

Agenda
Patient Centered Medical Home Workgroup
Maryland Health Care Commission, Room 100
April 29, 2010
3:00-5:00 p.m.

<https://www1.gotomeeting.com/join/205741064>

Dial 217-287-4117

Access Code: 205-741-064

Audio PIN: Shown after joining the meeting

Meeting ID: 205-741-064

1. Introduction – Dr. Kathleen White
2. Update SB 855/HB 929 – Nicole Stallings
3. Elements of the Program
 - a. Timeline – Karen Rezabek
 - b. Outreach strategy – Carol Bloomberg
 - c. Symposium Planning — Karen Rezabek
 - d. Program Financing — Ben Steffen
 - (a) Transformation
 - (b) Payments and Rewards
 - e. Care Coordination – Grace Zaczek
 - f. Practice Selection Universe – Ben Steffen and Eva Dugoff
4. Update on NASHP Medical Home Technical Assistance Grant – Ben Steffen
5. Wrap up – Dr. Kathleen White

Patient Centered Medical Home Program Legislation (SB 855/HB 929)

- Administration bill was signed into law on April 13, 2010 that will establish a PCMH program consisting of a multi-carrier pilot and approved single carrier initiatives under the authority of the MHCC.
- Waive prohibitions on cost-based incentives and information sharing in the Insurance Article when used in a PCMH initiative approved by the MHCC.
 - Specifically, a PCMH program may use cost-based incentives in addition to quality-based measures and a carrier may share information with practices in the PCMH if the patient consents to this when joining the PCMH.
- Establish a state action exemption under anti-trust law that will permit payers and providers to collaborate in the development of payment and performance measurement in the PCMH.
- Provide for an evaluation of the PCMH multi-carrier pilot using funds already held by MHCC.

PCMH Provider Participation Timeline

June-July 2010	Outreach symposia for providers Introduction to the Maryland Patient Centered Medical Home Program Symposia held in various locations in Maryland
June 2010	Release of Reward Structure and Practice Performance requirement
July 2010	Carriers sign participation agreements
July-August 2010	Practices complete a notice of interest in pilot participation Providers will notify MHCC that they are interested in participating
September – October 2010	Practices complete applications
October 2010	Selection committee identifies participating practices.
November 2010	Practices sign participation agreement and apply for Transformation Grants from CHRC.
December 2010	CHRC awards transformation grants in consultation with MHCC and practice selection committee

PCMH Provider Participation Timeline, cont'd

January February 2011 underway, 2011	Launch of pilot, transformation and learning collaborative begin patient outreach.
March 2011	Applications due to NCQA by March 31, 2011
May-June 2011	NCQA recognition, begin patient enrollment Participating provider practices begin operating as a PCMH once practice submits application to NCQA.



Communication and Outreach

Maryland Patient Centered Medical Home Project
Workgroup Meeting April 29, 2010



Communications and Outreach Goals

- Providers
 - Goal: Engage and encourage primary care practices to enroll in the Maryland Patient Centered Medical Home (PCMH) pilot.
 - Objective: Enroll 50 primary care practices in the pilot.
- Consumers/ Patients
 - Goal: Educate patients about the benefits of receiving care in a PCMH and create awareness of the pilot.
 - Objective: Enroll 200,000 patients.



Physician Outreach and Recruitment

- Communications Plan
 - Targets - What practices should we target?
 - Messages – What do they need to know to make the decision to join?
 - Materials – How do we package that information in a persuasive way?
 - Vehicles – Through what channels can we deliver the information?



Target PCP Practices

- Determine whether existing PCMH practices will participate in the pilot.
- Recruit new practices seeking balance in:
 - Size
 - Type of practice – family practice, internal medicine, pediatrics
 - Federally Qualified Health Centers
 - MCOs
 - Urban, suburban, and rural locations
 - Hospital owned



Determine Messages

- What are the benefits to the practice of joining the PCMH pilot?
- What are the expectations a practice would need to meet as part of the pilot?
- What are the anticipated costs to a practice?
- What is the process?
- What is the timeline?
- What assistance will the State provide in the development process?
- How does a practice apply?



Possible Benefit Messages

Move your practice to the next level/ Become a Patient Centered Medical Home

- Adopting this innovative enhanced primary care model results in:
 - Higher quality health care for patients at lower cost
 - Increased patient satisfaction
 - Increased job satisfaction for providers
 - A jump start to achieving meaningful use standards and obtaining federal funds for EHR adoption
 - Additional payments from all major Maryland insurers based on care coordination costs and savings (???)
 - Being ahead of the curve on the future of primary care



Develop Materials

- Overview of PCMH
- Overview of Maryland PCMH pilot
- FAQs about becoming a PCMH
- Case studies and success stories from MD and nation-wide
- Videos and testimonials
- Information and tools available from professional organizations, Patient Centered Primary Care Collaborative, NCQA
- Checklist to determine if becoming a PCMH is right for your practice
- Application



Develop Vehicles to Disseminate Information

- Through PCMH pilot:
 - Dedicated website
 - List serve /e-newsletter
 - Six regional symposia
 - Webinars
 - Twitter?
 - Articles in mainstream and local media
- Through electronic and print communications from other channels:
 - Merck representatives
 - Physician organizations
 - Insurers
 - Other Health Care Organizations



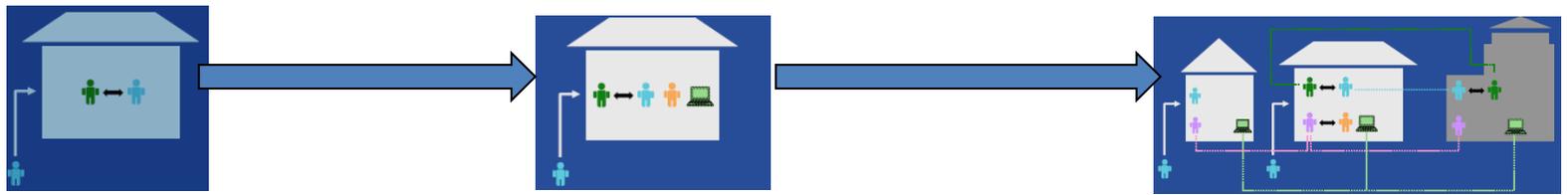
Next Steps

- Establish a Communications and Outreach committee of the Workgroup to assist in these efforts.
- Learn what has worked and what hasn't from other states that are further along in the process.
- Create awareness in the PCP community that the Maryland PCMH pilot is underway and ask practices to sign up for email updates on progress and dates for Regional Symposia.
- Develop a plan for creating messages, designing materials and selecting vehicles for message dissemination.
- Work on patient and consumer communications and outreach plan as well.



To volunteer for the Communications and Outreach Committee, or if you have any suggestions, please contact:

Carol Bloomberg
carol@ bloomberg-associates.com



Maryland's Patient Centered Medical Home Pilot

PCMH Financing

April 29, 2010

Ben Steffen

Maryland Health Care Commission

The Patient-Centered Medical Home

- The bad news: legislation provides little additional state funding except...
 - MHCC is permitted to use funds from the modest MHCC reserve to fund the program evaluation.
 - Community Health Resources Commission authorized to award grants as part of the Maryland PCMGH program.
 - May assist federally qualified health centers and other primary care practices to become patient centered medical homes
 - Seek grant funding -- leveraging additional assets to support the participation of federally qualified health centers and other primary care practices in a patient centered medical home program.
 - CHRC's budget is \$3 million in 2012, some is committed to prior year obligations.
 - MHCC is exploring other sources of financial support including HI-TECH funding and health reform financing support from the federal government

Transformation: what could it involve?

PCMH Recognition Support

External Consulting on Practice Enhancement

- Consultation on work flow analysis , Open Access Scheduling, Practice Culture Change,
- Ongoing support throughout the pilot from a quality Improvement (QI) Coach
- Implementation support for an EMR/conversion disease registry (required).
- Funding may be limited to practices with the highest need.

Learning collaborative – pilot participants would meet periodically in person and via electronic means to discuss successes and failures.

- All pilot practices would participate in learning collaborative.
- Practices participate in the 2 year Carefirst pilot could play a leadership role in the learning collaborative.

Transformation: who would lead?

- MHCC and CHRC are examining options for contracting with a consultant.
- MHCC recommends direct contracting with a vendor for transformation support – (learning collaborative and practice transformation).
 - Transformation funding to practices will be limited
 - Some practices may not be eligible – perhaps practices affiliated with hospitals and university faculties, and practices that are already participating in CMS’s EHR pilot.
- Alternative approach might be to award direct grants to practices based on need. Practices would individually contract with a transformation consultant.
 - Same eligibility criteria would apply
 - This approach is less desirable because transformation support will not be standardized.

Payment and Reward Structure

MHCC contracted with Discern Consulting and Linda Shelton to ...

- assist in development of per patient per month (PPPM) payment, and
- specify shared savings formula.
- Goal is to have reward structure in place by start of outreach sessions in late June/early July.

Process

- Refine approach and framework for payment
- Review approach with the major payers individually to discuss implementation issues (how will PPPM and reward be distributed)
- Further refinement by Discern
- Review with providers and the workgroup in middle June
- Presentation to practices at the outreach sessions in July.

Payment and Reward Structure

Key issues and unknowns

- **How much savings are possible?**
- **Is the shared savings model applicable to smaller practices?**
 - Rewards would be very sensitive to fluctuations in health care use by a few patients.
 - Smaller practices are likely to be closed to new patients which would be also affect rewards.
- **How should the PPPM structure account for practices that serve higher shares of special need populations?**
 - Should PPPM be differentiated by population served?
 - Is a risk adjustment needed?
- **At what point do we judge the payment and reward structures sufficient?**
 - All participants must balance their own interest against the need to test PCMH model in a real world settings.
 - If the model proves successful, likelihood for refinement.

Care Coordination in Maryland's Patient Centered Medical Home Pilot

**Sponsored by the *Maryland Health Quality
and Cost Council*
PCMH Work Group Meeting**

April 29, 2010

**Grace S. Zaczek
Medical Care Programs Administration**

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Care Coordination:

- Patient Centered
- Multi-disciplinary Team – Primary Care Provider and Other Health Professionals
- Culturally and Linguistically Sensitive
- Integrates Prevention, Treatment and Patient Education in Care
- Collaborates with Other Health Professionals and Services

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Challenge for Small and Rural Practices:

- Need for less than full time care coordination team members
- Shortage of health professionals in local communities

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Care Coordination Models in Other States:

- Vermont – Hospital Based Network
- Montana – Community Health and Tribal Health Centers
- North Carolina – Regional Networks
- Pennsylvania – Internal to practices, but small practices sharing a care coordinator

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Care Coordination Options in Maryland:

- Local Health Departments
- Community Based “Pool” Organizations
- Hospital Based Multi-disciplinary Teams
- Medicare Certified Home Care Agencies

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Local Health Departments - Advantages:

- Statewide Coverage
- Existing Infrastructure -Adult Evaluation and Referral Service (AERS)
- Stable staff
- Established relationships with primary care practices, community services and specialists
- Recognized as established and trusted health care leaders in their communities

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Local Health Departments - Disadvantages:

- Need additional funding to add PCMH to their missions
- Salary scales may make recruitment difficult
- Funding may be severely limited in the current budget climate
- Shortage of health professionals in rural areas

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Community-Based “Pool” Organizations - Advantages:

- Non-profit - potentially eligible for grant funding
- Can employ full time staff
- Provide consistent, readily available professionals for only as much time as is required to fulfill specific PCMH needs
- Services affordable for small practices and reduce costs

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Community-Based “Pool” Organizations - Disadvantages:

- Need significant time for start up and capacity development
- May be more expensive than other options

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Hospital-Based Multidisciplinary Teams - Advantages:

- Major source of health care for local community
- Existing hospital primary care clinics
- Health professionals already in place
- Direct links to services and resources

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Hospital-Based Multidisciplinary Teams - Disadvantages:

- Potential focus solely on hospital's primary care practices
- Conflicting priorities with inpatient responsibilities
- May not exist in rural communities

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Medicare Certified Home Care Agencies - Advantages:

- Statewide coverage
- Existing Infrastructure
- Stable staff
- Established relationships with primary care practices, community services and specialists
- Serve patients across the socio-economic spectrum
- Existing participation with private insurance carriers, Medicare, Medicaid

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Medicare Certified Home Care Agencies - Disadvantages:

- Difficulty recruiting health professionals
- Primary care coordination a secondary priority
- Paradigm shift from home care services
- Regulatory prohibitions
- Fee-based and fee-driven

Issues for Consideration

- One model may not work for all practices
 - Local health departments may be organized to provided CC in some communities and not in others
 - Use of health system resources will be linked to internal factors
- All models present funding challenges
- CMS will require care coordination makes use of community resources
- Some pilots let carriers and practices work out appropriate CC configuration

Care Coordination in Maryland's Patient Centered Medical Home Pilot

Next Steps

Criteria For Enrolling Primary Care Providers

PCMH Workgroup Meeting

April 30, 2010

Eva DuGoff, MS

Consultant to MHCC

PCMH Participation Criteria

Under the new law, eligibility to participate is limited to primary care practices

- §§19–1A–01. (G) “Primary care practice” means a practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners.
- §§19-3a-01 (b)(1) [MHCC shall establish] ... standards qualifying a primary care practice as a participant in the Maryland Patient Centered Medical Home Program.

Workgroup has previously discussed probable eligibility consideration

- Geographic and racial and ethnic diversity
- Practice IT readiness
- Practice size and type

- Participates with Maryland Medicaid and private insurance plans (is in network).

Data Methods

- Used 2008 and 2009 Maryland Board of Physicians Licensure Renewal Files
- Data screened to include only active practice primary care physicians. Inclusion criteria:
 - Reported primary practice location in Maryland
 - Reported practicing more than 5 hours
 - Reported practice concentration as pediatrics, family practice (general), family practice (geriatrics), internal medicine (general), and internal medicine (geriatrics)
- Some questions were asked in one year, but not in the other, e.g.,
 - Use of electronic health records
 - Acceptance of private insurance

Primary care physicians are concentrated in Baltimore and Montgomery County

Primary Care Physicians by County, 2008 and 2009

	Family Practice (General)	Internal Medicine (General)	Internal Medicine (Geriatrics)	Family Practice (Geriatrics)	Pediatrics	Total
Allegany	17	34	0	1	9	61
Anne Arundel	100	164	3	0	102	369
Baltimore County	118	469	20	8	183	798
Calvert	13	25	0	0	15	53
Caroline	10	5	0	1	2	18
Carroll	37	38	0	0	26	101
Cecil	32	18	1	0	8	59
Charles	19	27	0	0	28	74
Dorchester	8	11	0	0	1	20
Frederick	59	36	0	1	32	128
Garrett	11	1	0	0	0	12
Harford	36	67	0	0	45	148
Howard	48	81	1	2	57	189
Kent	8	5	0	0	3	16
Montgomery	180	435	6	9	289	919
Prince George's	132	226	4	1	125	488
Queen Anne's	14	5	0	0	2	21
St. Mary's	18	25	0	0	10	53
Somerset	4	3	0	0	4	11
Talbot	12	19	2	1	12	46
Washington	47	50	2	2	25	126
Wicomico	13	33	2	0	17	65
Worcester	18	15	0	0	0	33
Baltimore City	97	505	30	6	213	851
Total	1,051	2,297	71	32	1,208	4,659

Data Source: Internal analysis by MHCC staff of the 2008 and 2009 Maryland Physician License Renewal Database.

Physicians in IT ready practices will have an easier transition to PCMH

Primary Care Physicians by County Who Use of Electronic Health Records All or In Part, 2009

	Yes	No	Total
Allegany	14	14	28
Anne Arundel	100	76	176
Baltimore County	199	189	388
Calvert	16	13	29
Caroline	6	4	10
Carroll	20	24	44
Cecil	23	9	32
Charles	14	13	27
Dorchester	9	3	12
Frederick	30	22	52
Garrett	5	1	6
Harford	32	42	74
Howard	61	26	87
Kent	1	8	9
Montgomery	210	209	419
Prince George's	102	128	230
Queen Anne's	4	3	7
St. Mary's	11	7	18
Somerset	3	1	4
Talbot	13	6	19
Washington	35	28	63
Wicomico	15	18	33
Worcester	6	4	10
Baltimore City	255	120	375
Total	1,184	968	2,152

One-third of Eligible Physicians in Solo Practice

(Experience from other states suggest group practices may be associated with PCMH success)

Primary Care Physicians by Practice Configuration, 2008 and 2009

	Solo	Single-Specialty	Multi-Specialty	HMO, Group/ Staff	Total
Family Practice (General)	234	313	345	256	1,148
Internal Medicine (General)	971	640	562	445	2,618
Internal Medicine (Geriatrics)	37	13	24	6	80
Family Practice (Geriatrics)	15	12	5	7	39
Pediatricians	503	262	485	160	1,410
Total	1,760	1,240	1,421	874	5,295

Group practices are concentrated in urban areas

Primary Care Physicians by County and Practice Configuration, 2008 and 2009

	Solo	Single-Specialty	Multi-Specialty	HMO, Group/ Staff	Total
Allegany	21	25	1	0	47
Anne Arundel	106	124	70	8	308
Baltimore County	241	237	154	20	652
Calvert	11	19	18	0	48
Caroline	4	4	8	0	16
Carroll	25	49	6	2	82
Cecil	19	21	8	0	48
Charles	26	23	18	0	67
Dorchester	4	3	7	0	14
Frederick	23	77	11	3	114
Garrett	3	7	2	0	12
Harford	43	51	28	0	122
Howard	55	69	39	4	167
Kent	4	10	1	0	15
Montgomery	263	316	155	75	809
Prince George's	182	98	99	56	435
Queen Anne's	5	11	5	0	21
St. Mary's	9	6	32	0	47
Somerset	2	2	5	0	9
Talbot	12	19	5	0	36
Washington	30	50	17	7	104
Wicomico	13	35	7	0	55
Worcester	11	8	8	0	27
Baltimore City	125	157	169	16	467
Total	94	101	195	390	3,722

Physicians practicing in CHCs are concentrated in urban areas

Primary Care Physicians in CHCs by County, 2008 and 2009

	CHCs	
Allegany		1
Anne Arundel		7
Baltimore County		16
Calvert		2
Caroline		3
Carroll		0
Cecil		0
Charles		1
Dorchester		4
Frederick		0
Garrett		1
Harford		2
Howard		5
Kent		1
Montgomery		16
Prince George's		12
Queen Anne's		0
St. Mary's		0
Somerset		3
Talbot		1
Washington		7
Wicomico		1
Worcester		0
Baltimore City		60
Total		143

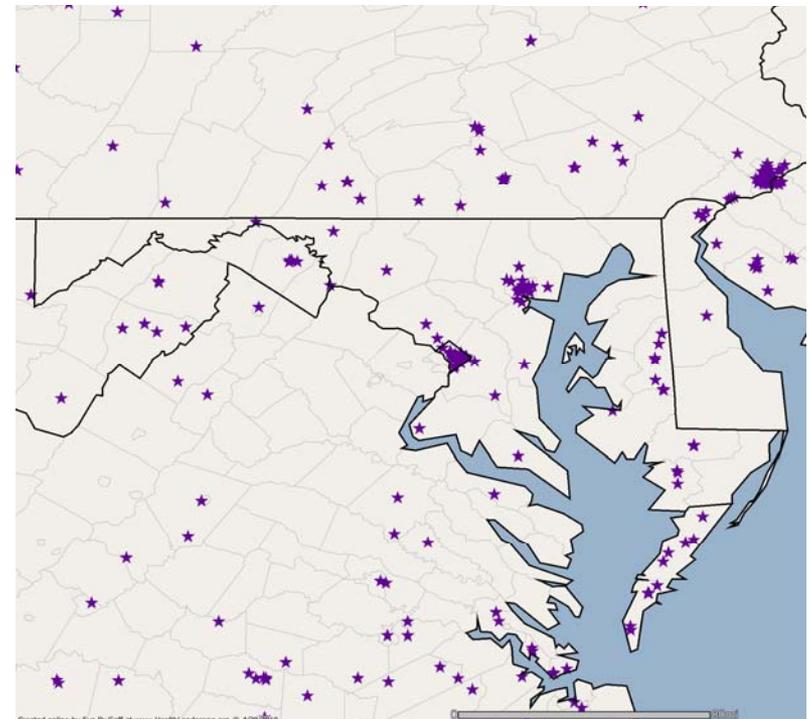
FQHC Background: Maryland Federally-Supported Health Centers, 2008

of Orgs: 16

of Delivery Sites: 126

Source: NACHC, 2009.

★ CHC Locations, 2005



75 % of primary care physicians accept Maryland Medicaid

Primary Care Physicians by County by Medicaid Acceptance, 2008 and 2009

	Yes	No	Total
Allegany	53	5	58
Anne Arundel	265	83	348
Baltimore County	567	201	768
Calvert	49	4	53
Caroline	14	3	17
Carroll	71	21	92
Cecil	50	6	56
Charles	56	15	71
Dorchester	14	4	18
Frederick	95	32	127
Garrett	12	0	12
Harford	94	41	135
Howard	119	64	183
Kent	13	1	14
Montgomery	502	340	842
Prince George's	335	120	455
Queen Anne's	18	1	19
St. Mary's	46	5	51
Somerset	8	2	10
Talbot	40	5	45
Washington	97	23	120
Wicomico	57	6	63
Worcester	22	7	29
Baltimore City	657	104	761
Total	3,254	1,093	4,347

Most primary care physicians accept private insurance

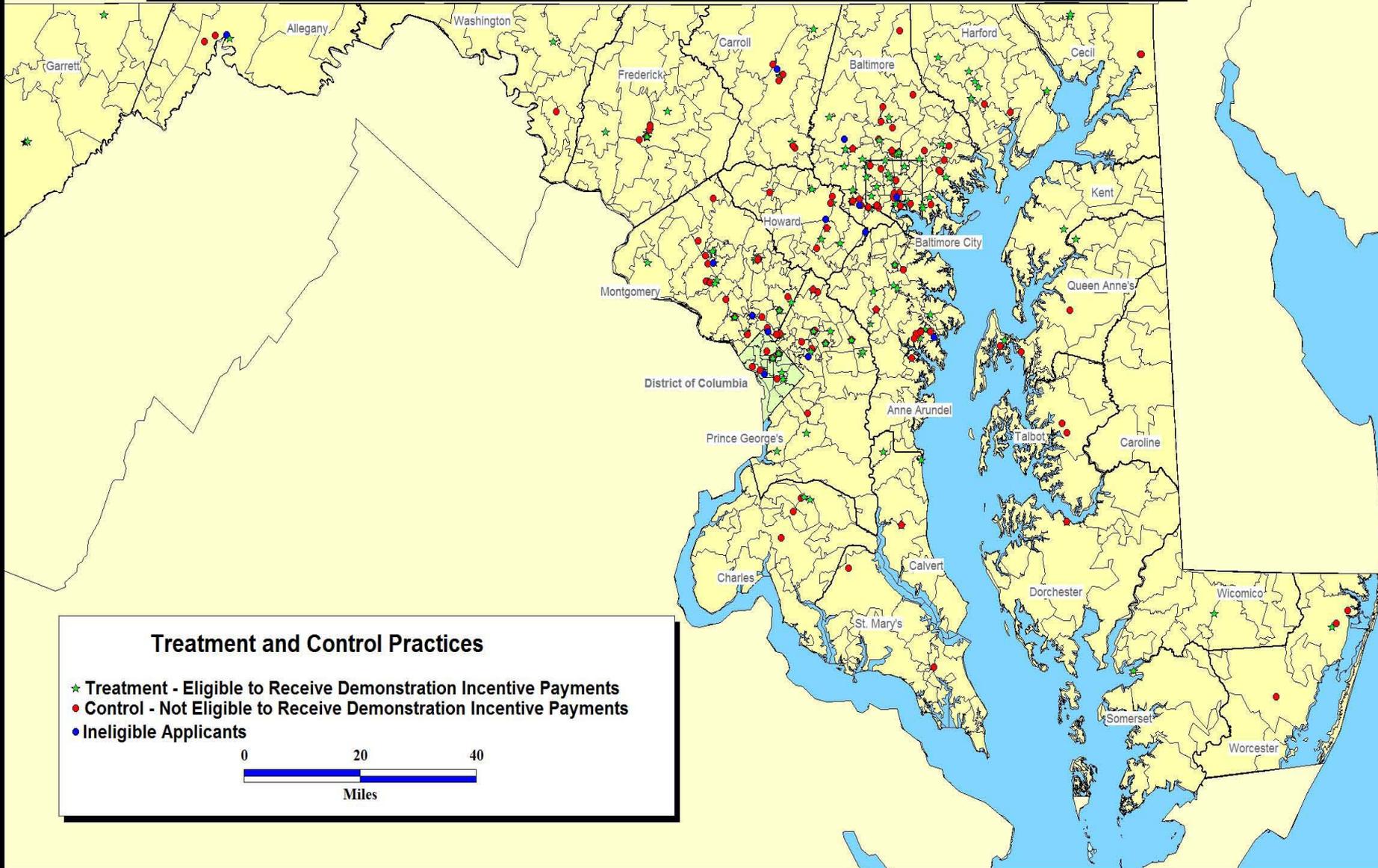
Primary Care Physicians by County by Private Insurance Acceptance, 2009

	Yes	No	Total
Allegany	25	3	28
Anne Arundel	150	26	176
Baltimore County	358	31	389
Calvert	26	3	29
Caroline	9	1	10
Carroll	41	3	44
Cecil	29	3	32
Charles	27	0	27
Dorchester	7	5	12
Frederick	45	7	52
Garrett	6	0	6
Harford	67	7	74
Howard	75	12	87
Kent	9	0	9
Montgomery	330	89	419
Prince George's	206	24	230
Queen Anne's	7	0	7
St. Mary's	18	0	18
Somerset	3	1	4
Talbot	16	3	19
Washington	55	8	63
Wicomico	33	0	33
Worcester	8	2	10
Baltimore City	321	55	376
Total	1,871	283	2,154

Special Considerations

- Nurse practitioners can serve as PCMHs – little data on number in private practice alone.
- The Maryland PCMH demonstration may overlap with current private and public demonstrations
 - CMS’s electronic health records demonstration includes 255 physicians in Maryland/Washington DC
 - CareFirst’s PCMH demonstration includes 9 practices in Maryland
 - Potentially a benefit and a challenge
 - some practices will already possess a highly of PCMH functionality, but may also suffer from pilot fatigue.
 - Competition for practices?

CMS Treatment and Control Groups



CMS EHR Demonstration Practice Distribution by County

County	Control	Treatment
Allegany	2	1
Anne Arundel	11	12
Baltimore Co.	28	24
Baltimore City	11	13
Calvert	1	2
Carroll	5	6
Cecil	2	3
Charles	3	3
Dorchester	1	1
Frederick	6	7
Garrett	0	2
Harford	2	6

County	Control	Treatment
Howard	5	4
Kent	0	2
Montgomery	21	16
Prince George's	11	15
Queen Anne's	3	1
Somerset	0	1
St. Mary's	2	0
Talbot	2	0
Washington	1	1
Wicomico	0	1
Worcester	3	1
Washington, DC	8	5

CareFirst's Primary Care Medical Home Pilot

- Includes 93 physicians across 9 practices
 - 1 practice is NCQA Level 3 recognized
 - 7 practices are NCQA Level 2 recognized
 - 1 practice is NCQA Level 1 recognized
- Practice locations include: Annapolis, Prince Frederick, Germantown, Riverside, Baltimore, and Laurel

Conclusions

- PCMH readiness is linked to practices in urban settings
- Practice configuration may be a factor limiting PCMH readiness – solo practice in particular may constrain participation.
- Some counties will see zero participation
- Participation from all five regions in Maryland is achievable.