



The MARYLAND  
HEALTH CARE COMMISSION

# Maryland

# Patient Centered Medical Home

*An Assessment of Practices that Achieved Pilot Goals*

*October 2014*

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## Table of Contents

Overview .....	1
Background .....	1
Limitations .....	2
Assessment Approach .....	2
Results .....	4
Remarks .....	12
Acknowledgement .....	12
Appendix A: Participating Practices in the Assessment .....	13
Appendix B: Site Visit Interview Questions .....	14
Appendix C: Quality Measures .....	16
Appendix D: National Committee for Quality Assurance Practice Level Patient Centered Medical Home Recognition .....	17
Appendix E: Other State Patient Centered Medical Home Initiatives .....	19
Appendix F: Maryland Annotated Code, Health-General .....	28

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## Overview

The Maryland Health Care Commission (MHCC) established the Maryland Multi-Payor Patient Centered Medical Home (PCMH) Program (MMPP) in 2011 as required by Health-General Article §19-1A-01, *et sequentes*.<sup>1</sup> The law required MHCC to develop a three-year pilot, 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 in the State. Approximately 52 primary care practices were selected for participation in the MMPP pilot. The MHCC conducted an interim assessment of participating practices that consistently achieved goals of the MMPP pilot over the first two years.<sup>2</sup> The assessment sought to identify key lessons learned from practices that have shown consistent improvements through their participation in the MMPP pilot. The MHCC expects to disseminate lessons learned to other providers participating in advanced care delivery programs.

Altogether, nine practices participating in the MMPP pilot have achieved shared savings consistently over the first two years. To achieve shared savings, the practice must meet specified quality, cost, and utilization measures.<sup>3</sup> In order to understand the characteristics of these nine practices, MHCC examined the organization structure, business operations, and clinical and technology components of these practices. The assessment was not intended to be exhaustive; rather, informative on identifying the leading attributes that may have enabled MMPP pilot practices to consistently achieve shared savings. The MHCC conducted on-site assessments using a questionnaire to identify transformation activities key to the success of these nine practices in achieving quality goals, improving care coordination and reducing costs.<sup>4</sup>

This assessment identified three key practice initiatives that may have attributed to the MMPP goal achievement: incorporating a care manager into the practice, tracking patient outcomes, and improving access to patients outside of normal office hours. Three additional notable responses reported by the nine practices were leadership, care coordination, and use of an electronic health record (EHR). Several practices also identified reporting of quality metrics, care manager activities and team meetings as a way of strengthening performance results.

## Background

The American Academy of Pediatrics first introduced the concept of a medical home in 1967 in an effort to enhance the care of children with special needs. In 2004, The Future of Family Medicine Project called for every American to have a personal medical home.<sup>5</sup> Over the last 10 years, a number of developments have expanded on this concept. In 2007, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association

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<sup>1</sup> Chapters 5 and 6, Acts 2010.

<sup>2</sup> At the time of the assessment, only data for the first two years was available.

<sup>3</sup> Quality measures enable the user to quantify the quality of a selected aspect of health care delivery by comparing it to an evidence-based criterion that specifies what constitutes better quality. Utilization measures quantify the extent to which a given group uses a particular service in a specified period, usually expressed as the number of services used per year per 100 or per 1,000 persons eligible for the service. Cost measures quantify the change in health care costs from one time period to another. All three measures were compared for one twelve month period to the prior twelve month period to determine if any changes occurred.

<sup>4</sup> See Appendix B for site visit interview questions.

<sup>5</sup> The Annals of Family Medicine, *The Future of Family Medicine: A Collaborative Project of the Family Medicine Community*, Vol. 2 No. Suppl 1 S3-S32, March 2004. Available at: [www.annfammed.org/content/2/suppl\\_1/S3.full](http://www.annfammed.org/content/2/suppl_1/S3.full).

developed joint PCMH principles. These principles suggest that characteristics of a PCMH should consist of a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety, enhanced access and adequate payment.<sup>6</sup>

The MMPP pilot was implemented to test the PCMH model and consists of both primary and multi-specialty practices. Private practices and federally-qualified health centers located across the State participate in the MMPP pilot. Maryland law required the State's five major insurance carriers, which includes: Aetna, Inc.; CareFirst BlueCross BlueShield; CIGNA Health Care, Mid-Atlantic Region; Coventry Health Care; and UnitedHealthcare, Mid-Atlantic Region, to take part in the pilot as well. In addition, the Federal Employees Health Benefit Plan, Maryland State Employees Health Benefit Plan, and TRICARE (the health care program serving Uniformed Service members) voluntarily elected to participate in the pilot. The unique reimbursement model promotes the delivery of high-value primary and preventive services and rewards improved health outcomes. It also offers them opportunities for infrastructure support and incentives to support and sustain practice transformation.

## Limitations

This assessment was not intended to be an in-depth evaluation of the MMPP pilot practices. The process that was used to collect the information does not allow for a statistical evaluation of the findings. Practices selected to participate in the assessment were chosen based upon achieving shared savings in both of the first two years of the pilot. The assessment of these practices does not take into account the severity of patients' health status treated by the practice or their use of technology beyond the adoption of an EHR. Information obtained from the assessment may have been influenced by the different level of practice staff that responded to the questions. An assessment of the characteristics of, or strategies employed by, the 43 practices that did not achieve shared savings for consecutive performance years was not conducted.

## Assessment Approach

The assessment focused on determining local best practices among MMPP pilot participants that achieved performance goals in the first two years specific to practice transformation and quality reporting linked to shared savings. The assessment focused largely on identifying common performance themes using on-site practice personnel interviews conducted after the end of the second year of the MMPP pilot, which occurred in March 2014. Key areas of the assessment aimed to gather select information regarding the clinical, technical, and business aspects of each practice's operations. The following MMPP pilot practices were assessed:

1. Family Health Centers of Baltimore; federally qualified health center;
2. Family Medical Associates (now part of Carroll Hospital Group – Manchester location);
3. Johns Hopkins Community Physicians – Canton Crossing location;
4. Johns Hopkins Community Physicians – Wyman Park location;
5. Johnston Family Medicine;

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<sup>6</sup> Joint Principles of the Patient-Centered Medical Home. Available at: [http://www.aafp.org/dam/AAFP/documents/practice\\_management/pcmh/initiatives/PCMHJoint.pdf](http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf).

6. Potomac Physicians – Security location;
7. Primary and Alternative Medical Center;
8. Shah Associates – Hollywood location; and
9. Stone Run Family Medicine.

The practices are located in Baltimore City, Baltimore County, Calvert County, Carroll County, and Cecil County and include a combination of urban, suburban and rural locations. Most of the practices are considered to be small based upon a patient panel size of less than 10,000. Two medium-sized practices, based upon patient panel size of between 10,000 and 20,000, were included in the assessment: Potomac Physicians and Johns Hopkins Community Physicians (JHCP) Wyman Park. Nearly all of the practices provide adult and pediatric care; JHCP Wyman Park only provides adult care. In addition to primary care, Family Health Centers of Baltimore provides on-site substance abuse, counseling and Suboxone services; Johnston Family Medicine also provides obesity, weight loss and healthy living services; and Primary and Alternative Medical Center provides substance abuse counseling and Suboxone prescribing.<sup>7</sup> Family Medical Associates, the Johns Hopkins practices and Stone Run Family Medicine are affiliated with a hospital system. All practices are recognized by the National Committee for Quality Assurance (NCQA) as a PCMH.<sup>8</sup> Presently, five of the practices have achieved the highest NCQA recognition at Level 3 and the other four have Level 2 recognition.<sup>9</sup>

NCQA offers three levels of PCMH recognition for practices; each level reflects the degree that the practice meets specific requirements with Level 3 considered to be the highest level of recognition. All MMPP pilot practices are required to achieve NCQA recognition Level 2 or greater. Financial incentives increase as NCQA recognition level increases. Practices that participate in the MMPP pilot can also receive financial incentives ranging from 30, 40, or 50 percent of calculated shared savings based on meeting quality outcomes, utilization, and cost measure goals. In general, incentives are paid to practices based on a reduction of health care costs. To qualify for an incentive, MMPP pilot practices must report on a certain number of quality measures.<sup>10</sup>

Site visits and interviews with practice staff that served in the role of practice manager, case manager, or medical director were conducted. Documentation from the practices reviewed as part of the assessment included the following:

- Organizational chart;
- Reports used to track medical costs and quality measures;
- Population management reports;
- Care coordination reports;
- Policies and procedures;

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<sup>7</sup> Suboxone is a controlled substance used to treat opiate addiction.

<sup>8</sup> Information pertaining to NCQA Patient Centered Medical Home Recognition is available at: <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>.

<sup>9</sup> Information pertaining to NCQA Level recognition is available at: [http://www.jointcommission.org/assets/1/18/PCMH-NCQA\\_crosswalk-final\\_June\\_2011.pdf](http://www.jointcommission.org/assets/1/18/PCMH-NCQA_crosswalk-final_June_2011.pdf).

<sup>10</sup> Requirements detailed in the *Patient Centered Medical Home Program Participation Agreement* available upon request from MHCC.

- Staff training materials; and
- Scoring detail from the most recent NCQA review.

## Results

The findings were grouped together by general/business, clinical, and technology.<sup>11</sup> Several notable observations in each category that spanned across the practices were identified during the assessment. Leadership was consistently reported as the catalyst for practices to perform well in the MMPP pilot. Practices that noted having leadership that embraced PCMH concepts and supported the adoption of PCMH principles was determined to be a factor for success. Another common attribute was the concept of “patient-first,” that is, treating a patient as if they were a family member. Minimal staff turnover was also cited as a contributing success factor.

Another factor that practices identified as impacting performance was the existence of a strong relationship with referring hospitals. Enhanced communication among practice team members and with patient and family members were identified as contributing to a practice’s success. Patient and staff education were found to be effective in bolstering practice performance.

### *General/Business*

The nine MMPP pilot practices implemented approaches to ensure they meet the changing landscape of health care delivery and the economic challenges in managing a business. As a business, ensuring financial success depends on the practice’s ability to execute sound business strategies and do more with less in order to remain financially solvent. Practices participating in the interview described a strong commitment to patients, organizational development based on a learning environment, physician engagement, and a clear sense of their mission. The learning environment is considered to be a critical component of practice transformation. In general, this is defined by practices as the ability to participate in learning collaboratives, quality improvement activities, access to practice level information, and support by practice coaching in workflow changes, practice teamwork and communication.

### *Key Practice Success Elements*

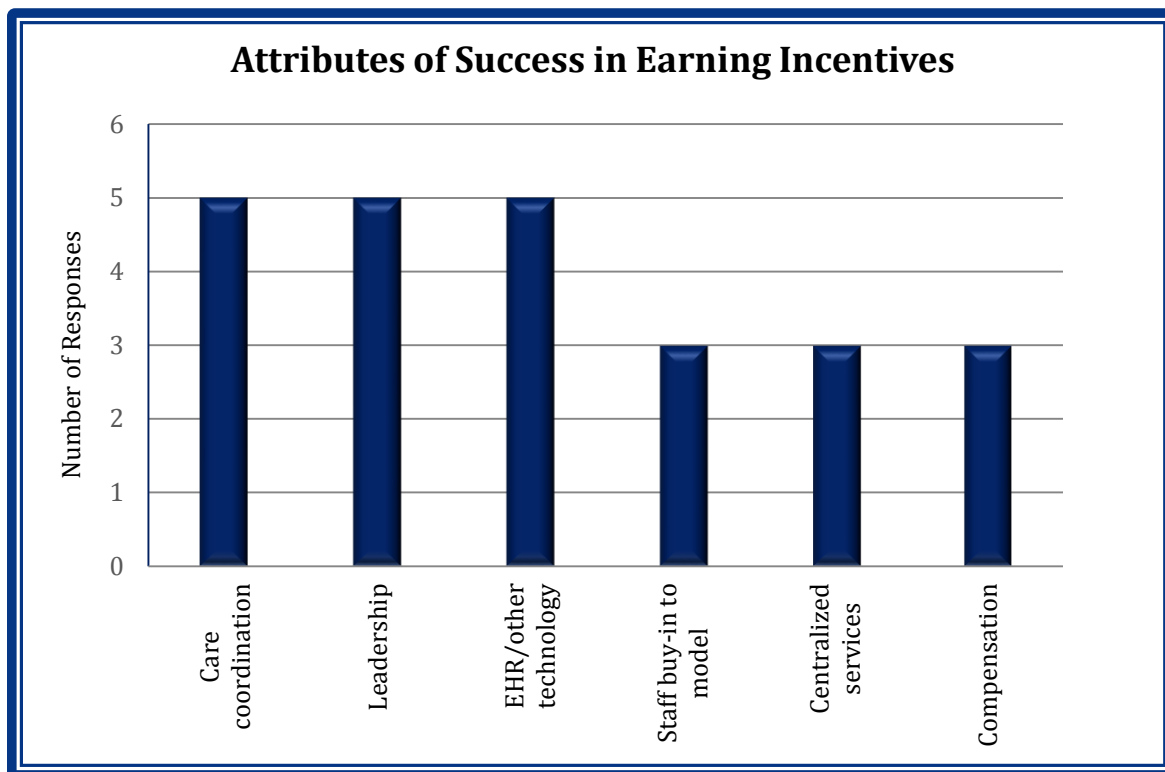
The MMPP pilot practices that participated in the assessment consistently identified three key areas required to achieve transformation: care coordination, leadership, and EHRs/other technology. These areas are closely related. Practice leadership is essential to conveying the importance of information sharing and motivating the group toward a shared vision. All participating practices were physician-led and about 33 percent of the practices included nurse practitioners and physician assistants. In general, it was reported that strong leadership leads to greater use of technology and more effective care coordination. The increased use and availability of technology enhances care coordination and better informs providers in the care delivery process.

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<sup>11</sup> Because practices could provide multiple responses to most questions, the total number of responses shown on the graphs below is often greater than nine.



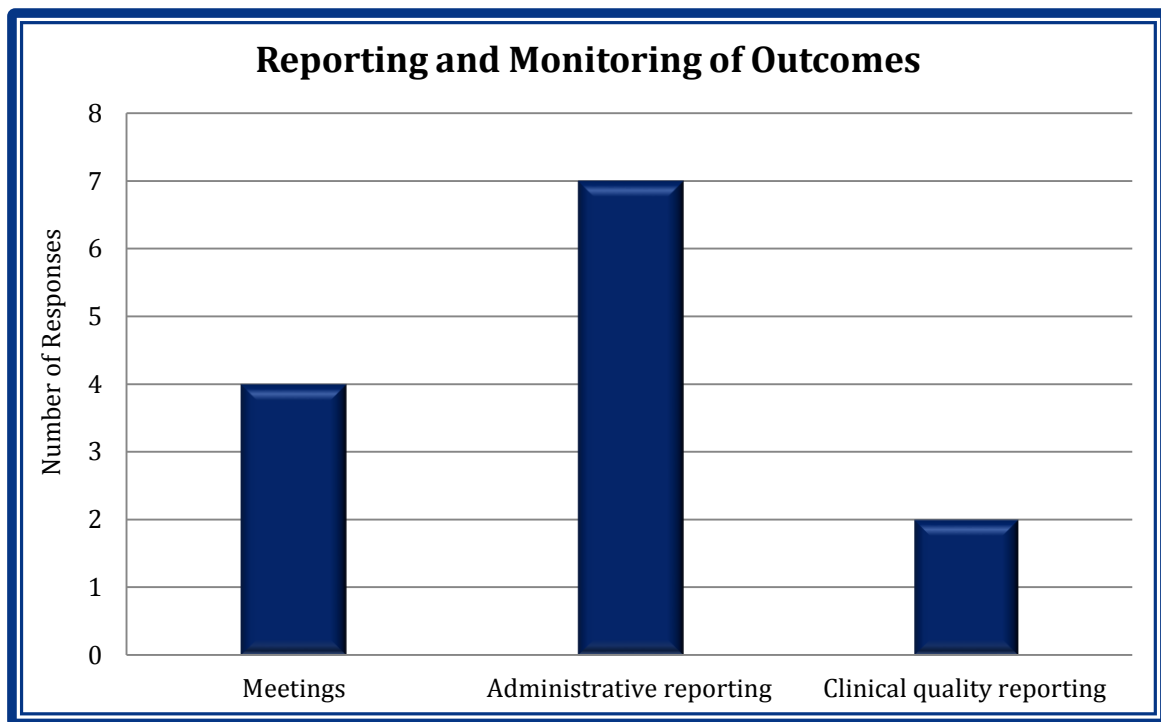
**Chart 1**



### Reporting and Program Monitoring

Different approaches are used among practices to monitor performance. The majority of practices indicated that they rely on monthly reports. In most practices these reports are focused on information gathered from administrative systems, such as billing reports from the payors. Two practices have developed dashboards that include a summary of program performance on select clinical quality indicators. The analysis of the information and subsequent use of the data varied across the nine practices. In four practices, meetings were held to discuss the information contained in the reports followed by workflow changes to achieve quality targets and goals.

**Chart 2**



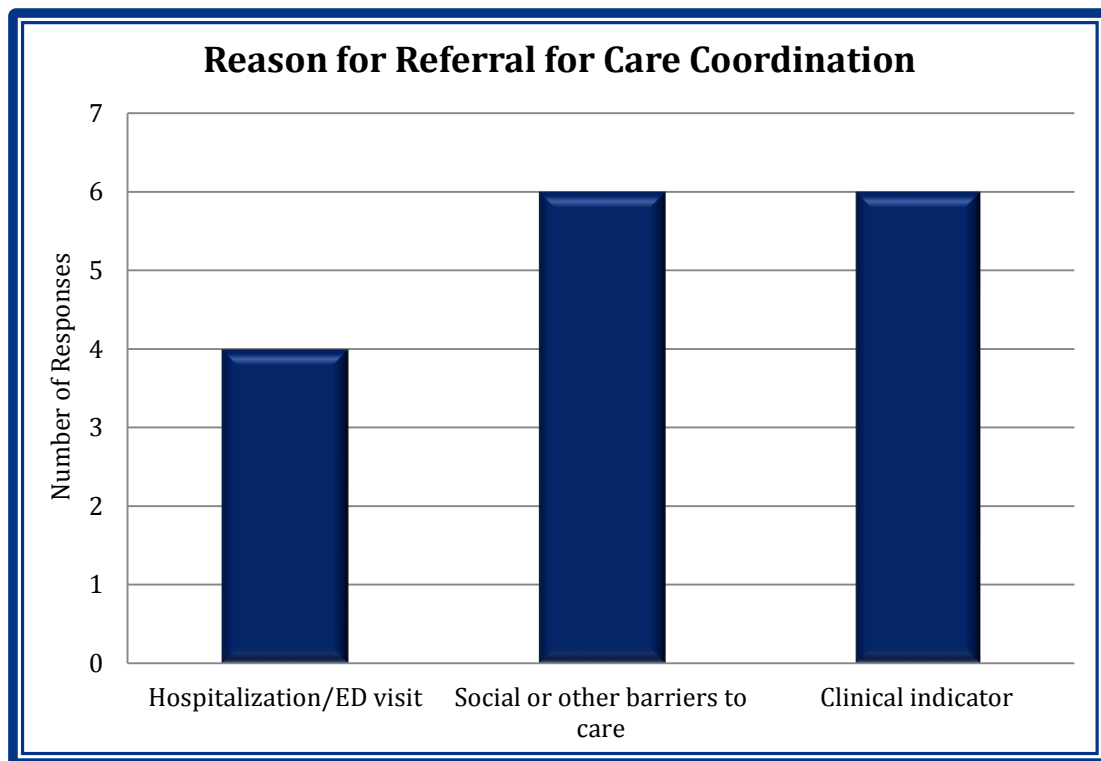
### *Clinical*

The assessment of the MMPP pilot practices' clinical aspects focused on care delivery processes, technology, and education. Key clinical aspects of care delivery noted by practices included relationships that the care coordinator established with the patients. Technology also aided practices in the care delivery process. Technology used to support care delivery allows appropriately authorized and authenticated users to exchange electronic health information in a more efficient manner. Practices relied on technology to obtain electronic alerts about their patients' inpatient admissions and emergency department (ED) visits. This information was made available through the State-Designated health information exchange (HIE), or directly from the community hospital.

### *Care Coordination Process*

Patients are assigned within a practice and prioritized for care coordination based on their clinical need, such as a new routine medication, an inpatient stay, or a recent ED visit. During patients' visits, care team members work to identify barriers that may make it difficult for a patient to comply with their care plan. These barriers could be health-related, language, transportation, or cultural, among other things.

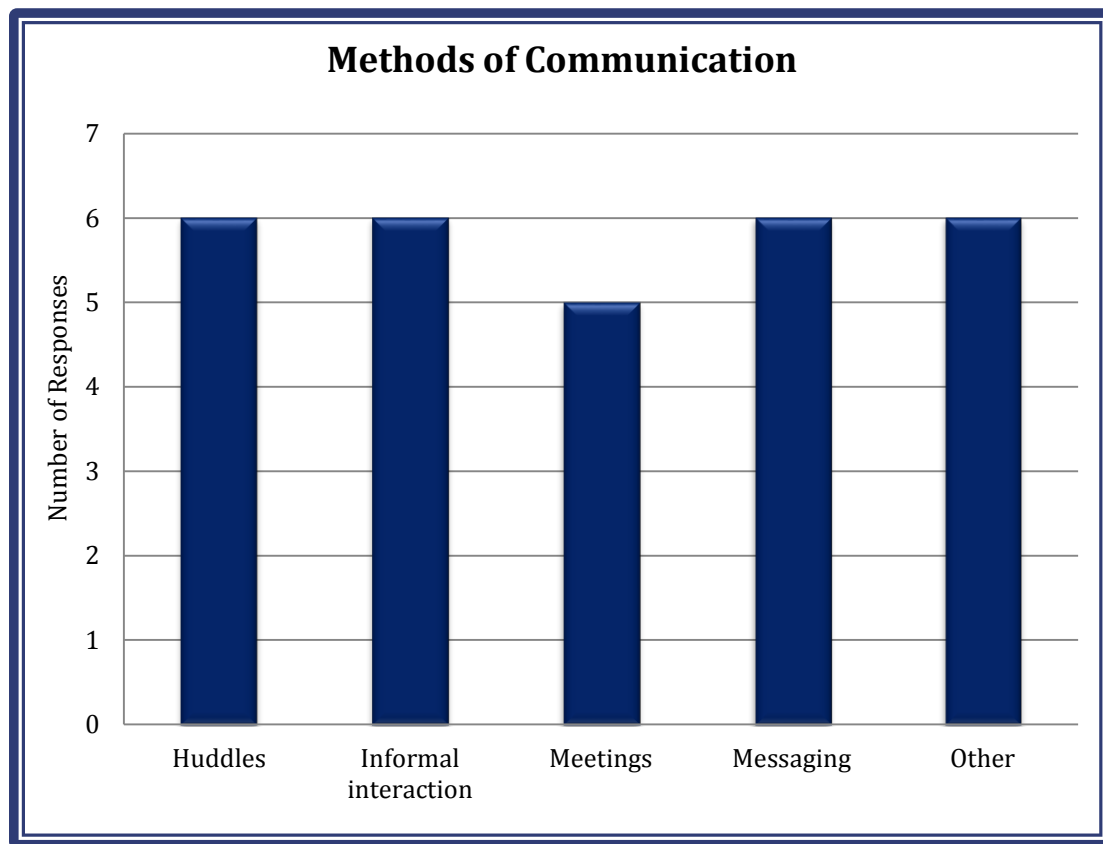
**Chart 3**



#### Practice Team Communication Methods

Many practices identified improved communications as contributing to their success in the MMPP pilot. Multiple methods for team communication are used among the practices to share information. Scheduled meetings with practice staff were held to discuss results of individual patients and offer a forum for sharing results. Informal interactions included unscheduled face-to-face meetings, or making contact by telephone or e-mail. Many practices reported messaging through increased use of EHRs and patient portals as a contributing success factor.

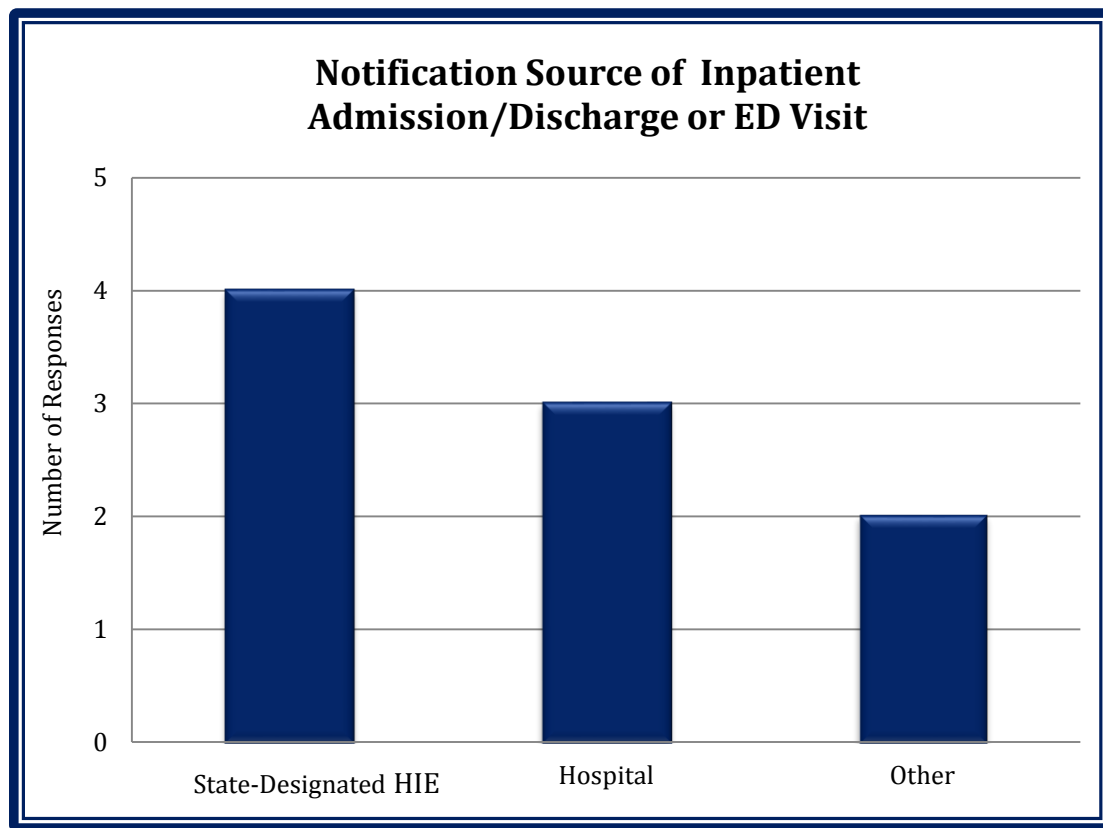
**Chart 4**



#### Patient Alerts to Practices

Knowledge about inpatient admissions or a visit to the ED enables practices to engage patients in order to provide appropriate and timely follow up care, which can contribute to better health outcomes. With appropriate and timely follow up care, both avoidable admissions and avoidable readmissions can be reduced. Practices had access to patient alerts through several sources. Four practices accessed the State-Designated HIE to obtain information on patients' admissions and discharges for all inpatient and ED visits. Some MMPP pilot practices elected to be notified through a web-based provider portal hosted by their local hospital. In practices with limited technology, they reported receiving notification by fax or email from hospitals.

**Chart 5**

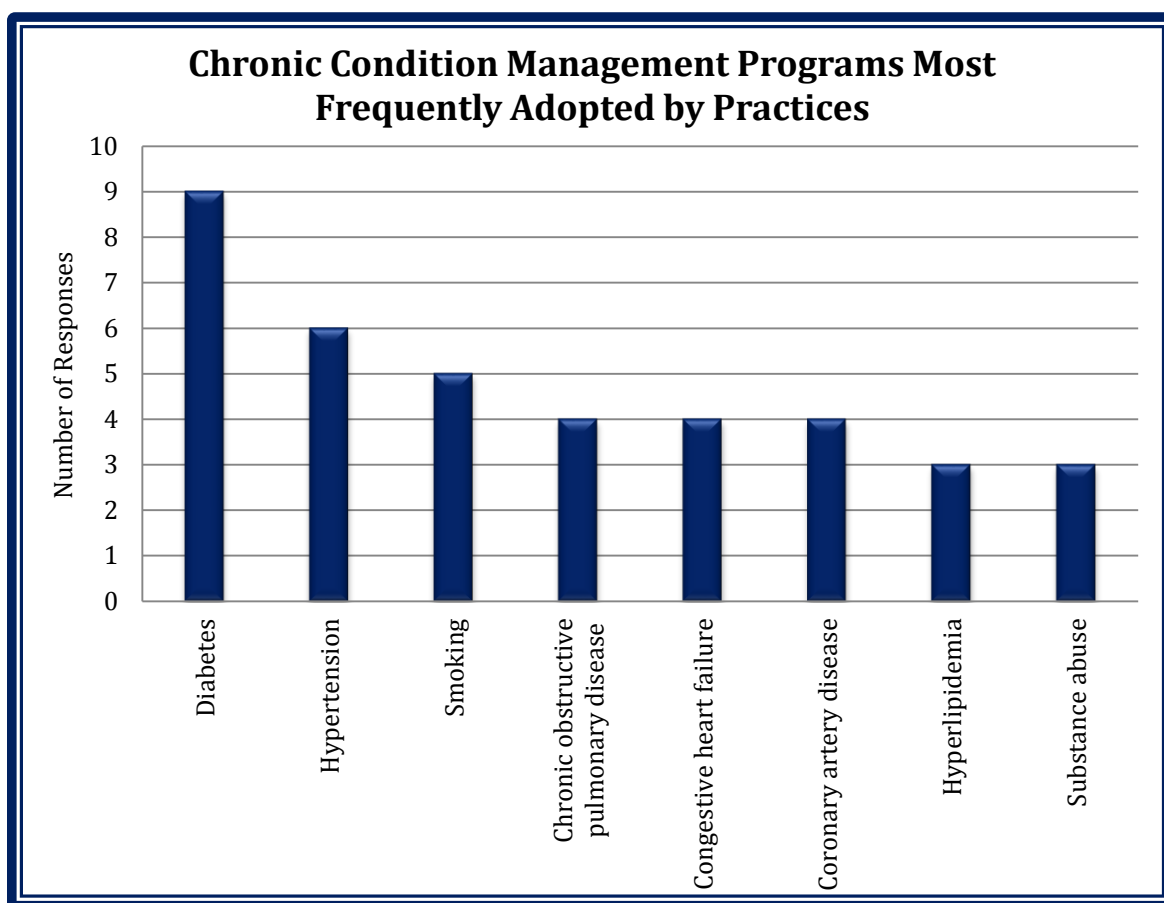


### Chronic Condition Management

The nine MMPP pilot practices reported educating patients as a critical part of helping them to take an active role in managing their chronic conditions. In general, education largely focuses on making healthy lifestyle choices and changes, adhering to prescribed medical treatments, and becoming more aware about their health care in order to improve their health status. The first year quality data suggests that practices had a positive impact on the health of patients with chronic conditions.<sup>12</sup> The chronic condition management programs most frequently adopted by the practices are shown on Chart 6.

<sup>12</sup> The Evaluation of the Maryland Multi-Payor Patient Centered Medical Home, First Annual Report, December 2013. Available at: [https://mhcc.maryland.gov/pcmh/documents/PCMH EvaluationYear1\\_Report%20FINAL.pdf](https://mhcc.maryland.gov/pcmh/documents/PCMH%20EvaluationYear1_Report%20FINAL.pdf).

Chart 6



## Technology

Health information technology adoption is an essential part of practice transformation and can improve the quality of health care, increase productivity, and reduce health care costs. EHR adoption has become a necessity for providers in managing care. They are increasingly relied upon to provide access to accurate, up-to-date, and complete information about patients at the point of care. EHRs are also used to share health information electronically with other providers.

## Participation in Meaningful Use

The *American Recovery and Reinvestment Act* of 2009 provides incentive payments from Medicare and Medicaid for eligible professionals (EPs) who are meaningful users of nationally certified EHRs.<sup>13, 14, 15</sup> To demonstrate meaningful use, EPs must meet certain thresholds for a number of

<sup>13</sup> Public Law 111-5.

<sup>14</sup> EPs for the Medicare program include: doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, and chiropractors. EPs for the Medicaid program must meet the minimum 30 percent Medicaid patient volume threshold or 20 percent for pediatricians; they must also be one of the following: physicians (Doctor of Medicine or Doctor of Osteopathic Medicine), dentists, nurse practitioners, certified nurse-midwives, or physician assistants (working for a federally qualified health center only).

<sup>15</sup> CMS was authorized to create the Medicare and Medicaid EHR Incentive Program under the *Health Information Technology for Economic and Clinical Health Act*. More information about the program is available at:

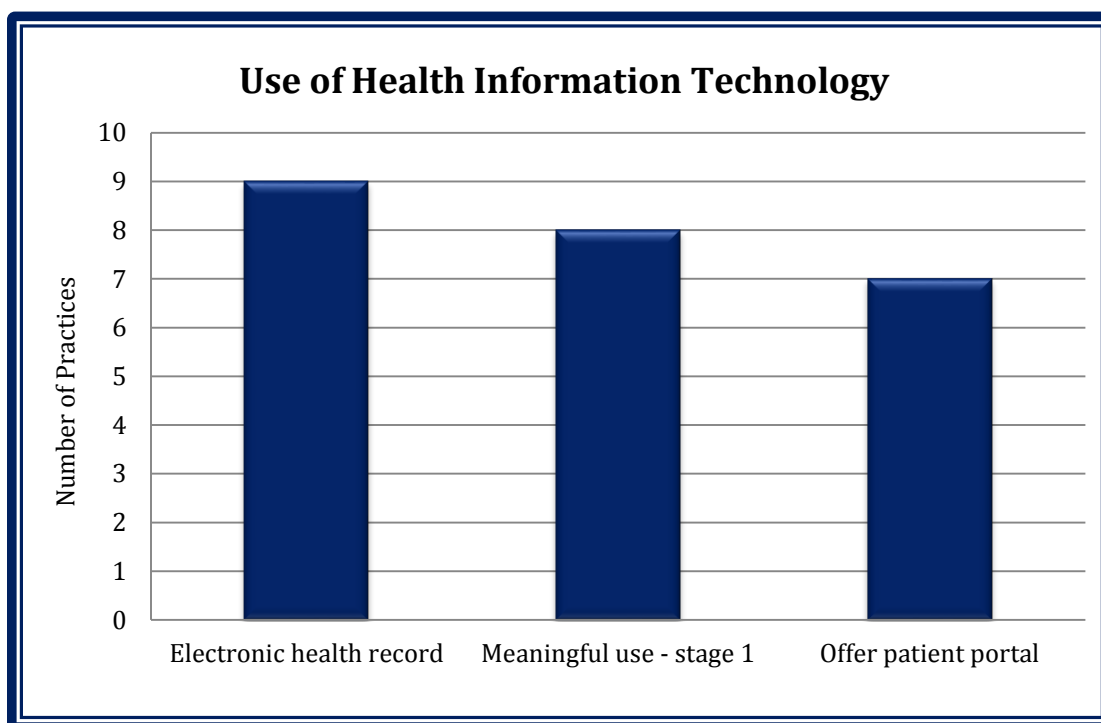
<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/>.

objectives in their use of EHRs.<sup>16</sup> Many of these objectives align with required activities under the MMPP pilot. Most practices observed that the timing of participating in the MMPP pilot aligned with their efforts to achieve meaningful use. Eight of the nine practices have achieved Stage 1 of meaningful use.

#### Patient Portal Availability

Patient portals allow individuals to access their electronic health information online. The capability to provide patients online access to their health information will be part of certified EHRs beginning in 2014. This enhancement to EHRs will allow patients to view, download, or transmit their health information. Patient portals can be used to communicate with providers and obtain patient health information from online sources. Seven of the nine practices offered patients access to their health information through a portal.

**Chart 7**



<sup>16</sup> 42 C.F.R. § 142, 143, 422, et. al. (2010).

## Remarks

The nine MMPP pilot practices that participated in the assessment identified initiatives that help practices to achieve transformation. In general, transformation to a PCMH involves a better understanding of patients' preferences and culture, shared decision-making between patient and providers, and patients' willingness to establish and work toward personal health goals. The MHCC intends to use the findings from the assessment to assist the remaining 43 MMPP pilot practices in adopting best practices that will help them maximize their value as a PCMH. In addition, the results of the assessment will be used to inform the design of future advanced care delivery programs in Maryland.

## Acknowledgement

The MHCC thanks Ms. Jennifer Ternay, President, JLS Advisory Group, LLC for her support in completing the field work. The MHCC appreciates the willingness of the nine pilot practices that gave their time to participate in this assessment. Special thanks go to Niharika Khanna, MD, Associate Professor, Department of Family and Community Medicine, University of Maryland School of Medicine, and Kathyryn Montgomery, PhD, Associate Professor, University of Maryland School of Nursing for their input in developing this report.



## Appendix A: Participating Practices in the Assessment

1. Family Health Centers of Baltimore  
631 Cherry Hill Road  
Baltimore, MD 21225
2. Carroll Hospital Center  
4175A Hanover Road  
Manchester, MD 21102
3. Johns Hopkins Community Physicians  
1501 S. Clinton Street, Suite 200  
Baltimore, MD 21224
4. Johns Hopkins Community Physicians  
3100 Wyman Park Drive  
Baltimore, MD 21211
5. Johnston Family Medicine  
444 WMC Drive, Suite 114  
Westminster, MD 21158  
Attn: Kimberly Johnston, MD
6. Potomac Physicians  
4 West Rolling Crossroads  
Catonsville, MD 21228
7. Primary and Alternative Medical Center  
10801 Lockwood Drive, Suite 310  
Hollywood, MD 21225
8. Shah Associates  
Phillip J Bean Medical Center  
24035 Three Notch Road  
Hollywood, MD 20636
9. Stone Run Family Medicine  
20101 Colonial Way, Suite A  
Rising Sun, MD 21911

## **Appendix B: Site Visit Interview Questions**

### **General/Business**

1. What do you attribute to your success in earning incentive payments?
2. What reports do you use to manage the practice?
3. What patient registries do you maintain and what state/national registries receive your information?
4. How are outcomes reported and monitored?
5. How are you reimbursed for services, i.e. fee for service, case rate, capitation, performance-based, etc.?
6. How has converting to a PCMH affected financial performance, including billing and denials?
7. What are the rates of no-shows and cancellations and has this changed since becoming a PCMH?
8. How do you reconcile the incentive payments received?
9. What additional incentive payments by carriers outside of the MMPP Program are received?
10. How are fixed transformation payments (FTP) spent by financial account category (i.e. salaries, benefits, systems - EHR, etc.)?
11. What financial incentives are provided to clinicians and/or teams?
12. What are the communication methods within the practice?
13. What training is provided regarding the PCMH model?

### **Clinical**

1. How are individuals assigned to care coordination?
2. What is the current care coordination caseload?
3. How many clinicians participate in the practice team?
4. What are communication methods within the practice team?
5. What are your three preventive care services (PCMH 2, Element D)
6. What are your three chronic care services (PCMH 2, Element D)
7. What best practice/guidelines are used?
8. How do you assess barriers to care? (language, transportation, support, etc.)
9. What do you do to mitigate barriers to care?
10. How do you know when a patient is admitted to a hospital or visits an emergency department?
11. Do you use a referral coordinator and if yes, why?

**Technology**

1. What system is used for your Electronic Health Record (EHR)?
2. How long have you utilized the particular EHR system?
3. What level of certification is the EHR for meaningful use (the operating platform)?
4. What is your level of participation in meaningful use?
5. How is your EHR configured for mandatory fields?
6. How are reports generated, i.e., part of EHR or add-on reporting?
7. What is your patient portal?
8. What is the frequency of use for the patient portal?

## Appendix C: Quality Measures

Below is a list of quality and outcome measures used to determine changes in health of patients in the Maryland Multi-Payor Patient Centered Medical Home Program.

Quality Measurement 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	Hypertension: Blood Pressure Measurement		YES
0018	NCQA	Controlling High Blood Pressure		YES
0024	NCQA	Weight Assessment and Counseling for Children and Adolescents	YES	
0028a	AMA	Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment		YES
0028b	AMA	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	Childhood immunization Status	YES	
0041	AMA	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 Low-Density Lipoproteins (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	Adult Weight Screening and Follow-Up		YES
0575	NCQA	Diabetes: HbA1c Control (<8%)		YES

## Appendix D: National Committee for Quality Assurance Practice Level Patient Centered Medical Home Recognition

National Committee Quality Assurance (NCQA) offers three levels of Patient Centered Medical Home recognition for practices; each level reflects the degree that the practice meets specific requirements with Level 3 considered to be the highest level of recognition. All MMPP practices are required to achieve NCQA recognition Level 2 or greater.

Count	Practice Name	NCQA Level
1	Atlantic General Hospital System Berlin Primary Care	2
2	Atlantic General Hospital System Townsend Medical Center	2
3	Bay Crossing Family Medicine	2
4	Family Health Centers of Baltimore	2
5	Family Medical Associates, LLC; Manchester	2
6	Family Medical Associates, LLC; Finksburg	2
7	Family Medical Associates, LLC; Reisterstown	2
8	Family Medical Associates, LLC; Eldersburg	2
9	Hahn & Nelson Family Medicine	2
10	Johnston Family Medicine	2
11	Parkview Medical Group; Rosehill	2
12	Parkview Medical Group; Mount Airy	2
13	Parkview Medical Group; Myersville	2
14	Patient First Waldorf	2
15	Primary and Alternative Medical Center	2
16	University of Maryland Pediatric Associates, PA	2
17	Andrew S Dobin, MD, PA	3
18	Calvert Convenient Care	3
19	Calvert Family Care	3
20	Calvert Internal Medicine Group, PA; Hospital Road	3
21	Calvert Internal Medicine Group, PA; Town Center Boulevard	3
22	Calvert Internal Medicine Group, PA; Solomon's Island Road	3
23	Cambridge Pediatrics, LLC	3
24	Children's Medical Group, PA	3
25	Comprehensive Women's Health	3
26	Family Care of Easton	3
27	Gerald Family Care, PC	3
28	Green Spring Internal Medicine, LLC	3
29	Johns Hopkins at Montgomery County	3
30	Johns Hopkins Community Physicians at Canton Crossing	3
31	Johns Hopkins Community Physicians at Hagerstown	3
32	Johns Hopkins Community Physicians at Water's Edge	3

Count	Practice Name	NCQA Level
33	Johns Hopkins Community Physicians at Wyman Park	3
34	Joseph K Weidner Jr, MD, LLC (dba Stone Run Family Medicine)	3
35	MedPeds, LLC	3
36	MedStar Health Physicians Franklin Square Family Health Center	3
37	Mountain Laurel Medical Center	3
38	Potomac Physicians Annapolis Regional Medical Center	3
39	Potomac Physicians Frederick Medical Center	3
40	Potomac Physicians Security Health Center	3
41	Shah Associates Calvert	3
42	Shah Associates Hollywood	3
43	Shah Associates Waldorf	3
44	The Pediatric Group LLP at Crofton	3
45	The Pediatric Group LLP at Davidsonville	3
46	The Pediatric Group LLP at Severna Park	3
47	Twin Beaches Community Health Center	3
48	Ulmer Family Medicine, PC	3
49	Union Primary Care	3
50	University of Maryland Family Medicine Associates, PA	3
51	UniversityCare at Edmondson Village	3
52	Vanessa Allen, MD	3

## Appendix E: Other State Patient Centered Medical Home Initiatives

Below is a summary of national Patient Centered Medical Home initiatives. The summary includes utilization, cost and quality outcome data.<sup>17</sup>

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Air Force 2009-2011 <sup>i</sup>	14% fewer emergency department (ED) and urgent care visits <sup>ii</sup>	Saved \$300,000 annually through improved diabetes care management; 77% of diabetic patients had improved glycemic control		
Alaska: Alaska Native Medical Center <sup>iii</sup>	50% reduction in urgent care and ED utilization; 53% reduction in hospital admissions; 65% reduction in specialist utilization			
California: Blue Cross Blue Shield of California Accountable Care Organization Pilot <sup>iv</sup>	15% fewer hospital readmissions; 15% fewer inpatient hospital stays; 50% fewer inpatient stays of 20 days or more			Overall health care cost savings of \$15.5 million
Colorado: Colorado Medicaid and State Children Health Insurance Program <sup>v</sup>			Increased provider participation in Children's Health Insurance Program (CHIP) from 20% to 96%; increased well-care visits for children from 54% in 2007 to 73% in 2009	\$215 lower per member per year for children
Florida: Capital Health Plan <sup>vi</sup>	40% lower inpatient hospital days; 37% lower ED visits		250% increase in primary care visits	18% lower health care claims costs
Idaho: Blue Cross Blue Shield of Idaho Health Service <sup>iv</sup>		Return on investments (ROI) of 4:1 for disease management programs		\$1 million reduction in single year medical claims
Maryland: CareFirst Blue Cross Blue Shield <sup>vii</sup> Blue Cross Blue Shield industry report				4.2% average reduction in expected patient's overall health care costs among 60% of practices participating for six or more months; nearly \$40 million savings in 2011

<sup>17</sup> References identified in this appendix are shown as endnotes on pages 26-27.

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Michigan: Blue Cross Blue Shield of Michigan	13.5% fewer ED visits among children in PCMH (vs. 9% non-PCMH); 10% fewer ED visits among adults in PCMH (vs. 6.5% non-PCMH) <sup>viii</sup> ; 7.5% lower use of high-tech radiology <sup>ix</sup> ; 17% lower ambulatory-care sensitive inpatient admissions 6% lower 30-day readmission rates <sup>iv</sup>			60% better access to care for participating practices that provide 24/7 access (as compared to 25% in non-participating sites) <sup>iv</sup>
Minnesota: HealthPartners <sup>x</sup>	39% lower ED visits 24% fewer hospital admissions; 40% lower readmission rates; 30% lower length of stay; 20% lower inpatient costs due to outpatient case management program for behavioral health; 10% decrease in diagnostic imaging scans in first year		Reduced appointment wait time by 350% from 26 days to 1 day; 129% increase in optimal diabetes care; 48% increase in optimal heart disease care	Overall costs decreased to 92% of state average in 2008 <sup>xi</sup> ; reduced outpatient costs of \$1,282 for patients using 11 or more medications <sup>xii</sup>
Nebraska: Blue Cross Blue Shield of Nebraska 2012 <sup>xiii</sup>	10% fewer hospitalizations; 27% fewer emergency visits			
New Jersey: Blue Cross Blue Shield of New Jersey (Horizon Blue Cross Blue Shield of New Jersey) 2012 <sup>xiv,xv</sup>	10% lower per member per month (PMPM) costs; 26% fewer ED visits 25% fewer hospital readmissions; 21% fewer inpatient admissions; 5% increase in use of generic prescriptions	8% improvement in HbA1c levels; 31% increase in ability to effectively self-manage blood sugar; 24% increase in Low-density lipoprotein (LDL) screening; 6% increase in breast and cervical cancer screening		
New York: Capital District Physicians' Health Plan (Albany, N.Y.) <sup>xvi</sup> 2008-2010	24% lower hospital admissions; 9% lower overall medical cost			Savings of \$32 PMPM



Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
New York: Priority Community Healthcare Center Medicaid Program (Chemung County, N.Y.) 2010 -2011 <sup>xvii</sup>	Reduced hospital spending by 27%; ED spending by 35%			Cost savings of 11% overall in first 9 months of approximately \$150,000
North Carolina: Blue Quality Physician's Program (BCBSNC) 2011 <sup>xviii</sup>	52% fewer visits to specialists; 70% fewer visits to the ED			
North Carolina: Community Care of North Carolina (Medicaid) <sup>xix</sup>	23% lower ED utilization and costs; 25% lower outpatient care costs; 11% lower pharmacy costs estimated cost savings of: \$60 million in 2005; \$161 million in 2006; \$103 million in 2007; \$204 million in 2008; \$295 million in 2009; \$382 million 2010 <sup>xx</sup>	Improvements in asthma care; 21% increase in asthma staging		112% increase in influenza inoculations
North Dakota: Blue Cross Blue Shield of North Dakota – MediQHome Quality Program 2012 <sup>xv</sup>	6% lower hospital admissions; 24% fewer ED visits; 18% lower inpatient hospital admission rates compared to general ND population	30% lower ED use among patients with chronic disease; 6.7% improvement in BP control; 10.3% improvement in cholesterol control; 64.3% improvement in optimal diabetes care; better coronary artery disease management 8.6% improvement in BP control; 9.4% improvement in cholesterol control; 53.8% improvement in optimal diabetes control; better care for hypertension 8% improvement in blood pressure control		

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Ohio: Humana Queen City Physicians <sup>xxi</sup>	34% decrease in ED visits	22% decrease in patients with uncontrolled blood pressure		
Oklahoma: Oklahoma Medicaid <sup>xxii</sup>			Reduction from 1,670 to 13 patient inquiries related to same-day/next-day appointment availability; 8% increase in patients “always getting treatment quickly.”	Reduced per capita member costs by \$29 per year
Oregon: Bend Memorial Clinic & Clear One Medicare Advantage <sup>xxiii</sup>	Lower hospital admission rates 231.5 per 1000 beneficiaries (compared to state/national averages of 257 and 351 per 1000, respectively); lower ER visit rates 242 per 1000 beneficiaries (compared to state/national averages of 490 and 530 per 1000, respectively)			
Oregon: CareOregon Medicaid		Better disease management among diabetics in one clinic; 65% had controlled HbA1c levels vs. 45% pre-PCMH <sup>xxiv</sup>		9% lower PMPM costs <sup>xxv</sup> ; reduced PMPM costs by \$89 <sup>xxvi</sup>
Pennsylvania: Geisinger Health System <sup>xxvii,xxviii</sup>	Reduced hospital length of stay by half a day; 25% lower hospital admissions; 50% lower readmissions following discharge; 18% reduced inpatient admissions	Improved quality of care; 74% for preventive care; 22% for coronary artery care; 34.5% for diabetes care <sup>xxix</sup>		Longer exposure to medical homes resulted in lower health care costs: 7.1% lower cumulative cost savings (from 2006 to 2010) with an ROI of 1.7 <sup>xxx</sup> ; 7% lower cumulative total spending (from 2005 to 2008) <sup>xxxi</sup>

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Pennsylvania: UPMC <sup>xxxii</sup> (Pittsburgh, PA) 2011	13% fewer hospitalizations by 2009; medical costs nearly 4% lower	Improved patient outcomes for diabetics: increases in eye exams from 50% to 90%; 20% long-term improvement in control of blood sugar; 37% long-term improvement of cholesterol control		
Pennsylvania: Independence Blue Cross— Pennsylvania Chronic Care Initiative (Southeast Pennsylvania) 2012 <sup>xv</sup>		49% improvement in HbA1c levels; 25% increase in blood pressure control; 27% increase in cholesterol control; 56% increase in patients with self-management goals increased diabetes screenings from 40% to 92%		
Pennsylvania: PinnacleHealth (2012) <sup>xxxiii</sup>	0% 30-day hospital readmission rate for PCMH patients vs. 10-20% for non-PCMH patients			
Rhode Island: Blue Cross Blue Shield of Rhode Island 2012 <sup>xv</sup>	17-33% lower health care costs among PCMH patients	Improved quality of care measures 44% for family & children's health; 35% for women's care; 24% for internal medicine		
South Carolina: Blue Cross Blue Shield of South Carolina 2012 <sup>xv</sup>	14.7% lower inpatient hospital days; 25.9% fewer ED visits			6.5% lower total PMPM medical and pharmacy costs
Tennessee: Blue Cross Blue Shield of Tennessee 2012 <sup>xv</sup>		3% for diabetes exams; 7% for diabetes retinal exams; 14% for diabetes nephropathy exams; 4% for lipid exams		
Texas: Blue Cross Blue Shield of Texas 2012 <sup>iv</sup>	23% lower readmission rates; \$1.2 million estimated health care cost savings			

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Texas: WellMed Inc. <sup>xxxiv</sup> (San Antonio, Tex.)		Increased control of HbA1c levels from 81% to 93% of diabetes patients; increased LDL levels under control, from 51% to 95%, for heart disease patients; increased control of BP levels from 67% to 90%; increased screening rates for mammography from 19% to 40%; increased screening rates for colon cancer from 11% to 50%; improved diabetes HbA1c testing from 55% to 71%; LDL screenings for all patients increased from 47% to 70%; LDL screenings for diabetic patients increased from 53% to 78%; LDL screenings for ischemic heart disease patients increased from 53 to 76%; BP screening rates for all patients increased from 38 to 76%; BP screenings for high BP patients increased from 46 to 88%.		
Vermont: Vermont Blueprint for Health 2012 <sup>xxxv</sup>	27% reduction in projected cost avoidance across its commercial insurer population			

Initiative	Utilization	Prevention & Disease Management	Access	Overall Costs
Vermont: Vermont Medicaid <sup>xxxvi</sup> 2008-2010	21% decreased inpatient utilization; 22% lower PMPM inpatient costs; 31% lower ED use; 36% lower PMPM ED costs			
Veterans Health Administration and VA Midwest Healthcare Network (VISN 23) 2012	8% lower urgent care visits; 4% lower acute admission rates by 4% <sup>xxxvii</sup>	27% lower hospitalizations and ED visits among chronic disease patients; \$593 per chronic disease patient cost savings <sup>xxxviii</sup>		
Washington: Regence Blue Shield (Intensive Outpatient Care Program with Boeing) 2012 <sup>iv</sup>		14.8% improved patient-reported physical function and mental function; 65% reduced patient reported missed workdays		20% lower health care costs
Washington: Group Health of Washington <sup>xxxix</sup> 2009, 2010	29% fewer ED visits; 11% fewer hospitalizations for ambulatory care-sensitive conditions	18% reduction in use of high-risk medications among elderly; 36% increase in use of cholesterol-lowering drugs; 65% increase in use of generic statin drug; improved quality of care: composite measures increased by 3.7% to 4.4%; Improved provider satisfaction: Less emotional exhaustion reported by staff (10% PCMH vs. 30% controls)	83% of patient calls resolved on the first call compared to 0% pre-PCMH <sup>x</sup>	Cost savings of \$17 PMPM <sup>xliii</sup> ; \$4 million in transcription cost savings through the use of EHRs; \$2.5 million in cost savings through medical records management; \$3.4 million in cost savings through medication use management program; 40% cost reduction through use of generic statin drug

## References for Appendix E

- <sup>i</sup> Green, C. B. (2011, May 11). FY 2012 Medical Programs. Statement of Lieutenant General (Dr.) Charles B. Green. Testimony Before the House Appropriations Committee, Subcommittee on Defense. United States Air Force.
- <sup>ii</sup> Arvantes, J.: U.S. Military Focuses on Patient Care by Implementing PCMH Model.
- <sup>iii</sup> Asinof, R. (2012, May 28). A new model of health care. Retrieved June 14, 2012 from Providence Business News. Available at: <http://www.pbn.com/A-new-model-of-health-care,67796>.
- <sup>iv</sup> Blue Cross Blue Shield Association. (2012) Building Tomorrow's Healthcare System.
- <sup>v</sup> Takach: Reinventing Medicaid.
- <sup>vi</sup> Institute for Healthcare Improvement. (2012). Report from Tallahassee Memorial HealthCare on Enhancing Continuity of Care. Retrieved April 12, 2012, from IHI Knowledge Center: <http://www.ihl.org/knowledge/Pages/ImprovementStories/ReportfromTallahasseeMemorialHospitalonEnhancingContinuityofCare.aspx>.
- <sup>vii</sup> Sun, L.: CareFirst says experimental program improves primary care.
- <sup>viii</sup> Sammer, J. (2011, December 1). Medical homes move from pilots to real-world implementation. Retrieved April 30, 2012, from Managed Healthcare Executive: <http://managedhealthcareexecutive.modernmedicine.com/mhe/News+Analysis/Medical-homes-move-to-real-world-implementation/ArticleStandard/Article/detail/750641>.
- <sup>ix</sup> BCBS of Michigan: Patient-Centered Medical Home Fact Sheet.
- <sup>x</sup> HealthPartners. (2009). HealthPartners BestCare: How to Deliver \$2 Trillion in Medicare Cost Savings, and Improve Care in the Process. Retrieved April 16, 2012, from HealthPartners: <http://www.healthpartners.com/files/47979.pdf>.
- <sup>xi</sup> Grumbach, K., Bodenheimer, T., & Grundy, P. (2009, August). The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Cost from Recent Prospective Evaluation Studies. Retrieved April 16, 2012, from Patient Centered Primary Care Collaborative: [http://www.pcpcc.net/files/Grumbach\\_et-al\\_Evidence-of-Quality\\_percent20101609\\_0.pdf](http://www.pcpcc.net/files/Grumbach_et-al_Evidence-of-Quality_percent20101609_0.pdf).
- <sup>xii</sup> Flottmesch, T., Fontaine, P., Asche, S., Solberg, L. (2011). Relationship of Clinic Medical Home Scores to Health Care Costs. *Journal of Ambulatory Care Management*. 34(1): 78-79.
- <sup>xiii</sup> Reutter, H. (2012, April 2). Medical Home: Better Health at Same or Reduced Cost? Retrieved April 16, 2012, from Lexington Clipper-Herald: [http://lexch.com/news/statewide/article\\_33fc4628-7cca-11e1-ae83-001a4bcf887a.html](http://lexch.com/news/statewide/article_33fc4628-7cca-11e1-ae83-001a4bcf887a.html).
- <sup>xiv</sup> Horizon Healthcare Innovations. (2012, April 10). Early Results Show Patient-Centered Medical Homes Drive Quality and Cost Improvements. Retrieved April 16, 2012, from News & Media: [http://www.horizonhealthcareinnovations.com/news-media/press-releases/20120410-early-results-show-patient-centered-medical-homes-drive-quality-a?utm\\_source=Patient+Centered+Care+Collaborative+List&utm\\_campaign=3629b33e8b-Thursdays+Call+March+1&utm\\_](http://www.horizonhealthcareinnovations.com/news-media/press-releases/20120410-early-results-show-patient-centered-medical-homes-drive-quality-a?utm_source=Patient+Centered+Care+Collaborative+List&utm_campaign=3629b33e8b-Thursdays+Call+March+1&utm_).
- <sup>xv</sup> BCBSA: Patient-Centered Medical Home Snapshots.
- <sup>xvi</sup> CDPHP. (2011, March 22). CDPHP Medical Home Pilot Results in Substantial Quality Improvements and Cost Savings. Pilot Practices Cost Growth Reduced to 2/3 That of Other Regional Providers. Retrieved April 12, 2012, from Vocus/PRWEB: [http://www.prweb.com/releases/CDPHP/medical\\_home\\_pilot/prweb8224444.htm](http://www.prweb.com/releases/CDPHP/medical_home_pilot/prweb8224444.htm).
- <sup>xvii</sup> Chemung County Government. (2011, April 18). Medicaid Medical Home Realizing Positive Results in First Year. Retrieved April 16, 2012, from Chemung County News: <http://www.chemungcounty.com/index.asp?pageid=105&nid=650>.
- <sup>xviii</sup> Blue Cross and Blue Shield Association. (2012, June 4). Blue Cross and Blue Shield Companies' Patient-Centered Medical Home Programs Are Improving The Practice and Delivery of Primary Care in Communities Nationwide. Retrieved June 14, 2012, from PRNewswire: <http://www.marketwatch.com/story/blue-cross-and-blue-shield-companies-patient-centered-medical-home-programs-are-improving-the-practice-and-delivery-of-primary-care-in-communities-nationwide-2012-06-04>.
- <sup>xix</sup> Steiner, B. D., Denham, A. C., Ashkin, E., Newton, W. P., Wroth, T., & Dobson, L. A. (2008, July/August). Community Care of North Carolina: Improving Care Through Community Health Networks. *Annals of Family Medicine*, 6(4), 361-367.
- <sup>xx</sup> Mahoney, P. (2011, December 21). Our Results: Making headway on cost and quality. Retrieved April 30, 2012, from Community Care of North Carolina: <http://www.communitycarenc.com/our-results/>.
- <sup>xxi</sup> Carey, M.A. (2012, May 17). Senate Panel Looks at Innovative Health Care Strategies. Retrieved June 14,

2012 from Kaiser Health News: <http://capsules.kaiserhealthnews.org/index.php/2012/05/senate-panel-looks-at-some-innovative-health-care-strategies/>.

xxii Takach, Mary. (2011, July 7). Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results. *Health Affairs*, 30(7):1325-34.

xxiii Bend Memorial Clinic. (2012, January 4). Bend Memorial Clinic Reduces Hospital Admissions and Emergency Visits. Retrieved April 30, 2012, from Bend Memorial Clinic: [http://www.bendmemorialclinic.com/aboutus/bmc\\_in\\_the\\_news/newsblog/12-01-04/BMC\\_reduces\\_hospital\\_admissions\\_and\\_emergency\\_room\\_visits\\_through\\_Medical\\_Home\\_Pilot.aspx](http://www.bendmemorialclinic.com/aboutus/bmc_in_the_news/newsblog/12-01-04/BMC_reduces_hospital_admissions_and_emergency_room_visits_through_Medical_Home_Pilot.aspx).

xxiv Miller, J. (2009, May 1). Unlocking Primary Care: CareOregon's Medical Home Model. Retrieved April 12, 2012, from Managed Healthcare Executive: <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=595822>.

xxv Klein, S., & McCarthy, D. (2010, July). CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner. Retrieved April 16, 2012, from The Commonwealth Fund: [http://www.commonwealthfund.org/~media/Files/Publications/Case percent20Study/2010/Jul/Triple percent20Aim percent20v2/1423\\_McCarthy\\_CareOregon\\_triple\\_aim\\_case\\_study\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2010/Jul/Triple%20Aim%20v2/1423_McCarthy_CareOregon_triple_aim_case_study_v2.pdf).

xxvi Ibid.

xxvii Steele, G. D. (2009). Reforming the Healthcare Delivery System. Committee on Finance: United States Senate (pp. 1-7). Washington, D.C.: Geisinger Health System.

xxviii Grumbach, et al: The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Cost from Recent Prospective Evaluation Studies.

xxix Geisinger Health System. (2009). Advanced Models of Primary Care. White Roundtable. Washington, D.C.: Geisinger Health System.

xxx Maeng, et al.: Reducing Long-Term Costs.

xxxi Gilfillan, R., Tomcavage, J., Rosenthal, M., Davis, D., Graham, J., & Roy, J. e. (2010). Value and the Medical Home: Effects of Transformed Primary Care. *American Journal of Managed Care*, 16(8), 607-614.

xxxii Mamula, K. B. (2011, May 20). UPMC expands medical home model. Retrieved April 30, 2012, from Pittsburgh Business Times: <http://www.bizjournals.com/pittsburgh/print-edition/2011/05/20/upmc-expands-medical-home-model.html?page=all>.

xxxiii Pinnacle Health Hospitals. (2012, June 1). PinnacleHealth Expands Patient-Centered Medical Home Model. Retrieved June 14, 2012 from PinnacleHealth News: <http://www.pinnaclehealth.org/General/About-Us/News/PinnacleHealth-News-Releases/PinnacleHealth-Expands-Patient-Centered-Medical-Ho.asp>.

xxxiv Phillis, R. L., Bronnikov, S., Petterson, S., Cifuentes, M., Teevan, B., Dodoo, M., . . . West, D. R. (2010, Jan-Mar). Case Study of a Primary Care-Based Accountable Care System Approach to Medical Home Transformation. *Journal of Ambulatory Care Management*, 34(1), 67-77.

xxxv Ibid.

xxxvi Takach, Mary. (2011, July 7). Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results. *Health Affairs*, 30(7):1325-34.

xxxvii Arvantes, J.: U.S. Military Focuses on Patient Care by Implementing PCMH Model.

xxxviii Grumbach and Grundy: Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States.

xxxix Reid, R. J., et al.: A patient-centered medical home demonstration.

## Appendix F: Maryland Annotated Code, Health-General

### § 19-1A-01. Definitions [Subtitle subject to abrogation]

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Carrier. -- "Carrier" has the meaning stated in § 15-1801 of the Insurance Article.

(c) Federally qualified health center. -- "Federally qualified health center" has the meaning stated in 42 U.S.C. § 254b.

(d) Health benefit plan. -- "Health benefit plan" has the meaning stated in § 15-1801 of the Insurance Article.

(e) Managed care organization. -- "Managed care organization" has the meaning stated in § 15-101 of this article.

(f) Patient centered medical home. -- "Patient centered medical home" means a primary care practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to:

- (1) Foster a partnership with a qualifying individual;
- (2) Coordinate health care services for a qualifying individual; and
- (3) Exchange medical information with carriers, other providers, and qualifying individuals.

(g) Primary care practice. -- "Primary care practice" means a practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners.

(h) Prominent carrier. --

(1) "Prominent carrier" means a carrier reporting at least \$ 90,000,000 in written premiums for health benefit plans in the State in the most recent Maryland health benefit plan report submitted to the Insurance Commissioner as required under § 15-605 of the Insurance Article.

(2) "Prominent carrier" does not include a group model health maintenance organization as defined in § 19-713.6 of this title.

(i) Qualifying individual. -- "Qualifying individual" means:

- (1) A person covered under a health benefit plan issued by a carrier; or
- (2) A member of a managed care organization.

(j) Single carrier patient centered medical home program. -- "Single carrier patient centered medical home program" has the meaning stated in § 15-1801 of the Insurance Article.



## § 19-1A-02. In general [Subtitle subject to abrogation]

(a) Established. -- Subject to § 19-1A-03(a) of this subtitle, the Commission shall establish the Maryland Patient Centered Medical Home Program to promote development of patient centered medical homes.

(b) Participation. --

(1) A carrier may elect to participate in the Maryland Patient Centered Medical Home Program.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, a prominent carrier shall participate in the Maryland Patient Centered Medical Home Program.

(3) Subject to the limitations of the State budget, the Department:

(i) May require that certain managed care organizations participate in the Maryland Patient Centered Medical Home Program as allowed by law; and

(ii) Notwithstanding any other provision of this article, may mandate the participation in the Maryland Patient Centered Medical Home Program of Maryland Medical Assistance Program enrollees.

(4) The Department shall ensure that participation in the Maryland Patient Centered Medical Home Program of managed care organizations and Maryland Medical Assistance Program enrollees shall support the quality and efficiency standards established in the HealthChoice Program.

(c) Authorization to implement single carrier patient centered medical home program. -- The Commission may also authorize a carrier to implement a single carrier patient centered medical home program that:

(1) Pays and shares medical information with a patient centered medical home in accordance with § 15-1802 of the Insurance Article; and

(2) Conforms with the principles of the patient centered medical home as adopted by a national coalition of physicians, carriers, purchasers, and consumers.

(d) Incentive-based compensation. -- Nothing in this section shall be construed to limit or prohibit a carrier from providing a bonus, fee based incentives, bundled incentives, or other incentive-based compensation:

(1) As authorized by the Commission for a patient centered medical home; or

(2) As allowed under § 15-113 of the Insurance Article.

### § 19-1A-03. Requirements for establishing Program [Subtitle subject to abrogation]

(a) In general. -- Notwithstanding any State or federal law that prohibits the collaboration of carriers or providers on payment, the Commission may establish the Maryland Patient Centered Medical Home Program, if the Commission concludes that the Program:

- (1) Is likely to result in the delivery of more efficient and effective health care services; and
- (2) Is in the public interest.

(b) Adoption of standards. -- In establishing the Maryland Patient Centered Medical Home Program, the Commission, in consultation with the Department, carriers, managed care organizations, and primary care practices, shall adopt:

(1) Standards qualifying a primary care practice as a participant in the Maryland Patient Centered Medical Home Program;

(2) General standards that may be used by a carrier or a managed care organization to pay a participating patient centered medical home for services associated with the coordination of covered health care services;

(3) General standards to govern the bonus, fee based incentive, bundled fees, or other incentives a carrier or a managed care organization may pay to a participating patient centered medical home based on the savings from reduced health care expenditures that are associated with improved health outcomes and care coordination by qualifying individuals attributed to the participating patient centered medical home;

(4) The method for attributing a patient to a participating patient centered medical home;

(5) The uniform set of health care quality and performance measures that the participating patient centered medical home is to report to the Commission and to carriers or managed care organizations;

(6) The enrollment form notifying carriers or managed care organizations a qualifying individual has voluntarily agreed to participate in the Maryland Patient Centered Medical Home Program; and

(7) The process for primary care practices to commence and terminate participation in the Maryland Patient Centered Medical Home Program.

(c) Considerations in developing standards. -- In developing the standards required in subsection (b)(1) of this section, the Commission shall consider:

- (1) The use of health information technology, including electronic medical records;
- (2) The relationship between the primary care practice, specialists, other providers, and hospitals;
- (3) The access standards for qualifying individuals to receive primary medical care in a timely manner;
- (4) The ability of the primary care practice to foster a partnership with qualifying individuals; and
- (5) The use of comprehensive medication management to improve clinical outcomes.

(d) Contents of general standards. -- The general standards required in subsection (b)(2) and (3) of this section shall:

(1) Define the payment method used by a carrier to pay a participating patient centered medical home for services associated with the coordination of covered health care services; and

(2) Define the methodology for determining any bonus, fee based incentive, bundled fees, or other incentives to be paid by a carrier to a participating patient centered medical home based on improvements in quality or efficiency.

(e) Forms; information sharing. --

(1) To commence, renew, or terminate participation in the Maryland Patient Centered Medical Home Program, a qualifying individual shall complete forms adopted by the Commission.

(2) The enrollment form shall authorize the carrier, the participating patient centered medical home treating the qualifying individual, and other providers treating the qualifying individual to share medical information about the qualifying individual with each other.

(3) The authorization under paragraph (2) of this subsection shall be valid for a period not to exceed 1 year.

(4) The renewal form shall extend the authorization under paragraph (2) of this subsection for an additional period not to exceed 1 year.

(5) A carrier participating in the Maryland Patient Centered Medical Home Program shall accept forms adopted by the Commission as the sole instrument for notification that a qualifying individual has voluntarily agreed to participate or terminate participation in the Maryland Patient Centered Medical Home Program.

(f) Provider and patient culturally and linguistically appropriate educational activities and care. --

(1) The Commission shall conduct culturally and linguistically appropriate provider and patient educational activities to increase awareness of the potential benefits for providers and patients of participating in the Maryland Patient Centered Medical Home Program.

(2) The Commission shall ensure that a participating patient centered medical home provides, on an ongoing basis, culturally and linguistically appropriate care for the purpose of reducing health disparities.

## § 19-1A-04. Regulations [Subtitle subject to abrogation]

The Commission may adopt regulations to:

(1) Establish the Maryland Patient Centered Medical Home Program; and

(2) Authorize a carrier to implement a single carrier patient centered medical home program

## § 19-1A-05. Evaluations [Subtitle subject to abrogation]

(a) Independent evaluations. --

(1) The Commission shall retain a consultant or consulting firm to conduct an independent evaluation of the effectiveness of the Maryland Patient Centered Medical Home Program in reducing health care costs and improving health care outcomes.

(2) A single carrier patient centered medical home program may request to be included in the evaluation described in paragraph (1) of this subsection.

(3) In conducting the evaluation, the Commission shall consider, subject to budget limitations, improvements in health care delivery, improved clinical care processes, increased access to care coordination, adequacy of enhanced payments to cover expanded services, increased patient satisfaction with care, increased clinician and staff work satisfaction, lower total costs of care, and reductions in health disparities resulting from the Maryland Patient Centered Medical Home Program and any authorized single carrier patient centered medical home program included in the study.

(b) Reports. -- On or before December 1, 2014, the Commission shall report its findings, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.



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