maryland
health services
cost review commission

Physician Engagement & Alignment Workgroup

TCOC Model Progression

Meeting #2

March 2, 2023

Workgroup Members

Physicians:

- Dr. James Elliott – Chairman
- Dr. Farzaneh Sabi
- Dr. David Safferman
- Dr. George Bone
- Dr. Ramani Peruvemba
- Dr. Benjamin Lowentritt
- Dr. Harbhajan Ajrawat
- Dr. James York

Program Administration:

- Gene Ransom, MedChi
- Jacqueline Howard, UMMS
- Ben Steffen, MHCC
- David Sharp, MHCC
- Laura Goodman, Medicaid
- Dr. Howard Haft, MDPCP PMO
- Zach Rabovsky, CareFirst
- Laura Russell, MHA

Guiding Principles

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

Agenda

1. MDPCP Status Update
2. HSCRC EQIP Planning
3. Public Comments
    a. MedChi
    b. Maryland Hospital Association
4. Workgroup Discussion
5. Comments and Next Steps - HSCRC

Timeline

Event	Topic	Sub-Topics
Meeting 1 (February 2nd)	Overview	Workgroup Agenda/Goals Health Equity Considerations
		View from MedChi
		EQIP Update
		MDPCP Update
		Other considerations – AHEAD, GBR 2.0, State Primary Care workgroup etc., Medicaid.
		Invite public comment on direction of model regarding physician programs and physician alignment
Meeting 2 (March 2nd)	Public Comment	Workgroup members reflect on key themes and views on priorities
	Workgroup Discussion	Identify areas of focus, common themes, etc.
Meeting 3 (March 30th)	Recap of Public Comment	
	First Draft Recommendation	HSCRC review of straw man proposal and discussion
Report Release (Late March)	First Draft Written Recommendation to Workgroup and Public	Workgroup will provide feedback and report will be refined via email etc.
Meeting 4 (Mid-May)	Review Final Draft	

MDPCP Status Update

Chad Perman
Executive Director, MDPCP Management Office

Agenda

- Status Update
- Preliminary themes from MDPCP Participant Workgroup

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2/23 Meeting with MDPCP Participant Leaders

- Obtained participant input on the future of MDPCP in the next iteration of the TCOC model.
  - Representative provider and administrative leaders - solo to healthcare system and rural, urban and suburban
  - Strong alignment among the group
- Reviewed major elements of MDPCP and discussed potential changes
- Awaiting additional written feedback

MDPCP Future Elements Feedback Process

Feb 23– MDPCP Practitioner/Key Leaders Workgroup Mtg

March 2 – HSCRC Model Physician stakeholder mtg – PMO discuss MDPCP draft elements (elements to maintain or add) in more details

March 3 – MDPCP Practitioner/Key Leaders written feedback

Mar 28 – MDPCP Adv Council mtg – Draft Elements presented and finalized for sharing with HSCRC

Apr 3 – MDPCP Adv Council Final elements sent to HSCRC for Progression Plan - HSCRC incorporates into April draft;

Late April/early May – PMO review before final May report to HSCRC

Spring/Summer – HSCRC aggregates stakeholder report recommendations into a Progression Plan

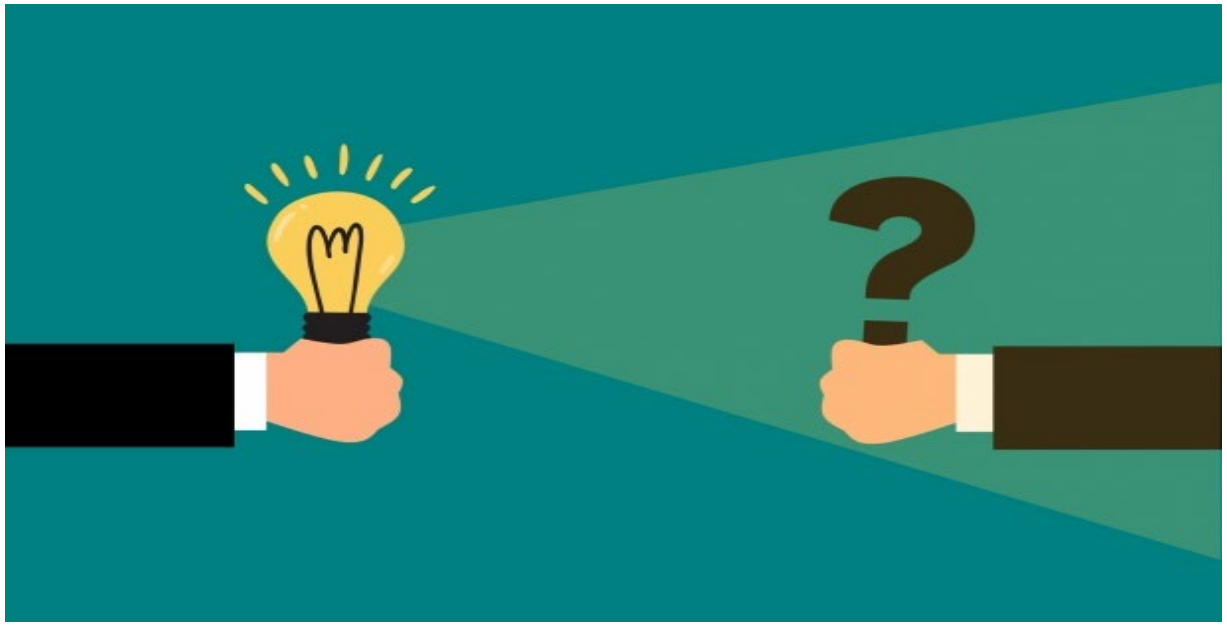
Summer/Fall – HSCRC submits Progression Plan to CMMI to initiate Future Model discussions

Preliminary Consensus Feedback for Future MDPCP

- Enhanced primary care investment sufficient to address medical, behavioral, and social needs of patients (additional health equity dollars important)
- Hybrid model of payment - FFS + Simplified, unified population based payment to fully support comprehensive, team-based primary care with flexibility on payment uses
- Risk
  - Not requiring downside risk on the core primary care payments
  - At risk performance incentive payment
- Payer alignment on payments and quality to reduce administrative burden
- Maintaining entry level track (T1) and Track 2 option
- Clear incentives for specialist co-management of patients
- Social needs HIT including bidirectional referral technology
- Health equity quality measurement
- Responsibility for core set of clinical quality measures and utilization, not total cost of care measure

Thank You!

Check out the MDPCP website for updates and more information



Email mdh.pcmodel@maryland.gov with any questions or concerns

Any questions?

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HSCRC EQIP Planning

The Episode Quality Improvement Program – EQIP

- The HSCRC created a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance	Upside-only risk with dissavings accountability	Alignment with CareFirst's episode payment program	AAPM/value-based payment participation opportunities for MD physicians

- EQIP uses the Prometheus Episode Grouper & episodes that are created by Maryland physicians.
- This approach has allowed Maryland physicians to define their own value-based payment models.

Next Steps on EQIP

1. Simplifying Payment Flows
   A. In order to pay physicians in EQIP, the HSCRC increases the UMMC's MPA to increase Medicare rates, the rates paid by Medicare to UMMC increases slightly, HSCRC and UMMS have entered into an MOU for UMMS to pay physicians, each physician must enter a 'care partner arrangement with UMMC', the HSCRC then tells UMMC how much to pay each physician.
   B. This is complex.
   C. We recommend simplifying the payment flow. For instance, we create Participation Agreements with the State/CMS for EQIP Participants.
2. Increasing technical assistance through CRISP
   1. The development of new episodes is complex. We have had a lot of success working with the physicians who have worked in other CMMI models, PTAC, or other value-based payment models.
   2. In areas without VBP penetration, the "pool" of physicians who could develop these episodes may be limited.
   3. We recommend building out the resources at CRISP to provide technical assistance for physicians to work with Medicare data, develop VBP, etc.

New Episode Development

- We anticipate developing and adding the following EQIP Episodes:
  - A Muscular Skeletal Episode around PT as an alternative to surgery.
  - A Dialysis care episodes for patients with chronic kidney disease.
- Additional Prometheus Episodes:
  - Acute CHF / Pulmonary Edema
  - Chronic Obstructive Pulmonary Disease
  - Deep Vein Thrombosis / Pulmonary Embolism
  - Pneumonia
  - Sepsis
  - Oncology Episodes

Public Comments

MedChi Recommendations

- MDPCP Enhancements
  1. **Payment/Risk** - Continue to offer Track 2 as an option open to all practices as an alternative to Track 3
  2. **Participant Participation** - Allow for additional application periods for new practices to join with more flexible requirements on attribution and specialty eligibility. Work with CRISP or with the Transformation Grant to focus on adding new practices to MDPCP.
  3. **Policy and State Leadership** - As the MDPCP is extended there should be additional shifting of policy making from CMMI to the State regarding quality measures, payment methodology, and enrollment eligibility. We need to ease the burden on CMMI and the State should take on more responsibility.
  4. **Administrative Burden on Participants** - Continue, intentional reduction in administrative burdens to practices.
  5. **Practice Support from CTOs** – Care Transition Organizations (CTOs) should continue to be program participants.
  6. **Performance Measurement** - Simple, easily captured, meaningful performance data on measures that matter, with sufficient financial incentives adjusted for health equity.
  7. **Multi-payer and Real Medicaid Participation** - Program should include as many payer partners as possible with shared payment design, quality measures, data, and care delivery alignment. The programs offered by other payors should mirror or be more lucrative than the Medicare offering.

MedChi Recommendations

- EQIP Enhancements
  1. **Participant Participation** - Allow for additional application periods for new practices to join with more flexible requirements. Physicians need additional help working with CRISP or with the Transformation Grant to focus on adding outreach to new practices to join EQIP.
  2. **CRISP Support Enhancement** - build out the resources at CRISP to increase outreach to physicians and for development of new codes and models for EQIP.
  3. **Create EQIP Entity** – Smaller practices need a trusted EQIP entity to allow them to participate, we need to work with MedChi, or another trusted third party to build a neutral entity to allow for increased small practice participation.
  4. **Multi-payer and Real Medicaid Participation** - Program should include as many payer partners as possible with shared payment design, quality measures, data, and care delivery alignment. The programs offered by other payors should mirror or be more lucrative than the Medicare offering.
  5. **Consider moving from Grouper** – As EQIP grows and as Prometheus group has been commercialized, we may need to reconsider its use as the base of the program.
  6. **Consider programing for Non-Covered Physicians** – As EQIP grows it should focus on specialties not covered by any AAPM program in the Maryland structure, like Anesthesiology, Pediatrics, Pathology and Radiology. If it is not possible to include uncovered specialties in EQIP we should consider adding them in new other program models.
  7. **Maintain Risk Structure** – The current program currently recognizes the risk our entire system is taking as well as, the risk a practice takes by redesigning their operations. The current structure is fair and should not be changed. It is not fair or logical to add another layer or greater layer of risk on the practices.

MHA Recommendations

- Explore opportunities with the state and CMS to improve EQIP timely data release.
- Increase state support to administer and expand CRP's.
  - Increase flexibility to enable state contracted entities to administer CRPs.
- Evaluate potential enhancements to ECIP.
- Determine whether revisions to SIHIS goals should be considered.
- Reassess how quality provider threshold scores are calculated for Maryland providers enrolled in CRPs.

MHA Recommendations

- EQIP Enhancements
  1. Explore longer episode lengths for chronic and preventative episodes.
  2. Explore methods to control for supply and drug costs for certain episodes.

- MDPCP Enhancements
  1. Maintain track two of the program.
  2. Recognize the importance of care transformation organizations (CTOs) as the program evolves.
  3. Request for CMS to provide monthly claims files instead of quarterly.
  4. Continue to expand acceptable uses for Health Equity Advancement Resource and Transformation (HEART) payments.

Workgroup Discussion

Guiding Questions

1. Reactions and thoughts on today's material?
2. Ideas for new directions and additional program expansion beyond the scope of the program?

Comments & Next Steps

Future Meetings

- The next Meeting will be held on **March 30th** at 7:30AM.
  - Further discussion on MDPCP.
  - Synthesis of Today's Discussion.

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

February 16, 2023

The Honorable James Elliott, MD
Chairman, Physician Alignment Commission
HSCRC
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Elliott,

MedChi, The Maryland State Medical Society, would like to follow up on the great initial meeting of the committee. As we promised, here are proposed recommendations related to The Maryland Primary Care Program (MDPCP) and The Episode Quality Improvement Program (EQIP). We recommend adding the following recommendations to the final report. We will outreach to specialty societies and look forward to a robust discussion around new physician alignment ideas for us to consider as part on the latest "Total Cost of Care Contract."

Please see the following recommendations:

MDPC enhancement recommendations

Recommendation 1 - Payment/Risk - Continue to offer Track 2 as an option open to all practices as an alternative to Track 3

Recommendation 2 - Participant Participation - Allow for additional application periods for new practices to join with more flexible requirements on attribution and specialty eligibility. Work with CRISP or with the Transformation Grant to focus on adding new practices to MDPCP.

Recommendation 3 - Policy and State Leadership - As the MDPCP is extended there should be additional shifting of policy making from CMMI to the State regarding quality measures, payment methodology, and enrollment eligibility. We need to ease the burden on CMMI and the State should take on more responsibility.

Recommendation 4 - Administrative Burden on Participants - Continue, intentional reduction in administrative burdens to practices.

Recommendation 5 - Practice Support from CTOs – Care Transition Organizations (CTOs) should continue to be program participants.

Recommendation 6 - Performance Measurement - Simple, easily captured, meaningful performance data on measures that matter, with sufficient financial incentives adjusted for health equity.

Recommendation 7 - Multi-payer and Real Medicaid Participation - Program should include as many payer partners as possible with shared payment design, quality measures, data, and care delivery alignment. The programs offered by other payors should mirror or be more lucrative than the Medicare offering.

EQIP Enhancement Recommendations

Recommendation 1 - Participant Participation - Allow for additional application periods for new practices to join with more flexible requirements. Physicians need additional help working with CRISP or with the Transformation Grant to focus on adding outreach to new practices to join EQIP.

Recommendation 2 – CRISP Support enhancement - build out the resources at CRISP to increase outreach to physicians and for development of new codes and models for EQIP.

Recommendation 3 – Create EQIP Entity – Smaller practices need a trusted EQIP entity to allow them to participate, we need to work with MedChi, or another trusted third party to build a neutral entity to allow for increased small practice participation.

Recommendation 4 - Multi-payer and Real Medicaid Participation - Program should include as many payer partners as possible with shared payment design, quality measures, data, and care delivery alignment. The programs offered by other payors should mirror or be more lucrative than the Medicare offering.

Recommendation 5 - Consider moving from Grouper – As EQIP grows and as Prometheus group has been commercialized, we may need to reconsider its use as the base of the program.

Recommendation 6 - Consider programing for Non-Covered Physicians – As EQIP grows it should focus on specialties not covered by any AAPM program in the Maryland structure, like Anesthesiology, Pediatrics, Pathology and Radiology. If it is not possible to include uncovered specialties in EQIP we should consider adding them in new other program models.

Recommendation 7 - Maintain Risk Structure – The current program currently recognizes the risk our entire system is taking as well as, the risk a practice takes by redesigning their operations. The current structure is fair and should not be changed. It is not fair or logical to add another layer or greater layer of risk on the practices.

Thank you for your time and attention to this important work, we will have more recommendations and ideas as we continue this process.

Sincerely,

Gene M Ransom III

Gene Ransom
CEO
MedChi, The Maryland State Medical Society

Maryland
Hospital Association

February 23, 2023

James Elliott, M.D.
Commissioner, Health Services Cost Review Commission
Chair, HSCRC Physician Engagement & Alignment Work Group
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Elliott:

On behalf of Maryland's 60 hospitals and health systems, we appreciate the opportunity to provide input on physician engagement and alignment as the state plans for progression of the Total Cost of Care Model (Model) beyond 2026. Partnerships among hospitals, health systems, community providers, and partners are integral to improve health outcomes for patients in the most appropriate care settings at lower costs.

During the Feb. 2 Physician Engagement & Alignment Work Group meeting, stakeholders discussed opportunities to enhance two care redesign programs (CRP): the Episodes of Quality Improvement Program (EQIP) and Maryland Primary Care Program (MDPCP). MHA agrees with suggestions raised during the meeting, including enhancing the ability of specialists to participate in bundled payments through additional waivers and flexibilities. For both programs, MHA supports continued alignment across payers and the ability to choose clinical quality metrics from a pool of options.

Health systems and providers have experienced data challenges with EQIP that significantly impact physician engagement. During the first performance year, performance data was not available to providers until late October. The lack of timely data has unfortunately reduced provider interest in continued program participation. MHA recommends exploring opportunities with the state and Centers for Medicare & Medicaid Services (CMS) to improve timely data release.

MHA offers potential modifications to EQIP episodes:

1. Explore longer episode lengths for chronic and preventive episodes. Episodes that focus on chronic conditions may benefit from multi-year episode periods, which present the opportunity to prevent high-cost procedures over time and realize the long-term effects of innovative interventions.
2. Explore methods to control for supply and drug costs for certain episodes. For some episodes, such as oncology, drug and supply costs may determine up to 40% of episode

costs, limiting the ability to control total cost of care. The ability to control for such costs should be considered as the program develops.

We support the Maryland Department of Health's (MDH) plans to request medication cost-sharing waivers through MDPCP. MHA recommends the state advocate for the following to enhance participation:

1. Maintain track two of the program, which is set to sunset in 2025. Track two provides an avenue for new practices to enter the program and build infrastructure to achieve advanced primary care before subjecting them to substantial downside risk.
2. Recognize the importance of care transformation organizations (CTOs) as the program evolves. As of 2021, 24 CTOs participated in the program, with 78% of practices electing to receive CTO support to meet program care transformation requirements.[1]
3. Request for CMS to provide monthly claims files instead of quarterly. This would allow for more real-time data analysis, leading to better physician engagement.
4. Continue to expand acceptable uses for Health Equity Advancement Resource and Transformation (HEART) payments. The innovative payment has received national attention and is critical to the state and the Center for Medicare & Medicaid Innovation's (CMMI) health equity focus.

Work Group members also discussed the need for more state support to administer and expand CRPs. MHA recommends exploring contract revisions to address the issue. Current language identifies the state as responsible for CRP administration. It further lists the Health Services Cost Review Commission (HSCRC) as the responsible agency for submitting CRP track proposals and amendments. More flexibility may be required to enable state contracted entities to administer CRPs. Such an alternative could benefit the programs by bringing in dedicated subject matter experts familiar with implementing care transformation programs and value-based arrangements.

The Episodes of Care Improvement Program (ECIP) is a CRP that garners participation from post-acute providers. The HSCRC Post-Acute and Long-Term Care Work Group is assessing opportunities to enhance hospital and post-acute partnerships. Any forthcoming recommendations should be evaluated to inform potential enhancements to ECIP.

The Statewide Integrated Health Improvement Strategy (SIHIS) sets targets for the Care Transformation Initiative (CTI) program and CRP participation. As reported at the Feb. 21 Consumer Engagement Work Group meeting, Maryland is not meeting these goals. Yet, data has not been shared, and commissioners have not discussed the targets. In February, HSCRC staff reported final CTI performance will not be available until April. HSCRC should work with the state and stakeholders to understand performance drivers and whether revisions to SIHIS goals should be considered.

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[1] 2021 Maryland Primary Care Program Report, *Maryland Department of Health,* health.maryland.gov/mdpcp/Documents/2021%20Annual%20Report.pdf.

Finally, we recommend reassessing how quality provider (QP) threshold scores are calculated for Maryland providers enrolled in CRPs. The continued ability to receive incentive payments will only enhance physician engagement in these programs. Under federal MACRA law, qualifying QPs will receive a 3.5% alternative payment model (APM) incentive bonus for performance year 2023.[2] For performance years 2024 and beyond, QPs will receive an increased physician fee schedule update based on the QP conversion factor. Previously, threshold scores in Maryland were based on the provider's percentage of payments through an advanced APM, or through the percentage of patients through an advanced APM. Since CMS designated the state as an APM under the Model, the QP determination should be modified so providers who receive 50% of their patients from Maryland Medicare beneficiaries or have 35% of Maryland Medicare patients are determined QPs.

The numerator of the QP threshold score is based on a clinician's linkage to the hospital based on Medicare Performance Adjustment (MPA) attribution and whether a beneficiary had an encounter at the hospital.[3] Since the MPA attribution methodology changed in 2023, HSCRC should evaluate whether the calculation needs to be changed.

Thank you for the opportunity to comment on opportunities to enhance physician engagement and alignment as the Model advances beyond 2026. We look forward to discussing our recommendations in future work group meetings and forums.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: William Henderson, HSCRC

[2] Advanced Alternative Payment Models, *Centers for Medicare & Medicaid Services*, qpp.cms.gov/apms/advanced-apms.
[3] July 25, 2018 Total Cost of Care Work Group PowerPoint Presentation, *Health Services Cost Review Commission.*