

## MEMORANDUM

To: Commissioners  
Maryland Health Care Commission

From: Susan M. Myers, MA, MPH

Date: February 14, 2013

Re: Staff Recommended Decision on Single Carrier PCMH Application by Cigna

### I. BACKGROUND

On April 13, 2010, Governor O'Malley signed into law the Patient Centered Medical Home (PCMH) Program which, in part, authorizes the Maryland Health Care Commission (MHCC, Commission) to approve a single carrier patient centered medical home program, and thereby allow a payer to implement certain innovative payment methods and data sharing to improve patient care. Pursuant to §15-1802 of the Maryland Insurance Article allows an approved single carrier PCMH program to take the following actions:

- (1) Pay PCMH practices for services associated with coordination of medical services for patients;
- (2) Pay PCMH practices a bonus, fee based incentive, or other incentive approved by MHCC; and
- (3) Share medical information about a patient who has elected to participate in the program with other treating providers.

While a carrier may implement a PCMH program without the approval by the Commission, Insurance Article, §15-1802 requires Commission approval for a single payer PCMH program that intends to use these tools.

In 2012, the General Assembly passed the Enhancement or Coordination of Patient Care Act, which broadens a carrier's and a provider's ability to share a participating patient's information for purposes of enhanced patient care, provided that certain requirements set forth in Health-General Article, §4-305 and the Insurance Article, § 4-403 are met.

Commission approval of a single carrier PCMH program applies the statutory requirements included in Health-General § 19-1A-02(c). In implementing this statute, the Commission adopted criteria that set forth PCMH principles, which are based on a set of guidelines endorsed by the Patient Centered Primary Care Collaborative ("PCPCC"), a multi-stakeholder national coalition.<sup>1</sup> These criteria include certain standards that also

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<sup>1</sup> Guidelines for PCMH Demonstration Programs, Patient-Centered Primary Care Collaborative, March 2009. Available at: [http://www.acponline.org/running\\_practice/pcmh/demonstrations/guidedemo.pdf](http://www.acponline.org/running_practice/pcmh/demonstrations/guidedemo.pdf).

include notice requirements, evidencing how a carrier plans on compliance with meeting the statutory requirements adopted in 2012. Commission approval is based on the application's conformance with these standards.

## **REVIEW CRITERIA**

In August 2010, the Commission reviewed and approved review criteria for single carrier PCMH programs based on PCPCC principles. The table in Appendix A of this Staff Recommendation displays these criteria. There are two classes of criteria: one class, described as "Required," must be addressed by the Applicant, Cigna, in its initial application; the second class, noted as "Required\*," may be addressed by the Applicant following approval by the Commission, but before commencement of the proposed program. This second class of criteria is functionally treated in the same manner as conditions for "unmet" standards, only they must be met prior to start of the program. Finally, some conditions may be met at a defined future point in time, after the approved program commences.

## **II. OVERVIEW OF THE APPLICATION SUBMITTED BY CIGNA**

On Tuesday December 4, 2012, the Commission received, via e-mail, Cigna's application to offer a single carrier Patient Centered Medical Home ("PCMH") in Maryland. The Commission received a hard copy version of the application with a CD-Rom of relevant files on Wednesday December 5, 2012.

Cigna is a for-profit national organization headquartered in Bloomfield, Connecticut with a regional office serving the Mid-Atlantic states and the District of Columbia. Cigna has provided health insurance products in this market for more than 100 years. With respect to PCMH activities in Maryland, Cigna has participated in the Maryland Multi-Payer Patient Centered Medical Home (MMPPC) pilot program since its inception in 2011. Nationally, Cigna operates the Collaborative Accountable Care program (the CAC) in 24 states and, with this Application, intends to introduce it in Maryland. Instead of a "benefits driven" model, Cigna characterizes the CAC as an "enhanced provider services" model.

Given Cigna's minor share of the insurance market share in Maryland, it is targeting the CAC program to provider groups with 2,500 to 10,000 patients. The six (6) hallmarks of the CAC in Maryland will be:

- Embedded case management;
- Care coordination fees;
- Regular data feeds;
- Action plans;
- Quarterly performance report cards; and
- Incentive payments

Within the CAC in Maryland, Cigna proposes to pay semi-annual care coordination fees and to offer incentives based on a provider group's performance relative to the market,

combined with maintenance of quality and utilization benchmarks within specified margins. Also, as part of the CAC, Cigna proposes to offer educational opportunities to participating groups on a periodic basis.

At this time, Cigna has identified three (3) large provider groups with more than 10,000 patients to participate in the CAC. Cigna has indicated that it may offer the program to additional provider groups in the future, including those with less than 10,000.

### **III. STAFF ANALYSIS AND RECOMMENDATION**

After review of Cigna’s application for conformance to program standards, Staff provides the following standard-by-standard analysis and recommendations.

#### **A. Overview:**

While Cigna took a novel position regarding the design of its program - characterizing it as “enhanced provider services” – Commission approval is still required. Thus, the program must meet the standards adopted by the Commission in August 2010, which are set forth below.

In its application, Cigna’s indicated that it viewed five standards, 1a, 8d, 8e, 13b, and 14a, as not applying to its program. Cigna took the position that as the CAC is an “enhanced provider services” model, and not a “benefits driven” model, these standards were inapplicable. Such an approach does not meet Commission standards and, in addition, could run afoul of statutory requirements. Staff provides recommended conditions within it recommendations below so that the CAC program may achieve compliance with MHCC standards and relevant statutes.

#### **B. Staff’s Findings and Recommendations**

**Standard 1:** Program ensures that the leaders of local/regional primary care professional organizations are adequately briefed.

The Carrier provides a list of briefing dates and meeting agendas regarding how it will explain the program to members of local/regional primary care professional organizations.

#### **Discussion:**

The Application did not provide a communications plan. Cigna stated this standard was “not applicable” given the program’s design. This standard requires that major stakeholders in Maryland be informed about the Applicant’s program. Staff believes this standard does apply and views this communication to stakeholders as the responsibility of the Applicant, not of the Commission.

#### **Staff Findings and Recommendations**

Staff believes the Application is not consistent with this standard, but recommends approval of the program subject to the following condition.

**Recommended Condition:**

Cigna shall inform leaders of local/regional primary care professional organizations, either in writing or in-person, about the CAC and provide documentation of that communication to MHCC within two weeks of the Commission's approval of the Applicant's program.

**Standard 2:** Program identifies an individual and department within the carrier responsible for convening participants and coordinating PCMH program activities.

The Carrier identifies the individual(s) within the carrier's organization responsible for administering PCMH program.

**Discussion:**

Cigna's application provided a contact person and the responsible business unit for its proposed program.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this standard.

**Standard 3:** Program uses NCQA PPC PCMH tool or a similar consensus-based recognition process.

The Carrier's PCMH program requires participating practices to receive formal recognition as a PCMH within 12 months of onset of practice participation through NCQA recognition, URAC recognition, or a carrier-defined recognition process that minimally ensures practices meet the factors listed in Appendix B of the Commission-approved PCMH Review Criteria document (attached hereto as Appendix A of the Recommended Decision.)

**Discussion:**

Staff notes that the current NCQA PCMH 2011 recognition requirements, not the 2008 recognition requirements, apply to this Standard.

Cigna's application specified that its program requires participating providers to receive attainment of NCQA level II within 18 months. Through its work with Maryland's pilot multi-payer program, Staff has since learned that a provider's attainment of Level I is possible within 12 months and that attainment of Level II or better is possible within 18 months. Requiring NCQA recognition submissions at both the 12 and 18 month mark would result in significant duplicative costs in dollars and staff time for the participating providers with very little, if any, additional

benefit. Thus, with reasonable and timely assurances that the Applicant's program is on target to achieve its 18 month goal, the Staff believes that the CAC will meet the intent of Standard 3.

**Staff Findings and Recommendations:**

Given that the participating providers are required to achieve Level II NCQA 2011 recognition within 18 months after commencement of this program, Staff believes that the CAC is consistent with the intent of this standard upon including in its first Annual Report a summary of the participating providers' progress toward meeting the program's 18 month-goal.

**Standard 4:** Program includes participation of a range of practice sizes, and is representative of the practices in the area.

- a. The Carrier must describe the PCMH program practice eligibility criteria such as provider type, geographic area, panel size, and practice size.
- b. The Carrier adequately describes its approach to accommodating small practices.
- c. The Carrier treats nurse practitioner-led practices and physician-led practices similarly for purposes of the PCMH program.

**Discussion:**

As to sub-part a., Cigna's application adequately explains the main components of its program for participating practices, including: Embedded Case Management; Care Coordination Fees; Regular Data Feeds; Action Plans; Quarterly Performance Report Cards; and Incentive Payments. Cigna proposes to target large provider groups with 2,500 - 10,000 patients.

As to sub-part b., the Application did not directly address "accommodations" for small practices. Cigna intends to target practices with 10,000 patients or more at the outset of its CAC program, and will consider engaging practices with 2,500 – 10,000 patients in the future.

This standard focuses on the size of participating practices; however, Staff observes that the size of the carrier-applicant should also be considered. Cigna has always been an active participant of the MMPP pilot project operated by the Commission, which has numerous accommodations for small practices including, but not limited to, adjustments in size of "per member, per month" fixed transformation payments. Staff believes that the intent of this Standard – that smaller practices are not disadvantaged – is met given the broad activities of the MMPP and Cigna's participation in these activities.

As to sub-part c., Cigna's application states that it does not treat nurse practitioner-led practices differently than physician-led practices for the purposes of this PCMH program.

**Staff Findings and Recommendations:**

Staff believes that the Applicant's is consistent with this standard given Cigna's active participation in the Multi-Payer Patient Centered Medical Home pilot program.

**Standard 5:** Program clearly outlines the responsibilities of all participating parties, including providers, payers, and patients/families.

- a. The Carrier adequately describes the responsibilities of the carrier, the provider, and the patient.
- b. The Carrier includes an adequate description of the responsibilities of relevant parties (e.g., carrier, provider, and patient) in program enrollment materials such as provider and patient contracts and program descriptions.
- d. Provider's responsibilities include commitments to: accept the PCPCC Joint Principles of the Medical Home, transform the practice into a patient centered medical home, and participate in the PCMH education program offered by the carrier.
- e. The Carrier's responsibilities include organizing a PCMH education program for participating practices, providing patients with educational materials at the time the patient enrolls in the medical home, and reporting program performance to the MHCC in an Annual Report.

**Discussion:**

Cigna's application provided several documents which, taken together, adequately address this standard. Sub-parts a. through d. of this standard are directly addressed by the following documents, which were included in the Application: the Physician Group Services Agreement (Appendix A), Embedded Care Coordination Training (Appendix C), Cigna Collaborative Accountable Care Requirements (Appendix D), and the Provider Services Agreement (Appendix F).

As to sub-part d., the patient engagement model required under Maryland statute, which is also discussed in Standard 8 below, the PCMH statute is one where the patient must be given an opportunity to opt-out (as opposed to opt-in upon enrollment) Cigna has provided Staff with copies of program educational materials that Cigna will share with each participating practice. Staff believes that these documents will provide

patients with sufficient educational materials upon their receipt of such documents.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this Standard.

**Standard 6:** Program incorporates support for health information technology (“HIT”) consistent with the requirements in Health-General, § 19-143 which includes using HIT for care management support, patient education, a mechanism to support enhanced patient communication, and performance reporting.

- a. The Carrier adequately describes program goals and requirements for practices using HIT in care management, patient education, patient communication, and performance reporting.
- b. The Carrier requires practices to comply with program goals and requirements for using HIT in care management including a disease registry and e-prescribing within 12 months of program start date. The registry may be either a stand-alone tool or one that is part of an electronic health record (EHR).

**Discussion:**

NCQA Levels I, II and III recognition standards include rigorous use of HIT in patient care processes including care management, patient education, patient communication, disease registry, e-prescribing, and performance reporting. Specifically, staff notes that the 2011 NCQA PCMH standards include Element E, e-Prescribing, which is a core meaningful use requirement. Element E is presented below:

“Element E: Use Electronic Prescribing 3 points

The practice uses an electronic prescription system with the following Capabilities:

- 1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies;
- 2. Generates at least 75 percent of eligible prescriptions;
- 3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list;
- 4. Performs patient-specific checks for drug-drug and drug-allergy Interactions;
- 5. Alerts prescribers to generic alternatives; and
- 6. Alerts prescribers to formulary status.”

As was noted in Staff’s analysis of Standard 3, requiring NCQA recognition submissions at both the 12 and 18 month mark would result in significant duplicative costs in dollars and staff time for the participating

providers with little, if any, added benefit. Therefore, given the requirement for Level II recognition level within 18 months, Staff believes that the Applicant's program would meet the intent of this standard if Cigna were to provide an update, such as in its first Annual Report, of the participating providers' progress toward NCQA Level II recognition.

**Staff Findings and Recommendations:**

As pointed out in Cigna's response to Standard 3, the CAC program requires participating providers to achieve Level II NCQA 2011 recognition within 18 months of commencement of this program. Thus, Staff believes that the program will be consistent with this standard conditioned on the inclusion of a summary in its first Annual Report of the participating providers' progress toward meeting the program's 18 month-goal.

**Standard 7:** Program provides practices with sufficient financial and non-financial resources to cover additional staff work and transformation activities.

The Carrier adequately describes its plan for assisting practices with PCMH transformation.

**Discussion:**

The Application adequately describes its incentive program through the presentation of the formula that will be used to calculate incentive payments. However, as it considers them proprietary, Cigna did not provide either estimates or dollar ranges for "Care Coordination Fees", or precise examples of how performance on quality measures would affect incentives earned by participating providers. The Application did provide a brief description of the planned educational support (i.e., non-financial support) offered through Cigna's learning collaborative. Staff believes that the submitted materials are sufficient to show that the program meets this Standard.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this standard.

**Standard 8:** Program design maximizes number of patients participating in the practice.

- a. The Carrier provides a grievance process for receiving, reviewing, and addressing patient complaints and disputes over coverage of medically necessary services.
- b. The program contract for providers documents a sufficient grievance process to resolve disputes.

- c. The Carrier includes grievance process description and contact information in patient enrollment materials and in annual program renewal materials.
- d. The Carrier adequately describes a plan for patients who desire to migrate to another PCMH if their practice leaves the PCMH program.
- e. The Carrier's enrollment materials and annual renewal materials for patients clearly explain the PCMH program's policy and process for patients who want to opt-out of the program or migrate to another PCMH. A patient is allowed to opt-out of the program at any time without leaving the practice.
- f. The Carrier is responsible for fees associated with hiring a third-party expert to resolve disputes over whether care is medically necessary.
- g. The Carrier submits enrollment and program materials for patients in English and Spanish.

**Discussion:**

Sub-part a is met through materials included in Appendix E, "Maryland Appeals Policy – Correspondence and Forms, Version 6.0, January 2012, of Cigna's application.

Sub-part b. is met through the materials included in Appendix F, Provider Services Agreement, of Cigna's application.

Sub-part c. is met by the description and information found in the "Summary Plan Description" and the "Certificate", which will be provided to the insured patients at annual renewal. This document was provided in the Application.

Sub-part d. Cigna documents submitted with its application specifically provide that "[a]lignment to a CAC program does not impede or limit a participant's ability to change physicians at any time they choose." This statement evidences the program's compliance with sub-part d.

As to sub-part e, Cigna's application states the CAC program is an enhanced provider payment program and not an enhanced benefit or a product offering. Participation of a patient in the program is directly linked to the patient's physician's participation in the program. Cigna takes the position that it is the responsibility of the CAC participating provider to conduct outreach and communicate with patients about the program.

Staff notes that the applicant's position is not consistent with sub-part e., which requires a clear explanation for participating patients of their ability to opt-out of the program at any time without leaving the practice. Sub-part e.,

which was included in furtherance of the goals set forth in the underlying PCMH statute, is also needed to show the carrier's compliance with statutory requirements set forth in the 2012 Enhancement or Coordination of Patient Care Act, codified at Maryland Insurance Article, §4-403 and Maryland Health-General Article, §4-305. This Act requires that, before a carrier shares medical information with a treating provider without a patient's authorization for the purpose of enhanced care or care coordination, the carrier must assure that the patient has been provided notice or an opportunity to opt-out of the sharing of information. Insurance Article §4-403 (c)(12)(v).<sup>2</sup> Given that one of the six hallmarks of the CAC, regular data feeds, involves the sharing of medical data authorized pursuant to this provision of the law, Staff believes that compliance with sub-part e. should be clear.

As Cigna's application does not set forth a manner in which the program will meet sub-part e. of this standard, Staff recommends that Commission approval of the program be contingent upon the Applicant providing updated materials showing compliance with subpart e. of this standard.

Sub-part f. is met through materials found in the Provider Services Agreement, Appendix F, section 5, of the application.

Sub-part g. Cigna enrollment materials are available in both English and Spanish.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with sub-parts a, b, c, d, f, and g. However, Staff does not believe that the Application conforms with sub-part e. Thus, Staff recommends the following condition be included in any Commission approval of this program to bring it into compliance with this subpart.. Staff notes that the Applicant's CAC program's compliance with subpart e. of this standard, and any Commission approval of the program, does not relieve Cigna of its broader responsibility to comply with the 2012 Enhancement or Coordination of Patient Care Act in all of its actions.

**Recommended Condition:**

Cigna shall provide updated patient enrollment materials and annual renewal materials – or other materials to be distributed to patients – that clearly explain the PCMH program's policy and process for patients who choose to opt-out of the program or to migrate to another PCMH and how Cigna will assure that participating patients are informed of their right to opt out of the CAC in accordance with Insurance Article, §4-403 (c)(12)(v).

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<sup>2</sup>Health-General Article, §4-305(b)(11)(v) places a similar requirement on a provider prior to sharing medical records without authorization for enhanced care or care coordination.

**Standard 9:** Prospective, bundled payment to cover PCMH-related practice expenses not covered by fees for service, or FFS.

The Carrier provides a clear explanation and adequate justification for its fixed reimbursement methodology.

**Discussion:** Cigna's application described its investment and incentive program in detail in Article IV of the Physician's Group Services Agreement, Appendix A. This Article presented detailed information on care coordination fees, shared savings formulae, performance adjustment factors, and a quality adjustment through use of a quality index.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this standard.

**Standard 10:** Performance-based component based on achievement of defined quality and efficiency goals as reflected by evidence-based quality, cost of care, and patient experience measures.

- a. The Carrier adequately describes its bonus, fee based incentive, or other incentive methodology and the eligibility criteria for the described bonus or incentive payment.
- b. The Carrier adequately explains additional reimbursement, including probable ranges, and expected services to be provided by participating practices in physician program enrollment materials.
- c. The Carrier adequately describes how it will ensure that practices will not risk select patients for the program.
- d. The Carrier adequately describes its patient attribution model.

**Discussion:**

As to sub-parts a. and b., Cigna described its investment and incentive program in detail in Article IV of the Physician's Group Services Agreement, Appendix A, which was included in its Application. This document presents detailed information on care coordination fees, shared savings formulae, performance adjustment factors, and quality adjustments through Quality Index scores.

While Cigna declined to provide anticipated ranges of the Care Coordination Fees (CCFs), stating that this information was proprietary, it did provide Staff with ranges of percentage increases in Fee For Service schedules that would be realized within their incentive program.

As to sub-part c. of this standard, the Applicant provided the following statement, which shows compliance with this sub-part.

*Cigna aligns patients to a practice based on actual utilization. Quality results are derived based on practice opportunities and successes for all aligned patients.*

*In addition to the alignment methodology as previously described, patients who are aligned to a CAC practice are assigned a retrospective risk score – based on historical claims data used for alignment – which is then used to case mix and severity adjust the practice population.*

As to sub-part d., Cigna described its process for “aligning” patients to the program in section 4 of the CAC Requirements found in the Cigna Collaborative Accountable Care Requirements, Appendix D. This alignment process is based on factors very similar to those used in the Maryland Multi-Payer Patient Centered Medical Home pilot program (for example, the physician is a primary care physician, evaluation and management services codes are reviewed, etc.).

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this standard.

**Standard 11:** Program contains a commitment to transparency of the data set, including selection of metrics.

- a. The Carrier adequately describes and justifies quality metrics to be used in the PCMH program.
- b. The Carrier includes the selected quality metrics in the program to participating providers and patients in program materials.
- c. The Carrier adequately addresses how quality measures and PCMH reimbursement methodology protect patients against inappropriate underutilization of services. The Carrier agrees to provide an Annual Report to the Commission in the form and manner required by the Commission as a condition for continuing approval of the program. The report will include the average savings per practice, the number of practices that earned rewards, average reward payment, the total savings per practice that are retained by the carrier, and quality scores achieved by practices in the pilot.

**Discussion:**

As to sub-parts a. and b., Cigna proposes to use quality measures in tandem with Evidence Based Medicine Rules. While Cigna declined to delineate quality measures, stating that such information is proprietary, it did share the Evidence Based Rules with Staff. The Evidence Based Medicine Rules encompass an array of quality measures more expansive than those associated with the Multi-Payer Patient Centered Medical

Home pilot program. Staff believes that the documentation provided by the Applicant is acceptable in meeting this standard.

As to sub-part c., the Applicant responded:

*The reimbursement methodology considers both cost and quality outcomes for the CAC. The quality index score is determined by using Evidence Based Medicine Rules which promote appropriate utilization of services relative to specific conditions*

The Applicant further asserts that it will comply with the requirement to provide an annual report. Staff notes that sub-part c. of the Standard does require that "...quality scores achieved by practices in the pilot" are to be included in the Annual Report.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with this standard.

**Standard 12:** Program includes a process to broadly disseminate performance results to participating practices and patients.

The Carrier agrees to make the PCMH program's aggregate results available to participating practices and patients.

**Discussion:**

Staff notes that this standard does not specify the type of performance measures to be reported upon. Standard 11 explicitly addresses quality. The Applicant's response to this standard assumed that quality is the focus of this standard as well. The required annual report by a single payer would address performance from the perspective of incentives. Thus, Staff does not believe the Application has met this standard.

**Staff Findings and Recommendations:**

Staff believes the Application is not consistent with this standard, but recommends approval of the program subject to the following condition.

**Recommended Condition:**

Cigna will report on performance outcome measures of the program in a way that will promote the ability of the public to compare its single carrier program with other single carrier and the multi-payer PCMH models in Maryland.

**Standard 13:** Carrier will only share a qualifying individual's medical information in the PCMH program with other treating providers after the individual has received opt-out documents.

- a. The Carrier adequately describes policies and systems in place for protecting patient medical information by only providing it to treating providers.
- b. The Carrier's participation materials adequately inform patients about what medical information will be shared and how it will be shared. The Carrier must specify how it will notify patients of the program each year and provide patients with the option of opting out of the program.

**Discussion:**

As to sub-part a., Staff finds the Applicant adequately described the relevant policies and systems in the CAC Requirements document.

As to sub-part b., Cigna asserts this standard does not apply to them because its model is not a "benefits driven" model. As stated in its discussion of Standard 8 above, the Applicant's position is not consistent with the specified requirements set forth in the underlying PCMH statute, and the subsequent statutory requirements set forth in the 2012 Enhancement or Coordination of Patient Care Act, codified at Maryland Insurance Article, §4-403 and Maryland Health-General Article, §4-305. As addressed in its discussion of Standard 8 above, Staff believes that compliance with sub-part b. of this standard should be clear, given that one of the six hallmarks of the CAC, regular data feeds, involves the sharing of medical data as permitted under this provision of the law.

Cigna's application does not set forth a manner in which the program will meet sub-part b. of this standard. Given the specific statutory language in the 2012 Enhancement or Coordination of Patient Care Act, Staff recommends that any Commission approval of the CAC program be contingent upon the applicant providing updated materials showing compliance with subpart b. of this standard. Staff would point out that, given that the General Assembly did not require that such notice be provided annually, Staff would recommend that the annual requirement noted in sub-part b. be relaxed to require only an initial notice to each participating patient.

**Staff Findings and Recommendations:**

Staff believes that the Application is consistent with sub-part a. However, Staff believes the Application is not consistent with sub-part b of this standard, but recommends approval of the program subject to the following condition. Staff notes that the compliance with subpart b. of this standard, does not relieve Cigna of its broader responsibility to comply with the 2012 Enhancement or Coordination of Patient Care Act in all of its actions.

**Recommended Condition:**

Cigna shall provide updated patient participation materials that will be distributed to each participating patient detailing what medical information will be shared and how it will be shared. Cigna shall also explain how it will distribute this initial notice to each participating patient.

**Standard 14:** Program shall ensure a participating practice provides culturally and linguistically appropriate care.

**Discussion:**

Cigna described its approach to ensuring cultural competency and encouraging language translation services, but did not clearly articulate how it would make certain such care would be delivered.

The Applicant initially claimed that this standard does not apply to them given the nature of its model. Staff did not agree with Cigna's position and requested that Cigna provide an example of material that it would use to promote cultural competency among participating providers in its CAC. Cigna provided materials, which are included in Appendix I, but has not adequately addressed this standard. Staff believes that any Commission approval of the program include a recommended condition that assures that Cigna will require participating practices to take steps to provide culturally and linguistically appropriate care.

**Staff Findings and Recommendations:**

Staff believes the Application is not consistent with this standard, but recommends approval of the program subject to the following condition.

**Recommended Condition:**

Cigna will require participating practices to take steps to provide culturally and linguistically appropriate care.

## **APPENDIX A**

### **Program Requirements**

Category	Source	Standard	Single Carrier Application Criteria	Status of the Element
<b>Collaboration and Leadership</b>	PCPCC	1. Program ensures that the leaders of local/regional primary care professional organizations are adequately briefed.	a. The Carrier provides a list of briefing dates with members of local/regional primary care professional organizations and meeting agendas.	Required*
	PCPCC	2. Program identifies an individual and department within the carrier responsible for convening participants and coordinating PCMH program activities.	a. The Carrier identifies the individual(s) within the carrier's organization responsible for administering PCMH program.	Required
<b>Practice Recognition</b>	PCPCC	3. Program uses NCQA PPC PCMH tool or a similar consensus-based recognition process.	a. The Carrier's PCMH program requires participating practices to receive formal recognition as a PCMH within 12 months of onset of practice participation through NCQA recognition, URAC recognition, or a carrier-defined recognition process that minimally ensures practices meet the factors listed in Appendix B.	Required
	PCPCC	4. Program includes participation of a range of practice sizes, and is representative of the practices in the area.	a. The Carrier must describe the PCMH program practice eligibility criteria such as provider type, geographic area, panel size, and practice size.	Required
			b. The Carrier adequately describes its approach to accommodating small practices.	Required
<b>Stakeholder Engagement</b>	PCPCC	5. Program clearly outlines the responsibilities of all participating parties, including providers, payers, and patients/families.	c. The Carrier treats nurse practitioner-led practices and physician-led practices similarly for purposes of the PCMH program.	Required
			a. The Carrier adequately describes the responsibilities of the carrier, the provider, and the patient.	Required
			b. The Carrier includes an adequate description of the responsibilities of relevant parties (e.g., carrier, provider, and patients) in program enrollment materials such as provider and patient contracts and program descriptions.	Required*

<b>Practice Support</b>	PCPCC	6. Program incorporates support for health information technology (HIT) consistent with requirements in HB 706, care management support, patient education, mechanism to support enhanced patient communication, and performance reporting.	c. Provider’s responsibilities include commitments to: accept the PCPCC Joint Principles of the Medical Home, transform practice into a patient centered medical home, and participate in the PCMH education program offered by the carrier.	Required		
			d. The Carrier’s responsibilities include organizing a PCMH education program for participating practices, providing patients with educational materials at the time the patient enrolls in the medical home, and reporting to the MHCC on program performance in an Annual Report.	Required		
			a. The Carrier adequately describes program goals and requirements for practices for using HIT in care management, patient education, patient communication, and performance reporting.	Required		
			b. The Carrier requires practices to comply with program goals and requirements for using HIT in care management including a disease registry and e-prescribing within 12 months of program start date. The registry may be either a stand-alone tool or one that is part of an electronic health record (EHR).	Required		
			PCPCC	7. Program provides practices with sufficient financial and non-financial resources to cover additional staff work and transformation activities	a. The Carrier adequately describes its plan for assisting practices with PCMH transformation.	Required
					a. The Carrier provides a grievance process for receiving, reviewing, and addressing patient complaints and disputes over coverage of medically necessary services.	Required
			PCPCC	8. Program design maximizes number of patients participating in the practice.	b. The program contract for providers documents a sufficient grievance process to resolve disputes.	Required*
					c. The Carrier includes grievance process description and contact information in patient enrollment materials and in annual program	Required*

			renewal materials.	
			d. The Carrier adequately describes a plan for patients who desire to migrate to another PCMH if their practice leaves the PCMH program.	Required
			e. The Carrier's enrollment materials and annual renewal materials for patients clearly explain the PCMH program's policy and process for patients who want to opt-out of the program or migrate to another PCMH. A patient is allowed to opt-out of the program at any time without leaving the practice.	Required*
			f. The Carrier is responsible for fees associated with hiring a third-party expert to resolve disputes over whether care is medically necessary.	Required
			g. The Carrier submits enrollment and program materials for patients in English and Spanish.	Required*
<b>Reimbursement Model</b>	PCPCC	9. Prospective, bundled payment to cover PCMH-related practice expenses not covered by FFS.	a. The Carrier provides a clear explanation and adequate justification for its fixed reimbursement methodology.	Required
	PCPCC	10. Performance-based component based on achievement of defined quality and efficiency goals as reflected by evidence-based quality, cost of care, and patient experience measures.	a. The Carrier adequately describes its bonus, fee based incentive, or other incentive methodology and the eligibility criteria for the described bonus or incentive payment. b. The Carrier adequately explains additional reimbursement, including probable ranges, and expected services to be provided by participating practices in physician program enrollment materials. c. The Carrier adequately describes how it will ensure that practices will not risk select patients for the program. d. The Carrier adequately describes its patient attribution model.	Required Required* Required Required
<b>Assessment and Reporting</b>	PCPCC	11. Program contains a commitment to	a. The Carrier adequately describes and justifies quality metrics to be used in the PCMH program.	Required

<b>of Results</b>		transparency of the data set, including selection of metrics.	b. The Carrier includes the selected quality metrics in the program to participating providers and patients in program materials.	Required*
			c. The Carrier adequately addresses how quality measures and PCMH reimbursement methodology protect patients against inappropriate underutilization of services.	Required
			d. The Carrier agrees to provide an Annual Report to the Commission in the form and manner required by the Commission as a condition for continuing approval of the program. The report will include the average savings per practice, the number of practices that earned rewards, average reward payment, the total savings per practice that are retained by the carrier, and quality scores achieved by practices in the pilot.	Required
	PCPCC	12. Program includes a process to broadly disseminate performance results to participating practices and patients.	a. The Carrier agrees to make the PCMH program aggregate results available to participating practices and patients.	Required
<b>Patient Protections</b>	§19-1A-02(C)	13. Carrier will only share a qualifying individual's medical information in the PCMH program with other treating providers after the individual has received opt-out documents.	a. The Carrier adequately describes policies and systems in place for protecting patient medical information by only providing it to treating providers.	Required
			b. The Carrier's participation materials adequately inform patients about what medical information will be shared and how it will be shared. The carrier must specify how it will notify patients of the program each year and provide patients with the option of opting out of the program.	Required*
	§19-1A-03(F2)	14. Program shall ensure a participating practice provides culturally and linguistically appropriate care.	a. The Carrier adequately describes its approach to ensuring cultural competency and encouraging language translation services.	Required