

Patient Centered Medical Home Dirigo Health Agency's Maine Quality Forum Progress Report

January 30, 2009

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.