Challenges and Opportunities:
Quality Measures and Future Payment Models

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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
- Impact of social determinants of health
- Workforce capacity/workforce development concerns
**Key Principles and Goals for Accountable Care Strategy**

What we plan to do: move to a sensible care delivery and payment structure where:

- We pay for value, not volume
- Members drive their care plan
- Providers are encouraged to partner in new ways across the care continuum to break down existing siloes across physical, BH and LTSS care
- **Community expertise** is respected and leveraged
- Cost growth and avoidable utilization are reduced
Key Principles

• **Partnerships** across the care continuum
• **Explicit goals** on reducing avoidable utilization (e.g., avoidable ED visits) and increasing primary, BH, and community-based care
• A feasible and **financially sustainable transition** for provider partnerships that commit to accountable care
• An appropriate focus on **complex care management**, e.g., through a Health Homes model
• **Explicit incorporation of social determinants of health**, through the technical details of the payment model and in care delivery requirements
• **Valuing and explicitly incorporating the member experience and outcomes**
Pop. Health: ACOs will be held to a high standard of care and will have tools to manage population health

ACO Expectations and Responsibilities

• Performing on quality measures that span several domains including population health and member satisfaction
• Increased access to high-value care and easier referrals within a coordinated network
• Tighter integration across physical health, BH, and LTSS
• Faster follow-up after key care events
• More care in home and community settings
• Care coordination services
• Comprehensive care planning for high-risk members that leverages appropriate expertise for members with SMI or LTSS needs
• Real investment in and connection to social services
Community Partners: Framework for Partnership (example)

This framework involves the creation of ACOs which will work in close collaboration with Behavioral Health (BH) and Long-Term Supports and Services (LTSS) Community Partners (CPs) to coordinate and manage care.

ACO Responsibilities

- Primary accountable entity for member’s total cost of care
- Provide team-based care coordination for appropriate members
- ACO’s PCP responsible for primary care referrals in all cases
- Refer and provide access to CPs for delegated services and integrate CPs where appropriate into care planning/coordination
Community Partner Responsibilities

BH CPs
• Primarily accountable to provide 6 Health Home (Section 2703 of ACA) services to SMI members
• Coordinate with ACO (i.e., ACO PCP must sign off on care plan, notification must go both ways, huddles should include both. ACO PCP still owns referral)
• May be direct service provider as well

LTSS CPs
• Provide expertise on community-based LTSS services
• Assess member’s LTSS service needs
• Provide options counseling and member advocacy
• Participate on member’s care team and inform care planning
• Provide navigational assistance for certain LTSS services
Principles of Measure Development

- Reliable, valid, stable, nationally vetted and accepted standards of measures (wherever possible) with broad impact and with stable baselines for payment / CMS accountability
- Variation and opportunity for improvement (e.g. provider level variation, disparities)
- Parsimony
- Alignment with other payers and CMS
- Feasibility of data collection and measurement, and minimization of administrative burden as much as possible
- Cross-cutting measures that fall into multiple domains
- Patient-centered, patient-reported, quality of life/functionality
- Promotion of co-management/coordination across spectrum of care
- Revision of quality strategy and measure slate as we gain more experience with ACOs and as measurement science advances

These principles were derived from several existing approaches in Massachusetts (AQC and SQAC), CMS guiding principles, and from a multi-stakeholder discussion in the Quality workgroup.
## Straw Slate for CMS Reporting – for Discussion

### Patient Experience Survey (PES)
- (in development)

### Care Coordination / Patient Safety
- Medication Reconciliation Post-Discharge (MRP)
- Timely transmission of transition record
- Care for Older Adult (COA) - Advanced care plan

### Prevention and Wellness
- Well child visits in first 15 months of life (W15)
- Well child visits 3-6 years (W34)
- Developmental screening in the first 36 months of life
- Oral Evaluation, Dental Services
- Adolescent well-care visit (AWC)
- Prenatal & postpartum Care (PPC)
- Tobacco use assess and cessation intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Adult BMI Assessment (ABA)
- Chlamydia Screening in Women (CHL)

### Efficiency of Care
- Use of imaging studies for Low Back Pain (LBP)
- Hospital All-Cause Readmissions
- Potentially preventable ED visits (NYU ED)
- PC-01 Elective Delivery

### At Risk Populations
- Controlling high blood pressure (CBP)
- PQI-5: COPD
- PQI-8: Congestive Heart Failure Admission Rate
- Medication Management for People with Asthma (MMA)
- Comprehensive diabetes care: A1c poor control (CDC)
- Comprehensive diabetes care: High blood pressure control (CDC)

### Behavioral Health / Substance Abuse
- Screening for clinical depression and follow-up plan: Ages 12-17
- Screening for clinical depression and follow-up plan: Age 18+
- Initiation and Engagement of AOD Treatment (IET)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Depression remission at 12 months
- Follow-up care for children prescribed ADHD medication

### Long Term Services and Supports
- Patients 18 and older with documentation of a functional outcome assessment and a care plan
- Service/care plans address participants' assessed needs (including health and safety risk factors) either by the provision of waiver services or through other means
- People who make choices about the people who support them (PES)
- People who feel their staff have adequate training (PES)

### End of Life Care
- Proportion admitted to Hospice for less than 3 days
- Hospice and Palliative Care – Pain Assessment

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Obtaining further input on these measures from workgroups and stakeholders

Working draft – for policy development purposes only
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
MassHealth Innovations Website:
www.mass.gov/hhs/masshealth-innovations

Questions