New Comment Letters

(As of April 27th, 2023)

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

MEMORANDUM

[CONFIDENTIAL & SUBJECT TO EXECUTIVE PRIVILEGE]

To: Dr. James Elliott, Chairman, HSCRC Physician Engagement and Alignment Workgroup
From: Chad Perman, Executive Director, Maryland Primary Care Program Management Office
Date: April 24, 2023
RE: MDPCP Priority Elements for Maryland Model Progression Plan - Input from MDPCP Stakeholders

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Summary

As we move closer to 2026, the PMO engaged MDPCP stakeholders over the first quarter of 2023 to identify key components of the Program that should either be maintained or modified to better enable participating practices to meet Maryland Model goals including reducing avoidable hospital utilization, ensuring better quality of care and improving health equity. The focus of the feedback provided by stakeholders to date is on changes necessary for MDPCP success under a future Maryland Model.

In consultation with MDPCP practice and CTO leaders (including participant physicians) and the MDPCP Advisory Council, the following elements have been compiled as priorities identified by stakeholders for the MDPCP moving forward.

Note: Elements that represent modifications of current MDPCP policy have been delineated in red text.

MDPCP Priority Elements

Category	Elements
Spending Level/Investment	• Enhanced primary care investment sufficient to address medical, behavioral, and social needs of patients (include additional health equity dollars) that ensures practice sustainability
Payments	• Hybrid model of payment = Fee for Service + Simplified, unified population-based payment to fully support comprehensive,

Category	Elements
	team-based primary care with flexibility on payment uses ● Provide practices the financial resources to address social needs, either through a specific equity-focused funding stream or within a unified MDPCP payment
Financial Risk	● No downside risk on the core primary care payments that fund operations and the basics of advanced primary care (health equity/BHI/care management) ● Limited level of downside risk on some of the additional MDPCP payments (e.g., after certain level of investment is achieved) ○ Risk should be shared by larger entities or pooled across the state/regions ○ Risk should be voluntary and/or voluntary for smaller practices
Payer Alignment	● Multi-payer alignment (including Medicaid) on payments, quality measures and data sharing to reduce administrative burden and make care more efficient
Participation and Eligibility	● Maintenance of Track 2 and entry level Track 1 for initial starters ● Additional application periods for new practices to join with more flexible requirements on attribution and specialty eligibility.
Performance Measurement	● Core set of clinical quality measures and utilization, with limited weight on Total Cost of Care measure ● Simple, easily captured, meaningful performance data on measures that matter, with sufficient financial incentives adjusted for health equity
Policy and State Leadership	● Additional shifting of policymaking and operations from CMMI to the State (e.g., quality measures, payment methodology, enrollment eligibility, operations, and data sharing)
CTOs	● CTOs participation with modifications to enhance care transformation support, effectiveness, and accountability

ESA
Emergency Service Associates

April 26, 2023

I am writing on behalf of the 55 Emergency Medicine providers of Emergency Service Associates. On April 19th Dr. Jesse Pines presented a proposal to MD ACEP for a global budget for emergency physicians in Maryland.

I cannot state emphatically enough what a disaster implementing such a proposal would be for the healthcare system in Maryland.

Emergency physicians currently are free to recommend treatments and dispositions of patients objectively, based solely on what is medically appropriate. Implementing a system where, in effect, they would be financially rewarded for not recommending admissions and for discouraging E.D. visits creates an intentional conflict of interest that has the potential to directly affect patient care in a negative way.

From the perspective of many providers in Maryland the hospital GBR is already a failed experiment. The very crowding Dr. Pines' plan touts as being able to help alleviate is in large part due to the current GBR model. Hospitals are reducing bed capacity in spite of increased need. They are reducing service lines--telling their specialists to refer patients three hours away to facilities in other states for expensive procedures that they are fully trained and willing to perform, but that the hospitals do not want to have performed within their cap. In the emergency departments of MD we are routinely transferring patients out of MD to neighboring states for definitive care because of in-state bed closures and capitated funding.

The concept that emergency physicians under a global budget administered by the HSCRC would not suffer financially over time, and would not be expected to continually do more with less, is more than just unlikely. Emergency physicians are already crippled in their ability to negotiate with insurers by regulation. To allow a regulatory body to have complete financial control over the emergency medicine work force we believe would destroy recruitment of qualified emergency physicians to MD.

Emergency Service Associates has provided emergency care to the Eastern Shore of MD for over 50 years. As an independent democratic group, we have recruited countless physicians and their families to live and work here on the Eastern Shore. We pride ourselves on taking care of our community's emergency needs at multiple local hospitals. A global budget for emergency physicians in MD would make it extraordinarily difficult to continue to recruit candidates here. We do not believe this will be isolated to our group but will be statewide.

Unlike hospitals themselves, physicians are quite mobile, and we believe they would abandon the state of MD or not come at all if physician salaries here are not competitive and if and they are subject to cuts by the HSCRC regardless of how hard they work.

Additionally, the vast majority of the goals that were suggested as being a benefit to implementing Dr. Pines' plan are not even under the control of emergency physicians. Most of the ones listed could be achieved now through the current GBR for hospitals if the HSCRC simply targeted or incentivized those items with the hospitals, without expanding the GBR to include physician salaries.

"Prehospital telehealth triage" could be done by the hospitals themselves if incentivized to do so by the HSCRC, without placing emergency physicians under a GBR, and without changing how the physicians are reimbursed for the patients they actually see in the emergency department.

"Targeting measures of admission efficiency" is listed as a potential benefit. However, the efficiency of the admissions process is almost entirely a hospital dependent metric that could easily be addressed in the current hospital GBR if the HSCRC desires. Emergency physicians have very little power to control the boarding and lack of throughput that currently exists in hospitals. It is well known that this is not an emergency department derived problem, but a hospital problem. Asserting that admission processes would somehow be made more efficient by including emergency physicians in the GBR makes no sense considering the source of the problem.

In fact, the contention made by Dr. Pines that emergency physicians make the most expensive decision in healthcare—'whether or not to admit patients to the hospital'--is incorrect. Emergency physicians do not admit patients. They may make the decision to consult the admitting physicians on call but the decision to admit or not is ultimately made by the hospitalists or admitting team on call. Efforts to reduce admissions should not be focused on the Emergency Physicians themselves but on the systems outside of the emergency departments that do not provide effective alternatives that allow for safe outpatient care.

Holding Emergency Physicians negatively responsible for seeing low acuity "avoidable patients" when they are mandated to do so by EMTALA would not be appropriate or fair, and would not create a positive change in the system. The failure to have those patients cared for elsewhere, if it is a failure at all, is a failure of the system outside of the ED.

“Smooth transitions in care after ED discharge, and programs to reduce repeat ED visits,...by addressing their needs outside of the ED" is again something that the hospitals can be, and I think already are, incentivized to provide by the current hospital global budget. These services are more appropriately provided by the hospitals using appropriately trained providers outside of the E.D. Emergency physicians are not trained in outpatient primary care. They should not be held responsible for, let alone be paid based upon, providing outpatient preventative or follow up care that they are not trained to perform.

In closing, we are not merely skeptical that moving forward with this proposal will achieve the desired outcomes. We are convinced that an emergency physician GBR, even if initiated as a voluntary program, would be an irreversible mistake that will impose real damage to the safety net in MD health care that emergency departments provide.

Respectfully,

Jeff Greenwood MD FACEP
President, Emergency Service Associates

April 12, 2023

James Elliott, M.D.
Commissioner; Chairman of Physician Engagement and Alignment Workgroup
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Elliott,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide input on the draft Total Cost of Care Model Progression recommendations proposed by the Physician Alignment and Engagement workgroup. As outlined in the workgroup's draft recommendation letter, the discussions have centered on modifications to the Episode Quality Improvement Program (EQIP), the Maryland Primary Care Program (MDPCP), and new programs to engage specialty providers, such as behavioral health, emergency physicians, and hospital-based physicians.

JHHS has strong participation in EQIP, with providers currently enrolled in 15 episodes. While the program has potential, the performance data to date has been limited. The program began in January 2022; providers began to see the first quarter of performance data in late fall of CY22, and the data for half of the first performance year, CY22, remains incomplete and has not yet been released. Given the incomplete data, JHHS believes further assessment of the program is needed before the program can be relied upon as a cornerstone for the next phase of the model. For both EQIP and MDPCP, JHHS urges the Health Services Cost Review Commission (HSCRC) to exercise caution as they consider aggressively expanding programs for which outcomes and impact are not yet fully understood.

The Physician Alignment and Engagement workgroup has also discussed the concept of a Global Budget Revenue (GBR) model for emergency physicians in Maryland. This is a new concept that has not yet been fully internally vetted; however, the current GBR model creates many distortions in care delivery. For the six years prior to the onset of the pandemic (2014-2019), Maryland was able to achieve significant utilization declines, but both the drivers and value to the Model of those declines and the resulting retained revenue remains unclear. The HSCRC's current policies do not differentiate between health management and simply discontinuing services, and there is no data at this time to indicate that the bulk of hospital utilization declines prior to the pandemic were achieved through care transformation or investment in addressing community needs. Instead, **all** volume reductions are rewarded as a positive outcome and there is limited accountability for continuously investing retained revenues in care transformation or improving health outcomes. JHHS believes the distortions in the current GBR model must be addressed before the HSCRC can consider expanding the model to the Emergency Department or other areas.

JHHS appreciates the efforts of the workgroup to generate policy recommendations to promote physician alignment and engagement for the next phase of the Model. As the Total Cost of Care Progression discussions continue, JHHS looks forward to the opportunity to collaborate with the HSCRC and workgroups to further the goals of the Maryland Model.

Sincerely,

Nicki Sandusky McCann

Nicki McCann, J.D.
Vice President, Provider/Payor Transformation
Johns Hopkins Health System

Maryland
Hospital Association

April 14, 2023

James Elliott, M.D.
Commissioner, Health Services Cost Review Commission
Chair, HSCRC Physician Engagement & Alignment Work Group
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Elliott,

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to provide additional feedback on physician engagement and alignment to inform the state's progression planning for the Total Cost of Care Model (Model) beyond 2026.

We maintain the recommendations in our Feb. 23 comment letter (attached). Since then, the Maryland Primary Care Program (MDPCP) Advisory Group shared future priorities, Health Services Cost Review Commission (HSCRC) staff released a draft work group report, and members presented ideas for new care redesign tracks. Today, we offer recommendations on these items.

Maryland Primary Care Program (MDPCP) Future Priorities
MHA is part of the Maryland Health Care Commission (MHCC) MDPCP Advisory Committee. MHCC requested feedback on future MDPCP priorities following the March 28 meeting. Our recommendations are attached.

Draft Work Group Report

- Priorities for Model Negotiation with the Centers for Medicare and Medicaid Services (CMS)

Additional recommendations:

1. As proposed for the Episode Quality Improvement Program (EQIP), MDPCP practices should be eligible to create a pooled entity, which would enable risk sharing among smaller practices.
2. As the state identifies new areas of opportunity to engage physician partners, it should be able to acquire additional fraud and abuse waivers as it currently does for new care redesign tracks.

- Priorities for State Model Leadership

Additional Recommendations:

1. The work group discussed flexibility to engage physicians that cannot participate in episodic based models, such as anesthesiologists. This recommendation should be added to the work group report.
2. The state should work to ease administrative burden, where possible, such as alignment on quality metrics among payers and programs.

Newly Proposed Care Redesign Tracks

- Global Budget Concept for Emergency Physicians in Maryland

MHA supports including emergency physicians as part of the Global Budget Revenue (GBR) 2.0 model HSCRC's Total Cost of Care Work Group is discussing. MHA supports this model, which allows voluntary hospital and provider participation. We support expanding this model to payers beyond Medicare in future years. MHA is awaiting draft contract language from HSCRC staff before offering additional recommendations.

We support emergency physicians' participation in the GBR 2.0 framework, yet we offer these considerations that will influence program design and implementation:

1. Hospital-based physicians receive professional payments on a fee-for-service basis. Movement to a GBR model will require new funding to pay for these services. MHA believes hospitals and providers would share accountability for certain outcomes and savings.
2. Many emergency room physician payment arrangements include an income guarantee to manage volume fluctuations. It is unclear how the payment structure is different from GBR structure if income is guaranteed and would incentivize physicians differently.
3. Many hospitals contract physicians to staff their emergency departments (EDs). These contracted employees often work for national staffing agencies. The program should be designed so it does not disincentivize staffing agencies from entering contracts with Maryland hospitals, and thus, exaggerating ED staffing issues.
4. Avoidable ED utilization is a suggested quality measure. Many factors influence avoidable utilization and are not entirely within the hospital or physician's control. MHA suggests focusing on measures care partners can reasonably influence.

- Additional Models

MHA agrees opportunities to include additional provider types not already included in state care redesign programs should be explored. Suggestions to engage hospital-based physicians,

create a critical primary care program, and a value-based drug cost program were presented at the March 30 and April 13 work group meetings. Unfortunately, details regarding the concept design remain largely unknown, and MHA does not have enough information to opine on these suggestions. We request to join the ad-hoc work group to discuss provider integration in a GBR model.

- Behavioral Health

CareFirst is launching a new behavioral health medical specialty home. It is our understanding the program would apply to CareFirst beneficiaries. MHA recommends maintaining flexibility within our future contract to pilot and expand successful programs to additional payers.

We appreciate the opportunity to comment on additional work group member proposals and the draft work group report. If you have any questions about the recommendations outlined in our letter, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: William Henderson, HSCRC

MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Maryland Primary Care Program (MDPCP) Advisory Council

Priorities for the Future of the MDPCP Maryland Hospital Association Recommendations

Instructions

This document provides a list of draft top priorities and potential modifications for the future of the MDPCP. *Please add your feedback related to Considerations, Recommendations, and Comments for each category directly within the table. The completed table should be submitted via email to the* MDPCP Program Management Office (PMO) at mdh.pcmodel@maryland.gov *by* ***Friday April 7th***. Council feedback will inform the MDPCP PMO's recommendations to the Health Services Cost Review Commission for the Progression Plan.

CATEGORY	ELEMENT
1. SPENDING LEVEL/ INVESTMENT	• Enhanced primary care investment sufficient to address medical, behavioral, and social needs of patients (include additional health equity dollars) that ensures sustainability ○ ***Considerations***: Currently, funds can only be used for a Health Equity Advancement Resource and Transformation (HEART) designated beneficiary. This does not align with methods practices use to identify patients with needs. Patients are not differentiated by insurer or payment type. ○ ***Recommendations***: MHA supports expanded uses of HEART payments.

CATEGORY	ELEMENT
	○ ***Comments***: Investments in primary care to address medical, behavioral, and social needs of patients aligns with the Centers for Medicare & Medicaid Innovation's (CMMI) focus on health equity and Maryland Hospital Association (MHA) priorities. It is unclear how the investment level would differ from the current program design and MHA requests more detailed information before opining on this matter.
2. PAYMENTS	• Hybrid model of payment = FFS + Simplified, unified population-based payment to fully support comprehensive, team-based primary care with flexibility on payment uses ○ Provide practices the financial resources to address social needs, either through a specific equity-focused funding stream or within a unified MDPCP payment ○ ***Considerations***: ○ ***Recommendations***: MHA supports consolidation of payments, where possible, to reduce the administrative burden on practices. Payment flexibility will better allow providers to address social needs to improve outcomes for patients. It is also important to add some type of accountability for the payments intended to mitigate the non-medical barriers to better health. As part of quality metrics, the program should assess practices' progress towards equitable outcomes. ○ ***Comments***:
3. FINANCIAL RISK	• Not requiring downside risk on the core primary care payments that fund operations and the basics of advanced primary care (health equity/BHI/care management) • Limited level of risk on some of the additional MDPCP payments (e.g., after certain level of investment is achieved)/At-risk performance incentive payment • Risk should be shared by larger entities or pooled across the State/ region/ Care Transformation Organizations (CTOs) • Risk should be voluntary and/or voluntary for smaller practices

CATEGORY	ELEMENT
	○ ***Considerations***: Introducing downside risk was a key component in negotiating continuation of the program with the CMMI. Suggesting a different method of sharing risk among practices may be more feasible, as recommended below. ○ ***Recommendations***: MHA supports the modified approach discussed at the last Advisory Council meeting, which would propose pooling of risk among practices. ○ ***Comments***:
4. PAYER ALIGNMENT	• Multi-payer alignment on payments, quality measures and data to reduce administrative burden and make care more efficient ○ ***Considerations***: ○ ***Recommendations***: MHA supports payer alignment, which will garner more participation in the program, reduce reporting burden on practices, and facilitate better outcomes. ○ ***Comments***:

CATEGORY	ELEMENT
5. PARTICIPATION AND ELIGIBILITY	• Maintain entry level Track 1 for initial starters and Track 2 • Allow for additional application periods for new practices to join with more flexible requirements on attribution and specialty eligibility. ○ ***Considerations***: A Statewide Integrated Health Improvement Strategy (SIHIS) goal is to increase the number of providers participating in advanced payment models. MDPCP is one of three avenues to meet this goal. 45% of practices in the state are enrolled in MDPCP, indicating more room for opportunity. Track two provides an avenue for new practices to enter the program and build infrastructure to achieve advanced primary care before subjecting them to substantial downside risk. ○ ***Recommendations***: Maintain track two of the program, which is set to sunset in 2025. MHA also recommends maintaining open enrollment to allow new practices to join. ○ ***Comments***:

CATEGORY	ELEMENT
6. PERFORMANCE MEASUREMENT	• Responsibility for core set of clinical quality measures and utilization, with limited weight on Total Cost of Care measure • Simple, easily captured, meaningful performance data on measures that matter, with sufficient financial incentives adjusted for health equity o ***Considerations***: o ***Recommendations***: MHA supports the ability to choose clinical quality metrics from a pool of options and introducing an equity component. Assessing equity could include stratifying measures by demographic groups or requiring practices to assess performance on guidance concordant care by demographic groups. o ***Comments***:
7. POLICY AND STATE LEADERSHIP	• Additional shifting of policymaking and operations from CMMI to the State regarding quality measures, payment methodology, enrollment eligibility, operations, and data o ***Considerations***: o ***Recommendations***: MHA agrees that the state should have administrative authority to operate the program and set policies within the contract authority provided by CMMI. o ***Comments***:

CATEGORY	ELEMENT
8. CTOS	• CTOs participation with guardrails and modifications to enhance care transformation support, effectiveness, and accountability ○ ***Considerations***: Care Transformation Organizations (CTO) play an important role in ensuring program success, especially for smaller practices, who benefit from a shared pool of resources. As of 2021, 24 CTOs participated in the program, with 78% of practices electing to receive CTO support to meet program care transformation requirements. ○ ***Recommendations***: Continue CTO participation in the program. ○ ***Comments***:

3/24 Draft HSCRC Workgroup Written Recommendation

maryland
health services
cost review commission

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.

Old Comment Letters/Recommendations

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

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 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

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.

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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

Maryland
Hospital Association

February 23, 2023

James Elliott, M.D.
Commissioner, Health Services Cost Review Commission
Chair, HSCRC Physician Engagement & Alignment Work Group
4160 Patterson Ave
Baltimore, MD 21215

Dear Dr. Elliott:

On behalf of Maryland's 60 hospitals and health systems, we appreciate the opportunity to provide input on physician engagement and alignment as the state plans for progression of the Total Cost of Care Model (Model) beyond 2026. Partnerships among hospitals, health systems, community providers, and partners are integral to improve health outcomes for patients in the most appropriate care settings at lower costs.

During the Feb. 2 Physician Engagement & Alignment Work Group meeting, stakeholders discussed opportunities to enhance two care redesign programs (CRP): the Episodes of Quality Improvement Program (EQIP) and Maryland Primary Care Program (MDPCP). MHA agrees with suggestions raised during the meeting, including enhancing the ability of specialists to participate in bundled payments through additional waivers and flexibilities. For both programs, MHA supports continued alignment across payers and the ability to choose clinical quality metrics from a pool of options.

Health systems and providers have experienced data challenges with EQIP that significantly impact physician engagement. During the first performance year, performance data was not available to providers until late October. The lack of timely data has unfortunately reduced provider interest in continued program participation. MHA recommends exploring opportunities with the state and Centers for Medicare & Medicaid Services (CMS) to improve timely data release.

MHA offers potential modifications to EQIP episodes:

1. Explore longer episode lengths for chronic and preventive episodes. Episodes that focus on chronic conditions may benefit from multi-year episode periods, which present the opportunity to prevent high-cost procedures over time and realize the long-term effects of innovative interventions.
2. Explore methods to control for supply and drug costs for certain episodes. For some episodes, such as oncology, drug and supply costs may determine up to 40% of episode

costs, limiting the ability to control total cost of care. The ability to control for such costs should be considered as the program develops.

We support the Maryland Department of Health's (MDH) plans to request medication cost-sharing waivers through MDPCP. MHA recommends the state advocate for the following to enhance participation:

1. Maintain track two of the program, which is set to sunset in 2025. Track two provides an avenue for new practices to enter the program and build infrastructure to achieve advanced primary care before subjecting them to substantial downside risk.
2. Recognize the importance of care transformation organizations (CTOs) as the program evolves. As of 2021, 24 CTOs participated in the program, with 78% of practices electing to receive CTO support to meet program care transformation requirements.[1]
3. Request for CMS to provide monthly claims files instead of quarterly. This would allow for more real-time data analysis, leading to better physician engagement.
4. Continue to expand acceptable uses for Health Equity Advancement Resource and Transformation (HEART) payments. The innovative payment has received national attention and is critical to the state and the Center for Medicare & Medicaid Innovation's (CMMI) health equity focus.

Work Group members also discussed the need for more state support to administer and expand CRPs. MHA recommends exploring contract revisions to address the issue. Current language identifies the state as responsible for CRP administration. It further lists the Health Services Cost Review Commission (HSCRC) as the responsible agency for submitting CRP track proposals and amendments. More flexibility may be required to enable state contracted entities to administer CRPs. Such an alternative could benefit the programs by bringing in dedicated subject matter experts familiar with implementing care transformation programs and value-based arrangements.

The Episodes of Care Improvement Program (ECIP) is a CRP that garners participation from post-acute providers. The HSCRC Post-Acute and Long-Term Care Work Group is assessing opportunities to enhance hospital and post-acute partnerships. Any forthcoming recommendations should be evaluated to inform potential enhancements to ECIP.

The Statewide Integrated Health Improvement Strategy (SIHIS) sets targets for the Care Transformation Initiative (CTI) program and CRP participation. As reported at the Feb. 21 Consumer Engagement Work Group meeting, Maryland is not meeting these goals. Yet, data has not been shared, and commissioners have not discussed the targets. In February, HSCRC staff reported final CTI performance will not be available until April. HSCRC should work with the state and stakeholders to understand performance drivers and whether revisions to SIHIS goals should be considered.

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[1] 2021 Maryland Primary Care Program Report, *Maryland Department of Health,* health.maryland.gov/mdpcp/Documents/2021%20Annual%20Report.pdf.

Finally, we recommend reassessing how quality provider (QP) threshold scores are calculated for Maryland providers enrolled in CRPs. The continued ability to receive incentive payments will only enhance physician engagement in these programs. Under federal MACRA law, qualifying QPs will receive a 3.5% alternative payment model (APM) incentive bonus for performance year 2023.[2] For performance years 2024 and beyond, QPs will receive an increased physician fee schedule update based on the QP conversion factor. Previously, threshold scores in Maryland were based on the provider's percentage of payments through an advanced APM, or through the percentage of patients through an advanced APM. Since CMS designated the state as an APM under the Model, the QP determination should be modified so providers who receive 50% of their patients from Maryland Medicare beneficiaries or have 35% of Maryland Medicare patients are determined QPs.

The numerator of the QP threshold score is based on a clinician's linkage to the hospital based on Medicare Performance Adjustment (MPA) attribution and whether a beneficiary had an encounter at the hospital.[3] Since the MPA attribution methodology changed in 2023, HSCRC should evaluate whether the calculation needs to be changed.

Thank you for the opportunity to comment on opportunities to enhance physician engagement and alignment as the Model advances beyond 2026. We look forward to discussing our recommendations in future work group meetings and forums.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: William Henderson, HSCRC

[2] Advanced Alternative Payment Models, *Centers for Medicare & Medicaid Services*, qpp.cms.gov/apms/advanced-apms.
[3] July 25, 2018 Total Cost of Care Work Group PowerPoint Presentation, *Health Services Cost Review Commission.*

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February 16, 2023

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

Dear Dr. Elliott,

MedChi, The Maryland State Medical Society, would like to follow up on the great initial meeting of the committee. As we promised, here are proposed recommendations related to The Maryland Primary Care Program (MDPCP) and The Episode Quality Improvement Program (EQIP). We recommend adding the following recommendations to the final report. We will outreach to specialty societies and look forward to a robust discussion around new physician alignment ideas for us to consider as part on the latest "Total Cost of Care Contract."

Please see the following recommendations:

MDPC 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 to MDPCP.

Recommendation 3 - Policy and State Leadership - As the MDPCP is extended there should be additional shifting of policy making from CMMI to the State regarding quality measures, payment methodology, and enrollment eligibility. 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 CTOs – Care Transition Organizations (CTOs) should continue to be program 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 - Program should 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 Medicare offering.

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 adding outreach to new practices to join EQIP.

Recommendation 2 – CRISP Support enhancement - build out the resources at CRISP to increase outreach to physicians and for development of new codes and models for EQIP.

Recommendation 3 – Create EQIP Entity – Smaller practices need a trusted EQIP entity to allow them to participate, we need to work with MedChi, or another trusted third party to build a neutral entity to allow for increased small practice participation.

Recommendation 4 - Multi-payer and Real Medicaid Participation - Program should 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 Medicare offering.

Recommendation 5 - Consider moving from Grouper – As EQIP grows and as Prometheus group has been commercialized, we may need to reconsider its use as the base of the program.

Recommendation 6 - Consider programing for Non-Covered Physicians – As EQIP grows it should 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 – The current program currently recognizes the risk our entire system is taking as well as, the risk a practice takes by redesigning their operations. The current structure is fair and should not be changed. It is not fair or logical to add another layer or greater layer of risk on the practices.

Thank you for your time and attention to this important work, we will have more recommendations and ideas as we continue this process.

Sincerely,

Gene M Ransom III

Gene Ransom
CEO
MedChi, The Maryland State Medical Society