# Key Principles to Strengthen and Support the All-Payer Model 2.0

Whereas, the All-Payer Model is changing the way Maryland hospitals provide care, shifting from a financing system based on volume of services to a system of hospital-specific global revenues and value-based incentives.

Whereas, the next iteration of the All-Payer Model must limit the growth in total cost of care for Medicare beneficiaries in a second term that will begin on January 1, 2019.[i]

Whereas, the State of Maryland is currently in negotiations with CMS on the parameters of the progression plan and Phase 2.

**We, the undersigned associations and organizations collectively representing thousands of Maryland physicians:**

**Support the goals and aims of improving healthcare quality and delivery for the benefit of our patients in Maryland.**

**Support the following Key Principles and request that the following key principles be incorporated into the agreements with CMS and the State of Maryland relating to the All-Payer Model and its future iterations.**

## KEY PRINCIPLES

### I. CARE REDESIGN PROGRAMS:

With any care redesign programs and risk based health care delivery models developed in accordance and under the authority of the All-Payer Model the following language is requested for inclusion:

- **AMONG MODEL PARTICIPANTS THE ALLOCATION OF PHYSICIAN PAYMENT SHALL BE BASED ON AN INDEPENDENT, UNBIASED CHARGE DATABASE TO ENSURE THE ALIGNED INCENTIVES AND QUALITY IMPROVEMENTS OF THE PARTICIPANT(S).**

  (**Rationale:** The Fiscal Year 2017 Consolidated Appropriations Act included language directing CMS' CCIIO to clarify "Usual, Customary & Reasonable" with guidance clarifying that a UCR is constituted using a "transparent and fair standard, such as an independent unbiased charge database." (Pg. 91 of Labor-HHS House Report, which was incorporated under H.R. 244 Division H ))

- **PHYSICIANS[ii] MUST BE COLLABORATORS IN DEVELOPING CARE REDESIGN PROGRAMS AND OTHER DELIVERY MODELS CONSISTENT WITH THE ALL-PAYER MODEL TO ENSURE THEIR VOLUNTARY PARTICIPATION.**

### II. MACRA:

The HSCRC's efforts to position the All-Payer Model as a MACRA eligible Advanced APM is helpful. To support that effort the following language is requested for inclusion:

- **THE STATE WILL ENCOURAGE AND SUPPORT PHYSICIANS IN ALL SPECIALTIES, WHO HAVE APPROPRIATE EXPERTISE, IN DEVELOPING CARE DESIGN OR OTHER PROGRAMS WITH THE GOAL OF INCREASING ACCESS TO CARE AND TEAM-BASED SUPPORT, IN PROVIDING COORDINATED TREATMENT AND MEDICATION MANAGEMENT, AS WELL AS IN PROVIDING OTHER SERVICES WHICH TEND TO FURTHER THE GOALS OF ACCESS TO CARE AND PATIENT HEALTH.**

## III. DATA:

The data that can be gathered and accessed from the All-Payer Model operations will be critically important to guide in the development of new care redesign models. Physician cost data collected for Medicare and Medicaid under the progression plan shall be done for compliance purposes only, and shall not be used to benchmark adequacy of compensation. Any benchmark must include a recognized fair market source.

- **MEDICARE PHYSICIAN COST DATA SHALL NOT BE THE BASIS OF PHYSICIAN REIMBURSEMENT OR ALLOCATION OF SHARED SAVINGS TO PHYSICIANS IN A CARE REDESIGN PROGRAM, PARTICULARLY THOSE PROGRAMS THAT TREAT NON-MEDICARE OR NON-MEDICAID BENEFICIARIES. THE STATE WILL UTILIZE THE CURRENT PAYMENT METHODOLOGY ESTABLISHED UNDER SECTION §14–205.2 OF THE INSURANCE ARTICLE OF THE CODE OF MARYLAND.**

  (**Rationale:** In addition to the federal cost-related guidelines, there is state-based law that also achieves this found within Maryland code §14–205.2 OF THE INSURANCE ARTICLE OF THE CODE OF MARYLAND. Section §14–205.2 of the Insurance Article of the Code of Maryland references the assignment of benefits law and reimbursement methodology which bases reimbursement on the greater of: 140% of the average commercial rate for a similarly licensed provider in the same geographic area, or the amount as of January 1, 2010 inflated by the MEI to the current year.)

## IV. LIABILITY PROTECTION:

With physicians being asked to take on financial risk as a means to provide efficient and higher quality of care, there must be a recognition of the increased liability exposure. The following language is requested for inclusion:

- **IN AN ACTION FOR DAMAGES FILED AGAINST A HEALTH CARE PROVIDER PRACTICING IN ACCORDANCE WITH THE PRINCIPLES UNDERLYING THE STATE'S ALL-PAYER MODEL CONTRACT, SUCH HEALTH CARE PROVIDER IS NOT LIABLE FOR THE PAYMENT OF DAMAGES UNLESS IT IS ESTABLISHED BY CLEAR AND CONVINCING EVIDENCE THAT THERE WAS GROSS NEGLIGENCE AND THE CARE GIVEN BY THE HEALTH CARE PROVIDER WAS NOT IN ACCORDANCE WITH THE STANDARDS OF PRACTICE AMONG MEMBERS OF THE SAME HEALTH CARE PROFESSION WITH SIMILAR TRAINING AND EXPERIENCE SITUATED IN THE SAME OR SIMILAR COMMUNITIES AT THE TIME OF THE ALLEGED ACT GIVING RISE TO THE CAUSE OF ACTION.**

  (**Rationale:** The President's FY18 Budget laid out modernizing the medical liability system (P.3 HHS FY18 Budget in Brief). The Administration highlighted these reforms as necessary to reduce cost, reduce the practice of defensive medicine, and restore the focus to evidence-based practices.)

## FOR ADDITIONAL INFORMATION:

**BARBARA MARX BROCATO**
barbara@bmbassoc.com

**GENE RANSOM**
gransom@medchi.org

## SUPPORTING ASSOCIATIONS & ORGANIZATIONS:

(ALPHABETICALLY)

| NAME | LOGO |
|---|---|



[i] http://www.hscrc.state.md.us/progression.cfm

[ii] **Physicians includes all physicians:** hospital employed, university hospital employed, independent and private physicians.