

Chronic Disease Management Initiative

Overview: Consistent with the intent of the Medicaid Simplification Act, Idaho Medicaid has implemented a pay-for-performance pilot for chronic disease management. The goal of this project is to:

Develop an incentive model to positively impact health outcomes of Medicaid clients with chronic disease.

Collaboration: Idaho Medicaid has worked with both Family Practice Residency programs in Idaho, the Idaho Primary Care Association, and the Terry Reilly Clinic to develop the pilot.

Approach: An incremental approach will be used that begins with voluntary provider partners and starts with one chronic disease. The group identified diabetes as the initial chronic disease. This selection was based on prevalence of diabetes, preventable adverse outcomes, and cost of this disease to our health care system. Overtime, other chronic diseases will be added and additional providers will be invited to participate.

Model Development/Implementation: A Clinical Work Group, including physicians and nurse practitioners from the Family Residency Programs and Terry Reilly Clinic worked in conjunction with Medicaid's Medical Director to research and identify nationally recognized evidence-based clinical standards. The group selected six criteria that represent the standard of practice in the care of Type I and Type II diabetes. The model was implemented July 1, 2006 and the first quarter of data was submitted October 15, 2006.

Short Term Goals – 18 months:

- ◆ Develop a consistent methodology of data collection - whether data is collected electronically or manually
- ◆ Establish baseline data
- ◆ Develop a payment structure that:
 - rewards providers based on evidence-based practice
 - does not encourage selection or de-selection of patients
 - helps identify non-compliant Medicaid participants
- ◆ Develop a "Pay-for-Performance for Chronic Disease Management" model that can be used statewide and for all targeted chronic diseases

Long-term Goal – 5 year: Within 5 years, Idaho Medicaid will have a fully developed incentive model that will positively impact the health outcomes of Medicaid participants with chronic diseases. The program will:

- ◆ Operate across the state
- ◆ Promote nationally recognized evidence based care
- ◆ Monitor populations with selected chronic diseases
- ◆ Support both provider and participant adherence to standard of care that is recognized as best practice and evidence-based