Patient Centered Medical Home Workgroup

Review of Recommendations: Report to the Council

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October 1, 2009
Underlying objectives of the Maryland PCMH Pilot

- Improve clinical care process
- Increase access to care coordination
- Enhance patient experience of care
- Increase clinician and staff work satisfaction
- LOWER TOTAL COSTS OF CARE
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 (in proportion to market share).
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 January 1, 2011 to December 2013

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 2010 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 it 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 practices and 200 physicians assumes, 4 per practice.

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

**Overall Number of Covered Lives:** 200,000 assumes about 1,000 patients per physician.

**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

**Payment Model:** Yr 1: FFS+PMPM fee for all patients based on standardized risk and attribution methodology + Quality reward; Yr 2: FFS + PMPM + Quality Bonus + Cost Eff., a portion of derived from shared savings; Yr 3 FFS+PMPM + Cost Eff. and Quality Bonus derived from savings

**Data to be Collected:** Measured of Clinical Quality, Patient Experience/Satisfaction, Provider Experience/Satisfaction, Cost Efficiency
## Key Steps and Milestones

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start</th>
<th>Time in months</th>
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</thead>
<tbody>
<tr>
<td>Apply to CMS for Medicaid participation</td>
<td>Nov-09</td>
<td>2</td>
</tr>
<tr>
<td>Submit Grant for Evaluation Funding AHRQ</td>
<td>Nov-09</td>
<td>1</td>
</tr>
<tr>
<td>Obtain letters of commitment from private payers</td>
<td>Dec-09</td>
<td>2</td>
</tr>
<tr>
<td>Council action on the demonstration</td>
<td>Dec-09</td>
<td>1</td>
</tr>
<tr>
<td>Award of implementation contractor by Medical Home Advisory Panel</td>
<td>Feb-10</td>
<td>2</td>
</tr>
<tr>
<td>Apply to CMS for Medicare Participation</td>
<td>Mar-10</td>
<td>1</td>
</tr>
<tr>
<td>Hold PCMH Symposium held to raise awareness</td>
<td>Mar-10</td>
<td>2</td>
</tr>
<tr>
<td>Recruit practices to apply for participation</td>
<td>Jul-10</td>
<td>2</td>
</tr>
<tr>
<td>Notify qualified practices, signs participation agreement</td>
<td>Aug-10</td>
<td>6</td>
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<tr>
<td>Provide technical assistance through implementation contractor</td>
<td>Sep-10</td>
<td>3</td>
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<tr>
<td>Qualified practices enroll eligible patients using commonly approved attribution rules</td>
<td>Jan-11</td>
<td>12</td>
</tr>
<tr>
<td>Practices begin medical home service delivery. Payers begin medical home payments using enhanced FFS + PMPM</td>
<td>Jan-12</td>
<td>12</td>
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<tr>
<td>Transition Practices to Shared Savings model (Yr 2)</td>
<td>Jan-13</td>
<td>12</td>
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<tr>
<td>Transition Practices shift to a full implementation of a Shared Savings model (yr 3)</td>
<td>Dec-13</td>
<td>5</td>
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<tr>
<td>End Demonstration, Create Final Report</td>
<td>May-14</td>
<td>10</td>
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<tr>
<td>Council action on Final Report recommendations and Council decision to go forward</td>
<td>May-14</td>
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## Cost Centers and Sources of Funding

<table>
<thead>
<tr>
<th>Cost Center</th>
<th>Possible Providers of These Services</th>
<th>Funding Source</th>
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<tbody>
<tr>
<td>PCMH Advisory Panel</td>
<td>Various Stakeholder Donated time</td>
<td>No Cost to Pilot</td>
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<tr>
<td>Outreach Awareness &amp; Symposium</td>
<td>TransforMED, ACP, Academy Health</td>
<td>Grants from NGO’s and others</td>
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<tr>
<td>Payment and Quality Measure Consulting</td>
<td>MPR, Bailit Associates, CHC, RTI, Lewin</td>
<td>Grant funds and state revenue</td>
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<tr>
<td>Implementation Coordinator</td>
<td>Lipitz Center for Integrated Health Care, JHU, MGMA, TransforMED, Delmarva, RTI</td>
<td>Public, Private Payers, Large Health Care Institutions</td>
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<tr>
<td>Publicity</td>
<td>AAP, ACP &amp; AAFP State supplied</td>
<td>Grant and state Funds</td>
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<tr>
<td>PCMH PMPM costs</td>
<td>n/a</td>
<td>Payers financed in relation to market share</td>
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<tr>
<td>Pilot Evaluation</td>
<td>Harvard, Rand, U Conn</td>
<td>Grants funds Commonwealth, AHRQ,RWJ</td>
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Turning Recommendations into Actions

Need Council to ratify recommendations and next anticipated activities ...

1. Identify and select technical experts. State selected by NASHP to participate in multi-state PCMH consortium.

2. Resolve possible anti-trust issues.

3. Finalize payment formula and measurement criteria.

4. Submit grant applications -- AHRQ, possibly Commonwealth
   Conduct win ability first

5. Obtain payer commitments to participate.
   (Aetna, CareFirst, Coventry, UHC, Medicaid)

Breaking News: HHS authorizes CMS to participate in multi-payer pilot

CMS will solicit applications from states. States certify that they:

- Established Advance Primary Care models in all or parts of their states.
- Can demonstrate that a majority of the primary care physicians in the demonstration areas would participate.
- Meet stringent requirements for designating Advance Primary Care providers, including independent accreditation and requirements for the use of health information technology.
- Have integrated public health services to emphasize wellness and prevention.
- Secured the participation of a sufficient number of private payers and Medicaid.

Staff is currently assessing feasibility of Medicare participation.

Existing Medical Home Demonstration under the Medicare Improvements for Patients and Providers Act (MIPPA) will continue.