Payer Alignment Workgroup Written Recommendation

Total Cost of Care Model 3.0 Progression Plan–May 2023

4/7/23 DISCUSSION DRAFT FOR COMMENT

Introduction

As part of advancing the Total Cost of Care (TCOC) Model, the Health Service Cost Review Commission (HSCRC) created a Progression Plan including the creation of several stakeholder working groups. Each group aimed to inform the Commission on continued innovations to improve the health of Marylanders. This report contains discussions and recommendations surrounding the Payer Alignment Workgroup.

The aim of the Payer Alignment Workgroup is to coalesce around solutions to control health care costs and improve the quality of care, with a specific perspective of health payers. Even with a common foundation of a payer's perspective, challenges to find consensus were evident during workgroup meetings, though there was agreement that alignment across payers should be the goal when possible. Finally, the Workgroup was in agreement that the TCOC Model is a complicated system of health delivery that poses difficulty in acquiring necessary buy-in from stakeholder groups and the general public.

The Payer Alignment Workgroup expressed meaningful thoughts and dialogue during meetings. The Workgroup achieved unity with the collective aim to improve access, equity and outcomes for our respective beneficiaries and Maryland at large.

Members

The Payer Alignment Workgroup had members spanning from both Medicaid and commercial payers (including Medicare Advantage plans), as well as representatives from the HSCRC and the Hilltop Institute.

- Tricia Roddy: Medicaid
- Kathlyn Wee: UnitedHealthcare
- Kathleen Loughran: Wellpoint
- Arin Foreman: CareFirst
- Matt Celentano: League of Life and Health Insurers
- Nicki McCann: Johns Hopkins/Maryland Medicaid Advisory Committee (MMAC) Chair
- Allan Pack: HSCRC
- Laura Spicer: The Hilltop Institute

Workgroup Objective and Guiding Principles

The Payer Alignment Workgroup convened with the objective of developing recommendations for the TCOC Model, through the lens of defining value to payers under the model. Recommendations discussed using the following framework:

- Improving outcomes;
- Understanding and creating cost savings;
- Reevaluating financial mechanisms; and
- Measuring and communicating impact.

The Workgroup adhered to the guiding principles that the HSCRC created for the overall Progression Plan.

1. The Progression Plan should further the goals of the TCOC Model to lead the nation in health equity, quality, access, cost of care and consumer experience through aligned incentives and value-based payment methodologies across providers and payers.
2. The Progression Plan should include high-level recommendations that are feasible to implement and build upon existing initiatives and programs, where possible.
3. The Progression Plan should utilize State flexibility in order to tailor delivery system and payment reform efforts unique to Maryland.
4. The Progression Plan recommendations should adhere to the all-payer nature of the system to align quality and cost incentives across payers.
5. The Progression Plan recommendations should be established through a collaborative public process.

The Workgroup met four times between February and May 2023. The first meeting identified a framework for developing recommendations and launched an initial brainstorm. During the second and third meetings, the Workgroup built out potential recommendations based on discussion and comments received in the interim between meetings. Workgroup coordinators shared a draft recommendations report for Workgroup and public comment in early April. The Workgroup discussed the final report at the last meeting in May. The MMAC received an update on the Workgroup's proceedings in March, and time was reserved for public comment at each Workgroup meeting.

Proposed Recommendations

The following section contains two kinds of recommendations. The first is a series of analyses that will help payers understand the drivers of cost savings. The second are policy recommendations that will be informed by the recommended analyses.

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Methodology

WORKGROUP MEMBERS: PLEASE PROVIDE COMMENTS ACCORDING TO THIS QUADRANT FOR EACH POLICY RECOMMENDATION BELOW.

To prioritize recommendations stemming from the Payer Alignment Workgroup, a brief quadrant analysis was completed for each option. Prioritization (High, Low) and Workforce Demand (High, Low) were identified as important variables for each proposed recommendation. The proposals were categorized and are summarized below.

Recommended Analyses to Understand Cost Savings

The Workgroup wished to fully explore what creates savings in the model, and how those drivers could be improved upon. The following proposed analyses would inform the Workgroup's policy recommendations moving forward, and as such are considered the highest priority. Proposed analyses include:

1. Determining hospital investment in physician subsidies, including effect on deregulation;
2. Measuring retained revenue (including how it is being spent and the outcomes of those investments) and operating margins by hospital;
3. Measuring how much additional federal money Maryland Medicaid is bringing into the state through the federal Medicaid match for the higher payment rates for regulated hospitals services under the model;
4. Measuring various types of savings accrued to the state as a result of the all-payer system, such as how much the state is saving by not having public hospitals, and instead being an all-payer system;
5. Investigating the effect of the update factor on variable costs; and
6. Investigating the impact of rebasing.

Policy Recommendation 1: Payer Alignment on Bundles, Primary Care and Quality

Prioritization:
Workforce Effort:

During this planning phase for TCOC progression, the HSCRC also convened a workgroup related to physician alignment. Two major recommendations from that workgroup are to promote Medicaid and commercial payer alignment with the Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPCP). The Payer Alignment Workgroup identified programmatic alignment as a high priority and noted it would take significant resources across payers.

While some commercial payers regularly utilize bundles, there is potential for Medicaid to align to improve outcomes. Historically, Medicaid participation has been challenged by issues such as churn and third party payer liability. The Medicaid program is willing to explore these issues with the managed care organizations (MCOs) and the industry.

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Payers are united in recognizing the role of primary care in closing health equity gaps and improving health outcomes. There needs to be a higher investment in primary care in effort to increase both the number of primary care providers and access to primary care. To achieve this investment, primary care spending targets may need to be set.

With regard to MDPCP, the Medicaid program is committed to expanding and standardizing advanced primary care. MDH has worked and continues to work collaboratively with CMMI, the MDPCP Program Management Office and its nine participating MCOs on the alignment initiative. CareFirst is already an aligned payer under MDPCP. Payer-specific programs should align where possible, such as around quality measures and investment targets. While keeping provider burden and consumer experience at the forefront, flexibility should be granted, given the administrative differences between payer types.

Maryland has the opportunity to improve outcomes through better alignment on quality across payers. The TCOC quality framework sets clear goals for achieving health care quality across payers. Commercial plans proposed utilizing HEDIS and other provider experience metrics included in Medicare Advantage Star Ratings, where relevant, to populations below the age of 65. This would enable more consistency across payers for primary care providers.

Policy Recommendation 2: Deregulation and Access to Care

Prioritization:
Workforce Effort:

The HSCRC developed a protocol for deregulating services, which they have applied over the course of the All-Payer and TCOC Models. The methodology maintains the 50 percent variable cost factor in regulated space. If hospitals do not alert the HSCRC proactively to the shifting of services outside of regulated space, the HSCRC applies a retroactive adjustment. Any increased deregulation of services needs to maintain the incentives inherent to the GBR system, while balancing how to eliminate or decrease inefficiencies in the system. Another factor for consideration is whether active deregulation of services should precede or follow the shifting of utilization toward unregulated spaces, *i.e.,* shifts that could result from increased Medicaid rates in the community.

The Workgroup also discussed the differentiation between deregulation to support access or capacity issues, versus deregulation with the primary goal of savings. Commercial payers and Medicaid differ. For Medicaid, both scenarios apply, as the transition of cost outside regulated space would allow Medicaid to increase rates for providers in unregulated space, such as ambulatory surgery centers. On the other hand, commercial payers may pay comparatively higher rates in the community, relative to respective settings in other states; strengthening the use of retained revenue, *e.g.,* the Revenue for Reform policy, may be a higher priority for commercial payers.

Overall, the Workgroup agreed that a standard of access must be defined and maintained based on measurement of supply and demand for services. The state should utilize a uniform definition to identify

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and correct the overexpansion of access in certain jurisdictions to certain services and make access to care more equitable.

Policy Recommendation 3: Remove the Medicare Performance Adjustment Savings Component

Prioritization:
Workforce Effort:

The Medicare Performance Adjustment Savings Component (MPA-SC) allows the HSCRC to approve a retroactive adjustment to Medicare rates, *i.e.,* in instances when the TCOC Model misses its Medicare savings targets. This methodology incentivizes the HSCRC to approve higher update factors, with the knowledge that savings to Medicare can be adjusted on the back-end. Per CMS, this does not constitute a breach of the Upper Payment Limit; if the MPA-SC is not removed, Medicaid may seek its own authority to similarly adjust rates retroactively. CMS has stated that this is an allowable Medicaid authority.

Policy Recommendation 4: Establish All- or Multi-Payer Savings Targets

Prioritization:
Workforce Effort:

The TCOC Model aims to progressively transform care delivery across the health care system, with the objective of improving health and quality of care. The Statewide Integrated Health Improvement Strategy (SIHIS) operationalizes these aims by targeting outcomes in three domains: hospital quality, care across the continuum and population health. The Medicaid program has implemented numerous new benefits and coverage expansions that support care across the continuum and population health in particular, with an estimated $500 million of new investments in calendar year (CY) 2022. Medicaid also has the opportunity to increase investment through primary care financial targets, as well as new CMS authorities related to the drivers of health. Approximately 60 percent of the Medicaid budget goes to rate-regulated services. The establishment of a savings target for Medicaid, in addition to the existing Medicare savings target, will greatly facilitate the Medicaid program’s ability to increase community investments. Workgroup members acknowledged that the TCOC framework does not direct additional funding to non-hospital based primary care outside of Medicare.

As included in the recommended analyses above, it is important to understand how much more federal matching dollars this brings into the state relative to its neighbors, as well as the potential impact on the state budget due to decreased commercial rates for its state employee workforce.

Policy Recommendation 5: Educate Payers, Consumers and Businesses on the Value of the Total Cost of Care Model

Prioritization:
Workforce Effort:

The Workgroup also discussed the importance of measuring and communicating the value of the model to stakeholders around the state. This discussion conforms with the recommendations put forth by the Consumer Engagement Workgroup, with the addition of the importance of educating payers and purchasers of health care on a broader level than they are currently. Payers should align on understanding the model, as identified by the results of the analyses presented in this report to define the value of the model to payers–as well as if savings from the model are passed down to consumers and employers.

Defining value will drive buy-in from payers and purchasers of health care and ideally results in clear commitments and alignment to improvements in health outcomes. The Workgroup sought to use outcome improvements to easily show the efficacy of the Model. One way this might be possible is to translate the combined effect of the HSCRC integrated efficiency policy, rate corridors and Revenue for Reform policy into an equivalent of a Medical Loss Ratio. Separately, they thought that the SIHIS goals could be used to obtain statewide buy-in around outcomes to build on the work HSCRC is already doing in this area, as well as the importance of measuring health outcomes across time.

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