Oregon Rural Health Conference
Pre-Conference Workshop

Oregon Health Authority
Patient-Centered Primary Care Home Initiative

September 21, 2011

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Presentation Objectives

- Provide a brief background on Oregon's Patient-Centered Primary Care Home program
- Outline goals and strategies for spreading access to primary care homes across the OHA
- Identify how the initiative will be operationalized within the Oregon Health Plan
- Identify linkages to Coordinated Care Organizations

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PCPCH Program

- HB 2009 established the PCPCH program within the Office for Oregon Health Policy and Research

- Key Functions:
  - PCPCH Recognition
  - Technical assistance development
  - Refinement and evaluation of the PCPCH Standards over time
  - Communication and provider outreach
  - Coordination across OHA divisions, CCO development and health reform initiatives

- Resources available on the PCPCH Program website
  - http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/index.shtml
  - Inquiries can be sent to PCPCH@state.or.us

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Why Primary Care Homes?

Goals of the Oregon Health Fund Board & HB 2009

- Improve individual and population health outcomes
- Reduce inappropriate utilization
- Reduce health system costs
- Strengthen primary care
- Encourage prevention and chronic disease management over acute, episodic care
- Stimulate delivery system change
- Establish in statute the PCPCH Program

" Right care at the right time and in the right place"

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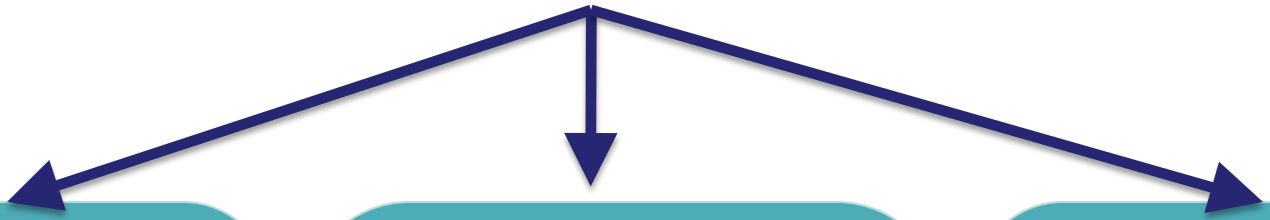
Improving "Triple Aim" Outcomes



A Healthy Population

- Care is focused on wellness, prevention and chronic disease management
- Clinics actively evaluate the needs of the population they serve and improve their care

Extraordinary Patient Care

- Patients have personal, continuous relationships in patient-centered clinics
- Services people want and need are easily available
- Patients' health information is available to them and their clinicians when it is needed
- Individual wishes about end-of-life care are known and followed

Reasonable Costs

- Care is coordinated, reducing duplication and medical errors
- Chronic diseases are managed or prevented, reducing utilization of expensive acute services

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Primary Care Home Standards Advisory Committee

- 15 members, 6 ex-officio content experts
- Multiple stakeholders (patients, providers, plans, employers, health authority, public health)
- 7 public meetings Nov 2009 - Jan 2010
- Reviewed past work in Oregon, other state, federal and private efforts across the country
- Three principle products
    - PCPCH Core Attributes and Standards
    - PCPCH Measures
    - Guiding Principles for Implementation
- Reconvened second group in Fall 2010 with focus on pediatric and adolescent populations

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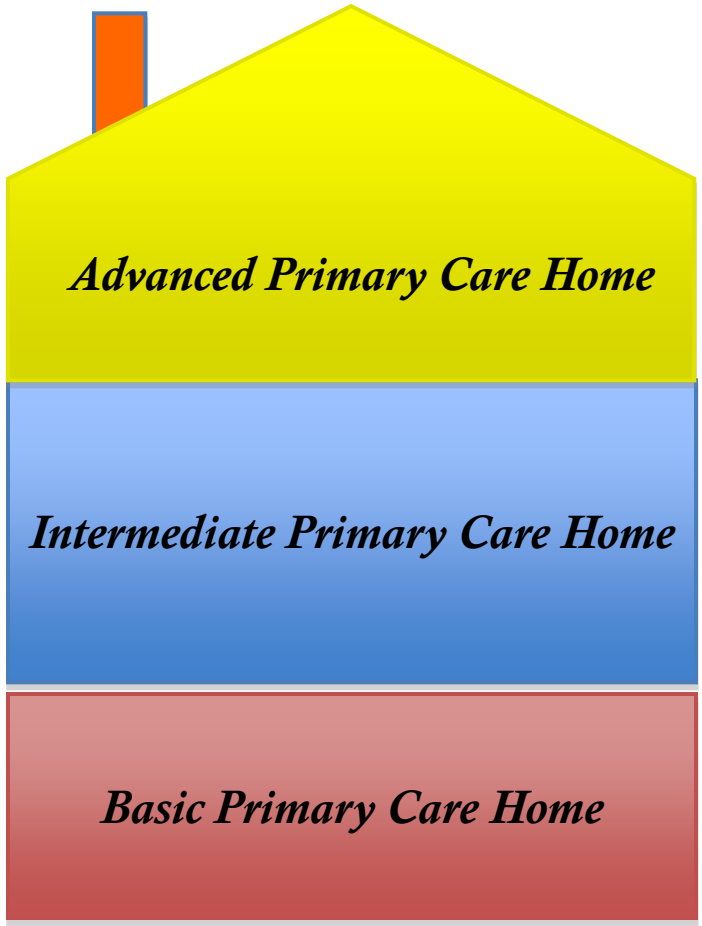
PCPCH Core Attributes, Standards and Recognition Process

- Oregon's PCPCH Model is defined by six core attributes, each with specific standards and measures:
  - Access to Care
  - Accountability
  - Comprehensive Whole Person Care
  - Continuity
  - Coordination and Integration
  - Person and Family Centered Care
- More information and an implementation guide is available at the following web address:
  - www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH

Different Levels of Primary Care "Home-ness"



- Proactive patient and population management
- Accountable for quality, utilization and cost of care outcomes

- Demonstrates performance improvement
- Additional structure and process improvements

- Foundational structures and processes

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Oregon Health Policy Board Subcommittee Recommendation on PCPC Homes

Move forward decisively to transform the primary care delivery system.

- Adopt the PCPCH standards and proposed structure for aligning payment to the tiers as the model for primary care home redesign in Oregon.
- Sponsor development of the measurement, reporting, and feedback infrastructure necessary to implement the standards as a basis for payment.
- Assist primary care practices to develop the capacity to measure and report in accordance with the standards.
- Restructure primary care payment to align with the PCPCH standards framework.

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OHA PCPCH Initiative

- Goals:
  - All OHA covered lives receive care through a PCPCH
    - Includes Medicaid, public employees, Oregon educators, Oregon high-risk pool, Family Health Insurance Assistance Program, and Healthy Kids
  - 75% of Oregonians have access to care through a PCPCH by 2015

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OHA PCPCH Initiative

- Alignment
  - Contract language and expectations among OHA programs
  - OHP Implementation and CMS approvals
  - Other quality improvement initiatives
  - Other primary care home initiatives

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OHA Implementation Team

- OHA Implementation Team has led development of an 'operational' PCPCH model, further defining both the PCPCH Standards and Payment Reform Objectives

- PCPCH Standards
  - Phased implementation approach
  - Informed by internal and external technical expertise

- Payment Objectives
  - Provides financial support for meeting the PCPCH standards;
  - Distinguishes providers for meeting the increasingly robust levels of standards; and
  - Is responsive to the OHA goal of pursuing payment reforms and moving away from a fee-for-service reimbursement model.

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OHA Implementation Team

- Recognition process
  - OHA is developing a centralized, web-based process for data reporting and recognition of PCPC homes
    - Contractual attestation
    - Data reporting
  - Information will flow back to providers for QI purposes
- Aim to have 1st Phase of infrastructure and processes for recognition in place October 2011.

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PCPCH In OHP/Medicaid
Federal Approval

- Obtain Federal CMS Approvals

  - ACA Authorizes financial incentives for Health Homes but authority is limited to individuals with chronic health conditions

    ACA Qualified Individuals have:
    - More than one chronic condition
    - One chronic condition at risk of others
    - A serious mental health disorder

  - Other options exist for states to include “Medical Homes” in their Medicaid program

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PCPCH In OHP/Medicaid
Provider Enrollment

- Develop Systems for PCPCH Provider Enrollment
    - After providers receive PCPCH recognition and Tier assignment from OHA they may submit an application or additional provider enrollment packet to DMAP.
    - Providers will also need to submit information about their OHP patients that are not enrolled in managed care, for primary care
    - Patient information will need to specify ACA Qualified or Non-ACA Qualified
    - FCHP's will provide information to DMAP about ACA Qualified patients that are assigned to a PCPCH and DMAP will provide payment to the plans
    - FCHP's are expected to reimburse PCPCH providers in their networks with strategies that reflect the Tier of the PCPCH

PCPCH In OHP/Medicaid
Provider/Plan Payment

- Develop Systems for Payment
  - Automated PMPM payment
  - Member engagement must be documented in Medical Record
  - Payment for ACA Qualified Members available to FCHP's/PCO's
  - Medicaid FFS, PCPH Fee Schedule
  - ACA Qualified Members
    - Tier 1 $10 PMPM
    - Tier 2 $15 PMPM
    - Tier 3 $24 PMPM
  - Non-ACA Qualified Members
    - Tier 1 $2 PMPM
    - Tier 2 $4 PMPM
    - Tier 3 $6 PMPM

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PCPCH In OHP/Medicaid
Regulatory Changes

- Medicaid Managed Care Contract Language Effective 10/1/11
  - Assist OHA with implementation of PCPCH
  - Encourage and assist network provides to meet PCPCH Standards
  - Reimburse PCPCH providers in a manner that reflects their Tier
  - DMAP will provide additional payments for ACA Qualified members receiving assigned to PCPCH recognized providers

- Make appropriate changes to Oregon Administrative Rules
  - Temporary OAR's will be in place 10/1/11
    - Provider Enrollment
    - Definition of the different types of patients
    - Payments
    - Authorize payment to FQHC/RHC/IHS
      - » Except providers that have filed a change in scope that includes Medical Home or similar service description

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Coordinated Care Organizations

- HB 3650 creates opportunity for coordinated care organization development
  - Draft operational plan due to the legislature February 2012
  - Goal to launch first CCO in July 2012

- Governor Appointed, Health Policy Board/OHA convening four stakeholder workgroups to develop recommendations for operational plan
  - CCO criteria
  - Global budget methodology
  - Outcomes, quality, and efficiency metrics
  - Medicare-Medicaid integration of services

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Coordinated Care Organizations

- Key elements of CCOs:
  - Local control
  - Coordination
  - Global budgets and shared savings
  - Metrics/Performance measures
  - **Patient-Centered Primary Care Homes**

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Next Steps

- Develop OARs for OHA PCPCH program implementation
- Implement PCPCH recognition process
- Continue working with stakeholders to refine the model over time
- If you have questions, please contact Tracy Gratto tracy.gratto@state.or.us or Nicole Merrithew nicole.merrithew@state.or.us or Ralph Summers ralph.h.summers@state.or.us

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