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AUGUST 28, 2012

Patient Centered Medical Homes and Massachusetts Health Care Cost Containment Legislation

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This advisory is another posting in a series discussing various aspects of the recently enacted Massachusetts health care reform legislation, Chapter 224 of the Acts of 2012 (the "Act"). The Act contains a number of elements that, taken together, are expected to have a positive impact on slowing the rate of increase in health care costs in the Commonwealth. An earlier alert discussed the mechanism of benchmarking total health care expenditures and implementing steps to address how providers, provider organizations, and carriers would stay within the benchmarks. This advisory describes the Act's promotion of Patient Centered Medical Homes (PCMH) as a model for improving the continuity and quality of care and perhaps the cost of care as well.

Background

PCMHs take a holistic approach to health care for their patients. PCMHs look to unite primary and specialty care, as well as institutional care, in a "medical home" under the guidance of primary care providers (PCPs). The members of the "health team" communicate with each other to more efficiently serve the needs of patients. Additionally, as PCP-centered operations, PCMHs focus on managing and preventing chronic diseases and disorders, such as diabetes or obesity, with the belief that addressing these situations earlier necessarily prevents later, more expensive hospitalizations or emergency room visits. By utilizing health information technology (IT) to track and monitor patients, PCPs can collect, interpret, and organize data about their patients, which enables them to prescribe and conduct proactive measures to limit the damage of chronic illness or prevent conditions like diabetes from even developing. PCMHs are seen as shifting the responsibility for the patient back to the PCP, who can develop a deeper relationship with the patient through enhanced communication, which in turn entices the patient to take a greater role in the self-care and self-management of his or her ailments (hence the term "patient centered").

NCQA Certification

To receive recognition as a PCMH, a practice must fulfill the certification qualifications of the National Center for Quality Assurance (NCQA), which has a stringent 100 point scoring system. A practice can reach three levels of recognition based on how many points it garners on the NCQA scorecard. The scorecard weighs 28 elements of care associated with six standards of primary care:

1. Enhanced access and continuity with providers (patients can select a clinician and the practice makes culturally and linguistically appropriate services available);
2. Identification and management of patient populations (finding the health risks for the population and working to prevent them proactively);
3. Planning and managing care (developing modes of care for patients with conditions based on

what is most appropriate for each patient);

4. Providing self-care education and community support (counseling and working with patients so that they manage their conditions better);
5. Tracking and coordination of care; and
6. Measurement and improvement of performance.

Additionally, NCQA requires practices to demonstrate six “must-pass” elements:

1. Access during office hours;
2. Using data for population management;
3. Care management;
4. Support of self-care processes;
5. Tracking referrals and following up with patients; and
6. Implementation of continuous quality improvement.

PCMHs under the Act

The Act expects to use the PCMH model, based largely on the NCQA guidelines, both to improve the quality of health care in Massachusetts and to begin to develop reimbursement methods that are alternatives to fee-for-service. PCMHs thus represent a change in the structure of health care delivery accompanied by a change in reimbursement incentives.

The Health Policy Commission created by the Act has the power to certify practices as PCMHs. However, certification is voluntary and does not supplant NCQA certification. There may be reputational and — perhaps eventually — market reasons why a practice wishing to be a PCMH would seek both NCQA and Commission certification. The Act sets out the areas in which the Commission is to develop certification standards. By January 1, 2014, the Commission is to codify the standards, which, closely resembling NCQA requirements, will be based on enhancing access, enabling utilization of qualified health professionals, encouraging teamwork and shared decision making, and ensuring that PCMHs create comprehensive care plans for their patients. Specifically, allowing physicians’ assistants, nurse practitioners, and social workers to act as the PCPs for patients in PCMHs is similar to the NCQA’s rule permitting “primary care clinicians” to serve as care providers. This approach in the Act, taken with other provisions of the Act relating to, for example, physicians’ assistants and limited services (retail) clinics, signifies legislative efforts to broaden the availability of primary care resources in the Commonwealth and decrease reliance predominantly on primary care physicians. While it is too early to make predictions, it seems likely that the Commission will rely on NCQA’s scoring system for its certification program.

The Act addresses alternative reimbursement methodologies by mandating the Commission to develop a model payment system for PCMHs by January 1, 2014. In the PCMH context, one of the elements of such a model payment system should be additional incentives for PCPs to manage care effectively. As compared to fee-for-service mechanisms, which often seem skewed toward specialists, in the PCMH model PCPs should be reimbursed at a higher rate in recognition of their increased role and importance in managing the overall health of the patient and the savings their work provides for the system at large.

The Act takes a strong position in support of PCMH development. For example, the Executive Office of Health and Human Services is to set a goal for all primary care practices in the Commonwealth to transition to PCMHs by 2015. But it does not use penalties, fines, or tax encouragements to enforce movement toward the model and away from traditional fee-for-service operations. This policy choice reflects an overall philosophy in the Act supporting existing developments that appear to be having a positive impact on overall costs by encouraging and monitoring such developments rather than forcing them through regulatory intervention.

The Act’s provisions on PCMH represent an important step to encouraging the development of more

efficient and patient-centered models of care. Authorizing nurse practitioners, physicians' assistants, social workers, and other qualified care-givers to act as primary care providers is a move in the right direction toward increasing the availability of primary care resources in an environment where over 97% of the residents of the Commonwealth have health insurance and can access services. While the precise methods by which Massachusetts will transition to PCMHs are not described in the Act, the Act makes a strong statement for the importance of innovative models of care, such as PCMHs. Massachusetts again becomes an innovator in governmental encouragement for innovations of this type. Taken with NCQA's activities and provisions of the Affordable Care Act that also promote the role of PCMHs, much attention will undoubtedly be paid to how this model of care improves quality of care and contains costs.

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2195-0812-NAT-HL-MLS