Pennsylvania’s Chronic Care Management, Reimbursement and Cost Reduction Commission

Transforming Primary Care Practice: The Southeast Pennsylvania Rollout

May 4, 2009
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Distinguishing Features

- State Government as *convener*
- *Multi-stakeholder participation* in design and implementation
- Transforming care for *all patients*
- Funding methodology *transparent and adequate*
- *Support* for practices
- *Scale* is sufficient to yield reliable results
- *Transferrable*
The State of Primary Care in the USA

- Research shows patients with PCPs have lower costs, but...
- Primary care practitioners declining in numbers – failure to attract new graduates
  - Low reimbursement compared to non-PCP peers
  - Low satisfaction
- Current primary care practice is reactive, often responding to acute episodes, resulting from poor self-management by patients with chronic illness
  - Access is inadequate
  - Emphasis is on issuing referrals and not on coordinating care
  - Minimal focus on patient education and no support staff for patients
  - Slow to adopt evidence-based medicine
  - Generally lower level of sophistication (EMR, support staff, etc.)
  - Minimal communication between providers
Chronic Care Commission

Part of **Prescription for Pennsylvania**

- Created by Executive Order of Gov. Rendell, May 2007
  - Goal - Improve chronic care delivery in PA
    - $1.7 billion in avoidable admissions
    - Missed opportunities noted in process/outcomes measures
- 45 Commission members
  - Provider, insurer, state government agency, organized labor, academic and consumer representatives
- Five subcommittees
  - Practice Redesign
  - Incentive Alignment
  - Performance Measurement
  - Pooled Claims Database
  - Consumer Engagement
- Due diligence
  - Wagner Chronic Care Model
  - Patient Centered Medical Home Model
The preferred model incorporates features of the **Chronic Care Model** and the **Patient-Centered Medical Home**

- Regional “Learning Collaborative” rollouts
- Practice coaches
- Registry (or EMR), e-Prescribing, open access scheduling
- Communication – telephonic, e-mail
- Team – health educators, case managers, CRNPs, PCPs
- Endorsement of NCQA PPC-PCMH recognition
- Provider and consumer incentive alignment
- Clinical, financial and satisfaction outcomes monitoring and reporting
Chronic Care Commission

- Strategic plan to Governor and Legislature in February 2008
  - Framework to guide rollout activities in the Commonwealth’s six regions
- A Steering Committee crafted a model with a 3 year commitment for:
  - The Governor’s Office of Health Care Reform (GOHCR)
  - Participating Payers
  - Participating Providers
  - IPIP (Improving Performance in Practice)
Role of GOHCR

- Convener
- Staffing
- Funding
  - Consultants
  - Faculty / expenses for year-long learning collaborative
  - Data collection, aggregation, evaluation and reporting activities through a 3rd party, including surveys
- Coordinating
  - Flow of data between practices and payers
  - Flow of funds from payers to practices and IPIP
  - Baseline and subsequent satisfaction surveys
Requirements of PCP Practices

- Attend “Learning Collaborative” meetings
  - Team(s) from each practice
  - Seven days in first year
  - Initial focus on diabetes and pediatric asthma
- Work with an assigned IPIP practice coach to transform practice
- Use a patient registry (or EMR) to track patients
- Report data from the patient registry and other sources required for evaluation purposes
- Achieve Level 1 NCQA PPC-PCMH Recognition within 12 months
- Reinvest funds into the practice site, including staff and technology
Requirements of Payers

- Three year commitment to fund and support
- Methodology – payments proportionate to revenue from all sources as validated and coordinated through GOHCR
- Payment to IPIP for Practice Coaches
- Payment to PCP Practices are intended to offset costs
  - Infrastructure development
    - NCQA PPC-PCMH survey tool $80/practice
    - Data entry to registry $800/practice
    - Office assistant $8,000/practice
    - NCQA application fee $360/clinician
    - Registry license fee $275/clinician
  - Time for practice team to attend learning collaborative
    - Seven days during 1st year $11,655/team
    - Consist of quarterly 2 day learning and final outcome meetings
Requirements of Payers

Enhancement to current payer contractual payments

- Annual lump sum payments upon NCQA PPC-PCMH recognition yield up to $4PMPM
  - Prorated for portion of year at each level of recognition
  - Prorated based on PCP/CRNP FTEs in practice
  - Discounted by % of revenue from Medicare FFS and non-par payers

<table>
<thead>
<tr>
<th>NCQA PCMH Recognition Level</th>
<th>Practice 1 FTE</th>
<th>Practice 2-4 FTEs</th>
<th>Practice 5-9 FTEs</th>
<th>Practice 10-20 FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$40,000</td>
<td>$36,000</td>
<td>$32,000</td>
<td>$28,000</td>
</tr>
<tr>
<td>Level 2</td>
<td>$60,000</td>
<td>$54,000</td>
<td>$48,000</td>
<td>$42,000</td>
</tr>
<tr>
<td>Level 3</td>
<td>$95,000</td>
<td>$85,500</td>
<td>$76,000</td>
<td>$66,500</td>
</tr>
</tbody>
</table>

- Pay-for-performance – standard process post first 3 years based on clinical, utilization, satisfaction and financial outcomes
Requirements of IPIP

- Provide Practice Coaches to assist
  - With transforming the practice
  - With data collection and reporting
  - Linking practices to community resources
  - With completing the NCQA PPC-PCMH recognition process
Southeast Pennsylvania Rollout

6 Participating Payers
- Independence Blue Cross, Keystone Mercy Health Plan, Aetna, Health Partners, AmeriChoice, CIGNA
- Commercial, Medicare Advantage, Managed Medicaid
- Account for 75-80% of revenue

32 Participating Practices
- Pediatric, Family Practice, Internal Medicine, CRNP-led
- 150 FTEs: 3 solo, 16 with 2-4 physicians, 10 with 5-8 physicians, and 3 practices of 10-20 physicians
- Over 220,000 patients
- Mix of independent and academic practices
- Nearly half have EMR

The Primary Care Coalition (the RWJF IPIP grantee in PA)
- The PA Academy of Family Physicians
- The PA Chapter, American Academy of Pediatrics
- The PA Chapter, American College of Physicians
NCQA PCMH Recognition

![Graph showing the recognition process from June 2008 to May 2009, with categories for Pending, Level 1, Level 2, and Level 3.]

- June 2008: 0
- July 2008: 1 (Pending)
- August 2008: 2 (Pending)
- September 2008: 2 (Level 1)
- October 2008: 2 (Level 1)
- November 2008: 4 (Level 1)
- December 2008: 2 (Level 2)
- January 2009: 7 (Level 2)
- February 2009: 2 (Level 2)
- March 2009: 11 (Level 3)
- April 2009: 3 (Level 3)
- May 2009: 2 (Level 3)

Legend:
- Pending
- Level 1
- Level 2
- Level 3
The Commission has approved an evaluation methodology

- Data from payers, providers, and surveys to be aggregated by 3rd party
- Rollout “intervention” groups to be compared to control groups
- Metrics are based on nationally endorsed measures where possible (NCQA, AQA, etc.)

The initiative will be evaluated using the following measurement domains:

- Engaged providers
- Patient self-care knowledge and skills
- Patient function and health status
- Primary care practice satisfaction
- Appropriate and efficient utilization of services
- Clinical care quality
- Cost
Anticipated Gains

- Improved quality of care within 1 year
- Reduced admissions and cost in 3 years
- Improved access to care and member satisfaction
- Support for the vulnerable and essential primary care professional community
- A robust demonstration of the impact of a far-reaching, multi-payer strategy to transform care delivery
- Lessons learned to hopefully apply to a broader system-wide model application
What are the practices doing?

- Focusing on “planned visits” to ensure patients get all needed care at visits
- Bringing in patients overdue for services
- Providing team-based care
- Establishing standing orders
- Overcoming clinical inertia with clinical guidelines
- Holding group visits
- Stratifying patients for care management, self-management support
- Setting goals with patients and following up on goals
All Diabetes Measures

DM Measures Aug-2008

DM Measures Feb-2009

Goal: lower = better
Aggregate Total Pop Diabetes
(25 SE PA practices, average of 400 patients per practice)
(10,000+ patients in total diabetes population)

- Pct of DM patients with latest A1C >9
- Pct of DM patients with latest A1C <=7
- Pct of DM patients with latest BP <=130/80
- Pct of DM patients with latest BP <=140/90
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(25 SE PA practices, average of 400 patients per practice)
(10,000+ patients in total diabetes population)
All Asthma Measures

Asthma Measures Aug-2008

Asthma Measures Feb-2009

Goal: lower = better
Aggregate Total Pop Asthma
(8 SE PA practices, average of 600 patients per practice)
(5,000 patients in total asthma population)
Next Steps

- 2009 regional rollouts
  - South Central Pennsylvania – April 2009
  - Western Pennsylvania – May 2009
  - Northeast Pennsylvania – June 2009
  - Northwest Pennsylvania – September 2009
  - North-central Pennsylvania – November 2009
  - Southeast Pennsylvania – November 2009
Appendix
“The Chronic Care Model”

- Team-based coordinated care, with a focus on patients with chronic illness
  - **Origin**: Ed Wagner, McColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound
    - Improved care coordination
    - Cost reductions from averted admissions
    - Improved quality of care
  - Several existing state and national collaboratives, e.g.,
    - Vermont’s “Blueprint for Health”
    - WA state - based on the IHI Breakthrough Series Model
    - HRSA implementation through Federally Qualified Health Centers across the U.S., including 16 in PA
What is the Chronic Care Model?

Community
- Resources and Policies
- Self-Management Support

Health System
- Health Care Organization
- Delivery System Design
- Decision Support
- Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Improved Outcomes

Prepared, Proactive Practice Team
“The Patient-Centered Medical Home”
(PCMHH)

**Origin:** American Academy of Pediatrics
- Now embraced by American Academy of Family Physicians, American College of Physicians and American Osteopathic Association
- Several pilots in place and emerging around the country (NY, CO)

**Features**
- Open access scheduling
- Use of a registry or EMR to manage a population
- Use of a team: Physician, CRNPs, case managers, health educators
- Improved communication (telephonic, e-mail)
- Decision support
<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Goal</th>
<th>Endorsements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1C</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1C documented</td>
<td>&gt;90%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td>Most recent A1C level greater than 9.0%</td>
<td>&lt;20%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td>Most recent A1C level less than 7.0%</td>
<td>&gt;40</td>
<td>NCQA</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP documented in the last year &lt;140/90</td>
<td>&gt;65%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td>BP documented in the last year &lt;130/80</td>
<td>&gt;35%</td>
<td>NCQA</td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one LDL</td>
<td>&gt;85%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td>LDL Control &lt;130 mg/dl</td>
<td>&gt;63%</td>
<td>NCQA, NQF</td>
</tr>
<tr>
<td>LDL Control &lt;100 mg/dl</td>
<td>&gt;36%</td>
<td>NCQA, NQF</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received a dilated eye exam</td>
<td>&gt;60%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td><strong>Foot Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot exam</td>
<td>&gt;80%</td>
<td>NCQA, NQF</td>
</tr>
<tr>
<td><strong>Smoking Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseled to stop tobacco use</td>
<td>&gt;80</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td><strong>Nephropathy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tested for nephropathy or already under treatment</td>
<td>&gt;80%</td>
<td>NCQA, NQF</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td>&gt;60%</td>
<td>AQA, NCQA, NQF</td>
</tr>
<tr>
<td>Asthma</td>
<td>Goal</td>
<td>Endorsements</td>
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<tr>
<td>Utilization</td>
<td></td>
<td></td>
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<tr>
<td>ED visit</td>
<td>&lt;0.3%</td>
<td></td>
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<tr>
<td>Hospitalization</td>
<td>&lt;0.1%</td>
<td></td>
</tr>
<tr>
<td>Classification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity classified</td>
<td>&gt;90%</td>
<td>NQF, Physicians Consortium</td>
</tr>
<tr>
<td>Anti-inflammatory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persistent asthma on anti-inflammatory medication</td>
<td>&gt;90%</td>
<td>AQA, NQF</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td>&gt;90%</td>
<td>AQA, NQF</td>
</tr>
<tr>
<td>Composite Measure</td>
<td>Get all 3 key strategies for asthma care (classification, anti-inflammatory, influenza vaccination)</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Hypertension (still under development)</td>
<td>Goal</td>
<td>Endorsements</td>
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<tr>
<td>----------------------------------------</td>
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<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most recent blood pressure below 140/90</td>
<td></td>
<td>NCQA, CMS, NQF</td>
</tr>
</tbody>
</table>
Additional Information

Link to the Chronic Care Commission’s Strategic Plan


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