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PROVIDENCE
Family Medicine
Center

**4.02.01 COVER LETTER**

**Providence Family Medicine Center is submitting this proposal for the Provider-Based Reform model under the Department of Health and Social Services Coordinated Care Demonstration Project.**

Providence Family Medicine Center (PFMC) is an integrated (primary care and behavioral health) clinic in midtown Anchorage. We are an ambulatory care site for Providence Alaska Medical Center, the largest private, nonprofit health care organization in Alaska.

PFMC is a level 3 Patient Centered Medical Home (PCMH), certified by the National Committee for Quality Assurance (NCQA). We provide the full scope of primary care services to patients of all ages and across all health care venues. We have a robust Integrated Direct Care Team (IDCT) that includes Behavioral Health, Social Work, RN Case Management, Pharmacy and Home Visits. The IDCT works closely with the patient's Primary Care Physician (PCP) to increase access, decrease inappropriate utilization and improve patient outcomes.

Our proposal for this Coordinated Care Demonstration Project is for the Provider-Based Reform model. Payment reform is essential to support patient-centered care. We propose a blended payment model that continues fee-for-service (FFS) payments for physician services and adds a capitated (PMPM) fee for care coordination to support the work accomplished outside the traditional doctor/patient office visit by care team members whose services are not currently billable. This is essential to support the State of Alaska's goals for Medicaid Redesign and Expansion (i.e. to improve health, optimize access, increase value and contain cost).

We thank you for your consideration and look forward to working with DHSS to accomplish our shared goals of improving the health of our patients and our communities.

Our project aligns with the State of Alaska's vision for health care redesign as outlined in SB 74, demonstrated by the implementation of 7 of the 9 elements included in SB 74:

- Comprehensive primary-care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support;
- Care coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical;
- Health promotion;
- Comprehensive transitional care and follow-up care after inpatient treatment;
- Referral to community and social support services, including career and education training services;
- Sustainability and the ability to achieve similar results in other regions of the state; and

- An innovative payment process, including bundled payments or global payments.

A description of our current and proposed incorporation of telehealth in our patient-centered care model is included on page 15 in Section 4.02.03(D).

**Project Lead and Primary Contact**
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**Declarations:**
We understand that state funds are not available to support any up-front implementation activities and our proposed project does not require an investment of state funds in the design, development or implementation of the demonstration project.

PFMC's transformation from a traditional Family Practice to a PCMH was funded by Providence Health & Services Alaska. We are not requesting any funds to support up-front development or implementation activities. The proposed PMPM payments will support care coordination for Medicaid beneficiaries.

We are not proposing a statewide model that includes behavioral health services.

Additionally, with regards to the Federal Policy on Tribal Medicaid Reimbursement, we are:

1. Aware of federal Medicaid policies related to American Indian/Alaska Native (AI/AN) populations,
2. Familiar with the current Federal Policy on Tribal Medicaid Reimbursement, and understand the State of Alaska's commitment to full implementation of that policy, and
3. Are committed to collaborating with the state on tribal health entities to optimize the Federal Policy on Tribal Medicaid Reimbursement.

PFMC serves a predominately non-tribal population. One exception is OB patients from the Aleutian Islands, which is described on in Section 4.02.03.

All professional staff involved with the project maintain the appropriate, relevant professional licenses. All of our clinical providers (i.e., Family Physicians, Physician Assistants, Behavioral Health and Pharmacy) are licensed by the State of Alaska and credentialed through Providence Alaska Medical Center. All other professional staff (i.e., Nurse Case Managers, Social Workers) maintain the appropriate license and certifications.

**Authorization:**
The authorized signature below serves as certification that we:

1. Acknowledge that the proposal must be signed by an individual authorized to bind the offeror to the provisions of the RRP, and that proposals must remain open and valid for at least 275 days from the date set as the deadline for receipt of proposals.
2. Comply with the following:
   a) the laws of the State of Alaska;
   b) the applicable portion of the Federal Civil Rights Act of 1964;
   c) the Equal Employment Opportunity Act and the regulations issued thereunder by the Federal Government;
   d) the Americans with Disabilities Act of 1990 and the regulations issued thereunder by the Federal Government;
   e) all terms and conditions of this RFP;
   f) a condition that the proposal was independently arrived at, without collusion, under penalty of perjury;
   g) that the offers will remain open and valid for at least 275 days; and
   h) that programs, services, and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the Federal Government.

**Vendor Tax ID: 92-0016429**

**Conflict of Interest:**
We have no conflict of interest to disclose.

**Federal Requirements:**
We acknowledge all known federal requirements that apply to the proposal, the evaluation, or the contract.

**Authorizing Signature:**

Bruce Lamoureux

Bruce Lamoureux
Chief Executive
Providence Health & Services Alaska

4-26-2017
Date

**Medicaid Coordinated Care Demonstration Project**

State of Alaska

Request for Proposals 170007291

**Providence Family Medicine Center**

Project Lead & Primary Contact

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**4.02.02 INTRODUCTION**

Providence Family Medicine Center (PFMC) is an integrated (primary care and behavioral health) clinic in midtown Anchorage. We are an ambulatory care site for Providence Alaska Medical Center (PAMC), the largest private/nonprofit health care organization in Alaska. We share a common mission: *to provide compassionate care for the poor and vulnerable in our community*.

PFMC is a Level 3 Physician Practice Connections® Patient-Centered Medical Home™ (PCMH) certified by the National Committee for Quality Assurance (NCQA), which means we have demonstrated that we provide full-scope primary care services for families (i.e., preventive care, acute care, chronic disease management, minor surgery, pediatric care, perinatal care [particularly for high-risk OB patients], and geriatric/palliative care), and we emphasize access, communication, and patient involvement. Additionally, as a fully integrated primary care clinic, we have a robust Integrated Direct Care Team (IDCT), which is described in detail in Section 4.02.04 and includes Behavioral Health, Social Work, Nurse Case Management, Home Visits, and Pharmacy. The IDCT works closely with the patient's primary care physician (PCP) to increase access, decrease utilization, and improve patient outcomes.

We currently serve approximately 11,000 patients, representing a variety of government and commercial payors. Approximately 4,800 of our patients are Medicaid enrollees, 700 of whom are dually eligible for Medicaid and Medicare. All of the services proposed by our project will be available to both of these cohorts. We provide an average of 38,000 PCP encounters per year and an additional 6,000 IDCT (primarily Behavioral Health and Social Work) encounters.

PFMC's transformation from a traditional family practice to a PCMH began in 2009. The transformation was funded by Providence Alaska Medical Center (PAMC). We now have fully functional care teams capable of providing comprehensive coordinated care that benefits our community. We have observed meaningful success with a select cohort of our high risk patients in substantially improving their health and well-being and greatly reducing unnecessary hospitalizations and Emergency Department visits.

The PCMH service model is not sustainable nor expandable in the traditional fee-for-service (FFS) environment. Most of the work that supports patient success and decreases unnecessary costs to the payor is accomplished outside the traditional doctor/patient office visit by care team members whose services are not currently billable.

Our proposal is for Provider-Based Reform (PBR) that will allow us to make our IDCT services available to all Medicaid enrollees seen in our clinic, based on level of need. We propose a blended payment model that continues FFS payments for physician services and adds a capitated (PMPM) fee for care coordination. Financial support for the work accomplished outside the traditional doctor/patient office visit, by care team members whose services are not currently billable, is essential to support the care of Medicaid enrollees and to improve the health of our community.

## 4.02.03 OVERVIEW AND UNDERSTANDING

### A. High Level Description of the Project

Providence Family Medicine Center (PFMC) is a primary care clinic serving the Anchorage community by providing integrated, full-scope primary care and behavioral health through our Patient Centered Medical Home (PCMH). PFMC is a department of Providence Alaska Medical Center (PAMC). PAMC is part of the Alaska Region of Providence St. Joseph Health System (PSJH), a faith-based, not-for-profit health and social services system that serves communities across seven states with 50 hospitals, 829 clinics, and hundreds of services offered outside hospital walls.

PFMC offers the full scope of primary care services including: preventive care; acute care; chronic disease management; same day appointments; procedures and minor surgery; psychological and behavioral health, and social services; maternity, pediatric, and geriatric/palliative care; and intensive case management. PFMC has been awarded recognition as a Level 3 Physician Practice Connections® Patient Centered Medical Home™ by the National Committee for Quality Assurance (NCQA). The Patient Centered Medical Home (PCMH) is a model of health care delivery that aims to improve the quality and efficiency of care. The NCQA standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication, and patient involvement. The details of this innovative care model and PFMC's journey to transform our practice to a PCMH are described in Section 4.02.04.

The cornerstone of PFMC's PCMH is our robust Integrated Direct Care Team (IDCT), which includes: Behavioral Health, Social Work, Nurse Case Management, Home Visits and Pharmacy. The IDCT works closely with the patient's primary care physician (PCP) to increase access, decrease inappropriate utilization, and improve patient outcomes. The IDCT is described in detail in Section 4.02.04.

Research suggests the PCMH model not only improves patient care but reduces costs. For example, in a recent multi-state demonstration project, an estimated $4.2 million was saved during the first year, including a 3% reduction in ED visits and a 2% reduction in inpatient admissions (Nielsen, Buelt, Patel, & Nichols, 2016).

Our project aligns with the vision of the State for Medicaid Redesign because it emphasizes the integral role of quality and individualized care coordination based on patients' needs. Our goal for the Coordinated Care Demonstration Project is to provide evidence that our PCMH model of care can be expanded to all Medicaid enrollees by making small changes to the reimbursement structure, which will result in increased access for patients, decreased ED/Hospital utilization and improved patient outcomes.

PFMC is also the continuity care clinic for the Alaska Family Medicine Residency (AFMR). AFMR is designed to train physicians to practice in any part of the Alaska, urban or rural, with the Family Physician providing comprehensive care to members of the entire community, while maintaining close relationships to sub-specialists at medical centers. AFMR is the only residency program in Alaska and is affiliated with the University of Washington WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) Family Medicine Residency Network. AFMR's purpose is to deliver comprehensive resident education supporting the development of competent family medicine physicians who provide quality care to diverse populations, including rural, culturally diverse, and underserved communities in Alaska. The residency is a 12-12-12 model, educating 36 family

medicine residents each year within our PCMH primary care clinic. Our graduates live and practice in communities throughout Alaska (see map, Appendix A).

Our proposal is for payment reform that will allow us to make our IDCT services available to all Medicaid enrollees in our clinic, based on level of need. We propose a blended payment model that continues fee-for-service (FFS) payments for physician services and adds a capitated (PMPM) fee for care coordination. Financial support for the work accomplished outside the traditional doctor/patient office visit, by care team members whose services are not currently billable, is essential to support the care of Medicaid enrollees and improve the health of our community.

Our proposal serves both the purpose of the Coordinated Care Demonstration Project, "to assess the efficacy of various healthcare delivery models with respect to cost, access and quality of care," and the goals of Alaska's Medicaid Redesign + Expansion to "improve health, optimize access, increase value and contain costs," (Agnew::Beck, 2016).

**B. Challenges to Delivering Accessible, High Quality and Effective Care to Alaskans**

Our proposed project provides solutions for several long-standing challenges and barriers to delivering accessible, high quality, and cost-effective care to Alaskans in Anchorage. For example, traditional approaches to care often focus on symptom reduction (reactive) as opposed to health promotion (proactive). As described in more detail in Section 4.02.04(E), our project includes a system for identifying a patient's level of risk and responding to needs proactively through interdisciplinary care plans. Relatedly, another long-standing challenge is fragmented/poorly coordinated care. Our project will demonstrate that an IDCT in a PCMH works closely together to augment (not duplicate) services and facilitates communication between providers through the use of an interdisciplinary care plan (see Section 4.02.04(E)(2)(f)) that enhances an individual provider's ability to meet patient needs as they are identified. Limited transparency between providers and difficulty in information-sharing are also barriers to quality patient care outside of a PCMH, and our project will demonstrate the effective use of communication networks (including the use of electronic health records and the health information exchange) to improve patient care. The sum of these efforts is that patient care is improved through clinical decision-making in collaboration with the patient, based on the latest and best clinical evidence. With effective, transparent, immediate, and cooperative communication between members of an IDCT in a PCMH, we will demonstrate clinical decision-making is improved by an increase in preventive screenings and health maintenance and targeted interventions for acute and chronic needs.

We describe overcoming barriers to the implementation of our project in more detail in Section 4.02.05(3)(A).

**C. Project Alignment with SB 74 Elements**

Our proposed project aligns with seven of the nine elements in SB 74:

1. **Comprehensive primary care-based management for medical assistance services, including behavioral health services and coordination of long-term services and support**
   Our project will expand our existing management of medical assistance services described in detail in Section 4.02.04 to all Medicaid enrollees in our clinic. Each patient will be screened for needs in the six domains outlined in Table 2 (Section 4.02.04) and referred to the appropriate

members of the IDCT. Every Medicaid enrollee, based on level of need, will be eligible for all services provided by the IDCT and will be followed by a coordinator to track progress on care plan goals. Members of the IDCT include Behavioral Health providers, Social Workers, Nurse Case Managers, Pharmacists, and Physician Assistants who provide home visits. Detailed descriptions of their roles and responsibilities of the IDCT are included in Section 4.02.04 and Appendix B.

High risk/high need patients may benefit from substantial support in all of these areas. Low risk/low need patients may only require episodic acute care office visits, as depicted in Figures 4, 5, and 6 in Section 4.02.04. Our IDCT is designed to provide patient-centered support and services for all patients (pre-natal through end-of-life) and across all health care venues: inpatient, outpatient, long-term care facilities, home and other living facilities.

2. **Care Coordination, including the assignment of a primary care provider located in the local geographic area of the recipient, to the extent practical**

   Each patient in our clinic chooses or is assigned a PCP and Certified Medical Assistant (CMA). That dyad, PCP and CMA, is the primary contact for each patient and is supported by the rest of the IDCT. Our goal for this project is to facilitate the coordination of all members of the care team and the patient. This is done primarily through care team meetings and communication through the use of a shared electronic health record (EHR). The EHR contains the IDCT care plan, based on the Domains of Need outlined in Table 2 in Section 4.02.04, so all members of the treatment team, including the patient, have access to the care plan. The patient has access to view his or her medical record, including the care plan, progress notes and labs, and to send and receive messages directly to members of his or her care team through MyChart, our online patient portal, which is described in more detail in Section 4.02.03(D) below.

3. **Health Promotion**

   Due to the significant increase in preventable chronic conditions, early identification of risk factors and prevention initiatives are now a part of everyday primary care practice. Health promotion, including education, self-management, and lifestyle modifications are all key to our model of care, which aligns with Healthy Alaskans 2020 (State of Alaska, Department of Health and Human Services [DHSS], 2017). We consider health promotion to include access to care, primary and secondary prevention, and disease or panel management. Our health promotion efforts are supported through the use of the panel management and population health software tools integrated into our EHR, such as EPIC Healthy Planet and athenahealth.

   On an individual patient level, our health promotion focuses on education, self-management and lifestyle modifications. Our approach begins with understanding the nature of the health problem, duration of problem, triggering events, problem frequency and intensity, positive and negative contributing factors, level and type of impairment, changes in lifestyle behaviors (e.g., sleep, appetite, exercise, concentration), substance use, mood changes (including thoughts of harming self or others), and family/social support. Our main intervention approach is using Motivational Interviewing (MI), an active, patient-centered approach effective in assisting individuals in resolving their ambivalence toward health behavior change (Rollick, Miller, & Butler, 2008). All of our providers are trained in MI. By utilizing MI, we are better able to elicit patients' own values and motivations for making life changes in the interest of their own health

and well-being, as well as enhancing their own self-efficacy for future challenges. Through our use of motivation enhancement, patients appear to have increased engagement and adherence to treatment, as well as better long-term outcomes.

On a clinic level, our health promotion relates to efforts in panel management and population health. Panel management is our proactive approach to identifying and contacting patients about care that they may not know they need. Our staff and Nurse Case Managers conduct *outreach management* through phone calls and letters to patients related to health needs (i.e., need A1C checks, clinic follow-up, etc.). *Inreach management* refers to informing patients about care gaps or providing education when they are in the clinic receiving care for an unrelated issue.

Our Quality Improvement (QI) program supports our efforts in both individual and population health. Our approach includes collecting and analyzing data on segments of our patient population and managing specific diseases within our clinic population (e.g., Diabetes, Colon Cancer, Breast Cancer). Once this process uncovers gaps in care, plans are developed and implemented for improving outcomes, aligning physicians, coordinating care, and optimizing efficiency and revenue.

**4. Comprehensive transitional care and follow-up care after inpatient treatment**

PFMC physicians practice full-scope Family Medicine across all health care venues. We manage our patients when they are in the hospital, in our clinic, in long-term care facilities and in their place of residence (including assisted living facilities and homeless shelters). One of our goals as a PCMH is to provide comprehensive transitional and follow-up care to our patients. In an effort to prevent reoccurring ED visits and/or hospital admissions, our clinic has implemented services that directly address this issue, including:

a) ED and Hospital Panel Management
Nurse Case Managers conduct daily panel management of discharged patients to determine appropriateness of visits and obstacles to alternative outpatient care. They contact patients to determine patient understanding of, and ability to follow through with, recommended treatment, offer support services, and arrange clinic follow-up as needed.

b) Transitions of Care Group Visits
Group medical visits allowing patients in a group setting to discuss ways they can work on their health in order to prevent reoccurring ED visits and/or hospital admissions. The group visit is co-facilitated by a physician, psychologist, nurse case manager, and a pharmacist (see Section 4.02.04(C)(2)(a) for more detail).

c) Interdisciplinary Care Team Meetings
Care team meetings are held regularly for routine care coordination needs and on an urgent basis. Examples of routine care team meetings include: High Risk OB Chart Review, Social Work Panel Management, and Geriatric/Palliative Care Treatment Team (Section 4.02.04(C)). The IDCT also convenes when a member of the IDCT has urgent

concerns about a patient (e.g., recent increase in ED visits, acute decompensation of mental status, etc.).

5. **Referral to community and social support services, including career and education training services**

   Social determinants of health can be barriers to accessing healthcare, even when the patient is insured (e.g., Medicaid) and services are available (e.g., same day appointments). PFMC works closely with community and social support services to identify and address these potential barriers to care, particularly in the Domains of Need outlined in Table 2 in Section 4.02.04. For example, our social workers assist patients in completing applications for housing through Neighbor Works, Cook Inlet Housing Authority, Alaska Housing Finance Corporation, RuralCAP, and other agencies. They also connect patients to local food banks and mobile food pantries. Our entire IDCT collaborates with other social service agencies to which patients may be connected, such as the Office of Children's Services, Nine Star, and Adult Protective Services. PFMC also works closely with other social support agencies based on patient-specific needs. We have close relationships with Refugee Assistance and Immigration Services (RAIS), Alaska CARES, the FASDx (Anchorage FASD Diagnostic Team), Anchorage Community Mental Health Services (ACMHS), Alaska Psychiatric Institute (API), Alaska Immigration Law Center, Disability Law Center of Alaska, the FBI (Victim Services), Anchorage Project Access, Anchorage School District (ASD), Brother Francis Shelter, Pride Foundation, and UAA, as well as many of the Providence system-based services such as Emergency Department, Psychiatric Emergency Department, Nurse Family Partnership, Home Health, Senior Clinic, and the Alaska Care Coordination Consortium (see Table 4 in Section 4.02.04(C)(2)(j) for an overview of our partner agencies and Appendix C for letters of support).

6. **Sustainability and the ability to achieve similar results in other regions of the state**

   Providence Health & Services operates health care facilities in several areas of Alaska outside of Anchorage (e.g., Seward, Valdez, Kodiak) as well as other primary care clinics in Anchorage. Providence Medical Group's ambulatory care clinics are in various stages of transforming from traditional primary care clinic models to PCMHs. Although those healthcare facilities/clinics are not included in this proposal, successful payment reform that supports care coordination will facilitate the expansion of PFMC's successful model to those clinics.

   PFMC is the continuity primary care clinic for the Alaska Family Medicine Residency program (AFMR). Each year we graduate 12 new Family Medicine Physicians, 77% of whom remain in Alaska to practice (see Appendix A for a map of Alaskan communities served by our graduates). To date, we have over 170 graduates. They practice in rural and underserved communities throughout Alaska. They are poised to be the agents of change for health care in our Alaskan communities. Supporting PFMC's successful PCMH model with an innovative payment model will benefit communities throughout Alaska. For example, one of our recent graduates is employed in a regional hub working at a tribal health organization to develop and seek NCQA accreditation as a PCMH.

7. **An innovative payment process, including bundled payments or global payments**
   As described in detail in Section 4.02.07, the cornerstone of our proposal is payment reform. We propose a blended payment model that continues FFS payments for physician services and adds a capitated (PMPM) fee for care coordination. Financial support for the work accomplished outside the traditional doctor/patient office visit, by care team members whose services are not currently billable, is essential to support the care of Medicaid enrollees and improve the health of our community. It will allow us to make our IDCT services available to all Medicaid enrollees, based on level of need, reducing overall utilization and total cost of care.

   Our proposed payment model is a logical first step on the road toward true payment reform which would likely include bundled/global payments and some element of risk sharing. This project will prepare us (DHSS and PFMC) to progress along the spectrum toward more advanced shared savings or risk-based models, and PFMC is fully committed to working collaboratively with DHSS as we continue the journey from fee-for-service to fee-for-value.

## D. Telehealth

Incorporating telemedicine and telehealth with the PCMH model means our patients, including patients with compromised mobility and other potentially marginalized groups, have increased access to supportive care from our providers and care teams. Telehealth can help us ensure continuity and effective coordination of care. According to the *Journal of General Internal Medicine*, primary care is valued when it comprehensively addresses "integration of care of acute and (often co-morbid) chronic illnesses, mental health and prevention," and allows for more narrowly focused care when necessary (Vogeli et al., 2007). In addition, telehealth has been found through randomized control trials to decrease hospital readmissions (e.g., Jerant, Azari, & Nesbitt, 2001). Over the past five years, PFMC has embarked on a multi-year plan to implement telehealth strategies. By consulting with primary care physicians and interprofessional providers in our clinic via telehealth, we believe that all aspects of the PCMH care can be anchored to one coordinating team and location.

Our first foray into telehealth was MyChart in 2011. MyChart is an online patient portal that allows patients to communicate with their doctor, access test results, request prescription refills, and manage appointments anytime, day or night. MyChart is a free service to all patients and gives secure, online access to the health care team and medical record – wherever the patient is. Through MyChart, all notes are open for patients to review the plan developed collaboratively with their care team.

In our transition to a PCMH, we restructured our nursing program to include four Nurse Case Managers, focusing on care coordination and patient education related to chronic medical conditions, as well as reducing ED utilization and inpatient hospitalizations. A component of the Nurse Case Managers' work includes the use of telephone-based interventions for patient education, health coaching, and self-management skill building between office visits. This effort has been found to be an efficient and effective way to improve patient care and patient self-efficacy around self-management of chronic health conditions, as well as a process to strengthen the

patient-care team relationship. This relationship enhances the effectiveness of care, and means patients are more comfortable speaking up if some aspect of their treatment is not working.

Because of our concern related to the possible lack of technology resources for patients in our safety net clinic, in 2015, we collaborated on a card study with the WWAMI Region Practice and Research Network (WPRN). Results suggest only 56% of our patient sample own a smartphone capable of using mobile health tools. Of those with access to a smartphone, 93% find health information, 77% use health apps, and 67% monitor their health issues using their smartphone. Based on these findings, we are committed to finding ways to further implement technology into our care and to support our patients in increasing their skillsets and access to this type of education, support, and health monitoring.

We believe telehealth is a natural bridge between patients in the PCMH and their primary care physicians. Therefore, by building on our current success, our future goals in telehealth include: (1) patient monitoring through personal technologies and remote monitoring devices and (2) secured face-to-face telehealth. Research suggests that proactive patient monitoring and education leads to earlier intervention and greater self-management, reducing costs and improving health. By allowing our Nurse Case Managers to provide care coordination to our patients through secured face-to-face telehealth, our follow-up after ED visits or inpatient hospitalizations will assure discharge plans are in place and barriers to care are addressed. We also plan to move from health coaching via telephone to the option of face-to-face telecommunication. Our HIPAA-compliant services will use computers and webcams to deliver a high-quality video conferencing experience without the cost of expensive video conferencing equipment. Our goal is to have the patient stay in the familiar surroundings of his or her home while receiving follow-up care.

## E. Project Alignment with SB 74 Initiatives

Our project aligns directly with the strategic vision of the State to re-conceptualize how health care is funded and delivered to Medicaid enrollees in a way that incentivizes quality care and cost containment/reduction. Our proposal reflects alignment with at least eight of the SB 74 initiatives.

1. **Behavioral Health Managed System of Care and 1115 Waiver**
   The 1115 Medicaid waiver process can allow for changes in eligibility, benefits, cost sharing, and provider payments. The State of Alaska is submitting its first 1115 Waiver Demonstration Project application in 2017. The 1115 Waiver application is focusing on behavioral health reform as a directive of SB 74. Through SB 74, DHSS is required to develop and manage a comprehensive and integrated behavioral health program that uses evidence-based, data-driven practices to achieve positive outcomes for people with mental health or substance abuse disorders and children with severe emotional disturbances. Within the Concept Paper submitted to Centers for Medicare and Medicaid Services (CMS), the State of Alaska recommended support for the development and expansion of integrated behavioral health services in primary care settings to provide evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) for these targeted populations, as well as trauma-informed primary care.

   Although there is no current billing mechanism for integrated behavioral health in primary care clinics in Alaska, PFMC has a strong track record for maintaining integrated behavioral

health services for our patients for the last seven years. Given our dedication to serving as a Level 3 PCMH, we have worked to refine the program with small seed grants from various entities (i.e., Mental Health Trust, Refugee Assistance & Immigration Services, and Pride Foundation) to better serve vulnerable populations in Anchorage. See Section 4.02.04(a) for a detailed description of our integrated Behavioral Health services. Our project includes the continued refinement of our integrated behavioral health program at PFMC and expansion to all Medicaid enrollees in our clinic.

Furthermore, as a component of SB 74 and the 1115 Waiver Demonstration Project, the State of Alaska is partnering with an Administrative Services Organization (ASO) for all behavioral health services. In this partnership, the ASO will provide behavioral health utilization management, claims processing, network management and provider recruitment, quality and data management, cost management, and other functions. Our clinic will become an approved provider through the ASO and commit to following all standards and contractual requirements outlined by Alaska ASO. Our integrated behavioral health services within our primary care clinic are an integral part of our PCMH and include trauma-informed and evidence-based screenings, assessments, and interventions. Our integrated behavioral health program targets care for complex, medically fragile, and dually diagnosed individuals, who struggle to access medical and behavioral health care. Our goal is to provide services earlier and more consistently to individuals who experience complex conditions that contribute to overutilization of emergency department and acute inpatient services. These goals align with the aspirations of SB 74, 1115 Waiver Demonstration Project, and the implementation of an ASO.

**2. Primary Care Case Management**

PFMC also aligns with the Primary Care Case Management initiative to increase the use of appropriate primary preventive care and decrease unnecessary ED utilization. At our clinic, case management is primarily conducted by our Nurse Case Managers, who manage different patient panels, making sure patients are checking in with their primary care provider and problem-solving barriers to accessing primary care service. Our Nurse Case Managers provide chronic disease management education, which emphasizes self-management and preventing complications that lead to ED visits and hospital admissions. Our Nurse Case Managers call every patient who visits the ED in order to assess the patient's understanding of their discharge instructions, ability to access medications and durable medical equipment, and barriers for the patients in accessing primary care. Appropriate referrals are made to members of our interdisciplinary team, such as Behavioral Health, Social Work, or Financial Counselor, if it is determined the patient has a psychosocial barrier which makes it difficult for them to access primary care services when appropriate.

For example, one patient was recently referred to Social Work and Financial Counseling after disclosing that he was going to the ED because he was uninsured and had no transportation, so it was easier for him to call an ambulance to take him to the ED. Our Financial Counselor helped him apply for Medicaid, and our Social Worker helped him arrange transportation to primary care medical appointments.

Our Social Workers also maintain a panel of patients with frequent ED utilization (i.e., 5+ visits in one year), and they meet on a regular basis with the patient's PCP, Nurse Case

Manager, and Behavioral Health Consultant to review the panel and develop a treatment plan to reduce ED visits.

**3. Health Homes**

Our PCMH reflects the vision of the Health Home initiative outlined in SB 74. We provide full-scope primary care, integrated behavioral health, and other long-term support and services, which address the person as a whole and emphasize chronic disease (both medical and mental health) management, as described throughout. We have the infrastructure to coordinate care across healthcare venues. We offer targeted, brief behavioral health consultation and intervention, which adheres to an SBIRT model, during primary care and urgent care appointments. We are able to address a wide variety of concerns, such as suicide risk assessment, mood and anxiety screenings and interventions, and mental status exams. We also frequently provide targeted health-related behavior change interventions for smoking cessation, chronic disease management, and substance use disorders. Additionally, we provide individual and group counseling for patients to provide longer term management of the aforementioned concerns. Medical and Behavioral Health providers also co-facilitate medical group visits, during which patients receive psychoeducation about chronic disease management and ways to manage stress. Our Nurse Case Managers are also strategically involved in the care of our patients with chronic disease, as discussed above, and we have on-site medical social workers who assist patients in arranging transportation, locating food, obtaining housing, accessing medications, applying for disability and guardianship and addressing other psychosocial barriers to accessing and benefitting from primary care.

4. **Emergency Department Improvement Project**

As the primary continuity clinic for Medicaid enrollees in the largest hospital system in Anchorage, we envision PFMC as a strategic partner in the Emergency Department Improvement Project. PFMC has already identified decreased ED utilization as a primary goal. In addition to our case management services described above, PFMC is launching innovative programs designed specifically to increase primary care access and decrease ED utilization. One example is our Transitions of Care (TOC) medical group visit, which is a standing, weekly group medical appointment available to all PFMC patients seen in the ED. During this visit, patients meet with a physician as well as the entire interdisciplinary team to identify and address the psychosocial obstacles that often underlie multiple ED visits. Ideally, all patients seen in the ED can be referred directly to the TOC group visit at discharge and have a direct pipeline into primary care, during which the interdisciplinary team will envelop the patient in supports designed to decrease reliance on the ED. Additionally, PFMC is in the process of expanding hours to increase access and decrease after-hours ED visits for non-emergent issues.

**5. Section 1915(i) and 1915(k) Home and Community Based Services**

Physician Assistants (PA-Cs) at PFMC conduct home visits and manage a panel of patients who are home-bound. They provide home safety evaluations in order to assess the needs for other services as well as necessary equipment. They also provide home wound

assessment which includes debridement and dressing recommendations, and work collaboratively with home health nurses. Home-based care also involves follow-up care for post-hospitalization and evaluation of needs due to other change in status, which can involve short-term home management services.

6. **Federal Policy on Tribal Medicaid Reimbursement**
   PHSA currently has an executed agreement with the tribal health system for tribal claiming.

7. **Innovative Payment Models**
   As described in detail in Section 4.02.07, the cornerstone of our proposal is innovative payment reform. We propose a blended payment model that continues FFS payments for physician services and adds a capitated (PMPM) fee for care coordination. Financial support for the work accomplished outside the traditional doctor/patient office visit, by care team members whose services are not currently billable, is essential to support the care of Medicaid enrollees and improve the health of our community. It will allow us to make our IDCT services available to all PFMC Medicaid enrollees, based on level of need.

   Our proposed payment model is a logical first step on the road toward true payment reform which would likely include bundled/global payments and some element of risk sharing. This project will prepare us (DHSS and PFMC) to progress along that spectrum toward more advanced shared savings or risk-based models, and PFMC is fully committed to working collaboratively with DHSS as we continue the journey from fee-for-service to fee-for-value.

8. **Stakeholder Engagement in Medicaid Redesign Implementation**
   To assure patient input and needs are incorporated into our care, we have maintained our own patient and family advisory group since 2011, entitled the Patient and Family Advisory Council (PFAC) Patient/Family/Staff Collaborating Council (See PFAC Charter and other documentation in Appendix D). The PFAC supports the mission of PFMC by working to enhance the patient and family care experience. The PFAC serves the purpose of informing and improving our service system. The PFAC will be a vital component of our Medicaid Redesign planning process by: (1) serving as an advisory resource to administration and staff of PFMC, (2) promoting improved communication and relationships between patients, families, and staff, (3) providing a venue for patients and families to provide input into policy and program development, (4) providing an opportunity for patients and families to participate in the development of new facilities, programs, and patient materials, and (5) actively helping to implement changes through input into the educational program for staff and securing timely customer feedback.

   The PFAC will continue to meet on a quarterly basis with additional meetings focused specifically on the needs of the Medicaid Redesign and Coordinated Care Demonstration Project. PFAC agendas shall be developed by the co-chairs with the assistance of Board members, and other PFMC representatives, to support the clinic in moving forward on the goals and objectives of the CCDP. Other stakeholder agencies, groups, organizations, or individuals desiring to participate in a specific meeting or place items on the agenda will be asked to do this in advance for approval by PFAC co-chairs and members. To maintain appropriate and confidential handling of personal information, no PFMC patient and/or

family member is discussed by name within or outside of PFAC meetings. In the event PFAC members have input regarding a particular patient or incident, that information shall be channeled to an appropriate hospital representative for follow-up. Non-staff guests are asked to sign a confidentiality agreement prior to attending a PFAC meetings.

Additionally, as described in Section 4.02.03(C)(5), PFMC routinely collaborates with community partners in the course of patient care. These partners, as well as other community stakeholders are summarized in Table 4 in Section 4.02.04(C)(2)(i); also see Appendix C for letters of support from some of our community partners.

## F. Alaska's Health Information Infrastructure

PFMC is committed to leveraging, where viable services exist, the health information infrastructure in the State of Alaska, including the Alaska eHealth Network (AeHN), recognizing that transparent, timely, and effective communication between providers is essential for health care redesign. Additionally, we recognize inter-agency communication is a key component of developing realistic payment models and quality metrics.

**4.02.04 PROGRAM STRUCTURE AND METHODS**

*Patient-centered care* became embedded in the language of health care through the Institute of Medicine's (IOM; 2001) landmark call to action entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*, in which they proposed six aims for improvement (health care needs to be: safe, effective, patient-centered, timely, efficient, and equitable) and ten rules for redesign of the U.S. health care delivery system to better meet the needs of Americans. Following the IOM publication, the primary care establishment quickly embraced the concept of *patient-centered care* due to long-standing values in primary care to provide whole-person care in collaboration with patients.

In the 15 years since IOM heralded patient-centered care, many attempts have been made to define, measure, and improve this model of practice including: National Committee for Quality Assurance (NCQA) certification, boutique amenities to enhance patient experience, infrastructural changes (e.g., electronic health records), a focus on chronic care management, population health, efficient clinic operations and/or a restructured payment model. The IOM's original aims and rules have been revised and now include four foundational elements (Bodenheimber, Ghorob, Willard-Grace, & Grumbach, 2014):

1. Engaged leadership
2. Data-driven improvement
3. Continuity of care
4. Team-based care

As well as six building blocks of *high-performing* primary care:

1. Patient-team partnerships
2. Population management
3. Continuity of care
4. Prompt access to care
5. Comprehensiveness
6. Care coordination

The original concerns that a patient-centered focus on individual needs might detract from an evidence-based approach to medicine have been resolved. "Proponents of evidence-based medicine now accept that a good outcome must be defined in terms of what is meaningful and valuable to the individual patient," (Epstein & Street, 2011).

In 2007, the American Academy of Family Physicians (AAFP), the American College of Family Physicians (ACP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) published the *Joint Principles of the Patient-Centered Medical Home,* which are outlined in Table 1.

Table 1.

*Joint Principles of the Patient-Centered Medical Home (AAFP, 2007)*

| Principle | Outcome |
|---|---|
| Physician-led practice | Patients have access to a personal physician, who leads the care team within a medical practice |
| Whole-person orientation | The care team provides comprehensive care, including acute care, at all stages of life |
| Integrated and coordinated care | Practices take steps to ensure that patients receive the care and services they need from the medical neighborhood, in a culturally and linguistically appropriate manner |
| Focus on quality and safety | Practices use the quality improvement process and evidence-based medicine to continually improve patient outcomes |
| Access | Practices commit to enhancing patients' access to care |

Also in 2007, PFMC began our transformation to become a PCMH, with a primary goal of providing more comprehensive patient-centered care. We began to evaluate our processes and to identify areas of improvement that would align us more closely with the Joint Principles of the Patient-Centered Medical Home (AAFP, 2007). We followed the TransforMED model of PCMH's outlined by the AAFP and endorsed by the Society for Teachers of Family Medicine (STFM). For eight years (2007-2014), TransforMED served as a model for PCMH development, and it guided the transformation of 700 primary care clinics, representing 25 million patient lives (AAFP, 2017; see Figure 1).

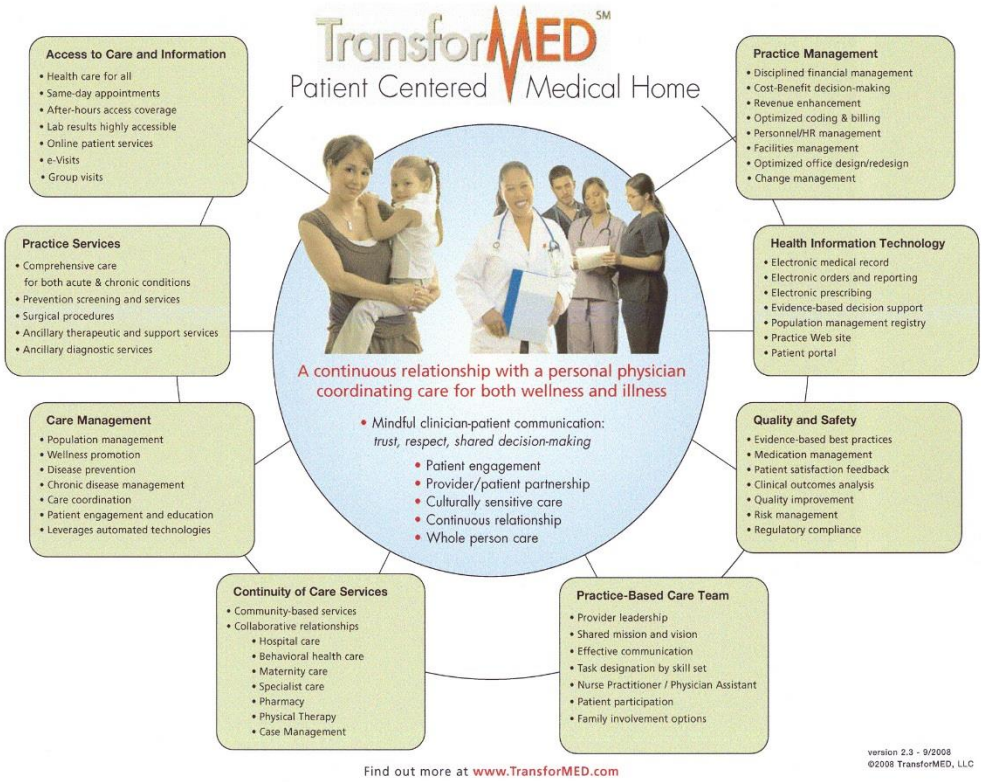


*Figure 1.* TransforMED

In 2009, PFMC was the first private/non-profit, non-tribal primary care clinic in Alaska to be certified as a Level 1 Patient Centered Medical Home by NCQA. In 2011, PFMC was certified as a Level 3 PCMH, which is currently the highest-level of certification obtainable through NCQA. In 2014 PFMC was re-certified as a Level 3 PCMH, and in early 2017, we were again re-certified with a rating of 99% (99 of 100 points). While NCQA recognition is rewarding, it is not enough. We need the infrastructure and payment reform in place to maximize the benefit of the PCMH. We are currently limited by FFS payment structures, as most services provided by the PCMH are not reimbursed, so the potential impact in patient care and outcomes are not fully realized at present. This is our purpose in applying for this demonstration project. We hope to validate the PCMH model of care for improving patient care and reducing cost for Medicaid enrollees.

At PFMC, we define the Patient Centered Medical Home as a robust practice model that efficiently and effectively accomplishes the "quadruple aim" of *improving population health, patient experience and provider satisfaction while reducing cost per capita*. At the core of our PCMH is the IDCT (illustrated in Figure 2), which includes the PCP/Certified Medical Assistant (CMA) pair, Behavioral Health, Social Work, Nurse Case Management, Home Visits, and Pharmacy. Our IDCT utilizes a biopsychosocial model for holistic and culture-centered care. In addition to the biological/physical needs of our patients, we consider the emotional, affective, cognitive, behavioral, spiritual, and personality subdomains and, within the social domains, the environmental, cultural, family, work, and interpersonal subdomains. Working from this expanded perspective makes us more aware of how aspects of diversity influence patients' clinical presentation and participation in health care. In addition, the role of stressful life events, repeated or chronic environmental challenges, and socioeconomic status are important in understanding an individual's vulnerability to illness. The need to consider functioning in daily life, productivity, performance of social roles, emotional stability and well-being, has emerged as crucial components in clinical investigation and interdisciplinary patient care.

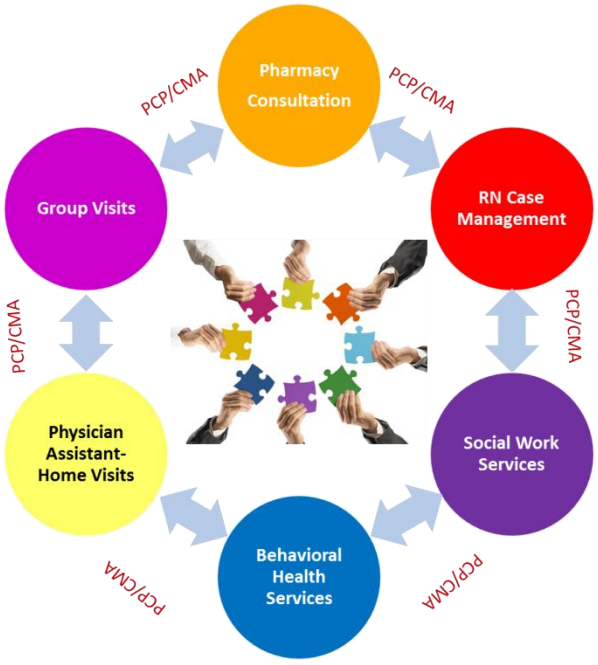


*Figure 2.* PFMC Integrated Direct Care Team

a) Integrated Behavioral Health Services
   Our integrated behavioral health program provides consultation and intervention; brief and long-term behavioral health care for co-occurring medical, mental health, and substance abuse issues; clinical health psychological assessment; shared medical appointments for chronic disease conditions; psycho-educational groups and medical group visits; interdisciplinary team consultation; and psychiatric consultation. Our program also provides on-site crisis triage and intervention for our primary care patients.

b) Social Work
   The essential function of our medical social workers is to connect patients to community resources including food, housing/shelter, financial support, and other services. Our social workers also arrange all Medicaid-funded transportation, including transportation for high-risk OB patients in Dutch Harbor and other Aleutian communities. Patients also meet with social workers for questions related to disability, guardianship, immigration, and safety planning.

c) Nurse Case Managers
   Our Nurse Case Managers provide psychoeducation about self-management of chronic disease. They also follow-up with patients who have been discharged from the ED or hospital inpatient and facilitate their transition of care back to primary care. Nurse Case Managers assist patients in acquiring durable medical equipment, accessing medications and identifying barriers to care.

d) Home Visits
   Physician Assistants (PA-Cs) conduct home visits with patients who are home-bound. Home Visits are individually designed services to provide diagnosis, treatment and health monitoring in order to preserve our patient's functional capacity to remain in his/her own home. Health monitoring includes disease prevention, the provision of health education and the identification of modifiable health risks. Through increased awareness and education, the patient is more apt to make healthy lifestyle choices which will decrease the likelihood of unnecessary institutionalization.

e) Pharmacy
   Through pharmaceutical consultation, our clinic provides comprehensive medication management, disease state management, drug interaction information, and anticoagulation management. Our pharmacy department also provides direct patient assistance with medical reconciliation and provides disease- and medication-specific psychoeducation to patients.

Additionally, the IDCT has developed a care plan that evaluates patient needs based on six domains (see Table 2).

Table 2.
*Domains of Need*

| Domains of Need | | |
|---|---|---|
| Domain 1 | Basic Needs | Shelter/living situation, food, safety, insurance, transportation, financial |
| Domain 2 | Diversity Needs | Language, legal/immigration, cultural beliefs, spiritual beliefs, gender identity and expression |
| Domain 3 | Functional Needs | Activities of Daily Living (ADLS), Instrumental Activities of Daily Living (IADLS), Other Activities of Daily Living (OADLS) |
| Domain 4 | Medical Needs | Acute, chronic disease, health maintenance |
| Domain 5 | Mental Health Needs | Mental Health/Substance Use Disorders, social support, stressors, coping, risk assessment and management |
| Domain 6 | Behavioral Health Needs | Health literacy, lifestyle (e.g., nutrition, exercise, safe sexual practices, etc.), stage of change (readiness, engagement) |

Once needs have been identified, patients are referred to the appropriate IDCT member. The IDCT members involved in a particular patient's care meet regularly to develop a care plan and coordinate specific interventions. In other words, in order to achieve *patient-centeredness*, we have "unpacked" the overcrowded office visit to re-focus on patient needs. We have re-distributed responsibilities among other members of the IDCT and across time (before, during, after, between office visits; see Figure 2). This has led to improved *patient-centeredness,* access, quality, cost, and provider/staff satisfaction, but is not sustainable because the services rendered outside the office visit and/or by the IDCT are not covered under the FFS payment structure, which also means our efforts have been concentrated on our patients with the highest, most apparent needs, and we have been unable to expand IDCT services to all PFMC Medicaid enrollees.

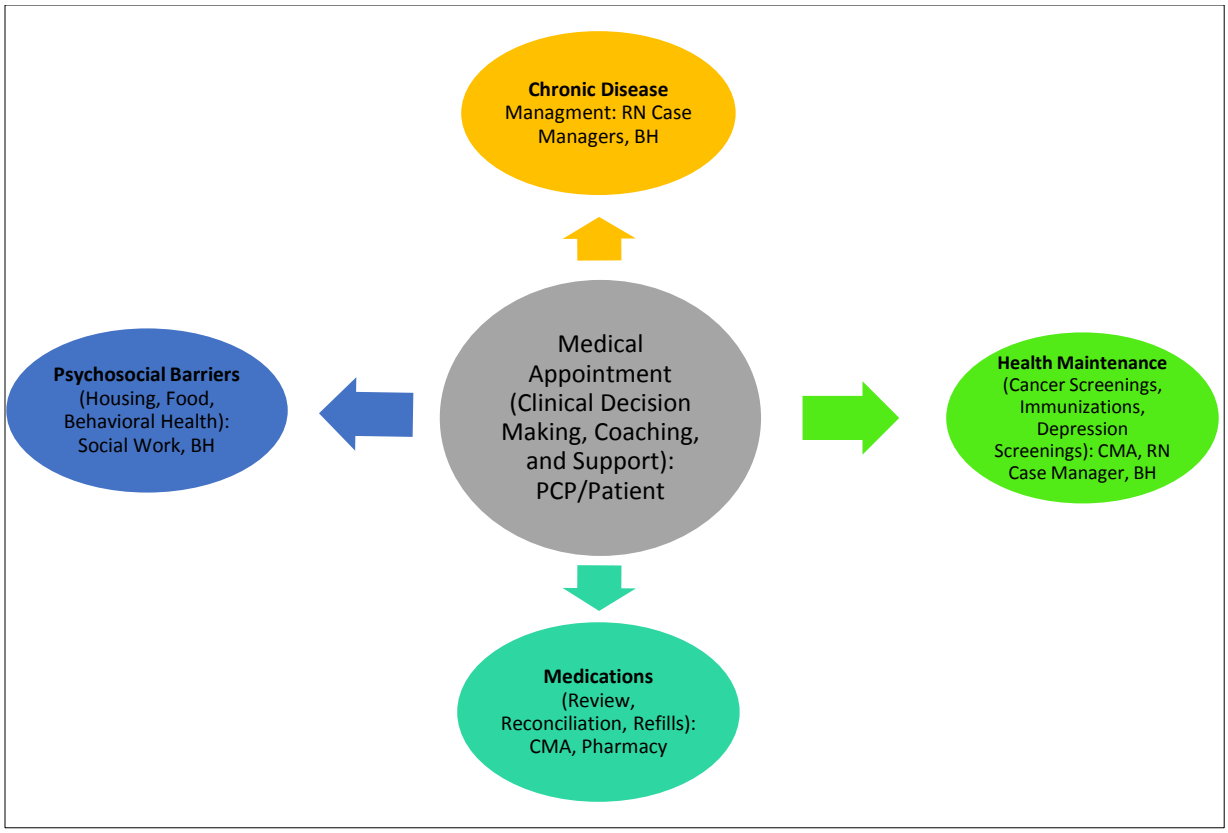


*Figure 3.* "Un-packing" the medical appointment and examples of how the IDCT supports patient care

The proposed project will promote person-centric care for all Medicaid enrollees seen in our clinic by providing access to IDCT services, which will be covered by a capitated PMPM payment structure. Therefore, Medicaid patients will be referred to the appropriate IDCT team member(s) based on identified needs in the six domains listed in Table 2 above. To illustrate the benefit of the PCMH model of care at PFMC and the IDCT, we have included one of our success stories:

*"Jane" is a young adult female, who has been a patient at PFMC for a little over one year. She was referred to PFMC by her OPA guardian, who said she was "out of options" for the patient. In the previous year, Jane had been to the Providence ED 155 times, and her guardian said she was also using EDs at Regional, ANMC, and Mat-Su, as well as urgent care clinics at a similar rate. No one knows exactly how many times she accessed those services, but it is assumed to be several hundred. The guardian also shared that Jane was calling 911 on a daily basis, not only for EMS transportation to EDs, but for "crises," such as her housemate stealing a stuffed animal. The guardian said she was in danger of losing her housing due to inappropriate uses of 911 and anger outbursts, and the patient was refusing to return to her primary care provider. The patient was referred with multiple diagnoses including Somatoform Disorder, Borderline Intellectual Functioning, FASD, PTSD, and Borderline Personality Disorder.*

*The IDCT met to develop a care plan for the patient before she was ever seen at PFMC. A resident was identified to be the primary medical provider, and a behavioral health counselor was assigned to work with the patient. A plan was developed that provided the patient with clear, specific*

*expectations and means of accessing support, including an identified CMA to take all of the patient's calls.*

*When the patient first came to PFMC, she presented as angry and resentful. Her hair was greasy and brushed in her face. She was not able to stay in the waiting area, because her behavior was disruptive, so she was immediately taken to an exam room, where she ignored providers and/or yelled profanities at them. However, her IDCT stuck to the care plan and slowly gained her trust. She began participating in behavioral health counseling, which focused on skill-building and appropriate expressions of frustration. Her behavioral health counselor met with the PCP regularly to coordinate their care and update the care plan as needed.*

*In the first 3 months of transferring to PFMC, the patient reduced her ED visits by more than half, and in the last year, she has only been to the ED once (for pneumonia). Moreover, the patient is actively participating in her treatment. She has not gotten into trouble at her Assisted Living Facility (ALF) in over a year, and her guardian has approved her to go on an out-of-state trip with her boyfriend, because her behavior has been so stable. Also, the patient seems happy. She frequently calls her behavioral health counselor, CMA, and/or PCP to relay good news.*

Jane represents one of many examples of patients who have benefitted from the PCMH at PFMC and from coordinated, targeted interventions by the IDCT. Our hope is to be able to expand this model to serve all Medicaid enrollees in our clinic. One strength of PFMC's PCMH is that it responds to an individual's needs. Some patients, for example, may not need to access the services of the entire IDCT, while other patients may require services from each member of the IDCT. Below are a few more examples of PFMC patients. We have chosen these examples, because they illustrate the adaptability of the PCMH to provide personalized care, based on need.

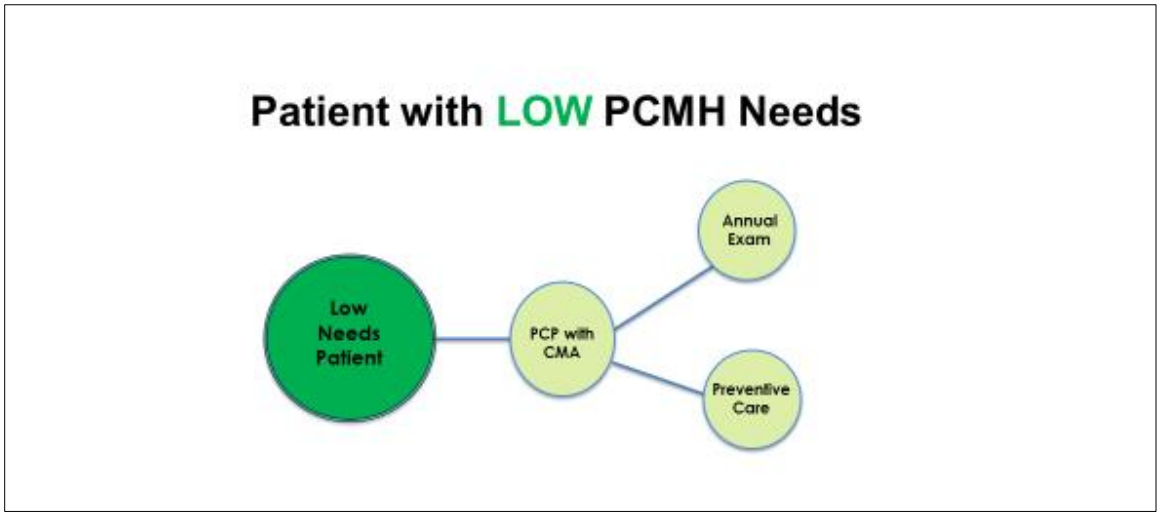


*Figure 4.* PCMH Example 1: 54 year old woman with no known chronic medical issues or significant risk factors. PCMH needs: annual exam (healthy lifestyle/self-management), reminders about preventive care, acute care (injuries/infections).

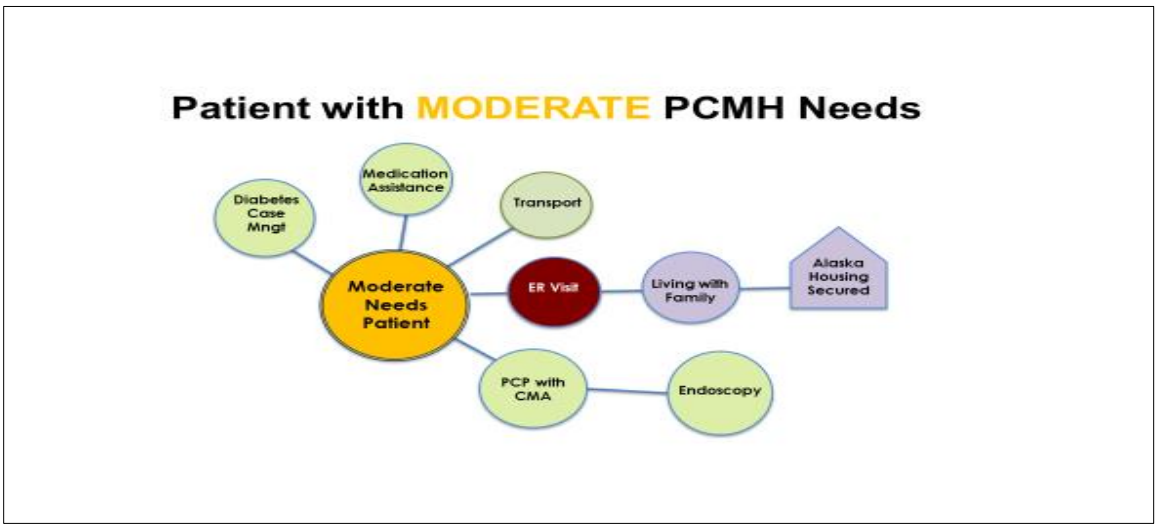


*Figure 5.* PCMH Example 2: 19 year old man with Type I diabetes, cognitive impairment (Fetal Alcohol Syndrome). Recently "graduated" from foster care. Struggles to navigate the Health Care system. Needs assistance securing safe housing, understanding/affording/using medications.

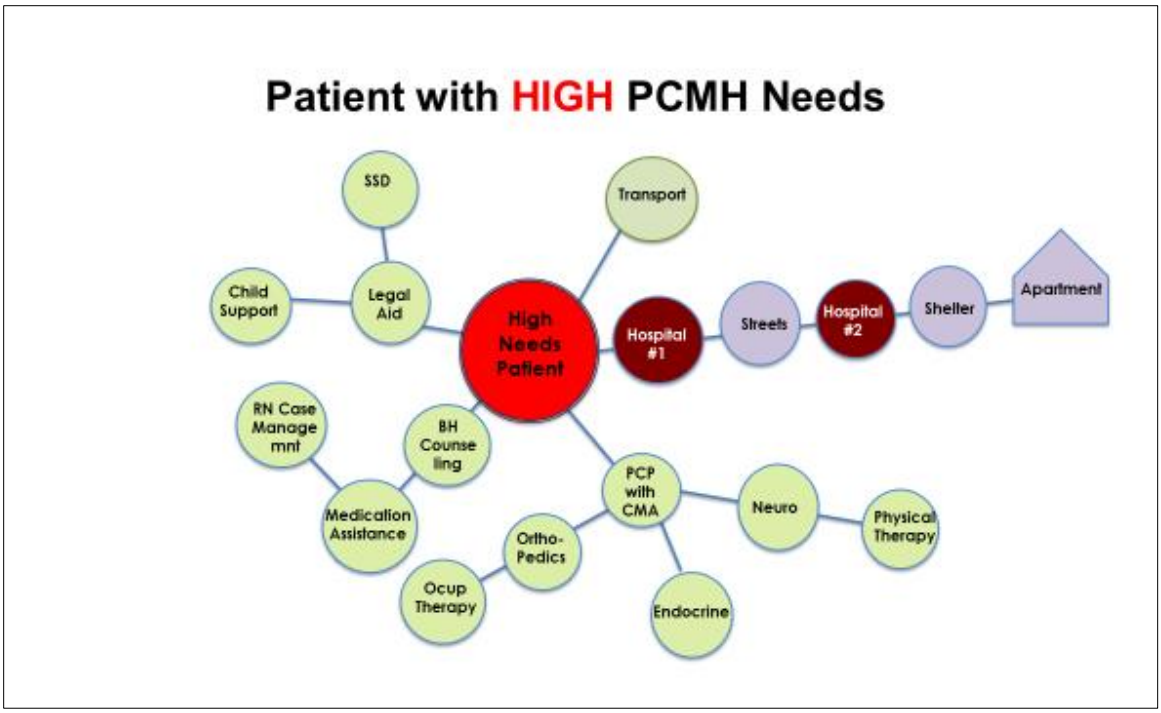


*Figure 6.* PCMH Example 3: 62 year old woman with multiple inter-related medical issues (obesity, DM II, HTN), cognitive impairment, low health literacy, mental health comorbidities (psychological and personality issues) that make it difficult to maintain housing, manage medications. Requires full IDCT team.

Research suggests the PCMH not only improves patient care but reduces costs (e.g., Nielsen et al., 2016). Our project aligns with the vision of the State for Medicaid Redesign because it emphasizes the integral role of quality, individualized care coordination based on patients' needs. Our goal for the Coordinated Care Demonstration Project (CCDP) is to provide evidence that our PCMH model of care can be expanded to all PFMC Medicaid enrollees by making small changes to the reimbursement structure, which will result in increased access for patients, decreased ED/Hospital utilization, and improved patient outcomes.

## A. Service Area

PFMC is located in midtown Anchorage and serves the entire Anchorage Bowl as well as some patients from the Mat-Su Valley and Kenai Peninsula. We also provide OB care for patients from the Aleutian chain who choose to relocate to Anchorage during the final trimester of pregnancy. We currently serve 11,000 unique patients, 4,100 of whom are Medicaid enrollees and 700 of whom are dually eligible for Medicare and Medicaid. We provide 38,000 office visits for medical appointments and 6,000 office visits with Behavioral Health and Social Work each year.

Providence Health & Services Alaska operates health care facilities in other areas in Alaska (e.g., Seward, Valdez, Kodiak) as well as other primary care clinics in Anchorage. Providence Medical Group's ambulatory care clinics are in various stages of transforming from traditional FFS models to PCMHs. Although those healthcare facilities are not included in this project proposal, successful payment reform that supports care coordination will facilitate the expansion of PFMC's successful model to those clinics.

There are also opportunities to expand our service area to communities where we have established connections through graduates of our residency program (see Appendix A).

## B. Covered Populations

### 1. Medicaid-eligible populations served by the proposed project

We have transformed our Family Practice into a PCMH. All of our patients are served by this model. We welcome all Medicaid-eligible patients. Most of our patients are not tribal beneficiaries, although some tribal beneficiaries enrolled in Medicaid do elect to receive care in our clinic. The number of Medicaid-eligible patients whom we can serve, and the extent to which those patients can be supported by the wide array of services that our care teams can provide, will be dependent on the payment model developed/implemented to support coordinated care.

### 2. Sub-populations

We recognize that the relationship between patients and chronic conditions is bidirectional, meaning that one condition (medical or mental health) can pre-dispose patients to, or exacerbate, another chronic (medical or mental health) condition and vice versa. The PCMH is strategically positioned to identify and provide care coordination for patients with one or more chronic diseases and/or co-morbid mental health conditions. For this demonstration project, we propose to validate the PCMH model and IDCT as a preferred model of primary care services, resulting in the *quadruple aim* discussed in Section 4.02.04, which is:

*improving population health, patient experience and provider satisfaction while reducing cost per capita.* For the purpose of this demonstration project, we have chosen to illustrate the usefulness of a PCMH and IDCT approach to the management of chronic medical and mental health conditions by focusing on the sub-populations listed below. It is important to note that patients who are not captured by the following sub-populations will still be enrolled in the PCMH and will receive essential care coordination of as part of the proposed project, which will include monitoring to determine if they become members of the sub-population over time. We have developed detailed care pathways for these sub-populations to ensure additional oversight needed by the IDCT and to monitor their effectiveness to meet sustainable goals.

The five subgroups currently identified for focused care coordination are outlined in Table 3.

Table 3
*Five subgroups for focused care coordination*

| **Sub-populations** | |
|---|---|
| **Cohort** | **Description** |
| High ED Utilization/Inpatient Hospital Admission | Patients with 5+ ED visits per year and/or 3+ inpatient admissions within one year |
| Patients requiring chronic pain management | Patients with an active prescription for an opioid from PFMC |
| Patients with uncontrolled diabetes | Patients with a most recent (within the last 3 months) A1C result of 7 or higher |
| Patients with depression | All adults (18+) who screen positive on a universal depression screening in the last 24 months |
| Patients in need of preventive cancer screenings | Patients in a qualifying age and gender cohort:<br>Colon Cancer (50-75 years old, male and female)<br>Breast Cancer (50-75 years old, female)<br>Cervical Cancer (21-64 years old, female) |

**3. Population changes over time**

Our Medicaid-eligible patient population is expected to evolve as changes in healthcare legislation are implemented. We will continue to enroll Mediciad patients in our PCMH. As we continue to assess our project efficiency, the subpopulations that we choose to focus on may change. We anticipate increasing the number of Medicaid enrollees in our panel by 10% (approximately 500 patients) over the course of this project (see Section 4.02.07). In addition, Providence Health & Services Alaska operates other ambulatory care clinics in Anchorage that are on the journey to becoming PCMH certified and are likely to expand capacity if/when payment reform will support coordinated care.

## C. Covered Services

### 1. Services for All Medicaid Patients

All patients served at PFMC are enrolled in our Level 3 PCMH (see Appendix E). They will have access to our full-scope primary care services for families (i.e., preventive care, acute care, chronic disease management, office procedures and minor surgery, pediatric care, perinatal care [particularly for high-risk OB patients], and geriatric/palliative care). Additionally, patients with identified needs will have access to our IDCT, which includes Behavioral Health, Social Work, Nurse Case Management, Home Visits, and Pharmacy. The IDCT works closely with the patient's primary care physician (PCP) to increase access, decrease utilization, and improve patient outcomes.

a) Chronic Disease Management

All staff, residents and faculty physicians are trained to use motivational interviewing (MI) techniques to illicit patient's own motivation for change while honoring their autonomy. Through the utilization of "behavior menus" PFMC providers offer additional education and resources around chronic disease management. See Appendix F for examples of behavioral modification tools, behavioral menus used with patients to identify and set goals. Additionally, identified patients will be referred to members of the IDCT who can support the patient's self-management of their own chronic disease. For example, as described above, our Nurse Case Managers can provide psychoeducation; our Behavioral Health Counselors can work with patients around motivation and overcoming barriers to achieving goals; and our Social Workers can assist patients and accessing resources that maximize their chances for success in meeting their goals (e.g., housing, food, transportation).

b) Universal Depression Screening

As part of our PCMH, we have implemented universal depression screening for our adult (18 year old+) patients, which is completed annually using the Patient Health Questionnaire-2 (PHQ-2) and followed by the Patient Health Questionnaire-9 (PHQ-9) if a patient screens positive on the PHQ-2 (see Appendix G for copies of the PHQ-2 and the PHQ-9). Universal screening gives providers an opportunity to speak to patients about depression and provide education and health promotion around symptoms management if applicable. Depression screening also helps to communicate to our patients that we strive to treat the whole person and reduces stigma related to depression and other mental health concerns common in primary care.

c) Integrated Behavioral Health Services

As described in Section 4.02.04, as part of our PCMH, PFMC offers fully integrated behavioral health (see Appendix H), which was developed from two evidence-based models: (1) Integrated Primary Care (Blount, 2003) and (2) the Primary Care Behavioral Health (Robinson & Reiter, 2007). Our integrated structure includes documentation in a shared EHR, shared clinic space, and shared administrative and financial systems. Types of behavioral health services are described in Section 4.02.04 and include evidence-based individual and group psychotherapy, psychological assessment, and brief,

solution-focused intervention. Our behavioral health consultants are trained to work with patients who often experience co-morbid medical and mental health conditions, and they work closely with PCPs to develop targeted interventions to improve motivation for self-management of chronic medical and mental health conditions. These interventions include Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use and other mental health conditions, Motivational Interviewing, Cognitive and Behavioral therapies, coping skills psychoeducation, and safety and stabilization for individuals who have experienced trauma. Integrated Behavioral Health Services are suited, not just for our sub-population of patients with depression, but for patients who need additional support managing chronic pain or diabetes, as well as for patients who have underlying behavioral health (e.g., motivation, problem-solving) and/or mental health (i.e., DSM-5 diagnosis), that underlie high ED utilization/inpatient admission.

d) Cancer Screening

PFMC follows the recommended guidelines for preventive cancer screening for colon, breast, and cervical cancer for all PFMC patients, as described in detail in Section 4.02.04(E)(2)(e) below. For those who screen positive, PFMC collaborates and makes referrals to Providence Oncology Services and/or other community partner agencies, such as Anchorage Project Access, to connect patients with additional screening and appropriate treatment and care.

**2. Services for Patients with Specific Identified Needs**

In addition to the services available for all Medicaid enrollees, those who have been identified through our domain-based needs assessment as having specific identified needs will be referred to as many of the following target services as applicable.

a) Transitions of Care Group Visits

PFMC is offering a post-hospitalization group medical appointment for most patients who have recently discharged from the ED or the hospital. The purpose of this group visit is to increase access and decrease utilization cost, and of course, to improve the health outcomes of our patients. More specifically, the purpose of this visit is to serve as a bridge between the hospital and primary care. During the visit, the patient will have an opportunity to identify a goal toward which they want to work with their PCP, in order to reduce the risk of re-hospitalization or ED utilization, and they will have a chance to discuss that goal, along with any questions they have about their discharge instructions, privately with a PCP for a brief assessment of emergent biopsychosocial needs (see Appendix I). Additionally, the patient has an opportunity to meet with the entire IDCT, which includes Behavioral Health, Social Work, Pharmacy, and Nurse Case Management, during which time the team works with the patient to identify psychosocial barriers to meeting health goals (e.g., insurance coverage, transportation, housing, anxiety, substance use, etc.), and begins to provide targeted, brief interventions to address those barriers. The group visit is offered on a weekly basis, so anyone who was in the hospital within the last week can attend.

b) Chronic Pain Management

PFMC is committed to effective chronic pain management, which includes reducing the use of opioid medications. PFMC recognizes that opioid addiction is an epidemic in Alaska (as recently stated by the Governor), and part of our PCMH model involves interdisciplinary support for alternative methods of managing pain. Existing management methods involve a controlled-substance agreement, which outlines the exact circumstances under which opioid medications will be prescribed and often require patients to connect to their interdisciplinary team (e.g., Behavioral Health) to explore alternative strategies. PFMC plans to launch a chronic pain management team, which will review the charts of all patients on controlled substances for chronic pain management and make recommendations to the PCP for consolidating and reducing opioid medications and providing alternative supports (e.g., cognitive behavioral therapy) that can be accessed within the medical home.

c) Diabetes Group Visits

PFMC offers interdisciplinary Diabetes Group Medical Visits (GMVs) for patients with diabetes and pre-diabetes. The group consists of 6 weekly modules, designed to increase self-management confidence and ability and decrease diabetes-related complications, for which patients often present to the ED and often result in hospital admissions. The group visit is co-facilitated by a Physician, Psychologist, Nurse Case Manager, Physician Assistant, and a Pharmacist. The interdisciplinary team provides psychoeducation about diabetes management, and members of the group set goals for themselves and provide support to one another. To evaluate the efficacy of our Diabetes GMV model, a research study was conducted between 2010 and 2013. The study findings support its use within our clinic setting as participants in our Diabetes MGV evidenced a reduction of 0.7% in blood glucose levels at the end of the intervention and a majority of participants attaining diabetes control at the 3-month follow-up visit (Zuniga, 2013).

d) Refugee Health Clinic

This clinic is an innovative, interdisciplinary approach to refugee health screening and includes a universal mental health screening for newly resettled refugees, as well as brief intervention and referral to treatment, based on the SBIRT model. The clinic includes a resident physician, behavioral health consultant and certified medical assistant. Each team member is responsible for completing different components of the visit, which includes a history and physical, immunizations, labs, and mental health screening (see Appendix J).

e) Hmong Refugee Support Group

This program has been in operation continuously since 2005, and approximately 15 members attend each week. The group was originally designed to serve as a peer support network for recently resettled refugees. Over the years, the group has served its original purpose as well as operating as a therapeutic processing group, providing training for citizenship examinations, providing social time, facilitating arts and crafts

activities, and providing psychoeducation about medical care. Currently, the group operates as an interdisciplinary group, which includes behavioral health counselors and resident physicians.

f) Geriatric Interdisciplinary Support Clinic
There is, and will continue to be, a need for palliative care and geriatric providers in Alaska. This gap cannot be met solely by specialty care. In our PCMH model, primary care providers work with an interdisciplinary team to provide comprehensive care that is informed by the expertise of our various providers. The clinic occurs every other week and includes Behavioral Health, Pharmacy, Social Work, Palliative Care, Spiritual Care, and Nurse Case Managers. Patients and their caregivers are seen by the team and recommendations are made to the patient's primary care team. The support clinic recommendations become the core of the patient's short and long-term treatment plan.

g) Maternal Psychosocial Intake and Needs Assessment
For newly established obstetric patients, PFMC behavioral health clinicians provide an initial psychosocial intake and needs assessment following the patient's prenatal appointment. The information gathered helps to identify potential areas of concern and needs for women early on in their pregnancy. Information gathered includes: relationship status, social support system, maternal health history, psychiatric and substance use history, domestic violence screening, social determinant concerns (i.e., health insurance, access to food, language need, cultural/spiritual considerations) and lifestyle practices (i.e., diet, exercise, stress management). The intake process also includes conducting an initial perinatal mood disorder screening using the Edinburgh Postnatal Depression Scale (see Appendix K). Based on the information gathered, clinicians offer a brief intervention (i.e., sharing information about normal mood fluctuations during pregnancy, mindfulness exercises, sleep hygiene, etc.) and referrals are made to connect women with appropriate resources (i.e., behavioral health counseling, social work, financial counseling). The information gathered is documented within the shared EHR so that all providers are aware of the psychosocial variables impacting their patients and how best to support women during their pregnancy and the post-partum period.

h) Interdisciplinary OB Chart Review
A weekly standardized chart review is performed for 4 to 6 PFMC OB patients who are typically in their 3rd trimester (see Appendix L). Team members include: OB Faculty, Family Medicine Residents, OB CMA, Social Work and Behavioral Health clinician. Residents present their assigned patients to the team in a standardized fashion utilizing a check-box form. One team member keeps track of items requiring follow up as well as other considerations based on the chart review. Social Work and Behavioral Health communicate any additional psychosocial variables which may impact the woman's care (prenatal and postpartum). An EHR message is sent to the patient's PCP with listed considerations and follow up items to complete.

i) Referrals to Partner Agencies

The IDCT works closely with community partners to identify resources for patients with specific needs and make referrals to appropriate agencies to augment the patient's PFMC care plan. See Table 4 for an overview of our primary community partners and Appendix C for letters of support from some of these stakeholders.

Table 4.

*Partner Agencies and Community Stakeholders*

| Partnering Community Organization | Partnering Community Contact | Population Served |
|---|---|---|
| Alaska Care Coordination Consortium | **LeeAnn Horn, RN, MSN** *Senior Services Director* | Population Health Management |
| Alaska CARES | **Bryant Skinner** *Manager* | Families in crisis |
| Alaska Institute for Justice | **Barb Jacobs** *Program Director of the Language Interpreter Center* | Immigrants & Refugees |
| Alaska Psychiatric Institute | **Michael Alexander, MD** Director of Psychiatry | Psychiatric acute care |
| Anchorage Community Mental Health Services (ACMHS) | **Mike Sobocinski, PhD** *Corporate Operations Officer* | Individuals with Severe and Persistent Mental Illness (SPMI) |
| Anchorage Project Access | **Charlene Spadafore Vassar** *Executive Director* | Low-income, Uninsured |
| Anchorage School Based Health Centers | **Heather Ireland** *Program Director* | Anchorage School District Middle & High School Age-Children |
| Brother Francis Shelter (BFS) | **Lisa Caldeira** *BFS Program Director* | Homeless population |
| Center for Behavioral Health Research & Services (CBHRS) – Artic-SBIRT Project | **Diane K. King, PhD** *Director of CBHRS* | Service Providers |
| Disability Law Center of Alaska | **Dave Fleurant** *Executive Director* | Patients applying for SSDI |
| Federal Bureau Intelligence (FBI - human trafficking) | **Erin Patterson, MA** *FBI Victim Specialist* | Victims of Human Trafficking |
| FASDx Services, LLC Anchorage FASD Diagnostic Team | **Marilyn Pierce-Bulger, ANP** *Owner/Manager* | For patients with possible FASD(s) |
| Municipality of Anchorage (Department of Health & Human Services) | **Melinda Freemon, MS, LPC, CCS** *Director of Department of Health & Human Services* | Medicaid, Medicare, Uninsured |
| Nine Star Education & Employment Services | **Monica Prince** *Case Manager* | Vocational Case Management |
| Nurse Family Partnership ® | **Dana Caudell, RN** *NFP Program Director* | Low-income, first time mothers |
| Pride Foundation | **Josh Hemsath** *Regional Philanthropy Officer* | LGBTQ population |
| Providence Emergency Department | **Daniel Safranek, MD** *Medical Director* | Patients in need of acute, basic care & psychiatric crisis services |
| Providence Home Health | **Deb Seidl** *Director of Home Services* | Home-bound patients |
| Providence Senior Care Center | **Sylvia Solomon, MD** *Medical Director* | Medicare patients |
| Refugee Assistance & Immigration Services (RAIS) | **Jessica Kovarik, MA** *RAIS Program Director* | Established and Newly Resettled Refugees |
| Vocational Rehabilitation (State of Alaska) | **Stacy Niwa** *Case Manager* | Patient with medical or mental health barriers to employment |

## D. Eligibility or Enrollment Criteria

### 1. Eligibility or Enrollment Criteria That Could Have a Significant Impact on the Enrolled Population

All Medicaid enrollees served in our PCMH have access to the full array of services (see above). We do not anticipate that eligibility or enrollment restrictions will have an impact on this demonstration project.

### 2. Mandatory vs. Voluntary Enrollment

All Medicaid enrollees served in our PCMH have access to our full array of services. All services offered through our clinic are voluntary. Patients have the right to participate in or refuse services offered through our clinic. Our clinic strongly embraces the Providence Health & Services Alaska policies on patient rights and privacy. Patients have a right to make decisions about their future and the future of their children or anyone for whom they serve as legal guardian and, therefore, we do not provide care that is mandatory in nature.

We intend to consider all Medicaid enrollees who seek care at our clinic to be "in scope" for this proposed demonstration project, and would consider their cost/quality/access metrics to be part of our project. That is, we do not intend to give Medicaid enrollees who seek primary care at PFMC the option to opt-out of the demonstration project itself.

### 3. Minimum and/or Maximum Thresholds and Rationale

All Medicaid eligible patients are automatically enrolled in our PCMH and receive various levels of intervention. There will be no defined minimum or maximum thresholds for enrollment or eligibility. Our goal is to utilize a risk based stratification formula to identify each patient's level of need and to provide effective/efficient care coordination for all of our patients based on their individual needs.

## E. Care Coordination

### 1. Risk Stratification

PFMC uses a variety of data sources available within Providence Health & Services Alaska (PHSA) to aggregate data for stratifying patients into different categories based on their use of services, demographics, and co-morbidities. This allows us to calculate an individualized risk score for each patient in our clinic. Variables used in the stratification are listed below in Figure 7. Variables in the stratified data were selected based on the intended goals we expect to impact, and the example below reflects some, but not all, of our current Medicaid enrollees. Our risk stratification is a continually evolving process and will be reviewed on a quarterly basis to identify appropriate focus on specific subpopulations, and to ensure that new patients have been integrated into the system. In addition, PFMC will compare our risk stratification of Medicaid enrollees to the Milliman Risk Score (described below in Section 4.02.04(E)(3)) to ensure fidelity of our stratification methodology.

*Figure 7.* Risk stratification

2. **Comprehensive Assessments for Members with Complex/Chronic Conditions**
Our clinic currently utilizes the EPIC EHR system. Providence Health & Services has built extensive reporting options for users to identify meaningful sub-populations from EHR data. Examples of our process for identifying five such sub-populations (High ED Utilization/Inpatient Admission, Chronic Pain, Diabetes, Depression, and Cancer Screening) are outlined below. Additionally, as described in Section 4.04.04(E)(f) below, PFMC is in the process of adopting athenahealth's population health management tool, which is designed to identify different cohorts of patients, including identified sub-populations.

a) Identifying Patients with High ED Utilization/Inpatient Admissions
On a daily basis, Nurse Case Managers produce and review an ED visit panel report. This report identifies patients who were discharged from PAMC ED within the last 24 hours. The list is filtered to identify patients with a PCP at PFMC and distributed to the appropriate team for follow-up. PFMC is divided into four clinical teams and each team has one Nurse Case Manager. The Nurse Case Manager on each team contacts the patients on his or her list to assess follow-up needs and barriers to care and to schedule a follow-up visit with a PCP and/or the Transition of Care Group Visit described above in Section 4.02.04(C)(2)(a). If, after three attempts, we are not successful in reaching the patient by phone, then a letter is sent for contact. The encounters are documented in the shared EHR, and routed to appropriate team members for additional follow-up. For example, if the Nurse Case Manager learns that one of the barriers to accessing primary care was a lack of insurance, the encounter will be routed to the Financial Counselor and/or Social Work for follow-up. Or, if the Nurse Case Manager learns that a barrier to accessing primary care is related to a mental health condition (e.g., anxiety), the encounter is routed to a Behavioral Health consultant for follow-up.

PFMC patients who are admitted to PAMC are managed by the PFMC providers on the Family Medicine Service (FMS). They are identified and monitored via the "whiteboard" in our shared EHR. Each Nurse Case Manager has access to the PAMC "whiteboard". The Nurse sorts the list by patient and PCP, monitors their progress during their stay and coordinates with the inpatient discharge planner for any follow-up needs that are identified during the stay. Once the patient is discharged, the Nurse Case Manager follows-up according to the same protocol outlined above for patients who have been discharged from the ED.

b) Identifying Patients with Chronic Pain
Currently, the PFMC Medical Director runs a monthly report of PFMC patients on chronic controlled substances (i.e., 3+ months of continuous use). PFMC is in the process of launching a comprehensive chronic pain management curriculum for our Family Medicine residents and a chronic pain management program for all patients receiving opioid medications for pain management. This program will include (1) a revised and updated controlled substance agreement, which will be signed in conjunction with patient education about policies regarding opioid use and objective assessment of mismanagement/misuse risk, (2) a chronic pain management interdisciplinary team, which will review patients at risk for opioid mismanagement and/or opioid misuse and make recommendations to the PCP, and (3) Behavioral Health

referrals when recommended for supplemental support and alternative pain management strategies, including individual therapy, brief intervention, and a chronic pain management group visit.

c) Identifying Patients with Diabetes
On a quarterly basis, the Nurse Case Managers produce and review a Diabetic Panel Report, sorted by care team (patient and PCP/CMA). The Nurse Case manager consults with the PCP about the most appropriate follow-up procedure (e.g., scheduling a PCP visit to discuss medication changes and evaluate potential complications, scheduling an Nurse Case Manager visit for psychoeducation, referring the patient for updated lab work, or referring the patient to the Diabetes Group Visit described in Section 4.02.04(C)(2)(c). Finally, the list is distributed to the CMAs and each CMA contacts the patients on his/her care team using a diabetes script (see Appendix M) to schedule the diabetes care plan visit and/or lab work. The telephone encounter is documented in in the shared EHR. If, after three attempts, the CMA is not able to reach the patient by phone, the CMA generates a letter to be mailed to the patient.

d) Identifying Patients with Depression
During each medical appointment, Best Practice Alerts (BPAs) and Health Maintenance Alerts (HMAs) appear in the patients EHR, which identify potential patient-based care needs. A BPA is an evidence-based advisory triggered by patient-based factors. The purpose of the BPA is to provide the clinician with clinical decision-making support. One of the BPAs is a depression screening within the last year. If a patient is in need of a depression screening, the CMA will conduct the initial screening with the PHQ-2. If the patient screens positive on the PHQ-2, he or she completes a longer screening tool, the PHQ-9 (see Appendix G for both screening tools). If the patient screens positive on the PHQ-9, the PCP discusses depression and options for treatment with the patient, which may include immediate intervention by a behavioral health consultant and/or a referral to Behavioral Health for follow-up. The PCP places a referral to the integrated Behavior Health Department based on patient request, PHQ-9 scores, or if the patient agrees with the PCP's recommendation for counseling. PCPs typically place referrals for individual counseling for patients who report psychological distress or desire for behavior change. Based on initial assessment, the PCP will document depression in the EHR problem list for notification to care team.

e) Identifying Patients in Need of Cancer Screenings
PFMC follows nationally recommended screening guidelines for colorectal, breast, and cervical cancer, which are:

i. Colorectal Screening (men and women aged 50-75 years)
For patients with no risk factors for colorectal cancer, patients are offered different screening options (i.e., FIT test or screening colonoscopy).

ii. Breast Cancer Screening (women aged 50-75 years)
An annual mammogram recommended for all low-risk patients.

iii. Cervical Cancer Screening (women aged 21-64 years old)
For those with no risk factors and normal past screening results, all patients are screened in the office every three years. PFMC also follows the recommended guidelines for vaccination against the Human Papilloma Virus (HPV) between ages 11-12 for males and females and females aged 13-16, who have not completed the series.

On a monthly basis, preventive cancer screening numbers for PFMC patients are reported as a primary care metric. PFMC has implemented the Primary Care Provider Dashboard, which highlights the percentage of each provider's patient panel that is current with preventive cancer screenings each month. This provides a visual 'report card' for each provider and illustrates patient compliance (see Appendix N for an example of a PCP Dashboard).

f) Care Plans for Members with Complex/Chronic Needs
Providence St. Joseph Health is currently adopting athenahealth as a resource for developing care plans, which gives PFMC access to the this platform for care coordination solutions. Athenahealth is a cloud-based care management and population health tool. Care team members can segment their patient population by factors such as diagnoses, risk scores, and hospital utilization to identify potential new patients for care management. Athenahealth allows providers to identify potential patient needs in all six of the domains of care described throughout (i.e., Basic Needs, Diversity Needs, Functional Needs, Medical Needs, Mental Health Needs, and Behavioral Health Needs), so it is a natural fit for our PCMH IDCT. Sources of data integrated into Athenahealth include payor claims and eligibility, Admit/Discharge/Transfer (ADT) feeds, and EPIC (EHR) information. The tool is also used to track and document care for actively managed patients, with the ability manage and update care plans, document patient events and assessments. Athenahealth also allows care managers to view, manage, and prioritize their panel of patients and find patients that need follow-up to ensure no one is slipping through the cracks. Athenahealth includes access to a risk score generated through the Milliman Advanced Risk Adjusters™ (MARA) which is a superior, scalable tool for the discovery of health risks, clinical conditions driving risk predictions, and resource needs from both prospective and retrospective view.

g) Health Information Infrastructures and Alaska's Health Information Exchange (AeHN)
As noted in 4.02.03(B), PFMC is committed to working with the State of Alaska to incorporate existing health information infrastructures for the sharing and management of all data related to this project.

## F. Payment Model

PFMC proposes a payment model which continues current fee-for-service payments for physician services and adds a capitated $5.00 PMPM care coordination fee component to support PCMH services which are currently non-reimbursable in the current FFS environment. This care coordination fee would include the following services at an expanded level: Behavioral Health, Social Work, Pharmacy, Home Visits and Nurse Case Management. PFMC is currently providing these services to Medicaid enrollees who seek care at our clinic, and this new source of funding will allow

us to expand and enhance these services for additional Medicaid enrollees who currently do not have a primary care provider in the community.

## G. Location of Operations

Clinical and administrative operations for this demonstration project will be performed at Providence Family Medicine Center at 1201 E. 36th Ave. in midtown Anchorage. Care coordination services will be based out of the clinic. Other healthcare services may be provided throughout Anchorage in the form of home visits, referrals and other care coordination services.

## 4.02.05 DEVELOPMENT, IMPLEMENTATION, MANAGEMENT, AND EVALUATION PLANS

### A. Overarching Goal of Demonstration Project

By receiving a PMPM Care Coordination payment, our PCMH model will expand services to all Medicaid enrollees, improving the quality of clinical care and patient health, resulting in reduced upstream service use and Medicaid expenditures. In order to meet this overarching goal, we have outlined four main objectives to guide us in the expansion needed to successfully conduct this demonstration project. These objectives are based on the recommendations from the Medicaid Redesign + Expansion Strategies for Alaska (Agnew::Beck Consulting, 2016). The four objective areas are: (1) Improve Health, (2) Optimize Access, (3) Increase Value, and (4) Contain Costs. All clinic strategies and activities, falling within these four objective areas, help us to successfully achieve a PMPM cost neutral service model by adapting and refining our current PCMH and IDCT care model.

1. **Objective 1: *Improve Health*** through full Medicaid patient engagement in our PCMH and IDCT care model.
    a) Clinic Strategies
        i. Initiate and continue active Care Coordination and Panel Management for Medicaid enrollees
        ii. Expand IDCT services to all eligible Medicaid enrollees based on need
        iii. Develop and maintain domain-based IDCT care plan for Medicaid enrollees
        iv. Conduct Patient Risk Stratification analyses
        v. Refine and implement workflows for high utilizers, as well as other target sub-populations

2. **Objective 2: *Optimize Access*** through extended hours and services for Medicaid enrollees to achieve effective whole-person care.
    a) Clinic Strategies
        i. Seek input from key stakeholders and internal/external partners related to clinic and services access
        ii. Assure prompt access to care through extended clinic hours
        iii. Assure expanded services reach Medicaid enrollees based on level of need
        iv. Evaluate activities, processes, and outputs related to access to care
        v. Assess patient and provider satisfaction related to access

3. **Objective 3: *Increase Value*** of care through monitoring and improving health outcomes within the Medicaid patient population
    a) Clinic Strategies
        i. Conduct on-going performance measurement and monitoring of all health-related metrics
        ii. Implement QI projects to improve quality metrics
        iii. Implement data-driven improvements related to quality and safety
        iv. Engage key stakeholders and internal/external partners in PCMH and IDCT evaluation
        v. Assess patient and provider satisfaction with overall system of care

4. **Objective 4: *Contain Costs*** through health promotion and reduction of unnecessary utilization by providing the right intervention in the right setting at the right time.
    a) Clinic Strategies
        i. Analyze baseline claims to understand over-utilization
        ii. Conduct on-going cost and utilization analyses with claims data
        iii. Evaluate activities, processes, and outputs related to cost neutrality
        iv. Disseminate findings related to PMPM cost neutrality

**B. Implementation Plan and Timeline**

**1. Major Development/Implementation Tasks**

In order to meet the goals and objectives as outlined in this proposal, specific strategies and development tasks will be necessary to carry out our demonstration project. These activities are listed below with a timeline, milestones expected to be achieved, and staff responsible for the activities listed. See our Gantt chart in Section 4.02.05(B)(3) for a more detailed view of our three-year plan and Tables 5-8 below for an overview of implementation strategies in relation to our four objectives.

Table 5.
*Objective 1: Improve Health through full Medicaid patient engagement in our PCMH and IDCT care model*

| Strategies | Responsible | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Initiate and continue active Care Coordination and Panel Management for Medicaid enrollees | QI Staff<br>RN Case Managers | x | x | x |
| Expand IDCT services to all eligible Medicaid patients based on need | IDCT*<br>PCP<br>CMA | x | | |
| Develop and maintain domain-based IDCT care plan for Medicaid patients | IDCT*<br>PCP<br>CMA | x | x | |
| Conduct Patient Risk Stratification analyses for all Medicaid enrollees | QI Manager<br>Business Analyst | x | | x |
| Refine and implement workflows for high utilizers, as well as other target sub-populations | Program Director<br>Medical Director<br>Practice Manager<br>RN Case Managers<br>QI Manager | x | x | |

Table 6.
*Objective 2: Increase Value of care through monitoring and improving health outcomes within the Medicaid patient population*

| Strategies | Responsible | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Conduct on-going performance measurement and monitoring of all health-related metrics | QI Staff | x | x | x |
| Implement QI projects to improve quality metrics | Program Director<br>Medical Director<br>Practice Manager<br>Clinic Manager<br>RN Case Managers<br>QI Manager<br>All clinic providers and staff | x | x | x |
| Implement data-driven improvements related to quality and safety | Program Director<br>Medical Director<br>Practice Manager<br>Clinic Manager<br>QI Manager | x | x | x |
| Engage key stakeholders and internal/external partners in PCMH and IDCT evaluation | QI Manager<br>BH Director<br>Clinic Manager | | x | x |
| Assess patient and provider satisfaction with overall system of care | QI Staff<br>Clinic Manager | | x | x |

Table 7.
*Objective 3: Optimize Access through extended hours and services for Medicaid patient to achieve effective whole-person care.*

| Strategies | Responsible | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Seek input from key stakeholders and internal/external partners related to clinic and services access | QI Manager<br>Clinic Manager | x | x | x |
| Assure prompt access to care through extended clinic hours | Clinic Manager<br>QI Manager<br>All clinic providers and staff | x | x | x |
| Assure expanded services reach Medicaid enrollees based on level of need | Medical Director<br>QI Manager<br>IDCT* | x | x | x |
| Evaluate activities, processes, and outputs related to access to care | Medical Director<br>QI Manager<br>BH Director<br>Business Analyst | | x | x |
| Assess patient and provider satisfaction related to access | QI Staff<br>Medical Director | | x | x |

Table 8
*Objective 4: Contain Costs through health promotion and reduction of unnecessary utilization by providing the right intervention in the right setting at the right time.*

| Strategies | Responsible | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Analyze baseline claims to understand over-utilization | QI Manager<br>Business Analyst | x | | x |
| Conduct on-going cost and utilization analyses with claims data | QI Manager<br>Business Analyst | | x | |
| Evaluate activities, processes, and outputs related to cost neutrality | QI Manager<br>Business Analyst | x | | |
| Disseminate findings related to PMPM cost neutrality | QI Manager<br>Business Analyst | | x | x |

**2. Barriers to Implementation**

In our experience, the most significant barriers to implementing the patient-centered model of care proposed in our CCDP are:

a) Fee-for-service Culture

Alaska's health care community is currently entrenched in a culture of fee-for-service (FFS) medical care. It is challenging to force behavior change in the system via our safety net population. This CCDP is a good first step.

b) Social Determinants of Health

Our mission is to provide compassionate care to the poor and vulnerable. Our IDCT is able to identify and to address each individual's health care needs. There are also social determinants of health that exist far beyond the reach of our clinic. We rely on our community and social service partners (see Table 4) to facilitate access to our services for some of our community's most poor and vulnerable residents.

c) Increasing Need

Many factors contribute to the increasing need for high quality and cost effective health care in our community. The aging population, decreasing number of practices able/willing to provide care through Medicaid, paucity of resources for behavioral health and substance abuse, and increased demand from patients combine to overwhelm currently available resources. We are expanding our clinic hours and are in the process of redesigning our clinic to increase our capacity.

d) Accurate data

It is challenging to track expense data in our current health care system. Patients may have a "PCP" in several different venues – e.g., Providence Family Medicine Center, Anchorage Neighborhood Health Canter and Alaska Native Medical Center – and determining which costs/savings are attributable to which organization is challenging. We will work with DHSS to define and to share accurate data.

e) Health Care reform

Reform in the healthcare system is occurring on the many different levels – organization, community, state and federal. It can be challenging to keep up with the changes. The fact that we are a residency program helps to position us for success. Providence Family Medicine Center is a healthy learning environment. We expect change. Our millennial learners are the next generation of physicians. They experience communication and define community more broadly than the generation before them. Their expectations for inclusion, social justice and data driven/evidence-based decision-making will help to define the future of healthcare in Alaska and the United States.

### 3. Gantt Chart

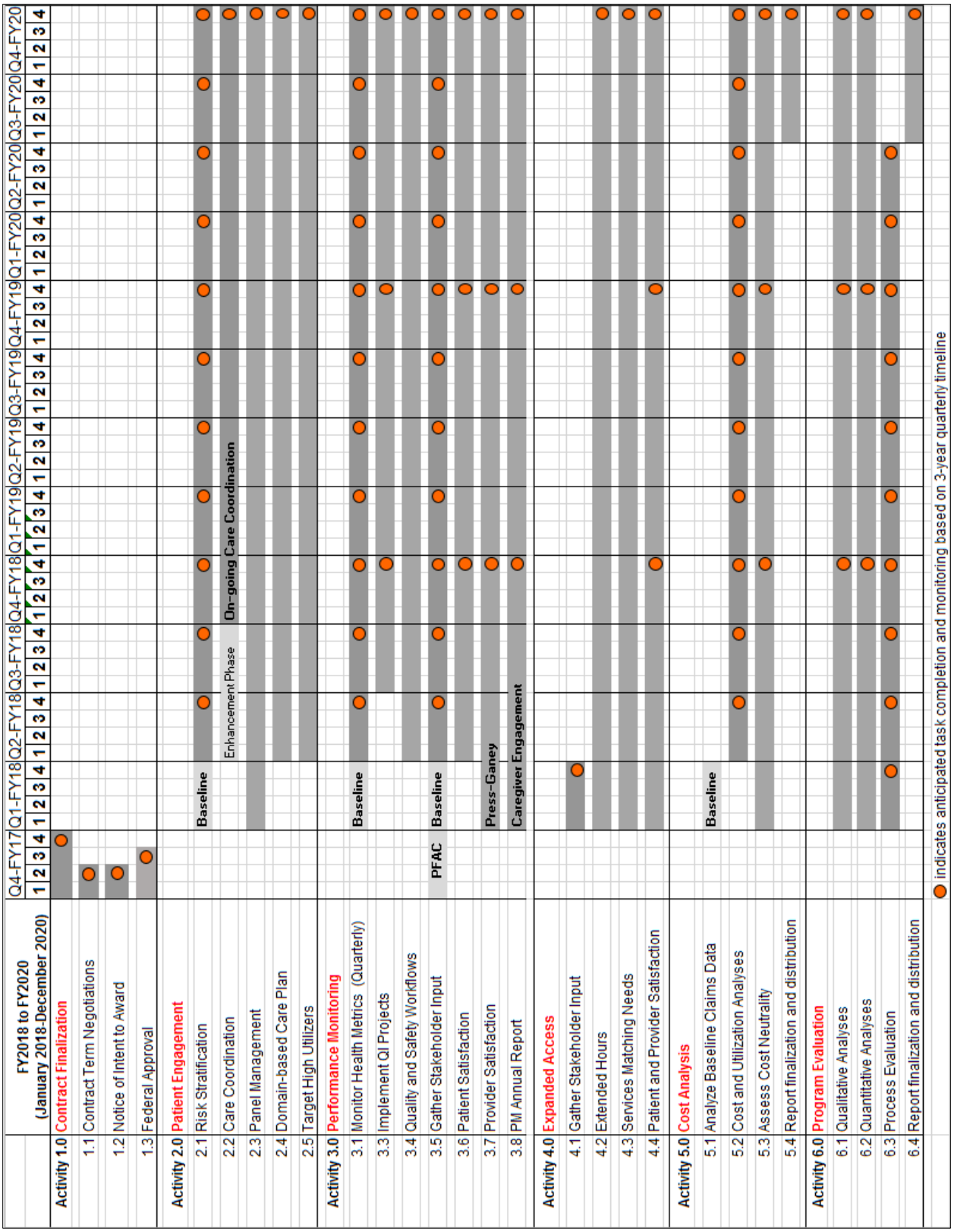


*Figure 8.* Gantt Chart

### C. Projected Development and Implementation Costs

As noted in 4.02.04 PFMC's transformation to a certified PCMH has been fully funded and supported by Providence Alaska Medical Center. Project development costs have already been incurred. PMPM Care Coordination fees paid to PFMC by the State will be utilized to expand our PCMH care coordination services to the all Medicaid enrollees based upon their individualized needs and risk-stratification. The additional funding from the State will also position PFMC to expand its services to additional Medicaid enrollees in the community who currently may not have primary care access.

### D. State Statutory or Regulatory Changes Necessary

Although this proposal aligns with many of the requirements of SB74, it is our understanding that the State of Alaska may need to make statute, regulation, or state plan changes in order to accommodate our request for a per member per month model. We are also aware of the State of Alaska's work in submitting an application for an 1115 Waiver to CMS that may include services provided through PCMH's and integrate behavioral health as an avenue to support a team-based approach with linkage to community supports and resources. Based on the State's current Medicaid Redesign efforts, we believe that steps have been taken to begin the process to allow for a PMPM model in primary care for PCMH's and interdisciplinary care and negotiations between CMS and the State may be required.

### E. Federal Authorities Necessary for Implementation

The State of Alaska will most likely at a minimum need to submit a State Plan Ammendment to CMS in order to provide a PMPM Care Coordination fee.

### F. Program Evaluation

As outlined in this proposal, our PCMH is founded on patient-centered care, innovations in practice redesign, and health information technology. We aspire through this project to take the next step in our evolutionary process by implementing changes to the way practices and providers are paid for PCMH services. To evaluate this project, our Quality Improvement Program (with the oversight of our Quality Improvement Manager) will utilize both qualitative and quantitative methodologies to structure a comprehensive utilization-focused evaluation to address questions related to the two domains of medical home outcomes recommended by the PCMH Evaluators' Collaborative (2012): (1) Cost/Utilization and (2) Clinical Quality (see Figure 9 to review our Logic Model). By addressing these two domains, our evaluation will be able to answer our three overarching evaluation questions noted below.

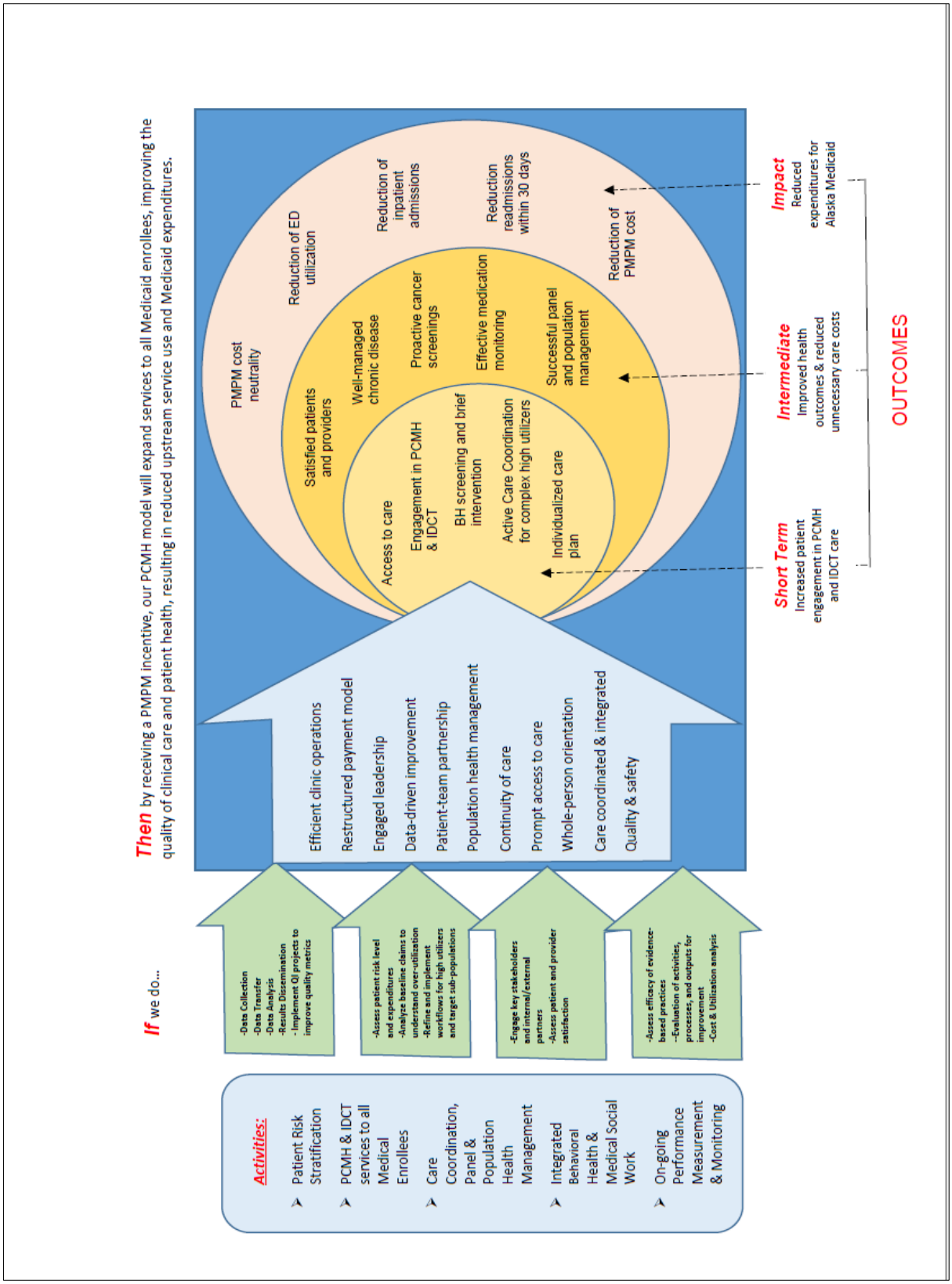


*Figure 9.* PFMC Logic Model

**1. Evaluation Questions**

a) Does our interdisciplinary PCMH model reduce expenditures for our Medicaid population resulting in cost neutrality with a PMPM payment system?

b) Does our interdisciplinary PCMH model decrease upstream service utilization, including emergency department visits, inpatient admission, and readmissions within 30 days?

c) Does our interdisciplinary PCMH model improve the quality of clinical care and improve patient health?

**2. Quantitative and Qualitative Data**

a) Quantitative Data

i. Cost/Utilization

To establish a baseline, PFMC will request to receive claims data for our clinic's Medicaid enrollees (all Medicaid and Dual Eligible enrollees) for the calendar year 2017 from the State of Alaska. This data will help to validate our internal risk stratification process outlined above by comparing it to the validated Milliman MARA Risk Score available to through athenahealth and, also, allow us to establish a true baseline for cost, quality, and access benchmarks specific to the Medicaid panel served at PFMC. Our Quality Improvement program will conduct cost analyses on a quarterly basis (see Section 4.02.08 for information about our on-going performance measurement and monitoring process). The quarterly cost analyses will compare the PMPM expenditures for all services provided to Medicaid enrollees (all Medicaid and Dual Eligible enrollees) during the fiscal year prior to implementation for reform (2017) to the PMPM expenditures for Medicaid enrollees during each quarter. In addition, these same analyses will be conducted at the end of each year of the project (2018, 2019, & 2020). In these analyses, we will make our results transparent by showing exactly how measures were defined, how costs were calculated, and by what methods the measures were adjusted for patient risk factors.

Table 9.
*Quantitative Measures for PCMH Evaluation*

| Measure* | Data Description | Data Source |
|---|---|---|
| **Utilization** | • Emergency department visits, ambulatory care-sensitive (ACS) acute inpatient admissions, and readmissions within 30 days | Claims data |
| **Cost** | • Total per member per month costs for total population<br>• Total per member per month costs for high-risk patients | Claims data |

*All utilization and cost issues should be risk-adjusted

ii. Clinical Quality

Our quality measures are standardized, validated, and nationally recognized. They were developed by taking into consideration the Healthcare Effectiveness Data and Information Set (HEDIS), the Physician Quality Reporting Initiative

(PQRI), and the NCQA standards, as well as our Providence Health System Quality Metrics and Healthy Alaskans 2020. Our six domains for clinic quality indicators for this project evaluation include: (1) preventive care, (2) acute care, (3) chronic disease management, (4) overuse, (5) safety, and (6) satisfaction. Below is a sample of our outcome measures proposed for this project. As our quality improvement process is iterative in nature, we expect to add more measures based on the findings from our analyses of the baseline claims data for 2017.

Table 10.

*Sample of Clinical Quality Measures for PCMH Evaluation*

| Domain | Measure and Description | Data Source |
|---|---|---|
| Preventive Care | • Depression Screening- Percentage of patients who complete annual depression screening<br>• Cancer Screenings- Percentage of patients who were screened for breast, cervical, and colorectal cancer | Electronic Health Record Athenahealth |
| Acute Care | • ED Utilization- Number of unnecessary ED visits (defined using the NYU algorithm) | Electronic Health Record Claims Data Athenahealth |
| Chronic Disease Management | • Comprehensive Diabetes Care- Percentage of patients with A1c≥7<br>• Hypertension reduction (BP at goal)<br>• CAD risk (statin use) | Electronic Health Record Athenahealth |
| Overuse | • Chronic Pain Medications- Number of patient prescribed opioids<br>• Morphine Milligram Equivalent (MME) is equal or less than 50 for every patient | Electronic Health Record Prescription Drug Monitoring System Athenahealth |
| Safety | • Medication Monitoring- Percentage of patients with annual monitoring of persistent medications. | Electronic Health Record Prescription Drug Monitoring System Athenahealth |
| Satisfaction | • Access to care-next 3rd available appointment under 14 days<br>• Patient Satisfaction- survey data and national comparative data<br>• Provider satisfaction- PHS Caregiver Engagement Survey | Appointment database Press Ganey Providence Health System Athenahealth |

b) Qualitative Data

The qualitative data evaluation measures will be developed in collaboration with project staff to tap the knowledge of relevant stakeholder groups (see Table 4 and letters of support in Appendix C) with regard to service implementation. We will rely heavily on our established *Patient and Family Advisory Council Patient/Family/Staff Collaborating Council* to seek feedback on the clinical quality of our PCMH and the payment reform components of this project. To that end, key informant and focus group protocols will be developed that assess the effectiveness of service implementation, barriers, adaptations, and underlying values, and similar process-related factors. All questions will be developed in such a way as to maximize their value to the formulation of

formative feedback to project staff. Questions will be framed in culturally and gender-sensitive and appropriate language.

c) Process Data

The process data elements will focus on measuring whether activities are being implemented as planned and modified as appropriate, as well as identifying and assisting in the removal of barriers to project implementation. This process evaluation will identify deviations from the original plan and their causes, as well as the effects of deviations and resultant adaptation. It will carefully document the implementation of the project, identifying in detail all services that are provided through the project. The process evaluation is the crucial component of the overall evaluation to assure fidelity to the risk stratification model and PCMH standards.

Ongoing, formative feedback is crucial to effective process evaluation and is an integral aspect of our evaluation plan. Ongoing formative feedback based on qualitative data collection will be used by project staff to make needed modifications to service implementation, resulting in more evaluation data, more formative feedback, and so forth, for a continuous feedback loop that will directly influence (and enhance) service implementation. This feedback loop will serve to monitor the fidelity, quality, and effectiveness of project implementation and can be used as a means of assuring quality cost management and service improvement. A formative feedback loop is also essential to the identification of implementation barriers and their removal. The temporal focus of the process evaluation is immediate, with ongoing and immediate feedback to the project staff responsible for implementation.

**3. Data Sources and Collection**

Relative to quantitative *data analyses*, PFMC maintains a site license for SPSS, a comprehensive statistical software package (IBM SPSS Statistics for Windows). SPSS is capable of a full range of statistical analyses, including those required for the evaluation. SPSS will be used for all quantitative data analyses and several PFMC staff members have significant expertise in the use of SPSS and in statistical data analysis. PFMC maintains a license for *NVivo,* the software package for qualitative data analysis*,* which is currently the preferred software used for qualitative data work. Several PFMC staff members are specifically trained in the use of *NVivo* software and all coding is done twice to assure accuracy and reduce bias.

Relative to *data interpretation*, PFMC is committed to accuracy and sensitivity and employs several procedures to assure reliability and validity of findings. First, involvement of relevant project implementation staff and system finance experts allows us to best understand our findings. Second, careful documentation is created of each step in all analysis and interpretive processes to enhance the dependability of findings and ensure that all interpretations are firmly grounded in the data. Third, all qualitative data sources are triangulated by interviewing various provider types and by interviewing consumers to ensure that findings are not biased toward the interests and experiences of one group over another. Finally, active seeking out of alternate explanations for identified phenomena is a part of testing the veracity of all interpretations. These procedures are cited in the methodological literature as reducing bias in analysis, especially qualitative analysis.

**4. On-going Performance Measurement and Monitoring**

Our clinic's performance measurement and monitoring process is iterative in nature and is overseen by the Quality Improvement Manager. On a monthly basis our clinic reviews action plans and current clinical outcomes, working collaboratively with our clinic team and other Providence-operated ambulatory clinics in Anchorage. As an Alaska Region, we develop a timeline for monitoring progress toward meeting our quality goals. More specific PFMC monitoring guidelines are outlined in Section 4.02.08(A)

**5. Evaluation and Performance Monitoring Timeline**

Our program evaluation will begin in January 2018 upon receipt of the Medicaid claims data and end with the conclusion of this demonstration project in December of 2020. See Table 11 for our proposed timeline.

Table 11.

*Evaluation Timeline*

| Evaluation Activity | Frequency | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Cost Analysis | Quarterly | x | x | x |
| Utilization Analysis | Quarterly | x | x | x |
| Performance Measurement and Monitoring (See Section 4.02.08(A)) | Monthly | x | x | x |
| Annual program evaluation to include stakeholder and implementation process findings | Yearly | x | x | x |
| Final Demonstration Project Evaluation Report | End of Project | | | x |

## 4.02.06 EXPERIERNCE, QUALIFICATIONS, AND FINANCIAL REQUIREMENTS

### A. Experience and Qualifications

#### 1. Experience

Providence Health & Services Alaska has provided health care in Alaska for 115 years, beginning with the Sisters of Providence landing in Nome in 1902. PFMC has operated a clinic and family medicine residency program since 2001, growing in scope and scale since that time to the 11,000 patient clinic we are today. We currently provide primary care to 4,800 Medicaid and Dual Eligible enrollees at our clinic, making PFMC one of the largest providers of primary care for Medicaid in Alaska and one of two "safety net" clinics in Anchorage, the other being Anchorage Neighborhood Health Center, a Federally Qualified Community Health Center. We believe our experience serving Medicaid enrollees in the community and our access to resources through Providence St. Joseph Health uniquely positions our clinic to successfully partner with the State on healthcare reform initiatives including this proposed demonstration project.

#### 2. Licenses and Certifications

PFMC is an outpatient department of Providence Alaska Medical Center licensed to provide medical care in the State of Alaska, accredited by The Joint Commission and certified by NCQA. See Appendix O. All providers are licensed and credentialed.

- National Committee for Quality Assurance
- American Osteopathic Association
- American Psychological Association
- PFMC Business License
- The Joint Commission Accreditation

#### 3. References

PFMC is involved in a wide array of collaborative agreements and community projects throughout Anchorage relating both to direct medical care and medical education. We work with several entities and universities to support the development of future healthcare professionals in Alaska. We have demonstrated the ability to cater our services to distinct patient populations to meet the needs of particular groups and individuals. See Table 4 for a review of our community partners.

## 4. Organizational Chart

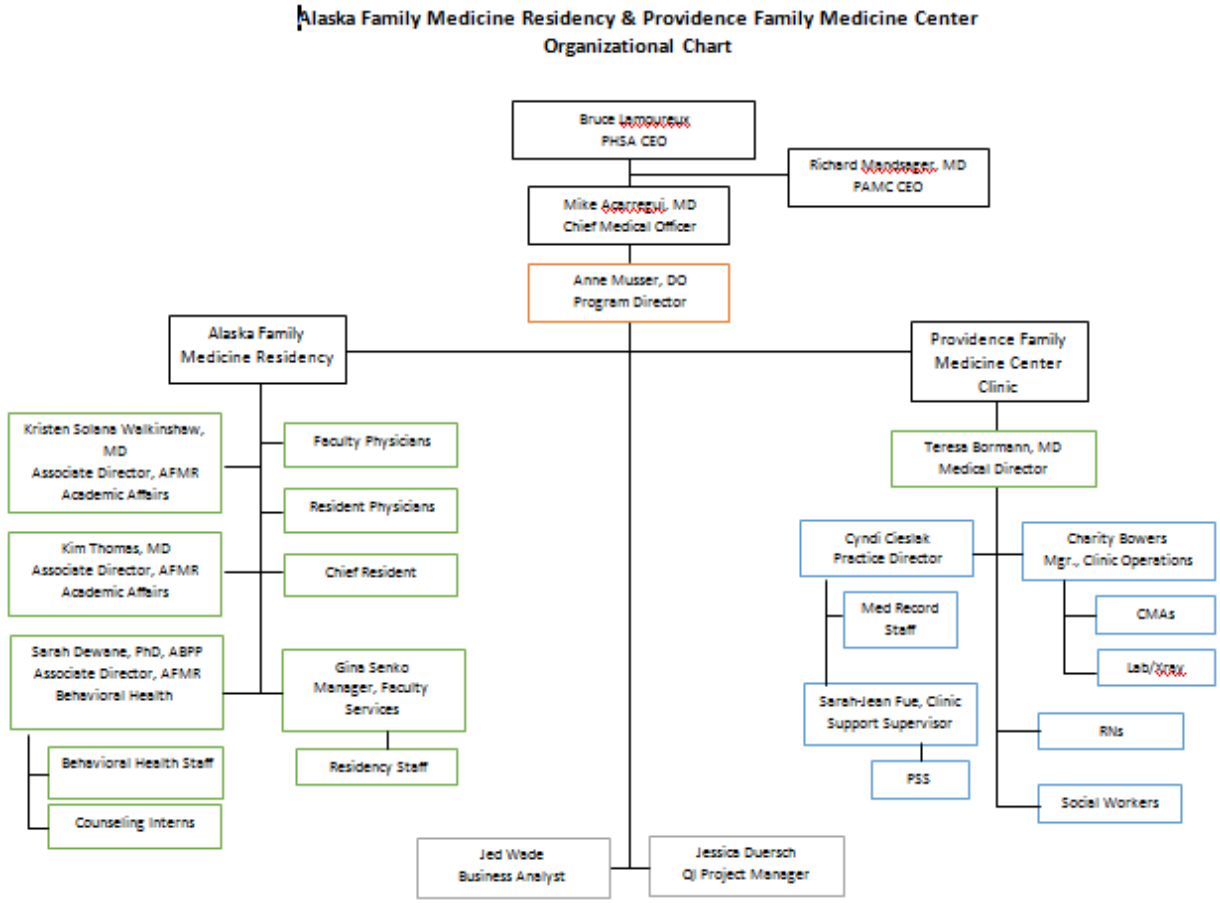


*Figure 10.* AKFMR & PFMC Organizational Chart

## 5. Project Team

PFMC's Project Team consists of both clinical and non-clinical staff, working closely together to meet the needs of our Medicaid population at PFMC. PFMC utilizes a team-based approach to primary care delivery, and our entire clinic and residency staff, 132 employees in all, contribute to the care received by Medicaid enrollees who come through our doors. The core Project Team who will be responsible for managing the operations of this demonstration project include the following individuals (See Appendix P for *CV*s and resumes):

Anne Musser, DO, Program Director, AFMR
Teresa Bormann, MD, Medical Director, PFMC
Sarah Dewane, PhD, ABPP, Behavioral Health Director, PFMC
Cyndi Cieslak, Practice Director, PFMC
Charity Bowers, Clinic Operations Manager, PFMC
Jessica Duersch, Quality Improvement Manager, PFMC
Jed Wade, Business Analyst, PFMC

We estimate the core Project Team will spend approximately 2,912 hours working directly on the administrative components of the CCDP annually, with a total associated labor cost of $162,073. To reiterate, these labor expenditures represent one example of Providence's investment in PFMC's PCMH, and we are not asking the State to fund any part of these positions directly. These are estimates of hours required to meet the operational and administrative goals of the CCDP, and do not include any component of the clinical care itself.

## B. Financial Stability, Capital Reserve and Solvency Requirements

### 1. 2013, 2014, 2015 Audited Statements and Enrollment Counts

Located in Appendix Q

2. **Recent Financial Statements** (including ratios listed below)
   Located in Appendix Q

   a) Working Capital
   b) Current Ratio
   c) Quick Ratio
   d) Net Worth
   e) Debt-to-Worth Ratio

3. **Statement on Bankruptcy**
   Providence St. Joseph Health, the parent company of PFMC, was formed July 1, 2016 and has not filed any bankruptcy or insolvency proceedings. Providence Health & Services, which preceded Providence St. Joseph Health, has not filed any bankruptcy or insolvency proceedings within the past 5 years.

### 4. Credit Rating

2016
Fitch AA-
Standard and Poor's AA-
Moody's Aa3

2015
Fitch AA
Standard and Poor's AA-
Moody's Aa3

2014
Fitch AA
Standard and Poor's AA-
Moody's Aa3

**4.02.07 FINANCIAL PROJECTIONS AND POTENTIAL COST CONTAINMENT OR SAVINGS**

**A. Description of Cost Containment or Savings**

The patient-centered model of care delivery at PFMC will lead to cost containment and savings for the State Medicaid program. An interdisciplinary team of health care providers will coordinate care delivery for the Medicaid population to achieve an overall decrease in utilization of high cost services. Specifically, PFMC's project is to decrease utilization of inpatient and outpatient hospital services, emergency department services and ambulatory clinic visits. PFMC is requesting a PMPM care coordination fee of $5.00 for each Medicaid enrollee who receives primary care at our clinic.

PFMC's PCMH is uniquely positioned to coordinate care for Medicaid enrollees in Anchorage. Pharmacy consultation, Nurse Case Management, Social Work, Behavioral Health services, Physician Assistant home visits, and in-clinic group visits are all part of PFMC's comprehensive approach to primary care delivery. Integrated behavioral health and the IDCT allows PFMC to meet both physical and psychosocial needs for patients in a seamless encounter. Risk stratification initiatives will allow PFMC to better understand the needs of our population, ensuring that clinical resources are being deployed appropriately and patients are receiving the right intervention in the right setting at the right time.

The target population for PFMC's demonstration project are all Medicaid enrollees who receive primary care at the clinic. As a full-scope family practice clinic with OB services, PFMC can meet the needs of each subpopulation within Alaska's Medicaid population. This includes children and adults, pregnant women, blind and disabled, dual eligible, as well as those eligible for old age assistance and waivers. No subpopulation is excluded from PFMC's demonstration project.

**B. Pro Forma**

PFMC's financial projections for this demonstration period (36 months) anticipate a near break-even in year 1 with savings of $2,541 and net savings to the State in subsequent years of $283,152 in year 2 and $609,214 in year 3. PFMC's enrollment projections are based on the current panel of Medicaid enrollees receiving care at the clinic with a 10% increase in year 3 of the demonstration project. Enrollment projections are 4,800 in 2018, 4,800 in 2019 and 5,280 in 2020.

Table 12.
*Pro Forma*

| PFMC's Medicaid Coordinated Care Demonstration Project -- Pro Forma | | | |
|---|---|---|---|
| | **CY 2018** | **CY 2019** | **CY 2020** |
| **Incremental Revenues:** | | | |
| PMPM Payments to PFMC: | $ (288,000) | $ (288,000) | $ (316,800) |
| Reduction in Inpatient Volumes: | $ 121,214 | $ 238,273 | $ 386,293 |
| Reduction in Outpatient Volumes: | $ 49,344 | $ 96,138 | $ 154,419 |
| Reduction in Outpatient ED Volumes: | $ 38,552 | $ 75,532 | $ 122,032 |
| Reduction in Professional Visits: | $ 81,430 | $ 161,209 | $ 263,271 |
| **Net Benefit (Cost) to State:** | **$ 2,541** | **$ 283,152** | **$ 609,214** |

| 2018 Monthly Pro Forma | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan 2018 | Feb 2018 | Mar 2018 | Apr 2018 | May 2018 | Jun 2018 | Jul 2018 | Aug 2018 | Sep 2018 | Oct 2018 | Nov 2018 | Dec 2018 | CY 2018 |
| **Incremental Revenues:** | | | | | | | | | | | | | |
| PMPM Payments to PFMC: | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $ (24,000) | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $ (288,000) |
| Reduction in Inpatient Volumes: | $ 4,040 | $ 4,040 | $ 4,040 | $ 8,081 | $ 8,081 | $ 8,081 | $ 12,121 | $ 12,121 | $ 12,121 | $ 16,162 | $ 16,162 | $ 16,162 | $ 121,214 |
| Reduction in Outpatient Volumes: | $ 1,645 | $ 1,645 | $ 1,645 | $ 3,290 | $ 3,290 | $ 3,290 | $ 4,934 | $ 4,934 | $ 4,934 | $ 6,579 | $ 6,579 | $ 6,579 | $ 49,344 |
| Reduction in Outpatient ED Volumes: | $ 1,285 | $ 1,285 | $ 1,285 | $ 2,570 | $ 2,570 | $ 2,570 | $ 3,855 | $ 3,855 | $ 3,855 | $ 5,140 | $ 5,140 | $ 5,140 | $ 38,552 |
| Reduction in Professional Visits: | $ 2,714 | $ 2,714 | $ 2,714 | $ 5,429 | $ 5,429 | $ 5,429 | $ 8,143 | $ 8,143 | $ 8,143 | $ 10,857 | $ 10,857 | $ 10,857 | $ 81,430 |
| **Net Benefit (Cost) to State:** | **$(14,315)** | **$(14,315)** | **$ (14,315)** | **$ (4,631)** | **$ (4,631)** | **$ (4,631)** | **$ 5,054** | **$ 5,054** | **$ 5,054** | **$ 14,739** | **$ 14,739** | **$ 14,739** | **$ 2,541** |

| 2019 Monthly Pro Forma | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan 2019 | Feb 2019 | Mar 2019 | Apr 2019 | May 2019 | Jun 2019 | Jul 2019 | Aug 2019 | Sep 2019 | Oct 2019 | Nov 2019 | Dec 2019 | CY 2019 |
| **Incremental Revenues:** | | | | | | | | | | | | | |
| PMPM Payments to PFMC: | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $ (24,000) | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $(24,000) | $ (24,000) | $(24,000) | $ (288,000) |
| Reduction in Inpatient Volumes: | $ 17,640 | $ 17,640 | $ 17,640 | $ 19,117 | $ 19,117 | $ 19,117 | $ 20,595 | $ 20,595 | $ 20,595 | $ 22,073 | $ 22,073 | $ 22,073 | $ 238,273 |
| Reduction in Outpatient Volumes: | $ 7,152 | $ 7,152 | $ 7,152 | $ 7,725 | $ 7,725 | $ 7,725 | $ 8,298 | $ 8,298 | $ 8,298 | $ 8,871 | $ 8,871 | $ 8,871 | $ 96,138 |
| Reduction in Outpatient ED Volumes: | $ 5,602 | $ 5,602 | $ 5,602 | $ 6,064 | $ 6,064 | $ 6,064 | $ 6,525 | $ 6,525 | $ 6,525 | $ 6,987 | $ 6,987 | $ 6,987 | $ 75,532 |
| Reduction in Professional Visits: | $ 11,888 | $ 11,888 | $ 11,888 | $ 12,919 | $ 12,919 | $ 12,919 | $ 13,949 | $ 13,949 | $ 13,949 | $ 14,980 | $ 14,980 | $ 14,980 | $ 161,209 |
| **Net Benefit (Cost) to State:** | **$ 18,282** | **$ 18,282** | **$ 18,282** | **$ 21,825** | **$ 21,825** | **$ 21,825** | **$ 25,367** | **$ 25,367** | **$ 25,367** | **$ 28,910** | **$ 28,910** | **$ 28,910** | **$ 283,152** |

| 2020 Monthly Pro Forma | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan 2020 | Feb 2020 | Mar 2020 | Apr 2020 | May 2020 | Jun 2020 | Jul 2020 | Aug 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Dec 2020 | CY 2020 |
| **Incremental Revenues:** | | | | | | | | | | | | | |
| PMPM Payments to PFMC: | $(26,400) | $(26,400) | $ (26,400) | $(26,400) | $ (26,400) | $(26,400) | $(26,400) | $ (26,400) | $(26,400) | $(26,400) | $ (26,400) | $(26,400) | $ (316,800) |
| Reduction in Inpatient Volumes: | $ 26,120 | $ 26,120 | $ 26,120 | $ 30,167 | $ 30,167 | $ 30,167 | $ 34,215 | $ 34,215 | $ 34,215 | $ 38,262 | $ 38,262 | $ 38,262 | $ 386,293 |
| Reduction in Outpatient Volumes: | $ 10,470 | $ 10,470 | $ 10,470 | $ 12,069 | $ 12,069 | $ 12,069 | $ 13,668 | $ 13,668 | $ 13,668 | $ 15,267 | $ 15,267 | $ 15,267 | $ 154,419 |
| Reduction in Outpatient ED Volumes: | $ 8,260 | $ 8,260 | $ 8,260 | $ 9,533 | $ 9,533 | $ 9,533 | $ 10,806 | $ 10,806 | $ 10,806 | $ 12,079 | $ 12,079 | $ 12,079 | $ 122,032 |
| Reduction in Professional Visits: | $ 17,764 | $ 17,764 | $ 17,764 | $ 20,547 | $ 20,547 | $ 20,547 | $ 23,331 | $ 23,331 | $ 23,331 | $ 26,115 | $ 26,115 | $ 26,115 | $ 263,271 |
| **Net Benefit (Cost) to State:** | **$ 36,213** | **$ 36,213** | **$ 36,213** | **$ 45,916** | **$ 45,916** | **$ 45,916** | **$ 55,619** | **$ 55,619** | **$ 55,619** | **$ 65,322** | **$ 65,322** | **$ 65,322** | **$ 609,214** |

## C. Annual Budget Neutrality Projection

### 1. 2016 Total Average PMPM Cost and Utilization

PFMC evaluated the data provided by the State in the Alaska Medicaid Data Book and determined that SFY 2016 Anchorage Municipality Non-Tribal data is most relevant to the population we serve and to the demonstration project we are proposing. Our projections for total average PMPM cost and utilization reductions are based on this 2016 benchmark which shows a total paid PMPM for all services of $821.57. PFMC is forecasting a decrease of the total paid PMPM for our panel of Medicaid enrollees in each year of the demonstration project, ultimately driving the rate down to $780.44 (see Table 13).

Table 13.
*Annual Paid PMPM Forecast*

| Annual Paid PMPM Forecast | | | | |
|---|---|---|---|---|
| | **Baseline*** | **2018** | **2019** | **2020** |
| Total Paid PMPM | $ 821.57 | $ 807.86 | $ 794.15 | $ 780.44 |
| *Baseline from Data Book 2016 Anchorage Non-Tribal. | | | | |

### 2. Major Assumptions

a) Total Paid PMPM projections are based on the Alaska Medicaid Data Book's population data which only goes to the Municipality level. For the sake of this proposal we are

assuming that PFMC's Medicaid panel is representative of the Anchorage Municipality population at large. If awarded, PFMC will request access to Milliman data down to the clinic, provider and patient level in order to more accurately understand this population.

b) A $5 PMPM Care Coordination fee will be paid to PFMC in addition to existing FFS payments.

c) PFMC's PCMH model of primary care will decrease utilization of services by Medicaid enrollees in both inpatient and outpatient settings, resulting in a total cost of care savings for the State.

## 4.02.08 POTENTIAL FOR IMPROVING CARE AND OUTCOME FOR MEDICAID ENROLLEES

### A. Quality Outcome Measures

Data collection and analysis is a top priority for our organization. Our parent organization, Providence St. Joseph Health (PSJH), has invested in an extensive domain of data systems and predictive analytic platforms to assess opportunities for improvement. This data is used to set goals for improvement in a variety of metrics, including quality of care metrics. The vast data sets have been made available to all caregivers in multiple formats. This allows our clinic to utilize the data for goal setting and improvement initiatives.

On a monthly basis our clinic reviews action plans and current outcomes, working collaboratively with other Providence-operated ambulatory clinics in Anchorage to develop a timeline for monitoring progress toward meeting our quality goals. Below is an example of our timeline for the 2017 calendar year. Alaska region goals for 2017 include 8 metrics: Colorectal Cancer Screening, Cervical Cancer Screening, Breast Cancer Screening, Childhood Immunizations, Diabetes Not Poor A1c Control, Hypertension BP, Cardiovascular Statin, and Depression Assessment.

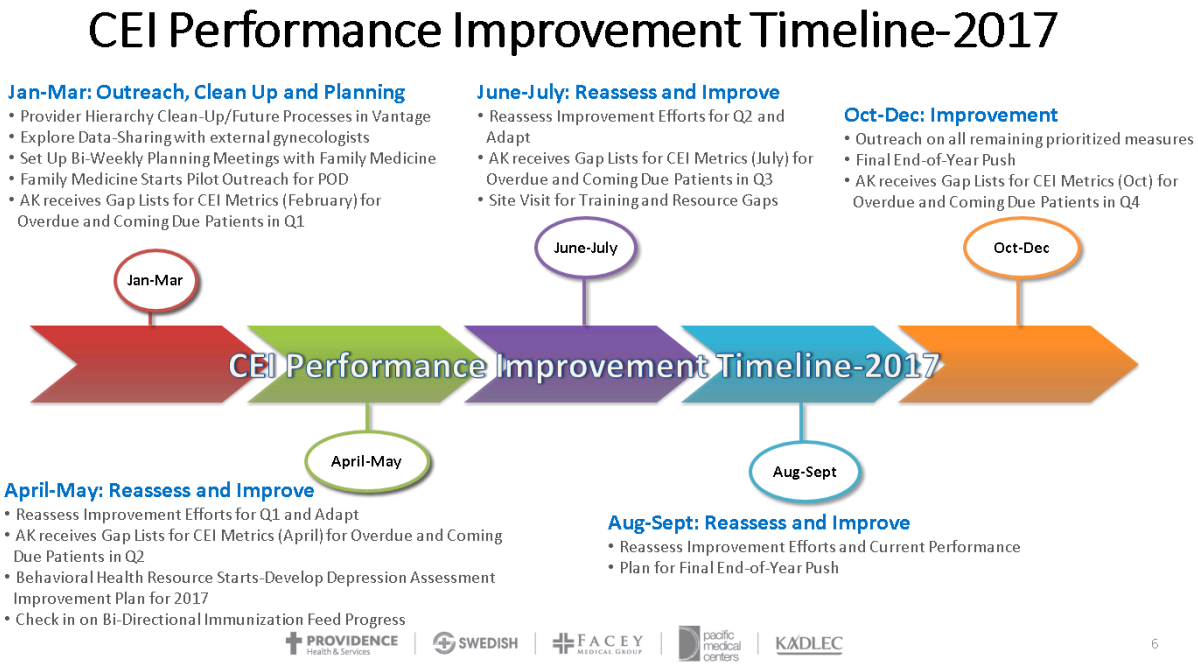


*Figure 11.* CEI Performance Improvement Timeline-2-17

On an annual basis PFMC's Quality Committee identifies metrics to track for the year which integrate State (Healthy Alaskans 2020, 2016), Providence, and clinic goals. Initially, we plan to monitor the quality metrics outlined in Table 15 as part of the proposed CCDP.

Table 14
*Quality Metrics*

| **Metrics** | |
|---|---|
| **Sub-population** | **Goal** |
| High ED Utilization/Inpatient Admits | Reduce the number of unnecessary ED visits and hospital admits within 36 months |
| Chronic Pain | Reduce the number of patients prescribed opiates by 20% within 36 months |
| Patients with Diabetes | Reduce the % of patients with A1c ≥ 7 by 20% within 36 months |
| Depression | Increase the % of patients with completed annual depression screening by 40% within 36 months |
| Cancer Screening | Increase completed testing by 30% within 36 months |
| Clinic Goals | |
| Access | Next 3rd appointment available under 14 days |
| Patient Satisfaction | Improve "likely to recommend practice" to 90% |
| Caregiver Engagement | Improve provider engagement by 5% |

**B. Baseline Data**

PFMC has used the 2016 Anchorage Municipality Non-Tribal data provided by the State in the Alaska Medicaid Data Book to establish baselines for utilization metrics. These metrics include hospital admissions, emergency room visits and primary care visits per 1,000 Medicaid member enrollees. PFMC used a statewide data book for Non-Tribal members for claims incurred in 2014 to establish a baseline for Inpatient Admissions per 1,000 Medicaid Member Enrollees because Inpatient Admission data was not available as a data point in the 2016 data book.

PFMC intends to reduce utilization in each of these 4 categories over the 36 month demonstration project. Baseline data and improvement benchmarks by month are shown in the tables below.

1. <u>Baseline Utilization Benchmarks (from Alaska Medicaid Data Book, 2016):</u>
   i. Inpatient Admits/1,000 enrollees – 168.4
   ii. Inpatient Days/1,000 enrollees – 548.1
   iii. Outpatient ED Visits/1,000 enrollees – 711.7
   iv. Professional Visits/1,000 enrollees – 14,407.2

Table 15.
*Proposed Monthly Utilization Benchmarks*

| 2018 Monthly Utilization Benchmarks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Jan 2018** | **Feb 2018** | **Mar 2018** | **Apr 2018** | **May 2018** | **Jun 2018** | **Jul 2018** | **Aug 2018** | **Sep 2018** | **Oct 2018** | **Nov 2018** | **Dec 2018** | **2018 Avg** |
| Inpatient Admits/1,000 | 168.2 | 168.2 | 168.2 | 168.0 | 168.0 | 168.0 | 167.8 | 167.8 | 167.8 | 167.7 | 167.7 | 167.7 | 167.9 |
| Inpatient Days/1,000 | 546.1 | 546.1 | 546.1 | 544.2 | 544.2 | 544.2 | 542.3 | 542.3 | 542.3 | 540.3 | 540.3 | 540.3 | 543.2 |
| Outpatient ED Visits/1,000 | 707.1 | 707.1 | 707.1 | 702.6 | 702.6 | 702.6 | 698.0 | 698.0 | 698.0 | 693.5 | 693.5 | 693.5 | 700.3 |
| Professional Visits/1,000 | 14,381.5 | 14,381.5 | 14,381.5 | 14,355.8 | 14,355.8 | 14,355.8 | 14,330.2 | 14,330.2 | 14,330.2 | 14,304.5 | 14,304.5 | 14,304.5 | 14,343.0 |

| 2019 Monthly Utilization Benchmarks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Jan 2019** | **Feb 2019** | **Mar 2019** | **Apr 2019** | **May 2019** | **Jun 2019** | **Jul 2019** | **Aug 2019** | **Sep 2019** | **Oct 2019** | **Nov 2019** | **Dec 2019** | **2019 Avg.** |
| Inpatient Admits/1,000 | 167.5 | 167.5 | 167.5 | 167.3 | 167.3 | 167.3 | 167.1 | 167.1 | 167.1 | 166.9 | 166.9 | 166.9 | 167.2 |
| Inpatient Days/1,000 | 538.4 | 538.4 | 538.4 | 536.5 | 536.5 | 536.5 | 534.5 | 534.5 | 534.5 | 532.6 | 532.6 | 532.6 | 535.5 |
| Outpatient ED Visits/1,000 | 688.9 | 688.9 | 688.9 | 684.4 | 684.4 | 684.4 | 679.8 | 679.8 | 679.8 | 675.3 | 675.3 | 675.3 | 682.1 |
| Professional Visits/1,000 | 14,278.8 | 14,278.8 | 14,278.8 | 14,253.1 | 14,253.1 | 14,253.1 | 14,227.4 | 14,227.4 | 14,227.4 | 14,201.7 | 14,201.7 | 14,201.7 | 14,240.2 |

| 2020 Monthly Utilization Benchmarks | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Jan 2020** | **Feb 2020** | **Mar 2020** | **Apr 2020** | **May 2020** | **Jun 2020** | **Jul 2020** | **Aug 2020** | **Sep 2020** | **Oct 2020** | **Nov 2020** | **Dec 2020** | **2020 Avg.** |
| Inpatient Admits/1,000 | 166.8 | 166.8 | 166.8 | 166.6 | 166.6 | 166.6 | 166.4 | 166.4 | 166.4 | 166.2 | 166.2 | 166.2 | 166.5 |
| Inpatient Days/1,000 | 530.6 | 530.6 | 530.6 | 528.7 | 528.7 | 528.7 | 526.8 | 526.8 | 526.8 | 524.8 | 524.8 | 524.8 | 527.7 |
| Outpatient ED Visits/1,000 | 670.7 | 670.7 | 670.7 | 666.2 | 666.2 | 666.2 | 661.6 | 661.6 | 661.6 | 657.1 | 657.1 | 657.1 | 663.9 |
| Professional Visits/1,000 | 14,176.0 | 14,176.0 | 14,176.0 | 14,150.3 | 14,150.3 | 14,150.3 | 14,124.6 | 14,124.6 | 14,124.6 | 14,098.9 | 14,098.9 | 14,098.9 | 14,137.5 |

## C. Expectations for Attaining Goals

The PCMH model is vital to the success of our improvement goals. There are several components that define an effective PCMH including: enhanced access, chronic disease management, team based coordinated care, self-management, and performance improvement. Each component allows our care team to coordinate comprehensive care for our panel of patients and to provide multiple options for interventions that will fit each Medicaid enrollees individual needs.

A growing body of scientific evidence demonstrates that PCMH's are reducing overall cost of care by decreasing hospital and emergency department visits and improving patient outcomes. In 2015, the National Committee for Quality Assurance (NCQA) published a report summarizing multiple studies on the impact of PCMH's on quality, health care utilization and cost. In one retrospective study, citing data from Empire Blue Cross and Blue Shield, the study compared PCMH and non-PCMH patients.

The results showed, "among PCMH-treated patients, diabetics had higher rates of glycated hemoglobin testing; cardiovascular disease patients had higher rates of testing and better low-density lipoprotein cholesterol control; imaging rates for low back pain were lower; among pediatric patients, inappropriate antibiotic use for nonspecific or viral respiratory infections was lower. PCMH-treated adults and children had 12% and 23% lower odds of hospitalization, and required 11% and 17% fewer ED services, respectively, than non-PCMH patients. PCMH practices were associated with better preventive health, higher levels of disease management, and lower resource utilization and costs compared with practices not pursuing PCMH status." (DeVries).

We are confident that our PCMH can be a successful partner with DHSS on the journey from fee-for-service to fee-for-value, and we look forward to collaborating to achieve the goals of this demonstration project and of Medicaid redesign in Alaska – to improve health, optimize access, increase value and contain costs.

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