

## RESOLUTION 5 - 2010

Subject: Primary Medical Home for BadgerCare Enrollees  
Introduced by: Cheryl Maenpaa and the Medical Society of Milwaukee County  
Referred to: Health Insurance Coverage and Access

1 Whereas, The Wisconsin Medical Society supports the principles of a medical home including:

- 2 • Personal physician—each patient has an ongoing relationship with a personal physician trained to  
3 provide first contact, continuous and comprehensive care.
- 4 • Physician directed medical practice – the personal physician leads a team of individuals at the  
5 practice level who collectively take responsibility for ongoing care of patients.
- 6 • Whole person orientation – the personal physician is responsible for providing for all the patient’s  
7 health care needs or taking responsibility for appropriately arranging care with other qualified  
8 professionals. This includes care for all stages of life; acute care; chronic care; preventive  
9 services; and end-of-life care.
- 10 • Care is coordinated and/or integrated across all elements of the complex health care system (e.g.,  
11 subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community  
12 (e.g., family, public and private community-based services). Care is facilitated by registries,  
13 information technology, health information exchange and other means to assure that patients get  
14 the indicated care when and where they need and want it in a culturally and linguistically  
15 appropriate manner.
- 16 • Quality and safety are hallmarks of the medical home.
- 17 • Enhanced access to care is available through systems such as open scheduling, expanded hours  
18 and new options for communication between patients, their personal physician, and practice staff.
- 19 • Payment appropriately recognizes the added value provided to patients who have a patient-  
20 centered medical home; and

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22 Whereas, The State of Wisconsin has expanded healthcare coverage through the expansion of the  
23 BadgerCare entitlement program resulting in a reduction of uninsured Wisconsin residents to  
24 approximately 2%; and

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26 Whereas, The BadgerCare program has a number of managed care organizations (MCO) contracting  
27 for the access and care of enrollees; and

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29 Whereas, A responsibility of the managed care organization is to assign all enrollees to a primary  
30 medical home to insure the optimal management of the patients care and to reduce healthcare costs  
31 while improving community health; and

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33 Whereas, A very high number (30-40%) of SE Wisconsin BadgerCare Enrollees are not able to be  
34 contacted by the (MCO) and are generally unaware of or unable to access a primary medical home  
35 resulting in delayed obstetrical care, increased emergency department utilization, increased  
36 hospitalizations for acute and chronic illness; and

37  
38 Whereas, The overall quality of care for the BadgerCare population, as measured by the State  
39 Department of Health Services is significantly lower in SE Wisconsin in comparison with other  
40 regions of the State of Wisconsin; therefore be it

41 RESOLVED, That the Wisconsin Medical Society, in conjunction with the State Department of  
42 Health Services, develop measures to be monitored quarterly to assure that ALL BadgerCare

43 enrollees have a primary medical home at point of portal, that the medical home meets the principles  
44 adopted by the Society and that a primary medical home presented as part of an MCO network as  
45 open to new patients be frequently monitored with the goal of access.  
46

Fiscal note: State Department of Health Services unlikely to fund due to budget considerations.  
\$100,000 or greater depending upon Society staff expertise and IT resources needed.

## Relevant Policies

### Society:

#### MER-012

**Regional Information Sharing of Medical Records:** The Wisconsin Medical Society supports the development of the Milwaukee Regional Informatics System through the WHA/MCMS Community Collaboration with the Wisconsin Hospital Association and WHIE.

The Wisconsin Medical Society supports the development of medical homes and plans of care for at-risk populations that benefit the patient, are consistent across competing health system platforms, have means of being updated, have means of being challenged by patients, reviewed by ethics committees, coordinated with health care providers, managed care organizations, governmental payors, advocacy groups and experts in specialty providers (psychiatry, emergency medicine, pain management, etc).

The Wisconsin Medical Society supports the research and methodology by which such care plans can be shown to improve patient outcomes and save valuable and scarce health care resources.

The Wisconsin Medical Society supports the collaboration between emerging methods of health information sharing into a common method such that multiple disparate means are reduced to effective sources of useful information. (Example: rare diseases protocols for pediatrics may be merged in a common web based access point with plans of care for mental health patients who are homeless and being managed by case managers, or dialysis patients, or patients with pain clinic contracts.) (HOD, 0407)

#### MRC-038

**Medicaid Cost Control:** The Wisconsin Medical Society supports the following in efforts to control the costs in Medicaid:

- Consider first the costs reduction opportunities in the long-term care arena, through such mechanisms as tax-incentives for Wisconsin residents to purchase private long-term care insurance, and further pursuit of community-based alternatives to institutional care, while assuring equal access to appropriate palliative care.
- Expand use of preferred drug lists and supplemental rebate programs.
- Use principles of pharmacy benefits management to leverage purchasing power and industry best practices where data indicate potential to decrease administrative burden and product cost.
- Consider restructuring the BadgerCare benefit package to offer benefits that more resemble a commercial plan, while retaining barrier-free access to preventive and primary care services.
- Increase opportunities for BadgerCare families to purchase commercial insurance.
- Explore further use of medically-defined, evidenced-based disease management programs for Medicaid fee-for-service patients with diabetes, congestive heart failure, asthma and end-stage renal disease/chronic kidney disease, and reward appropriate use of such programs in managed care programs. (HOD, 0407)

#### REQ-007

**Patient-Centered Medical Home:** The Wisconsin Medical Society supports the Joint Principles of the Patient-Centered Medical Home developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association as guidelines for Wisconsin and all states to improve the health of its citizens.

The Wisconsin Medical Society encourages Wisconsin to implement and fund pilot programs to demonstrate the quality, safety, value, payment mechanisms and effectiveness of the patient-centered medical home.

The Wisconsin Medical Society will put forward a resolution to the American Medical Association in support of the Joint Principles of the Patient-Centered Medical Home and to encourage national payors to implement and fund pilot programs to demonstrate the quality safety, value, payment mechanisms and effectiveness of the patient-centered medical home.

#### Principles (2/07)

*Personal physician* - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. *Physician directed medical practice* – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

*Whole person orientation* – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

*Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community based services).

Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

*Quality and safety* are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

*Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

*Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits.

(Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

- It should allow for additional payments for achieving measurable and continuous quality improvements. (HOD, 0408)

**AMA:**

**H-160.919 Principles of the Patient-Centered Medical Home**

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: Principles Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement. It should support provision of enhanced communication access such as secure e-mail and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements. 2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care. 3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home. (Res. 804, I-08; CMS Rep. 8, A-09)