maryland health services cost review commission

Physician Engagement & Alignment Workgroup

TCOC Model Progression

Meeting #3

March 30, 2023

Workgroup Members

Physicians:

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

Program Administration:

- Gene Ransom, MedChi
- Jacqueline Howard, UMMS
- Ben Steffen, MHCC
- David Sharp, MHCC
- Laura Goodman, Medicaid
- Zach Rabovsky, CareFirst
- Laura Russell, MHA
- Secretary Laura Herrera Scott, Maryland Secretary of Health

Guiding Principles

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

Timeline

Event	Topic	Sub-Topics
Meeting 1 (February 2nd)	Overview	Workgroup Agenda/Goals Health Equity Considerations
		View from MedChi
		EQIP Update
		MDPCP Update
		Other considerations – Multi-State Model, GBR 2.0, State Primary Care workgroup etc., Medicaid.
		Invite public comment on direction of model regarding physician programs and physician alignment
Meeting 2 (March 2nd)	Public Comment	Workgroup members reflect on key themes and views on priorities
	Workgroup Discussion	Identify areas of focus, common themes, etc.
Meeting 3 (March 30th)	Recap of Public Comment	
	First Draft Recommendation	HSCRC review of straw man proposal and discussion
Report Release (Late March)	First Draft Written Recommendation to Workgroup and Public	Workgroup will provide feedback and report will be refined via email etc.
Potential Meeting 4 (April 13th)	Review Final Draft	
Final Meeting 5 (May 11th)	Finalize Written Recommendations	

Agenda

1. Draft Recommendation Document Updates
2. New Ideas Discussion
    1. Emergency Department Physicians
    2. MedChi Recommendations
    3. CareFirst Models
3. MHA Comment Letter Update
4. MDPCP Status Update
5. Comments and Next Steps

Draft Recommendation Document Update

- Distributed draft in email earlier this week addressing EQIP and MDPCP
  - Intended as a draft for discussion purposes, please feel free to edit or provide suggestions.
  - Does NOT include:
    - Final recommendations from MDPCP advisory council (MDPCP comments reflect comment letter received and discussion in the workgroup).
    - New program items being discussed today.
  - Suggestions or questions can be directly related to HSCRC team (Lynne/William) or made to "reply all" email if you wish to raise to the group.
  - Would like to receive comments by Friday, April 14th and then will circulate a revised draft.

Global Budget Concept for Emergency Physicians in Maryland

Summary of Program Idea

- Transition to non-fee-for-service based global budget model for emergency physician services.
- Anticipated success would be measured by improved access to care, improved experience and quality of care, reduced avoidable ED utilization, ensured safe transitions in post-discharge, improvement of health equity, and reduced TCOC.
- Entire ED would be required to enroll all clinicians, rather than individual agreements.
- Potentially leverage a similar model for other hospital-based groups

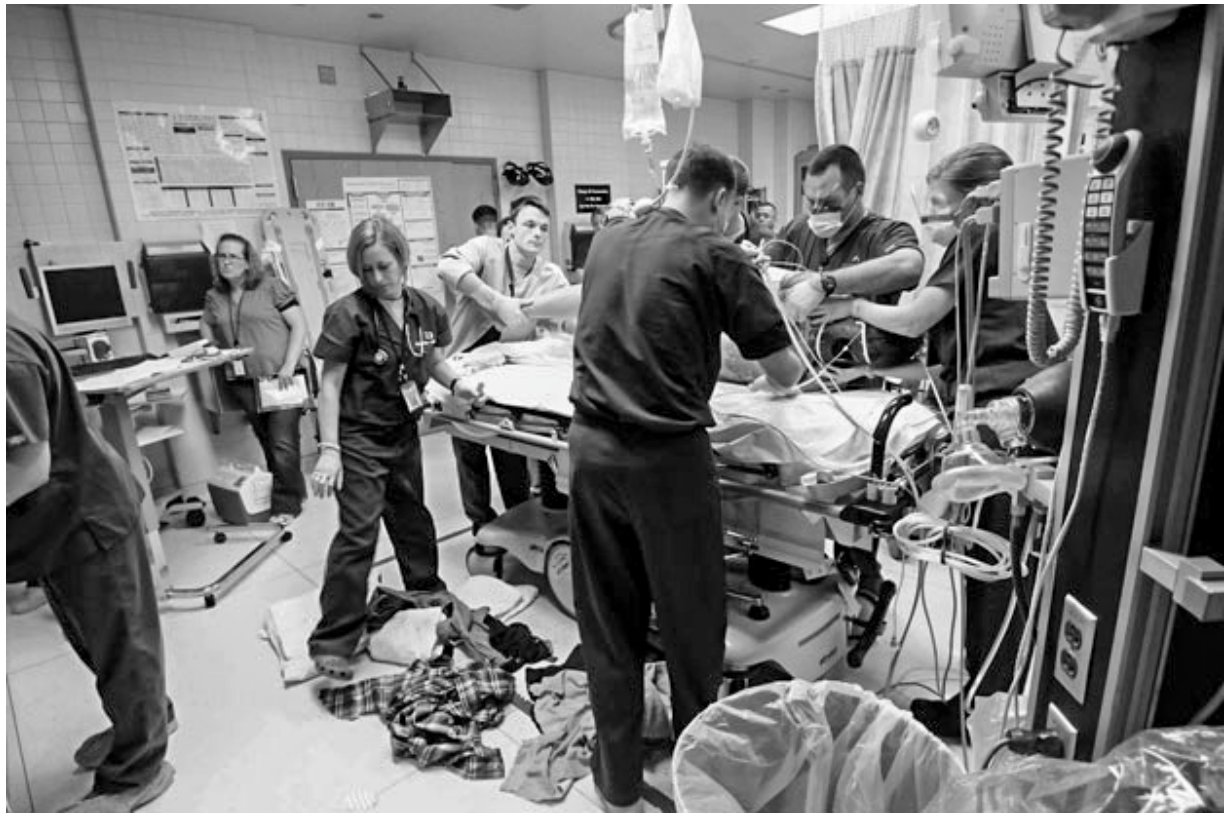
EM Global Budgets

Jesse M. Pines, MD, MBA, MSCE
National Director of Clinical Innovation
US Acute Care Solutions
March 29, 2023

US Acute Care Solutions

Global budgets in Maryland for emergency medicine

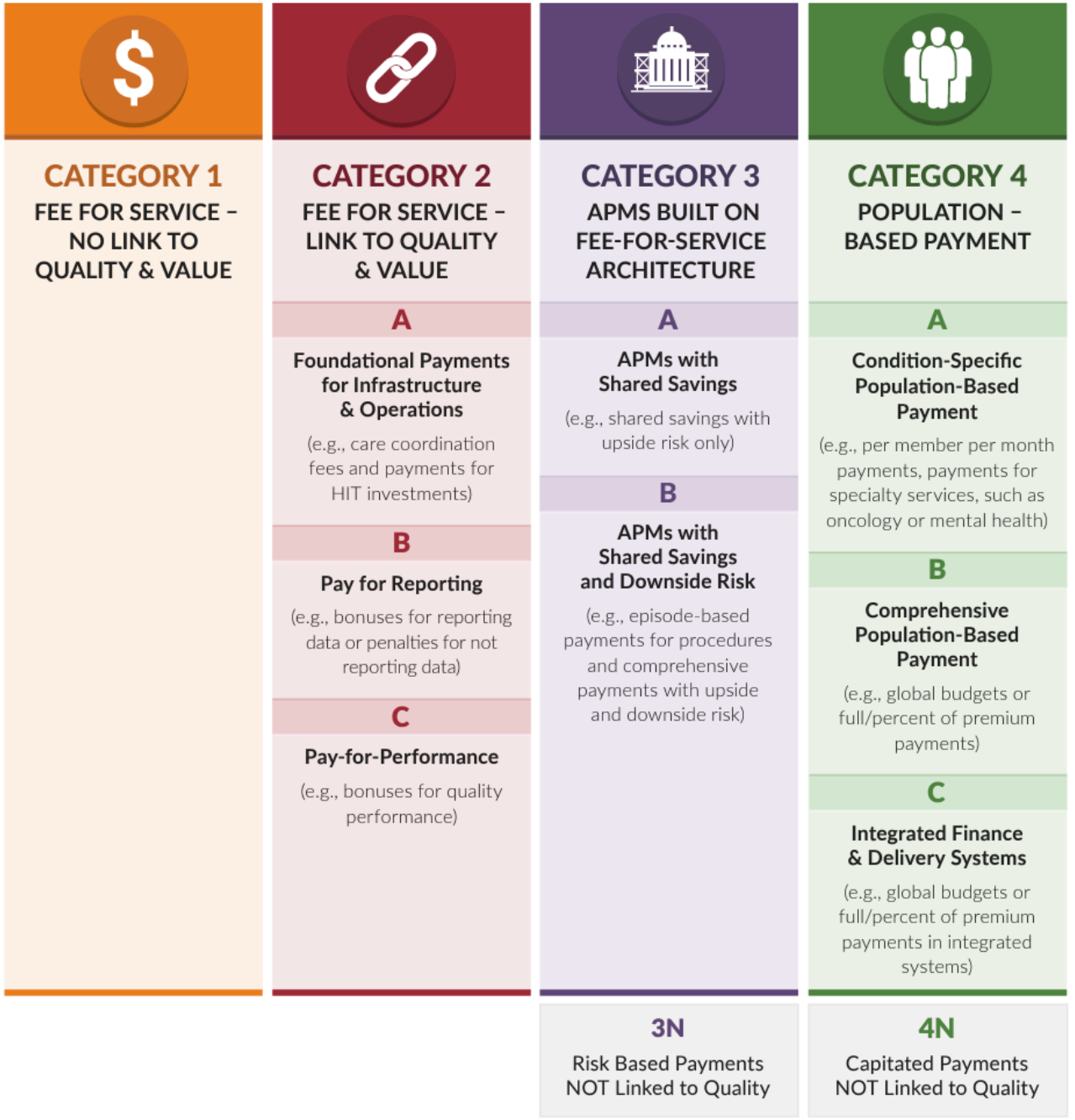
- ED EQIP launched in 1/23. Goal is to reduce 14-day total cost of care for 535 ED ICD-10 codes in Medicare FFS. Shared savings through HSCRC.
- Issues:
  - ED EQIP is a short-term model.
  - Baseline is 2019 costs, which becomes more remote over time.
  - TCOC cannot be continuously reduced.
  - All shared savings programs are time-limited.



Where EM global budgets fit into APMs

- Category 1: FFS
- Category 2: FFS + quality
- Category 3: FFS architecture
- Category 4: Population-based

EM global budgets = Category 4B



Global budgets in Maryland for emergency medicine

- Reduce uncertainty in payments to MD ED docs allowing them to more consistently and effectively staff EDs.
- Improve access to care for MD residents and visitors.
- Improve experience / quality who use MD EDs.
- Reduce avoidable MD ED utilization.
- Ensure MD ED patients have safe transitions in care
- Address the social determinants of health that lead to frequent ED use and improve health equity.
- Reduce total cost of care in MD

Global budgets in Maryland for emergency medicine

- Active engagement: HSCRC, MedChi, MDACEP, CMS, MD clinician leadership
- Maryland GBR 2.0 model may be the best mechanism.
- Requires partnership with the hospital to reduce costs & improve pop health.
- Goal: Alignment of ED physicians (or other hospital-based physicians with GBR).

Global budgets in Maryland for emergency medicine

- Global budget ideally would replace most FFS payments for ED docs.
- Proposed calculation:
  - 1) Prior year's total revenue
  - 2) Payment for maintaining 1.8 PPH staffing
  - 3) Payment for call-in program (telemed) to direct patients to best care site
  - 4) Payment for call-back program (digital engagement / telemed) to improve care transitions
  - 5) Payment for ED engagement in frequent users' program

Global budgets in Maryland for emergency medicine

- Shared quality metrics w hospital (in development):
  - 1) LWBS
  - 2) ED LOS (DC)
  - 3) 72-hour return / admission
  - 4) Admission intensity (ED EQIP)
  - Possible: ED LOS (admission), other patient safety indicators, patient experience, clinical measures (opioid rx, sepsis)

- Need to be developed collaboratively: MD ACEP/hospitals

Global budgets in Maryland for emergency medicine

- Monitoring telemedicine / follow-up services (success = implementation + high utilization).
- Monitoring quality. Goals: decrease LWBS, reduce LOS, lower ED admissions, reduce 72 return/admits
- Lower population-level utilization of avoidable, low-acuity ED use = success
- Reduce TCOC in Maryland (within a hospital's catchment area).

MedChi Recommendations

MedChi Recommendations

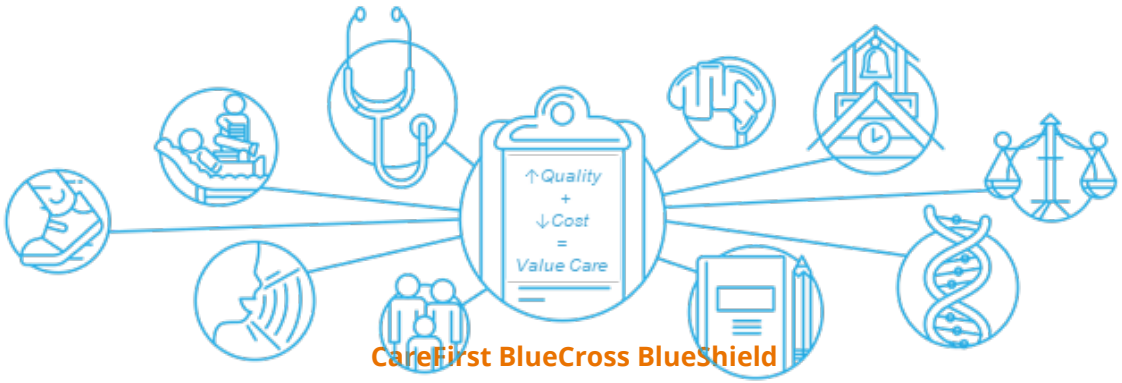
- General Recommendations:
  1. Appropriate Risk in Any Physician Program
  2. Voluntary
- Specific program ideas:
  1. Emergency Physician Program
  2. Hospital-based Physicians Program
  3. Critical Primary Care Program
  4. Value-based Drug Costs Program

CareFirst Models

CareFirst Physician Engagement in Value Based Care

CareFirst PCMH Program: Overview of Key Principles

- **Primary Care Providers (PCPs):** PCPs are central to the PCMH Program. The Program incentivizes PCPs to improve health care outcomes and reduce the global cost of care by using care coordination and population health strategies to manage their patient population.
- **Global Accountability:** PCPs are organized into Panels, and as a team, are accountable for aggregate quality and cost outcomes of their pooled population.
- **Incentives:** Panels have the opportunity to earn robust financial incentives
  - 12% Participation Incentive
  - Reimbursement for Care Coordination
  - Shared savings through increase in fee schedule.
- **Clinical/Nursing Support:** Registered Nurse Care Managers are dedicated to supporting PCPs manage the care of their most complex patients
- **Analytical/Infrastructure Support:** Access to data, consulting, and web-based tools providing a holistic view of patient populations



The PCMH Medical Panel

How CareFirst supports independent primary care providers

- Primary Care Providers (PCPs) work together in panels of at least 5 PCPs and no more than 15 PCPs
- Panels may be formed by an existing group practice or be composed of solo practitioners and/or small independent group practices that agree to voluntarily work together to achieve Program goals
- At this size, Panels are big enough to accumulate a credible cohort of CareFirst Members, but small enough for the contribution of each PCP to be seen and have an impact that matters to all Panel participants
- **Global Accountability:** Panels, as a team, are accountable for aggregate quality and cost outcomes of their pooled population
- **Independence:** The PCMH Support Team will make evidence-based suggestions and provide actionable recommendations that will help your Panel achieve the program goals, but PCPs will ultimately retain full independence to make decisions

Benefits of the "Virtual Panel"

To allow independent practitioners to participate, panels are organized together. By forming likeminded groups, they:

- Pool their data to form a larger sample size, which protects them from market swings and increases reporting accuracy.
- Are able to offer patients expanded coverage through in-panel referrals and shared resources.
- Our virtual and independent practices have historically made up roughly 60% of the program's participating providers.
- In 2019, 75% of panels experienced savings.
- We had 4,066 PCPs in 440 panels in 2014, and in 2022 we had 3,858 PCPs in 382 panels.
  - Note: In 2021, we launched the ACO model for health systems, encouraging some large systems to switch from PCMH
- Historically, independent panels have performed better than health system panels. They have been more engaged with the program, likely because they see the dollars that they earn directly, as opposed to health systems where the shared savings payments may or may not funnel to the PCP.

Value-Based Care

- CareFirst expanded our VBC offerings and created Accountable Care Organizations (ACOs) and Episode of Care (EOC) models to enfranchise health systems and specialists, creating greater collaboration across the health care delivery system
  - ACOs
    - 8.000 providers
    - 440,000 members
    - Annual total cost of care totaling $3.7B
  - EOCs
    - 1,000 specialists
    - Annual total cost of care totaling $110M

- Where we're going:
  - Maryland law now allows both two-sided incentives and capitation arrangements, enabling us to offer greater incentives to those that share accountability.
  - Working towards offering capitation in the commercial market.
  - Testing specialty medical home arrangements in behavioral health, nephrology, and oncology.
  - Goal is for VBC to be the default for providers in the region.

Behavioral Health

- The Behavioral Health (BH) Specialty Medical Home has three aims:
  - To have BH providers coordinate BH care for members with severe mental illness
  - To have Serious Mental Illness (SMI) members dually-attributed to their PCP and a BH "cooperative" for comprehensive care
  - To have BH providers work closely with PCPs to jointly improve adherence to medications and appointments

- The model serves members with severe mental illness (SMI), BH prescribers, and BH therapists.

- Under this program, BH co-ops will see shared savings if they meet a quality gate and reduce their members' cost of care.

THANK YOU

Workgroup Discussion on New Models

MHA Update

MHA Recommendations

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

MHA Recommendations

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

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

MDPCP Status Update

Comments & Next Steps

Future Meetings

- Potentially a meeting on **April 13th** at 7:30AM.
  - Review/continue/refine today's discussion

- Final meeting on **May 11th** at 7:30 AM
  - Finalize final written recommendations.

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Physician Engagement and Alignment Workgroup Written Recommendation

Maryland Model 3.0 Progression Plan

April 2023

3-24 DRAFT - FOR DISCUSSION ONLY - DO NOT DISTRIBUTE

1. Background

Physician Engagement and Alignment Model Goals

Under the Total Cost of Care (TCOC) Model, Maryland works toward the three key goals of improving population health, improving healthcare outcomes for individuals, and controlling growth of the total cost of care. Achieving the goals of the Model is a collaborative effort between the State, hospitals, non-hospital providers, payers, and a broad spectrum of community partners, all working together to create long-term health improvements and cost savings for Marylanders.

The TCOC Model requires care transformation and partnerships across the healthcare system. Implementing care redesign strategies helps hospitals and providers gain access to new tools and resources to better meet the needs of patients, improve population health, and achieve the goals of the Model. Under the model Maryland initiated a number of care redesign programs, two of these focused specifically on engaging physicians to achieve the goals of the model. These two programs are the Maryland Primary Care Program and Episode Quality Improved Program.

Maryland Primary Care Program

The Maryland Primary Care Program (MDPCP) began in 2019 as a voluntary program open to all qualifying Maryland primary care providers. As a component of the Total Cost of Care Model Agreement with CMMI, MDPCP provides funding and support for the delivery of advanced primary care throughout the State and the overall health care transformation process. Primary care providers are supported to play an increased role in prevention and management of chronic disease, prevention of unnecessary hospital utilization, and integration of behavioral health within primary care. MDPCP also provides practices with the resources needed to expand hours services are available to patients and works to improve transitions of care between health facilities for patients. MDPCP focuses on areas of access to high value care, improved outcomes, behavioral health integration, and data driven care.

Episode Quality Improvement Program

The Episode Quality Improvement Program (EQIP) was created in 2022 as a voluntary, episodic incentive payment program to engage specialist physicians who treat Maryland Medicare beneficiaries. EQIP holds participants accountable for achieving cost and quality targets for one of more Clinical Episodes. The program uses the Prometheus Episode Group and episodes that are created by Maryland physicians, which allows physicians to define their own value-based payment models. An episode is triggered when a physician performs one of the triggering conditions. A target price is set for the episode and the physician earns an incentive payment if the episode cost of care is less than the target price. Examples of episodes include: congestive heart failure, major joint replacement, etc. Physicians are also held accountable for performing quality of care activities, such as performing medication reconciliation, conducting BMI screening, and discussing advanced care plans with their patients.

Workgroup Profile

The Physician Engagement and Alignment Workgroup met from February 2023 to April 2023 to support progression planning for the Maryland Total Cost of Care Model. 16 workgroup members consisted of 8 practicing physicians, MedChi, Maryland Hospital Association, University of Maryland Medical System, Maryland Heath Care Commission, Medicaid, Maryland Primary Care Program, and CareFirst. These members, as well as outside stakeholders, met to review existing physician alignment programs, identify potential expansions and revisions to current programs, and make recommendations for additional programs and enhancements while incorporating Health Equity principles.

2. Recommendations in Relation to Current Programs

Priorities for Model Negotiation for CMS

Introduction:

The workgroup and stakeholders developed a number of recommendations with regard to the current programs (MDPCP and EQIP). Some of these recommendations are reliant on the contractual relationship with CMS while others could be implemented by model leadership without waiting for further negotiations with CMS. While generally the workgroup focused on new program elements some existing items are noted where the workgroup felt it was important to emphasize continued support for the program element.

This section discusses areas where the State requires new flexibilities to continue to evolve and enhance physician alignment and engagement in Maryland. These flexibilities will be dependent on the language of a future agreement and other negotiations with CMS.

Recommendations

1. **Add payment flexibilities to support the EQIP and other future physician programs**. Currently the State can not directly adjust physician payments related to value based programs. Instead payments have to be passed through a hospital entity. The State should work with CMS to allow direct payments to the participating physicians which would simplify program administration and allow more timely payment of program rewards.

2. **Add/Restore various flexibilities to the MDPCP program,** specifically:
    a. **Track 2 of MDPCP should be continued and Track 3 should be optional.** MDPCP has 3 tracks ranging from Standard (Track 1) to Advanced with Upside and Downside risk (Track 3). Generally the expectations and level of financial risk and reward increases as practices move to Track 3. Under the current program practices are required to transition to Track 3 or drop out of the program by 2026. After 2025 only Track 3 will remain, requiring practices to participate at the maximum level or not participate. The workgroup believes that it is not realistic for all practices to participate under Track 3. Instead, a model like Track 1 should be made available to practices as (1) an entry point to the program for new participants for some period prior to moving to Track 2 and (2) and Track 2 should be an endpoint for practices that do not have the wherewithal to operate under Track 3.
    b. **The option to include Care Transformation Organization (CTO) participation and associated payments should be continued**. CTO payments are a portion of MDPCP fees that are paid to an organization which then assists the practice with functions such as care coordination, reporting and uses economies of scale to secure and deploy the advanced care team staff that are difficult for small and medium size practices to acquire independently. The program should continue to support this function.

c. **Additional state flexibility**. The State should advocate with CMS to delegate additional responsibility for program operations to the State as long as the State operates within agreed upon financial and operational boundaries. Areas for additional flexibility should include, application periods for new participants, practice eligibility requirements, quality measures and administrative reporting requirements. Delegating responsibility to the State will reduce burden on CMS, allow the State to customize the program to local needs and accelerate the incorporation of new elements in areas like health equity.

3. **Promote Medicaid alignment with EQIP and MDPCP.** State leadership from the Department of Health (MDH), Medicaid, MDPCP Program Management Office (MDPCP PMO), Medicaid, and the Health Service Cost Review Commission (HSCRC) and other interested parties should work together to implement equivalent programs to MDPCP and EQIP within the Medicaid program. Where possible program design should mirror the Medicare programs. For example programs should align around common goals like quality and investment targets but specific program elements will have to vary due to different administrative structures (e.g. CTOs).

4. **Promote Commercial payer alignment with EQIP and MDPCP.** State leadership from MDH, MDPCP PMO, and the HSCRC should work with commercial payers and interested providers to implement/expand equivalent programs to MDPCP and EQIP within the Commercial space. Where possible program design should mirror the Medicare programs. For example programs should align around common goals like quality and investment targets but specific program elements will have to vary due to different administrative structures (e.g. CTOs).

Priorities for State Model Leadership

Introduction:

This section discusses where the workgroup identified recommendations that could be implemented by the State without waiting for additional negotiations with CMS.

Recommendations:

1. **Continue to enhance the EQIP program**. Specifically:
   a. **Fund additional CRISP support.** The HSCRC should make available additional funding to CRISP to allow CRISP to provide greater support for (a) practices considering participation, (b) practices with questions about how to operate/succeed in the EQIP program and (c) for physicians who wish to investigate new episodes for areas not covered by the existing episode grouper.
   b. **Explore Additional Program Elements**. The HSCRC should explore additional program enhancements that would expand program participation and/or improve the measurement of results. Specific elements could include:
      i. Support for industry to create a “Pooled” EQIP entity. Currently physicians participate in EQIP by grouping together as an “EQIP Entity”, however practices that do not have sufficient size may not be able to participate because they do not have sufficient volumes or the administrative capacity to participate. A “Pooled” entity would be intended to allow these smaller practices to combine efforts in a single entity. However, such an entity may need accommodations from the HSCRC for certain program elements, for example how savings are distributed within an EQIP Entity.
      ii. Additional episode parameters such as more episode windows (program is currently only on a calendar year basis), longer episode lengths and accommodations around medical drug costs where significant price volatility exists.

Global Budget Concept for Emergency Physicians in Maryland

Jesse M. Pines, MD, MBA
Draft: March 1, 2023

Since 2014, Maryland's global budget model has paid hospitals a fixed amount to manage all emergency department (ED) and in-hospital care for a population of patients, through its Global Budget Revenue (GBR) model which is administered by the Health Services Cost Review Commission (HSCRC). This model seeks to reduce the cost of hospital care by rewarding population health rather than paying for higher volume.[1] By contrast, physician billing in Maryland, including emergency physicians, is still paid based on a fee-for-service model. This model incentivizes physicians to perform more services, as their revenue is tied to volume, putting hospitals and physicians at odds when it comes to alignment around population health. Extending the global budget model to cover physician services would improve the alignment of incentives for Maryland hospitals and physicians.

Emergency medicine physicians provide an excellent opportunity to test the concept of a physician global budget model. This is because: 1) emergency physicians practice within hospitals, 2) they do not directly generate demand for care, 3) ED budgets tend to be relatively stable over time, and 4) emergency physician models that are centered on population health have demonstrated potential to reduce costs, and 5) emergency physicians regularly make the most expensive decision in healthcare to admit patients to the hospital or discharge them.[2,3] An ED physician global budget model would include ensuring that patients go to the ED if required and avoid it if not required, only get admitted when required, have smooth transitions in care after ED discharge, and programs to reduce repeat ED visits, especially from high-cost frequent users, by addressing their needs outside the ED.[4,5] When integrated healthsystems – in particular Kaiser Permante – have implemented clinical models that target these aspects of acute care utilization and management, the results are substantial. ED utilization in Kaiser in the age <65 population is two-thirds the rate of non-Kaiser California. In the age 65+ population, ED use is similar as older adults require intensive diagnostic evaluation when ill; however, the inpatient utilization is two-thirds the rate of non-Kaiser California.[6] These results are due largely to the systems that have been implemented by ED physicians to control acute care population health.

The current fee-for-service model for ED physician reimbursement does not directly support the additional services that could help achieve these results. Furthermore, it does not directly reward

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[1] https://www.rti.org/publication/marylands-global-hospital-budgets

[2] Anderson ES, Hsieh D, Alter HJ. Social Emergency Medicine: Embracing the Dual Role of the Emergency Department in Acute Care and Population Health. Ann Emerg Med. 2016 Jul;68(1):21-5.

[3] Lin MP, Blanchfield BB, Kakoza RM, Vaidya V, Price C, Goldner JS, Higgins M, Lessenich E, Laskowski K, Schuur JD. ED-based care coordination reduces costs for frequent ED users. Am J Manag Care. 2017 Dec;23(12):762-766.

[4] Bergenstal TD, Reitsema J, Heppner P, Geerts J, Cho A, Smallheer B. Personalized Care Plans: Are They Effective in Decreasing ED Visits and Health Care Expenditure Among Adult Super-Utilizers? J Emerg Nurs. 2020 Jan;46(1):83-90.

[5] Fruhan S, Bills CB. Association of a callback program with emergency department revisit rates among patients seeking emergency care. JAMA Netw Open. 2022;5(5):e2213154

[6] Selevan J, Kindermann D, Pines JM, Fields WW. What Accountable Care Organizations Can Learn from Kaiser Permanente California's Acute Care Strategy. Popul Health Manag. 2015 Aug;18(4):233-6.

ED physicians for reducing low-acuity utilization which could be achieved through implementing a patient-focused pre-hospital telehealth triage system, targeting measures of admission efficiency, ensuring smooth transitions which could be achieved by engaging higher-risk patients after discharge digitally and through telehealth, or addressing the social determinants of health that underlie some frequent ED use through the deployment of offline social services and through the creation of care plans. In the current reimbursement model, a substantial reduction in volume achieved by improving population health under the current fee-for-service paradigm would paradoxically cripple ED physician reimbursement. A global budget for emergency physicians with additional resources for population health would better align with the Maryland's hospital GBR model. In addition, emergency physicians could be incentivized to improve the experience, safety, and efficiency of care through imposing quality measures that could be directly aligned with hospitals.

This model, if effective, would be anticipated to:

1. Reduce the uncertainty in payments to Maryland ED physicians allowing them to more consistently and effectively staff EDs.
2. Improve access to care for Maryland residents and visitors.
3. Improve the experience and quality of care of people who come to use Maryland EDs.
4. Reduce avoidable Maryland ED utilization.
5. Ensure that Maryland ED patients have safe transitions in care post-discharge.
6. Address the social determinants of health that lead to frequent ED use, and improve health equity.
7. Reduce total cost of care in Maryland.

The conceptual design of the emergency physician global budget is below. The target would be to launch in the year 2025 utilizing 2022-2024 data, or a subset thereof. This would occur as a pilot program with groups of ED physicians partnering with hospitals to align on interventions in a small group of hosptials aimed at improving access and reducing total of care. Global budgets would be piloted after the existing ED Episode Quality Improvement Program (EQIP) that is currently being implemented by Maryland's Health Service Cost Review Commission (HSCRC) has been in place for two years. We anticipate that ED EQIP would remain in place for EDs that want to utilize the program, however, we anticipate the ED-physician global budget program could eventually replace that program, particularly for sites that had already effectively reduced 14-day total cost of care. While EQIP does an essential job by infusing the current fee-for-service chassis of emergency physician reimbursement with incentives for value-based care, transitioning to non-fee-for-service based global budget for emergency physicians can further align their incentives with the goals of the Maryland GBR.

A 2025 ED physician global budget would be calculated based upon the following components:

1. Average ED-specific historical healthcare consumer price index (CPI)-adjusted revenues for fee-for-service billings for the years 2022-2023. Data would include clinical revenue only (e.g. from fee-for-service billings), specifically from fee-for-service care delivery by ED physicians within the hospital. Any non-clinical revenue would not be included within the model.

2. An upward adjustment factor based on the medical CPI index, relative to the base period.
3. An upward adjustment factor for hospitals with EDs that average > 40 patients per day to allow time for investment in improving post-discharge care, by moving from their current staffing (measured as patients per physician per hour) to a maximum of 1.8 patients per hour, based on extrapolated 2022-2023 volumes.
4. An upward adjustment factor for hospitals with less than < 50 patients per day that would allow them to maintain 24/7/365 emergency physician staffing, with a maximum of 1.8 patients per hour during peak periods.
5. *Expansion of telehealth services, intended to reduce ED use, where patients are served better elsewhere, and those resources are available*. An upward adjustment factor for providing pre-ED emergency physician-led tele-triage / telehealth services for the local population, including advice on when an ED visit is warranted, versus an urgent care visit, a primary care visit, or watchful waiting for less-serious, non-urgent conditions such as infectious disease. This could be combined across multiple EDs within a health system for economies of scale.
6. *Expansion to include telehealth follow-up for high-needs patients*. An adjustment factor for providing post-ED follow-up telehealth services for high-needs or high-risk patients, who have a higher risk of repeat ED visits or for unanticipated clinical problems after discharge. This could be combined across multiple EDs within a health system for economies of scale.
7. *ED physician engagement in hospital-based programs intended to reduce high-cost users*. An adjustment factor for executing a program within the ED that focuses on high-cost, frequent ED users. This would consist of identifying patients who are frequent ED users, and the creation and deployment of specific care plans for the ED or offline services to address the social determinants of health (e.g. social work services).
8. A bonus pool, that would be distributed to EDs and hospitals for meeting / exceeding specific quality metrics:
    a. Admission rate for ED intensity measure (i.e. the proportion of visits admitted to the hospital with 535 ICD-10 codes [same measure as is used in ED EQIP])
    b. Left without being seen rate (i.e. the proportion of patients who present to the ED who leave without being seen or leave against medical advice)
    c. Average length of stay for ED discharged patients (i.e. the median length of visit for ED patients who are treated and released from the ED)
    d. CT imaging rate for discharged patients < 60 years of age (i.e. the proportion of visits < 60 years who receive one or more CT imaging studies), and >=60 years for imaging excluding head, spine, and abdominal CT imaging.
    e. Opioid prescribing rate at discharge (i.e. the proportion of ED discharges with one or more opioid prescriptions)
    f. Repeat ED visit with hospital admission within defined periods (e.g., 72-hours, 30 days) with admission to the hospital or transfer to another facility)

The model could be administered through the state's GBR 2.0 infrastructure through HSCRC, or through another mechanism if that became available. Within GBR 2.0, EDs would need to partner with hospitals implementing the program and partner on quality metrics. Note that because this model would include the entire ED, the ED would need to enroll for all its clinicians, rather than through individual provider agreements, as is currently used for ED EQIP.

Success for this program would measured by:

1. Monitoring utilization of the triage telemedicine services and tele-follow-up services (success = implementation, and high levels of utilization).
2. Monitoring quality in Maryland EDs. The goal would be to decrease left without being seen, reduce length of stay to a target level, judged to be clinically reasonable, lower ED intensity of care metric (hospital admission rate), lower opioid prescribing, and lower rates of repeat ED visits with admission to the hospital or transfer to another facility.
3. Population-level utilization of avoidable, low-acuity ED use would be monitored in each ED. Lower rates of low-acuity use would be a marker of success.
4. Reduce total cost of care in Maryland, specifically includes ED and hospital costs, as well as total population-level costs within a hospital's catchment area.

The program would be developed during 2023-2024, and go through vetting and approvals with HSCRC, and ultimately CMS during that period. Stakeholders who would participate in program development: HSCRC, Maryland ACEP, Maryland Hospital Association, MedChi, CareFirst BlueCross, Maryland State Medicaid, and others. The program would apply to all billings by emergency clinicians (99281-5, 99291, 99292) in 2025.

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

March 24, 2023

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

Dear Dr. Elliott,

I am writing in response to the HSCRC memo dated March 14, 2023, requesting additional physician recommendations for the final report of the Physician Alignment Committee ("Committee"). As a member of the Committee, I am pleased to offer the following recommendations for consideration.

General Recommendations:

1. Appropriate Risk in Any Physician Program: The introduction of any new program must be approached with caution to avoid unintended consequences. EQIP has been successful because the risk is not born by physicians directly. It is important to remember that physicians are already taking the risk of losing their time by taking part in new and experimental programs.

2. Voluntary: Any new program should be voluntary—giving physicians the option to opt-in or opt-out.

Specific 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.

I trust that these ideas will be given serious consideration as we work towards the final report of the Physician Alignment Committee.

Thank you for your attention to this matter.

Sincerely,

Gene M Ransom III

Gene Ransom
CEO
MedChi, The Maryland State Medical Society