

Partnering with the Private Sector in State Medical Home Initiatives

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Prescription for Pennsylvania

Prescription for Pennsylvania is a set of integrated practical strategies for improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost. Our Medical Home initiative came out of Rx for PA.



Right State | Right Plan | Right Now

GOHCR

WORKING TO ACHIEVE ACCESSIBLE, AFFORDABLE QUALITY HEALTH AND LONG TERM LIVING SERVICES FOR ALL PENNSYLVANIANS

Transforming Chronic Care in Pennsylvania

- Improving chronic care is win-win for both cost reduction and improved quality.
- For 2007, PA hospitals charged \$4 billion for avoidable hospitalizations for those with chronic conditions. This does not include avoidable ER.
- We know that patients are receiving only about 56% of the evidence-based primary care they need and it is even less for those with multiple chronic conditions.
- We needed to change both how care is delivered at the primary care level and how it is paid for, and to do so we needed to partner with the private sector to get it done.

Transforming Chronic Care in Pennsylvania

- We involved consumers, insurers and primary care providers in developing a plan to (1) change how care was provided to all patients through a combination of the PCMH and Chronic Care Models, and (2) reward practices that transform how care is provided.
- State supervision of the discussions on payment provided antitrust protection.
- All major payers, except Medicare FFS, participated including our Medicaid HMOs. Payors and PCPs committed to a three-year initiative.
- First year chronic care focus was on patients with diabetes and pediatric asthma.

Requirements: GOHCR

- Funding faculty and expenses for three year-long learning collaboratives for participating primary care practices
- Coordinating the flow of data and funds to practices based on PCPs 990 percentage by payor
- Providing ongoing project management support
- Funding cost of registry (first rollout excluded due to lack of appropriations)
- Funding data collection, evaluation and reporting activities through a contracted 3rd party
- Funding the evaluation

SE Requirements: Primary Care Practices

- Participate in seven days of learning collaborative meetings in Year 1; initial focus on diabetes and pediatric asthma
- Work with an assigned practice coach between learning collaborative sessions to transform practice
- Use a patient registry to track patients with chronic illness starting with diabetes for adults and asthma
- Achieve Level 1 NCQA PPC-PCMH Recognition within 12 months
- Report data from the patient registry and other sources required for evaluation purposes
- Reinvest funds into the practice site, including for case management in those instances where the practice does not already have that resource in place

SE Requirements: Payers

- **Infrastructure development payments**
 - Licensing fee for registry, support for data entry to registry, cost of NCQA survey tool, NCQA application fee, and lost revenue for time to attend seven days of learning collaborative meetings in the first year (\$21,170 per practice)
- **Enhanced payments to FFS/capitation**
 - For initial three years, lump sum payments aligned with stepwise achievement of the three levels of NCQA PPC-PCMH recognition
- **Pay-for-performance**
 - Maintenance of existing program – common measures across insurers by 2010

Payment Triggered by NCQA PPC-PCMH Recognition

Annualized revenue per full-time-equivalent practitioner from all sources for implementing the features of the PCMH recognizes economies of scale and the incremental resources to achieve full transformation of the practice to include all features, *discounted by* the % of practice revenue derived by Medicare FFS and insurers with low market share.

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

SE Participants

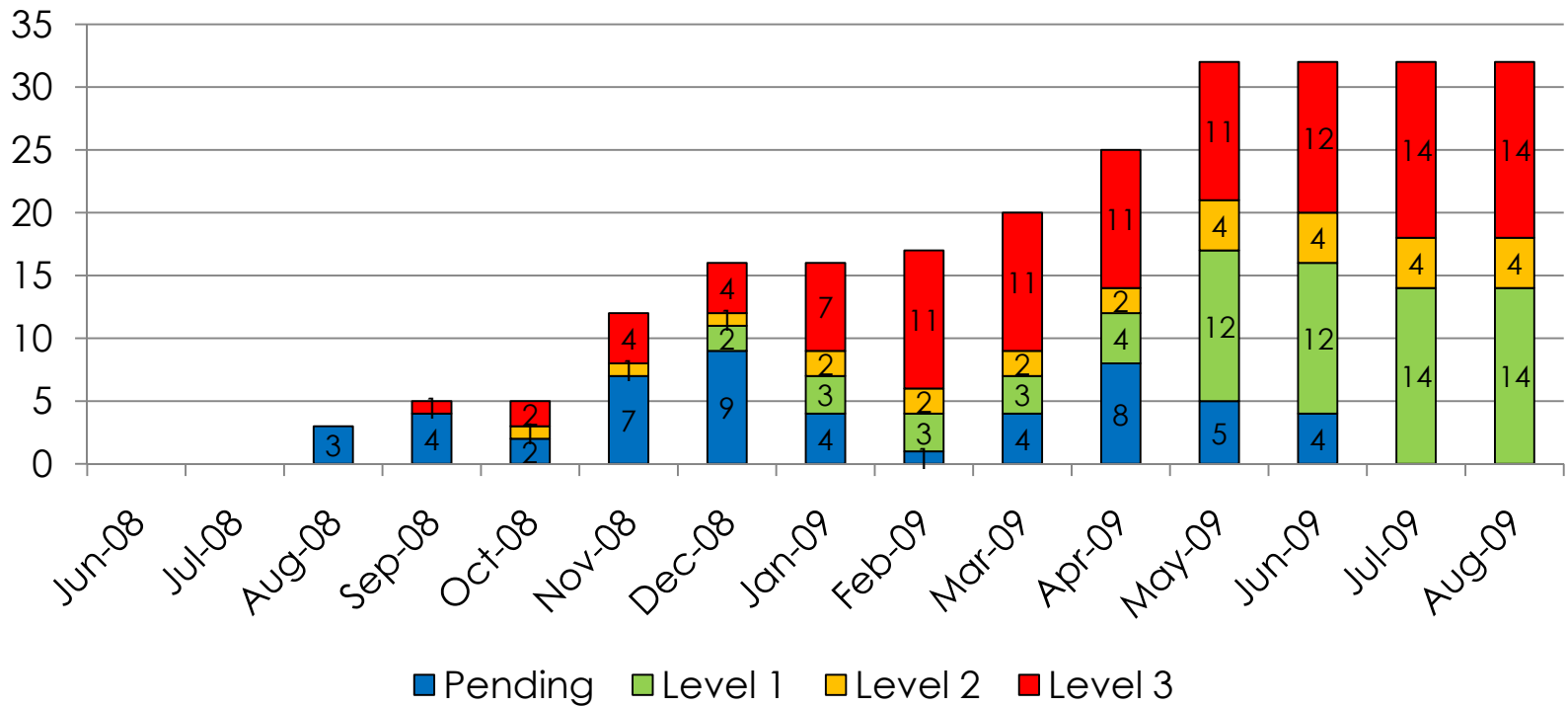
- 32 practices, of which 9 are FQHCs/FQHC look a likes
 - representing 165 clinician FTEs
 - serving 176,000 patients
 - internal medicine, family practice, pediatrics and NP-led practices
 - all sizes of practices (three 1-physician practices to three 10-20 physician practices)

SE First Year Outcomes

- All 32 practices achieved at least Level 1 NCQA certification within 12 months
- 33% improvement in diabetics who gained control of their blood sugar.
- Number of diabetics getting eye exams increased 71% and foot exams 142%
- Those who lowered cholesterol below 130 increased by 43% and blood pressure below 140/90 by 25%
- In the first 10 months, one plan saw a 26% decrease in diabetic hospitalizations and 10% reduction in costs for pediatric asthmatics

SE PA

NCQA PPC-PCMH Recognition



SE Lessons Learned

- Practices spent initial time writing up policies for NCQA certification - not changing work flow, using patient registries and client self-management. Need to push out date.
- Practices need more lead time before the first learning collaborative to get their patients into the patient registry and understand what they are being asked to do. Need good baseline.
- Need to work on behavioral health integration.
- NCQA certification is a lot of work for practices.
- Need to continue learning collaborative meetings and calls beyond Year 1, but can be less.
- Need monthly calls with public and private partners to address issues, provide feedback, etc.

Year 2 SE Initiatives

- Piloting consumer incentive program in two low income practices for Type 2 diabetic patients, which allows patient volunteers to work with a care manager to develop specific measurable action plans which are logged weekly and for which patients can earn up to \$10/week in gift cards based on achievement.
- Piloting with four practices' carriers sending hospital admission data and pharmacy data on patients to practices.
- Also teaming nearby behavioral health providers with PCPs for better integration of physical and behavioral health care.
- Spreading to all chronic conditions with emphasis on patients identified as high risk by the payers.

South Central Rollout

- Provide up to \$20,000 per practice, prorated by carriers, for participation in Year 1 learning collaborative, working with practice coaches, timely reporting, entering data into patient registry, etc.
- Felt there was too much emphasis in SE to get NCQA certification and not enough about implementing the Chronic Care Model, so not paid for obtaining certification until 18 months. Also, care management and patient self management support are required components (standards 3 and 4 in NCQA PCMH).
- Had more practices that wanted to be in the SC collaborative than funding from the payers, so a number of practices are doing it without additional compensation.

South Central Lessons Learned

- It is different working with health systems on a roll out as opposed to individual practices in a health system.
- Worked with the Hershey and Lehigh Valley Hospital systems, which involved their residency programs, etc.
- Pre-work time at the office site to help them get patient registry operating and good baseline data before the first learning collaborative was key.
- Practices concentrated much more on transforming patient care in the first months instead of spending time on NCQA documentation requirements. Better outcomes came much earlier.

South West Rollout and Lessons Learned

- Same compensation arrangement and 18-month NCQA certification as SC.
- There will be three learning collaboratives in SW - one facilitated by GOHCR, one facilitated by the Pittsburgh Regional Health Initiative and one by UPMC.
- Practices had done a lot of previous work with the Pittsburgh Regional Health Initiative, HRSA, etc. We made the mistake of not initially acknowledging that work and explaining how this initiative was different and how it would improve their practice work flow and outcomes to a greater extent.

NE Rollout

- Rolling out next month with 37 practices with 139 PCPs who care for 279,932 patients.
- NE has a much older population and we had to exclude some PCPs that wanted to participate because their Medicare FFS ratio was so high.
- Practices will be given resources to hire care coordinators to be located in their practices in month 4.
- Additional compensation will come from shared savings from avoidable hospitalizations, ER visits, etc.

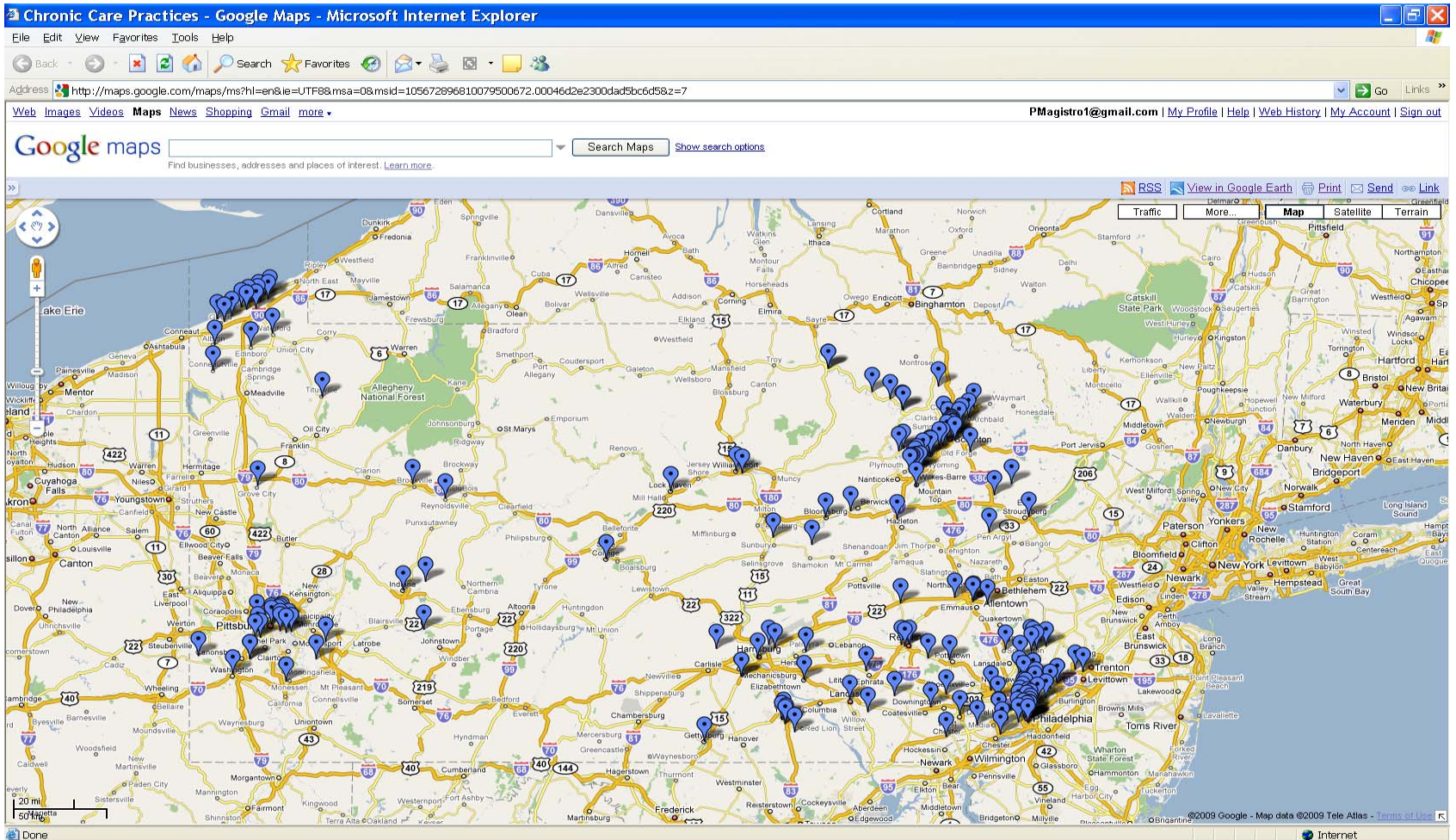
NE Rollouts Lessons Learned So Far

- Insurers in the NR prefer shared savings because no pay out unless savings are realized.
- Insurers prefer ensuring that money meant for care management goes to care management early in the initiative.
- Need Medicare FFS participating in this effort. The governors of Maine, Vermont, Connecticut, Massachusetts and Pennsylvania have written to CMS asking to have Medicare participate in a NE initiative.

Future Rollouts

- Payors have made a three-year commitment, but want to evaluate before committing additional funding
- We will roll out four no-enhanced payment by payors collaboratives in SW, Erie, State College and SE
- By end of 2009 we will have over 800 PCPs transforming their practices and caring for 1.2 million patients

Locations of Practices Participating in Learning Collaboratives



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Evaluation

- We are contracting for an independent evaluation design utilizing matched pairs of practices as a control group.
- The initiative will be evaluated using the following measurement domains:
 1. engaged providers
 2. patient self-care knowledge and skills
 3. patient function and health status
 4. primary care practice satisfaction
 5. appropriate and efficient utilization of services
 6. clinical care quality
 7. cost.

Anticipated Gains

- Improved quality of care within one year
- Reduced admissions and cost in three 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

In Conclusion

- Only 1.75 years left in the Administration and collaboratives will continue into 2012. We need to find a safe home for the continuation of this work that provides the antitrust protection and is a trusted entity for the participants.
- We are seeing results already that this will result in a decline in specialist referral, avoidable ER use and avoidable hospitalizations.
- We know from the work of the Dartmouth Atlas that supply induced demand will continue without further interventions.
- Specialists may increase frequency of seeing other patients to adjust for volume loss from patients of practices in the learning collaboratives.

In Conclusion

- Meaningful change in the provision of chronic and primary care cannot happen without a private-public partnership.
- Keys to making the partnership work:
 - Common reporting on process and outcomes
 - Layering additional PCP compensation onto existing FFS/capitation payments so existing contracts did not need to be changed
 - Monthly calls and data reporting
 - State providing antitrust protection and letting the plans know their pro rata share of payment for each practice
 - Agreed upon clinical guidelines based on evidenced-based care
 - Shared commitment for continuous quality improvement, shared learning and moving from payment for volume to payment for value.

Contact for Additional Information

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