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 multi-payer 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.

The legislative interest was also reflected in the 2007 – 2008 State Health Plan which calls on Dirigo Health Agency's Maine Quality Forum to establish a broad based steering group and develop and implement a multi-payer pilot program. 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 multi-stakeholder 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

The Medical Home Pilot project is a very important demonstration for the people of Maine, and the MaineCare program is an essential part of the Pilot project. In many Maine primary care practices, the percentage of insurance by MaineCare exceeds 30%. Provider, payer, and purchaser collaborators in the Pilot project universally have held that MaineCare, and through it, Maine State government are essential partners in the project.

As is detailed above, the Pilot project requires both changes in primary care medical practices and changes in reimbursement for the care delivered in those practices. Most changes in reimbursement add to the usual fee-for-service payments per-patient monthly fees and incentive payments for improved quality, patient experience of care, and cost efficiency.

MaineCare is well positioned to participate in the proposed reimbursement model for the Medical Home Pilot. For the past 10 years, MaineCare has had in place a "Primary Care Case Management" program whereby MaineCare members enroll or are 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, and
- 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 have been 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 on 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 during fiscal 2009.

In the past year, the MaineCare has improved and extended the PCCM program by:

- Opening PCCM enrollment to all MaineCare members except Medicare-Medicaid dual-eligible members, members with comprehensive third-party liability insurance and limited MaineCare benefits; and

- Increasing 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. It is expected that these practices will be well-positioned to become PCMH Pilot demonstration sites.

MaineCare intends to continue participating in the Maine Patient-Centered Medical Home (PCMH) pilot. The Centers for Medicare and Medicaid Services requires that Medicaid services be offered equally on a statewide basis unless the state obtains a Waiver from CMS. Discussions have begun with CMS to identify the possible need for such a Waiver to allow MaineCare participation in the pilot. MaineCare will use its present PCCM structure to provide financial incentives to PCMH demonstration sites, within existing resources, paying an enhanced monthly patient management fee and adopting practice results on PCMH measures of access, quality and efficiency as part of its current PCPIP payment incentives

Funding distribution to support the desired outcomes would include:

1. Enhanced funding 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. In particular, funding should be proportional to the disease burden and demographics of the MaineCare population served by a primary care practice.

3. Regular monthly payments include support for the practice changes expected of those practices, and for the extra work of providing services to MaineCare members beyond those provided at the point of care. In addition, payments should include substantial incentives for good performance on comparative measures of member access, quality of care, and cost efficiency of care delivered.

   The overall cost of MaineCare participation in the PCMH Pilot will be no more than $1,000,000 - $2,000,000 total, or $350,000 - $700,000 general fund appropriation. These costs can be met by re-structuring the current PCCM/PCIP program or through the legislatively mandated revisions to physician fees. If the legislature wishes to de-appropriate funds from hospital based outpatient physician payments to fund physician payments, DHHS anticipates enough funding to both pay non-hospital-based physicians at a 70% of Medicare level and fund the $1M - $2M total cost of PCCM.

Recommendation: The Legislature support the funding distribution noted above and determine whether to fund the pilot from restructuring PCCM or from the fees budget initiative.

Section 2: Physician fee schedule.

In LD45, Part V, the Legislature has recently adopted legislation to de-appropriate $1.947M in general funds for reimbursement of hospital-based outpatient physicians and requires that DHHS amend its rules effective February 1, 2009 to pay for hospital-based outpatient physician services by a method that approximates 70% of the Medicare fee schedule for the professional service. It further requires that DHHS amend rules effective July 1, 2009 regarding reimbursement under MaineCare for non-hospital-based physicians who are reimbursed below the rate provided to hospital-based outpatient physicians to provide reimbursement at the same percentage of the Medicare reimbursement rate as is provided to hospital-based physicians.

MaineCare has developed a fiscal impact analysis of the hospital-based outpatient physician payment change of LD45 and estimates that the funds de-appropriated from outpatient hospital-based physician services, if extended to FY10-11, would cover the required increase in reimbursement to non-hospital-based physicians for outpatient services to 70% of the Medicare fee schedule and would also cover the cost of the PCMH Pilot project. This assumes that the legislature finds an alternative to the Governor's proposed savings.

Section 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 (PDL), 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 as well as receiving technical assistance from GOHPF 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, they were exempted 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 depending 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 percuntaneous 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; and
- 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.

Section 4: Provide flexibility in dispensing prescribed medications.

Multiple strategies are used in managing the pharmacy benefit to achieve cost-savings while ensuring access to medically necessary medications. One strategy used to achieve better compliance as well as cost-effectiveness is to use "dose consolidation" that means when a particular strength of a mediation is available for once a day dosing and it essentially costs the same as twice a day dosing we recommend that a member use this medication once a day. This is not only cost effective but also increases medication compliance. The Primary Care Commission asked us to review our current policies as they relate to flexibility in dispensing

medication. MaineCare allows coverage of medications through the out patient pharmacy benefit as long as the appropriate dose and strength is listed on the prescription. We also review the prescription to it's appropriateness for "dose consolidation". This helps us achieve our program goals of good patient care and cost effectiveness.

Meetings were held at Maine Merchants association over the past year to review the implementation of our current "dose consolidation" policy. The Maine Pharmacy Board rules require that pharmacists fill the prescription as written on the prescription. Currently Pharmacists licensed under Maine Board of Pharmacy rules do not have the authority to change the dose of medication prescribed by the physician. We have reviewed the impact of this recommendation with both the Maine Board of Pharmacy, the National Association of Chain Drug Stores and the Pharmacy Group of New England. The general consensus of the group was that current MaineCare policy allows a process for cost effective prescribing and that further evaluation of flexible dispensing be coordinated through the Maine Board of Pharmacy.

Recommendations:

MaineCare will coordinate and receive guidance from the Board of Pharmacy on the implementation of recommendations of this section. If appropriate, 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. MaineCare will work with its 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.