PATIENT CENTERED MEDICAL HOMES

Maryland's Multi-Payer Patient Centered Medical Home Program

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MHCC | MARYLAND HEALTH CARE COMMISSION

MARYLAND

PCMH model is anchored in primary care

- **Builds on key principles of primary care:**
  - ✓ 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 health care needs;
  - ✓ Coordinated - integration of care across a person's conditions, providers, and settings and with the patient's family, caregivers, and community.
- **Other primary care principles**
  - ✓ Improvements through a systems-based approach to quality and safety
  - ✓ Patient-centered – needs and wishes of patient and family are consciously considered.

- **PCMH practices place special emphasis on developing the chronic care and preventive care processes that can improve the health of the practice's entire population.**

What we ask of practices

- Designate a Practice Champion and an Internal Coach
- Participate in a learning collaborative convened by organized medicine and seasoned practice transformation experts
- Build the care team and deliver team-based care
- Achieve NCQA Recognition as a PCMH
- Measure and report on quality and performance
- Participate in a new reimbursement program
- Continue on the path of improvement

Maryland Multi-Payer PCMH Program

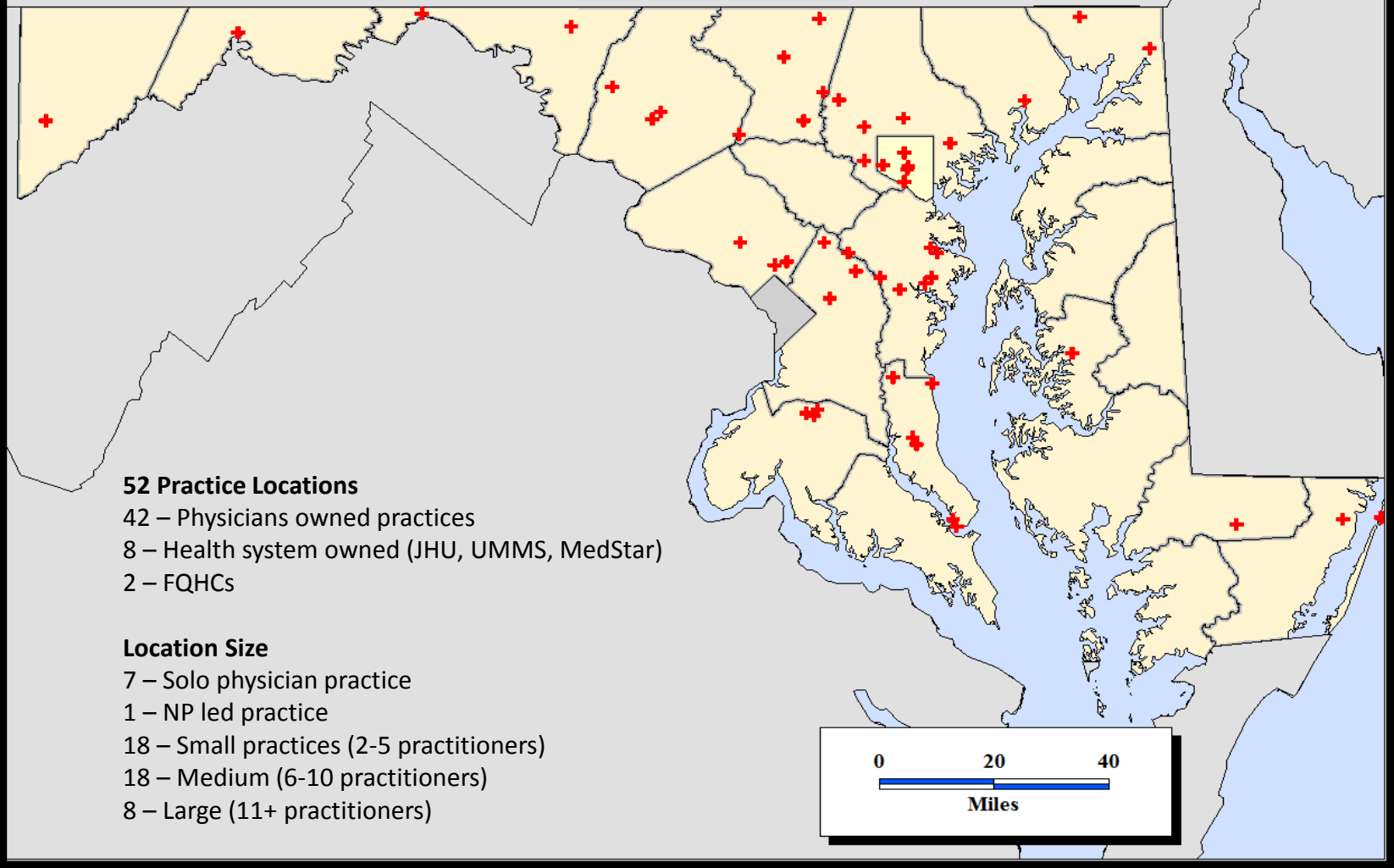
2010 Legislation …

- Authorized incentive-based reward structure (shared savings)

- Directed MHCC to …
  - establish a multi-payer program and provided exemption from Federal anti-trust law;
  - develop a program to accredit single payer programs; and
  - report to General Assembly in December 2014 on the success of the program.

Practice Transformation Maryland Learning Collaborative	Innovative Payment Discern Consulting	Program Evaluation IMPAQ, Inc.
• Obtain NCQA Recognition • Broaden the Scope of Care	• Upfront Investment (Fixed Transformation Payments) • Shared savings	• Can the model achieve savings? • Does the model increase satisfaction? • Can PCMH reduce disparities?

MMPP Practice Sites



52 Practice Locations
42 – Physicians owned practices
8 – Health system owned (JHU, UMMS, MedStar)
2 – FQHCs

Location Size
7 – Solo physician practice
1 – NP led practice
18 – Small practices (2-5 practitioners)
18 – Medium (6-10 practitioners)
8 – Large (11+ practitioners)

Key Features : Payment Model

Fee-For-Service

Primary care practices continue to be reimbursed under their existing fee-for-service payment arrangements with health plans.

+

Fixed "Transformation" Payment

Primary care practices receive a per patient per month fee (paid semi-annually) between $3.50 and $6.00.

Practices must achieve NCQA recognition and invest a portion of their fixed payment in care coordination.

+

Incentive Payment (Shared Savings)

Primary care practices receive a share of any actual savings generated by reducing total cost of care through improved patient outcomes.

Practices must report on a set of clinical quality and utilization measures. (Performance requirements increase over 3 years.)

Evaluation Design: Three Components

- Data Driven Outcomes evaluation
  - Use of the APCD to Assess the Impact of MMPP on:
    - Quality of Care
    - Access to and delivery of healthcare
    - Cost due to changes in utilization
    - Health disparities: racial and urban/rural

- Experience and data driven transformation and implementation evaluation
  - Sites visits and interviews - nine practice sites; years 1 and 3
  - Time Trend Analysis
    - Maryland Recognition Level
    - Financial

- Experience driven satisfaction evaluation
  - Patient (telephone survey) - 1,000 patients (all practices); adult and children; years 1 and 3
  - Provider (web-based survey) – all clinicians; years 1 and 3

What we have accomplished

- ✓ 330 providers, including physicians and nurse practitioners, participate in the program.

- ✓ 250,000 privately insured and Medicaid patients are attributed to practices.

- ✓ Practice Transformation
  - Created and funded the Maryland Learning Collaborative
  - Payers distributed payments of approximately $9.4 mil. in the first 1 ½ years

- ✓ 52 practices achieved NCQA recognition
  - Two-Thirds achieved Level II or III at first milestone (3/31/12)
  - NCQA Level I practices all submitted for Level II or III (9/30/12)

- ✓ Quality Reporting -- 52 practices submitted 2011 data in February 2012
  - Alignment – 7 of the measures are core or alternate core under ONC MU.
  - 6 measures for pediatric practices
  - 18 measures for adult practices

- ✓ Issued Shared Savings of approximately $900,000 to 23 practices in 2012

- ✓ Launched a robust evaluation

- ✓ Assessed how payment incentives could be used to reduce disparities

MMPP Plans for 2013

- Expand sharing of carriers' claims data with participating practices
  - Ultimate goal is a common interface
  - Shorter term goal is to ensure practices have guaranteed access to each carrier's best system

- Align PCMH participating practices with Maryland's health information exchange.

- Implement 2nd stage shared savings – FY 2014 – governed by ability of practices to meet quality thresholds…
  - Practices can achieve 30%-50% shared savings based on success in meeting thresholds
  - Hybrid approach to quality thresholds, similar to CMS's process for hospital value-based purchasing:
    - Practices can meet an absolute value benchmark, or
    - Meet a threshold for improvement , % of the quality gap closed

- Launch patient survey and provider survey – January/February 2013

Key Considerations for Program Expansion

- Payer agnostic model
  - Consistent shared savings model and quality metrics
  - Ability to align reward structure with state improvement goals
  - Carriers have less flexibility in aligning a program with organization-wide goals

- Practice transformation must be sustained
  - External practice transformation support is critical for most practices
  - Essential to identify practice transformation entity(ies) and provide stable funding.

- Care coordination/management is essential
  - Scope is highly dependent on who is providing the CC/CM
  - A combination of provider-based, payer-based, and community-based support may work best
  - Providers should have opportunity to define the mix and should be held accountable for results.

Key Considerations for Program Expansion

- Integration of Health IT
  - An EHR is an essential element for success
  - Carrier information is needed…
    - Discharge, admission, and claims data are helpful.
    - Aim to provide access through a common portal.
    - Link PCMH practices to HIE initiatives to build synergy between both programs.

- Spring 2013, MHCC will convene workgroup to consider future of the program
  - Align with broader state innovation initiative.
  - Link to health delivery system reforms such as ACOs and hospital payment innovations.

- Report due to Legislature in December 2014