Maryland Health Care Commission

Patient Centered Medical Home Program Participation Agreement

Whereas, health care costs continue to increase, making it more difficult for individuals, families, and businesses to afford a health benefit plan;

Whereas, the increase in health care costs is, in part, attributable to inadequate coordination of care among providers, difficulties accessing primary care, and a lack of engagement between patients and their primary care providers;

Whereas, in an effort to address these concerns, the Maryland General Assembly directed the Maryland Health Care Commission to establish a medical home program ("Program") in cooperation with a limited number of health providers and insurers;

Whereas, establishing and promoting a range of patient centered medical homes through public and private sector initiatives will help promote the delivery of higher quality health care and will help slow the continuing escalation of health care costs;

Whereas, although primary care practices will incur expenses in establishing a patient centered medical home ("PCMH"), the services provided through this system of care have the potential to reduce overall medical costs and to improve individual health care outcomes;

Whereas, the Maryland Health Care Commission is required under Maryland law to calculate medical home practice payments and savings and to provide an ongoing evaluation of the clinical and fiscal outcomes associated with the Program.

Now, therefore, this Participation Agreement ("Agreement") establishes a Patient Centered Medical Home Program, which is consistent with the time frame and requirements set forth in Maryland Health-General Code Ann., § 19–1A–02, *et seq.* The Agreement is the template for all contracts between the Commission and each participating insurance carrier and between the Commission and each health provider practice (herein collectively referred to as "Program Participant"), which are identified in Attachment A. A modification to any contract entered into under this Agreement shall be considered an "Amendment" and shall comply with the process set forth in Section X.3. In furtherance of this Agreement, each Program Participant agrees to incorporate the following into its contract with the Commission:

I. Definitions

1. "Carrier" means:
   a. an insurer, a health maintenance organization, or a nonprofit health service plan meeting the requirements set forth in Md. Health General Article, § 19–1A–02(b);

b. a Medicaid Managed Care Organization required by the Secretary of Health and Mental Hygiene to participate;

c. an insurer, a health maintenance organization, or a nonprofit health service plan acting as a third party administrator on behalf of a self-insured employer who has agreed to participate in the Maryland Multi-payer PCMH Program; or

d. an employer acting as its own third party administrator who has agreed to participate in the Maryland Multi-payer PCMH Program.

2. "Commencement Letter" means the document adopted by the Commission which provides notice to the participating Patient about the Program and explains the benefits provided by the Program at no additional cost to the Patient and the affirmative authorization required prior to sharing the Patient's medical information. The Commencement Letter will also include the opportunity to Opt-out Form to terminate participation in the Program.

3. "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health – General Article, Maryland Code Ann.

4. "Department" means the Maryland Department of Health and Mental Hygiene.

5. "Fixed Transformation Payment" means the semi-annual lump sum payment made by a Carrier to a Practice as set forth in Appendix B.

6. "Incentive Payment" means the payment a Practice receives which is the difference between a Practice's historical medical expenses by carrier category and the total medical expenses per patient by the same carrier category in the current year, adjusted for inflation. Incentive Payments are subject to the limitations described in the Agreement.

7. "Initial Authorization Form" means the document adopted by the Commission and completed by each Patient which gives the initial authority required under Md. Health-General Code Ann. §19.1A.03(e)(2) to share the Patient's medical information. The Initial Authorization Form is valid for a period not to exceed one year.

8. "Maryland Multi-Payer PCMH Program Submission Guide" means the document that describes that data files needed for attribution and schedules for delivering those data files to the Commission.

9. "Medical Assistance Administration" means the organization within the Department of Health and Mental Hygiene responsible for administering the Medicaid program.

10. "Medical Care Data Base" means the systems of claim and eligibility information that all carriers that sell over $1 million dollars in health care premiums are required to submit to the Commission under COMAR 10.25.06.

11. "Medical Expenses" mean carrier reimbursements and patient liabilities for hospital inpatient services, hospital outpatient services, freestanding medical facility services, health care professional services, nursing homes care, skilled nursing facility care, home health care, hospice services, and durable medical equipment.

12. "ONC" means the Office of National Coordinator for Information Technology, Department of Health and Human Services.

13. "Opt-Out Form" means the Form adopted by the Commission that a qualifying individual shall complete to terminate participation in the Program.

14. "PPC-PCMH" means the Physician Practice Connections Patient-Centered Medical Home program operated by the National Committee for Quality Assurance ("NCQA") in accordance with standards published at: http://www.ncqa.org/tabid/631/default.aspx

15. "Participating Patient" means a qualifying individual who is a person covered under the health benefit plan issued by a participating Carrier and is a patient of a participating practice.

16. "Patient Centered Medical Home" has the meaning stated in Md. Health-General Code Ann. § 19–1A–01(f).

17. "Patient Enrollment List" means the list of all of a Practice's patients who have been attributed to the program and have not opted out.

18. "Practice" means a primary care practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners.

19. "Practice Site" means a specific office location where a Practice provides services to patients in accordance with the requirements of this medical home program.

a. If a Practice delivers care from a single site, the Federal Tax Identifier (Tax Id) or organizational National Provider Identifier (NPI), will be used to define the site for PCMH and patient attribution purposes.

b. If the Practice operates from multiple sites, the Practice will designate the individual providers and their National Provider Identifiers that will operate at that site and for whom it will seek NCQA recognition. Those NPIs will used for attributing patients to that Practice site.

20. "Practice Transformation Coaches" mean individuals independent of the Practice that work with the Program to assist Practices to become PCMH Practices.

21. "Program" means the Patient Centered Medical Home Program administered by the Maryland Health Care Commission in accordance with Md. Health-General Code Ann. Sections 19-1A-01, et seq.

22. "Renewal Form" means the document adopted by the Commission and completed by each Patient which extends the authority each subsequent year of participation required under Md. Health-General Code Ann. §19.1A.03(e)(4) to share the Patient's medical information. A Renewal Form is valid for a period not to exceed one year.

II. General Terms and Conditions

1. The term of this Agreement shall be from April 1, 2011 through and including December 31, 2014 unless the Program is terminated by action of the Commission.

2. In accordance with its enabling legislation, the Commission shall select Practices and Carriers that are willing and able to participate in the Program. Each such Practice and Carrier that executes this Participation Agreement hereby agrees to fully abide by the programmatic and fiscal standards set forth herein.

3. In order to participate in the Program, a Practice must establish and maintain the medical home services and capabilities required under the terms of this Agreement. A Practice will be reimbursed by a Carrier for medical home services rendered to a Carrier's participating patients at Practice Sites specified by the Practice and identified in Attachment A in accordance with the procedures set forth herein.
    a. A Practice Site may be added to the Program in accordance with the procedures set by the Commission.

b. A Practice Site may be removed from the Program in accordance with the procedures set forth in Appendix E attached hereto.

c. A Practice will remain as a participant in the Program so long as it operates at least one approved Practice Site.

d. A Practice will not be reimbursed for medical home services at any location that is not an approved Practice Site.

4. Each Practice and Carrier participating in this Program shall continue to maintain such contractual arrangements and other legal obligations that each deems appropriate to protect their individual interests. Enrollment in the Program does not supersede, terminate, or nullify any existing obligations undertaken by a Party.

5. A Practice and Carrier shall continue to maintain the types and amounts of insurance coverage as it deems necessary to protect its respective interests. Nothing contained herein shall constitute an agreement by the State of Maryland or the Commission to provide legal representation or liability coverage to Practices and Carriers. In particular, the Maryland Tort Claims Act shall not be applicable to nor provide coverage for any action or inaction undertaken by a Practice or Carrier under this Agreement.

6. Patient information will be fully protected in accordance with State and federal law. Consistent with this requirement, each Party agrees to execute such agreements and secure such patient consent as may be necessary to implement the Program in accordance with the Commission's enabling statute and the procedures set forth herein. In particular, each Party agrees to take such steps as are necessary to share utilization and quality information generated by the Program with authorized individuals implementing the Learning Collaborative described in Section III, Paragraph 3, Commission representatives, and other authorized individuals who are responsible for Program management and evaluation.

III. Maryland Health Care Commission Responsibilities

1. The Commission shall maintain overall direction and control of the Program consistent with the requirements set forth in Sections 19-1A-01 through 19-1A-05 of the Maryland Health-General Code Ann. The Commission shall establish programmatic standards for the Program, monitor ongoing efforts by Practices and Carriers to implement the Program, clarify the respective obligations of each Program Participant, and otherwise oversee and direct each Program Participant's activities during the period covered by the Agreement.

2. Based on consultation with Practices and Carriers, the Commission will:

    a. Establish a starting date for the Program;

    b. Implement the payment methodology (Appendix B) that governs Carrier reimbursement of Practices under the Program;

    c. Attribute participating patients to Practices using the rules defined in Appendix F;

    d. Notify each Carrier in writing (electronic or hard copy) of the Practice's recognition and its recognition level and provide supporting documentation of such recognition in writing regarding of the PCMH Fixed Transformation Payment amounts due;

    e. Confirm that each Practice submits its quality measures and required reports;

    f. Confirm that each Practice receives payments from each Carrier;

    g. Assist Practices in identifying local or regional community resources to facilitate medical home care management for participating patients;

    h. Perform a Program evaluation in conjunction with Practices and Carriers;

    i. Notify each Carrier in writing of the amount due and payment due dates for each Practice eligible for Payment specified in Appendix B within fifteen (15) business days of receiving the necessary information upon which payment calculations are based.

        i. The notification shall include sufficient detail to support the specified amount due.

        ii. Any disagreement concerning a Payment shall be addressed in accordance with Section IX of this Agreement.

j. The Commission will record payments made by a Carrier to each Practice on receiving notification from a Carrier that the payments specified in Appendix B have been made.

k. Monitor primary care utilization and reserve the right to investigate any reduction in primary care visits and to take appropriate action (including adjusting payment or disqualifying the Practice from the program) if savings are achieved through unjustified reductions in primary care services.

l. In conjunction with Maryland Community Health Resources Commission ("CHRC"), establish a "Learning Collaborative" to provide assistance to each Practice seeking NCQA PPC-PCMH recognition, implementing NCQA requirements, and making use of a Care Manager. The CHRC will provide the Commission with the funds to operate the Learning Collaborative and to contract with "Practice Transformation Coaches." Practice Transformation Coaches will assist each Practice in meeting Program requirements by:

    i. Assisting the Practice in establishing a Practice Redesign Team ("Redesign Team") made up of key Practice personnel;

    ii. Preparing each Redesign Team to actively participate in the Learning Collaborative (from pre-work stages through Learning Sessions) and to otherwise assist the Practice in conforming to the PCMH Model for advanced primary medical care;

    iii. Providing training and support for a Redesign Team in implementing a patient registry system if the Practice does not have and chooses not to implement an electronic medical record;

    iv. Performing Practice assessments and working with the Redesign Team to develop a baseline understanding of the Practice and provide the basis on which to develop the Practice redesign plan;

    v. In conjunction with the Redesign Team, developing an annual implementation plan with goals, timelines, and benchmarks;

    vi. Communicating with each Practice on key Program components, including performance measures, the use of registries, and the expectations for participation in the Learning Collaborative;

    vii. Providing technical assistance to each Practice in meeting the NCQA PPC-PCMH standards.

m. Reserve the right to make use of "Transformation Coaches" subject to the funds available from CHRC.

IV. Practice Responsibilities

1. Each Practice participating in the Program shall:

   a. Provide the Individual National Provider Identifiers to the Commission for all providers that will obtain NCQA recognition at the Practice Site by April 1, 2011.

   b. Preserve the confidentiality of all patient information in accordance with applicable State and federal law. Unless otherwise permitted by law, patient information shall not be disseminated to or otherwise shared with any Practice that is not delivering care to that patient or any Carrier that does not hold a health insurance or HMO contract with that patient;

   c. Implement the patient centered medical home model in accordance with the standards set forth in this Agreement;

   d. Submit an application for NCQA PPC-PCMH recognition by September 30, 2011, or six months after the start of the Program, which ever comes later. Each Practice agrees to achieve NCQA Level 1 recognition ("Level 1+") and to meet the NCQA PPC-PCMH elements specified in Paragraph 2 of Appendix B, Payment Methodology. In the event that a Practice fails to achieve Level 1 + recognition by December 31, 2011, and thereafter fails to achieve Level 1+ recognition during the 3 month grace period ending March 31, 2012, the Practice henceforth will no longer be eligible to participate in the Program or to receive the financial support set forth in this Agreement;

   e. After a Practice meets NCQA Level 1+, the Practice thereafter agrees to seek PPC-PCMH Level 2+ ("Level 2+") recognition by submitting an NCQA application by September 30, 2012. In order to achieve Level 2+ recognition, the Practice is required to meet the 5 NCQA PPC-PCMH elements specified in Paragraph 3 of Appendix B;

   f. In the event that a Practice has previously been awarded NCQA PPC-PCMH recognition, the Practice may use that recognition as a basis for meeting the requirements described in Paragraphs 3a and 3b of Appendix B. The Practice shall provide evidence, or authorize NCQA to provide evidence, to the Commission that it meets the required elements under Level 1 + and the 5 required elements under Level 2+ by the dates set forth above. If a Practice has already achieved PPC-PCMH recognition prior to the start of the Program, the Practice shall be paid at the appropriate recognition level after the Commission has confirmed that the Practice has met the required elements for that level of recognition as described in Appendix B, paragraph 3.

g. If a Practice achieves PPC-PCMH recognition above a Level 1 +, the Practice shall receive Fixed Transformation Payments appropriate for that level when the next semi-annual payment is made by a Carrier;

h. Pay the cost of its own PPC-PCMH application from the Practice's funds or the Fixed Transformation Payments provided to the Practice;

i. Provide information as requested by the Commission, including the provider identifiers issued by each participating Carrier for commercially insured, Medicaid, Medicaid MCOs, Medicare Advantage products, and organizational and individual NPIs for professionals in the Practice;

j. Provide care management services by a designated Care Manager whose responsibilities are set forth in Appendix C;

k. Agree to the following conditions on the operation of care management at the Practice. A Practice shall apportion at least 35 percent of the Fixed Transformation Payment to the "Care Manager" position and the remaining 65 percent to "practice support" activities as described in Appendices B and C. Spend all of the Care Management Payments on Care Management Services, and agree not to spend Care Management Payments for any other purpose.

l. Should the employment or the contract of the "Care Manager" terminate subsequent to the initiation of Fixed Transformation Payments for Care Management, the Practice shall notify the Commission within five working days of the termination. The Commission will notify each Carrier within five working days of receiving the termination notice and instruct them to suspend future Fixed Transformation Payments for Care Management until the Practice informs the Commission of such date that another Care Manager begins working for the Practice on an employed or contracted basis.

m. If a Practice requests that a Carrier provide a care manager paid for by the Carrier, the Practice is not entitled to the care management portion of the Fixed Transformation Payment.

n. Should a participating Practice contract with or hire a Care Manager part-time and utilize the individual as a Practice nurse in another capacity the balance of the time, such Practice will be permitted to do so as long as the Care Management Services specified in Appendix C are provided to all patients assigned to the Care Manager and the Care Manager dedicates the contracted number of weekly hours to performing Care Manager Services;

o. Report to the Commission on a semi-annual basis on the information specified in Appendix D, "Framework for Care Manager Reporting of Time

Spent on Care Management Responsibilities," attached hereto and made a part of this Agreement;

p. Accept decisions made by the Commission regarding elements of the Program, including attribution of Participating Patients, quality measures and reporting, and payment levels as final and not subject to appeal or further review;

q. Keep each patient, or the patient's legal guardian, informed about the Program throughout the process. Provide information via the Commencement Letter and the Annual Renewal Form about the Program and the qualifying individual's opportunity to gain additional services under the Program at no cost to the patient. Ensure that no patient data will be shared under the Program until the patient completes an Initial Authorization Form or an Annual Renewal Form.

   i. Notify each qualifying individual via the Commencement Letter about the Program and the right to opt out of participating in the Program.

   ii. Notify and provide an opportunity for each qualifying individual to opt out of the Program via the Termination Letter at the time of commencement and each subsequent year.

   iii. Obtain an initial authorization form from each Participating Patient to share medical information with the patient's Carrier, the Commission, and the evaluator, or its designee, prior to the sharing of any data and no later than the patient's first clinical visit to the Practice following the effective date of this Agreement.

   iv. Obtain a Renewal Form from each Participating Patient to extend the authorization allowed by the Initial Authorization Form. A Renewal Form must be obtained annually from each patient prior to sharing any data concerning that patient that is not covered in the preceding year's authorization received from that patient.

r. Use the patient registry provided by the Commission unless the Practice has an ONC-certified electronic medical record system capable of meeting the Commission's data requirements;

s. Provide the Commission and the evaluator, or its designee with access to the Practice's quality performance data, consistent with federal and state law, for evaluation and/or audit purposes.

V. Carrier Responsibilities

1. Each Carrier participating in the Program shall:

   a. Preserve the confidentiality of patient information in accordance with applicable law and otherwise take such steps as to facilitate the full implementation of the Program;

   b. Not share patient identifiable health care information with any Practice that is not delivering care to that patient or any Carrier that does not hold a health insurance contract with that patient;

   c. With the exception of the MCOs, supply the Commission or its designee with the information described in Appendix F that is required to attribute patients to Practices by April 1 and October 1 beginning in April 2011. MCO patients will be attributed to Practices based on whether the Practice is assigned as the primary care provider for the patient.

   d. Pay a Practice a Fixed Transformation Payment per patient per month The Carrier agrees to provide Practices with a Fixed Transformation payment in the amount developed by the MHCC within 30 days of receiving a Practice's Patient Enrollment form. This payment will be made in the form of a semi-annual lump sum payment as described in Appendix B.

   e. Consistent with Appendix B and any guidance issued by the Commission, make the Fixed Transformation Payments to Practices. The Carrier is responsible for the currently enrolled members attributed to that practice. The amount of the Fixed Transformation Payment shall be based on a calculation using the amounts and within the timelines specified in Tables 2 through 4 in Paragraph 3 of Appendix B.

   f. Have no obligation to pay the Practice any Fixed Transformation Payment amounts due prospectively under this Agreement if a Practice terminates its relationship with a Carrier.

   g. Except when an objection is made in accordance with § IX, a Carrier will have no ability to recover a Fixed Transformation Payment after it has been paid unless a Practice has failed to submit, or has erroneously submitted, a Patient Enrollment Form.

   h. Share up to 50 percent of the savings generated by a Practice with that Practice so long as the Practice has met threshold performance levels specified in Paragraph 5 ("Incentive Payments") of Appendix B ("Incentive Payments"). The amount of Incentive Payments will be determined based on the number of quality criteria met, as specified in Paragraphs 5 and 7 of Appendix B.

i. Pay Incentive Payments no later than 240 days after the close of the calendar year and will be subject to the termination clauses set forth in Paragraph IX of this Agreement, so long as the Practice meets all qualification requirements for Incentive Payments.

j. Agree to pay each Practice the Incentive Payment specified in the Commission's notification document all amounts due within thirty (30) days of receiving the notification document from the Commission and to return to the Commission a written acknowledgement within five (5) business days of making the payments that such payments have been made.

k. In addition to payments made under this Agreement, each Carrier may continue to implement any pay-for-performance arrangement established with a Practice.

l. If the average total spending per participating patient, as calculated by the Commission, is 10% or higher than the Practice's (s') inflation adjusted historical baseline using an industry standard statewide inflation adjustment factor, the Carrier may request a reduction in its participation level from the Commission in accordance with Section X.3 herein. The Commission, in consultation with the Carrier and participating Practice(s), may:

   i. Reduce the level of Fixed Transformation Payments;

   ii. Limit the Practice sites with whom the Carrier must make fixed transformation payments; or

   iii. Eliminate the Practice (s) from the Program that has average costs significantly above its own historical baseline.

VI. Program Monitoring and Evaluation

1. Each Practice and Carrier agrees to the following conditions governing collection, reporting, and sharing of information in the Program:

   a. Consistent with applicable confidentiality and privacy requirements, the Practices shall collect and monitor specified health care process and outcome data on its population of Participating Patients for incentive reward computation, quality improvement, and evaluation;

   b. The Practice agrees to share de-identified quality improvement data with other Practices participating in the Program as directed by the Commission;

c. Each Practice shall collect and monitor specified health care process and outcome data as directed by the Commission;

d. Subject to the requirements of the Public Information Act, individual Practice performance data will remain confidential;

e. Carriers and Practices will provide specified data regarding the performance of the participating Practices in order for the Commission to conduct a Program evaluation. This evaluation will include data from a matched group of non-participating Practices that will serve as a control group for Program evaluation purposes. The Commission will determine the type of information required for the Program evaluation, which may include claims data-based calculations of cost, utilization and quality; and may be supplemented by other electronic data (e.g., laboratory and pharmacy) as well as chart-extracted data for HEDIS-based and HEDIS-like measures, where available;

f. Carriers and Practices shall submit requested data to a contracted Program evaluator who shall maintain the confidentiality of the data in accordance with applicable law.

VII. Medicaid Reimbursement Requirements

1. Fixed Transformation Payments. The Medical Assistance Administration has established a fixed transformation payments budget of $1,500,000 for FY 2012 and for amounts to be determined by the Department for the following two years.

    a. Medicaid reserves the right to reduce the fixed transformation payments for Medicaid Program participants if it determines that number of participants will exceed the $1,500,000 budget.

    b. If fixed transformation payments are reduced, Practices will be notified 30 days prior to the delivery of the payment.

    c. If fixed transformation payments are reduced, shared savings payments will be adjusted to reflect the reduction in the fixed transformation payment.

2. For Federally Qualified Health Centers that treat Medicaid patients the following special provisions apply:

a. Participate on a full shared savings incentive model for their Medicaid population and will receive 65% of the shared savings in year 1.

b. Do not receive Fixed Transformation Payments for their Medicaid patients.

3. Medicaid will establish an annual Program budget for 2013 and 2014 and will notify Program Participants to this Agreement of the budget at least sixty (60) days prior to the start of the fiscal year.

VIII. Provider Composition Requirements

1. Each Practice and Carrier agrees to the following conditions governing the composition of health care providers who will staff a Practice:

   a. Practices shall maintain staffing and ancillary resources as are necessary to establish and maintain the applicable level of NCQA recognition;

   b. Practices may change staffing arrangements in accordance with Appendix E, Policy Concerning Practice Changes in the Maryland PCMH Program;

   c. In the event that additional physicians join the Practice any time after the first Learning Collaborative Session has been held such that the count of attributed participating patients in the Practice increases above the count in place as of July 1, 2011, the payments due to the Practice under the terms of this Agreement shall be calculated according to the terms set forth in Appendix E of this Agreement.

IX. Disputes, Appeals, and Remedies

1. A Program Participant shall seek a Commission staff determination concerning a dispute among Program Participants pursuant to procedures to be established in regulation by the Commission. Such disputes may include the following:

   a. Patient attribution, performance measurement, or computation of an Incentive Payment;

b. Carrier documented losses that are equal to or greater than 10 percent relative to the Carrier's base year total medical expenses for all Practices in the Program;

c. Payment that is untimely and/or in an amount that differs from the Commission notification of the amount due to a Practice from the Carrier.

2. A Commission staff determination shall be made in compliance with the procedures to be adopted in regulations by the Commission. A Commission staff determination may address matters including the following:

   a. Patient attribution;

   b. Performance measures;

   c. Incentive Payments;

   d. Practice termination from the Program for failure to meet Program requirements;

   e. Imposition of a fine and/or application of interest for significant or repeated violations by Program Participants of one or more conditions in this Agreement.

3. A Program Participant may appeal a Commission staff determination to the Commission upon written notice filed with the Commission within 20 days after notification of the determination in dispute and in accordance with the regulations adopted by the Commission. Commission staff determinations shall be made in a timely manner.

4. Potential violations of law shall be referred to the State or federal agency with requisite authority to address the identified concern.

X. Miscellaneous Provisions

1. This Agreement shall be governed by and construed according to the laws of State of Maryland.

2. The Program Participant shall provide the Commission with access to such information and records consistent with relevant federal and state law as may be necessary to facilitate appropriate reimbursement levels and to otherwise monitor and evaluate the Program;

3. This Agreement cannot be amended without the consent of the Commission.

    a. Waivers and/or adjustments to the requirements set forth herein will be considered amendments when approved by the Commission.

    b. At least 7 days prior to Commission action on a proposed amendment, the Commission shall notify each Program Participant by email to the address given to Commission staff and by a dated posting on the Commission's website of a proposed amendment.

    c. At least 30 days prior to the effective date of an amendment, notice of the Commission's approval of the amendment shall be sent to each Program Participant by email to the address given to Commission staff and by a dated posting on the Commission's website.

4. Fixed Transformation Payments shall begin no earlier than July 1, 2011 provided that a Practice has:

    a. Implemented a seven days per week, 24 hours per day patient access protocol;

    b. Designated one or more individuals who will perform all services specified in Appendix C, Care Manager Roles and Responsibilities.

5. The Commission staff may suspend or terminate this Agreement with a Practice in whole or in part under the following circumstances:

    a. The Practice no longer complies with the requirements set forth in this Agreement (including participation in the Learning Collaborative Sessions);

    b. The Practice fails to maintain network participation agreements with three or more Commercial Carriers required to participate under Md. Health-General Code Ann. § 19.1A.02 (B)(2); or

    c. The Practice fails to provide reasonable and necessary services in accordance with professional standards.

6. Procedure for termination:

    a. A termination will be effective thirty (30) days after written notice from Commission staff to the Practice.

b. Commission staff will determine if any annual Incentive Payments are due to a Practice as a result of termination.

c. A Practice may appeal a Commission staff determination pursuant to § IX.

7. A Practice may end its participation in the Program by providing ninety (90) days written notice of its intent to withdraw to the Commission and to each Carrier.

   a. A practice that terminates during a program year shall be eligible for incentive payments earned through the termination date.

   b. A Carrier shall be responsible for paying the Practice for Fixed Transformation Payment obligations made prior to the termination date.

   c. A Carrier providing reimbursement to the Practice shall not be required to pay any fixed transformation or incentive payments for services rendered after the termination date.

   d. Payment shall be no later than 240 days after the end of the program year in which the termination occurred.

8. Nothing in this Agreement shall be construed to disallow a Carrier from terminating its relationship with a clinician subject to the contractual terms of an independent agreement with that clinician. However, such termination is subject to the following:

   a. The Fixed Transformation Payment obligation of the Carrier and other prospective obligations under the Agreement with regard to that particular clinician shall cease to be effective upon the date of such termination.

   b. Commission staff shall determine if any annual Incentive Payments are due for a clinician whose relationship is terminated by a Carrier and will provide a written explanation of such determination to the Carrier and Practice.

   c. Termination of the relationship with an individual clinician operating within a multi-provider Practice does not terminate the Carrier's responsibilities to that Practice under this Agreement.

9. A Carrier defined in Section I.2. that is not mandated to participate in the Maryland Multi-payer PCMH Program under Maryland Health-General Code Ann., § 19.1A.02 (B)(2) may terminate participation in the Program by

providing the Commission and all participating Practices with ninety (90) days prior written notice of its intent to withdraw.

10. It is the intent of each Program Participant that this Agreement shall supplement any existing agreement between a Carrier and a Practice. Each Program Participant will seek to implement this Agreement in a manner that is consistent with and supportive of any existing contractual arrangement between a Practice and a Carrier. To the extent that conflicts exist between this Agreement and another contractual arrangement between a Carrier and a Practice, each Program Participant agrees to make good faith efforts to modify the existing agreement in a manner that supports the goals and objectives of this Agreement.

11. Notwithstanding any other agreement between a Carrier and a Practice, this Agreement takes precedence with regard to data submission, Fixed Transformation Payments, and Incentive Payments.

12. Each Program Participant's performance under the Agreement shall be as an independent contractor, and not as an agent, employee, or representative of any other Party. No provision of the Agreement is intended to create, or to be construed as creating, any agency, partnership, joint venture, or employer-employee relationship between Program Participants. No Program Participant shall have the authority to act on behalf of another Program Participant or bind another Program Participant directly or indirectly as a result of this Agreement.

CARRIER CONTRACT AND SIGNATURE PAGE

I, _____, _____(title) of _____ ("Carrier"), a carrier as defined in Md. Ins. §15-1801 Code Ann., acknowledge that I am duly authorized to and have the requisite authority to bind Carrier under this Contract with the Maryland Health Care Commission. The Carrier acknowledges its intent to enter this Contract with the Commission that incorporates the terms and conditions set forth in the Agreement for participation in the Maryland Patient Centered Medical Home Program. The Carrier attests that this Contract shall not be modified except in accordance with the provisions set forth in Section X.3 of the Agreement.

_____
(NAME OF CARRIER)

BY: _____Witness_____

(TITLE)_____ (TITLE) _____

Date_____ Date_____

Maryland Health Care Commission

BY: _____Witness_____

(TITLE)_____ (TITLE) _____

Date_____ Date_____

PRACTICE CONTRACT AND SIGNATURE PAGE

I, _____, _____(title) of _____ ("Practice"), a primary care practice, as defined in Md. Health-General §19-1A-01(g) Code Ann., acknowledge that I am duly authorized to and have the requisite authority to bind Practice under this Contract with the Maryland Health Care Commission. The Practice acknowledges its intent to enter this Contract with the Commission that incorporates the terms and conditions set forth in the Agreement for participation in the Maryland Patient Centered Medical Home Program. The Practice attests that this Contract shall not be modified except in accordance with the provisions set forth in Section X.3 of the Agreement.

_____
(NAME OF PRIMARY CARE PRACTICE)

BY: _____Witness_____

(TITLE)_____ (TITLE) _____

Date_____ Date_____

Maryland Health Care Commission

BY: _____Witness_____

(TITLE)_____ (TITLE) _____

Date_____ Date_____

Appendix A
Maryland Patient Centered Medical Home Program
Participating Practices

Appendix B
Payment Methodology

Practices participating in the Maryland PCMH Program will be eligible for two types of payments as long as all qualifying requirements are met.

1. Fixed Transformation Payments (the amount shown in Table 2) beginning in Year 1 consist of semi-annual lump sum payments to be made over the course of the three-year Program by a Carrier directly to a Practice for:

    a. Care coordination, which must be used to fund an employed or contracted care manager who will operate in an integrated fashion as a member of the care team with special focus on patients with the highest risk of hospitalization.

    b. Fixed Transformation Payments may be applied to any of the following:

        i. Other staffing: a Practice may use a portion of the funds to supplement its staffing with a hired or contracted full-time or part-time nurse care coordinator, nurse practitioner, physician's assistant, nutritionist, health educator, behavioral health clinician, pharmacist, or any other individual identified by the Practice.
        ii. Provision of historically non-reimbursed services: a portion of the funds may be used to provide functions that are traditionally not reimbursed but are necessary for effective care planning and management.
        iii. Other equipment and office space: a portion of the funds may be applied to covering the costs of additional office space and information systems' expenses necessary to operate as a PCMH.

2. Incentive Payments are awarded to a Practice from the difference between a Practice's historical total medical expenses by carrier category and total medical expenses per patient by the same carrier category in the current year, adjusted for inflation. The Practice shall be eligible from between 30 to 50 percent of the difference between historical and current total medical expenses per patient depending on the number of quality requirements the Practice has met.

3. A Practice that is selected to participate in the Program will be required to obtain NCQA PPC-PCMH Level 1 '+' or better recognition by December 31, 2011 and NCQA PPC-PCMH Level 2'+' or better recognition by December 31, 2012.

    a. To continue to participate in the Program, a Practice shall achieve Level 1 recognition, including a passing score on the requirements shown in the

column labeled “Level 1+” on Table 1 below, by December 31, 2011 and Level 2 recognition, including a passing score on the elements set forth in the column labeled “Level 2+” by December 31, 2012.

b. The estimated maximum values for the Fixed Transformation Payment, consisting of Care Management and Practice Support Payments, are shown in Tables 2-4 below. The Fixed Transformation Payment will be determined by a Practice’s attainment of a specific level of NCQA PPC-PCMH recognition defined as Level 1+, Level 2+, or Level 3. The Fixed Transformation Payment is delivered to a Practice in six month installments calculated by multiplying by six the appropriate amount in Table 2 for each of the Practice’s attributed patients.

4. The Practice’s patient size count for calculating the Fixed Transformation Payment will be created as follows for each Practice Site:

   a. The number of all patients treated at each Practice Site as reported by the Practice in its Program application(s) will determine the Physician Practice size category.

      i. If the total number of patients reported is less than 10,000, the Practice Site will be paid at the rate for the smallest practice size category.

      ii. If the total number of patients for the Practice Site is from 10,000 to less than 20,000, the Practice Site will be paid at the rate for the middle practice size category.

      iii. If the total number of patients for the Practice Site is 20,000 or above, the Practice Site will be paid at the rate for the largest practice size category.

   b. The Commission shall notify Program Participants of each Practice Site’s practice size designation by July 1 of each year.

Table 1. Maryland PCMH Program's NCQA Recognition Requirements					
Requirements (all included in NCQA PCMH Review)	Maryland Recognition Level			Specific NCQA Requirements PPC-PCMH 2008 (Revised 12/31/10) For Practices with Existing NCQA Recognition, or with Recognition Expiring by 3/31/11	Specific NCQA Requirements PCMH 2011 For Practices without NCQA Recognition or with Recognition Expiring After 3/31/11
	Level 1 +	Level 2 +	Level 3 +		
Level 1 NCQA PCMH Recognition	X			1. Overall NCQA Recognition Level (Level 1 = 25%; Level 2 = 50%, Level 3 = 75%)	1. Overall NCQA Recognition Level (Level 1 = 35%; Level 2 = 60%, Level 3 = 85%)
Level 2 NCQA PCMH Recognition		X			
Level 3 NCQA PCMH Recognition			X		
24-7 phone response with clinician for urgent needs	X	X	X	2. Response of Yes to PPC 1A Factor #8	2. Response of Yes to PCMH 1A Factor #2 and 1B Factor #3
Registry as part of EHR or as stand-alone	X	X	X	3. Score of 50% for PPC 2F	3. No additional requirement--included in Must-Pass for all levels (PCMH 2D)
Summary of care record for transitions	X	X	X	4. Response of Yes to PPC 3E Factor #2	4. Response of Yes to PCMH 5C Factor #2
Advanced access for appointments	X	X	X	5. Response of Yes to PPC 1B Factor #2	5. Response of Yes to PCMH 1A Factor #1
Care management and coordination by specially trained team members	X	X	X	6. Score of 50% on PPC 3C	6. Score of 50% on PCMH 1G
Problem list for all patients	X	X	X	7. Response of Yes to PPC 2D Factor #1	7. Response of Yes to PCMH 2B Factor #1
Medication reconciliation every visit	X	X	X	8. Response of Yes to PPC 3D Factor #5	8. Response of Yes to PCMH 3D Factor #2
Pre-visit planning and after-visit follow-up for care management	X	X	X	9. Response to Yes to PPC 3D Factors #1 and #11	9. No additional requirement—included in Must-Pass for all levels--PCMH 3C
Use of EHR		X	X	10. Score of 75% for PPC 2B	10. Score of 100% for PCMH 2B
CPOE for all orders; test tracking and follow-up		X	X	11. Score of 100% for PPC 6A and score of 75% for PPC 6B	11. Score of 100% for PCMH 5A
E-prescribing with decision support: drug-drug, drug-allergy and drug-formulary		X	X	12. Score of 75% for PPC 5A; score of 50% for PPC 5B; score of 50% for PPC 5C	12. Score of 75% for PCMH 3E including response of Yes to Factors #4 and #6 (Factor #4 is core meaningful use)

Table 2. Commercial Population - Fixed Transformation Payments			
Physician Practice Site Size (# of patients)	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	$4.68	$5.34	$6.01
10,000 - 20,000	$3.90	$4.45	$5.01
> 20,000	$3.51	$4.01	$4.51
Note: Level 1+ applies only to the first year of the Program. In Years 2 and after, medical homes must achieve Level 2+ or better to receive Fixed Transformation Payments.			

Table 3. Medicaid Population - Fixed Transformation Payments			
Physician Practice Size	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
All Practices	$4.54	$5.19	$5.84
Note: Level 1+ applies only to the first year of the Program. In Years 2 and after, medical homes must achieve Level 2+ or better to receive Fixed Transformation Payments. Fixed payments will NOT be available for Federally Qualified Health Centers.			

Table 4. Medicare Advantage Population - Fixed Transformation Payments			
Physician Practice Size	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
All Practices	$8.66	9.62	11.54

5. Fixed Transformation Payments
    a. A Carrier shall make Fixed Transformation Payments to a participating Practice semi-annually using one of the following methods:
        i. By a claim for each attributed PCMH patient using a local HCPCS code that has been approved by the Commission.
        ii. By a lump sum payment to a participating Practice for all patients attributed to that Practice in the current 6-month attribution period.
        iii. By an alternative method approved by the Commission at least 60 days prior to date when the payment is due.
    b. The sum of all claim payments or the lump sum payment shall represent the total semi-annual payment for the attributed participating patients associated with that Practice.

c. The Carrier shall provide the Practice with sufficient information to enable the Practice to reconcile Fixed Transformation Payments with the specific patients attributed to the program.
d. Fixed Transformation Payments shall be adjusted annually by the change in the Medicare Economic Index between the current year and the ensuing years.

6. Incentive Payments: Beginning in Year 1 and continuing through Year 3.
    a. Practices that have met the annual performance criteria specified in Tables 5 and 6 will be qualified to receive the defined percent of any savings generated by the Practice during Years 1, 2, and 3 as shown on Table 7.
    b. Practices shall report the criteria defined in Table 5 and the Commission will calculate the utilization criteria for each Practice.
    c. The baseline for measuring changes in utilization for each participating Practice shall be participating patients attributed to that Practice in the calendar year preceding the start of the Program.
    d. The savings shall be based on the difference between expected medical costs for the Practice's patient population and the actual total medical care spending per attributed participating patient, including the cost of the "Fixed Transformation Payments," and any existing Carrier incentive programs, including an EHR incentive paid as a result of passage of HB 706.
    e. The total expected medical expenses are defined as the per participating patient medical expense in the year prior to the start of the Program, adjusted for medical inflation.
    f. The Commission may adjust the shared savings algorithm to account for outliers and changing case mix in a Practice based on evidence that these factors would present a significant disadvantage to a Carrier or participating Practice.
    g. In determining shared savings, separate saving calculations shall be constructed for the commercially insured population, the Medicaid population, and the Medicare population, including traditional Medicare (if CMS decides to participate) and Medicare Advantage.
    h. Should there be no savings as defined herein, the Practice will not be eligible for an Incentive Payment, nor will it be required to repay the Carriers for the Fixed Transformation Payments.

7. The medical inflation factor used to adjust expected expenses will be derived by estimating the change in spending in the Maryland market for the commercially insured, the Medicaid, and the Medicare populations from the base year to the current program year using a nationally known industry source such as the Milliman Medical Index or the Medical Care Data Base. Separate medical

inflation factors will be applied to base spending for the commercially insured, Medicaid, and Medicare populations.

8. Procedure for Paying the Incentive Payments
    a. The Commission will notify each participating Carrier of the shared savings achieved for its covered individuals that are attributed to a Practice.
    b. The Commission may assign Carriers the responsibility of calculating the shared savings using the Commission's calculation approach.
    c. The Carrier shall obtain the Commission's approval for making an Incentive Payment to a Practice.

9. The Commission may negotiate with self-insured employers and their representatives on the level of Fixed Transformation Payments paid by self-insured employers according to the following conventions:
    a. Any reduction in the Fixed Transformation Payment amount shall be offset by an equivalent increase in the percent of shared savings awarded to the plan.
    b. The self-insured employer, or its agent, can provide a method to Practices for differentiating participating patients insured by self-insured employers and other forms of coverage.

10. For purposes of this Agreement, Month 1 begins on July 1, 2011.

Table 5 Quality Measurement Criteria				
Group One Criteria*				
NQF Measure	**Developer**	**Recommended Measure Title**	**Reported by Pediatric Practices**	**Reported by Adult Practices**
0001	AMA	Asthma Assessment	YES	YES
0002	NCQA	Appropriate Testing for Children with Pharyngitis	YES	
0013	AMA	Core: Hypertension: Blood Pressure Measurement		YES
0018	NCQA	Controlling High Blood Pressure		YES
0024	NCQA	Alternate Core: Weight Assessment and Counseling for Children and Adolescents	YES	
0028a	AMA	Core: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment		YES
0028b	AMA	Core: Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention		YES
0034	NCQA	Colorectal Cancer Screening		YES
0036	NCQA	Use of Appropriate Medications for Asthma	YES	YES
0038	NCQA	Alternate Core: Childhood immunization Status	YES	
0041	AMA	Alternate Core: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old		YES
0043	NCQA	Pneumonia Vaccination Status for Older Adults		YES
0047	AMA	Asthma Pharmacologic Therapy	YES	YES
0059	NCQA	Diabetes: HbA1c Poor Control		YES
0061	NCQA	Diabetes: Blood Pressure Management		YES
0067	AMA	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD		YES
0075	NCQA	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control		YES
0081	AMA	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		YES
0105	NCQA	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment		YES
0421	QIP	Core: Adult Weight Screening and Follow-Up		YES
0575	NCQA	Diabetes: HbA1c Control (<8%)		YES

***NOTE: Shaded rows are the CMS EHR Meaningful Use Core or Alternate Core measures. Non-shaded rows are additional recommended measures to be included in the Program.**

Table 6 Reductions in Utilization			
Group Two Criteria (Adults must meet 2 of 3, Pediatrics must meet Emergency Room visit reduction)			
	Measures will be generated from the All Payer Claims Data Base	**Analyzed for Pediatric Practices**	**Analyzed for Adult Practices**
Year 1	n/a	**No standard**	**No standard**
Year 2	2-percentage point reduction from the baseline in the 30-day readmission rate (members of participating Carriers only)	n/a	YES
	2-percentage point reduction from the baseline in number hospital days per 1000 (members of participating Carriers only).	n/a	YES
	2% decrease from the baseline in emergency room visits per 1000 (members of participating Carriers only)	YES	YES
Year 3	3-percentage point reduction from the baseline in the 30-day readmission rate (members of participating Carriers only)	n/a	YES
	3-percentage point reduction from the baseline in number hospital days per 1000 (members of participating Carriers only)	n/a	YES
	4% decrease from the baseline in emergency room visits per 1000 (members of participating Carriers only)	YES	YES

Table 7 Shared Savings Available based on the Attainment of Group One and Group Two Criteria*				
	Group One Criteria		Group Two Criteria	
Year 1	**Pediatric Practices**	**Adult Care Practices**	**Pediatric Practices**	**Adult Care Practices**
50 % share of savings	Report on 5 measures.	Report on 18 measures.	n/a	n/a
40 % share of savings	Report on 4 measures.	Report on 15 measures.	n/a	n/a
30 % share of savings	Report on 3 measures.	Report on 12 measures.	n/a	n/a
Year 2				
50 % share of savings	Report on 5 measures.	Report on 18 measures.	Meet thresholds on 2 measures.	Meet thresholds on 4 of 4 measures.
40 % share of savings	Report on 4 measures.	Report on 15 measures.	Meet thresholds on 1 of 2 measures.	Meet thresholds on 3 of 4 measures.
30 % share of savings	Report on 3 measures.	Report on 12 measures.	n/a	Meet thresholds on 3 of 4 measures.
Year 3				
50 % share of savings	Meet thresholds for the 5 measures.	Meet thresholds for the 18 measures.	Meet thresholds on 2 measures.	Meet thresholds on 4 of 4 measures.
40 % share of savings	Meet thresholds for 4 measures.	Meet thresholds for 15 measures.	Meet thresholds on 1 of 2 measures.	Meet thresholds on 3 of 4 measures.
30 % share of savings	Meet thresholds on 3 measures.	Meet thresholds on 12 measures.	n/a	Meet thresholds on 3 of 4 measures.

***Note: Requirements for Group One and Group Two Criteria are set out in Tables 5 and 6 herein.**

Appendix C
Care Manager Roles and Responsibilities

For a specific, identified population of participating patients, the Care Manager is expected to fulfill the following functions:

1. Population Management:
    a. In conjunction with the Practice team, identify participating patients at risk for poor outcomes, those in transition from hospital to home or from skilled nursing home to home, and those experiencing poor coordination of services who would benefit from more intensive follow-up.
    b. Provide proactive outreach, including telephonic and face-to-face encounters in the home or clinical setting.
    c. Identify participating patients in need of disease management intervention.
    d. Prioritize patient follow-up based on care management assessment and risk stratification.

2. Care Review and Planning:
    a. Complete a structured assessment of medical, biopsychosocial support and self-management support needs.
    b. Work collaboratively with the primary care provider and other staff at the Practice Site to develop an individualized plan of care that identifies goals and targeted interventions for all patients in care management.

3. Care Coordination:
    a. Provide transition of care management and act as liaison to hospital, long-term care, specialty, home health services and other community-based services for high-risk care managed participating patients.
    b. Maintain ongoing appropriate documentation on care coordination to promote Practice team awareness and ensure patient safety and follow through on the care plan.
    c. Assist participating patients in problem-solving potential issues related to the health care system, financial, and psychological barriers.
    d. Function as the system navigator and point-of-contact for high-risk participating patients and family, with the patient and family having direct access for asking questions and raising concerns.
    e. Ensure open communication regarding patient interactions with physicians and office staff.
    f. Help participating patients with problems in arranging referrals, screenings, and test procedures.
    g. Screen and refer as appropriate for depression and other psychological treatments.

h. Assume an advocacy role on the participating patient's behalf with the Carrier to coordinate benefit management for appropriate supplies and services for the patient in a timely fashion.
i. Identify and utilize cultural and community resources; establish and maintain relationships with identified service providers.
j. If a patient is assigned to a case manager at a Carrier, coordinate patient care with the Carrier's case manager.

4. Follow Up:
    a. Provide medication management, including medication reconciliation and making recommendations to primary care providers for medication changes based on evidence-based protocols.
    b. Collaborate with the Participating Practice's clinicians to establish and update a shared care plan.
    c. Provide support for improving health behaviors and self-management skills - Goal Setting, Action Planning, and Problem Solving.
    d. Provide more intensive follow-up during care transitions and other high-risk periods.
    e. Provide information and education regarding screenings and diagnostic test results.

5. System Development:
    a. Care Managers play an important role in supporting quality improvement for chronic care, such as participating in and supporting planned individual and group visits, and development of new forms and procedures.
    b. Care Managers play a key role in providing clinical and self-management support training to non-RN and other Practice staff, as needed.

Appendix D
Framework for Care Manager Reporting of
Time Spent on Care Management Responsibilities

Practices will be required to report semiannually to the Commission in Years 2 and 3 of the Program on the distribution of Care Manager time. Practices and Care Managers may track time in the manner of their preference, e.g., utilizing case management software, or manual tracking.

Practices must report the following information to the Commission:

1. Number of Patient Contacts:
    a. The number of patients with whom the Care Manager worked during the prior six months.
    b. Activity Categories:
        i. Patient encounters:
            1. Type: face-to-face (office or home), telephone, or e-mail;
            2. Content: assessment, self-management education and support, monitoring, and/or care coordination.
        ii. Caregiver support
        iii. Practice's Care Manager (CM) interactions:
            1. Practice site;
            2. Telephone;
            3. E-mail;
            4. Other.

2. Care arrangements or coordination outside of patient encounters:
    a. Other clinicians;
    b. Hospital or SNF;
    c. Other service or resource providers;
    d. Other community agencies.

3. Population management (registry and other related activities) :
    a. Registry review and analysis;
    b. Risk stratification or patient identification;
    c. Visit or other encounter planning;

4. Participation in educational activities:
    a. Learning Collaborative sessions;
    b. Training from other independent care management organizations.

Appendix E
Policy Concerning Practice Changes in the Maryland PCMH Program

1. A Practice participating in the Program may experience changes in practice composition or ownership during the course of the Program's three-year period. Potential changes could include the following:
    a. Practice is acquired by another Practice;
    b. Practice merges with another Practice;
    c. Practice acquires another Practice;
    d. One or more clinicians leave the Practice to start their own Practice or to join another Practice; and
    e. One or more clinicians leave or join the Practice.

2. A Practice shall inform the Commission in the event any of the above changes, or any other substantive changes in Practice ownership or composition, within thirty days of the substantive change.

3. If a Participating Practice is acquired by another Practice, the original Practice site may continue to participate in the Program so long as the acquiring Practice:
    a. Signs a new contract under the Participation Agreement, and
    b. Maintains contracts with three or more participating Carriers.
    c. Additional sites owned by the acquiring Practice may join the Program during the three year Program period, if:
        i. The practice meets the performance and utilization standards at its practice sites currently in the Program.
        ii. The Commission determines that adding additional practice sites is in the best interest of the Program.
    d. Sites owned by an acquiring Practice that are participating in the Program at the time of acquisition may continue in the Program.

4. If a Participating Practice merges with another practice, the original Participating Practice site may continue to participate in the Program so long as the merged Practice:
    a. Signs a new contract under the Agreement, and
    b. Maintains contracts with one or more participating Carriers.
    c. Additional sites owned by the merged entity may not join the Program during the Program's three year period.
    d. Sites owned by the second merging Practice that are participating in the Program at the time of the merger may continue in the Program.

5. If a Participating Practice acquires another Practice, its participation in the Program will remain unchanged. Additional acquired sites will not be eligible to join the Program.

6. If a clinician leaves a Participating Practice to start their own practice or to join a non-participating practice, the departing clinicians forfeit their opportunity to participate in the Program.

7. If a clinician joins a Participating Practice, the added clinician may participate in the Program so long as the Practice:
    a. Conforms with NCQA requirements regarding adding a clinician to a PPC-PCMH recognized Practice;
    b. Submits an orientation plan to the Commission for training the new clinician on the PCMH model of advanced primary care which shall be deemed approved unless the Practice receives notice of disapproval from the Commission within ten (10) working days of receipt of the orientation plan by the Commission.
    c. The new clinician, at the discretion of the Practice, may participate in any transformation program component of the Learning Collaborative offered by the State that is part of the Program.
    d. A new clinician must provide a letter of confirmation to the Commission within 6 months of joining the Participating Practice that the components of the PCMH orientation plan submitted by the Practice have been provided to him/her.

Appendix F
Attribution Rules for the Maryland PCMH Program

The algorithm will be executed at the start of the Program and in 6 month intervals throughout the Program's three years.

The basic requirements for each Carrier are as follows:

1. At the start of the initiative, each Carrier shall provide 24 months of retrospective professional claims for currently living individuals covered under a fully insured contract or covered under a self insured contract, if the plan sponsor has agreed to participate in the Program.

2. Extraction rules
    a. The extract of professional services claims should be limited to line items containing the following CPTs.
        i. Office Visit E&M New & Established (99201 – 99205; 99211 – 99215)
        ii. Office Visit Preventive New & Established (99381 – 99387; 99391 – 99397)
        iii. Office Consult (99241 – 99245).
    b. The professional services should be limited to those in which the rendering provider has a specialty of:
        i. General Practice,
        ii. Family Medicine,
        iii. Internal Medicine,
        iv. Pediatrics, and
        v. Nurse Practitioner-led Practices in primary care.

3. The extracted claims supplied by each commercial and public Carrier will contain a unique one-way encrypted identifier assigned by that Carrier using software provided by the Commission. The software supplied to each Carrier by the Commission is hardware-independent and can be installed on Windows, Solaris, and IBM-based hardware. Using the patient's Social Security number, birth date, and gender, the algorithm generates a unique identifier that will be common across multiple Carriers' claim files.

4. The extracted claim file from each Carrier is combined with claim files from the other participating Carriers and the attribution logic is applied by Commission staff.

5. Logic for attributing participating patients to practices using a 2-step, 24-month look-back.
    a. Attribution for the most recent 12 months:
        i. Count the number of visits for the E & M codes and sum by encrypted patient identifier and Practice site identifier (organizational NPI, Federal Tax ID, or individual NPIs if the site is part of larger Practice) (sort by member, # of visits).

ii. Each encrypted ID that has claims will be assigned to the PCP Practice site with the most visits.

iii. If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most recent visit.

b. If no attribution can be done, then use the prior 12 months (no PCP visit):

i. Count the number of visits for the E & M codes and sum by the encrypted patient identifier and billing NPI (sort by member, # of visits) for the prior 12 months.

ii. Each encrypted ID that has claims will be assigned to the Practice (billing NPI) with the most visits.

iii. If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most recent visit.

6. NPIs for Practices in the Maryland PCMH Program are a subset from the universe of PCPs included in the claim files. Each Practice is provided a count of the total number of patients attributed by the participating Carrier. The list of encrypted patient identifiers attributed to each Practice is returned to the respective Carrier by the Commission.

7. The Carrier is responsible for making Fixed Transformation Payments directly to each Practice for the total number of participating patients attributed to each Practice.

8. The attribution process is repeated every 6 months. Each Carrier submits an additional set of claims for the most recent 6 months using the selection criteria defined in steps 1-4 above. The new subset is combined with the claims for the recent 18 months and the attribution process is repeated.

9. A Carrier as defined in Section I.2. of the Participation Agreement may propose an alternate attribution process to the Commission if the Carrier wishes to include more patients than would be attributed under the approach set forth in this Appendix F.