Patient-Centered Medical Home Advisory Council
Work Plan Outline
Adopted: January 11, 2011

1) Introduction

a) Concept of Patient-Centered Medical Home (PCMH)

The Patient-Centered Medical Home is defined as an approach to providing comprehensive primary care that facilitates partnerships between individual patients, their personal providers, and their families as appropriate. A PCMH allows for better access to health care, increased satisfaction with care, and improved health outcomes for patients and whole populations. The personal physician leads a team of professionals who collectively take responsibility for ongoing patient care at all stages: acute care, chronic care, preventive services, and end of life care.

Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the appropriate care they need at the right time and location, and in the manner that works for the patient. Evidence-based medicine and clinical decision-support tools guide decision making by the team of providers.

Providers accept accountability for continuous quality improvement through voluntary engagement in performance measurement. Practices go through a voluntary recognition process to demonstrate their capacity to provide patient-centered services consistent with the medical home model.

Patients actively participate in decision-making. Providers solicit patient feedback to ensure patient expectations are being met. Enhanced access to care is available through open scheduling, expanded hours, and use of patient-preferred communication options such as email, text messaging, or video conferencing

Payment from insurance plans appropriately recognizes the added value provided to patients who have a PCMH. In addition to payment for office visits and procedures, payment also reflects the value of care management that falls outside the face-to-face visit. It pays for services associated with the coordination of care both within the practice and between providers, specialists and community resources. Payment incentives encourage adoption of health information technology for quality improvement. It supports enhanced communication modes for contacting patients and recognizes the value of physician work associated with remote monitoring of clinical data. It allows primary care providers to share in the savings from reduced hospitalizations resulting for practice changes. A reformed framework provides additional payments for achieving measurable quality improvement.*

*Information summarized from the Patient-Centered Primary Care Collaborative at http://www.pcpcc.net/joint-principles

b) Purpose of the PCMH Advisory Council

Commissioner of Securities and Insurance, Monica Lindeen, created the PCMH Advisory Council September 9, 2011 to furnish advice on setting up a working model for a state-wide system of patient-centered medical homes in Montana. She asked the Council to gather information on other PCMH projects across the country and assess which have the most value to Montana efforts; to recommend procedures and policies for launching a pilot project in Montana; and to recommend a legal structure, governance model, and funding mechanism for an on-going program to support patient-centered medical homes.

The Advisory Council is not authorized to administer a program or set policy.

Commissioner Lindeen determined that the composition of the PCMH Advisory Council be drawn from those who had actively participated in the Montana Medical Homes Working Group over the past year. It was to include representatives of medical providers, payers, and consumers in the public and private sectors. The council is set to expire September 8, 2013 unless dissolved earlier or extended at the commissioner's request.

c) History of the PCMH effort in Montana.

In the fall of 2009,(date specific?) Montana Medicaid at the Department of Health and Human Services (DPHHS) was awarded a technical assistance grant from the National Academy for State Health Policy (NASHP). This grant established a consortium of eight states which agreed to individually and collectively work with NASHP to advance medical homes for Medicaid and CHIP program participants. This advancement was to be driven by an improvement plan focused on five core elements: 1. Developing key partnerships, 2. Defining and recognizing medical homes, 3. Improving purchasing and reimbursement policies, 4. Supporting practice change, and 5. Measuring progress.

NASHP staff facilitated a meeting in March of 2010 to address the need for a statewide, multi-payer medical home initiative with providers, major payers, provider associations, state programs, and other interested parties. The goal of the meeting was to define the medical home for Montana and begin to discuss how to collectively meet the needs of providers, payers and patients in a medical home setting. A definition was adopted.

Montana Medicaid hosted a webinar by the National Committee on Quality Assurance (NCQA) and invited the Commissioner of Securities and Insurance (CSI) office to participate. Following the webinar, the stakeholder group recommended Montana adopt the NCQA standards and recognize practices that meet a Level 1 standard along with several additional standards. The group referred to the standard as Level 1 PLUS.

Montana Medicaid hosted a visit by national payment expert, Michael Bailit of Bailit Health Purchasing. Mr. Bailit discussed payment options, anti-trust laws, other state multi-payer initiatives and recognition processes. After further discussion with NASHP staff, the stakeholders recommended they be convened by a neutral governmental entity other than Montana Medicaid. In August, CSI agreed to serve as the convener for the Montana Medical Home Initiative.

CSI convened the Working Group whose members drafted a work plan with a goal of starting a pilot medical home project. The group concluded progress on reimbursement reform could not move forward until the recognition standards were in place and anti-trust laws fully considered.

In March of 2011, the working group reconvened, the work plan was revisited and revised, the definition revisited and affirmed, the NCQA 2011 standards examined, and a webpage developed. Weekly calls continued with expert guests, discussion about other state's projects, discussion of the 2011 NCQA recognition standards and discussion on the BCBS of MT pilot project for chronic disease management. A list serve was established.

Commissioner Lindeen met with major domestic health insurance carriers to discuss the Montana Medical Home initiative and confirm their continued involvement. The recognition subgroup convened to discuss NCQA PCMH 2011 recognition standards. They recognized that the 2011 updates were more comprehensive than the 2008 standards and were inclusive of the additional standards identified in

April 2010. The subgroup recommended practices meet the 2011 level 1 standard for recognition as part of Montana's initiative.

The Working Group met with HealthShare Montana to discuss the state's Health Information Exchange and the potential use of the system as the data repository to support PCMH. The working group agreed it was important to focus on adopting a single platform statewide for medical homes. Group members participated in webinars highlighting the capacity of several systems.

Commissioner Lindeen forwarded a proposal to the Working Group to adopt the NCQA PCMH 2011 standards for recognition of medical homes. During a comment period, discussion concerned those practices that were already recognized under 2008 standards and how they would be grandfathered or transitioned into an on-going project. The group recommended revised recognition standards to the Commissioner which she adopted on July 12th, 2011

The Working Group adopted a set of measures for provider performance and outlined a process for setting goals and benchmarks for improved performance which may eventually be tied to enhanced reimbursement. The group examined a crosswalk between NCQA and Meaningful Use. The group continued evaluating technology platforms for potential use by a PCMH project.

With input from CSI legal staff, the Working Group discussed ways to avoid anti-trust violations while working on payment models for PCMH. They concluded there was much work they could do on the structure of PCMH without confronting anti-trust issues, and that legislation was likely needed to establish a state action declaring Montana's intent to displace competition for the purpose of PCMH. They decided to explore if it could be accomplished by executive authority, but also agreed to consider draft legislation to accomplish this goal.

Commissioner Lindeen formed the PCMH Advisory Council on September 9,' 2011 and held its first meeting on September 14.

d) <u>Key decisions made by working group prior to September 2011</u>

i) Definition

In Montana, a patient centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.

ii) Recognition Standards

Montana will use standards accepted by NCQA PCMH to recognize a primary care clinic as eligible for the pilot project as a medical home and potentially to receive enhanced reimbursement. Pilot sites will commit to moving along the NCQA tiered recognition process. Those recognized as Level 1 under NCQA PCMH 2008 standards must reach 2008 Level 2 or higher, or 2011 Level 1 or higher by January 1, 2013. Once anti-trust issues are resolved, progression may be encouraged with enhanced reimbursement rates based on the level of recognition achieved.

2) Steps toward recommendations to Commissioner

a) Consideration of administration of a pilot program

An advisory council cannot administer a program. CSI does not have the executive authority to administer a program not authorized by the legislature. The governor's office has declined to use its executive authority to administer a pilot program. A strictly private entity could administer a pilot program; however, without state action and on-going supervision, the program has potential to run afoul of anti-trust laws (see discussion below).

One possibility is to draft legislation for the 2013 legislative session that defines a quasi-governmental board and provides it the authority and resources to administer a pilot program. The legislation would authorize a governmental agency to provide on-going oversight. Such a program could not be operational until April 2013 at the earliest.

This Advisory Council can continue to recommend policies and procedures for a pilot program, hold discussions with practices and payers interested in joining a pilot, recommend a governing structure through legislation, recommend the framework for payment, prepare a technology platform for service, set quality metrics and performance standards, etc. The Advisory Council could provide its work to the members of a new quasi-governmental board created under the legislation. The new board should include many those on the Advisory Council for the smoothest possible transition.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she provide legal staff for the drafting of legislation for introduction in the 2013 session meeting the goals above.
- That she support the draft legislation in the legislative process
- That she continue to explore her executive authority to initiate a pilot program.
- That she commit to CSI's continued involvement on behalf of consumers throughout the PCMH process, including her potential membership on a quasi-governmental governing structure.

b) Consideration of anti-trust law

Federal and state anti-trust laws prohibit collusion between insurers on prices. The law helps maintains robust competition which benefits consumers by producing lower prices, more choices and greater innovation. In the case of PCMH, the cooperative approach contemplated by the model has the potential to run afoul of anti-trust laws.

CSI legal staff has provided information regarding anti-trust law suggesting several possible courses of action for the Council. They might be used in combination or succession.

1. The Council can promote legislation that triggers the "state action immunity doctrine." The US Supreme Court has found that legitimate state decisions to supplant competition may override federal antitrust law. The court established a two-pronged test that provides the basis for immunity: First, has the state clearly articulated and affirmatively expressed, as state policy, its

intent to displace competition? Second, has the state itself committed to actively supervise the anti-competitive conduct and its results with ongoing oversight?

2. The Council could ask a state agency to issue an executive order that creates the state action described above.

3. The Council can proceed to develop a payment schema and model contract language as long as it stops short of setting prices. The Council might ask for an Attorney General's opinion about the relationship of these documents to anti-trust laws. Activities that involve convening stakeholders, providing historic cost and quality outcomes, presenting information on innovations in health care organization and payment, educating and informing interested parties and providing technical support to test payment and delivery innovations appear to raise no antitrust problems, as long as there is no attempt to control the price in a particular geographic region or product market.

Horizontal price-fixing (including establishing minimum and maximum prices), group boycotts, bid-rigging and market-allocation agreements are considered *per se* illegal. *Per se* determinations must be avoided. "Conscious parallelism" is one anti-trust safety zone that should avoid a *per se* determination. A pattern of uniform business conduct among competitors is not, in and of itself, a violation of anti-trust laws, as long as no "meeting of the minds" occurred with regard to actual implementation and roll-out related to the setting of price or other competitively-sensitive terms. Adequate safeguards must be built in to assure there is no agreement on pricing.

Collaboration between insurers and physicians who agree to test a "medical home model" approach to physician payment that would involve basic clinical fees plus a monthly care coordination fee does not appear to violate antitrust law. The parties agree that they will share data on clinical care outcomes and transmit to a third party for analysis. The group agrees on outcomes they will monitor over time. As long as the insurers do not agree to set the fee or bonus amount, anti-trust law should not be violated. However, insurers may not agree on fees or, for instance the amount of incentive payments based on previously agreed to performance measures.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she provide legal staff for the drafting of legislation for introduction in the 2013 session meeting the goals above.
- That she support the legislation in the legislative process.
- That she continue to explore her executive authority to initiate a state action.
- That she support the Council's payment schema and model contract language and request an Attorney General's opinion about their relationship to anti-trust laws.
- That she give due consideration to CSI's ongoing role in PCMH, including potential oversight of a pilot program if granted by legislation.

c) Consideration of resources for on-going activity

The administration of a pilot program and other activities going forward will require financial resources. CSI has not been appropriated state funds or the authority to gather any funds for this purpose. It is likely that a small staff would be needed to carry out the work directed by a governing structure. In addition, mechanisms for fiscal accountability and transparency to the public would

need to be implemented. These tasks cannot be accomplished without some investment of resources.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she examine a list of options provided by the council for funding the administration of a pilot program.
- That she advance the options favored by the council through legislation or by other means.

d) Consideration of quality metrics to measure quality improvement of practices

In order to measure quality improvement of medical practices under PCMH, a comprehensive program must identify quality metrics for an agreed upon set of measures. Participating practices will be required to report on these metrics using a uniform technology platform. Benchmarks for minimum performance, a reasonable improvement percentage, and optimal performance will need to be determined. A subcommittee of the Council has been working on these issues since September and will make recommendations to the Advisory Council.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she examine the quality metrics identified by Council and recommend them to any future board, commission, or agency that may be administering a pilot project.
- That she support the Council's proposed method for setting benchmarks.

e) Consideration of attributes needed for a technology platform

A functioning PCMH pilot program will need to rely on a uniform technology platform to measure quality improvement. Because an Advisory Council cannot recommend a particular vender, but feels strongly that this is an important decision, its discussion will be summarized in a statement of "Attributes needed for a Technology Platform."

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she examine the Council's document and recommend it for consideration by any board, commission or agency charged with administering a pilot program in the future.

f) Consideration of framework for enhanced payment

Enhanced payment for practices which make a PCMH transformation according to the recognition standards, is a critical element to the success of a future program. Since September 2011, a subcommittee of the Council has been charged with developing a framework for payment that does not run afoul of anti-trust law (see discussion above.) The subcommittee will be making a recommendation to the Advisory Council.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she provide ongoing advice of legal staff on these documents and their relationship to anti-trust laws.
- That she support the Council's payment schema and model contract language and request an Attorney General's opinion about their relationship to anti-trust laws.
- That she accept the Council's documents and recommend them for consideration by any board, commission or agency charged with administering a pilot program in the future.

g) Consideration of education of providers

PCMH will not be successful in Montana without engaged leadership from providers who are educated about its benefits, successes, and challenges. Providers will need to support a complete transformation in the culture of primary care delivery, as well as specific strategies to improve quality and sustain change. They will need to collaborate with a quality improvement team at their practice and ensure that team members have the support they need to conduct PCMH activities.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she support the administration and analysis of an online survey for providers and practice managers.
- That she support a series of webinars to educate providers on basic PCMH principles.
- That she recommend to any future PCMH board, commission or agency that they continue ongoing education programs for providers.

h) Consideration of education of public

PCMH will be more successful with engagement from a hopeful and educated public willing to take additional responsibility for their care and provide feedback to PCMH practices.

Following are examples of the type of recommendations the Council may wish to consider making to the Commissioner. They are not decisions, nor are they meant to imply an endorsement or limitation on possible recommendations.

- That she support a statewide tour designed to educate the public about the basic principles of PCMH, the status of PCMH in their community, and what they can expect as patients.
- That she recommend to any future PCMH board, commission or agency that they continue with ongoing education programs for the public.

3) Timeline

a) November 2011
   i) Conduct administrator/provider survey
   ii) Make recommendation to Commissioner on the attributes of a data system
   iii) Develop new work plan
   iv) Coordinate efforts for CMS RFP

b) December 2011
   i) Summarize responses to survey
   ii) Review and adopt as recommendations to the commissioner, subcommittee work on Quality Metrics and Framework for Payment
   iii) Plan for provider education
   iv) Provide input to CSI staff to initiate legislative draft
   v) Meet with Governor on potential for executive order to create a pilot
c) January 2012
   i) Conduct provider education webinars
   ii) Make recommendation to Commissioner on Quality Metrics and process for setting benchmarks to measure quality improvement
   iii) Make recommendation to Commissioner on a framework for payment under PCMH designed to meet anti-trust concerns
   iv) Provide feedback to CSI on legislative draft
   v) Begin work with HealthShare Montana on Quality Metrics measurement
d) February 2012
   i) Continue provider education
   ii) Circulate legislative draft to interested parties
   iii) Continue work with HSM on Quality Metrics
e) March 2012
   i) Refine and re-circulate legislative proposals
   ii) Continue work with HSM on Quality Metrics
f) April 2012
   i) Make recommendation to commissioner on legislative proposals for 2013
   ii) Conduct public education tour
g) May 2012
h) June 2012
i) July 2012
j) August 2012
   i) Propose final legislation for 2013 to deal with anti-trust concerns