

**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:

*Jeffrey Sánchez*

*15th Suffolk*

*Jason M. Lewis*

*31st Middlesex*

*William N. Brownsberger*

**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:*

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

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

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

20 (c) The office shall enter into three-year contracts with selected physician group  
21 practices, hospitals, or integrated delivery systems (participants) that provide for the payment of  
22 care to eligible beneficiaries utilizing a fee-at-risk payment methodology that includes a  
23 negotiated per-beneficiary-per-month management fee and pay-for-performance payments based  
24 on quality measures as determined by the office. In addition to terms and conditions deemed  
25 necessary by the office, all contracts shall require selected participants to (i) achieve a minimum  
26 2 percent net savings in MassHealth costs for the treatment population as compared to the  
27 MassHealth costs for the control group plus the sum total of beneficiary-per-month management  
28 fees and pay-for-performance payments (ii) provide for adjustments in payment rates to a  
29 participant insofar as the office determines that the participant failed to meet the performance  
30 standards specified in the contract (iii) monitor and report to the office, in a manner specified by  
31 the office, on health care quality, cost, utilization of services, and outcomes (iv) meet the  
32 eligibility standards for participations in subsection (d).

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

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

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

60 patient self-management of medical conditions, conduct visits to patient homes on an as-needed  
61 basis, and perform other functions deemed necessary to achieve successful health outcomes  
62 under the program. The panel of beneficiaries assigned to a nurse case manager shall not exceed  
63 200.

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

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