



Oregon Health Authority Patient-Centered Primary Care Home Program Updates

April 2013



Presentation Objectives

- Provide a brief program overview including accomplishments to date, and verification process and model refinement updates
- Outline available technical assistance and other resources
- Describe how PCPCHs fit into health system transformation and CCOs
- Discuss PCPCH payment opportunities

Program Overview

PATIENT  **CENTERED**
PRIMARY CARE HOME PROGRAM

Oregon
Health
Authority

Patient-Centered Primary Care Home Program

HB 2009 established the PCPCH Program:

Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

Key PCPCH Program Functions:

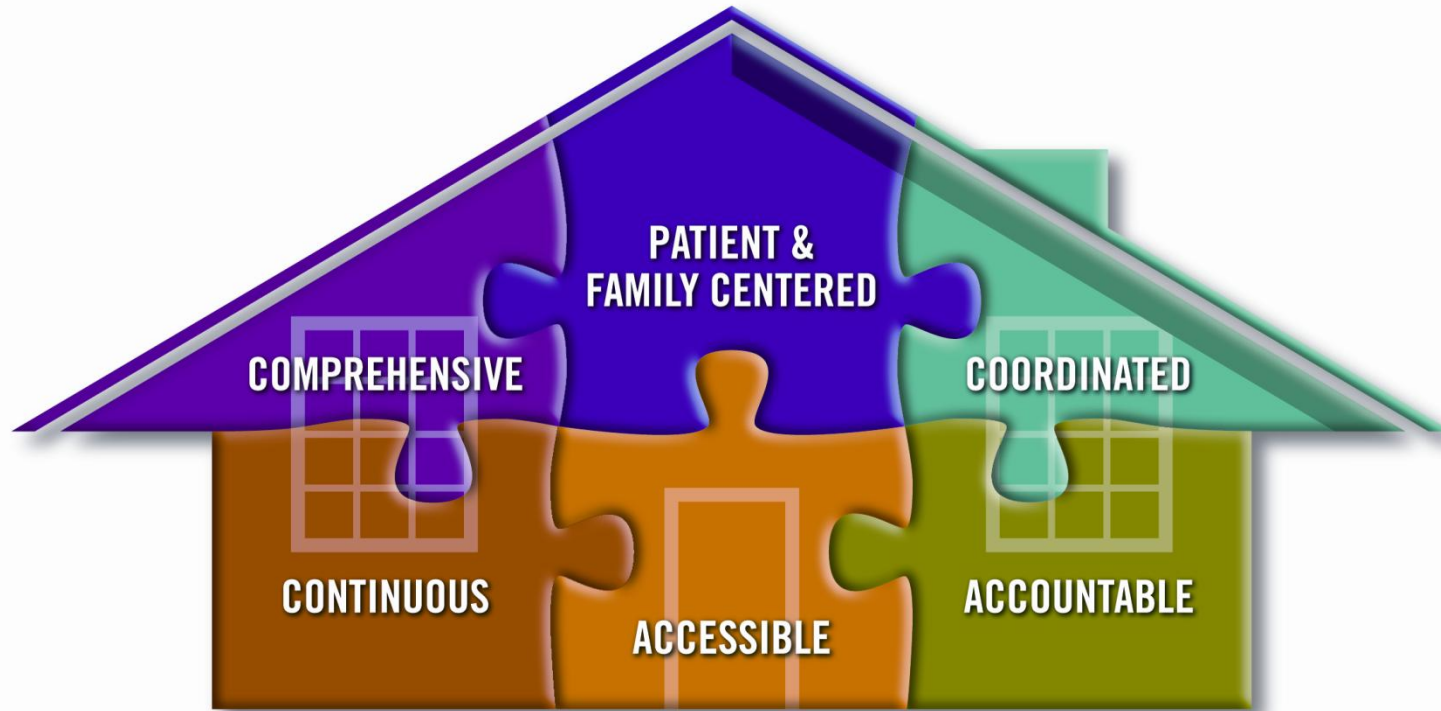
- PCPCH recognition and verification
- Refinement and evaluation of the PCPCH Standards over time
- Communication and provider outreach
- Coordination across OHA divisions, CCO development and health reform initiatives
- Restructure primary care payment to align with the PCPCH framework
- Technical assistance development

Oregon's Goals for PCPCH

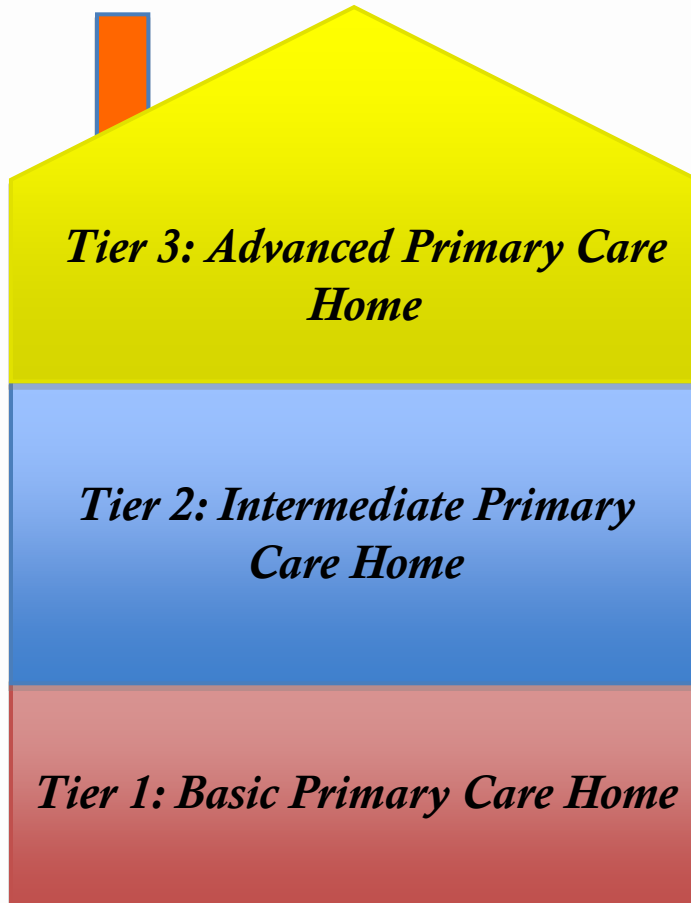
Based on the Oregon Health Policy Board's Action Plan:

- All OHA covered lives (almost 900, 000) receive care through a Patient-Centered Primary Care Home
 - Includes Medicaid, public employees, Oregon educators, Oregon high-risk pool, Family Health Insurance Assistance Program, and Healthy Kids
- 75% of Oregonians have access to quality care through a PCPCH by 2015
- Spread to private payers and Qualified Health Plans via the Exchange

Core Attributes of a Primary Care Home



Different Levels of Primary Care “Home-ness”

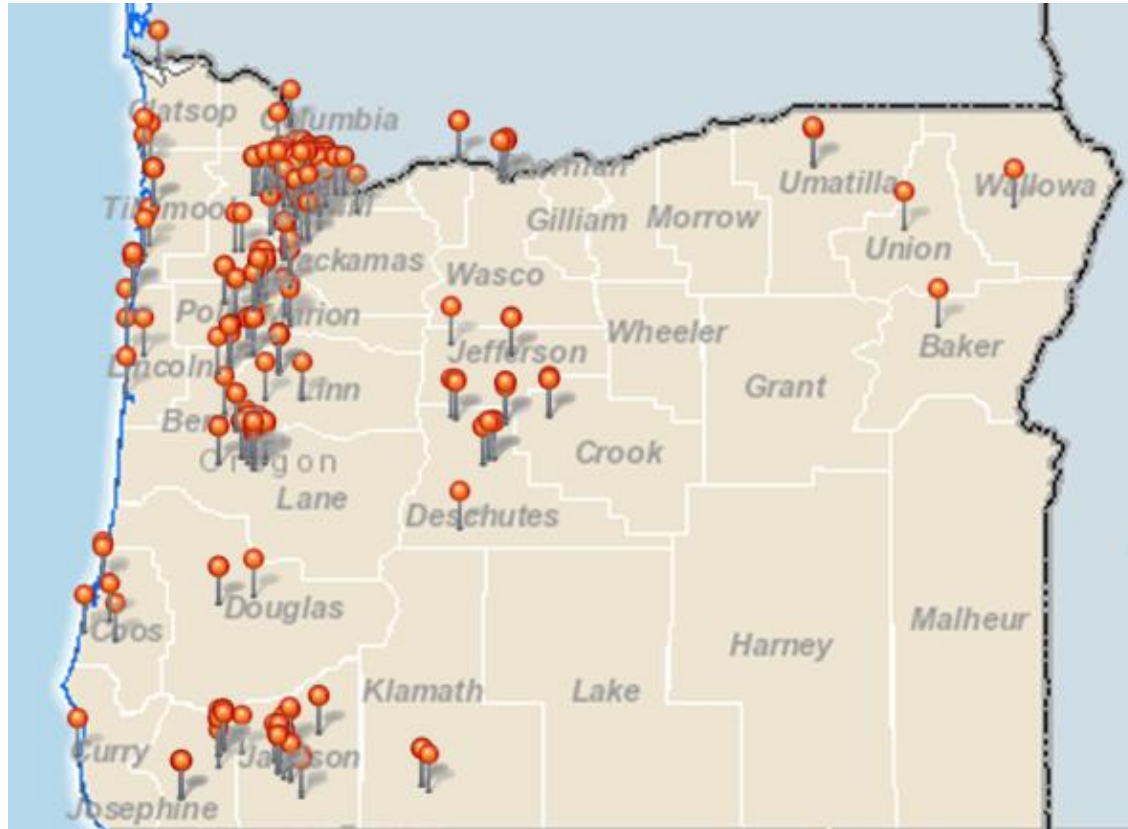


- Proactive patient and population management
- Accountable for quality outcomes

- Demonstrates performance improvement
- Additional structure and process improvements

- Foundational structures and processes

Patient-Centered Primary Care Home in Oregon as of March 2013 (365 clinics recognized)



Success Stories and Continued Partnership

Visit the [News & Stories](#) page to read about how primary care homes fulfill a vision for better health, better care, and lower costs for all Oregonians



Verification Site Visits

- Launched in September 2012
- Conducted more than 20 site visits to-date
- Goals:
 - **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to on their PCPCH recognition application. Additionally, for clinics participating in the Medicaid PCPCH payments, verifying evidence of required documentation, care planning, and service performance for “ACA-qualified” patients.
 - **Assessment** of the care delivery and team transformation process to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH.
 - **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with technical/colleague assistance through the [Patient-Centered Primary Care Institute](#)

Verification Site Visits

- What to expect during a site visit
 - Clinic will be notified at least 30 days in advance; moving this policy to be at least 60 days in advance
 - Work with OHA planner to confirm site visit date/time and agenda
 - At least two site visitors present with clinical background
 - Mixture of discussion and document review
- What to expect after a site visit
 - OHA staff summarize findings and report back to clinic
 - Areas for improvement will be identified if applicable
 - Clinic will be connected with technical assistance opportunities
- Resources
 - Materials to assist clinics in preparing for site visits will be available on our website in early May

PCPCH Model Refinement

- PCPCH Standards Advisory Committee met between August - October 2012
- [Final report](#) now available online
 - Clarified current measures
 - Incorporated new standards and measures to improve the current model
- New model effective October 1, 2013
- Resources and technical assistance
 - [Webinar](#) on May 7 to provide overview of new model
 - Online learning modules available later this spring through the [Patient-Centered Primary Care Institute](#)

PCPCH Technical Assistance and Resources

Technical Assistance Resources

Visit PrimaryCareHome.oregon.gov

- ✓ Implementation [Guide](#) and Technical Assistance and Reporting [Guidelines](#)
- ✓ Payment Incentives [Webpage](#)
- ✓ Supplemental Payment Options [Packet](#)
- ✓ [FAQs](#) for Medicaid PCPCH payment program
- ✓ [Guide](#) for Understanding the Core Service Requirement (now available)
- ✓ PCPCH Program [Rules](#) and Medicaid PCPCH Payment Program [Rules](#)
- ✓ [Four webinars](#) conducted from May 2012 – January 2013 specific to Medicaid PCPCH payments
- ✓ On-site verification process
- ✓ Regional forums, presentations
- ✓ Patient-Centered Primary Care Institute

Technical Assistance & Learning Collaborative Efforts Underway



- The OHA, in partnership with the Oregon Health Care Quality Corporation, and North West Health Foundation launched the **Patient-Centered Primary Care Institute** in September 2012 to support primary care practice transformation in Oregon.
- A broad array of resources will be available over the coming year, including the first PCPCH Learning Collaborative.
- TA website recently launched at www.pcpci.org
 - Additional tools and resources being added now

Patient-Centered Primary Care Institute Objectives



- ❖ **Promote knowledge sharing** through a comprehensive website with easy access to tools, resources, online learning, best practice information and networking opportunities
- ❖ **Facilitate collaborative learning** using a network of technical assistance providers who provide face-to-face learning and practice facilitation to selected practices
- ❖ **Build capacity** for ongoing quality improvement by offering opportunities for technical assistance providers to collaborate and deploy resources collectively through networking and train-the-trainer programs
- ❖ **Create alignment** by coordinating efforts with other practice transformation initiatives in Oregon to leverage resources, maximize benefits for practices, and accelerate transformation. Alignment is critical.

PCPC Institute Key Strategies



- Assessment of needs – surveys, key stakeholder interviews
- Institute’s Expert Oversight Panel – diverse stakeholders
- Curriculum developed using local and national content expertise
- Initial Learning Collaborative – 25 clinics selected in December
- Practice facilitation or “coaching” services
- A comprehensive, interactive learning system website
- Online learning modules and monthly webinars
- Quality improvement training via a train-the-trainer model
- Convening TA organizations/providers, strategically re-deploying resources over time as needed
- Developing sustainable business plan

What about Patient-Centered Primary Care Homes and Coordinated Care Organizations?

Coordinated Care Organizations

Replace today's MCO/MHO/DCO system

Local health entities that deliver health care and coverage for people eligible for Medicaid (the Oregon Health Plan).

- ✓ Local control
- ✓ One point of accountability
- ✓ Global (single) budget – *fixed rate of growth*
- ✓ Expected health outcomes
- ✓ Health Equity
- ✓ Integrate physical and behavioral health
- ✓ Community health workers
- ✓ Focus on prevention
- ✓ Reduced administrative overhead
- ✓ Electronic health records
- ✓ **Patient-Centered Primary Care Homes***

*CCOs required to include recognized clinics in their networks of care to the maximum extent feasible

Key Components Expected in Transformation Plans on PCPCH

- Understanding the extent of PCPCH implementation in the CCO's Network
- Innovative Payment/Financing to support practice transformation and sustain PCPCHs
- CCO's plans to assist PCPCH Patient Engagement
- Overall PCPCH facilitation/engagement
- Workforce allocation and assessment
- Information Sharing with PCPCHs

PCPCH Payment Opportunities

Current Incentive Payments to PCPCHs

“ACA-Qualified” Medicaid Payments

- Health Home Enhanced Payments from the Affordable Care Act (ACA) for Medicaid members with certain chronic conditions being cared for by a PCPCH – continues through September 2013

Comprehensive Primary Care Initiative (CPCI) -

- Almost 70 clinics selected to be paid an enhanced payment by Medicare & 5 local payers including OHA Medicaid FFS

Commercial Health Plan Enhanced Payments and Incentives -

- e.g. PEBB Providence Choice age-adjusted PMPM for tiers 2 & 3, and consumer incentives by benefits favoring PCPCHs with reduced cost-sharing
- [Aetna](#) launches PCPCH incentive payment program

“ACA-qualified” Medicaid Payments

- Provision of Affordable Care Act (ACA) Section 2703 to create “health homes” that provide enhanced services to individuals that meet certain criteria. Payments available through September 2013.

ACA-Qualified OHP Patients

Tier 1 PCPCH \$10 PMPM

Tier 2 PCPCH \$15 PMPM

Tier 3 PCPCH \$24 PMPM

- Submit patient lists separately for FFS and CCO enrolled individuals via the online portal
- DMAP makes payments directly to clinic for FFS individuals and to CCOs for managed care enrolled clients; CCOs forward the payment to clinics
- Deadlines for retrospective patient list submission

Core Service Provision Period

4/1/12 to 6/30/12

7/1/12 to 12/31/12

Deadline

June 15, 2013

September 15, 2013

“ACA-Qualified” Medicaid Payment Service and Documentation Requirements

To gain approval from CMS for this specific opportunity, OHA needed to make a few modifications to the original proposal. Through a series of negotiations, the proposal was modified such that recognized PCPCH clinics are *eligible* for the additional payment if the service and documentation requirements are met for each patient.

When a clinic submits the quarterly patient list, they are attesting to meeting the following requirements for each patient on that list:

- ✓ Providing at least one Core Service for that quarter
- ✓ Performing panel management at least once that quarter
- ✓ Performing patient engagement, education, and obtaining agreement
- ✓ Developing and documenting a person-centered health plan

Understanding the Core Service Requirements for “ACA- Qualified” Medicaid Payments

The Core Services* Are:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community Support Services

*Please see the [Guide for Understanding the Core Services](#) for definitions and examples.

Visit: www.PrimaryCareHome.oregon.gov
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