Transitioning to
Patient-Centered Primary Care ...
in the
Managed Care Medicaid Model
(and beyond)

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The Collaborative: What We Do

Our Vision
• The achievement of an effective and efficient US health system built on a strong foundation of primary care and the patient-centered medical home (PCMH)

Our Mission
• To be a key driver of the growing national primary care movement by:
  – Convening diverse health care stakeholders to promote learning, awareness, and innovation
  – Disseminating results and outcomes from advanced primary care and PCMH initiatives
  – Educating stakeholders and strengthening public and private sector policies that improve the US health system for patients, providers, and payers
Overall Goal: *Health System* Transformation

- **Delivery Reform**
- **Payment Reform & Benefit Redesign**
- **Trained Health Work Force**

Public Engagement

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**How? Through Collective Action**

PCPCC’s goals achieved through its 5 Stakeholder Centers

- **Advocacy and Public Policy**: Drives health system reform that incorporates key features of PCMH
- **Care Delivery and Integration**: Encourages widespread transformation & development of medical neighborhoods
- **Employers & Purchasers**: Engages employers in redesigning health benefits to promote primary care
- **Outcomes & Evaluation**: Builds awareness on value of primary care & PCMH using quality and cost evidence
- **Patients, Families & Consumers**: Assures patients and families are active partners in improving primary care delivery
Our Goal: Unify Diverse Perspectives

Public:
Patients, Families, Caregivers, Consumers

Payers:
Employees, Employers, Health plans, Government, Policymakers

PCPCC

Providers: Primary care team, specialists, community orgs

What does alignment across interests look like?

Building Blocks:
Trajectory to Value-Based Purchasing

HIT Infrastructure:
EHRs and population health management tools

Primary Care Capacity:
PCMH or advanced primary care

Care Coordination:
Coordination of care across medical neighborhood & community supports for patient, families, & caregivers

Value/Outcome Measurement:
Reporting of quality, utilization and patient engagement & population health measures

Value-Based Purchasing:
Reimbursement tied to performance on value

Alternative Payment Models (APMs): ACOs, PCMH, & other value-based arrangements

THINC - Taconic Health Information Network and Community.
PCMH as Part of Larger Whole

Patient-Centered Medical Home

Community Centers
Public Health
Schools
Employers
Faith-Based Organizations
Community Organizations

Health IT

Home Health
Hospital
Oral Health
Pharmacy
Specialty & Subspecialty
Skilled Nursing Facility
Mental Health

Health Care Delivery Organizations

Painting the Vision: Need for New Paradigm

Current Health Care System
- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial
- "Everyone For Themselves"

Future with PCMH Implementation
- Managing Populations
- Collaborative Care
- Primary Care Driven
- Integrated eHealth Records
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative
- Joint Contracting

Future with PCMH Implementation
- Managing Populations
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Defining the Patient-Centered Medical Home

The medical home is an approach to primary care that is:

- **Person-Centered**: Supports patients and families in managing decisions and care plans.
- **Comprehensive**: Whole person care provided by a team.
- **Coordinated**: Care is organized across the "medical neighborhood".
- **Accessible**: Care is delivered with short waiting times, 24/7 access and extended in-person hours.
- **Committed to Quality and Safety**: Maximizes use of health IT, decision support and other tools.

IT = information technology.
www.ahrq.gov.

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PCMH as a “certification”

- External validation (the test!)
- "Short term" view of model
- Focused more on process measures
- Role in practice transformation & increased reimbursement
- Role in assessing value by payers

PCMH as ideal primary care

- "North star" – aspirational goal of true transformation
- "Long term" view of model
- Focused more on outcomes
- What’s most important to patients, families, caregivers & consumers?
Figure 5

Comprehensive Medicaid Managed Care Models in the States, 2014

As of July 1, 2014

- MCO only (26 states including DC)
- MCO and PCCM (13 states)
- PCCM only (9 states)
- No Comprehensive MMC (3 states)

NOTES: ID’s WMCP program, which is secondary to Medicare, has been re-categorized by CMS from a PAHIP to an MCO by CMS but is not counted here as such. CA has a small PCCM program operating in LA county for those with HIV.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Figure 6

Managed Care Expansions and Quality Initiatives, FYs 2014 and 2015

Actions to Expand Managed Care

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<th>Category</th>
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Policy Changes in Either Year

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</tbody>
</table>

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.
Outcomes of Advanced Primary Care

- Cost Savings
- Fewer ED/Hospital Visits
- Improved Access
- Increased Preventive Services
- Improved Health
- Improved Patient & Clinician Satisfaction

ED = emergency department.
Mapping Primary Care Innovations

CASE STUDY:
Anthem’s Enhanced Personalized Healthcare Program Delivers Cost of Care Savings

Anthem Year 1 Results

$9.51
PaPMPM GROSS SAVINGS OVER THE FIRST YEAR (3.3%)

$6.62
NET SAVINGS

7.8% fewer acute inpatient admits per 1,000

5.1% PMPM decrease in outpatient surgery costs

5.7% fewer inpatient days per 1,000

7.4% decrease in acute admissions for high risk patients, and an increase of 22.9 per 1,000 PCP visits for high risk patients

3.5% PMPM decrease in ER visit costs and a 1.6% decrease in ER utilization

Results from Anthem’s EPHC Program year 1
PCPCC’s Strategic Priorities 2015-2018

1. Promote increased primary care investment
2. Promote clinical transformation and integration with the medical neighborhood & communities
3. Promote patient, consumer, employee, & employer engagement
4. Support an interprofessional team-based health workforce

Priority 1: Increased Investment in Primary Care

Reduce/control total cost of health care by increasing resources allocated to primary care

Shift from fee-for-service models to value-based / comprehensive primary care payments

Incentivize practices to focus on improving patient experience of care and population health outcomes
Current Primary Care Investment

- Primary Care: 4%
- Drugs: 17%
- Professional procedures (non-hospital): 30%
- Hospital inpatient: 21%
- Hospital outpatient visits/other: 28%

U.S. per-capita health spending, 2012 (under 65 with employer-sponsored health insurance)

How PCPCC Plans to Promote Investments in Primary Care

- Push for **payment reform**: Value over Volume
- **Define primary care** for provider payments
- Develop a primary care **investment measure/indicator**
- Develop common outreach themes to **engage the public**
- Encourage employers to invest in & incentivize **value-based purchasing** that supports primary care
Priority 2: Clinical Transformation and Integration into Medical Neighborhoods & Communities

1. Promote a shared definition of advanced primary care and the PCMH
2. Define how to integrate PCMH functions within medical neighborhood, ACOs, and communities – both inside and outside of primary care practices
3. Develop new resources, tools, and supports to help clinicians and communities transform into high-performing, integrated systems of care

How Can We Support Integration into the Medical Neighborhood?

- Convene experts to improve PCMH standards & accreditation programs = administrative simplification + patient-centered measures
- Identify **key features of high performing** PCMHs and ACOs
- **Integrate population health** into primary care (behavioral & oral health, HIT infrastructure, medication management, etc.)
- Define & promote **clinic-to-community linkages**
Promoting Clinical Transformation & Integration

- Community Centers
- Public Health
- Schools
- Employers
- Faith-Based Organizations

Patient-Centered Medical Home

Community Organizations

Health IT

Health Care Delivery Organizations

Priority 3: Increased Engagement of Patients, Consumers, Employees & Employers

- Engaging and educating consumers and employees in their own communities – where they live, work, and play
- Patients and families/caregivers working alongside clinicians and staff as partners in improving primary care practices
- Providing employers and employees with tools/resources to help them to understand the value of advanced primary care models
How do Families and Caregivers fit in?

Establish core components of recognized training to ensure the care team recognizes contributions of a "family partner"

1) Emotional support
2) Ability to discern where a patient or family member might be in the emotional process
3) Ability to walk with the patient/family through seasons of life or stages of the disease process
4) Community resource awareness
5) Family planning, goal setting
6) Healthy communication strategies that allow us to both hear and be heard
7) Support in other family relationships

Priority 4: Developing an Interprofessional Health Workforce to Support the PCMH

Include patients and families as members of the care team & faculty of training programs
Build trusted teams to address comprehensive needs of populations
Train current & future health workers on interprofessional team-based care competencies that address health disparities in primary care
Preparationg a Health Work Force for Team-Based Primary Care

- Define & promote effective team-based interprofessional care
- Develop a national strategy of IPE training – one that includes patients & families
- Integrate peer support into primary care and communities
- Allocate funding for primary care clinician training

PCPCC’s Report on Interprofessional Training
Collaborators Across the Health Professions

Team-Based Primary Care Training Competencies
Developed in 2011 by PCPCC’s Education & Training Task Force

Patient-Centered Care Competencies
- Advocacy for patient-centered integrated care
- Cultural sensitivity & competence in culturally appropriate practice
- Development of effective, caring relationships with patients
- Patient-centered care planning, including collaborative decision-making & patient self-management

Comprehensive Care Competencies
- Assessment of biopsychosocial needs across the lifespan
- Population-based approaches to health care delivery
- Risk identification

Accessible Care Competencies
- Promotion of appropriate access to care (e.g., group appointments, open scheduling)

Coordinated Care Competencies
- Care coordination for comprehensive care of patient & family in the community
- Health information technology, including e-communications with patients & other providers
- Intersprofessionalism & interdisciplinary team collaboration
- Team leadership

Care Quality & Safety Competencies
- Assessment of patient outcomes
- Business models for patient-centered integrated care
- Evidence-based practice
- Quality improvement methods, including assessment of patient-experience for use in practice-based improvement efforts
Opportunities in Nevada

- UNLV – Building a medical school with end game in mind (IPE!)
- Medicaid expansion, impressive state leadership, SIM grant opportunities
- Community engagement – ex. Las Vegas HEALS
- Employer engagement – ex. MGM
- MULTI-PAYER INITIATIVE!

Q & A: How can we help?

If your organization is dedicated to transforming health care to deliver more patient-centered, compassionate and accessible primary care...

Become an Executive Member,
Attend our Annual Conference,
Partner on the Western PCPCC Meeting!

Visit our website for more details:

[www.pcpcc.org](http://www.pcpcc.org)