



Patient Centered Medical Home Workgroup

*Review of Recommendations: Preparing to
Report to the Council*

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August 28, 2009

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The Goal of the Patient Centered Medical Home Workgroup

To establish a design for an all-payer pilot encompassing common standards and interventions for creating and sustaining patient centered medical homes in geographically and demographically diverse practices. The design will strive to identify a consistent payment methodology across payers and select measurement tools that can equitably measure impact across a range of practice settings.

Recommendation 1: What is a medical home?

A patient-centered medical home is a model of practice in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner throughout a patient's lifetime . The PCMH, accessible to all Marylanders, provides for all of a patient's health care needs or appropriately collaborates with other qualified professionals to provide patient-centered care through evidence-based medicine, expanded access and communication, care coordination and integration, and care quality and safety. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues, within their practice or through the coordination with other providers.

Recommendations On The Foundations of the Pilot

- **Recommendation 2: Which Patients are Eligible?** –All patients are eligible. The Workgroup recognizes that chronically ill patients and their families will be an important focus as care improvements and cost savings on this group are most likely to be most significant.
- **Recommendation 3: How will Practices be Recognized?** – Use NCQA’s recognition model, require Level I PPC-PCMH, then migration over a defined period to at least Level II PPC-PCMH (requires an EHR).
- **Recommendation 4: Which Physician Practices Are Eligible?** Adult primary care and pediatric practices that endorse the Joint Principles and can attain NCQA Level 1 recognition.
- **Recommendation 5: Who can lead a Medical Home Practice?** Recognize PCMH team may be led by nurse practitioner as permitted under Maryland law.
- **Recommendation 6: Which Payers Should Participate?** All major private payers (Aetna, CareFirst, Coventry, UHC) and Medicaid.

Recommendations on Process for the Pilot

- **Recommendation 7: How Will Physician Practices Apply And Become Enrolled?**
The unit that applies will be the practice. Not all physicians in a practice will be required to join the application, and some practices may have physicians who are not eligible to join. If a practice is eligible, the implementation contractor will certify the capabilities of the practice and determine if the practice qualifies.
- **Recommendation 8: How Will Pilot Sites (areas) Be Selected?** The Workgroup endorses the establishment of pilot sites so that a wide variety of practice configurations can participate, including solo and group practices, FQHCs, and faculty practices in rural and urban parts of the state.
- **Recommendation 9: How will patients be attributed to a Practice?** Patients will be attributed to a PCMH based on where the patient received the plurality of E&M services in the last 2 years. The participating physician will be responsible for enrolling his or her eligible patients. The physician will explain to the patient what a medical home is and its benefits.

Recommendations on Rewards and Outcomes

- **Recommendation 10: How Are Participating Practices Reimbursed?** Follow Joint Principles on payment in phase 1 (year 1). Maintain PMPM but transition practices to a shared savings approach by year 3 with no penalty for losses.
- **Recommendation 11: What are the measures of success?** In the short-term, improved quality of care and improved patient/physician satisfaction. In the long-term, improved cost efficiency in the system is essential if the PCMH model is to be self-sustaining.

Revised Vision August 2009

What a Maryland PCMH pilot might look like?

Project Title Maryland Multi-Stakeholder Medical Home Pilot

Project Location: Statewide

Project Status: *Underway!*

Target Start Date: Begin enrollment of practices 7/1/10 with an expanded payment start of 01/01/2011

Pilot Length: 3 years from payment start

Convening Entity: Office of the Governor

Brief Overview/Research Question/Focus of Project: The MD Multi-Stakeholder Medical Home Project was initiated in January of 2009 as a joint effort of all carriers and representatives of the clinical, consumer, purchaser, public policy, and academic communities. It is an outgrowth of the work of the Maryland Health Quality and Cost Council, whose goal was to design and implement systems that value, prescribe, and reward medical care that is superior in quality and efficiency.

Our research questions are as follows:

1. Can a PCMH create value defined by higher quality and lower cost?
2. Will there be sufficient value created to cover costs of investment?
3. What populations are likely to benefit from a new model?
4. Are the savings sufficient to sustain the model?

Care to imagine what a Maryland PCMH pilot would look like? (cont.)

Hypothetical Participating Stakeholders: CareFirst, UHC, Aetna, CIGNA, Coventry; Medicaid, Amerigroup, Priority Partners, MD Physicians Care, University of Maryland Medical System and School of Medicine, Johns Hopkins University Health System and School Medicine, MedStar, LifeBridge, Insurance Commission, Hospital Association, MedChi, MD chapters of ACP, AAFP, AAP, Perdue, Marriott Corporation, IBM Corporation, Merck, and others.

Number of Practices and Total Providers: 50 and 200

Health Plan Lines of Business: Commercial, Medicare Advantage, Medicaid Managed Care,

Overall Number of Covered Lives: 200,000

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Medical Home Recognition Program: NCQA PPC-PCMH, Level 1 in 6 months, Level 2 in 18 months

Practice transformation support: Carriers providing funding for consultants based on market share.

Care management support: On-site nurse care manager for each pilot site

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Payment Model: Phase 1: FFS+PMPM fee for all patients based on standardized risk and attribution methodology + Quality reward

Phase 2: FFS plus direct-to-practice payments for care coordination and shared savings

Data to be Collected: Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction