

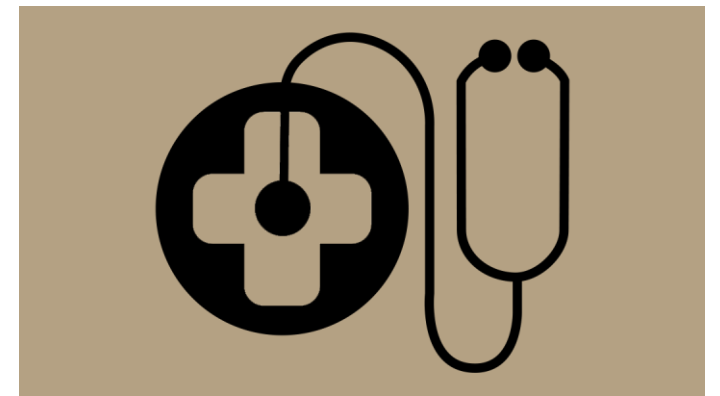
Value Based Payment in Maryland AMA Advocacy Call

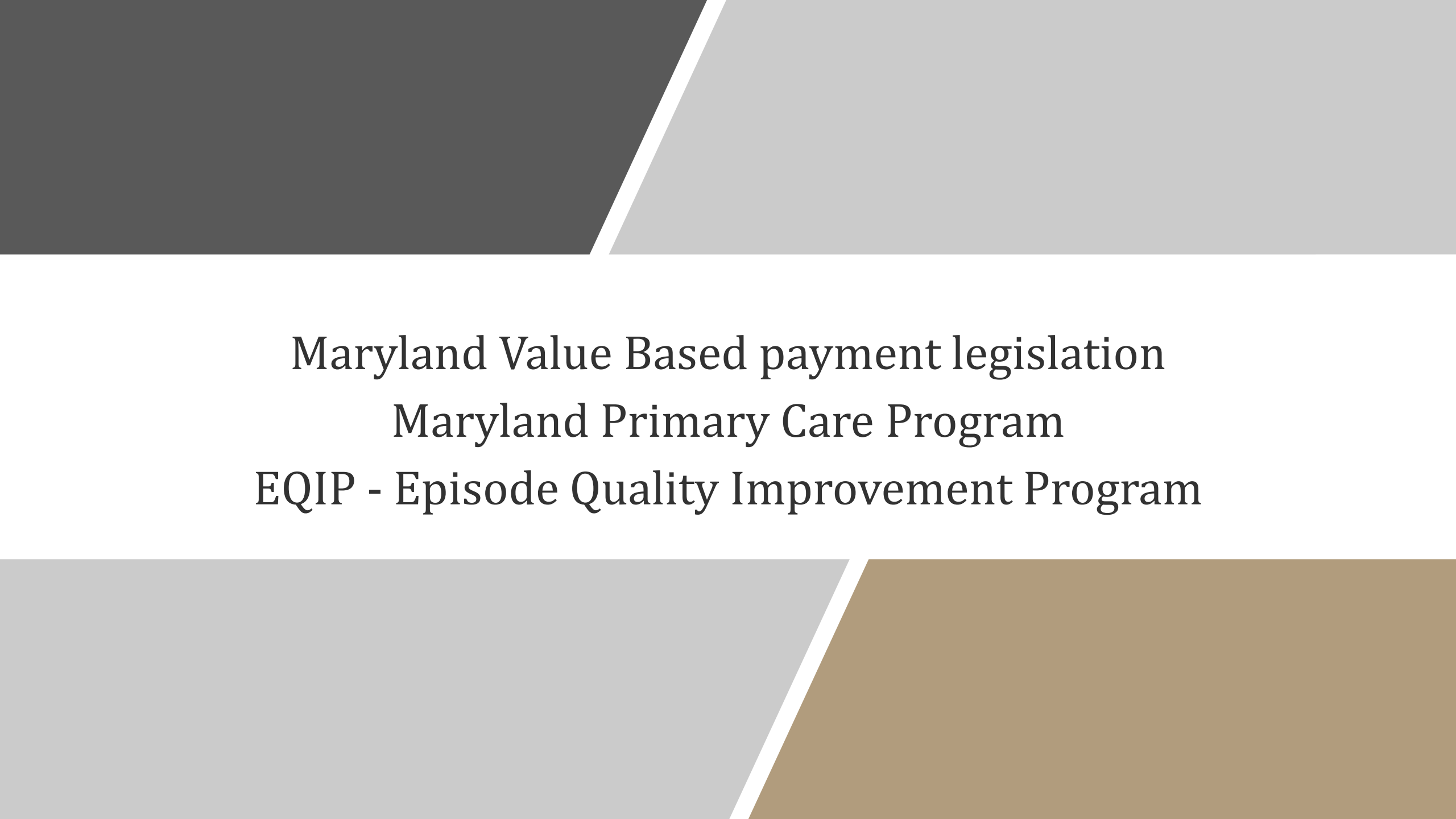


Gene M. Ransom III
Chief Executive Officer
MedChi, The Maryland State Medical Society
April 5 2022

Introduction to MedChi

- MedChi is the seventh oldest medical society, formed in 1799 in Annapolis, MD.
- The Mission of MedChi, The Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health of Maryland.
- MedChi is the largest physician organization in Maryland
 - Physicians – Primary Care and Specialists
 - Medical Residents and Students
 - Practice Managers and Medical Staff





Maryland Value Based payment legislation
Maryland Primary Care Program
EQIP - Episode Quality Improvement Program

Maryland Value Based Payment Legislation AKA CareFirst Legislation

MedChi has been working for over a year on a proposal that would authorize insurers to enter arrangements with health care practitioners and health systems to allow for both bonus payments and the recoupment of funds.

Maryland's current law for State plans does not allow these arrangements to be entered into outside of the federal waivers granted under Maryland's Total Cost of Care contract because any recoupment is categorized as "the practice of insurance" since it is managing risk.

Under the auspice of the MedChi Physician Task Force, MedChi representatives held biweekly meetings with representatives from MHA and CareFirst to discuss the proposal.

MedChi heard from both sides of the spectrum – those that wished to enter into such arrangements and those that did not want to enter into such arrangements (and did not want to feel pressure to do so). Therefore, throughout this process, MedChi has attempted to "thread the needle" to provide authorization and protections for both viewpoints.

Maryland Value Based payment Legislation AKA CareFirst Legislation

CareFirst[®]



House Bill 1148/Senate Bill 834: Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

Agreement Reached in March of 2022

The House and the Senate committees voted favorable with amendments on the above-referenced legislation.

MedChi is pleased to report that this legislation contains the strongest protections for the physician community for those physicians that chose to enter into these arrangements and for those that want to remain fee-for-service, including a provision that states that a carrier may not reduce the fee schedule of a physician who remains fee-for-service and does not participate in a two-sided incentive arrangement.

HOUSE BILL 1148

Pendergrass, Cullison, ~~and Kipke~~ Kipke, J
Carr, Chisholm, Hill, Johnson, Kaiser, Kelly, J
Morgan, Reilly, Rosenberg, Saab, Szeliga, and

Read first time: February 11, 2022

Health and Government Operations

Vote: Favorable with amendments

Adopted

Effective: March 7, 2022

CHAPTER _____

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Insurance – Two-Sided Incentive Arrangements Payments – Authorization

of providing that value-based arrangements established under federal law are exempt from certain provisions of the Health Care Practitioner Referral Act; providing that a health care practitioner that accepts capitated payments in accordance with certain other acts is not considered to be engaged in the business; authorizing certain bonus or incentive—

Maryland Value Based payment Legislation AKA CareFirst Legislation

- On the next three (3) slides, there is a chart illustrating the bill as initially put forth in December 2020 and the bill as passed by the committees.
- It is anticipated that the legislation will move through the full General Assembly and that the Governor will sign it.

Main Topic in Legislation	2020 Draft	2022 Draft
Capitation Authorization: Who is Covered	Allowed a health care provider to enter into a capitation agreement by exempting a health care provider who accepts capitated payments from the practice of insurance	<p>Changes health care provider to health care practitioner (more appropriate term when referencing physicians) and a set of health care practitioner to allow the entering into capitation agreements in both the self-funded and fully insured marketplace.</p> <p>NOTE: Capitation is currently allowed in the fully insured marketplace.</p>
Two-Sided Incentive Arrangement Authorization: Who is Covered	Extended the current bonus arrangement law to authorize a carrier to recoup funds paid under a two-sided incentive arrangement for any health care practitioner or set of health care practitioners	<p>Uses the definition of “eligible provider,” which means a licensed physician or a set of health care practitioners (group practice, CIO, CIN or ACO). A set of health care practitioners would include those non-physicians affiliated with a physician’s group.</p> <p>Adds a definition for two-sided incentive arrangement that reflects both the receiving of a bonus and the recoupment of funds.</p>
Protections for Non-Participation	Participation is voluntary and cannot be a condition of participation in a carrier’s network.	<p>Maintains voluntary and cannot be a condition of participation in a carrier’s network and adds that a carrier may not reduce the fee schedule of a health care practitioner or set of health care practitioners based on non-participation in its bonus or other incentive-based compensation or two-sided arrangement program.</p> <p>NOTE: The statute allows a practitioner to file a complaint with the mia for any violation of the above measures, including the reduction of the fee schedule.</p>

Data Transparency	Makes no changes to current law	<p>Expands current law to add requirements to increase the information that must be provided to the physician entering into a bonus or two-sided incentive arrangement (i.e., requires that at least all the applicable fees or at least fifty of the most common services billed in that specialty, whichever is less be provided rather than “up to” fifty; requires information to be provided by the carrier about the practitioner and the methodology that the carrier uses to determine whether to recoup compensation from the practitioner).</p> <p>** The information must be also provided in writing prior to entering into a contract (not just at contract execution); 30 days prior to a change; and upon the request of the health care practitioner and prior to entering into the contract.</p> <p>In addition, at least quarterly carriers must provide:</p> <p>1. any amount paid to another health care provider that is included in the cost of care of a patient in the population or episode of care ; and</p> <p>2. any copayment, coinsurance or deductible that is included in the total cost of care of a patient in the population or episode of care.</p>
Capitation	<p>Authorizes capitated rates in the self-insured market if the self-funded employer group leases a carrier’s network; the self-funded employer group retains the obligation to provide access to covered health care benefits; and the contract not include other reimbursement arrangements that are considered insurance.</p> <p>Note: Already permissible in fully insured.</p>	<p>At the request of MedChi, initially limited to primary care providers but then expanded again to all health care practitioners based upon member’s requests.</p> <p>At the request of the MIA, language now includes fully and self-insured market (adding protections to the fully insured).</p> <p>Language added that capitation is voluntary.</p>
10-year Reporting Requirement	Silent	Beginning December 31, 2023, and annually thereafter for a period of ten years, the Maryland Health Care Commission must report to the Health and Government Operations Committee and Finance Committee on the progress of implementation of value-based care arrangements in Maryland, including the number and type of arrangements entered into, quality outcomes, impact of two-sided incentive arrangements on the fee schedules of health care practitioners included in the target budget that are not eligible providers, and disputes and resolutions thereof and cost-effectiveness of the programs.
Self-Referral	Silent – Did not address self-referral	Exempts a value-based arrangement established pursuant to an operated in accordance with the terms of the exceptions set forth at 42 C.F.R. 411.357 (AA)(1)-(3)

Protections for Participation

Any recoupment is limited to: (1) no more than 50% of the excess above the mutually agreed upon annual target for cost of care; and (2) a mutually agreed upon maximum liability.

1. Requires that a contract, at a minimum,

(i) establish a target budget for the total cost of care of a population of patients population size; or on episode of care

(ii) limit recoupment to no more than 50% of the excess above the mutually agreed budget

(iii) specify a mutually agreed upon maximum liability for total recoupment that of the annual payments

(iv) provide an opportunity for gains by an eligible provider that is greater than recoupment by the carrier

(v) provide an opportunity for an audit by an independent third party and an independent party dispute resolution process following good faith negotiation, which does not have to be filing an appeal of a coverage decision under Maryland's appeals and grievance law

(vi) require the carrier and the eligible provider to negotiate in good faith adjustment budget:

1. When certain circumstances beyond the control of the carrier or the eligible provider affect in hospital rates; and

2. When material changes occur in health care economics, health care delivery or regulatory arrangement

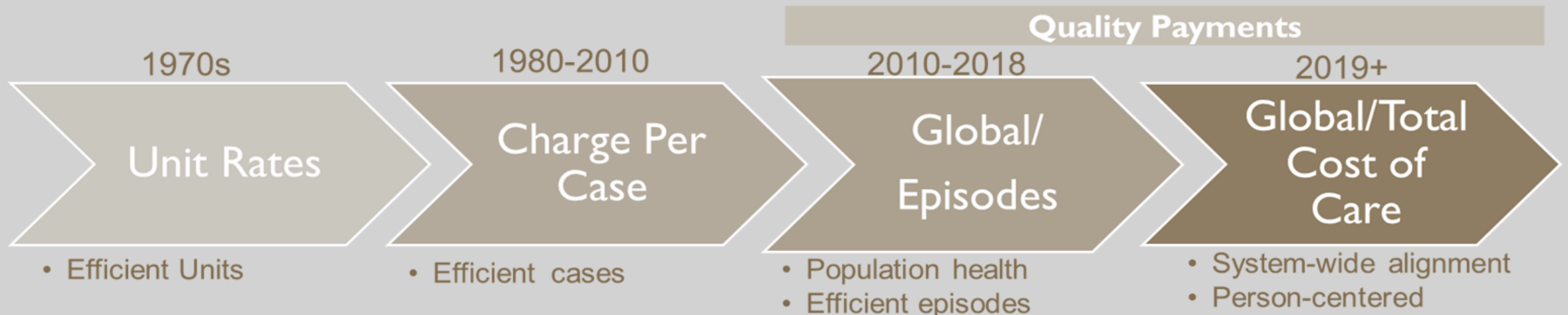
(vii) require the carrier to pay any incentive or request any recoupment from the amount owed under the contract within 6 months after the end of the contract year, unless the carrier or provider initiates a dispute relating to the recoupment or incentive amount

2. In addition, an arrangement shall not provide an opportunity for recoupment based on the provider performance under the first twelve months of the arrangement, unless mutually agreed to by the provider and the carrier; and on the date the eligible provider and the carrier enter the arrangement, the provider has operated under an arrangement that includes an opportunity for incentive payment and provider performance with any payer for at least 12 months.

3. Also, states that an arrangement may not be amended during the term of the contract unless mutually agreed to by the parties.

Background: Maryland's All-Payer Model

- Since 1977, Maryland has had an all-payer hospital rate-setting system
- In 2014, Maryland updated its approach through the All-Payer Model
 - 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation
 - Per capita, value-based payment framework for hospitals
 - Provider-led efforts to reduce avoidable use and improve quality and coordination
 - Savings to Medicare without cost shifting
 - Sustains rural health care with stable revenue base



What is the Maryland Primary Care Program?



[Pages - Home](#)
(maryland.gov)

The State of Maryland has entered a Total Cost of Care All-Payer Model contract with the Federal Government that is designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland.

A key element of the model is the development of the Maryland Primary Care Program (MDPCP). MDPCP is a voluntary program open to all qualifying Maryland primary care practitioners that provides funding and support for the delivery of advanced primary care throughout the state.

The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.

Payment Incentives in the MDPCP

Practices – Track 1/Track 2

Care Management Fee

- \$6-\$100 Per Beneficiary, Per Month (PBPM)
 - Tiered payments based on acuity/risk tier of patients in practice including \$50/\$100 to support patients with complex needs, dementia, and behavioral health diagnoses
- Timing: Paid prospectively on a quarterly basis, not subject to repayment

Performance-Based Incentive Payment

- Up to a \$2.50/\$4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met

Underlying Payment Structure

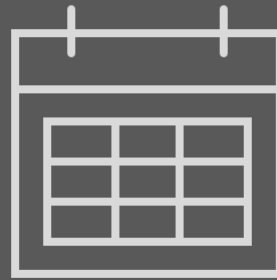
- Track 1: Standard FFS
- Track 2: Partial pre-payment of historical E&M volume with 10% bonus
- Timing: Track 1: FFS; Track 2: prospective

Maryland Primary Care



MARYLAND
Department of Health

- Program has been extended



- Open enrollment coming soon



The Purpose of Episode Quality Improvement Program (EQIP)

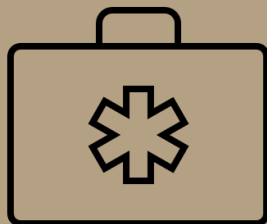


Under the Total Cost of Care Model, **Maryland's healthcare system has focused on reducing costs and improving quality of care** for Marylanders who receive care in both hospital and non-hospital settings.

Maryland **physicians largely remain on fee-for-service** reimbursement incentives and, as a result of the TCOC Model, are left out of national, **Medicare** value-based payment programs.

Therefore, it is imperative that the State **creates new value-based reimbursement opportunities to ensure cost containment in non-hospital settings.**

Eligible Specialties



General Practice (01)

Family Medicine (08)

Internal Medicine (11)

Obstetrics and Gynecology (16)

Pediatric Medicine (37)

Geriatric Medicine (38)

Nurse Practitioner (50)

Clinical Nurse Specialist (89)

Co-located Psychiatry (26)*

Physician Assistant (97)

Preventive Medicine (84)

Certified Nurse Midwife (42)

Ensure providers are listed as one of the eligible specialties:

- Specialists with these primary specialty codes are not eligible to participate
- * Practitioners identified with a primary specialty code of Psychiatry (26) must be co-located with an eligible practitioner with a primary specialty code other than Psychiatry in order to participate

EQIP - The Episode Quality Improvement Program

The HSCRC plans to start a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance

Upside-only risk with dissavings accountability

Alignment with CareFirst's episode payment program

AAPM/value-based payment participation opportunities for MD physicians

EQIP will utilize the Prometheus Episode Grouper approach. The first performance year will include episodes in the following specialty areas:

- Gastroenterology and General Surgery
- Orthopedics and Neurosurgery
- Cardiology

EQIP Specialty Meeting Dates



MSEPS

- April 6th
- 7:00 pm – 8:00 pm



Urology

- April 14th
- 8:00 am – 9:00 am

Episodic Value-Based Payment

Physicians Agree to Episodic Payment

- Signed Agreement with a CRP Entity
- Enroll in clinical episodes that will **Trigger** when a specific Medicare beneficiary or procedure is performed

Target Price is Set

- Costs from episodes triggered in the baseline year are aggregated
- A per episode average cost or **Target Price** is set

Performance Assessed

- Performance year episode costs are compared to the Target Price
- Savings are aggregated to determine the **Incentive Payment** due to the physician

- Bundled-payment programs, in-particular, are effective at controlling episodic care and improving quality outcome among physicians via a financial assessment
- Analyses of CMS bundled-payment programs have shown 4-6 percent reductions in gross Medicare spending

Multi-Payer Demonstration with CareFirst

MedChi

The Maryland State Medical Society
Your Advocate. Your Resource. Your Profession.

CareFirst 

- The HSCRC, MedChi and CareFirst have aligned episode program definitions so that the Episodes of Care (EOC) program and EQIP can provide parallel incentives to participating physicians.
 - **Prometheus Episode Definitions** will be utilized in both programs
 - Incentive Payment and other **policy decisions will remain separate** where appropriate
 - Opportunity for **rewards across both Medicare and CareFirst** increases program outcomes
- The HSCRC will encourage other payers to start programs similar to EQIP in Maryland



- Maryland law now has strong physician patient protections for value-based care contracts and could serve as a model bill.
- The Maryland Primary Care program has provided a higher level of service to hundreds of thousands of Medicare patients in Maryland and helped with the response to covid. It is one of the largest and most successful advanced payment models in the country.
- The newly launched Episode Quality improvement program is a new opportunity to include proceduralist in value-based payment. It has been created in an aligned fashion with at least one private insurance carrier.
- Physician and other community practitioner involvement is key to the success of any value based payment program.

Closing Remarks

Questions?



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Medical Society