

Maryland's Multi-Payor Patient Centered Medical Home Program

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About PCMH

- **PCMH is a model of primary care delivery designed to strengthen the patient-clinician relationship by replacing episodic care with coordinated care and a long term relationship**
- **PCMH encourages teamwork and coordination among clinicians, mid-level medical technicians, and administrative staff to give patients' better access to care and to take a greater role in making care decisions**
- **PCMH can lower costs of care through its focus on care coordination, patient engagement, and patient self-management**

Concepts endorsed by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians

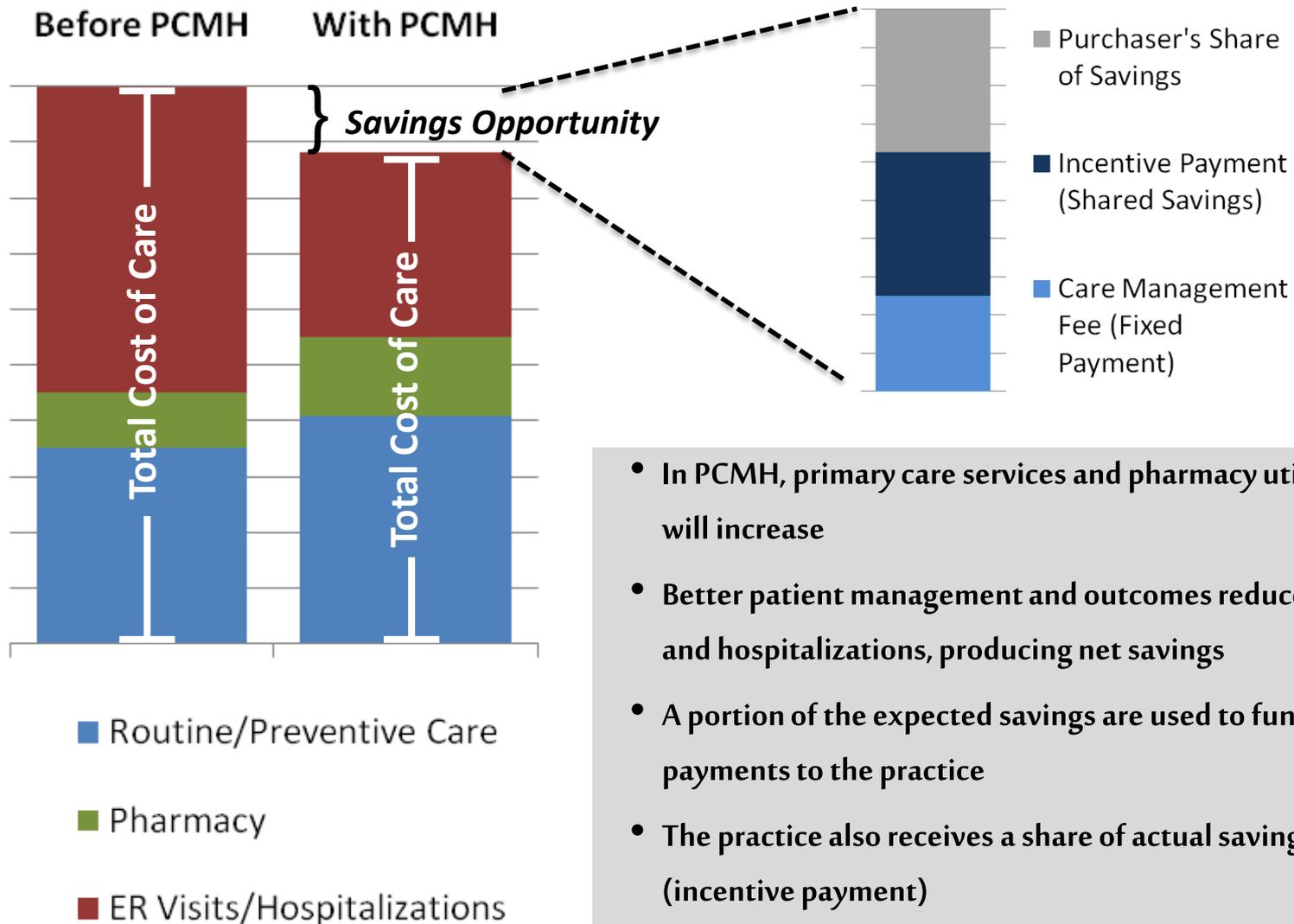
MMPP Background

- **The law required (2011) MHCC to develop a three-year pilot Multi-Payor Patient Centered Medical Home (PCMH) Program, which aims to improve the health and satisfaction of patients and slow the growth of health care costs in Maryland while supporting the satisfaction and financial viability of primary care providers statewide**
- **Exemption for a cost-based incentive payment tied to PCMH**
- **Authority for carriers to establish single carrier PCMH programs with an incentive-based reward structure (shared savings) and data sharing**
- **An evaluation report is targeted for release in March**

Key Requirements of a PCMH Practice

- 24-7 phone response with clinician for urgent needs
- Open access scheduling for appointments
- Use of electronic health records
- Summary of care record for transitions
- Care management and coordination by specially trained team members
- Problem list maintained for all patients
- Medication reconciliation every visit
- Pre-visit planning and after-visit follow-up for care management
- e-Prescribing with decision support: drug-drug, drug-allergy, and drug-formulary

PCMH Financial Model



Payment Model

Fee-For-Service

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



Fixed Transformation Payment

Participating practices receive a fixed, per patient per month fee (paid semi-annually); the purpose of this fee is to defray the costs of providing enhanced primary care services, including care coordination

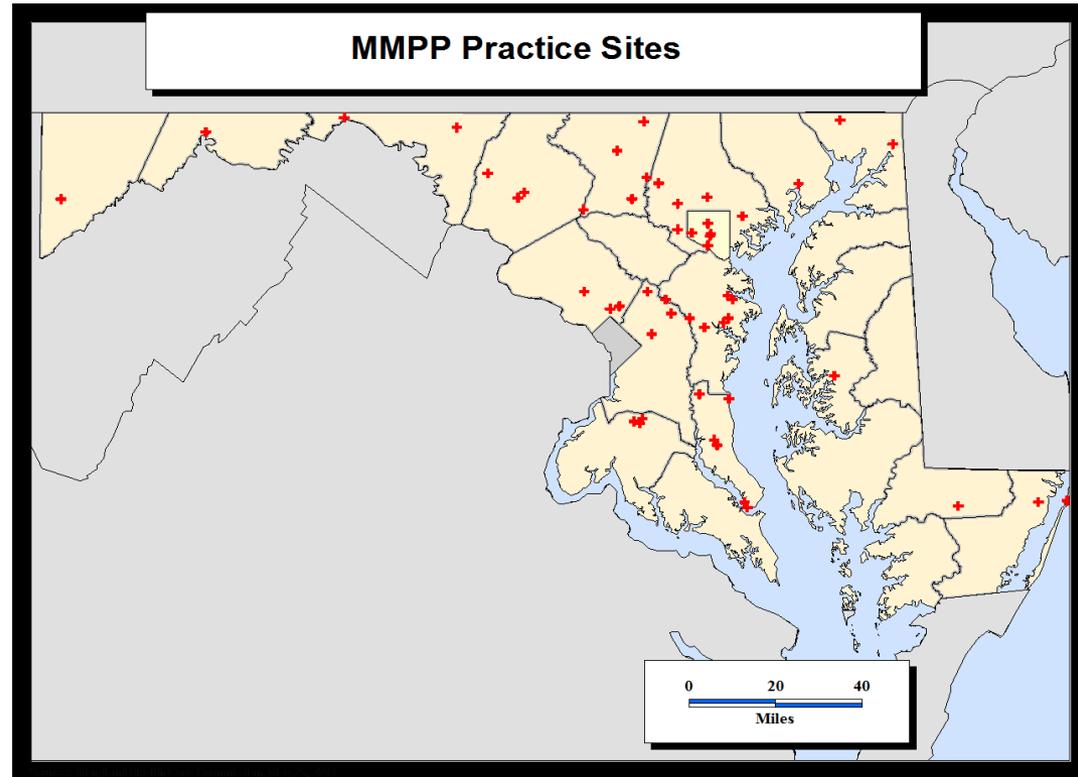


Incentive Payment (Shared Savings)

Participating practices that meet established quality, utilization, and cost goals receive a share of savings generated by improved patient outcomes

Participating Practices

- 52 practices from varying geographic, ownership, and specialty types, including two FQHCs
- Practices include pediatric, family practice, internal medicine and geriatric practices
- 339 practitioners, most physicians, and some CRNPs
- 100,000 attributed commercial patients
- 56,000 Medicaid patients



For 15 of 52 practices in 2014, Medicaid enrollees are 20 percent or greater of their patient mix

Preliminary Evaluation Results

- **MMPP providers compared to non-MMPP providers**
 - **Participating providers are more satisfied with their job, and the care provided to their patients, and are more likely to include medical assistants, social workers, and health educators in their care teams**
- **Patient satisfaction levels by year three**
 - **Adult patients rated patient-provider communication higher over time**
 - **Respondents for children remain highly satisfied with the care**

Preliminary Evaluation Results *(Continued)*

- **Chronically ill patients reported higher care satisfaction on some measures than those without chronic conditions**
- **African Americans and Caucasians reported similar levels of satisfaction with their providers**
- **Practice Transformation**
 - **Key components of practice transformation include improved care coordination, increased communication, advancement of monitoring and reporting systems, and better standardization of policies and procedures**
 - **Practices believe the program elevated their practice to the next level, allowing some to consider involvement in accountable care organizations**

Preliminary Evaluation Results *(Continued)*

- **Quality of care**
 - **Improvements in chronic disease management of ambulatory care sensitive conditions were identified, which may have resulted from a positive impact of the MMPP on emergency department visits and inpatient stays among Medicaid patients**
- **Health care costs**
 - **Successfully slowed the growth of health care costs as outpatient visits were positively affected in both Medicaid and commercially insured patients, and inpatient payments among Medicaid patients**

Next Steps

- **Maintain the MMPP program through 2015**
- **Seek new legislation to extend certain elements of the PCMH program such as:**
 - **Exemption for a cost-based incentive payment tied to PCMH**
 - **Authority for carriers to establish single carrier PCMH programs with incentive-based reward structures (shared savings) and data sharing**
 - **Single carrier accreditation program**
- **Provide support to MMPP practices in migrating to existing single carrier PCMH programs**

Thank You!

