PATIENT CENTERED MEDICAL HOME

Getting Started with Maryland's Patient Centered Medical Home Program

Outreach Symposium

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MARYLAND HEALTH CARE COMMISSION

MARYLAND

Goals For the Program

To test the Patient Centered Medical Home model in qualified primary care practices to determine if this model provides higher quality and more efficient care for Maryland residents and leads to higher satisfaction for patients, nurse practitioners, and primary care physicians.

The Pilot seeks to reward medical homes for the additional services, while creating a viable economic model for health care purchasers and maintaining administrative simplicity given multiple payers, diverse physician practices, and our desire to avoid risk selection against sicker patients.

Underlying Assumptions:

1. Medical homes must generate savings (which are validated through the performance measures) to be self-sustaining.
2. The medical home payment model must **guarantee** support for the investments that practices make in transformation and operation as a medical home.
3. Practices must share (significantly) in savings that result.
4. Practices are responsible for performance (as measured through specified process and outcome indicators (or financial claims analysis) to earn incentive payments.

Why Should I Consider the Program?

- PCMH is an exciting new way to practice primary care medicine that is gaining traction throughout the country.
- Innovative practices across the country are tackling the challenges of introducing new programs in a difficult economic environment.
- The PCMH model is associated with increased provider and patient satisfaction.
- The model has been shown to reduce the total costs of care for diverse populations in the Medicare managed care program in Washington state, the Medicaid population in North Carolina, and the largely commercially insured populations in Pennsylvania.
- Participating in Maryland's PCMH Pilot will position a practice to take advantage of the incentives under Health Reform (nationally and in Maryland.)

Criteria For Selection Of Practices

- Practices that are committed to the principles of the PCMH model.
  http://www.pcpcc.net/joint-principles

- Practices that reflect the diversity of PCP practices, including the following characteristics:
  - Geographic location;
  - Practice size;
  - Practice ownership (e.g., privately-owned, hospital-owned, FQHC);
  - Populations served (commercially insured, Medicaid, Medicare Advantage);
  - Ethnic and racial diversity of patient and providers in the practice.

- Ability to submit and achieve at least NCQA PPC-PCMH Level 1^{+} recognition.

- Practices that provide opportunities for linking the Maryland PCMH program with other initiatives – e.g., participation in employee wellness initiatives or primary care residency training.

😐 Practices in the CMS EHR Demonstration program can participate in the State Pilot, but will not be eligible for Medicare's Advanced Primary Care Practice Demonstration (MAPCP).

Maryland Medical Home Pilot – Key Elements

Scope and Duration

- ✓ Primary care practices – physician and nurse practitioner led pediatric, family practice, internal medical, and geriatric practices.
- ✓ Pilot will last 3 years.
- ✓ Fifty practices, 200 providers, and at least 200,000 patients will be enrolled in the pilot. Prime objective is 200,000 patients.
- ✓ Maryland will seek to engage insured and self-insured employers in the program.
- ✓ Practices must apply for NCQA PPC-PCMH recognition within 6 months of the start of the program.
- ✓ Patients 'attributed' to the practice will be eligible to participate.

Support from the State and Carriers

- ✓ Maryland will support a learning collaborative for participating practices.
- ✓ Maryland may provide additional funding for safety-net providers and vulnerable practices seeking to evolve to the PCMH model.
- ✓ Carriers will provide additional payments to participating practices in the form of fixed payments and calculated shared savings.

Maryland Medical Home Pilot – Key elements (continued)

Requirements for Participating Practices

- ✓ Practices will provide expanded access, document that they are managing patients' health needs, coordinate care of chronically ill patients, and maintain quality improvement efforts.
- ✓ Practices must meet quality performance standards established for the Pilot in order to receive higher calculated shared savings payments.

KEY ELEMENTS – SOME ELABORATION

PPC-PCMH is the most widely adopted PCMH recognition tool

www.ncqa.org

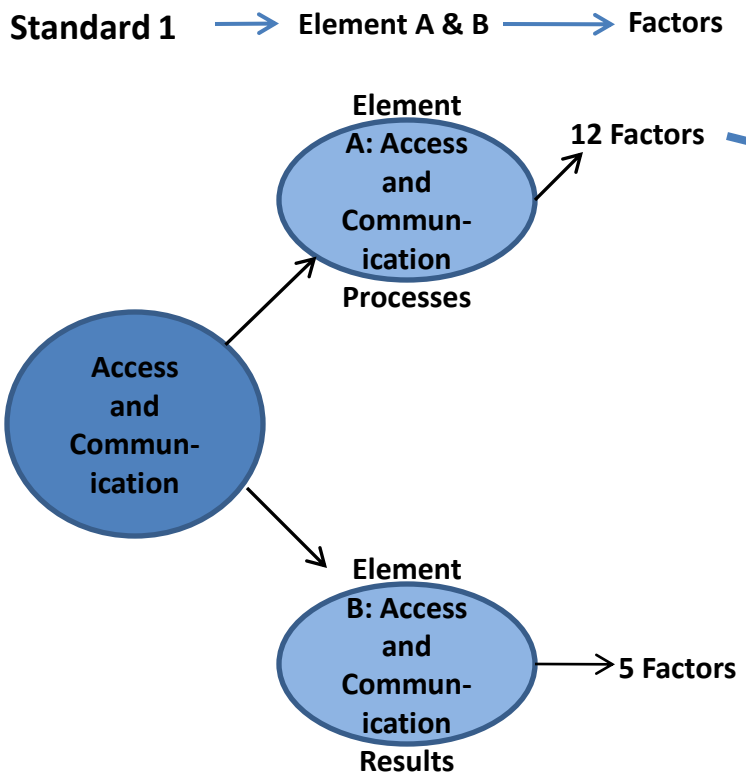
Standards (number of must pass elements)

1. Access and Communication (2)
2. Patient Tracking and Registry (2)
3. Care Management (1)
4. Patient Self-Management Support
5. Electronic Prescribing (0)
6. Test Tracking (1)
7. Referral Tracking (1)
8. Performance Reporting and Improvement (2)
9. Advanced Electronic Communication (0)

- Three Levels of Certification based on increasing points earned by meeting standards.
- 30 NCQA elements in total, across the nine standards, ten "must pass" elements for Levels II and III; five of ten necessary for Level I.
- For Level I, no priority for which 5 elements are met.
- The meaning of '**+**': Maryland has designated some factors in the NCQA elements that are required for each level of recognition.
- "Must pass" factors are highly correlated with cost savings.
  - ✓ 24-7 phone response with clinician for urgent needs
  - ✓ Registry as part of an EHR or as a stand-alone
  - ✓ Summary of care record for transitions
  - ✓ Advanced access for appointments

12 Maryland practices and about 90 physicians have achieved NCQA recognition to date.

Maryland PCMH Recognition – Required Factors



All included in NCQA PCMH Review	Maryland Recognition
24-7 phone response with clinician for urgent needs	1+
Registry as part of an EHR or as a stand-alone	1+
Summary of care record for transitions	1+
Advanced access for appointments	1+
Care management and coordination by specially trained team members	1+
Problem list for all patients	1+
Medication reconciliation for every visit	1+
Pre-visit planning and after-visit follow-up for care management	1+
EHR with decision support	2+
Physician-led team with regular communication	2+
CPOE for all orders; test tracking and follow-up	2+
E-prescribing	2+
Patient self-management support	2+
Decision support: drug-drug, drug-allergy and drug-formulary	3+
Summary of visit to patient every visit	3+
Reporting of relevant clinical measures	3+

Attribution of Patients – Use the Developing National Standard

Implications: Number of patients attributed to the practice affects the magnitude of payment.

Eligible specialties - provider specialty must be a PCP (Family Practice - FP, General Practice - GP, Internal medicine - IM, pediatrics, geriatrics.)

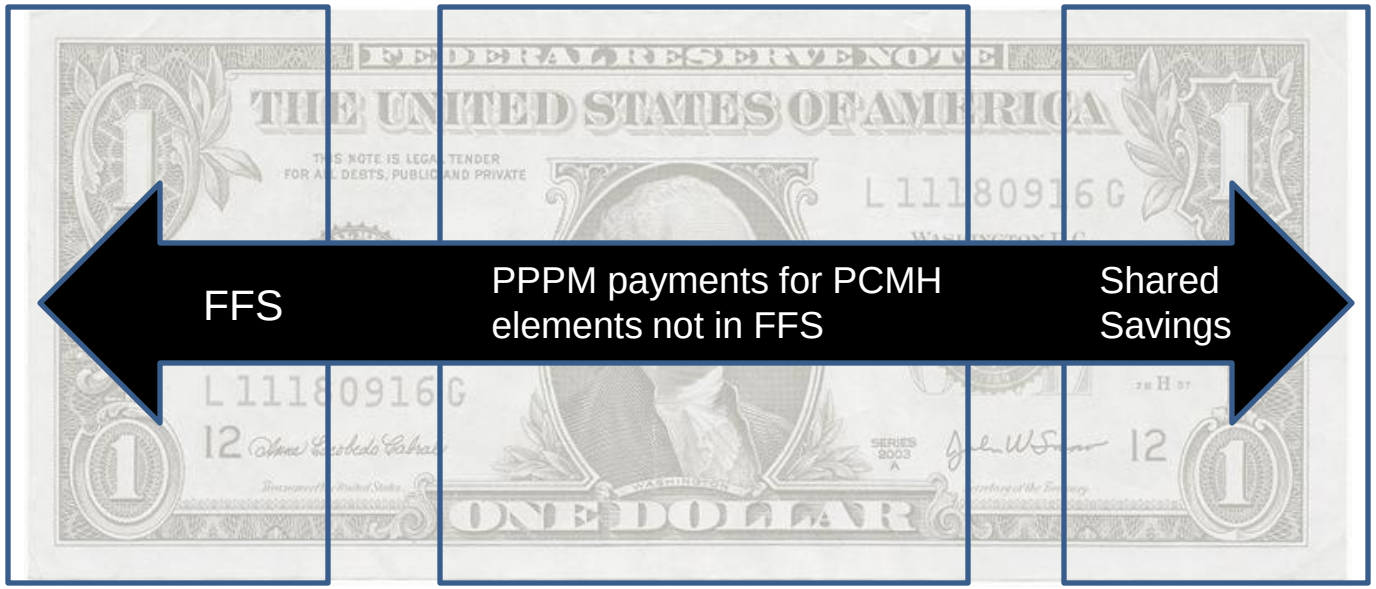
Goal is to assign patients to the current or the most commonly used primary care provider.

- Assignment is based on the occurrence of Evaluation & Management (E & M) Codes
  - (Office Visit E&M, Office Visit Preventive, Office Consult)
- **Step 1 (most recent 12 months)**
  - Member is assigned to the PCP with the most visits.
  - For ties in the number of visits (to multiple PCPs), assignment is to the PCP with the most recent visit.

- **Step 2 (prior 12 months)**
  - For members NOT aligned for the most recent 12 months (no PCP visit), select services sort by service date.
  - Member is assigned to the PCP with the most recent visit.

- **If patient has not been seen in last 2 years, s/he is not considered in the panel – not attributed to the practice, practice is not eligible for PPPM.**

Payment Reform for Primary Care
A Three-Tiered Approach



No change, each carrier uses its own system, as is done today.

PPPM set by NCQA recognition level, payer category, and practice size. Payments are made upfront either quarterly or semi-annually.

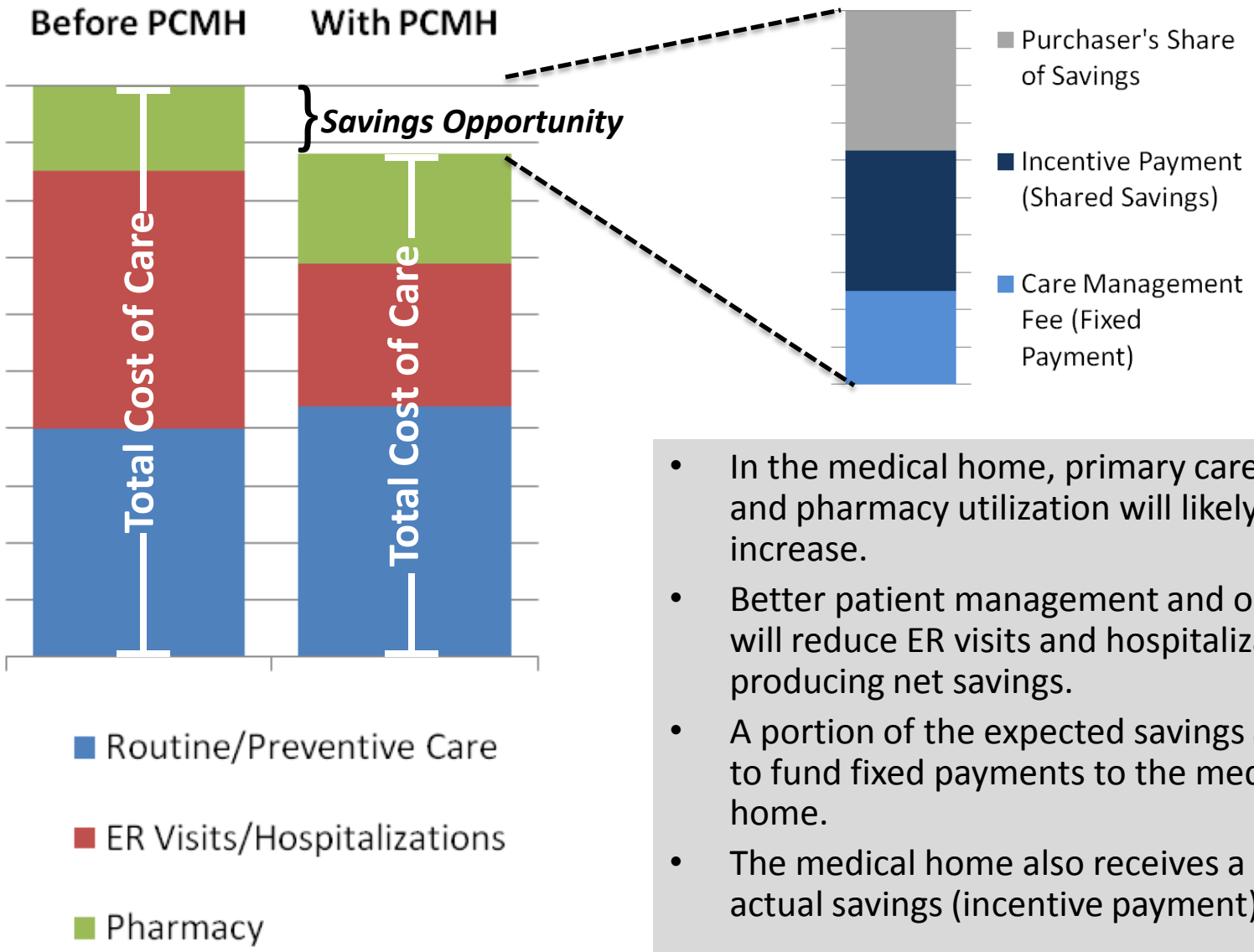
Average savings per patient calculated relative to the practice's historical performance.

There is no downside other than the need to adopt an EHR and to invest in practicing more efficiently. The upside is the potential for very real and substantial shared savings.

How one carrier views the saving opportunity

The opportunity to improve affordability can change the reimbursement to primary care physicians. Assuming total medical costs are on the order of $250 PMPM (per member per month), primary care physicians receive about 6% of this, or $15 PMPM. Therefore, sharing half of a 2% improvement in total medical costs would result in a $2.50 increase in PMPM, or a 17% increase in primary care payments.

PCMH Financial Model



- In the medical home, primary care services and pharmacy utilization will likely increase.
- Better patient management and outcomes will reduce ER visits and hospitalizations, producing net savings.
- A portion of the expected savings are used to fund fixed payments to the medical home.
- The medical home also receives a share of actual savings (incentive payment).

Details of the Payment Methodology

Fixed Payments are guaranteed, adjusted by PCMH recognition level, category of carrier – private, Medicaid MCO, and Medicare MCO – and practice size.

- Paid prospectively: quarterly or semi-annually.
- Ranging from approximately $3.00 - $6.00 PPPM for commercially insured populations.
- Medicaid MCO PPPM and Medicare payment levels will be higher.

Practices are eligible for **shared savings payments**

- Calculated based on achieved total savings from all care (IP, Rx, Outpt, and Prof). Majority of savings will come from avoided hospitalizations & ED visits.
- Savings calculated separately for commercial (grouped together for all carriers), Medicaid, and Medicare (if Maryland participates in the CMS demonstration) patient populations.
- Baseline for savings will be the practice's patients total medical expenses adjusted for inflation and plan benefit changes at the start of the Pilot.
- Practice's share will be substantial: **+50%** .

Source: Graphic , TransforMed, June 2009

Alignment – A Key Incentive for Quality Reporting – PQRI, "meaningful use," and NCQA Plan Reporting

- Meeting clinical performance thresholds is a hurdle to achieving shared savings.

- Workgroup recommendations (focus on alignment with other initiatives)

  - Align with existing requirements under CMS PQRIs and ARRA (health IT) "meaningful use" final regulations.
  - Focus on NQF-recognized measures for conditions that are significant cost drivers – diabetes and heart/stroke.
  - Allow practices to use performance measures in treating 3 conditions under PPC-PCMH.

- Carriers want performance alignment → PCMH quality measures to the standards that plans understand and use in MHCC's Quality Report Card, NCQA's *Quality Compass©*.

- Pediatric measures – asthma, required preventive care visits, obesity, scheduled immunizations.

- Address 'patient-centeredness' and patient satisfaction via patient surveys.

What's Next?

http://mhcc.maryland.gov/pcmh/gettingstarted.aspx

- Learn more about PCMH and NCQA Recognition – three organizations offer tools for PCMH transformation.
- Sign-up for the list serve → pcmhpractices@mhcc.state.md.us
- Complete the expression of interest form → http://mhcc.maryland.gov/pcmh/documents/Expression_of_Interest.pdf
- Prepare to attend the Maryland-sponsored meetings beginning in July after the last symposium.
  - Meetings will be held late in the afternoon.
  - Geared to addressing the details of the program.
  - Attendance will be available electronically and in-person.
  - We will assist in explaining NCQA requirements.
- Submit an application to participate →(application forthcoming).

At least 12 pioneering practices in Maryland and more than 150 practices in Pennsylvania have become Patient Centered Medical Homes, will your practice be next?

Implementation

June 2010	**Outreach symposia for providers begin.**
June 2010	**MHCC releases of reward structure and practice performance requirements.**
August 31, 2010	**Deadline for practices to submit an expression of interest in pilot participation. Providers must notify MHCC if they are interested in participating.**
October 8, 2010	**Deadline for practices to submit application to participate**
October 29, 2010	**Selection committee announces participating practices.**
November 5,2010 **November 29, 2010**	**Deadline for carriers to sign participation agreement** **Deadline for practices to sign participation agreement.**
January 4, 2011 **January 2011**	**Launch of practice transformation and learning collaborative.** **Carriers provide enrollee rosters for attribution.**
February 2011	**MHCC releases patient attribution results.**
March 2011	**Private carriers and Medicare* begin paying PPPM fixed payments to practices that attest to meeting NCQA criteria.** **(*Provided that Maryland is selected to participate in the CMS Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration.)**
June 30, 2011	**Deadline to submit applications to NCQA's Physician Practice Connections–Patient-Centered Medical Home for recognition.**
July 2011	**PCMH practices begin receiving payments from Medicaid MCOs.**

For questions regarding the PCMH Provider Participation Timeline or other Patient Centered Medical Home issues, please contact our staff by email at pcmhpractices@mhcc.state.md.us

Let’s Talk About Modest Expectations

“We wish this player was 7-feet, but he isn't. There just wasn't a center available. What can you do? He isn't going to turn this franchise around. I wouldn't ask him to. He's a very good offensive player, but not an overpowering offensive player." – *Rod Thorn, NBA general manager*