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TO: The Honorable Peter A. Hammen, Chairman
Members, House Health & Government Operations Committee

FROM: Joseph A. Schwartz, III
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J. Steven Wise

DATE: March 11, 2010

RE: **SUPPORT WITH AMENDMENTS** – House Bill 929 – *Patient Centered Medical Home Program*

The Maryland State Medical Society (MedChi), which represents over 7,300 Maryland physicians and their patients, supports with amendments, House Bill 929.

MedChi believes that House Bill 929 represents, with respect to the preservation of primary care medicine, the most important health care legislation filed in this year's General Assembly. It is the outgrowth of two years of work by the Governor's Health Quality and Cost Council, chaired by Health Secretary Colmers and participated in by all segments of the health care industry. Essentially, House Bill 929 establishes a uniform set of guidelines so that health insurers participating in the Maryland Patient Centered Medical Home Program (pg. 4, line 16) will pay primary care doctors for services associated with the coordination of covered medical services to patients and pay for the administration of such services. The notion is that a properly administered "medical home" will result in better and more coordinated medical care for a patient and allow for the free exchange of medical information between practitioners treating a particular patient. The Medical Home Program established by House Bill 929 would be under the auspices of the Maryland Health Care Commission (MHCC).

MedChi is very supportive of House Bill 929 but believes that two amendments are necessary. The first concern relates to incentive payments (pg. 7, lines 20-25) that may be paid to participating doctors "...based on the savings from reduced health care expenditures..." MedChi believes that this language is subject to abuse and is reminiscent of the "cost saving" disasters brought to medicine by HMOs who rewarded

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doctors for not ordering appropriate diagnostic tests. The point should be to reward economic efficiencies that result in quality health care outcomes not simply in reduced expenditures.

The second concerns the inclusion of nurse practitioners in the definition of “primary care practice.” While nurse practitioners are a vital part of Maryland primary care medicine, they should not have primary responsibility for a “medical home” in part because of certain legal and practical limitations on their practice. For example, nurse practitioners do not have privileges at hospitals and part of the challenge of a “medical home” doctor would be to coordinate care with hospital based physicians. Moreover, one of the challenges for a medical home physician will be to coordinate medication management, a task which requires the greater medical education required of a physician.

With these two caveats (amendments attached), MedChi strongly supports House Bill 929.

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cc: Governor’s Legislative Office

Amendments to House Bill 929 – Submitted by Med Chi

Amendment 1: Amend the definition of Primary Care Practice to make it consistent with NCQA standards that speak only to physician practices.

Rationale: Nurse Practitioners are an important part of the health care team in many primary care practices. However, given the enhanced requirements for comprehensive patient management, including medication management, the training and scope of practice of a nurse practitioner is not sufficient to enable an independent nurse practitioner practice to serve as a patient centered medical home (PCMH). By their own acknowledgement in hearings on separate legislation, nurse practitioners who do not work in close collaboration with a primary care physician refer to specialists and the emergency room for issues they are not able to address. This is the very pattern of practice the PCMH is trying to address. The expanded care coordination requirements anticipated for a PCMH can only be appropriated provided through a primary care physician working in collaboration with other providers such as nurse practitioners.

The NCQA patient centered medical home program only encompasses physician practices as the medical home. In fact, the NCQA website for their program utilizes as its definition of a patient centered medical home, the Joint Principles of the Patient Centered Medical Home adopted by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. Furthermore, the CMS patient center home pilot program is also limited to physician practices. This is a particularly critical amendment given other pending legislation that would eliminate the requirement for nurse practitioners to collaborate with physicians. The alternative language amends the definition of primary care practice to clarify that it is a physician practice or FQHC but includes nurse practitioners. As amended, it would still enable a NP to serve as a leader within a physician practice or FQHC PCMH.

Language:

On page 5, in line 28, before “PRACTICE”, insert “PHYSICIAN”; in line 29, strike “ORGANIZED BY OR INCLUDING” and substitute “THAT MAY INCLUDE”; and in line 30 before “OR” insert “DOCTORS OF OSTEOPOTHY”.

Amendment 2: Clarify that incentives based on savings are associated with improved outcomes and not from incentives to deny or fail to provide care.

Rationale: The patient centered medical home model is not significantly different than the original concept of the “gatekeeper” in the early HMO models. Many of the HMO models ultimately created physician incentives that were largely based denying access to care or not providing needed services. This amendment will ensure that incentives are based on improved care coordination, improvement in health outcomes and increased access to the primary care provider.

Language:

On page 7, in line 23, after “EXPENDITURES”, insert “THAT ARE ASSOCIATED WITH IMPROVED HEALTH OUTCOMES AND CARE COORDINATION”