

Primary Care Case Management (PCCM)

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During last week's discussion of care delivery for low income medical assistance patients, there was a good discussion of many valuable services (frequently cost-saving measures) that HCMC, the community clinics, and Southern Prairie are providing for their patients. While there are efforts to find new methods of incentivizing such services, there is currently no system that would do so.

We do not have a "quality" measurement system that can accurately reflect the work being performed by the clinics. There are high administrative costs for grading the quality of each health care service and designing and administering a payment system to reward quality. Also, there is evidence that such payment systems are counterproductive—requiring significant provider resources, while increasing health disparities and discouraging quality care.

As a result, we should consider replacing our delivery and payment system with a "**Primary Care Case Management**" (PCCM) system in which DHS would contract directly with providers, and the role of navigators would change. Because there would no longer be a need to help people navigate the *coverage* they get, they could focus on helping people navigate the *care* they need.

Under the current system, the state pays a "managed care organization" to pay the providers, with the hope that, somehow, the patient's care will be "managed" or coordinated. However, despite the name "*managed care*," they are essentially managing claims, not managing the patient's care. In the PCCM model, the state would pay the providers directly, and have the primary provider directly coordinate the care, compensating them for providing that service.

Here is the rationale for the proposal:

Medical Assistance and MNcare patients, especially those with chronic or complex conditions or disabilities, and those with socio-economic challenges that lead to health disparities, would have better health outcomes if they had a care coordinator.

In the PCCM model, the Department of Human Services would contract directly with providers (clinics, doctors, hospitals) for care, paying them for the services that they actually *provide* to patients. This eliminates all of the arguments about "prospective attribution" or "retrospective attribution" of patients. It would also avoid the unintended consequence of harming providers who treat poorer, sicker patients.

Patients would be encouraged to choose a primary care provider, where they would receive help navigating the health care system. Both the patient and the clinic would understand the relationship, unlike the current situation where patients can be "attributed" to a clinic, without their knowledge. The clinic would then receive a care coordination payment for performing that work. The care coordination fee would be significantly higher, based on the level of medical and social complexity, for patients with chronic or complex conditions or disabilities. The PCCM provider would provide overall oversight of the patient's health and coordinate with the patient's other providers to ensure that patients get appropriate care.

The PCCM, or primary care case manager, would typically be a primary care clinic, but in some cases where the patient has a chronic condition or specific needs, such as mental health, a

specialist or specialty clinic that regularly works with the patient might fill that role. Minnesota's community health clinics would be well prepared to provide care coordination because of their extensive experience with low income patients, but whichever clinic a patient is using for care could provide the coordination.

Under the proposal, the Commissioner of Human Services would collaborate with community clinics and social service providers to do outreach to low income people who need care but are unlikely to access it due to homelessness, mental illness, or other challenges.

The commissioner would also work with medical and social service providers to reduce hospital admissions and readmissions by providing transitional care and other help to people that would help them stay out of inpatient facilities and emergency rooms.

As we discussed last week, some of these types of services are already being done by Hennepin Health and a few other providers and programs. Under PCCM, these services would be used to help all patients and to save public money.

Instead of hoping that an extremely complex, unproven payment model *might* provide some incentives which *might* result in better coordination of care, the PCCM model would simply, and directly, pay for the care coordination that we want. It would significantly reduce the administrative burden on doctors and clinics, and consequently, reduce costs. Unlike the other payment models we are considering, this one is understandable, transparent, and fair.