Legal Issues, Quality Measures, Payment

PCMH Workgroup
October 26, 2009
What must be done?

• Resolve remaining legal issues so that payer recruitment and then practice outreach can start.

• Develop quality measures suitable for multiple populations and payers.

• Refine payment methodology, particularly transformation costs and care coordination payments.

• Plan outreach and awareness strategy

Workgroup needs to participate in development of quality measures, resolution of payment issues, outreach planning.
Legal issues – Antitrust

State pilots point to state action preemptions as providing protection from federal anti-trust violations.

- Two-pronged test:
  1. Direct and strong commitment for state action as evidenced by legislation.
  2. Direct involvement of the State in creating and managing the process.
- Authority for launching a PCMH pilot in Maryland is linked to Gov. O’Malley’s Executive Order establishing Council – clear commitment is not evident in EO.
- State is serving as convener and manager of payment process.

Approach: Take advantage of active role of State in developing the program.
1. State will develop payment methodology with the direct involvement of the Workgroup.
2. Payment model will be offered to each payer individually.
   a. Participation is voluntary, no coercion applied.
   b. Payments will be what has been agreed to in the Workgroup.
3. Bind payers to pilot via a no-cost contract with the State.
Legal issues – Self-Insured ERISA Exempted Employers

Issue: Will self-insured employers pay additional costs of PCMH for their employees?
• Initial start-up costs will not be recovered within that year. Pilot hopes to be budget neutral by achieving savings by year 3.
   1. Self-insured account for about 50% of privately insured covered lives.
   2. Resistance to finance a pilot that could cost more $$s in the short-run.
   3. Implications to carriers – self-insured ASO contracts awarded through competitive contracts.
      • Contract specific language may prohibit use of capitation.
      • Unilateral increases may violate terms of the contract.
   4. Contract-by-contract approval will be expensive for payers.

Approach: Build on high-level state endorsements from Council.
• Launch further outreach to generate commitments from largest Maryland public (state and local gov’t) and private employers and large self-insured employers.
• Build on extensive support from leading national firms: IBM, Caterpillar, General Mills, General Motors, Proctor & Gamble, US Steel, XEROX. National Business Group/Coalition are strong supporters.
Legal issues – Other state laws (privacy and payment)

Maryland state privacy laws Insurance Article Sec.14-138 – *Disclosure of medical information* and Insurance Article Sec. 4-403 – *Disclosure of Insured’s medical records* limit carriers in providing claim information to treating providers.  
• Claim information may be important sources of clinical information as EMRs will not be fully deployed during the life of the pilot.  
• Some suggest that the law requires patient consent for every occurrence. An annual consent would not be adequate.  
• Release of these data to treating providers would be permitted under payment, treatment, and health care operation exemptions under HIPAA. HIPAA does not preempt stringent state law.

Maryland law forbids payment withholds – bonus structure could run afoul of law.

Approach: Move forward cautiously as privacy rights are highly valued.  
• Determine from AG whether a single annual consent will be adequate. Part of commitment to participate in a PCMH.  
• Investigate with stakeholder groups how the law could be changed.  
• Payers should consider limiting the sharing of claims data.
Selection of Quality Measures

Achievement of quality measures will be one component of a reward structure built on a shared saving foundation.

- Selection of quality measures: preferred approach in pilots is a combination of process and outcome measures.
- Covered populations: management of the overall patient population versus those with chronic conditions.
- How is the quality reward accounted for in the total structure?

Approach: Convene subgroup to identify those measures appropriate for pediatric and adult practices and that could be applied for Medicaid and privately-insured market. Seek clinical leadership of the subgroup.
Payment Methodology

Areas of Agreement
• Use requirements under HB 706 to subsidize PCMH transformation.
• Build reimbursement on a foundation of shared savings -- Practices will received payments for savings due to reduced hospitalizations and emergency room visits. Synergy for hospitals, in 07-01-2010, HSCRC will not pay for some highly avoidable readmissions.
• Expanded FFS in a limited manner – payers use their traditional fee schedule + reimbursement for E-visits and after-hours care.

Challenges
How to finance practice transformation?
Care coordination implementation and payment
• Will PMPM work for all payers, issues with self-insured firms?
• Level of PMPM, to risk adjust or not?
• Who will provide the care management service?
What is the reward structure given possible legal constraints (withholds)?
Maryland PCMH Pilot
Outreach Strategy

• Planning for up to 6 local conferences to be held around the state in the Spring of 2010 for practitioners and purchasers is underway; multiple sponsors are being sought for each of these meetings.

• Collaborating with Merck Pharmaceuticals’ consultants for the local conferences.

• Informational release regarding the pilot was distributed by MedChi to its members this month.

• Press releases will be coordinated with DHMH Council staff and Office of Governmental Affairs for statewide distribution

• Informational releases will be shared with Workgroup participants for distribution to their organizations as we roll out the pilot.

• Outreach to employers is in the development phase.
## Key Actions and Milestones

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