Change in All Payer Bed Days CYTD15 vs. CYTD16 = -0.57%**
**Change in All Payer Bed Days CYTD16 vs. CYTD17 = -1.68%**

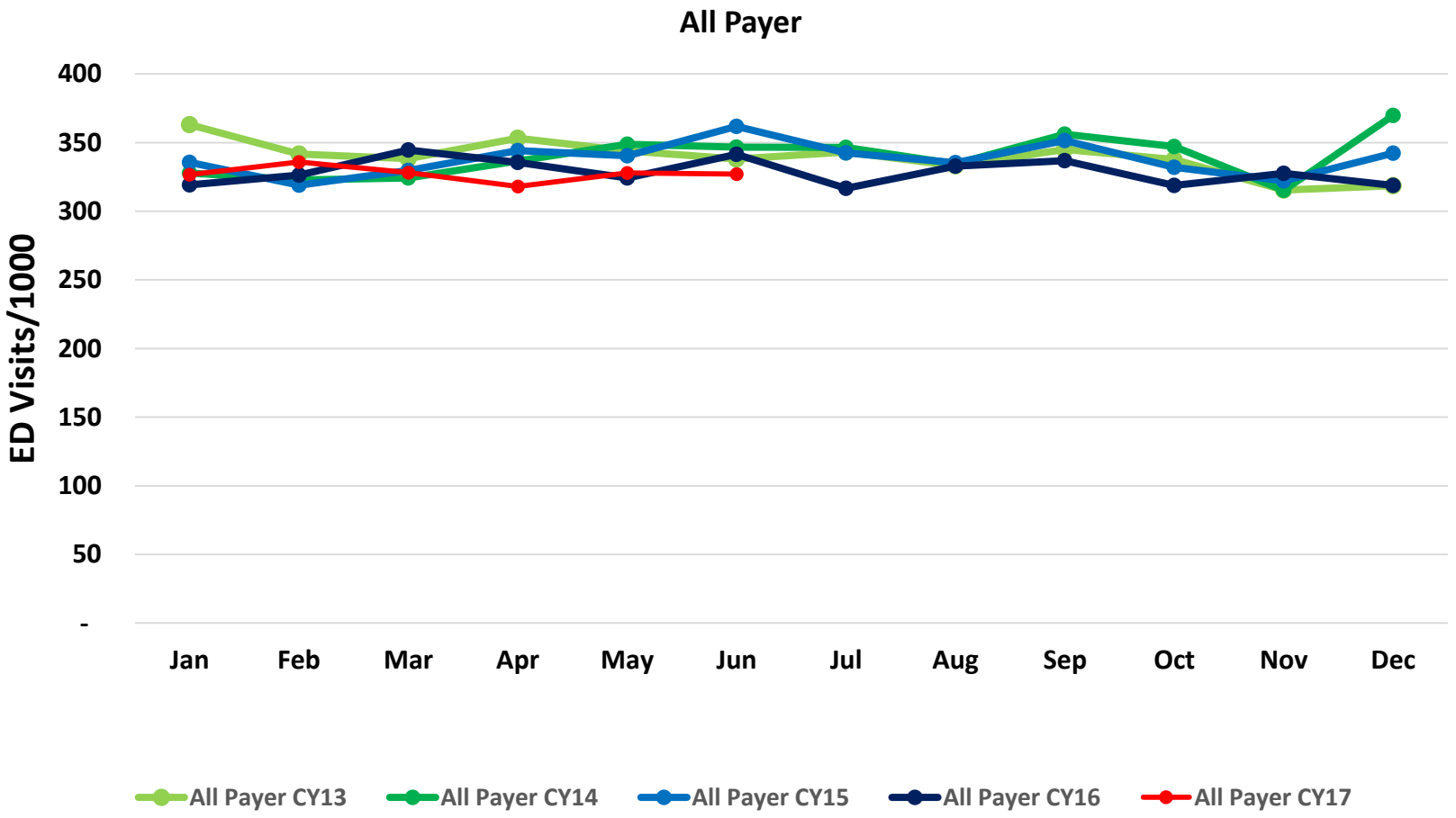
**Change in BDK CYTD 13 vs. CYTD 14 = -2.86%**
**Change in BDK CYTD 14 vs. CYTD 15 = -1.95%**
**Change in BDK CYTD 15 vs. CYTD 16 = -0.92%**
**Change in BDK CYTD 16 vs. CYTD 17 = -1.68%**

**Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -1.78%**
**Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = 0.31%**
**Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -1.79%**
**Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -3.27%**

**Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -4.87%**
**Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -2.84%**
**Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -3.46%**
**Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -4.27%**

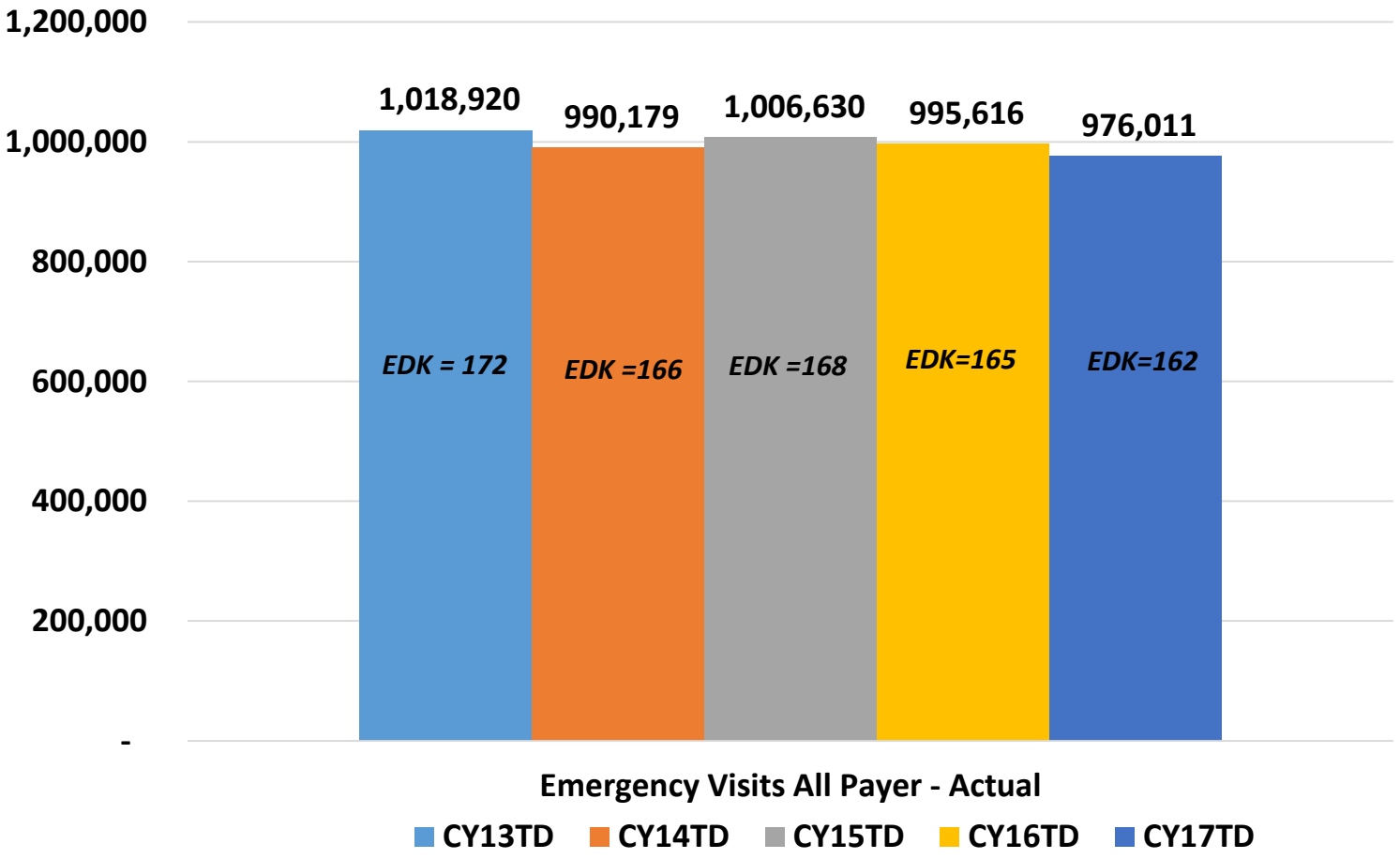
# Annual Trends for EDK Annualized

All Payer (CY 2013 through CY2017 June)




**Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.**

# Actual Emergency Department Visits by Calendar YTD June (CY 2013 through CY 2017)




Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.

# Change in ED Visits by Calendar YTD June

(CY 2013 through CY 2017)

**Change in ED Visits CYTD 13 vs. CYTD 14 = -2.82%**

**Change in ED Visits CYTD 14 vs. CYTD 15 = 1.66%**

**Change in ED Visits CYTD 15 vs. CYTD 16 = -1.09%**

**Change in ED Visits CYTD 16 vs. CYTD 17 = -1.97%**

**Change in EDK CYTD 13 vs. CYTD 14 = -3.41%**

**Change in EDK CYTD 14 vs. CYTD 15 = 1.19%**

**Change in EDK CYTD 15 vs. CYTD 16 = -1.45%**

**Change in EDK CYTD 16 vs. CYTD 17 = -1.97%**

# Purpose of Monitoring Maryland Performance

## Evaluate Maryland's performance against All-Payer Model requirements:

**All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita

- 3.58% annual growth rate

- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

# Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there June be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This June cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 CY 2016 and FY 2017 rely on Maryland Department of Planning projections of population growth of .36% for FY17, .52% for FY 16, and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

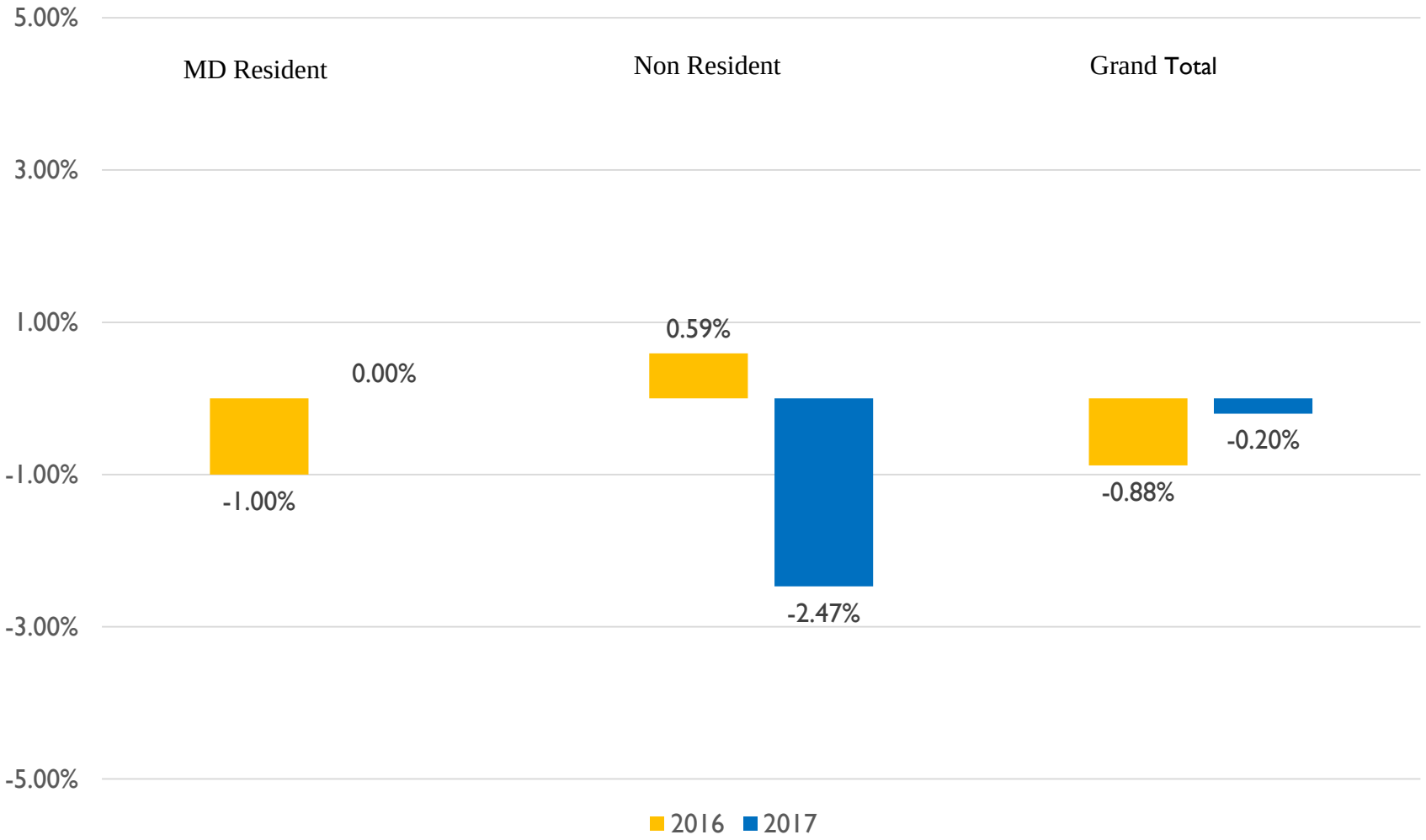
# Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

# Monitoring Maryland Performance
# Preliminary Utilization Trends

2017 vs 2016
(January to August)

# All Payer ECMAD CYTD Annual Growth



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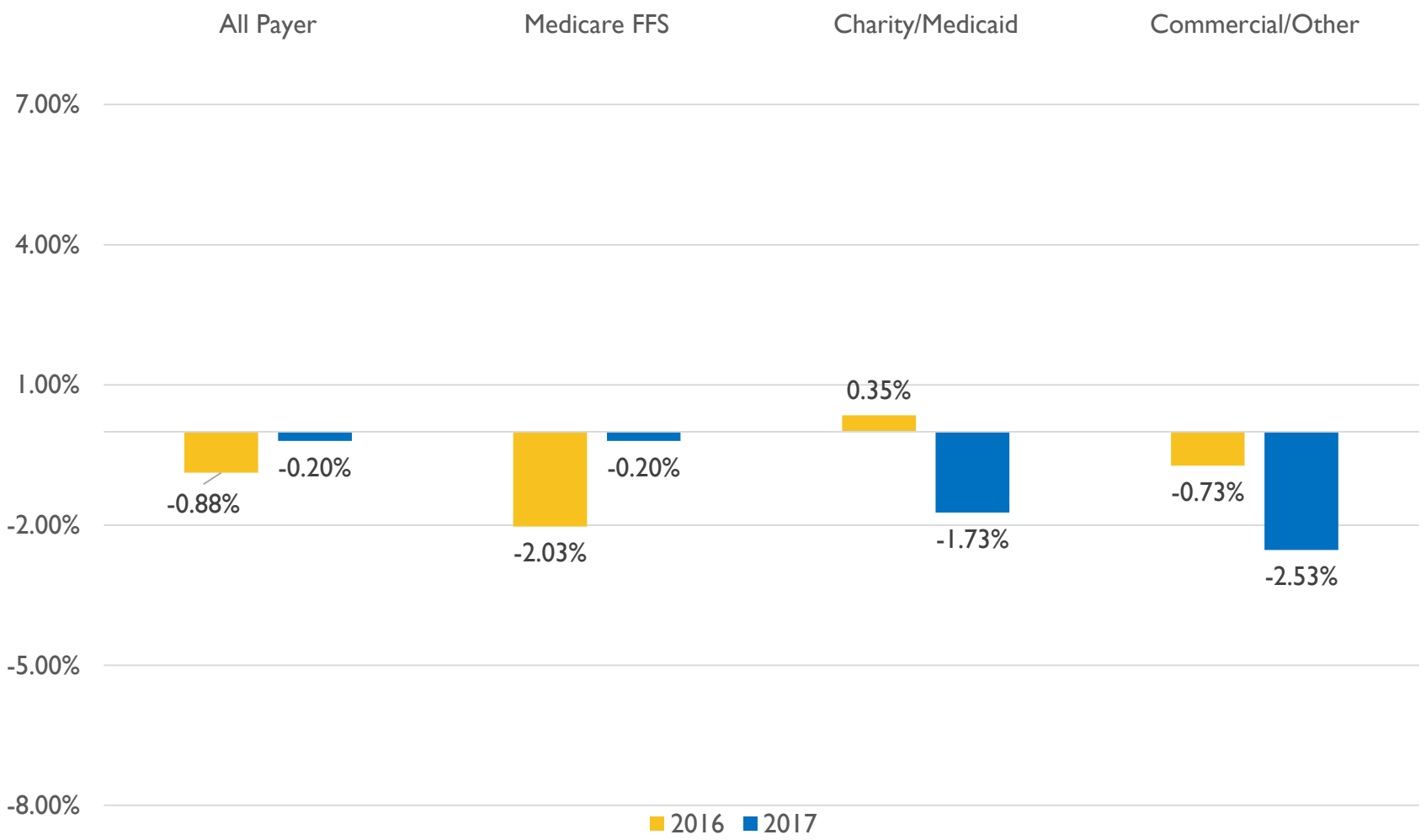
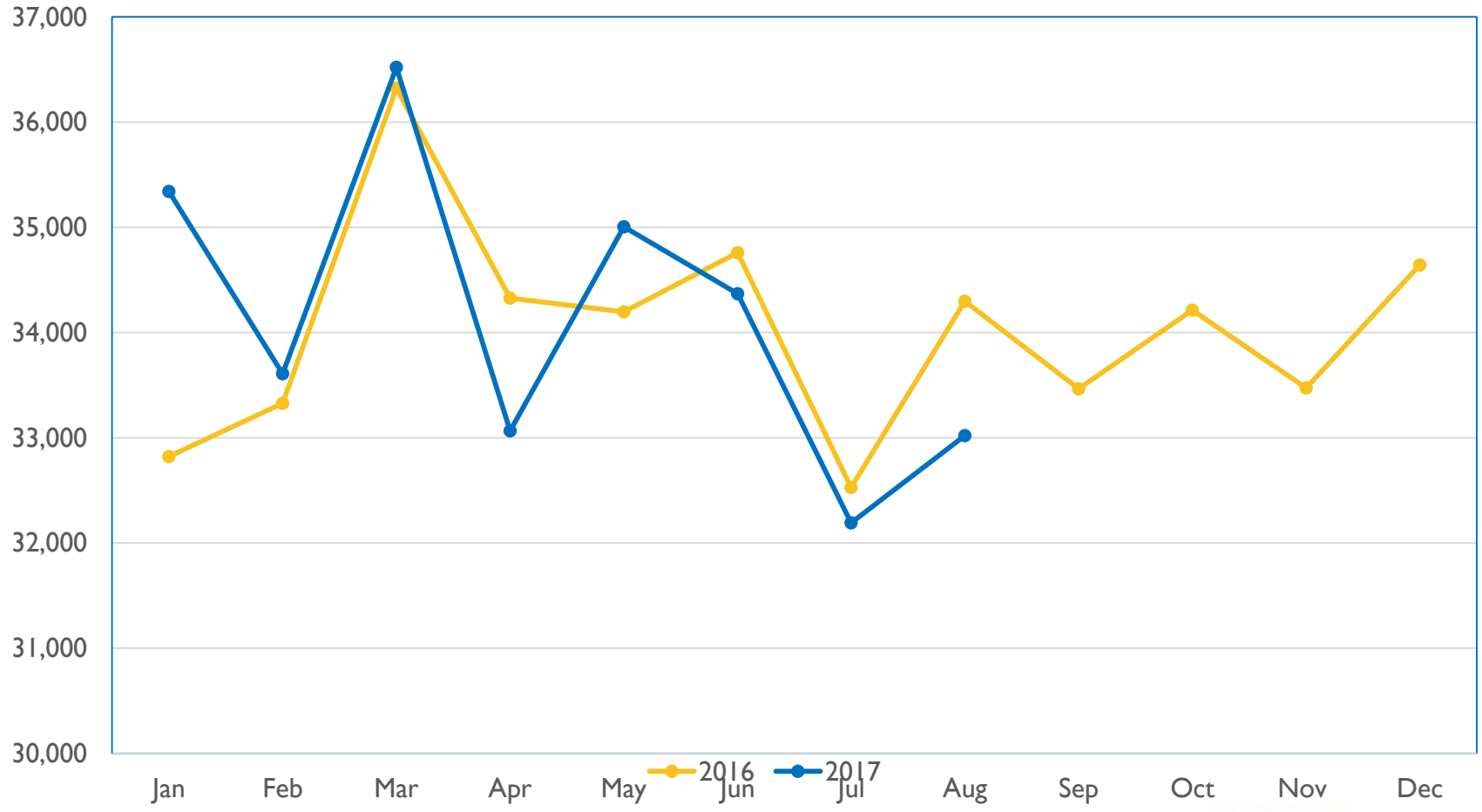
# MD Resident ECMAD CYTD Annual Growth



# Medicare MD Resident ECMAD Annual Growth by Month



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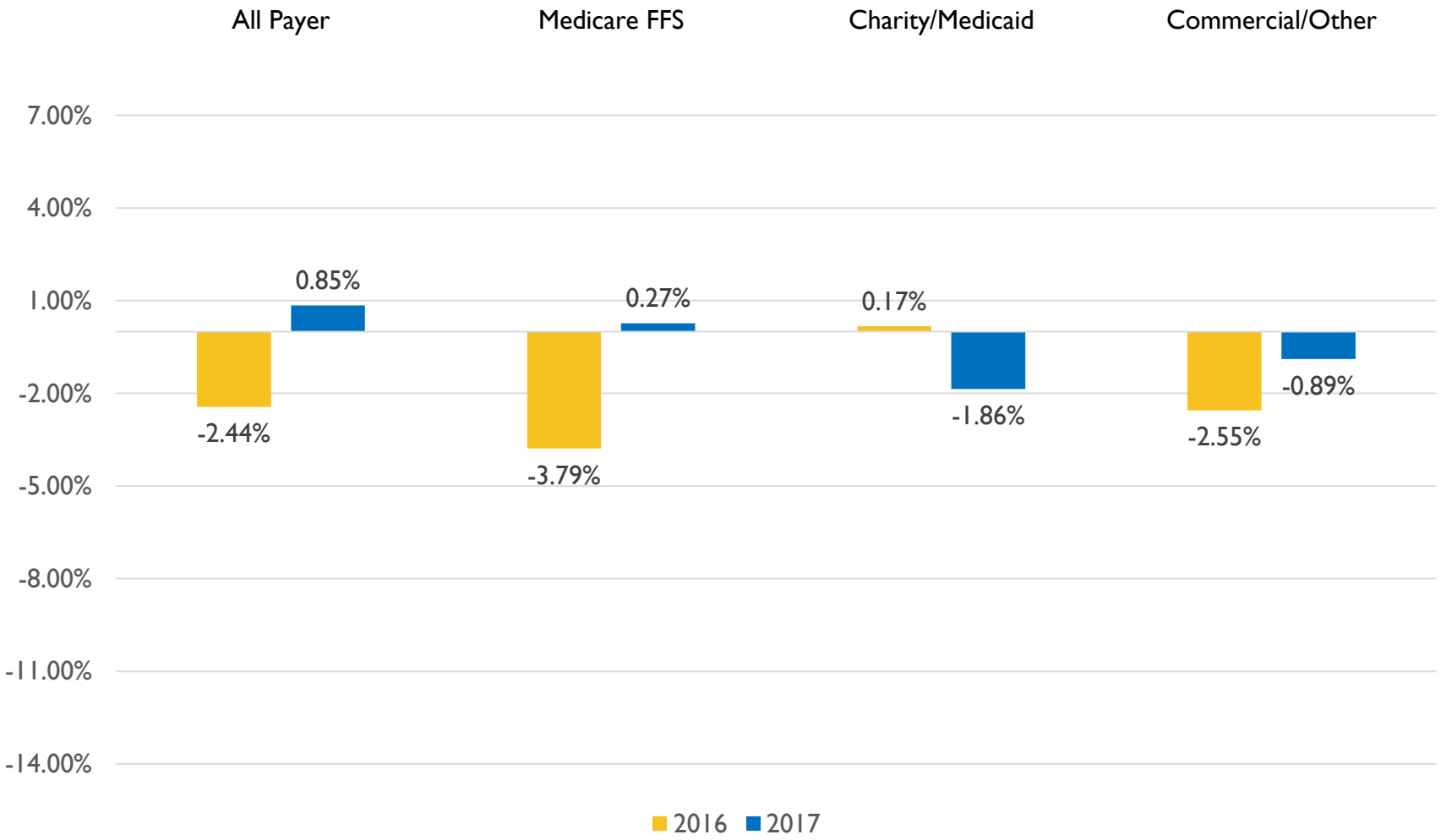
# MD Resident Inpatient ECMAD CYTD Annual Growth



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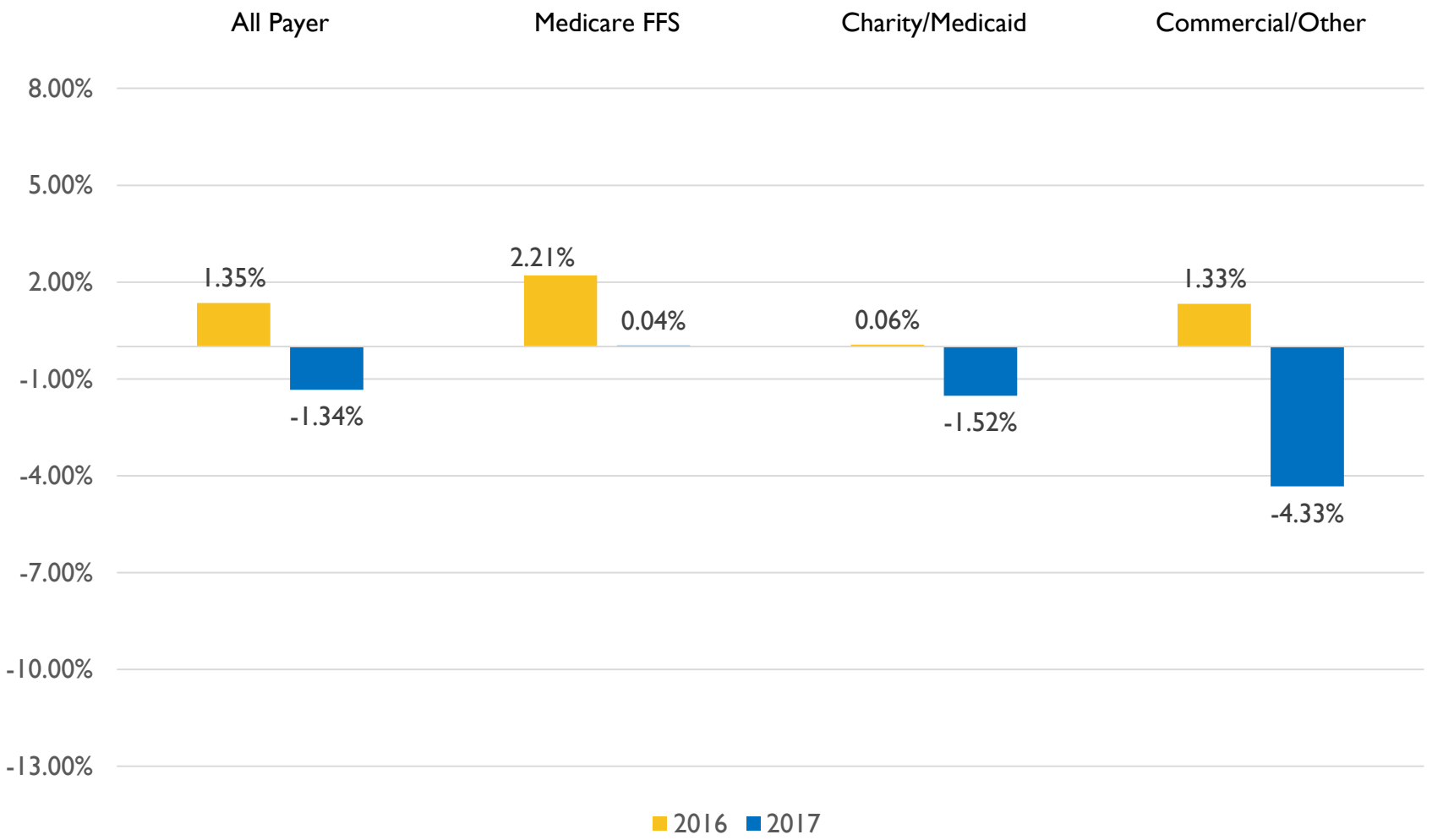
# MD Resident Outpatient ECMAD CYTD Annual Growth





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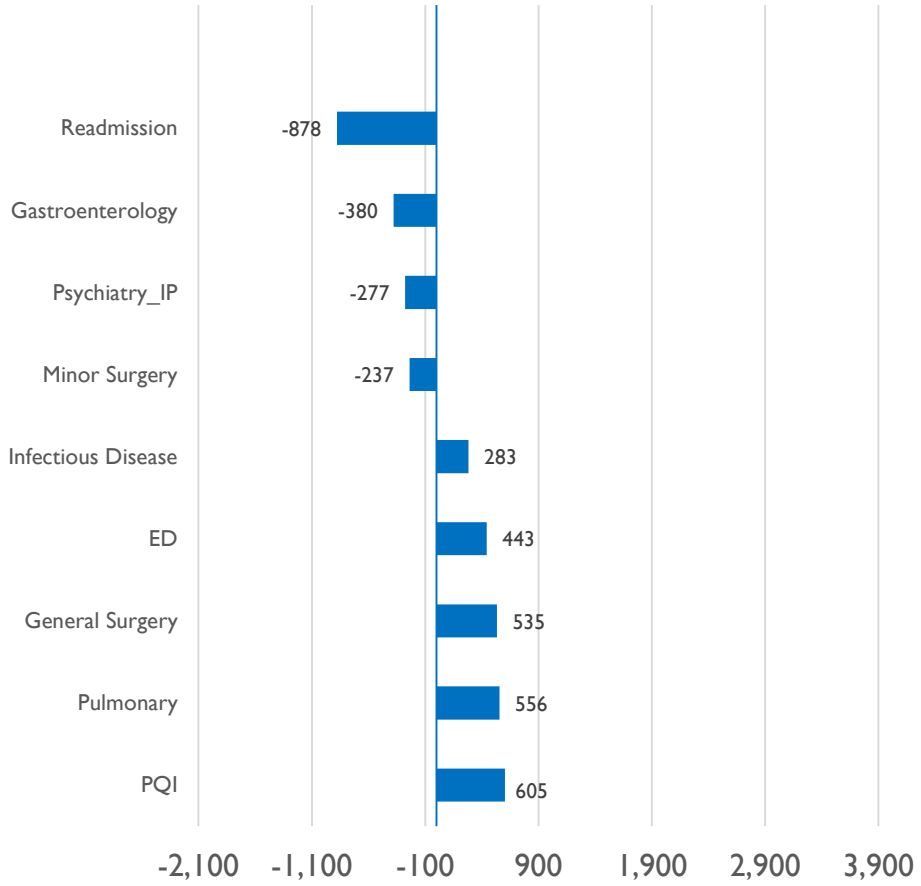
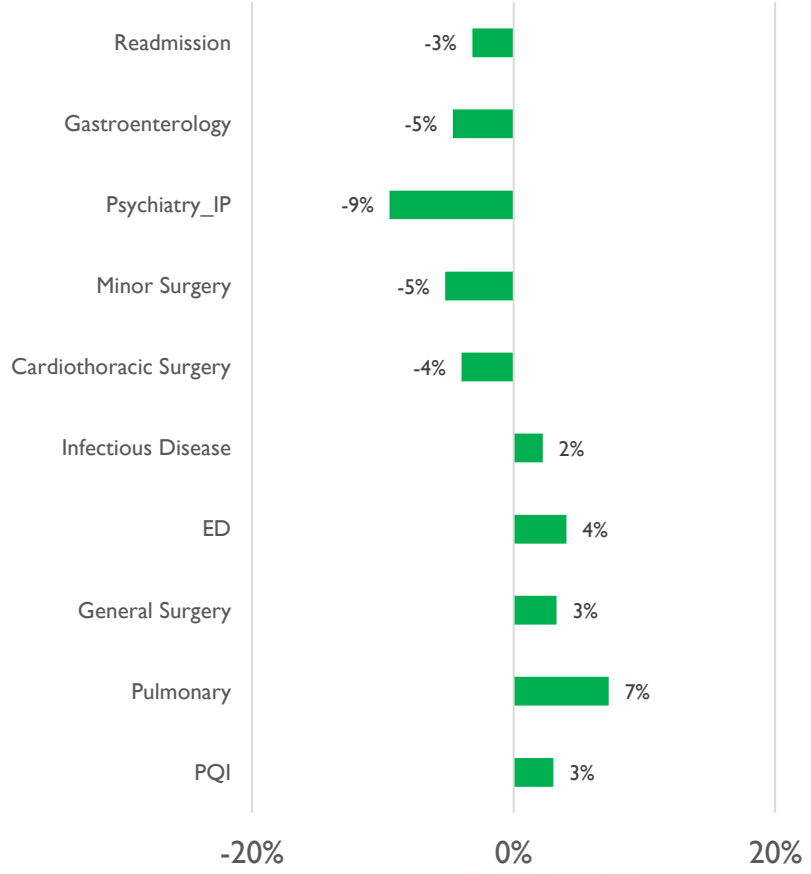
# Medicare MD Resident Top 5 Service Line Changes (Total ECMAD Increase = 540



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# Utilization Analytics – Data Notes

- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - IP=IP + Observation cases >23 hrs.
  - OP=OP - Observation cases >23 hrs.
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed

# Service Line Definitions

- Inpatient service lines:
  - APR DRG (All Patient Refined Diagnostic Related Groups) to service line mapping
  - Readmissions and PQIs (Prevention Quality Indicators) are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG (Enhanced Ambulatory Patient Grouping System) to service line mapping
  - Hierarchical classifications (Emergency Department, major surgery etc)
- Market Shift technical documentation

# 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 SEPTEMBER 28, 2017

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 |
|---|---|---|---|---|---|---|---|
| 2398N | Univeristy of Maryland Midtown Campus | 8/7/2017 | 10/11/2017 | 1/5/2018 | Defniitive Observation | CK | OPEN |
| 2399A | Priority Partners | 8/28/2017 | N/A | N/A | ARM | DNP | OPEN |
| 2400A | University of Maryland Medical Center | 9/15/2017 | N/A | N/A | ARM | DNP | OPEN |
| 2401A | MedStar Health | 9/15/2017 | N/A | N/A | ARM | DNP | OPEN |
| 2402A | MedStar Medicare Choice | 9/15/2017 | N/A | N/A | ARM | DNP | OPEN |
| 2403A | MedStar Family Choice | 9/15/2017 | N/A | N/A | ARM | DNP | OPEN |
| 2404A | Hohns Hopkins Health System | 9/28/2017 | 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** | |
| **UNIVERSITY OF MARYLAND** | ***** | **DOCKET:** | **2017** |
| **MEDICAL CENTER** | ***** | **FOLIO:** | **2210** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2400A** |

**Staff Recommendation**

**October 11, 2017**

## I. INTRODUCTION

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 15, 2017 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, 2017.

## 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, 2017.

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** | |
| **MEDSTAR HEALTH** | * | **DOCKET:** | **2017** |
| | * | **FOLIO:** | **2211** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2401A** |

**Staff Recommendation**

**October 11, 2017**

## I. INTRODUCTION

MedStar Health filed an application with the HSCRC on September 15, 2017 on behalf of Union Memorial Hospital (the "Hospital") to participate once again in an alternative method of rate determination, pursuant to COMAR 10.37.10.06 with the National Orthopedic & Spine Alliance. This same global rate arrangement for orthopedic and spinal services with the National Orthopedic & Spine Alliance arrangement was approved by the Commission at its February 10, 2016 public meeting for one year effective February 6, 2016 and was not renewed. MedStar Health now requests that the arrangement with National Orthopedic & Spine Alliance be approved for a one year period beginning November 1, 2017.

## II. OVERVIEW OF APPLICATION

The contract will be held and administered by Helix Resources Management, Inc. ("HRMI"). HRMI will 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 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 orthopedic and spine services, for a one year period, commencing November 1, 2017. 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.

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|---|---|---|---|
| **IN RE: THE APPLICATION FOR** | ***** | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | ***** | **SERVICES COST REVIEW** | |
| **DETERMINATION** | ***** | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | ***** | **DOCKET:** | **2017** |
| **SYSTEM** | ***** | **FOLIO:** | **2214** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2404** |

**Staff Recommendation**

**October 11, 2017**

## I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on September 28, 2017 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2017.

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## 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 continue to manage all financial transactions related to the global price contract including payments to the 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 calculated for cases that exceed a specific length of stay outlier threshold were similarly adjusted.

## 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

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

been favorable.

## VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning November 1, 2017. The Hospitals must file a renewal 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 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.

**Johns Hopkins Hospital Presentation**

Representatives from Johns Hopkins Hospital will present materials at the Commission meeting.

# DRAFT Recommendations for Updates to the Inter-hospital Cost Comparison Tool Program

October 11, 2017

Health Services Cost Review Commission
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This document contains the draft staff recommendations for updating the Inter-hospital Cost Comparison Tool for consideration at the October 11, 2017 Commission meeting. Please submit comments on the draft to the Commission by Tuesday, October 31, 2017 via hard copy mail or e-mail to allani.pack@maryland.gov.

# Table of Contents



## LIST OF ABBREVIATIONS

| | |
|---|---|
| ACA | Affordable Care Act |
| CMS | Centers for Medicare & Medicaid Services |
| DRG | Diagnosis-related group |
| FY | Fiscal year |
| FFY | Federal fiscal year |
| HSCRC | Health Services Cost Review Commission |
| QBR | Quality-based reimbursement |
| RY | Maryland HSCRC Rate Year |
| VBP | Value-based purchasing |

## INTRODUCTION

The State of Maryland is leading an effort to transform its health care system by increasing the emphasis on patient-centered care, improving population health, and lowering health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Center for Medicare & Medicaid Innovation (CMMI) at the federal Centers for Medicare and Medicaid Services (CMS) to develop the new Maryland All-Payer Model, which was implemented in 2014. The new Model moved away from a volume based payment system and limitation on growth in charge-per-case to a system that limits growth in total hospital spending per capita and increasingly focuses on outcomes. Prior to the implementation of the new Model, the HSCRC had begun to transform the payment system away from charge-per-case; with ten rural hospitals on global hospital payment models initiated in 2010, and most other hospitals with readmissions incorporated into a charge-per-episode system.

In November 2015, full rate reviews were suspended to allow development of tools and methodologies consistent with the new Model. Regulations were introduced at the September 2017 Commission meeting that updated filing requirements for full rate reviews. These updated filing requirements are intended to collect information that will support a more robust review of cost and efficiency, going beyond the cost-per-case or per visit efficiency previously embodied in the review. Cost-per-case and per visit continue to be an important part of the efficiency consideration. This draft report provides staff analysis and proposed updates to the Inter-hospital Cost Comparison (ICC) methodology, a tool that HSCRC staff proposes to continue using in evaluating hospitals' cost-per-case or per visit efficiency as a key element of full rate reviews. It also provides policy recommendations that go beyond the historical per-case/visit efficiency construct to address the need of evaluating efficiency in the context of a per capita system that also considers levels of utilization.

## BACKGROUND

To encourage efficiency and to limit the growth in charge per case prior to 2011, hospital's charges per case were compared to a peer group average. This comparison, referred to as Reasonableness of Charges or "ROC", was used to "scale" hospitals' approved charge-per case/visit, gradually giving hospitals with lower charges an incremental per-case increase and gradually lowering the approved charge-per-case for those hospitals with higher charges. In 2011, the ROC was suspended to encourage hospitals to reduce unnecessary utilization because it worked against the incentives to reduce unnecessary and avoidable volumes that might result in higher cost per case. Since 2011, hospitals have not faced efficiency scaling per the ROC, allowing hospitals to adjust to their focus on per capita efficiency and to invest in new models of delivery.

While the ROC was suspended in 2011, a derivative methodology, referred to as Inter-hospital Cost Comparison or "ICC", continued to be used for full rate reviews and partial rate

applications for capital. In November 2015, the HSCRC suspended full rate reviews to allow for evolution of the review methodologies, while retaining several avenues to adjust hospitals' global budgets through Global Budget Revenue (GBR) Agreements, emergency adjustments, and partial rate applications for large capital projects.

In the September 2017, the Commission introduced revisions to its regulations, updating filing requirements for full rate reviews, and laying out a review construct that considers both cost-per-case/visit and utilization, which will continue to evolve. The revisions require the filing of information regarding a hospital's full financial requirements associated with regulated costs and services, volumes of services, and avoidable and unnecessary utilization. The revisions continue the use of an Inter-hospital Cost Comparison as part of conducting a full review. This draft report presents staff's proposed approach to updating the ICC methodologies, which will be used in conjunction with other review components when evaluating possible increases or decreases to global budgets in the context of a full rate review. It also lays out policy recommendations regarding the expansion of the scope of the review to encompass efficiency and effectiveness in the context of the All-Payer Model demonstration that was implemented under the Agreement with CMS in 2014.

## ASSESSMENT

### Efficiency in the Context of Per Capita Costs

#### Affordability

Healthcare costs have reached a state of crisis in affordability, with ever increasing proportions of household income spent on healthcare services. Reductions in real wage growth and disposable income that can be attributed to healthcare cost increases have had an increasing impact on consumers and affordability of coverage. They have also placed an increasing burden on federal and state budgets, with increased proportions of costs borne by government. If Medicare and Medicaid costs continue to rise faster than GDP, more than ever Americans will be faced with paying more in taxes for healthcare as a share of economic output, and the need to further curtail expenditures on non-health outlays.

Several statistics from the National Institute for Healthcare Management (NICHM) Foundation substantiate these statements: (Source: https://www.nihcm.org/topics/cost-quality/the-burden-of-rising-health-spending)

- Per capita healthcare spending increased by nearly 40 percent over the decade 2006 through 2015.
- Healthcare spending now accounts for 28 percent of median personal income, based on 2015 figures.
- Hospital care contributed to 43 percent of the cost increase from 2006 through 2015.
- Out of pocket spending plus premiums for employer-based PPO coverage rose 73 percent during the decade from $15,609 for a family of four in 2008 to $26,944 for a family of

four in 2017, with employees bearing an increasing proportion of costs directly through a combination of employee contribution to premium and out-of-pocket spending.

- Medicare spending has risen 58 percent and Medicaid spending has risen 72 percent for the decade ended in 2015.

Maryland's per capita healthcare spending is no exception. Hospital and total personal health care spending per capita ranked 20th and 13th respectively when adjusted for age, and compared by state for 2014, based on figures recently released by CMS' Office of the Actuary and presented at the July 2017 Commission meeting.

### Context of Rate Setting in a Per Capita System

Under the historic charge-per-case system construct of Maryland's Medicare waiver in place from 1977 through 2013, the focus of the regulatory system and therefore the related full rate review was in constraining the growth and ensuring the reasonableness of cost per case or per visit. Congress, through the bi-partisan MACRA legislation as well as the ACA, has focused on high value care as efficient delivery of high-quality, evidence-based, patient-centered care. The Maryland All-Payer Model Agreement approved by CMS in 2014 under federal demonstration authority, relies on this definition of efficiency and value. The HSCRC's statute requires it to approve rates that are sufficient to allow hospitals to provide "efficient and effective" care. Potentially avoidable care—i.e., care that results from healthcare acquired conditions, from poor coordination, from inadequate condition management as well as unnecessary care—i.e., care that is rarely useful; care that is sometimes useful and needed but often overused; care that is needed and effective that could be provided in lower cost settings; and care that can be avoided with better community interventions—does not meet the standard of efficiency and effectiveness.

Higher cost and cost variation per case, per visit, or per episode continues to be important factors in excessive spending and the HSCRC will need to continue focusing on efficiency in this context. For ease of understanding, this analysis will refer to this as price efficiency. The Inter-hospital Cost Comparison (ICC) is a construct that HSCRC historically has used to evaluate price efficiency. The HSCRC staff propose that the Commission continue to use this tool as part of evaluating efficiency in the context of a full rate review. The HSCRC staff is proposing updates to the ICC methodology for review with this recommendation.

While higher cost per service and episode contribute to excessive spending, clinical waste also contributes to inefficient costs and poor outcomes. Clinical "waste" consists of care that could be eliminated without reducing quality or outcomes, and staff intend for this to encompass both potentially avoidable care and unnecessary care. Many estimates (e.g., from the Institute of Medicine) place waste at approximately 30% of American healthcare expenditures. The Maryland hospital system is unique in that it operates under a unique demonstration and waiver arrangement with the federal government which has permitted the establishment of "fixed budget" agreements that give hospitals the ability to eliminate unnecessary care without incurring financial harm. The success of the Maryland demonstration under the All-Payer Model is highly dependent on the progress that is made by hospitals in controlling volume levels—

specifically, efforts to curb volume increases and to eliminate potentially avoidable and unnecessary care. Failure to address the problem of potentially avoidable and unnecessary care will endanger the affordability of health care for individuals, companies and government; it will undermine the profitability and financial status of the hospitals if rate updates are tightly controlled; it will limit the funds that are available for innovation; and it will potentially threaten the long term continuation of the waivered All-Payer Model system.

- It is clear that there are many opportunities to improve value and efficiency in the healthcare system. Reductions in treatments that go beyond the levels determined to be efficacious by widely accepted clinical guidelines are a key potential source of value and efficiency improvements. Reductions in potentially avoidable utilization that can be achieved through reductions in healthcare acquired conditions, poor coordination of care, and ineffective management of chronic and complex conditions are another key potential source of value and efficiency.
- These opportunities exist throughout the health care system, to a greater or lesser degree, but are substantial in virtually all cases across all hospitals and health systems.
- Hospitals and their medical staffs, in concert with other health care providers and consumer representatives, are positioned to work with other providers, health departments and consumers to determine which areas of medical care offer the greatest opportunities for value improvement in their communities.
- The HSCRC has provided infrastructure funding to support efforts at value improvement. The fiscal stability of the Maryland hospitals and the viability of the federally-waivered All-Payer Model and the proposed enhanced Total Cost of Care Model depend on the implementation of effective actions to address the overuse problem and provide resources to address areas of underuse such as primary care.
- The HSCRC should allow the hospitals significant latitude to devise the ways in which they will work with physicians, other providers and their communities to identify the greatest opportunities for value improvement in their service areas.

In addition to providing evidence of price per service efficiency, hospitals, especially when they file a full rate application seeking higher global revenue budgets, should be expected to demonstrate that they are making substantial and demonstrable ongoing progress in achieving more appropriate levels of care, eliminating potentially avoidable and unnecessary care and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts to improve care and to reduce unnecessary care in key areas that have been shown by the health services literature to be particularly problematic.

## INTER-HOSPITAL COST COMPARISON METHODOLOGY UPDATE

### Background

The Commission has utilized an Inter-hospital Cost Comparison (ICC) approach for decades to evaluate the reasonableness of hospital costs and to determine the relative efficiency of a particular hospital in comparison to similar institutions. In the earliest years of the Commission, the comparisons used cost per unit comparisons. When Diagnosis Related Groups (DRGs) were developed in the late 1970s and early 1980s, the Commission adopted a charge-per-case approach for inpatient cost comparisons while maintaining unit based comparisons for outpatient services. On June 1, 2005, the Commission moved to 3Ms All Patient Refined DRGs (APR-DRGs), which offered major advancements in severity level classifications that allowed for better cost comparisons as well as quality and outcomes comparisons. When moving to the APR-DRG system, the Commission found that hospital's coding enhancements resulted in excess revenue growth, and the Commission suspended full rate reviews for three years and instituted case-mix governors to limit the impact of coding changes.

In the last decade, as outpatient services grew as a proportion of hospital costs, the Commission focused on moving outpatient service comparisons to a cost-per-visit approach using 3M's Enhanced Ambulatory Grouping System (EAPGs) to allow for more comprehensive cost comparisons in the outpatient setting. The ICC approach evolved to incorporate some outpatient hospital services into a charge-per-case construct, while continuing to maintain selected services on a cost per unit basis. The visits where the HSCRC was unable to develop charge-per-visit comparisons were for cycle-billed services, meaning that the services were billed for on a monthly basis rather than for each visit. Principal services that continue with this billing condition are clinics, physical therapy services, and oncology services. This difficulty still persists. The HSCRC does not collect all of the line item billing elements for these cases that would allow them to be parsed into visits, and this inhibits analysis. Staff will revisit this issue later in this draft recommendation. With the improvements in computing software, the lowering of hardware costs, and advent of cloud computing, it may be time to collect this data.

The HSCRC staff has evaluated needed updates to the ICC approach and has completed preliminary calculations using the proposed revised approach for those services that would be incorporated into a charge-per-case or charge-per-visit construct. As discussed below, staff needs final rate year-end 2017 data (July 1, 2016 through June 30, 2017) to complete the calculations; which should be forthcoming in the near term. Also, as with all data analyses and technical calculations, the work should be subjected to a technical review prior to its finalization. In the following paragraphs, the staff will explain the changes that are being proposed to the methodology at a high level.

As discussed above, the objective of a cost-per-case/cost-per-visit comparison is to allow HSCRC to assess the relative costs of hospitals compared to other hospitals or potentially to other providers offering similar services. The HSCRC has developed a construct to combine these analyses for inpatient and outpatient services, which we refer to as Equivalent Case-Mix Adjusted Discharges or "ECMADs". In the following paragraphs, staff will use the term

ECMADs to denote the combination of included inpatient and outpatient cases and visits, while noting that staff is excluding ECMAD data for cycle billed visits at this time (clinics, infusions and related drugs, radiation therapy, physical therapy services, and outpatient psychiatric visits).

Staff will describe at a high level the process used to reach the comparisons in the ICC, including a description of proposed changes. A companion detailed technical document and calculations will be made available at future Commission meetings, once updated data is obtained, documentation is complete, and technical review and input are considered.

## Overview of Calculation

The general steps used by staff, consistent with prior practices, are as follows:

1. Calculate approved permanent revenue for included ECMADs. This excludes the hospital revenues for one-time temporary adjustments and assessments for funding Medicaid expansion and deficits as well as Commission and other user fees.

2. Permanent revenues are adjusted for social goods (e.g. medical education costs) and for costs that take into consideration factors beyond a hospital's control (e.g. labor market areas as well as markup on costs to cover uncompensated care and payer differential).

3. Hospitals are divided into peer groups for comparison, recognizing that the adjustments may not fully account for cost differences. The adjusted revenue per ECMAD is compared to other hospitals within the peer group to assess relative adjusted charge levels. The peer groups are:

- Peer Group 1 (Non-Urban Teaching)
- Peer Group 3 (Suburban/Rural Non-Teaching)
- Peer Group 4 (Urban Hospitals)
- Peer Group 5 (Academic Medical Center Virtual, which overlaps with peer group 4)

4. For full rate reviews there are two additional steps to convert revenues to cost. The first additional adjustment is to remove profits from regulated services from the adjusted revenues. The second is to make a productivity adjustment to the costs. These two adjustments are made to allow for consideration of efficient costs for purposes of rate setting.

5. In a full rate review process, an analysis of efficiency is performed with the ICC while also taking into account other information put forward by the hospital or staff and incorporating further analysis and consideration of the services (i.e. cycle-billed services) that are not included in the base ICC analysis. Once the process of review is complete, the process of rebuilding back from an adjusted peer group standard to approved revenue is completed by reversing steps one and two.

## Proposed Changes to ICC Methodology

The staff will now discuss its considerations in proposing changes to the ICC relative to the methodology in effect in 2011.

We have focused on the approach to adjust revenues for social goods and for factors that are partially beyond a hospital's control (step 2) as well as for the productivity adjustment discussed in step 4. At this time, the staff has not reformulated peer groups (step 3) and has proposed one substantive change to the calculation of permanent revenues (step 1).

Step 1- Calculate Permanent Revenue

*Outpatient Drug Overhead Adjustment-*

As previously discussed, outpatient cases that are subject to cycle billing are excluded from the cost-per case/visit comparisons and handled separately. Staff proposes to exclude only the cost of outpatient drugs for the cycle billed cases (primarily cancer drugs and biological drugs) and not the charges/cost for overhead. In the HSCRC rate setting calculations, a significant portion of costs continue to be allocated based on "accumulated costs". This process is allocating too much overhead to outpatient biological drugs and staff has concluded that this allocation distorts cost comparisons. Medicare adds five percent to average sales price to pay for physician administered drugs that are not bundled into a visit cost, while non-governmental payers use a somewhat higher overhead figure when using average sales price in their payment formulation. It is likely that HSCRC will need to change its overhead allocation and rate setting formulation for these biological and cancer drugs in the near term as costs continue to escalate. In the meantime, staff recommends leaving the overhead costs in the revenues and costs subject to charge-per case/visit comparisons.

Step 2- Adjustments to revenue

Each key adjustment to revenue along with changes to the approach proposed by staff follow:

*Medical Education Costs-*

Consistent with past practices, direct medical education costs, including nurse and other training as well as graduate medical education (GME) costs, are stripped from the permanent revenues using amounts reported in hospitals' annual cost filings. HSCRC policies limited recognition of growth in residencies beginning in 2002, unless increases in residencies were approved through a rate setting process, consistent with Medicare policies that also limit recognition of growth in residencies. For the proposed ICC formulation, the staff is limiting the counts and costs used in the GME calculations based on the number of residents and interns that were included in the 2011 regression.

Over the years, Maryland has struggled with the calculation of indirect medical education ("IME") costs. In 2011, HSCRC reached a calculation after much debate of an IME allowance per resident of $230,746. Staff believes this figure may be too high for those hospitals that are

not academic medical centers. Staff proposes to use the 2011 figure and inflate it to current dollar figures, building on the significant work and resource investment that resulted in this formulation in 2011. The most significant concerns with reformulation of the allowance is that the calculation results are unstable and are driven primarily by variations in charges of Maryland's two academic medical centers. Staff is undertaking analyses of national cost data to determine if it is possible to create a more empirically justified calculation, but this will take some time and may not be ready for use prior to RY 2019.

*Labor Market Adjustment-*

In the prior ICC, the labor market adjustment was constructed using an HSCRC wage and salary survey that was based on two weeks of pay and included fringe benefits and contract labor. Each hospital was provided with a unique labor market adjustor. Staff suspended the wage and salary survey submission for 2017 and intends to replace this survey data with CMS's nationally reported data. Although this national CMS data is available historically, HSCRC staff have not had the opportunity to audit the data and there may be reporting errors. Staff and MHA have stressed the importance of accurate data in the 2017 reports to Medicare which are due this year.

While staff will continue to use the HSCRC wage and salary survey in its formulation of the ICC until the new Medicare survey is available, it proposes to eliminate hospital specific adjustments for most hospitals. Specifically, staff proposes to use two sets of hospital groupings, with the first set of grouping for Prince George's County and Montgomery County where wages are higher than Maryland's average and a second grouping of all other hospitals, excluding various border hospitals located in isolated or rural areas.

*Capital Cost Adjustment-*

Previously, there was a capital cost adjustment for differences in capital costs that was being phased out over time. The time has elapsed and there is no longer an adjustment for capital cost differences.

*Disproportionate Share Hospital (DSH) Adjustment-*

In the 2011 analysis, staff made an adjustment to charges for patients considered to be poor, in consideration of the cost burden that those patients may place on hospitals with higher levels of poor patients. Prior calculations utilized the percentage of Medicaid, charity pay and self-pay to determine this cost burden.

Medicaid expansion has dramatically increased the number of individuals with coverage. First, the expansion was extended to children, then was extended to childless adults and those with higher incomes through the ACA expansion, rendering the prior definitions of limited use. Additionally, with increased payments available to physicians for hospital and community based services and reductions in hospitals' uncompensated care, the financial reasons for potentially continuing this policy are more limited. To evaluate the need for this adjustment, HSCRC compared the case-mix adjusted inpatient charges of potentially poor patients at each hospital (Medicaid, a new category of dually-eligible for Medicare and Medicaid, and self-pay and

charity) to the case-mix adjusted charges of all other patients. A weighted comparison using the more sensitive severity adjusted APR-DRG's showed a small higher adjusted charge-per-case for Medicaid and dually-eligible persons and a lower charge-per-case for charity and self-pay patients. This leads staff to conclude that this adjustment is no longer needed, although staff does believe that the retention of peer groups helps to adjust for other costs that might not otherwise be well accounted for, such as security costs in inner city settings.

While Medicare has retained a DSH adjustment, it has been split into two parts. One part is for uncompensated care, which the HSCRC addresses through the uncompensated care pool. The other part of the adjustment may help Medicare continue to address a concentration of governmental payers, as Medicare and Medicaid typically reimburse hospitals at a reduced rate. Given Maryland's unique All-Payer Model, which eliminates the cross subsidization between governmental payers and private payers as seen in other states, there appears to be a limited need for a DSH adjustment and the charge comparisons do not support it.

Step 4- Productivity and Cost Adjustments

Staff has retained the same adjustment used to remove profits from the ICC costs that has been used historically. Consistent with the statutory authority of HSCRC, the Commission does not regulate professional physician services. The adjustment removes profits for regulated services and does not incorporate subsidies or losses for professional physician services.

Staff recommends however, an alternative approach to calculate the productivity adjustment. In 2011, the methodology used a productivity adjustment of two percent that was applied across the board to all hospitals in all peer groups. Staff is recommending consideration of an excess capacity adjustment, which it has formulated based on the declines in patient days (including observation cases >23 hours) from 2010 through 2017 in each peer group. The adjustment varies by peer group. Alternative formulations could consider adjustments for unnecessary and potentially avoidable utilization.

Other ICC Considerations and Issues

The Commission considers other information in making full rate reviews and establishing revenue budgets. For example, staff has paid attention to the needs of rural hospitals. Rural hospitals were among the first hospitals in the state to move to a global budget beginning in 2011, referred to as a Total Patient Revenue (TPR) budget. Hospitals (except for Garrett Regional Medical Center which was already on TPR in 2011) were provided substantial revenue allowances to support the conversion and transition to population based systems, and were able to invest funds in alternative services when inpatient days declined. The Maryland Health Care Commission (MHCC) is in the process of completing a report on rural healthcare delivery and its challenges in Maryland. The HSCRC staff will need to continue to pay close attention to the needs of rural hospitals, including possible residencies and rotations of residents to address critical physician shortages where they exist.

Another concern is the limitation of comparisons to other hospitals. Some of the services provided by hospitals can be performed in community settings and those cost comparisons should incorporate community payment levels. This will be a topic for future consideration.

The ICC is currently constructed using cases and visits. Future iterations could extend to episodes, per capita benchmarks, and regional comparisons; however there is more data that would be needed for this analysis, which is complex. The ICC could also evaluate hospital utilization per capita benchmarks. However, this requires data beyond hospitals to adjust for differences in site of service and population based risk adjustment to account for patient characteristics. These tools are not yet developed.

## RECOMMENDATIONS

In light of the change in the All-Payer Model from the historic cost-per-case focus to a per capita system with demonstrable care delivery and outcomes improvement requirements, the HSCRC staff makes the following recommendations for consideration:

1. Hospitals filing full rate reviews should demonstrate efficiency in both price and utilization and the evaluation should consider the total hospital cost of care subject to the Commission's' rate setting authority.
    a. Price efficiency (i.e. the cost of performing cases or episodes) should take into account ICC comparison results, supplemented with unit cost or other efficiency analysis of those "cycle billed" services excluded from the ICC. The rate setting process should also continue to consider other information and analysis supplied by the hospital or performed by HSCRC staff regarding efficiency.
    b. For evaluation of utilization efficiency, hospitals should be required to demonstrate that they are making substantial and demonstrable ongoing progress in achieving more appropriate levels of care, reducing avoidable utilization, eliminating unnecessary care and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts and investments to improve care and to reduce unnecessary care and potentially avoidable care. Additionally, the staff should be directed to consider reducing the allowed global budget of hospitals that have high levels of avoidable utilization requiring them to achieve additional utilization efficiency over time.
    c. The evaluation should through this process take into account efficiency in both price and utilization of inpatient and outpatient regulated services.

2. The HSCRC staff should seek review from a Technical Review Group on its proposed modifications to the Inter-hospital Cost Comparison. This group may provide input, similar to the Total Cost of Care Advisory Group, but rate setting is a regulatory tool and does not lend itself to consensus-based input.

3. The HSCRC staff should evaluate an expansion of claims data submissions from hospitals for outpatient hospital claims that are “cycle billed claims” to allow for more accurate construction of ECMADs and benchmarks for the outpatient visits and episodes that are now excluded from the ICC.

Maryland
Hospital Association

September 27, 2017

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

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I am writing to comment on Health Services Cost Review Commission (HSCRC) regulation 10.37.10 – Rate Application and Approval Procedures. The commission approved emergency promulgation of this regulation at its September public meeting.

**Background**
A regular or "full" rate application is a structured administrative proceeding that allows Maryland's hospitals to seek rate relief from the commission. It is hospitals' only recourse to question rates and revenues they believe are unreasonable. A full rate application allows for the complete, open and transparent review of hospital rates and revenues by the commission, which means more than changing the global budget revenue cap. The process begins with application filing and HSCRC staff review, commission action, and if necessary, allows for a public hearing and judicial appeal. Maryland's hospitals have been prohibited from filing a full rate application since December 2015, even though the full rate application is a critical administrative proceeding under HSCRC regulation.

**A rate efficiency methodology has not been proposed by HSCRC staff**
Our most serious concern with adopting the regulation on an emergency basis is that the hospital comparison methodology is not yet complete. The moratorium on rate applications was to last until the commission adopted a rate efficiency, or Inter-hospital Cost Comparison measure, consistent with the All-Payer Model. The rate efficiency measure was originally scheduled to be in place on or about July 1, 2016, with the deadline further extended until October 31, 2017.

We appreciate HSCRC's efforts to meet the moratorium deadline, but are concerned about advancing regulations supported by a critical methodology that is not yet in place. Commission staff stated that the cost comparison methodology will be proposed at the October public meeting, just 22 days before the end of the moratorium. Following its proposal, HSCRC staff should immediately convene a work group to discuss the proposed methodology. Open communication and fair consideration of feedback from Maryland's hospitals will be crucial to creating an effective comparison methodology.

Section 10.37.10.04-1 describes using a rate efficiency methodology "with the appropriate adjustments to reflect changes in the hospital volume since the beginning of the new All-Payer Model agreement and the inception of (global budget revenue) agreements." We note that section 10.37.10.04-2(A) changes "reasonable rates" to "reasonable revenues." Though subtle, this change implies that revenue levels are affected by both price (rates), and service use (volume). The All-Payer Model reflects per capita revenue incentives. Maryland's hospitals will work with HSCRC staff to ensure that a new efficiency measure will align with the All-Payer Model's incentives.

**Proposal Increases information required to submit application**
Section 10.37.03.B reflects the information required to submit a full rate application, including many items already submitted by hospitals to HSCRC. These include Medicare's Interns and Residents Information System report files, lists of expensive outpatient drugs, and transactions with related entities. The proposed regulations require resubmitting the reconciliations of HSCRC abstract volumes to the monthly departmental revenues and statistics *for the last three years*. This level of detail is not necessary because commission staff can review the prior hospital submissions as needed.

**Rate applications by hospitals in a system**
Section 10.37.10.04-1.C proposes that the commission may take into account the financial situation of other Maryland hospitals if they are part of the same health system as the requesting hospital. Each Maryland hospital is allowed reasonable rates to provide efficient and effective services. Economies of scale and cost saving efforts lead to resource sharing among hospitals in a system. Should HSCRC staff and the commission choose to consider volumes and costs within a system, HSCRC staff and the commission should consider granting explicit, greater flexibility to share global budget revenue limits among the same hospitals.

**References to global budget revenue methodology**
We support the proposed updates to outdated references to charge-per-case target methodology. Many of the references in this regulation have been outdated since adoption of the All-Payer Model in 2014.

**Alternative to evidentiary hearing**
Section 10.37.10.11 proposes that the commission may allow written submissions to support an application in lieu of a public hearing. A hospital that chooses this process therefore waives its right to a hearing, though it retains its right to a judicial review of a final commission decision. A hospital may also choose to enter into a binding arbitration process as prescribed by the commission. These appear to be reasonable alternatives to a public hearing, giving each hospital the flexibility to appropriately address its issues.

Thank you for your consideration of these important matters. MHA and Maryland's hospitals look forward to working with HSCRC staff on the proposed regulations, and on a collaborative process to implement the new hospital comparison methodology in a timely fashion. Should you have any questions, please call (410) 540 5060, or email bmccone@mhaonline.org.

Sincerely,

Brett McCone
Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Adam Kane
Jack C. Keane
Donna Kinzer, Executive Director
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September 25, 2017

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

Dear Mr. Sabatini and Ms. Kinzer:

I am writing to express CareFirst's support for the HSCRC's proposed regulations regarding hospitals' full rate reviews. These proposed regulations will enable the HSCRC to (1) properly reflect any factors that are relevant to the determination of a hospital's reasonable cost level; and (2) develop a methodology that is consistent with and supports the policy goals of the current Demonstration. We provide our detailed comments below.

CareFirst supports the proposed requirement that hospitals demonstrate that they have made effective efforts to reduce unnecessary services that go beyond the current definition of PAUs (i.e., excess diagnostic tests, scans and procedures, as well as, care that is needed but that should be performed in a lower-cost setting). A foundation of the current Demonstration is that reductions in unnecessary services will be a key source of financial sustainability of hospitals operating under fixed global budgets.

CareFirst also believes the HSCRC should evaluate the financial status and efficiency of each hospital requesting a rate review after considering overall performance of other hospitals in the same healthcare system. Presumably, hospital systems have been established to achieve system-wide efficiencies, improve quality of care and enhance overall care-coordination. Therefore, it is appropriate for the HSCRC to evaluate an individual hospital's rate request in the context of the overall performance of the hospital system.

Finally, CareFirst supports the proposed evaluation of the profits and losses of physician practices acquired by a hospital seeking a rate review. Data made available by the HSCRC has long demonstrated that most Maryland hospitals are spending considerable sums to attract and support physician practices for strategic purposes. Many hospitals appear to be losing considerable sums of money through the subsidization of physician-related activities. Under its current authority, the HSCRC cannot include Medicare Part B expenditures in establishing rate bases of regulated hospitals. Therefore, we believe that these subsidies should be carefully examined and evaluated in determining the merits of a hospital's rate request.

We look forward to providing testimony at the October Public meeting in support of these regulations.

Sincerely,

Chet Burrell
President & CEO

Cc: Joseph Antos
Victoria Bayless
George Bone
John Colmers
Adam Kane
Jack Keane

**Ed Beranek**
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September 27, 2017

Donna Kinzer, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

The purpose of this letter is to provide comments on COMAR 10.37.10 on behalf of the Johns Hopkins Health System (JHHS).

The proposed regulatory changes are designed to update the HSCRC's requirements for hospitals seeking full rate reviews, making the approach compatible with the All Payer Model adopted in 2014. JHHS agrees that changes are necessary for alignment between the model and the Commission's administrative responsibility to review the adequacy of a hospital's rate structure under Maryland law and supports the need to modify the information collected to provide the Commission with a complete financial picture of a petitioning hospital's needs. However, the proposed changes are too vague for applicants to understand how to successfully submit an application. They are also excessively burdensome with requirements for submission of multiple years of information that the Commission already collects. These new requirements should not be so burdensome that it is impractical for hospitals to file an application and have a rate review docketed for the Commission's consideration. The extensive and open-ended list of requirements in the proposed regulations seem designed to be a barrier to filing more than a reasonable list of information for assessing a hospital's financial needs. The changes as written will significantly increase the time and cost required to construct the application to approach the Commission for administrative relief.

Furthermore, the regulations refer to a methodology for evaluating the adequacy of hospital's rate structure, but no clear methodology exists as these regulations are being proposed. Applicant hospitals should have a clear understanding of how they will be evaluated prior to the filing of an application, either through the regulations or through supporting policies that have been subject to the input of system stakeholders. The regulations should lay out clear requirements for what a hospital needs to submit for an application to be docketed for Commission consideration and for the standards by which the hospital will be evaluated. The proposed regulations call for any information that the staff deems necessary to assess the hospital's request. While it may be necessary for Commission staff to request additional information after it reviews an application,

it should not be able to withhold consideration while probing endlessly for additional information that may or may not be central to understanding a hospital's rate request. From the current proposed regulations, the path for a hospital to get its application docketed is not clear and cannot be clarified as long as non-specific, open-ended requirements remain as part of the language for *filing* the application for a full review.

JHHS is also concerned about the requirements for health system information when a petitioning hospital is part of a system. The review should not be a full review of the hospital's system but of the specific facility's needs. The full review process is a consideration of a hospital's rates, not the entire system's performance. A hospital's rate application should not become an opportunity for an unlimited exploration of the system's data, some of which is proprietary information and may be outside the Commission's regulatory authority.

JHHS appreciates the opportunity to comment on these regulations. While revisions to the current regulations are necessary to modernize and align them with the All Payer Model, the proposed regulations should be clarified to require the information necessary to support a hospital's rate request in an efficient manner with clear guidelines for providing an application that will be docketed by the staff. The regulations should clarify the method for evaluating applicant hospitals so that the standards of review are clear and can be evaluated in advance of applications. Thank you for your consideration of these comments. Please contact us if you have any questions.

Sincerely,

Ed Beranek
Vice President of Revenue Management and Reimbursement
The Johns Hopkins Health System

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

October 11, 2017

Health Services Cost Review Commission
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# Table of Contents

# LIST OF ABBREVIATIONS

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

## INTRODUCTION

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

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

## 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. This all-payer rate-setting approach eliminates cost-shifting among 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. Maryland submitted a "Progression Plan" (Plan) to CMS in December 2016, describing its goals and plans for an Enhanced TCOC All-Payer Model. The Plan describes how the State will expand the Model's focus to incorporate the entire continuum of care.

This new TCOC measure will be constructed by attributing Maryland Medicare beneficiaries with Part A and Part B FFS coverage to one or more hospitals. Their Medicare TCOC will include costs in both hospital and non-hospital settings. To incentivize increased focus on TCOC growth, HSCRC is proposing to make a percentage adjustment to federal Medicare payments called the Medicare Performance Adjustment (MPA). For its initial year (Performance Year 2018, affecting hospital payments from Medicare in Rate Year (RY) 2020), the MPA will be based on per capita TCOC spending for the beneficiaries attributed to a given hospital. (In future years, the MPA may also be used to share in statewide Medicare TCOC performance.)

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

- An algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals;

- A methodology assessing hospitals' TCOC performance based on the beneficiaries and TCOC attributed; and
- A methodology for determining a hospital's MPA based on its TCOC performance.

The remainder of this document describes the staff recommendation for calculating the MPA for RY 2020, based on extensive feedback from the industry and other stakeholders through the Total Cost of Care Work Group and other meetings.

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

The key objectives of the MPA for Year 1 are 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 increased financial accountability, but also increased accountability on care, outcomes and population health; and

- Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing clinicians participating in Care Redesign Programs (e.g., HCIP and CCIP) to be eligible for bonuses and increased rates under the federal MACRA law.

## ASSESSMENT

The HSCRC worked extensively with a stakeholder group, the Total Cost of Care Work Group, on the technical specifications to determine a hospital-specific measure of Medicare FFS TCOC. This recommendation reflects valuable insights provided by the work group over the past several months as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR).

Based on the State's experience with performance-based payment adjustments, as well as well-established guiding principles for quality payment programs from the HSCRC Performance Work Group, the TCOC Work Group discussed the following general 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 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.

3. **The measure should build on existing transformation efforts**
   3.1. The measure should build upon existing investments and efforts to reduce TCOC, including on current and future provider relationships already managed by hospitals or their partners.
   3.2. The measure should be based on prospective or predictable populations that are "known" to hospitals.

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.

### *Assessment Methods*

A number of methods for attributing beneficiaries to hospitals were explored with the TCOC Work Group over the past several months. In coming to a staff recommendation, HSCRC staff evaluated the methods selected for attribution based on the degree to which they conform to the principles above. In particular, the following metrics were used to assess each method.

**Scope:** Measured by the share of Medicare TCOC and beneficiaries attributed, statewide and by hospital

**Incentives:** Measured by the share of Medicare TCOC and beneficiaries uniquely attributed to hospitals, in total and by hospital

**Relation to existing efforts:** Promoted by adopting existing ACO and primary-care arrangements, and measured by the extent to which these arrangements are reflected in the attribution.

**Hospital efforts reflected:** The stability of attribution resulting from proposed methods to ensure that hospital efforts are reflected, measured as the share attributed to the same provider, hospital, and system (as applicable) in consecutive years.

**Calibrated responsibility:** Measured as the association of hospitals' Medicare revenue with the Medicare TCOC to which they were assigned responsibility, and the impact of current and proposed future payment adjustments on hospitals' revenues.

## Total Cost of Care Attribution Algorithm

Based on the Total Cost of Care Work Group's input and discussion, the staff has developed a multi-step prospective attribution method. The method will assign beneficiaries and their costs to Maryland hospitals based primarily on beneficiaries' treatment relationship with a primary care provider (PCP) and that PCP's relationship to a hospital, based on a formal Accountable Care Organization (ACO) relationship or through the PCPs' hospital referral patterns.

The TCOC Attribution Algorithm uses the following hierarchy (each method of attribution is explained more fully below): 1) ACO-like attribution; 2) Maryland Primary Care Program (MDPCP)-like attribution; and 3) Geographic attribution. This approach is intended to recognize that hospitals can identify and influence most easily the quality and costs of patients who use them and their affiliated providers, while ensuring that responsibility for beneficiaries for whom no hospital use can be equitably assigned.

The total costs for a hospital's beneficiaries attributed through the ACO-like method, MDPCP-like method, and Geographic method will be summed and divided by the total number of beneficiaries attributed to the hospital through those methods to result in a single total cost of care per capita number.

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

### *ACO-like attribution*

The ACO-like attribution enables hospitals that have already agreed to be accountable for beneficiaries in their ACO to build on those relationships. This step in the attribution is relevant for Maryland hospitals participating in the Medicare Shared Savings Program or Medicare Next Generation ACO Program. Assignment is based on MSSP attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then specialist use if a PCP cannot be identified. Beneficiaries are assigned to ACOs according to their use of participating providers

(Appendix). Beneficiaries affiliated with the ACO are then attributed to hospitals affiliated with that ACO. (If an ACO does not have a Maryland hospital as a participant, it is not included in the algorithm.) For ACOs with more than one hospital participating, the beneficiaries and their TCOC will be distributed proportionally according to the participating hospitals' Medicare market share in the beneficiaries' place of residence. (See Appendix for technical details.)

### *Maryland Primary Care Program-like Attribution*

Beneficiaries not assigned to hospitals through the ACO-like method will be assigned to hospitals based on the beneficiary's relationship with primary care providers and those providers' relationships with hospitals. Their relationship with primary care providers is determined through beneficiaries' use of PCP services as detailed in the Maryland Primary Care Program (MDPCP). The method is similar to that by which beneficiaries are assigned to ACO providers.

Each provider is assigned to the hospital from which that provider's patients receive the plurality of their care. Primary care providers are defined by unique NPIs, regardless of practice location, and are not aggregated or attributed through practice group or TIN. (See Appendix for technical details.)

### *Geographic Attribution*

The remaining beneficiaries and their TCOC — or the "residual of the residual" — will be assigned to hospitals based on geography. The Geographic methodology assigns zip codes to hospitals based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. Zip codes not contained in a hospital's PSA are assigned to the hospital with the greatest share of hospital use in that zip code, or, if that hospital is not sufficiently nearby, to the nearest hospital. This approach is also referred to as PSA-Plus or PSAP. (See Appendix for technical details.)

## Performance Assessment

For Rate Year 2020, the MPA's first year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2018) will be compared against the TCOC Benchmark. The TCOC benchmark will be the hospital's prior (CY 2017) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission. Thus for Rate Year 2020, performance will be assessed based on each hospital's own improvement.

Attribution is performed prospectively. That is, beneficiaries' connection to hospitals is measured based on the two Federal fiscal years preceding the performance year (for example October 1, 2014 to September 30, 2016 for attribution for performance year 2017). The benchmark value for the purpose of performance measurement would then be trended from the 2016 attribution based on the preceding two Federal fiscal years (October 1, 2013 to September 30, 2015).

### *TCOC Trend Factor*

The Final TCOC Trend Factor must be approved and determined by the Commission and approved by CMS before the MPA is applied, beginning July 1, 2019. Final TCOC data for the State and the Nation are available in the May following the end of a Calendar Year. For Rate Year 2020, this means that Calendar Year 2018 Performance data will be available in May 2019, and the MPA would be applied in July 2019.

The HSCRC staff originally proposed that the TCOC Trend Factor should be set with reference to national Medicare FFS growth. For example, to attain the required Medicare TCOC savings by 2023 under the Enhanced Model, average annual TCOC growth in Maryland must be 0.33% below the national growth rate.

However, some stakeholders have expressed interest in the development of a pre-set Trend Factor prior to the start of the Performance Period. To this end, the Commission may choose to approve an interim or prospective trend factor for the MPA closer to the beginning of the Performance Period. As with any HSCRC program, the Commission may adjust or update this policy if necessary. Any subsequent updates to a pre-set trend factor must receive CMS approval before becoming a Final Trend Factor for implementation. However, staff is concerned about balancing the needs for a prospective and predictable target with accuracy and consistency. If the Commission sets a preset trend factor that is not aggressive enough, hospitals may expect and budget for a reward even if the State has an unfavorable year compared to the Nation. In this case, the Commission may need to adjust the target after the Performance Period, which may be difficult for hospital budgets.

**Figure 1. Medicare TCOC Per Capita Growth***

| Year | Actual Nation TCOC Per Capita Growth | Nation growth rate less 0.33% | Actual Maryland TCOC Per Capita Growth | MD compared to Nation less 0.33% |
|---|---|---|---|---|
| 2014 | 0.86% | 0.53% | -0.67% | -1.20% |
| 2015 | 1.61% | 1.28% | 2.32% | 1.04% |
| 2016 | 0.73% | 0.40% | 0.04% | -0.36% |

*Numbers may differ slightly from MPA TCOC due to adjustments made for the MPA methodology (inclusion of benes with Medicare FFS Part A AND Part B, certain exclusions, etc.)

## Medicare Performance Adjustment Methodology

TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine scaled rewards and penalties. For Rate Year 2020, staff proposes to set the maximum penalty at 0.5% and the maximum reward at 0.5% of hospital federal Medicare revenue. The staff also recommends that maximum performance thresholds be set as the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained (either maximum reward or penalty) in order to minimize volatility risk. For Rate Year 2020, staff proposes a maximum performance threshold of ±2%.

The scaled result, a reward or penalty equal to 25% of the amount by which the hospital's TCOC differs from its TCOC target, will be multiplied by the sum of the hospital's quality adjustments. For Rate Year 2020, the staff proposes to use the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC) for the quality adjustments; however, staff recognizes that the Commission may choose revise the programs used for the quality adjustments if necessary. Both programs have maximum penalties of 2% and maximum rewards of 1%. For example, a hospital with TCOC scaled reward equivalent to a 0.3%, MHAC quality adjustment of 1% and RRIP quality adjustment of 0% would receive an MPA adjustment of 0.303%. (See Appendix for technical details.) Regardless of the quality adjustment, the maximum reward and penalty of ±0.5% will not be exceeded.

With the maximum ±0.5% adjustment, the staff recommends that MPA is included in the HSCRC's portfolio of value-based programs and will be counted as part of the aggregate revenue at-risk for HSCRC quality programs. Staff will examine the impact of including the MPA in aggregate revenue at risk from both Medicare and All-Payer perspectives.

### *MPA Implementation*

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

HSCRC staff intends to provide hospitals with information so they can more effectively engage in quality improvement activities, assess their performance, and better manage TCOC based on the PCPs and beneficiaries attributed to them under the MPA. This information may include, as appropriate and consistent with federal and state privacy laws and requirements:

- List of PCPs attributed to a hospital under the attribution algorithm
- List of beneficiaries attributed to a hospital under the attribution algorithm
- Reports of hospital performance on the TCOC of its attributed population during the performance year

## RECOMMENDATIONS

Based on this assessment, staff recommends the following for Rate Year 2020:

1) Ensure implementation of the Medicare Performance Adjustment by CMS based on HSCRC calculations
2) Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like and PSAP attribution, as specified above
3) Set the TCOC benchmark as each hospital's TCOC from the previous year, updated with a Trend Factor decided by the Commission. The Commission should decide in the final policy

whether to set a prospective Trend Factor target prior to the performance period or to base the Trend Factor on the national experience after the end of the performance period.

4) Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%
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 a Year 2 MPA policy, obtaining input through continued meetings of the TCOC Workgroup
7) Provide information to hospitals so they can more effectively engage in quality improvement activities, assess their performance, and better manage the TCOC based on the PCPs and beneficiaries attributed to them under the MPA

# APPENDIX. TCOC ATTRIBUTION METHODOLOGIES

**Eligible Population:** Maryland Medicare Fee-for-Service beneficiaries, defined as Medicare beneficiaries who have at least one month of Part A and Part B enrollment during the previous two years, and no months of HMO enrollment or in enrollment in Part A or Part B alone, who resided in Maryland or in an out-of-state PSA claimed by a Maryland hospital.

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

**Exclusions**: Claims associated with categorically excluded conditions are removed prior to episode assignment. Claims in any setting from an episode beginning 3-days before and extending to 90-days after a hospital stay for such a condition are excluded from the TCOC and from the determination of ACO-like and PCM-like affiliation. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

## ACO-like Attribution

All beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all. However, only ACOs with participating Maryland hospitals in the Medicare Shared Savings Program (MSSP) or Next Generation ACOs will be attributed beneficiaries through this method. Beneficiaries are attached to clinicians through use of professional services, while clinicians are attached to ACOs if their identifier appears on the ACO's participant list. Hospital affiliation is also identified through ACO affiliation and only Hospitals affiliated with a Maryland ACO are used for attribution.

### *Beneficiary-to-Provider attribution*

Based on the two Federal Fiscal Years preceding the performance period, eligible beneficiaries with at least one visit for a primary care service are attributed to clinicians based on the plurality of allowed charges for primary care services. If the identified clinician is on a list of ACO providers, the beneficiaries is attributed to the corresponding 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.

### *Provider-to-ACO attribution*

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

### *ACO-to-Hospital attribution*

Maryland hospitals participating in an ACO for the purposes of this method will be defined as hospitals listed on the Participant List of an ACO domiciled in Maryland. All beneficiaries and costs for beneficiaries of ACOs with a participating Maryland hospital will be attributed to that hospital. For ACOs with more than one hospital, TCOC will be distributed by Medicare market share.

### *ACO Specialties*

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

### *ACO Primary Care Codes*

Domiciliary, rest home or custodial care

- CPT 99324 – 99337
- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

Domiciliary, rest home or custodial care

- CPT 99324 – 99337

- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

## MDPCP-like Attribution

After removing the cost and beneficiaries assigned to hospitals through the ACO-like method, hospitals will be assigned beneficiaries based on beneficiaries' primary care providers (identified based on primary care utilization) and hospitals used by the beneficiaries of those providers over the two Federal fiscal year period preceding the performance period. Assignment of beneficiaries to primary care providers is determined based on the beneficiaries' use of patient designated provider (PDP) services — mostly primary care services — as originally proposed in the Maryland Primary Care Program (MDPCP) by MDH to CMMI. A PDP includes traditional PCPs but also physicians from other selected specialties if the beneficiary has chosen that clinician to provide primary care. Each clinician is assigned to a hospital based on the hospital most used by the clinician's beneficiaries.

### *Beneficiary-to-Provider attribution*

Primary care providers are attributed beneficiaries based on proposed MDPCP logic with minor adjustments. Each Medicare FFS beneficiary with Medicare Part A and Part B is assigned the National Provider Identification (NPI) number of the clinician who billed for the plurality of that beneficiary's office visits during the 24 month period preceding the performance period AND who also billed for a minimum of 25 Total Office Visits by attributed Maryland beneficiaries in the same performance period. If a beneficiary has an equal number of qualifying visits to more than one practice, the provider with the highest cost is used as a tie-breaker. Beneficiaries are attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.

The cost of primary care services must represent 60% of total costs in a practice during the most recent 12 months, excluding hospital and emergency department costs. Primary care services are identified by procedure codes from the list appended below. Clinicians enrolled in the Next Generation ACO Model, ACO Investment Model, or Advanced Payment ACO Model; or any

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

### *Provider-to-Hospital attribution*

A provider and the beneficiaries and costs assigned to that provider's NPI are in turn assigned to a hospital based on the number of inpatient and outpatient hospital visits by the provider's attributed beneficiaries. All of the provider's beneficiaries are attributed to the hospital with the greatest number of visits by beneficiaries assigned to that provider. If a provider's beneficiaries have equal visits to more than one hospital, the provider is attributed to the hospital responsible for the greatest total hospital cost. Practice group and location do not impact provider to hospital attribution, nor does the number of practices or TINs to which the provider is affiliated.

### *MDPCP Eligible Specialties*

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

### *MDPCP Primary Care Codes*

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

## Geographic Attribution

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

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

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

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

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

Maryland
Hospital Association

September 20, 2017

Chris L. Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chris:

On behalf of Maryland's 47 acute care hospitals, we appreciate the opportunity to comment on HSCRC's Medicare Performance Adjustment policy. The policy brings accountability for Medicare total cost of care, previously only measured statewide, to the individual hospital. This requires attributing all Maryland beneficiaries to an individual hospital or system. All other providers that have entered into Medicare demonstrations with the federal government have attributed beneficiaries to a physician who has agreed to be part of an Accountable Care Organization (ACO) or other demonstration entity. The Medicare Performance Adjustment is the first policy to base payment on the efficacy of a hospital's care for its entire Medicare population – a policy that goes beyond global budgets and fully aligns an individual hospital's Medicare total cost of care risk with the statewide risk under the enhanced model demonstration. HSCRC is proposing an attribution approach which would first attribute beneficiaries to physicians and then link the physicians to a hospital or system. This approach supports the view, which we share, that physician partnerships are fundamental to managing and controlling total cost of care.

The Medicare total cost of care attribution brings the accountability to individual hospitals and health systems for the statewide Medicare total cost of care. As a result, the attribution approach is a necessary methodology that could be used in other policies, such as: a mechanism to reduce hospital budgets more broadly, if the state was in danger of exceeding a savings target; an "efficiency" component of a full rate review process or determination of eligibility to access capital funds; a "denominator" in a population health measure. Measurement of spending per beneficiary is aligned with the current demonstration and the proposed enhanced model, unlike previous measures of spending per discharge which can create an incentive for volume growth. However, because many details have not been scrutinized or tested, we caution the commission against using the Medicare total cost of care per beneficiary measurement in other policies and placing additional revenue at risk without further discussion of the implications.

While the Medicare Performance Adjustment policy is an important component of Maryland's progress toward the enhanced model and a requirement to qualify Maryland's hospitals as Advanced Alternative Payment Models under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), it is also important to recognize that the methodology is untested. The development process has been thoughtful and collaborative, but the timing required to implement

in calendar 2018 does not allow for testing and validation before implementation. As such, we recommend that the commission continue to work with the hospital field to refine, test and modify the policy over the coming year.

The method of attributing beneficiaries to individual hospitals or systems should match, as closely as possible, the mechanisms by which hospitals can manage care delivery and influence total cost of care. Hospitals have invested significant resources in arrangements with physicians and other providers to manage Medicare total cost of care, including ACOs, and physician practice ownership and management arrangements. Although participation in those arrangements may change over time, attributing beneficiaries to hospitals based on existing arrangements should be the first step of an attribution methodology. The commission has also proposed a methodology that links a physician and their attributed beneficiaries to a hospital based on where the plurality of the physician's patients are admitted. This model attributes based on actual practice patterns instead of formal agreements to work together. As expected, the two attribution approaches overlap, but are not identical. This approach also has merit, but only if a hospital is provided information on the physicians linked to their hospital and driving their total cost of care. Knowing which physicians are linked to the hospital, whether the physician refers primarily to one hospitals or a handful of hospitals in a region, and the risk profile of their associated beneficiaries, provides the hospital with the opportunity to reinforce regional partnerships and influence care patterns and total cost of care.

We would like to continue working with the commission staff on the following issues, incorporating as many as possible into a calendar 2018 performance year (fiscal 2020 adjustment) policy as possible, and carrying the remaining issues forward to adopt as part of the calendar 2019/fiscal 2021 policy.

1. **Reduce Risk on Other Quality Policies**
   The revenue at risk in the Medicare Performance Adjustment should offset a portion of the risk in the Quality-Based Reimbursement program, as Maryland now has a corollary to the national Medicare spending per beneficiary measure.

2. **Operational Issues**
   Maryland's hospitals are taking on risk for the entire Medicare population in Maryland. Managing therefore requires identification and engagement of beneficiaries who are most at risk. In accordance with federal and state privacy laws and requirements, hospitals and physicians are eligible to receive data on beneficiaries with whom they have existing relationships. It remains unclear how much access hospitals will have to information that allows them to adequately manage the total cost of care and associated financial risk. While this issue is manageable for year one, we look forward to working with the commission to ensure appropriate access to information.

3. **Risk Adjustment**
   The pool of beneficiaries attributed to each hospital will have different risk profiles. Although measuring the annual change in spending per beneficiary mitigates some of the volatility in

using unadjusted data, adjusting for beneficiaries' age, gender and comorbidities will explain some variation in spending growth. Hierarchical Condition Categories are widely used by Medicare for risk adjustment and need to be evaluated along with simpler demographic models.

4. **Methodology Validation**
   - Over the coming year, the hospital field will need to validate the HSCRC methodology, including exclusions, programming, and other details.
   - We would recommend that HSCRC continue the Total Cost of Care Work Group to focus on issues that are unaddressed in the first year, and that may be discovered as the policy is implemented.
   - Consideration may need to be given for hospitals with fewer than 5,000 attributed beneficiaries. Medicare requires a minimum of 5,000 beneficiaries in an ACO's risk pool, and it is not yet clear what impact a smaller risk pool has on certain Maryland hospitals.

5. **Improvement Only or Attainment and Improvement**
   For the first year, the HSCRC is considering an individual hospital's annual change compared to the prior year. However, improvement-only assumes that all hospitals have the same opportunity to reduce spending in their beneficiary pools. Differences in base period spending per beneficiary may impact the relative opportunity in the same way that hospitals with lower base period readmission rates were disadvantaged by an improvement-only methodology. Risk adjustment will help address the differences in opportunity for improvement; however, a policy that recognizes attainment or improvement can address concerns about penalizing hospitals that have reduced total cost of care.

We appreciate the commission's consideration of our feedback and the opportunity to continue working with the HSCRC. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle, Vice President

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Adam Kane
Jack C. Keane
Donna Kinzer, Executive Director

**Update on Future Direction for RY 2020 and Enhanced Model Quality Programs**

Staff will present materials at the Commission meeting.

State of Maryland
Department of Health

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Chairman

Joseph Antos, PhD
Vice-Chairman

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Compliance

**TO:** **Commissioners**

**FROM:** **HSCRC Staff**

**DATE:** **October 11, 2017**

**RE:** **Hearing and Meeting Schedule**

| | |
|---|---|
| November 13, 2017 | To be determined - 4160 Patterson Avenue<br>HSCRC/MHCC Conference Room<br>****Please note that this will NOT be held on the second Wednesday of the month and has been moved to the following Monday** |
| December 13, 2017 | To be determined - 4160 Patterson Avenue<br>HSCRC/MHCC Conference Room |

Please note that Commissioner's binders will be available in the Commission's office at 9:15 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/commission-meetings-2017.cfm.

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