Pennsylvania’s Medicaid FFS Managed Care Program

Office of Medical Assistance Programs
David K. Kelley MD, MPA
Pennsylvania Medical Assistance

• Provides health care coverage to 1.9 million consumers (14% of the Commonwealth’s population)

• Operates a capitated managed care program - HealthChoices - in 25 urban and suburban counties covering 1.1 million consumers

• Operates a managed FFS program in 42 rural counties for 290,000 consumers- Access Plus
What is the ACCESS-Plus Program?

1. Access Plus is an Enhanced Primary Care Case Management (EPCCM) medical home

2. **Disease Management (DM) Program**-CAD, CHF, Asthma, COPD, Diabetes

3. Complex Case Management

4. 290,000 members, excludes dual eligibles, 34,000 with chronic diseases covered by DM

5. Vendor has guaranteed cost savings, and is at risk for DM performance
Department of Public Welfare continues to do the following:

- Enrolls providers
- Pays providers
- Prior authorizes services
- Performs utilization management
- Manages the pharmacy benefit
- Manages Special Needs Unit (SNU)
- Manages high risk pre-natal care
Role of Contractor- McKesson

• Establish a medical home for each consumer- (Automated Health Systems AHS)

• Coordinate care and help consumer access needed services- (AHS)
  - EPSDT
  - Immunizations and screenings
  - Transportation coordination
  - Dental outreach
  - Prenatal care- (low risk)

• Operate DM programs (McKesson Health Solutions)
  - Identifies, stratifies, and performs predictive modeling
  - Consumer education
  - Provider education
  - Improve provider access
  - Improve consumer compliance
  - Coordinate between primary and specialty care
Disease Management (DM)

The contractor manages the following:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Co-morbidities (special attention on depression and schizophrenia)
- Focus on smoking cessation and medication compliance
- Pay for performance implementation / administration
Care Coordination Techniques

- DM is done primarily via RN telephone contact from Pa. and Colorado
- 8 FTE community-based RNs
- 6 FTE community-based non-clinical care coordinators
- 5 field-based provider service representatives
- Coordination between DM nurses and Special Needs Unit (SNU) nurses
Special Needs Unit (SNU)

- Centralized telephonic based
- Occasional community-based visits
- 24 total RN FTEs (75-80 cases per RN)
- 2 Pain management RNs
- 1 Rehabilitation specialist
- 6 high risk Ob
- 2 NICU management
- 1 RN for behavioral health coordination
Payment to eligible* providers for 3 critical areas:

• **Assistance with enrollment** of eligible patients in DM programs

• **Collaboration** in care management of DM enrollees

• **Delivery of key clinical interventions** that help improve quality of care and clinical outcomes

* Any individual provider (including certified registered nurse practitioners) or provider entity participating in the Pennsylvania ACCESS Plus network who has any patient with at least one of the targeted diseases (i.e., congestive heart failure, diabetes, asthma, chronic obstructive pulmonary disease or coronary artery disease), regardless of risk level.
PCP Incentives - Phase 1 & 2

• Phase #1
  ✦ Payment for participation (allows early rewards)
    - Sign-up for P4P program- $200
    - Encouraging consumer participation- $30 per patient
    - Identification of candidates for DM- $40 per patient

• Phase #2
  ✦ Payment for collaboration
    - Care plan development- $60 per care plan
    - Payment for 2 care plans per year
PCP Incentives- Phase 3

- Quality of care process improvement
  - Year 1:
    - CHF- Beta Blockers,
    - DM & CAD- ASA
    - Asthma- “controller” medication
  - Year 2:
    - CHF-Beta Blockers,
    - DM- LDL measured,
    - CAD-statin use,
    - Asthma- “controller” medication

- Payment of $17 per process accomplished for each patient
Guidelines for P4P Success

- Involve stakeholders
- Avoid relative scales and scoring
- Link payment to clearly defined “widgets”
- Reward quickly!!
- Don’t “penalize” for patient non-compliance
- AMA P4P guidelines
P4P Potential Revisions

• Increase funding to $1 pmpm
• Lead screening
• Chronic Care Feedback Form for children with special needs
• Pregnant women- dental visits, depression screening
• Smoking cessation counseling- 5 DM diseases and pregnant women
• ACE/ARB use in CHF and DM-- current self reported use <60% for CHF
• HgA1C lab done, result <7, result improved by 2 %
• B-Blocker use post-MI-- current self reported use <80%
• Use of statewide immunization registry
Clinical Results 12 Months

- Asthmatics taking inhaled corticosteroids increased from 60% to 67%
- Heart Failure patients monitoring weight daily increased from 42% to 74%
- COPD patients able to recognize disease exacerbation increased from 32% to 63%
- Consumers with Coronary Artery Disease
  - Taking aspirin increased from 79% to 85%
  - BP systolic <140 increased from 83% to 94%
  - Statin use increased from 80% to 88%
- Diabetics with LDL < 100 increased from 15% to 33%
- Diabetics taking aspirin increased from 36% to 61%
Results 12 Months

- 50% of DM recipients in the highest severity of illness (level 3) improved to a level 1 or 2
- Cost savings of DM program- year 1 estimated $27 million
Barriers/Issues

• Reaching consumers via telephone
• Enrollment “churn” in DM
  - 1-5% per month
  - 25% in 18 months
• PCP participation in P4P
• Better use of pharmacy data to identify opportunity to coordinate care
• Care coordination between physical health and behavioral health providers
• Complexity of program assessment
Next Steps

• Expand community-based approach to care coordination
• Implement care coordination software to identify, manage, and assess patients in SNU and prenatal program
• Evaluate program year 2 with HEDIS-like measurement
• Implement consumer incentives?
Questions??

David K. Kelley MD, MPA
c-dkelley@pa.state.us

“Energy and persistence conquer all things”. Benjamin Franklin