Chronic Disease Management

Pay-for-Performance

**VISION:** To create a chronic disease management program using a pay for performance model that will progressively improve the delivery of healthcare to Medicaid participants with chronic disease.
BACKGROUND

2004  –  Began Collaborative Meetings

2005  –  Continued Collaboration and Program Design
  ➢  Provider Incentives
  ➢  Non-punitive
  ➢  Encourage Providers to Accept Medicaid Participants With Chronic Disease
  ➢  High Impact

2006  –  CHCS P4P Purchasing Institute Program Implementation SPA-Approval Process Started
Incentive Structure

Focus on Diabetes

• Selected Six Evidence-Based Indicators
• Point System Developed
• Indicators - Collectable and Reportable

1. Patient Identification ($50 1x payment per patient)
2. Development and/or Annual Review of a Diabetes Management Plan ($10 annual payment per patient)
3. Semi-annual Assessment of Hemoglobin A1C ($10 - 2x/year per patient or up to 4x/year per patient when treating elevated levels)
4. Annual Serum Lipid Evaluation ($10 annual payment per patient)
5. Annual Dilated Retinal Exam ($10 annual payment per patient)
6. Annual Influenza Immunization ($10 annual payment per patient)
IMPLEMENTATION

• Data for Idaho Medicaid Showed
  ➢ 180,000 Medicaid Participants
  ➢ 9,000 Have Diabetes
  ➢ May Be An Additional 5,800 Pre-diabetics

• Three Providers Volunteered for Pilot
  ➢ Two Residency Practices
  ➢ One FQHC

• Positive Stakeholder Buy-In
FIRST-YEAR LESSONS

• Start the State Plan Amendment Early
• Some Data is Difficult to Collect – By Provider and State
  ➢ Flu Shots Not Always Given by the PCP
  ➢ Flu Shots May not Cross Over for Medicare Clients
  ➢ Eye Exam Results Not Reported to PCP
• Providers Reported Changing Office Procedures
  ➢ To Ensure They Collect Necessary Data
  ➢ To Ensure They Recognize the Diabetic Patient Each Visit and Follow the Plan of Care
SECOND-YEAR PILOT

• Re-Designed Program
• State Plan Amendment Revision
• Delayed: Adding Other Diseases
• Added: Seven FQHC Providers
• Continued: Focus on Diabetes
• Changed: Added More Indicators
Criteria:
Continue First Year Pilot Criteria
1. Patient Identification
2. Development and/or Annual Review of Diabetes Management Plan
3. Semi-annual Hemoglobin A1C
4. Annual Serum Lipid Evaluation
5. Annual Dilated Retinal Exam
6. Annual Influenza Immunization
Second-Year Additions:

7. Annual Urine Microalbumin
8. Annual Foot Exam by Inspection
9. Annual Foot Exam – Microfilament
10. Annual Depression Screening
11. Annual Assessment/Counseling on Tobacco Use
12. Annual Assessment/Counseling of Weight and BMI
GOING FORWARD

• July – Second Year’s Data Submission
• Awaiting State Plan Amendment Approval
• Awaiting CMS Approval of Provider Agreement
• Website Ready to go
• New Data Collection Tool Ready
• Ready to Offer to all Primary Care Case Manager Providers Statewide
STILL-TO-DO LIST

✓ Quality Assurance Process
✓ Newsletters
✓ Recruitment of New Providers
✓ Random Chart Audit Procedures
✓ Site Visit Procedures
✓ Handbook Revisions
✓ Provider Agreement Approval From CMS