

COMMONWEALTH OF MASSACHUSETTS  
HEALTH POLICY COMMISSION

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Sustaining the Efforts Set Forth in the  
Prevention and Wellness Trust Fund:  
*View from the Health Policy Commission*

Prevention and Wellness Trust Fund Sustainability Committee

October 29, 2015





# The US health care system is not getting better outcomes for the high spend, and is in dire need of reform to get higher value health care

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- **GDP**

- U.S. health expenditures are high and increasing at an **unsustainable** rate.
  - In 2013, health care spending was 17% of GDP; \$9,255 per capita
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- **Lack of Value**

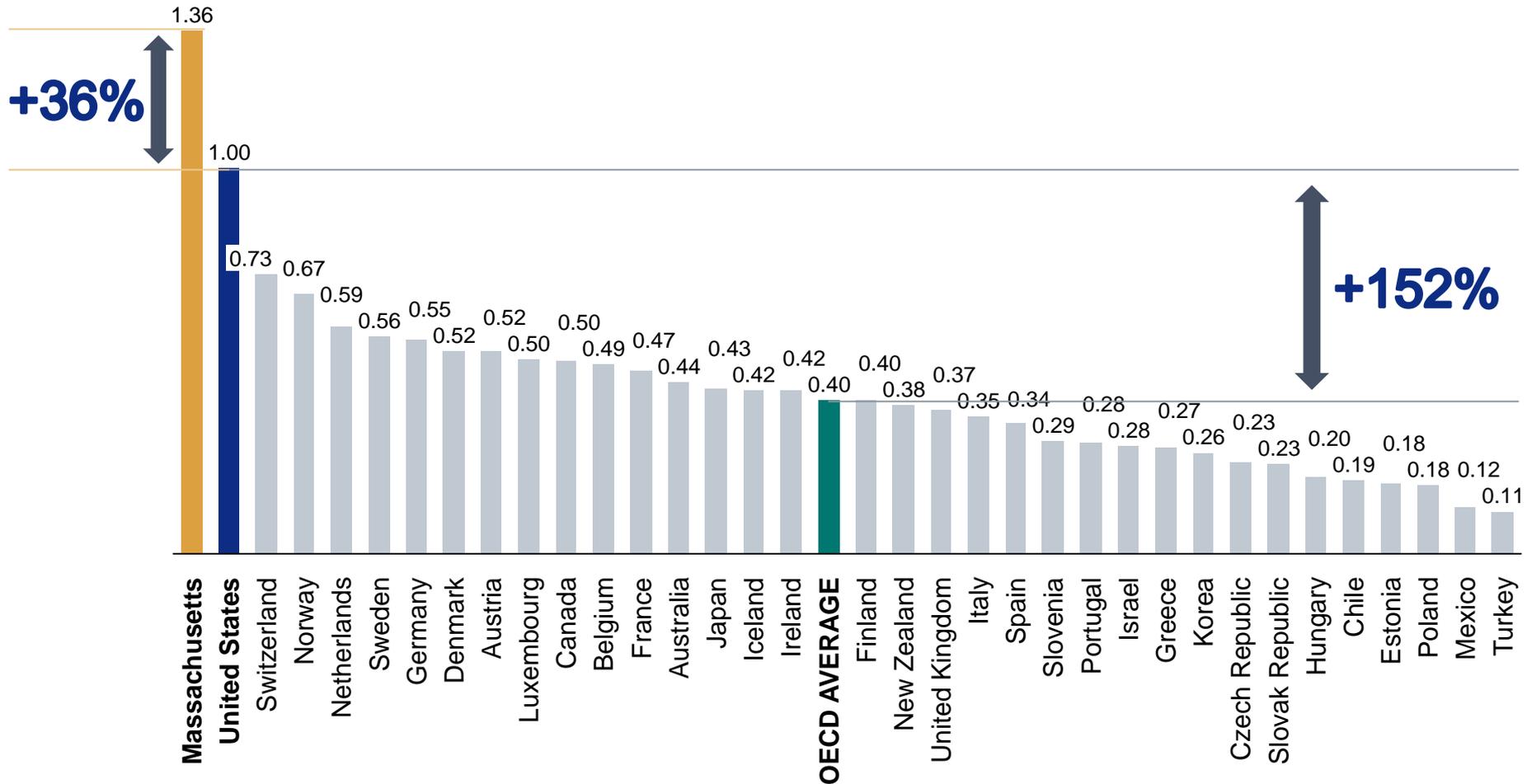
- More health spending has not produced a commensurate improvement in the nation's health (i.e. **better care or better outcomes**)
  - In health status, U.S. ranks 37th in comparison to other nations
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- **Fee-for-service problem**

- The predominant current payment method (fee-for-service) was not designed to promote value
- Creates **skewed incentives and disincentives**

# Massachusetts has the highest per capita spending on health care of any state in the US, which spends the most per capita of any OECD country

Per capita health care expenditures, indexed to U.S. average



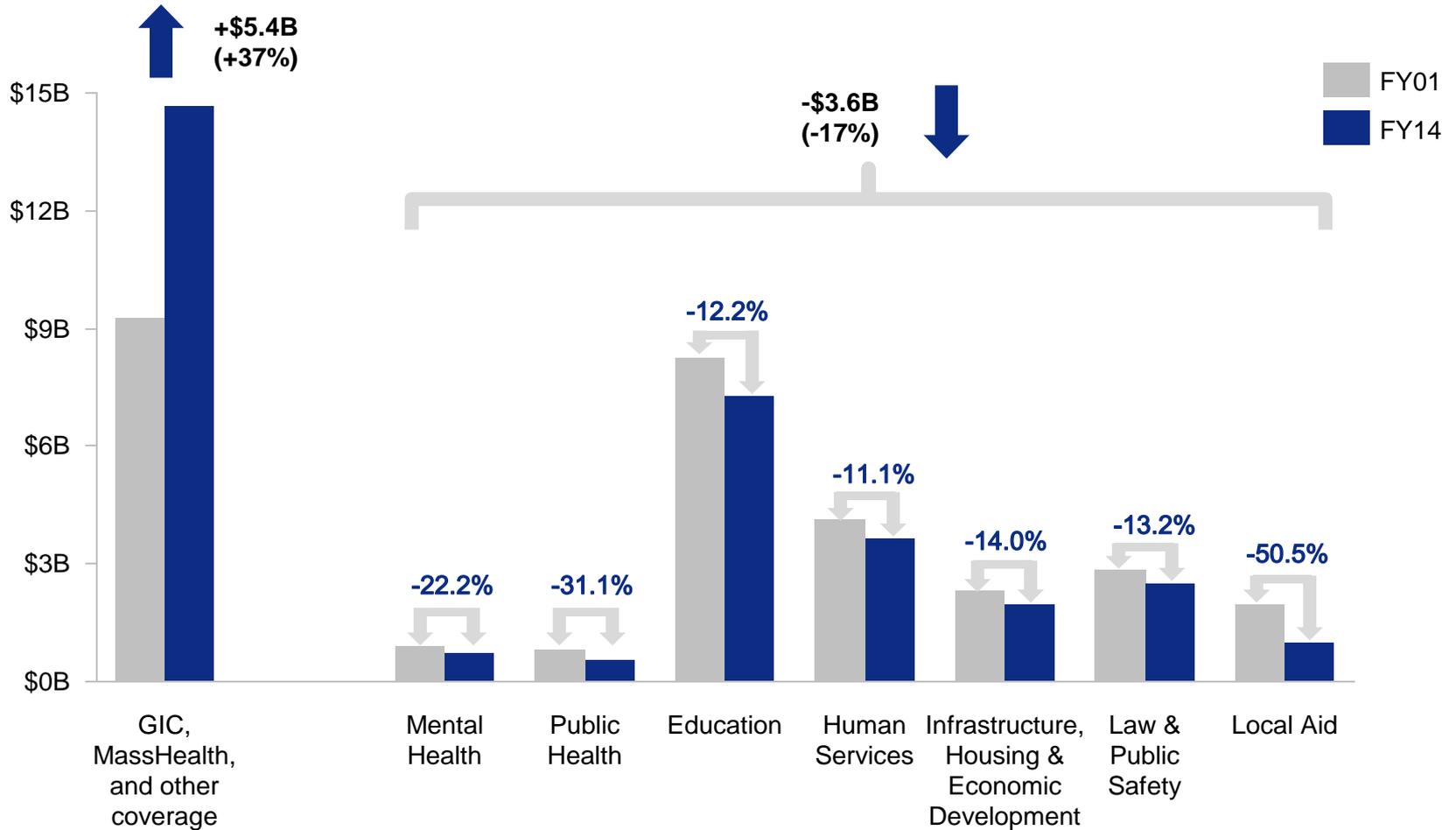
Note: OECD country wide averages indexed to US average spending 2013 (or most recent year) expenditure on health, per capita, US\$ purchasing power parities (2012 is most recent year available for countries denoted by \*). MA per capita spending is from Health Care Expenditures per Capita by State of Residence from 2009 and indexed to US Health Care Expenditures per Capita by State of Residence from 2009.

Source: OECD Health Statistics 2014 - Frequently Requested Data; KFF, "Health Care Expenditures per Capita by State of Residence", 2009

# The Massachusetts story

## Massachusetts State Budget Comparison, FY2001 and FY2014

Billions of dollars



# The Massachusetts story

**Insurance Reforms**  
Community Rating,  
Guaranteed Coverage

**Ch. 58 Passed**  
Health care reform

**Ch. 305 Passed**  
Health care  
transparency and  
e-Health

**Ch. 288 Passed**  
Small business  
health care relief

**Ch. 224 Passed**  
Health care cost  
containment

1990s

2006

2008

2010

2012

Guaranteed issue

Modified community  
rating

Pre-existing  
condition limitations

Individual mandate

Employer  
responsibility

Medicaid expansion

Insurance exchange

New state authority  
to examine cost  
drivers/conduct cost  
trend hearings

Key requirements  
around HIT/HIE

Increased  
transparency

Development of  
tiered/limited  
network products

Reform of unfair  
contracting practices

Formation of the  
independent *Health  
Policy Commission*  
and *Center for  
Health Information  
and Analysis*

Health care cost  
growth benchmark

## Drivers of Health Care Spending

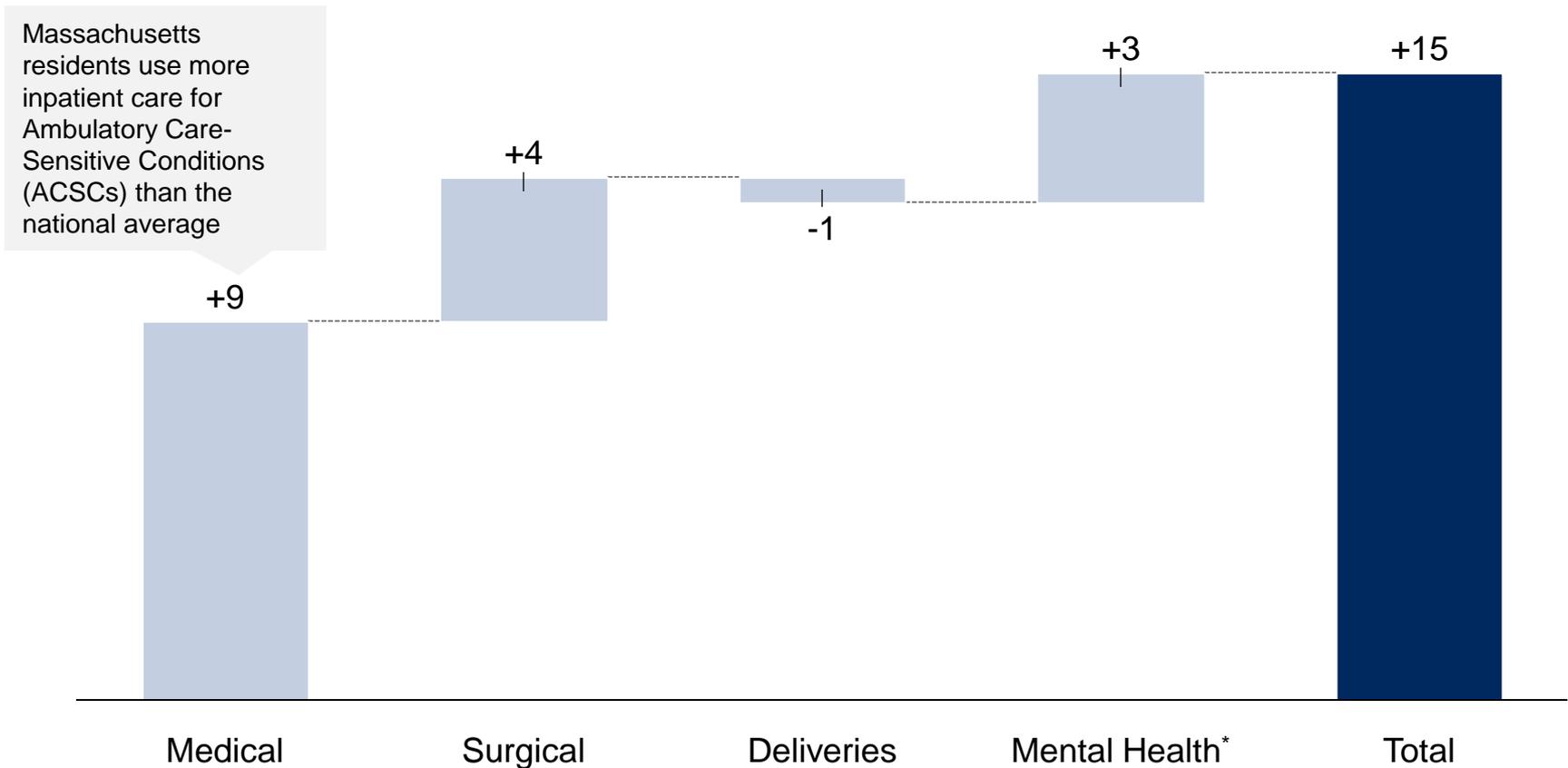
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- **Utilization:** Health care spending rises when patients use more services. For example, if the average number of physician visits increased in Massachusetts, overall spending would increase.
- **Price:** Health care spending rises when the price of services increases.
- **Provider mix:** Health spending increases when a population increases its use of higher-priced providers. For example, if instead of going to a freestanding facility for radiology or laboratory services, patients get those services in a more costly hospital setting, overall spending would increase.
- **Service mix:** Health care spending increases when a population receives more expensive services in place of cheaper ones. For example, if more patients receive MRI or CT scans instead of lower-priced X-rays, overall spending would increase.

# Massachusetts has a 10 percent higher rate of inpatient admissions than the national average, adjusted for age differences

## BREAKDOWN OF DIFFERENCE IN DISCHARGES BETWEEN MASSACHUSETTS AND U.S. BY INPATIENT SERVICE CATEGORY

Inpatient discharges per 1,000 persons, 2011



\* Based on discharges in general acute hospitals. Data exclude discharges in specialty psychiatric hospitals.  
SOURCE: Agency for Healthcare Research and Quality, Kaiser Family Foundation, American Hospital Association

# Characteristics of ED use among Massachusetts residents in 2014

Among Emergency Department (ED) visits in the past 12 months

38.7%



Of recent ED visits were for a non-emergency condition



60.3%

Of recent emergency room visits were unable to get an appointment at a doctor's office or clinic as soon as needed

76.1%

Of recent emergency room visits was for care after normal operating hours at the doctor's office or clinic



ED utilization in MA is higher than US

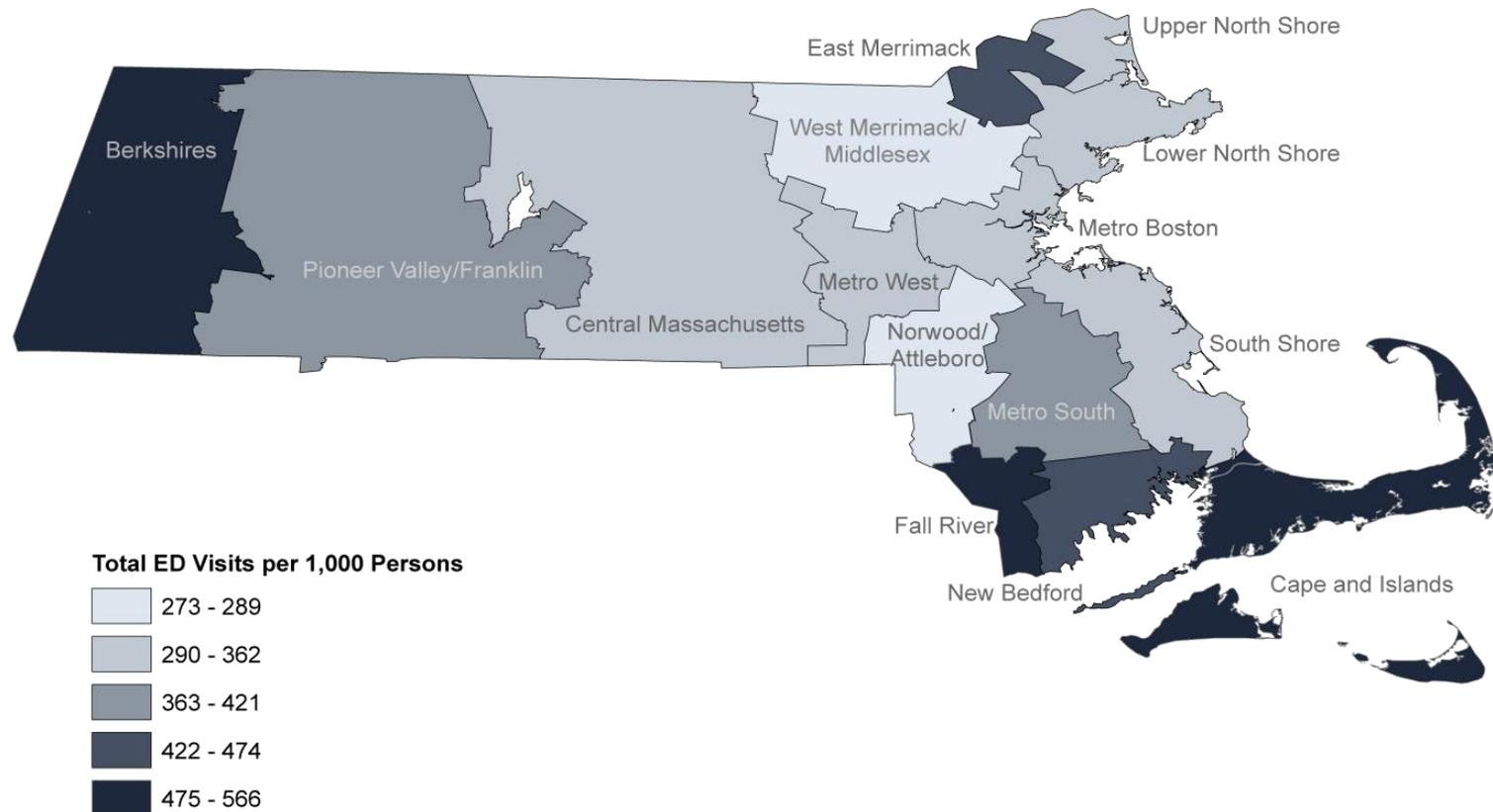
Note: A non-emergency condition is one that the respondent thought could have been treated by a regular doctor if one had been available.

Source: 2014 Massachusetts Health Insurance Survey



# Total outpatient ED visits vary widely by region

Total ED visits per 1,000 persons, 2012

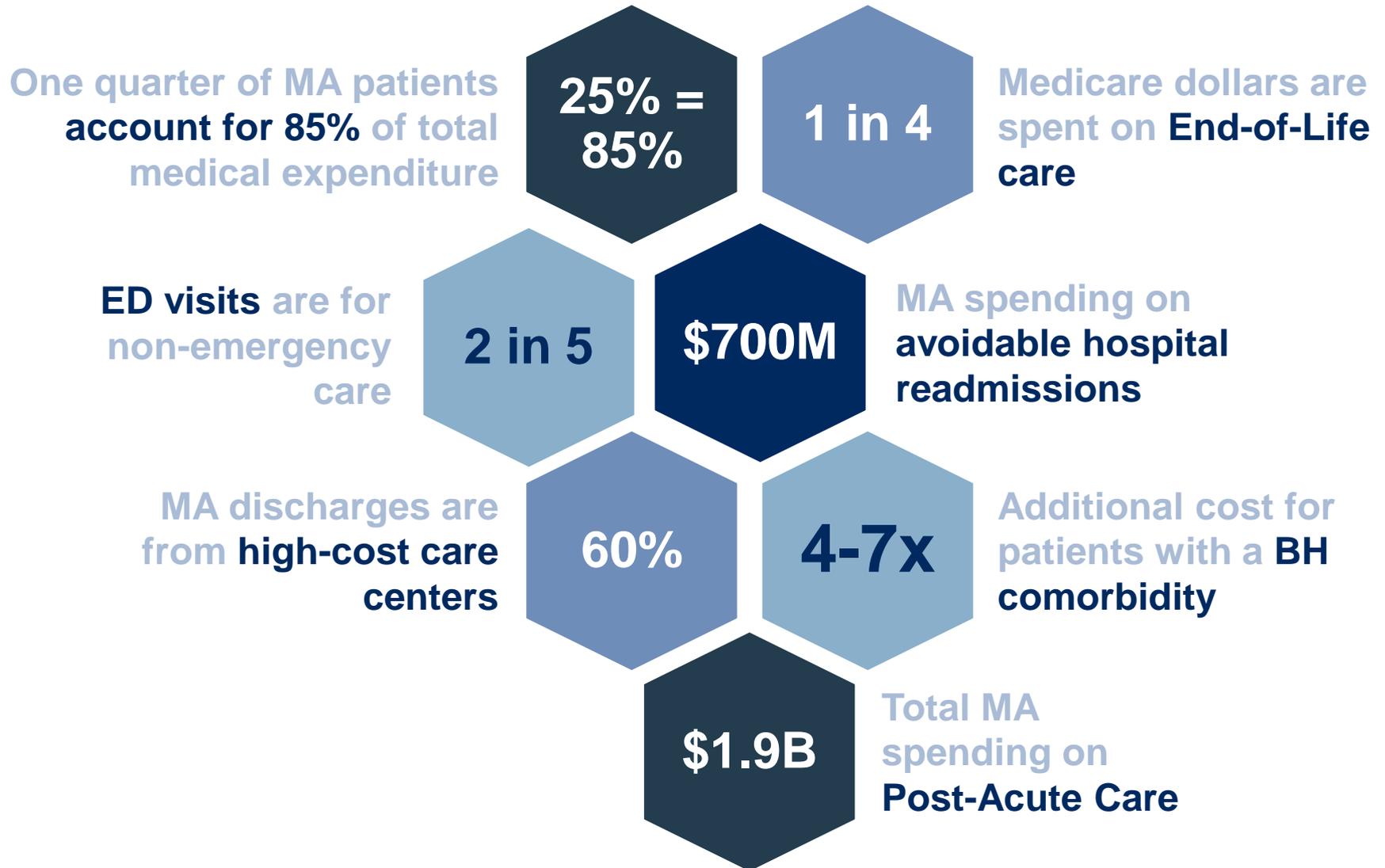


The ED visits per 1,000 persons in Fall River (highest) is double that of West Merrimack/Middlesex (lowest)

Note: All rates are adjusted for age and sex.

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, 2012

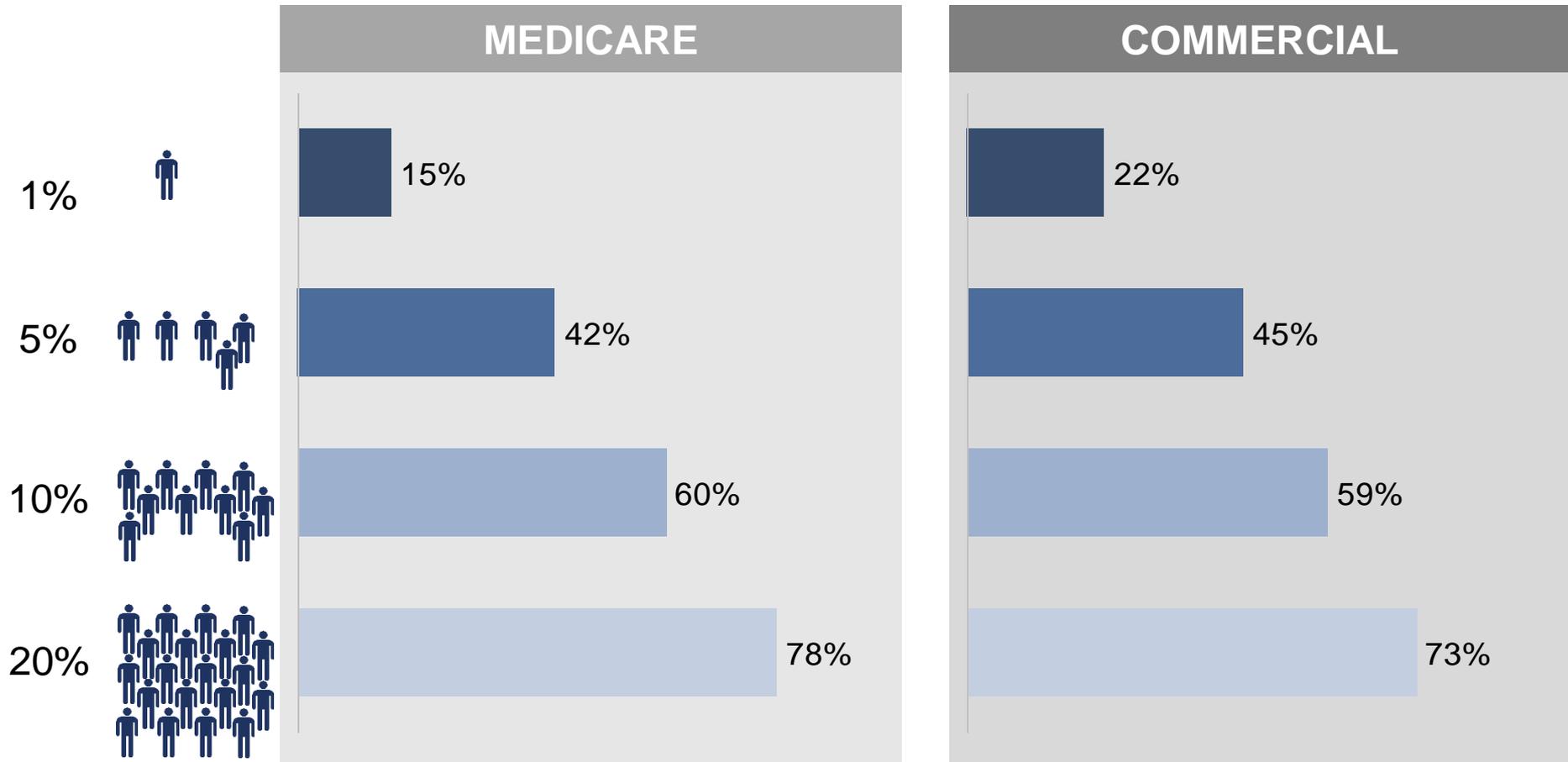
# Primary cost drivers in Massachusetts identified by HPC



# Small subgroup of population represents large proportion of spending among Medicare and commercial populations

## Spending concentration in Massachusetts

Percent of claims-based medical expenditures (excluding pharmacy spending), 2010



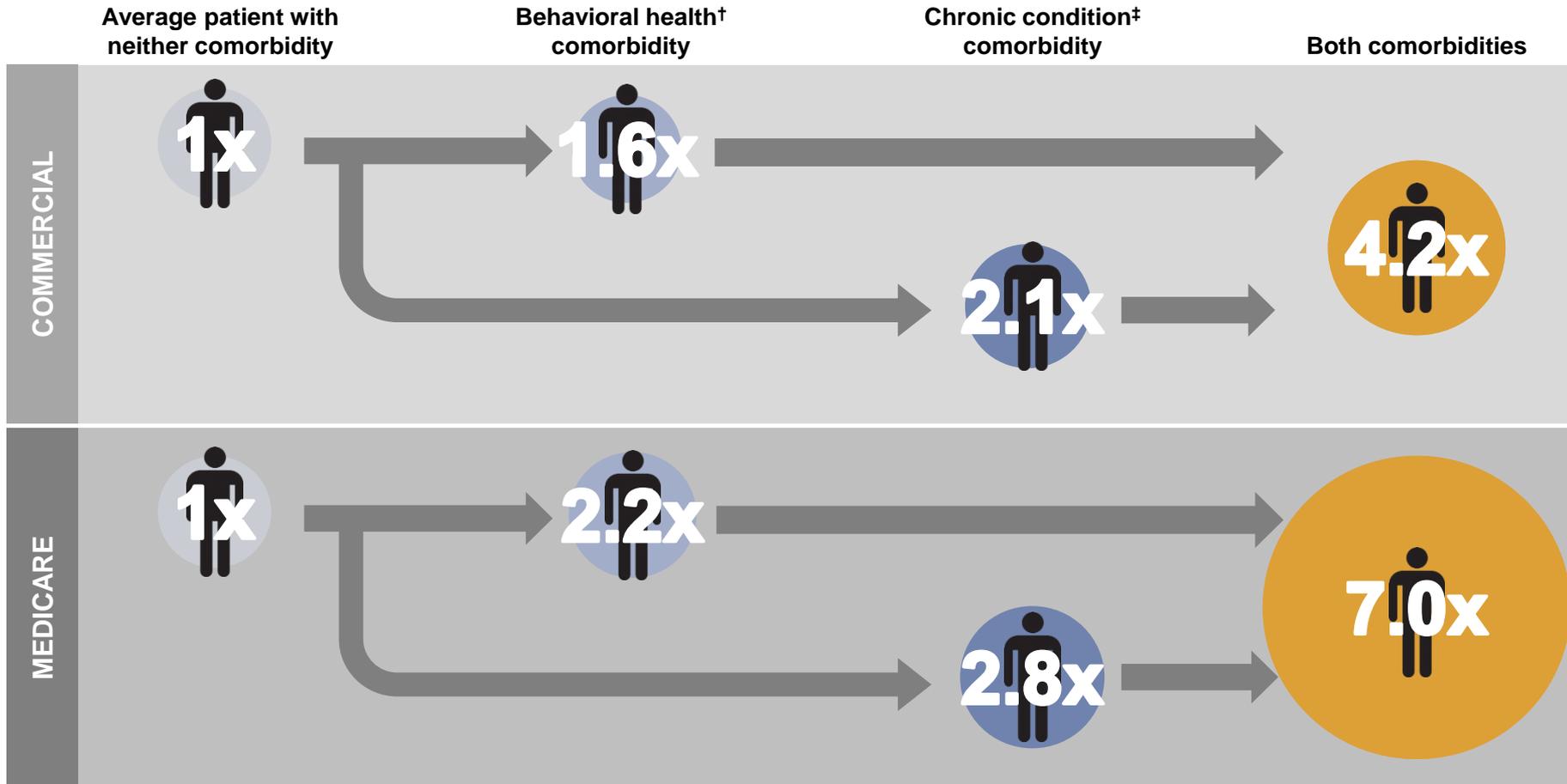
**Notes:** The sample was limited to patients who had at least six months of enrollment in both 2010 and 2011 and costs of at least \$1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or the first half of 2011.

**Source:** All-Payer Claims Database; HPC analysis

# In Massachusetts, patients with behavioral health and chronic conditions have significantly higher medical expenditures

Medical expenditures per patient (excludes drug spending)\*

Relative to average patient with no behavioral health or chronic comorbidity in 2010



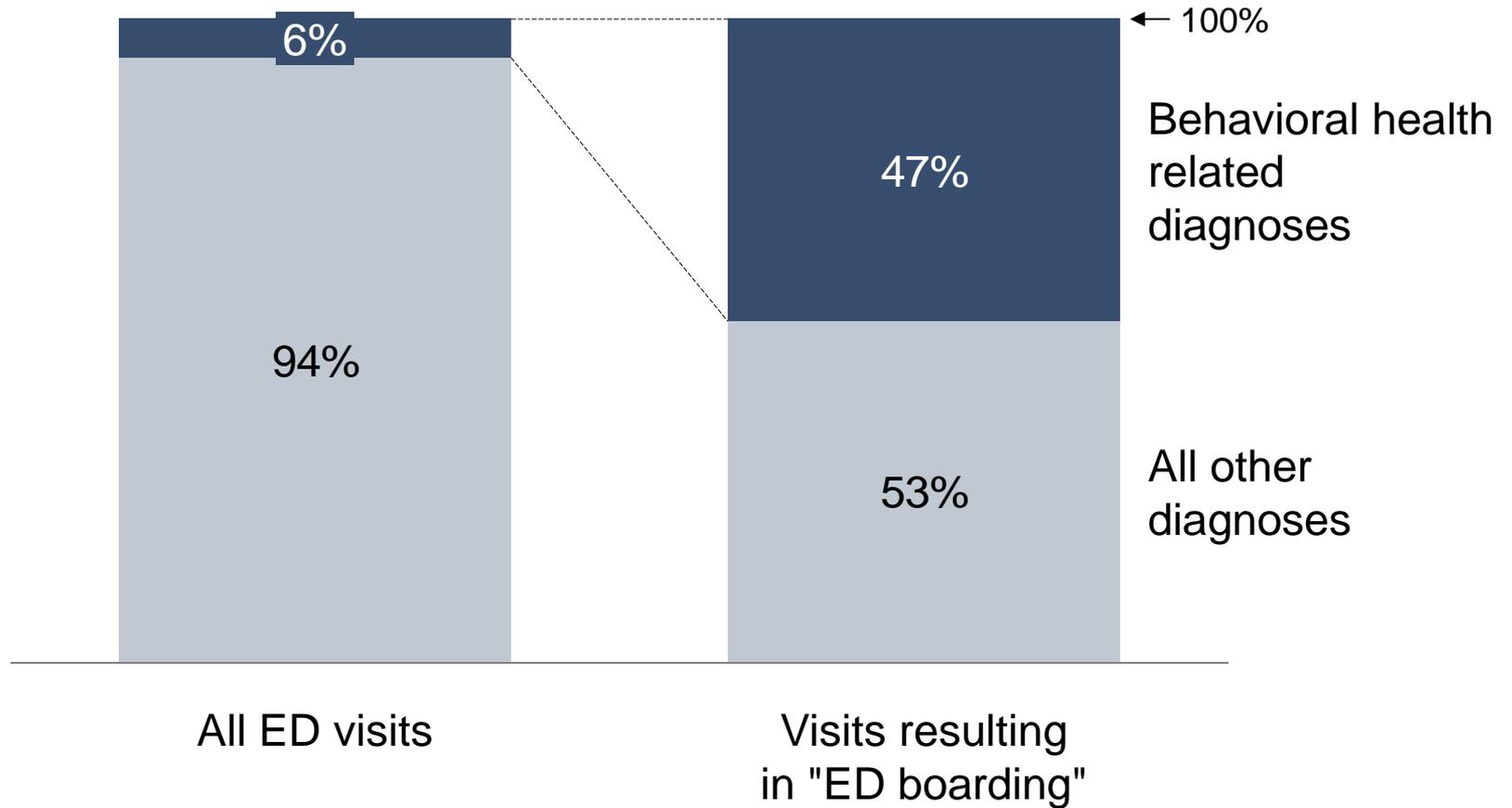
\* The sample for analysis was limited to patients who had continuous enrollment from 1/1/2010 – 12/31/2011 and costs of at least \$1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or 2011.

† Behavioral health comorbidity includes child psychology, severe and persistent mental illness, mental health, psychiatry, and substance abuse

‡ Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes

# ED boarding is disproportionately driven by patients with behavioral health diagnoses

Percent of visits, 2012



# Vision of Massachusetts cost containment reform law

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- 1 Transforming the way we deliver care
- 2 Reforming the way we pay for care
- 3 Developing a value-based health care market
- 4 Engaging purchasers through information and incentives

A more transparent, accountable health care system that ensures quality, affordable health care for Massachusetts residents

# Payment arrangement between payers and providers determine the economic incentives physicians face and impact care decisions and costs

**The Washington Post**

Rise in spinal fusion surgeries may be driven partly by financial incentives, study says

**npr**

**Money May Be Motivating Doctors To Do More C-Sections**

“Obstetricians perform more cesarean sections when there are financial incentives to do so, according to a new study that explores links between economic incentives and medical decision-making during childbirth..”

**U.S. News** & WORLD REPORT

**NEWS**

**How Your Doctor Is Driving Up Health Care Costs**

Financial incentives facing doctors and hospitals are pushing up costs

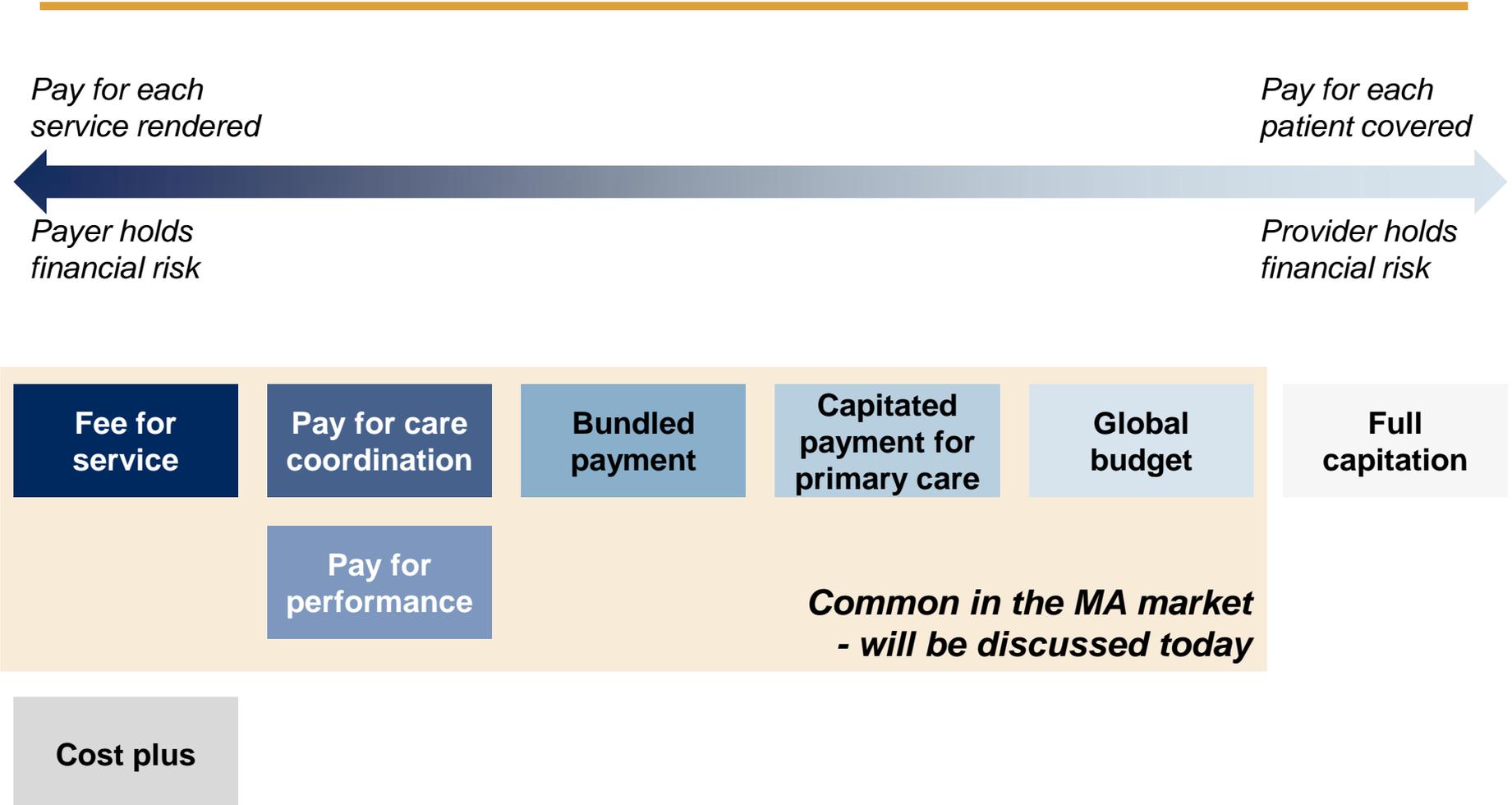
Article headlines pulled from:

The NPR (2013): <http://www.npr.org/sections/health-shots/2013/08/30/216479305/money-may-be-motivating-doctors-to-do-more-c-sections>

US News (2013): <http://www.usnews.com/opinion/blogs/economic-intelligence/2013/08/22/how-financial-incentives-for-doctors-drive-up-health-care-costs>

The Washington Post (2013): [http://www.washingtonpost.com/business/economy/rise-in-spinal-fusion-surgeries-may-be-driven-partly-by-financial-incentives-study-says/2013/11/13/2c87188a-4c87-11e3-be6b-d3d28122e6d4\\_story.html](http://www.washingtonpost.com/business/economy/rise-in-spinal-fusion-surgeries-may-be-driven-partly-by-financial-incentives-study-says/2013/11/13/2c87188a-4c87-11e3-be6b-d3d28122e6d4_story.html)

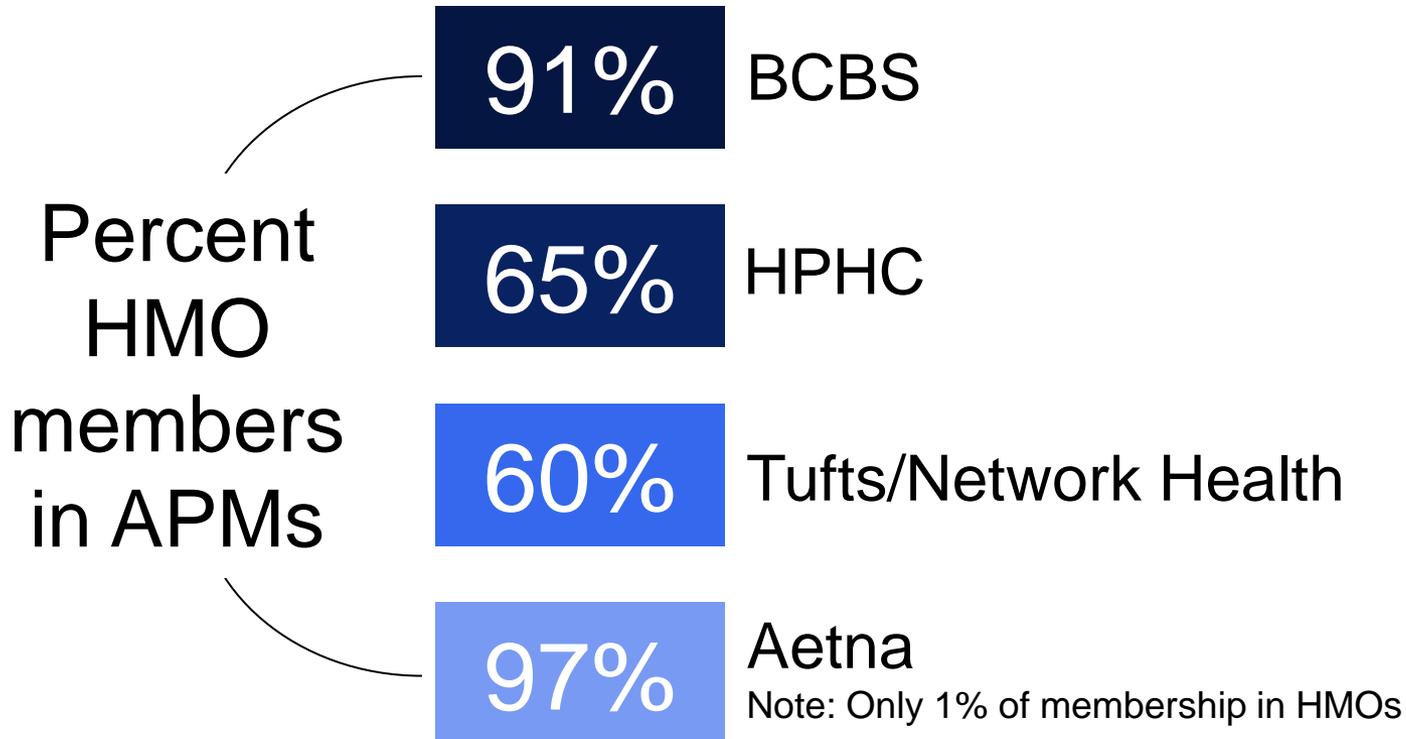
# There are many ways for insurers (private and government payers) to pay providers for services



**Note:** payment methodologies that are not fee for service are often referred to as “Alternative Payment Methods” or APMs

## All major commercial plans have a substantial proportion of HMO members in APMs

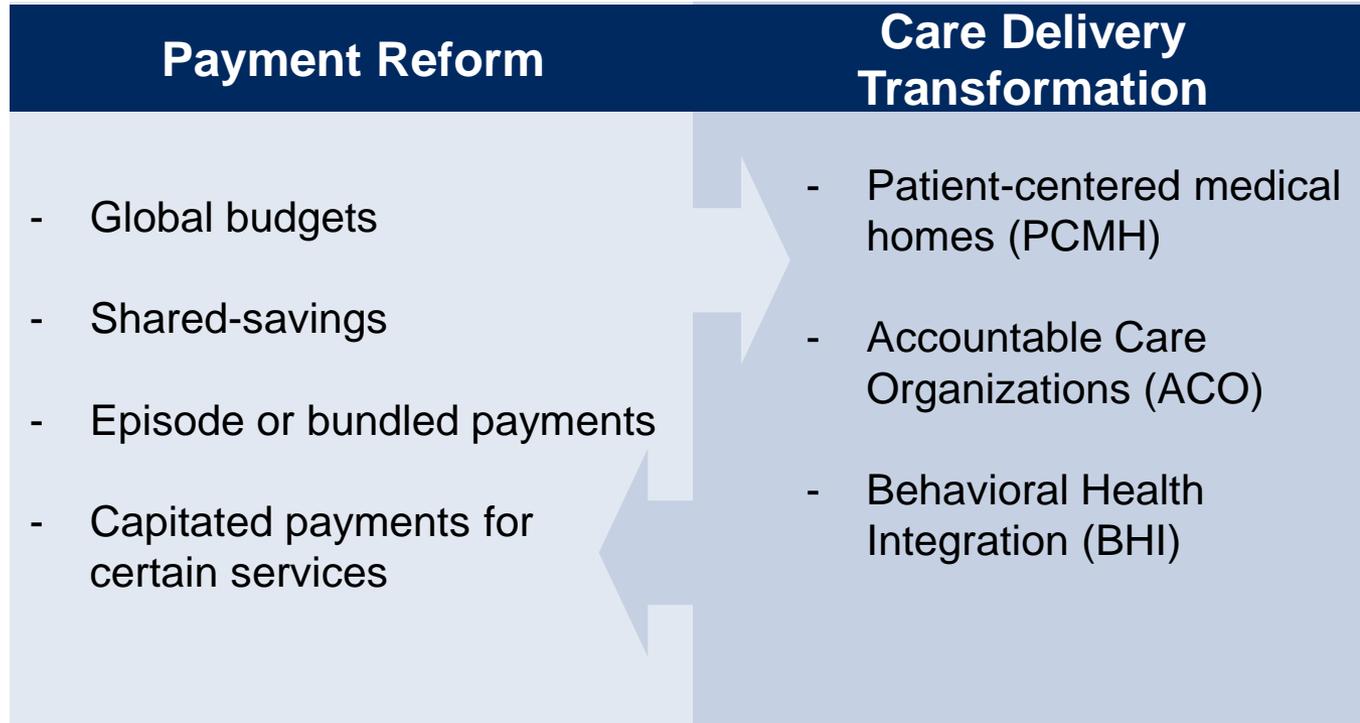
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Source: CHIA, analyzed by HPC. Sept. 2014.  
HPHC includes data from Health Plans, Inc.  
Other includes Health New England, Fallon, Cigna, Aetna, and other plan

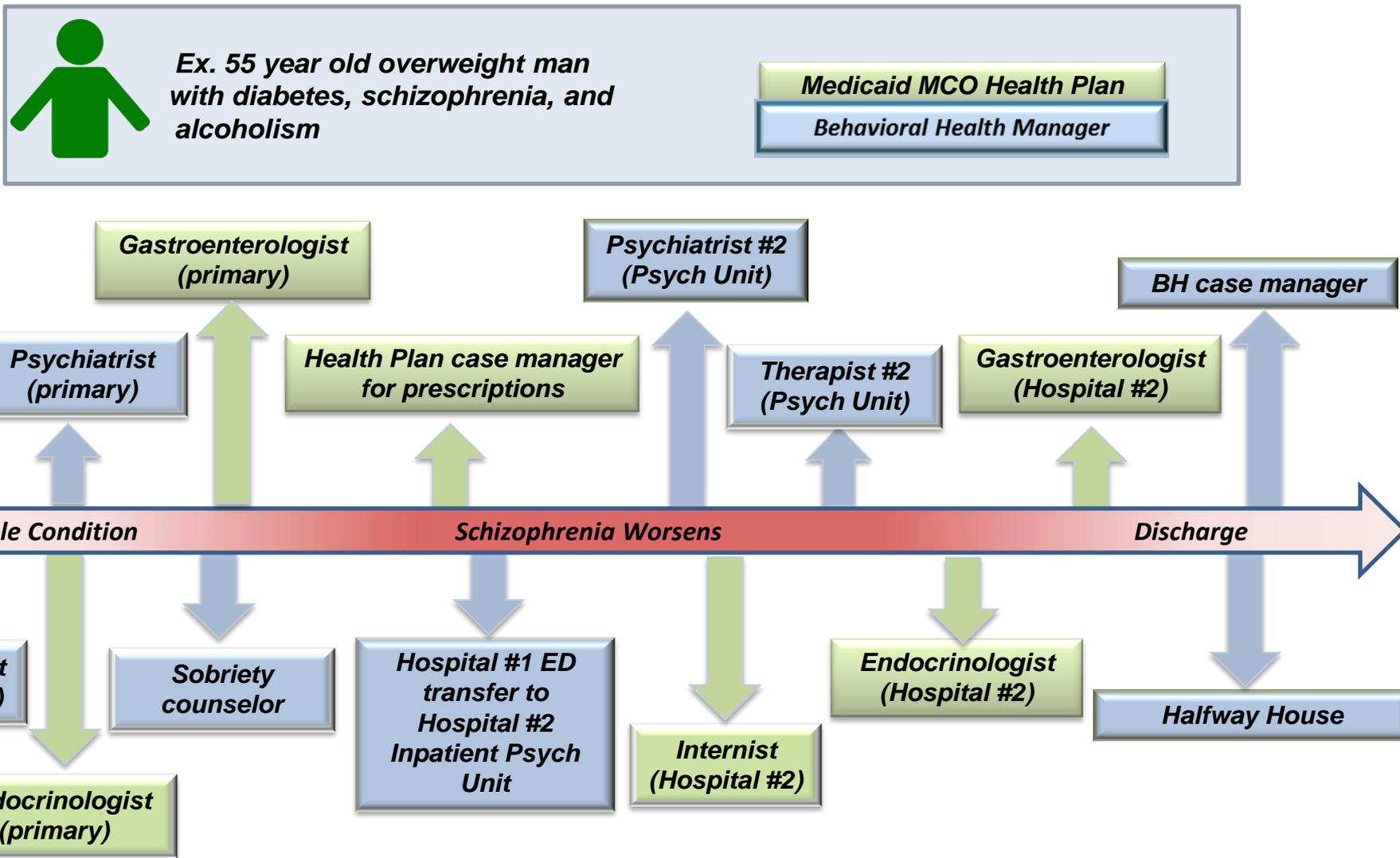
## Reform of these incentives is critical to financially enable care delivery transformation

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**HPC Goal: Advancing payment reform and care delivery transformation through various policy initiatives and certification programs**

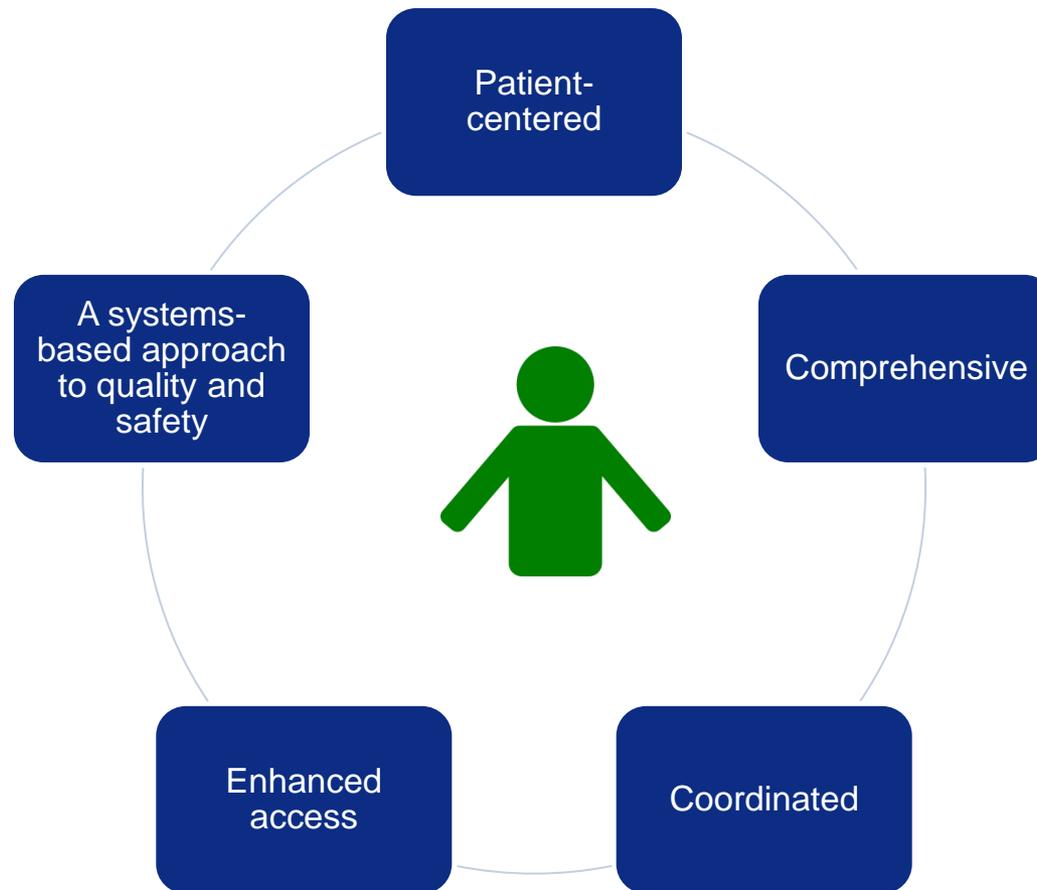
# Current challenge in the health care system: fragmented care delivery



# The Patient Centered Medical Home (PCMH) is a model for organizing primary care across the full range of an individual's health care needs

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The PCMH is...



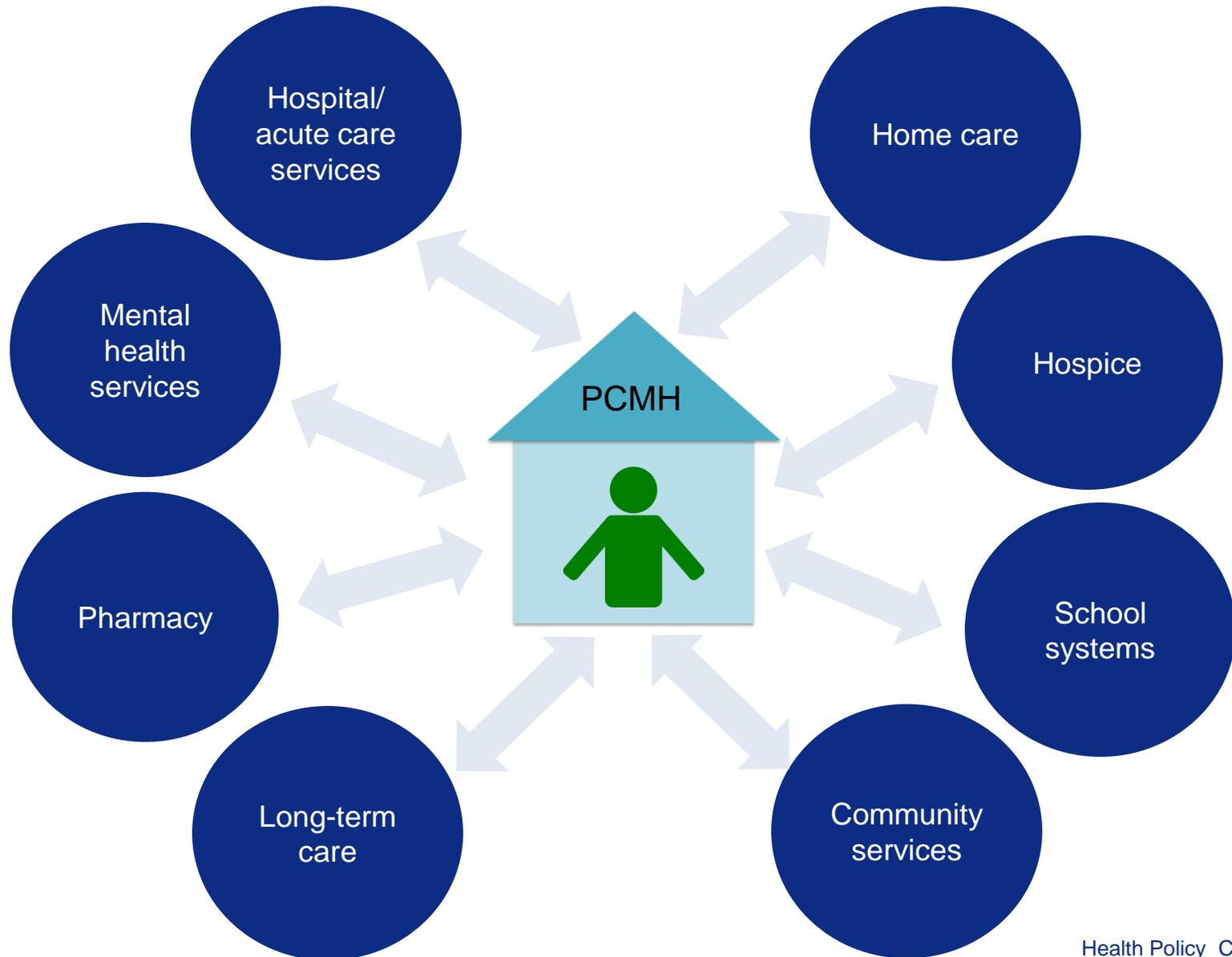
The PCMH *is not* limited to a physical “brick and mortar” location

PCMH potential outcomes:

improved quality of care, decreased health care costs, improved patient experience, and/or improved provider experience

# Conceptually, the PCMH serves as the central hub for all health and social support services to achieve care coordination and integration

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## What is an ACO?

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An **ACO** is a group of physicians, hospitals, and other providers that receive financial rewards for achieving patient-focused quality targets and demonstrating reductions in overall spending growth for their defined patient population.<sup>1</sup>

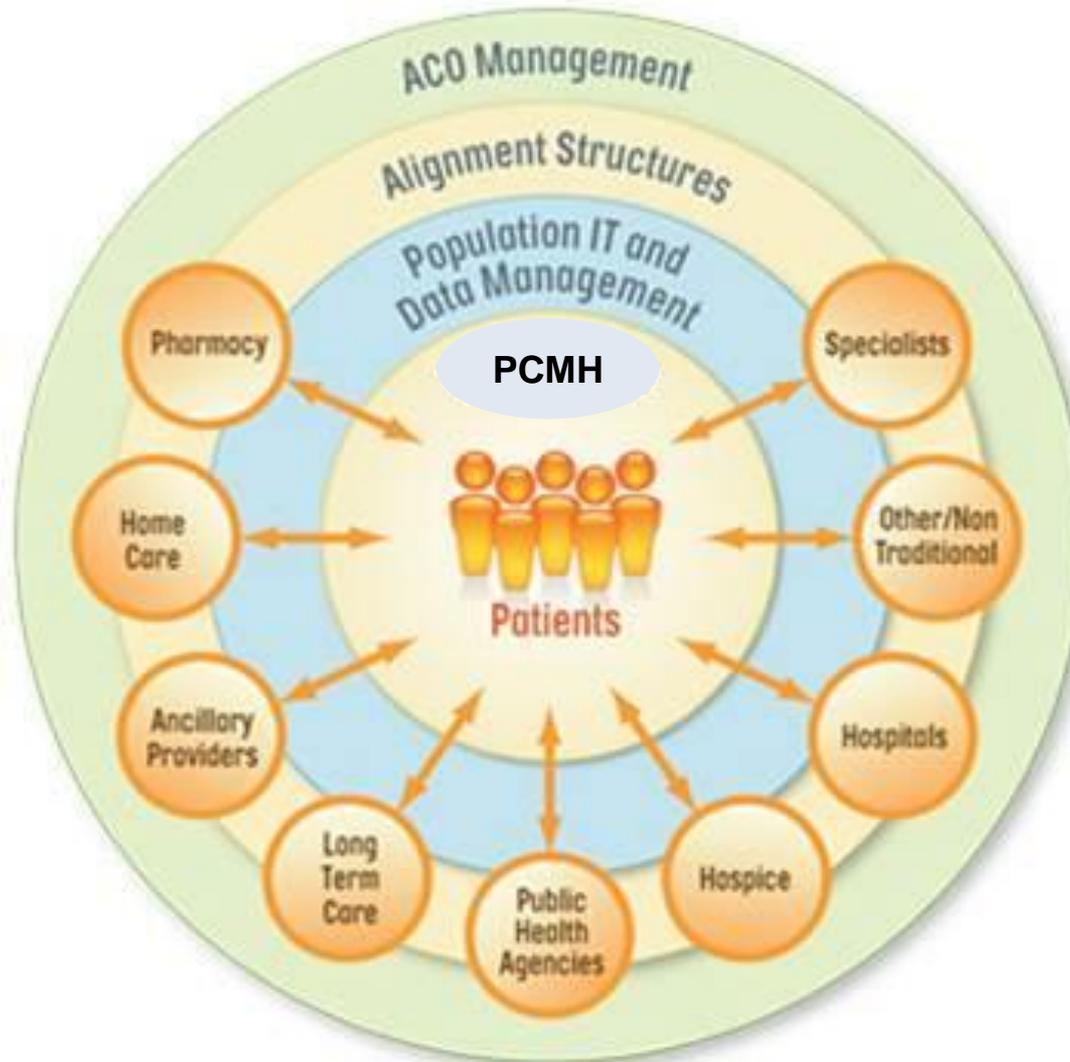


An **ACO** is a provider-led organization whose mission is to be accountable for the overall cost and quality for a full spectrum of care for a defined population.<sup>2</sup>

<sup>1</sup> [http://www.brookings.edu/about/centers/health/focus-areas/accountable-care#recent\\_rr/](http://www.brookings.edu/about/centers/health/focus-areas/accountable-care#recent_rr/)

<sup>2</sup> <http://tdi.dartmouth.edu/research/evaluating/health-system-focus/accountable-care-organizations/about-us>

# ACO: The Medical Neighborhood



If a **PCMH** is the medical “home,” or locus of primary care, of a patient’s health care interactions, then an **ACO** is the neighborhood in which a PCMH sits.

An **ACO** not only links together and coordinates care across the entire network of health care services (primary care, specialty care, post-acute care, pharmacy), it also provides the management oversight, the IT infrastructure, and data systems necessary for the entire system to thrive and work efficiently and cost-effectively.

Much like the PCMH, the **patient** is always at the center of the ACO.

# HPC ACO certification program goals

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1

**Collaborate** with **providers, payers, and consumers** to obtain feedback on overall ACO development and enabling policy development

2

Create a **roadmap** for providers to work toward **care delivery transformation** – **balancing** the establishment of **minimum standards** with room and assistance for **innovation**

3

Establish an **evaluation framework** for data collection, information gathering, and dissemination of best practices to promote transparency

4

Enhance **patient protection and engagement**, including increasing patient access to services, especially for vulnerable populations

5

Promote **behavioral health integration** with ACOs through BH-specific criteria, quality metrics, and technical assistance

6

Develop standards that **align with payers' own principles for accountable care** (e.g., MassHealth and Group Insurance Commission (GIC)) to further link accountability

7

To the extent possible, **align** with **other state and federal programmatic requirements** to **minimize administrative burden** for providers

# Previous proposed ACO certification approach

## Who fulfills:

## Three-part process:

ACO

### 1. **Mandatory Requirements**

An ACO must meet each criteria within this category in order to move on to the assessment portion of the certification evaluation process.

Criteria covers:

- Legal structure
- Governance
- APM adoption for primary care
- Patient protection
- Market protection

### 2. **Assessment Criteria**

An ACO must meet 50% of the criteria within this category in order to pass HPC certification.

Criteria are spread across five domains:

- Care Delivery
- Analytics & Performance Improvement
- Clinical Data Systems
- Financial Incentives
- Patient/Family Experience

HPC

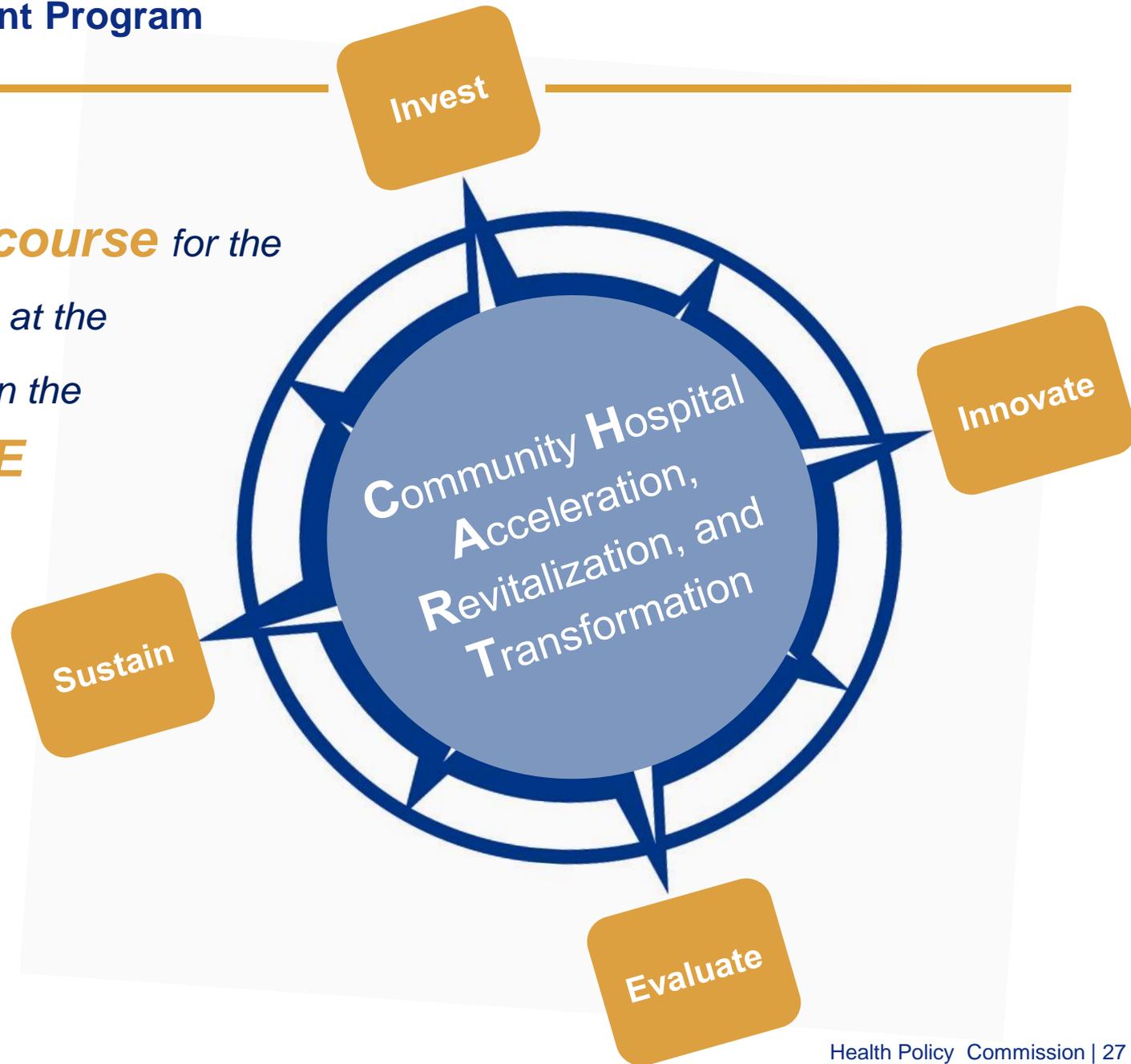
### 3. **Transparency & Reporting**

For the purposes of certification and public evaluation of each ACO, the HPC will collect and report the following data for each ACO:

- TME
- Quality / Health Outcomes

# CHART Investment Program

**CHARTing a course** for the  
**RIGHT CARE** at the  
**RIGHT TIME** in the  
**RIGHT PLACE**



# Statutory Goals

*Investments shall support at least one of six statutory goals:*

*Encouraging technology adoption to easily exchange information across hospitals*

**Enhance health information technology**

**Increase efficiency and coordination**

*Community-based care should be efficient, high-quality, safe, and affordable*

**Allow for the secure transfer of health records across the Commonwealth**

**Patient-centered care through quality, safety, affordability**

**Demonstrate structures of accountable care**

**Support the transition to alternative payment methodologies**

*Building a structure for creating accountable care*

# Foundational Investments in System Transformation

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*Four key elements of system transformation advanced by CHART:*

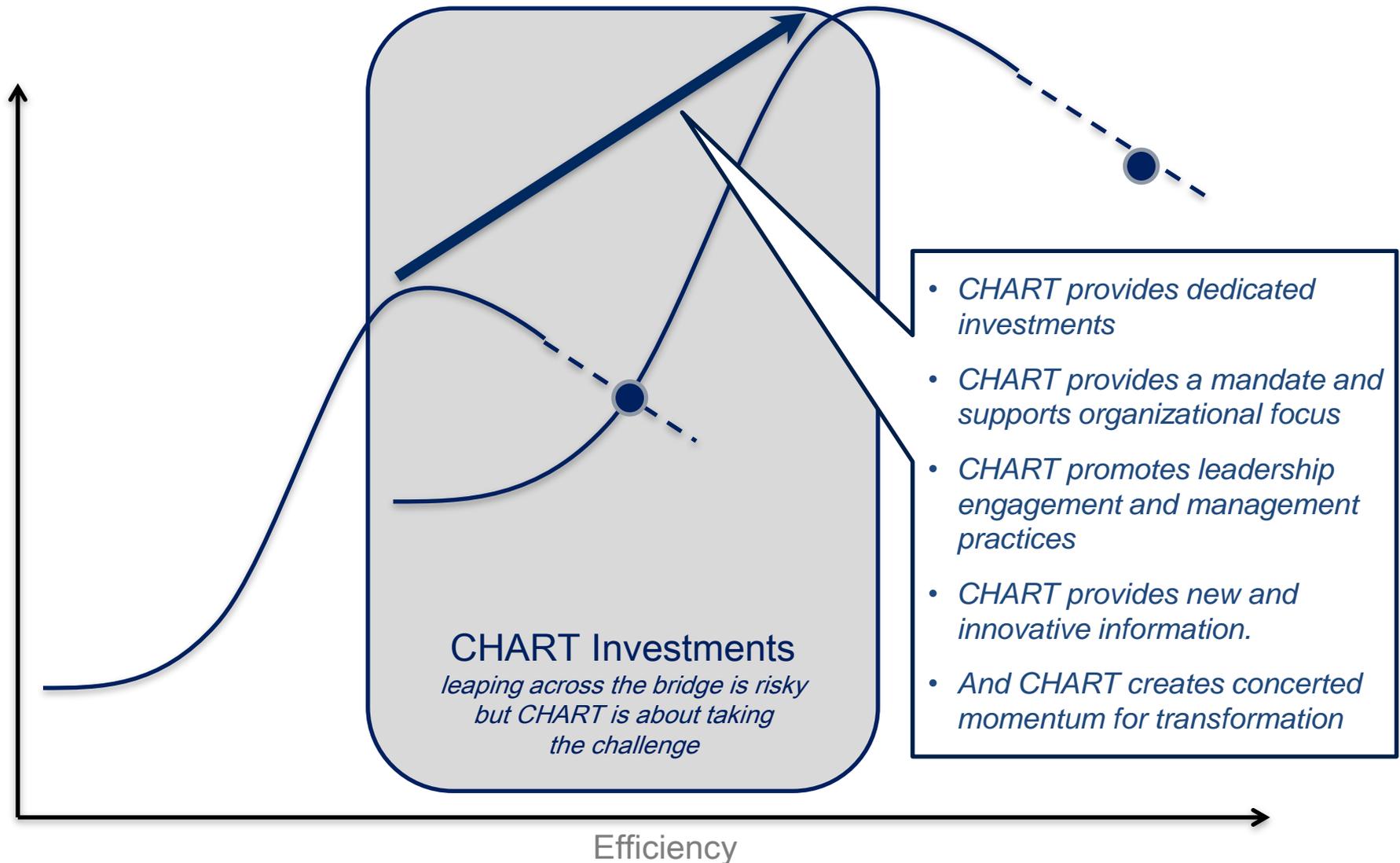
**Safety and Reliability:** As CHART hospitals strive to deliver care based on value, not volume, organizational focus on safety, reliability, and efficiency are imperative.

**Population Health:** The community orientation of CHART hospitals requires a primary focus on whole-person care across settings and time.

**Business Transformation:** In parallel with operational transformation, CHART hospitals need to prepare themselves for success in an alternative payment environment.

**Community Partnership:** Meaningful community engagement is required for successful transformation of CHART hospitals. Early engagement will foster long-term success.

# CHARTing the way to the Second Curve



# CHART Phase 1: \$9.2M



**2,334**  
Hospital employees trained



**400+**  
Hours of direct technical assistance to awardees



**27** | **260**  
HOSPITALS | UNITS  
Primed for transformation



**90%**  
of respondents believed that CHART Phase 1 moved their organization along the path to system transformation



**316**  
Community partnerships formed or enhanced by awardees



**167,000+**  
Patients impacted by Phase 1 initiatives

# PHASE ONE

# Key Lessons Learned from Hospital Performance in Phase 1

1

**The composition of transformation teams is important.**

Multi-disciplinary skill sets were key to success.

2

**Process improvement leads to increased efficiency.** CHART

initiatives that focused on process improvement improved efficiency and led to measureable outcomes.

3

**Leadership and project management must be engaged throughout the improvement process.**

Leadership involvement and dedicated project managers were correlated to the success of an initiative.

4

**Data analysis is essential to measure performance and drive improvement.**

The presence of meaningful data drives and enables improvement by defining target populations, monitoring progress, and assessing outcomes.

5

**Community partnerships are critical to success.**

While challenging to build, community partnerships extend the reach of hospital staff through collaboration with external resources.

6

**Low-cost options for acute care are critical to maintaining a value-based system.**

CHART awardees were encouraged to focus on building internal capacity and capability to increase sustainability.





550+

Hours of direct technical assistance for Awardees during IPP, alone



81%

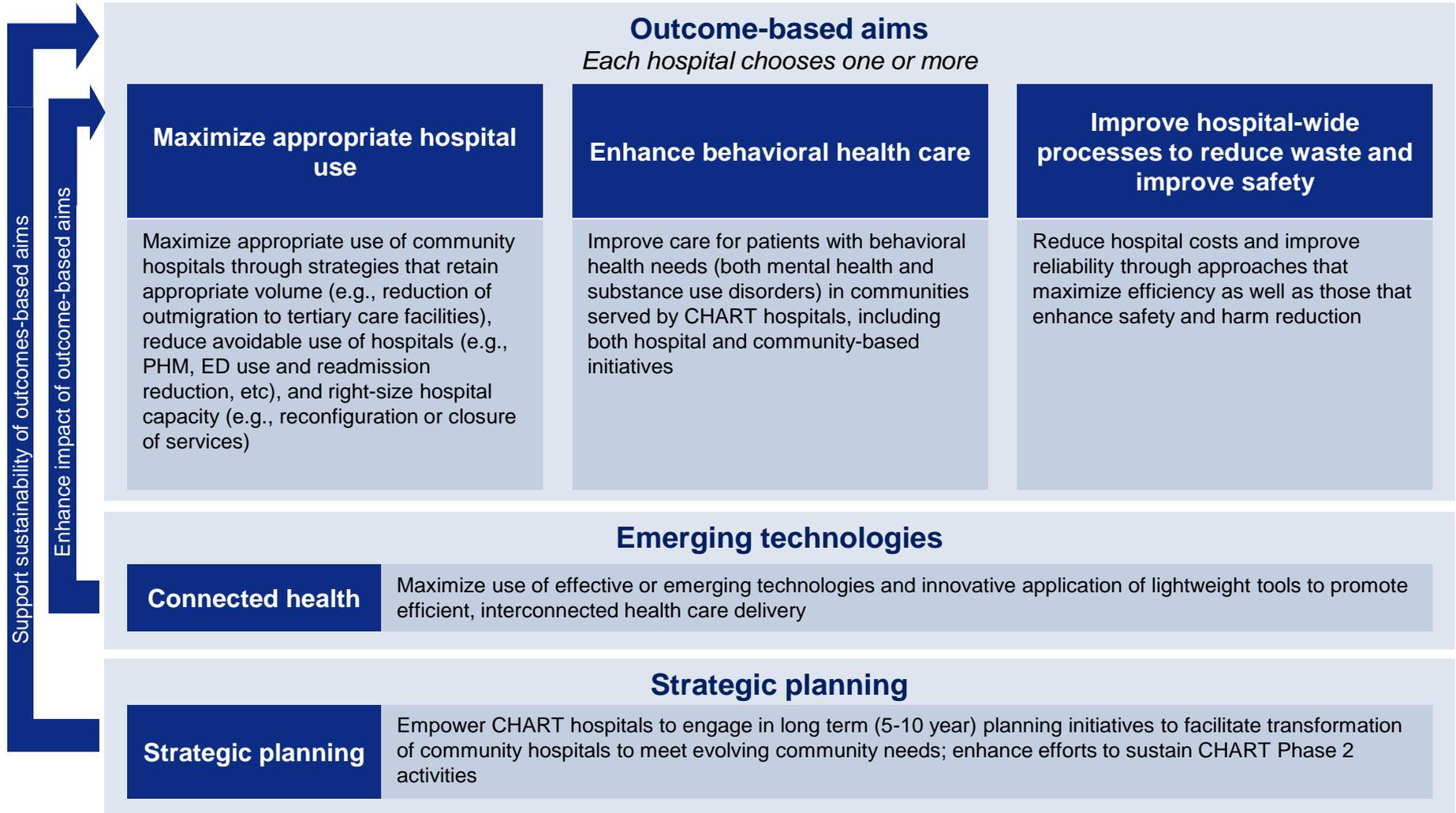
Of CHART Hospital respondents found HPC Staff support helpful

# PHASE TWO

## 28 Hospitals, 24 Months, \$60M

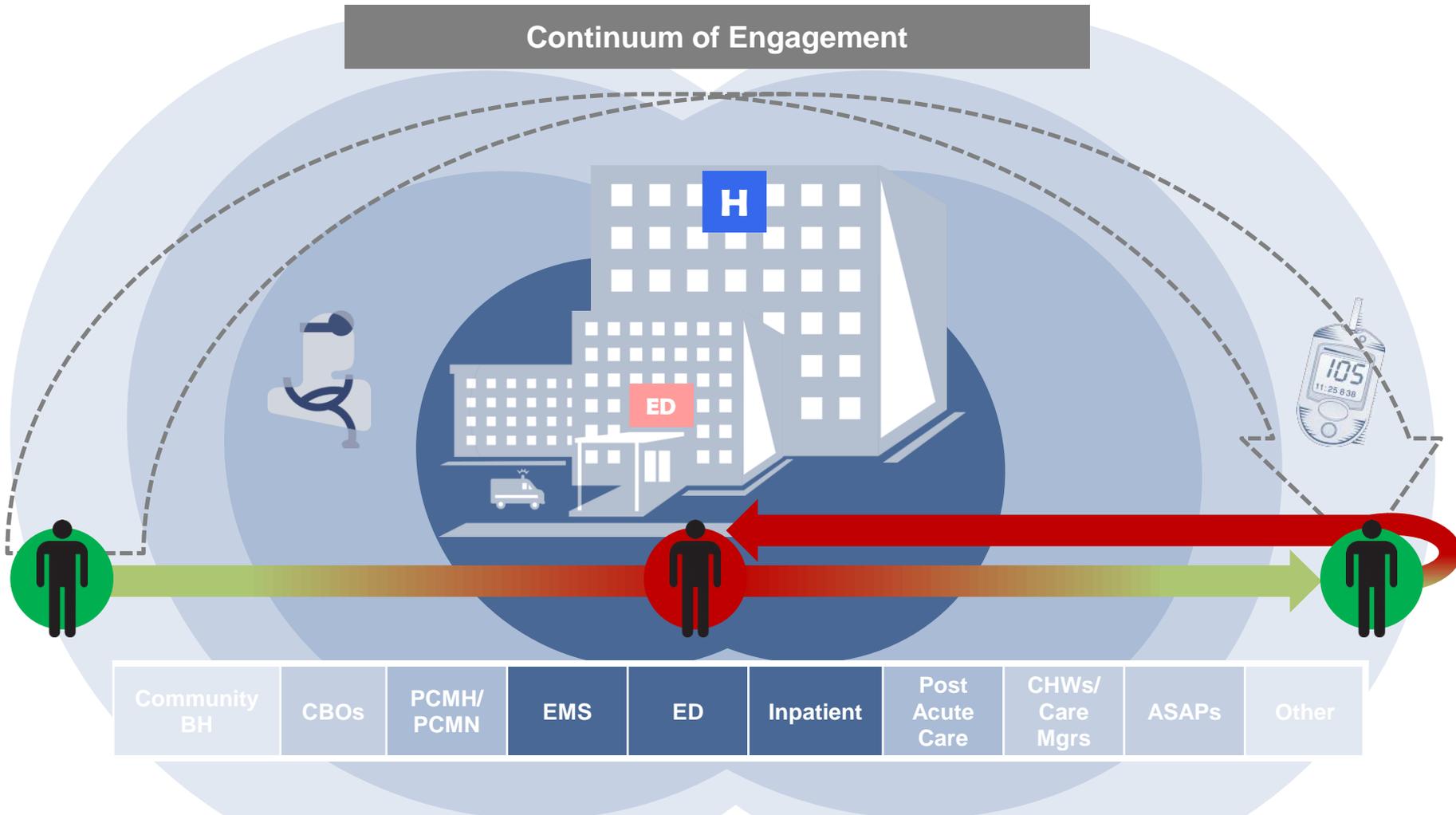
# In Phase 2, hospitals meet specified aims, with the overarching goal to drive transformation toward accountable care

## CHART Phase 2: Driving transformation to accountable care

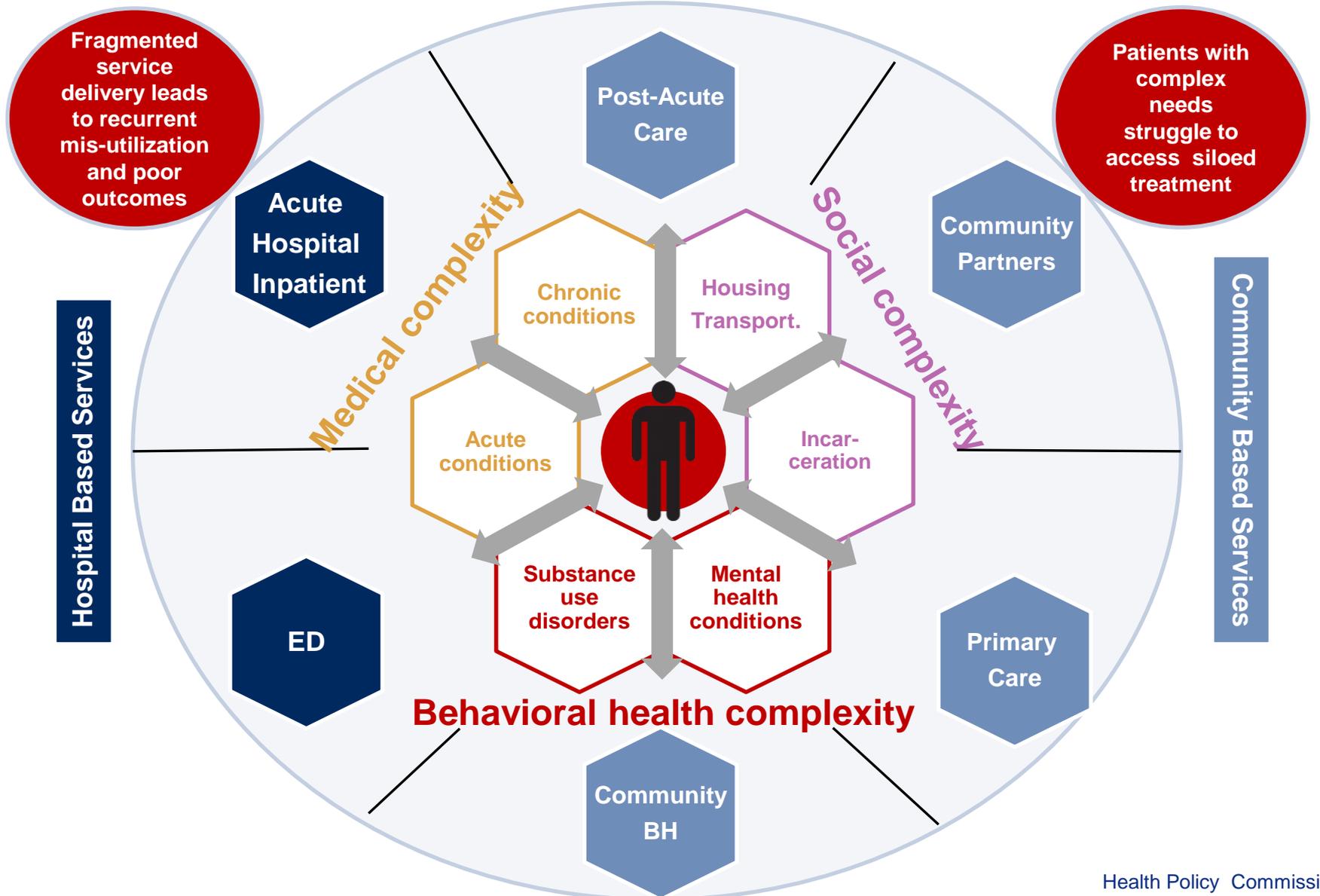


# Investments empower CHART hospitals as integrators, while engaging providers across the continuum through community-oriented models

Primary focus of the majority of initiatives is ↓ hospital use (↓ readmissions and ED visits) and ↑ community care; when patients are in hospital, proposals focus on ↓ LOS and ↑ discharge to appropriate setting with services. Investments are distributed across the continuum.



# Fragmented Service Delivery for Complex Needs

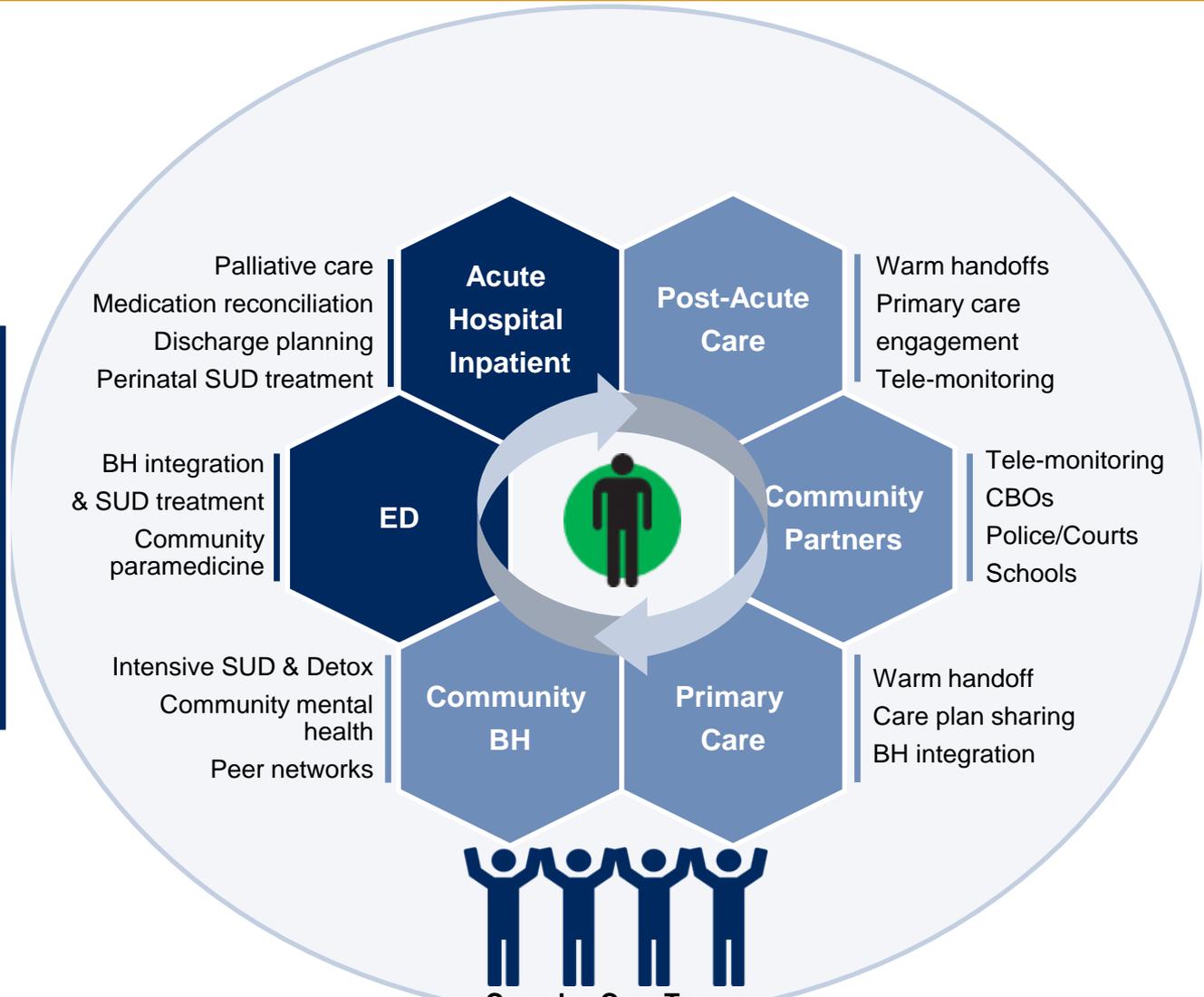


# CHART Care Teams: Coordinated patient care with high intensity services that leverage innovative technology

CHART funding & capacity-building promote integrated BH care that is:

- Patient-centered
- Coordinated
- Efficient

Hospital Based Services



Community Based Services



**Complex Care Teams**  
**Care Navigators / CHWs**  
**Individualized Care Plans**

## Contact Information

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For more information about the Health Policy Commission:

Visit us: <http://www.mass.gov/hpc>

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E-mail us: [HPC-Info@state.ma.us](mailto:HPC-Info@state.ma.us)