Maryland Model 3.0 Progression Plan:

Report on Medicare Waiver Enhancements

May 2023

The Total Cost of Care Model ends in 2026. The Health Services Cost Review Commission (HSCRC) sought to gather input from hospitals and other interested parties to inform the design and management of future refinements to the Model agreement with the Centers for Medicare and Medicaid Services (CMS). This is aligned with CMS's strategic plan, which seeks to "engage partners and the communities we serve throughout the policymaking and implementation process".

The workgroup consisted of a broad section of Maryland hospitals, payers, and other interested parties. HSCRC held a number of meetings throughout the end of 2022 and 2023. The HSCRC workgroup discussed three topics: 1) a 'Version 2.0' of the Global Budget Revenue (GBR) Model; 2) retaining a portion of the annual savings rate to invest in the additional benefits for consumers; and 3) reducing consumer cost sharing to account for the 'GBR affect' on hospital rates. The workgroup solicited input from stakeholders on other model changes but did not receive any.

GBR 2.0

The workgroup discussed a proposal originally made by Meritus Health for an expansion of the GBR. Under the proposal, hospitals would have a total cost of care target based on the historical total cost of care for an attributed beneficiary population and updated for inflation and demographic growth. The hospital would receive any total cost of care savings created and would be at risk for an increase in total cost of care (this would generally be analogous to the a fully capitation risk). The workgroup considered several features of the GBR 2.0.

- The workgroup discussed the attribution of beneficiaries to hospitals. The consensus of the workgroup was that GBR 2.0 could work in rural areas where the geographic relationship between hospitals and their patients is clear and predictable. More work on the attribution algorithm would be needed before GBR 2.0 could work in an urban area where patient populations overlap.

- The workgroup discussed the need for payer participation. Hospital participants questioned whether GBR 2.0 would work if only a single payer was participating, and the consensus of the workgroup was that the GBR 2.0 should include all (or virtually all)payers. However, there was a recognition that the timing of the negotiation with CMS may necessitate that GBR 2.0 is implemented for Medicare first, followed by other payers.

The workgroup discussed how payments would be made under GBR 2.0. Two options were discussed: 1) the aggregate total cost of care savings/losses could be distributed to hospitals using the GBR rate setting system; 2) a new legal structure could receive and distribute payments to its constitute members, similar to an ACO. The second option was generally seen as superior but would require significant operational changes for hospitals and payers.

The workgroup recommends that, in developing any future demonstration designs under the Maryland Model, the State should prioritize and preserve the voluntary nature of Global Budget Revenue 2.0 (GBR 2.0). The State is strongly encouraged to proactively seek out the necessary flexibilities and accommodations, ensuring that participation in GBR 2.0 or similar initiatives remains entirely voluntary for all eligible entities. GBR 2.0 should not lead HSCRC or the State to determine physician payment levels, or otherwise determine maximum physician payments. This principle of voluntariness must be a cornerstone of the State's approach to promoting and facilitating innovative solutions through the Maryland Model.

Expanded Benefits

The workgroup discussed retaining a portion of the Medicare savings under the next version of the Model and using those savings to provide additional supplemental benefits to consumers. These benefits would be similar to supplemental benefits provided to Medicare Advantage plans, such as dental care, reduced copays on prescription drugs, and so forth. The workgroup was supportive of providing additional benefits to consumers, though some workgroup members were concerned this would supplant the role of Medicare Advantage Plans, and the discussion focused on the operational logistics of providing additional benefits.

- The workgroup recommended including a clause in the next Model Agreement, that allows the state to provide additional consumer benefits. The agreement would be contingent on a lower Medicare savings target. The workgroup recommended that the State propose to CMS that half of the Medicare savings rate be retained for population health investments, including additional benefits provided to Medicare beneficiaries.

- The workgroup discussed how the benefits shoulder be structured to provide the additional benefits. The workgroup believed that the simplest mechanic would be for the state to use a hospital assessment to collect revenues from the hospital and then contract with a benefit management company to provide benefits to consumers.

- The workgroup discussed how to manage the waiver test while also providing additional benefits to consumers. A disruption of benefits to consumers must be avoided and that obligation would add to existing the State’s obligations under the waiver test. The workgroup discussed the possibility that the benefits fund would need to be capitalized for a year or two before benefits could be provided.

Reduced Cost Sharing

The workgroup discussed modifying beneficiary cost sharing to hold hospitals harmless for the ‘GBR affect’. Under a GBR, hospitals increase the charges on consumers as volumes decline. The result may be lower costs for consumers in the aggregate but higher costs for some consumers. The workgroup believes that it would be desirable to limit consumer cost sharing but noted that the economic incidence of the problem was small, and the administrative costs of fixing it would be substantial.

- The workgroup noted that the magnitude of the increases on consumers was likely to be relatively small, even with substantial reductions in hospital volumes (i.e. even more optimistic utilization scenarios only assume 5-10% additional reductions, which would translate to a 5-10% increase in costs shares for remaining patients). Commercial beneficiaries already pay lower cost sharing due to the all-payer system. Medicaid beneficiaries pay no cost sharing and Medicare beneficiaries only pay cost sharing on outpatient services and have limits on out-of-pocket cost sharing.

- The workgroup discussed the possibility of revisiting the Medicare waiver so that Maryland beneficiaries would only be charged the same cost sharing that would be paid under IPPS and OPPS. While this change would be feasible, it would be administratively burdensome on hospitals. As an alternative, the HSCRC could create a stop-loss on cost sharing and require any abnormally high-cost sharing to be written of under the hospitals financial aid policy.

- The workgroup discussed the impact of limiting cost-sharing on hospitals' finances. Forgoing a portion of the beneficiary cost-sharing would either reduce hospital revenues or would need to be offset by increasing hospital rates. The consensus of the workgroup was that the hospitals should be held-harmless for changes in cost sharing.

Overall, the workgroup recommends the State should seek the flexibilities in a future model to allow an approach like GBR 2.0 on a voluntary basis and to permit savings sharing with consumers through the addition of benefits should sustained savings be sufficient to merit this addition. While the work group thought there was some opportunities for rationalizing cost sharing, they did not believe this should be a priority in future negotiations.