Pennsylvania's

Chronic Care Management, Reimbursement and Cost Reduction Commission

Transforming Primary Care Practice:

The Southeast Pennsylvania Rollout

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The State of Primary Care in the USA

- PCPs declining in number
  - Failure to attract new residents
  - Low reimbursement compared to non-PCP peers
  - Low satisfaction
- Current primary care practice is reactive
  - Inadequate access to care
  - Emphasis on triage, not on coordinating care
  - Minimal focus on education and self-management
  - Slow to adopt evidence-based medicine
  - Generally lower level of sophistication (EMR, support staff, etc.)
  - Minimal communication between providers

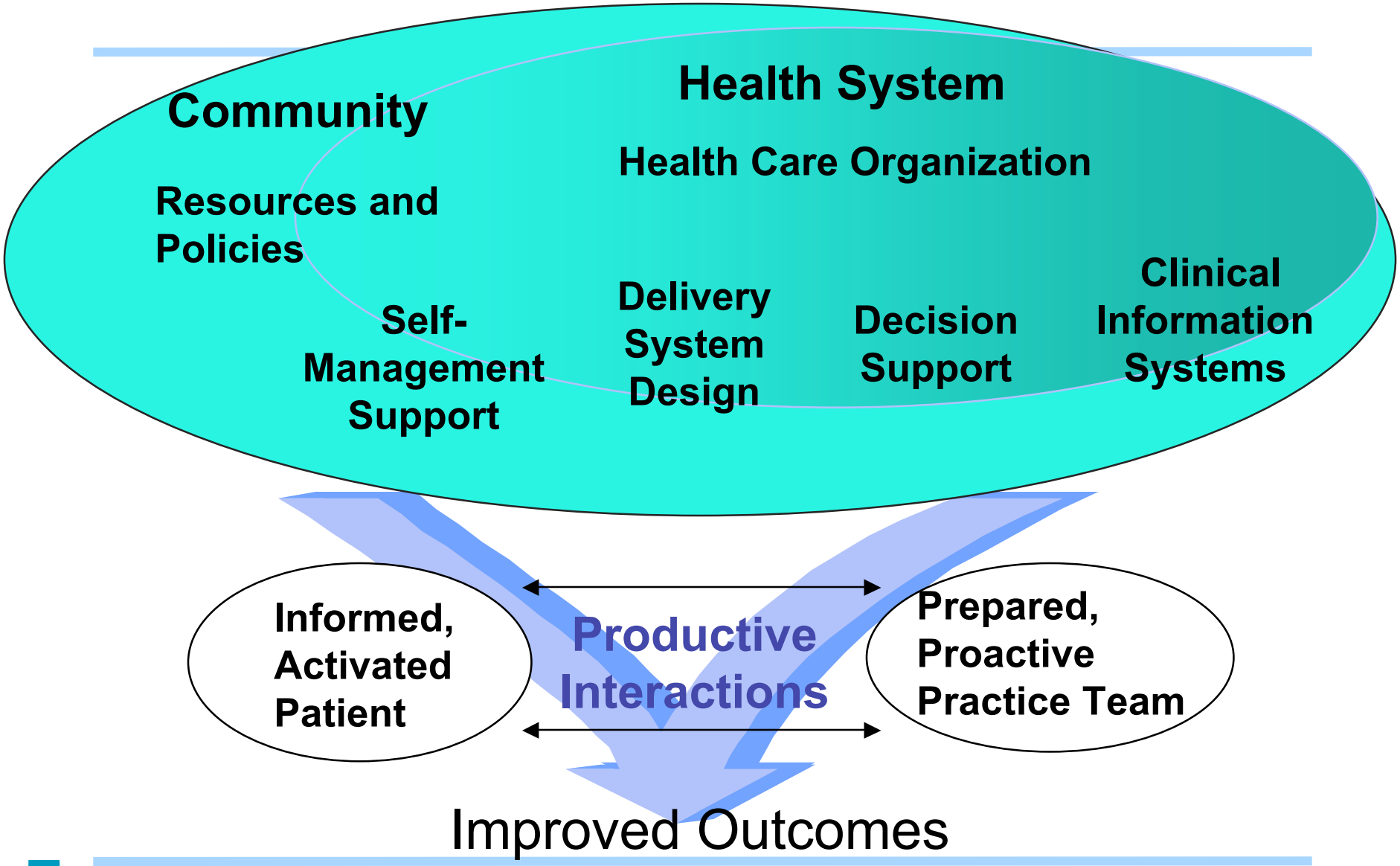
Chronic Care Commission

- Part of **Prescription for Pennsylvania**
- Created by Executive Order, 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 Chronic Care Model"

- Origin: Ed Wagner, MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound
- Team-based coordinated care, with a focus on patients with chronic illness
  - Improved care coordination
  - Cost reductions from averted admissions
  - Improved quality of care
- Several state & 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?



"The Patient-Centered Medical Home"

- Origin: American Academy of Pediatrics
  - Now embraced by AAFP, ACP and AOA as well
  - Numerous pilots in place and emerging around the country
- Features
  - Use of a team: Physician, CRNPs, case managers, health educators
  - Open access scheduling
  - Use of a registry or EMR to manage a population
  - Improved communication (telephonic, e-mail)
  - Decision support
  - Enhancements impact all patients

Chronic Care Commission

- Strategic plan
  - To the Governor and Legislature in February 2008
- 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 created a framework to guide rollout activities in the Commonwealth's six regions
- Each regional rollout must adhere to the framework, but has room to vary its approach
- A Southeast PA Regional Rollout Steering Committee crafted the following specific model with a 3 year commitment for:
  - The Governor's Office on Health Care Reform (GOHCR)
  - Participating Payers
  - Participating Providers
  - IPIP (Improving Performance in Practice)

Role of GOHCR

- Staffing
  - Project management
- Funding
  - Consultants
  - Faculty and expenses for a year-long learning collaborative for participating primary care practices
  - Cost of registry
  - Data collection, 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

Independence Blue Cross

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 PCP Practices

- Most importantly, implement fundamental redesign of the practice for *all* patients, including, for example:
  - Using the registry to send patient reminders
  - Conducting planned visits to address all aspects of the patients conditions
  - Providing team-based care, using non-physician personnel to support the patient (education, care coordination, etc.)
  - Providing self-management support, involving the patient in goal setting, action planning, problem-solving and follow-up
  - Providing enhanced access to the care team
  - Performing population-based data analysis

What is NCQA PPC-PCMH Recognition?

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

****Must Pass Elements**

Independence Blue Cross

Requirements of Payers

- Funding
  - Methodology
    - PCPs submitted 1099 revenue from all sources to GOHCR
    - Payers validated payer specific 1099 revenue
    - GOHCR formula charges each payer for each PCP practice proportionate to revenue from payer
    - GOHCR “bills” payers when payments are due
  - Payment to IPIP for Practice Coaches
    - 1 for every 15 practices
    - $130K per coach per year
  - Payment to PCP Practices are intended to offset costs
    - Infrastructure development
    - Enhancement to current payer contractual payments
    - Pay-for-performance

Requirements of Payers

- Infrastructure development
  - Infrastructure Costs to Practice During the first year are paid at the outset of the rollout
    - 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 are paid after attendance
    - Seven days during 1st year $11,655/team
    - Consist of quarterly 2 day learning meetings and final outcome meeting

Requirements of Payers

- Enhancement to current payer contractual payments
  - Intended to cover the cost of incremental staff and technology
    - Informed by analysis of limited available estimates of practice costs to implement CCM/PCMH ($4-$9PMPM range – excluding EMR) and of existing CCM/PCMH programs and pilots (Appendix)
  - 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

NCQA PCMH Recognition Level	Practice 1 FTE	Practice 2-4 FTEs	Practice 5-9 FTEs	Practice 10-20 FTEs
Level 1	$40,000	$36,000	$32,000	$28,000
Level 2	$60,000	$54,000	$48,000	$42,000
Level 3	$95,000	$85,500	$76,000	$66,500

Independence Blue Cross

Requirements of Payers

- Pay for Performance
  - Intended to provide a standardized funding mechanism after the first 3 years
  - Based on the aggregate clinical and financial outcomes of the rollout across all payers
  - Maintenance of existing program – common measures across insurers by 2010
  - Will be developed by the Commission and implemented by GOHCR
- Contribute to Consumer Engagement Strategy
  - Community Registry of resources available to practices
  - Building public-private partnerships to support self-management
  - IPIP practice coach resource for training on self-management
  - Reimburse self-management education services
  - Contribute to community sponsored lay support services
  - Contribute to standardized incentive program

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
  - 166 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

Evaluation

- 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

Next Steps

- Planning for 2009 regional rollouts
  - South Central Pennsylvania
  - Western Pennsylvania
  - Northeast Pennsylvania