Maryland
Hospital Association

May 9, 2023

Willem Daniel
Deputy Director, Payment Reform, Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Mr. Daniel,

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to provide feedback on financial containment and alignment concepts to inform the state's progression planning for the Total Cost of Care Model (Model) beyond 2026. We appreciate HSCRC's engagement with MHA prior to drafting the Total Cost of Care Work Group report.

Global Budget Revenue (GBR) 2.0
MHA supports voluntary hospital and care partner risk-sharing arrangements. As mentioned by staff, the GBR 2.0 model in its current form is best suited for rural hospital participation. GBR 2.0 would likely need refinement before applying to other geographic regions.

Historically, models such as total patient revenue (TPR), the predecessor to GBR, were initially voluntary but became mandatory under GBR. HSCRC also requires minimum participation rates for care redesign tracks. These stringent requirements limit the ability to conduct feasibility studies among interested parties, which can garner additional participation. Finally, network adequacy requirements like those discussed in the Work Group, may force a hospital's direct or indirect participation in GBR 2.0, even if they did not plan to participate.

We suggest emphasizing the voluntary nature of this model by revising the language in the report to:

"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."

We support expanding this model to payers beyond Medicare in future years, in addition to other provider-payer arrangements negotiated by hospitals and health systems. We understand waiver

authority is needed from the Center for Medicare and Medicaid Innovation within a set timeline and recommend mechanical considerations prior to implementation:

- As the model evolves, maintain flexibility to voluntarily engage care partners across settings. Care partners should have more direct opportunities for collaboration, as well as accountability for defined populations.
- Hospitals must be allowed the freedom and flexibility to determine physician payments with commercial payers. For Medicare and Medicaid, depending on the payment structure, this may require additional per capita funding.
- An important component of this model is shared accountability. In addition to aligning payment structure, the model should incorporate shared accountability for equity and quality measures that participating care partners can reasonably affect.
- The model should include partial and full-risk options. Similar to the Maryland Primary Care Program and national value-based programs, new care partners require an onboarding period before accepting significant downside risk. We recommend adopting upside risk only at the onset of the model, with defined expectations of when care partners may be required to accept downside risk.
- HSCRC must engage in ongoing communication and collaboration with interested hospitals to ensure their concerns are heard and that they have ample opportunity to participate voluntarily in GBR 2.0. At the same time, the program should allow for rapid learning from successes and failures.
- HSCRC must demonstrate its commitment to transparency by providing comprehensive and timely information to hospitals on contract agreements, performance metrics, potential benefits, associated risks, and the necessary criteria for participation.

Additional Benefits for Medicare Fee-for-Service (FFS) Beneficiaries
MHA supports the concept of retaining a portion of Medicare savings to reinvest in population health initiatives. However, the hospital field is hesitant to approve this concept without knowing how it would affect hospital payment policy and rate structure.

HSCRC staff outlined the concept well. Yet, we recommend the field and HSCRC study policy mechanics—particularly the risks of not meeting the savings target, if specific hospitals are accountable for savings, and how an assessment is applied to specific hospitals.

It is also important to consider the timing given the financial condition of hospitals at present. MHA initially supported exploring this concept when hospitals performed well on the Medicare savings test. Since then, savings erosion led to corrective action by HSCRC, and hospitals are being forced to make difficult operational decisions amid growing expenses. HSCRC should first ensure GBR's core pillars are met—adequately funding inflation and population growth. If these criteria are met, we support HSCRC staff's April 25 Work Group suggestions to embed certain thresholds in the proposal. This may include ensuring sufficient savings are accrued over a defined timeline, which would enable provision of the benefits for a certain number of years.

Another consideration is the impact on existing Medicare supplemental insurance plans. Such benefits may already be included in more comprehensive plans available to consumers. Provision

of benefits by the state may cause large plan exits and unintentionally result in care fragmentation due to loss of care coordination services or loss of other benefits to manage chronic conditions.

MHA agrees statewide investment in certain benefits may lead to large-scale health, quality, and savings improvements. The language in the report suggests the statewide funding pool may only be used for additional benefits. However, the state may prioritize other population needs such as housing, transportation, or food security. We suggest modifying the language in the report from "expanded" or "additional supplemental benefits" to "addressing identified statewide population needs."

Reduced Cost Shares for Medicare Beneficiaries
MHA opposes standardizing cost sharing, at least at this time, for reasons listed below. MHA is open to revisiting when financial stability returns, and the next phase of the Model is decided.

- The potential impact is minimal because it would primarily affect cost shares for Medicare outpatient services
- HSCRC GBR compliance targets, like splitting the annual update into two measurement periods, create price variability for consumers. All contributing factors should be explored.
- The proposal may put Maryland at risk of failing its Medicare savings test by reconciling price differences through Medicare payments
- Administrative costs will rise if billing and collection practices must adjust to new requirements

MHA does not support the cost share reduction proposal, yet we maintain the Model must continue to benefit consumers, and the impact should be assessed on an all-payer basis. As the state evaluates potential changes to financial targets and quality metrics, we recommend exploring measures that can be monitored, setting applicable thresholds for review or corrective action where necessary. Measures that may be of interest are an affordability index, payer reporting on cost shares, out-of-pocket costs, and enrollment in high deductible plans.

Thank you again for the opportunity to comment on the draft report. If you have questions or would like to discuss any of our recommendations, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment