CPEHN
California Pan-Ethnic Health Network

Advancing Health Equity through Systems Transformation and Payment Reform

February 2020

Strengthening Primary Care

Recommendation: Medi-Cal managed care plans (MCPs) can advance health equity by increasing the percentage of Medi-Cal primary care providers that are advanced primary care practices, such as those recognized by national accreditation organizations as patient-centered medical homes (PCMHs).

Background: Advanced primary care practices such as PCMHs are primary care providers who establish an ongoing relationship with a patient, get to know that patient's needs and preferences, and co-design and help support that patient in meeting goals to improve or maintain optimal health.[i] Most advanced primary care practices/PCMHs use health care teams (including nurses, medical assistants, health educators, community health workers) who share responsibilities with the physician/primary care provider, and provide proactive coordination of care with specialists, hospitals, and other health care providers, as well as community-based resources and services.

There is strong evidence that advanced primary care practices/PCMHs increase the quality of care.[ii] Advanced primary care practices/PCMHs also can advance health equity and assist California Medi-Cal MCPs in meeting the new proposed requirements in the California Department of Health Care Services (DHCS) population health management strategy by:

- Collecting and using comprehensive demographic information about every patient, including self-reported race, ethnicity, language, functional disability, sexual orientation, and gender identity
- Conducting comprehensive needs assessments (that include identification of health-related social needs),
- Developing individualized care plans (along with designated family and caregivers) that consider health literacy, are culturally and linguistically appropriate, and address the health and social needs identified,
- Supporting shared-decision making, self-management, and patient, family, and caregiver engagement,
- Ensuring culturally and linguistically appropriate services, including access to multilingual staff, trained and qualified health care interpreters, and translated patient education and engagement materials and other health information,
- Obtaining feedback from diverse patients, and
- Continuously improving quality, including reducing identified disparities.[iii]

Problem/Community Evidence

FROM CPEHN CONSUMER FOCUS GROUP:

One consumer shared that she had confidence in her doctor because she felt as though many patients at that health center had similar struggles. She didn't feel ashamed to discuss financial and family matters with her doctor because she felt her doctors knew how to handle the situation and would get her the best care possible according to her needs. This openness with her doctor allowed her to discuss affordable treatments that were right for her and her family.

FROM CPEHN CONSUMER FOCUS GROUP:

Doctors should understand the value of what it means for a person to be able to trust a doctor with themselves and their family members. For some people, doctors are more than just a physician. And health care needs more whole-person care, instead of each separate doctor having their own exclusive piece of a person's health, or just plugging holes. For example, physical injuries can lead to mental health issues, and doctors should be aware of the link between the two, and be able to treat both as a whole.

Advanced Primary Care Practices/ PCMHs in California

Here in California, Covered California has been tracking the percentage of primary care providers in its qualified health plan (QHP) networks who are recognized as PCMHs. While the overall percentage increased to 40% in 2018, almost all of those providers were part of Kaiser Permanente (who have 100% of its primary care providers in California recognized as PCMHs). Without the Kaiser PCMHs, the percentage of primary care providers who were recognized as PCMHs in Covered California QHP networks was only 11%.[iv.]

On the other hand, according to the Health Resources and Services Administration (HRSA), 67% of the federally qualified health centers (FQHCs) in California are recognized as PCMHs.[v] Since almost all the California FQHCs and many Kaiser Permanente practices are included in current Medi-Cal managed care provider networks, they can provide a baseline for Medi-Cal managed care plans to move their entire provider networks towards practice transformation as PCMHs.

Solutions and Best Practices:

Medicaid programs in other states have required and incentivized the strengthening of primary care through advanced primary care practices. For example, the state of Oregon has set goals for the percentage of its Medicaid providers that are recognized as patient-centered primary care homes (PCPCHs),[vi] and now over 90% of Medicaid beneficiaries in the state are assigned to a PCPCH for primary care.[vii] Another example is the state of North Carolina, which is implementing Advanced Medical Homes (AMH)[viii] as part of its statewide transition of Medicaid to managed care that began in November 2019.[ix] The state will recognize three tiers of AMHs, with increasing primary care provider responsibilities, and accompanying increasing payments; nearly 2,800 practices are participating as AMHs.[x] The experiences of Medicaid programs in other states demonstrates that improvement in transforming California's primary care practices into advanced primary care practices/ PCMHs is achievable. Medicare and other payers also are incentivizing advanced primary care/PCMHs.

Recommendations:

- DHCS should require Medi-Cal MCPs to report on the percentage of their contracted primary care providers who are currently recognized as advanced primary care practices such as PCMHs.[xi]
- DHCS should work with Medi-Cal MCPs to offer meaningful and significant financial incentives (upfront payments to prepare for recognition, payment of fees for recognition, pay-for-reporting once recognized, etc.)[xii] as well as non-financial incentives (technical assistance, practice coaching, etc.)[xiii] to providers to support their recognition as advanced primary care practices such as PCMHs, especially solo and small practices; DHCS should invest in the development of sustainable technical assistance capacity to support ongoing practice improvement throughout California.
- DHCS should set an annual target goal for increasing that baseline percentage of Medi-Cal primary care providers that are recognized as advanced primary care practices such as PCMHs, should monitor progress towards achieving the annual target goal, and should continue to increase the target goal until it reaches at least 90 percent of Medi-Cal primary care providers.
- DHCS could also work with Medi-Cal MCPs to create opportunities to link advanced primary care practice/ PCMH recognition with alternate payment models (APMs), e.g., recognized advanced primary care practices/PCMH's could receive additional bonus payments for meeting quality improvement goals.[xiv]

- DHCS should work with Medi-Cal MCPs to develop and offer advanced PCMH practices additional opportunities to share savings for holding down Total Cost of Care (TCOC); these improvement goals should explicitly identify and reduce health care disparities.[xv]

Establishing multiple supports for advanced primary care practices/PCMH recognition, and then multiple incentives for sustaining practice transformation and improvement, would engage both more advanced practices while encouraging other practices to get started on practice transformation and improvement.

Supported by the California Health Care Foundation (CHCF), which works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit www.chcf.org to learn more.

Sources:

[i] There are several national recognition programs which could be used in California, for example, the National Committee for Quality Assurance's Patient-Centered Medical Home: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/; the Joint Commission's Primary Care Medical Home: https://www.jointcommission.org/accreditation/pchi.aspx; and the Accreditation Association for Ambulatory Health Care Medical Home Certification and Accreditation:https://www.aaahc.org/accreditation/medical-home/

For simplicity, this issue brief will refer to "PCMHs" without endorsing any specific recognition program.

[ii] Landon BE, Gill JM, Antonelli RC, Rich EC. Prospects for rebuilding primary care using the patient-centered medical home. Health Aff. (2010);29(5):827-834; Patient-Centered Primary Care Collaborative, Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization, 2017, https://www.pcpcc.org/resource/impact-primary-care-practice-transformation-cost-quality-and-utilization; Patient-Centered Primary Care Collaborative: The Medical Home's Impact on Cost & Quality: An Annual Update on the Evidence, 2014, https://www.pcpcc.org/resource/medical-homes-impact-cost-quality

[iii] California Pan Ethnic Health Network, How Medical Homes Can Advance Health Equity, 2010, http://cpehn.org/sites/default/files/resource_files/medical_homes.pdf

[iv] Oregon Health Authority, Patient-Centered Primary Care Homes, https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx

[v] Oregon moved from having 52% of its Medicaid beneficiaries assigned to PCPCHs through its coordinated care organization (CCO) program in 2012, to 79% in 2013, to 92% in 2017, Oregon Health Authority, Oregon Health System Transformation: CCO Metrics 2017 Final Report, 2018, https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2017-CCO-Performance-Report.pdf

[vi] https://files.nc.gov/ncdma/documents/Medicaid/Provider/AMH%20Provider%20Manual%208-27-18.pdf

[vii] https://files.nc.gov/ncdma/AMH_FAQs_2.8.2019.pdf

[viii] https://files.nc.gov/ncdma/Map-Graphic-3.25.19-changes--002-.pdf

[ix] Covered California, Attachment 7 Refresh Workgroup, December 2019, https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Attachment_7_Refresh_Workgroup_December_2019_Primary_Care.pdf

[x] https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/TechnicalAssistanceQIA-508_090519.pdf

[xi] National Committee for Quality Assurance, https://reportcards.ncqa.org/#/practices/list?state=California&recognition=Patient-Centered%20Medical%20Home (535 practices in California are recognized by NCQA as PCMHs, including the Kaiser Permanente practices and many Federally Qualified Health Centers)

[xii] Qualis Health, The Commonwealth Fund, and Group Health: Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net, 2010, http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-¹.pdf; Patient-Centered Primary Care Collaborative, Payment Rate Brief, 2011, http://www.pcpcc.org/sites/default/files/media/payment_brief_2011.pdf

[xiii] Abrams M, Schor EL, Schoenbaum S. How physician practices could share personnel and resources to support medical homes. Health Aff. 2010; 29(6):1194-1199; Highsmith N, Berenson J. Driving Value in Medicaid Primary Care: The Role of Shared Support Networks for Physician Practices, Center for Health Care Strategies, 2011, http://www.chcs.org/usr_doc/Report.pdf; Highsmith N. Creating Physician-Support Entities in Medicaid. Center for Health Care Strategies, 2011, http://www.chcs.org/usr_doc/CMWF_Shared_Support_Practices_FINAL.pdf; Grumbach K, Mold JW. A health care cooperative extension service: transforming primary care and community health. JAMA. 2009;301(24):2589-2591

[xiv] https://bphc.hrsa.gov/program-opportunities/funding-opportunities/quality

[xv] HRSA's QIAs includes its Health Disparities Reducer Awards, which recognize health centers that met or exceeded Healthy People 2020 goals, or made at least a 10% improvement across different racial/ethnic groups.