

Implementing the Recommendations of the Commission to Study Primary Care Medical Practice

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Report to the Joint Committee on Health and Human Services

From
The Governor's Office of Health Policy and Finance
The Dirigo Health Agency's Maine Quality Forum
The Department of Health and Human Services

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Section 1 Patient-centered medical home.

I. Activities for implementing a multipayer patient centered medical home pilot project

Health systems in other countries and pilot projects in the United States have demonstrated that effective primary patient care that is comprehensive and accessible has the potential to improve health outcomes and lower costs. Primary care does this by ensuring that patients receive effective care measures for prevention and for management of chronic illness, by coordinating the use of testing and specialist evaluation and treatment, and by providing a comprehensive array of medical services in one clinic or office. Avoidance of duplicative care, unnecessary hospitalizations, and emergency room visits results in reduced health care costs. However, the necessary infrastructure and human resources to provide comprehensive and effective primary care are generally not adequately reimbursed to practitioners by payers. For this reason, it is difficult for primary care practices to supply services that are recognized as effective. Moreover, the growing difference between reimbursement for primary care services and for medical specialty services results in a documented decrease in the number of young physicians choosing the field of primary care.

The patient-centered medical home model exists to describe the characteristics of effective primary care. As noted in the report of the 123rd Legislature's Commission to Study Primary Medical Practice, "*Principles of a patient centered medical home include a personal physician who leads a medical team that collectively takes responsibility for the ongoing care of patients with a whole-person orientation. Under the model, primary*

care is coordinated and integrated, and quality, safety and access are of the utmost importance. Hallmarks of the patient-centered medical home include planning, evidence-based medicine, clinical decision support tools, accountability, active participation in decision making by the patient and appropriate information technology supporting an environment of continual quality improvement and increased access through means including expanded hours, open scheduling and new options for expanded communication between doctor and patient.” The report further recognized the need for evaluation of new reimbursement models to support the services necessary to implement the medical home model. The Commission recommended the development of a pilot project to assess the feasibility of wide implementation of the medical home model in Maine.

Because of this support, and because of similar recognition of the advantages of the medical home model by the State Health Plan, the Dirigo Health Agency’s Maine Quality Forum, along with the Maine Health Management Coalition (an employer-led partnership of multiple stakeholders committed to improvement in the value of health care of its members’ employees and their families) and Quality Counts (a nonprofit organization which aims to improve chronic disease management and adoption of the chronic care model), convened a multistakeholder effort to develop, implement, and evaluate the Maine Patient Centered Medical Home Pilot. The goal of this pilot is to demonstrate the feasibility of the medical home model in Maine and that this model can sustain and revitalize primary care while improving health outcomes and reducing costs.

The Dirigo Health Agency contracted with Lisa Letourneau, M.D., M.P.H., an internist who is a former health care quality improvement officer with MaineHealth and currently the executive director of Quality Counts, to supervise and facilitate the pilot project. The initial convener group expanded to include MaineCare representatives and representatives of Maine’s purchaser and insurer community as well as primary care and behavioral health care providers. Now called the Maine Patient Centered Medical Home Pilot Working Group, it includes physical and behavioral health care providers; representatives from the Maine Chapters of the American College of Physicians, American Academy of Pediatrics, the American Association of Family Practice, the Maine Medical Association, and Maine’s major health systems; employers, payers, and consumers.

Important activities of the Maine PCMH Pilot under its Working Group to date have included the following:

- The program of the annual **Governor’s Summit conference of the Maine Cardiovascular Health Council** in June 2008 centered on the patient centered medical home in practice and included national speakers from innovative primary care centers as well as the Commonwealth Fund.

- The annual **Hanley Forum**, in June 2008, brought national figures in government and primary care organizations to Maine for discussions of primary care policy and financing.
- The **Maine Center for Public Health annual FOCUS conference** in October 2008 included discussions from Maine and New England speakers on the connections between the patient centered medical home and the public health system.
- A larger stakeholder group has been formed, the **Coalition for the Advancement of Primary Care**. This group of over sixty members includes patients, physical and behavioral health providers, employers, all of Maine's commercial health plans, MaineCare, and public health that has been meeting since July 2008 to promote the Patient Centered Medical Home in Maine. The Coalition provides guidance and advice for the pilot project and provides leadership to other initiatives in the state aimed at supporting primary care. The group is open to all interested parties.
- A **statement of guiding principles** for the Maine Patient Centered Medical Home model and a **mission and vision statement** for the Maine Pilot have been written (appended to this report).
- A **memorandum of agreement** for participating practices has been written (appended to this report).
- A **Physician Payment Reform Committee** was convened and met several times through November, 2008. This committee was comprised of providers, payers, and purchasers and was charged with investigating payment models for medical home practices that would cover infrastructural, human resource, and time investment involved in becoming and sustaining a medical home practice. Several models were considered; however, a single reimbursement model satisfactory to each insurer and purchaser could not be identified. Therefore, it is anticipated that pilot practices, after they are identified, will negotiate reimbursement plans with each payer. Basic models of compensation are enhanced monthly payments for each patient in the practice with or without continued fee-for-service payment and shared-savings mechanisms. The largest self-insured employers, Anthem, Aetna, Cigna, and Harvard Pilgrim, and MaineCare have all expressed commitment to participation in the pilot. (A recognized disadvantage for adult primary care practices in the pilot will be Medicare's nonparticipation as a payer in Maine's pilot.)
- An **Evaluation and Measures Subcommittee** has convened. This group will be responsible for formulating the body of performance, quality, and cost measures on which the pilot practices will be evaluated. Initial structural measure of the medical home pilot practices will be based on the National Committee on Quality Assurance (NCQA) criteria for patient centered medical home practices. In

addition, other practice cultural and technological indicators will be used. Efforts are being made to coordinate this evaluation as much as possible with pilot evaluations in other states. Professor Andrew Coburn and other researchers from the University of Southern Maine's Muskie School of Public Service are working with other states' evaluators to develop methodologies and pursue funding.

- A formal process has been developed for **obtaining consumer input** into development of the Maine PCMH Pilot. With support from the Maine Health Access Foundation, a series of consumer focus groups has been conducted to gain direct input from consumers about their needs from primary care and the medical home model, and how consumers can be actively engaged in partnering with their primary care provider to make the Pilot successful. Consumers have also been involved in the development and governance of the Pilot and will be actively involved in its implementation.
- An application process has been developed for primary care practices interested in participating in the Pilot. Formal **announcement of the opening of applications was made on January 5, 2009**. Applications will remain open until February 28, 2009. Practice selection will take place March 1-15, 2009 using a set of predetermined criteria (appended). After a six month ramp-up period, the pilot will start on October 1, 2009 and continue to September 31, 2012. Please see the appended *Background Information and Application Process* document for more details of this timeline.
- Those involved in the development of the pilot are participating with **other states' initiatives**. A multistate platform for evaluation is emerging. In addition, a group comprised of representatives from Maine, New Hampshire, Vermont, and Massachusetts has developed whose task is to explore support from Medicare with regional and national offices of the Center for Medicare and Medicaid Services (CMS).
- **Financial and in-kind support** for the pilot has come from the Dirigo Health Agency, the Maine Health Management Coalition, Anthem Blue Cross and Blue Shield of Maine, and Martins Point Health Care. Importantly, Quality Counts has been awarded a Maine Health Access Foundation "Integration Initiative" grant which will be directed at practice transformation and support during the term of the pilot.
- Under the auspices of the Maine Medical Association, a **dialog has begun between primary care and specialist groups** in order to involve the wider medical community in efforts to strengthen primary care.

II. MaineCare activities in the patient centered medical home pilot

In addition to directly supporting the Maine PCMH Pilot, MaineCare has undertaken several specific initiatives over the past year that support the medical home model, and to strengthen its support of primary care services. MaineCare has had a Medicaid Primary Care Case Management (PCCM) program underway for the past decade. Under this program, a majority of MaineCare members have enrolled or been enrolled with a primary care physician practice. As a participant in the PCCM program, the primary care physician practice contracts with MaineCare for the following services:

- provide ongoing access to enrolled MaineCare members,
- provide at least telephone access to a practice clinician 24 hours a day, seven days a week
- provide most primary care medical services
- authorize most medical specialty services through a referral program.

In return for these services, primary care practices are paid a monthly per-enrolled-member “care management” fee, at present \$3.50, in addition to fee for service payments for physician services. Hospital-based practices which are paid on a cost basis are not eligible for this additional PCCM monthly fee. In addition, primary care practices paid by fee schedule participate in a Primary Care Physician Incentive Payment (PCPIP) program. The PCPIP program pays primary care practices an incentive payment based comparative practice scores on measures of access, cost efficiency, and quality. Practices paid on a cost basis, including federally qualified health centers, rural health centers, and cost-settled hospital-based physician practices are not eligible for the PCPIP payment. It is estimated that approximately \$7M will be distributed to primary care physician through the PCCM program.

In the past year, the PCCM program has done the following to maximize the impact of MaineCare’s participation in the pilot:

- Opened PCCM enrollment to all MaineCare members except Medicare-Medicaid dual-eligible members, members with comprehensive third-party liability insurance and limited MaineCare benefits.
- Increased the monthly PCCM payment from \$2.50 to \$3.50 per member per month.

MaineCare has also built a community care management demonstration project into its contract with Schaller Anderson Medical Administrators. In this demonstration project, Schaller Anderson is working with selected Maine primary care practices and practice organizations such that those organizations have assumed certain of Schaller Anderson’s care management responsibilities of high-needs MaineCare members.

MaineCare intends to continue participating fully in the Maine Patient-Centered Medical Home (PCMH) pilot. Discussions have begun with CMS to identify possible need for a CMS Waiver or Medicaid State Plan Amendment to allow MaineCare participation in the pilot. MaineCare will use its present PCCM structure to provide financial incentives to PCMH demonstration sites, paying an enhanced monthly patient management fee and adopting practice results on PCMH measures of access, quality and efficiency as part of its PCPIP payment incentives. If extra monies are not provided in the state budgeting

process for this demonstration, MaineCare will use part of its existing PCCM budget to fund the additional fees paid to primary care practices participating in the PCMH Pilot.

We would recommend to the legislature that

1. Enhanced funding should be provided to primary care practices proportional to the burden of care of MaineCare patients on primary care practices in order to allow and incentivize those practices to make the necessary structural and process changes in order to fully adopt the primary care medical home model.
2. Funding should be proportional to the burden of caring for and managing the care of MaineCare members. In particular, funding should be proportional to the disease burden and demographics of the MaineCare population served by a primary care practice.
3. The funding be supplied to PCMH practices in the following manner:
 - 40% on a fixed, per-member basis
 - 40% on a traditional, fee-for-service basis,
 - 20% as an incentive based on comparative measures of member access, quality of care, and cost efficiency of care delivered.

Section 2. Physician fee schedule.

MaineCare has developed several scenarios that would pay hospital-based physicians on the same fee schedule as physicians in private, community practice on a basis that would be cost-neutral to MaineCare. These scenarios include the following possibilities:

1. Including all hospital-based physician services on the fee schedule,
2. Excluding physician services provided to inpatients,
3. Including hospital-based physicians in the PCMH and PCPIP systems, and
4. Setting aside \$2M to provide increased management fees and incentive payments to physicians participating in the PCMH demonstration project.

We would recommend that possibilities #1, #3, and #4 be included in the FY10-11 budget.

Sec. 3: Streamline MaineCare procedures for cost-effective prescribers.

The Department's pharmacy costs are kept in line through multiple strategies designed to provide medically necessary pharmacy services to MaineCare members in the most cost effective manner while continuing to meet the medical needs of MaineCare members. This is done primarily through the preferred drug list, prior authorization and step therapy for non preferred higher cost prescriptions, tight management of generic prescription pricing, negotiating with manufacturers for rebates for brand name drugs, as well as other strategies. Despite the need for tight control, the MaineCare program has continued to work to minimize the impact of its' pharmacy costs savings strategies on MaineCare enrolled providers and has consulted with provider associations and individual providers

for assistance in doing so. As a result many strategies have been implemented and some are still underway.

MaineCare allows exemptions for prescribers from requesting prior authorizations (PA) if they have demonstrated exemplary practice in adhering to pharmacy prior authorization guidelines.

In the past quarter, this exception was applied to 484 providers in over 500 PDL categories who were exempt from seeking prior authorization for their MaineCare members who were prescribed non preferred medications ordinarily requiring PA, for some providers in multiple categories. This exemption is further applied to maintenance drugs when changes to the PDL occur. A recent example of this practice is plavix, this drug is exempt from prior authorization based on the diagnosis of the member. Plavix does not require Prior Authorization (PA) when it is prescribed for patients who:

- have a percutaneous angioplasty procedure (PCI) scheduled, or
- have had percutaneous angioplasty (PCI) procedure in the past 12 months.

Providers are asked to write on the prescription: “PCI procedure” scheduled for (date)” or PCI procedure occurred (date)”. MaineCare will waive the PA process on a drug by drug basis for providers and have extended this strategy to other non-preferred medications as well.

In addition, when a provider prescribes a non preferred drug without seeking prior authorization, MaineCare’s response to the provider includes a list of alternative drugs in the class that are preferred and can be prescribed without the need for prior authorization. In the future, there will be an additional box added to the PA form to let us know when the prescriber requesting PA is the primary care provider (PCP). If this is the case, the exemption will be extended to the primary care provider as well as the specialist. In the same response when applicable, MaineCare provides information about any other third party payer that should be billed prior to submitting to MaineCare.

MaineCare is also focusing on other opportunities for provider education to be certain that providers are informed in advance of MaineCare requirements and that this information is easily accessible. These strategies include:

- Web based information which gives instruction on prescriptions that require PA, how to request PA, and how to navigate the preferred drug list, (PDL) available on the web.
- MaineCare staff have visited provider offices to assist with educational needs and to better understand how to minimize the impact for a provider by understanding the process in the provider’s office.
- To make it easier for providers to request PA, most PA documents on the PDL web site are Microsoft Word documents. These documents can be completed and saved to a provider’s server for future requests. Training is available through the pharmacy help desk.

Future projects include:

- a complete web based PA process, prescribers will be able to fill out the PA on line and submit instantly on line with results delivered to email
- creation of a link from the PDL to the correct PA form so that the provider does not have to access the form by choosing from the list.

Sec 4: Provide flexibility in dispensing prescribed medications.

MaineCare allows medication coverage in any strength while encouraging the use of the most cost effective dosage for the great majority of covered drugs. Not all strengths of drugs are sold at reduced pricing.

In consultation with the Maine Merchant's Association, we have learned that pharmacists are not able to change dosages without first discussing the change in dose with the provider. Any changes to this requirement would require discussions with the Board of Pharmacy.

Recommendations:

MaineCare could develop written guidance templates that physicians can share with pharmacies that indicate under what conditions they would feel comfortable with a pharmacist contacting them to suggest PDL related medication changes. There are many drugs that physicians would not object to pharmacists suggesting a preferred alternative and there are some drug categories that many physicians would never be amenable to potential substitution. MaineCare is working with the drug utilization review committee to create a master template/checklist that could indicate to pharmacists which physicians in a practice would be open to discussing potential therapeutic switches. This would reduce the number of calls by pharmacists to physicians who do not want pharmacists to change dosages while increasing the rate and speed to participating providers who are willing to do so.