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HB 1148 – Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization

Position: Support

Thank you for the opportunity to provide written comments in support of House Bill 1148. 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

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.

HB 1148 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.

HB 1148 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

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.

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.

A 2019 CMS analysis showed that
TWO-SIDED INCENTIVE ACOS PERFORMED BETTER
than upside-only ACOs in improving affordability

2 Continue to encourage CMMI* models

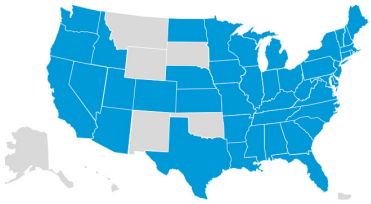
The tides of the VBC landscape are changing... WITH CURRENT CMMI DIRECTOR LIZ FOWLER COMMUNICATING HER INTENTION TO MOVE TOWARDS MORE MANDATORY MODELS OF VALUE-BASED CARE. CareFirst agrees, and strongly supports CMMI's continued efforts in designing, testing and implementing strategies that improve health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

$400 MILLION IN 7 YEARS:
savings expected from CareFirst/ MedStar value-based partnership

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.

BlueCross BlueShield value-based models
IN 43 STATES AND THE DISTRICT OF COLUMBIA



*CMMI – Center for Medicare and Medicaid Innovation

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.

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.

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

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