

2008 Innovations Awards Program APPLICATION

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ID # (assigned by CSG): 08-E-19PA

Please provide the following information, adding space as necessary:

State: Pennsylvania

Assign Program Category (applicant): Health & Human Services: Health Services

1. Program Name: **ACCESS Plus**
2. Administering Agency: **PA Department of Public Welfare**
3. Contact Person (Name and Title): **Jennifer Basom, Director, Division of Quality Management**
4. Address: **DPW Complex 2, Cherrywood Bldg #33, 49 Beech Drive, Harrisburg, PA 17105**
5. Telephone Number: **(717) 772-6132**
6. FAX Number: **(717) 772-6179**
7. E-mail Address: **jbasom@state.pa.us**
8. Web site Address: **www.accessplus.org**
9. Please provide a two-sentence description of the program.
ACCESS Plus is a ground-breaking way to deliver health care services to low income children and families that takes the incentives for prevention and disease management found in managed care and adapts them to fee for service settings. Originated by Pennsylvania Department of Public Welfare, ACCESS Plus now offers physical health services and chronic disease management to Medicaid recipients in the 42 Pennsylvania counties where traditional managed care is not available.
10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on March 1, 2008 to be considered.
ACCESS Plus has been operational since March 1, 2005.
11. Why was the program created? What problem[s] or issue[s] was it designed to address?
The program was created to address the following goals:
 - **To improve access to primary care and provide a medical home for children and adults,**

- **To improve access to health care services for Medical Assistance recipients,**
- **To improve the quality of health care available to Medical Assistance recipients,**
- **To provide access to Disease Management and Case Management services, and**
- **To stabilize Pennsylvania's Medical Assistance spending.**

Prior to the implementation of the ACCESS Plus program many consumers in rural areas of Pennsylvania had difficulty in finding primary care physicians and medical specialists willing to serve them. In addition, consumers who had chronic conditions often did not receive early or preventive care. As a result, they frequently ended up in an emergency room or hospitalized.

The traditional managed care program operating in 25 counties within Pennsylvania prior to ACCESS Plus was not a viable option for expansion into the remaining 42 rural counties. It was determined that the Managed Care Organizations would not be able to leverage an adequate provider network based on the rural nature of this region and in accordance with federal mandates for managed care entities.

12. Describe the specific activities and operations of the program in chronological order.

Throughout the implementation of the ACCESS Plus program, many key milestones have occurred. As the program was implemented and accepted by enrollees and providers, many enhancements to the program have been implemented, building upon the original program design and success. These key milestones and enhancements are noted below:

- **July 2003-** Policy decision to implement new model of Fee for Service managed care for Medical Assistance.
- **August 2004-** ACCESS Plus RFP issued.
- **March 1, 2005-** Children eligible under the Family Care Network were converted to the ACCESS Plus program.
- **May 1, 2005-** All remaining eligible adults were enrolled in the program.
- **August 24, 2005-** The first Quality Management monthly meeting was held.
- **November 1, 2005-** ACCESS Plus Provider Pay for Performance program was implemented in an effort to gain the participation and support of Primary Care Physicians in the management of chronic disease.
- **January, 2006-** Preparations for the collection of clinical quality of care and medical utilization measurements began.
- **June 27, 2006-** The first Quality Management Committee meeting was held.
- **October 3, 2006-** The first ACCESS Plus clinical quality of care and medical utilization measurements were released.
- **November 1, 2006-** ACCESS Plus paperless referral process instituted to assist Primary Care Practitioners in the coordination of care for their patients.
- **August 13, 2007-** Year 1 savings: \$27 Million in cost avoidance.
- **October 1, 2007-** Implemented field based model for disease management.
- **November 1, 2007-** Implemented enhancements to the ACCESS Plus Provider Pay for Performance program to increase the number of providers eligible for participation and to improve the quality of services provided to recipients for complying with standard clinical practice guidelines.
- **December 13, 2007-** Began programming to institute predictive modeling in the ACCESS Plus Disease Management program.

- **March 31, 2008- Projected** implementation of predictive modeling that will focus care management efforts on recipients who are at risk for exacerbation of their chronic conditions and therefore predicted to incur higher costs

13. Why is the program a new and creative approach or method?

The ACCESS Plus program has implemented a new and creative approach to Fee for Service delivery and in many ways mirrors the services provided within managed care.

Key elements of this innovative model include:

- **Developed a new model of managed care within a rural fee- for- service population where traditional managed care cannot economically operate.**
- **All enrollees must have a “medical home” to ensure coordination of care**
- **Established comprehensive disease management programs and intense medical case management for high risk ACCESS Plus enrollees to reverse traditional fee for service incentives that work against quality care.**
- **Adopt predictive modeling and other innovative data mining techniques to assist with high-risk case identification; establishment of a referral process to disease management and intense case management,**
- **Emphasize coordination between behavioral and physical health entities,**
- **Exploration of a HEDIS compliance audit to assess the accuracy and reliability of ACCESS Plus performance measures. HEDIS (Healthcare Effectiveness Data and Information Set) is a tool created by the National Committee for Quality Assurance (NCQA) to uniformly collect data about the quality of care and services provided by health plans. HEDIS consists of a set of performance measures that compare how well health plans perform in key areas: quality of care, access to care, use of services and member satisfaction with the health plan and doctors;**
- **Collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data within a FFS population. CAHPS is a standardized survey that asks recipients to report on and evaluate their experiences with healthcare;**
- **Establish financial incentives for quality outcomes by implementing a Pay for Performance program for providers and contractors.**

In summary, ACCESS Plus has provided eligible applicable MA recipients and providers with a comprehensive care management framework, one that mirrors the services provided within a managed care delivery system. The program is exceptionally creative given its components such as care coordination, Intense Medical Case Management (via DPW), Disease Management, Pay for Performance, and overall quality-driven evaluation utilizing clinical quality of care and medical utilization measurements modeled after HEDIS specifications. These components are not customarily seen within a Fee for Service framework and have served to enhance the health care services provided to Medical Assistance recipients enrolled in ACCESS Plus as well as Medical Assistance providers.

14. What were the program’s start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

The DPW’s program start up costs included:

	ACTIVITY	COST
1.	Consulting expenses for assistance in the research and drafting of the ACCESS Plus request for proposal.	\$950,000

2.	Consulting expenses for the actuarial expertise required in the development of the methodology for the Contractor's guaranteed savings requirement.	\$45,000
3.	Costs incurred to amend the existing enrollment assistance program contract to include PCP selection and PCP changes for the ACCESS Plus program.	\$904,000

Staff assigned to the implementation of the program was pulled from various divisions within the Office of Medical Assistance Programs. There were 8 Full Time Equivalents dedicated to the ACCESS Plus implementation including a Program Manager, Section Chief, 2 Registered Nurses, and 4 Program Specialists responsible for contract negotiations, readiness review activities, and recipient and stakeholder education.

15. What are the program's annual operational costs?

The program's operational costs are broken out by medical and administrative expenses expressed in PMPMs (per member per month).

Medical	\$203.76
Administrative	<u>\$ 12.80</u>
Total Program PMPM	\$216.56

There are approximately 290,000 recipients participating in the program; annualized results in an annual operational cost of \$753,628,800.00.

16. How is the program funded?

The program is funded jointly by state and federal sources based on the current Federal Medical Assistance Percentage (FMAP) rate (i.e., federal funded at 54.08%, state funded at 45.92%).

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

In 2003 the newly elected administration of Governor Edward G. Rendell halted the state wide expansion of mandatory full-risk capitation for Medicaid in Pennsylvania. Secretary of the Department of Public Welfare, Estelle Richman, was given the task of developing new, cost effective, models of care. The result was a new program establishing a medical home for children and adults, initiating disease management, and implementing pay for performance. An RFP outlining the tenets of the program was developed in early 2004 with the comments and input from the Medical Assistance Advisory Committee (MAAC) and the Consumer Advisory Sub-Committee. The Pennsylvania Legislature approved the funding of the program as part of 2004-2005 State General Fund Appropriation.

The program currently operates under a 1915(b) Waiver for the under 21 years of age population. Pennsylvania's State Plan covers the adults participating in the program.

18. What equipment, technology and software are used to operate and administer this program?

Pennsylvania's Claims processing engine

PA PROMISE™ provides a user-friendly and maintainable claims processing environment. Data elements owned by PA PROMISE™ are captured and stored with a single key name in one physical location within the database, and are accessed by all

other PA PROMISE™ processes, as needed. A majority of the claims processing activities, such as edit and audit functions, claims pricing, claims resolution, and claims adjudication, are completed in their logical entirety for each claim processed. These activities occur concurrently, with many claims processed simultaneously with continuous claims processing.

The PA PROMISE™ infrastructure is a multi-entity environment linked by a redundant high-speed communications infrastructure. The PROMISE™ system incorporates data from mainframe, Web, and mid-tier application platforms hosted and supported across three separate data centers. PROMISE™ interfaces with external interface partners, such as the Primary Care Case Management contractor for the ACCESS Plus program. This includes real-time, interactive interfaces with the Commonwealth's Client Information System (CIS) that captures eligibility data for MA recipients. PROMISE™ accesses CIS for every claim in seconds as claims process interactively through the MMIS. PROMISE™ also interfaces with the Department's Master Provider Index and Geographic Interface systems to support operational tasks, such as housing the Provider Network for DPW's Medical Assistance program. PROMISE™ provides a web portal for interactive claims submission and eligibility verification in addition to standard methods of submissions such as batch, interactive pharmacy point of sale, and paper.

Computer hardware	Client/server, midrange server, PCs, Intel, Sun, Tandem
Systems software	Oracle 9, Windows 2000 and 2003, and UNIX Solaris operating systems
Programming languages	C, SQL PowerBuilder, VB Script, JScript, ASP, and ASP.Net

DPW's Medical Management Review System (MMRS)

The MMRS includes a subsystem called CaseNet that provides the ACCESS Plus program with a user-friendly, case management and utilization review component that includes clinical guidelines and tools to access, facilitate, and support integrated approaches to care management, case management, and disease management. This software, through a common environment allows users to manage tasks, capture data, perform care planning, generate letters, manage communication, and create reports.

The CaseNet system provides and supports an integrated care management solution. This system provides care team members with an opportunity to better manage and intervene, for the purpose of improving compliance and care regimens to ACCESS Plus recipients.

Enhanced Primary Care Case Management Contractor Proprietary Software

The Enhanced Primary Care Case Management Contractor uses its own proprietary software to deliver the Disease Management and Primary Care Case Management components of the program. This proprietary software applies eligibility and claims data provided by PA PROMISE™ for the purpose of building history and stratifying

recipients with chronic conditions into low, medium, or high risk categories. This application also tracks consumer and provider contacts, and is the resource for program reporting.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.

Yes, the ACCESS Plus program did originate in the state of Pennsylvania.

The principal designer of the ACCESS Plus program was Jim Hardy, who later became Deputy Secretary of the Office of Medical Assistance Programs. His current contact information is:

**James L. Hardy
Sellers Feinberg
230 South Broad Street
Suite 1802
Philadelphia, PA 19102
Phone: 215 279-9754
Email: jhardy@sellers-feinberg.com**

20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

Illinois, Texas and Washington have integrated many aspects of the ACCESS Plus program into their own. Although these programs are similar, the ACCESS Plus Program differs from them by providing overall comprehensiveness of services not seen within the other programs.

21. Has the program been fully implemented? If NO, what actions remain to be taken?

Yes.

22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

The ACCESS Plus Program has been very effective in addressing the limited services provided through the original Family Care Network program. As mentioned earlier, the program has implemented many comprehensive services for eligible Medical Assistance recipients.

The three most important measures used to evaluate success of the ACCESS Plus program are financial, clinical and quality of care measures, and satisfaction results.

From a financial perspective, in April 2007, an independent analysis by Mercer Human Government Consulting verified \$27 million dollars in cost avoidance for the Disease Management population in the first year of the program, which was FY 05-06. Due to the methodology used in the calculation of cost avoidance for this program, these figures are not yet available for the second year of the program.

From a clinical perspective, one of the main issues within the Fee for Service population prior to the formation of ACCESS Plus was the lack of a medical home and overall coordination of care for Medical Assistance recipients. ACCESS Plus provides a medical home for each recipient thus improving interaction between the provider and enrollee. This improved care coordination resulted in a decrease in emergency room

utilization from 61.1% in 2005 to 55.4% per 1,000 member months in 2006. In addition, ACCESS Plus significantly exceeded the 2006 and 2007 national HEDIS averages for Primary Care Physician and dental visits.

Secondly, there are currently 37,000 recipients participating in the Disease Management Programs offered through ACCESS Plus. The ACCESS Plus program assesses the population utilizing clinical quality of care and medical utilization measures modeled after the HEDIS specifications. Some results demonstrated to date include:

Measure	ACCESS Plus 2005 Result	ACCESS Plus 2006 Result
HBA1C Poorly Controlled (>9%)	43.31 %	35.52%
Retinal Exams for Diabetics	33.68%	35.3%
Cholesterol Management in Diabetics (LDL <100)	25.3%	31.8%
Persistence of Beta Blocker Usage in CAD	55.8%	67.9%
Appropriate Use of Asthma Controller Medications in Asthmatics	79.4%	87.5%

Finally, ACCESS Plus conducts a series of annual satisfaction surveys which cover provider, enrollee, and Disease Management enrollee satisfaction. These surveys provide valuable feedback from major program stakeholders, which are used to guide ongoing program improvements. The provider and enrollee satisfaction surveys showed a high level of satisfaction with the program. The results of the Disease Management enrollee satisfaction survey demonstrated the highest level of satisfaction among enrollees participating in disease management.

Although the program has demonstrated success as noted above, obstacles do remain. The program's most significant obstacle encountered thus far has been the need to improve the level of ongoing contact with eligible recipients. To assist with addressing this obstacle, the ACCESS Plus program is undergoing a recent enhancement redesign as it relates to Disease Management and Enhanced Primary Care Case Management activities.

The Disease Management program is built on solid data intake strategies, in-office support to high volume physicians, clinically strong community based interactions with patients and integrated reporting of both Disease Management components and Pay for Performance components. Predictive Modeling will be the foundation for data intake that will lead to member identification, enrollment and risk stratification.

The core Disease Management program using telephonic outreach, triage and community based nurses (CBRN) will be continued. However, there has been a refocus on community outreach with a reduction in the telephonic nurse staffing and an increase in the field based staff.

The new Disease Management program design for the ACCESS Plus region is organized around four sub-regions – North East, North West, North Central and South Central. While the overall goal of the Disease Management program is to stabilize those enrollees with one or more of the five contracted disease states (Asthma, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, and Diabetes); the goal in the renewal design is unique to the specific issues identified for each region and addresses the overall goal using different approaches.

The Enhanced Primary Care Case Management program redesign and enhancements include additional field-based care coordination support to assist providers in eliminating barriers that prevent enrollees' access to care and increase utilization of Emergency Departments. This support includes: the coordination of field/home visits to enrollees, providers and community-based agencies; improved enrollee and provider communication strategies including targeted web-support; and expanded Pay for Performance support through Provider field-based education.

23. How has the program grown and/or changed since its inception?

The foundation for the design of the ACCESS Plus program was the Family Care Network program; which served only children. As a result the ACCESS Plus program was developed to address children as well as adults.

We have been proactive in incorporating best practices and innovations implemented by other organizations. Examples of this include the implementation of elements of the Chronic Care Model developed by Dr. Ed Wagner at the MacColl Institute for Healthcare Innovation to improve coordination of care efforts, and the implementation of a Diabetes Collaborative based on the US Health Resources and Services Administration's Health Disparities Collaborative project in an effort to delay or decrease complications of patients with diabetes.

In addition to the above, we have also participated in the Agency for Healthcare Research and Quality (AHRQ) Care Management Learning Network. This has enabled us to learn from the experience of other state programs and to also benefit from the knowledge surrounding what other states are currently measuring from a programmatic standpoint.

For example, through input provided by Illinois, we learned the importance of community-based nursing and incorporated that aspect into the ACCESS Plus Program. We also learned from Washington that although Disease Management is important, other care management programs are necessary as well to achieve comprehensive program success. Finally, from Texas we learned the importance of a valid, cost savings model emphasizing a guaranteed cost savings approach.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

States must recognize the challenges associated with implementing a comprehensive program for Medical Assistance recipients in a time of reduced federal support for Medicaid. The resulting constraint on reimbursement can complicate efforts to build an adequate network of Medicaid providers.



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FEB 29 2008

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CSG Innovations Awards 2008
The Council of State Governments
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Lexington, Kentucky 40578-1910

Dear Nancy,

The Pennsylvania Department of Public Welfare's Office of Medical Assistance Programs is pleased to submit this application in response to the CSG Innovations Awards 2008. We look forward to the potential selection of our program as your organization seeks to showcase exemplary state programs and the dissemination of these best practices to other states. We feel very strongly that our ACCESS Plus Enhanced Primary Care Case Management Program is such an exemplary state program.

Prior to the implementation of the ACCESS Plus program many consumers in rural areas of Pennsylvania had difficulty in finding primary care physicians and medical specialists willing to serve them. In addition, consumers who had chronic conditions often did not receive early or preventive care. As a result, they frequently ended up in an emergency room or hospitalized.

Since the implementation of the ACCESS Plus program in 2005, participants under the fee for service delivery model now benefit from the ability to choose their own Primary Care Providers, while receiving the added benefit of active care coordination, case management, and disease management services for those who have chronic conditions.

We appreciate CSG taking an interest in the improvements in service delivery that we have made under the ACCESS Plus program. Please contact Jennifer Basom at 717-772-6132 if you require any further information or have any questions concerning this application.

Sincerely,

Michael Nardone