SB 834_Two Sided Incentive Arrangements_Support.pd
Uploaded by: Allison Taylor
Position: FAV

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

March 8, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 834 – Support

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente is pleased to support SB 834, Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 800,000 members. In Maryland, we deliver care to over 460,000 members.

At the heart of Kaiser Permanente's mission is the belief that all people deserve access to high-quality, affordable health care. We are committed to achieving that mission by building on our country's progress over the past decade that has enabled more people to access health care and coverage than ever before.

We support a model of care that best serves patients by aligning physicians and health plans to drive coordination wherever patients receive care. This model rewards quality clinical outcomes instead of encouraging unnecessary and often extremely expensive treatments. SB 834 envisions two ways to do this. First, it allows carriers and providers to enter into two-sided incentive arrangements, where a provider may earn an incentive and a carrier may recoup funds in accordance with the terms of a contract between the provider and carrier.

Second, the bill establishes that a provider or set of providers is not engaged in insurance business solely because the provider or providers enter into a contract with a carrier that includes capitated payments in a self-funded group health insurance plan. As a result, the bill provides an additional avenue for carriers and providers to provide a value-based plan offering to Marylanders.

---

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

SB834 Adventust HealthCare - Favorable.pdf

Uploaded by: Andrew Nicklas

Position: FAV

March 9, 2022

To: The Senate Finance Committee

From: Adventist HealthCare

Re: SB834 - Health Insurance – Two-Sided Incentive Arrangements & Capitated Payments – Authorization

POSITION: SUPPORT

Adventist HealthCare is a faith-based, not-for-profit organization that has served the Greater Washington region for more than 115 years. We operate the largest health system in Montgomery County, and offer services across the region. Our goal is to provide a world-class patient experience to every person. Adventist HealthCare is also one of the largest behavioral health providers in the state and operates the state's largest clinically integrated network of community providers.

SB824 expands voluntary contracting options between provider organizations and health plans for commercial populations in Maryland. Adventist HealthCare joined a months-long multistakeholder coalition focused on shaping this bill to serve our communities and safeguard those responsible for their care. That collaboration resulted in this innovative blueprint to permit voluntary partnerships between provider organizations and health plans.

Value-based care is not a new endeavor, to the healthcare system or to us. In fact, we support the Maryland Primary Care Program as a Care Transformation Organization and partner with health plans in numerous similar value-based arrangements. Adventist HealthCare hospitals have also long helped the State achieve success under the Maryland Total Cost of Care Model. However, despite our extensive experience, and long history of success, we are barred from entering into similar agreements for commercial populations. This bill is necessary to address that limitation and allow leaders like Adventist HealthCare to partner in new ways that meet the growing and evolving needs of all Maryland residents.

Adventist HealthCare stands committed to improving the health of the communities we serve. Expanding the ways provider groups and health plans can voluntarily partner, including value-based contracts with two-sided incentives and capitation for commercial populations, means we, and other forward-facing organizations, can provide greater access to care and better meet the needs of all Marylanders.

For these reasons, Adventist HealthCare supports SB834 and encourages the committee to issue **a favorable report**.

820 West Diamond Avenue, Gaithersburg, MD 20878 | 301-315-3030 | AdventistHealthCare.com

Hagerstown Letterhead copy.pdf
Uploaded by: Andrew Oh
Position: FAV

HB 1148/SB 834 Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of this important legislation. Capital Women's Care is the largest OB/GYN private practice in the mid-Atlantic region, with locations throughout the greater Washington-Baltimore Metropolitan Area including Anne Arundel, Baltimore, Carroll, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, Washington, and Wicomico counties. Capital Women's Care is proud to support this bill as it expands options for us and other physician groups to contract with health insurers through value-based contracts, which would give us additional opportunities to better treat and support our patients within the state of Maryland.

Our premier group consists of more than 200 physicians, nurse practitioners, physician's assistants, and certified nurse midwives with over 55 centers primarily in Maryland. We have offered our patients obstetric, gynecologic, and specialized women's health care services for over 40 years and are as committed as we were from our inception to providing the best care possible to our patients.

Despite our best efforts, maternal health remains a significant challenge – Maryland's maternal mortality rate from 2013 to 2017 ranked 22nd among states. In response, the State has made maternal health a priority with adoption of Statewide Integrated Health Improvement Strategy (SIHIS) goals to reduce severe maternal morbidity. As the largest OB/GYN practice in the mid-Atlantic region, we play a pivotal role in addressing maternal health in the state and advancement of these goals. Having the ability to partner with insurers in value-based arrangements will allow us to better develop innovative, outcomes-based programs that improve the quality and cost of care for our patients. This bill is needed to enable us to pursue such value-based care arrangements. Unfortunately, unlike other states and commonwealths in the nation, Maryland's law does not allow for certain value-based partnerships between providers and payers where we can better focus on value, quality, and healthcare outcomes. These restrictions in the law limit the tools that can be deployed to meaningfully improve quality and reduce costs in our healthcare system.

Capital Women's Care strongly supports this bill. These necessary changes will give providers and insurers the options to voluntarily work together on innovative initiatives that can improve the health and wellbeing of the Maryland residents we collectively serve.

We urge a favorable report.

Sincerely,

Andrew Oh, MD

Andrew Oh, MD, FACOG
Medical Director, Capital Women's Care

SB 834 - Support.pdf
Uploaded by: Brian Pieninck
Position: FAV

Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981

SB 834 – Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of Senate Bill 834. CareFirst is dedicated to providing high quality, affordable health care services to the members and communities we are honored to serve. However, we are limited in our ability to fulfill that promise in Maryland. Insurers currently are not able to form critical types of value-based partnerships with providers that hold clinicians accountable for their patients' health outcomes and are proven to:

- Reduce health disparities through proactive outreach and coordinated care;
- Facilitate a whole person approach to care that improves health outcomes, quality, and patient experience;
- Promote health equity by addressing social determinants of health—long known as the root cause for many illnesses, particularly for historically marginalized communities;
- Improve affordability by emphasizing value not volume.

Maryland is the only state in the country that does not allow the full spectrum of value-based care arrangements in the commercial market. Throughout the rest of the country, large insurers, including UnitedHealthcare, Aetna, Humana, and Cigna, have more than 50% of their payment tied to value-based arrangements. In fact, less than 40% of payments across commercial, Medicare Advantage, Medicaid, and Medicare still flow through a traditional fee-for-service model that has no link to quality and value.

Value-based care contracts hold providers accountable for the outcomes of their patients and incentivize keeping patients healthy. Value-based care encourages insurers and providers to work together to analyze data, identify gaps in care, and proactively address social determinants of health. This patient-centered framework results in patients experiencing an array of positive outcomes. For Humana, their value-based care Medicare Advantage members receive more care and spend less time in the hospital. Incidents of costly hospital admissions were reduced by 7% and emergency room visits by 12% for members with value-based care providers compared to those not cared for by providers in value-based care arrangements. On average, hospital admission rates for patients in Humana's value-based care arrangements were 22% lower than traditional Medicare in 2020.

Blue Cross Blue Shield plans around the country have entered into nearly 90 value-based care arrangements that include two-sided risk in 33 states. For example, BlueCross BlueShield of Massachusetts's Alternative Quality Contract resulted in improvements in adult and pediatric preventive care and reduced health disparities, while also lowering costs, from 2007-2012. More recently, BlueCross BlueShield of North Carolina's "Blue Premier" value-based program reported significant increases in the percentage of members who had their blood pressure regularly monitored and an increase in colorectal screenings, possibly averting an additional 200 deaths from colorectal cancer, according to health screening calculations from the U.S. Preventive Services Task Force. We also know these improved outcomes are enhanced when providers participate in arrangements where risk-sharing is involved. A 2019 Integrated

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc.

Healthcare Association Report showed that commercially insured members in California, cared for by providers sharing financial risk, received more preventive screenings, and paid $400 less per year in out-of-pocket costs for medical services compared to those cared for by providers not sharing financial risk.

SB 834 makes changes to Maryland law to expand the scope of value-based care arrangements that insurers and providers may enter to allow for participation in two-sided incentive arrangements and expanded participation in capitation arrangements on a voluntary basis. It also preserves existing protections for consumers and providers to ensure access to the best care possible, and most importantly facilitate better health outcomes for Maryland residents.

SB 834 was developed through nine months of collaboration among representatives of various hospitals, provider groups, and insurers. We have made numerous changes to last year's version of this bill to craft a product that creates opportunity and fosters innovative voluntary partnerships that will yield better health outcomes for all Maryland residents. The bill's goal is to create a flexible and optional pathway for payers and providers in our state to transition to broader value-based care opportunities on a strictly voluntary basis. This bill is aligned with the American Medical Association's position of supporting the use of value-based insurance design when it promotes affordable access to high-value care and reduces utilization of low-value care, across the care continuum, with an emphasis on the importance of transparency.

Value-based care arrangements are not a new concept in Maryland, which has a strong track record of leadership in healthcare. **Maryland's Total Cost of Care model and the Maryland Primary Care Program are both types of value-based care contracts, and two-sided incentive arrangements through these models are already permitted in the Medicare Advantage and Medicaid markets.** Marylanders deserve to further benefit from patient-centric innovative value-based payment models. We look forward to partnering with legislators, health departments, providers, public health groups, and other stakeholders on this journey to enhance value-based care offerings in Maryland.

We urge a favorable report.

For additional information that highlights the success of value-based plans throughout the nation, please view the attached resources.

About CareFirst BlueCross BlueShield

In its 84th year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.5 million individuals and employers in Maryland, the District of Columbia and Northern Virginia. In 2020, CareFirst invested $27.8 million to improve overall health, and increase the accessibility, affordability, safety and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn or Instagram.

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc.

VALUE-BASED CARE:

Improving access, equity, affordability and health outcomes

Healthcare nationally and in our region is in need of transformation. Despite spending 2.5 TIMES MORE per capita on healthcare than peer countries, rampant disparities in the U.S. persist based on race, income and geography.

> "IT IS VERY CLEAR THAT THE "FEE FOR SERVICE" CHASSIS ON WHICH THE U.S. HEALTH SYSTEM IS CONSTRUCTED CANNOT DELIVER EFFECTIVE, EFFICIENT, AND EQUITABLE RESULTS IN TODAY'S, AND CERTAINLY NOT TOMORROW'S ENVIRONMENT."
>
> —NATIONAL ACADEMY OF MEDICINE EXPERT PANEL

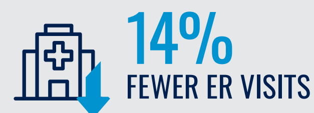
CareFirst's approach to transforming healthcare

Our healthcare system is not working to provide needed care because the current fee-for-service (FFS) system pays for the volume of services, not the quality of care. CareFirst is partnering with hospitals and practitioners to transition to a VALUE-BASED SYSTEM, which ties a health system or physician practice's revenue to IMPROVED HEALTH OUTCOMES and VALUE of services delivered, rather than volume of office visits.

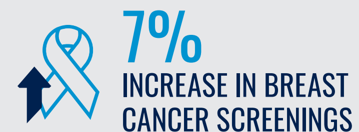
With an emphasis on preventive care, a value-based approach can:

- IMPROVE QUALITY, OUTCOMES AND PATIENT EXPERIENCE by emphasizing quality improvements, enabling richer information sharing and allowing for proactive population health management.
- EXPAND ACCESS TO CARE by giving practitioners financial stability and flexibility to deliver care in the most efficient and effective way, such as via telehealth.
- IMPROVE AFFORDABILITY by lowering total costs of care and, in turn, costs of coverage.
- ADDRESS EQUITY by incentivizing practitioners to focus on the overall health of their entire patient population.

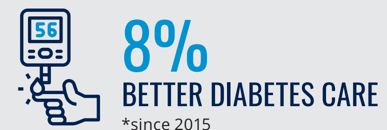
BLUE CROSS BLUE SHIELD'S TOTAL CARE PROGRAM*:



14%
FEWER ER VISITS



7%
INCREASE IN BREAST CANCER SCREENINGS



8%
BETTER DIABETES CARE

*since 2015

CareFirst's value-based programs

CareFirst has offered a value-based program for 11 years for primary care practitioners—the Patient-Centered Medical Home (PCMH) program. More recently, we implemented new value-based programs—Episode of Care Programs (EOCs) for top high-cost specialists and Accountable Care Organizations (ACOs) for health systems—and plan to offer capitated programs soon.

- VALUE-BASED PROGRAMS INCREASINGLY HAVE TWO-SIDED INCENTIVES.* The evidence shows that patients experience improved outcomes, quality and affordability from health systems and physician practices in two-sided arrangements compared to those in upside only arrangements.
- OUR CAPITATION MODELS ARE DESIGNED TO EMPOWER PRACTITIONERS to focus on holistic population management rather than high-volume daily visits. With a predictable monthly cash flow, the entire practice can be redesigned to most effectively treat patients.
- TO PROTECT CONSUMERS, PRACTITIONERS MUST MEET NATIONAL QUALITY STANDARDS to be eligible for shared savings. These include both clinical and patient experience measures.

All of CareFirst's value-based arrangements are VOLUNTARY and include SAFEGUARDS FOR HEALTHCARE PRACTITIONERS, such as a maximum liability cap for shared risk.

*Voluntary two-sided incentives and capitated models are aligned with other commercial payers as well as national and state initiatives to reduce practitioner burden and drive impact. They are also aligned with Maryland's Total Cost of Care model.

CareFirst

VALUE-BASED CARE WILL MAKE A DIFFERENCE IN THE LIVES OF THOSE WE SERVE.

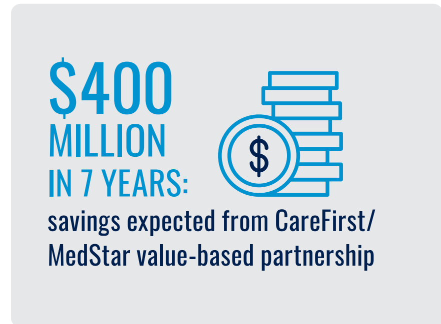
We recommend policymakers consider the following areas to encourage the transition to a value-based system:

1 Permit two-sided incentive and capitated value-based arrangements

In Maryland, changes are needed to the physician/practitioner incentive compensation law to allow both two-sided incentives and capitation arrangements to flourish with commercial plans, while preserving existing protections for consumers and providers to ensure access to high-quality care. Such changes will improve health care quality and reduce costs. EXPERTS AGREE; PREVIOUS CMMI DIRECTOR BRAD SMITH AND A NATIONAL ACADEMY OF MEDICINE EXPERT PANEL HAVE BOTH ADVOCATED FOR WIDER ADOPTION OF TWO-SIDED RISK MODELS.

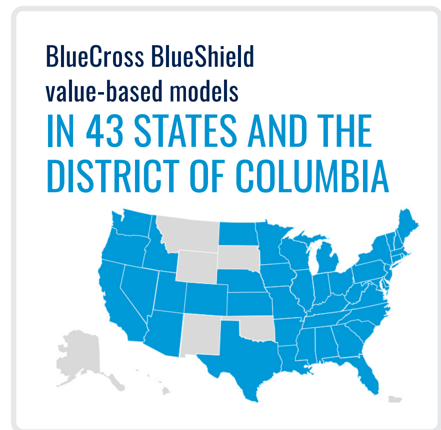
2 Continue to encourage CMMI* models

The tides of the VBC landscape are changing... WITH CURRENT CMMI DIRECTOR LIZ FOWLER COMMUNICATING HER INTENTION TO MOVE TOWARDS MORE MANDATORY MODELS OF VALUE-BASED CARE. CareFirst agrees, and strongly supports CMMI's continued efforts in designing, testing and implementing strategies that improve health outcomes and affordability. The potential benefits of innovative models are clear.



3 Facilitate opportunities for multi-payer alignment to drive system change and impact

Multi-payer alignment is key to advancing value-based care, reducing provider burden and driving large population health impact. CareFirst is currently an aligned payer for CMMI's Primary Care First in Virginia and Maryland Primary Care Program (MDPCP) to support primary care practice transformation. PAST AND PRESENT CMMI LEADERS HAVE REITERATED THE IMPORTANCE OF MULTI-PAYER ALIGNMENT. We are looking forward to continuing to partner with stakeholders to align our efforts and advance value-based care. State legislative changes are also needed to remain aligned.



*CMMI – Center for Medicare and Medicaid Innovation

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association.

CareFirst

HEALTH CARE EXPERTS & THE PUBLISHED EXPERIENCE AGREE: WE MUST EMBRACE VALUE-BASED CARE

National Policy Momentum for Innovative Payment Models

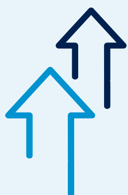
Stakeholders from across the industry recognize the importance of value-based payment programs.

- In May 2021, an expert panel CONVENED BY THE NATIONAL ACADEMY OF MEDICINE EMPHASIZED the importance of value-based care—ADVOCATING FOR MANDATORY CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI) MODELS, MULTI-PAYER ALIGNMENT, AND TWO-SIDED INCENTIVES.
- A task force of MULTIDISCIPLINARY INDUSTRY EXPERTS formed by the Commonwealth Fund in November 2020 RECOMMENDED federal and state officials SPEED UP ADOPTION RATES OF VALUE-BASED PAYMENT APPROACHES proven to enhance accountability for health care cost, quality, and equity, emphasizing that value-based arrangements SHOULD INCLUDE SUBSTANTIAL DOWNSIDE RISK.
- Findings from Better Medicare Alliance's November 2021 REPORT show CAPITATED PAYMENT ARRANGEMENTS IN MEDICARE ADVANTAGE OFFERED KEY FLEXIBILITIES AND FINANCIAL SUPPORT TO PROVIDERS FACING REVENUE LOSSES AS PATIENT VISIT VOLUMES DECLINED IN THE FIRST MONTHS OF THE PUBLIC HEALTH EMERGENCY.

In 2021, current and former Center for Medicare and Medicaid Services (CMS) leaders put a spotlight on value-based care programs with two-sided incentives:

- Donald Berwick, former acting CMS administrator, STATED the health care system should MOVE AWAY FROM A FEE-FOR-SERVICE SYSTEM to expand access to affordable health care.
- Brad Smith, a previous CMMI director, NOTED CMMI MUST LAUNCH NEW MODELS WITH TWO-SIDED INCENTIVE ARRANGEMENTS.
- Liz Fowler, current CMMI director, ANNOUNCED the innovation center's intention to MAKE MORE CMMI MODELS MANDATORY as CMMI implements a more patient-centric vision for value-based care.
- As part of a STRATEGY REFRESH, CMMI set a goal to have all Medicare beneficiaries with Parts A and B be in a care relationship WITH ACCOUNTABILITY FOR QUALITY AND TOTAL COST OF CARE BY 2030

National measurement data shows downside risk adoption is increasing over time:



As of January 1, 2021, 41% of Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) took on two-sided risk. AS OF JANUARY 1, 2022, THIS NUMBER ROSE TO 59%. Continuing the year over year pattern of increase in ACOs taking on two-sided risk in the country's largest value-based program, WHICH COVERS OVER 11 MILLION PEOPLE.

NEARLY 30% of Medicare Advantage payments in 2020 flowed through a two-sided risk value-based payment arrangement.

Across all payment types, LESS THAN 40% OF PAYMENTS ACROSS COMMERCIAL, MEDICARE ADVANTAGE, MEDICAID, & MEDICARE still flow through a traditional fee-for-service model that has no link to quality and value.

CareFirst

Published Experience: Provider Success in VBC Programs with Two-Sided Incentives

Published Examples[1] Value-Based Care Programs Increase Quality of Care & Reduce Costs

Programs that include two-sided incentive arrangements can meaningfully improve quality and reduce health care costs.

- 2019 MSSP RESULTS showed ACOS WITH TWO-SIDED INCENTIVES OUTPERFORMED ACOS WITHOUT two-sided incentives, with net per beneficiary savings of $152 per beneficiary compared to $107.
- MASSACHUSETTS' ALTERNATIVE QUALITY CONTRACT (AQC) SAVED 11.7% in relative savings ON CLAIMS FROM 2009-2016. Adult preventive care and pediatric care also improved among members in lower socioeconomic areas, REDUCING HEALTH DISPARITIES from 2007-2012.
- A 2019 Integrated Healthcare Association Report SHOWED that commercially insured members in California, cared for by providers SHARING FINANCIAL RISK (PAID CAPITATION), RECEIVED MORE PREVENTATIVE SCREENINGS AND PAID $400 LESS PER YEAR IN OUT-OF-POCKET COSTS for medical services compared to those cared for by providers not sharing financial risk.
- ACCORDING TO CIGNA'S 2020 ANNUAL REPORT, 85% OF CIGNA'S MEDICARE ADVANTAGE CUSTOMERS ARE ALIGNED WITH VALUE-BASED PROVIDERS. 92% of these providers met or exceeded quality benchmarks, and half of their providers participating in value-based care arrangements have taken on two-sided risk. These arrangements have produced MORE THAN 600 MILLION in MEDICAL COST SAVINGS spanning five years.
- In 2020, NORTH CAROLINA'S BLUE PREMIER PROGRAM GENERATED AN ESTIMATED $197 MILLION IN COST SAVINGS. Quality improvements included a 15% reduction in unplanned hospital readmissions & 10,000 more colorectal screenings than in the previous year. THIS FOLLOWS $153 MILLION IN SAVINGS IN 2019, giving the program a $350 million impact in its first two years.
- Highmark's True Performance value-based reimbursement program for primary care physicians (PCPs) has ACHIEVED NEARLY $2 BILLION IN AVOIDED-COST SAVINGS SINCE 2017 DUE TO BETTER HEALTH MANAGEMENT. In 2020, Highmark members seeing a PCP in the True Performance program had lower emergency department utilization than those not in the program, with potentially avoided costs of $66.7 million. Members seeing a True Performance PCP also had lower inpatient admissions than those not in the program, with potentially avoided costs of $660.4 million.

Published Experience: VBC Arrangements Improve the Patient Experience

- In 2020, among patients in UnitedHealthcare's 1500 ACO agreements, commercial ACO members were MORE LIKELY to see a PCP, get preventive screenings, and avoid a hospital admission or visit to the emergency department.
- In their 2000+ value-based contracts, Aetna has seen IMPROVED OUTCOMES for patients such as:
  - INCREASES IN PREVENTIVE SERVICES PERFORMED
  - EARLIER DETECTION OF DISEASE
  - GREATER LIKELIHOOD OF CHRONIC DISEASE MANAGEMENT
  - FEWER EMERGENCY ROOM VISITS, HOSPITALIZATIONS, AND RE-ADMISSIONS
  - ALL WHILE SAVING THE HEALTH CARE SYSTEM $675 PER MEMBER.

Results show increasing provider support for and success in VBC contracts that feature downside risk.

- Support for value-based care models is not new to providers. In 2019, the American Medical Group Association (AMGA) president EXPRESSED data is a clear testament that their members (more than 400 physician groups) BELIEVE VALUE-BASED MODELS SUPPORT THEIR TEAM-BASED, COORDINATED, DATA-DRIVEN MODEL OF CARE, WHICH RESULTS IN BETTER PATIENT OUTCOMES.
- IN 2020, 88% OF MSSP ACOS IN TWO-SIDED RISK MODELS RECEIVED BONUSES AND 97% GENERATED SAVINGS. Comparatively, only 57% of ACOs in one-sided risk models received bonuses and 88% generated savings.
- Physicians in value-based contracts with Humana RECEIVE MORE of the overall health care dollar—encompassing medical claims and capitation, bonus, and surplus payments—EARNING 17.5 CENTS OF EVERY DOLLAR SPENT COMPARED TO 6.7 CENTS FOR NON-VALUE-BASED PHYSICIANS.

[1]As many two-sided incentive arrangements are private contracts between providers and payers, comprehensive data is not available. Here, we have provided a line of sight into some results that are available.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Value-Based Contracting Protections

	Draft MD Bill	MSSP[1]	Next Gen ACO[1]	BPCI Adv.[1]	CJR[1]	CPC+[1]	PCF[1]	MDPCP[2]	EQIP[2]
Voluntary participation	✓	✓	✓	✓		✓	✓	✓	✓
Not a prerequisite to become a network provider	✓	✓	✓	✓	✓	✓	✓	✓	✓
50% shared loss rate cap*	✓								
10% maximum liability cap*	✓						✓		
Upside incentives must exceed financial risk	✓	✓				✓	✓	✓	
Financial reconciliation within 6 months**	✓			✓			✓		✓
12-months upside only	✓	✓			✓			✓	
Third-party appeal/dispute resolution process	✓								
Performance data shared at least quarterly	✓	✓	✓	✓	✓	✓	✓	✓	✓

*Recoupment of prospectively paid incentives are considered "losses"
**Blanks denote programs requiring longer than 6 months or without an explicit reconciliation timeline
1. Federal Medicare Program 2. State of Maryland Medicare Program

Acronym Guide:
MSSP: Medicare Shared Savings Program, **Next Gen. ACO:** Next Generation ACO, **BPCI Advanced:** Bundled Payments for Care Improvement Advanced, **CJR:** Comprehensive Care for Joint Replacement, **CPC+:** Comprehensive Primary Care Plus, **PCF:** Primary Care First, **EQIP:** Episode Quality Improvement Program

This bill expands the types of value-based contracts payers and providers may voluntarily enter in Maryland—aligning commercial health plans with value-based programs offered by the State of Maryland, Centers for Medicare & Medicaid Services, and throughout the country.

Consumer Protections

- **Value-based programs are inherently consumer focused**—they drive better patient care, improved population health, and greater affordability.
- **Value-based programs do not limit access to care**—they create provider incentives which emphasize delivery of preventative and holistic care, creating a more accessible, equitable, and affordable health care delivery system for all.
- **CareFirst's value-based programs create dynamic protections for seriously ill patients and populations**—CareFirst reviews patient claims continuously and implements adjustments to a provider's risk score ("risk adjustment") to ensure that providers' quality and financial benchmarks match any changes in the burden of disease.
- **Our bill upholds all existing consumer protections in the Insurance Article**—it also includes more quality, transparency, and financial protections than any other similar state or national law (see attached chart)
- **Providers maintain complete control over care delivery**—CareFirst's value-based programs explicitly preserve provider's responsibility to deliver the best care, as determined by their professional judgment

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

Quality Measurement

- **Value-Based programs use financial incentives to reward care based on improving outcomes and quality**—Traditional payment structures do not include a nexus between care payment and care quality or patient outcomes. Payments are made solely on a per service basis.

- **CareFirst's value-based programs use nationally-recognized quality measures**—these national measures are universally regarded as important metrics of patient care. CareFirst providers have a long history (over ten years) of focusing on these measures through our PCMH program.

- **Use of nationally-recognized quality measures reduces provider's administrative burden**—these measures use readily-available data (e.g., claims) and align with the metrics that provider groups report to other organizations, including CMS and the State of Maryland. CareFirst is also automating data exchange to remove any administrative burden associated with sharing non-claims-based quality data.

- **CareFirst collaborates with its provider partners in establishing quality reporting metrics—**CareFirst focuses on the quality measures below for many of its value-based programs but also seeks opportunities to create alignment with other metrics prioritized by our provider partners. For more narrowly focused programs (e.g., episode of care for select specialties), CareFirst uses nationally recognized quality measures relevant to the specialty or care event.

1. Optimal Care for Diabetic Population
2. Controlling High Blood Pressure
3. Colorectal Cancer Screening
4. Use of Imaging Studies for Low Back Pain
5. Depression Screening for Adolescents and Adults
6. Appropriate Opioid Prescribing
7. Acute Hospital Utilization
8. All-Cause Readmissions
9. Emergency Department Utilization
10. Consumer Assessment of Healthcare Providers (CAHPS) Composite

SB 834 - Support.pdf
Uploaded by: Brian Wheeler
Position: FAV

Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-528-7981

SB 834 – Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of Senate Bill 834. CareFirst is dedicated to providing high quality, affordable health care services to the members and communities we are honored to serve. However, we are limited in our ability to fulfill that promise in Maryland. Insurers currently are not able to form critical types of value-based partnerships with providers that hold clinicians accountable for their patients' health outcomes and are proven to:

- Reduce health disparities through proactive outreach and coordinated care;
- Facilitate a whole person approach to care that improves health outcomes, quality, and patient experience;
- Promote health equity by addressing social determinants of health—long known as the root cause for many illnesses, particularly for historically marginalized communities;
- Improve affordability by emphasizing value not volume.

Maryland is the only state in the country that does not allow the full spectrum of value-based care arrangements in the commercial market. Throughout the rest of the country, large insurers, including UnitedHealthcare, Aetna, Humana, and Cigna, have more than 50% of their payment tied to value-based arrangements. In fact, less than 40% of payments across commercial, Medicare Advantage, Medicaid, and Medicare still flow through a traditional fee-for-service model that has no link to quality and value.

Value-based care contracts hold providers accountable for the outcomes of their patients and incentivize keeping patients healthy. Value-based care encourages insurers and providers to work together to analyze data, identify gaps in care, and proactively address social determinants of health. This patient-centered framework results in patients experiencing an array of positive outcomes. For Humana, their value-based care Medicare Advantage members receive more care and spend less time in the hospital. Incidents of costly hospital admissions were reduced by 7% and emergency room visits by 12% for members with value-based care providers compared to those not cared for by providers in value-based care arrangements. On average, hospital admission rates for patients in Humana's value-based care arrangements were 22% lower than traditional Medicare in 2020.

Blue Cross Blue Shield plans around the country have entered into nearly 90 value-based care arrangements that include two-sided risk in 33 states. For example, BlueCross BlueShield of Massachusetts's Alternative Quality Contract resulted in improvements in adult and pediatric preventive care and reduced health disparities, while also lowering costs, from 2007-2012. More recently, BlueCross BlueShield of North Carolina's "Blue Premier" value-based program reported significant increases in the percentage of members who had their blood pressure regularly monitored and an increase in colorectal screenings, possibly averting an additional 200 deaths from colorectal cancer, according to health screening calculations from the U.S. Preventive Services Task Force. We also know these improved outcomes are enhanced when providers participate in arrangements where risk-sharing is involved. A 2019 Integrated

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc.

Healthcare Association Report showed that commercially insured members in California, cared for by providers sharing financial risk, received more preventive screenings, and paid $400 less per year in out-of-pocket costs for medical services compared to those cared for by providers not sharing financial risk.

SB 834 makes changes to Maryland law to expand the scope of value-based care arrangements that insurers and providers may enter to allow for participation in two-sided incentive arrangements and expanded participation in capitation arrangements on a voluntary basis. It also preserves existing protections for consumers and providers to ensure access to the best care possible, and most importantly facilitate better health outcomes for Maryland residents.

SB 834 was developed through nine months of collaboration among representatives of various hospitals, provider groups, and insurers. We have made numerous changes to last year's version of this bill to craft a product that creates opportunity and fosters innovative voluntary partnerships that will yield better health outcomes for all Maryland residents. The bill's goal is to create a flexible and optional pathway for payers and providers in our state to transition to broader value-based care opportunities on a strictly voluntary basis. This bill is aligned with the American Medical Association's position of supporting the use of value-based insurance design when it promotes affordable access to high-value care and reduces utilization of low-value care, across the care continuum, with an emphasis on the importance of transparency.

Value-based care arrangements are not a new concept in Maryland, which has a strong track record of leadership in healthcare. **Maryland's Total Cost of Care model and the Maryland Primary Care Program are both types of value-based care contracts, and two-sided incentive arrangements through these models are already permitted in the Medicare Advantage and Medicaid markets.** Marylanders deserve to further benefit from patient-centric innovative value-based payment models. We look forward to partnering with legislators, health departments, providers, public health groups, and other stakeholders on this journey to enhance value-based care offerings in Maryland.

We urge a favorable report.

For additional information that highlights the success of value-based plans throughout the nation, please view the attached resources.

About CareFirst BlueCross BlueShield

In its 84th year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.5 million individuals and employers in Maryland, the District of Columbia and Northern Virginia. In 2020, CareFirst invested $27.8 million to improve overall health, and increase the accessibility, affordability, safety and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn or Instagram.

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®´ Registered trademark of CareFirst of Maryland, Inc.

CareFirst

VALUE-BASED CARE:

Improving access, equity, affordability and health outcomes

Healthcare nationally and in our region is in need of transformation. Despite spending 2.5 TIMES MORE per capita on healthcare than peer countries, rampant disparities in the U.S. persist based on race, income and geography.

"IT IS VERY CLEAR THAT THE "FEE FOR SERVICE" CHASSIS ON WHICH THE U.S. HEALTH SYSTEM IS CONSTRUCTED CANNOT DELIVER EFFECTIVE, EFFICIENT, AND EQUITABLE RESULTS IN TODAY'S, AND CERTAINLY NOT TOMORROW'S ENVIRONMENT."

—NATIONAL ACADEMY OF MEDICINE EXPERT PANEL

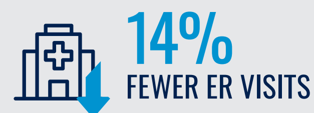
CareFirst's approach to transforming healthcare

Our healthcare system is not working to provide needed care because the current fee-for-service (FFS) system pays for the volume of services, not the quality of care. CareFirst is partnering with hospitals and practitioners to transition to a VALUE-BASED SYSTEM, which ties a health system or physician practice's revenue to IMPROVED HEALTH OUTCOMES and VALUE of services delivered, rather than volume of office visits.

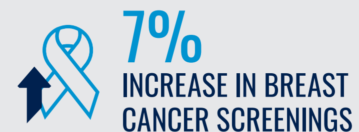
With an emphasis on preventive care, a value-based approach can:

- IMPROVE QUALITY, OUTCOMES AND PATIENT EXPERIENCE by emphasizing quality improvements, enabling richer information sharing and allowing for proactive population health management.
- EXPAND ACCESS TO CARE by giving practitioners financial stability and flexibility to deliver care in the most efficient and effective way, such as via telehealth.
- IMPROVE AFFORDABILITY by lowering total costs of care and, in turn, costs of coverage.
- ADDRESS EQUITY by incentivizing practitioners to focus on the overall health of their entire patient population.

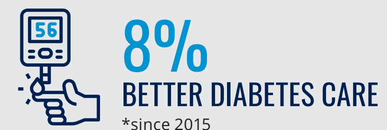
BLUE CROSS BLUE SHIELD'S TOTAL CARE PROGRAM*:



14% FEWER ER VISITS



7% INCREASE IN BREAST CANCER SCREENINGS



8% BETTER DIABETES CARE

*since 2015

CareFirst's value-based programs

CareFirst has offered a value-based program for 11 years for primary care practitioners—the Patient-Centered Medical Home (PCMH) program. More recently, we implemented new value-based programs—Episode of Care Programs (EOCs) for top high-cost specialists and Accountable Care Organizations (ACOs) for health systems—and plan to offer capitated programs soon.

- VALUE-BASED PROGRAMS INCREASINGLY HAVE TWO-SIDED INCENTIVES.* The evidence shows that patients experience improved outcomes, quality and affordability from health systems and physician practices in two-sided arrangements compared to those in upside only arrangements.
- OUR CAPITATION MODELS ARE DESIGNED TO EMPOWER PRACTITIONERS to focus on holistic population management rather than high-volume daily visits. With a predictable monthly cash flow, the entire practice can be redesigned to most effectively treat patients.
- TO PROTECT CONSUMERS, PRACTITIONERS MUST MEET NATIONAL QUALITY STANDARDS to be eligible for shared savings. These include both clinical and patient experience measures.

All of CareFirst's value-based arrangements are VOLUNTARY and include SAFEGUARDS FOR HEALTHCARE PRACTITIONERS, such as a maximum liability cap for shared risk.

*Voluntary two-sided incentives and capitated models are aligned with other commercial payers as well as national and state initiatives to reduce practitioner burden and drive impact. They are also aligned with Maryland's Total Cost of Care model.

CareFirst

VALUE-BASED CARE WILL MAKE A DIFFERENCE IN THE LIVES OF THOSE WE SERVE.

We recommend policymakers consider the following areas to encourage the transition to a value-based system:

1

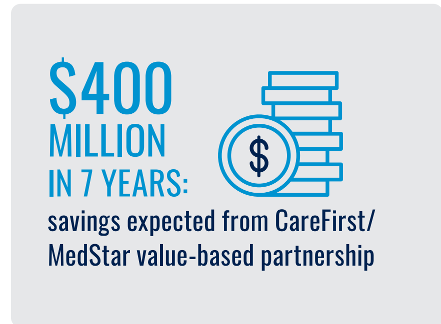
Permit two-sided incentive and capitated value-based arrangements

In Maryland, changes are needed to the physician/practitioner incentive compensation law to allow both two-sided incentives and capitation arrangements to flourish with commercial plans, while preserving existing protections for consumers and providers to ensure access to high-quality care. Such changes will improve health care quality and reduce costs. EXPERTS AGREE; PREVIOUS CMMI DIRECTOR BRAD SMITH AND A NATIONAL ACADEMY OF MEDICINE EXPERT PANEL HAVE BOTH ADVOCATED FOR WIDER ADOPTION OF TWO-SIDED RISK MODELS.

2

Continue to encourage CMMI* models

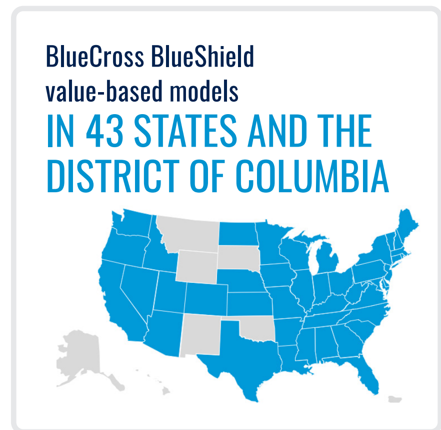
The tides of the VBC landscape are changing... WITH CURRENT CMMI DIRECTOR LIZ FOWLER COMMUNICATING HER INTENTION TO MOVE TOWARDS MORE MANDATORY MODELS OF VALUE-BASED CARE. CareFirst agrees, and strongly supports CMMI's continued efforts in designing, testing and implementing strategies that improve health outcomes and affordability. The potential benefits of innovative models are clear.



3

Facilitate opportunities for multi-payer alignment to drive system change and impact

Multi-payer alignment is key to advancing value-based care, reducing provider burden and driving large population health impact. CareFirst is currently an aligned payer for CMMI's Primary Care First in Virginia and Maryland Primary Care Program (MDPCP) to support primary care practice transformation. PAST AND PRESENT CMMI LEADERS HAVE REITERATED THE IMPORTANCE OF MULTI-PAYER ALIGNMENT. We are looking forward to continuing to partner with stakeholders to align our efforts and advance value-based care. State legislative changes are also needed to remain aligned.



*CMMI – Center for Medicare and Medicaid Innovation

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association.

CareFirst

HEALTH CARE EXPERTS & THE PUBLISHED EXPERIENCE AGREE: WE MUST EMBRACE VALUE-BASED CARE

National Policy Momentum for Innovative Payment Models

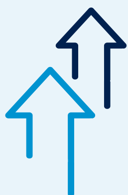
Stakeholders from across the industry recognize the importance of value-based payment programs.

- In May 2021, an expert panel CONVENED BY THE NATIONAL ACADEMY OF MEDICINE EMPHASIZED the importance of value-based care—ADVOCATING FOR MANDATORY CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI) MODELS, MULTI-PAYER ALIGNMENT, AND TWO-SIDED INCENTIVES.
- A task force of MULTIDISCIPLINARY INDUSTRY EXPERTS formed by the Commonwealth Fund in November 2020 RECOMMENDED federal and state officials SPEED UP ADOPTION RATES OF VALUE-BASED PAYMENT APPROACHES proven to enhance accountability for health care cost, quality, and equity, emphasizing that value-based arrangements SHOULD INCLUDE SUBSTANTIAL DOWNSIDE RISK.
- Findings from Better Medicare Alliance's November 2021 REPORT show CAPITATED PAYMENT ARRANGEMENTS IN MEDICARE ADVANTAGE OFFERED KEY FLEXIBILITIES AND FINANCIAL SUPPORT TO PROVIDERS FACING REVENUE LOSSES AS PATIENT VISIT VOLUMES DECLINED IN THE FIRST MONTHS OF THE PUBLIC HEALTH EMERGENCY.

In 2021, current and former Center for Medicare and Medicaid Services (CMS) leaders put a spotlight on value-based care programs with two-sided incentives:

- Donald Berwick, former acting CMS administrator, STATED the health care system should MOVE AWAY FROM A FEE-FOR-SERVICE SYSTEM to expand access to affordable health care.
- Brad Smith, a previous CMMI director, NOTED CMMI MUST LAUNCH NEW MODELS WITH TWO-SIDED INCENTIVE ARRANGEMENTS.
- Liz Fowler, current CMMI director, ANNOUNCED the innovation center's intention to MAKE MORE CMMI MODELS MANDATORY as CMMI implements a more patient-centric vision for value-based care.
- As part of a STRATEGY REFRESH, CMMI set a goal to have all Medicare beneficiaries with Parts A and B be in a care relationship WITH ACCOUNTABILITY FOR QUALITY AND TOTAL COST OF CARE BY 2030

National measurement data shows downside risk adoption is increasing over time:



As of January 1, 2021, 41% of Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) took on two-sided risk. AS OF JANUARY 1, 2022, THIS NUMBER ROSE TO 59%. Continuing the year over year pattern of increase in ACOs taking on two-sided risk in the country's largest value-based program, WHICH COVERS OVER 11 MILLION PEOPLE.

NEARLY 30% of Medicare Advantage payments in 2020 flowed through a two-sided risk value-based payment arrangement.

Across all payment types, LESS THAN 40% OF PAYMENTS ACROSS COMMERCIAL, MEDICARE ADVANTAGE, MEDICAID, & MEDICARE still flow through a traditional fee-for-service model that has no link to quality and value.

CareFirst

Published Experience: Provider Success in VBC Programs with Two-Sided Incentives

Published Examples[1] Value-Based Care Programs Increase Quality of Care & Reduce Costs

Programs that include two-sided incentive arrangements can meaningfully improve quality and reduce health care costs.

- 2019 MSSP RESULTS showed ACOS WITH TWO-SIDED INCENTIVES OUTPERFORMED ACOS WITHOUT two-sided incentives, with net per beneficiary savings of $152 per beneficiary compared to $107.
- MASSACHUSETTS' ALTERNATIVE QUALITY CONTRACT (AQC) SAVED 11.7% in relative savings ON CLAIMS FROM 2009-2016. Adult preventive care and pediatric care also improved among members in lower socioeconomic areas, REDUCING HEALTH DISPARITIES from 2007-2012.
- A 2019 Integrated Healthcare Association Report SHOWED that commercially insured members in California, cared for by providers SHARING FINANCIAL RISK (PAID CAPITATION), RECEIVED MORE PREVENTATIVE SCREENINGS AND PAID $400 LESS PER YEAR IN OUT-OF-POCKET COSTS for medical services compared to those cared for by providers not sharing financial risk.
- ACCORDING TO CIGNA'S 2020 ANNUAL REPORT, 85% OF CIGNA'S MEDICARE ADVANTAGE CUSTOMERS ARE ALIGNED WITH VALUE-BASED PROVIDERS. 92% of these providers met or exceeded quality benchmarks, and half of their providers participating in value-based care arrangements have taken on two-sided risk. These arrangements have produced MORE THAN 600 MILLION in MEDICAL COST SAVINGS spanning five years.
- In 2020, NORTH CAROLINA'S BLUE PREMIER PROGRAM GENERATED AN ESTIMATED $197 MILLION IN COST SAVINGS. Quality improvements included a 15% reduction in unplanned hospital readmissions & 10,000 more colorectal screenings than in the previous year. THIS FOLLOWS $153 MILLION IN SAVINGS IN 2019, giving the program a $350 million impact in its first two years.
- Highmark's True Performance value-based reimbursement program for primary care physicians (PCPs) has ACHIEVED NEARLY $2 BILLION IN AVOIDED-COST SAVINGS SINCE 2017 DUE TO BETTER HEALTH MANAGEMENT. In 2020, Highmark members seeing a PCP in the True Performance program had lower emergency department utilization than those not in the program, with potentially avoided costs of $66.7 million. Members seeing a True Performance PCP also had lower inpatient admissions than those not in the program, with potentially avoided costs of $660.4 million.

Published Experience: VBC Arrangements Improve the Patient Experience

- In 2020, among patients in UnitedHealthcare's 1500 ACO agreements, commercial ACO members were MORE LIKELY to see a PCP, get preventive screenings, and avoid a hospital admission or visit to the emergency department.
- In their 2000+ value-based contracts, Aetna has seen IMPROVED OUTCOMES for patients such as:
  - INCREASES IN PREVENTIVE SERVICES PERFORMED
  - EARLIER DETECTION OF DISEASE
  - GREATER LIKELIHOOD OF CHRONIC DISEASE MANAGEMENT
  - FEWER EMERGENCY ROOM VISITS, HOSPITALIZATIONS, AND RE-ADMISSIONS
  - ALL WHILE SAVING THE HEALTH CARE SYSTEM $675 PER MEMBER.

Results show increasing provider support for and success in VBC contracts that feature downside risk.

- Support for value-based care models is not new to providers. In 2019, the American Medical Group Association (AMGA) president EXPRESSED data is a clear testament that their members (more than 400 physician groups) BELIEVE VALUE-BASED MODELS SUPPORT THEIR TEAM-BASED, COORDINATED, DATA-DRIVEN MODEL OF CARE, WHICH RESULTS IN BETTER PATIENT OUTCOMES.
- IN 2020, 88% OF MSSP ACOS IN TWO-SIDED RISK MODELS RECEIVED BONUSES AND 97% GENERATED SAVINGS. Comparatively, only 57% of ACOs in one-sided risk models received bonuses and 88% generated savings.
- Physicians in value-based contracts with Humana RECEIVE MORE of the overall health care dollar—encompassing medical claims and capitation, bonus, and surplus payments—EARNING 17.5 CENTS OF EVERY DOLLAR SPENT COMPARED TO 6.7 CENTS FOR NON-VALUE-BASED PHYSICIANS.

[1]As many two-sided incentive arrangements are private contracts between providers and payers, comprehensive data is not available. Here, we have provided a line of sight into some results that are available.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Value-Based Contracting Protections

	Draft MD Bill	MSSP[1]	Next Gen ACO[1]	BPCI Adv.[1]	CJR[1]	CPC+[1]	PCF[1]	MDPCP[2]	EQIP[2]
Voluntary participation	✓	✓	✓	✓		✓	✓	✓	✓
Not a prerequisite to become a network provider	✓	✓	✓	✓	✓	✓	✓	✓	✓
50% shared loss rate cap*	✓								
10% maximum liability cap*	✓						✓		
Upside incentives must exceed financial risk	✓	✓				✓	✓	✓	
Financial reconciliation within 6 months**	✓			✓			✓		✓
12-months upside only	✓	✓			✓			✓	
Third-party appeal/dispute resolution process	✓								
Performance data shared at least quarterly	✓	✓	✓	✓	✓	✓	✓	✓	✓

*Recoupment of prospectively paid incentives are considered "losses"
**Blanks denote programs requiring longer than 6 months or without an explicit reconciliation timeline
1. Federal Medicare Program 2. State of Maryland Medicare Program

Acronym Guide:
MSSP: Medicare Shared Savings Program, **Next Gen. ACO:** Next Generation ACO, **BPCI Advanced:** Bundled Payments for Care Improvement Advanced, **CJR:** Comprehensive Care for Joint Replacement, **CPC+:** Comprehensive Primary Care Plus, **PCF:** Primary Care First, **EQIP:** Episode Quality Improvement Program

This bill expands the types of value-based contracts payers and providers may voluntarily enter in Maryland—aligning commercial health plans with value-based programs offered by the State of Maryland, Centers for Medicare & Medicaid Services, and throughout the country.

Consumer Protections

- **Value-based programs are inherently consumer focused**—they drive better patient care, improved population health, and greater affordability.

- **Value-based programs do not limit access to care**—they create provider incentives which emphasize delivery of preventative and holistic care, creating a more accessible, equitable, and affordable health care delivery system for all.

- **CareFirst's value-based programs create dynamic protections for seriously ill patients and populations**—CareFirst reviews patient claims continuously and implements adjustments to a provider's risk score ("risk adjustment") to ensure that providers' quality and financial benchmarks match any changes in the burden of disease.

- **Our bill upholds all existing consumer protections in the Insurance Article**—it also includes more quality, transparency, and financial protections than any other similar state or national law (see attached chart)

- **Providers maintain complete control over care delivery**—CareFirst's value-based programs explicitly preserve provider's responsibility to deliver the best care, as determined by their professional judgment

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

Quality Measurement

- **Value-Based programs use financial incentives to reward care based on improving outcomes and quality**—Traditional payment structures do not include a nexus between care payment and care quality or patient outcomes. Payments are made solely on a per service basis.

- **CareFirst's value-based programs use nationally-recognized quality measures**—these national measures are universally regarded as important metrics of patient care. CareFirst providers have a long history (over ten years) of focusing on these measures through our PCMH program.

- **Use of nationally-recognized quality measures reduces provider's administrative burden**—these measures use readily-available data (e.g., claims) and align with the metrics that provider groups report to other organizations, including CMS and the State of Maryland. CareFirst is also automating data exchange to remove any administrative burden associated with sharing non-claims-based quality data.

- **CareFirst collaborates with its provider partners in establishing quality reporting metrics—**CareFirst focuses on the quality measures below for many of its value-based programs but also seeks opportunities to create alignment with other metrics prioritized by our provider partners. For more narrowly focused programs (e.g., episode of care for select specialties), CareFirst uses nationally recognized quality measures relevant to the specialty or care event.

1. Optimal Care for Diabetic Population
2. Controlling High Blood Pressure
3. Colorectal Cancer Screening
4. Use of Imaging Studies for Low Back Pain
5. Depression Screening for Adolescents and Adults
6. Appropriate Opioid Prescribing
7. Acute Hospital Utilization
8. All-Cause Readmissions
9. Emergency Department Utilization
10. Consumer Assessment of Healthcare Providers (CAHPS) Composite

MDSB 834-Dana Gelb-Safran Letter of Support.pdf
Uploaded by: Dana dsafran Gelb-Safran
Position: FAV

NATIONAL QUALITY FORUM
Driving measurable health improvements together

March 1, 2022

Re: Support for SB 834/HB 1148: Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Honorable Members of the House Health and Government Operations Committee and the Senate Finance Committee,

I am writing to express my strong support for the proposed legislation SB 834/HB 1148 (Health Insurance – Two Sided Arrangements and Capitated Payments). The provisions included in this bill will enable Maryland's value-based payment models to incorporate several highly effective components of payment models implemented in other states and nationally that have, heretofore, not been permitted in Maryland. Based on my experiences both as an architect of value-based payment models and as an evaluator of these models, I firmly believe that the Bill's provisions will support the success of Maryland's payment models in delivering better quality and outcomes while reducing cost and cost growth.

Prior to my role as CEO of the National Quality Forum, I served as Senior Vice President of Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts (BCBSMA), where I was one of the architects of the BCBSMA Alternative Quality Contract (AQC). Launched in 2009, the AQC combines provider accountability for total cost of care, quality, outcomes and patient experience. Its results, published in more than a dozen peer reviewed scientific articles, catalyzed similar payment reform models nationally and internationally. Specifically, through combining provider accountability for a global, population-based budget with a broad set of quality measures, the AQC has driven improved quality and health outcomes, while reducing cost and cost growth for over more than a decade. In addition, within 4 years of its launch, nearly all Massachusetts providers statewide were participating and continue to do so, despite the program being voluntary. The major features of the AQC mirror those provided for in this bill – global budgets balanced with quality measures and significant performance incentives.

In my role as a Commissioner on the Medicare Payment Advisory Commission (MedPAC), I have similarly worked to incorporate the best and most proven features of value-based payment into recommendations for payment reform. And in my roughly two years of experience as a founding executive at Haven, the joint venture of Amazon, JPMorgan Chase and Berkshire Hathaway, I worked to address the significant challenges that purchasers face with health care affordability and the absence of value for the ever-growing share of wallet that health care costs consume. This combination of experiences has shown me that we need a health care system in which financial and clinical goals are aligned. Now, as the CEO of NQF, I am eager to ensure that our nation's portfolio of quality measures is able to deliver on the promise of payment reform – affording reliable and valid measures of health care performance that can be the basis for incentives in innovative payment models. SB 834/HB 1148 will enable Maryland providers and health plans to use the powerful lever of payment reform to those important ends.

Maryland has a strong and proud history of health care leadership. These changes will give providers and health plans critical tools to work together on innovative payment models that can improve the health and wellbeing of Maryland residents while enabling a more sustainable spending growth rate. I urge passage of this bill.

Sincerely yours,

Dana Gelb Safran, Sc.D.
National Quality Forum
President & CEO

UHG Comments on SB834.pdf
Uploaded by: Joseph Winn
Position: FAV

UNITEDHEALTH GROUP

9900 Bren Road East, MN000-T000, Minnetonka, MN 55343

March 9, 2022

Comments in support of Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

UnitedHealth Group is a highly diversified health and well-being company dedicated to helping people live healthier lives and helping to make the health system work better for everyone. In Maryland, UnitedHealth Group employs more than 3,200 people and serves over 810,000 members with a variety of products including Medicare Advantage, Medicare Supplement, Part D, Medicaid and individual and commercial insurance products. These comments on behalf of UnitedHealth Group are to express support for Senate Bill 834.

Senate Bill 834, if enacted, would increase the adoption of voluntary value-based purchasing models that incentivize quality and value while promoting coordinated care and improved outcomes for patients. Maryland currently does not permit providers to engage in risk-based contracts with payers. Senate Bill 834 would provide the necessary reforms to quickly adopt value-based purchasing models that include both upside and downside risk contracts between providers and health insurers and managed care companies.

The transition to value-based models with risk-based contracts is underway across the country. For example, in our care delivery businesses UHG is engaged in 26 risk-based contracts with multiple payers, providing care to patients from more than one hundred health plans, including Medicare, Medicare Advantage, Medicaid, Exchange plans and employer-sponsored plans. The same trend is emergent in private and public coverage as well. For example, our national Medicaid business has value-based contracts with over 284 provider groups with more than ten percent of the claims volume managed through two-side risk arrangements. UnitedHealthcare's commercial business includes approximately 15 percent of spend through downside risk arrangements with more renewals expected to include these value-based purchasing approaches.

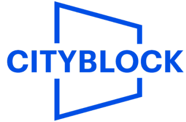
UnitedHealth Group's experience with value-based purchasing models demonstrate that these payment approaches lead to improved health outcomes for our members. In 2019, our commercial value-based contracts out-performed non-value-based contracts leading to 10 percent lower readmissions, 7 percent lower emergency room visits, 34 percent lower out of network laboratory usage and 18 percent lower utilization of out of network specialists. The metrics suggest that they emphasis being placed on provider collaboration and transparency lead to improved outcomes compared to payment models based solely on a fee for service model.

<u>We respectfully request a favorable report on Senate Bill 834.</u>

FINAL_KM Senate Bill 834 Testimony_03 01 22.docx.p

Uploaded by: Kameron Matthews

Position: FAV



CITYBLOCK HEALTH
495 Flatbush Ave Suite 5C
Brooklyn, NY 11225

HB 1148/SB 834 Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

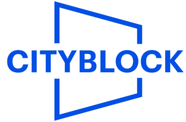
Position: Support

Thank you for the opportunity to provide written comments in support of HB 1148/SB834. At Cityblock Health, we believe health starts in our neighborhoods. That is why we show up for our members with radically better care. We provide integrated physical, mental, and social services to care for the whole self and support individuals in daily life. Through our programs, we have successfully reduced costs, improved individual experience and the quality of care, and transformed the health and quality of life of people in the communities we serve. Improving health equity and reducing health disparities are at the core of our care model and mission as an organization. We currently serve members in Connecticut, Massachusetts, New York, North Carolina and Washington, D.C., and will begin operations in Ohio later this year.

When people think of health, the image of a doctor providing treatment often comes to mind. As a physician, I agree that doctors are essential to keeping our communities healthy. However, being healthy is so much more than going to your doctor to treat disease. At Cityblock Health, we make it our mission to ensure we deliver care that is all-encompassing, including understanding and addressing any social determinants of health and other issues that impede a member's ability to live a healthy life. This comprehensive approach to health and wellness requires multidisciplinary care teams, many of whom may not perform a clinical intervention.

It also requires a payment model that gives providers like Cityblock Health the flexibility to meet the full range of members' needs, focusing on outcomes and value rather than the volume and type of individual services. The traditional fee-for-service model is structured around reimbursement for the volume of clinical services performed. It is not set up to incentivize or compensate providers and care teams for addressing the full range of clinical and non-clinical needs required to achieve long-term, whole-person health – and which is in turn necessary to make strides towards health equity.

In the value-based care models in which we participate, our capitated compensation gives us the flexibility to provide integrated, person-centric care with a focus on value and quality instead of quantity. Unlike traditional fee-for-service models, providers participating in value-based arrangements are incentivized to spend time and resources proactively identifying



CITYBLOCK HEALTH
495 Flatbush Ave Suite 5C
Brooklyn, NY 11225

gaps in care, assessing social risk factors, and addressing social determinants of health. This is because the framework of value-based care is designed to measure success in members' health outcomes.

Cityblock Health's unique value-based care model – underpinned by custom care delivery technology – has significantly improved engagement and health outcomes for our existing members. Data from our first member cohort with complex needs showed a 15% reduction in emergency room visits and a 20% reduction in in-patient hospital admissions.

Cityblock Health enthusiastically supports HB 1134/SB 834 because we know that value-based care works. Many of the members we serve have not only chronic conditions, but also unmet social needs, such as lack of stable housing, inability to consistently access reliable transportation to medical appointments, and food insecurity. At Cityblock Health we treat the whole person, not just their medical conditions. We are able to do this because of the flexibilities offered in our value-based partnerships that fee-for-service reimbursement cannot provide.

I urge a favorable report.

Sincerely,

Kameron Matthews, MD, JD, FAAFP
Chief Health Officer
Cityblock Health

MD SB 834 (2022) VBC Support FIN.pdf
Uploaded by: Kimberly Robinson
Position: FAV

Kimberly Y. Robinson, Esq.
Regulatory & State Government Affairs Director

March 9, 2022

The Honorable Delores Kelley, Chair
Finance Committee
Senate of Maryland3 East Miller Senate Office Building
11 Bladden Street
Annapolis, Maryland 21401

Routing B6LPA
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.907.6396
Kimberly.Robinson@Cigna.com

Submitted electronically

Re Senate Bill SB 834- Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chairwoman Kelley:

Thank you for the opportunity to share Cigna's support for Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization. Cigna appreciates the effort to allow Value Based Care arrangements in Maryland. ***The bill begins the work needed to place Maryland on par with the majority of country and would allow for innovative and modern approaches to reimbursement and collaboration between payers and providers.***

Since the passage of the Affordable Care Act in 2010, there has been increasing focus on reducing health care costs and improving quality and patient experience through value-based reimbursement. Value-based reimbursement pays health care providers based on the quality and efficiency of care delivered rather than the number of services delivered. The industry has made steady progress transitioning to value-based reimbursement models. Payers continue to align more health care spend to value and launch new value-based models designed to support providers' transition to value-based care.

The Department of Health and Human Services (HHS) has been an accelerating force behind the value-based care transition. Several key legislative efforts have reinvigorated and brought health care quality and efficiency efforts to the forefront, beginning with the passage of The Patient Protection and Affordable Care Act (ACA), comprehensive health care reform, in 2010. A key provision of the ACA was to support innovative care delivery models designed to lower health care costs through the establishment of the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The ACA also created a pathway for Medicare to reward providers that lower expenditure growth while achieving quality standards through the Medicare Shared Savings Program (MSSP). In 2015, HHS also put pressure on the industry by releasing their value-based payment goal that 50% of fee for service (FFS) Medicare payments be tied to

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

"alternative payment models" (APMs) and 90% of payments were anticipated to be tied to "value-based arrangements," by the end of 2018.[1]

Cigna believes that value-based relationships with providers are key to continually improving sustainable affordability, quality care and experience. The Cigna Collaborative Care® program is Cigna's set of value-based provider collaboration models aimed at delivering better health, affordability, and customer and provider experience. ***We meet providers where they are in terms of risk readiness, experience, and their own strategic goals, and work with them to help ensure their success in value-based care. We do this through aligned incentives, peer-to-peer consultative support, actionable information, and alignment with our consumer health engagement programs.***

We launched our first value-based care relationship with a large primary care physician group in 2008, and since then have expanded Cigna Collaborative Care to include hospitals and specialty groups. Over the past decade, we have refined our program based on insights from our collaborative providers to better support them and their journey to value-based care, and have launched a payer-agnostic solution to work with independent providers. ***By 2019, over 50% of our payments in our Top 40 markets are in alternative payment models[2] and we established more than 650 commercial value-based arrangements nationwide, with strong results.[3]***

We are building on our success with Cigna Collaborative Care to deliver sustainable affordability and quality, while preserving customer choice and delivering a differentiated customer and provider experience. We are doing this by:

- Continuing to grow and innovate in Cigna Collaborative Care, expanding our model types to address areas of care where medical costs are highest.
- Taking a "whole" person view of the customer by integrating behavioral and pharmacy into value-based models.
- Connecting customers with quality doctors across all network solutions and helping them along their health journey based on their unique needs and preferences.
- Helping providers succeed in value-based care by delivering the right incentives and tools to support care coordination and anticipating and addressing obstacles to good outcomes.
- Delivering more affordable, cost predictable solutions to employers and support a healthier, more productive workforce.

To deliver our vision, we need to support providers to successfully manage the health of their patients, work with employers to guide their customers to value-based providers who are

---

[1] U.S. Department of Health and Human Services, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," News, January 26, 2015. An APM is a payment approach that offers additional incentive payments for high-quality and cost-efficient care

[2] Cigna January 2019 analysis of medical payments in the top 40 US markets as of Q4 2018

[3] Cigna internal analysis of existing arrangements as of April 2019. Subject to change.

delivering good health outcomes, and help customers make informed health care decisions. Together, we can make it easier for customers to access affordable, quality care and promote our collective goal of building a more sustainable health care system.

Passage of SB 834 will facilitate our ability to begin bringing this success to Maryland for patients and providers. ***For these reasons, we urge the committee to give SB 834 a favorable report.***

Sincerely,

Kimberly Y. Robinson

Kimberly Y. Robinson, Esq.
Director, Regulatory and State Government Affairs

cc: Members, Health and Government Operations Committee

DOCS-#225815-v1-VBC_Support_Senate.pdf
Uploaded by: Matthew Celentano
Position: FAV

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

Testimony
for the Senate Finance Committee
In **SUPPORT** of
Senate Bill 834– Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

March 9, 2022

The League of Life and Health Insurers of Maryland Inc. is in strong support of Senate Bill 834 and urges the committee for a favorable report.

As the health care system continues to evolve, it important that the state work towards innovative solutions to save patients money and improve health outcomes. The current antiquated fee-for-service system in Maryland is out of step with much of the rest of the country. Under a value-based care system, like that created with this bill, providers are paid based on the health outcomes of the patients and the quality of their service rather than simply the quantity of services rendered. As a result, patients are rewarded with better outcomes and lower cost treatments.

Value-based care models are successfully promoting better patient health outcomes across the country. 2019 Medicare Shared Savings Program (MSSP) results showed that Accountable Care Organizations (ACOs) with two-sided incentives outperformed ACOs without two-sided incentives, with net per beneficiary savings of $152 compared to $107.[1] Massachusetts' Alternative Quality Contract saved 11.7% in relative savings on claims from 2009-2016. Adult preventive care and pediatric care also improved 1.2% per year more among members in lower socioeconomic areas, reducing health disparities from 2007-2012.[2] In Maryland, two-sided incentive arrangements are already taking place in Medicare Advantage and Medicaid. It is time that these arrangements are allowed in the commercial market.

This bill is an important step in the continued work that carriers and providers do to lower healthcare costs. The bill does not require any provider to enter into a value-based arrangement if they prefer to continue to use the fee-for-service model. In our member's experiences in other

[1] Health Affairs "2019 Medicare Shared Savings Program ACO Performance: Lower Costs And Promising Results Under 'Pathways To Success'" https://www.healthaffairs.org/do/10.1377/forefront.20200914.598838/full/
[2] The New England Journal of Medicine "Health Care Spending, Utilization, and Quality 8 Years into Global Payment" https://www.nejm.org/doi/full/10.1056/NEJMsa1813621

states, this law would contain considerable protections for physicians that other laws do not include. Value-based arrangements offer physicians additional flexibility around the way they provide patient care, as it frees them from a volume-based fee-for-service system that only pays for certain services and can create pressures to increase the volume of patient visits.

Value-based care is not a new concept. League members are at the forefront of these arrangements across the country. Below are some ways that our member companies are utilizing value-based care to improve patient outcomes:

Aetna, a CVS Health Company:

Aetna has more than 2,000 value-based contracts in place, representing more than 50 percent of medical expenditures. At the center of Aetna's value-based care model is a robust, team-oriented approach, often led by the patient's primary care doctor. Patients aren't left to navigate the health care system on their own. The care team is there to support them along their health care journey. Teams are expected to focus on prevention, wellness, strategies and coordination throughout the care continuum, priorities especially important for those managing chronic conditions.

UnitedHealthcare:

Through UnitedHealthcare's value-based partnerships and strong provider relationships, physicians continue to progress toward use of risk-based payment models, including capitation. Today, UnitedHealthcare works with more than 113,000 physicians and 1,200 hospitals in some form of value-based relationship, including more than 1,250 accountable care organizations. The company's collaboration with these providers delivers meaningful results and better health outcomes to more than 17 million members.

Cigna:

Cigna launched their first value-based care relationship with a large primary care physician group in 2008, and since then it has expanded to include hospitals and specialty groups. Over the past decade, Cigna has refined the program based on insights for their collaborative providers to better support them and their journey to value-based care. Today, over 50% of Cigna's payments in the top 40 markets are in alternative payment models, and they have more than 650 commercial value-based arrangements nationwide.

Kaiser Permanente:

Kaiser Permanente's approach to financing and organizing care delivery results in high-quality care and services, and excellent member and population health outcomes, in contrast to the fee-for-service model. In each of their markets, Kaiser Permanente provides care to members and delivers value to communities though distinct but interconnected entities. Under this model, they receive prepayment for each member and then are responsible for their health care. This incentivizes helping members improve their health and stay health – supporting a focus on prevention, health promotion, health maintenance, and effective management of both acute and chronic conditions.

CareFirst:

CareFirst was an early adopter of bonus value-based programs and, working within the confines of existing regulatory requirements, has created several broadly adopted value-based programs, most notably with the launch of its patient-centered medical home over 10 years ago. While these programs have helped create a greater value-oriented mindset within the region, resulting in improved quality and lower costs, their ability to drive continued systemic transformation is limited by the necessity to adhere to strict fee-for-service payment and limit shared financial accountability.

As you can see, value-based care is working across the country to improve health outcomes. This bill provides an important approach to improve healthcare quality, expand access to care, improve affordability, and address equity. For these reasons, the League urges the committee to give Senate Bill 834 a favorable report.

Very truly yours,

Matthew Celentano

Executive Director

cc: Members, Senate Finance Committee

AHIP Comments_MD VBC-SB834_3_8_21.pdf
Uploaded by: Mollie Gelburd
Position: FAV

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

March 8, 2022

Senator Delores Goodwin Kelley
Senate Finance Committee, Chair
Maryland General Assembly
Miller Senate Office Building, 3 East Wing
Annapolis, Maryland 21401

Re: SB 834 Two-Side Incentive Arrangements

Dear Senator Kelley;

On behalf of AHIP and its members, we appreciate the opportunity to provide our input on proposed legislation related to the critical issue of value-based care. AHIP and our members are in full support of SB 834, which updates Maryland's law to provide flexibility when linking provider revenues to improved health outcomes and aligns with other states' current laws.

The health care payment system has historically been based on a fee-for-service model that reimburses providers based on the volume of services that patients receive. In recognition that this model does not promote efficiency, care coordination, or equity, the health care system has been working for more than a decade to advance payment models that instead tie provider reimbursement to the value of services they provide. This movement brings together public and private payers, the physician community, patients, and policymakers who all have a shared interest in leveraging value-based payment models to improve clinical outcomes, while also containing or reducing health care costs.

Studies[i] recognize the critical need to improve health care quality, patient safety, coordination of chronic care, and support of evidence-based medicine. Health insurance providers have long been at the forefront of developing innovative payment arrangements to promote accountable, high-quality care furnished in a cost-effective manner. **Value-based payment arrangements:**

- **Incentivize higher-quality care and improved patient experience;**
- **Promote health equity and reduce disparities by focusing on quality and outcomes;**
- **Increase affordability by emphasizing value, not volume.**

HB 1148 will update Maryland law to permit providers and commercial payers to enter voluntary value-based contracts that encourage accountable, high-quality care using two-sided incentives. Value-based arrangements offer physicians additional flexibility around the way they provide patient care, as it frees them from a volume-based fee-for-service system that only pays for certain services and creates pressure to increase the volume of patient visits. The benefit to patients is an increased focus on high-value services, outcomes, disease management and prevention, care coordination, and affordability. Moreover, the bill includes extensive patient and provider protections.

Physician participation in Accountable Care Organizations (ACOs), which is a type of value-based care model, has increased steadily over time. A study conducted by the American Medical Association showed one-third of physicians (66.8%) participated in at least one value-based contract in 2020[ii], compared to 59.1% in 2016.[iii] Furthermore, participation in value-based models with two-sided incentives has also been increasing: More than half of Medicare Shared Savings Program (MSSP) ACOs (59%) are in a two-sided incentive arrangement in performance year (PY) 2022, an increase from 41% in PY 2021 and from 37% in PY 2020.

The MSSP is the largest and longest running value-based care model in the country. Evaluations of MSSP performance results suggest that ACOs who participated in value-based programs with other payers, in addition to Medicare, were more likely to receive bonuses and generate savings for Medicare.[iv] Specifically, an analysis published in Health Affairs showed:

- Organizations who only participated in Medicare ACO programs received 65% bonus payments and 81% generated savings;
- ACOs who participated in commercial ACO programs in addition to Medicare, 73% received bonuses and 88% achieved savings.
- The effect was further increased if the providers participated in Medicare, Medicaid, and commercial ACO programs: 92% of these ACOs received a bonus payment and 100% generated savings. [v]

The Center for Medicare and Medicaid Innovation Center has also recognized the value of alignment across payers: the Innovation Center recently released a strategic refresh that includes a commitment to multi-payer alignment in value-based payment models. Another predictor for success in the MSSP is the participation in two-sided incentive models: in 2020, 88% of ACOs in two-sided arrangements received shared savings bonuses compared to 55% in one-sided arrangements.[vi]

The Maryland law, as currently written, creates restrictions that impede plan and provider flexibility in creating innovative payment arrangements built on the aforementioned predictors of success. It also impedes the Center for Medicare & Medicaid Innovation Center's stated goal of promoting multi-payer alignment, as commercial plans are restricted from aligning their contracts with Medicare models that entail two-sided incentives.

Maryland is the only state in the nation that prevents payers and providers from partnering into certain types of value-based care arrangements in the commercial market. However, these arrangements are not new in the state, which currently permits them in both the Medicare and Medicaid markets. The Total Cost of Care Model, which has been rightfully hailed as transformative, is a form of a value-based care arrangement. The state should afford commercial payers the same flexibility in undertaking such arrangements with providers.

AHIP members are at the forefront of value-based care as they work hand in hand with employers and providers building progressive networks in which quality and affordability are fundamental and not in opposition with each other. For these reasons, AHIP and its members advocate for the passage of SB 834.

Thank you for the opportunity to provide feedback on this legislation. If you have any questions or concerns regarding our feedback and would like to discuss the matter further, please contact me at khathaway@ahip.org or by phone at (202)-870-4468.

Sincerely,

Kris Hathaway
Vice President, State Affairs
America's Health Insurance Plans

America's Health Insurance Plans (AHIP) is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

---

[i] Studies for review:

- Better Medicare Alliance, "State of Medicare Advantage Report". May 2021
- National Academy of Medicine. "Priorities in Advancing High Quality Value-Based Health & Health Care", May 2021
- Commonwealth Fund Task Force on Payment and Delivery System Reform, "Health Care Delivery System Reform: Six Policy Imperatives", November 2020

[ii] Apoorva Rama, PhD, "Payment and Delivery in 2020: Fee-for-Service Revenue Remains Stable While Participation Shifts in Accountable Care Organizations During the Pandemic," AMA; available from: https://www.ama-assn.org/system/files/2020-prp-payment-and-delivery.pdf

[iii] Apoorva Rama, PhD, "Payment and Delivery in 2016: The Prevalence of Medical Homes, Accountable Care Organizations, and Payment Methods Reported by Physicians," AMA; available from: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/prp-medical-home-aco-payment.pdf.

[iv] Mark McClellan, et al. The Medicare Shared Savings Program In 2020: Positive Movement (And Uncertainty) During A Pandemic, Health Affairs (Oct. 14, 2021).

[v] Ibid.

[vi] Ibid.

2022 SB834 - Health Insurance - Two-Sided Incentiv

Uploaded by: Neil Meltzer

Position: FAV

CARE BRAVELY

SB834 – Health Insurance – Two-Sided Incentive Arrangements & Capitated Payments – Authorization – March 9
Senate Finance Committee
Testimony of Neil Meltzer, President and Chief Executive Officer, LifeBridge Health and David Krajewski, Executive Vice President & Chief Financial Officer, LifeBridge Health
Position: **SUPPORT**

We are writing in SUPPORT of SB834 - Health Insurance – Two-Sided Incentive Arrangements & Capitated Payments – Authorization. LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, an independent academic medical center; Levindale Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County, and; Grace Medical Center in Baltimore (formerly Bon Secours Hospital).

SB824 expands voluntary contracting options between provider organizations and health plans for commercial populations in Maryland. As Maryland leads the nation in innovation in health care, this bill moves us one step forward in enabling the full transition from volume-based service payment incentives to value-based care for patients. Maryland's Total Cost of Care Model already promotes value-based care, and given our historic focus at LifeBridge on addressing social determinants of health in creative ways, LifeBridge Health supports the expansion of value-based contracting arrangements provided in this bill to allow us to continue to both incentivize and reward high-quality, efficient, and transformative care delivery to all our communities.

Rewarding health care practitioners leads to improved health outcomes and the overall enhanced patient experience. We have already seen the benefit of this process and support this bill as an even greater "push" toward additional innovation among providers, practitioners and health insurers. We believe this legislation supporting value-based care will promote even greater innovation between providers and health insurers, leading to more effective and efficient care delivery that will in turn help the health care system address disparities and access challenges.

For all the above stated reasons, we request a **FAVORABLE** report for SB834.

Contact: Martha D. Nathanson, Esq.
Vice President, Government Relations & Community Development
mnathans@lifebridgehealth.org
Mobile: 443-286-4812

SB 834 - Health Insurance-Two-Sided Incentive Arra

Uploaded by: Pegeen A. Townsend

Position: FAV

MedStar Health

10980 Grantchester Way
Columbia, MD 21044
410-772-6500 PHONE
410-772-6929 FAX

Debi Kuchka-Craig
Senior Vice President, Managed Care

MedStarHealth.org

March 9, 2022

To: The Honorable Delores G. Kelley
Chair, Senate Finance Committee

Re: **Letter of Support**: SB 834 – Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chair Kelley:

On behalf of MedStar Health, I am writing in support of ***SB 834 – Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments- Authorization,*** which intends to expand voluntary contracting options between provider organizations and health plans for commercial populations in Maryland. MedStar Health has engaged in multiple value-based contracting arrangements for over a decade and continues to believe these arrangements incent and reward high-quality, efficient, and transformative care delivery.

We work closely with the insurance health plans to design creative approaches that will improve the healthcare experience for the patients we serve. MedStar Health believes the proposed value-based legislation will promote even greater innovation between providers and health insurers, which is needed given the significant challenges facing the healthcare industry today.

MedStar Health actively participated in discussions with the Maryland Hospital Association, MedChi, CareFirst, other health systems, and independent provider groups to address stakeholder concerns surrounding this concept. Our efforts have resulted in proposed legislation that allows for creative arrangements between provider organizations and health plans, while also providing needed guardrails for risk protection and transparency.

MedStar Health will continue to work to transform healthcare delivery to better serve our patients. With experience in alternative payment methodologies, shared savings program participation, and various population health management initiatives, MedStar Health welcomes the continued expansion of voluntary value-based arrangements in Maryland.

For these reasons, we urge a *favorable* report on SB 834.

Sincerely,

Debora Kuchka-Craig

Debi Kuchka-Craig, FHFMA, MHS
Senior Vice President, Managed Care

cc: Members, Senate Finance Committee
David A. Smulski, Staff

Knowledge and Compassion
Focused on You

Privia Letter of support updated.pdf

Uploaded by: Sam Starbuck

Position: FAV

PRIVIA
MEDICAL GROUP
Mid-Atlantic

Privia Medical Group – Mid-Atlantic
950 N. Glebe Road, Suite 700
Arlington, Virginia 22203

HB 1148/SB 834 Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments -Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of this bill that expands options for physician groups to contract with health insurers for commercial populations in Maryland. We support this bill.

Privia Health ("Privia") is a national physician-focused-organization with more than 90 Privia group practices that represent over 400 physicians and providers in Maryland and Washington DC. Privia operates in five additional states with more than 350 group practices and over 2,300 physicians and providers. Collectively, we deliver healthcare to more than 3 million Americans, including more than 700,000 seniors over the age of 65. We are committed to transforming the healthcare delivery experience for providers and consumers. Privia supports the proposed legislation to broaden voluntary contracting options for the financing of healthcare delivery. We have demonstrated great success in improving outcomes for Medicare beneficiaries through the use of two-sided incentive models and would like to have the option to contract for these models in the commercial sector as well.

The COVID-19 pandemic has brought to light the significant challenges of fee-for-service primary care and the need to transition to a value-based system where payment is made at predictable intervals (such as a per-member, per-month payment) and based on improved health outcomes, instead of volume of visits. Privia and our physicians would like to have the option to contract in capitated primary care models in the future that offer greater flexibility and financial sustainability. We believe the removal of the legal barriers identified in the bill can enable us to best care for our unique patient population with predictable and stable payments.

Additionally, effective population health management in these models requires timely and transparent data. We support the provision in this law that makes quality and cost information transparent to providers in value-based contracts with payers.

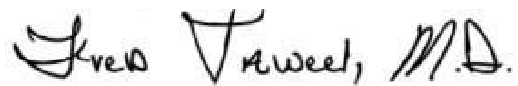
Two-sided incentive and capitated arrangements are not new. National payers and federal and state governments are aggressively pursuing these programs. For example, the Centers for Medicare and Medicaid Services (CMS) overhauled the Medicare Shared Savings Program (MSSP) in 2018 to accelerate Medicare ACOs toward two-sided incentives – now nearly 41% of Medicare ACOs feature shared risk and more are expected to join in the coming years. These arrangements hold the promise to improve quality, outcomes, equity, access, and affordability for patients and communities. Privia is proud to have a demonstrated track record of success in these models.

Privia strongly supports the policy goals advanced by this bill. These necessary changes will give providers and insurers the options to voluntarily work together on innovative initiatives that can improve the health and wellbeing of the Maryland residents we collectively serve. We look forward to partnering with legislators and other stakeholders in transforming healthcare for the better in Maryland.

We urge a favorable report.

Privia Medical Group – Mid-Atlantic
950 N. Glebe Road, Suite 700
Arlington, Virginia 22203

Market President, Mid-Atlantic



Fred Taweel, MD
CMO and Chairman of the Board of Governors,
PMG Mid-Atlantic

Trusted Doctors - Sandy Chung Testimony.pdf
Uploaded by: Sandy Chung
Position: FAV

HB 1148/SB 834 Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of this legislation. My name is Sandy Chung. I am a board-certified pediatrician and am CEO of Trusted Doctors, a large practice with 120 pediatric providers and 22 locations. At Trusted Doctors, we provide nationally recognized patient-centered pediatric care to Maryland's youngest residents in Frederick County. On behalf of Trusted Doctors, I would like to express our support for HB 1148/SB 834. This bill would enable us to enter into capitation arrangements and two-sided incentive contracts with commercial health insurers, thus increasing the level of coordinated care we can offer, which for vulnerable populations such as children, is key to delivering high quality care.

In addition to my roles named above, I am also CEO of Health Connect IPA, a clinically integrated network of internal medicine, family medicine, and pediatrics, which has been delivering over a decade of value-based care for adults and children. Additionally, I am a member of a large health insurer's soon to be first pediatric only accountable care organization for value-based care. These experiences have informed my deep understanding of value-based reimbursement models and are among the reasons I ardently support Maryland joining the rest of the nation in transiting from fee-for-service payment to value-based care. A patient's insurance type should not exclude them from benefiting from the improved health outcomes and reduced costs that result when health plans and health care providers create value-based care partnerships.

Unlike fee-for-service models that pay for volume of services, value-based payment allows us as pediatricians to make the necessary investments in prevention, health promotion, and the overall well-being of the children we serve because the reimbursement structure is built around a holistic framework for health.

On behalf of Trusted Doctors, I strongly urge you to support this legislation.

Sandy L. Chung, MD, FAAP, FACHE
CEO
Trusted Doctors
MD: 1475 Taney Avenue, Suite 201 and 202, Frederick, MD 21702
VA: 13135 Lee Jackson Memorial Hwy, Suite 201, Fairfax, VA 22033

SB 834 Aledade.pdf
Uploaded by: Sean Cavanaugh
Position: FAV

Sean Cavanaugh
Chief Commercial Officer
Chief Policy Officer
Aledade, Inc.
4550 Montgomery Ave., Suite 950N
Bethesda, MD 20814

March 8, 2022

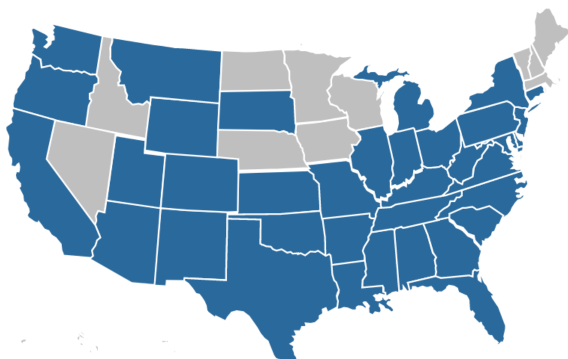
To Whom it May Concern:

Aledade is pleased to support SB 834 Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization.

Aledade supports this bill because we know that value-based care works. Today, we partner with primary care practices in 37 states and have entered into successful two-sided risk sharing arrangements in many of those states. We support this legislation because it will help Maryland continue to progress toward a higher performing health system; the legislation includes important protections for physician practices including the requirement that these arrangements be truly voluntary; and, when these value-based arrangements are properly structured, they are good for patients, good for physicians, and good for society. **We are not aware of any other state that prohibits this type of partnership between willing physician groups and a health plan.**

Who we are:

Aledade is building a movement of independent physicians by aligning financial models with patient outcomes.



- 37 States
- 38 MSSP ACOs
- 98 Medicare & 47 Other Value-Based Care Partnerships
- 1K+ Independent Practices
- 11.9K+ Clinicians
- 752k MSSP patients, 1.7M+ total patients
- 90+ Electronic Health Records & Practice Management Systems
- $17+ Billion Under Management

Aledade was founded in 2014 and is headquartered in Bethesda, Maryland. In Maryland, we partner with 38 physician-led, independent primary care practices in the state, with more than 120 primary care clinicians who care for more than 26,000 attributed patients in an Enhanced Track (2-sided risk) Medicare Shared Savings Plan ACO.

Aledade participates as a Care Transformation Organization with the Maryland Primary Care Program (MDPCP) operated in Maryland by the Center for Medicare and Medicaid Innovation (CMMI) and the Maryland Department of Health. Aledade provides technology, analytics, and an interdisciplinary care team to 14 primary care practices who have 11,000 attributed Medicare beneficiaries.

But we are a national company. Across 37 states, Aledade partners with more than 1000 primary care physician practices, Federally Qualified Health Centers, and Rural Health Centers in value-based health care. Aledade does not own or build practices–we partner with these primary care practices to help them succeed in value-based care. By doing this, we are providing a new pathway to preserve independent primary care practices in Maryland and throughout the country. We are committed to outcome-based payment models to improve the value of health care delivered to Medicare beneficiaries and other Americans.

The physician practices we partner with are accountable for the quality and total cost of care for more than 1.8 million lives. Nearly half of those lives are in the Medicare Shared Savings Program (MSSP), but we also have value-based contracts with commercial health plans, Medicare Advantage organizations, and Medicaid managed care organizations.

A few more facts about Aledade and the practices we partner with:

- More than half of our primary care providers are in practices with fewer than 10 clinicians.
- More than 65% of our practices are in a federally-designated Primary Care Health Professional Shortage Area and nearly half are in a Medically Underserved Area.
- We have significant experience in two-sided (upside/downside) risk:
    - Medicare Shared Savings Program (Traditional Medicare): 38 ACOs, all 2-sided risk
    - Medicare Advantage: 25 ACOs are in two-sided risk
    - Commercial: 19 ACOs are in two-sided risk
    - Medicaid: 6 ACOs are in two-sided risk

Value-based care works

Value-based care is a way to structure payment away from rewarding the volume of services delivered and instead rewarding things that matter such as the quality of care delivered, clinical outcomes, and patient experience.

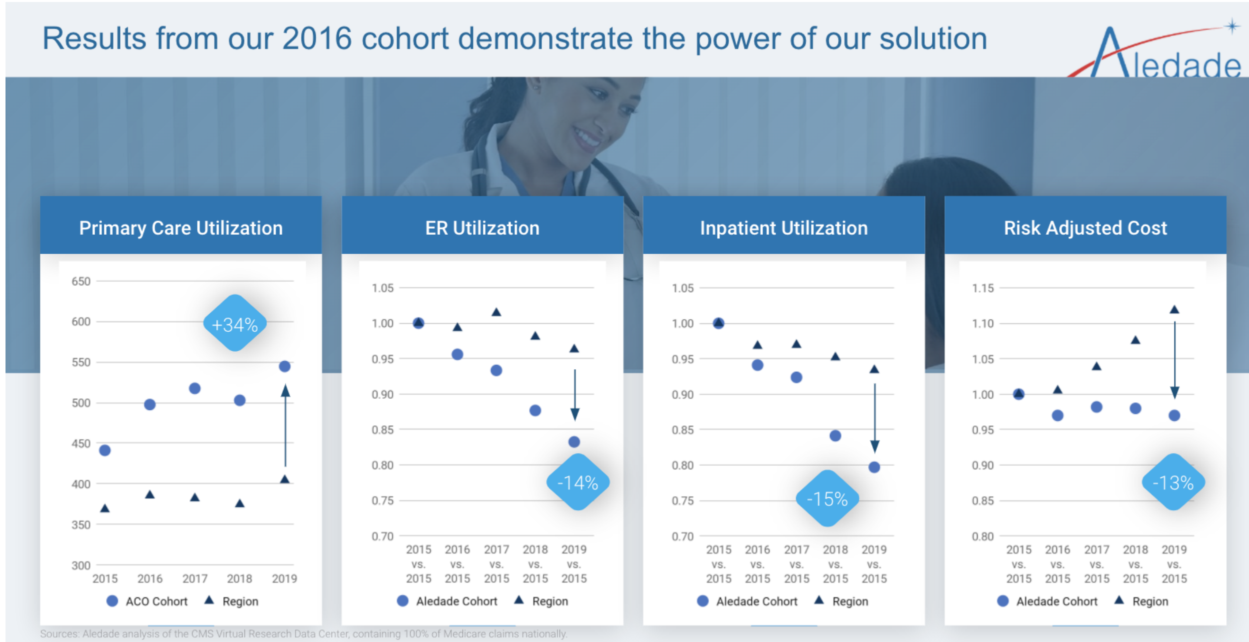
In 2020, despite the turmoil of the COVID pandemic, 92% of Aledade Medicare Shared Savings Program ACOs achieved savings, reducing the total cost of care by 7.4 percent and saving Medicare $315 million. For their success and work in providing care to over 400,000 Medicare patients,

Aledade practices shared in over $93 million. Practices working with Aledade experience an average increase of 20-30% in Medicare revenue from participating in MSSP; our most mature practices have seen an increase of 50% or higher. And that's just Medicare. Our practices want to transform care for all of their patients and that increases their savings opportunities.

These savings come from real improvements in health care. Using objective, publicly available data from Medicare, a retrospective study of a cohort of 5 Aledade ACOs in disparate states including Louisiana, Kansas, West VA, Mississippi, and Florida:

- Prevented 10,917 unnecessary hospitalizations (20% below the cohort's historical baseline, and 15% better than the region's 4-year trend)
- Prevented 19,338 unnecessary emergency department visits (17% below the baseline and 14% better than the four year regional trend)
- Prevented 8,859 unnecessary skilled nursing facility visits (27% below the cohort's historical baseline, and 18% better than the region's 4-year trend) compared with the region)
- The cohort's risk-adjusted costs were 13% lower than the region's.

These results were generated by increasing Medicare beneficiaries' access to primary care. These ACOs provided 265% more annual wellness visits in 2019 compared to similar practices in their communities.



This legislation will advance value-based care

Aledade works with all the major national health plans and dozens of Blue Cross plans. Our experience is that these plans often offer a variety of value-based contracts, with varying levels of risk sharing depending on the capabilities of a practice and their risk tolerance. We favor the ability of health plans in Maryland to offer two-sided risk models because we know this means that some plans will offer higher upside opportunities to our practices.

We also acknowledge that the health plans and the physician groups in Maryland have worked for months to improve the original version of this legislation. We believe the latest version nicely balances the legitimate concerns with physicians, especially ensuring that these arrangements are voluntary, while still allowing appropriate levels of risk sharing that can incentivize better care at lower cost.

Our nationwide network of hundreds of primary care practices has proven across states and across payers that you can reduce spending in health care and you can do it the right way: by helping patients stay healthy rather than waiting for them to get sick. We're excited to keep accelerating this success by moving Aledade ACOs into more advanced two-sided risk models, in which our partner physicians can be rewarded for their exceptional care.

We urge the Maryland General Assembly to pass SB 834, to align Maryland with the many other states we do business in and allow Maryland providers the opportunity to partner with innovative organizations like Aledade to enter into payment arrangements that simultaneously improve patient care and lower health care costs.

Thank you for the opportunity to share our experience and our support of this legislation.

Sean Cavanaugh
Chief Commercial Officer & Chief Policy Officer
sean@aledade.com

2022 Testimony - Favorable with Amendment - Senate

Uploaded by: Barbara Brocato

Position: FWA

BROCATO & SHATTUCK

Date: Wednesday, March 9, 2022
Committee: Senate Finance Committee
The Honorable Delores Kelley, Chair
Bill: Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization
Position: **Favorable with Amendment**

On behalf of our clients: the Maryland Society of Anesthesiologists (MSA); US Acute Care Solutions (USACS); US Anesthesia Partners (USAP); and the Maryland Society of Otolaryngology (MSO) we support the need for innovation, improved efficiency, and improving the quality of patient care. With the advance of new models of care, physicians need adequate safeguards and guardrails within these models to ensure continued access to high quality and equitable care for all Marylanders. While we support many of the provisions of Senate Bill 834, **we urge the passage of a critically essential amendment that provides protection for physicians who treat a patient who is part of a 2-sided risk model, but the physician is not a direct participant in the 2-sided risk model.**

Over the past year, the Medical Society, the Maryland Hospital Association and CareFirst have worked together to develop mutually agreeable safeguards and guardrails for providers who voluntarily agree to participate in a 2-sided risk arrangement. However, CareFirst refused to include safeguards and guardrails for other providers who will be impacted by the 2-sided risk arrangement – all those caring for patients included in the targeted budget. These providers fees (e.g., family physicians, internists, hospital-based physicians, physical therapists) have a direct impact on whether the physician in a 2-sided risk arrangement receives a bonus or must pay money back to the carrier.

This introduces a new dynamic into the insurance marketplace at a time when physicians and other health care practitioners are continuing to grapple with implications from Covid-19 related practice changes. Maryland has an extensive history and track record of advancing innovation and addressing barriers to care. However, the health care delivery landscape and patient access to care has never been at a more pivotal juncture.

Many studies have documented the low physician reimbursement rate in Maryland when compared to the national average. In 2017, commercial reimbursement for physician services averaged 122% for the U.S. but only 104% in Maryland.1 In 2019, commercial reimbursement was about 103% of Medicare in Maryland.2 These low reimbursement rates mean physicians in Maryland earn less than their national counterparts.3

---

[1] See https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices
[2] See https://mhcc.maryland.gov/mhcc/pages/home/commissioners/documents/20201119/Ag6_Pymt_for_Professional_Services_in_Maryland_2019.pdf
[3] See https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/MerrittHawkins_2018_MedChi_Survey.pdf

200 DUKE OF GLOUCESTER STREET * ANNAPOLIS, MARYLAND 21401
P: 410-269-1503 * F: 410-269-5021 * BARBARA@BMBASSOC.COM

We all agree there is room to improve the health care delivery system to ensure access to high quality, equitable care for all Marylanders. However, we need to protect against the unintended consequence that physicians will not come to Maryland because reimbursement levels fall dangerously below what can be earned in other states. Such an outcome would place the health of all Marylanders at risk.

To be sure this bill delivers on its promise of improving access to high quality, equitable health care and does not result in physician shortages, we urge you to adopt the amendment below.

Amendment: 15-113 (c)

5. A CARRIER MAY NOT REDUCE THE FEE SCHEDULE OF A:

(I) HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS **BASED WHOLLY OR IN PART** ON THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS **NON-PARTICIPATION** IN THE CARRIER'S BONUS OR OTHER INCENTIVE–BASED COMPENSATION OR TWO–SIDED INCENTIVE ARRANGEMENT PROGRAM; OR

(II) HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS BASED WHOLLY OR IN PART ON THE HEALTH CARE PRACTITIONER'S OR SET OF HEALTH CARE PRACTITIONER'S PERFORMANCE UNDER AN ELIGIBLE PROVIDER'S TWO–SIDED INCENTIVE ARRANGEMENT WITH THE CARRIER.

6. PARTICIPATION IN A TWO-SIDED INCENTIVE ARRANGEMENT MAY NOT BE THE SOLE OPPORTUNITY FOR A HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS TO BE ELIGIBLE TO RECEIVE INCREASES IN REIMBURSEMENT. (*already accepted by carriers*)

We request that you pass this bill only if it includes the amendment to provide safeguards and guardrails for all providers.

For these reasons we ask for a **Favorable report on Senate Bill 834 with this amendment**.

For more information:

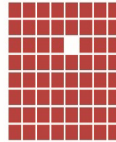
Barbara Brocato – barbara@bmbassoc.com
Dan Shattuck – dans@bmbassoc.com

SB0834_FWA_MDAFP, MDACEP, MDAAP_HI - Two-Sided Inc

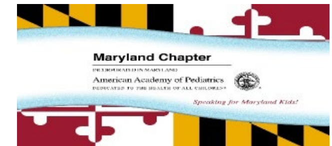
Uploaded by: Danna Kauffman

Position: FWA

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: mdacep@aol.com
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS



TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Pamela Beidle

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: March 9, 2022

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 834 – *Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization*

The Maryland Academy of Family Physicians, the Maryland Chapter of the American College of Emergency Physicians, and the Maryland Chapter of the American Academy of Pediatrics **supports with amendment** Senate Bill 834. Senate Bill 834 changes the scope of the payment and care delivery landscape in Maryland by authorizing two-sided incentive arrangements. The bill also permits capitation arrangements for self-funded group health insurance plans.

Under a two-sided incentive arrangement, a carrier may enter into a contract with a physician that allows a physician to receive a bonus payment (currently allowed under Maryland law) but also subjects the physician to the recoupment of funds. Arrangements such as these have been prohibited in Maryland because they have been determined to be the "practice of insurance." Up until this bill, the practice of insurance has been rightfully left to the insurance carriers. Whereas the main responsibility of an insurance carrier is to manage risk, the main responsibility of a physician is to manage a patient's health care needs. Yet this bill puts the physician in the position of managing risk.

Therefore, if Maryland is to enact this legislation, it is imperative that adequate protections are in place for both the physicians that want to enter into these arrangements and those that do not. Both are equally important. As currently drafted, we believe that the protections outlined in the bill requiring minimum contract standards for entering into a two-sided incentive arrangement will assist in ensuring that physicians have a fair starting point for negotiating such agreements. However, we remain concerned that the protections for those physicians that do not want to enter into such arrangements are not adequate, especially as it relates to ensuring that an insurance carrier cannot reduce a physician's fee structure for non-participation in a two-sided arrangement. While we recognize that the bill states that such arrangements are "voluntary," the reality of the situation is that physicians rarely have equal negotiating power, especially when one carrier controls the majority of the market. As such, we support strengthening this provision to remove the term "solely" and replace it with "wholly or in part"; to add protections for those physicians that may not contract directly with a carrier under a two-sided incentive arrangement but may still be otherwise affected; and to include language stating that there must be other opportunities for reimbursement increases that do not include entering into a two-sided incentive arrangement. With this change, which we consider paramount to the legislation, we urge a favorable vote on Senate Bill 834.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone
410-244-7000

SB0834_FWA_MedChi_HI - Two-Sided Incentive Arrange

Uploaded by: Gene Ransom

Position: FWA

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 834 – *Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization*

Dear Chair Kelley:

On behalf of the Maryland State Medical Society (MedChi), the largest physician organization in Maryland, we support with amendments *Senate Bill 834: Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization*. At your request and that of Senator Beidle and the Senate Finance Committee, MedChi has diligently been working over the last year to reach consensus with CareFirst, the Maryland Hospital Association, and other insurance carriers to authorize two-sided incentive arrangements between physicians and insurance carriers, a practice currently prohibited in Maryland. From April 13, 2021 - February 7, 2022, twenty-seven (27) meetings occurred between the three organizations. MedChi also convened a special Physicians Task Force and included all physician specialty societies to participate and provide feedback on the proposal.

A two-sided incentive arrangement allows a physician to contract with an insurance carrier to earn bonus payments, but it also subjects physicians to recoupment of funds. While this has been characterized as “value-based,” the reality is that physicians are accepting risk and thus these arrangements have always been deemed the “practice of insurance” in Maryland. Physicians are in the business of providing medical care to patients. That is what they learn in medical school. There are no classes provided on managing or accepting risk; that has UNTIL NOW been left to insurance companies. Senate Bill 834 is a clear shift in the delivery of health care in Maryland and, if Maryland is to authorize this shift, it must be done carefully to ensure that both physician practices and patients are not unknowingly placed in jeopardy.

Throughout our negotiations, we have been pleased with the progress made in crafting Senate Bill 834. Senate Bill 834 recognizes both sides of the spectrum – physicians who want to enter into two-sided incentive arrangements and those who do not. Given the complexity of these arrangements, not every physician is well-suited to accepting risk, especially smaller practices that you may find in more rural areas of the State. And, even for those that may want to take part in such contracts, it is important to ensure that the terms are just and fair, especially given that physician offices do not have the staff and resources afforded to insurance companies to properly analyze them for fairness and to ensure that the physician won’t be inappropriately penalized.

Therefore, Senate Bill 834 seeks to accomplish two goals. The first goal is to provide adequate safeguards for physicians that ultimately decide to enter into these arrangements. Senate

Bill 834 contains minimum requirements for what must be included in a contract between an insurance carrier and a physician practice. These safeguards include limiting recoupment to not more than 50% of the excess above the mutually agreed on target budget and specifying a mutually agreed on maximum liability for total recoupment that may not exceed 10% of the annual payments from the insurance carrier to the physician practice.

The second goal is to provide adequate safeguards for physicians that do not want to participate in two-sided incentive arrangements but want to remain fee-for-service. While we acknowledge that Senate Bill 834 states that acceptance of a two-sided incentive arrangement is "voluntary," this is simply not strong enough language. Physicians are always at a disadvantage when negotiating with insurance carriers. Insurance carriers may argue that they "need" physicians to ensure network adequacy standards, but the reality is that insurance coverage in Maryland is operated as a monopoly with one insurance carrier representing the vast majority of the market. If physicians do not want to place their own patients in harm's way or want to maintain physician-patient relations, physicians must contract, often to their disadvantage.

It is easy to say that these arrangements are voluntary, but there are ways to pressure physicians to ultimately need to accept these arrangements simply to stay in business. We are disappointed that we have come so far but have not had a "meeting of the minds" on this issue. From the beginning, MedChi has stated that protections for physicians was our paramount concern and that a "floor" must be established to ensure that payment rates could not be reduced for non-participation. Even when this issue was not agreed upon early on, MedChi continued to negotiate in good faith.

The language in the bill (page 8, lines 5-10) is not acceptable. Using the term "solely" negates all protections for physicians and renders the language useless. Insurance carriers may argue that Senate Bill 834 should not be changing fee-for-serve standards, but the reality is that the inclusion of two-sided incentive arrangements forever changes both the delivery of care and payment standards. One simply cannot be separated from the other. In addition, the notion that physicians will be subjecting insurance carriers to constant complaints before the Maryland Insurance Administration (MIA) is also without merit. Physicians can file complaints now with the MIA and don't at any significant rate. They are too busy caring for patients, often despite insurance carrier's policies. Lastly, while we fully support the 10-year study by the Maryland Health Care Commission, it is not a substitute for clear and strong language supporting the concept of "voluntary." The study is after the fact. Physicians need reassurance during the negotiation stage.

Therefore, MedChi has proposed the following substitute language:

15-113 (c)

5. A CARRIER MAY NOT REDUCE THE FEE SCHEDULE OF A:

(I) HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS BASED WHOLLY OR IN PART ON THE HEALTH CARE PRACTITIONER OR SET OF HEALTH CARE PRACTITIONERS NON-

PARTICIPATION IN THE CARRIER'S BONUS OR OTHER INCENTIVE–BASED COMPENSATION OR TWO–SIDED INCENTIVE ARRANGEMENT PROGRAM; OR

(II) HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS BASED WHOLLY OR IN PART ON THE HEALTH CARE PRACTITIONER'S OR SET OF HEALTH CARE PRACTITIONER'S PERFORMANCE UNDER AN ELIGIBLE PROVIDER'S TWO–SIDED INCENTIVE ARRANGEMENT WITH THE CARRIER.

6. PARTICIPATION IN A TWO-SIDED INCENTIVE ARRANGEMENT MAY NOT BE THE SOLE OPPORTUNITY FOR A HEALTH CARE PRACTITIONER OR A SET OF HEALTH CARE PRACTITIONERS TO BE ELIGIBLE TO RECEIVE INCREASES IN REIMBURSEMENT. (*already accepted by carriers*)

With this language, MedChi believes that Senate Bill 834 can move forward and that both physicians that want to participate and those that do not want to participate will have the needed protections. With this change and <u>only with this change</u> do we urge a favorable vote on Senate Bill 834.

Sincerely,

Gene M. Ransom, III
Chief Executive Officer
MedChi, The Maryland State Medical Society

SB834-CBH-FWA.pdf

Uploaded by: Lauren Grimes

Position: FWA

Testimony on SB 834
Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments - Authorization
Senate Finance Committee
March 9, 2022
POSITION: SUPPORT WITH AMENDMENTS

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 95 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

While reimbursement mechanisms are not inherently good or bad, they can and do impact provider behavior through incentives and disincentives. The fee-for-service system rewards volume; the more services provided, the more revenue generated. It does not reward the achievement of outcomes, nor does it allow for flexibility beyond the strict confines of the covered billing codes.

SB 834 would allow providers to enter into capitated and two-sided risk arrangements with commercial carriers. We have long supported value-based payment arrangements that reward us, not for volume, but for the actual results the individuals we serve experience. We are confident that the treatment and supports we provide lead to better health outcomes for those we serve and feel that it is in the best interests of consumers, providers, and payers to be measured on our results.

Another advantage that these arrangements have over fee-for-service is that they allow provider flexibility to meet the individual needs of the persons served. Behavioral health conditions often wax and wane, as individuals recover or relapse, requiring more intensive supports and services or less frequent or intensive interventions. Fee-for-service demands that we either provide a certain volume of services or face the financial impact of declining reimbursement. We prefer to tailor the frequency and intensity of our interventions to meet the needs of each individual we serve.

Capitation is not new to behavioral health. There have been two long-term Medicaid capitation programs operating in Baltimore city that have shown remarkable results for high-cost and high-risk individuals with serious mental illness. Many of these individuals have co-occurring substance use or somatic disorders as well. The capitated payments allow these providers to do what it takes to support their members. And if the programs meet their contractual outcomes and are able to operate within the capitated amount, those savings can be reinvested in their services and workforce.

CBH has worked with CareFirst representatives on amendment language to clarify that networks of behavioral health programs licensed under Health-General § 7.5-401 are eligible to enter into capitated and two-sided risk arrangements with commercial carriers. This is important since our provider network is comprised of licensed programs that employ clinicians and other behavioral health professionals.

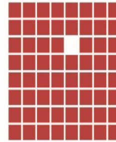
We urge a favorable report on SB 834 with the inclusion of that language.

For more information contact Lori Doyle, Public Policy Director, at (410) 456-1127 or lori@mdcbh.org.

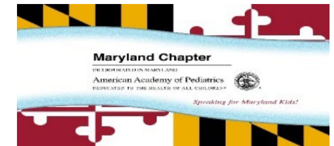
SB0834_FWA_MDAFP, MDACEP, MDAAP_HI - Two-Sided Inc

Uploaded by: Pam Kasemeyer
Position: FWA

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: mdacep@aol.com
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS



TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Pamela Beidle

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: March 9, 2022

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 834 – *Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization*

The Maryland Academy of Family Physicians, the Maryland Chapter of the American College of Emergency Physicians, and the Maryland Chapter of the American Academy of Pediatrics **supports with amendment** Senate Bill 834. Senate Bill 834 changes the scope of the payment and care delivery landscape in Maryland by authorizing two-sided incentive arrangements. The bill also permits capitation arrangements for self-funded group health insurance plans.

Under a two-sided incentive arrangement, a carrier may enter into a contract with a physician that allows a physician to receive a bonus payment (currently allowed under Maryland law) but also subjects the physician to the recoupment of funds. Arrangements such as these have been prohibited in Maryland because they have been determined to be the "practice of insurance." Up until this bill, the practice of insurance has been rightfully left to the insurance carriers. Whereas the main responsibility of an insurance carrier is to manage risk, the main responsibility of a physician is to manage a patient's health care needs. Yet this bill puts the physician in the position of managing risk.

Therefore, if Maryland is to enact this legislation, it is imperative that adequate protections are in place for both the physicians that want to enter into these arrangements and those that do not. Both are equally important. As currently drafted, we believe that the protections outlined in the bill requiring minimum contract standards for entering into a two-sided incentive arrangement will assist in ensuring that physicians have a fair starting point for negotiating such agreements. However, we remain concerned that the protections for those physicians that do not want to enter into such arrangements are not adequate, especially as it relates to ensuring that an insurance carrier cannot reduce a physician's fee structure for non-participation in a two-sided arrangement. While we recognize that the bill states that such arrangements are "voluntary," the reality of the situation is that physicians rarely have equal negotiating power, especially when one carrier controls the majority of the market. As such, we support strengthening this provision to remove the term "solely" and replace it with "wholly or in part"; to add protections for those physicians that may not contract directly with a carrier under a two-sided incentive arrangement but may still be otherwise affected; and to include language stating that there must be other opportunities for reimbursement increases that do not include entering into a two-sided incentive arrangement. With this change, which we consider paramount to the legislation, we urge a favorable vote on Senate Bill 834.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone
410-244-7000

SB 834 Amendment 20220308_16343674.pdf

Uploaded by: Pamela Beidle

Position: FWA

SB0834/873524/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

01 MAR 22
16:17:07

BY: Senator Beidle
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 834
(First Reading File Bill)

On page 6, in line 19, after "**COMMISSION**" insert "**, INCLUDING A NETWORK OF BEHAVIORAL HEALTH CARE PROGRAMS LICENSED UNDER § 7.5–401 OF THE HEALTH – GENERAL ARTICLE**".

SB 834 Testimony20220308_16340091.pdf
Uploaded by: Pamela Beidle
Position: FWA

Pamela G. Beidle
Legislative District 32
Anne Arundel County

Finance Committee

Vice Chair
Executive Nominations Committee

James Senate Office Building
11 Bladen Street, Room 202
Annapolis, Maryland 21401
410-841-3593 · 301-858-3593
800-492-7122 *Ext.* 3593
Pamela.Beidle@senate.state.md.us

THE SENATE OF MARYLAND
Annapolis, Maryland 21401

March 1, 2022

SB 834
Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization

Good Afternoon Chair Kelley, Vice Chair Feldman and Members of the Committee;

Thank you for the opportunity to present SB 834, Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization.

There is a national movement in health care away from fee-for-service payment, where the focus is on high-volume care, and towards value-based care that puts patients' needs and their health outcomes at the center of care delivery. When providers are engaged in value-based partnerships, their success and financial incentives depend on improving patients' health, not just if they received a medical service. Providers in value-based partnerships are empowered to address their patients' care needs holistically by focusing on coordinated care that proactively identifies gaps in treatment and social risk factors. These are core elements to a healthy life but are repeatedly overlooked in a fee-for-service relationship when the economic incentives are not tied to health outcomes. The framework **encourages providers to address health equity, social determinants of health, and improve the patient experience**.

However, Marylanders are not able to benefit from the improved quality and better outcomes that result when payers and providers come together and form value-based care arrangements. **Maryland is the only state in the country where payers and providers in the commercial market are precluded from partnering to form the full spectrum of value-based payment arrangements.** These arrangements are not new in the state – both the Maryland Primary Care Program and Maryland's Total Cost of Care model are value-based care arrangements. SB 834 will align rules across all markets, which will enable **voluntary**, two-sided incentive and capitation arrangements to flourish with commercial plans.

SB 834 is the culmination of nearly one year of active and thoughtful collaboration among hospitals, health care providers, and health plans. It ensures participation in value-based arrangements is voluntary, and that providers are protected should they choose not to participate. It contains numerous additional patient and provider protections

that are unparalleled in federal programs or laws or private contracts in other states, including but not limited to:

- A requirement that a bonus or two-sided incentive arrangement must promote health equity, improvement of healthcare outcomes and the provision of preventive healthcare services;
- A requirement that these arrangements must be voluntary, and a carrier cannot require providers to participate in a two-sided arrangement to participate in the carrier's provider network;
- An opportunity for an audit by an independent third party and an independent third-party dispute resolution process;
- Protects providers by setting a maximum downside risk that a provider can agree to in any arrangement and the opportunity for gains must be greater than the amount that can be recouped;
- Ensures transparency requiring that each year for the next 10 years the General Assembly will be briefed on the number and types of value-based arrangements that have been entered into in the state, the quality outcomes reported, any complaints that have been made and the cost effectiveness of the value-based arrangements.

Less than 40% of payments across commercial, Medicare Advantage, Medicaid, and Medicare still flow through a traditional fee-for-service model that has no link to quality and value. It is time for Maryland to join the rest of the country in expanding value-based care partnership opportunities among payers and providers. Doing so will result in a more resilient health care system in our state and improve the health of Marylanders for generations.

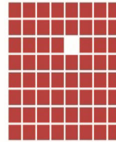
Thank you for your consideration of SB 834. I urge the committee to move this bill with a favorable report.

SB0834_FWA_MDAFP, MDACEP, MDAAP_HI - Two-Sided Inc

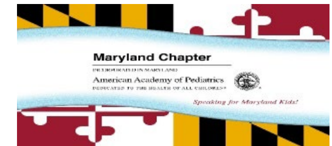
Uploaded by: Steve Wise

Position: FWA

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: mdacep@aol.com
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS



TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Pamela Beidle

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: March 9, 2022

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 834 – *Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization*

The Maryland Academy of Family Physicians, the Maryland Chapter of the American College of Emergency Physicians, and the Maryland Chapter of the American Academy of Pediatrics **supports with amendment** Senate Bill 834. Senate Bill 834 changes the scope of the payment and care delivery landscape in Maryland by authorizing two-sided incentive arrangements. The bill also permits capitation arrangements for self-funded group health insurance plans.

Under a two-sided incentive arrangement, a carrier may enter into a contract with a physician that allows a physician to receive a bonus payment (currently allowed under Maryland law) but also subjects the physician to the recoupment of funds. Arrangements such as these have been prohibited in Maryland because they have been determined to be the "practice of insurance." Up until this bill, the practice of insurance has been rightfully left to the insurance carriers. Whereas the main responsibility of an insurance carrier is to manage risk, the main responsibility of a physician is to manage a patient's health care needs. Yet this bill puts the physician in the position of managing risk.

Therefore, if Maryland is to enact this legislation, it is imperative that adequate protections are in place for both the physicians that want to enter into these arrangements and those that do not. Both are equally important. As currently drafted, we believe that the protections outlined in the bill requiring minimum contract standards for entering into a two-sided incentive arrangement will assist in ensuring that physicians have a fair starting point for negotiating such agreements. However, we remain concerned that the protections for those physicians that do not want to enter into such arrangements are not adequate, especially as it relates to ensuring that an insurance carrier cannot reduce a physician's fee structure for non-participation in a two-sided arrangement. While we recognize that the bill states that such arrangements are "voluntary," the reality of the situation is that physicians rarely have equal negotiating power, especially when one carrier controls the majority of the market. As such, we support strengthening this provision to remove the term "solely" and replace it with "wholly or in part"; to add protections for those physicians that may not contract directly with a carrier under a two-sided incentive arrangement but may still be otherwise affected; and to include language stating that there must be other opportunities for reimbursement increases that do not include entering into a two-sided incentive arrangement. With this change, which we consider paramount to the legislation, we urge a favorable vote on Senate Bill 834.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone
410-244-7000

SB834_APTAMD_UNF
Uploaded by: Dan Shattuck
Position: UNF

APTA Maryland

Board of Directors

President
JD Sheppard, PT, DPT

Past President
Kevin Platt, PT, DPT, MBA

Vice President
Roy Film, PT, DPT, MPT

Secretary
Monique Caruth, PT, DPT

Treasurer
Melissa Reinhardt, PT, MSPT

Director for Education
Gretchen Michaels, PT

Director for Gov't Relations
Carolyn Chanoski, PT,DPT,MS

Director for Practice
Michael Zarro, PT, DPT

Director for Reimbursement
Krista Frederic, PT, DPT

Director
Carolyn Dockins PT, DPT

Director
Richard T. Peret, PT

Director
Michael Ukoha PT, DPT

Chief Delegate
Linda Horn, PT, DScPT

March 9, 2022

The Honorable Delores Kelley, Chair
Senate Finance Committee
Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Position: **UNFAVORABLE**

Dear Chair Kelley,

The American Physical Therapy Association Maryland is writing to urge an unfavorable report on Senate Bill 834.

The bill, as drafted, will allow insurance carriers to enter into "two-sided" arrangements with health care practitioners, whereby they can earn upside risk through gain sharing or bonuses, and experience downside risk through the recoupment of funds. The bill also allows for capitated payment model arrangements.

Physical Therapist's involvement in patient care improves outcomes and reduces cost and strain to the healthcare delivery system. Physical Therapists understand the importance of innovation in health care and support value-based care models, both as a profession and behalf of its patients.

APTA MD has concerns when it becomes unclear what role physical therapists play in health care models, and how much protection is afforded them as providers in these models. PT, as a specialty, at times gets overlooked and encapsulated in care models and episodes of care. This limits our ability to objectively determine and control our involvement in value-based care models.

We understand Senate Bill 834 was initially focused on physician involvement, and now expands to all health care practitioners. In our review of the bill, we do not see sufficient protections for PT involvement in these models. Again, we understand efforts have been made to secure protections for providers who choose to be involved and for those who opt not to. Absent these protections we ask for an unfavorable report on Senate Bill 834.

Sincerely,
JD Sheppard
John D. Sheppard, II, PT, DPT
President, APTA Maryland

APTA Maryland Ph. 800.306.5596 Fax 877.622.0960 aptamd@aptamd.org

APTA Maryland
A Chapter of the American Physical Therapy Association

SB834_BNWS_UNF
Uploaded by: Dan Shattuck
Position: UNF

March 9, 2022

The Honorable Delores Kelley, Chair
Senate Finance Committee
Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Unfavorable

Dear Chair Kelley and Members of the Committee:

We are writing on behalf of Bethesda NEWtrition and Wellness Solutions (BNWS) to express our concerns with House Bill 1148 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization. As drafted, Senate Bill 834 among other provisions will allow carriers to enter into 2-sided risk arrangements and also capitated payment programs with all healthcare practitioners, not just physicians. While participation in the models would be voluntary, this change in law gives us pause.

BNWS is a health care, wellness and care coordination organization serving a growing number of patients. Founded initially to provide nutrition services for diabetes and weight management in Bethesda, Maryland, primary care services were added in 2016 to support BNWS's mission of coordinated patient care. In order to create a patient-centered, comprehensive care practice, adjunct therapies like physical, occupational therapy and behavioral health services were incorporated into the practice. BNWS is now a comprehensive source for a variety of health care services, both onsite and in the home.

We strongly support innovation and the development of new healthcare delivery models. Our focus is on partnering with patients and creating connections in the community to provide the most well-rounded, patient-centered care for our patients. While our size allows us to be nimble to meet the changing needs of our clients, it also puts us at a disadvantage compared to larger health systems and larger group practices.

We are concerned that small practices like ours will not be able to withstand the unintended consequences of 2-sided and capitated care models. As drafted, Senate Bill 834 will create more advantages for larger practices which may in fact lead to the acquisition of smaller practices.

This will leave an ever-growing gap in care access and delivery for those patients who are chronically underserved or pose higher health risks that may not align well with the incentives of 2-sided risk or capitated care models. These outlier patients will have fewer options to seek care in the community and will have to resort to hospitals and emergency departments for their care.

We are concerned that there is not enough clarity in what exactly the 2-sided risk models will be and if there will be sufficient protection in the law for small practices like ours if we do or do not want to participate. There needs to be additional oversight of these models to ensure that all involved, including patients, have the resources available to succeed and recourse to appeal to the Maryland Insurance Administration or other entity if needed.

For these reasons we ask for an unfavorable report on Senate Bill 834 until more is known about the specific models envisioned by the carriers.

Sincerely,

Loreto S. Albiol, MD
Tierra Anderson, CRNP
Harlivleen Gill, MBA, RDN, LDN
Emily Metzger, LMSW
Susan J. Miller, MD
Susita Moorthy, PT

SB 834 -Health Insurance - Two-Sided Incentive Arr

Uploaded by: Ben Steffen

Position: INFO

MARYLAND
Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

March 9, 2022

The Honorable Dolores G. Kelley
Chairman, Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chairman Pendergrass:

The Maryland Health Care Commission (the "MHCC") is submitting this letter of information on *SB 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization*

SB 834 expands the Value-Based Care arrangements that carriers and providers may enter. The bill allows providers to voluntarily enter contracts with insurance carriers in either a two-sided incentive arrangement or a capitation arrangement, similar to the arrangements that exist in most other states. The bill also clarifies that health care providers or a set of health care providers that accepts capitated payments is not engaging in the business of insurance and is not considered to be performing acts of an insurance business. Additionally, the bill requires the MHCC to aggregate and report data on these arrangements on an annual basis from 2023 through 2032.

Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.[1] Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The "value" in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

---

[1] American Academy of Family Physicians, Value-Based Payment, 2022, https://www.aafp.org/about/policies/all/value-based payment.html#:~:text=Value%20Based%20Payment%20(VBP)%20is,quality%20and%20cost%20of%20care.

VBP is a framework for restructuring health care systems with the overarching goal of value for patients, with value defined as health outcomes per unit of costs.[2] Value in health care is the measured improvement in a patient's health outcomes for the cost of achieving that improvement.[3]

The goal of value-based care transformation is to enable the health care system to create more value for patients. Because value is created only when a person's health outcomes improve, descriptions of value-based health care that focus on cost reduction are incomplete. Value-based health care is often conflated with quality, a vague concept that implies myriad virtues and in health care often focuses on inputs and process compliance. Improving a patient's health outcomes relative to the cost of care is an aspiration embraced across the health care continuum, including patients, providers, health plans, employers, and government organizations.[4] The goal of value-based health care is better health outcomes. By focusing on the outcomes that matter most to patients, value aligns care with how patients experience their health.[5]

Moving from a fee-for-service to a payment for-value system will take time. As the healthcare landscape continues to evolve and providers increase their adoption of value-based care models, they may see short-term financial issues before longer-term costs decline. These short-term risks have proven to be stumbling blocks in the adoption of VBPs, particularly for smaller practices. SB 834 does not permit private payors to mandate participation in a VBP, nor does it permit payors to penalize practices that do not join a VBP. This feature of SB 834 is noteworthy as it allows health care providers to opt-in to VBP as their practice transformation efforts mature. In that regard, MHCC has launched a grant program to assist practices in preparing for participation in VBPs.

SB 834 aligns with the Maryland Total Cost of Care Model (TCOC) and enables Maryland commercial payors to launch VBP that are well-established in other commercial markets. Negative dynamics in commercial markets can modulate the impact of the TCOC policies on our performance under the TCOC targets. Private-sector contracts and competitive relationships influence a provider's overall business strategy, including how they assess and

---

[2] Porter ME (December 2010). "What is value in health care?". *The New England Journal of Medicine*. **363** (26): 2477–81. doi:10.1056/NEJMp1011024. PMID 21142528

[3]Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results*. 2006Boston, MA: Harvard Business School Press. [Google Scholar]

[4] Reinhardt UE. Health Reform: Porter and Teisberg's utopian vision. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20061010.000063/full. Published October 10, 2006. Accessed November 12, 2019.

[5] Teisberg, Elizabeth et al. "Defining and Implementing Value-Based Health Care: A Strategic Framework." *Academic medicine: journal of the Association of American Medical Colleges* vol. 95,5 (2020): 682-685. doi:10.1097/ACM.0000000000003122

engage with the Maryland TCOC. SB 834 provides a framework for enabling commercial payors to offer models aligned with the TCOC.

Disparities in health care are well documented in Maryland as they are in all the United States. Fee-For-Service is not the sole cause of disparities and simply moving to VBPs will not eliminate these inequities. However, population-based approaches, which are common in VBPs provides a stronger foundation for reducing disparities. In Massachusetts, Blue Cross Blue Shield's Alternative Quality Contract, a two-sided population-based payment model with substantial incentives tied to quality yielded larger or comparable improvements in outcome and spending measures among enrollees in areas with lower socioeconomic status.[6] MHCC believes that directly addressing health disparities in the design of VBP programs and in the recruitment of providers to participate is critical to reducing these health inequities.

MHCC is committed to working even more collaboratively with providers and payors on practice transformation efforts and in the design of VBPs that incorporate reductions of health disparities as a measure of success should this legislation pass.

I hope you find this information useful. If you would like to discuss this further, please contact Tracey DeShields, Director of Policy Development and External Affairs, Maryland Health Care Commission at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollak, M.D.
Chair

Ben Steffen,
Executive Director

cc: Tracey DeShields, Director of Policy Development and External Affairs, Maryland Health Care Commission

[6] Song Z, Rose S, Chernew M, and Safran D, Lower- Versus Higher-Income Populations In The Alternative Quality Contract: Improved Quality And Similar Spending, Health Affairs 36, No. 1 (2017): 74–82, accessed at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0682.

SB 834 - Health Insurance - Two-Sided Incentive Ar

Uploaded by: Bob Atlas

Position: INFO

Maryland
Hospital Association

March 9, 2022

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Information- Senate Bill 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 834.

An earlier version of this bill was introduced during the 2021 legislative session. Given the comprehensive nature of the reforms and limited time to consider its far-reaching implications, the bill was withdrawn, and MHA, MedChi and the lead proponent, CareFirst, agreed to meet over the interim.

MHA participated in this process in earnest, attending more than 20 meetings. MHA and our members are committed to advancing sensible reforms to health care payment and delivery arrangements. As you know, Maryland's unique Total Cost of Care Model agreement with the federal government already gives our state a significant head start in value-based care (VBC). No other state comes close. Every hospital's payment is regulated, and every acute care hospital bears a high degree of risk for performance against cost and quality goals. These provisions place profound responsibilities on hospitals and the state. Yet, we know there is still more we can do.

Over the interim, hospital and physician representatives suggested many improvements to the draft bill. Among the needs of greatest concern were:

- To make plain that risk-based VBC contracting is purely voluntary for health care providers and to protect those that elect not to participate in such contracts with insurers from suffering any penalties. This is an important concern given that Maryland's commercial health insurance market is highly concentrated, with CareFirst alone holding approximately 65% share and thus having significant market power
- To ensure health care practitioners and other provider entities that participate in two-sided risk contracts with insurers are not made to bear outsized risk for health care costs incurred by their patients and/or attributed populations
- To guarantee that health care practitioners and other provider entities that enter capitation payment contracts with insurance carriers serving self-funded employer accounts on an "administrative services only" (ASO) basis—in which the carriers themselves do not insure the risk of heath care costs incurred by the covered

population—are not made to bear any form or amount of risk that would effectively place them in the business of insurance as defined by Maryland law

- To protect health care practitioners and other provider entities that participate in two-sided risk arrangements with insurers or that receive capitation payments from carriers functioning on an ASO basis through various means, including, but not limited to: timely delivery of data and reports on their performance sufficient to allow them to analyze sources of variance and to take corrective action; swift reconciliation of risk accounts and payment of penalties or rewards due; and dispute resolution involving independent agents of mediation or arbitration

All Maryland hospitals and health systems are committed to the principles of value-based care. We are very aware, though, that not every physician can or ought to engage in two-sided risk arrangements. Physicians in small independent practices, those in teaching roles, and others may have competing imperatives.

Any expansion of risk arrangements in health benefit programs should be approached judiciously and cautiously. Regulators will need to monitor these activities closely and act resolutely in response to concerns that affected parties may raise.

For more information, please contact:
Bob Atlas, President & CEO
Batlas@mhaonline.org

2c - X - SB 834 - FIN - MDH - LOI.docx.pdf

Uploaded by: Heather Shek

Position: INFO

DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

March 9, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 834 – Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization – Letter of Information

Dear Chair Kelley and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information on Senate Bill (SB) 834 – Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization. SB 834 provides that value-based arrangements established under certain provisions of federal law are exempt from certain provisions of State law regulating health care practitioner referrals and would provide that a health care practitioner or set of health care practitioners that accepts capitated payments in a certain manner, but does not perform certain other acts, is not considered to be performing acts of an insurance business.

SB 834 is consistent with value-based care models in health care delivery and financing, which has been gaining momentum nationally. Maryland has been a national leader on value-based care models since the 1970's when Maryland and Centers for Medicare and Medicaid Services (CMS) worked collaboratively to develop and refine payment methodologies for healthcare to combat rising health care costs utilizing an All Payer model. In 2019, Maryland and CMS further refined this model with a "Total Cost of Care" payment program. This payment model encourages hospitals to use savings under the global budget to offer incentives to non-hospital providers that improve care quality. It also offers monthly, per-beneficiary payments to primary care providers for care coordination services that can reduce hospitalizations and improve outcomes. Savings are anticipated from eliminating wasteful, unnecessary care. Savings are also expected as better preventive and chronic care reduces the number of emergency department (ED) visits and acute hospital admissions. Maryland Medicaid's application of uniform prices within global budgets lowers total care costs, reduces unnecessary utilization, and incentivizes proactive preventive and chronic disease management care.

This bill enables Maryland Insurers to develop value-based care programs in Maryland, like the Total Cost of Care Program. Private insurers have not offered value-based payment models because regulators have traditionally interpreted existing Maryland law to prohibit two-sided incentive arrangements. If enacted, SB 834 will allow carriers to streamline and coordinate contracting agreements with providers across markets and across the nation by aligning the

Maryland commercial market with Medicare, Medicaid, and the national commercial markets. Greater uniformity may lead to increased efficiencies and an improved ability to influence total health care costs by promoting better health outcomes for patients and avoiding potentially preventable future health problems.

If you would like to discuss this further, please contact Heather Shek, Director, Office of Governmental Affairs at (410) 260-3190 or heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

SB 834 2022 MIA Letter of Information Final.pdf
Uploaded by: Kathleen Birrane
Position: INFO

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

GREGORY M. DERWART
Deputy Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2471 Fax: 410-468-2020
Email: kathleen.birrane@maryland.gov
www.insurance.maryland.gov

**TESTIMONY OF
THE
MARYLAND INSURANCE ADMINISTRATION
BEFORE THE
SENATE FINANCE COMMITTEE**

MARCH 9, 2022

SENATE BILL 834 – HEALTH INSURANCE - TWO-SIDED INCENTIVE ARRANGEMENTS AND CAPITATED PAYMENTS - AUTHORIZATION

POSITION: LETTER OF INFORMATION

Thank you for the opportunity to provide written comments on SB 834.

SB 834, if enacted, would amend certain statutes in the Health-Occupations and Insurance Article to allow plans in Maryland's commercial market to utilize voluntary "two-sided incentive arrangements" between carriers and health care providers, and to authorize all carriers to compensate health care providers on a capitated basis without triggering a requirement for the health care provider to be licensed as an insurer. **The bill intends to align provider compensation models in the commercial insured market in Maryland more closely with the commercial markets nationally, and with the public markets (Medicare and Medicaid) within Maryland.** The bill is consistent with the national shift toward value-based care models in health care delivery and financing, which has been gaining momentum as data seems to increasingly suggest that such models reduce health care costs while also improving patient care, particularly with the emphasis on wellness and prevention. The statutory changes proposed in the bill are necessary to fully implement value-based care programs in Maryland because the Maryland Insurance Administration (MIA) and other regulators have historically interpreted existing Maryland statutes as prohibiting two-sided incentive arrangements in the commercial market, and only permitting incentive-based compensation programs that provide upward adjustments to compensation. Additionally, under existing Maryland statutes, only health maintenance organizations and dental plan organizations are expressly authorized to capitate providers.

The MIA examined the bill closely to ensure that the bill had been drafted to fit within the current statutory framework and included necessary guardrails and protections for consumers and providers. To that end, SB 834 makes several changes to the provisions of § 15-113 of the Insurance Article that describe the types of bonuses or other incentive-based compensation programs between carriers and providers that are permitted in the commercial market. These changes include authorizing carriers to enter into two-sided incentive arrangements where the eligible provider may earn an incentive for meeting performance standards, and the carrier may recoup funds from the provider if certain contractual benchmarks are not reached. The bill also revises § 4-205 of the Insurance Article to clarify that a health care practitioner or set of health care practitioners that accepts capitated payments under certain circumstances is not engaging in insurance business. Correspondingly, the bill adds a new Subtitle 21 under Title 15, which authorizes health care practitioners and sets of health care practitioners to receive capitated payments under insured or self-funded plans without being considered as engaging in insurance business.

Generally, the two-sided incentive arrangements authorized under this bill must comply with the same standards for other incentive-based compensation programs currently allowed under § 15-113, but will also establish a target budget for the cost of care for a population of patients attributed to the provider or group of providers who have agreed to the arrangement. Providers that meet the agreed upon performance measures will share in the savings achieved by the carrier if the health care spending of the population comes in under the target budget. However, the same providers will also share in the losses incurred by the carrier if the target budget is exceeded.

SB 834 includes specific guardrails for these two-sided incentive arrangements to ensure that: 1) the arrangements are voluntary on the part of the provider; 2) the specific terms of the arrangements are clearly disclosed to the provider and are mutually agreed upon by both parties; 3) limits are placed on the magnitude of the annual and total recoupments that may be collected from the provider; 4) providers have an opportunity for an independent audit and dispute resolution process; 5) good faith adjustments to the target budget must be negotiated when unforeseen circumstances occur during the term of the agreement; and, 6) recoupments will not be collected during the first 12 months of an arrangement, unless mutually agreed by both parties. It is also very important to note that these new two-sided incentive arrangements are made subject to the existing requirement in § 15-113 that incentive-based compensation may not create a disincentive to the provision of medical appropriate or medically necessary health care services.

The guardrails included in the proposed bill address some of the specific concerns that have been raised in the past about implementing value-based care programs in Maryland. These guardrails are important to ensure that the programs do not financially incentivize providers to reduce the number and types of services the providers deem medically necessary, and do not align provider interests too closely with carrier interests at the expense of patient care. Value-based care programs have been implemented across the country for years, and these types of arrangements are already in semi-existence now in Maryland in the Medicaid and Medicare markets, as well as in the self-funded market (to an extent). The concerns referenced above have

not materialized in those other markets. This is likely because providers have a strong financial incentive under these programs to meet quality benchmarks to help avoid preventable future health care expenses, which includes the provision of all medically necessary services for each policyholder, regardless of health status. However, due to the fact that some aspects of these programs are currently prohibited in the commercial market in Maryland, discussions about expanding value-based care have often included a focus on potential drawbacks of the programs. As a result of these discussions, SB 834 includes significantly more express language addressing checks and balances under the programs than has customarily been included in applicable regulatory standards for Medicare, Medicaid, and other states.

If enacted, SB 834 will provide industry with more options for provider reimbursement arrangements in the commercial market and will allow carriers to be able to develop arrangements that incentivize contracted health care providers to consider the total cost of care provided to patients. Operationally, the bill allows carriers to streamline and coordinate contracting agreements with providers across markets and across the nation by aligning the Maryland commercial market with Medicare, Medicaid, and the national commercial markets. Greater uniformity may lead to increased efficiencies and an improved ability to influence total health care costs by promoting better health outcomes for patients and avoiding potentially preventable future health problems. If the new programs are implemented effectively, consumers should ultimately benefit from receiving more efficient and coordinated high quality care from providers, as reimbursement shifts away from straight fee-for-service arrangements to total cost of care models where providers have a stronger financial incentive to meet quality benchmarks and remain engaged in all aspects of a patient's treatment.

The MIA did note one technical issue with the bill that may need to be addressed. Section 15-2102 on page 13 appears intended to apply to all insured plans in addition to self-funded group health insurance plans. However, lines 13 and 14 on page 13 include the phrase "an insured or a self-funded group health insurance plan." This language implies that the insured plan must be a "group" health insurance plan, which does not appear to be the intent based on the other provisions of § 15-2102. It appears the phrase should be reworded in a manner such as the following to accomplish the perceived intent: "a health benefit plan offered by a carrier or a self-funded group health insurance plan." In this case, § 15-2101 should likely also be revised to include a definition of "health benefit plan," and it seems that a broad definition, such as that currently used in § 2-112.2 of the Insurance Article, would be appropriate.

The MIA thanks the committee for its attention to this information concerning SB 834.

2a - X - SB 834 - FIN -HSCRC - LOI .docx.pdf

Uploaded by: Maryland State of
Position: INFO

March 9, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 834 – Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chair Kelley and Committee Members:

The Health Services Cost Review Commission (HSCRC) submits this letter of information for Senate Bill 834 (SB 834), "Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization." SB 834 is an important step forward, allowing insurers and certain non-hospital providers to enter into value-based payment arrangements. These arrangements have the potential to support the State in meeting the Maryland Health Model's goals of reducing healthcare costs and improving health outcomes.

The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare. The HSCRC establishes rates for hospital services and helps direct the State's innovative efforts to transform the health care delivery system and achieve goals under the Maryland Health Model. One of the main components of the Maryland Health Model is the Total Cost of Care (TCOC) Model Agreement (2019 to 2028) between the State of Maryland and the Federal Centers for Medicare and Medicaid Services (CMS).

Prior to the TCOC Model, Maryland and CMS participated in the All-Payer Model Agreement (2014-2018). Under the All-Payer Model, hospitals in Maryland transitioned to global budget revenues (GBRs). GBRs are considered the highest category of value-based care.[1] HSCRC sets an annual revenue target (GBR) for each hospital by taking into account inflation, changes in population, the hospital's performance on quality and efficiency metrics, and other factors. The hospital must meet, but not exceed this target. Maryland was highly successful under the All-Payer Model, generating significant Medicare savings while also improving quality of care in hospitals and reducing unnecessary hospitalizations. Under this model, hospitals gained significant experience operating under a value-based care payment system. As this model drew to a close, it was clear that the next model would need to foster greater collaboration and innovation across the health care system, not just in hospitals, to further improve population health, manage chronic conditions outside of hospitals, and generate additional savings across the whole health care system.

The TCOC Model, which began in 2019, contains annual targets that Maryland must meet to satisfy the terms of the agreement. Achieving these goals requires hospital and non-hospital providers to work together to improve outcomes across the care spectrum and advance population health. The State, in collaboration with CMS, has developed new, innovative programs such as the Maryland Primary Care Program (MDPCP) and the Episode Quality Improvement Program (EQIP). These programs use value-based payments to align incentives for primary care doctors and specialists, respectively, with the goals of the TCOC Model.

Adam Kane, Esq
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

James N. Elliott, MD

Maulik Joshi, DrPH

Sam Malhotra

Katie Wunderlich
Executive Director

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

William Henderson
Director
Medical Economics & Data Analytics

[1] https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

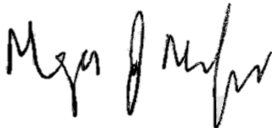
The MDPCP and EQIP programs are particularly important because physicians in Maryland have generally been excluded from the value-based payment programs that CMS has made available in other States due to the existence of the state-wide model agreements in Maryland. Thus, while Maryland is ahead of other states in adopting value-based payment in hospitals, the opportunity for these programs for physicians arose in Maryland later than it did in other states. In addition, these programs are limited to Medicare payments. Maryland law restricts the sorts of value-based programs that commercial insurers can enter into, limiting opportunities for all-payer alignment. CMS has been encouraging Maryland to seek opportunities to align Medicaid and commercial payers with the incentives under the Total Cost of Care Model.

By allowing for certain voluntary capitated payment arrangements and two–sided incentive arrangements between commercial payers and healthcare practitioners, SB 834 helps to further align hospital and non-hospital providers in alignment with the Maryland Health Model and creates an opportunity for greater all-payer alignment outside of hospitals. HSCRC believes that SB 834 is an important step forward towards value-based payment in the commercial market. HSCRC urges insurers to consider the needs of small practices when implementing this bill, to ensure that these practices understand the benefits and risks inherent in these new value-based contracts. In the coming years, HSCRC hopes that providers and insurers continue to discuss opportunities to take additional steps forward on the value-based payment journey.

We encourage, as part of the reports required by section 2 of SB 834, inclusion of information on the implications and impact of the payment arrangements allowed by SB 834 on the Total Cost of Care Model, including any interaction between the arrangements and hospital GBR payments. This will help the State to better understand how to design and implement incentives that align hospital and non-hospital services.

Hospital and non-hospital provider alignment is critical to the success of the Maryland Health Model, as is Medicare, Medicaid, and commercial payer alignment. HSCRC believes that SB 834 supports this aim by increasing value-based opportunities in the State. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,



Megan Renfrew
Associate Director of External Affairs

OAG HEAU_INF_SB0834.pdf
Uploaded by: Patricia O'Connor
Position: INFO

Brian E. Frosh
Attorney General

Elizabeth F. Harris
Chief Deputy Attorney General

Carolyn Quattrocki
Deputy Attorney General

Writer's Direct Fax No.
(410) 576-6571

Writer's Direct Email:
poconnor@oag.state.md.us

State of Maryland
Office of the Attorney General
Consumer Protection Division

William D. Gruhn
Chief
Consumer Protection Division

Writer's Direct Dial No.
(410) 576-6515

March 9, 2022

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: The Office of the Attorney General's Health Education and Advocacy Unit

Re: Senate Bill 1148 (Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization): Concern

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) asks that the committee consider the following information about potential improvements to the bill that would better serve consumers because of the HEAU's concerns about the impact that risk-shifting may have on consumers without independent review of patient outcomes. We understand that fee-for-service models invite unneeded services, upcoding, or adding extra diagnosis codes to patient charts to increase profits, but are concerned that incentivizing cost savings will drive provider profits, not patient care. We are especially concerned about such models with investor owned and controlled entities, including private equity firms.

1) **Consumers must be informed if their healthcare providers are participating in these models.** Consumers would be better served by more clarity and transparency than the bill provides about Capitated Payments and Two-Sided Arrangements to compensate physicians in Preferred Provider Organization (PPO) plans as well as Health Maintenance Organization (HMO) plans. While carriers are already required to provide material information about the costs and coverage terms of the plans they market and sell, we believe it is important that specific information be provided a) before plans are purchased about the differences in cost and coverage terms of PPO plans versus HMO plans that would use these arrangements and b) after plans are purchased about the providers who are eligible for these payments by identifying them in directories and on the website. Information about the incentives that physicians receive that may

decrease access to care is material information that would need to be disclosed under the Consumer Protection Act and this bill should require providers engaged in these arrangements to alert consumers, in advance, to these incentives.

2) **The performance measures upon which the payment arrangements are based must include improved health care quality and must be based on objective, nationally based clinical or quality improvement standards that are clearly defined, objectively measured, and well-documented.**

3) **The performance measures must be independently evaluated by a state agency.** The Maryland Health Care Commission, in consultation with the Maryland Insurance Administration should, within three years, evaluate these payment arrangements and performance measures to verify that patients are not simply being short-changed without any improvement in health outcomes or reduction in costs and premiums, and to screen for potential misuse by carriers of the payment arrangements to avoid premium reimbursements to consumers pursuant to the Medical Loss Ratio and other provisions of the Affordable Care Act. https://chirblog.org/questionable-quality-improvement-expenses-drive-proposed-changes-medical-loss-ratio-reporting/ ("Under the Affordable Care Act (ACA), insurers must provide rebates to enrollees when their spending on clinical services and quality improvement, as a proportion of premium dollars, falls below a minimum threshold known as the "medical loss ratio" (MLR). Federal regulators have discovered some insurers are gaming the system by misallocating expenses or inflating their spending on providers, while minimizing their reported administrative expenses and profits. When this happens, consumers don't receive the rebates they deserve. New proposed rules aim to crack down on these practices.")

Providers and consumers would be better served by requiring communications about the performance measures and the shared medical decision making between carriers and providers that is built into these payment arrangements because including consumers as equal partners in meeting the metrics should result in premium reimbursements under the Affordable Care Act.

Such communications, combined with meaningful oversight, would be needed for the appeals and grievances processes under current law to remain effective for consumers.

cc: Sponsors

2b - X- SB 834 - FIN - MHCC - LOI.pdf
Uploaded by: State of Maryland (MD)
Position: INFO

MARYLAND
Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

March 9, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 214013 East

RE: SB 834 - Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization

Dear Chair Kelley and Committee Members:

The Maryland Health Care Commission (the MHCC) is submitting this letter of information on *SB 834- Health Insurance - Two-Sided Incentive Arrangements and Capitated Payments - Authorization*

SB 834 expands the Value-Based Care arrangements that carriers and providers may enter. The bill allows providers to voluntarily enter contracts with insurance carriers in either a two-sided incentive arrangement or a capitation arrangement, similar to the arrangements that exist in most other states. The bill also clarifies that health care providers or a set of health care providers that accepts capitated payments is not engaging in the business of insurance and is not considered to be performing acts of an insurance business. Additionally, the bill requires the MHCC to aggregate and report data on these arrangements on an annual basis from 2023 through 2032.

Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.[1] Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The "value" in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

---

[1] American Academy of Family Physicians, Value-Based Payment, 2022, https://www.aafp.org/about/policies/all/value-based payment.html#: ~:text=Value%20Based%20Payment%20(VBP)%20is,quality%20and%20cost%20of%20care.

VBP is a framework for restructuring health care systems with the overarching goal of value for patients, with value defined as health outcomes per unit of costs.[2] Value in health care is the measured improvement in a patient's health outcomes for the cost of achieving that improvement.[3]

The goal of value-based care transformation is to enable the health care system to create more value for patients. Because value is created only when a person's health outcomes improve, descriptions of value-based health care that focus on cost reduction are incomplete. Value-based health care is often conflated with quality, a vague concept that implies myriad virtues and in health care often focuses on inputs and process compliance. Improving a patient's health outcomes relative to the cost of care is an aspiration embraced across the health care continuum, including patients, providers, health plans, employers, and government organizations.[4] The goal of value-based health care is better health outcomes. By focusing on the outcomes that matter most to patients, value aligns care with how patients experience their health.[5]

Moving from a fee-for-service to a payment for-value system will take time. As the healthcare landscape continues to evolve and providers increase their adoption of value-based care models, they may see short-term financial issues before longer-term costs decline. These short-term risks have proven to be stumbling blocks in the adoption of VBPs, particularly for smaller practices. SB 834 does not permit private payors to mandate participation in a VBP, nor does it permit payors to penalize practices that do not join a VBP. This feature of SB 834 is noteworthy as it allows health care providers to opt-in to VBP as their practice transformation efforts mature. In that regard, MHCC has launched a grant program to assist practices in preparing for participation in VBPs.

SB 834 aligns with the Maryland Total Cost of Care Model (TCOC) and enables Maryland commercial payors to launch VBP that are well-established in other commercial markets. Negative dynamics in commercial markets can modulate the impact of the TCOC policies on our performance under the TCOC targets. Private-sector contracts and competitive relationships influence a provider's overall business strategy, including how they assess and

---

[2] Porter ME (December 2010). "What is value in health care?". *The New England Journal of Medicine*. **363** (26): 2477–81. doi:10.1056/NEJMp1011024. PMID 21142528

[3]Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results*. 2006Boston, MA: Harvard Business School Press. [Google Scholar]

[4] Reinhardt UE. Health Reform: Porter and Teisberg's utopian vision. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20061010.000063/full. Published October 10, 2006. Accessed November 12, 2019.

[5] Teisberg, Elizabeth et al. "Defining and Implementing Value-Based Health Care: A Strategic Framework." *Academic medicine: journal of the Association of American Medical Colleges* vol. 95,5 (2020): 682-685. doi:10.1097/ACM.0000000000003122

engage with the Maryland TCOC. SB 834 provides a framework for enabling commercial payors to offer models aligned with the TCOC.

Disparities in health care are well documented in Maryland as they are in all the United States. Fee-For-Service is not the sole cause of disparities and simply moving to VBPs will not eliminate these inequities. However, population-based approaches, which are common in VBPs provides a stronger foundation for reducing disparities. In Massachusetts, Blue Cross Blue Shield's Alternative Quality Contract, a two-sided population-based payment model with substantial incentives tied to quality yielded larger or comparable improvements in outcome and spending measures among enrollees in areas with lower socioeconomic status.[6] MHCC believes that directly addressing health disparities in the design of VBP programs and in the recruitment of providers to participate is critical to reducing these health inequities.

MHCC is committed to working even more collaboratively with providers and payors on practice transformation efforts and in the design of VBPs that incorporate reductions of health disparities as a measure of success should this legislation pass.

I hope you find this information useful. If you would like to discuss this further, please contact Tracey DeShields, Director of Policy Development and External Affairs, Maryland Health Care Commission at tracey.deshields2@maryland.gov.

Sincerely,

Andrew Pollack, M.D.
Chair

Ben Steffen,
Executive Director

cc: Tracey DeShields, Director of Policy Development and External Affairs, Maryland Health Care Commission

[6] Song Z, Rose S, Chernew M, and Safran D, Lower- Versus Higher-Income Populations In The Alternative Quality Contract: Improved Quality And Similar Spending, Health Affairs 36, No. 1 (2017): 74–82, accessed at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0682.