HOUSE DOCKET, NO. 3209 FILED ON: 1/21/2011

HOUSE . . . . . No. 2781

The Commonwealth of Massachusetts

PRESENTED BY:

Jeffrey Sánchez

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act directing MassHealth to establish a chronic care improvement demonstration project.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Jeffrey Sánchez	*15th Suffolk*	*1/21/2011*
Jason M. Lewis	*31st Middlesex*	*2/4/2011*
William N. Brownsberger		*1/31/2011*

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HOUSE . . . . . No. 2781

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 2781) of Jeffrey Sánchez, Jason M. Lewis and William N. Brownsberger for legislation directing MassHealth to establish a chronic care improvement demonstration project. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act directing MassHealth to establish a chronic care improvement demonstration project.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. (a)Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall establish a chronic care improvement demonstration project. Within the chronic care improvement demonstration, the office shall solicit the participation of physician group practices, hospitals, or integrated delivery systems which meet the terms, conditions, and eligibility standards for participations in subsection (c) and (d) to provide practice-based care management to high-cost beneficiaries with multiple chronic illnesses through the utilization of nurse case managers integrated into physician-based primary care practices.

(b) The office shall establish a method for identifying eligible beneficiaries who may benefit from participation in a chronic care improvement program, provided, that beneficiaries shall have a high level of disease severity as indicated by Hierarchical Condition Categories scores and high health care costs and utilization of services based on claims data from the

calendar year prior to enrollment in the project. The office shall utilize a population-based intent-to-treat model to enroll eligible beneficiaries into control and treatment populations. Beneficiary participation will be voluntary, and may terminate participation at any time. Beneficiary participation will not change the amount, duration or scope of a participating beneficiary's traditional benefits. Eligible beneficiaries shall not be charged an additional fee for participation in chronic care improvement program.

(c) The office shall enter into three-year contracts with selected physician group practices, hospitals, or integrated delivery systems (participants) that provide for the payment of care to eligible beneficiaries utilizing a fee-at-risk payment methodology that includes a negotiated per-beneficiary-per-month management fee and pay-for-performance payments based on quality measures as determined by the office. In addition to terms and conditions deemed necessary by the office, all contracts shall require selected participants to (i) achieve a minimum 2 percent net savings in MassHealth costs for the treatment population as compared to the MassHealth costs for the control group plus the sum total of beneficiary-per-month management fees and pay-for-performance payments (ii) provide for adjustments in payment rates to a participant insofar as the office determines that the participant failed to meet the performance standards specified in the contract (iii) monitor and report to the office, in a manner specified by the office, on health care quality, cost, utilization of services, and outcomes (iv) meet the eligibility standards for participations in subsection (d).

(d) (1) To be eligible to submit a request for participation in the chronic care improvement demonstration project, a physician group practice, hospital, or integrated delivery system must demonstrate to the office that it possesses sufficient resources to (i) provide an enhanced level of care to eligible beneficiaries to reduce cost as well as improve quality of care

and quality of life for those beneficiaries (ii) execute a process to screen each eligible beneficiary for conditions other than those required for inclusion in the demonstration such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal oriented care management plan (iii) incorporate decision-support tools such as evidence-based practice guidelines or other criteria as determined by the office (iv) incorporate health information and clinical monitoring technologies that enable beneficiary guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment and permit the participant to track and monitor each eligible beneficiaries across settings and to evaluate outcomes (v) designate a nurse case manager as the primary point of contact responsible for communications with the eligible beneficiary and for facilitating communication with other health care providers under the projects (vi) meet any other standard for participation as determined by the office.

(2) To be eligible to submit a request for participation in the chronic care improvement demonstration project, a physician group practice, hospital, or integrated delivery system must employ a delivery practice model that encourages the development of a one-on-one relationship between patients and their practice-based nurse case managers, supplemented by support received from dedicated mental health, pharmacist, and end-of-life components mental health, pharmacy, community resource, end-of-life and financial service components, data analytics care team members. Each nurse case manager shall be located in a physician practice case managers, conduct comprehensive assessments to evaluate the unique needs of each patient, collaborate with physicians and the practice's clinical team to develop treatment plans, facilitate the coordination of patient care across the continuum of health care services, educate patients about options for medical treatment and support services, facilitate patient access to services, support

patient self-management of medical conditions, conduct visits to patient homes on an as-needed basis, and perform other functions deemed necessary to achieve successful health outcomes under the program. The panel of beneficiaries assigned to a nurse case manager shall not exceed 200.

(e) The office shall conduct an annual project evaluation including documentation of (i) cost savings achieved through implementation (ii) improved clinical and quality outcomes, including reductions of preventable hospitalizations, emergency department visits, and by reducing mortality rates, and (iii) beneficiary and provider satisfaction. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

(f) The office shall, in consult with the Massachusetts General Physicians Organization Care Management Program at Massachusetts General Hospital, promulgate regulations for the phase-in and implementation and evaluation of this demonstration project.