HB 929

Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE
Revised

House Bill 929 (The Speaker, *et al.*) (By Request - Administration)
Health and Government Operations Finance

Patient Centered Medical Home Program

This Administration bill requires the Maryland Health Care Commission (MHCC) to establish a Patient Centered Medical Home Program if it concludes that the program will likely result in the delivery of more efficient and effective health care services and is in the public interest. Insurers, health maintenance organizations (HMOs), managed care organizations (MCOs), and nonprofit health service providers (carriers) are authorized to pay a patient centered medical home, including specified incentives, for coordinated covered medical services provided to covered individuals. The bill also authorizes carriers to share medical information about a covered individual who elects to participate in a medical home with the individual's medical home and other treating providers.

The bill takes effect July 1, 2010, and terminates December 31, 2015.

Fiscal Summary

State Effect: MHCC expenditures increase by $221,600 in FY 2011 to establish the program and conduct an independent evaluation. Expenditures (all funds) for the State Employee and Retiree Health and Welfare Benefits Program (State plan) increase by an indeterminate, but likely minimal, amount beginning in FY 2012 to pay patient centered medical homes. Any future savings resulting from the program cannot be determined at this time. Future years reflect the expected conclusion of MHCC's report at the end of FY 2014 (although the report is not due until FY 2015). Revenues are not affected.

(in dollars)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Revenues	$0	$0	$0	$0	$0
GF Expenditure	0	-	-	-	-
SF Expenditure	221,600	218,800	221,300	160,000	-
FF Expenditure	0	-	-	-	-
Net Effect	($221,600)	($218,800)	($221,300)	($160,000)	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Expenditures may increase for some local governments beginning in FY 2012 to pay patient centered medical homes; however, the bill may result in long-term savings for health costs.

Small Business Effect: The Administration has determined that this bill has minimal or no impact on small business (attached). Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary: "Patient centered medical home" means a primary care practice organized to provide first, coordinated, ongoing, and comprehensive source of care to patients to foster a partnership with a qualifying individual, coordinate health care services for a qualifying individual, and exchange medical information with carriers, other providers, and qualifying individuals. "Primary care practice" means a practice or federally qualified health center (FQHC) organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners. "Qualifying individual" means a person covered under a carrier's health benefit plan or a member of an MCO.

A carrier, other than a group model HMO, reporting at least $90 million in written premiums for health benefit plans in the State in the most recent Maryland health benefit plan report submitted to the Insurance Commissioner must participate in the Patient Centered Medical Home Program. Nevertheless, the Department of Health and Mental Hygiene (DHMH) may require that certain MCOs and Medicaid MCO enrollees participate in the program. DHMH must ensure that MCO and Medicaid enrollee participation supports the quality and efficiency standards established in the HealthChoice Program. Enrollment in the program is otherwise voluntary for qualifying individuals, who may participate for one year with the option to renew.

The bill requires MHCC to conduct an independent evaluation of program effectiveness in reducing health care costs and improving health care outcomes. MHCC must report its findings to specified committees by December 1, 2014.

The bill also requires MHCC to consult with the Community Health Resources Commission (CHRC) regarding the inclusion of FQHCs and other primary care practices in the program. CHRC, in consultation with MHCC, may assist FQHCs and other primary care practices to become patient centered medical homes and identify ways that CHRC can leverage additional assets to support the participation of FQHCs and primary care practices in a patient centered medical home program.

Current Law: State law does not address patient centered medical homes.

Under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule "covered entities," including carriers, health care clearinghouses, and health care providers, may not use or disclose protected health information, except either as the privacy rule permits or as an individual authorizes in writing. Covered entities may disclose protected health information without an individual's authorization for such purposes as treatment, payment, health care operations, and public interest activities.

Maryland's Confidentiality of Medical Records Act requires health care providers and facilities to keep the medical record of a patient confidential and obtain written consent for disclosure. Generally, a person to whom a medical record is disclosed may not redisclose the medical record unless authorized by the person in interest. Exceptions are made for such purposes as provision of health care services, billing, utilization review, and legal claims.

An insurer is generally prohibited from disclosing an insured's medical records without written authorization. Exceptions include legal proceedings, coordination of benefits, reinsurance, renewal of insurance, and claims administration.

MHCC is special funded by user fees imposed on payors and providers. Fees are used exclusively to cover the costs of fulfilling the commission's statutory and regulatory duties.

Background: The medical home model of care is a way to provide comprehensive care that is designed around the patient's needs. The goal is to coordinate care, increase the value of health care received, expand administrative and quality innovations, promote patient and family involvement, and help control health care costs.

According to the National Conference of State Legislatures, at least 24 states have enacted legislation involving the medical home model as a tool to improve primary care and health outcomes since 2005.

The Maryland Health Quality and Cost Council established, as one of its three initial priorities, facilitating statewide implementation of a patient centered medical home demonstration project. The council established a Patient Centered Medical Home Workgroup to develop recommendations to strengthen primary care and promote the adoption of the medical home model. In carrying out its charge, the workgroup identified several legal issues that needed to be overcome before moving forward with a demonstration project:

- antitrust law that could be construed to prohibit the collaboration of carriers or providers on payment;
- State insurance law that limits the use of capitation to HMOs and requires performance bonuses to be based on quality;
- Maryland's Confidentiality of Medical Records Act, that requires carriers to obtain patient consent before sharing data with other providers; and
- authorization for members of the State Employee and Retiree Health and Welfare Benefits Program to participate in a patient centered medical home demonstration project.

State Expenditures: MHCC expenditures increase by $221,571 in fiscal 2011 to establish the program with a contractual employee and conduct an independent evaluation that considers health care delivery and clinical care process improvements; increased access to care coordination; payment adequacy; patient, clinician, and staff work satisfaction; cost of care; and health care disparity reductions. Future years reflect the continued need to retain a consultant or consulting firm, as required by the bill, to conduct the independent evaluation through fiscal 2014 and termination of the contractual employee at the end of fiscal 2013. Although the report is not due until December 1, 2014, MHCC assumes that it will finish its review by the end of fiscal 2014.

Legislative Services assumes that the State plan will not make any changes to its fiscal 2011 contract while MHCC establishes the program. Expenditures for the State plan increase by an indeterminate, but likely minimal, amount beginning in fiscal 2012 to pay patient centered medical homes. The Department of Budget and Management expects the program to include just 50 practices, minimizing any impact on State plan administrative costs.

Any future savings resulting from improved delivery of care under the program cannot be determined at this time.

This estimate does not account for the potential participation of the Maryland Medical Assistance Program (Medicaid).

Local Expenditures: Local government expenditures may increase for some local governments beginning in fiscal 2012 to pay patient centered medical homes.

Additional Information

Prior Introductions: None.

Cross File: SB 855 (The President, *et al.*) (By Request - Administration) - Finance.

Information Source(s): Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, National Conference of State Legislatures, Department of Legislative Services

Fiscal Note History: First Reader - March 9, 2010
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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Patient Centered Medical Home Program

BILL NUMBER: HB 929

PREPARED BY: Office of the Lt. Governor

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__X__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

The proposed legislation will have no impact on small business in Maryland.