State Initiatives that Promote the Triple Aim for Children with Complex Health Care Needs

Designing Systems that Work for Children with Complex Health Care Needs

Lucile Packard Foundation for Children's Health

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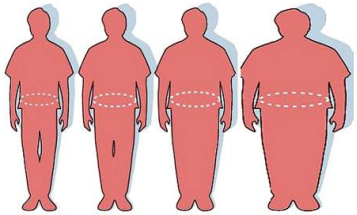
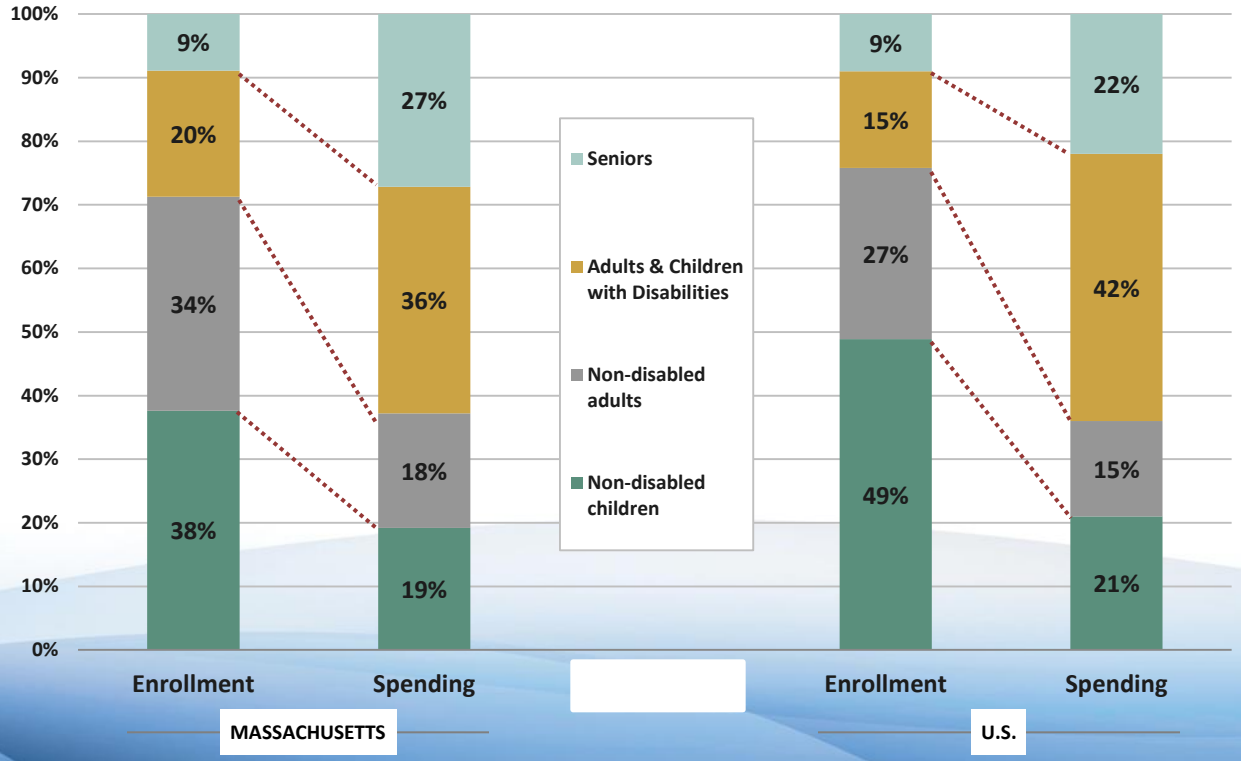
The Status Quo

- Emphasis on acute, episodic encounters
- Fragmented care
- Poor coordination of care
- Lack of focus on population health
- Poor management of chronic disease
- Payment for volume, not for value
- Access issues
- Inadequate data
- Lack of transparency
- Slow dissemination of evidence-based practices
- Poor integration with behavioral health or long-term services and supports
- Workforce capacity/workforce development concerns



Medicaid Enrollment and Spending by Various Populations

DISTRIBUTION OF MASSHEALTH AND US AVERAGE MEDICAID ENROLLMENT AND SPENDING BY VARIOUS POPULATIONS

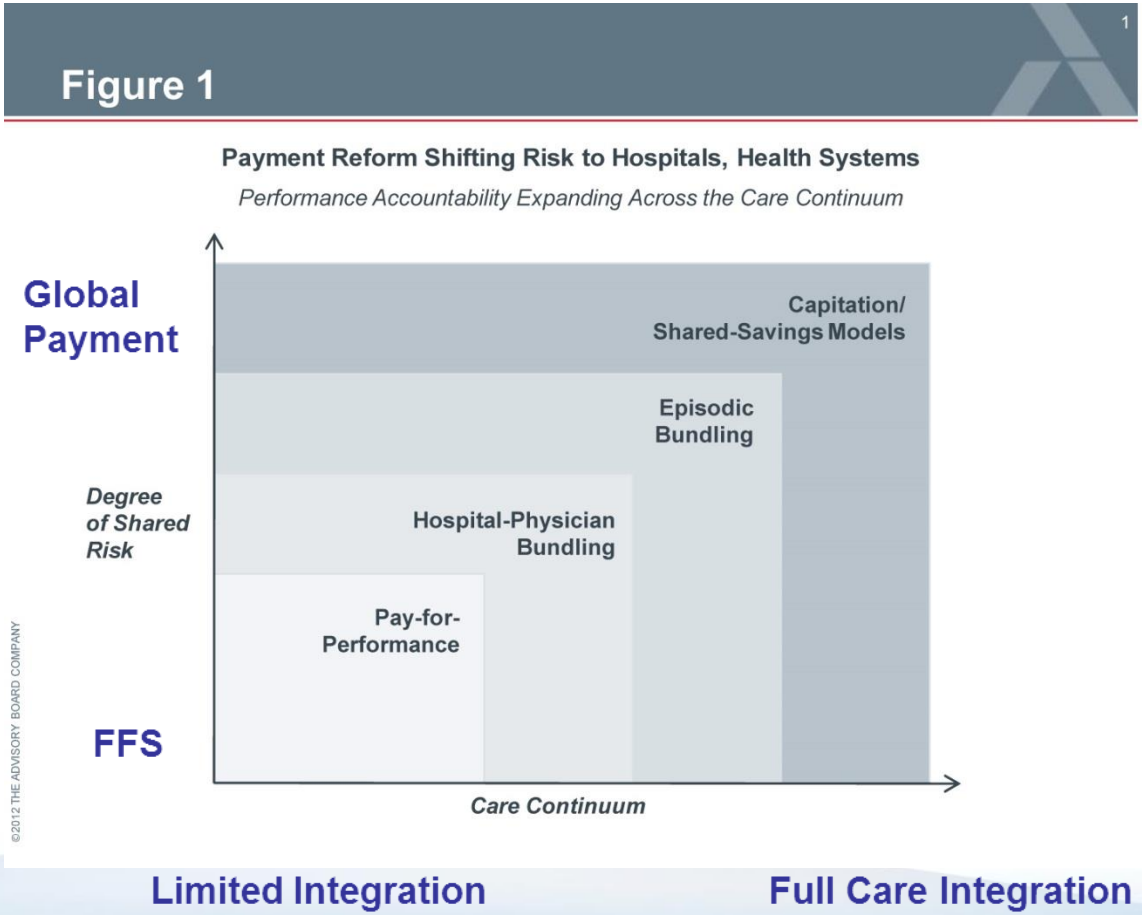


SOURCES: MassHealth Budget Unit, SFY 2013 data; Kaiser Commission on Medicaid and the Uninsured, FFY 2010 data.

MassHealth spending is not spread evenly across the various categories of beneficiaries.

- Nearly two-thirds of benefit spending in SFY 2013 was for services to people with disabilities and seniors, though these groups comprised less than a third of MassHealth membership.
- The same general pattern holds for Medicaid spending nationally.

Payment Reform



Opportunity for shared savings with improved outcomes and lower costs

MassHealth Primary Care Payment Reform (PCPR)—New Payment and Care Delivery Model that Supports Attainment of the Triple Aim

- **Better Experience with Care**
  - Founded on the patient-centered **medical home** model of care
  - Focused on **integrating behavioral health** and medical care
- **Better Care**
  - **Bundled Payments and Shared Savings** provide incentives and mechanisms for more coordination of care
  - **Pay for Quality** provides incentives to improve quality through more coordinated care and performance improvement
- **Reduced Health Care Costs**
  - **Shared Savings** provide incentives for controlling costs (while monitoring quality)

PCPR Payment Structure

A

Comprehensive Primary Care Payment (CPCP)

- Risk-adjusted capitated payment **for primary care services**
- Payment for **medical home activities**
- 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 does not change billing for non-primary care services (specialists, hospital); PCP's are not responsible for paying claims for these services.

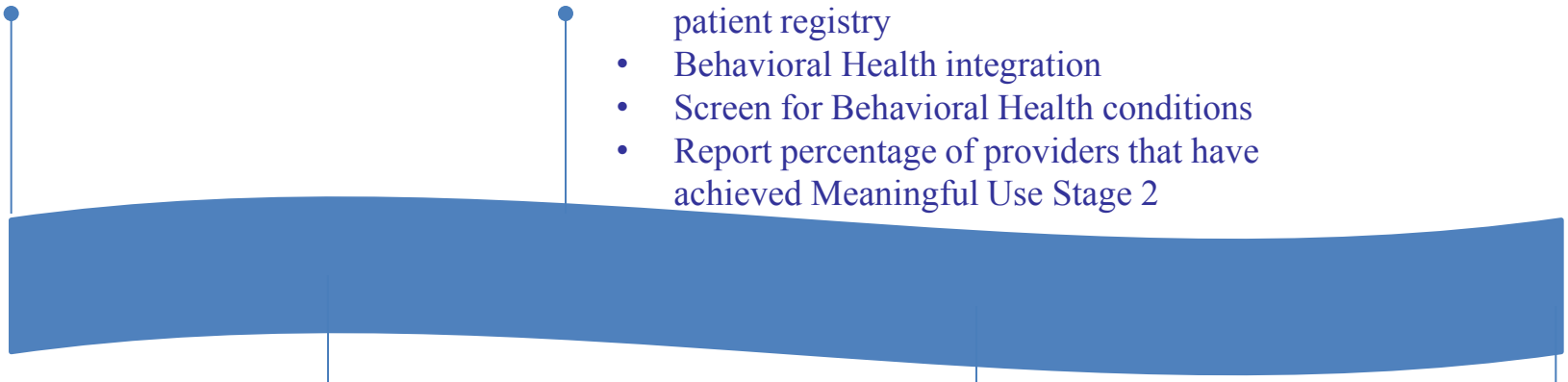
BH Integration Options

- **Tier 1** ('floor' for any participating practice)
  - A written agreement with a Behavioral Health Provider to coordinate and integrate medical and behavioral health care
  - Examples: care coordination, care management
- **Tier 2**
  - Co-located Master's or Doctoral level Behavioral Health Provider no less than 40 hours per week
  - Able to schedule "first available" Behavioral Health Services appointment within 14 days from time of request
  - Examples: alcohol/drug assessment, mental health assessment, crisis intervention, BH prevention education
- **Tier 3**
  - Co-located Psychiatrist for at least 8 hours a week
  - Provide 24/7 access to a Behavioral Health provider
  - 24/7 access to components of the Behavioral Health record (diagnoses, medications, acute safety issues)
  - Examples: psychiatric assessment, medication management, cognitive-behavioral therapy

Advantages of the Comprehensive Primary Care Payment (CPCP)

- Does not limit practices to revenue streams that are dependent on appointment volume or RVU's; incents practices to invest in **infrastructure**
- 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

Contractual Timeline for Clinical Milestones



Effective date
- Have achieved Meaningful Use Stage 1
- BH requirements (Tier 2 & 3)

6 months
- Provide Clinical Care Management for highest risk panel enrollees using Integrated Care Plans

12 months
- Identify Multidisciplinary Care Team for each panel enrollee
- Manage care for chronic diseases using a patient registry
- Behavioral Health integration
- Screen for Behavioral Health conditions
- Report percentage of providers that have achieved Meaningful Use Stage 2

18 months
- Operate as a Patient-Centered Medical Home
- Provide 24/7 access to Behavioral Health Providers

24 months
- National Committee for Quality Assurance (NCQA) recognition as a Level 1 PCMH
- Full BH integration
- Payment model transformation

#	NQF #	Measure Name	Measure Steward	Payment			Data Source	
				Yr 1	Yr 2	Yr 3	Claims	Record
Adult Prevention and Screening								
1	421	Adult weight screening and follow up	CMS	P4R	P4R	P4Q		✓
2	28	Tobacco use assessment and tobacco cessation intervention	CMS	P4R	P4R	P4Q		✓
3	33	Chlamydia screening (2 rates – Ages 16-17, ages 18-24)	NCQA (HEDIS)	N/A	N/A	P4Q	✓	
4	32	Cervical cancer screening	NCQA (HEDIS)	SS	SS	SS	✓	
5	31	Mammography screening	NCQA (HEDIS)	SS	SS	SS	✓	
Behavioral Health (Adult and Pediatric)								
6	418	Depression screening (2 rates - Ages 12-17, Ages 18+)	CMS	P4R	P4R	P4Q		✓
7	4	Initiation and engagement of alcohol/drug dependence treatment	NCQA (HEDIS)	N/A	N/A	P4Q	✓	
8	576	Follow up after hospitalization for mental illness (2 rates – Ages 6-17, ages 18+)	NCQA (HEDIS)	N/A	N/A	P4Q	✓	
9	108	ADHD medication management for children	NCQA (HEDIS)	N/A	N/A	P4Q	✓	
Pediatric Measures (excluding behavioral health)								
10	36	Appropriate use of asthma medication (2 rates – Ages 5-17, ages 18-64)	NCQA (HEDIS)	N/A	N/A	P4Q	✓	
11	24	Pediatric BMI assessment and counseling •BMI assessment •Nutritional counseling •Physical Activity counseling	NCQA (HEDIS)	P4R	P4R	P4Q		✓
12	1506	Adolescent immunization	NCQA (HEDIS)	P4R	P4R	P4Q		✓
13	1448	Developmental screening in first three years	CAMHI	P4R	P4R	P4Q		✓
14	1392	Well child visits: <15 months	NCQA (HEDIS)	P4R	P4Q	SS		✓
15	1516	Well child visits, 3-6 years	NCQA (HEDIS)	SS	SS	SS	✓	
16		Adolescent well visits (2 rates)	NCQA (HEDIS)	N/A	P4Q	SS	✓	
17	38	Childhood immunizations	NCQA (HEDIS)	P4R	P4R	P4Q		✓

#	NQF #	Measure Name	Measure Steward	Payment			Data Source	
				Yr 1	Yr 2	Yr 3	Claims	Record
Adult Chronic Conditions								
18	731	Diabetes •HbA1c > 9% •HbA1c < 8 •LDL control •BP control	NCQA (HEDIS)	P4R	P4R	P4Q		✓
19	18	Hypertension: Controlling high blood pressure	NCQA (HEDIS)	P4R	P4R	P4Q		✓
Access (Adult and Pediatric)								
20	6	• Getting timely appointments, care and information (2 rates)	AHRQ	N/A	P4Q	P4Q	Patient Experience Survey	
21		• Ambulatory sensitive emergency department visits (2 rates – 0-17, 18+)	NYU Algorithm (CHIA version)	N/A	P4Q	P4Q	✓	
Care Coordination (Adult and Pediatric)								
22	6	• Provider seemed informed and up-to-date about care from specialists (2 rates) • Provider talked about all the prescription medications being taken (2 rates)	AHRQ	N/A	P4Q	P4Q	Patient Experience Survey	
23	97	Medication reconciliation (2 rates - 3 to 17 and 18 – 64)	NCQA (HEDIS)	P4R	P4R	P4Q		✓

A New Care Delivery Model Emphasizing:

- Patient-Centered Care
- Multi-disciplinary Team
- Enhanced Access to Care
- Self-management support
- Planned Visits and Follow-up Care
- Population-based Tracking and Analysis
- Inclusion of Quality Improvement Strategies and Techniques
- Clinic System Integration
- Care Management
- Care Coordination

Implications of Alternative Payment Models (APMs) and Service Delivery Models for the Care of CYSHCN

- Expands medical home model
  - Promotion of care coordination and care management
  - Incentives for coordinating care with other providers and community-based organizations
  - Flexibility to meet the unique needs of special populations
- APMs can ensure the adoption of medical home elements through:
  - Certification requirements
  - Contractual obligations
  - Quality measures
- Processes that improve pediatric care may also improve adult care (and vice versa)
- Stakeholder input is valued (and can be impactful)
- Learning collaboratives can inform the care coordination "how-to"

Questions