maryland
health services
cost review commission

Physician Engagement and Alignment Workgroup Written Recommendation

Maryland Model 3.0 Progression Plan
May 2023

A. 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.

The Program Management Office for MDPCP facilitated the development of a specific set of recommendations related to MDPCP in consultation with their stakeholders and the MDPCP Advisory Council. These recommendations were considered by the Physician Alignment Workgroup in the summarized recommendations below.

Episode Quality Improvement Program

The Episode Quality Improvement Program (EQIP) was launched 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 May 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.

B. Workgroup Recommendations

Priorities for Model Negotiation for CMS

Introduction:

The workgroup and stakeholders developed several recommendations with regard to the current programs (MDPCP and EQIP). These recommendations reflect the consensus of the workgroup and not necessarily the positions of the Maryland Department of Health (MDH) or the Health Services Cost Review Commission (HSCRC). 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 and waiver flexibilities to support the EQIP and other future physician programs**. Currently the State cannot directly adjust physician payments related to value-based programs. The State should work with CMS to allow direct adjustment of payments to the participating physicians which would simplify program administration and allow more timely payment of program rewards. The workgroup discussed a number of potential voluntary programs that would be facilitated by this capability in addition to simplifying EQIP. Note these are examples of programs that could benefit from this capability rather than an endorsement of these particular programs:
    a) A capitated program for physicians in underserved areas. A GBR-type payment could only be implemented for physicians if payments could be directly adjusted to equal the earned capitation.
    b) Value based payments including but not limited to hospital-based physician types neglected by more traditional episode-based programs.

2) **Enhance State Program Design Flexibility.** State program design flexibility would allow for additional delegation of responsibilities for program operations and customizations to the State. This would allow more rapid testing and expansion of new programs and would be vital to the kind of programs discussed in item 1. State leadership should have flexibility to design program rules as long as overall savings targets and quality goals are being met. All physician alignment programs should be voluntary and structured to qualify for the QP bonus.

3) **Add/Restore various flexibilities to the MDPCP program,** specifically:
    a) **Track 1 and 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 a reasonable time limited 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) **Payments under MDPCP should be simplified and downside risk restricted to additional program payments.** The payments under the program should be simplified to a single unified population-based payment. Risk under Track 3 should not impact the core primary care reimbursement and be limited to risk on the additional payments under the MDPCP program.

c) **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.

d) **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 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.

e) **Enhance flexibilities around HEART Payments.** The state and participating practices should have flexibility to expand HEART payment uses to address all patient needs related to health disparities. Use of funds should not be limited to HEART designated beneficiaries but should align with practice methods to identify and address such disparities.

f) **MDPCP Enrollment.** The State should be permitted to allow new MDPCP enrollment windows. New enrollment periods should be coupled with efforts to engage practitioners in underserved and minority communities.

4) **Promote Medicaid alignment with EQIP and MDPCP and in future programs.** State leadership from the MDH, Medicaid, MDPCP Program Management Office (MDPCP PMO), Medicaid, and the HSCRC and other interested parties should work together to implement advanced primary care and bundled payment programs (e.g. 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.

5) **Promote Commercial payer alignment with EQIP and MDPCP and in future programs.** 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 and encourage participation in future programs 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.

6) **Part D Programs.** The State should be able to design programs that offer physicians incentives based on management of drugs. While the State does not have the capability to take risk on drugs there is substantial opportunity to leverage physician involvement to control drug costs. CMS could use Maryland as a laboratory for testing drug management strategies.

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. An effort should be made to identify and recruit physicians into such an entity. This approach could also be used to support programs beyond EQIP described elsewhere in this letter.
    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.

2) **Mechanic for Creating Pools to Fund Physician Alignment Programs.** A number of the priorities identified in this letter will require the State to invest in physician programs ahead of the returns as Medicare has done in MDPCP. The State could accelerate program innovation and demonstrate commitment to CMS by establishing a budget and funding mechanism that would allow for paying additional physician incentives whether that be as bonus pools within critical specialist programs (such as Behavioral Health), to enable Medicaid alignment with other programs or to support physician capitation in underserved areas.

3) **Accelerate Current Efforts by Developing a State Physician Value Based Program Incubator.** The State should ensure additional program elements such as the payment and design flexibilities discussed above achieve maximum impact by building upon the current program development resources built by the HSCRC and CRISP. A program incubator could serve to rapidly develop, implement and evaluate new programs. The existence of such a capability would also signal the State's commitment to CMS.

4) **Additional Focus on Quality Outcome Measures.** As the programs described above begin to expand into other segments of care it is important that the State has a suite of quality measures to draw upon in establishing program-level and physician-level goals. While extensive quality reporting is available within MDPCP for primary care and for hospitals there is more limited, relevant, and impactful reporting implemented in the ambulatory specialty space. This could be due to resourcing, data gathering and technical limitations, a lack of appropriate measures or some combination of the three. The State should attempt to develop measurement capabilities in expectation of future programs. Having adequate quality reporting capabilities will be vital to the implementation of new programs and will be important to demonstrate commitment to CMS.

5) **ECIP Program.** The state should continue to support the ECIP program which facilitates physician alignment through hospital resource sharing opportunities.