The Feasibility of Including Reductions in Disparities As a Performance Factor in Maryland's Multi-payer PCMH Program

Report to the Maryland General Assembly

December 2012

Maryland Health Care Commission

Craig Tanio, MD, MBA
Chair

Ben Steffen
Executive Director

Charge to the Maryland Health Care Commission

Chapter 3 of the 2012 regular session, the Maryland Health Improvement and Disparities Reduction Act of 2012, established a process that requires, among other things, that the Maryland Health Care Commission (MHCC, or Commission) complete and submit a report on the possibility of including racial and ethnic performance data tracking in statewide quality incentive programs. Specifically, the bill requires that MHCC:

> "*In coordination with the evaluation of the Maryland Patient Centered Medical Home (PCMH) program, develop recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes;*
>
> *Report to the General Assembly on or before January 1, 2013:*
>
> - *Criteria and standards to measure the impact of the Maryland Patient Centered Medical Home program on eliminating disparities in health care outcomes; and*
> - *How current data collections' limitations will be overcome to enable better reporting of health outcomes by race and ethnicity."*

Introduction

The current shared savings payment methodology in the Maryland Multipayer PCMH (MMPP) program makes an implicit assumption that practices will identify reducing disparities as one strategy for reducing total patient spending. Practices receive up to 50 percent of any savings in the total cost of care for patients in that medical home. There are significantly more financial incentives to reduce disparities by providing better access to primary care to all patients and more effective care management of patients with chronic conditions.

As evidenced by the passage of this legislation, the Maryland General Assembly recognized that physician-based shared savings initiatives can widen resource gaps among physicians' organizations. Those physicians located in areas with recognized greater health disparities might be less able to obtain bonuses due to their difficult patient mix. Several pay-for-performance programs established in the last decade have published findings, one of which was that practices with a higher percentage of minority patients were less likely to generate total savings in the cost of care. These results suggest that reward programs may need to be designed to provide additional incentives to practices that serve more vulnerable populations.[1, 2, 3]

---

[1] Joel S. Weissman. and Romana Hasnain-Wynia. and Robin M. Weinick. and Raymond Kang. and Christine Vogeli. and Lisa Iezzoni. and Mary Beth Landrum. "Pay-For-Performance Programs to Reduce Racial/Ethnic Disparities: What Might Different Designs Achieve?" *Journal of Health Care for the Poor and Underserved.* 2012; 23.1, 144-160.

[2] Friedberg, Mark W. Safran, Dana Gelb, Coltin, Kathryn, Dresser, Marguerite, Schneider, Eric C. "Paying For Performance In Primary Care: Potential Impact On Practices And Disparities," *Health Affairs.* 2010; 29,5, 926-932.

[3] Casalino, Lawrence P, Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery, and Diana Ramos. "Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities?" *Health Affairs*. 2007; 26(3):w405-w414.

Background

The Maryland Patient Centered Medical Home Program, established unanimously by the 2010 General Assembly, is designed to improve patients' health status and elevate the role of the primary care provider in our health system. Maryland's MMPP medical homes provide primary care clinicians – both physicians and nurse practitioners – with financial incentives and technical assistance to expand access to high-quality primary care, promote wellness and prevention, advance care by using multi-disciplinary teams, and coordinate care to improve disease management and the overall health of their patients. Primary care clinicians and health insurance carriers share incentives to reduce patient costs and increase quality through this pilot program.

The MMPP launched in May 2011 with 53 pilot sites.[4] These practices, reflecting a broad range of practice sizes, structures, and geographic locations, were selected in order to test what it takes to transform a traditional practice into a PCMH practice. The five largest commercial health insurers in the State are required to participate. Six of the seven Medicaid managed care organizations also agreed to participate after the Medicaid Administration solicited their participation. Medicare is not participating in the MMPP program.

The Commission selected a diverse set of practices to participate in the MMPP. Academic medicine-affiliated, health system-owned, and clinician-owned practices participate in the Program. Practices are also fairly evenly distributed geographically across the state. However, MHCC did not consider the racial/ethnic mix of clinicians in making the selections. Despite this, when compared to the overall race/ethnicity mix of Maryland's primary care physicians, the MMPP is composed of somewhat more African American physicians and fewer Asian American physicians. Non-Hispanic white physicians are represented in the MMPP in almost the same proportion as the overall primary care physician population. Table 1 sets forth the race/ethnic breakdown of MMPP physicians and primary care physicians Statewide; while Exhibit 1, below, displays the MMPP practices' locations.

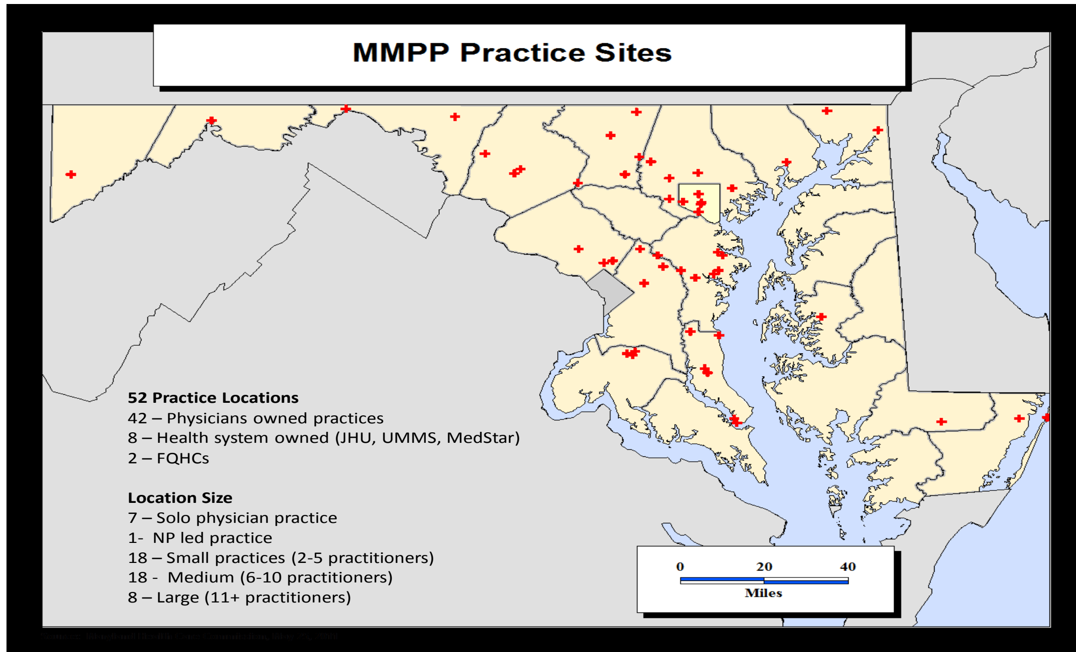
Table 1 – Race/Ethnicity Distribution of Primary Care Physicians in the MMPP and Statewide

Race/Ethnicity	MMPP	Statewide
Caucasian (Non-Hispanic)	49%	48%
Black/African American	27%	17%
Hispanic/Latin American	2%	4%
Asian	18%	26%
Other	5%	9%

Source: 2011-2012 Maryland Board of Physician Licensure Survey

[4] One practice voluntarily left the program in December 2011.

Exhibit 1
Maryland's Multipayer Patient Centered Medical Home
Participating Practices' Locations



Key Elements of the MMPP That Are Aligned with the Goal of Reducing Disparities

NCQA PCMH Recognition

Beginning in March 2012, practices participating in the MMPP program were required to receive, at a minimum, PCMH Level I recognition from the National Committee for Quality Assurance (NCQA). To achieve NCQA recognition, practices must demonstrate the ability to successfully provide six elements of care, including: access during expanded office hours, use of data for population management, care management, support of a self care process, tracking of referrals and follow up, and implementation of continuous quality improvement.

Several NCQA Recognition criteria encompass elements that are related, either directly or indirectly, to eliminating disparities in patients' health care outcomes, such as:

- PCMH Standard 1, Enhance Access and Continuity,
    - Element F1: Culturally and Linguistically Appropriate Services, the practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by assessing the racial and ethnic diversity of its population, assessing their language needs, and providing interpretation or bilingual services and printed materials to meet the language needs of its population.
    - Element G: The Practice Team, Factor 7, requires the care team to be trained on "effective patient communication for all segments of the practice's patient population, but particularly the practice's vulnerable population." Training may include information on health literacy and other approaches to addressing communication needs.

- PCMH Standard 2—Identitify and manage patient populations,
  - Element A2, Patient Information, requires that the practice use an electronic health system that records patient information. Race, Ethnicity and preferred language are core meaningful use requirements for incentive payments—Factors 3 and 4 require these data to be collected using OMB race and ethnicity categories;
  - Element D, Identify and Manage Patient Populations, while not specifically related to reducing disparities, requires practices to use data for chronic disease management.

- PCMH Standard 3, Plan and Manage Care, requires the practice to identify high risk patients and to implement care management plans, among other things.

Additional information regarding NCQA's PCMH Recognition criteria – a summary chart of the NCQA PCMH 2011 6 Standards, 27 Elements, 149 Factors, is set forth below as Exhibit 2.

Exhibit 2

NCQA PCMH 2011

6 Standards, 27 Elements, 149 Factors

Points	Standard and Element	No. Factors	Must Pass 50% score
20	**1 Enhance Access and Continuity**	34	
4	A Access During Office Hours	4	X
4	B Access After Hours	5	
2	C Electronic Access	6	
2	D Continuity	3	
2	E Medical Home Responsibilities	4	
2	F Culturally and Linguistically Appropriate Services (CLAS)	4	
4	G Practice Organization	8	
17	**2 Identify and Manage Patient Populations**	35	
3	A Patient Information	12	
4	B Clinical Data	9	
4	C Comprehensive Health Assessment	10	
5	D Using Data for Population Management	4	X
17	**3 Plan and Manage Care**	23	
4	A Implement Evidence-Based Guidelines	3	
3	B Identify High-Risk Patients	2	
4	C Manage Care	7	X
3	D Manage Medications	5	
3	E Electronic Prescribing	6	
9	**4 Provide Self-Care and Community Support**	10	
6	A Self-Care Process	6	X
3	B Referrals to Community Resources	4	
18	**5 Track and Coordinate Care**	25	
6	A Test Tracking and Follow-up	10	
6	B Referral Tracking and Follow-up	7	X
6	C Coordinate with Facilities/Care Transitions	8	
20	**6 Measure and Improve Performance**	22	
4	A Measures of Performance	4	
4	B Patient/Family Feedback	4	
4	C Implements Continuous Quality Improvement	4	X
3	D Demonstrates Continuous Quality Improvement	4	
3	E Performance Reporting	3	
2	F Report Data Externally	3	
100 Points		**149 Factors**	**6 MP Elements**

Table 2, below, summarizes the NCQA Level 1, Level 2, or Level 3 recognition status of the MMPP participating practices as of October 2012.

Table 2: NCQA PCMH Recognition Level as of October 2012

NCQA Level 3 = 20 practice sites Highest level of NCQA Achievement	NCQA Level 2 = 14 practice sites	NCQA Level 1 = 13 practice sites Lowest level of NCQA Achievement
Calvert Internal Medicine: • Dunkirk • Solomons • Prince Frederick	Bay Crossing Family Medicine, Arnold	Atlantic General • Townsend • Berlin
Cambridge Pediatrics, Waldorf	Children's Medical Group, Cumberland	Comprehensive Women's Health, Silver Spring
Dobin & Hoeck, Silver Spring	Family Care of Easton	Family Health Center of Baltimore
Greenspring Internal Medicine, Towson	Family Medical Associates (Carroll Hospital Center) • Eldersburg • Finksburg	Family Medical Associates (Carroll Hospital Center) • Manchester • Reisterstown
Johns Hopkins Community Physicians • Canton Crossing • Hagerstown • Montgomery • Water's Edge • Wyman Park	Gerald Family Care, Cheverly	Parkview Medical Group • Myersville • RoseHill • Mt. Airy
MEDPEDS, Laurel	Hahn & Nelson Family Medicine, Hancock	The Pediatric Group • Crofton • Severna Park • Davidsonville
MedStar (Franklin Square Family Health Center), Baltimore	Johnston Family Medicine, Westminster	Primary & Alternative Medicine, Silver Spring
Potomac Physicians • Frederick Medical Center • Security Health Center, Baltimore • Annapolis Regional Medical Center	Natural Family Wellness, Glenn Dale	
Stone Run Family Medicine, Rising Sun	Patient First, Waldorf	
Ulmer Family Medicine, Annapolis	Shah Associates • Hollywood • Prince Frederick • Waldorf	
University of Maryland Family & Community Medicine, Baltimore	University of Maryland Pediatrics at the Harbor, Baltimore	
University Care at Edmonson Village, Baltimore		

Source: Maryland Health Care Commission, October 2012

Financial Incentives

Participating carriers and Managed Care Organizations (MCOs) pay prospective, semi-annual payments to participating practices. The fixed transformation payment (FTP) is paid prospectively on a per member per month rate depending on the size of the practice and its level of NCQA recognition. These payments are, in effect, economic development funds. Practices are required to expend 35% of their FTP payments on the care management function. Approximately $9.4 million has been invested in the program since its inception by commercial payers and Medicaid MCOs.

A second financial incentive for practices to participate in the program is the shared savings component. A practice must achieve a savings against its expected total costs of care (minus FTP payments received) and report on up to 21 measures that gauge the quality of care provided to its patients for the practice to earn shared savings. The expected total cost of care is calculated from the 2010 total costs of care for patients attributed to the participating practice site, adjusted for overall growth in health care spending. The 21 quality measures are all National Quality Forum (NQF) recognized. Five of the measures are specific to pediatric patients.

The scoring methodology allows practices to earn credit through both achievement (doing well relative to a defined performance threshold) and improvement (doing well relative to the practice's own previous performance). Practice sites receive two scores for each quality measure reported: an achievement score and an improvement score. A practice site's performance score for each measure is the higher of the achievement or improvement score. This allows for all practice sites to have an opportunity to earn credit regardless of their initial performance level. High performing practice sites with little room for improvement are rewarded with a high (or passing) achievement score, while lower performing practice sites have the opportunity to earn credit through improvement relative to their baseline performance.

During the first six months of the MMPP program, 22 practices achieved savings and received shared savings payments from five participating private health plans: Aetna, CareFirst, Cigna, Coventry, and United Healthcare. These payments averaged $36,500 per practice and totaled over $800,0000. Fifty of the fifty-two practices in the program reported quality metrics extracted from their electronic health record systems and were eligible for savings payments. Medicaid shared savings payments will be calculated in the first quarter of calendar year of 2013.

The selection of measures that highlight existing disparities in care can be used to spark action, especially if reductions in the disparity as well as meeting a quality level are part of the financial incentive. Such an approach will be discussed in the Recommendations section. When shared savings programs include performance measures that exhibit disparities, developers must design the methodology to reward practices for both the absolute performance improvement and for improvement in narrowing the gaps in care.

Table 3, below, displays some of the disparity measures tracked by the Agency for Health Care Research and Quality (AHRQ) if there is a significant disparity in results for that measure between white and minority populations as reported by AHRQ in either the 2010 or 2011 *National Healthcare Disparities Report* and selected quality measures that are reported by the MMPP practices. Please note that the measures tracked and reported by AHRQ do not fully align with the NQF measures that the participating practices report to the Commission.

Table 3
Comparison of Disparities as Measured and Reported by AHRQ in 2010 and 2011
With Selected MMPP Quality Measures

AHRQ Disparity Measure	MMPP Quality Measure
Asthma Screening and Treatment	√
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	√
Colorectal Screening	√
Tobacco Use Assessment	√
Pneumonia Vaccination Status in Older Adults	√
Diabetes control	√
Anti-Depressant Medication Management	√
Adult Weight Screening and Follow-up	√

Sources: Maryland Health Care Commission, December 2012 and Agency for Health Research and Quality (AHRQ), *National Healthcare Disparities Report, 2010* and *National Healthcare Disparities Report, 2011*

Program Evaluation

The legislation that established the MMPP requires the Commission to conduct an independent evaluation of the program. In early 2012, the MHCC awarded a contract to IMPAQ International, LLC to conduct an evaluation of the Maryland Multipayer Patient Centered Medical Home program. IMPAQ will employ a mixed-method evaluation approach employing quantitative and qualitative methods. Quantitative research, using existing claim and practice databases, practices' quality reporting results, and patient surveys will be the source of information for identifying the structural changes in participating practices, improvements in patient quality, and reductions in costs. Qualitative research into practice transformation, gathered through interviews and site visits for a random sample of participating practices, will be used to chart changes in practice, provider, and patient perspectives that are difficult to calculate.

The IMPAQ team will conduct analyses to address research questions specified under the enabling legislation related to the Maryland Program's impact on: (1) improvements in access to and delivery of healthcare, (2) improvements in quality of care, (3) lower costs through reduced utilization, (4) reduced health disparities, (5) increased patient satisfaction, and (6) increased provider and staff satisfaction.

For the outcome evaluation, the IMPAQ team has contractually agreed to characterize outcome measures using Donabedian's structure/process/outcome (SPO) model on measures of healthcare quality (Donabedian 1966; Burns 1995). These three categories of quality measures are linked in an underlying framework, such that good structure promotes good process and good process promotes good outcomes (Donabedian 1988). Structural measures of quality refer to the organizational and professional resources related to provision of care, such as availability of after-hours care or use of electronic health records. Process measures of quality refer to the things done to and for the patient by practitioners in the course of treatment; examples include processes for cancer screening and for medication reconciliation. Outcome measures are the desired states resulting from care processes, which may include reduction in morbidity and mortality, and improvement in the quality of life (Kane and Kane 1988). Donabedian described two types of outcomes: a) technical outcomes (e.g., physical and functional outcomes) and b) interpersonal outcomes (e.g., patient satisfaction). Since these two types of outcomes are interdependent, both must be considered when evaluating quality of care.

IMPAQ will be using the CAHPS® PCMH Survey, which provides a rich set of indicators that capture patient satisfaction with issues surrounding healthcare access and effective communication. The evaluation team will administer the survey to patients in the practices participating in the Maryland program. In addition to questions addressing PCMH issues, the CAHPS® PCMH Survey also includes questions from the CAHPS® Clinician and Group Survey to be administered to participating clinicians.

IMPAQ will use data available through the Medical Claims Data Base (MCDB) for overall Program evaluation. They will use also use data available from the MCDB through the Maryland Medicaid program to estimate the effect of the Program on the reduction of health disparities. That evaluation is limited to the Medicaid population because private health insurance carriers participating in the program are only now beginning to collect racial and ethnic data on enrollees. This limits the generalizability of the findings due to the fact that Medicaid enrollees are concentrated among certain practices and are not uniformly enrolled in MMPP practices throughout the State. The rigorous evaluation results will be presented to the Commission in early 2014.

Current Program Limitations

Data Needed to Measure Reductions in Disparities are Sparse

As discussed above, information on demographics is just beginning to be gathered at the carrier level. Medicaid and Medicare both collect racial and ethnic enrollee data; however, only Medicaid participates in the MMPP program. The Commission could establish a process to impute the patients' racial and ethnic characteristics for participating practices using census data and participant zip code information in Maryland's MCDB. However, due to the inexact nature of imputation, such an estimation should not be used in the methodology for incentive payment requirements.

To address requirements in the Health Improvement and Disparities Reduction Act regarding quality reporting for health benefit plans MHCC is implementing a Maryland-specific health plan quality reporting tool for the 2013 reporting period that will measure how many state regulated plans are collecting race, ethnicity, and related data through either direct or indirect methods. The Race/Ethnicity, Language, Interpreters and Cultural Competency ("RELICC") assessment tool was developed for Maryland with input from the participating health benefit plans and results will be incorporated into the 2013 Health Benefit Quality and Performance Report.

However, requirements for all health benefit plan quality reporting and reporting to the MCDB would not apply to self-insured plans, as they must comply with the statutory and regulatory requirements of the federal Employee Retirement Income Security Act ("ERISA"), and are specifically exempt from meeting Maryland's statutory and regulatory requirements for health benefit plans. The ERISA statute applies to all self insured plans, the Maryland State Employees health benefits plan, the federal employee health benefits plan, and TRICARE military benefit plans which (combined) encompasses more than 50% of the total insured Maryland population.

As an alternative, data collected by the practices through their EHR systems could be used as part of a multichannel data collection effort. In this scenario, data reported by the practices could be audited by the carriers and verified through analysis of claims submissions to the MCDB. This alternative would mitigate issues surrounding demographic data collection at the time of enrollment in a carrier's health benefits plan.

Integrating the Incentive Payment: The Pilot Program Is Already Underway

The MMPP program is currently in year two of the three-year pilot program. Participating practices and carriers signed an agreement specifying participants' responsibilities for participation, including data reporting and payment requirements prior to the program's launch. The terms of that Participation Agreement may be altered *only* by agreement of all signatories. Thus, incorporating racial and ethnic performance data requirements into the practices' data reporting and in the shared savings payment methodology is only feasible in the next generation of the program. At its discretion, the General Assembly will decide whether the Maryland's PCMH program will continue past 2014.

If the General Assembly extends the Patient Centered Medical Home Program beyond calendar year 2014, program components should include explicit requirements for reductions in health disparities *only* if the carriers' data collection efforts increase. Currently, only one carrier has collected data on race and ethnicity and these data are incomplete. In order for incentives for reductions in disparities to be included in this program, data collection must be accurate and robust at the carrier level; an estimation methodology (including setting baseline data) must be agreed upon by both participating practices and carriers and from the outset.

Chapter 3 of 2012 also establishes Health Enterprise Zones (HEZ). Chosen zones will form action plans (similar to plans in economic development zones) aimed at increasing the health outcomes for citizens of those zones. Specifically, the legislation requires that any practice in a HEZ that wishes to become an MMPP practice be given priority for entry into the program.

Bringing new practices into the program offers an opportunity to further tailor participation agreements to include improvement in minority health outcomes as a specific aim. New practices' sites would be at the beginning of transformation and, therefore, would create a second wave of implementation that could act as an incubator pilot built from the existing MMPP model.

Recommendations

Increase Engagement in Improving Minorities' Health Status within the Current Program

There is opportunity to increase engagement by the program participants in improving minority patients' health status and outcomes within the existing program. All current practices operate electronic health record systems. As mentioned above, scoring standards and factors associated with achieving NCQA recognition require practices to identify and manage patient populations through collection of demographic data, including race. Practices' EHR systems must include report-generation functionality and the data must be searchable.

The MHCC should engage with MMPP practices in using their EHR systems to generate reports on key process measures, such as diabetic screening, by race and ethnicity characteristics. Through the Maryland Learning Collaborative, the MHCC could provide training on the use of practices' EHR systems for collecting and reporting data by race and ethnicity characteristics through the Commission's established, secure data portal. The initial set of data measures should focus on patient care processes, such as medication adherence, rather than patient treatment outcomes.

Increase Pressure on Carriers to Collect Data

Carriers in Maryland are in the early stages of collecting enrollee data by race and ethnicity. In order to implement a PCMH program encompassing the measurement of patients' health outcomes by these characteristics, data must be collected at the carrier level. Carriers should collect these data through a variety of channels, including their health benefit plan enrollment process and through patients' self-reporting as they use carriers' electronic portals.

Require Minority Improvement Plans and Bonus Incentives in Future Programs

Assuming that the Maryland General Assembly extends the Maryland PCMH Program beyond calendar year 2014, future PCMH programs should include a requirement for the inclusion of practice-specific performance improvement plans. These plans should be data driven from the practices' EHR systems and address the needs of the unique patient population enrolled in each practice. These performance improvement plans should include a component to address disparities in care and must be included in the practices' quality measure reporting to the Commission.

Further, all new Maryland PCMH programs, whether launched as a multipayer or single payer initiative, should be required to include a methodology for setting baseline patient health status data and making additional bonus payments to practices for improvements in their minority patients' health status outcomes.

Maryland Health Care Commission

Disparities Study Work Group Members, 2012

Linda Bartnyska, MHCC
Linda Dietsch, Maryland Physicians Care
Erin Dorrien, MHCC
Seth Eaton, MD, MedPeds
Rick Fornadel, MD, Aetna
Ed Koza, MD, United Healthcare
Theressa Lee, MHCC
Mark Luckner, Executive Director, Community Health Resources Commission
David A. Mann M.D., Ph.D., DHMH, Office of Minority Health and Health Disparities
Susan Myers, MHCC
Mariam Rahman, MHCC
Carol Reynolds, MD, Potomac Physicians
Karen Rezabek, MHCC
Scharmaine Robinson, MHCC
Jon Shematek, MD, CareFirst
Srinivas Sridhara, MHCC
Ben Steffen, Executive Director, MHCC
David L. Stewart, M.D., M.P.H, University of Maryland
Ben Stutz, Policy Director, Office of Lt. Governor Anthony G. Brown
Leahanne C. Thomas, United Healthcare
Lesley Wallace, MedStar Family Choice