Supporting Effective Team-Based Primary Care through Medicaid Managed Care

April 15, 2021, 1:00-2:00 pm ET

Part of CHCS’ Strengthening Primary Care through Medicaid Managed Care learning series.

Made possible through support from The Commonwealth Fund.
To submit a question online, please click the Q&A icon located at the bottom of the screen.
Today’s Learning Objectives

- An introduction to the *Strengthening Primary Care through Medicaid Managed Care* webinar series.
- Learn how states can support and incentivize team-based care through managed care contracting levers, particularly in a way that advances long-term state goals.
- Understand the importance of team-based care at the provider level, and what value it offers to patients and states.
Agenda

- Welcome and Introductions
- Opening Comments from Melinda Abrams
- An Introduction to the *Strengthening Primary Care through Medicaid Managed Care* series
- An Overview of Oregon’s Patient-Centered Primary Care Home Program
- Articulating the Value of Team-Based Care from a Provider Perspective
- Moderated Q&A
- Wrap Up and Next Steps
Welcome & Introductions
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Today’s Presenters

Rob Houston, MBA, MPP
Director, Delivery System and Payment Reform
Center for Health Care Strategies

Melinda K. Abrams, MS
Executive Vice President for Programs
The Commonwealth Fund

Neelam Gupta, MPH, MSW
Director, Clinical Supports, Innovation, and Workforce Unit
Oregon Health Authority

Courtney Pladsen, DNP, FNP-BC
Clinical Director
National Health Care for the Homeless Council

Matthew Ralls, MPH
Program Officer
Center for Health Care Strategies
Opening Comments

Melinda Abrams, Executive Vice President for Programs
The Commonwealth Fund
This webinar is first in a series, *Strengthening Primary Care through Medicaid Managed Care*. The series, made possible by The Commonwealth Fund, will examine the tools and levers that states can use to advance comprehensive primary care strategies. Future topics include:

» Achieving health equity  
» Identifying and addressing social needs  
» Integrating behavioral health care  
» Using technology to improve primary care access  
» Exploring state approaches to patient-centered medical homes  
» Monitoring primary care spending and investment  
» Encouraging MCO accountability for primary care goals  
» Advancing value-based payment in primary care

Be on the lookout for upcoming webinars and new resources.
Core Features of Advanced Primary Care and Levers to Drive Uptake and Spread

- Promote Accountability for MCOs
- Move to Value-Based Payment in Primary Care
- Monitor Primary Care Spending and Investment

Enhance Team-Based Care
Engage Communities and Achieve Health Equity
Identify and Address Social Needs
Integrate Behavioral Health Care
Use Technology to Improve Access
Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States

For implementation considerations, state examples, and sample managed care contract language, access the toolkit at: www.chcs.org/primary-care-innovation.
Team-based care is an essential building block for state Medicaid agencies to advance high-quality, equitable primary care.

Team-based care places the patient and their unique needs at the center for care planning and delivery.

These models often focus on employing staff with diverse expertise and backgrounds.

In addition to clinical staff, primary care practices often incorporate community health workers into care teams to support functions such as patient education, care management and coordination, and resource navigation.
Oregon’s Patient-Centered Primary Care Home Program

Neelam Gupta
Director of Clinical Supports, Integration, and Workforce Unit

April 15, 2021
Oregon’s Patient-Centered Primary Care Home (PCPCH) Program

- Established in 2009 by the Oregon Legislature to support the Triple Aim
- PCPCH standards are developed by Oregon Health Authority (OHA) in partnership with a multi-stakeholder Standards Advisory Committee (SAC)
- Primary care practices apply to become a PCPCH by attesting to meeting the standards of how they provide care to their patients
PCPCH Practices in Oregon

Close to 650 recognized PCPCH clinics (Approximately 75% of all Oregonians receive care at a PCPCH site)
Oregon’s PCPCH Model

- Participation is voluntary and attestation-based
- Six core attributes, each with specific standards and measures
- 11 “Must-Pass” measures all clinics must meet
- Five tiers of recognition based on which measures a clinic meets
### Six Core Attributes of PCPCHs

**ACCESS TO CARE**

“Health care team, be there when we need you.”

**ACCOUNTABILITY**

“Take responsibility for making sure we receive the best possible health care.”

**COMPREHENSIVE WHOLE PERSON CARE**

“Provide or help us get the health care, information, and services we need.”

**CONTINUITY**

“Be our partner over time in caring for us.”

**COORDINATION AND INTEGRATION**

“Help us navigate the health care system to get the care we need in a safe and timely way.”

**PERSON AND FAMILY CENTERED CARE**

“Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”
Which Practices Can Become a PCPCH Program?

- Any type of health care practice that provides comprehensive primary care services is eligible to apply for PCPCH recognition.
  - Family practice, internal medicine, naturopathic clinics, school-based health centers, tribal health clinics, behavioral health clinics with integrated primary care, FQHCs, rural health clinics, etc.
- Practices must be operational for 12 months before applying for recognition.
- Practices do not have to be based in Oregon but do have to see patients who live in Oregon.
  - There are PCPCHs in the border communities in Washington, Idaho, and California.
PCPCHs and Team-Based Care

PCPCH practices operate different care delivery models. Some examples of team-based care models include:

• **Pediatric practice focused on meeting the needs of the whole child** that supports children and families partnering with health care provider, other team members, and outside organizations to identify, coordinate, and address shared goals.

• **Practice with an integrated, on-site behavioral health clinician delivering comprehensive services:** warm hand-offs, brief assessments and interventions, consultations to primary care clinicians and other care team members, and collaborative treatment planning.

• **Practice that supports patients and families/caregivers with health-related social needs screening, identification, and community resource referrals and follow up,** with role held by a Community Health Worker, Patient Navigator, Care Coordinator, or other staff.
New PCPCH Standards

The 2020 PCPCH Recognition Criteria Technical Specifications and Reporting Guide describes in detail the program requirements and specifications for each measure in the PCPCH model.

Oregon’s Coordinated Care Organization (CCO) Model for Medicaid Managed Care

- **Community governed organizations** that bring together physical, behavioral, and dental health providers to coordinate care.

- Receive **fixed monthly budget** from the state to coordinate care for patients.

- Receive **financial incentives** for improving outcomes and quality.

- Have **flexibility** to address their members’ health needs outside traditional medical services.

- This model is designed to **improve member care** and reduce taxpayer costs.
CCOs and Primary Care

• CCOs are required to use PCPCHs for primary care to the greatest extent possible.
• Approximately 96% of CCO members receive care through a recognized PCPCH practice.
• Member enrollment in a PCPCH was a CCO Incentive Measure, which are quality metrics used to show how well CCOs are improving equity and team-based care, reducing health care costs, and eliminating health disparities. In 2019, this measure was removed partially due to CCO success in meeting the benchmark.
PCPCHs Demonstrate Return on Investment

Return on Investment

• PCPCH program implementation has resulted in $240 million in savings to Oregon’s health system between 2012 and 2014.

• For every $1 increase in primary care expenditures related to the PCPCH program, there is a $13 in savings in other services, such as specialty care, emergency department and inpatient care.

The whole is greater than the sum

• Cumulative effect of the PCPCH attributes has more impact on cost and utilization than any independent effects of the attributes.

Primary Care Payment

*Primary Care Spending in Oregon* report

- Annual report to the legislature on primary care spending by health plans and CCOs

Primary Care Payment Reform Collaborative

- Over 40 member organizations have been convening since 2016 to increase the investment in primary care, align reimbursement by purchasers of care, and move to value-based payments

CCOs and Value-Based Payment

- CCOs required to provide a per-member-per-month (PMPM) payment to PCPCHs based on tier level
PCPCHs and Health Equity

OHA has a 10-year goal of eliminating health inequities.

• COVID-19 highlighted that the primary care system does not meet the needs of all people living in Oregon, especially those who experience inequities because they cannot access linguistically, culturally appropriate care or do not engage in care.

• OHA has initiated a process to ensure the PCPCH program supports a primary care system that comprehensively addresses community-identified needs and provides patient-centered, team-based care.

• This process will inform changes to the PCPCH Standards to confirm primary care practices are providing care that aligns with the PCPCH core attributes, improves equity and team-care, and supports OHA’s 10-year goal.
Contact Information

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Articulating the Value of Team-Based Care from a Provider Perspective

April 15, 2021

Courtney Pladsen, DNP, FNP-BC
Director of Clinical and Quality Improvement
This is an Equity Issue

1. To improve racial inequities in health outcomes we must integrate screening and addressing SDOH into primary care.

2. If health care teams are not aware of the barriers to care, treatment plans are rendered ineffective.

3. DEI has gained a great deal of attention, and team based care can provide an avenue for action.
Jails, ERs, and Shelters are the most expensive types of “housing” we have

Inpatient stays are twice as long for PEH compared to the general population

PEH do NOT commit more crimes compared to the general population, but there has been a persistent trend of the criminalization of homelessness
Case Study

• 36 y/o M with history of Chronic Lymphocytic Leukemia, Bipolar Disorder, Opiate Use Disorder

• Has had prolonged psychiatric hospital admissions

• Has had a total of 12 years of incarceration

• In the past year has been intubated and in the ICU three times

• Sleeps either outdoors or in the emergency shelter
The most common risks/barriers included:

- Limited English Proficiency
- Less than high school education
- Lack of insurance
- High stress
- Unemployment
Enabling Services Promising Practices

- Housing
- Transportation
- Food Access
- Respite
Respite/Recuperative Care

Medical respite care is acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover on the street or in a shelter, but are not ill enough to need hospital-level care.

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https://www.uhccommunityandstate.com/articles/financing-approaches-for-medical-respite-care.html
Estimating Cost Reductions Associated with the Community Support Program for People Experiencing Homelessness.

- Community-based support services for chronically homeless individuals in addition to separately funded housing
- Health care costs decreased by an average of $226pp in month 1, and persisted at month 24 with $765pp
- Significant reductions in inpatient and outpatient behavioral and medical costs
FIGURE 2. AVERAGE MONTHLY PER-PERSON HEALTH CARE COSTS, PRE-/POST-CSPECH ENTRY (BY SERVICE TYPE)
Food Access

THE FVRx PROCESS

1. Patients are enrolled by a health provider as a FVRx participant.

2. Participants attend a FVRx clinical visit to set goals and discuss nutrition and the importance of healthy eating.

3. Participants receive a FVRx prescription during the visit and health indicators are collected.

4. Prescriptions are redeemed for fresh fruits and vegetables at participating retailer, where redemption is tracked.

5. Participants attend monthly clinic visits to refill their FVRx prescription and set new goals for healthy eating.
Food Access

Research Findings

• Over a lifetime, the F&V incentive would prevent 1.93 million cardiovascular disease events and 0.35 million CVD deaths and save $40 billion in healthcare costs. The healthy food incentive would prevent 3.28 million CVD cases, 0.62 million CVD deaths, and 0.12 million diabetes cases and save $100 billion in healthcare costs.
• Both programs were highly cost-effective from a healthcare perspective—with lifetime incremental cost-effectiveness ratios (ICERs) of $18,184 per quality-adjusted life year (QALY) for the F&V incentive and $13,194/QALY for the healthy food incentive—and from a societal perspective (ICER: $14,576/QALY and $9,497/QALY, respectively).
• Results were consistent across subgroups within each insurance group including by age, race/ethnicity, education, income, and participation status in the Supplemental Nutrition Assistance Program (SNAP).

Implications

• Implementing healthy food prescriptions within large government healthcare programs to promote healthier eating could generate substantial health gains and be highly cost-effective.
• Our findings support the implementation and evaluation of such programs within private and public healthcare systems.
• In the US, a new $25 million Produce Prescription Program was just passed in the 2018 Farm Bill, which will provide funding support for such pilot projects over the next 5 years.
There is moderate evidence that providing non-emergency medical transportation (NEMT) to low-income people, those with certain chronic conditions, or dually eligible enrollees can increase the receipt of outpatient, preventive care; prevent expensive forms of care; and produce an ROI.

States may require their managed care plan partners to provide NEMT for eligible beneficiaries. Under this model, states usually provide managed care organizations (MCOs) a capitated per member payment to cover the benefit, and MCOs (in accordance with their state managed care contract guidelines) arrange for NEMT services, including through purchased services and contracts with taxis, public buses, and private vehicles.
Question & Answer
Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
Wrap Up and Next Steps
Wrap Up and Next Steps

- Visit CHCS.org to access:
  - The team-based care module in our *Advancing Primary Care Innovation in Medicaid Managed Care* toolkit
  - A companion blog post to this webinar, *State Strategies to Promote Team-Based Primary Care Through Medicaid Managed Care*

- Look for upcoming webinars in the series:
  - Next topic: Advancing value-based payment in primary care - May 20th, 2021
    - Registration details forthcoming

- Please complete the evaluation at the conclusion of this webinar
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