

Maryland Medicine

The Maryland Medical Journal Volume 17, Issue 2

VALUE-BASED PAYMENT— WHOSE VALUES?

COST

VALUE

QUALITY

Also Inside:

MedChi's 2016
Legislative Accomplishments

MedChi
The Maryland State Medical Society



**Some ideas are better than others
for keeping your practice safe.**

MEDICAL MUTUAL offers comprehensive protection for your practice and professional reputation.

You would need 360° vision to see all the possible perils of the current health care and legal environments. In particular, even for good Doctors, claims can strike at any time from any direction. So, if you want to wrap your practice in a blanket of protection the best idea is to look to MEDICAL MUTUAL, Maryland's leading medical professional liability insurance company. Since 1975, we've successfully defended thousands of Doctors from the unexpected and given them the peace of mind they need to practice quality medicine.

MEDICAL  MUTUAL
Liability Insurance Society of Maryland



225 International Circle | Hunt Valley, Maryland 21030
410-785-0050 | 800-492-0193 | mmlis.com

I N S I D E



This issue of *Maryland Medicine* provides perspectives on the challenges and opportunities in the transition to value-based care.

Departments

President’s Message Brooke Buckley, MD	5
CEO’s Message Gene Ransom, III, Esq.	7
Editor’s Corner Bruce M. Smoller, MD	9
MedChi Presents: Music & Medicine Bruce Hershfield, MD	31
Classic Word Rounds Barton J. Gershen, MD	32
The Last Word	34

Features

Introduction Mark Jameson, MD	11
MedChi Accomplishments During the 2016 Maryland Legislative Session Stephen J. Rockower, MD	13
<i>Clinician Perspective:</i> Value-Based Payment Models: It Pays to be Prepared Tom Walsh, MD	15
<i>Regulator Perspective:</i> Transforming Health Care in Maryland to Deliver Value Donna Kinzer	17
<i>Hospital Perspective:</i> For Maryland’s Hospitals, Everything Is Value-Based Carmela Coyle	19
<i>Health System Perspective:</i> Value-Based Payments: Lessons Learned Joseph P. Ross	21
<i>Post-Acute Care Perspective:</i> Value-Based Payment Strategy Can Improve Care for Maryland’s Seniors Isabella Firth	23
<i>Payer Perspective:</i> Health Care Cost Improvement: Be Careful of the Common Wisdom Chet Burrell	24
<i>Association Perspective:</i> The Shift to Value-Based Payment and MACRA: AMA at the Forefront with Support for Physicians Carol L. Vargo, MHS; Lindsey E. Goeders, MBA; and Mary Copping	26
<i>Personal Perspective:</i> Reflections on Value-Based Payment: The Latest Strategy in the Search for Cost-Cutting Miracles Mark Jameson, MD	28



Scan the code with your smart phone and download *Maryland Medicine* to your mobile device.

MAKING HEALTHCARE ORGANIZATIONS BETTER.

Do you want to take control of your energy spend? Buy less energy and cut costs with our full suite of smarter solutions customized to your business.

Contact our Affinity Manager Elaine Guidry at DEBAffinityPartners@directenergy.com



Arriving at Value: Placing Cost on Quality



PRESIDENT'S MESSAGE

Brooke Buckley, MD
@medchipsest

What is value? Seems like a simple question.

As a mathematical truth, value is quality divided by cost. Value-based medicine follows as medical treatment provided, with cost and quality as the drivers to arrive at value.

Cost, while less straightforward, is quantifiable. Services and supplies are bought and sold. Cost is the exchange of dollars to provide the commodity of health care. We can argue over the relative value units placed on physician services, and on the retail mark-up of goods, but at the end of the day, cost can be derived.

Quality, the other determinant of value, is more elusive. A businessperson might say it is simple. Quality is a set of metrics placed into a database, relatively compared and regurgitated as resultant degrees of excellence. Simple? Maybe.

Value is a major focus of the Institute for Healthcare Improvement (IHI) Triple Aim. The aim is defined as providing care that increases population health, at decreased costs, and thereby provides improved patient satisfaction. For a decade, the goals of the IHI Triple Aim have been pursued.

As with any initiative, there has been great good as a result. However, the lurking unintended consequences are what concern physicians. As advocates for our profession, as healers, and as patients, we see quality as more elusive.

As a physician, a healer, an imperfect human dealing with imperfect humans, I find quality metrics difficult to pin down. I don't deny that given a platform with infinite capacity to combine and weigh values, a true quality metric could be derived. My concern is that imperfect, incomplete data offer actionable data that can be broadly applied causing the opposite intent...increased cost and harm.

Non-physician vested stakeholders have challenged me. I have fielded the accusation that to pushback is a stall-tactic, and even "whining," by the physician community to avoid measurement and transparency.

Perhaps. However, in the quiet recesses of the cacophony of the Triple Aim, vast exceptions thrive: The provider who takes higher acuity cases, the solo practitioner in low health-literacy and poverty stricken communities who is "meeting people where they are," the robust rural community program physicians who know their limits and with proven track records are handling otherwise complex cases (the stuff of large tertiary care centers), the physicians who are making complicated weighted decisions on variables beyond the scope of present, rudimentary, tabulation. I've heard it said that imperfect measures are being taken equally; therefore, they are being fairly applied and thus are valid. I say nay.

Physicians are caring for patients on the trajectory of the Triple Aim but not justly on the grid of measurable outcomes. Worse, in the vast data dump, these vulnerable practices and patients are tabulated as n (a variable) and not as a complex human calculation of health and life and community. Their attributed dollars have no appropriate complexity modifiers, and patients are underserved for more binary and "transparent" decisions in the name of achieving the Triple Aim.

We are not evading transparency. This is bold recognition of the physician's responsibility to stand for the vulnerable. To shepherd our flock and bring wellness to those in need. As an emergency surgeon, I am certain that I could enter an equation, as approved by an insurer, to verify the decisions regarding surgery of the World War II vet philatelist for ischemic bowel. I know a computer could give me an answer. The answer might even include the age of his children and their likely gains and losses from his varied medical bills and post-hospitalization arrangements. However, a computer cannot sense what these decisions will do to the fabric of his family, what the costs will be to society in terms of fundamentally altered family relationships, change in attitudes and

motivation toward the local health care system and the providing physicians. A computer cannot account for the distrust in underserved populations regarding the true application of equitable care or the disruption of a trust, which is required to go from complete stranger to sleeping under a knife in a matter of moments.

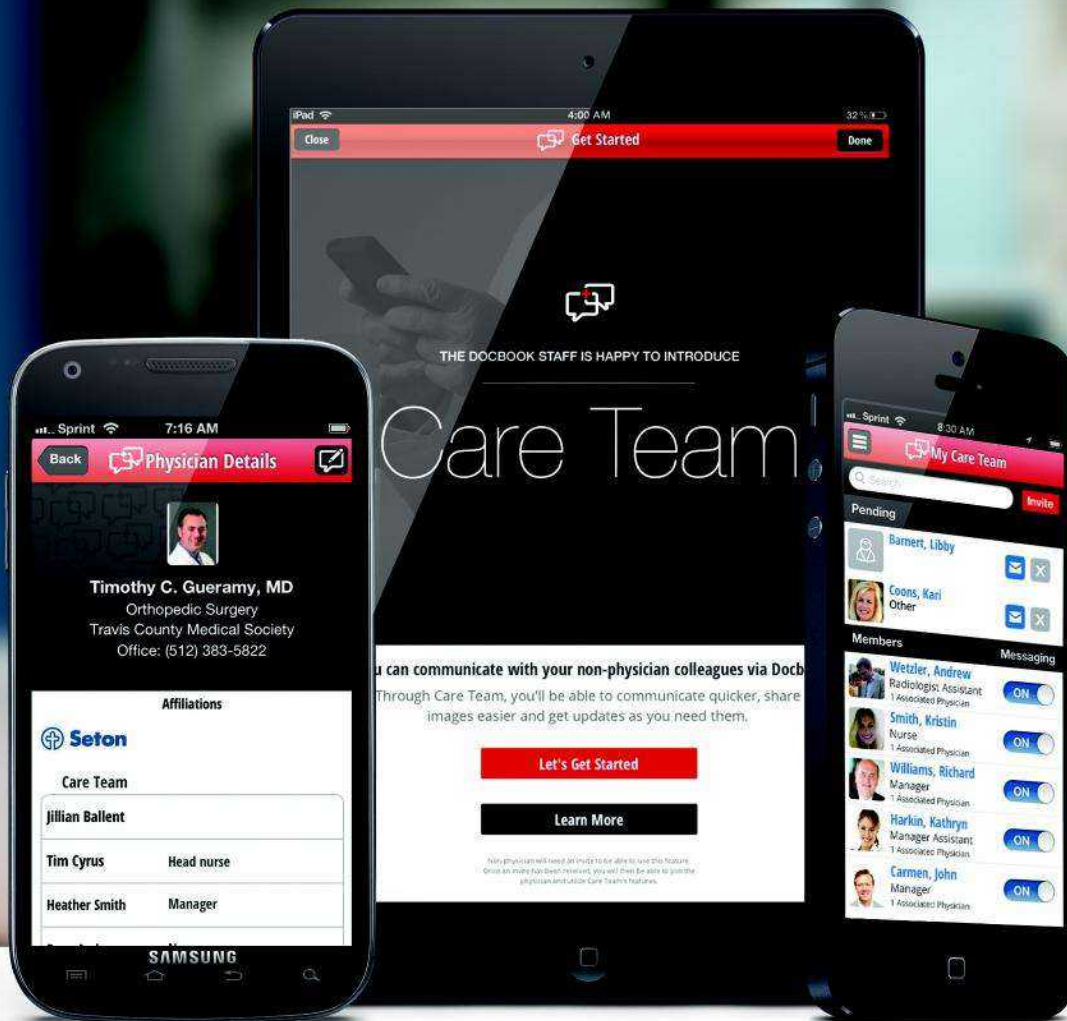
I cannot deny that numbers don't lie. However, I will stand up for my patients and say that numbers can prove anything you want them to prove and the devil is in the details. Physicians are tired. We are stressed and seeking outlets to prevent burnout and disease among our ranks. We are wired to fight and to push and to protect. We will literally kill ourselves in the pursuit of the higher good for our patients. However, we are small islands standing against a tsunami of capitalism poised to make billions on big data and quality initiatives, self-fulfilling prophecies of predetermined value propositions, and pre-arranged conclusions and success following dollars, not universal value.

As physicians we are small voices in the dark. We know what it feels like to be desperately tired, without backup, as a heart ceases to beat. We know how it feels to attend the moment of terminal diagnoses and to help find moments of joy in the hopelessness, in the face of imminent mortality. We know how it feels to bring a new infant into the world and a family who has lost and loved and lost again. We know how it feels to partner in the impossible decisions of choice. We know what it feels like to harness hopeless and rehabilitate to walk, learn, see, hear, live, and love again.

As physicians, we *are* the computers that do the calculations. We need the support of data and protocol to guide such calculations. Physicians can never cease the fight to be the stalwart keepers of the final decisions. We will, and we must, lead teams and research and policy, and we must never be replaced by them.



Your care team is now
just a tap away.



DocbookMD is a **free benefit** for MedChi members.

DocbookMD has now made it easier than ever to engage and communicate with your non-physician colleagues in a new feature to our app called Care Team. With Care Team, physicians can invite members of the patient care team to join them on DocbookMD to communicate in a secure, fast and efficient way through their mobile device. Now, all of those caring directly for patients can share messages and

images like X-rays, EKGs and images of wounds or rashes wherever and whenever they need to. Simply download the app from either the App Store or Google Play and start building your Care Team.



For more questions, please visit docbookmd.com or you can contact us at 888-930-2048 or info@docbookmd.com. The Care Team feature is only available with the latest app version of 5.0.



New Models — What's a Doc to Do?



CEO'S MESSAGE

Gene Ransom, III, Esq.
@GeneRansom

The federal government wants to change the way physicians are paid. Bureaucrats talk about the triple aim, or shifting from volume to value-based payments. It all sounds wonderful, but the reality is that they want to reduce health care costs and shift the incentives to have you help them lower costs. The Sustainable Growth Rate, which organized medicine helped to eliminate and was about lowering costs, has been replaced with new measures. However, I believe the goal hasn't changed; it's still about lowering costs.

The Centers for Medicare & Medicaid Services Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reforms Medicare payment by making the following changes:

- Ends the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services;
- Creates a new framework for rewarding health care providers for giving better care not just more care; and
- Combines our existing quality reporting programs into one new system.
- The MACRA Quality Payment Program created two paths: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured using the following standards:

- Quality;
- Resource use;
- Clinical practice improvement; and
- Meaningful use of certified EHR technology.

APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries. Private insurers will surely copy the new framework for Medicare payments. Some insurers in Maryland have instituted their own payment models, such as the Blue Cross Blue Shield Medical Home Program. In Maryland, the move to new payment models has occurred at a quicker rate because of the Maryland Medicare Hospital Waiver.

Maryland Medicare Waiver

Maryland operates under a Medicare waiver program that guarantees hospital payments. The Maryland waiver has provided billions of extra dollars to Maryland hospitals, but as it has evolved it has created new challenges. The manner in which new payment models being pushed by the federal government are implemented will likely be different in Maryland. We will have to work proactively to protect physicians' rights as the process continues.

As the state of Maryland has implemented and developed the waiver, MedChi has been at the forefront of the discussion and has participated at every step of the process. The Health Services Cost Review Commission (HSCRC) Advisory Council is doing most of the work to update the waiver. The purpose of the Advisory Council is to provide the Department of Health and Mental Hygiene (DHMH) and HSCRC with senior-level stakeholder input on the long-term vision for Maryland's transformation efforts. Its stated goal of "successful implementation of a new payment model and meeting the terms of the CMS demonstration will require the input and support of hospitals, payers, providers and other stakeholders, including patients and families." The Advisory Council meetings are open to the public, and the Council solicits public feedback throughout this process.

The waiver contract requires a blueprint for phase two by the end of 2016. MedChi has consistently opposed a straight rate-setting system for physicians. We have been working with the HSCRC and others to create alignment with gain sharing and other economic incentives for physicians, and we have asked the State to present a blueprint to CMS.

What's A Doc To Do?

The complexity of the new federal rules, the Maryland Waiver, and the system will cause many physicians to make drastic changes. I would suggest that now is the time to take a deep breath and learn as much as you can before you leap. You wouldn't perform a surgery on a patient without first doing a history and a physical. I would strongly

urge you to learn as much about MACRA, MIPS, and the Maryland Medicare Waiver as possible. You can start by visiting MedChi's website for more information: www.medchi.org/medicare-waiver.

I also would suggest that you sign up for the free services through Chesapeake Regional Information System for our Patients (CRISP), Maryland's Statewide Health Information Exchange (HIE). An HIE is the technology that supports the flow of health information among physician practices, hospital labs, radiology centers, and other health care institutions. HIE allows delivery of the right health information to the right place at the right time, providing safer, more timely, efficient, patient-centered care. CRISP offers many free services to physicians, including the following:

- Encounter Notification System (ENS): CRISP is now offering a service that enables physicians to receive real-time alerts when a patient is hospitalized. The service is offered in partnership with all Maryland hospitals at no cost to ambulatory providers. This valuable tool can help you bill certain value-based codes under Medicare and other insurers.
- CRISP Portal: Connect, share, and improve patient care.
- CRISP Direct Messaging: CRISP Direct Messaging is a secure and encrypted email service that supports electronic communication between physicians, nurse practitioners, physician assistants, and other health care providers.
- Prescription Drug Monitoring Program (PDMP): The PDMP monitors the prescribing and dispensing of drugs that contain controlled dangerous substances (CDS).

If you need more information on any of the tools available, or want more information on the policies, please contact MedChi. As we move toward a new payment model, MedChi will continue to advocate from Annapolis to Washington, DC, and back for physicians, their patients, and the public health of Maryland.

If you are Dispensing Medications you are now Required by law to complete CME.



Rx

Effective July 2013, if you are dispensing medications you must complete Continuing Medical Education credits on dispensing to apply for your permit.

ONLINE COURSES ARE AVAILABLE NOW

MedChi and The University of Maryland School of Pharmacy have collaborated to develop content to meet your needs. Introducing **Physician Dispensing in Maryland: An Educational Series**. We have made the process easy for you with the launch of three online modules:

- **Law and Regulation: An Overview Maximum 1 AMA PRA Category 1 Credit™**
- **Dispensing, Labeling & Documentation Maximum 1 AMA PRA Category 1 Credit™**
- **Controlled Substances and Inventory Maximum 1.25 AMA PRA Category 1 Credit™**

These tailored offerings are comprehensive, cost-effective, and focused to meet the Maryland drug dispensing permit requirements.

- Convenient online courses may be completed from your home or office.
- Accredited by MedChi, The Maryland State Medical Society, content is Board-approved and Secretary-approved.
- Discounted for MedChi members. \$150 per credit for MedChi Physicians. \$425 for Non-member Physicians.

Join MedChi online today at www.medchi.org. You can also register and join to receive the member discount by scanning the QR code on this form.

Simply visit www.pharmacists4knowledge.org/cips/courses/view/87, select the modules you wish to take, pay online, and complete when time permits. It's that Easy!

Additional modules will be coming soon to support your efforts to be fully compliant.

ACCREDITATION STATEMENT

Activities were planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society, and The University of Maryland School of Pharmacy. MedChi is accredited by the ACCME to provide continuing medical education for physicians.

FOR MORE INFORMATION



Roxanne Ward Zaghbab, DM, CKM
Director
CIPS Knowledge Enterprise
Center for Innovative Pharmacy Solutions
University of Maryland School of Pharmacy
20 N. Pine Street, PHN427
Baltimore, MD21201
410-706-2963



The Maryland State Medical Society

Frank C. Berry, BS, CCMEP

Director
Division of Continuing Professional Development
MedChi, The Maryland State Medical Society
1211 Cathedral Street
Baltimore, Maryland 21201
410-539-0872, Extension 3307



A Resolution by Any Other Name



EDITOR'S CORNER

Bruce M. Smoller, MD

Having traveled to Chicago and the annual meeting of our American Medical Association in June, I am happy to have the opportunity through this editorial to look back and take stock of what was accomplished and what was not. The pace of the meetings is so intense, the hours long, and the adoptions and deletions so prolific, that digesting the scope of production during the meeting is next to impossible.

One of the most anticipated topics in the weeks prior to the meeting was the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA is the replacement for the now dead SGR (Sustainable Growth Rate), the miserable formula that promised a 20 percent reduction in payments to physicians each year and required a super lobbying effort, often banging up against the very last day deadline, to keep the cut at only 3 or 4 percent. It is gone, thanks to a lobbying effort, and replaced by MACRA. We were not sure, and many of us are still not sure, if MACRA is going to be any better, but a talk at AMA by Andy Slavitt, the administrator of CMS (Centers for Medicare & Medicaid Services), at least gave some hope that it might be a bit more physician friendly. Basically, MACRA consists of two different payment systems, and a system of bonuses and penalties (yes, those again) and cost sharing. It is complicated and potentially, at least to some, worse than SGR, but Mr. Slavitt, at least, was more conciliatory and physician friendly than ever I have heard from a CMS administrator.

"I'm also here to talk about something bigger: Reversing a pattern of regulations and frustration and ultimately unleashing a new wave of collaboration between the people who spend their lives taking care of us and those of us whose job it is to support that cause."

Well, at least the cosmetics bode better than in the past. MACRA doesn't take effect for a while, and Slavitt promised that he would listen to our complaints. Time, of course, will tell. Or not. After all, this is CMS!

AMA's annual meeting took place at the time of the tragic Orlando massacre. It was directly after this horror that the Resident and Fellow Section and the Student Section showed their mettle. In the course of a day, they organized a resolution describing gun violence as a "public health crisis" and calling on our AMA to lobby the federal government to end the ban on gun violence research. A ban on research? I had no idea there was such a prohibition. No one I spoke to, with one exception, had any idea that participating in gun violence RESEARCH was enough to get one's funding yanked. For twenty years! In the United States! The Resident and Fellow Section and the students worked feverishly well and organized this, of necessity, late resolution with little time to spare. The students and residents and fellows from Maryland, or attached to MedChi, were in the forefront of this resolution, I am proud to say, and asked us to co-sponsor. Maryland rose to the occasion, but in the breach so did fifty-four other components and organizations to make this the most co-sponsor laden resolution in the history of the AMA. It passed just about unanimously.

Many other diverse resolutions and organizing principles were passed, from a revamp of the Code of Medical Ethics, eight years in the making and fifty years since the last major revision, to regulating telemedicine.

Public health issues abounded, and again the list of topics was diverse: school start times, the wavelength of street lighting, supporting paid sick leave. Maryland's resolution banning powdered alcohol made its way through MedChi to the House of Delegates last year to the Council on Science and Public Health, passed the reference committee to finally be adopted by the full House last week.

Many, many other resolutions and policies were adopted, and a full list can be found on the AMA website (www.ama-assn.org). It turns out that the passage of a resolution has currency in the real world. Policy makers and newspapers do pay attention to the AMA. General Electric and Apple are both changing bulb wavelengths to accommodate policy based on research in part conducted by AMA members and based on AMA policy. School start times all over the country and here in Maryland are being reconsidered based partially on AMA promulgated policy. Initiatives on obesity and diabetes pushed by our AMA find their way into public policy.

The AMA has problems, to be sure, but it also serves, in a very serious and wide-ranging way, as the voice-in-chief of medicine. That deserves our support. That's my resolution!

EDITORIAL STATEMENT

Editorial Offices
Montgomery County Medical Society
15855 Crabbs Branch Way
Rockville, MD 20855-0689
Phone 301.921.4300, ext. 202
Fax 301.921.4368
sdantoni@montgomerymedicine.org

Advertising
800.492.1056

Classified and Display Advertising Rates
Veena Sarin
301.921.4300,
vsarin@montgomerymedicine.org

All opinions and statements of supposed fact expressed by authors are their own, and not necessarily those of *Maryland Medicine* or MedChi. The Editorial Board reserves the right to edit all contributions, as well as to reject any material or advertisements submitted.

Copyright © 2016. *Maryland Medicine*, The Maryland Medical Journal. USPS 332080. ISSN 1538-2656 is published quarterly by the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore, Maryland 21201, and is a membership benefit.

All rights reserved. No portion of this journal may be reproduced, by any process or technique, without the express written consent of the publisher. Advertising in *Maryland Medicine* does not imply approval or endorsement by MedChi unless expressly stated.

DISCLAIMER: Some articles may contain information regarding general principles of law. They are not intended as legal advice and cannot be substituted for such. For advice regarding a specific legal situation, consult an attorney licensed in the applicable jurisdiction and with appropriate training and/or experience in the legal area in question.



MARYLANDRxCARD.com

Free Statewide Prescription Assistance Program

Compliments of:



The exclusive Rx program for the Maryland State Medical Society

The Maryland State Medical Society has partnered with Maryland Rx Card to provide savings to your patients of up to 75% on prescription drugs at over 56,000 retail pharmacies.

You can help by encouraging your patients to print a free Maryland Rx Card at:
www.marylandrxcard.com

Customize the Maryland Rx Card for your practice!

Program Highlights:



- ✓ Free to all patients.
- ✓ Cards are pre-activated, no sign-up forms needed.
- ✓ Discounts on brand and generic medications.
- ✓ Helps patients that have high deductible plans or are uninsured.
- ✓ Reduces patient callbacks.
- ✓ Enhances physicians ability to treat patients with drugs that may not otherwise be affordable.
- ✓ HIPAA Compliant

For more information or to order your free personalized Maryland Rx Card please contact:

John Cenerazzo - Program Director
john@marylandrxcard.com



Free Rx iCard



Maryland Rx Card

Introduction

Mark Jameson, MD

Modern medicine has been characterized as a twenty-first century high tech Maglev locomotive financed on nineteenth century railroad tracks. The seemingly unabatable rising costs of health care, borne largely by employers and government, prompted the search for novel financing methods. Value-based payment represents the newest attempt to control costs.

At its core, value-based payment aligns payment with specified clinical or financial criteria. For the first time, physicians are reimbursed in part based on their costs and the health of their patient population.

The concept of value-based payment is often attributed to authors Michael Porter and Elizabeth Teisberg's 2006 book *Redefining Health Care*. A decade later, value-based payment has changed the configuration of medical practice. Today, 30 percent of Medicare and Medicaid payments are value-based and are projected to reach 50 percent by 2018. More than 90 percent of commercial insurance companies offer value-based plans. Even medical school curriculums include value-based payment. Value-based payment represents a gyroscopic change in the way physicians are paid.

Recently, the Centers for Medicare and Medicaid (CMS) issued new draft regulations for the payment options that will affect all practicing physicians, not just those physicians already participating in a model. The final regulations will be issued in the fall of 2016 (<https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf>).

These regulations represent a new dimension of health care delivery directly impacting every physician, no matter what type of practice environment. The only realistic option confronting physicians is to prepare in advance and adapt to the upcoming changes. In previous years passively "going along" was sufficient to accommodate incremental changes in regulations and policies. However, the upcoming changes in health care delivery are so dramatic that careful planning and preparation are essential.

How can physicians prepare for the new era of value-based payment? In this issue of *Maryland Medicine*, several types of value-based payment programs in Maryland are presented. Tom Walsh, MD, who serves on the Advisory Board of the HSCRC, writes his perspective. Donna Kinzer, Executive Director of the Maryland Health Services Cost Review Commission (HSCRC), writes about several new initiatives in Maryland. Carmela Coyle, CEO of the Maryland Hospital Association, updates hospitals' status and strategies. Joe Ross, CEO of Meritus Health, writes of the experiences in the Medicare Shared-Savings ACO. Isabella Firth, CEO of LifeSpan Network, reviews the experiences in post-acute care facilities. Chet Burrell, CEO of CareFirst, discusses the Patient-Centered Medical Home. Carol Vargo of the American Medical Association reviews a recent RAND® study on value-based payment. On a smaller note, this writer offers his personal reflections.

The regular *Maryland Medicine* features include Dr. Brooke Buckley, President of MedChi writing the President's Message. Dr. Bruce Smoller, editor of *Maryland Medicine* contributes the Editor's Corner. Gene Ransom, the Executive Director of MedChi writes the CEO's Message, focusing on Value-based Payment. We are also pleased to present another of Dr. Bart Gershen's classic Word Rounds.

Finally, in the era of value-based payment, clinical skills alone are no longer sufficient for physicians to successfully practice medicine. Value-based payment requires physicians to learn and practice vital new skills: leadership of team-based care and knowledge of new financial structures and methods.

Editor

Bruce M. Smoller, MD

Editorial Board

John W. Buckley, MD
Tyler Cymet, DO
Barton J. Gershen, MD
(Editor Emeritus)

Mark G. Jameson, MD, MPH
Stephen J. Rockower, MD
Taylor T. DesRosiers, MD

Director of Publications

Susan G. D'Antoni

Managing Editor

Susanna M. Carey

Production

Megan Morris

MedChi, The Maryland State Medical Society

CEO

Gene M. Ransom, III, Esq.

President

Brooke M. Buckley, MD

President-Elect

Stephen J. Rockower, MD

Immediate Past President

Tyler Cymet, DO

Secretary

Benjamin Lowentritt, MD

Treasurer

Shannon P. Pryor, MD

Speaker of the House

Michele Manahan, MD

Vice Speaker of the House

Benjamin Z. Stallings, MD

AMA Delegation Representative

Bruce M. Smoller, MD

Anne Arundel County Trustee

James J. York, MD

Baltimore City Trustee

Anuradha Reddy, MD

Baltimore County Trustee

Gary W. Pushkin, MD

Montgomery County Trustee

Shannon P. Pryor, MD

Prince George's County Trustee

Jagdeep Singh, MD

Eastern Group Trustee

Michael P. Murphy, MD

Southern Group Trustee

Vacancy to be filled

Western Group Trustee

J. Ramsay Farah, MD, MPH

Trustee at Large

Mark T. Edney, MD

Trustee at Large

Padmini D. Ranasinghe, MD

Specialty Society Trustee

Benjamin H. Lowentritt, MD

IMG Section Trustee

Laurel G. Yap, MD

Resident Section Trustee

Richard A. Bruno, MD

Medical Student Section Trustee

Regina Cho

Bylaws Council Co-Chair

Shannon P. Pryor, MD

Communications Council Co-Chairs

Bruce M. Smoller, MD

Legislative Council Co-Chairs

Gary Pushkin, MD

Sarah Merritt, MD

Medical Economics Council Co-Chairs

Loralie Ma, MD and Francisco A. Ward, DO

Medical Policy Council Co-Chairs

Ramani Peruvemba, MD and David Safferman, MD

Operations Council Co-Chairs

Seth Y. Flagg, MD and J. Michael Niehoff, MD

continued on page 12

Introduction ...

Continued from page 11

MedChi offers two programs for physicians to confidently acquire the necessary new skills and knowledge. The first is the Certificate Program in Physician Leadership by Paul Gurny and Dr. David Joyce. Physicians may enroll for the online course at: <http://healthymaryland.org/maryland-physician-leadership-institute/2016-certificate-program/>. The second is a four-hour CME "MACRA Rules: Pay For Performance" by Dr. David Joyce, also through the Maryland Physician Leadership program. Writing from the perspective of someone who has completed both courses, I highly recommend them for all physicians to prepare for the future.

Thank you for reading this issue of *Maryland Medicine*. Our hope is that this issue will help prepare physicians for the new era of value-based payment.

VALUE-BASED CARE

Is Your Practice Ready?

The Practice Transformation Network provides:

No cost consulting, coaching and education to help your practice successfully transition to Value-Based Care.

Sign up today.

Your coach is ready and raring to help your practice transform.



Call 301.921.4300

Take a closer look at the MedChi Career Center...



Create your job seeker or employer profile today at CAREERS.MEDCHI.ORG/

MedChi

The Maryland State Medical Society

All services are FREE to Job Seekers

- Build your own in-depth profile to market your skills & talent
- Upload your resume and update it as often as you want (confidentially, if you prefer)
- Set up a personal Job Agent and be alerted when new jobs are posted
- Review career-search tips and advice from recruiting experts

MedChi Employer Features

- Find the best products and rates to meet your staffing needs
- Search for qualified candidates based on job specific qualifications
- Create an online Resume Agent to email qualified candidates right to your inbox daily
- Use Employer Resources to get help with government compliance, job posting tips and other resources

MedChi Accomplishments During the 2016 Maryland Legislative Session



Stephen J. Rockower, MD
@DrBonesMD

We are now more than half way through this Legislature. Two years ago, many new delegates and senators were elected. They nervously and cautiously approached their jobs in January 2015 trying to figure how it all worked, and where the bathrooms were. Now, two sessions later, they have learned how to get things done, and actually have done it.

The annual Maryland House of Delegates met for ninety days from January to April. More than 2,800 bills were introduced, and 235 of them pertained to some aspect of medicine. MedChi's lobbying team of Schwartz, Metz, and Wise sorted through the bills, and the Legislative Council, chaired by Dr. Gary Pushkin and Dr. Sarah Merritt, considered them on a weekly basis. Subcommittees concentrating on Insurance, Public Health, and Boards and Commissions discussed the bills thoroughly on conference calls each weekend, and the entire Council took positions at our Monday meetings. Numerous physicians, residents, and students took time to testify on the bills in Annapolis. Overall, we did reasonably well this session. MedChi's Legislative Agenda, passed by our House of Delegates in the Fall of 2015, had three overarching themes:

1. **Advocating for Physicians** (including strengthening medical liability laws, enhancing payment and insurance concerns),
2. **Advocating for Patients** (including Medicaid access, Scope of Practice issues, and reforming unfair insurance practices), and
3. **Advocating for Public Health** (including our Tobacco Free Initiative, protecting children's health, and ensuring toxic chemical information).

We worked closely with our four physician legislators, Drs. Dan Morheim, Terri Hill, Jay Jalisi, and Clarence Lam. While we did not win everything, we did well on all fronts.

Medicaid Payment For E&M Codes:

At the end of the O'Malley administration, Medicaid fees for E&M codes were slashed to 86 percent of Medicare. In 2015, we successfully increased fees to 92 percent, and this year we were able to convince the Legislature to bring it up to 96 percent. The Governor recently approved a 2 percent increase in the fees, resulting in \$14 million more in provider payments.

Board of Physicians Fees:

For many years, 12 percent of licensure fees were diverted to two programs: one to help physicians who practice in underserved areas repay their loans (which we liked) and one for HPSIG, or a "Health Personnel Shortage Incentive Grant" (which we didn't). The HPSIG program was rarely used for any type of health-related program, and the funds now will remain with the Board.

CME Requirements:

As we all know, there was a recent requirement for all physicians to take mandated CME (Continuing Medical Education) concerning opioids and opioid abuse. While this is a laudatory idea, not all physicians prescribe or deal with these issues. House Bill 185, introduced by Delegate Dr. Dan Morhaim, removes the CME requirement beginning in 2017.

Prescription Drug Monitoring Program (PDMP):

While the problem of opioid abuse is well known to physicians in Maryland, a number of bills were introduced to require our querying of the CRISP database for each and every prescription written. Obviously, this would be a significant impediment to efficient use of physician time and patient flow. In addition, we would be obligated to inform law enforcement agencies of irregularities. We strongly objected to these measures, and we were able to successfully remove all law enforcement language and delay the implementation of any requirement until at least 2018. We were able to argue that, while the program has advantages, the requirement factor would overwhelm the database, which "isn't ready for prime time" yet.

However, if you hold a CDS registration, you will need to register for the PDMP and query the PDMP before initially prescribing an opioid or benzodiazepine and at least every ninety days thereafter as long as the course of treatment continues to include these drugs. The prescription drug monitoring program registration deadline has been misreported by some because it is so confusing under Maryland law. The law itself takes effect on October 1, 2016, but the mandatory registration requirement kicks in either when the prescriber needs to renew or obtain a new CDS registration, or by July 1, 2017, whichever is sooner.

If a prescriber renewed or obtained a new CDS on August 1, he or she would not need to register until July 1, 2017. However, if the prescriber's registration is new or has to be renewed on December 1, he or she would register at that time. We are encouraging everyone to register sooner rather than later.

If you do not have a CDS license, you do not need to register. Please email Rachel Hennick (rhennick@medchi.org) for assistance in signing up for the PDMP and CRISP services.

Network Adequacy:

The Insurance Commissioner will now have the authority to determine the adequacy of an insurer's network. Are there enough primary care physicians? Enough specialists? Is the website accurate for correct addresses and phone numbers? Or even if the physician is alive? The insurers can be fined if they are found to have inaccurate information. MedChi eliminated language that would have penalized physicians for not updating their information.

Naturopath Formulary:

As a result of a workgroup of physicians, pharmacists, and naturopaths, a very limited formulary of “non-legend” drugs was approved, which does not include any Schedule II, III, or IV drugs. The formulary also limits the routes of administration of anything naturopaths prescribe. A naturopath can, however administer epinephrine in ways that other non-physicians can.

Medicine Liability Issues:

The only bill to pass in our favor allows one insurance policy to cover not only liability issues, but also any disciplinary hearings arising from the practice of medicine. In previous years, we had to purchase separate policies. We were successful (again) in preventing a bill to triple the cap on non-economic damages (“pain and suffering”) from leaving committee. We were unsuccessful, however, in moving a bill to allow hospitals to set up a “Safety Task Force” arising from medical misadventures. This “apology bill” could head off any further litigation if the parties could discuss the issues in an open forum. The No-Fault Birth Injury bill also failed to pass.

Physician Payment Reform:

You may not have noticed the increase in use of virtual credit cards by insurance companies for payment of claims, instead of checks or an electronic funds transfer. While it may be an efficient way to be paid, the credit card processors were extracting a 3.5 percent to 5 percent fee for the “convenience” of getting paid by this insecure method without an actual card to swipe. House Bill 639 requires insurers to have physicians “opt-in” to these programs before they make payments via credit cards to collect the perqs of miles or receive cash back from the credit card processors.

Other Bills That Passed:

- Fees for Copies of Medical Records from EMRs set at 85 percent of paper copies.
- Child Abuse Reporting was made non-criminal for a physician’s failure to report
- Telemedicine Services were approved for primary care providers under Medicaid under certain circumstances.
- Notice Language for Lyme testing—certain language must be provided to patients that the test may be unreliable.
- Physicians who have dispensing licenses may now delegate the task of dispensing to Physician Assistants and Nurse Practitioners.
- A very narrowly crafted bill allows the Department of Health and Mental Hygiene (DHMH) to estimate overpayments by extrapolation from a subset of claims.

Other Bills That Did Not Pass:

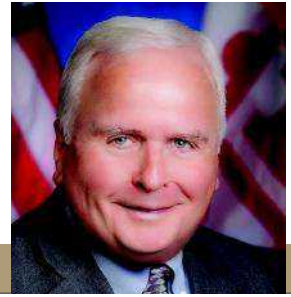
- Multiple Aid in Dying bills were introduced to allow Maryland physicians to participate in a patient’s choice to end their life when they have an incurable disease. There was much discussion on both sides of this issue, not only in the legislature, but also in the media and within the medical community. MedChi’s official policy, as determined at the April 2015 House of Delegates meeting, is in line with the AMA, which is to oppose. Many physicians have taken stands on both sides of this issue, and have communicated personally with their representatives.
- The bill to allow a sixty-day grace period in renewing your medical license did not pass. Physicians must send information (and fees) in on time.

- A bill requiring hospitals or physicians to report any “financial arrangements” with pharmaceutical or surgical hardware manufacturers did not pass.

As always, physician input is essential in formulating and promoting MedChi’s agenda. Personal contacts with legislators, especially over the summer and fall, are invaluable when the legislative season arrives in the winter. Attend a fundraiser. Donate to MedChi’s Maryland Medical PAC. Become involved. We need each and every one of you to be part of the process. “If you are not at the table, you are on the menu.”

Stephen J. Rockower, MD, is an orthopaedist practicing in Rockville, MD. He is president-elect of MedChi, and co-chair of MCMS’ Legislative Committee. He also is a subcommittee chair of the Council on Legislation for MedChi. He can be reached at drrockower@cordocs.com and on Twitter @DrBonesMD and @MedChiPresident.

Value-Based Payment Models: It Pays to Be Prepared



CLINICIAN PERSPECTIVE

Tom Walsh, MD

Payment for physician services in Maryland and throughout the country is about to change, in a big way. There is a meaningful change toward value-based payment happening as I write. I believe all physicians should stop what they are doing and spend some time understanding these significant changes and what they mean, not only for the way we are paid but also for the way we practice. I personally have spent the last three and one-half decades, all in Maryland, in the private practice of primary care medicine. What we are about to experience is more significant than any of the changes we have seen during my career.

Let's flash back to the early 1980s when I first started in practice. In some ways it seems like "the good old days." You worked hard, submitted lots of claims to Medicare and commercial insurers, and got paid "reasonable and customary" rates. Sounded good on the surface; however, there were no incentives to manage costs, nor was there any accountability for the expenses. There was nothing in place, at least at the payer level, to look at quality outcomes. The payment system of the 1980s gave way to the capitated, risk-sharing arrangements of the 1990s. There were some financial incentives to better manage costs. Built in to some of these arrangements were incentive based payments with some quality metrics, like hospitalization rates, pharmaceutical costs, and others. It was a start, but it was not a real "payment for quality" system.

On April 15, 2015, Congress and President Obama approved one of the most significant bills in the history of U.S. health care reform. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made important changes in how Medicare pays those who provide care to Medicare beneficiaries. These changes create a Quality Payment Program. While MACRA ended the previous formula for determining Medicare payments for health care provider services, it also set up a framework to reward health care providers for giving better, not just more, care. MACRA combined our existing quality reporting programs into one new system. The changes replace a patchwork system of Medicare reporting programs with a flexible system that allows a physician to choose from two paths that link quality to payments: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS and APMs will go into effect from 2015 to 2021 and beyond.

MIPS is a new program that combines parts of previously in-place programs, such as the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier, and the Medicare Electronic Health Record (EHR) incentive program, into a single program in which eligible professionals will be measured. The metrics used will be quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology.

Providers may choose to not participate in the MIPS program and instead choose the Alternative Payment Models. Examples of Alternative Payment Models are Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and bundled payment models.

These new programs are more than just "alphabet soup." The changes will undoubtedly drive us toward a more accountable system that should produce higher quality care. The goal is to deliver better care to our Medicare patients. It is very important for all eligible professionals who provide care to Medicare recipients to spend time understanding the programs. Performance will have significant financial impact on Medicare providers. Congress intended for a large part of this program to be revenue neutral; there will be winners and losers. Understanding the programs will help a provider end up on the winning side of these incentives. I am sure that most people reading this are asking what this all really means for those in private practice treating Medicare patients. There are two paths a provider can take in the Quality Payment Program. Let's look at the financial impact of each.

If a physician chose the Alternative Payment Model (APM), he or she would participate in one of several qualified APM model programs. These programs include a Medicare Shared Savings Program Accountable Care Organization (ACO), a model expanded under the Center for Medicare and Medicaid Innovation (CMMI) that is not a Health Care Innovation Award recipient, a Medicare Health Care Quality Demonstration Program or Medicare Acute Care Episode Demonstration program, or a demonstration program required by federal law. The practices will use quality measures comparable to measures used under MIPS, they will use certified electronic health record technology, and assume a "nominal financial risk" or is a medical home expanded under the CMMI. From 2019 to 2024, those practices will receive a 5 percent annual lump-sum bonus. There will be a transition into a payment with more risk. Depending on how much annual Medicare payment dollars a practice receives, the bonus could be a significant amount of money.

A physician could choose the MIPS payment system. Participants must meet a volume threshold of a minimum number of one or more of the following: Medicare beneficiaries, items/services, and/or allowable charges OR have submitted Medicare Part B reimbursement for over a year. A weighted score based on four metrics determines payment adjustments: quality, resource use, meaningful use of certified EHR technology, and clinical practice improvement activities. Space doesn't allow me to go into the specifics of each metric, but they are spelled out in detail on the Medicare websites. The payment adjustments are based on the score and can be positive or negative. From 2019 to 2022 the payment adjustment can vary from 4 percent to 9 percent, either positive or negative. This payment system is revenue neutral so a performance score of 50 out of a possible 100 will yield no adjustment up or down. In 2022 the spread would be from -9

percent to +9 percent; exceptional performers may be eligible for an additional positive payment adjustment of up to another 10 percent. There is a significant amount of money to be gained (or not gained) in the MIPS program, again depending on how much annual Medicare payment dollars a practice receives. For a single Medicare provider who is paid \$100,000 a year in Medicare Part B payments there is a possible annual top to bottom variation of \$28,000. The numbers can be significant.

The goal, however, is to find a way to not only reward Medicare providers with more money or to penalize other providers with lower payments, but also to find a way to reward quality. Based on the metrics that Medicare has and will develop, the hope is that Medicare recipients will receive a higher level of care. CMS seems to indicate that this will likely be an evolving program. For my Medicare patients and me it seems like a step in the right direction.

It's important for all providers who see Medicare Part B patients to take time to understand the program and make the necessary moves to position themselves to work with one or the other payment systems. The systems will start collecting information based on 2017 data for payments made in 2019.

It pays to be prepared. Change can be difficult but often it's worthwhile. Thinking back to the early 1980s again, things certainly have changed.

Thomas Walsh, MD, is in private practice in Queen Anne's County. Dr Walsh also is a founding partner of Maryland Primary Care Physicians, one of the largest physician owned and managed primary care groups in the state. He can be reached at tmw113@gmail.com.

The ABCs of VBC (Value-Based Care)

Mark Jameson, MD

Accountable Care Organization (ACO): Begun in 2012, an ACO consists of groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated care to Medicare patients. When an ACO documents the defined care within cost limits, it will share in the savings it achieves for the Medicare program. Subtypes include the Medicare Shared Savings Program.

Alternative Payment Model (APM): One of two mandatory options for physician payment under the draft Medicare regulations scheduled to start in 2019 (based on a physician's 2017 practice cost information). Physicians work with their specialty societies to participate.

Children's Health Insurance Program (CHIP): Created by Congress in 1997 to provide insurance to low income children who are ineligible or Medicaid but not otherwise covered by health insurance. Became part of the MACRA legislation in 2015 (see MACRA below).

Centers for Medicare and Medicaid Services (CMS): The federal agency that issues regulations on Medicare and Medicaid. Additional information on the various models and proposals is available at <https://innovation.cms.gov/>.

Health Services Cost Review Commission (HSCRC): Established in Maryland in 1971 as an independent state agency, with seven commissioners, that sets hospital rates for all payors. HSCRC does not regulate physician fees at this time, although this has been proposed.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation enacted by Congress in 2015 that repealed the Sustainable Growth Rate formula and replaced it with the choice of two physician payment models to go into effect in 2019 (based on a physician's 2017 practice cost information). The two options are Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Models (APMs).

Merit-Based Incentive Payment System (MIPS): One of two mandatory options for physician payment under the draft Medicare Regulations to start in 2019 (based on a physician's 2017 practice costs.) Under MIPS, payment will be adjusted based on a composite score starting at 4 percent in 2019 and up to 9 percent in 2022. The adjustment is based on four components:

1. **Quality (50 percent decreasing to 30 percent in 2021):** Physicians select six measures to report instead of the current nine measures from among a range of options that accommodate differences in specialties and practice settings.
2. **Resource use (10 percent increasing to 30 percent in 2021):** These measures will be determined by CMS using claims and replace the Value-Based Modifier program.
3. **Advancing Care Information (25 percent):** Physicians choose to report customizable measures that reflect how they use technology in their daily practice.
4. **Clinical Practice Improvement Activities (15 percent):** Physicians would select criteria that match their practice from among 90 options, which include expanded practice access, care coordination, and patient engagement.

Patient Centered Medical Home (PCMH): A "medical home" alternative payment model for primary care. Consists of team led primary care. Payment is based on predetermined cost and quality criteria.

Total Patient Revenue (TPR): A mandated global, or total budget, "cap" set for each hospital in Maryland irrespective of hospital admissions.

Value-Based Care or Value-Based Payment/Purchasing (VBC or VBP): General category of alternative payment methods in which payment is tied to achieving predefined clinical and cost criteria. Actual criteria and payment incentives/penalties vary by program.

Transforming Health Care in Maryland to Deliver Value



REGULATOR PERSPECTIVE

Donna Kinzer

Maryland continues to align with the national movement to transition from volume-based to value-based health care. We are enacting Maryland's value-based health care delivery transformation through our statewide All-Payer Model, as well as through emerging regional and local models. We look forward to working with all Maryland physicians as we broaden our delivery system transformation efforts.

National Strategy

The Centers for Medicare and Medicaid Services (CMS) has laid out a national health care strategy that focuses on three areas: provider payments, delivery of care, and distribution of information. Through this strategy, CMS will link provider payments to value, encourage payment models that move away from fee-for-service (FFS), and scale proven payment models. To improve delivery of care, the strategy focuses on encouraging integration and coordination of care, improving population health, and promoting patient engagement. To improve distribution of information, the focus will be on creating transparency on cost and quality information and bringing electronic health information to the point of care.

As part of this national strategy driving value-based care, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) on April 14, 2015, which was signed into law by President Obama. MACRA repeals the Sustainable Growth Rate (SGR) formula, which linked the Medicare annual payment adjustment for physician services to GDP growth. In place of the SGR, MACRA establishes a new system for rewarding physicians for value rather than volume.

Two primary components of the MACRA intended to promote value-driven care are the Merit Based Incentive Payment System (MIPS), which streamlines multiple quality reporting programs into one new system, and incentive payments for participation in advanced Alternative Payment Models (APMs). MIPS payment adjustments and qualifying APM bonuses will begin in 2019.

Maryland Strategy

In January 2014, CMS and the state of Maryland launched the new Maryland All-Payer Model, which aligns with the broader national strategy. The All-Payer Model builds on our long-standing tradition of leadership in hospital rate-setting and payment-related reform initiatives. Under the All-Payer Model, all health care payers, including Medicare, pay the same rates for inpatient and outpatient hospital services. Maryland is the only state with an all payer hospital rate regulation system, which is led by the Health Services Cost Review Commission (HSCRC), a Maryland state agency. The Maryland All-Payer

Model is an effort to improve health care for all patients regardless of their health care payer, and facilitates Maryland's transition from volume-based care to value-based care.

Under the All-Payer Model, Maryland established a new hospital global budget payment program through which all payers collectively pay hospitals a fixed annual amount for inpatient and outpatient services. The aggregate revenue is adjusted annually for inflation, various quality metrics, and other factors. Hospitals began moving to all-payer global budgets in July 2014. All forty-seven acute care hospitals have moved to global budgets. In 2014, the All-Payer Model's first performance year, more than 95 percent of hospital revenue moved from volume-based payment to per-capita measures. Additionally, the annual growth of all-payer per capita hospital costs was contained to 1.47 percent, and Medicare saved \$116 million in costs. The State also overhauled its value-based purchasing (VBP) and dramatically reduced hospital-acquired conditions. Finally, the State reduced its thirty-day all cause readmissions rate, which was historically much higher than the national rate, with the eventual goal of aligning with the national average. As we move through the third performance year of the All-Payer Model, we continue to see encouraging results.

Catalyzed by the global budget model and the new VBPs, innovative clinical transformation is underway in Maryland. Hospitals published strategic transformation plans that reorient care toward population health, and are developing partnerships with non-hospital providers. Such efforts are driven in part by the new model, which incentivizes hospitals to partner with primary care physicians and other providers to provide better care for patients outside of the hospital, reducing hospitalizations and other avoidable use.

While the All-Payer Model is achieving positive results, the current model is focused on hospital performance. HSCRC and other State agencies are working with stakeholders on a strategic plan that expands health care delivery system reform to include additional health care entities. Under this plan, the State will partner with stakeholders and test innovative models to share responsibility for system-wide outcomes and cost. This plan will first focus on Medicare beneficiaries, while maintaining a commitment to all-payer principles.

Emerging Models of Care

Maryland health care providers are also implementing regional and local models. These emerging models include regional partnerships, Accountable Care Organizations (ACOs), and Patient Centered Medical Homes (PCMHs). The models align with national and state strategies, and focus on person-centered care coordination under a value-based payment system.

The HSCRC is facilitating the development and implementation of several regional partnerships. These partnerships, while facilitated by hospitals, extend beyond the hospital walls to better coordinate care with community-based health care providers. Key benefits of the regional partnerships include improved information flow and streamlined communication, which will make standardized, person-centered information more easily available to physicians, as well as broader care coordination efforts with community-based health care providers. As we move forward, HSCRC is hopeful that regional partnerships will encourage collaboration across health care providers to improve patient care.

A second emerging model of care is the ACO. There are approximately twenty-one Maryland-based ACOs, which provide care to nearly one quarter of the State's Medicare FFS beneficiaries. ACOs are intended to integrate care delivery across multiple health care providers and foster collaborative efforts among physicians, hospitals, and other health professionals that are clinically and financially accountable for the delivery of care. ACOs are structured around a patient-centered approach of care that emphasizes primary care and preventive efforts. ACOs that succeed in delivering high-quality care and spending health care dollars wisely share the savings with Medicare and participating providers.

A final emerging model of care in Maryland is the PCMH. PCMHs provide a centralized setting that facilitates partnerships between patients and their physicians to closely coordinate care, and are particularly beneficial for patients with chronic illnesses. Physicians may be paid incentives for additional time devoted to providing care coordination, as well as for improving specific health outcome measures. In Maryland, private insurer CareFirst facilitates a PCMH that is among the nation's first network-wide programs, with robust physician participation and patient reach within Maryland, Washington, DC, and Virginia. Launched in 2011, CareFirst's PCMH program has nearly 4,000 primary care providers who participate voluntarily and provide care to approximately 1.1 million CareFirst members.

These and other emerging models of care in Maryland will catalyze further delivery system transformation.

Emerging Models of Care

The All-Payer Model developments, as well as the more localized emerging models of care, will have many benefits for physicians, including the following:

- Increased efforts by hospitals and providers to reduce potentially avoidable hospital care, including reducing unnecessary hospital admissions and readmissions.
- Increased focus on interoperability among health care systems.
- Improved data infrastructure and exchange tools for care management and care coordination, which may assist physicians with reporting requirements under the new MACRA legislation.
- Increased opportunities for shared savings arrangements, outcomes-based payment, and incentive payments when care is improved and avoidable use is reduced, which may help physicians qualify for higher performance scores under the new MACRA legislation.
- Greater ability to provide health care in the most appropriate setting for patients.

Physicians in Maryland can take advantage of these opportunities in the following ways:

- Connect by using CRISP services, such as Encounter Notification Services, DIRECT Messaging, and the Prescription Drug Monitoring Program.
- Coordinate by working with case managers to address medical and social needs of complex patients.
- Participate in ACOs, PCMHs, and other geographic initiatives.
- Contribute to the redesign of the state's health care delivery system through State workgroups run by HSCRC, Department of Health and Mental Hygiene, and Maryland Health Care Commission.

Maryland hospitals, regional partnerships, ACOs, and PCHMs are aligned in transitioning from traditional health care in our state to value-based care. As we strive toward this common set of values, care delivery reform will extend further to encompass community-based health care providers. Both national and state models of care are highly dependent on strong partnerships between hospitals and community-based care providers. Maryland is gaining momentum in this exciting transformation, and we are uniquely positioned to serve as a model for other states in years to come.

Donna Kinzer is the executive director at Maryland Health Services Cost Review Commission. Prior to joining HSCRC, Ms. Kinzer was a director at Berkeley Research Group. She can be reached at Donna.Kinzer@maryland.gov.

Take a PAGE out of our HISTORY!

The Maryland Medical Journals, from 1870 to 1960, are now digital and fully searchable. This is just one project of the Center for a Healthy Maryland, and was funded by a gift from a very generous donor.

We hope that you will support all of our important projects. For information on making a gift, email events@medchi.org

Center for a
Healthy Maryland

For Maryland's Hospitals, Everything Is Value-Based



Carmela Coyle

HOSPITAL PERSPECTIVE

Maryland's hospitals are midway through a five-year experiment that could legitimately be considered one of the nation's largest and most ambitious experiments in "value-based purchasing."

In January 2014, Maryland's hospitals agreed to a modernized version of a nearly forty-year-old agreement with the Centers for Medicare & Medicaid Services (CMS). The updated agreement—often referred to as Maryland's "Medicare waiver" (because it waives federal payment rules and provides that all payers pay the same amount for the same service at the same hospital)—provided a framework that, for the first time on a statewide level, held the promise to reduce per capita health care costs, improve the health of communities, and improve the care experience for patients. A "Triple Aim roadmap," if you will.

Specifically, there are five targets that hospitals must meet to ensure that the agreement, and the nearly \$2 billion in additional federal revenue that flows to Maryland each year, remain intact:

1. Limit all-payer hospital per capita spending in Maryland to annual growth of 3.58 percent.
2. Reduce total Medicare hospital spending in Maryland by \$330 million over five years.
3. Limit growth in total Medicare spending per beneficiary in Maryland to no more than national growth.
4. Reduce the readmissions rate in Maryland to the national average within five years.
5. Reduce infections and other hospital-acquired conditions by 30 percent within five years.

Hospitals are making significant progress on all of these targets. Cumulative spending growth is well below the goal, readmissions rates are declining even faster than the national rate of decline, and hospital-acquired infections and complications have dropped by more than one-third.

The targets dovetail neatly with CMS's broad national push to contain costs by improving quality and efficiency in all health care settings. Physicians are experiencing improvements through the Medicare Access & CHIP Reauthorization Act, or MACRA (more on this later). Maryland has been an early and fertile testing ground for new payment models and incentive programs for hospitals, thanks to the state's longstanding unique relationship with CMS and hospitals' willingness to have skin in the game when it comes to making the transition from volume to value.

The principles that the Maryland hospital experiment embody are spreading in other states through CMS's formal value-based purchasing programs—initiatives that reward acute care hospitals for the quality of care they provide to Medicare beneficiaries. Department of Health and Human Services Secretary Sylvia Mathews Burwell describes the goals of these initiatives aptly: "Whether you are a patient, a provider, a business, a health plan,

or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people" (January 26, 2015; available at www.hhs.gov/news).

Maryland's Waiver and Value-Based Purchasing

CMS's formal value-based purchasing initiatives reward hospitals for improvement in multiple areas: patient care, reduced readmissions, and reduced hospital-acquired conditions and mortality rates.

In Maryland, similar incentive programs drive the push toward quality care under the modernized Medicare waiver. The programs work in concert with a focus on reducing readmissions and hospital-acquired conditions.

Because of Maryland's unique hospital payment system, hospitals have embarked on a path different from that of the rest of the country to achieve the same quality improvement goals sought by Hospital Engagement Networks and other national initiatives. Maryland has a more rigorous pay-for-performance system that applies not only to Medicare patients, but also to all 6 million citizens in the state. The program includes sixty-five potentially preventable complications, compared to the fourteen tracked across the rest of the nation.

However, these programs are simply mechanisms to achieve the targets of the modernized agreement. The real game-changing force behind the wholesale transformation to quality over quantity was the upending of hospitals' traditional fee-for-service model in favor of fixed global budgets, which cap the annual revenue for each hospital. By the end of the first year under the new waiver, 95 percent of all hospital revenue was governed by global budgets. This has been a potent incentive for hospitals to reduce costs by reducing unnecessary use and improving quality.

The shift from fee-for-service to value-based, especially in such a short time period, has not been without challenges. Maryland's hospitals have completely changed their business model and the way in which they deliver care. Individual hospitals have been feverishly investing in (1) new care coordination partnerships with providers outside the hospital, (2) population health initiatives, and (3) staff development to drive patients to the most appropriate care in the most appropriate setting. For health care leaders accustomed to the fee-for-service world, it has been challenging to step outside the traditional mindset. Maryland's hospitals are now paid the same revenue no matter how many people they treat. Reducing volume is actually beneficial because unnecessary care under a fixed annual budget directly affects a hospital's ability to make strategic investments in care where and when necessary.

Why and How It's Working

Transformation on this scale isn't possible without a major cultural shift at the organizational level, and three principles underpin the progress that's been made so far:

1. Data transparency—By sharing data among the entire hospital field, including monthly CMS updates on readmissions and hospital-acquired conditions, hospitals are able to benchmark against their peers to assess trends and identify the driving factors.
2. Collaboration/Shared Learning—Because the targets under the modernized Medicare waiver are statewide, despite remaining competitive in many ways, hospitals are naturally incentivized to help one another improve, and do so by sharing best practices.
3. Experimentation—To ensure that patients receive the right care at the right time in the right setting, they are partnering with providers across the continuum in new ways, such as embedding physicians in skilled nursing facilities. And hospitals are redefining themselves away from episodic, acute care centers and toward proactive care centers that aim to keep people healthy and out of the hospital unless necessary

Hospital care is now *health* care.

Despite the energy invested in care transformation and the early success that has been achieved, the sustainability of the progress is uncertain. At this stage, it is still critically important to invest in the resources needed to care for an unknown number of patients with unpredictable care needs within a fixed global budget. Perhaps the greatest challenge to achieving this kind of transformation is resources. The continued success of the Maryland model depends on state regulators' willingness to adequately fund the system. Maryland must be cautious to not be pennywise and pound-foolish as we reshape care delivery for success. And that's where Maryland's physicians will play an essential role.

Change Is Here and Will Continue

The national movement toward value-based care for physicians, via the Medicare Access & CHIP Reauthorization Act (MACRA), will incentivize similar changes to the ones that Maryland's hospitals have undergone in the past two

years. MACRA rewards physicians for participating in new payment and delivery models to improve the efficiency of care. In the context of Maryland's Medicare waiver, the incentives for hospitals and physicians will be more closely aligned than ever. This is an exciting time for doctors, for hospitals, for patients, and for Maryland's communities.

Already, many models are being tested to capitalize on this collective commitment to value: gainsharing, bundled payments, clinically integrated networks, Accountable Care Organizations, patient-centered medical homes, to name a few. There are other models, and even more will be developed as we continue to learn about the best way to leverage the strengths of different care providers so that value carries through across the care continuum.

Hospitals have long understood, and their belief has been reinforced in the past two years, that they are but one piece of the overall health care landscape. To truly transform health care, it will take cooperation and buy-in along the entire continuum—providers, payers, social service organizations, and more—and the models to do so are still being tested and refined. It is doubtful that any one method will be appropriate for all partnerships, so the wide breadth of experimentation in this arena is beneficial for all providers.

What Can Physicians Do?

The seeds have been planted for the broad trends that will define health care in the twenty-first century, and the bright future that we can see now can only be achieved if we shed past trappings. No longer can physicians work in silos. At last, quality will have an equal voice with finance in strategic planning meetings; a focus on patients is expanding from the physician's office to the entire system of care.

The details of the path to this future are not set, but we know that hospitals and physicians will join in new ways to achieve a shared vision. There are tools to help: enhanced data sharing from the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP), new arrangements between hospitals and physicians to align incentives, and others.

This change will be difficult and will require new thinking and resources. But there is no going back. I encourage physi-

cians throughout Maryland to embrace this new direction. To be successful, we have to work together. Seek out opportunities to help patients by engaging in new and different ways with hospitals, skilled nursing facilities, home health providers, pharmacists, social workers, Meals on Wheels, and others.

All of us are headed to the same place when it comes to how we care for patients. Not only can we help one another get there, but we need one another to get there too.

Carmela Coyle is President and CEO of the Maryland Hospital Association. In 2015, Ms. Coyle was elected to a three-year term on the Board of Trustees of the American Hospital Association (AHA). She can be reached at ccoyle@MHALONLINE.org.

Value-Based Payments: Lessons Learned



Joseph P. Ross

HEALTH SYSTEM PERSPECTIVE

Nearly six years ago, Meritus Medical Center became the largest rural hospital in Maryland to enroll in Total Patient Revenue, or TPR, a global budgeting financial management system regulated by the state's Health Services Cost Review Commission (HSCRC). Under TPR, at the beginning of each fiscal year a hospital's revenue cap is set. Under Maryland's CMS waiver, hospitals are also required to reduce overall health care costs by implementing payment-related incentives designed to promote quality of care, safety of care, and population health. As a result, Meritus Medical Center receives monetary awards or penalties related to the patient experience, patient safety, and core measures. Meritus has also agreed to lower the thirty-day readmission rate for Medicare beneficiaries and reduce hospital-acquired conditions.

During this time of care-delivery changes, Meritus Health has also formed a Medicare Shared Savings Plan (MSSP) Accountable Care Organization or ACO that provides care to more than 13,000 Medicare beneficiaries in collaboration with 135 providers.

Lessons Learned

During this health care transformation journey, we have learned many lessons.

Primary care must lead population health. The path to population health will be achieved when primary care addresses not only acute and chronic medical concerns, but also social circumstances and behavioral health needs. Physicians at Meritus Medical Group practices function less as individual providers and more as leaders of the health care team.

For example, if a physician spends the majority of an appointment discussing a patient's psychosocial concerns rather than how to control hypertension, the provider introduces the patient to an on-site care manager. When the care manager discovers the patient can't afford her blood pressure medication, the care manager and social

worker identify resources for affordable medication to help the patient comply with her physician-directed care plan.

Health care delivery is about quality, not quantity. When we shifted our view from keeping beds filled to providing efficient, high-quality care, we shifted our focus to quality and patient outcomes and efficiency and effectiveness of care. We also have experienced a reduction in patient harm events and hospital acquired conditions, decreased readmission rates from skilled nursing facilities, improved patient flow in the emergency department, and we have instituted many other cost-saving initiatives.

If physicians are committed to providing care in a population health improvement model and to improving quality while reducing the cost of care in their patient population, they will have to examine care transitions from one level to the next—be it a hospital observation unit, home health, or a skilled nursing facility.

A small percentage of the population represents a large percentage of health care costs. The care of the patients representing the larger percentage of costs must be closely managed. Type 2 Diabetes is the biggest challenge our health system faces today. Meritus hired an inpatient diabetes educator to educate patients about their disease process and provide resources to help them comply with their care plan. Meritus also placed diabetic educators in primary care practices to serve as a resource to physicians and patients and round out the continuum of diabetic care. Finally, we created disease management programs for patients with COPD, asthma, and congestive heart failure.

Understanding why patients don't take their medication is one of the greatest challenges for Meritus Health. Is it a lack of insurance coverage, a behavioral health issue, or a more nuanced barrier, such as medication side effects? You

must identify your most at-risk patient population and target care delivery plans for these diagnoses.

A partnership between physicians and care managers lowers health care use. The physicians in our primary care practices use RN care managers, social work care managers, diabetic educators, pharmacists, behavioral health counselors, and respiratory therapists to proactively manage patients' health care needs. The outpatient team allows primary care providers to work at the top of their license and focus on the practice of medicine while the team helps educate, mitigate, and resolve psychosocial barriers to improve patient compliance and outcomes.

Care managers and the multidisciplinary team guide patients "in between appointments" and coordinate and manage patients with chronic diseases and other identified health care needs to reduce use and prevent patients from becoming high users of health care services. We educate patients on their diagnosis; reconcile and confirm medications; make clinician follow-up appointments; arrange post-discharge services such as home health; identify providers to contact for specific care concerns; and send patients home with a newly designed discharge binder.

Patient-centered care helps overcome fragmented health care delivery. When we focus on silos of care, we lose sight of how people should receive care. Both inside and outside the hospital, our care managers act as "project managers" to help patients and their families navigate health care delivery and integrate services.

When a primary care physician identified a patient with behavioral health needs, a same-day meeting with an on-site care manager resulted in the scheduling of intensive outpatient behavioral health therapy. Therapy, which once

took several weeks to schedule, occurred within five days of the primary care visit. Care was provided at the patient's convenience and at a time when he was most likely to act and comply.

Formulary changes occur when patients are discharged from the hospital to a skilled nursing facility (SNF). A care manager-pharmacist team deciphers the medication trail, makes recommendations on affordable prescriptions, and presents a medication plan to the patient's primary care physician. The teamwork saves time and money, prevents possible adverse medication events, and optimizes drug therapy.

Socioeconomic status affects the health status of a population. Social issues play an important role in understanding the health problems of our community members. When a broken elevator in a subsidized housing unit prevented a congestive heart failure patient from seeing her physician regularly, a care manager took action to get the elevator repaired. As a result, countless visits to the emergency department to address the patient's chronic condition ended.

Standardization of work can work. Over time, the more evidence-based the care delivery process becomes, the more effective it will become. In our primary care practices, we instituted a policy of scheduling same-day appointments for chronically ill patients. In some of our physician practices, physicians care for the more chronically ill patients, and advanced practice professionals handle routine patient visits. In the hospital setting, the use of CVC insertion bundles, or evidence-based processes, help prevent hospital-acquired infections such as CAUTI (Catheter-Associated Urinary Tract Infections) and CLABSI (Central Line Associated Blood Stream Infections).

Reducing readmissions is not just a hospital function. Our biggest challenge continues to be care coordination with post-acute care providers and community providers. While partnerships with SNFs remain strong, the pace of progress is slow.

Data are helpful but do not solve all problems. If you wait for perfect data, you'll find yourself in a data chase instead of succeeding at interventions.

We looked at our high-resource users, and although we didn't fully understand what made these patients high-resource users, we understood the resources that they needed. We took action to help these patients improve their health and created a patient-centered medical home model in our primary care practices to reduce unnecessary use.

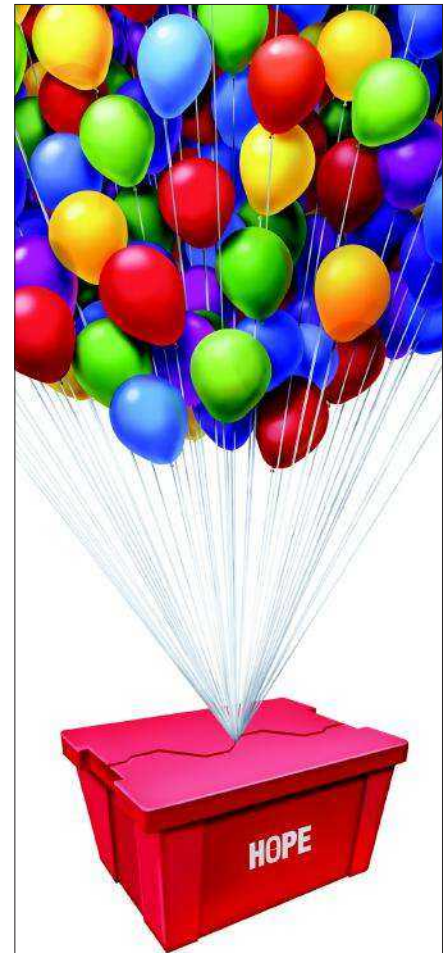
Physicians can make a difference. As a result of bringing full-time intensivists, or critical care physicians, into our critical care unit, we have seen a \$1.8 million savings in drug use. Intensivists have increased quality and shortened length of stay, enhanced medication selection, and reduced dosing. In addition, our contracted hospitalist team, once compensated on patient volume, now focuses on continuity of care, throughput, and patient satisfaction.

Change Is Here To Stay

The future path of payment reform will make fee-for-service increasingly less attractive and encourage physicians to participate in an alternative payment model (APM). Under the Medicare Access and CHIP Reauthorization Act (MACRA), physicians will have an option to participate in an APM or the Merit-Based Incentive Payment System (MIPS), a significantly modified fee-for-service payment system. CMS has made it clear that it wants the majority of physicians to be paid under a value-based payment model by paying annual bonus payments to physicians who participate in APMs.

The playbook is still evolving for value-based payments. For physicians, this new era in health care offers an opportunity to connect with the community and make a profound difference in people's lives. For this longtime health care administrator, navigating through the new era of payment reform is both endlessly challenging and fascinating.

Joseph P. Ross is President and CEO of Meritus Health in Hagerstown, Maryland. His nearly forty years of health care experience includes positions as president and CEO of Shore Health System of Maryland in Easton and President and CEO of Mercy Medical Center in Oshkosh, Wisconsin. He can be reached at joe.ross@meritushealth.com.



FILL THE BOX FILL THE NEED

The Dispensary of Hope is a national not-for-profit that helps uninsured patients get the medications they need. After we receive unused sample medications donated from practices like yours, we coordinate their distribution to charitable clinics and pharmacies across the country.

**More Hope.
Less Paperwork.
No Waste.**

DISPENSARY OF
HOPE

Join the movement.
Call **888.428.HOPE**

www.dispensaryofhope.org/give-meds

© 2013 Dispensary of Hope. All rights reserved.
Hope Box is a trademark of Dispensary of Hope.

Value-Based Payment Strategy Can Improve Care for Maryland's Seniors

Isabella Firth



POST-ACUTE CARE PERSPECTIVE

LifeSpan is the largest post-acute care provider association in Maryland, representing approximately 250 organizations that care for more than 45,000 Marylanders in various settings throughout the State, including skilled nursing, assisted living, continuing care retirement communities (CCRCs), affordable senior housing, and community-based providers (home health, hospice, adult day, and others).

Maryland post-acute providers are only just beginning to understand value-based payment models under development here and elsewhere. Fee-for-service (via Medicaid, Medicare, or private pay) is still the primary way care is financed. We know big change is coming soon. Preferred networks are forming between hospitals and LTPAC (long-term and post-acute care) providers, both physicians and hospitals have organized ACOs (accountable care organizations), Medicaid managed care is in the works, and discussion around how to care for the “duals” (persons eligible for both Medicare and Medicaid) is well underway.

There is no question that the State's health care policy shift is complicated and audacious. Nearly three years into the new program (the “Waiver”) approved by CMS (Centers for Medicare & Medicaid Services), Maryland leaders are well invested in this new direction, one that moves hospitals to total population health and into global budgets. Value-based purchasing is not just a concept being put into place here in Maryland; it is the wave of the future. Maryland has simply promised to show results sooner.

As policy is being formed, LifeSpan is advocating for the following:

Updated oversight rules. Current regulations for post-acute providers are costly, restrictive, and ineffective in a new reimbursement environment. For providers to survive under ACOs, bundled payments, or any other hybrid model, they must provide a higher quality of care at a lower cost. Such a task is a difficult one made even more difficult with the current and new regulations being imposed by both CMS and the State.

Providers must be encouraged to take the right action rather than the least expensive action. Under the hospital readmission reduction program, hospitals, physicians, and post-acute providers will be placed in the position of having to balance placing a resident in the most proper setting (which may be more expensive) with the possibility of incurring a readmission penalty. Lower costs upfront should not and cannot outweigh the possible readmission penalty.

Access to accurate and timely data. Such data that is shared by partners are vital to success. Complete, adequate data on resident conditions and treatment are essential, and such data need to be available and communicated in real time. While hospitals and the State are working on data sharing structures and systems, the physician and post-acute world is a long way from being ready.

Person-centered care. LifeSpan supports person-centered care, which implies patient engagement, choice, and control. It is important to acknowledge that these concepts, however, could be at odds with man-

aged care designs and concepts. Additional resources will be required to effectively translate person-centered care concepts into practice (such as involving and investing physicians, family members, and informal caregivers), as patients are often physically and/or cognitively impaired.

A correctly designed bundled payment system with safeguards to protect the downstream providers. Thus far, bundled payment approaches have not been successful in other states, and therefore we are reluctant to support this direction. We would be open to investigate a correctly designed bundled payment system with safeguards to protect the downstream providers. We are not aware of any successful examples of bundled payment arrangements in other states that demonstrate improved outcomes and reduced expenses in LTPAC settings.

Greater focus on behavioral health needs. The majority of LTPAC population has moderate to severe cognitive impairment. Nearly 20 percent of SNF (skilled nursing facility) residents take anti-psychotic medications.

A system for LTPAC that is structured similarly to hospital global payment. Under any system (fee-for-service, etc.), which reimburses a LTPAC provider for providing a day of care, the incentive exists to keep the bed (slot) filled. The new system needs to reduce this dependence, similar to the global payment system operating for acute care hospitals, which addresses both financial risk and reward. Medicaid restrictions and counter-incentives are daunting.

We support the following guiding principles as the State moves forward in implementation of the Waiver:

- Reward health care partners for high quality care;
- Require standardized and proven performance metrics from health care partners;
- Assure that data are accurate, secure, and accessible by the partners involved;
- Protect patient privacy, dignity, choice, and self-determination; and
- Include the broadest practicable array of community-based partners that have a demonstrated ability in effective care coordination.

While we recognize the perils of moving into a value-based payment system, LifeSpan supports such a system. We believe that with aligned payment systems, connected data systems, and coordinated partnerships between caregiving professionals and organizations, we will ultimately improve care outcomes for Maryland's seniors. Intuitively we know care delivery can be done better, but getting there will be challenging and chaotic. After all, this is the most significant shift in health care payment and delivery for Maryland seniors since the advent of Medicare and Medicaid.

Isabella Firth is President and CEO of LifeSpan Network. She can be reached at ifirth@lifespans-network.org.



Health Care Cost Improvement: Be Careful of the Common Wisdom

PAYER PERSPECTIVE

Chet Burrell

We are bombarded these days with the message (from health care industry experts as well as policy wonks at the state and federal levels) that the U.S. health care system needs to move from “volume to value” and that payment systems need to be changed to encourage a shift in this direction. Experts say that the time-honored fee-for-service system of payment must go the way of buggy whips in favor of outcome-based payment methods.

Hence, we hear of bundled payments, global budgets, integrated delivery systems, and a host of other related terms. We also hear that to achieve meaningful change it is essential to shift the risk to providers—especially physicians and hospitals. In effect, this line of thinking says that there must be risk of payment loss if desired outcomes are to be achieved.

Medicare is moving directly to tie a portion of its physician fee payments to measures of value relating to the care physicians provide. Accountable Care Organizations (ACOs) have formed all over the country to coordinate care and prepare to take on risk. There are now more than twenty ACOs in Maryland. Most ACOs are hospital centric, that is, built around hospitals whose capabilities to organize, lead, coordinate, and offer a spectrum of services for a target population are thought to be essential. So far, very few have taken on risk. Some that have taken on the risk have learned to regret it. Few have demonstrated savings or demonstrably better outcomes.

It is certainly true that health care costs have reached levels that society, employers, and the government can barely sustain. The burden has shifted more to individuals through greater cost sharing responsibilities (e.g., higher deductibles and copayments). A 2017 Bronze Plan purchased on Maryland’s Health Exchange will carry more than \$7,000 a year in out of pocket expense for an individual and more than \$14,000 for a family when unsubsidized by the government. More than 75 percent of small employers who buy coverage offer high deductible coverage options to their employees. These costs are in addition to premium costs that average nearly \$6,000 per year per person and \$12,000 per family.

CareFirst BlueCross BlueShield (CareFirst) is now in its sixth year of a region-wide initiative to build and offer a Patient Centered Medical Home (PCMH) Program. The program, which began on January 1, 2011, serves nearly 1.2 million people in the region, involves nearly 4,400 primary care providers, and manages approximately \$5 billion in annual health care expenditures. Under a Health Care Innovation Award with CMS, the program piloted use of a “Common Model” for 60,000 CareFirst and 40,000 Medicare fee-for-service beneficiaries built on the PCMH design. The central



idea was to see if common rules, incentives, data, and supports made a difference when applied to the region’s largest public and private payers.

At the core of the Common Model design is the belief that a group of primary care providers (PCPs) who work as a team can achieve better overall cost and quality, especially when supported by nurses, data, and other infrastructure. The concept of “team” is essential not only in coordinating care, but also in seeing patterns of care outcomes for a population of patients that is big enough to produce reliable, stable patterns.

PCMH has had significant success. Overall, the upward trend in health care costs paid by CareFirst on a per member per month (PMPM) basis has been cut in half from previous sustained levels, while the rate of hospitalization has declined by more than 15 percent. Overall, quality outcomes have substantially improved. For the Medicare beneficiaries in the Common Model pilot program with CMS, overall costs per beneficiary per month remained flat for three years running (2013–2015), and hospital admits declined by more than 15 percent.

High levels of patient satisfaction have been achieved, and physician participation in the program has steadily grown to the point at which nearly 90 percent of all actively practicing primary care providers in the region are now participating.

A number of insights might have come from this large-scale experience. Some of these insights go against policy “gospel.” The following is a list of the top five insights:

Don’t build only through hospital/health system ACOs. Build through physicians organized into independent group practices. The congealing that is underway among U.S. hospital systems is leading to a clear and compelling outcome: inexorably higher costs and narrower access. We see ever-larger hospital centric systems as community hospitals are absorbed into large academic centered systems along with their medical staffs. We see the decline of the independent physician as more physicians seek employment in these larger systems—often as shelter in a storm. Taken as a whole, the larger systems cost 50 to 80 percent more for the same basket of services on a risk adjusted basis than in community, non-system settings. Reflecting on the CareFirst PCMH experience, we now know that panels of PCPs that are independent in the

community outperform their big system counterparts by as much as 15 to 20 percent in aggregate PMPM costs for the sixty-five and under population on a risk-adjusted basis. The same results were seen in the Medicare population that participated in the Innovation Award with CMS.

In a large hospital-centered system, primary care providers become the inlets to the larger system and become tied ever more closely to the capabilities, specialists, and facilities of the larger system. This inherently builds in higher costs in a marketplace desperate to avoid such costs.

Don't abandon fee-for-service payments. Rather, hold the negative volume inducing tendencies of fee-for-service in check. The extreme variability and randomness of patient conditions and circumstances is very difficult to account for in global payment methods. Fee-for-service captures this variability with great sensitivity while expressing the relative economic value of the services actually rendered by all caregivers to all patients. With the advent of ICD-10, the level of detail in this data is extremely rich and gives rise to enormously valuable data that enable indispensable profiles in judging the efficacy of services actually rendered.

Physicians almost never see this data and have little idea of what services actually cost. Nor do they know of the extreme variability in cost for similar services and episodes of care. Indeed, the variability in cost to treat patients in the same episode ranges from 50 to 200 percent across the region. When physicians gain access to such data, they react—particularly when given an incentive through a shared savings model.

We have found that a shared savings model is most powerful when it does not involve or pass through a hospital. In Maryland, hospitals already have their own version of such a model in the all-payer reimbursement model under which they operate, since it guarantees their global revenue even if their volume drops.

Don't shift risk to physicians. Instead, use incentives only. As the key decision makers in the health care system, physicians are the drivers of cost. This does not mean they are in a position to take risk. As a carrier with more than 3.2 million members who generate \$35 billion a year in claim billings, even CareFirst finds it difficult to properly judge and take on risk, especially in the rapidly evolving field of new treatments and ACA coverage plans. Recent price increases in specialty drugs are a vivid reminder of the minefield of risks that lie in wait for even the most careful and efficient providers.

The absorption of risk—even the possibility of it—has driven physicians into the big systems on the grounds that it is a safer place to be in the coming storm. We think not. Instead, we have found that incentives—if applied consistently and fairly over time—work effectively to change behaviors toward higher value without the downside risk of poor performance or unexpected circumstances.

Don't focus on bundled payments. Instead, pay close attention to PCP-specialist referral patterns, which are the key to real value attainment. Payment by bundles rewards bundles just as certainly as fee-for-service rewards volume. Bundles are averages, and as such they will inevitably overpay some providers and underpay others in a

nearly random way. PCPs are in the best position to direct patients to the right specialist. We have been tracking PCP-specialist referral patterns for years and have observed increasingly discriminating judgments by PCPs, as they are given increasing insight into specialty cost and quality outcomes. Decision-making should remain in physician hands—not in the hands of hospitals, big health care systems, or payers.

Don't intrude so much. Instead, let peer review, data, and incentives do their work. Physicians are inundated with the demands of payers and government. These intrusions have begun to materially interfere in the conduct of medical practice. Our experience has been that when physicians are armed with data, are able to talk among themselves in small care teams about what the data show, and have a meaningful incentive to achieve better results for their patients, they need little government and payer intrusion.

Given a sensible framework and time, small independent teams of PCPs—such as those in the CareFirst PCMH Program—seem to find the best pathways to improved outcomes in concert with their self-chosen specialist partners. All PCPs need is to be given the data, time, freedom, and reward for doing so. We have tried this approach and let it play out for the last five years on a region-wide scale. We, and our members, have been very pleased with the results.

Today's struggle is the same as the struggles of the 1970s, when the HMO movement in the United States first got underway as a response to rising costs. If we are any wiser for these struggles, our view would be that physicians should lead the way forward while the payers and government establish a sensible framework that allows them to do so.

Chet Burrell is President and Chief Executive Officer of CareFirst BlueCross BlueShield. Before joining CareFirst in December 2007, Mr. Burrell served as President and Chief Executive Officer of RealMed Corporation, and as Chairman and CEO for Novalis Corporation. In addition to his private sector health care experience, Burrell has also served in the New York State government in a variety of capacities, including the Offices of Mental Health and Health Systems Management and as a member of the New York Governor's Staff. To contact Mr. Burrell, please email Sandra.Stemmer@Carefirst.com.

The Shift to Value-Based Payment and MACRA: AMA at the Forefront with Support for Physicians

Carol L. Vargo, MHS; Lindsey E. Goeders, MBA; and Mary Coppage

ASSOCIATION PERSPECTIVE

Introduction

The expansion of value-based payment models in the U.S. health care system by both private and government payers is part of an ongoing effort to pursue higher quality care at a lower cost. The American Medical Association (AMA) recognizes the importance of the development of innovative physician payment models that emphasize quality and reduce cost. The AMA also sees the challenges that expansion of value-based payment present, and is committed to informing and supporting physician and practice choice so practices can remain sustainable no matter which path is chosen.

Early successes in value-based payment models and recent adoption by public and private payers suggest their presence will continue to expand for years to come—and the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has catalyzed significant changes that almost guarantee it. The AMA is leading these changes through its work to support physicians throughout the transition by conducting research, advocating at the national and state levels, and providing tools and resources at the physician and practice levels.

Impact of Payment Reform on Physician Practices

To study and better understand the effects of alternative payment models (APMs), in 2014 the AMA engaged the RAND Corporation to conduct the first study examining the impact of payment reform on physician practices. The qualitative study examined thirty-four practices within six geographically defined health care markets in the United States. The sample included small and medium primary care, large multi-specialty, hospital-owned, small and medium single-subspecialty, and IPA (independent practice association) practices.

The effects of value-based payment models reported in the study varied from practice-wide impacts to individual-level changes.¹ Evidence demonstrated that moving to value-based care models increased the need for more timely and accurate data to make real-time practice improvements. Furthermore, lack of transparent, actionable payer quality reporting can demotivate the physician from making an effort to collect and maintain accurate data when financial incentives are nominal. Such data-related concerns reflect an overall need for better IT infrastructures and data management systems.

Challenges and opportunities associated with changes prompted by APMs exist on several fronts. For physicians and practices, significant challenges are in the increased stress and time pressure, growth and mergers, and new incentives. To help curb pressure, practice administrators should seize opportunities to reallocate physician time, create and enhance nonfinancial incentives, involve physicians in organizational changes, and provide better tools for success in value-based payment.¹



Operational challenges, such as data errors, difficult system integration, and inaccuracies in patient attribution or procedure, can undermine trust in these models and have negative financial impacts on practices. Payers looking to preempt these challenges should communicate proactively with clinicians, detect and correct operational errors, and invite physician input to validate the performance measures.¹ Furthermore, payers should better align quality measures to ease the burden on physicians and practices.

Move to Value-Based Care Is Driving Innovation

Commercial payers are realigning business models to enable adoption of value-based payment that promises to increase quality of care and decrease costs. A 2015 survey from HealthEdge indicated 80 percent of health insurance executives are moving toward value-based models.⁴ Blue Cross and Blue Shield (BCBS) companies' value-based programs account for \$71 billion in payments tied to value-based care.⁵ CareFirst BCBS, a Maryland-based payer, introduced a patient centered medical home (PCMH) initiative to improve quality of care and reduce health care costs. In 2015, the program reported a 19 percent reduction in hospital admissions, 15 percent fewer days spent in the hospital, and 20 percent fewer hospital readmissions.⁶

Value-based payment systems are also on the rise within government payers. The U.S. Department of Health and Human Services (HHS) reached its goal of moving 30 percent of Medicare payments to value-based APMs since 2015 and aims to have 50 percent tied to APMs by 2018.⁹ The Center for Medicare & Medicaid Innovation (the Innovation Center) is testing numerous value-driven payment and delivery models.

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to replace the repealed SGR formula. In April 2016, CMS proposed a rule that is the first step in implementing the provisions of MACRA that aim to change the way Medicare payments link to quality and cost of care. By reducing the patchwork of quality reporting programs into two distinct paths, merit-based incentive payment system (MIPS) and APMs, and implementing other broad changes, CMS has the opportunity to streamline the programs through which physicians are paid, and promote value-based care.

AMA Efforts to Ensure Sustainable Physician Payment and Delivery Reform

The transition to value-based payment is a long-term, ongoing process. Throughout this process the AMA is committed to supporting various modes of practice that meet the unique needs of each physician, specialty, and geography. The AMA also is working on a number of fronts to provide resources physicians need to succeed and lead through the upcoming changes in physician payment.

The AMA STEPS Forward™ practice transformation series helps physicians address challenges through interactive presentation of real-world strategies, tools, and resources. Online CME modules cover topics including revenue management, quality measurement, technology adoption, and practice organization. Additionally, the AMA was selected by the CMS Transforming Clinical Practice Initiative (TCPI) as one of thirty-nine health care networks to support its efforts in assisting clinicians at the local level in achieving large-scale transformation. Later this year, the AMA will launch an online payment evaluator tool to assist physicians and practices in determining the best, most effective payment model for their specialty, patient mix, and practice type.

On the federal level, the AMA advocates for all physicians, seeking regulatory improvements and continued payment and delivery reform. The AMA is working closely with state and national medical societies to shape the early stages of MACRA implementation, and will continue to do so as the law evolves.

Conclusion

The AMA-RAND study emphasized the existence and impact of multiple simultaneous changes taking place in the move to value-based models. The changes are palpable across the industry, from practice-level impacts to the realignment of commercial payer business models to comprehensive state and federal legislation. The AMA will continue to support physicians and practices as they adapt.

References

1. Friedberg M, Chen P, White C, Jung O, et al., Effects of Health Care Payment Models on Physician Practice in the United States. RAND Corporation, 2015. Available at: http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf

2. Chaix-Couturier C, Durand-Zaleski I, Jolly D, Durieux P, Effects of financial incentives on medical practice: results from a systematic review of the literature and methodological issues, *International Journal for Quality in Health Care*, Vol. 12, No. 2, 2000, pp. 133-142. Available at: <http://intqhc.oxfordjournals.org/content/12/2/133>
3. Petersen L, Woodard L, Urech T, Daw C, Sookanan S, Does Pay-for-Performance Improve the Quality of Health Care? *Annals of Internal Medicine*, Vol. 145, No. 4, 2006, pp. 265-272. <http://annals.org/article.aspx?articleid=727450>

Carol L. Vargo, MHS, is the Director of Physician Practice Sustainability Strategy Group at the American Medical Association. She can be reached at Carol.Vargo@ama-assn.org. Lindsey E. Goeders, MBA is a Senior Policy Analyst in the Physician Practice Sustainability Strategy Group at the American Medical Association. She can be reached at Lindsey.Goeders@ama-assn.org. Mary Coppage is the Manager of Care Delivery and Payment in the Physician Practice Sustainability Strategy Group at the American Medical Association. She can be reached at Mary.Coppage@ama-assn.org.

Reflections on Value-Based Payment: The Latest Strategy in the Search for Cost-Cutting Miracles

Mark Jameson, MD

PERSONAL PERSPECTIVE

Value-based payment is the current catch phrase in health care. Enthusiasm abounds anticipating its promised miraculous results. As one nearing the end of his career, I recall many previous buzzwords and programs, which also promised the nirvana of improved efficiency and reduced costs—such as second opinions, networks, consolidation, preauthorization, salaried physicians, and an entire entourage of three-letter acronyms (HMO, PPO, EPO, and MCO).

Although these cost-containment approaches successfully curtailed physicians' autonomy, they have not appreciably reduced health care costs. Furthermore, the previous attempts at health care reform have never measured the new costs they impose. The compelled additional costs of regulatory compliance, such as new layers of administration and additional ancillary staff, are never measured. For example, the budget for the Innovation Center at the Centers for Medicare and Medicaid Services (CMS), which promulgates the value-based payment requirements, reports spending approximately \$4.3 billion between 2010 and 2015. This figure represents a mere fraction of the imposed new costs to comply with the new systems for medical practices across the United States. The total cost of value-based care is never calculated.

Previous attempts at cost control measures have all identified the physician as the primary inflationary "cost generator," and as a consequence, have further limited physicians' medical authority. The truth is that physicians are merely responding to increasing demands for health services.

The social determinants of health care demand—aging of the population, poverty, obesity, smoking, substance misuse, violence—are far beyond a physician's control and are rarely addressed. The Centers for Disease Control (CDC) estimates that half of all deaths in the United States are attributable to a small number of preventable behaviors and exposures.¹ Just as pilots cannot control the weather impacting a flight, and teachers cannot control the powerful effects of poverty and family disruption on learning, physicians cannot reduce the inflationary health care demands brought on by social conditions.

Traditionally, insurance companies have assumed full financial risk of their policies by charging health insurance premiums based on actuarially determined rates. Physicians simply billed the insurance companies for payment of services. Critics termed this "volume-based payment," claiming it rewarded excessive utilization caused by unnecessary office visits, surgeries, and other services. Physicians considered the criticism artificial and absurd, based on the reality of their daily practice in which far more patients required treatment than could be accommodated. Still, the criticism resonated with government and commercial payers, which prompted the search for new financing systems.



Cost control efforts have now evolved to shift financial risk to the physician. For the first time, physicians have been forced to assume partial financial risk of the population they serve. Value-based payment takes a step that no prior cost control attempt has made: it includes financial risk with physician payment. The educational analogy is paying school teachers in part based on a student's test scores. Physicians are now being held financially responsible for patient outcomes.

Health care is not the only entity undergoing tremendous financial change in response to cost pressure. Lower paid adjunct professors and open online courses are replacing tenured college professors. Certified public accountants have yielded exclusive domain of tax expertise to TurboTax®. Financial advisors now compete with low-cost computer advisor programs offered by Vanguard® and Fidelity®.

Value-based payment structures financial rewards to attain specified clinical goals. Although there are several models, reimbursement is now associated with attaining specified benchmarks of patient care or remaining below a cost ceiling. Benchmarks vary by carrier and program. For instance, the clinical quality measures in the recently announced Medicare

Comprehensive Primary Care Plus model include controlling high blood pressure and screening for breast, cervical, and colorectal cancer.

Value-based payment represents an operational shift, with physicians surrendering the role of custodians of quality of care to the insurance companies and government agencies. The irony is that the same insurance companies and government agencies, which denied payment or placed barriers for patients to receive the standard of care for years, now herald themselves as innovators in patient care. Physicians are chastised as being obsessed with self-remuneration and therefore must be held “accountable” to ensure the standard of care is met.

From a practicing physician’s perspective, the single most critical value is time spent with the patient. Just as teachers prize time devoted to student learning, physicians treasure time dedicated to patients. Tellingly, although “volume-based care” is derided as wasteful, under a value-based payment system physicians will be expected to maintain current patient volume.

To date, the results on value-based payment’s ability to reduce costs have been mixed. As recently reported in the *New England Journal of Medicine*, midway through the Medicare Comprehensive Primary Care Initiative, no savings in expenditures and no appreciable improvement in quality have occurred.² However, Medicare is already launching version 2.0, the Comprehensive Primary Care Plus model. Additionally, the savings in the Medicare Shared Savings Program overall have been modest at best.³

I suspect that value-based medicine, while currently in vogue, will be replaced in the coming years by another yet unknown approach, in the ongoing search to control costs. According to a recent article in the *Wall Street Journal*, twenty major U.S. corporations are currently banding together to form an alliance to independently reduce costs.

It is hoped that these attempts to reduce costs will be successful. However, there is unlikely to be significant cost reduction until there is a reckoning with the inflationary social drivers of health care utilization. Otherwise, value-based payments may offer little more than a vacuous veneer of cost reduction.

Mark Jameson, MD, is an addiction medicine physician who lives in Hagerstown, Maryland. He can be reached at m.jameson@myactv.com.

References

1. A. H. Mokdad, J. S. Marks, D. F. Stroup, J. L. Gerberding. “Actual causes of death in the United States, 2000,” *JAMA* 291:1238–45 (2004).
2. S. B. Dale, A. Ghosh, D. N. Peikes, et al. “Two year costs and quality in the Comprehensive Primary Care Initiative,” *New England Journal of Medicine* in press (2016).
3. J. M. McWilliams, L. A. Hatfield, M. E. Chernew, et al. “Early Performance of Accountable Care Organizations in Medicare,” *New England Journal of Medicine* in press (2016).

PHYSICIANS & PRACTICE ADMINISTRATORS

What is Keeping You **AWAKE** at Night?

Payor Concerns?

Electronic Preauthorization?

Medicare and Medicaid EHR Incentive Programs?

Medicare Payment Penalties?

Federal and State regulations?

ICD-10 training?

Data Breach?

One of your most valuable member benefits is to receive **FREE** guidance from MedChi, The Maryland State Medical Society. Why not take advantage of it?

We are here as your resource to answer any questions you may have.

Call now to receive your complimentary practice assessment from MedChi Network Services as part of your membership service.

MedChi
Network Services

WWW.MEDCHISERVICES.ORG

1211 CATHEDRAL STREET | BALTIMORE, MD | 21201 | 1.888.507.6024 | 1.888.507.6034 FX

MedChi, The Maryland State Medical Society

Presidential *Gala*

Honoring our 169th President

Stephen J. Rockower, M.D.

SATURDAY OCTOBER 29, 2016

7:00 PM

STRATHMORE • BETHESDA, MARYLAND

www.medchi.org/gala

CLASSIFIEDS

LEASE/SUBLEASE/SALE

SILVER SPRING: DOCTOR'S MEDICAL PARK. Georgia Ave. at Medical Park Drive. Close to Holy Cross Hospital. 1/2 mile to Beltway/495 and Forest Glen Metro Station. Join numerous physicians in 3-building medical campus. 5-suites available from 880 to 2,600 sq ft. Contact Craig Burton @ 301.795.1456 or cburton@vanguardrealty.com.

MEDICAL OFFICE SPACE. Medical Plaza 1 & 2, Rockville Md @ Shady Grove Hospital. 9711 & 9715 Medical Center Drive. Two medical buildings w/suites available from 750 to over 5,000 sq. ft. On-site pharmacy, deli and engineering services. Ample parking! Competitive terms. Contact Craig Burton @ 301.795.1456 or cburton@vanguardrealty.com.

OFFICE sublease available Silver Spring location, share with Internal Medicine office, ideal for IM subspecialists to grow practice. Available any day of week. Call 301-946-6623, Teresa for details.

HAMILTON E2 SERIES EXAM TABLE MODEL 4K783. Used table in excellent condition! \$375. Contact becky@rockvilleconciergedocs.com for more information.

EMPLOYMENT

LOOKING FOR A PART-TIME OR FULL-TIME PRIMARY CARE PHYSICIAN to join my practice in Silver Spring. Great environment, flexible schedule, competitive salary and benefits. If you are interested please e-mail me at simona@mhcemd.com.

PHYSICIAN AND FAMILY NURSE PRACTITIONER needed for a fast growing Primary Care office in Greenbelt MD. Please send your resume to greenbeltprimarycare@gmail.com. Flexible hrs Retired Providers (Full or Part time) are welcome.

PRACTICE ACQUISITION

PHYSICIAN LED COMPANY IS SEEKING TO BUY PRIMARY CARE MEDICAL PRACTICES of retiring physicians or physicians making other career choices. Company will consider city and suburban locations. The review process and decision will be confidential and quick. Practices for Sale (visit www.landissgroup.com for more information): Pediatric Practice located in Waldorf, Maryland; Family Medicine Practice located in Glen Burnie, Maryland; Family Medicine Practice located in Pikesville, Maryland; Women's Health Center serving the Baltimore market (full service GYN, Pro Choice). Please send inquiries to info@landissgroup.com or call 240.416.8080.

Music & Medicine:

An Interdisciplinary Approach to Beethoven:

A Lecture and Performance by Richard Kogan, MD

Bruce Hershfield, MD

MEDCHI PRESENTS



On November 19, 2016, Richard Kogan, MD, a renowned pianist who has performed in a trio with cellist Yo-Yo Ma and violinist Lynn Chang and a Weill Cornell Medical Center psychiatrist, will give a presentation about Beethoven. Dr. Kogan has been lecturing about musicians with psychiatric problems—Schumann, Tchaikovsky, Gershwin, Mozart, Leonard Bernstein, Scott Joplin—since at least 2001.

The son of a gastroenterologist, Dr. Kogan began performing at piano recitals at age six. He went on to study piano and cello at Juilliard. After he decided that he was interested in medicine, he pursued a pre-medical course of studies at Harvard University. He then attended Harvard Medical School.

In 2000, Dr. Kogan decided to combine his two careers. The *Boston Globe* commented, Kogan has somehow managed to excel at the world's two most demanding professions. "I found that actually learning something about these individuals' lives and struggles gave me some insight into the music that I was playing and helped me be more effective," says Dr. Kogan. Dr. Kogan is a clinical instructor in psychiatry and co-director of the Human Sexuality Program at Weill Cornell. In addition, he is artistic director of the music and medicine program and has a private practice in New York City.


Dr. Kogan feels passionately not only about his mission of combining the two professions and teaching audiences about how they interact, but also about efforts to destigmatize

patients who suffer from mental disorders. He said of the composers, "In many cases they composed masterpieces, not in spite of their illness, but because of it...It feels perverse to stigmatize a group whose members have made such extraordinary contributions to civilization...We have benefited in some cases because of their illnesses. In many cases, we could have helped them."

Dr. Kogan believes that Beethoven is the quintessential example of the mad genius or the tortured artist, although it is not confirmed that he did suffer from mental illness. "The deafness is such an essential part of his biography and the creative process, because he actually became a much greater composer after he became deaf," says Dr. Kogan. "Once he retreated into the silent world of his imagination, he was no longer hearing the music of his contemporaries and he was less under the influence of prevailing traditions. He started conjuring up sounds that were different from anything that anyone had ever created."

Beethoven's Deafness: Music & Medicine: An Interdisciplinary Approach to Beethoven, will be presented and performed by Richard Kogan, MD,

Psychiatrist and Concert Pianist on November 19, 2016, at Kraushaar Auditorium, Goucher College, 1021 Dulany Valley Road, Towson, Maryland 21204. Call 410-625-0232 to register or for more information. You may also register online at <http://kogan2016.eventbrite.com>.



The Maryland Psychiatric Society & MedChi
present

Music & Medicine:
**An Interdisciplinary Approach
to Beethoven**

featuring Richard Kogan, M.D.

Saturday, November 19th
6:30pm

Goucher College Towson, MD
Call 410-625-0232 for more information.
Brochures to be sent summer 2016.

Mythology in Medicine



CLASSIC WORD ROUNDS

Barton J. Gershen, MD
Editor Emeritus

The **tragus** is the small cartilaginous projection anterior to the external meatus of the ear. It is often covered with **tragi**, which are small hairs growing over the surface of the pinnae. (*Pinna*, Latin for “feather.” The pinnae of the ears are sort of “wings,” which project from our head, and since a bird’s wing is largely comprised of feathers, the analogy was carried to completion by the presence of these tiny hairs. The word **pen** derives directly from *pinna*, and originally referred to the feathered or quill pen.) *Tragus* developed from the Greek word *tragos*, “goat.” An imaginative, early prosector must have visualized a goat’s chin and beard as he described the external ear. A **tragedy** is literally “a goat’s song,” deriving as it does from Greek *tragos* plus *oide* (“song”). It had its origin in the ancient Greek chorus, whose dramatic function was to mock fate. These plays often dealt with great misfortune and sorrow, and the chorus members frequently portrayed satyrs, dressing themselves in goatskins for the part. The term *tragos oides* ultimately was applied to the entire play (*Oide*, “song,” is found in the term **ode**, as in those written to a Grecian urn, or a Nightingale).

The Greek god of forests and wild animals was **Pan**. He was the patron of shepherds and hunters and flaunted the ears, horns, tail, and inguinal parts of a goat. The less spectacular aspects of his anatomy were those of a man. He was playful, frisky, lustful, libidinous, and unpredictable. One of his favorite diversions was to frighten unwary travelers as they wandered through his forest. Hence he incited **panic**.

Pan was one of a group of woodland deities known as **satyrs**. They attended **Bacchus**, god of wine (the “**Bacchanalia**” was a Roman festival, an orgy of drinking and eating). Pan and his friends are famous for a disorder known as **satyriasis**, which requires a goat-like constitution as well. It is the masculine counterpart of **nym-**

phomania (Greek *nymphē*, “bride,” plus Greek *mania*, “frenzy, passion, madness”). Pan was also venerated by the Romans, but they renamed him **Faunus**. Debussy’s orchestral work *Prelude a l’après-midi d’un faune* (Prelude to Afternoon of a Faun) exalted these woodland creatures.

In addition, the renowned Swedish physician and botanist, Dr. Carl Von Linne, immortalized these woodland deities in his seminal classification of plants and animals, calling them flora and **fauna**. (Incidentally, you may know Von Linne only by his latinized name, a convention of his era. It is **Carolus Linnaeus**.)

A number of geographic names stem from mythology. **Phoenix** (Arizona), for instance, is named for an ancient Egyptian bird which built its own funeral pyre, died, and arose from its own ashes. **Europe** derives from **Europa**, a Phoenician princess who was kidnaped by **Zeus**. **Olympia** (Washington) stems from **Mount Olympus**. **Rome** was built by **Romulus** and named after its mythical creator.

Medicine has a lexicon of words which have descended from early mythology. **Asklepios**, the legendary Greek physician (also called **Aesculapius**), was the son of Apollo, and also the Greek god of Medicine. He was taught the art of healing by Chiron the Centaur, who had also tutored Hercules, Aeneas (of Virgil’s “Aeniad”), and Achilles. Asklepios is most often depicted in a flowing white robe, holding a cane, which has a single snake coiled around it.

A winged staff with **two** serpents entwined about it, on the other hand, was the famous **Caduceus** of **Mercury**, who was the messenger of the gods (He was also known as **Hermes** to the Greeks.).

Originally, the staff of Asklepios was the official seal of the U.S. Surgeon General’s office, and the universal symbol for medicine. However, in 1871, the Surgeon General mistakenly replaced the

single serpent with dual reptiles intertwined on a winged staff, which represents the **Caduceus** of Hermes. This change was done for aesthetic reasons, and would ordinarily not be terribly disconcerting, unless you remember that Mercury was the god of **trade**, of **commerce**, and of **wealth**. He was, unfortunately, also the god of **thieves**. His duties, moreover, included placing his serpentine wand over the eyes of the newly deceased, and escorting them into Hades!

One suspects that this distinguished medical symbol could have been chosen more carefully.

Asklepios, as mythology relates, was physician to Jason and his Argonauts. If you recall, these adventurous sailors undertook a dangerous journey to obtain the Golden Fleece, the coat of a ram, which had safely flown two young people, Phrixus and his sister Helle, to safety, away from their murderous uncle. (Unfortunately, Helle fell off the ram, and drowned in the waters that were later named for her: the **Hellespont**, from Helle plus *pont*, Latin for “Sea.” This is the narrow strait connecting the Aegean Sea with the Sea of Marmara, and separates Asian from European Turkey. The strait is currently named the **Dardanelles**, honoring Dardanus, the mythological ancestor of the kings of Troy.) The Argonauts discovered the Golden Fleece in **Colchis**, a region at the eastern end of the Black Sea, now part of the Republic of Georgia, and formerly part of the U.S.S.R.

A lovely flower grows in that part of the world. It is a member of the lily family, blooms in late autumn, and brandishes an array of pink, purple, and white petals. The plant is named for the region: *Colchicum autumnale*. One of its primordial secrets lies in its underground root, which, when eaten, exhibits anti-inflammatory properties. Asklepios often used it to treat rheumatism and gout. The ancient ingredient within its root is today known as **Colchicine**.

Asklepios had two daughters, **Hygeia** and **Panacea**, who are known to physicians and their patients alike, and who have given us two excellent eponymic nouns.

Mercury (Hermes), in addition to his courier position, was also the father of Greek alchemy. Alchemists were sorcerers, pseudoscientists, and magicians, but were nonetheless the first craftsmen to soften metals by utilizing an intense heat source. And they learned how to use the hot molten ore to fasten objects tightly together, such as the lid on a jar. This process has become known as **hermetic** sealing.

Aphrodite, one of the twelve Olympic gods, was famous for her beauty and her promiscuity. She had reluctantly married the grotesque and repulsive **Vulcan**, god of fire (**volcano** and **vulcanism**), hence she developed a passion for importing comely paramours to gratify her carnal desires. Occasionally she resorted to **aphrodisiacs** in order to achieve these ends.

Among her lovers was Hermes with whom she conceived a son. The baby was named for both parents—**Hermaphroditus**. As he grew into handsome maturity, **Salmacis**, a water nymph, fell in love with him but could not tolerate a moment's separation from her sweetheart. She, therefore, merged her spirit with his. Salmacis and her lover thus occupied the same body, which developed both male and female sexual characteristics, a **hermaphrodite**.

Aphrodite was also known as **Venus** to early Romans. She was the goddess of beauty, the mother of love, and the mistress of pleasures. One of her children was **Eros**, the god of love. A second child was **Hymen**, the god of marriage. The third child was **Priapus**, god of fertility. **Priapism**, **hymen**, and **erotic** are their medical cognates. In addition, Venus gave us a wealth of **venereal** diseases.

Other characters from ancient mythology have augmented our medical vocabulary, such as **Psyche**, goddess of the human soul, and **Narcissus**, a beautiful youth who fell in love with his own reflection. One must also include the sea god **Proteus**, who had the ability to assume various shapes. The bacterial genus *Proteus* was named for him. And we can credit him also with that ubiquitous expression of sophomoric rhetoric, often heard at grand rounds: “the **protean** manifestations of disease.”

Saturn was the Roman god of agriculture. His temple served as the Roman state treasury, and its vestiges may still be found

at the west end of the Forum. A great festival, the **Saturnalia**, was held each December in his honor. It was the most popular and joyful of Roman festivals. Commerce was suspended, slaves were granted temporary freedom, moral constraints were relaxed, and gifts exchanged.

During that era, astronomers became aware of five unique celestial objects. They already knew that stars were “fixed” in their position, each relative to the others, and that they rotated nightly from east to west in the dome of the sky. This was true for most stars, but not for five idiosyncratic “stars” which appeared to wander aimlessly through the heavens, pursuing their own enigmatic destinies. The primitive stargazers called these bizarre objects **planets** (Greek: *planets*, “wanderers”).

One of these—the outermost planet visible to the naked eye—was named Saturn, in honor of their god. It was a very slow moving celestial body, hence the alchemists hypothesized that it must be made of lead, which was the heaviest known element of that era. Therefore, to have a **saturnine** disposition meant to have a plodding, morose, and rather gloomy personality. In addition, chronic lead poisoning was known as **saturnism**, and (since we now realize that lead hinders the excretion of uric acid) the resulting illness has become known as **saturnine gout**.

Of course, the definitive Latin word for lead is *plumbum*, from which our chemical symbol **Pb** is derived. This explains the alternate term for lead toxicity, **plumbism**. It also explains why one calls a **plumber** when the pipes leak, since all water pipes were originally fabricated from lead. (Someone has even suggested that this may explain the fall of the Roman Empire.)

Finally, you may suspect why that lovely home you have just built exhibits such a paucity of true right angles. The builder obviously had failed to hang a heavy lead weight onto a string in order to obtain a perpendicular. He had not used a **plumb line**.

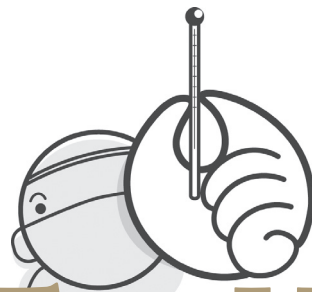
The Romans thought so much of Saturn that they named one day of their week after him: *dies Saturni*. This ultimately became **Saeturndaeg** in Old English and, finally, **Saturday**. Sunday was originally the “sun’s day,” Monday the “moon’s day.” The other four days of the week were named respectively for Mars, Mercury, Jupiter, and Venus (“Mars day,” or *dies Martis*, in French became *Mardi*. Thus *Mardi gras*, or

Mardi gros [“fat Tuesday”], which initiates the Christian season of Lent). Ultimately, the five Roman days were replaced by their Anglo-Saxon (Teutonic) cognates: *Tiu*, the Norse god of war (*Tiu’s daeg*, or **Tuesday**); *Wodin*, the king of all the Norse gods (*Wodin’s daeg*, or **Wednesday**); *Thor*, the Norse god of thunder (*Thor’s daeg*, or **Thursday**), and *Frigga*, Wodin’s wife and goddess of love (*Frigga’s daeg*, or **Friday**). Remember these derivations next time you expound on our Western scientific and cultural sophistication.

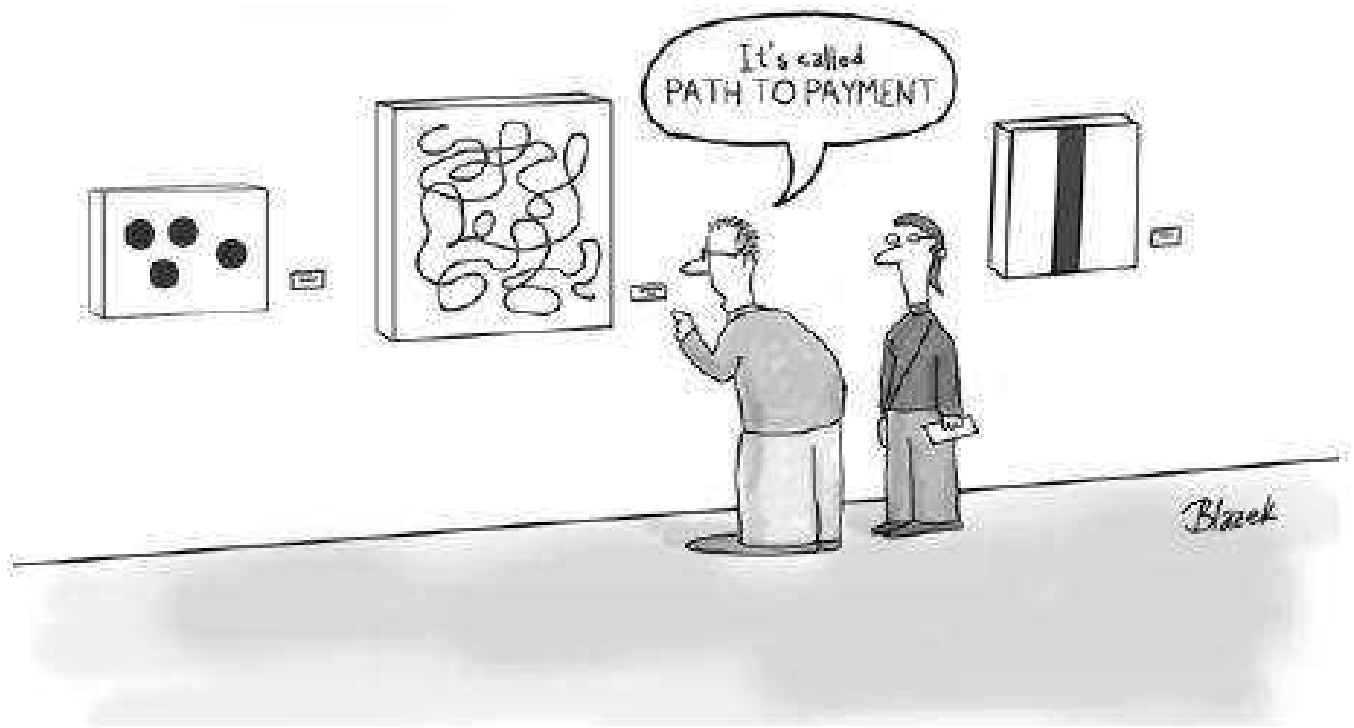
Returning for a moment to goats, Zeus, the chief god of the Greek pantheon, possessed a magnificent shield that protected him from any harm. The shield—known as *aegis*—was forged out of the hide of a goat named **Amalthea**, who had suckled Zeus as an infant. All who were under that shield were symbolically under divine protection. The term **aegis** derives from that mythology.

Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland.

THE LAST WORD



MODERN ART GALLERY



© 2015 McKesson. Please share freely. More cartoons at PayerSmiles.com. **MCKESSON**

CRISP HIE Services for Ambulatory Practices

Connect. Share. Improve Patient Care

CRISP is a regional health information exchange (HIE) serving Maryland and the District of Columbia. We are a not-for-profit organization advised by a wide range of stakeholders who are responsible for healthcare throughout the region. CRISP has been formally designated as Maryland's statewide health information exchange by the Maryland Health Care Commission.

Clinical Query Portal

The CRISP clinical query portal is a free, web based tool to access your patient's clinical data through the HIE.

- Contains clinical data from all 47 Maryland and 6 D.C. acute care hospitals, as well as numerous lab & radiology centers.
- Physicians, licensed health providers, care coordinators, and support staff can have access to query patients they are treating, or have a care coordination relationship with and view clinical data.
- Access patient demographics, lab results, radiology reports, Maryland Prescription Drug Monitoring (PDMP), discharge summaries, history and physicals, operative notes, and consults.
- For more information visit the CRISP website at www.crisphealth.org.

Encounter Notification Service (ENS)

ENS allows primary care physicians, care coordinators, and others responsible for patient care to receive real-time alerts when patients are admitted/discharged at hospitals. Proactively coordinate your patients' care and schedule any necessary follow-up treatment or visits. ENS services currently receive feeds from:

- All Maryland hospitals
- Most D.C. hospitals
- All Delaware hospitals
- Over 40 Long-Term Care Sites

Prescription Drug Monitoring Program (PDMP)

The Maryland Prescription Drug Monitoring Program gives you access to prescription information for all Schedule II-V drugs filled in Maryland and Virginia.

- Available inside Clinical Query Portal
- Prescribers, Dispensers, & other Licensed Staff may have access.
- View interstate PDMP data for neighboring states.

For more information and to sign up for any of these

CRISP User Services

contact MedChi at **888.507.6024** or email info@medchiservices.org.





CONSULTATIVE INSURANCE REVIEW

Med Chi Insurance Agency was established in 1975 "by physicians for physicians" to satisfy the needs of doctors and medical practices.

Contact Keith Mathis at 800.543.1262, ext. 4422 or KMathis@medchiagency.com today to schedule your "no obligation" review at no cost!

1204 Maryland Avenue | Baltimore, Maryland 21201
410.539.6642 or 800.543.1262
410.649.4154 fax

www.medchiagency.com

YOUR "NO OBLIGATION" REVIEW INCLUDES THE FOLLOWING:

Employee Benefits:

Group Medical, Dental, and Vision Coverage | Group Life & Disability | Voluntary Benefits

Property & Liability:

Medical Malpractice | Workers Compensation | Medical Office Insurance | Employment Practices Liability | Directors & Officers Liability | Privacy/Data Breach Coverage | Bonds (Fiduciary/Fidelity/ERISA)

Personal:

Life Insurance | Disability (Individual/Pension/Business Overhead) | Annuities | Long Term Care | Estate Planning/Retirement Planning | Auto/Homeowners/ Umbrella Coverage



MedChi
The Maryland State Medical Society
1211 Cathedral St. s Baltimore, MD 21201

Address Service Requested

Presorted Standard
U.S. Postage
PAID
Pemit No. 48
Merrifield, VA