Pennsylvania Department of Public Welfare

ACCESS Plus Implementation: Key Considerations

This document provides a high level overview of the key issues and steps taken in the development, implementation and continued monitoring of the Pennsylvania ACCESS Plus program. This information is offered to other State Medicaid agencies interested in implementing a primary care case management (PCCM) and disease management program similar to Pennsylvania's ACCESS Plus program.

No.	Key Considerations	ACCESS Plus Program Planning
Program Development and Design		
1.	Determine program goals	• The ACCESS Plus program goals are: – 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 (MA) recipients – To improve the quality of health care available to MA recipients – To stabilize Pennsylvania's MA spending – To provide access to disease management and care coordination
2.	Identify the services to be included in program design	• ACCESS Plus members receive: – A medical home through an assigned PCP – Case management and disease management services, if eligible, in addition to MA benefits – EPSDT services – Dental services (based upon the individual's benefit package) – Adult preventive care services – Inpatient and outpatient mental health and substance abuse disorders treatment (provided via HealthChoices Behavioral Health-managed care organizations [BH-MCOs])
3.	Identify disease management program requirements	• ACCESS Plus used the revised Disease Management Association of America (DMAA) definition of disease management. • Members diagnosed with the following conditions are eligible for disease management services: Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease and Congestive Heart Failure.
4.	Determine the population(s) eligible to participate in the program	• The program design was built upon an existing PCCM program for individuals under the age of 21, and was expanded to include adults. The following individuals are excluded from enrollment into the ACCESS Plus Program: – Enrollees enrolled in a Voluntary Managed Care Program – Enrollees in the Long Term Care Capitation Program – Enrollees over the age of 21 who are "dually eligible" (on MA and Medicare) – Enrollees enrolled in the Health Insurance Premium Payment (HIPP) Program – Enrollees who live in a nursing home. • The Department is responsible for determining the disease management program eligibility criteria and the Vendor has the responsibility for analyzing claims data to identify eligible members.

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5.	Determine if participation in the new program will be mandatory or voluntary	• Members are automatically enrolled into ACCESS Plus but may opt into Voluntary Managed Care at any time (in counties with both the ACCESS Plus and Voluntary Managed Care programs).
6.	Identify possible interactions and/or integrations with current State programs and other Department contracts	• In selected counties, both the ACCESS Plus program and the HealthChoices Voluntary Managed Care program operate concurrently. • The Department expanded its enrollment broker contract to include services for ACCESS Plus. • The Department developed Letters of Agreement (LOA) for interaction with the HealthChoices Behavioral Health program that included assuring coordination of care for persons with behavioral health and/or co-occurring disorders. • The ACCESS Plus Vendor must submit to the Department, a LOA from each County Mental Health/Mental Retardation (MH/MR) Administrator and Single County Authority (SCA) Administrator, and any operational Medicaid behavioral health managed care organization participating in the Behavioral Health HealthChoices Program within the ACCESS Plus service area outlining agreements reached regarding service coordination. • The Department developed a strategy to maintain continuity of care for members transitioning from the HealthChoices Medicaid Managed Care program to ACCESS Plus that required ACCESS Plus Vendor communications with HealthChoices Physical Health-managed care organizations (PH-MCOs). • The ACCESS Plus Vendor must coordinate care with the voluntary and HealthChoices managed care organizations to ensure a smooth transition for Enrollees who transfer among delivery systems. • The Department maintains an Intense Medical Case Management Unit responsible for coordinating care for high-risk ACCESS Plus members (e.g., women with high-risk pregnancies, members with co-morbidities not managed by the Vendor). The Department requires the ACCESS Plus Vendor to identify and refer high-risk members to the Intense Medical Case Management Unit.
7.	Identify applicable State and Federal requirements and regulations (including CMS review)	• ACCESS Plus was authorized under a 1915(b) Waiver for services to children and a State Plan Amendment for adults. • The development of ACCESS Plus included discussions on the categorization of the program as a prepaid ambulatory health plan (PAHP) or a primary care case management (PCCM) program. This required discussions with CMS and a determination of the impacts of each option on the Waiver requirements. The Department ultimately decided that the ACCESS Plus program would operate as both a PCCM (for primary care case management services) and PAHP (for disease management services).
8.	Determine if a phased or full implementation of populations is appropriate approach	• The Department implemented the program using a phased approach. Enrollment of all eligible individuals 0 – 20 years of age began on March 1, 2005 in all 42 rural counties within the Commonwealth where the program operates. Enrollment of eligible individuals 21 years of age or older began on May 1, 2005 in all 42 rural counties within the Commonwealth where the program operates.

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9.	Identify required information systems changes (e.g., claims processing)	• The ACCESS Plus Vendor and the Department exchange data through a Commonwealth-wide secure information exchange system.
10.	Identify required infrastructure changes (e.g., staffing and administrative structure)	• The Department contracted with a Vendor to administer key program components, such as provider network development for PCPs, member services and operation of the disease management program. The selected Vendor was composed of a prime contractor performing disease management services and a subcontractor performing PCCM services. • The Department also developed a new division, the Division of Quality Management/ACCESS Plus, to oversee the program and perform activities such as Agreement monitoring, program evaluation, quality improvement monitoring, regulatory compliance, Federal reporting and fraud and abuse monitoring. • The Department also performed the following internal activities: MA provider enrollment, prior authorization of services, claims payment, and Specialist recruitment.
11.	Determine Vendor and provider payment strategies	• The Department pays the Vendor a combined per member per month payment (based on actual enrollment) for the PCCM and disease management components of the program. • The Vendor must guarantee cost savings through the disease management program. • A Provider pay-for-performance (P4P) program provides financial incentives for PCPs who meet goals for specified performance measures. • A Vendor P4P program provides financial incentives for the Vendor to meet goals for specified performance measures. • The Department has policies and procedures in place to recover payments made to the Vendor for members later determined to be ineligible, including off-setting the amount against future payments.
12.	Identify a strategy for developing provider network	• The Vendor must establish a PCP network. PCPs must enroll in the MA program and sign a supplemental provider agreement with additional requirements specific to ACCESS Plus participation. • The provider network must maintain an adequate number of certain provider types, including: – PCPs; including ensuring an adequate number of PCPs who can provide EPSDT services – Specialists; including a Specialist Resource and Referral Database – Dentists • In the initial Agreement period, the Department did not define "adequate number" due to the uncertainty of the Department's ability to enroll ACCESS Plus providers. • The Department worked with the Vendor to develop a "pay for participation" strategy to address provider shortages in health professional shortage areas (HPSAs) and dental health professional shortage areas (DHPSAs). • The Department also developed a methodology to monitor provider network adequacy, including the use of geomapping technologies.

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ACCESS PLUS Adding Quality to Your Life ™

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13.	Determine a strategy for assignment of members to PCP	• Members are encouraged to voluntarily select a PCP. • If a member does not select a PCP within 14 days, the ACCESS Plus Vendor auto-assigns that member to a PCP. • The Vendor makes every effort to assign the same PCP to those members re-entering the MA program after a defined period of ineligibility.
Public Outreach/Stakeholder Involvement		
14.	Identify stakeholders (e.g., consumers, advocates, providers, other State agencies)	• ACCESS Plus stakeholders include: – Consumers and consumer advocacy groups – Public officials – Regional committees and subcommittees – Providers and provider associations – Health care advocates, including behavioral health – Other interested Commonwealth departments
15.	Conduct public input process and respond to public comments	• The Department initially conducted outreach meetings with stakeholder groups such as the Medical Assistance Advisory Committee (MAAC), MAAC subcommittees (Fee-for-Service and Consumer), the Hospital Association of Pennsylvania and primary care associations prior to finalizing the program design and release of a Request for Proposals (RFP) to procure the services of an ACCESS Plus Vendor. The Department also regularly discussed program planning during monthly MAAC meetings. • The Department regularly published program updates on its website. • The Department continued to receive and consider comments and feedback throughout the program development process.
Contracting Process (Including Procurement and Contracting Activities)		
16.	Develop RFP and draft Agreement	• The Department: – Defined RFP and Agreement requirements and terms. Sample requirements and terms include: ➢ PH-MCOs operating in the Voluntary Managed Care program were allowed to submit proposals for the ACCESS Plus program. However, if selected, the MCO would have to terminate participation in the Voluntary Managed Care program if it or an affiliate had a five percent or more interest or ownership in the Voluntary MCO. ➢ The Vendor was required to have National Committee for Quality Assurance (NCQA), URAC or Joint Commission (JCAHO) accreditation for its disease management programs. ➢ The length of the initial Agreement and Agreement renewal periods was for two years with one two-year renewal. – Released an RFP with a draft Agreement. – Requested best and final offers from qualified Offerors. – Selected a Vendor and conducted Agreement negotiations.

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17.	Identify quality and performance monitoring strategy	• The Department has developed an ACCESS Plus monitoring database to facilitate staff's ability to monitor the ACCESS Plus Vendor and verify that the Vendor is meeting program requirements. • The Department works with the ACCESS Plus Vendor to develop reports used to assess ACCESS Plus performance. • The Department has developed Vendor and provider P4P programs to link quality performance with reimbursement. • The Department, in conjunction with the Vendor, conducts routine Quality Improvement Committee and Vendor Status meetings to review quality and financial performance.
Program Implementation		
18.	Conduct a readiness review to determine Vendor readiness	• The Department conducted a readiness review of the ACCESS Plus Vendor prior to program start-up to verify the Vendor was prepared for program operations. • The ACCESS Plus Agreement was conditional upon the Vendor passing the readiness review.
19.	Develop a strategy for consumer and provider education, including enrollment broker education responsibilities	• The Department posted information about the ACCESS Plus program under the "What's New" section of its website. • The Department markets ACCESS Plus through MA Bulletins, newsletters, enrollee and provider notices. • The Department worked with the Pennsylvania Health Law Project to disseminate ACCESS Plus program information.
20.	Coordinate implementation activities (e.g., State agencies, providers, enrollment broker)	• When possible, the Department worked closely with other Commonwealth agencies and vendors to ensure a smooth implementation, particularly with other agencies located within the counties to be served by ACCESS Plus (e.g., County Assistance Offices, high volume facilities within the service area).

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