August 18, 2010

Mr. Ben Steffen  
Director, Center for Information Services and Analysis  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD  21215

RE:   Patient Centered Medical Home Pilot: Measurement and Payment Framework 
and Single Carrier PCMH Programs

Dear Mr. Steffen:

The Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Academy of Family Physicians, the American College of Physicians - Maryland Section, the Mid-Atlantic Association of Community Health Centers and the Maryland Hospital Association appreciate the opportunity to comment on the draft report entitled “Patient-Centered Medical Home Pilot: Measurement and Payment Framework” dated July 21, 2010 as well as the proposed regulatory structure for the “Single Carrier PCMH” program. The undersigned organizations jointly submit these comments in order to underscore the collective opinion of the primary care physicians of the State with respect to the two draft proposals identified above. These comments also reflect generic concerns regarding the framework of the PCMH pilot and single carrier PCMH program as we understand their proposed configurations. These collective comments may be supplemented by separate correspondence from any of the organizations on issues that may be specifically germane to their interests.

With respect to the specific payment proposals outlined in Discern’s draft report, we would like to voice our belief that the proposed compensation is inadequate to cover the costs associated with complying with the requirements of a PCMH under the program. As we understand the proposed model, there is an upfront per patient per month payment presumably intended to cover the costs of providing the additional services required of a PCMH. This fixed payment would then be supplemented by a “shared savings” payment based on the expected and/or realized savings to the health system.

After careful consideration, we would assert that the initial per patient per month number is not sufficient to cover the costs a practice will incur to provide the required additional services. A number of factors, either explicitly required and or inferred in the structure of the program, lead to this conclusion. For instance, it appears that the physician practice will be responsible for contacting their patients to encourage their participation in the program. This is a very labor intensive responsibility and will require the use of resources that should be spent providing health care services. Few practices will have the capacity to undertake this outreach with existing resources.

Further, because it is not anticipated that all patients of a given payor will participate in PCMH program, the practice will bear significant costs to develop and maintain a system that
differentiates participating and non-participating patients. Not only will this require substantial administrative resources that a practice will not be able to underwrite, it creates an unrealistic expectation that a physician practice will practice two different types of medicine – one for PCMH participants and one for the balance of their patients. This is neither practical nor desirable.

We recommend that for participating practices, all patients of the participating payers be enrolled in the pilot unless the patient “opts out” of participation. Payers should have the preemptive responsibility to inform patients of their automatic enrollment in the PCMH pilot. This will afford the opportunity for the payers to provide consistent, concise, and transparent information describing the pilot and its implications to all subscribers. An opt-out option should be included in this information, with the stipulation that, unless opt-out notification is received by the payer by a certain deadline, subscribers should understand that their informed consent is implied, and that they are in fact enrollees in the PCMH pilot. On “opt out” approach to patient enrollment would help ensure the critical mass of patients necessary to make the payment system reasonably meaningful in achieving the program’s objectives and would greatly diminish some of the administrative costs outlined above.

Additional structural issues that support our conclusion that the proposed payment structure is insufficient include the requirement that care management personnel be engaged. Given the uncertainty of patient participation in the program, it is not reasonable to require or expect that a practice can hire a care coordinator. There are a number of models for the provision of care management, many of which do not require specifically designated practice personnel. This requirement is particularly problematic for smaller practices which by their very definition are likely to have fewer participating patients and consequently will be unable to afford to meet the program requirements based on the proposed per patient payment.

Underlying all of the above concerns is the clear understanding that participation in the pilot by very small practices (smaller than 5 physicians) is virtually impossible. The Commission has asserted its interest in including small practices, and has not specifically excluded their participation. However, the Commission has acknowledged the difficulty that small practices will face in meeting the requirements and suggests that small practices consider forming some type of structural alliance with other small practices to collectively meet the requirements of the program. The creation of such “cooperative” ventures is unrealistic, expensive and fraught with significant legal complications. Consequently, for all intents and purposes, participation in the current PCMH pilot program will be limited to large practices. Given the predominance of small practices across the State, failure to incorporate small practices in the pilot in a meaningful way will yield very limited information on how to expand the PCMH model in Maryland beyond the pilot participants.

The same concerns discussed above with respect to the Commission’s PCMH pilot program are also applicable to the single carrier program application requirements. While specific per member per month payments rates are not specified, it is our understanding that payments will be structured similarly to the Commission’s pilot. The lack of specificity however has our organizations are concerned about the ability of the single carrier model to potentially choose “in-kind” or other payment structures to meet their obligation to pay incentives to participating physicians. In addition, the concerns regarding administrative burdens for securing
patient participation, care coordination staffing expectations and the failure to accommodate the
issues relevant to small practices are similarly absent from the single carrier PCMH
requirements. If fact, in at least one single carrier model, practices with less than 5 physicians
are specifically excluded from the program.

Based on the concerns outlined above we would request the Commission consider
making a number of modifications to both the pilot and the single carrier programs. First, with
respect to the Commission’s pilot, we would request that a greater percentage of the incentive
payment be incorporated in the upfront per patient per month payment, especially in the initial
years of the pilot. This would provide additional capital to the practices to invest in necessary
practice infrastructure to meet the demands of the program. “Shared savings” would then
become the equivalent of a bonus for effective patient management and resultant cost savings. It
would also lessen the potential for incentive payments to become a mechanism for withholding
or denying access to necessary services. We would also encourage the Commission to calculate
shared savings on a practice specific evaluation. This will ensure that each practice is fairly
evaluated based on its specific patient mix.

We would ask that the Commission modify the structure of the program to place the
burden of patient enrollment on the carrier, both under the pilot program and the single carrier
program. This change would lessen the administrative burden on the practices and is a more
logical approach to enrollment given that the insurers have the most efficient mechanisms for
communication with patients about the program as well as an incentive to encourage enrollment.

Finally, we strongly encourage the Commission to reevaluate the structure of the program
to develop mechanisms that will allow small and solo practices to participate in the
Commission’s pilot as well as require single carrier programs to incorporate the participation of
small and solo practices. Without the inclusion of these practices, the vast majority of primary
care physicians and their patients will be prohibited from participating in these programs and
therefore denied the potential benefits of quality improvement and cost savings that are the
objectives of the program.

We appreciate the opportunity to register our concerns and suggestions with the
Commission. Despite the concerns expressed in this letter, we want to applaud the Commission
for its efforts at payment reform which we see as essential if we are to attract and retain primary
care physicians in the State. We look forward to continuing to work with you as these important
programs progress.

Sincerely,

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