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health services
cost review commission

Total Cost of Care Workgroup

January 2023

Happy 2023!

1. Medicare Performance Adjustment
2. Progression Planning
    1. Consumer Cost Sharing
    2. Supplemental Benefits
    3. GBR 2.0

Medicare Performance Adjustment

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MPA Updates

- CMS has approved the MPA (including the savings component). The effective date of the MPA will be March 1st instead of February 1st.
  - We distributed an MPA file to hospitals.
  - Please check the calculate and get back to us with any comments by 1/27.
- Staff will be presenting a final recommendation on the traditional MPA for CY 2023 to the Commission at the February. This recommendation will be unchanged from the draft except for:
  - Revised geographic zip codes for the AMC. All Baltimore City zip codes will be assigned to the AMCs.
  - Potential revision of the UMROI adjustment.

MPA Revenue at Risk

- CMS approved the MPA for CY2023. However, CMS indicated an expectation to increase the revenue at risk under the MPA, increase the weights on the quality measures, and incorporate a population health measure.
  - "As stated in the MPA PY 2022 CMS response letter issued October 10,2021, CMS expects the State to increase the revenue at risk (± 1%) under the traditional MPA in 2024. CMS appreciates HSCRC's continued effort to improve quality of care using the MPA as a tool to incentivize continued improvement, and approve the modest increases to maximum revenue at risk in PY 2023 to allow quality measures to have a greater impact. However, CMS believes that increased financial risk tied to quality measures is key to driving improvement, and we strongly encourage Maryland to consider further increasing the level of risk associated with quality programs in PY 2024. Additionally, we look forward to the inclusion of population health measures as a component of the MPA in PY 2024. CMS will heavily weigh a further increase of the maximum revenue at risk and the inclusion of population health measures when considering the MPA Proposal for 2024. "
- Staff continue to believe that quality programs should be all payer in nature. We expect to increase the revenue at risk under the traditional MPA in CY24.

CONSUMER COST SHARING

Maryland
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MHA position

The Maryland Model creates price variability for consumers. Standardizing consumer cost sharing raises several concerns affecting it feasibility:

- HSCRC GBR compliance targets create price variability for consumers. All contributing factors should be explored.
- If Medicare backfills a limit on cost sharing, it will negatively affect Waiver performance
- It is not clear how HSCRC's authority would affect commercial payers, particularly those not solely regulated in Maryland
- Administrative costs are likely to risk as hospitals would have to adjust billing and collection practices

Key considerations

1. Commercial inpatient cost shares are higher than Medicare
2. Medicare outpatient cost shares are higher than inpatient
3. Medicare prices are higher in Maryland, but Commercial is lower
4. What is the impact on private insurers?
5. How to limit passing costs to consumers through premiums and high deductible plans?

Cost sharing examples

INPATIENT

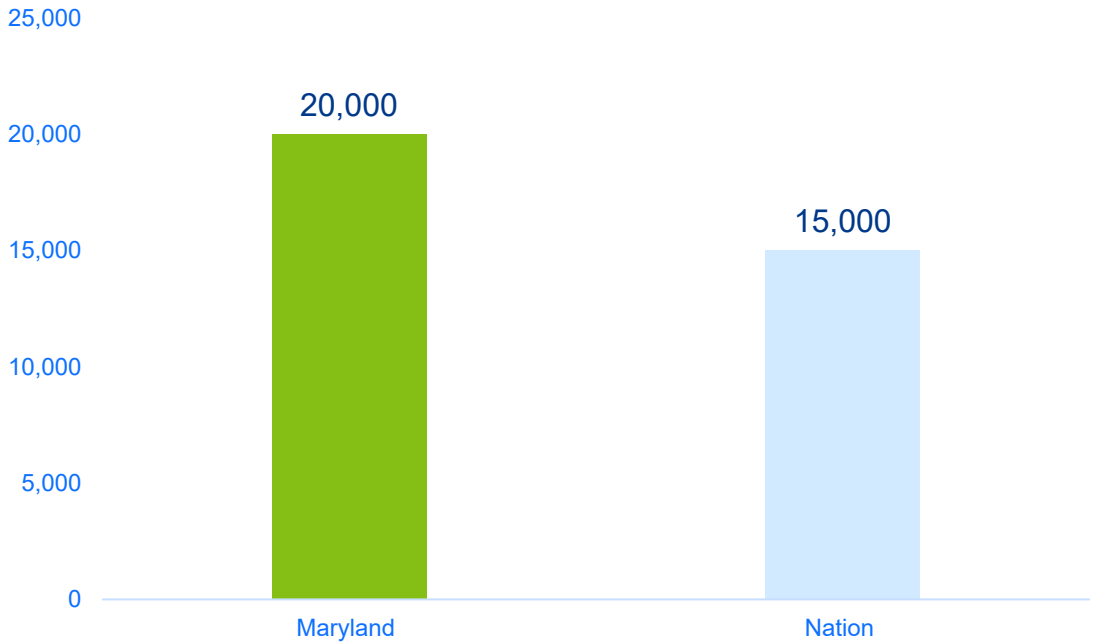
	Medicare	Commercial
Deductible	$1600	$2,500
Co-pay (patient share	$0*	5%

OUTPATIENT

	Medicare	Commercial
Deductible	$226	$2,500
Co-pay	20%	20%

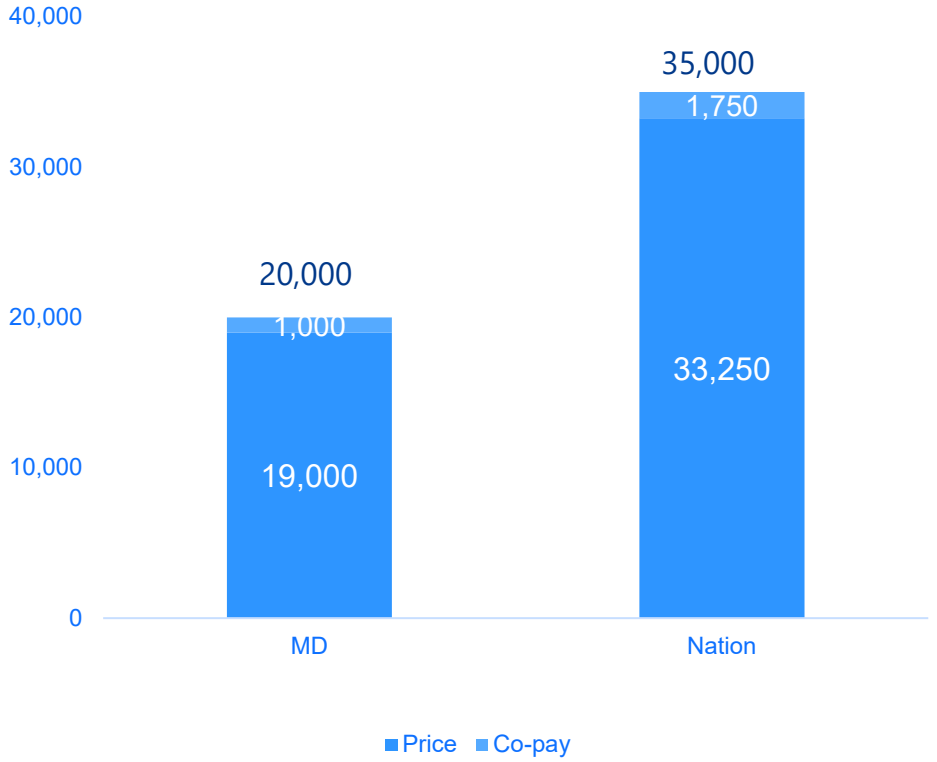
Inpatient cost share*

MEDICARE, 0% CO-PAY



Though Maryland charge is higher, no difference in cost share

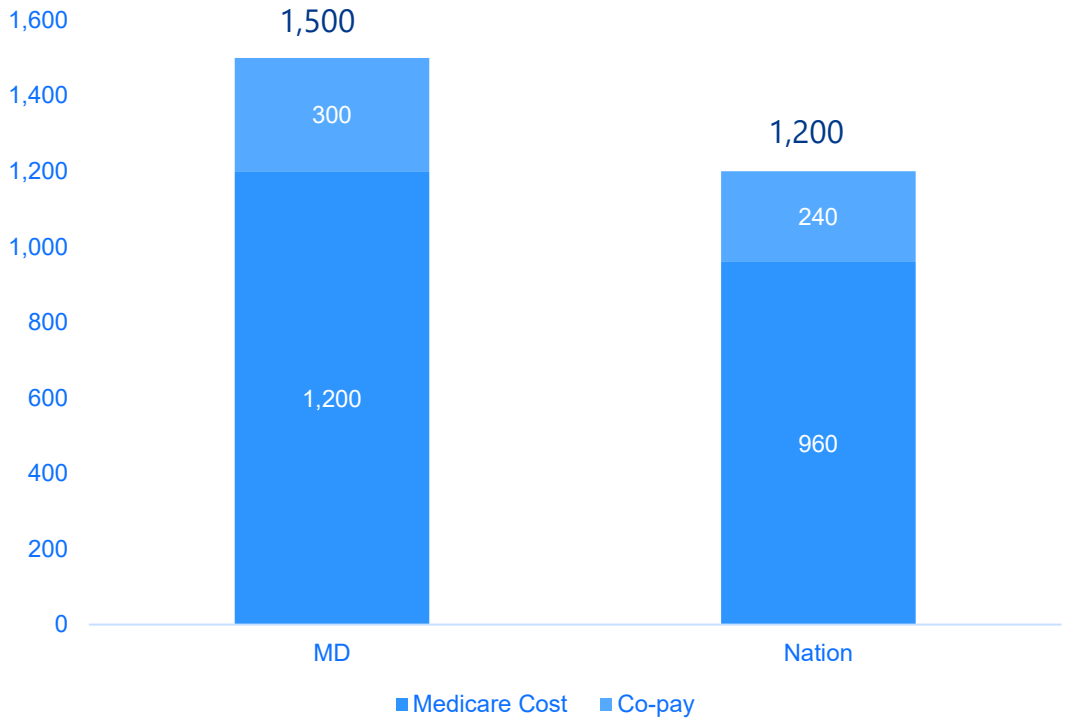
COMMERCIAL, 5% CO-PAY



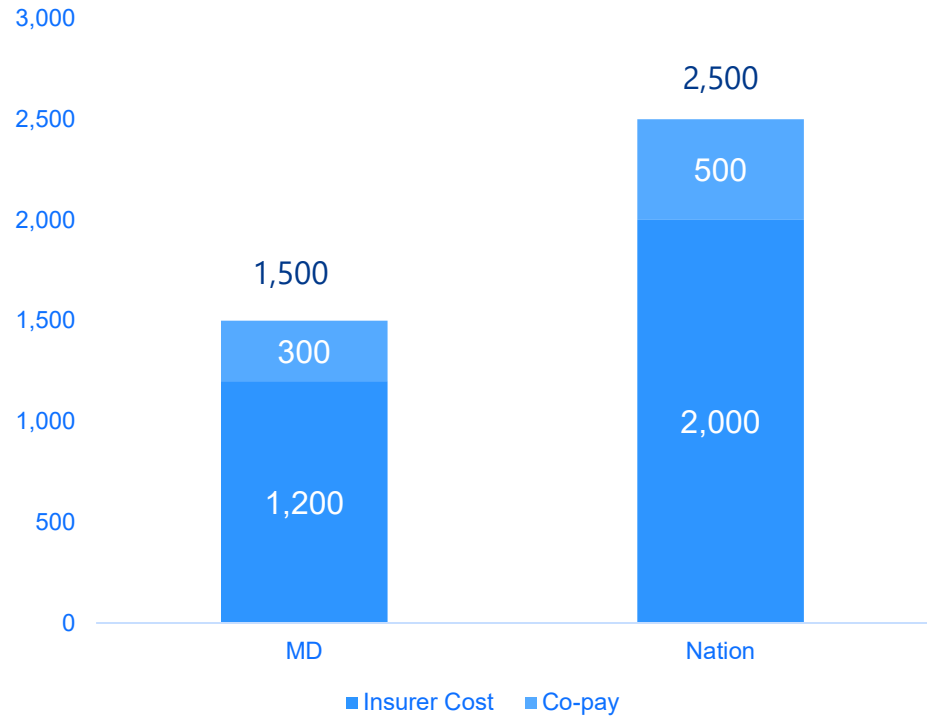
Cost shifting outside of Maryland results in much higher co-pay

Outpatient cost share*

MEDICARE

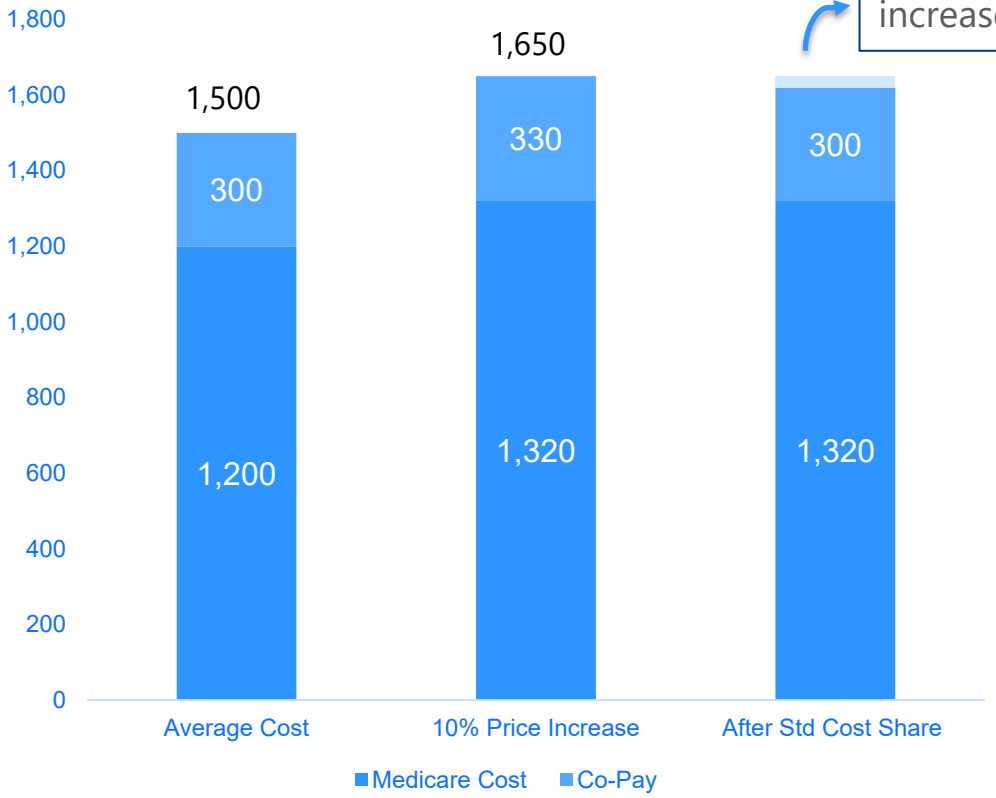


COMMERCIAL



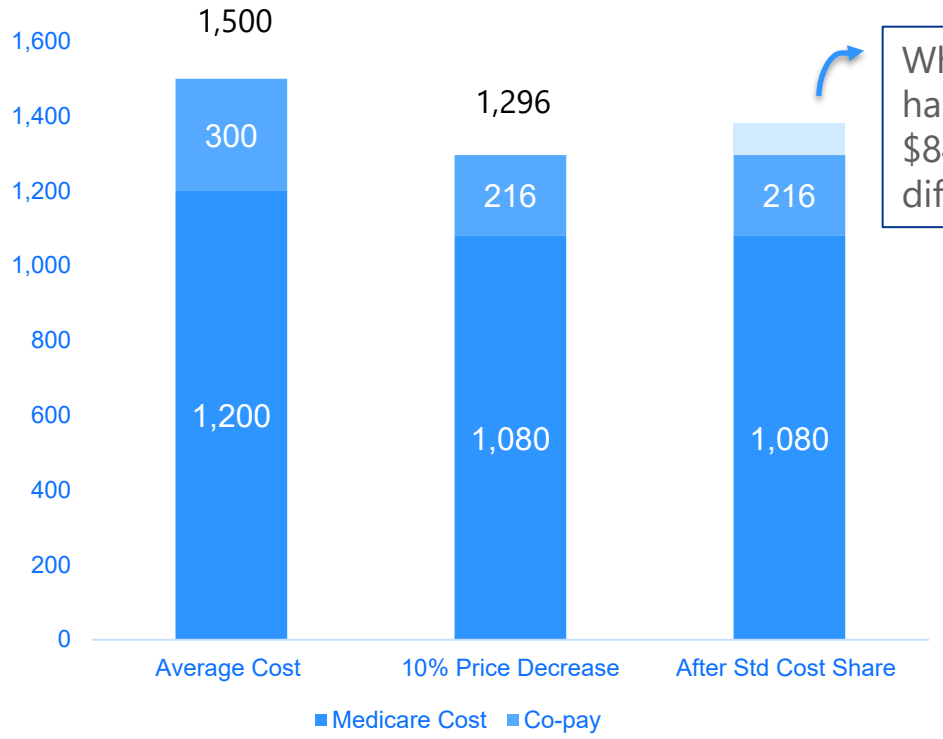
Impact of GBR

10% PRICE INCREASE



What happens to $30 increase?

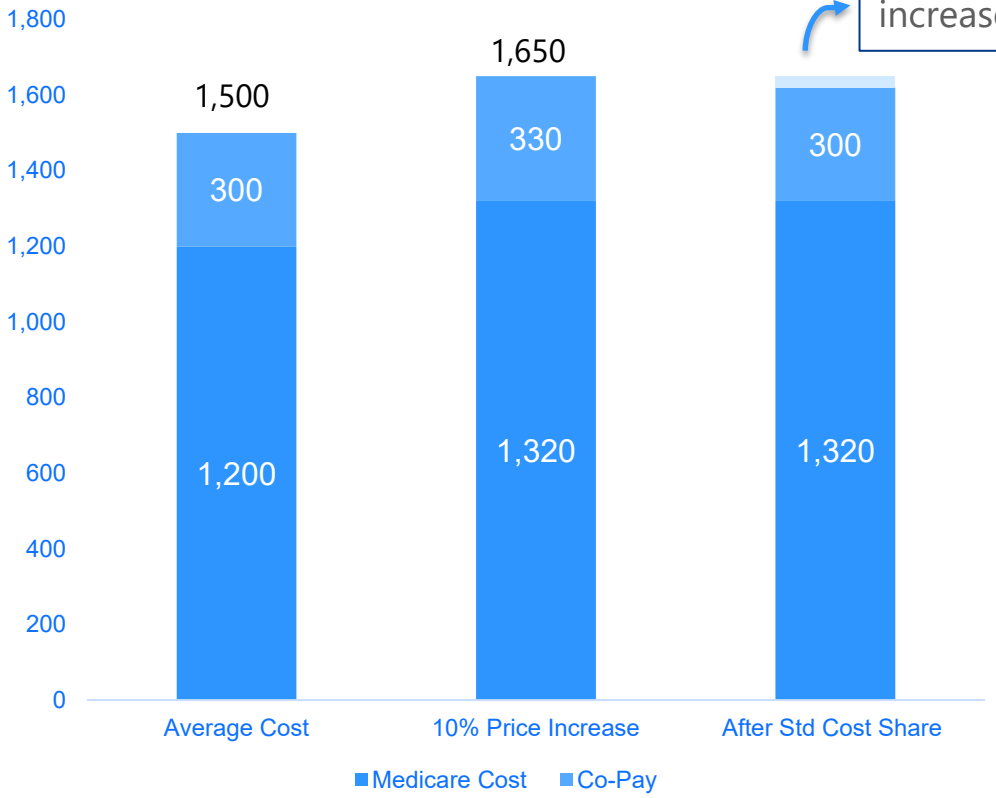
10% PRICE DECREASE



What happens to $84 difference?

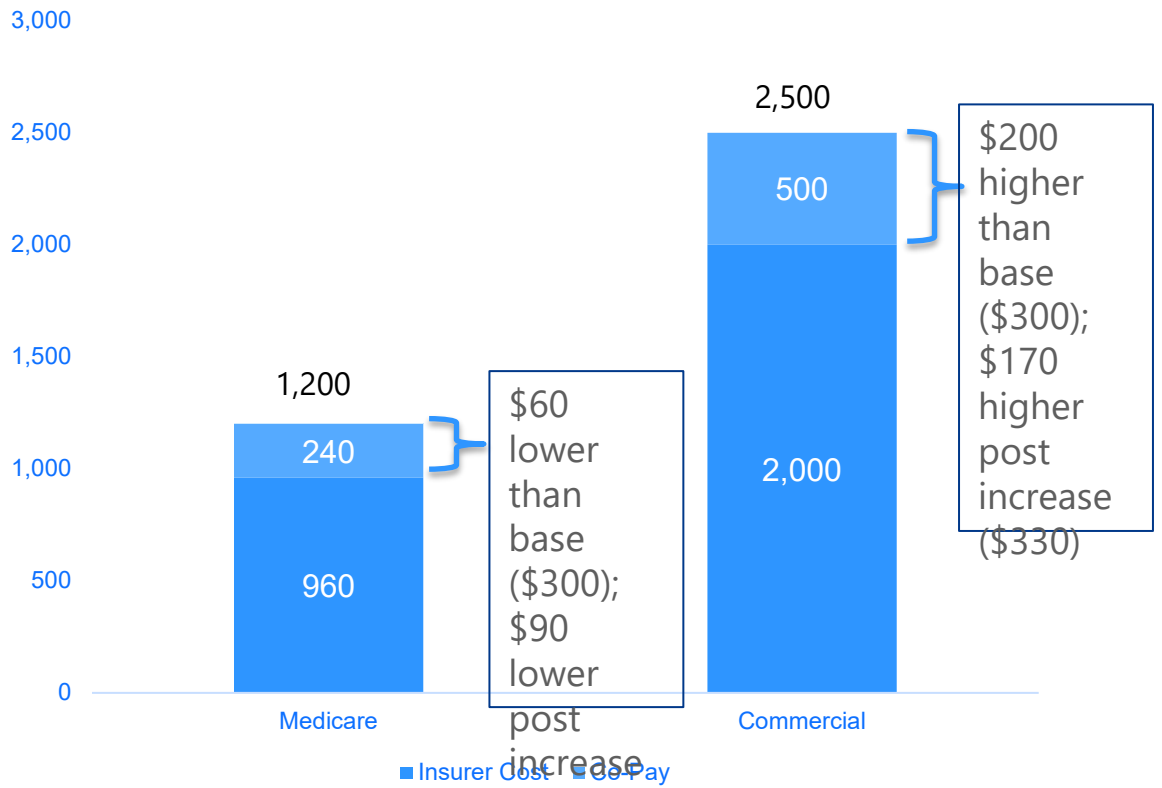
Impact of GBR, National price structure

GBR PRICE INCREASE



What happens to $30 increase?

NATIONAL COMPARISON

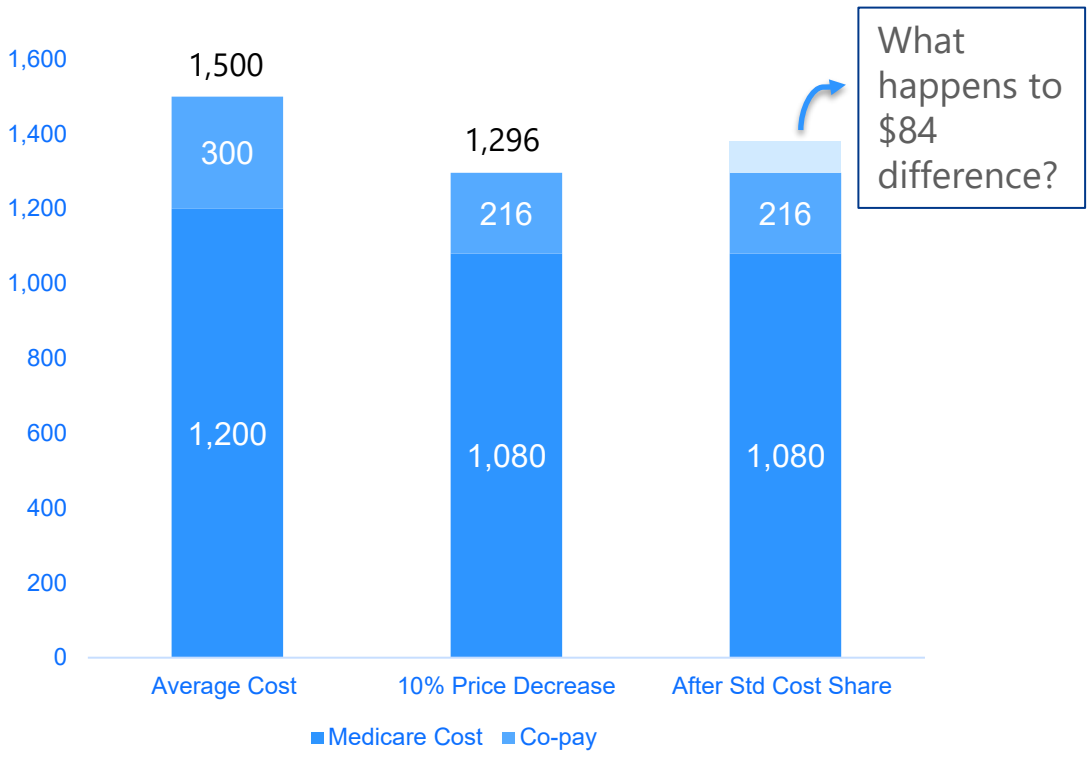


$60 lower than base ($300); $90 lower post increase ($330)

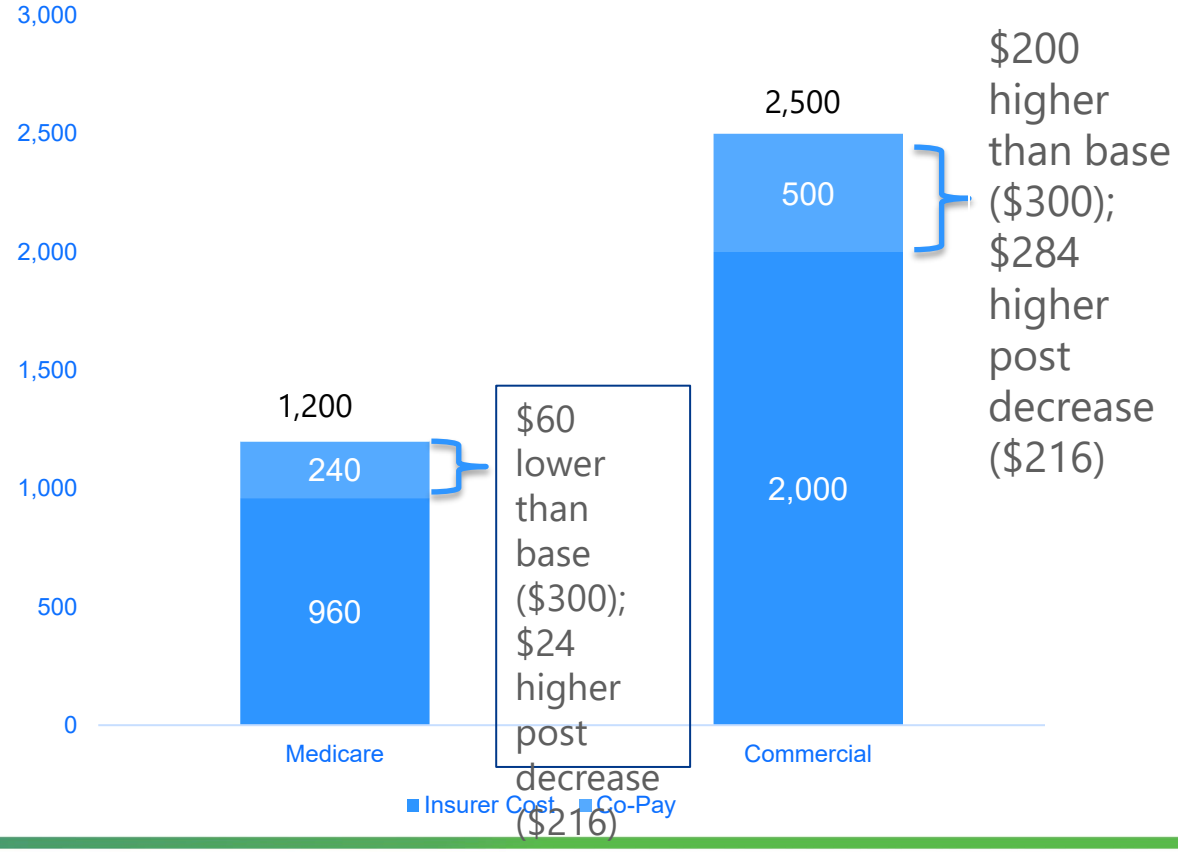
$200 higher than base ($300); $170 higher post increase ($330)

Impact of GBR, National price structure (cont.)

10% PRICE DECREASE



NATIONAL COMPARISON



Staff Perspectives Cost-Sharing

- The magnitude of the cost sharing problem is relatively small:
  - Commercial Cost-Sharing is less than it is in most other states.
  - Medicare cost sharing is limited:
    - No cost sharing on inpatient utilization.
    - The impact of overall cost sharing is limited by Medicare supplemental insurance.
- However, there may be large impacts on specific consumers, which are economically meaningful to household budgets even if small in aggregate.
- Moreover, HSCRC policies have been driven by a concern about the impact on individual consumers. If consumer impacts were not a concern, then policymaking may be less constrained.
  - Rate corridor policies.
  - Undercharge policies.

Strawman # 1: Use IPPS / OPPS Cost Sharing Amounts

- HSCRC could limit the amount of cost sharing charged to beneficiaries to 20% of the CMS allowed amount instead of 20% of the charged amount.
  - This would limit the cost sharing to what would be charged for OPPS services in the rest of the country.
  - Currently, Maryland OPPS rates are 30-40% higher than under OPPS. This would reduce hospital outpatient cost sharing amounts by approx. 6% of total charges.
  - This is equivalent to reducing outpatient cost sharing from $300 to $240 in the MHA example.
- This would have a negative impact on hospital financials. It could be financed by:
  - Being put into rates (like uncompensated care) or the MPA.
  - This would require using some of the excess savings.
- Alternatively, we could set the cost sharing limits at the current level of cost sharing.
  - Hospitals would not take a financial hit.
  - Beneficiaries would be protected from future rate increases.

Strawman # 2: Cap Individual Cost Sharing Amounts

- Cost sharing amounts for individual consumers could be capped.
  - A dollar cap could be instituted. E.g., hospitals could be prohibited from collecting more than $X dollars per outpatient visit.
  - This could be added to the hospitals financial assistance policy.
- This would have a more limited impact on hospital budgets, depending on the cost sharing cap.
  - Cost sharing added to financial assistance policies would be a financial loss to hospitals.
  - The impact would be relatively small (e.g. capping cost sharing at the 99th percentile of all cost sharing amounts).

MEDICARE BENEFIT ADD-ONS

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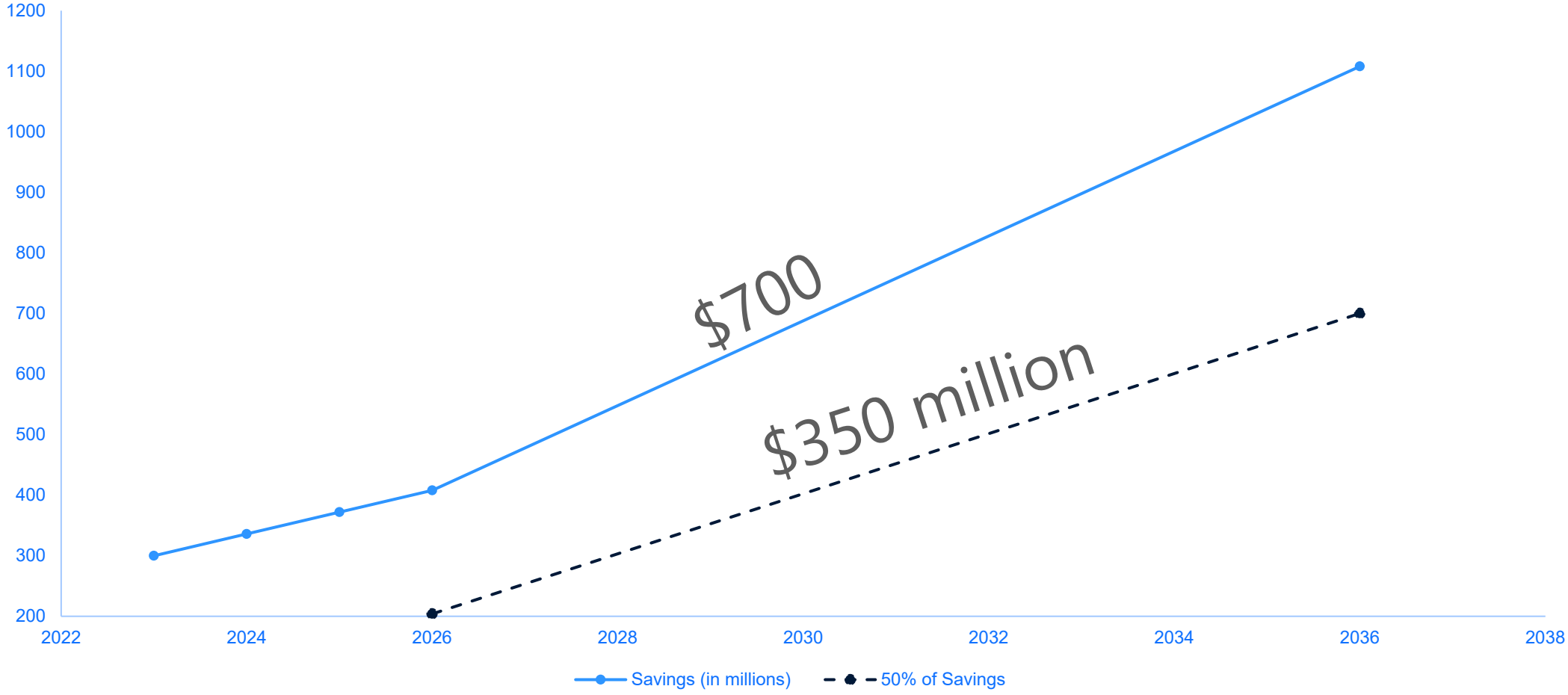
Hospital Association

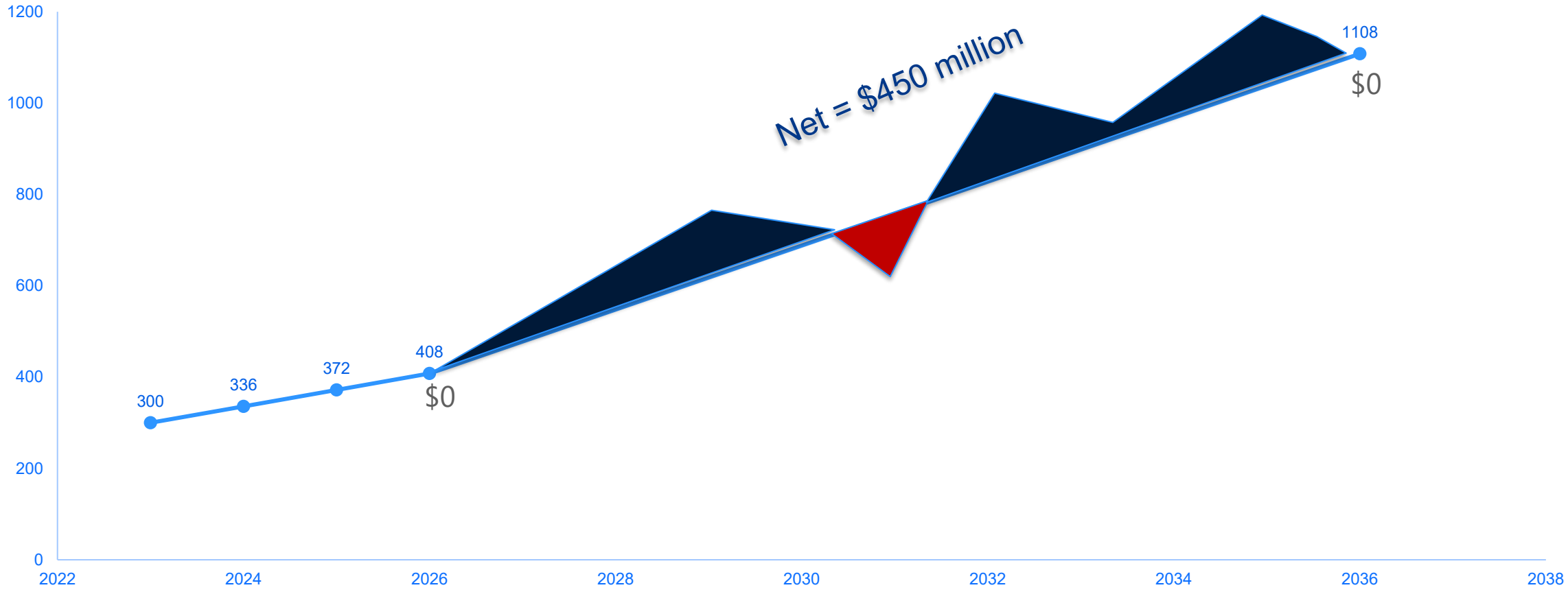
MHA Positions

- Support overarching concept to invest additional Medicare savings in population health
- Recent savings target performance highlights issues with savings fluctuations
- Concerns about impact to Medicare savings test and Medigap plans
- Determine administrative feasibility

Option 1: Retain 50% of Savings



Option 2: Use savings above annual targets

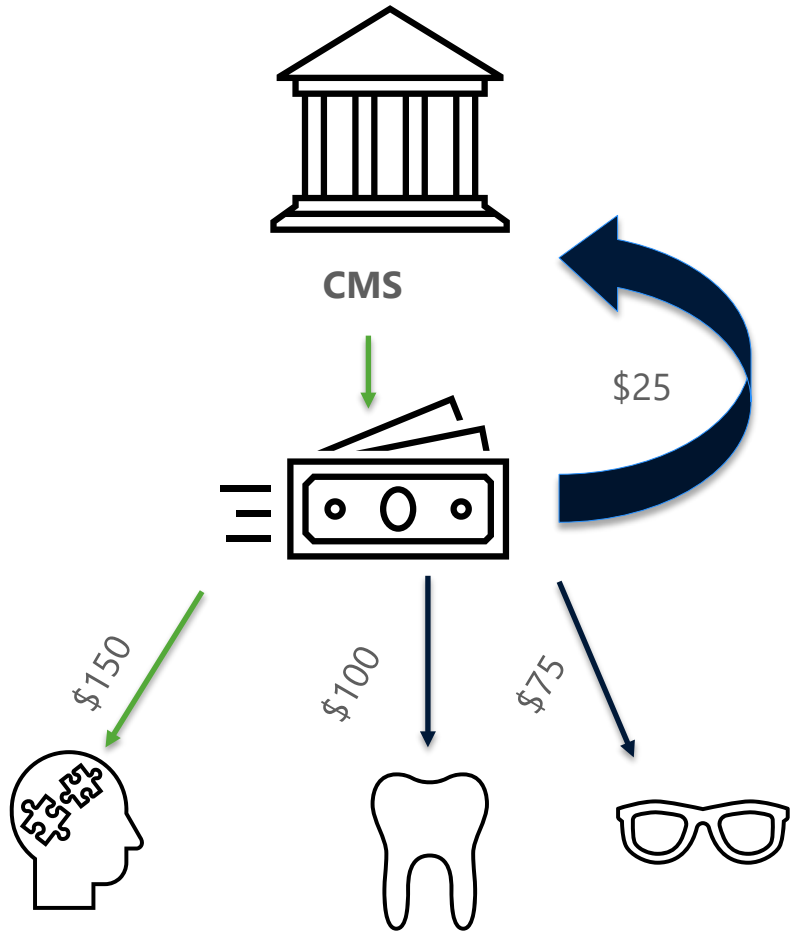


Payment Flow Option A: CMS Direct payments to providers

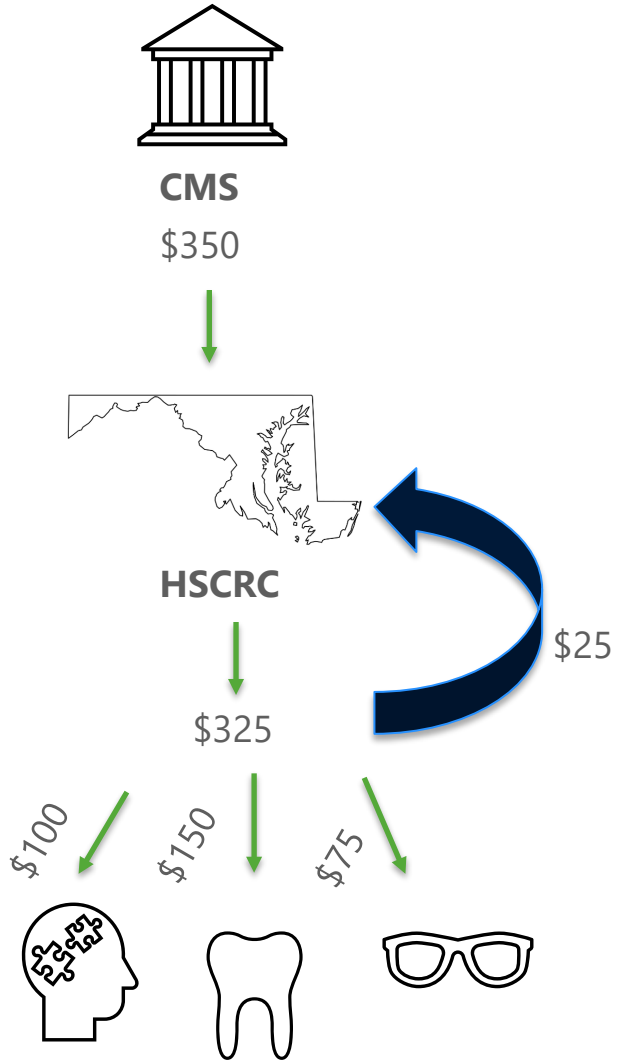
PAYMENTS TO PROVIDERS

(in millions)

Available Savings	$350
Mental Health Claims	(150)
Dental Claims	(100)
Vision Claims	(75)
Carryover	25

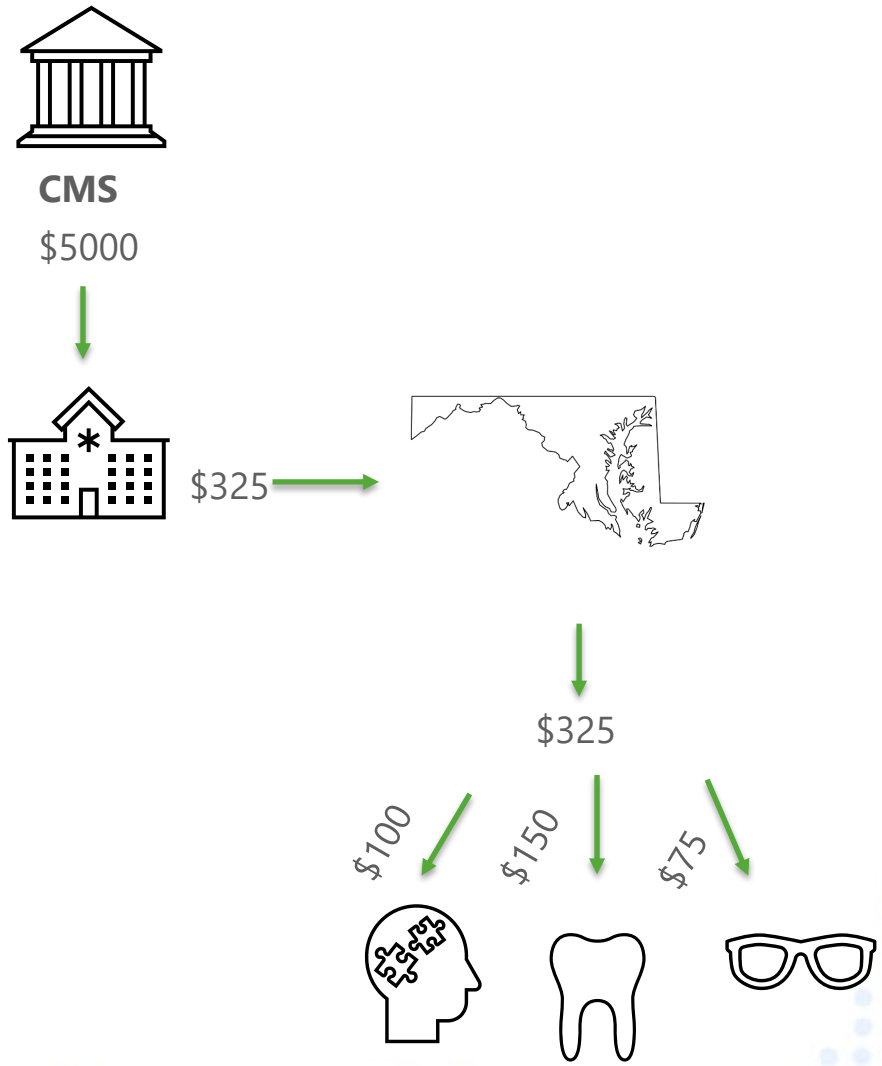


Payment Flow Option B: Regional Pool



Proposed strawman

- Staff expect this option to work by reducing the required saving (Option 1) and investing in a regional pool (Option B).
  - The TCOC Contract would have a lower savings target but a requirement to spend on providing extra benefits.
  - HSCRC would collect an assessment from hospitals equal to the amount to be invested in extra benefits.
  - The State would contract with a benefit manager to administer contract with providers and pay claims.



Strawman

- Current Language:
  - The annual savings target for Maryland Medicare TCOC per Beneficiary (“Annual Savings Target”) for each Model Year from MY1 (2019) through MY5 (2023), shall be:
    - MY 1 (2019): $120 million
    - MY 2 (2020): $156 million
    - MY 3 (2021): $222 million
    - MY 4 (2022): $267 million
    - MY 5 (2023): $300 million
- Example Language:
  - The annual savings target for Maryland Medicare TCOC per Beneficiary (“Annual Savings Target”) and the required Supplemental Benefit Spending for each Model Year from MY1 (2019) through MY5 (2023), shall be:
    - MY 1 (2019): $60 million in savings and $60 million in supplemental benefit spending
    - MY 2 (2020): $78 million in savings and $78 million in supplemental benefit spending
    - MY 3 (2021): $111 million in savings and $111 million in supplemental benefit spending
    - MY 4 (2022): $133 million in savings and $133 million in supplemental benefit spending
    - MY 5 (2023): $150 million in savings and $150 million in supplemental benefit spending

GBR 2.0

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MHA Positions

- Support allowing voluntary hospital and health system agreements to expand risk and revenue sharing beyond the regulated hospital setting.
- Encourage expansion of GBR 2.0 to all payers in the future
- Include partial and full-risk options
- Transparency amongst HSCRC and hospitals on contract agreements, performance, etc.

Network Adequacy requirements

Discussion Questions

1. How will the HSCRC measure network adequacy?
2. Will all services be held to adequacy requirements? If not, how will this be determined?
3. Will there be a clause around external conditions?
4. Are the requirements for the entire network or the hospital only?
5. What is the penalty for hospitals that cannot meet the standard?

Flexibilities

Discussion Questions

1. Clarification is needed of flexibilities within the following areas shared previously:
   a) Utilization Management
   b) Voluntary Partial Capitation for non-hospital providers

2. Potential flexibilities to consider:
   a) Waivers for HH/SNF – allowing flexibility to discharge patients earlier than 30 days
   b) Direct discharges from ER to the sub-acute unit
   c) Other?

Other Questions / Considerations

1. Will GBR 2.0 allow participating hospitals to be exempt from certain HSCRC policies (i.e., Market Shift, Demographic Adjustment, MPA, etc.)

2. What is the estimated timeline for implementation?

3. When can hospitals expect to see a strawman of GBR 2.0?

Network Adequacy Requirements

1. How will the HSCRC measure network adequacy?

   We propose to follow the Medicare Advantage Network Adequacy Requirements.

2. Will all services be held to adequacy requirements? If not, how will this be determined?

   We propose to follow the Medicare Advantage standards, but additional services could be added / modified based on the consensus of the workgroup / commission.

3. Will there be a clause around external conditions?

   Yes.

4. Are the requirements for the entire network or the hospital only?

   The entire geographic county.

5. What is the penalty for hospitals that cannot meet the standard?

   If a hospital did not meet the network adequacy standards, any retained revenues / savings from GBR 2.0 would be forfeit.

Strawman Network Adequacy Requirements

- The participating hospital will be allowed to retain revenues under the GBR 2.0 if they continue to meet the network adequacy standards.
  - Minimum number of physicians per capita
  - Minimum drive time / distance to facilities for 85% of the beneficiary population
- If the hospital failed to meet the network adequacy requirements for two consecutive years, they would lose the additional revenues associated with the GBR 2.0.
  - They would be spent down to some hospital only spending target.
  - This could be the ICC standard cost per case or other spending target.

Physicians per 1000 beneficiaries

Code	Specialty Type	Geographic Type				
		Large Metro	Metro	Micro	Rural	CEAC
S03	Primary Care	1.29	1.29	1.40	1.40	1.40
007	Allergy and Immunology	0.05	0.05	0.02	0.02	0.02
008	Cardiology	0.11	0.11	0.10	0.10	0.10
010	Chiropractor	0.01	0.01	0.03	0.03	0.03
011	Dermatology	0.04	0.04	0.03	0.03	0.03
012	Endocrinology	0.02	0.02	0.01	0.01	0.01
013	ENT/Otolaryngology	0.03	0.03	0.03	0.03	0.03
014	Gastroenterology	0.09	0.09	0.05	0.05	0.05
015	General Surgery	0.16	0.16	0.22	0.22	0.22
016	Gynecology, OB/GYN	0.03	0.03	0.02	0.02	0.02
017	Infectious Diseases	0.02	0.02	0.01	0.01	0.01
018	Nephrology	0.10	0.10	0.08	0.08	0.08
019	Neurology	0.10	0.10	0.08	0.08	0.08
020	Neurosurgery	0.01	0.01	0.01	0.01	0.01
021	Oncology - Medical, Surgical	0.08	0.08	0.07	0.07	0.07
022	Oncology - Radiation/Radiation Oncology	0.03	0.03	0.03	0.03	0.03
023	Ophthalmology	0.12	0.12	0.08	0.08	0.08
025	Orthopedic Surgery	0.09	0.09	0.11	0.11	0.11
026	Physiatry, Rehabilitative Medicine	0.06	0.06	0.04	0.04	0.04
027	Plastic Surgery	0.01	0.01	0.01	0.01	0.01
028	Podiatry	0.12	0.12	0.09	0.09	0.09
029	Psychiatry	0.16	0.16	0.10	0.10	0.10
030	Pulmonology	0.08	0.08	0.06	0.06	0.06
031	Rheumatology	0.03	0.03	0.02	0.02	0.02
033	Urology	0.05	0.05	0.05	0.05	0.05
034	Vascular Surgery	0.01	0.01	0.01	0.01	0.01
035	Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01

Network Adequacy for Facilities

Specialt	Large Metro	
	MMP **Maximum Time** (minutes)	**MMP** **Maximum Distance** (miles)
Acute Inpatient Hospitals	20	10
Cardiac Surgery Program	30	15
Cardiac Catheterization Services	30	15
Critical Care Services – Intensive Care Units (ICU)	20	10
Outpatient Dialysis	20	10
Surgical Services (Outpatient or ASC)	20	10
Skilled Nursing Facilities	20	10
Diagnostic Radiology	20	10
Mammography	20	10
Physical Therapy	20	10
Occupational Therapy	20	10
Speech Therapy	20	10
Inpatient Psychiatric Facility Services	30	15
Orthotics and Prosthetics	30	15
Home Health		
Durable Medical Equipment		
Outpatient Infusion/Chemotherapy	20	10
Heart Transplant Program		
Heart/Lung Transplant		
Kidney Transplant Program		
Liver Transplant Program		

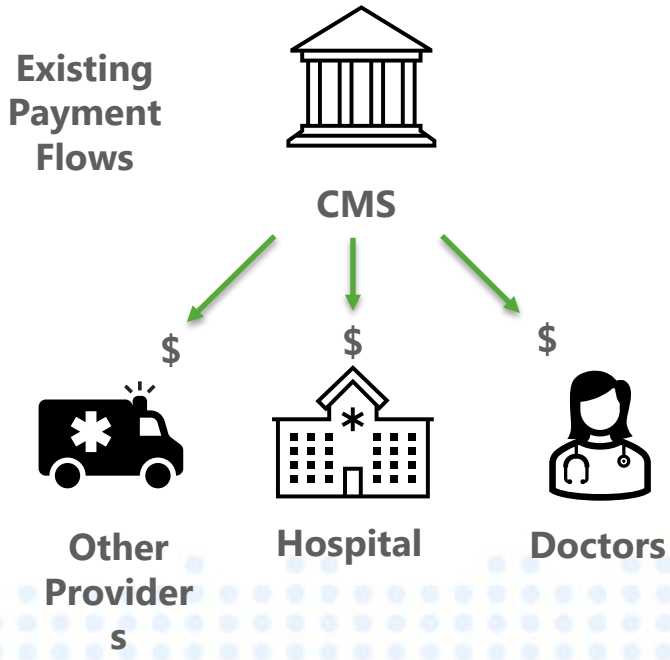
Flexibilities

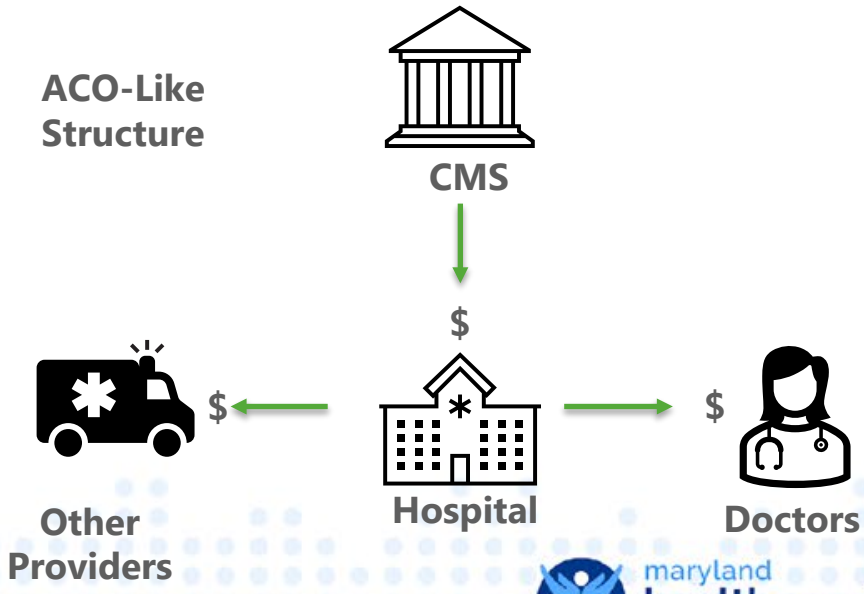
1. Clarification is needed of flexibilities within the following areas shared previously:
   a) Utilization Management

   We need more details on what / how / if hospitals want to do utilization review.

   b) Voluntary Partial Capitation for non-hospital providers

   HSCRC and CMS would create an ACO-Like structure that would reassign revenues to the ACO instead of (voluntary) participants. Hospitals would then pay participating providers themselves and could use that revenue for any (medical / care management purpose).





Possible Waivers

1. Potential flexibilities to consider:
   a) Waivers for HH/SNF – allowing flexibility to discharge patients earlier than 30 days
   b) Direct discharges from ER to the sub-acute unit
   c) Other?

All these waivers are possible. We would need a list of desired waivers from the industry.

GBR 2.0 Strawman

- Participating hospitals will be assigned a geographic region and a per capita TCOC target will be set.
  - The hospital will be guaranteed the TCOC target using either the MPA (if Medicare only) or rates (if All-Payer).
  - Hospitals receive all payments on behalf of (voluntary) affiliated providers. Hospitals may then distribute those payments as bundles, capitation, shared savings, etc.
  - Non-affiliated providers are paid as usual and their costs are held against the GBR 2.0 target.
  - The hospital will retain all revenues under the GBR 2.0 unless they fail to meet the network adequacy standards.

Exempted Policies

- Deregulation
- MPA
- CTI
- Others?

Included Policies

- Market Shift
- Hospital Quality
- New Population Health Measures

Potential for All-Payer Participation

- Staff believe that the GBR 2.0 should be all-payer but staff also believe that it will be easier to get participation from multiple payers with an existing framework.
  - Therefore, staff propose to start the with a Medicare framework.
  - We will incentivize participation from other payers.
- To participate payers would need to:
  - Provide sufficient data for us to determine the TCOC.
  - Replicate any flexibilities in their contracts.
- GBR 2.0 could incentivize other payers to participate by providing a ‘prompt pay discount’ to rates.

Next Steps

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Upcoming Agenda

- February – Continued discussion based on stakeholder feedback.
- March – Staff will present a draft report on the workgroup's progress for review, discussion, and comments by participants.
- April – Staff will present a final draft of the report, incorporating stakeholder feedback.