

FINAL: 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 final 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.

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

Executive Summary

Purpose

The purpose of this draft report is to provide the HSCRC with the Workgroup's suggestions on how to prioritize the development and implementation of a full range of strategies to better align hospitals, physicians and other health care providers to achieve the goals of the new All-Payer Model. While alignment will involve strategies to be employed by providers, payers, and other stakeholders, this report focuses on what the State and Commission could do as a regulator, facilitator and catalyst to promote alignment of strategies between hospitals and other health care providers.

Recommendations are intended to provide direction, recognizing that the HSCRC's role in implementation will vary, resources will be required for planning and implementation, and additional details will need to be fleshed out. The new All-Payer Model and hospitals' global budgets have changed the incentives in the Maryland system to encourage meeting the goals of the Three-Part Aim--better care, better health, and lower cost. The report is prescriptive in recommending that the HSCRC and State should work to obtain federal waivers and address State legal barriers that enable alignment under the new model. In other recommendations, the role of the HSCRC will be to encourage and work with the hospitals, physicians, and other providers to create and utilize alignment models and care management activities to improve the delivery of care..

The Issue

Under the new All-Payer approach, hospitals are moving to global budget arrangements to facilitate achieving the goals of the new Model. Changes will need to be made to improve alignment with physicians and other providers. In most instances, physicians and other health care providers are paid on a fee-for-service basis. Moreover, a substantial percentage of physicians are employed by or contracted with hospitals using approaches that will need to be adjusted. In order to reach the goals of the new All-Payer Model, there needs to be some harmonization of incentives and increased integration of care. There are various aspects of this harmonization where the HSCRC may play a role. The potential strategies are both compensatory and non-compensatory. Below is a list of some of some of the potential alignment strategies:

- Non-Compensatory
 - Shared infrastructure, analytics and other resources;
 - Better health care quality and cost reporting;
 - Investment to improve ease of practice, such as care management support.
- Compensatory
 - Pay for Performance
 - Gain Sharing
 - Shared Savings
 - A continuum of case-based, episode-based, and population based models

Some of these strategies face legal barriers that would first need to be addressed including State and federal Stark laws, the Anti-Kickback Statute, the False Claims Act, the Civil Monetary Penalty Act, antitrust limitations, IRS limitations on charitable hospitals, and State insurance law restrictions.

Opportunities

Medical care for Medicare enrollees is largely unmanaged even though they require more acute and chronic care services and are often less able than younger persons to access and manage their own health and care needs. Medicare offers the greatest opportunity for improvement in the quality and cost goals of the All-Payer model. Therefore, ACO's, Integrated Shared Savings Organizations (ISSOs), PCMH's, and other similar models could be most effective for this population. As these models are developed, it would be most useful to establish a baseline of agreed upon principles, standards, and language to facilitate compatible efforts with measureable outcomes. Ideally, the models would create financial incentives and incorporate evidence-based strategies that would gain support among payers, hospitals, physicians and other providers and would promote efficient, high quality, patient centric, medical services.

Goals and Desirable Features

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

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
- Promote aligned incentives to improve the overall health of the entire population, including hospital and non-hospital-based health care services
- Encourage the development of programs and services that keep stride with the national trend of movement from a volume based provider centric system to a value based consumer centric system
- Strive to engage all payers in the incentive and alignment programs

Desirable Features

- Alignment
 - Attention of different providers is focused on strategies that are most likely to help meet the All-Payer and Medicare savings requirements of the new model.
 - The models are tailored to specific health care provider roles, and recognize that significant differences exist among primary care physicians and specialists, independent and hospital-owned practices, and physicians and other health care providers in terms of their goals, capabilities, resources and other characteristics.
 - The models reward value, and take into consideration in the development of rewards, both higher existing levels of value, as well as, value improvement.

- In order to have the greatest impact, staging of models is based on opportunities that are possible today under the current regulatory environment, while working to remove barriers to enable broader population-based approaches.
 - To the extent practicable, savings are targeted to those who have produced the savings.
- Engagement
 - Physicians are provided an active role in developing and refining alignment strategies related to the All-Payer Model.
 - Health care consumers are engaged in the alignment process across all segments of the health care industry.
 - Hospitals and physicians are invited to participate on a voluntary basis.
 - Physicians are sufficiently incentivized to commit time and effort to improving quality and lowering cost.
 - Awareness
 - Education is available to ensure all stakeholders understand the existence and incentives of the new Triple Aim-focused model.
 - Transparency
 - Data are presented in a timely and actionable form.
 - Metrics are clear in purpose and meaning and, to the extent practicable, understood in advance by the providers to which they apply.
 - Accountability is required from providers and payers.
 - Scalability
 - Strategies are simple in design and replicable.
 - Hospitals and physicians have sufficient support for the infrastructure investments needed to succeed under new alignment strategies.
 - All payers and hospitals/systems are permitted and encouraged 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 unnecessary duplication and fragmentation are reduced.
 - The regulatory, legal and administrative environments prudently encourage innovation under the All-Payer Model.
 - Hospital payment models and alignment models should aim for consistency and predictability, to encourage participation, investment, and sustainability.
 - Sustainability ultimately rests on the ability to improve the overall health of the citizens of Maryland. All programs should be evaluated through the effectiveness of this overarching goal.

Potential Options

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

- The HSCRC could serve as a catalyst to encourage the hospital industry, physicians, and other providers to consider ways to:
 - share infrastructure, analytics, and other resources;
 - improve reporting between and for hospitals and providers;
 - make the practice of medicine more efficient for providers; and
 - promote broad awareness of the objectives of the new model financial incentives promoting it and the various types of programs designed to support it.

- HSCRC serve as catalyst for hospitals, physicians, and other providers to work collaboratively toward models that are consistent with the goals of the Three-Part Aim and the new All-Payer Model.

- HSCRC should work with the field to pursue confirming with CMS/OIG (and/or other appropriate regulatory bodies) the ability of Maryland hospitals to pursue pay-for-performance models, without additional regulatory approval.

- The Maryland Hospital Association and MedChi work collaboratively to pursue a New Jersey type physician incentive model that is modified to be consistent with the goals of the new All-Payer Model (with input and advocacy from the HSCRC).

- HSCRC should work with the State and key stakeholders to pursue a Maryland-specific ACO-like or Integrated Share Savings Organization (ISSO) option, which would require infrastructure development and 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.

- HSCRC should serve as catalyst for encouraging and expanding alignment models across all payers, and consistency regarding incentives, including working with stakeholders to determine if legislative or regulatory changes are necessary to achieve the options above and to sponsor or promote those changes, as appropriate.

- HSCRC should serve as catalyst for encouraging models that are possible today (e.g., Primary Care Medical Homes, pay for performance enhancements to fee-for-service, and changes in salary models), while pursuing broader population-based models (e.g., ISSO) that require regulatory approvals and additional infrastructure development.

Maryland could use a staged combination of strategies, including a gain sharing strategy (New Jersey-type model) that could be implemented relatively quickly and target inpatient hospital costs per case (and may be expanded to include episode costs), while the State works in collaboration with the field to further develop details of an ISSO methodology and to receive regulatory approvals for broader population-based shared savings strategies.

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 on per capita total hospital costs, and eventually on total per capita health care costs. HSCRC recognizes that in order to reach this goal on a sustainable basis the overall health of the citizens of the State of Maryland must be addressed and improved. This goal cannot be achieved exclusively through measures addressing hospital payments without the inclusion and effective engagement of the entire health care delivery system in the state. For these reasons, it is important that physicians and other providers 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 better align hospitals, physicians and other health care providers to achieve the goals of the new All-Payer Model. Note that throughout the report, references to physician alignment are intended to include alignment with other providers, including physician extenders and other allied health professionals. A future report of the Workgroup will focus more explicitly on Care Improvement Opportunities, and the Alignment and Engagement strategies will 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, as well as the Maryland Multi-Payer PCMH Program (MMPP). 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, improve the experience of care, and reduce costs.

During the last several years, the HSCRC's payment reform focused on reducing readmissions and hospital 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 to achieve continued 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 success of the all-payer model. The HSCRC and hospitals must focus on developing resources that address these barriers and remove obstacles that prevent collaboration. 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 will suggest ways to 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 typically paid on a fee-for-service basis. Several approaches have been raised to address this concern, including financial alignment strategies. Financial alignment strategies considered by the Work Group have included gain sharing, pay-for-performance and shared savings models that redistribute resources from hospitals to other providers, to help align standards and interests to improve quality and reduce costs.

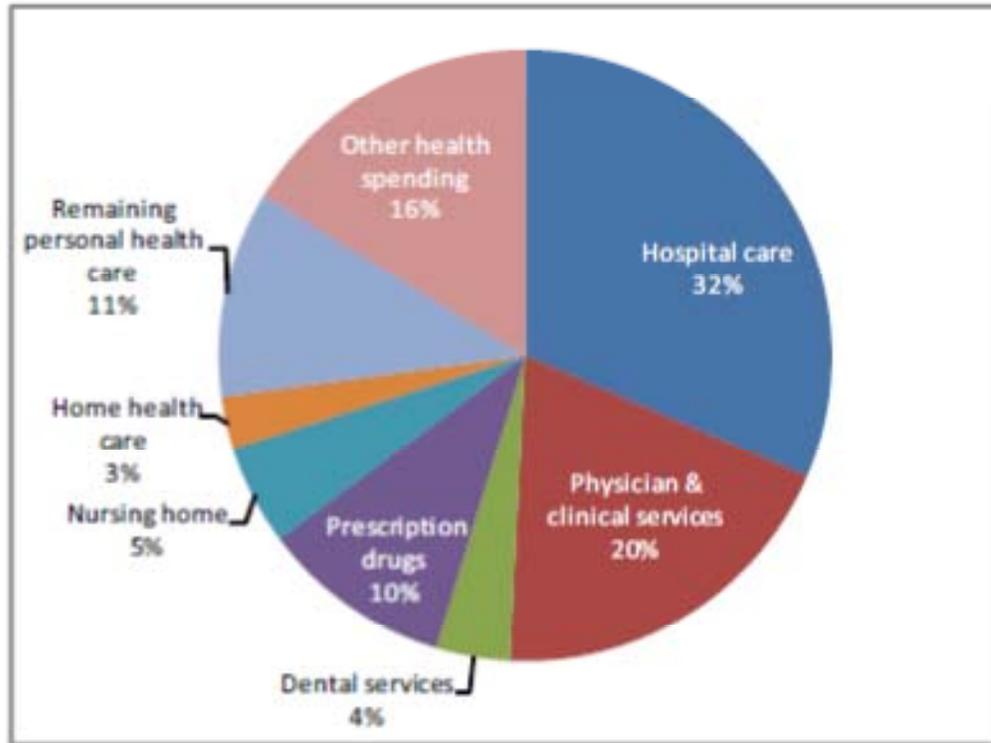
Gain sharing is a term that is used to describe arrangements between hospitals and physicians whereby the hospital agrees to share with the physicians any reduction in the hospital's costs for patient care attributable in part to the efforts of the physician. Pay for Performance is a model that rewards or penalizes physicians or other healthcare providers for meeting or not meeting certain predetermined performance measures for quality and efficiency. The basic concept behind shared savings is that if a healthcare system or provider reduces total healthcare spending for its patients below the level that the payer (e.g., Medicare or a private health insurance plan) would have otherwise expected, the provider is rewarded with a portion of the savings. The result is that the payer still spends less than it would have otherwise, and the provider gets more revenue than it would have otherwise expected. As one can glean from these descriptions, there is overlap in the concepts and also potential for variation on these themes. Appendix I provides a comparison between gain sharing and shared savings.

Another financial alignment strategy considered is to work towards physicians being paid less based upon fee for service, and more based upon quality and value. Since a substantial percentage of physicians are employed by or contracted with hospitals and health systems, and their compensation is based upon their employment/contractual agreements, another financial alignment would be for hospitals and health systems to revise the employment and contractual agreements to be more consistent with the goals of the all-payer model.

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

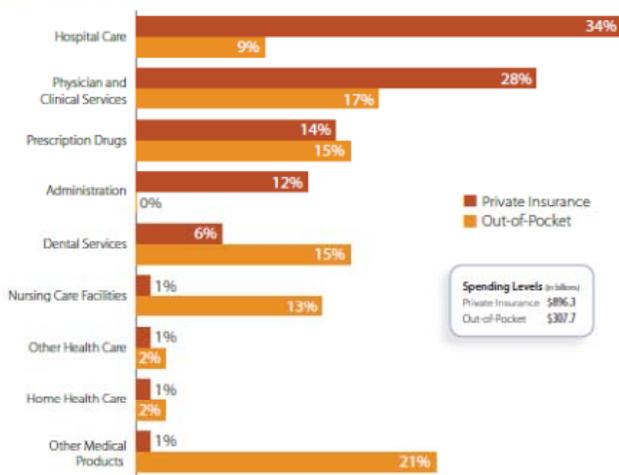
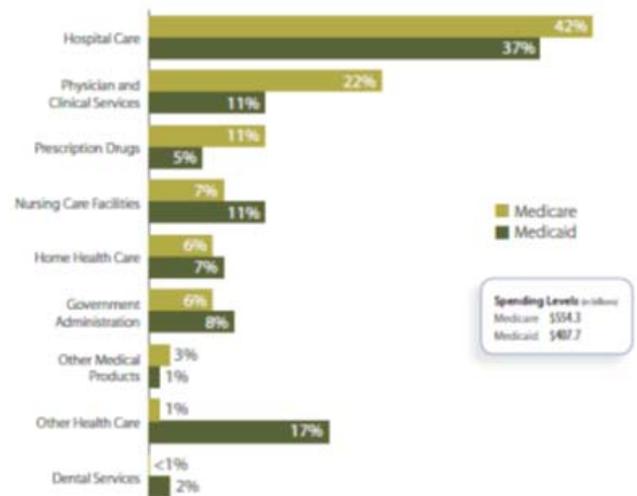


Figure 3

Spending Distribution, Medicare vs. Medicaid United States, 2011



In developing alignment models, it will be important to consider the appropriate funds that may be able to be shared in order to improve quality, and reduce cost and practice variation. This consideration will involve looking at care on a program-by-program basis, what physicians and other providers are involved in the particular clinical conditions targeted, and to look at the costs and potential savings for the program, and with whom savings may be shared.

The workgroup has also considered non-compensatory alignment strategies, including shared infrastructure, analytics and other resources, better health care quality and cost reporting, and investments in areas that improve the ease of practice, such as care management support.

This paper will consider both gainsharing and shared savings models, where Phase 1 of the shared savings model will be calculated only from regulated hospital inpatient and outpatient costs. This has implications in terms of the amount that may be saved. Comprehensive ACO-like structures, bundled payment structures, or Medicare Advantage may be necessary to more fully align the delivery system and provide the ability to better understand non-hospital savings.

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 increase the volume of services provided, and had little incentive to reduce cost per case

Opportunities

Under the new Global Budget model and the established quality targets, for hospitals that are under a global budget (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 develop more robust and inclusive systems that improve the quality of care, improve the experience of care, and reduce the overall per capita cost of care particularly as it relates to hospital services.

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, many commercial payers invest in care management activities and in some cases are working collaboratively with hospitals and physicians to improve care, albeit many of the activities and metrics can vary from payer to payer. However, 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 from the Global Budget Model and aligned incentives are Medicare patients because there is no payer already doing the care management 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 or contracted 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 or contracted versus community-based physicians varies substantially, with a strong and growing trend toward hospitalists and other hospital employed/contracted providers responsible for the care of inpatients. 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. Appendix II provides data from the Maryland Board of

Physicians License Renewal Data on the amount and distribution of physicians in Maryland, by geography, and primary versus specialty care.

Overall, Maryland does not have a preponderance of independent, large multi-specialty groups, though some do exist, and in some geographic areas of the state (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 type of groups in existence has implications for the ability to implement alignment models. For example, if community-based primary care is provided by either hospital employed providers or spread out in small practices, and community-based specialty care is provided by independent groups that spread across multiple community hospitals, there will be 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 Demonstration Model 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 fee-for-service 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 relatively low penetration in Maryland and represents another 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.

The increase in PCMHs, ACOs, and other innovative care models serves as a basis to grow and a template to implement additional 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). With the new financial and quality tests contained within the new waiver and the gravitation to global budget models, hospitals also now have an incentive to implement alignment models that encourage population health.

As these models are developed it is important to establish a baseline of agreed upon principles, standards, and language to facilitate a coordinated effort with measureable outcomes. In order to accomplish this goal there must be multi-payer, hospital, and provider agreement. There should be evidence-based incentives across alignment programs, so that hospitals, physicians, and other providers have consistent incentives to coordinate and provide care in the high quality, patient centric, and 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 all payers are still fee-for-service with limited (e.g., at most 5%) 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.

Small practices and solo physicians are compensated by payers using fee-for-service approaches, with varying but typically small bonus increments for quality measures. These providers achieve their incomes as a net of revenue less practice expenses.

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

Fee-for-Service:

Through this method, 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 billings and collections and allows the practice to cover operating costs, and share in additional revenues beyond the threshold. It also creates a disincentive to treat uninsured or underinsured patients.

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 and typically represent just a small portion of the incentive. 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, this method reflects work effort of the provider independent of collections.

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." . The Stark Law applies to designated health services, and prohibits reimbursement of any kind between a hospital and physicians who refer to or at the hospital except for permitted arrangements, the most common of which are employment, independent contractor services and rental arrangements. 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 provides physicians an incentive to increase the volume of services. There is little or no incentive to provide incremental improvements in population health, reduce unnecessary admissions, improve measures of quality, or improve the experience of care for patients. In fact, any investment by the physician in these activities is an uncompensated expenditure of time, money, and resources.

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
- Promote aligned incentives to improve the overall health of the entire population, including hospital and non-hospital-based health care services
- Encourage the development of programs and services that keep stride with the national trend of movement from a volume based provider centric system to a value based consumer centric system
- Strive to engage all payers in the incentive and alignment programs

Desirable Features

- Alignment
 - Attention of different providers is focused on strategies that are most likely to help meet the All-Payer and Medicare savings requirements of the new model.
 - The models are tailored to specific health care provider roles, and recognize that significant differences exist among primary care physicians and specialists, independent and hospital-owned practices, and physicians and other health care providers in terms of their goals, capabilities, resources and other characteristics.
 - The models reward value, and take into consideration in the development of rewards, both higher existing levels of value, as well as, value improvement.
 - In order to have the greatest impact, staging of models is based on opportunities that are possible today under the current regulatory environment, while working to remove barriers to enable broader population-based approaches.
 - To the extent practicable, savings are targeted to those who have produced the savings.

- 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 invited to participate on a voluntary basis.
 - Physicians are sufficiently incentivized to commit time and effort to improving quality and lowering cost.

- Awareness
 - Education is available to ensure all stakeholders understand the existence and incentives of the new Triple Aim-focused model.

- Transparency
 - Data are presented in a timely and actionable form.
 - Metrics are clear in purpose and meaning and, to the extent practicable, understood in advance by the providers to which they apply.
 - Accountability is required from providers and payers.

- Scalability
 - Strategies are simple in design and replicable.
 - Hospitals and physicians have sufficient support for the infrastructure investments needed to succeed under new alignment strategies.
 - All payers and hospitals / systems are permitted and encouraged 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 unnecessary duplication and fragmentation are reduced.
 - The regulatory, legal and administrative environments prudently encourage innovation under the All-Payer Model.
 - Hospital payment models and alignment models should aim for consistency and predictability, to encourage participation, investment, and sustainability.
 - Sustainability ultimately rests on the ability to improve the overall health of the citizens of Maryland. All programs should be evaluated through the effectiveness of this overarching goal.

Integration with other HSCRC New Model Workgroups, and other Initiatives

The Physician Alignment and Engagement Workgroup has been coordinating with the other HSCRC modernization workgroups.

In addition to HSCRC work groups, there are other agencies and organizations with which the Work Group has been coordinating, including the Maryland Hospital Association's (MHA) Care Transitions Steering Committee and its Clinical Leadership Subcommittee, and the Department of Health and Mental Hygiene's State Innovation Model initiative. The Commission and the Work Group should 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 barriers to implementing the necessary health care reforms for the success of the All-Payer Model.

Payment models in this country do not encourage physicians to provide co-operative treatment and to reduce utilization. On the contrary, the fee-for-service payment system dictates that the physician attempt to provide more service units and in less time/unit. If we could tie the physician financially into the risk/benefit of utilization control strategies to change the status quo in favor of a new approach that would allow the physician to share in the savings to cover the increased costs of providing this unreimbursed care, the concept of effective and comprehensive population based health would receive a significant boost. Unfortunately, there is a plethora of laws that impede the achievement of this objective. The major regulatory impediments include: state and federal Stark, Anti-Kickback Statute, False Claims Act, Civil Monetary Penalty Act, antitrust limitations, IRS limitations on charitable hospitals, state insurance law restrictions, the high cost of creating, maintaining, and managing an effective statewide electronic health record system, lack of effective controls on defensive medicine costs, difficulty of implementing effective clinical guidelines, capturing all the necessary data needed under the new Model, HIPAA concerns, and the oftentimes uncoordinated regulatory structures in place.

The Secretary of DHHS was given authority to grant waivers from the reach of at least some of these impediments for programs under the Center for Medicare and Medicaid Innovation (CMMI) (see the list below) , and the State reserved the right in the Model agreement to pursue this avenue. Waivers are absolutely necessary to permit a hospital-physician relationship of any size and complexity to succeed. ACOs have already been granted a number of these waivers in order to function, and the State can seek to follow this path. Similarly, the Federal Trade Commission has provided limited anti-trust protection for ACOs and has long established standards to permit clinically integrated networks of hospitals and physicians to work together to reduce costs for privately insured patients. The IRS has issued guidance on ACOs which provides protection to ACOs and participating charitable hospitals that are structured in accordance with that guidance. Thus, it would seem incumbent on the State, acting through the

HSCRC in cooperation with the MHA, Med-Chi, and the state's insurers to seek exceptions from CMS in order to gain as much opportunity to match the needs of physicians and hospitals and other providers as possible. The HSCRC should also continue in its attempts to get the data necessary to make population based health care succeed.

On the State level, there is opportunity for change. Since the various state health-related regulatory agencies typically operate under different agendas with different goals, it would be worthwhile to explore a consolidated approach whereby the State could create a single point of review and approval of health care proposals intended to provide population-based health. This unified approval process would involve the Maryland Insurance Administration, the MHCC, CRISP, State Medical Records Provisions, licensing boards, OHCQ, Medicaid, and the HSCRC. Other issues incumbent upon the State to consider include legislative barriers such as the Maryland version of the Stark Law, the high cost of drugs and supplies, data collection, information sharing and predictive analytics, involving the patient, medical malpractice relief and practice guidelines, clinically integrated networks and the exchange of information. Please see Appendix III for a more complete explanation.

The five waivers available to ACOs are intended to protect bona fide ACO investment, start-up, operating and other arrangements that are intended to carry out the Shared Savings Program and include:

1. An "ACO pre-participation" waiver of the Physician Self-Referral Law (Stark), the Federal anti-kickback statute (AKS), and the Gainsharing Civil Monetary Penalty (CMP) that applies to ACO-related start-up arrangements in anticipation of participating in the Shared Savings Program, subject to certain limitations on the duration of the waiver and the types of parties covered;
 2. An "ACO participation" waiver of the Stark Law, AKS, and the Gainsharing CMP that applies broadly to ACO-related arrangements during the term of the ACO's participation agreement under the Shared Savings Program and for a specified time thereafter;
 3. A "shared savings distributions" waiver of the Stark Law, AKS, and the Gainsharing CMP that applies to distributions and uses of shared savings payments earned under the Shared Savings Program;
 4. A waiver of the AKS, and the Gainsharing CMP for ACO arrangements that implicate Stark but meet an existing Stark exception; and
 5. A "patient incentive" waiver of the Beneficiary Inducements CMP and AKS for medically related incentives offered by ACOs under the Shared Savings Program to beneficiaries to encourage preventive care and compliance with treatment regimes.
- The four waivers applicable to ACOs are good as long as the ACO has a participation agreement and remains in good standing under its agreement.

- The pre-participation waiver was intended to protect a wide variety of expenditures that an entity would need while it was in the process of start-up operations prior to its start date.

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-compensatory and compensatory 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, short-term consideration should be focused on those areas that are within the Commission's existing purview to promote alignment. In addition, many of the non-compensatory strategies can be done within the industry without obtaining federal approval.

Non-Compensatory Incentives to Physicians

Non-compensatory alignment strategies such as sharing of infrastructure, analytics and other resources; better health care quality and cost reporting; promotion of ease of practice; and, promoting awareness and education about the existence and incentives of the new model; should be seriously considered and in many cases can be instituted without additional regulatory approval.

One non-compensatory strategy that has been suggested is to expand the use of data to encourage population health, evidence-based approaches to better understand practice variation. “Choosing Wisely,” is one strategy that has been discussed which is an approach designed to spark conversations between providers and patients to ensure that the right care is delivered at the right time. Participating organizations have created lists of “Things Providers and Patients Should Question” which include evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on a patients’ individual situation. Providing access to timely actionable information in a convenient format, and highlighting variation in performance and outcomes, can improve the quality of care, reduce costs and mitigate practice variation.

Another non-compensatory alignment strategy is to improve the efficiency of the practice of medicine. For example, by implementing multi-disciplinary care management and other care coordination approaches, it is possible to improve the efficiency of physician encounters. Pre- and post-visit patient education and team follow-up will make patient care more effective and leverage the physician’s time. For example, for Medicare patients with multiple chronic diseases, instituting multi-disciplinary care teams will extend the effective contact time with the healthcare delivery system, provide a higher level of health care literacy and patient engagement, and offer opportunities to physicians for more equitable fee for service payments.

Also, a non-compensatory strategy is simply to promote awareness and education about the existence and incentives of the new model. This includes physicians and other allied health professionals, and all health care workers, so that they all understand the incentives of their organizations.

One specific concern related to the need for non-compensatory 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 or Compensatory Incentives to Physicians

Under the new all-payer model it is important to align the interests of hospitals and other providers to improve quality and reduce costs. This can be done by ensuring that high quality care is provided in the most appropriate setting. In order to reduce hospitalization, the physician alignment strategy must promote better health by supporting physicians and other health care providers to manage the long-term health of patients particularly those with chronic conditions. By treating patients in the most appropriate setting diseases can be recognized and treated before it progresses in severity and rather than carrying out a routine procedures in a hospital, when appropriate, that care is provided in a less costly outpatient setting.



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. However, one key cross-cutting strategy is for hospitals and physicians to revise their existing physician employment contracts, from almost entirely RVU based to include meaningful Three-Part Aim related incentives.

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, the continuum may be viewed 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 fund and pay out dollars, such as based solely on savings (e.g., 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 VI.

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. Also, the models available today may be able to be expanded, and used as incremental steps toward more comprehensive models. 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, several gain sharing models have already been approved and can be implemented more quickly. The workgroup agreed that gain sharing should be explored as a first step for interested providers, while working to pursue initiatives that will move the state towards the longer term goal of population-based models.

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 compensatory and non-

compensatory, should be appropriately designed to encourage the delivery system change that is necessary to achieve the various goals of the new all-payer model.

Finally, focus must be maintained on 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 IV.

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. This strategy will be discussed further as part of the care coordination portion of the Work Group's activities.

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, as well as Model 1 of the CMMI Bundled Payments for Care Initiative (BPCI) program. More detail on the New Jersey model can be found in Appendix V. An advantage is that CMS has approved this specific model three times. 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) could choose to participate.

Case-based strategies would only incorporate hospital services that are included within each admission. One downside to case-based strategies, unless there are volume controls included, 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 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, which incorporates the incentive to reduce readmissions, and therefore better episode of care management.

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. The population-based methods considered include existing ACO approaches, expanded Maryland-specific ACO-like approaches, PCCM, Medicare Advantage, and payer / provider risk sharing agreements. It is worthwhile to note that the gain sharing model under consideration is not considered shared savings by CMS, and therefore can complement other efforts that impact population based reimbursement, such as ACOs.

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, mental health / substance abuse, 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 all 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 ACOs, Medicare Advantage, and other Medicare Demos / Programs. So, while approximately 150,000 beneficiaries are in programs that have the incentive to improve care and reduce costs, the vast majority of Medicare beneficiaries are in fee-for-service arrangements. 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.

- The HSCRC could serve as a catalyst to encourage the hospital industry, physicians, and other providers to consider ways to:
 - o share infrastructure, analytics, and other resources;
 - o improve reporting between and for hospitals and providers;
 - o make the practice of medicine more efficient for providers; and
 - o promote broad awareness of the objectives of the new model financial incentives, promoting it and the various types of programs designed to support it.

- HSCRC serve as catalyst for hospitals, physicians, and other providers to work collaboratively towards models that are consistent with the goals of the Three-Part Aim and the new All-Payer Model.

- HSCRC should work with the field to pursue confirming with CMS / OIG (and / or other appropriate regulatory bodies) 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 physician incentive model that is modified to be consistent with the goals of the new all-payer model (with input and advocacy from the HSCRC). The MHA, MedChi, and the HSCRC will participate in a workgroup, for the purpose of submitting an Application to CMS / OIG, with the intent of having ongoing dialogue to expand the model over time to be consistent with the Maryland all payer model including moving beyond a focus on reducing costs on per case basis. For example, the Maryland model

could be expanded to include readmissions, MHACs, ambulatory sensitive conditions, Potentially Avoidable Utilization (PAUs), and Bundled Payments for Episodes of Care. The current strategy is most applicable to hospital inpatient treating physicians, and, could be expanded to episodes of care, to include physicians and other providers that treat post-acute patients.

- The HSCRC should work with the State and key stakeholders to pursue a Maryland-specific ACO-like or Integrated Share Savings Organization (ISSO) option, which would require infrastructure development and 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, the concept 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. Specifically, the State should consider requesting that CMMI grant one or more 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. This strategy is most applicable to primary care physicians, and specialists that serve as the principal providers due to patients with certain chronic conditions.
- HSCRC should serve as catalyst for encouraging and expanding alignment models across all payers, and consistency regarding incentives, including working with stakeholders to determine if legislative or regulatory changes are necessary to achieve the options above and to sponsor or promote those changes, as appropriate.
- HSCRC should serve as catalyst for encouraging models that are possible today (e.g., Primary Care Medicare Homes, pay for performance enhancements to fee-for-service, and changes in salary models), while pursuing broader population-based models (e.g., ISSO) that require regulatory approvals and additional infrastructure development.

Maryland could use a staged combination of strategies, including a gain sharing strategy (New Jersey-type model) that could be implemented relatively quickly and target inpatient hospital costs per case (and may be expanded to include episode costs), while the State works in collaboration with the field to further develop details of an ISSO methodology and to receive regulatory approvals for broader population-based Shared Savings strategies. This may be an inefficient approach, as a Gain Sharing strategy alone will not achieve the long-term goal of improved population health, but may offer more immediate savings, and a platform that can be expanded and incorporated into broader episode and/or population-based strategies. Figure 4

below illustrates how such a staged approach could be effective in meeting the goals of improving quality of care, and reducing costs and practice variation.

Figure 4

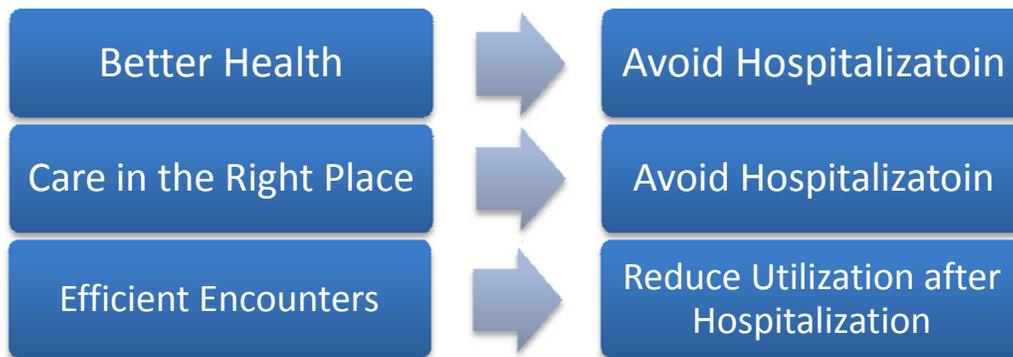
AIM	High quality efficient cases/episodes	Better health, better chronic care reduces expensive hospitalizations
Phase 1- Payments from Hospital to Physicians Based on Hospital Savings or Performance Criteria (Gainsharing or Pay-for-Performance)		
Target Providers	Physicians practicing at the hospital	Primary care, selected others
Opportunity Level	\$\$	\$\$\$

Infrastructure	\$\$	Practice Variation Measurement, Quality Metrics, Cost Metrics	\$\$\$\$	Focused Care Management Tools and Resources, Quality Metrics, Cost Metrics
Measurement		Hospital Case or Episode Model		Avoidable Hospital Use, Quality Indicators Focused on Chronic Care
Phase 2- Payments from Payers to Integrated Shared Savings Convenor				
Target Providers		Physicians practicing at the hospital, hospital, post acute, other		Primary Care, Other Providers
Additional Opportunity	\$\$-\$\$\$	Post-acute savings	\$\$\$	Post-acute, reduced
Additional Infrastructure		Data collection from payers on total cost of episodes, including non-hospital		Data collection from payers on total cost of care, including non hospital

Appendix I

Gain Sharing/ Shared Savings Section

Our goal is to create a physician alignment strategy that will align with the All-Payer Model to reduce avoidable utilization of hospital services. This can be done by (1) reducing overall hospitalization and (2) by reducing utilization once hospitalization occurs. In order to reduce hospitalization, the physician alignment strategy must promote better health by supporting physicians and other health care providers to manage the long-term health of patients particularly those with chronic conditions. Secondly, the strategy must encourage physicians to provide high quality care in the most appropriate settings in both time and location so that rather than treating an exacerbation of a chronic disease, that disease is recognized and treated before it progresses in severity and rather than carrying out a routine procedures in a hospital, when appropriate, that care is provided in a less costly outpatient setting. Finally, once hospitalization occurs, the physician alignment strategy must encourage hospital-based physicians and other healthcare providers to have efficient encounters that limit unnecessary procedures and diagnostics.



Gain Sharing has been proposed as a potential strategy to increase efficiency inside the walls of the hospital. Gain Sharing is broadly defined as an incentive plan in which physicians receive incentive payments directly as a result of improvement in performance, both efficiency and quality. The Work Group discussion around Gain Sharing has centered on the New Jersey Model launched in 2009, which provides physicians at twelve New Jersey hospitals with incentives for improvements in inpatient performance (both cost and quality) when providing care to Medicare patients. The program includes mechanisms such as incentive payments to physicians for reducing cost and conditions these payments upon improvements in quality and care

redesign initiatives prioritized by an internal steering committee at each hospital. This strategy could be effective in capturing savings from avoidable utilization after the patient has entered the hospital.

This strategy is advantageous as methodologies and software have been developed and granted regulatory approval in New Jersey and New York. This pre-existing foundation will reduce the time and effort of implementation. However, Gain Sharing is limited as the strategy is centered on reducing costs after the patient has been admitted to the hospital and the model cannot easily be expanded to reduce the overall rate of hospitalization because the model is only applied within the walls of the hospital. It should be noted that the proposed model includes features designed to interface with strategies that may be developed for other aspects of the delivery system. However, in order to reduce overall utilization physicians must manage a patient's long-term health and provide care in the right place. A significant portion of care management activities and treatments of early stage chronic diseases does not take place in the hospital and are therefore not aligned with the incentives created by a Gain Sharing strategy.

A larger Shared Savings strategy may be an effective way to capture savings from both reducing utilization within the hospital and reducing overall hospitalization. Shared Savings is a payment strategy that offers incentives for provider entities to reduce health care spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts. Shared Savings can realize savings from avoiding hospitalization as well as reducing utilization inside the hospital as payments are linked to the health of designated population irrespective of whether or not each member of that population is admitted to the hospital. Medicare considers gain sharing and shared savings as separate strategies that can be utilized in combination.

A regional Shared Savings model could be created by initially focusing on the Medicare inpatient population similar to the focus of a Gain Sharing strategy. Medicare patients could be attributed to participating healthcare providers and regional shared savings benchmarks and goals could be created to align with global budgeting and the larger goals of the All-Payer Model. The HSCRC, CRISP and other State resources could develop and distribute tools to promote incentives, improve population health and avoid hospitalizations.

This strategy is potentially broader-reaching than Gain Sharing though, as it is not inherently hospital-based and can be expanded beyond the inpatient services to incorporate non-hospital based physicians and healthcare providers. The long-term goal of the All-Payer Model is to improve population health and non-hospital based physicians and healthcare providers are a crucial resource for care management and must be leveraged to ensure that care is being provided in the right place. The implementation of a Shared Savings strategy will require more time and effort, as there is not a pre-existing regional Shared Savings model with tested methodology and regulatory approval. Gain sharing, on the other hand, can provide a quick start, as catalyst to begin to change the culture to one that is oriented towards performance and measureable results. Therefore, the objective should be to consider utilizing gainsharing and shared savings in combination, capitalizing on the different strengths of each strategy.

Gain Sharing	Shared Savings
Reduce Inpatient Hospital Utilization after Admission <ul style="list-style-type: none"> Engage Hospital-Based Physicians 	Reduce Inpatient Hospital Utilization after Admission <ul style="list-style-type: none"> Engage Hospital-Based Physicians
	
	Reduce Hospitalization through Care Management and Providing Care in the Right Place <ul style="list-style-type: none"> Engage Hospital and Non-Hospital-Based Physicians

Appendix II: Physician Landscape in Maryland

Region	County	Specialist Total	Primary Care Total	Percent Primary Care Total
Baltimore Metro	Anne Arundel	679	381	35.9%
	Baltimore City	2721	690	20.2%
	Baltimore County	1571	789	33.4%
	Carroll	142	101	41.6%
	Harford	210	142	40.3%
	Howard	379	199	34.4%
BALTIMORE METRO TOTAL		5702	2302	28.8%
Eastern Shore	Caroline	1	12	92.3%
	Cecil	97	58	37.4%
	Dorchester	24	15	38.5%
	Kent	25	14	35.9%
	Queen Anne's	16	24	60.0%
	Somerset	7	5	41.7%
	Talbot	126	36	22.2%
	Wicomico	221	73	24.8%
	Worcester	39	40	50.6%
EASTERN SHORE TOTAL		556	277	33.3%
National Capital	Montgomery	1958	822	29.6%
	Prince George's	774	447	36.6%
NATIONAL CAPITAL TOTAL		2732	1269	31.7%
Northwest	Allegany	110	59	34.9%
	Frederick	264	150	36.2%
	Garrett	14	17	54.8%
	Washington	212	106	33.3%
NORTHWEST TOTAL		600	332	35.6%
Southern	Calvert	99	53	34.9%
	Charles	112	91	44.8%
	Saint Mary's	83	53	39.0%
SOUTHERN TOTAL		294	197	40.1%
MARYLAND TOTAL		9884	4377	30.7%

Source: Maryland Board of Physicians License Renewal Data (2011-2012)

Appendix III

LEGAL BARRIERS AND POTENTIAL RESPONSES

Maryland, at least in some areas of the State, has a problem attracting and retaining physicians. At least part of that problem is the fact that physician reimbursement in Maryland is relatively low compared to the cost of living. The fee for service payment system dictates that the physician attempt to provide more and in less time. Unless payors increase the payment levels for units of service, the problem will continue to persist, and unless payment models are changed to encourage physicians to provide co-operative treatment and to reduce utilization population based health faces significant hurdles.

As noted by the graph on Figure 1, the problem/opportunity is that although physicians receive less than 20% of the total health care spend, they are responsible for most of it, since they order the care provided by the other elements. The logical approach to reducing health care costs must at a minimum include physicians in a meaningful manner, which requires money to incentivize behavior change. Indeed, the desire of physicians to have a share of the health care dollars their patients use lies both at the core of reducing health care costs and presents the largest single regulatory impediment.

One answer is to tie the physician into the risk/benefit of utilization control strategies to break the fee for service cycle in favor of a new approach and give the physician the ability to share in the savings. The problem is a plethora of laws that make that difficult or unlawful. A brief discussion follows.

THE MAJOR REGULATORY IMPEDIMENTS

1. State and Federal Stark, Anti-Kickback Statute (AKS), False Claims Act and Civil Monetary Penalty Act make it difficult to share savings resulting from physician actions with the physicians who generate those savings
2. Antitrust limitations on agreements and activities among competitors
3. IRS limitations on the activities of charitable hospitals with private interests such as the medical staff
4. State insurance law restrictions
5. Privacy concerns based on but not limited to HIPAA
6. Cost and implementation barriers to create, maintain and manage an effective statewide electronic health record system to share information, manage care and monitor and report results
7. Lack of effective controls on defensive medicine costs, a major driver in unnecessary utilization
8. Difficulty of implementing clinical guidelines to effectively manage care
9. Capturing, analyzing and disseminating all the data needed to apply any changed Waiver Test
10. Extensive and uncoordinated regulatory structure that rivals the highly fragmented health care delivery system

To enhance its ability to accomplish the goal of improving the coordination, quality, and efficiency of health care services, CMMI was given authority to grant waivers from the reach of Stark, AKS and the Civil Monetary Penalties Act. The State reserved the right to request such waivers, and a structured request to gain as much leeway as possible under these provisions of the Social Security Act is the starting point of exploring methods to align incentives of physicians with hospitals and payors in exploring alternative co-operative approaches to the utilization control and quality issues. Finding legal ways for physicians to benefit financially from, or at least to be able to recover the additional costs they may incur to, reducing unnecessary utilization while increasing quality is one of the, if not the most important, key to success

FEDERAL – The key factors and regulatory impediments to each are listed below

ACOs were created by the Affordable Care Act, but it was apparent that ACOs could not succeed without significant relaxation of federal laws: A) limiting payments to physicians found in the Social Security Act (Stark, AKS, Civil Monetary Penalty), B) restricting collaboration between competitors (the Anti-Trust laws) and C) imposing limitations on a tax-exempt hospital sharing profit or buying power with its physicians (the Internal Revenue Code). These laws were enacted to minimize what was perceived to be the corrupting influence of personal profit on physician decision making. The literally thousands of pages of Federal Register discussion on what health care entities and physicians are prohibited from doing serve as the largest single impediment to innovation, and only the federal government can provide some degree of protection against these laws.

- A. With respect to the first category, the Affordable Care Act permits the Secretary of Health and Human Services to waive certain provisions of the Stark, AKS and Civil Monetary Penalties Act to permit ACOs and other pilot programs authorized by the ACA to function. The State reserved the right to request waivers from these statutes with respect to its New Model Agreement. Waivers are absolutely necessary to permit a hospital-physician relationship of any size and complexity to succeed, and the Commission will need to take the lead on these efforts in collaboration with DHMH, MHA and Med Chi. Maryland hospitals are not “sub-section (d)” hospitals and therefore are not eligible for all waivers, but the State under its CMMI waiver can seek the same exceptions that CMS has granted ACOs.
 1. ACOs are already eligible for these protections, but other innovative approaches (such as gain sharing arrangements that would permit hospitals to share the reduced costs of treatment with participating physicians for hospital care designed to reduce the expense of care in one or a group of treatment modalities) that are outside an ACO require specific approval. The Secretary can, but does not have to, grant the same waivers for which ACOs are eligible to other programs approved by CMMI.
 2. To date, most gain sharing arrangements have been approved through the issuance of an Advisory Opinion from the Office of the Inspector General

(OIG) of DHHS. Such opinions are time consuming and are both time limited and can be relied upon solely by the parties which requested it, limiting their usefulness. Several large scale gain sharing pilots were approved by the ACA. The State should pursue this waiver with CMS.

3. We note that ACOs are focused on fee for service Medicare patients, the group of patients used as the measuring stick for many of the requirements for continuation of the Model. That is highly useful, but is not the end all for population health. They should be able to grow to serve non-Medicare patients, or even as an alternative for Medicaid and dual-eligible patients as an alternative provider.

B. With respect to the second, the Federal Trade Commission (FTC) has provided limited anti-trust protection for ACOs and has long established standards to permit clinically integrated networks of hospitals and physicians to work to reduce costs and improve quality for privately insured patients. The problem is two-fold -- making clinical integration work, including paying for the superstructure to form the entities, and contracting with commercial payors to fund it going forward. In addition, other aspects of the antitrust laws (the Robinson-Patman Act) limit the ability of a hospital or group of hospitals to use their purchasing power to reduce the cost of care outside the hospital setting. Clinically integrated networks offer promise to commercial payers, but they will not succeed without the active participation of commercial payers and sufficient clinical integration to pass anti-trust review.

C. A tax-exempt hospital cannot let any of its profit inure to the benefit of private parties and insiders. Members of its medical staff are both. Gain sharing works for the tax law since it is focused on reducing (and sharing with participating physicians) savings on the expense side. It would also work to a lesser extent on sharing the revenue. However, profit cannot be shared. Joint ventures offer a limited opportunity to share the venture's profits in those rare ventures that can survive a Stark analysis -- ambulatory surgical centers, radiology joint ventures with radiologists and the ownership of physician practices. Tax laws effectively limit the ownership or control of the private interests in a joint venture unless the hospital uses a for profit entity. Other ventures may be able to be formed as charitable entities themselves as long as there is no physician or other private ownership. The IRS has issued guidance on ACOs which provides protection to ACOs that are structured in accordance with the guidance.

HIPAA and Electronic Health Records. HIPAA poses challenges to the successful implementation of coordinated care. The State has acted to authorize CRISP to facilitate information exchanges, which must include the ability of the consumer to participate. From a physician's standpoint, the major obstacle is the cost of implementing and maintaining an effective electronic health record to be able to enjoy the benefits of virtually instantaneous communication between and among providers. The Safe Harbor that permitted hospitals to subsidize the majority of the cost of EHR systems for members of its medical staff was used by many State hospitals to encourage use of EHR, and the payment of meaningful use dollars

also encouraged conversion. Although all EHRs must be “inter-operable”, there is still difficulty and cost to permit the various systems to communicate with each other which many physician groups can ill afford, as well as capital to keep the initiative going forward.

Data Sharing. Medicare is a payer subject to HIPAA. As a federal agency, it is also subject to the federal Privacy Act. Both laws limit the disclosure and use of individual’s health information. To the extent that data mining is regarded as essential to facilitate and guide population health, the State must be able to obtain and then share medical information with the State’s physicians and hospitals. The Model Agreement requires a data use agreement between the State and CMS, but this at this point is a work in progress. To the extent that similar data is desired from commercial payers, state legislative authority to obtain that information in a manner that appropriately protects individual’s rights to privacy may be required.

STATE ISSUES

State Version of Stark The State has its own, and different, version of Stark. (Md Ann Code, Health-Occupations Article, Title 1, subtitle 3). The largest single distinction between the Maryland statute and Stark is that MRI, CT and radiation therapy services are excluded from the exception for in-office ancillary services for all practices except a radiologist group practice, making it difficult to provide these services in a multi-specialty practice or some other specialty. The State law applies to all payers and is therefore much wider in its reach than Stark.

Medical Malpractice Relief and Practice Guidelines. The cost of medical malpractice premiums has long been viewed as the visible manifestation of a much bigger problem – defensive medicine. The State has enacted legislation that limits most non-economic damages in malpractice cases, but that does little or nothing to curb defensive medicine.

Unified Approval Process. The State and its agencies also have a direct influence on health care entities, and unlike the highly restrictive federal laws discussed above, the State is relatively free to change the law. The Insurance Commission, the HSCRC, the MHCC, DHMH, the Office of Health Care Quality and all of the many regulatory and licensing boards (for physicians, nurses, pharmacies, therapists, etc.) and enforcement by the Attorney General all influence and have the ability to stifle innovation. Some Maryland counties have also carved out regulatory authority over certain health care entities within the county.

Appendix IV

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 (and other providers) to conduct 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.

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 model, 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 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. The New Jersey-like gainsharing model being considered could serve as an effective starting point, and could potentially be expanded over time, with additional CMS / CMMI approval.

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

services continue to be billed fee-for-service, and there is reconciliation. Additionally, the hospitals are able to make incentive payments directly to physicians, based upon performance. 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 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 or Integrated Shared Savings Organization (ISSO) 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 allows 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. Under this model consideration should be given as to whether to create the authority, and hospitals would have the option to participate, in which case hospitals 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 ER physicians to reduce admissions, 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. Additionally, population-based models that have the incentive to be patient centric, and are therefore better able to address the intersection between somatic and mental health issues, resulting in higher quality and decreased costs.

Appendix V

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 36 months of the program, participating hospitals recognized \$112.7 million in cumulative savings, which equates to \$822, or 8.5 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 the 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

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

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

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

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

$$(\text{Prior Year LOS} - \text{Current Year LOS}) \text{ (Maximum Physician Incentive per Day)}$$

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 VI

Western Maryland Health System Model



Western Maryland Health System

Pay for Performance CY2014

March 11, 2014

- 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

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

Source: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. Craig, C., Eby, D. and Whittington, J. Institute for Healthcare Improvement: 2011.

Targeted enrollment is critical to success

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

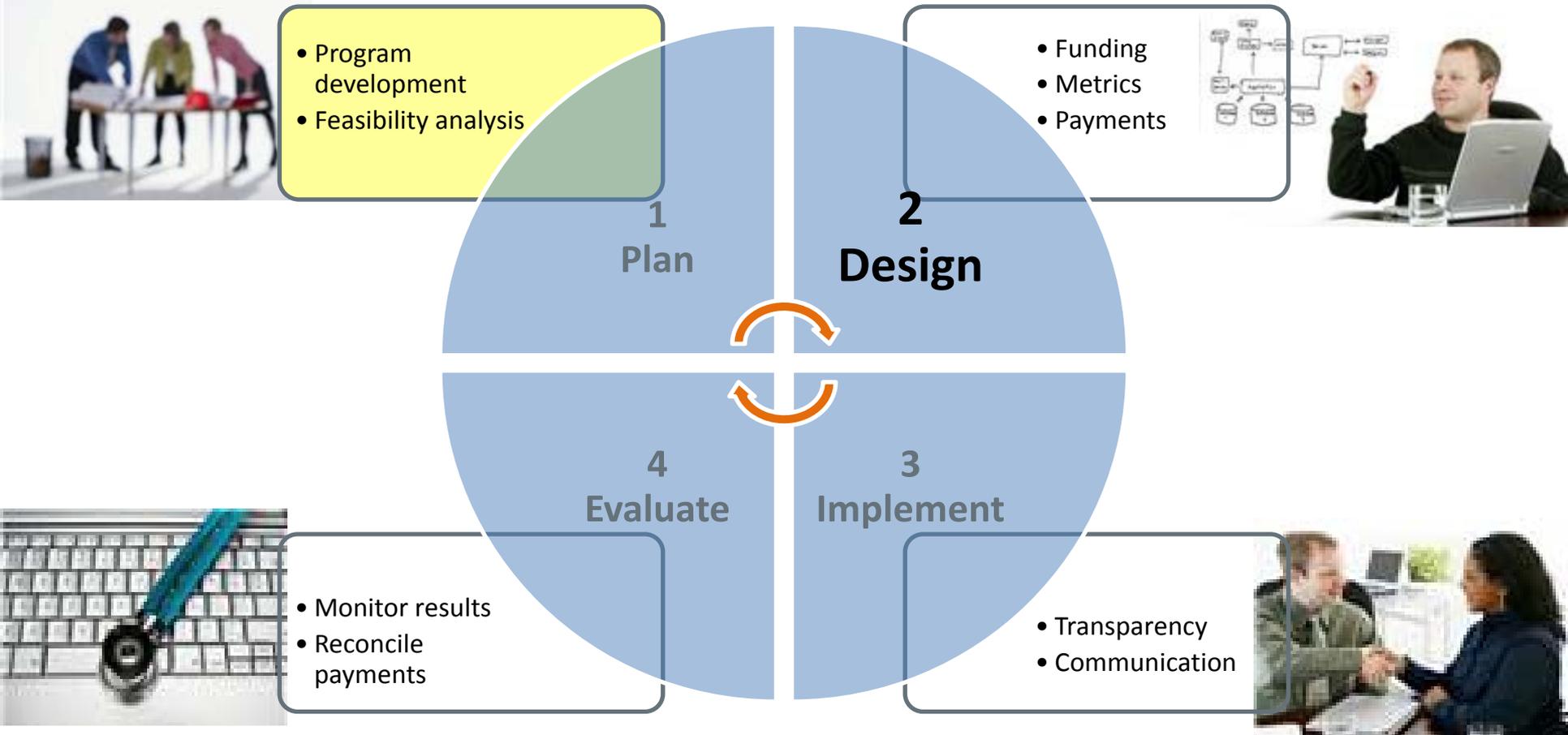
- “Targeting patients according to predictors of continued high utilization (e.g. recent hospitalization, frequent emergency room (ER) use, certain clinical indicators) substantially enhances the opportunity for savings.”
- “Successful interventions include:
 - Targeting interventions to sicker patients 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).

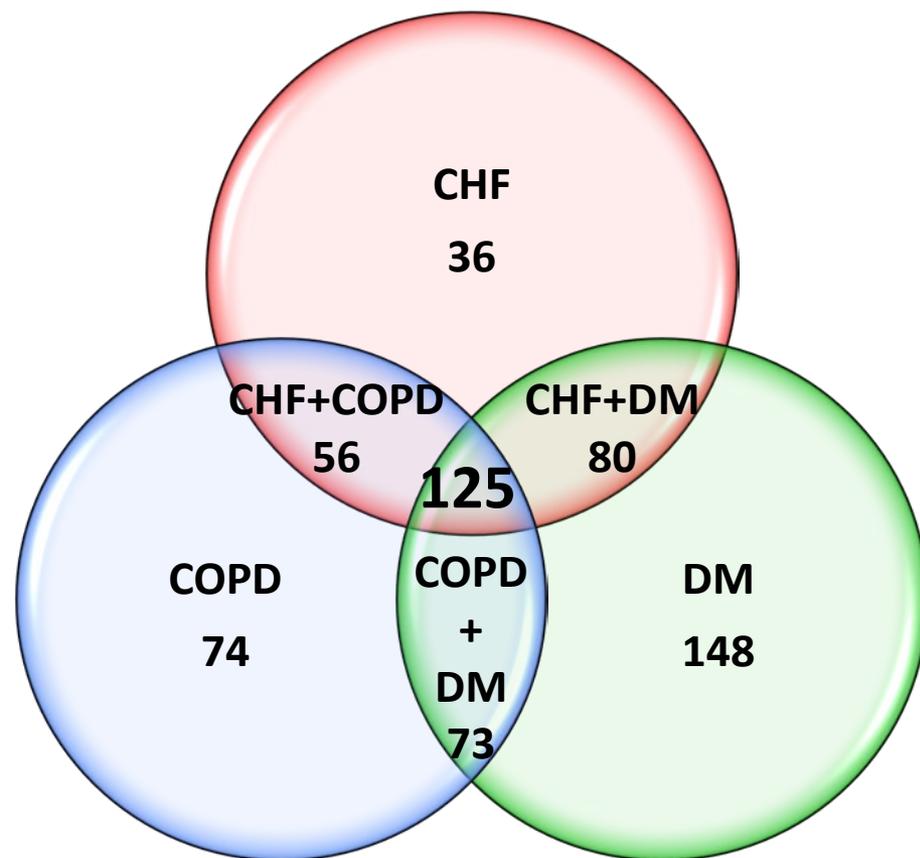
Process





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



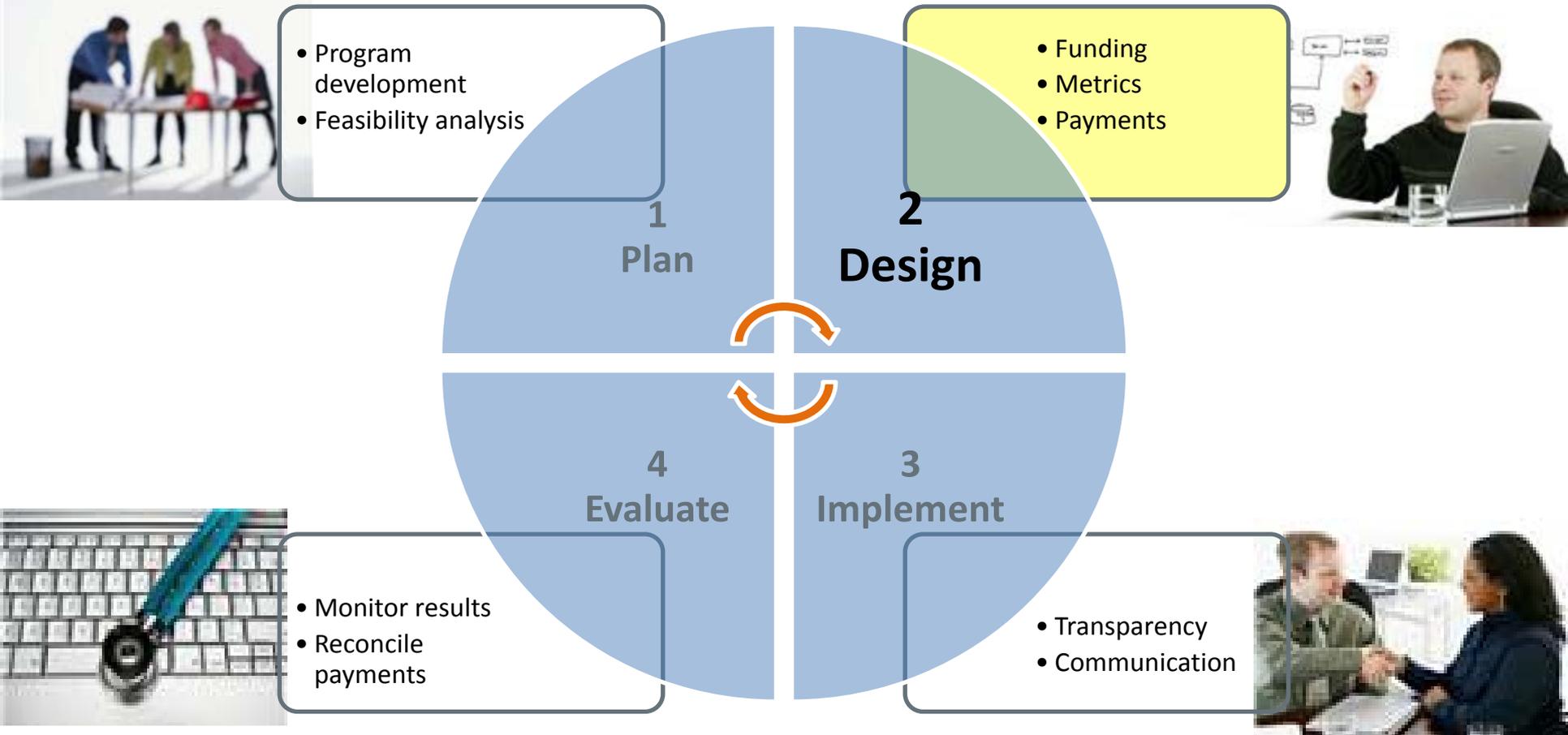
¹ "Frequent fliers" are patients with 3 or more admissions to WMHS for any condition in CY2012

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

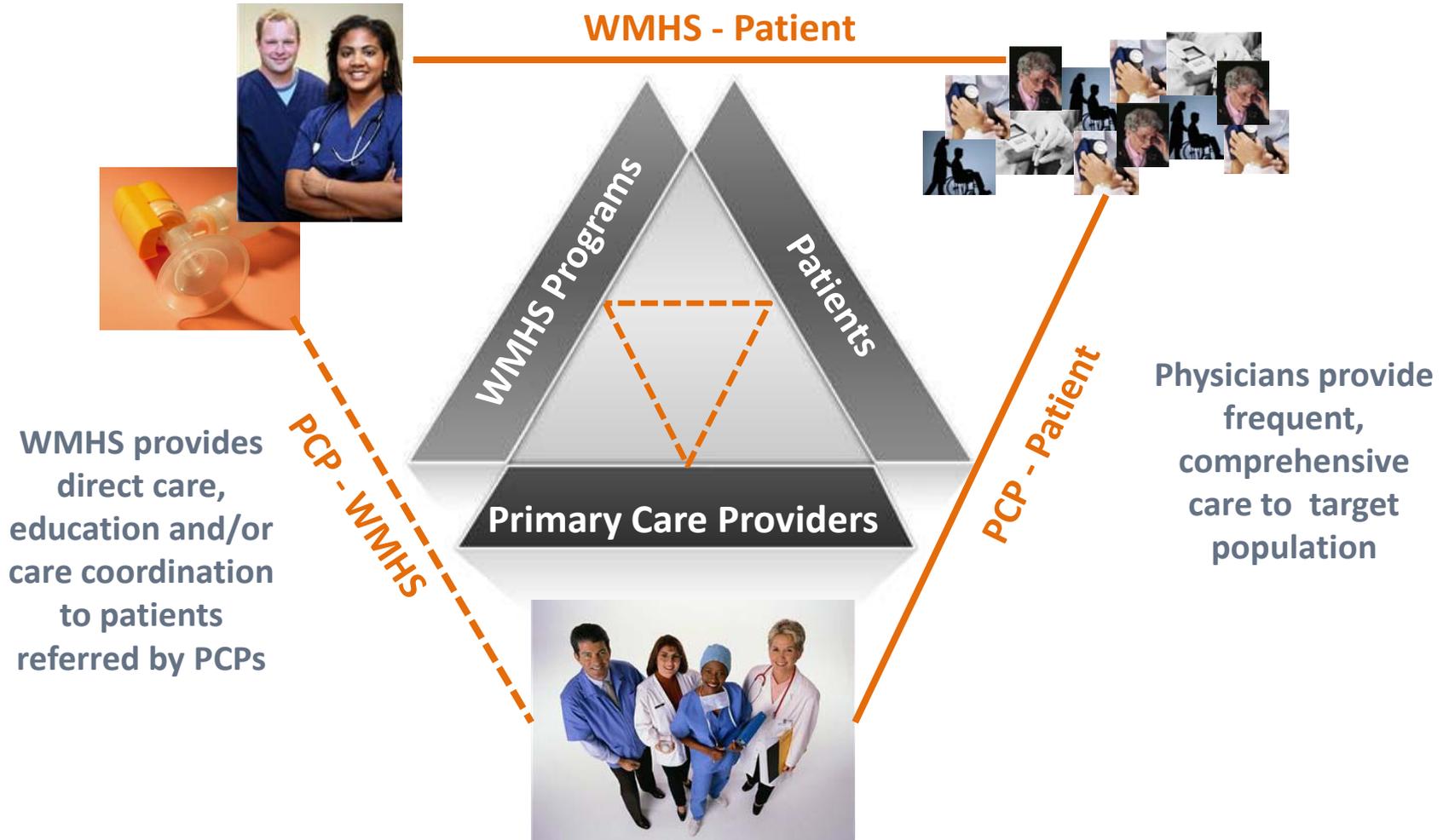
- WMHS's composite score for chronic PQIs is 36% higher than the U.S. average , although it is in line with the average for the lowest quartile income population
- Within the chronic PQIs, significant opportunities exist in CHF and COPD
- WMHS's pneumonia admission rate is 62% higher than the U.S. average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



Patient-centered Care

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



DRAFT

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



DRAFT

Funding Methodology

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

	#			
	Admissions	Charges	Costs	Funding
Reduce Chronic PQIs by 9%	72	\$845,055	\$507,033	\$253,517
Reduce Pneumonia PQI by 9%	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
Reduce Chronic PQIs by 17%	135	\$1,596,216	\$957,729	\$478,865
Reduce Pneumonia PQI by 17%	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-twotier-medical-home-care-management-fee>

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

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	4		5		6
	Possible Score	4		5		6
	Percent	100%		100%		100%
	Total Available Distribution/Patient	\$586		\$651		\$781
	Payment	\$586		\$651		\$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	5		3.5		3
	Possible Score	5		5		5
	Percent	100%		70%		60%
	Total Available Distribution/Patient	\$651		\$651		\$651
	Payment	\$651		\$456		\$391