Quality Tools for the Medicaid Medical Home

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Fourth National Medicaid Congress 2009

Primary Care Case Management

- Hybrid model of healthcare delivery that combines emphasis on primary care and management through a medical home with fee-for-service payment
- Participating PCPs or “medical homes” agree to meet certain quality standards like 24/7 access and receive a monthly care management fee per client
- IL PCCM program is titled “Illinois Health Connect” and sponsored by IL Department of Healthcare and Family Services (IDHFS)
- Administered by Automated Health Systems

Medical Home

American Academy of Pediatrics Definition:

"A medical home is a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health promotion in wellness, acute and chronic condition management."

Starfield and Shi, *Pediatrics* 2004;113:1493-1498:

"International and with-in nation studies indicate that a relationship with a medical home is associated with better health, on both the individual and population levels, with lower overall costs of care and with reduction of disparities in health…"

Illinois Health Connect Implementation Timeline

- July 2006: contract awarded to Automated Health Systems
- Aug 2006-Feb 2007: PCP recruitment and voluntary client enrollment at FQHC sites
- April 2007: Collar County enrollment: 225,000 clients
- July 2007: Cook County enrollment: 850,000 clients
- Aug 2007: NW region enrollment: 185,000 clients
- Nov 2007: Downstate enrollment: 350,000 clients

Illinois Health Connect Today

- 5,442 participating “Medical Homes” (each PCP counts as one medical home, each FQHC or RHC counts as one medical home)
- Capacity for 5.3 million clients
- 1.9 million of total 2.5 million IDHFS clients are mandatorily eligible
- Clients in some counties have an MCO option. Total clients selecting MCO is 180,000

Disease Management: Your Healthcare Plus

Three Distinct FFS Medicaid Populations

Non-Dual Aged Blind Disabled

Institutionalized (11,106)

1

CHRONIC CONDITIONS

(N = 103,275)

Family Health

2

PERSISTENT ASTHMA

(N = 93,722)

3

FREQUENT ER USERS

(N = 41,326)

Total about **249,429** enrollees (NOTE: DM population is a subset of the larger PCCM population)

Participation is voluntary. Individuals can "opt out."

NOTE: Data current through 1/30/09

Disease Management: Your Healthcare Plus

- Your Healthcare Plus has programs for:
  - Asthma
  - Diabetes
  - Heart Failure
  - CAD
  - COPD
  - Schizophrenia
  - Depression
  - Chronic Pain
  - Complex case management, including conditions such as hemophilia, HIV, cancer, etc
  - Frequent ED utilizers

IHC Three-Pronged QA Strategy

1. “High Tech”
2. “High Touch”
3. Adequate financial support

1-2-3

IHC Three-Pronged QA Strategy

"High tech": Multiple QA Tools providing large amounts of data to practices

- Panel Rosters
- Claims History
- Provider Profiles

IHC Three-Pronged QA Strategy

2

"High Touch" outreach to providers

- Field representatives and QA nurses make approximately 250 visits to provider offices per week to assist with billing/coding, IHC administration, EPSDT standards and clinical quality improvement.
- Five advisory subcommittees meet quarterly and create opportunity for stakeholder input
- Information provided via quarterly newsletter, blast fax, IHC website

IHC Three-Pronged QA Strategy

2

"High Touch" Outreach to Clients

- Assist client who call with scheduling well-child visits
- Send annual/bi-annual notification letters to kids based on IDHFS periodicity schedule
- Send annual letters to adults for preventive care
- Outbound calls to "overdue" kids (17,000 per week)
- Send appointment reminder letters for appointments scheduled 7 days in advance
- Client education through semi-annual newsletter, health fairs, etc

IHC Three-Pronged QA Strategy

Adequate financial support

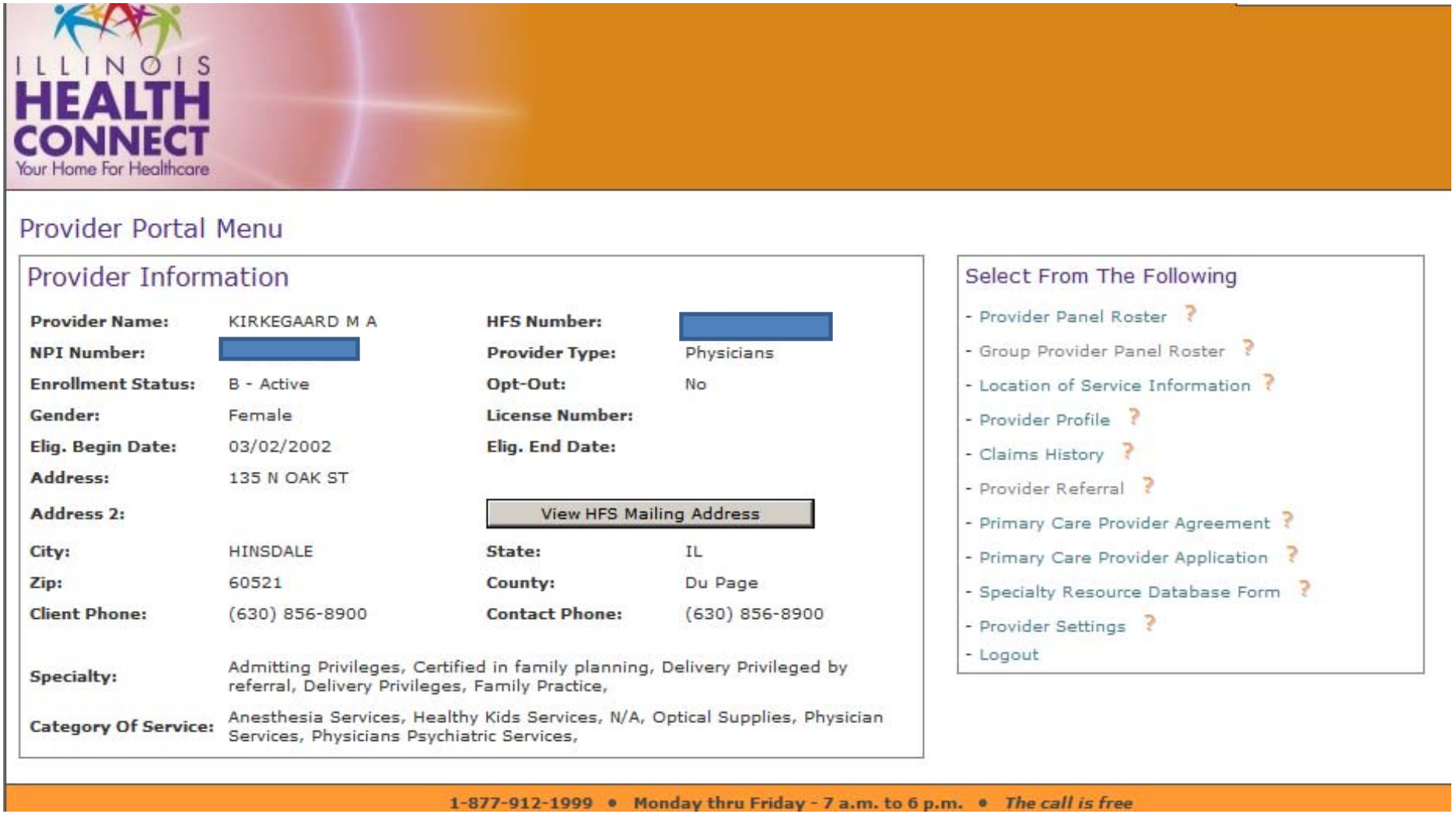
- Monthly care management fees
  - $2 per child
  - $3 per adult
  - $4 per disabled adult
- Bonus payments for high performance

3

Electronic Security for QA Tools

- In order to access the Quality Tools online, providers must use the Medical Electronic Data Interchange System (MEDI) originally created by IDHFS to submit and track claims and check eligibility
- Users create a Digital Certification by submitting info from drivers license, then must also register with MEDI to obtain authorization
- Providers, payees, other business and their employees may register for specific functions
- Complete instructions for MEDI registration available on www.illinoishealthconnect.com under Provider Information or by contacting Provider Service Representative

Illinois Health Connect Provider Portal



Panel Rosters

- Available online to download in CSV (Excel format), can be sorted, can request a mailed paper copy
- Lists all clients currently “linked” to that PCP/medical home
- Most recent client demographic data included
- Shows Disease Management eligibility

Panel Rosters Clinical Data

- Panel Roster shows date of last claim, scheduled appointment or kept appointment for well child visits
- Developmental screening, vision and lead screening, mammogram and pap currently reflect date of last paid claim, reflect “due” status based on IDHFS periodicity schedule
- Captures claims data from other providers

Provider Enrollee Panel Roster

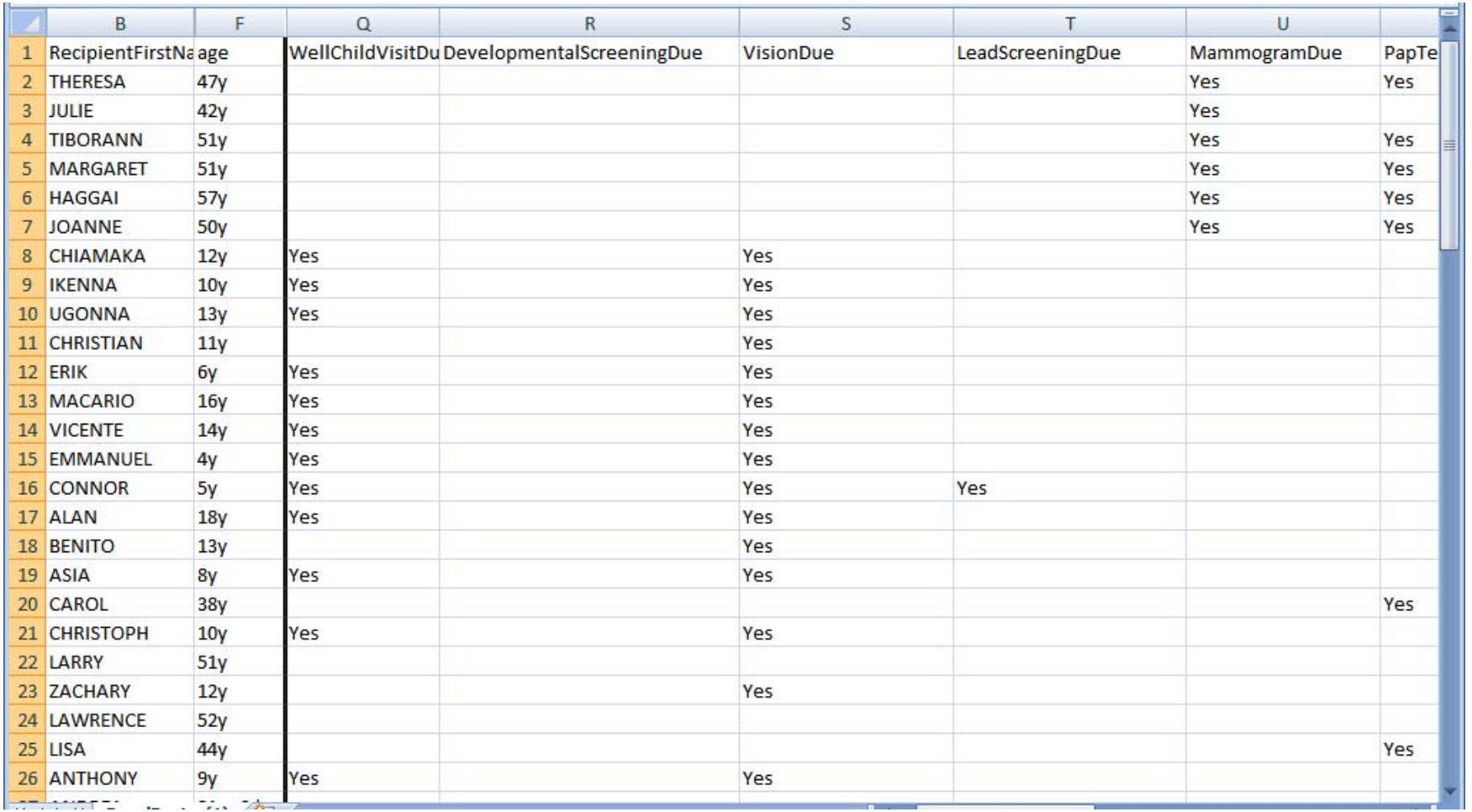
June 2008

Provider HFS Number: [redacted]
Illinois Health Connect Number: 03000047
KIRKEGAARD M A (Fax (630) 856-8933)

Enrollee Information	Address/Phone	Begin Link Date End Link Date	Disease Management Eligibility	Preventive Services	Status	Services Reported to IHC
[redacted]		9/5/2007		Well Child Visit:	Due	2/20/2006 Claim
				Screenings - Developmental:		2/20/2006 Claim
				Vision:	Due	
				Lead:		2/22/2005 Claim
[redacted] 3/26/2002 - 6y (Female)	[redacted]					
[redacted]		12/14/2007				
				PAP Test:		8/16/2007 Claim
- 47y (Female)				Mammogram:	Due	
476100						
BERTA		5/4/2007		Well Child Visit:		12/11/2007 Claim
				Screenings - Developmental:		
				Vision:	Due	
				Lead:		
11y (Female)						
238300						
ELA	C402	5/4/2007				
				PAP Test:	Due	7/6/2006 Claim
- 26y (Female)						
231000						
RGARET		5/4/2007	Disease Management Eligible			
	15		Persistent Asthma	PAP Test:	Due	
50y (Female)				Mammogram:	Due	
042400						
AMED		7/3/2007		Well Child Visit:	Due	9/9/2004 Claim
				Screenings - Developmental:		
				Vision:	Due	
				Lead:		
- 9y (Male)						
261800						

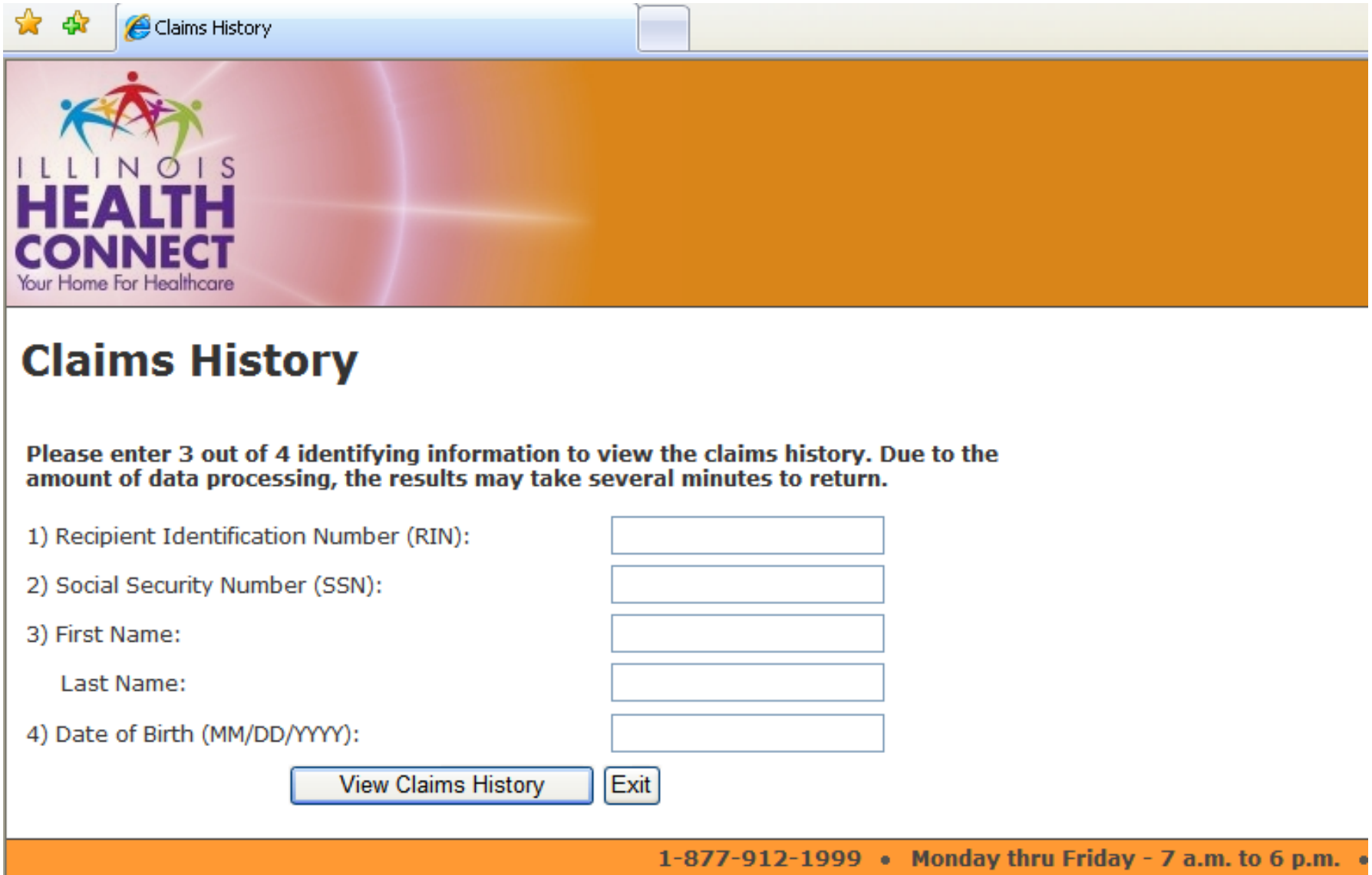
Panel Roster in CSV Format

sorted by "due for mammogram"



	B	F	Q	R	S	T	U	
1	RecipientFirstNa	age	WellChildVisitDu	DevelopmentalScreeningDue	VisionDue	LeadScreeningDue	MammogramDue	PapTe
2	THERESA	47y					Yes	Yes
3	JULIE	42y					Yes	
4	TIBORANN	51y					Yes	Yes
5	MARGARET	51y					Yes	Yes
6	HAGGAI	57y					Yes	Yes
7	JOANNE	50y					Yes	Yes
8	CHIAMAKA	12y	Yes		Yes			
9	IKENNA	10y	Yes		Yes			
10	UGONNA	13y	Yes		Yes			
11	CHRISTIAN	11y			Yes			
12	ERIK	6y	Yes		Yes			
13	MACARIO	16y	Yes		Yes			
14	VICENTE	14y	Yes		Yes			
15	EMMANUEL	4y	Yes		Yes			
16	CONNOR	5y	Yes		Yes	Yes		
17	ALAN	18y	Yes		Yes			
18	BENITO	13y			Yes			
19	ASIA	8y	Yes		Yes			
20	CAROL	38y						Yes
21	CHRISTOPH	10y	Yes		Yes			
22	LARRY	51y						
23	ZACHARY	12y			Yes			
24	LAWRENCE	52y						
25	LISA	44y						Yes
26	ANTHONY	9y	Yes		Yes			

Illinois Health Connect
Claims History



Claims History Report Content

- Prescription Summary (2 years of data)
  - Prescription Date
  - Prescription Quantity
  - Prescription Description
- Immunization Summary (currently 4 years of data, will expand to 7 years)
  - Immunization Date
  - Immunization Code
  - Immunization Description
- Claim Summary (2 years of data)
  - Service Date
  - Claim Date
  - Provider Name
  - Diagnosis Code
  - Procedure Code
  - Claim Type

Report Screen Shot - Child

PRESCRIPTION SUMMARY

Prescription Date	Prescription Qty	Prescription Description
11/06/2007		
	60.000	NYSTATIN 100,000 UNIT/GM CREAM
10/05/2007		
	75.000	AMOXICILLIN 400 MG/5 ML SUSP

Total Prescriptions: 2

IMMUNIZATION SUMMARY

Immunization Date	Immunization Code	Immunization Description
07/31/2007		
	90723	DTAP-HEP B-IPV IM
	90645	HEMOPHILUS INFLUEZA B VACCINE HBOC CONJUGATE 4 DOSE IM
	90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, IM FOR UNDER 5

Total Immunizations: 3

CLAIM SUMMARY

Service Date	Claim Date	Provider Name	Diagnosis Code Description	Procedure Code Description	Claim Type
02/07/2008					
	02/20/2008	[redacted] C	38200 AC SUPP OTITIS MEDIA NOS	T1015 CLINIC VISIT/ENCOUNTER ALL INCLUSIVE	
		C	38200 AC SUPP OTITIS MEDIA NOS	99213 E/M OFFICE/OH VISIT EST PT	

Provider Profiles

- Sent semi-annually to all IHC PCPs
- Developed with input from Quality Management Subcommittee
- QA Nurses visit PCP offices to discuss results and strategize about QI
- HEDIS or “HEDIS-like” measures
- Some providers receive similar profiles from Disease Management program on chronic disease metrics

Provider Profile Clinical Measures

- Immunizations
- Developmental screening
- Diabetes Management
- Asthma management
- Well child care
- Adolescent well care
- Vision screening
- Breast cancer screening
- Cervical cancer screening
- Lead toxicity screening (anticipated 2009)

Provider Profile Example

Quality of Care Indicators

Indicator		# Eligible Enrollees	# Eligible Events	Current Rate	Prior Rate	State-wide Rate (2007)	Comparison to State	Bonus Payment Benchmarks
1a.	Immunization status for 2 year olds - Combination 2	6	2	33%		52%		NA
1b.	Immunization status for 2 year olds - Combination 3	6	1	17%		46%		63%
3a.	Developmental screening by age 12 months	5	3	60%	67%	23%		35%
3b.	Developmental screening between age 12 and 24 months	6	1	17%	0%	19%		25%
3c.	Developmental screening between age 24 and 36 months	3	0	0%	50%	14%	L	20%
4c.	Appropriate asthma medications for patients age 10 to 17 years	1	1	100%	0%	90%		89%
4d.	Appropriate asthma medications for patients age 18 to 56 years	2	2	100%	100%	83%	H	85%
6a.	Zero well baby visits in the first 15 months of life	2	0	0%	0%	14%		NA
6g.	Six well baby visits in the first 15 months of life	2	0	0%	67%	48%	L	NA
7.	Well child visit in the 3rd, 4th, 5th and 6th years of life	14	6	43%	31%	57%		NA
8a.	Vision screening in the 3rd year of life	6	0	0%	0%	6%		NA
8b.	Vision screening in the 4th year of life	2	0	0%	0%	13%		NA
9.	Cervical cancer screening for women age 21 to 64 years	25	8	32%	52%	28%		NA

NA Not Available / Not Applicable
H PCP performance on this indicator is in the top 10 percentile of all IHC PCPs
L PCP performance on this indicator is in the bottom 10 percentile of all IHC PCPs

2008 Bonus Payment for High Performance

- Count the number of qualifying patients for each measure enrolled on each PCP's Illinois Health Connect panel roster on December 1, 2008. (determines denominator)
- IDHFS claims data will be used to determine whether a service was rendered during the measurement period. (determines numerator)
- Based on measurement year 2008 claims, allows a 3 month run out to submit claims until April 1, 2009

2008 Bonus Payment for High Performance

- Benchmarks established by national norms
- Input from Quality Management Subcommittee
- PCPs do not have to report any special information to earn a bonus payment
- Claim is counted whether or not it was the current PCP or another provider who rendered the service during the measurement period
- Bonus payments will be at least $20 per patient
- Pay the bonus payments by June 2009

2008 Bonus Payment for High Performance

- **Immunization Combo 3:** Children who receive designated immunizations by age 24 months (benchmark 62.6%).
- **Developmental Screening:** Children who receive at least one objective screening by the age of 12 months (benchmark 35%), between the ages of 12 and 24 months (benchmark 25%), and between the ages of 24 and 36 months (benchmark 20%). A bonus will be available for each separate age group.
- **Asthma management:** Patients with persistent asthma, ages 5-9 years (benchmark 91.7%), ages 10-17 years (benchmark 88.8%) and ages 18-56 years (benchmark 85.4%) who fill an asthma controller medication prescription.

2008 Bonus Payment for High Performance

- **Diabetes Management:** Patients with diabetes, ages 18 to 65 years who receive at least one HbA1c test annually (benchmark 79.3%).
- **Breast Cancer Screening:** Women ages between ages 40 and 69 who have had a mammogram in the last two years (benchmark 49.2%).

Evaluation

- Enrollee Survey: in progress
- PCP Survey: completed for 2008, 2009 in progress
- Clinical metrics
- Financial savings and Utilization metrics

Provider Satisfaction Survey

Question	2008 Data N= 687		2009 Data	
	SA or A	D or SD	SA or A	D or SD
IHC is beneficial to my patients.	81.3%	12.7%		
Overall, I am satisfied with the administration of IHC.	76.1%	23.9%		
I would recommend IHC to my colleagues.	75.2%	24.8%		

Clinical Metrics Examples

Measure	2007 All IHC enrolled*	2008 All IHC enrolled**
Children ages 0-3 with at least 1 objective developmental screen	25.5%	28.9%
Women ages 42-69 receiving at least 1 mammogram in measurement yr or yr prior	37.45%	36.76%

* Includes all clients enrolled at the end of the measurement period, does not require continuous enrollment.

** Data compiled 3/26/08. Providers have one year to file claims.

Financial Savings and Utilization metrics

- Disease Management program undergoes yearly financial reconciliation
  - $34 million in savings FY 07
  - $104 million in savings for FY 08
- Preliminary data suggest equal savings attributed to IHC
- Preliminary data demonstrates decreased ED usage in IHC population
- Preliminary data demonstrates decreased hospitalizations in IHC population

Future Challenges

- Aligning and streamlining quality data provided to PCPs
- Moving medical homes to higher standards (eg NCQA)
- Improving client education through the medical home
- Assessing outcomes through clinical metrics
- Increasing eligible population

Illinois Health Connect Summary

- The cornerstone of the Illinois Health Connect program is getting every client linked to the “best fit” medical home
- Several QA tools have been developed to support the medical home
- IHC staff are available to assist providers with implementation of the tools to improve quality of care
- Favorable prelim outcomes data

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Thank you!

For more info:

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