Responses from John Marty:

How PCCM model would accomplish goals in Mat Spaan’s evaluation framework

Work group members:

Mat has provided some important points to use when evaluating proposals, whether the PCCM model or others. As the one who proposed the PCCM model, here are my comments on each of his points:

1. **Health disparities** - Does it address health disparities, overtly or implicitly, better than current APMs? Does it mitigate health disparities directly or indirectly?

Thanks for listing this as a top measure! It is critically important.

The PCCM model would address disparities, directly, by helping providers who deal with vulnerable people—giving them resources for coordinating care—with significant payments to deal with the most vulnerable. Vulnerable people will now have a navigator/care coordinator who will provide oversight of the patient’s health, coordinate care with other providers, and ensure 24-hour access to health care, emergency treatment, and referrals.

The proposal also requires DHS to collaborate with community health clinics and social service providers to provide outreach, medical care, and case management services in the community for people who, because of mental illness, homelessness, or other challenges, are unlikely to obtain needed care. Part of this outreach would seek out people who are not getting preventive care, and help them connect with a primary care provider.

DHS would also be directed to collaborate with medical and social service providers to reduce hospital admissions and readmissions by providing discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs.

In other words, the PCCM model would be directly, proactively addressing health disparities.

I offered this proposal as an alternative to VBP payment models, because of concerns that they may actually make disparities *worse*, when we need to work aggressively to address those health disparities.

1. **Financial stability** of health care system – Does the model create an incentive to manage costs at the provider level in a sufficient manner? Does it add to costs (is an additional cost built on the existing system)? How does the model control cost inflation within the care system?

The PCCM model would significantly *reduce* costs outside of the provider level, and would also reduce provider administrative costs. The administrative savings alone would save money for Medical Assistance and MinnesotaCare.

With some of those savings, the state would be able to directly invest more in care coordination and primary care, helping providers provide *appropriate* care to patients. This will save money in reduced ER and hospital visits, as well as detox and law enforcement costs.

At the provider level, medical professionals have a strong motivation to give their patients good care, and because this model would give them care coordination resources to provide the services needed, they will prevent costly, inappropriate care. Because DHS would have a more direct connection with providers under the PCCM model, the Commissioner would have a better chance to make sure providers are following best practices and working to hold down costs.

The current system is unsustainable, not because people go to the doctor too often, but because they get *inappropriate* care. Many medical assistance enrollees get minimal preventive care, little primary care, and consequently, too much expensive care (often in hospitals and ERs)—because they don’t have a good connection with a primary care clinic and a care coordinator, and because they don’t get the treatment (such as dental care) that leads to more intensive care as their condition worsens.

1. **Patient attachment** - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate **patient choice** of provider?

As we have discussed previously, the PCCM model works upfront to help people connect with a primary provider and as a result, both the patient and the provider know about the connection. The state would actually reach out to enrollees who are not getting primary care, to help them connect to a clinic. Under the PCCM model patients would have their choice of providers, not limited by network restrictions they may currently have under a health plan.

**Multi-payer alignment** - Does the model incent alignment or provide an opportunity for alignment across payers? What is the role for the MCOs and commercial payers under the model?

By putting about 740,000 medical assistance enrollees into this model, plus about 125,000 MinnesotaCare enrollees, under the direct contracting, we would have almost one of every seven Minnesotans covered under this model—that immediately “aligns” 850 thousand people.

There would be no need for MCOs and commercial payers for the 850 thousand people where the state is directly contracting with providers.

Although MCOs and commercial payers would not be *required* to align with this, there would be pressure from providers, employers, and people buying insurance in the private market, for insurers to follow suit because of the focus on primary care and prevention, as well as the transparency and administrative simplicity of the system.

**Triple aim goals** - Does it include a way to monitor the patient outcomes, cost, and quality of the care delivered? Is there any incentive to deliver towards positive patient outcomes and care quality at a sustainable cost?

The PCCM model would directly work to improve patient outcomes, starting with the basics—getting people primary and preventive care, and pulling in people currently outside of the healthcare system. That would address all three of the triple aim goals (better health outcomes, better population health, and lower cost).

The PCCM legislation would not take away any current monitoring efforts, and would direct DHS to track utilization rates for all levels of health care services. It would also track health outcomes for enrollees; reduction in avoidable costs, unnecessary emergency room visits, and hospitalization, improved care coordination; patient self-management knowledge and treatment of chronic disease; and implementation of evidence-based clinical practice guidelines.

1. **Innovation** - Are there activities that are already taking place through other existing payment models/activities proposed in the model (e.g. through HCHs, MCO care management)? If so, how does the model differ, enhance, the existing activities? How do we reconcile for these potentially duplicative activities?

As we discussed in St. Cloud, some of these valuable, frequently cost-saving concepts are already are already being implemented by Hennepin Health and a few other providers and programs. Under PCCM, these services would be significantly expanded to help all of the patients and to save public money.

This proposal would be similar to the health care homes (HCH), but would be designed to address weaknesses in the current HCH program, so that people have access to care coordination.

The work group heard from former Senator Linda Berglin, who said that in authoring the HCH legislation she never envisioned HCH’s to be so complicated that it would take a couple years for a clinic to be certified, nor did she intend the payments to be so small that providers felt it wasn’t worth applying for the money. The PCCM proposal is designed to address those problems. It may be helpful to specify in the legislation that DHS must set care coordination payments at levels sufficient to meet the desired outcomes.

In the PCCM model, clinics would receive direct help from DHS to hire people to do outreach and care coordination, so they could begin immediately, rather than spending time and resources to get foundation grants or other funds to hire such employees with the hope that they might get some compensation later. Also, by working directly with clinics on outreach, DHS would be able to bring in people who homeless and eligible for Medical Assistance, but not currently connected with a clinic. This could significantly reduce hospitalization and ER visits.

1. **Social determinants** - Does the model enable a flexible way to integrate/pay for services addressing the social determinants of health (e.g. flexible payment options that enable payment for non-medical services)?

Yes. By avoiding the administrative complexity of multiple plans covering Medical Assistance patients, and by having DHS work directly with the clinics serving socially and medically complex patients, and by funding care coordinators (whether social workers or “navigators”) up front, the clinics could partner with the counties and social service organizations to address non-Medical needs.

To illustrate how efficiently this can work, simply look at what Hennepin Health is doing. Because all of their patients are handled by one plan (Metropolitan Health Plan), they don’t need to spend resources to figure out what health care services are covered, and they can focus on figuring out how to address the non-medical services, whether with funding from the county or non-profit social service programs.

1. **Complexity of patients** – Does the model sufficiently account for variation in the complexity of patients across providers?

Yes, the proposed legislation clearly states that the DHS Commissioner is required to set different PCCM (case management) fees for different patients, and requiring higher fees “based on the level of medical and social complexity for patients with chronic or complex conditions or disabilities as well as patients who have other challenges due to poverty, or other socioeconomic factors that lead to health disparities.”

Because of the testimony that the work group heard from former Senator Berglin, it may be necessary to provide stronger guidance in the legislation to ensure that the variation in fees is sufficient to account for the variation in need. A patient with complex needs may require *many times* as much attention as a patient with fewer challenges.

1. **Implementable –** How is the model operationalized? Who does what within the model (e.g. who oversees and/or makes payments? Who delivers the care coordination services, and what do those services look like?) What infrastructure would need to be in place for the model to be implemented?

In contrast to our current health care system, which is characterized by increasingly complex administrative structures, the PCCM model would bring in a less complicated, less bureaucratic administrative system.

To address the work group’s goal of increasing care coordination and patient attachment with primary care providers, the PCCM model would ***directly*** address both goals. Instead of attempting to find a payment system that *might* provide incentives for providers to coordinate care, this approach would directly compensate providers for doing so.

The plan would be easily operationalized: DHS and providers would encourage MA and MNCare patients to choose the clinic or provider who will serve as their PCCM, and educate them on the services that the clinic will provide (this would be an on-going process). DHS would negotiate fees for care coordination (and similar services) with providers.

On the date when the PCCM program would go into effect, DHS would begin paying providers directly for the services they provide (instead of using health plans as a middleman to pay them). DHS and providers could negotiate alternative forms of payment, such as a global budget for a hospital to cover all of the MA and MNCare patients they serve.

Infrastructure needs, such as the hiring of navigators or social workers to provide the care coordination, would be relatively simple (without requiring providers to seek grants, loans or other funds to get started), because primary care providers would be paid directly for the work their new employees would be performing.