MassHealth

Massachusetts Partnership for Health Promotion and Chronic Disease Prevention Annual Summit:

Achieving Health Equity Through Community-Clinical Linkages

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MassHealth's Mission Statement

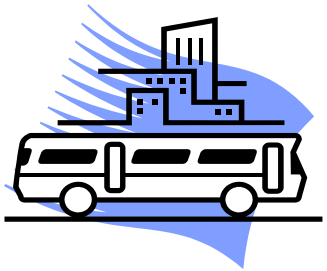
To improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.

The Status Quo

- Fragmented care
- Lack of coordination
- Poor management of chronic disease
- Lack of focus on population health
- Pay for volume, not for value
- Inadequate data
- Lack of transparency
- Slow dissemination of evidence-based practices
- Poor behavioral health (BH) integration
- Workforce shortages/workforce development issues

Medicaid Population*

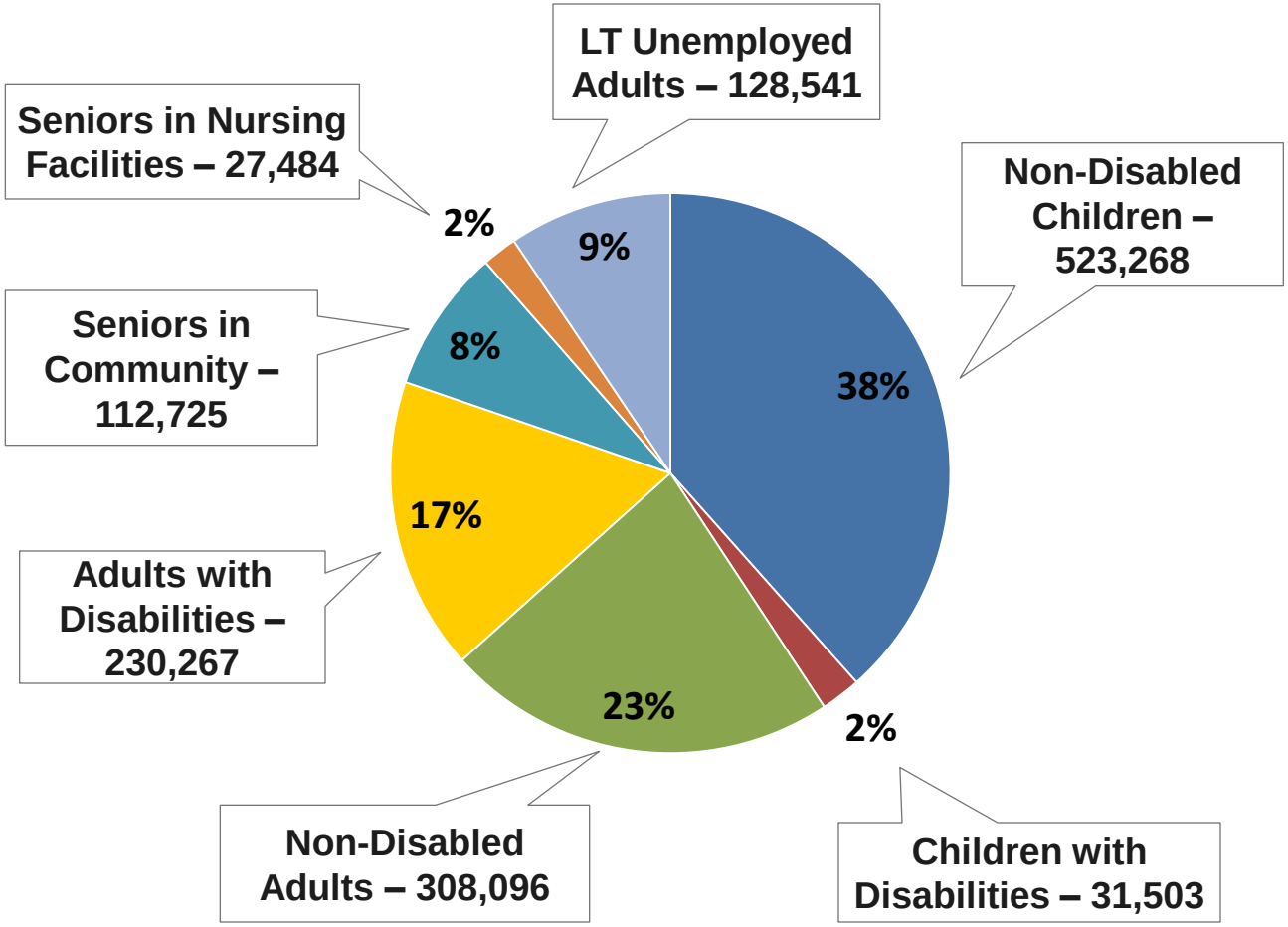
- Lower income
- Less educated
- Racially and ethnically diverse
- Lower literacy levels; ESL
- Fewer social supports
- Less reliable transportation
- More frequent housing/utility issues



*Adapted in part from Paul Mendis, MD

MassHealth covers children, adults, and seniors, and often supplements other insurance

Percent of total MassHealth enrollment, FY 2012 Estimate



Examples of MassHealth Initiatives that Address Health Disparities and Promote Community Linkages

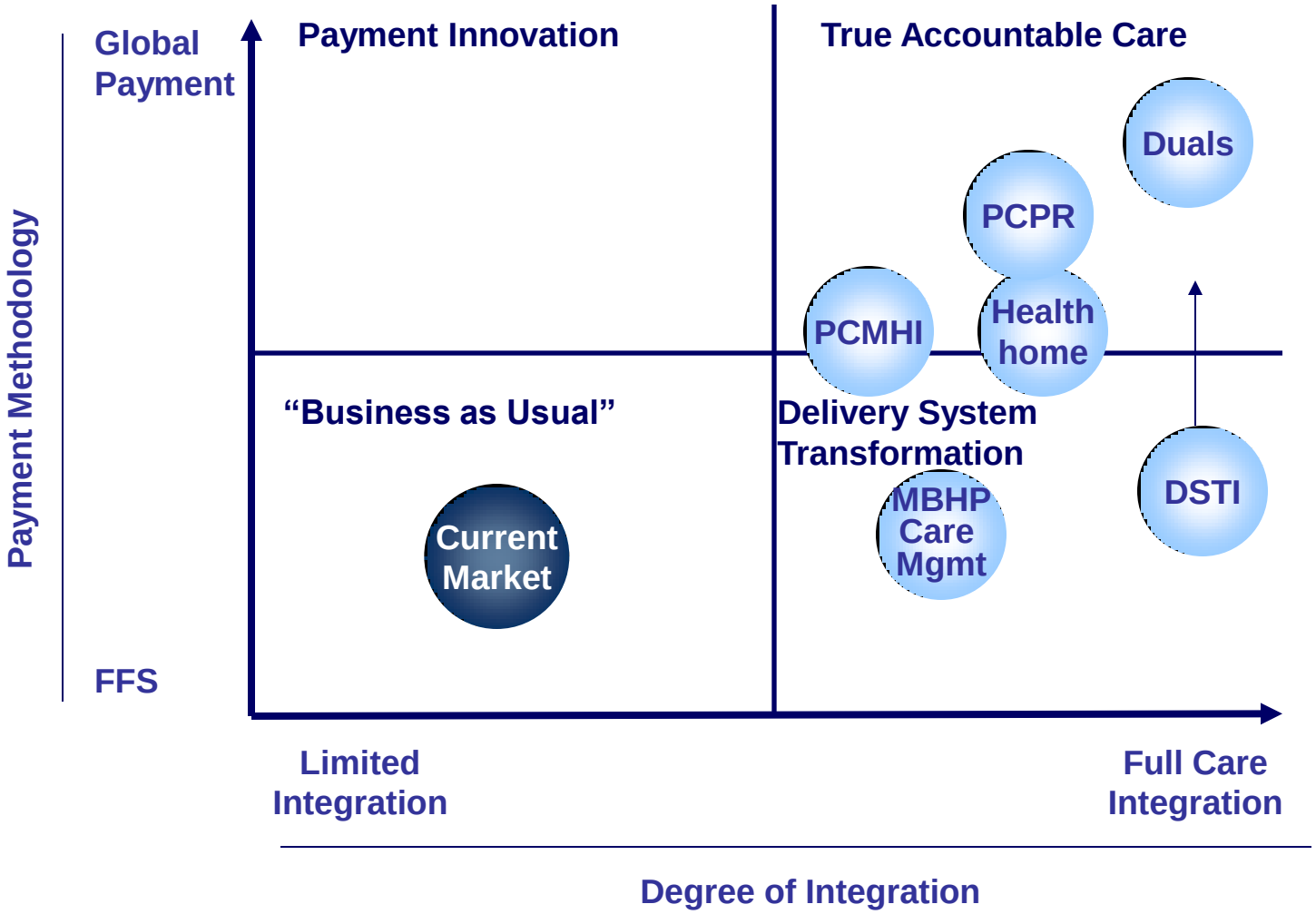
- **Intensive care management programs**
- **Waiver programs**
- **Acute hospital P4P program**
- **New payment reform and care delivery models**

1915(c) Waivers

Massachusetts currently operates 10 Home and Community Based Services or 1915(c) Waivers, including:

- **Frail Elder waiver**
- **DDS Intensive Supports waiver**
- **DDS Community Living waiver**
- **DDS Adult Supports waiver**
- **Traumatic Brain Injury waiver**
- **Acquired Brain Injury – Residential Habilitation waiver**
- **Acquired Brain Injury – Non-residential waiver**
- **Money Follows the Person – Residential Supports waiver**
- **Money Follows the Person– Community Living waiver**
- **Autism Spectrum Disorder Waiver (for children through age 8)**

MassHealth has multiple programs to move towards integrated, accountable care



OneCare Program
Duals Demonstration Project

- Began coverage on October 1, 2013
- Blends Medicare and Medicaid funding to pay participating plans a per-member-per-month capitation
- Includes 111,000 individuals aged 21-64 who are dually eligible for MassHealth and Medicare
- Over 2/3 have a behavioral health diagnosis
- ~50% have a chronic medical diagnosis
- Majority of these members currently reside in the community

OneCare Performance Measures

- HEDIS, Health Outcomes Survey (HOS), and CAHPS measures consistent with Medicare requirements
- All existing Part D metrics
- Additional MassHealth-proposed metrics pertinent to target population, in such areas as:
  - Care management, appropriate care, follow-up for behavioral health
  - Person-centered care planning, management, transitions
  - Access to care, including LTSS services and ADA compliance
- Examples:
  - Tracking of demographic information: Race, Ethnicity, Primary language, Homelessness, Disability type
  - Screening for preferred language
  - Wait time for interpreter

Primary Care Payment Reform Initiative Goals

Enhance:

- Access to care
- Panel enrollee experience
- Quality of care
- Efficiency
- Wellness
- Innovation

Implements a New Care Delivery Model Emphasizing:

- Patient centered medical home
- Primary care and behavioral health integration
- Change in payment mechanisms
  - Comprehensive Primary Care Payment (CPCP)
  - Quality Incentive Payments
  - Shared savings/risk

Proposed payment structure

A

Comprehensive Primary Care Payment (CPCP)

- Risk-adjusted capitated payment **for primary care services**
- Options for including outpatient behavioral health services

B

Quality Incentive Payment

- Annual incentive for quality performance, based on primary care performance

C

Shared savings payment

- Primary care providers share in savings on **non primary care spend**, including hospital and specialist services

The payment structure will not change billing for non-primary care services (specialists, hospital); PCP's will not be responsible for paying claims for these services. However, we are evaluating complementary alternative payment methodologies to hospitals and specialists for acute services.

Components of the Comprehensive Primary Care Payment (CPCP)

- **Fee-for-service billable primary care services**
  - Example: evaluation and management of acute illness
- **Non-billable medical home activities**
  - Examples: medication reconciliation, care coordination
- **Behavioral health services:**
  - Tier 1: Only non billable BH services
    - Examples: case management, care coordination
  - Tier 2: Fee-for-service billable outpatient BH services provided by master's level and/or bachelor's level professionals
    - Examples: alcohol/drug assessment, mental health assessment by non-physician, crisis intervention, BH prevention education
  - Tier 3: Fee-for-service billable outpatient BH services provided by prescribing clinicians and psychotherapists (masters/doctoral level)
    - Examples: psychiatric assessment, medication management, cognitive-behavioral therapy

A

Proposed Payment Structure: Comprehensive Primary Care Payment (CPCP)

What is the purpose of this payment?

- **Does not limit practices to revenue streams that are dependent on appointment volume or RVU's**
- **Gives practices the flexibility to provide care as the patient needs it**, without depending on fee for service billing codes. This arrangement may support an expanded care team, community health workers, peer supports, phone and email consultations, group appointments, targeting appointment length to patient complexity, etc.
- **Allows a range** of primary care practice types and sizes to participate
- **Provides financial support for behavioral health integration** by including some outpatient behavioral health services in the CPCP
- **Ensures support and access for high-risk members through risk adjustment** based on age, sex, diagnoses, social status, comorbid conditions

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B

Proposed Payment Structure: Quality Incentive Payment

- Similar to pay-for-performance programs, participants will win some percentage bonus to the base payment based on quality performance
- Uses a set of metrics that are common across other programs, including programs deployed by other payers or used for other quality measurement purposes
- Measurement Areas
  - Pediatric Health
  - Adult Chronic Conditions
  - Access
  - Care Coordination

Role of Quality Metrics

- Financial incentives
  - Determines amount of quality incentive payment
  - Determines eligibility for shared savings payment
  - Determines percentage payout for shared savings payment
- Quality improvement
- Program monitoring & evaluation

Critical Domains of Quality

- **Enhanced access**:
  - Improved access to primary care services through extended hours, partnerships with urgent care, or other ways means
- **Patient-centeredness**:
  - Patient involvement in decision making, increased focus on the patient experience
- **Behavioral health integration**:
  - Appropriate screening and testing for behavioral health conditions in primary care settings; enhanced coordination between behavioral health and primary care providers
- **Care coordination**:
  - Better management of care transitions, alignment on care plans with other providers
- **Improved health and wellness**:
  - Improvements in patient health and wellness outcomes, child and adult, chronic and acute

Measure Prioritization Criteria

- Broadly accepted and validated (e.g., NQF measures)
- Aligned with MassHealth's goals and quality domains
- Able to be influenced by primary care physicians
- Not currently at uniformly high level of performance across providers
- Feasible to track and report
- Aligned with other EOHHS initiatives and other payers' programs (e.g. BCBSMA AQC)

Claims-Based Measures

#	NQF #	Measure Name	Measure Steward
3	33	Chlamydia screening	NCQA (HEDIS)
4	32	Cervical cancer screening	NCQA (HEDIS)
5	31	Mammography screening	NCQA (HEDIS)
7	4	Initiation and engagement of alcohol/drug dependence treatment	NCQA (HEDIS)
8	576	Follow up after hospitalization for mental illness (includes children and adults)	NCQA (HEDIS)
15	1516	Well child visits 3 – 6 years	NCQA (HEDIS)
16		Adolescent well visits	NCQA (HEDIS)
9	108	ADHD medication management for children	NCQA (HEDIS)
10	36	Asthma medication	NCQA (HEDIS)
21		Ambulatory Sensitive ED Visits	Mercer

Record-Based Measures

#	NQF #	Measure Name	Measure Steward
1	421	Adult weight screening and follow up	CMS
2	28	Tobacco use assessment and tobacco cessation intervention	CMS
6	418	Depression screening	CMS
11	24	BMI assessment and counseling	NCQA (HEDIS)
12	1506	Adolescent immunization	NCQA (HEDIS)
13	1448	Developmental screening in first three years	CAMHI
14	1392	Well child visits: <15 months,	NCQA (HEDIS)
17	38	Childhood immunizations	NCQA (HEDIS)
18	731	Diabetes composite	NCQA (HEDIS)
19	18	Hypertension: Controlling high blood pressure	NCQA (HEDIS)
23	97	Medication reconciliation (all patients, regardless of age)	NCQA (HEDIS)

Survey Based Measures

#	NQF #	Measure Name	Measure Steward
20	6	Getting timely appointments, care and information	AHRQ
	6	How well providers communicate with patients	AHRQ
	6	Helpful, courteous, and respectful office staff	AHRQ
	6	Patients' rating of provider	AHRQ
	6	Child growth and development	AHRQ
	6	Advice to parents on keeping a child safe and health	AHRQ
22	6	Follow-up of test results	AHRQ
	6	Providers pay attention to mental or emotional health	AHRQ
	6	Providers support you in taking care of your own health	AHRQ
	6	Providers discuss medication decisions	AHRQ

Coordination with Other Payer Initiatives

CPCR #	Measure Name	EOHHS Medical Home	BCBS AQC	Meaningful Use	CMS Adult Core	CMS CHIPRA	SQAC
	Adult Prevention and Screening						
1	Adult weight screening and follow-up	✱		✱			
2	Tobacco use assessment and tobacco cessation intervention	✱		✱			✱
3	Chlamydia screening in women		✱	✱	✱	✱	✱
4	Cervical cancer screening		✱	✱	✱		✱
5	Mammography screening (breast cancer)		✱	✱	✱		✱
	Behavioral Health						
6	Screening for clinical depression and follow-up plan			✱	✱		✱
7	Initiation and engagement of alcohol and other drug dependence treatment			✱	✱		✱
8	Follow-up after hospitalization for mental illness				✱	✱	✱
	Pediatric Health						
9	Follow-up care for children prescribed attention-deficit/hyperactivity disorder mediation	✱		✱		✱	✱
10	Use of appropriate medications for people with asthma			✱			✱
11	Weight assessment for children and adolescent			✱		✱	✱
12	Adolescent immunization					✱	✱
13	Screening using standardized screening tools for potential delays in social and emotional		✱			✱	✱
14	Well child visits in the first 15 months of life					✱	✱
15	Well child visits in the third, fourth , fifth and sixth years of life					✱	✱
16	Adolescent well-care visit		✱			✱	✱
17	Childhood immunization status	✱		✱		✱	✱
	Adult Chronic Conditions						
18	Comprehensive diabetes care		✱	✱	✱		✱
19	HTN: Controlling high blood pressure (hypertension)	✱	✱	✱	✱		✱
	Access						
20	CAHPS: Getting timely care, appointments and information						✱
21	Ambulatory sensitive ED visits						✱
	Care Coordination						
22	CAHPS: Follow-up of test results						
23	Reconciled Medication List						

Questions