

# Pennsylvania's ACCESS Plus Program

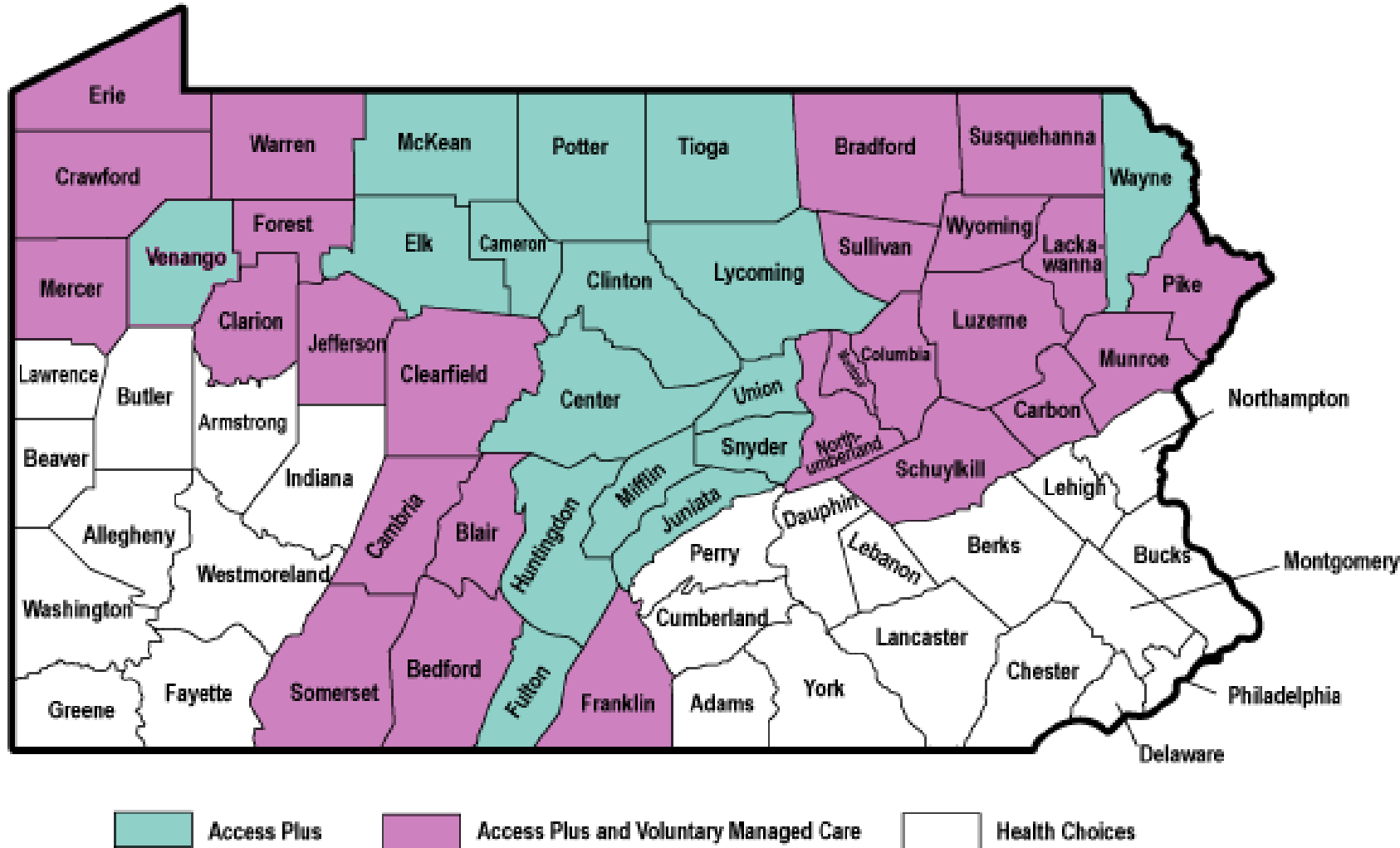
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Medical Assistance  
Programs

# What is ACCESS Plus?

1. Enhanced Primary Care Case Management (EPCCM) medical home model
2. 290,000 Medicaid members, excludes dual eligibles but includes ABD, over 40,000 with chronic diseases covered by DM
3. Disease Management (DM) Program- done by vendor for CAD, CHF, Asthma, COPD, Diabetes
4. Complex Case Management
5. Vendor has guaranteed cost savings, is at risk for DM performance, and responsible for P4P implementation

# ACCESS Plus Service Area



# Goals of ACCESS Plus

- **Improve access** to primary care and other appropriate health care services
- Provide a **medical home** for children and adults
- **Improve the quality** of health care available to Medical Assistance recipients
- Provide access to **disease management (DM)** and **care coordination**
- **Stabilize** Pennsylvania's Medical Assistance spending

# Enhancements For Consumers

- Medical home for children and adults
- Enrollment Assistance Contractor to assist with enrollment
- Enrollee hotline
- Increased access to PCPs
- PCP directories
- Consumer empowerment/education
- Consumer input through Regional Advisory Committees
- Assessment of healthcare quality
- Assessment of consumer satisfaction
- Disease Management
- 24 hour nurse call line
- Complex Care Management
- Care Coordination- dental & specialty referral, transportation

# Enhancements For Providers

- Access to community-based nurses
- Coordinated Disease and Case Management services
- Community-based provider service representatives
- Resources for coordination with BH and dental providers
- Access to consumer education and action plan materials
- Provider education and guideline based charting tools
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- Provider education and guideline based charting tools
- Care gap identification
- Provider Call Center
- Input through participation in Regional Advisory Committee
- Provider incentive opportunities
- Fees increased for primary care services (EPSDT, E&M codes)

# Consumer Services Integration

## PCCM - Automated Health Systems

Medical Home

Preventive  
Visits

Care  
Coordination

BH

Low risk  
Pregnancies

Depression  
Screening

High Volume  
ED users

Home Visits

## DM - McKesson Health Solutions

24 Hour Nurse  
Advice Line

Care  
Coordination

Case  
Management

Home Visits

## Medical Case Management - DPW

Medically Complex Case  
Management

High Risk Pregnancies

# Disease Management Resources

- **CBRN - Community Based Registered Nurse (21 – up from 6)**
  - Visits enrollees, completes assessment, provides self-management education and resources
  - Visits providers to establish working relationship – POCs to introduce CBRNs to providers
- **POC - Provider Outreach Coordinator (4 - up from 3)**
  - Enrolls and assists providers with P4P Program
  - Facilitates provider/CBRN relationships
  - Helps with HEDIS audits
- **Telephonic Nurses (16 – down from 24)**
  - Telephonic outreach to complete assessments and conduct educational sessions

# Disease Management Resources

- **PSC – Practice Support Coordinator (5 - new)- Practice Coach**
  - Roles vary by region – PSC is either aligned with specific practice or works with all practices in the region
  - Promote process improvements in provider offices
  - Focus on P4P measures
  - Coordinates handoffs to CBRNs
  - Attends patient appointments as necessary
- **HBRN – Hospital Based Registered Nurse (1 – new)**
  - Aligned with Geisinger Hospitals
  - Interfaces with DM patients seen in the ER to promote medical home and manage patient conditions
  - Works with discharge planners to ensure appropriate utilization and discharge planning with follow-up
  - Works with hospital case managers for appropriate referrals to Complex Care Management Unit

# Complex Case Management Unit

- 40 FTEs
- Managed by DPW
- Focus on complex special need children and adults
- Transplant, cancer, pain management, high risk Ob
- Referrals from providers, DM vendor, inpatient nurse reviewers, predictive modeling

# DM Staff Distribution

North West

North Central

Practice Support Coordinators (3)

CBRNs (5)

Provider Outreach Coordinator (1)

Practice Support Coordinator (1)

CBRNs (3)

Provider Outreach Coordinator (1)

Practice Support Coordinator (1)

CBRNs (4)

Provider Outreach Coordinator (1)

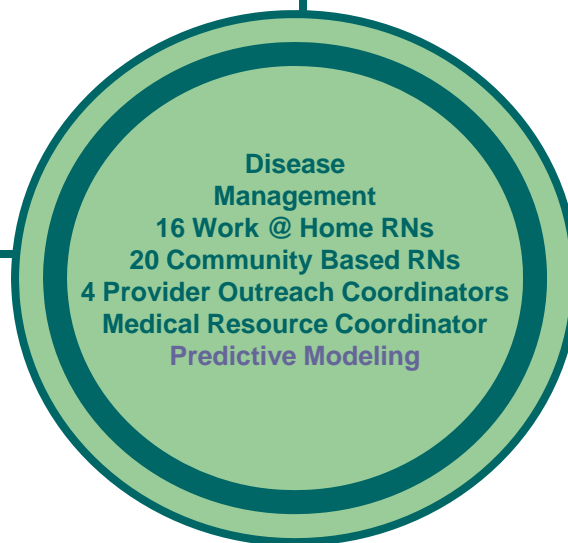
Hospital Based RN (1)

CBRN (8)

Provider Outreach Coordinator (1)

South Central

North East



# Commitment to Quality

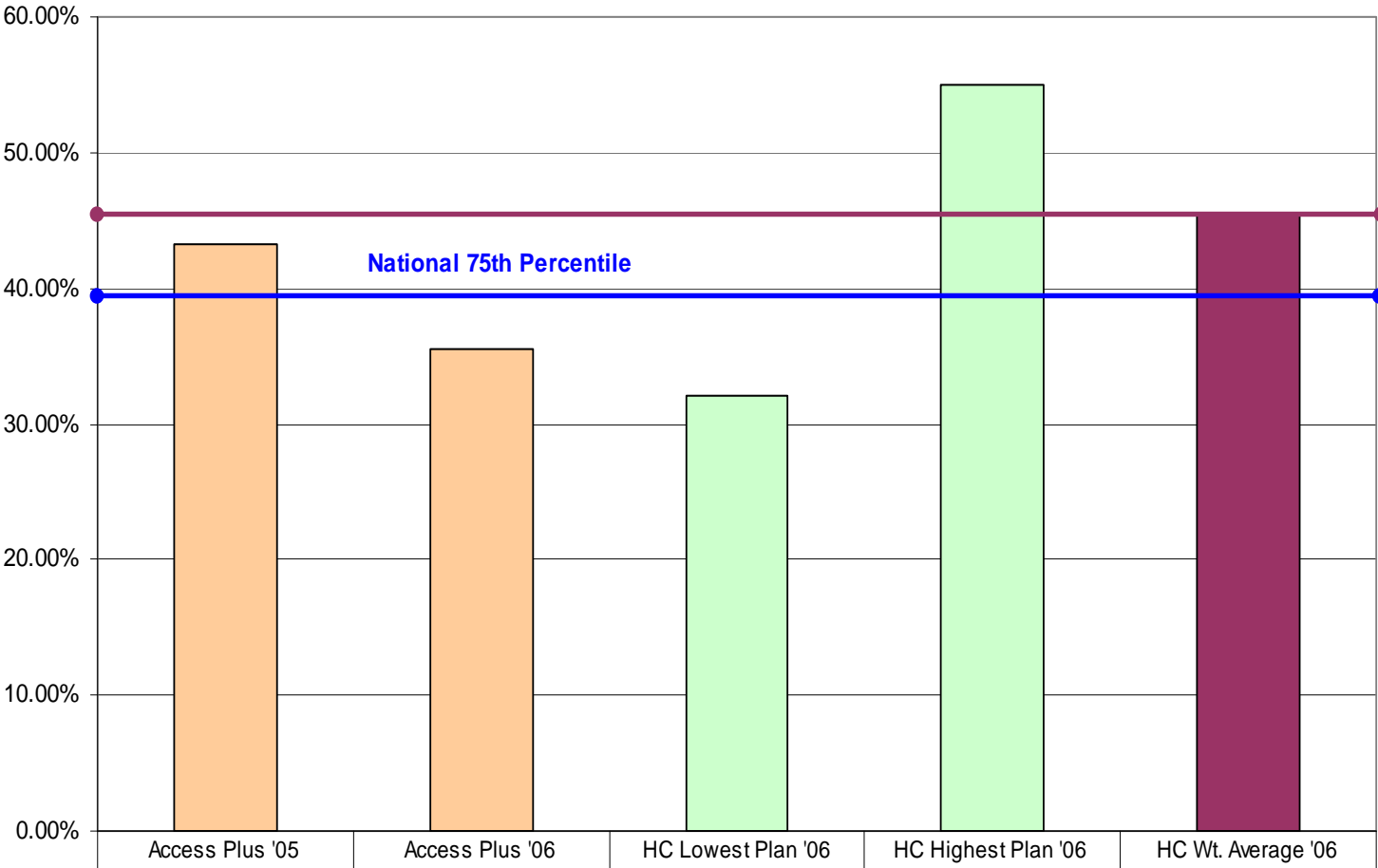
- Annual HEDIS-like measures
- Comparison to MCOs
- Quarterly Quality Management Committee meeting with providers and consumers
- Consumer/provider satisfaction
- Consumer report
- Provider chart audits
- Peer review
- P4P focused on quality

# Clinical Results

- Asthma- controller medication use increased from 79.5% to 87.5%
- Diabetes
  - HgA1C performed: 78.1% to 80.1%
  - HgA1C poor control: 43.3% to 35.5%
  - LDL<100: 25.3% to 31.9%
- CAD
  - Beta-blocker post MI: 78.7% to 94.2%
  - LDL performed: 64.2% to 71.1%
  - LDL<100: 18.7% to 36.9%
- CHF Beta-blocker prescription: 61% to 64%

**HbA1C Poorly Controlled  
(Greater than 9.0%)  
Access Plus/Health Choices Comparison**

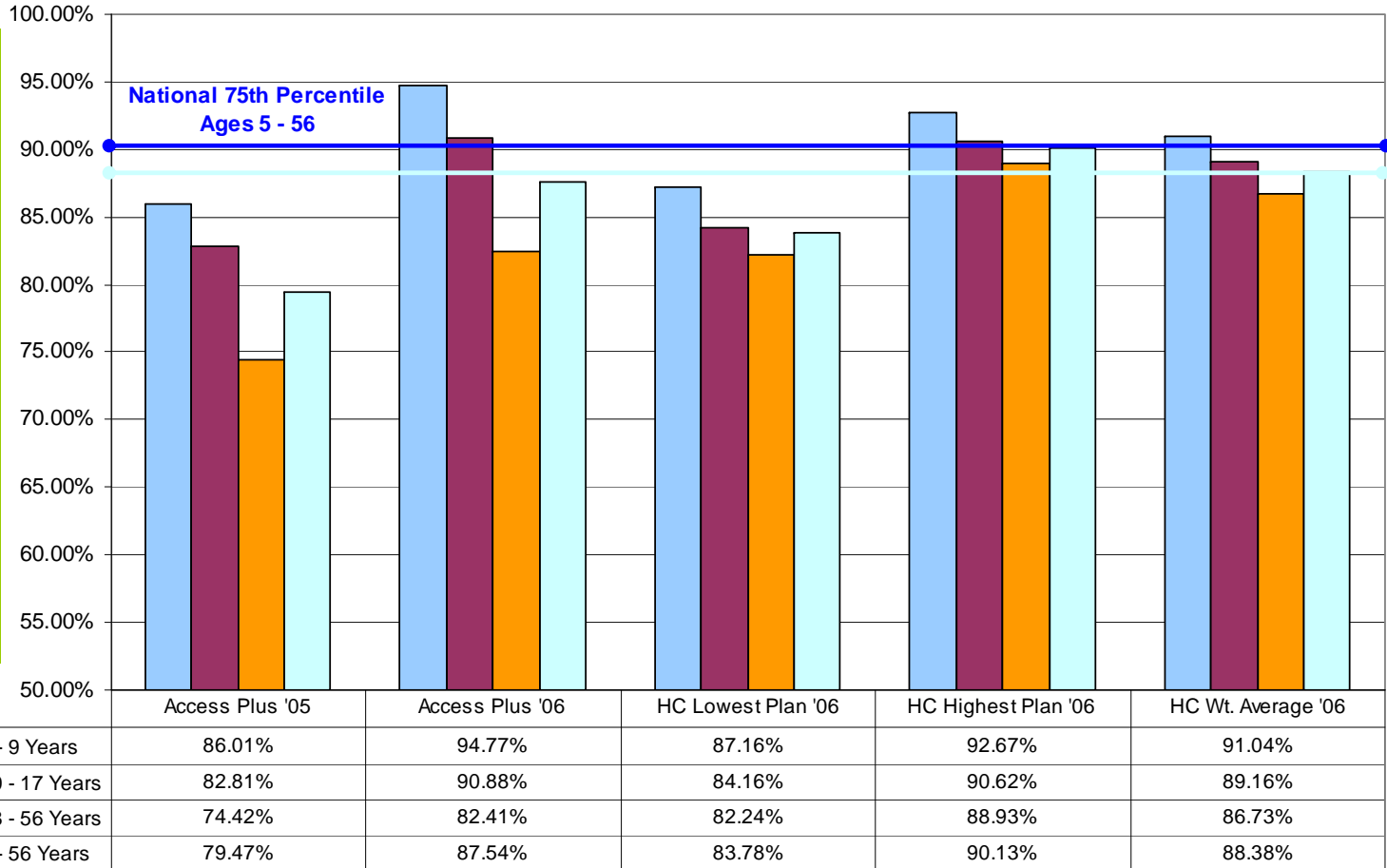
**Chronic Disease Care**



HbA1C Poorly Controlled Greater than 9.0 %	43.31%	35.52%	32.12%	54.99%	45.36%
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## Appropriate Use of Asthma Controller Medications in Asthmatics Access Plus/Health Choices Comparison

**Chronic Disease Care**



# ACCESS Plus P4P: Background

- Administered by vendor
- Original P4P Program implemented 11/05
- “Widget” approach for payment
- Initially focused more on “Pay for Participation” and the 5 chronic disease conditions:
  - **Asthma**
  - **Diabetes**
  - **Chronic Obstructive Pulmonary Disease**
  - **Coronary Artery Disease**
  - **Congestive Heart Failure**

# PCP Incentives- Phase 1 & 2

- Phase 1: Payment for participation (allowed for early rewards)
  - Sign-up for P4P program- \$200
  - Encouraging consumer participation- \$30 per patient
  - Identification of candidates for DM- \$40 per patient
- Phase 2: Payment for collaboration
  - Care plan development- \$60 per care plan
  - Payment for 2 care plans per year

# PCP Incentives- Phase 3

Quality of care process improvement

- Year 1:
  - CHF- Beta Blockers,
  - DM & CAD- ASA
  - Asthma- “controller” medication
- Year 2 :
  - CHF-Beta Blockers,
  - DM- LDL measured,
  - CAD-statin use,
  - Asthma- “controller” medication

Payment of \$17 per process accomplished for each patient

# Expansion of P4P

- Chronic disease
- Pediatric care
- Women's health
- Maternity care
- Access to care

# Pay For Performance Diabetes Measures

Item	Payment	Frequency (per year)	NCQA Bonus	Total
Eye Exam	\$15	1	\$2	\$ 17
HbA1c test	\$15	2	\$2	\$ 32
HbA1c <7	\$30	2	\$10	\$ 70
LDL test	\$15	1	\$2	\$ 17
LDL <100	\$30	1	\$10	\$ 40

# Pay For Performance Diabetes Measures

Item	Payment	Frequency (per year)	NCQA Bonus	Total
BP Control	\$25	2	\$10	\$ 60
ACE/ARB	\$10	4	0	\$ 40
Aspirin	\$10	2	0	\$ 22
CCAT	\$40	2	0	\$ 80
Total				\$ 378

# ACCESS Plus P4P Experience

- Over 1450 providers participating (as of Aug 1 2008)
- Approx. \$3.2M in incentives to enrolled Providers (Program to date).
  - These dollars are over and above standard fees paid for services as determined by OMAP
- Participating offices care for >15,000 DM patients
  - >7,000 (50%) of the high risk patients

# P4P Analysis

- Findings suggest that for patients who receive care from PCPs engaged in P4P:
  - Costs are lower
  - Utilization rates are lower
- \$823 annual savings per member.
- Reduction of 38 admissions per 1000 members.
- Analysis less clear on impact on ED visits during first year.

# DM Program Results

- 50% of DM recipients in the highest severity of illness (level 3) improved to a level 1 or 2
- Cost savings of DM program
  - \$27 million in year 1
  - \$35 million in year 2
- Regression analysis- lower PMPM costs for individuals managed by P4P participating physicians

# Lessons Learned

- Help consumers find a medical home
- Help PCPs build a better medical home
- Consumer and provider involvement essential
- Focus on measuring quality and satisfaction
- Contract risk requirements focused on quality
- Care management focused on the entire person not specific diseases
- Move off the telephone and into the community

# New RFP Issued 12/08

- Focus on broader chronic disease categories
- Expand community based approach
- Vender at risk for cost savings and 12 quality measures
- Focus on BH-PH coordination
- Innovation project
- Centralized predictive modeling

# Conclusions

- Clinical quality improved
- Clinical access improved
- Consumer satisfaction improved
- Expanded P4P program focused more on outcomes not just process
- DM program provided cost savings
- Questions?
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