GMCB Primary Care Advisory Group

VERMONT
GREEN MOUNTAIN CARE BOARD

Wednesday, December 14, 2016

PCAG Member Attendees	Ellen Watson, Leo Kline, Valery Rooney, Ben Clements, Rob Penney, Tim Tanner, Mark Peluso, Fay Homan, Christina Harlow, Kate McIntosh, Alan Ramsay, Paul Reiss, Sharon Fine, Bob Schwartz
GMCB Attendees	Susan Barrett, Pat Jones, Michele Lawrence

1. Welcome: GMCB updates & Review of PCAG duties per Act 113 Section 10
    a. Recent updates – Al Gobeille will be leaving to be Secretary of Administration.
    b. Susan reviews nominating process. Fay Homan wants to articulate that there be a primary care physician on the board. Interest in private practice experience.
    c. Action items
        i. PCAG to draft letter re: physician nomination to the Board
        ii. GMCB to provide PCAG with information about who to contact on Gov. Scott's transition team

2. Prior Authorization Presentation and Discussion
    a. Background: Dr. Ramsay – 2013 Health Care Reform included language that insurers would work with GMCB to reduce prior authorization burden. GMCB convened and provided staffing; included consumer and physician representation, DFR, VMS as well as insurers (Cigna was invited but did not participate). In total, 19-23 people met 19 times, starting in 2013. Informational to start; insurers said that changes would increase premiums. Lots of resistance to doing anything. Dr. Ramsay said that they would report to the legislature that they got nowhere. Drug pilot ended in May 2016, MRI Pilot in July 2016. Overall impact on clinicians was small because the scope of the pilot was small.
    b. Drug Pilot: Question about whether to focus on high-volume and low-cost procedures, or low-volume and high-cost procedures. Then they focused on drugs (PPIs [Nexium-type] and Statins) and high-end imaging. Tried to include inhalers, but Medicaid drug rebate program precluded that (hard to find any pediatric classes of drugs).
        i. Q: Dr. Homan – was ED excluded since they don't get prior authorization?
        A: Yes. Results showed that PPI costs didn't go up for commercials, but went up for Medicaid because no cost-sharing incentive for Medicaid to prescribe generics.
        ii. General Comments: Dr. McIntosh: putting responsibility for cost on provider vs. payer, but insurers will not give it up easily. Also seems like we are prescribing generics. A 1% drop in generic Rx can be a lot of money. Dr. Schwartz: need better point of care information.
    c. Attorney General's report (first in the country) is an indictment of how we price drugs. Brian Murphy from BCBSVT tried to share information. Big frustration is that providers don't know which drugs are covered.

d. Advanced Imaging (MRI) Pilot: Eliminated prior authorization for independent physicians, used FQHCs and Hospital-owned for control group. For imaging went with Porter (low volume) and Rutland (high volume) for MRI for low back pain. Rutland developed an electronic mechanism for this. Sort of did their own self-prior authorization.
    i. General Comments: Most MRIs meet criteria – doesn't seem like MRIs for low back pain are being over-utilized. Insures came around, even though it involved changing their own systems. Insurers think prior authorization saves dollars, that they have worked to reduce burden. They don't understand the impact of multiple payers having different systems.
    ii. Q: Paul Reiss: physicians are unreimbursed for essentially managing their formularies – can legislature require insurers to pay physicians for doing prior authorization. Create CPT code for prior authorization? Dr. Reiss notes that CHP got rid of referrals because they weren't cost-effective. Common formulary?
    A: Christina said she spent an entire visit on this earlier in the week. Alan talked about impact on premiums and administrative costs. Admin costs include salaries, care and case management (latter probably more necessary than the former), and utilization management.
    iii. Q: Dr. Homan asks again about legislative action.
    A: Paul Reiss indicates that VCO has negotiated reduction in imaging prior authorization with VHA as part of new Medicaid SSP starting in 2017.

    Dr. Ramsay suggests working closely with VCO. VCO will be subject to certification and rule from GMCB. Input would be helpful; opportunity for participation in governance and public portion of ACO meetings.

    Dr. Reiss said that it is unpaid work and a big hassle. The people to do the work should be the ones who benefit (e.g., radiologists, pharmacists, insurers, etc.). Why are primary care providers in the middle? Underutilizing skills of pharmacists and others. Don't necessarily get info from providers. Can this be pushed off on insurers or PBMs? Lots of consolidation in PBMs.

    Dr. Peluso – lack of transparency from insurers and PBMs. Changes are challenging. Physicians don't have contracts with PBMs. What are solutions?

    Dr. Tanner – what about a common PA process? Common formulary didn't fly, even though BCBSVT seemed interested. Even though drugs aren't part of the APM, this is about reducing burden on primary care.

    Dr. McIntosh – can primary care providers get buy-in to self-regulate, and do they have the tools to self-regulate? Want to make primary care more

attractive. Can EHRs provide information on tiering or pricing? BCBSVT thinks e-prescribing with real-time information would be the answer. Sounds like one BCBSVT plan in the country might have tried to do that. All payers need to participate.

Dr. Homan – should they try for uniform formulary, no prior auth requirements for primary care? Impact on patients? Patient responsibility?

e. Action items

i. Create subcommittee to develop next steps

3. Act 112: An Act Relating to Cataloguing & Aligning Health Care Performance Measures Presentation and Discussion
    a. Several comments from the group. Feedback included: challenges and questions regarding coding for payment, clicking boxes, coding accurately for risk adjustment purposes, whether participation in AAPM exempts providers from non-quality MIPS and MACRA requirements, eliminating NCQA PCMH recognition from Blueprint requirements.
    b. Action items
        i. Pat will draft paragraph reflecting PCAG feedback for addition to the report, and send it out for review.
        ii. Pat will check with CMS about whether participation in AAPM exempts providers from non-quality MIPS and MACRA requirements.