



Maryland's Patient Centered Medical Home Pilot

Sponsored by the *Maryland Health Quality and Cost Council*

PCMH Work Group Meeting
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The medical home model builds on primary care concepts

Primary Care -- central organizing principle of effective health care systems⁽⁶⁾

- Accessible (first contact care)- point of entry for each new problem
- Continuous-ongoing care over time
- Comprehensive- provides or arranges for services across all of patient's healthcare needs
- Coordinated-integration of care across a person's conditions, providers, and settings, and with the patient's family, caregivers, and community.

Maryland

MD Multi-Stakeholder Medical Home Pilot

Statutory authority: executive order; 2010 legislation will be introduced to resolve: antitrust issues, ensure self-insured employer participation, clarify privacy concerns, and shared-savings bonus.

Multi-payer database: Expand Medical Care Data Base, more rapid submission for Pilot

Status: Finalize payment methods, seek payer commitments

- Planning for 6 local outreach sessions in 2010
- 07/10 begin practice enrollment

Payers: Seek all major private payers (Aetna, CareFirst, Coventry, UHC) and Medicaid. Plan to seek Medicare participation if permitted by CMS

Scope # practices/physicians/covered lives:

- Target: 50/200/200,000

Practice qualification: NCQA PPC-PCMH Level I

Community Integration: Governor appointed MD Health Quality & Cost Council serves as the vehicle to mobilize state resources & pair with resources in local communities to improve health of those communities.

Integration with wellness/disease prevention:

- Integrate with Healthiest Maryland," a campaign aimed at "grasstop" local leadership across Maryland. A recognition program honoring participating state organizations that target behaviors to prevent diabetes & obesity and its complications

Evaluation: NOW INCLUDED IN LEGISLATION

Attribution:

- Based on where the patient received the plurality of E&M services in the last 2 yrs. Participating physician will be responsible for enrolling eligible patients

Quality measurement

Pediatrics: management # of specific conditions.
Adults: management of specific chronic diseases implemented through CPT2

Payment model:

Payers use their traditional fee schedule + E-visits & afterhours care included in care coordination PMPM. Year 2: Transition Practices to Shared Savings model with no penalty for losses.

Support to practices:

Goal: learning collaborative; on-site or shared nurse care manager for each pilot site

Elements of the Legislation

- Provide gentle ‘pre-emption” of Maryland Law that will conflict with PCMH Sections of the Health Insurance Article.
- Establish a state program that would allow for collaboration among stakeholders, but not run afoul of Anti-trust.
- Define a state program with sufficient detail to assure participants that the program as conceived in this Workgroup and the Council was being implemented in law.
- Provide a framework for carriers to continue their own PCMH programs within scope of reasonable state oversight.
- Create a mechanism for evaluating the program and broadly define the questions the evaluation is to answer.

Provide gentle ‘pre-emption’ of Maryland Law

Carriers are limited in their use of incentive payment systems.

- Incentive payments based on costs are not permitted – this would conflict with the shared-savings approaches discussed in the workgroup.

Approach: Legislation will permit cost-based incentives under the pilot program only

- Carriers are prohibited from sharing PHI with providers without patient consent for every transaction.

Approach: Legislation permits Carriers to share information if the patient at the time of enrollment in the PCMH signs a consent form. The consent form would need to be renewed annually, perhaps at open-enrollment

Establish a state program that would allow for collaboration among stakeholders, but not run afoul of Federal Anti-trust Law.

Legislation crafted to meet the 2 pronged test of recent Supreme Court Law. Resolves Anti-Trust -- 2 point Test of Supreme Ct. (MIDCAL)

1. **Regulation supplants competition.** PCMH program ...
 - “is likely to result in the delivery of more efficient and effective health care services”
 - “is demonstrated in the public interest.”

2. **Patient Centered Medical Home Program with MHCC**
 - actively supervises activity of participants , MHCC granted authority to ...
 - defines qualifying standards for A PCMH
 - Specify payment for care coordination,
 - Quality and efficiency standards and bonus payment structure

3. **All Payers with Premium Revenue above \$90 Million should participate**

Provide a framework for carriers to continue their own PCMH programs within scope of reasonable state oversight.

Single Carrier PCMH pilots are now underway.

These pilots face the same issues with respect to the Insurance Article.

- No Cost-based incentive payments
- No Information sharing back to the plan, except on per transaction basis after patient consent

Approach: These programs could have exemptions from Insurance Article, if they were approved by MHCC using broadly recognized standards of a PCMH program.

Single carrier plans could operate subsequent to the Maryland multi-carrier program and might operate for longer than 3 years.

How much additional revenue will be available?

- FFS + PMPM + Performance bonus based on meeting quality standards & generating cost saving
- Some start-up costs associated with practice transformation, some support
- PMPM payments for care coordination functions of the physician: \$3-\$ per month in other pilots.
- Quality -- practices select among list of performances measures
 - Preventive care measures + 1 or more chronic conditions – model after PQRI
 - Pediatric specific measures would be defined including preventive care and screenings
- If Practices meet quality measure will eligible for bonus payments if the practice generates savings. Practices that do not generate savings, get no cost bonus.

Steps in a simple Shared Savings Model (Assuming practice competes against itself)

1. Calculate the base year per capita expenditures for the practice.
2. Establish the Target= Adjusted Base Year Per Capita Expenditures × (1 + Expected Growth Rate)
3. Savings = Target*FTE Patients - Performance Year Per Capita Expenditures × FTE Patients.

Note: Per capita expenditures =Prof+RX+Institutional+DME+MH

How do I participate and what is the time line?

- Join the Workgroup now and help shape decisions.
PCMH@MHCC.STATE.MD.US
- Legislation will be introduced in the next several days
- Planning for up to 6 local outreach sessions with practices across state for early summer 2010.
- 07/10 begin practice enrollment
- Pilot will launch in 2011