

**DRAFT: Report on Current Physician Payment Models and Recommendations for Physician
Alignment Strategies under the All-Payer Model**

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This document contains the draft report from the Physician Alignment and Engagement Work Group on current physician payment models and potential options for physician alignment strategies under the All-Payer Model.

DRAFT: Report on Current Physician Payment Models and Recommendations for Shared Strategies under the All-Payer Model

Introduction

On January 10, 2014 the Center for Medicare and Medicaid Innovation (CMMI) approved the implementation of the All-Payer Model for Maryland. The All-Payer Model has a three part aim of promoting better care, better health and lower cost for all Maryland residents by shifting from a hospital payment system focused on cost per admission to one focused per capita total hospital costs, and eventually total per capita health care costs. It is important that physicians are engaged in the process of developing and implementing the Model and that physician and other health provider interests are aligned to promote the Model's long-term success.

The HSCRC formed the Physician Alignment and Engagement Workgroup to recommend strategies for supporting and incentivizing physicians to coordinate and cooperate among themselves and other providers to deliver better health, better care and reduced cost to Maryland residents. The two primary charges of the Physician Alignment & Engagement Workgroup relate to 1) Care Improvement Opportunities (e.g., improving quality and outcomes. Care Coordination, etc.); and, 2) Physician and other Provider Alignment & Engagement.

The purpose of this paper is to address the second charge and to provide the HSCRC with the Workgroup's recommendations on how to prioritize the development and implementation of a full range of strategies to align hospital and physician interests under new global payment models. A future report of the Workgroup will focus more explicitly on Care Improvement Opportunities, and the Alignment and Engagement strategies should enable and support those Care Improvement Opportunities. This report first provides background on existing physician payment models, discusses the challenges and opportunities for physician alignment, and provides an analysis of potential strategies.

Framing the Challenges and Opportunities for Physician Alignment under the All-Payer Model

The HSCRC is focused on integrating its approaches within the context of the existing physician landscape and in concert with the care delivery changes and innovations already occurring both inside of hospitals and in other parts of the provider community. Primary care medical home models (PCMHs) have grown rapidly in the private insurance sector in Maryland. In the PCMH model in Maryland, health insurers are working with care managers and primary care practices to improve care and cost-effectiveness with a focus on chronic conditions. Accountable care organizations (ACOs) are also growing in number and importance on the national stage and in Maryland to provide high quality care particularly to the Medicare population. In the ACO model doctors, hospitals, and others coordinate care to improve quality and cost-effectiveness.

During the last several years, the HSCRC's payment reform focused on reducing readmissions and health care acquired conditions. This focus was aligned with the goals of PCMH and ACO models and likely contributed to the success of these models. This focus also accelerated the process to develop an investment in infrastructure that supports the activities of both hospital and physician delivery changes, particularly in the areas of care transitions, quality improvement, health information exchange through investments in CRISP, and in data collection and analytics infrastructure. The HSCRC and hospitals' past focus on reducing avoidable utilization and improving care coordination has led to significant improvements in health care delivery in the State. In order to achieve success under the All-Payer Model and within the context of global budgets, certain obstacles must be addressed.

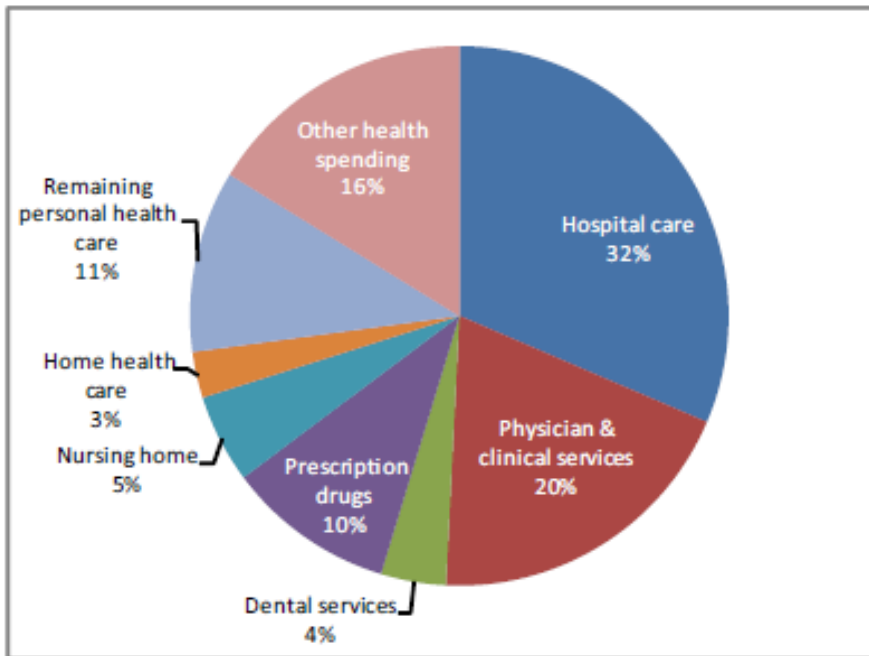
Infrastructure costs and care coordination costs are key barriers to the future expansion of ACOs, PCMHs and similar care coordination models. The HSCRC and hospitals must focus on developing resources that address these barriers. Additionally, the HSCRC and hospitals must support care delivery innovations and care coordination activities particularly for Medicare and Medicaid patients, so that these new approaches grow and gain early success. The Physician Engagement and Alignment Work Group should continue to work toward recommendations that will address these barriers to care coordination and support the development of alignment resources.

In addition to infrastructure and care coordination costs, a second area of concern is the potentially divergent interests of hospitals that are reimbursed under global budgets with quality incentives, from physicians and other providers that are paid under volume based systems with limited quality incentives. Several approaches have been raised to address this concern, including gain sharing, pay-for-performance and sharing savings payments from hospitals to other providers, to help align interests to improve quality and reduce cost. While there are merits in these approaches, they have limitations.

As shown in the Figure 1, physician expenditures are about two-thirds of the size of hospital expenditures. This relationship is quite different for Medicare (Figure 2), where hospitals consume almost two times the resources as physicians, as it is for commercial payers (Figure 3), where the resource consumption is about equal for physicians and hospitals.

Figure 1

Exhibit 3. Health Spending by Category, February 2014



Source: Altarum monthly NHE estimates

Figure 2

Spending Distribution, Private Insurance vs. Out-of-Pocket United States, 2011

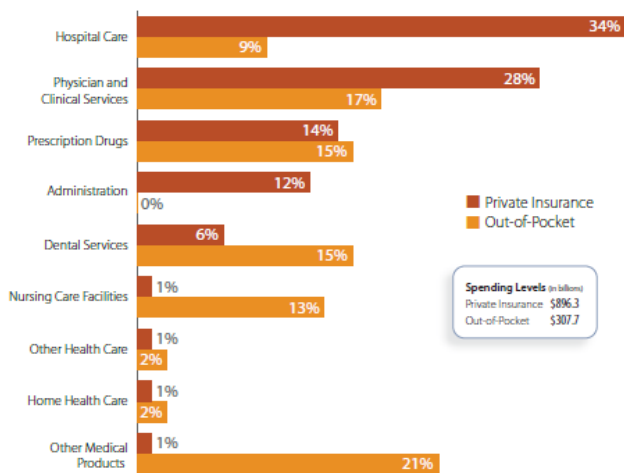
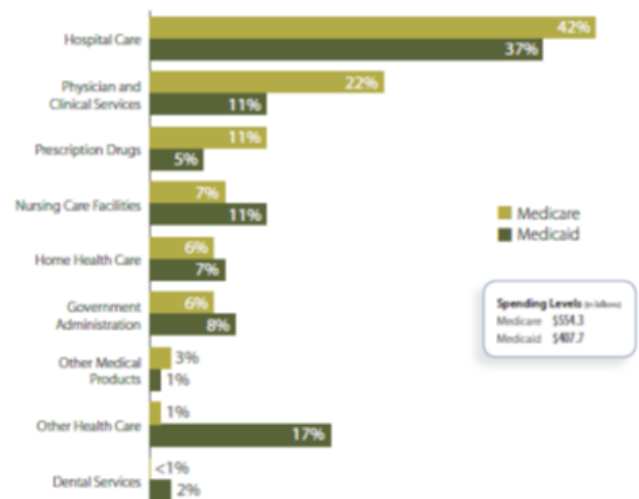


Figure 3

Spending Distribution, Medicare vs. Medicaid United States, 2011



While hospitals can share some savings from joint interventions to improve care and lower costs, hospitals do not have sufficient financial resources to offset lost volumes in the physician enterprise and in post-acute care. Comprehensive ACO like structures or bundled payment structures are necessary to more fully align all of these parties.

This should not prevent start-up approaches which include opportunities for shared savings or pay for performance incentives that are derived from hospital savings and quality improvement, especially for care improvement activities and better chronic care that is cross cutting for all payers but particularly present in Medicare patients. Additionally hospitals may consider working with physicians to reduce practice variation for procedures performed in the hospital. This may merit gain sharing expenditures, but this will need to be budgeted in tandem and balanced with shared savings opportunities that involve reducing hospitalizations through better care.

Background

Overview of the Payer / Hospital / Physician Payment Environment

Before discussing the Physician Payment Environment, it is instructive to place into context the background of Maryland's hospital and physician payment models, and the alignment of Payers, Hospitals, and Physicians.

In the early years of the HSCRC, the Commission instituted a cost per case constraint, while at the same time approving "unit rates" to be charged to all payers. This system is distinctly different than the national DRG system, for example, because it aligns payers and hospitals for achieving lower case costs. That is, the expenditures of individual payers will be lower if what hospitals charge per case is lower. Under the Maryland system, patients are still being billed for the resources being used. Under the DRG system, on the other hand, there is a fixed reimbursable amount per each DRG.

Thus, historically, from the 1970's until this year, the broad incentives under the old system were as follows:

- Payers were incentivized to reduce cases and reduce their expenditures
- Hospitals were incentivized to increase cases while reducing their cost per case
- Under the Fee for Service system, physicians were incentivized to influence the volume of services provided

In summary, under the Commission's Charge per Case system, while payers had the incentive to reduce both cases and their expenditures per case, the only alignment between payers and

hospitals was to reduce the resource use per case. The misalignment for hospitals and physicians is on both the number of cases and the resources used within the case.

Under the new Global Budget model, for hospitals that are under a global budget (or other population-based cost constraint, such as TPR or GBR), there is an improvement of the alignment between payers and hospitals, but still misalignment with physicians, at least to the extent that the vast majority of physician payments remain fee for service. Under the Global Budget model, there is a fundamental change in that the hospitals' incentive shifts to gain the right volumes, while decreasing preventable complications and reducing avoidable utilization that comes from improved care. A goal of the Physician Alignment & Engagement Workgroup is to focus on improving the alignment for physicians to improve care.

Additionally, it is important to consider not only what broad incentives exist with payers and hospitals, but the extent to which the payers and hospitals are working to take advantage of those incentives. In particular, while many commercial payers invest in care management activities and in some cases are working collaboratively with hospitals and physicians to improve care, Medicare simply pays bills and leaves care management to the hospitals and physicians (with the exception of the limited number of beneficiaries in ACOs, Medicare Advantage, or other CMS Demos). As a result, some of the patients who can benefit the most are Medicare patients because there is no payer already doing the work and there is no overlap in roles. Medicare fee for service offers the greatest opportunity because: it is the largest hospital payer (nearly 40% of the system); it is one of the only payers not investing in care management and, it is the payer for which there is the greatest link between manageable chronic disease and concentration of expenditures, so the best opportunity to increase quality and decrease cost.

Overview of the Current Physician Practice Situation and Payments

In terms of the practice situation in Maryland, there are both a substantial number of hospital employed physicians, as well as many physicians in private practice. The level to which individual hospital and health system referrals and admissions are managed by employed vs community-based physicians varies substantially. Additionally, there is variation by physician type with respect to hospitals that do employ physicians, in terms of the distribution between primary and specialty care. There is also variation with respect to community based physicians, both by geography and specialty, in terms of the types of practice situation.

Overall, Maryland does not have a prevalence of independent, large multi-specialty groups, though some do exist, and in some geographies (such as Southern Maryland) they represent a substantial part of the physician landscape. There are many physicians in small, independent practices, and there are also some relatively large single specialty groups. The types of groups in existence could have implications for the ability to implement alignment models. For example, if community-based primary care is mostly either employed by hospitals and health systems or spread out in small practices, and community-based specialty care is mostly in independent small

groups and large groups that spread across multiple community hospitals, this may have implications for the types of alignment models that are possible.

In terms of the physician landscape in Maryland, there has been in recent years an increase in the number and percentage of employed physicians, with more physicians, especially primary care physicians, being employed by hospitals and health systems. There has also been an increase in the number of employed specialists.

Also, there are additional structures that have created methods for independent practice physicians to participate in alignment models, such as PCMH programs, ACOs, and Medicare Advantage. CareFirst for example has a large PCMH program, including for CareFirst commercial members, as well as a CMS Demo for approximately 25,000 Medicare beneficiaries. Additionally, the Maryland Health Care Commission operates a PCMH program, and the MHCC estimates that approximately 50% of Maryland's primary care physicians participate in some type of PCMH program. This is a large increase from a few years ago and has positive implications for the ability to implement alignment models.

Also, according to CMS data, there are 15 ACOs in Maryland as of January 2014, spread geographically throughout the State, of which 4 started in 2012, 5 started in 2013, and 6 started in 2014. As these and other ACOs grow in volume, they could represent a fairly substantial percentage of the Medicare beneficiaries in Maryland. At the same time, many Medicare beneficiaries are likely to remain in FFS outside of ACOs, including many high risk beneficiaries, so it is important to consider population health and alignment strategies for those Medicare beneficiaries outside of ACOs.

Medicare Advantage currently has a relatively low percentage of Medicare Advantage penetration in Maryland and represents another alignment model that offers the potential to align incentives. There are important differences between Medicare Advantage and ACOs, both of which offer total cost of care incentives and the opportunity to share in Medicare savings, which should be considered.

In summary, there is an increase in both employed physicians and models such as PCMHs and ACOs, which creates the ability to implement alignment models with community-based physicians. Payers have been increasing their implementation of alignment models that encourage population health (i.e., increased quality and reduced cost), and with the change in the Waiver to Global Budgets, hospitals also now have an incentive to implement alignment models that encourage population health.

Also, one dynamic that been discussed is the need to encourage multi-payer collaboration and consistent and evidence-based incentives across alignment programs, so that hospitals, physicians, and other providers have consistent incentives to coordinate and provide care in the most high quality, cost effective manner.

Overview of Current Physician Payment Models

In order to frame the discussion around physician payment models, it is important to consider the overall context of physician payments, including the payer sources and employment situations.

In terms of how payments flow from the payer sources to physician practices, payments are primarily as follows:

- Medicare: mostly fee-for-service, with a small amount of incentive compensation related to ACOs, Demos, Medicare Advantage
- Medicaid: mostly fee-for-service, with a small amount of incentive compensation from Medicaid Managed Care
- Commercial: Mostly fee-for-service, with a growing and somewhat meaningful (but still relatively small) amount of incentive compensation for primary care physicians

In summary, while there is some incentive compensation from the commercial sector to primary care physicians, the vast majority of payments from payers are still fee-for-service with limited or no quality incentives.

It is next important to consider the practice situation, to consider how the practices in turn pay out dollars to the physicians. As discussed above, there are both hospital (and health system) employed and independent physicians. For the most part, independent physicians are paid using fee-for-service approaches, especially those in smaller practices, where they are “small business owners”.

For hospital (or health system) owned, and some larger practices, these following are the most common payment methods:

Fee-for-Service:

Through this method, which we believe is the most common overall method across all physicians, each physician or physician group is designated as producing its own distinct revenue and is assigned a certain portion of practice overhead. The difference between revenue and overhead is what the physician takes home as pay; therefore, physicians are incentivized to raise revenue as well as to limit overhead expenses, to the extent they have the ability to control overhead.

Collections-Based Salary Plus Bonus:

Under this structure, the physician is paid a base salary and receives a bonus if actual collections are greater than a specified threshold. A prevalent threshold is two times the physician’s base salary. This threshold encourages physicians to

increase collections and allows the practice to cover operating costs, and share in additional revenues beyond the threshold.

Some practices use other metrics besides productivity measures to determine physician bonuses, such as process or outcome measures; however, these are not an industry norm. Additionally, a small number of hospital owned practices have started to give bonuses to primary care physicians for reducing overall expenditures for distinct populations, but this is also not prevalent.

Relative Value Units (RVUs):

This method is very similar to the Collections-Based method above, except by using each physician's RVUs to spread the total revenues, rather than simply spreading the revenue across the physicians, it addresses differences in payer mix.

Payments for Designated Health Services:

Another method by which physicians are compensated, which also has an underlying fee-for-service incentive, is to compensate physicians for "designated health services." These are health services for which physicians cannot receive bonuses under the Stark Law. The Stark Law prohibits bonuses for certain types of referrals such as all inpatient and outpatient hospital services and radiology or lab services. This law is in place to discourage potential over-utilization of services that would be associated with paying physicians for referrals to these services.

Each of the four payment structures listed above encourages physicians to focus on volumes, and they reduce compensation even when physicians spend time to improve care that may reduce potentially avoidable utilization.

Goals and Desirable Features

The Physician Alignment and Engagement workgroup created a list of goals and desirable features it hopes to achieve through any physician alignment and engagement strategies recommended under the All-Payer Model. While some of these goals and desired features are aspirational, they serve as a guide in prioritizing efforts and a roadmap for developing future policies.

Goals

- Engage health care providers and align their incentives based on quality improvement goals, consistent with the goals, requirements and policies of the All-Payer Model

- Align incentives to improve the overall health of the entire population, including hospital and non-hospital-based health care services
- Move from a volume based provider centric system to a value based consumer centric system
- Strive to apply incentives equally among all payers

Desirable Features

- Engagement
 - Physicians are provided an active role in developing and refining alignment strategies related to the All-Payer Model
 - Health care consumers are engaged through coordinated efforts of all segments of the health care industry
 - Hospitals and physicians are able to participate on a voluntary basis
 - Sufficiently motivational to incentivize physicians to commit time and effort to improving quality and lowering cost
- Alignment
 - Focus attention of different providers on strategies that are most impactful to meeting the All-Payer and Medicare savings requirements of the new model.
 - Tailored to specific health care provider roles, recognizing that significant differences exist between primary care physicians and specialists, independent and hospital-owned practices, and physicians and other health care providers
- Transparency
 - Employ data that are presented in a timely and actionable form
 - Rely on metrics that are clear in purpose and meaning
 - Require accountability from providers and payers
- Scalability
 - Strategies should be simple in design and replicable
 - Hospitals and physicians have sufficient support for infrastructure needed to succeed under new alignment strategies
 - Balance the need for flexibility for each hospital to construct arrangements to meet specific organizational and community goals with common elements that have the power to focus attention on shared goals and encourage collaboration.
- Sustainability
 - Existing health care infrastructure is repurposed and current assets are fully leveraged so that the health care delivery system is consolidated and duplication and fragmentation are reduced

- Regulatory, legal and administrative environment must be permissive and supportive of innovation under the All-Payer Model

Integration with other HSCRC New Model Workgroups, and other Initiatives

The Physician Alignment and Engagement Workgroup has been coordinating with the other New Model Workgroups.,

In addition to HSCRC work groups, there are other agencies and organizations with whom we have been coordinating, including the MHA's Transitions Workgroup and Clinical Leadership Committee, and the DHMH SIM Initiative. We will continue to monitor the landscape to be able to use other organizations to facilitate consistent approaches and incentives, and welcome any connections to and input from any relevant organization.

Legal Barriers to Reform

There are federal and state laws in place that may pose as barriers to implementing the necessary health care reforms for the success of the All-Payer Model.

Some of the most common legal barriers in healthcare related to physicians and hospital relationships with physicians are the Stark / Physician Self-Referral Law, Federal Anti-Kickback Statute, and Civil Monetary Penalty laws. Most of the issues with these laws are related to preventing payment for referrals in the fee-for-service system. ACOs have been granted some waivers from aspects of these laws. Since the Maryland Global Budget Model does not incent increased referrals, and the regulations setting forth the ACO exemptions specifically indicate that CMS envisions granting these same Waivers to other CMMI Demos (of which the Maryland Global Budget Model is one), Maryland should consider requesting that CMS allow the same package of ACO Waivers to be applied in Maryland in programs that align and engage physicians to meet the Three Part Aim objectives.

Still there are some legal impediments which we should attempt to address, including ... (to be discussed at Workgroup meeting, and expanded).

Potential Alignment Strategies

The ultimate goal of any alignment strategy is to help advance the Three Part Aim. As a result, any strategies developed should target areas with the greatest opportunity to achieve improved results and where alignment strategies can simultaneously improve quality and reduce cost. Alignment strategies should encourage care coordination in areas with the potential to achieve the greatest results ranging from cross-cutting areas (e.g., discharge planning, medication management, care transitions, patient safety) to specific high cost clinical areas (e.g., CHF, COPD, Diabetes, ESRD).

The Work Group considered both non-financial and financial strategies to align the interests and goals of hospitals and providers. Both have potential and limitations, but a long-term strategy would be to include a combination of both in a well-rounded alignment structure.

In addition, authority for alignment strategies can be implemented through different mechanisms:

- Through HSCRC approval for those strategies that are within the Commission's jurisdiction;
- State policy changes including through DHMH policy and programs, and legislative changes;
- Through industry changes made through policy and clinical practice, such as mechanisms to improve care management and coordination;
- Authority provided by the federal government, such as obtaining waivers, demonstrations or other authority pursuant to federal law or policy.

While all of these mechanisms are important in establishing alignment, immediate consideration should be focused on what the Commission can do in the short-term to promote alignment. In addition, many of the non-financial strategies can be done within the industry without obtaining federal approval.

Non-Financial Incentives to Physicians

Non-financial alignment strategies such as sharing of infrastructure, analytics and other resources, public reporting, or promotion of ease of practice should be seriously considered and in many cases can be instituted without additional regulatory approval.

One non-financial strategy that has been recommended is to expand what data are available, such as related to population health, evidence-based approaches, "Choosing Wisely," practice variation, and physician and other provider profiling. We believe that providing access to information, and highlighting variation in performance and outcomes, will facilitate better performance, due to the general desire to improve care.

Another non-financial alignment strategy is to improve the ease of the practice of medicine. For example, by implementing multi-disciplinary care management and other care coordination approaches, it is possible to improve the ease of physician encounters, and pre- and post-visit education and follow-up, making patient treatment easier and more rewarding. For example, for Medicare patients with multiple chronic diseases, by instituting multi-disciplinary care teams, time commitments for primary care and other physicians can be reduced and more in line with the fee schedules they are receiving for these high needs patients..

One specific concern related to the need for non-financial incentives is that the globally budgeted system is relatively constrained versus historical revenue growth. Therefore, in order to generate any ability to share savings, the industry will have to first be able to meet the stringent 3.58% overall per-capita revenue cap.

Financial Incentives to Physicians

The Workgroup categorizes potential financial alignment strategies along a continuum based on the comprehensiveness of both time and services. Another way to consider this is the extent to which various models encourage patient-centeredness.

With respect to time, the continuum goes from less to more comprehensive, and from less to more patient-centeredness, as follows:

- Fee-For-Service Care Management strategy (so time is the unit of service)
- Case-based strategies (so time is the length of the admission)
- Episode-based strategies (so time is a defined episode length, such as 90 days)
- Population-based strategies (365 days per year)

With respect to services, we view the continuum in terms of which services are included, such as inpatient, outpatient, physician, long-term care, and / or other services. It is important to note that even if the time dimension is made longer, the services dimension does not necessarily include all services during the time window. For example, a model could be population-based (i.e., 365 days per year), but still include only inpatient services or all hospital based (i.e., regulated) services.

Another consideration is the method by which various alignment strategies pay out dollars, such as based solely on savings (e.g., gain sharing or shared savings), or based upon metrics that are not only financial savings (e.g., pay-for-performance or P4P). For information on the Western Maryland Health System pay-for-performance model, see Appendix III.

An additional aspect related to prioritization is the balance between moving ahead with what is currently feasible, while maintaining vision for models that need regulatory approvals, but may be more aligned with the overall vision of population health. As a result, we believe that over time, it is desirable to move towards more comprehensive population-based models, which encourage managing the total cost of care, through using improved quality to reduce cost. At the same time, we recognize that several gain sharing models have all ready been approved and can be implemented more quickly. If the conclusion is reached that this opportunity does not distract from the longer term goal of pursuing population-based models, this may be a place to begin.

Another important aspect of alignment models is that even if there are models which share in savings or pay for quality improvement the incentives, both financial and non-financial, should be significant enough to encourage the appropriate change that is necessary to achieve the various goals of the new all-payer model.

Finally, we have discussed the balance between needing to meet model requirements in the short term, with the need to perform most effectively over the long term.

Below is a summary of each alignment strategy described above. More detail on each strategy can be found in Appendix I.

Fee-For-Service for Care Management Strategy:

The concept of this strategy is that, within the global budget payment structure, hospitals would be able to add to their chargemasters items that are care management functions. As a result, hospitals would be able to reallocate charges to activities that improve quality and reduce costs. Also, for example, hospitals could reallocate charges to be more closely aligned with costs, such as by charging for care management activities to patients that need versus do not need certain activities. The idea is that these care management activities could be at or expand beyond the hospital.

Case-Based Strategies:

Case-based strategies would serve to reduce cost per case (i.e., costs within each admission). While the Maryland system has largely (with the exception of the TPR hospitals) been a case-based system for more than 35 years, there is a belief that there is still opportunity to reduce cost per case. Additionally, having a cost per case system with relatively high marginal payments per case, along with having no overall per capita cost constraint, has likely limited the focus on achieving cost per case reductions.

One specific strategy that has been considered as a potential short-term priority is to develop a CMS-approved “gain sharing” model, similar to the one being administered through the New Jersey Hospital Association, under a Waiver with CMS. More detail on the New Jersey model can be found in Appendix II. An advantage is that CMS has already approved this model. However, the New Jersey version of this model is case-based and focuses on cost per admission, while the all-payer model is geared toward improving quality and reducing costs on a per-capita basis. If this type of approach is considered, participants should work together to gain approval from CMS to broaden the approval to include episode and/or population-based incentives. Thus, the model could begin to be operational based on what CMS has already approved, and could be expanded when CMS approves a broader model.

While there are hospitals in Maryland that have already participated in limited CMS approved gain sharing programs, the idea is that this would be a broader and more consistent program, with the MHA, MedChi, and the HSCRC working collaboratively to gain an approval in which all hospitals and their physicians (whether employed or not) can participate.

Case-based strategies would only incorporate hospital services that are included within each admission. One downside to case-based strategies is that they do not encourage the reduction of cases, and may continue to encourage an increase in cases, since in order for there to be savings to share, there needs to be a case.

Episode-Based Strategies:

Episode-based strategies could serve to reduce costs for episodes of care. With respect to the time dimension, the episode could, for example, be 30, 60 or 90 days, such as with the CMS Bundled Payments for Care Initiative (BPCI) program. With respect to the services dimension, episode-based strategies may or may not include various services that occur during the time period to which the bundle applies. For example, over the course of 90 days, there could be charges for readmissions, outpatient services, physicians, skilled nursing, home health, and other services. The Commission's Admission-Readmission Revenue (ARR) structure in which most hospitals have participated represents an episode-based approach.

Population-Based Strategies:

Population-based strategies would serve to reduce the total cost of care for the defined population. With respect to the time dimension, population based strategies encourage improving care 365 days per year, and would be fully aligned with the global budget model. Population-based methods we have considered include existing ACO approaches, expanded Maryland-specific ACO-like approaches, PCCM, Medicare Advantage, and payer / provider risk sharing agreements.

With respect to the services dimension, population-based strategies may include some or all services that occur throughout the year. For example, population-based strategies could include all hospital-based services, and may or may not include other services such as physician, skilled nursing, home health and other services.

Any population-based strategies should at least have the ability to cover all inpatient and outpatient hospital services, and may or may not include additional services. Since the current Waiver Test is hospital services only, and for reasons related to data collection, ease of implementation, and ability to gain CMS approval, it may be appropriate to begin with a hospital services only strategy, with a vision towards incorporating other services in the future, including for when the model is expected to change in year 6 to encompass Medicare covered services. If population-based models were implemented that focused on hospital services only, there would still be oversight related to potential cost-shifting, and the ability to address cost-shifting if that were to occur.

Focusing on Medicare, there are approximately 800,000 Maryland Medicare beneficiaries, including in the range of 150,000 Maryland Medicare beneficiaries that are attached to a Medicare payment model that is something other than strictly fee for service, including ACO, Medicare Advantage, and other Medicare Demos / Programs. So, while approximately 150,000 beneficiaries are in programs that have the incentive to manage volume, the vast majority of Medicare beneficiaries are in fee for service, with no one other than the hospital having the incentive to manage volume. Therefore, a top priority is to encourage globally budgeted hospitals to align with providers in a manner that will maximize care management approaches

for the approximately 650,000 Medicare beneficiaries that are in fee for service only, so that there are aligned incentives to reduce population based costs and improve quality.

Potential Options

Below are some initial potential options for consideration related to the strategies discussed above.

- Encourage the hospital industry and providers to consider ways to:
 - o share infrastructure, analytics, and other resources;
 - o improve public reporting; and/or
 - o make the practice of medicine less cumbersome for providers.
- Pursue the ability to expand chargemasters to bill fee for service for care management activities, within the global budgets
- Confirm with CMS the ability of Maryland hospitals to pursue pay-for-performance models, without additional regulatory approval. The industry has indicated that having the HSCRC receive confirmation of approval from the appropriate regulatory agencies would be more cost efficient and would provide the necessary comfort to move forward with these types of initiatives.
- The Maryland Hospital Association and MedChi work collaboratively to pursue a New Jersey type model that is modified to be consistent with the goals of the new all-payer model, with advocacy from the HSCRC.
- Consider pursuing a Maryland-specific ACO like option, which would require regulatory approval, and provide Maryland with increased flexibility in the development of a default model for beneficiaries not in ACOs, Medicare Advantage, or other CMS demonstration projects. More specifically, since hospitals are under global budgets, one method is to request extension of the ACO waivers in Maryland to be able to be used for all Medicare beneficiaries, since the global budgets provide hospitals with an ACO-like structure for all of their Medicare patients, not only patients that are in other already defined CMS programs. The general concept of this approach is to request that CMMI grant 5 specific ACO Waivers as a part of the Maryland All Payer Demonstration, and that the MHA, MedChi, and HSCRC would work collaboratively to create alignment models based on using those same Waivers granted to ACOs, including the ability to share savings.

Appendix I

Fee-For-Service Care Management Strategy

This strategy would support all the strategies below, including the case-based, episode-based, and population-based strategies. It is not meant to be a comprehensive strategy in and of itself, but it could go a long way in enabling hospitals and physicians to do care coordination and deliver better patient-centered care.

As opposed to other states, where a concern would be that adding the ability to bill for otherwise non-billable functions may result in “the woodwork effect,” or at least not be cost-effective, under Maryland’s global budget, there is no potential for this to cause increased costs. It would, however, allow hospitals to align revenue with costs, and, importantly, by attributing revenue to these activities, may make it easier to link these activities with hospital expenses. More specifically, it would make it so that, if a hospital reallocated some of its global budget to revenue attributable to care management functions, performed by physicians, nurses, NPs, pharmacists, social workers, etc., it could use the revenues to pay the persons involved in these activities, to properly match revenues and expenses.

Episode-Based Strategies

Under this structure, the bundles should at least cover all inpatient and outpatient hospital services, and may or may not include additional services. Since the current Waiver Test is on hospital services only, and for reasons related to data collection, there could be interest in starting with a hospital services only test, with a vision towards incorporating other services in the future. If this were to be the case, there would still be oversight related to potential cost-shifting, and the ability to address cost-shifting if that were to occur.

The CMS BPCI program covers all Medicare covered services. One option considered by the Work Group is to work with CMS to gain approval for a Maryland version of the BPCI program, since that Program is precluded in Maryland. This BPCI program is solely for hospitals on the Medicare IPPS payment system, which is the case for all states but Maryland. A Maryland version of BPCI would enable hospitals to work with physicians to reduce the cost of episodes of care, so it would have the potential to be broader in both time and services than case-based approaches. The CMS BPCI approach typically has 30, 60, and 90 day options. By focusing on episodes over the course of 30, 60, or 90 days, it would give hospitals and physicians the ability to work together to reduce readmissions and other post-acute costs, and invest in better health and better care, in the most cost-effective setting.

It is important to note that the BPCI program, and we would expect any Maryland version thereof, does not actually provide a bundled payment to the BPCI participant. The provider

services continue to be billed fee-for-service, and there is reconciliation. This is important because, for example, if hospitals and physicians worked together on a BPCI-like approach, the hospital and the physicians (and any post-acute providers) would continue to bill fee-for-service for their own services. The bundled aspect is that there would be reconciliation versus targets, and a sharing of savings based on the roll-up of the fee-for-service payments versus the targets.

Also, a BPCI-like approach may give hospitals and specialists the ability to target both medical and surgical conditions. It has been indicated that there is tremendous practice pattern variation regarding what types of surgeries are done inpatient versus outpatient, and a BPCI-like approach may help to create incentives to provide high quality care in the most cost effective setting.

Similar to with case-based strategies, a concern is that with episode-based models there needs to be an episode to generate the opportunity for shared savings, so there is not an incentive to avoid potentially preventable episodes.

To some extent, the HSCRC through its readmissions policies and the ARR program has already instituted an episode-based strategy, for which the services included are inpatient hospital services only. This program has shown that expanding the time horizon to include the incentive to reduce readmissions can be helpful in improving quality and reducing cost. Gaining authority from CMS to include episode-based alignment models as part of these programs may further help to reduce potentially avoidable volume.

Population-based Strategies

The Maryland global budget model makes it so that hospitals have an ACO-like incentive for all Medicare beneficiaries. Additionally, the federal regulations that set forth the basis of the ACO waivers specifically set forth that CMS envisions extending the same package of 5 Waivers to other CMMI Demos that encourage population health, which is the case with the Maryland global budget model. Therefore, it seems reasonable that CMMI would extend the ACO waivers to the Maryland All-Payer Demonstration, in order to align physicians and other providers with the success of the Global Budget model.

A key part of the difference between other states and Maryland, which highlights why CMS should grant the package of ACO-like Waivers to the Maryland Global Budget Model, is that in other states, ACOs are used to reduce volume, and the shared savings between the ACOs and CMS is to allow the ACOs to share in the savings from reduced volume. In Maryland, the CMS payments and the ability of hospitals to share in savings has already been predetermined, since the system is globally budgeted.

At the same time, while this Model would be an excellent starting point for persons not in other CMS structures like ACOs, Medicare Advantage, or other Demos, it would still not be completely aligned, since it would include only the regulated hospital dollars, and it would not incent reduction of total beneficiary costs, including the other Medicare covered services, such as

physician, skilled nursing, non-regulated outpatient, home health, etc. Therefore, the vision over time would be to expand the authority of this option to include other Medicare covered services, and/or to utilize more broad Medicare alignment structures, such as ACOs, Medicare Advantage, Dual Eligible Financial Alignment Demos, or other CMS Demos.

One dynamic that should be considered is whether in this proposed model, beneficiaries should be automatically assigned to a state-wide ACO and then the HSCRC and the industry would work on assignment rules to attribute the beneficiaries (including sharing based on percentages in shared service areas) across all the hospitals. We should consider whether the concept is to create the authority, and hospitals would have the option to participate, in which case would work with the HSCRC to determine which beneficiaries (and %s of beneficiaries) are assigned.

Within this model, the State would then seek CMS approval for defined shared savings programs that operate under the model. For example, there could be cross-cutting programs such as shared savings with primary care physicians similar to as with ACOs. Additionally, given the incentive for hospitals to reduce potentially avoidable volume, there could be physician alignment programs to improve quality and reduce avoidable volume with nephrologists for persons with ESRD, with endocrinologists for persons with diabetes, with cardiologists for persons with congestive heart failure, pulmonologists for persons with COPD, etc., similar to what is envisioned in current CMMI Demos targeted to work with specialty physicians.

Appendix II

Evidence on Physician Gain Sharing: An Overview of the New Jersey Model

In 2009, the New Jersey Hospital Association launched a physician gain sharing demonstration program at 12 hospitals, providing doctors with bonuses for saving the hospitals money when providing care to Medicare patients. The program included quality controls to protect patients, and three mechanisms to reduce costs: efficiency strategies, quality standards, and financial incentives.

In the first 18 months of the program, participating hospitals recognized \$38.6 million in cumulative savings, which equates to \$540, or 5.6 percent, per admission. The Centers for Medicare & Medicaid Service's (CMS) Bundled Payments for Care Improvement Initiative allows gain sharing that is based on the New Jersey demonstration. Model 1, an inpatient-only part of the CMS initiative, is a test of gain sharing.

CMS issued five criteria for gain sharing arrangements in the demonstration:

- Gain sharing must support care redesign to achieve improved quality and patient experience, and anticipated cost savings.
- Total incentive payments to an individual physician or non-physician practitioner must be limited to 50 percent of the aggregate annual Medicare payment amount determined under the Physician Fee Schedule.

- Incentive Payments must not be based on the volume or value of referrals, or business otherwise generated, between hospital and a physician or non-physician practitioner.
- Physician or non-physician practitioner participation in gain sharing must be voluntary.
- Individual physician and non-physician practitioners must meet quality thresholds and engage in quality improvement to be eligible to participate in gain sharing.

As noted above, the federal government has been careful about gain sharing, in part due to concerns about fraud and abuse laws, including the Civil Monetary Penalty Law, federal anti-kickback statutes, and federal physician self-referral (Stark) laws that address providers stinting on patient care or “cherry picking” healthier patients, and hospitals offering physicians bonuses that go beyond savings achieved, in order to generate physician loyalty and drive referrals. The Office of the Inspector General must approve physician gain sharing arrangements and, so far, has approved only those with a limited scope and only on a time-limited demonstration basis. New Jersey addressed these key concerns in its demonstration by operating within the parameters CMS outlined in its Bundled Payments for Care Improvement initiative.

The New Jersey program established broad guidelines for the redesign of patient care management, and quality monitoring and maintenance that complement the physician gain sharing methodology. This allowed hospital-based steering committees, which are at least 50 percent physicians, to work with medical staff, clinical departments, and hospital administrators to align provider interests and maximize the effectiveness of the gain sharing methodology.

The New Jersey program used the Applied Medical Software Performance Based Incentive System gain sharing methodology. During the first year, the maximum physician incentive was apportioned as one-third for performance and two-thirds for improvement. The total physician incentive was a combination of a surgical and medical incentive formula. Computations were performed at the case level for each admission. Descriptions of the incentive formulas follow:

Surgical Improvement: Measures a physician’s current performance compared with the prior year, adjusted for case mix and severity of illness

$$\frac{((\text{Prior Year Cost} - \text{Current Year Cost}) / (90\text{th Percentile of Patient Cost} - \text{Best Practice Norm}))}{(\text{Maximum Physician Incentive})}$$

Surgical/Medical Performance: Measures a physician’s resource utilization compared to their peers, adjusted for case mix and severity of illness.

$$\frac{((90\text{th Percentile of Patient Cost} - \text{Current Year Cost}) / (90\text{th Percentile of Patient Cost} - \text{Best Practice Norm}))}{(\text{Maximum Physician Incentive})}$$

The medical incentive payment used the same performance incentive formula as the surgical performance formula (described above) but used a revised medical improvement incentive formula.

Medical Improvement Incentive: Accounts for loss of physician income as a result of shorter lengths of stay

(Prior Year LOS – Current Year LOS) (Maximum Physician Incentive per Day)

As part of their participation in the Model 1 demonstration, hospitals were required to provide Medicare with discounted care. Medicare required a discount of 0.5 percent in the second six-months of Year 1, 1 percent in Year 2, and 2 percent in Year 3. To maintain the financial health of the hospital and ensure the sustainability of the program, steering committees could tie incentives to the achievement of a minimum economic threshold based on specific hospital needs.

In the future, a methodology will be developed to measure year-over-year improvement at the hospital level. The physician incentive payment will be tied to overall hospital performance to ensure that hospital financial condition is taken into consideration.

Participating hospitals had to realize sufficient improvement in performance to enable them to make incentive payments. Additionally, physician involvement could be expanded to add ancillary physicians and consultants to the program beginning in Year two on a voluntary basis.

Appendix III

Western Maryland Health System (see next page)



Western Maryland Health System

Pay for Performance CY2014

March 11, 2014

Background

- Western Maryland Health System (WMHS) is reimbursed under the Total Patient Revenue (TPR) model
- WMHS launched two Center of Excellence (CoE) programs (CHF and COPD) and a Diabetes Medical Home program
- These programs are designed to improve care delivery and care coordination for patients with chronic conditions, thus reducing acute exacerbations of the illness that require hospital care
- WMHS developed a Pay for Performance (P4P) methodology for primary care physicians who partner with WMHS to improve the care of selected patients with one of these three chronic conditions

Institute for Healthcare Improvement



THE PROBLEM:

- 50% of health care expenditures in the U.S. are spent on 5% of the population
- This includes individuals with chronic conditions, and often, multiple medical and social needs
- Many of the needs are not complicated, but they are numerous and many are outside the scope of traditional health care service delivery

THE OPPORTUNITY

- Focus efforts on individuals with chronic conditions and/or multiple health and social needs
- Use care coordination, including patient navigators, community health workers, care managers and transition coaches
- Providers may be aware of patients' needs but not have the staff or capacity to meet those needs
- Payment structures in the health care system remain misaligned to deliver coordinated services and connect individuals with crucial supports

Targeted enrollment is critical to success

Chronic Disease Management: Evidence of Predictable Savings. Health Management Associates, 2008.

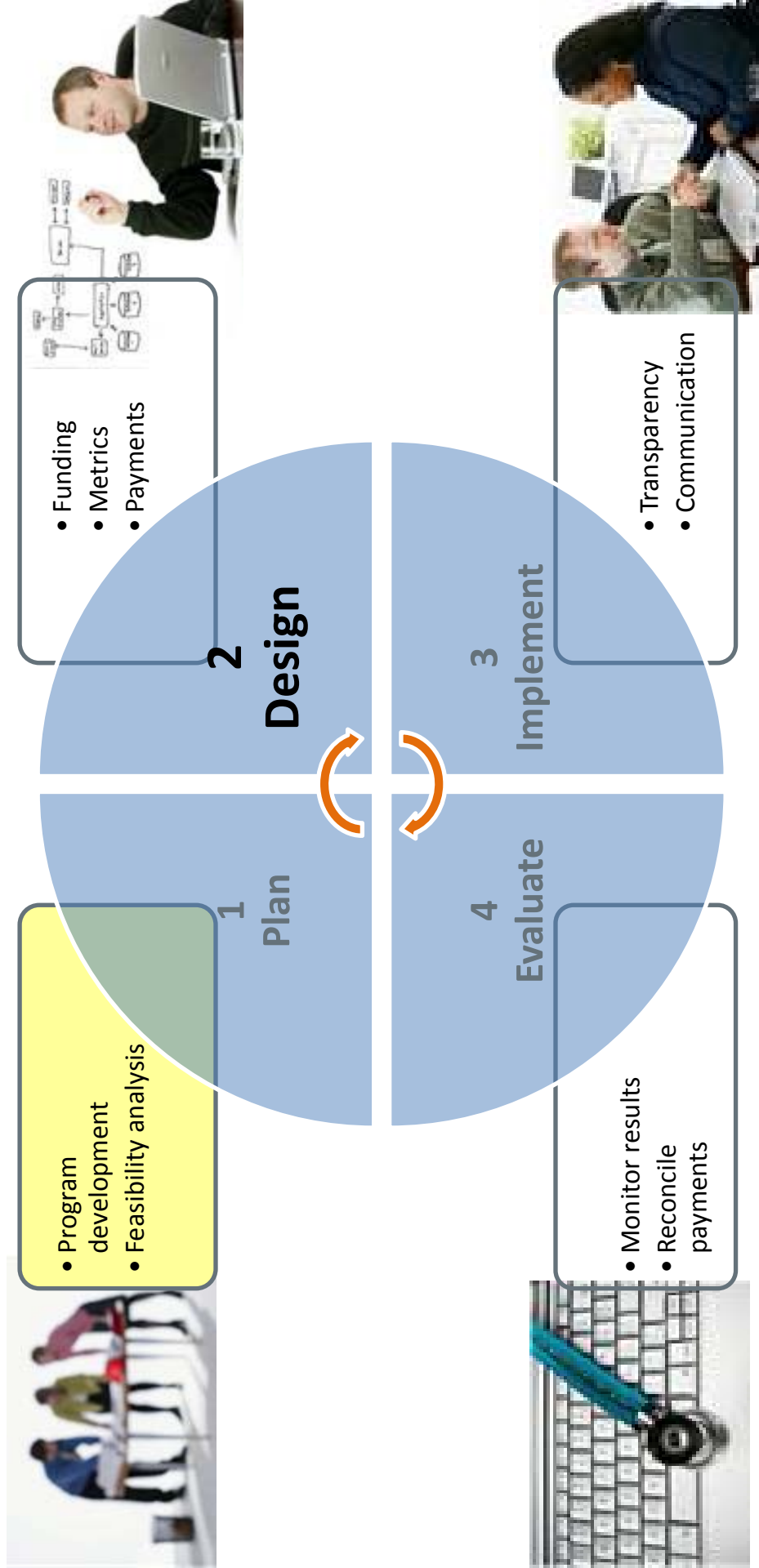
- “Targeting patients according to predictors of continued high utilization (e.g. recent hospitalization, frequent emergency room (ER) use, certain clinical indicators) substantially enhances the opportunity for savings.”
- “Successful interventions include:
 - Targeting interventions to sicker patients who are likely to generate high costs in the future
 - Intensive time spent with the patient . . . , frequency of contact, face-to-face patient contact, early access to physicians, and sustained follow-up
 - Use of multi-disciplinary teams to provide support across multiple interventions, e.g. dietary, pharmaceutical, social service support, education, self-management, early symptom spotting and access to physicians to prevent exacerbations
 - Telephonic interventions that initially are time-intensive and frequent”

Effective Interventions to Reduce Rehospitalization.

Institute for Healthcare Improvement/Commonwealth Fund, 2009.

- Project RED intervention was most effective for patients with higher rates of hospital utilization in the preceding 6 months.
- In the Commonwealth Care Alliance clinic for Medicaid patients a subgroup of enrollees with higher costs demonstrated cost decreases from \$9,400 to \$2,500 due to decreased utilization of hospital-based services.
- Kaiser Permanente chronic care coordination program sets eligibility criteria based on one or more of the following, and demonstrated reductions in hospital and ED use of about \$1,900 per patient per year
 - Four or more chronic illnesses;
 - Recent hospitalization;
 - High utilization of the emergency department;
 - Recently discharged from a skilled nursing facility (SNF).

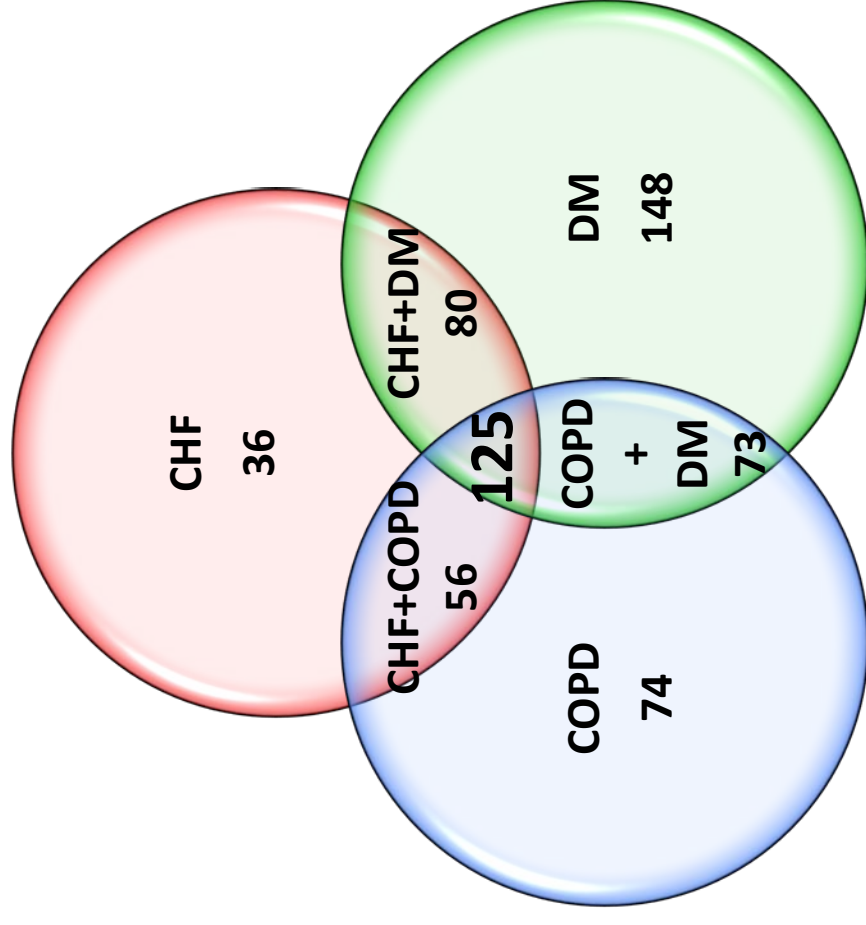
Process





Population Analysis

- 14,330 patients with CHF, COPD and/or diabetes
- 592 frequent fliers¹ (4% of population) drove 12% of costs
 - 258 (44%) have 1 condition
 - 209 (35%) have 2 conditions
 - 125 (21%) have 3 conditions
- Substantial overlap in the reasons these patients are admitted to the hospital
- 796 admissions for chronic Prevention Quality Indicators (PQIs) in all patients with CHF, COPD and/or diabetes
- 328 chronic PQI admissions within frequent flier population



¹ “Frequent fliers” are patients with 3 or more admissions to WMHS for any condition in CY2012



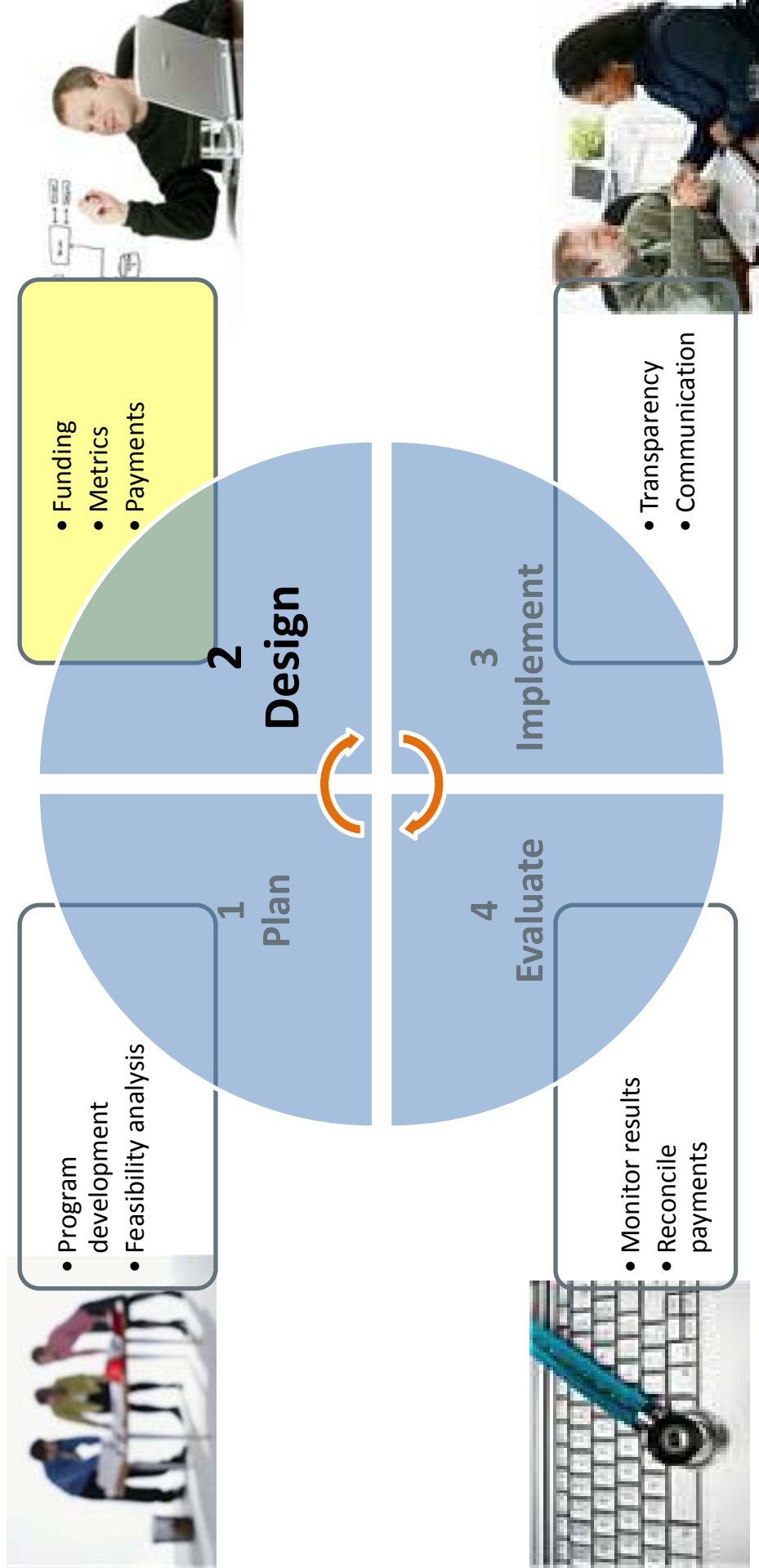
Prevention Quality Indicators

Prevention Quality Indicators (PQIs) are developed and maintained by the **Agency for Healthcare Research and Quality** and are a **measure of the availability and effectiveness of community-based care**

- WMHS's composite score for chronic PQIs is 36% higher than the U.S. average , although it is in line with the average for the lowest quartile income population
- Within the chronic PQIs, significant opportunities exist in CHF and COPD
- WMHS's pneumonia admission rate is 62% higher than the U.S. average for the lowest quartile income population

PQI Description	Numerator Dec201212 Nov2013	Denominator	Admission Rate	Per 100K Population			
				WMHS	U.S.	U.S. Lowest Quartile Income	% Diff WMHS vs U.S. Lowest Income
PQI #1 Diabetes Short-Term Complications	68	60,657	0.1%	112	69	109	3%
PQI #3 Diabetes Long-Term Complications	107	60,657	0.2%	176	116	179	-1%
PQI #5 COPD or Asthma in Older Adults	273	38,754	0.5%	450	213	332	35%
PQI #7 Hypertension	60	60,657	0.1%	99	62	101	-2%
PQI #8 Heart Failure	255	60,657	0.6%	420	332	448	27%
PQI #13 Angina Without Procedure	10	60,657	0.0%	16	19	29	-43%
PQI #14 Uncontrolled Diabetes	8	60,657	0.0%	13	19	35	-62%
PQI #15 Asthma in Younger Adults	8	21,903	0.0%	13	119	194	-93%
PQI #16 Lower-Extremity Amputation among Patients with Diabetes	12	60,657	0.0%	20	33	52	-62%
PQI #92 Prevention Quality Chronic Composite	796	60,657	1.5%	1,313	963	1,433	-8%
PQI #11 Bacterial Pneumonia Admission Rate	384	60,657	0.6%	633	296	390	62%

Process

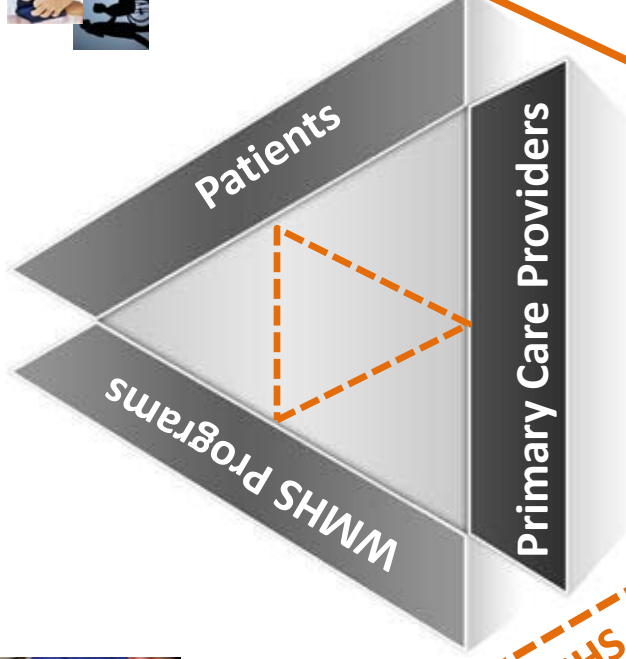


Patient-centered Care

WMHS provides direct care, education and care coordination to patients without PCPs



WMHS - Patient



WMHS provides
direct care,
education and/or
care coordination
to patients
referred by PCPs

Physicians provide
frequent,
comprehensive
care to target
population



Funding

- Funding methodology
- Funding levels

Metrics

- Types of measures, e.g., outcomes, processes, satisfaction
- Patient population(s), e.g., all, frequent fliers only
- Relative or absolute thresholds, i.e., progress or experience

Payments

- Provider eligibility, e.g., PCPs, specialists
- Per physician vs per capita
- All or nothing vs prorated per measure



Funding Methodology

- Prefund the P4P payment pool with approximately \$400,000

#	Admissions	Charges	Costs	Funding
	72	\$845,055	\$507,033	\$253,517
	35	\$438,607	\$263,164	\$131,582
	106	\$1,283,663	\$770,198	\$385,099
Potential Annual Payment Per Unique Frequent Flier				\$651

- If PQIs are reduced by up to 17%, additional funding will be available

#	Admissions	Charges	Costs	Funding
	135	\$1,596,216	\$957,729	\$478,865
	65	\$828,481	\$497,088	\$248,544
	201	\$2,424,696	\$1,454,818	\$727,409
Potential Annual Payment Per Unique Frequent Flier				\$1,229 ¹

¹ In 2009, CMS launched a pilot program for advanced medical home services which paid up to \$100 PMPM (\$1,200 PMPY) for full care management services for the most at-risk patients). <http://www.healthleadersmedia.com/HOM-224120-4625/CMS-unveils-two-tier-medical-home-care-management-fee>

Payment Distribution Methodology

1: Measure reduction in PQIs and fund pool with dollars associated with percent reduction

2: Adjust maximum available payment per patient based on presence of one, two or all three chronic conditions

3: Measure patient- and condition-specific metrics

4: Calculate actual payment per patient

Payment Distribution Step 1

1: Measure reduction in PQIs and fund pool with dollars associated with percent reduction

Percent Reduction	Chronic PQIs	Pneumonia PQI	Total
9%	\$ 428	\$ 222	\$ 651
10%	\$ 476	\$ 247	\$ 723
11%	\$ 523	\$ 272	\$ 795
12%	\$ 571	\$ 296	\$ 867
13%	\$ 619	\$ 321	\$ 940
14%	\$ 666	\$ 346	\$ 1,012
15%	\$ 714	\$ 370	\$ 1,084
16%	\$ 761	\$ 395	\$ 1,156
17%	\$ 809	\$ 420	\$ 1,229

Payment Distribution Step 2

2: Adjust maximum available payment per patient based on presence of one, two or all three chronic conditions

- Use Hierarchical Condition Categories (HCC) risk adjustment methodology to calculate the risk score for each patient
- Aggregate scores for patients with one, two or all three conditions
- Calculate median HCC score for each patient subgroup
- Apply payment variation weights to maximum per patient weights

Average HCC Weight **# of Conditions** **Payment Variation**

39% lower



22% higher

1

2

3

11% lower



20% higher

Payment Distribution Step 3

3: Measure patient- and condition-specific metrics

- Additional metrics¹ for all patients include:
 - Evidence of pneumonia vaccine (and booster 5 years later if applicable)
 - Interval (days) between hospital discharge and PCP visit
 - Within 7 days – 100%
 - Within 2 weeks – 50%
 - Medication reconciliation performed and documented during post-discharge PCP visit – Yes/No
- Condition-specific metrics are:
 - Diabetes - Hgb A1C < 8.0%
 - CHF – ACE or ARB for LVEF < 40%
 - COPD - spirometry results documented

¹ Metrics are based on measures endorsed by the National Quality Forum and WMHS policy. Pneumonia vaccination and medication reconciliation are used in ACO evaluation, PCP follow up visit within 7 days is WMHS standard and within 2 weeks is a Project RED recommendation

² HgbA1C is part of the ACO evaluation metrics. ACE/ARB for CHF and spirometry for COPD are both endorsed by the AMA

Payment Distribution Step 4

4: Calculate actual payment per patient

Sample scorecard for 100% scores but different risk categories

Measure	Category 1		Category 2		Category 3	
	Patient	Score	Patient	Score	Patient	Score
Pneumonia vaccine	Yes	1	Yes	1	Yes	1
Post-discharge follow up	Yes	1	Yes	1	Yes	1
Post-discharge med reconciliation	Yes	1	Yes	1	Yes	1
Hgb A1C	N/A		N/A		Yes	1
ACE or ARB therapy	N/A		Yes	1	Yes	1
Spirometry results documented	Yes	1	Yes	1	Yes	1

Score
Possible Score
Percent
Total Available Distribution/Patient
Payment

4
4
100%
\$586
\$586

5
5
100%
\$651
\$651

6
6
100%
\$781
\$781

Payment Distribution Step 4

4: Calculate actual payment per patient

Sample scorecard different patient scores but same risk category

Measure	Category 2 Patient	Score	Category 2 Patient	Score	Category 2 Patient	Score
Pneumonia vaccine	Yes	1	Yes	1	Yes	1
Post-discharge follow up	Yes	1	Within 8-14 Days	0.5	No	0
Post-discharge med reconciliation	Yes	1	No	0	No	0
Hgb A1C	N/A		N/A		N/A	
ACE or ARB therapy	Yes	1	Yes	1	Yes	1
Spirometry results documented	Yes	1	Yes	1	Yes	1

Score
Possible Score
Percent
Total Available Distribution/Patient
Payment

5
5
100%
\$651
\$651

3.5
5
70%
\$651
\$456

3
5
60%
\$651
\$391