Maryland Multi-Payer PCMH Program

Update Presentation to the Health Quality and Cost Council

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Presentation Overview

• Goals For Maryland’s PCMH program

• Application Update

• Program Implementation Timeline
PCMH Value Proposition

- Enhanced primary care will improve health status and outcomes for patients (especially the chronically ill).
- The result will be fewer complications, ER visits, and hospitalizations.
- Savings from these improved outcomes can be used to fund increased payment to primary care practices.
- What it means
  - Medical homes must generate savings (which are validated through the performance measures) to be self-sustaining.
  - Investors (payers and purchasers) must guarantee support for the investments that practices make in transformation and operation as a medical home.
  - Practices are responsible for performance (as measured through specified process and outcome indicators or through financial claims analysis) to earn incentive payments.
PCMH Incentive Payment

- Incentive payments are based on shared savings.
- Practices are eligible for incentive payments if they:
  - Meet performance and measurement criteria
  - Achieve savings relative to their own baseline
- Calculations to be performed by MHCC, which may adjust for case mix or outliers.
- Achieve savings, report on quality, reduce utilization
Payer Participation Status

- SB 855 Mandates participation by private “fully insured” programs.
  - Aetna
  - CareFirst BlueCross BlueShield
  - CIGNA
  - United Healthcare
  - Coventry
- MHCC recruiting self-insured programs
  - State employee health plan will participate
  - High risk plan – MHIP will participate
- Medicaid will participate, but cap participation at 30,000 participants.
- Medicare
  - Maryland was not selected by CMS.
  - Hope to include Medicare Advantage Plans.
Application Update

• Our goal....
  – 200,000 patients by involving 50 practices and at least 200 providers,
  – FQHCs, solo providers, minority-led practices, and CRNPs.

• What we achieved...
  – 179 practices applied
  – Over 1,000 physicians
  – Practices reported they cared for 1.2 million patients.

• Practices are distributed throughout the state
• Select practices in Central Maryland, DC Metro, Eastern Shore, Southern Maryland, and Western Maryland.
• Plan to select 2-3 virtual practices composed of 3-5 solo practitioners that agree to work together to become medical home.
• Selection Panel composed of carrier representatives, Medicaid representatives, providers knowledgeable about PCMH capabilities and challenges of implementing the program for different practices.
Overview of the Applicants

<table>
<thead>
<tr>
<th>MHCC Planning Regions</th>
<th>Practice Type</th>
<th>Applied</th>
<th>Selection Goal</th>
<th>Applied</th>
<th>Selection Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Maryland</td>
<td>FQHC</td>
<td>94</td>
<td>26</td>
<td>14</td>
<td>5-6</td>
</tr>
<tr>
<td>EASTERN SHORE</td>
<td>Multi Spec</td>
<td>13</td>
<td>5</td>
<td>51</td>
<td>18</td>
</tr>
<tr>
<td>MONTGOMERY COUNTY and PRINCE GEORGE’s COUNTY</td>
<td>Single Spec</td>
<td>28</td>
<td>12</td>
<td>96</td>
<td>31-33</td>
</tr>
<tr>
<td>SOUTHERN MARYLAND</td>
<td>Solo</td>
<td>22</td>
<td>6</td>
<td>17</td>
<td>7</td>
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<tr>
<td>WESTERN MARYLAND</td>
<td></td>
<td>21</td>
<td>12</td>
<td></td>
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</tbody>
</table>
Refining Governance

• MHCC will manage the MMPP
  – Key activities include direction of practices, coordinating activities of learning collaborative, directing evaluator.
  – MHCC will maintain clear authority over the program to preserve pre-emption from Federal anti-trust law under the “State Action” Doctrine.

• Council, participating practices, payers will serve on the MMPP Advisory Panel. Panel will provide recommendations to MHCC on…
  – payment and quality reporting
  – practice transformation
  – dispute resolution

• First advisory panel meeting planned shortly after the selection process.
Operational Structure
## Revised Implementation for 2011

<table>
<thead>
<tr>
<th>Month</th>
<th>Events</th>
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<tbody>
<tr>
<td><strong>February 2011</strong></td>
<td>MHCC releases patient attribution requirements. RFP Evaluator submissions due.</td>
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<tr>
<td><strong>March 2011</strong></td>
<td>Maryland BPW awards Evaluator contract. Carriers submit attribution data to MHCC.</td>
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<td><strong>April 2011</strong></td>
<td>Start of Transformation and Learning Collaborative. Patients attributed to PCMH practices.</td>
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<tr>
<td><strong>May 2011</strong></td>
<td>Meeting of PCMH Advisory Panel. Evaluator gathers baseline data from practices and patients.</td>
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<tr>
<td><strong>June 2011</strong></td>
<td>Private carriers and Medicaid begin paying PPPM fixed payments to practices that attest to meeting NCQA criteria.</td>
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<td><strong>November 2011</strong></td>
<td>First re-attribution results delivered to practices.</td>
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<tr>
<td><strong>December 2011</strong></td>
<td>Update to General Assembly on Status of the Program. Deadline to submit applications to NCQA's Physician Practice Connections—Patient-Centered Medical Home for recognition.</td>
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