MedChi, The Maryland State Medical Society
House of Delegates

CMP Report 1-23 - INFORMATION

INTRODUCED BY: Council on Medical Policy

SUBJECT: Report of the Council on Medical Policy

Much of the work of the Medical Policy Council ("Council") has been around MedChi's involvement with and response to the Total Cost of Care Model, and our work to develop more physician friendly programs. The Council's recommendations to the physician alignment committee of the HSCRC maintain two key guiding principles: (1) minimizing risks to physician participation and (2) voluntary physician participation. What follows is what we have requested through the physician alignment committee of the HSCRC.

Maryland Primary Care Program ("MDPCP") Enhancement Recommendations:

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

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

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

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

Recommendation 5 - Practice Support from Care Transformation Organizations ("CTOs"): Continue allowing CTOs to be MDPCP participants.

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

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

Episode Quality Improvement Program (EQIP) Enhancement Recommendations:

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

Recommendation 2 - CRISP Support Enhancement: Build out the resources at CRISP to increase outreach to physicians and for the development of new codes and models for EQIP.

Recommendation 3 - Create EQIP Entity: Work with MedChi or another trusted third party to build a neutral entity to allow for increased small practice participation in EQIP.

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

Recommendation 5 - Consider moving from Grouper: Reconsider the use of Prometheus as the base of EQIP.

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

Recommendation 7 - Maintain Risk Structure: Keep the current risk structure. It is not fair or logical to add another layer or greater layer of risk to physician practices.

Specific New Physician Program Ideas:

1. Emergency Physician Program: Emergency physicians are working on a global budget program that MedChi supports.

2. Hospital-based Physicians Program: The HSCRC and MedChi should work to create a program for pathology, radiology, and anesthesiology. A possible program would involve agreements with proceduralists around complex and difficult bundles.

3. Critical Primary Care Program: Primary care physicians play a crucial role in the provision of healthcare services. It is recommended that a critical primary care program be developed to increase access to primary care in underserved and disadvantaged areas. The idea would be a global budget program and be for rural settings and urban settings with primary care shortages. The program would be paid for by Medicaid and the HSCRC to improve outcomes, access, and population health. The program would target creating new pediatric and adult primary care services through a public-private partnership.

4. Value-Based Drug Costs Program: The cost of drugs is a significant concern for physicians and patients. It is recommended that a pilot program be introduced to assess the impact of reducing drug costs on physician practices and patient outcomes.