Pennsylvania’s Chronic Care/Medical Home Initiative: Transforming Primary Care

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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.
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 visits.
- 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.
- There is a lot of room to earn increased reimbursement if primary care can help eliminate avoidable costs.
Transforming Chronic Care in PA

• PA’s strategic plan outlined how 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. The goal is to improve care for all patients.
• State supervision of the discussions on payment provided antitrust protection.
• All major payers, except Medicare FFS, participated including our Medicaid HMOs.
• Payers and PCPs committed to a three-year initiative.
General Framework

- Financial Incentives for start up (infrastructure) and NCQA certification
- Practices selected and their teams identified (physician, RN/MA/LPN and other key staff)
- Learning (educational) Sessions seven days first year
- Monthly Data and Narrative Reporting
- Apply for Patient-Centered Medical Home recognition from NCQA
- Monthly Conference Calls
- Coaching and Expert Faculty Support
Started in SE PA in May 2008

• 32 practices, of which nine are FQHCs/FQHC look a likes
  - representing 236 PCPs
  - serving 209,354 patients
  - internal medicine, family practice, pediatrics and CRNP-led practices
  - all sizes of practices (three one-physician practices to three 10-20 physician practices)
SE Requirements: Payers

• Derivation of infrastructure development payments:
  – Infrastructure Costs to Practice During for SE
    – 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 to attend learning collaboratives (seven days/year) $11,655/clinician
SE 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.

<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>
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<tr>
<td>Level 2</td>
<td>$60,000</td>
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<td>Level 3</td>
<td>$95,000</td>
<td>$85,500</td>
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</table>
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%
Preliminary Results From One HMO

• Diabetes (1452)
  – 11.3% increase in prescription costs
  – 26% reduction in inpatient admissions
  – 18.4% reduction in ER visits
  – 15.9% reduction in overall costs ($46.37 pmpm)
• Asthma (1227)
  – 17% reduction in inpatient admissions
  – 6.3% reduction in overall costs ($9.60 pmpm)
  – 42% reduction in ER visits
• “utilization definitely went down”
Lessons Learned from SE Model

- Practices spent too much initial time on drafting policies to get NCQA recognition and not enough time on practice transformation.
- Practices were supposed to use some of the payments from NCQA certification to enhance case management and helping patients set and achieve goals. Some did not.
- Practices were given the patient registry at the first session and it took some practices six months to load their patients and be able to do monthly reporting.
- Some practices that received Level 1 certification had better health outcomes and process measures than those with Level 3 certification because they were doing more components of the Chronic Care Model.
Changes Made in the SC and SW Models

• Practices received the patient registry and training on its use and were expected to have it loaded and bring baseline patient data to the first learning collaborative.

• Cannot apply for NCQA recognition before month 18 (12 for SE) and instead use the first 12 months on practice transformation.

• SC and SW provided $20,000 for infrastructure support to attend sessions, use the registry and for application costs.

• SC and SW provided $1.50 pmpm in month 13 for care management (average of $31,356/year) and $1.50 pmpm (average of $31,356/year) for NCQA Level 1 plus certification after 18 months.

• This dedicated resources for case management at month 13 and, by requiring Level I, it assured that more components of the Wagner Chronic Care model in PCMH model were met.
Lessons Learned from SC and SW Model

- Some practices did not have the resources to pay for case management in advance of receiving funding to do so and really needed to have case management resources much earlier than month 13.
- Practices needed infrastructure support beyond the first year.
- There was concern that some practices were getting a free ride and that NCQA certification did not mean that costs were being reduced for the plans.
Changes Made in SC and SW Model

• NE provides $1.50 pmpm for practice support ($99,360 over three years) and $1.50 pmpm (max of $74,529) for care management in month four.

• Infrastructure resources provided all three years and care management resources much earlier. No automatic additional $ for NCQA.

• Additional “Value Reimbursement available at month 12
  – Practices must meet Level 1 Plus
  – Practices must have a 2% improvement in at least 5 of 9 Group 1 criteria or be 90% or above for the Mid-Atlantic NCQA for those measures
  – Practices must meet at least 3 of 4 Group 2 Criteria
Group 1 Criteria (at least 5 of 9)

- improvement in the percentage of total population diabetic patients with HbA1c below 9%
- improvement in the percentage of total population diabetic patients with LDL-C below 100
- improvement in the percentage of total population diabetic patients with blood pressure < 130/80
- improvement in the percentage of hypertensive patients with blood pressure < 140/90 (members of participating Carriers only)
- improvement in the percentage of coronary artery disease patients with LDL-C below 100 (members of participating Carriers only)
- 2-percentage points reduction in the 30-day readmission rate (members of participating Carriers only)
- 2-percentage points reduction in the Ambulatory Care Sensitive Condition (ACSC) hospitalization rate (members of participating Carriers only)
- 2-percentage points increase in total primary care Practice visits (members of participating Carriers only)
- 5% decrease in emergency room visits per 1000 (members of participating Carriers only)
Group 2 Criteria (at least 3 of 4)

- documented care plan for all patients identified by each Carrier as high risk
- documented self-management support goal setting with 90% of all patients identified by each Carrier as high risk
- documented 75% Practice team clinical telephonic or face-to-face patient follow-up within two days after hospitalization discharge
- documentation that there is a care manager in place and that the care manager is operating consistently with the requirements set forth in the Participation Agreement
Value Reimbursement Levels

• Savings are determined after subtracting the infrastructure support and care manager supports made for the year.
• Practices then share according to the number of criteria met, if they have at least met the minimum.
  – 14 of 14 criteria met: 50% share
  – 12-13 of 14 criteria met: 47% share
  – 10-11 of 14 criteria met: 44% share
  – 9 of 14 criteria met: 41% share
This Type of Model May Be the Future

• One practice of five doctors saved $600,000, which they split with the plan.
• These types of models have the potential to realize much more revenue than the SE model, but also the potential to not.
• With all the talk of accountable care organizations and basing pay on performance, FQHCs need to think about what they need to do to thrive in this environment.
GO HCR
WORKING TO ACHIEVE ACCESSIBLE, AFFORDABLE QUALITY HEALTH AND LONG TERM LIVING SERVICES FOR ALL PENNSYLVANIANS
## A Look at the Numbers

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Practices</th>
<th>Total Providers</th>
<th>FTE'S</th>
<th>Total Reported Patients</th>
<th>Average FTE's/Practice</th>
<th>Average Patients/FTE</th>
<th>Year 1 Payments</th>
<th>Total Estimated Payments By Insurers</th>
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<tr>
<td>SEPA</td>
<td>32</td>
<td>206</td>
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Contact for Additional Information

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