maryland
health services
cost review commission

Physician Engagement & Alignment Workgroup

TCOC Model Progression

Meeting #4

April 13, 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.
Meeting 4 (April 13th)	Review/Recap/Discuss	
Final Meeting 5 (May 11th)	Finalize Written Recommendations	

Agenda

1. Draft Recommendation Document Update
2. Medicaid Alignment
3. Further Development of New Ideas
    1. Recap
    2. Key Enablers
4. Comments and Next Steps

Draft Recommendation Document Update

- Still taking comments for distributed draft 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 still 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 to recirculate a revised draft by next meeting.**

Medicaid Alignment Discussion

Medicaid Alignment

- Current Document Language –
  - "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)."
- Medicaid Suggestion –
  - "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 advanced primary care and bundled payment programs** 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)."
- MedChi Suggestion –
  - Prefer **"real Medicaid alignment"**, similar to current Medicare EQIP and MDPCP Programs.
    - If MCOs are not interested- suggests looking at the State's authority to remove any attributed lives from the MCO and create Medicaid ACOs with physicians who want to participate in alignment.

Further Development of New Ideas

Recap of New Ideas Proposed

- "Global Budget" Type Programs
  - Emergency Department (and other hospital based?)
  - Critical Primary Care Program
    - GBR-based State-endorsed primary care practices for underserved areas
    - Potentially expand to multi-specialty
- Value-Based Programs (VBP) for Currently "Neglected" Physician types
  - Pathology
  - Radiology
  - Anesthesiology
  - Hospitalists
  - Behavioral Health
- Accommodations for small/financially limited practices
  - Virtual Panels
  - Limited downside or no downside alternatives
  - Limited risk "introductory offers"
- No Risk Value-Based Drug Program Pilots

Other Ideas?

Key Enablers - Background

- Goal of this process is to generate a set of recommendations State leadership should pursue as the model moves forward
- Leadership may choose to adopt or not adopt these recommendations
- Following slides to prompt discussion of key enablers that would be required for some of the new ideas to be implementable.
    - These are not statements of HSCRC or State policy or intent
    - Final directions will be determined by State leadership as this process progresses

Definitions – Key Enablers

- **Flexible Medicare Payment Model** – Direct adjustment of payments to physicians from the State.
  - EQIP method only allows additional payments – for GBR-like programs State would need to be able to replace standard physician payments or apply a downward adjustment
  - EQIP payments are highly lagged, GBR-type programs would require more concurrent payment capabilities.
- **Multi-Payer Alignment** – At least two major payers involved? More?
- **State Program Design Flexibility** – Delegate responsibility for program operations and customization to the State.
  - More EQIP than MDPCP – parameters for MDPCP program are managed by CMS which reduces State flexibility and slows the process of enhancing the program. EQIP design approach (not payment approach) allows State leadership to more quickly adapt and expand the program
  - As the State is accountable for savings under the program the State should have flexibility to design program rules as long as those savings are being achieved.
- **Part D Opportunity –** State should be able to design programs that offer physicians incentives based on management of drugs. Program should allow for pilots without the State taking risk on Part D.

Definitions – Key Enablers, cont.

- **Mechanic for Creating Pools to Fund Physician Alignment Program**
  - Need to fund shared savings under ED GBR Bonus pool concept (or with similar programs for other hospital-based physicians)
  - Funding for underserved area primary care investments
- **Provider "Matchmaking"** – Ability to pair & align physician groups.
  - Virtual panel concept exists in EQIP. Process for creating groups to take advantage of this capability does not exist
- **State Program Incubator**– For more nascent programs a group of people to provide greater support for physicians, develop programs, complete administrative tasks, etc.
- **Additional Focus on Quality Measures** – While the State has put a lot of work into primary care and hospital quality and high level SIHIS measures, reporting on specific measures for specialty areas like ED and BH is less developed.

Key Enablers - Matrix

Concept	Flexible Medicare Payment Model	Multi-Payer Alignment	State Program Design Flexibility	Funding for Bonus Pools/ Investments	Provider "Matchmaking"	State Program Incubator	Additional Focus on Quality Measures	Part D Opportunity
GBR for ED or Other Hospital Based Physician	X	X	X	X		X	X	
Underserved Area Physician Care Program	X	X	X	X				
VBP for "Neglected" Physician Types			X	?		X	X	
Virtual Panels					X			
Risk Limitation Strategies			X	X				
No Risk, Value-Based Drug Program Pilots						X		X

Comments & Next Steps

Future Meetings

- Final meeting on **May 11th** at 7:30 AM.
  - Finalize recommendations for written document.
- Final Written Recommendations Document due by the end of May.

***Based on today's conversation – a Version 2 will be redistributed. New edits and suggestions to this version are due by **Thursday, May 4th** .

MedChi
The Maryland State Medical Society

Your Advocate.
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Your Profession.

April 10, 2023

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

Dear Dr. Elliott,

I am writing to express MedChi, The Maryland State Medical Society's disagreement with the current draft of the policy report because it fails to include real alignment on Medicaid for EQIP and MDPCP. We have and continue to strongly believe that Medicaid alignment should be very similar to the current Medicare EQIP and MDPCP programs.

As drafted, it is our fear that the report memorializes the MCOs' efforts to impose their view on alignment without any meaningful effort to work on a more equitable solution with other stakeholders. If the MCOs are not interested in alignment, we suggest that this group look at the State's authority to remove any attributed lives from the MCO that wish to be in a value-based program and to then create Medicaid ACOs with physicians who want to participate in MDPCP and EQIP alignment. Obviously, we prefer full alignment where all the stakeholders are working together towards the common goal of providing the best possible care to Medicaid patients.

We understand and appreciate that this is a complex issue, and we are committed to working with you and other stakeholders to find a solution that works for everyone. It remains our steadfast view that alignment on Medicaid is essential to improving the quality of care for Medicaid patients because we have seen the success of Medicare programs like EQIP and MDPCP on Maryland's Medicare population. We, therefore, urge you to amend the policy report to include real alignment on Medicaid.

Thank you for your attention to this matter, and we look forward to discussing this at our next meeting.

Sincerely,

Gene M Ransom III

Gene Ransom
CEO
MedChi, The Maryland State Medical Society

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

April 10, 2023

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

Dear Dr. Elliott,

I am writing to follow up on the issue of drug pricing and express once again our stance on the matter. While we understand that there is opposition to taking downside risk with Part D drugs, we would like to reiterate that we do support the authority to try no-risk programs and pilots around drug pricing, and we see no downside to CMS allowing the exploration of these options.

To be clear, we are not advocating for value-based payment for drugs without the proper evaluation and assessment. Rather, we are requesting the opportunity to pilot and test new payment models that are designed to incentive prescribers to encourage better value for money in drug pricing. We respectfully request that you include this considering the urgent need to address the issue of drug pricing.

I think a recommendation on "no risk value-based drug program pilots" should be included in the final report. Thank you for your attention to this matter.

Sincerely,

Gene M Ransom III

Gene Ransom
CEO
MedChi, The Maryland State Medical Society