Care Delivery and Payment System Reform Committee

Health Policy Commission
July 25, 2013

Agenda

- Approval of minutes from May 20, 2013 meeting
- Update on framework of Patient Centered Medical Home (PCMH) certification
  - CDPSR Committee discussion questions and proposed timeline
  - Next steps
- Update on the registration of provider organizations
- Schedule of next Committee meeting

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Vote: Approving minutes

Motion: That the Care Delivery and Payment System Reform Committee hereby approves the minutes of the Committee meeting held on May 20, 2013, as presented.

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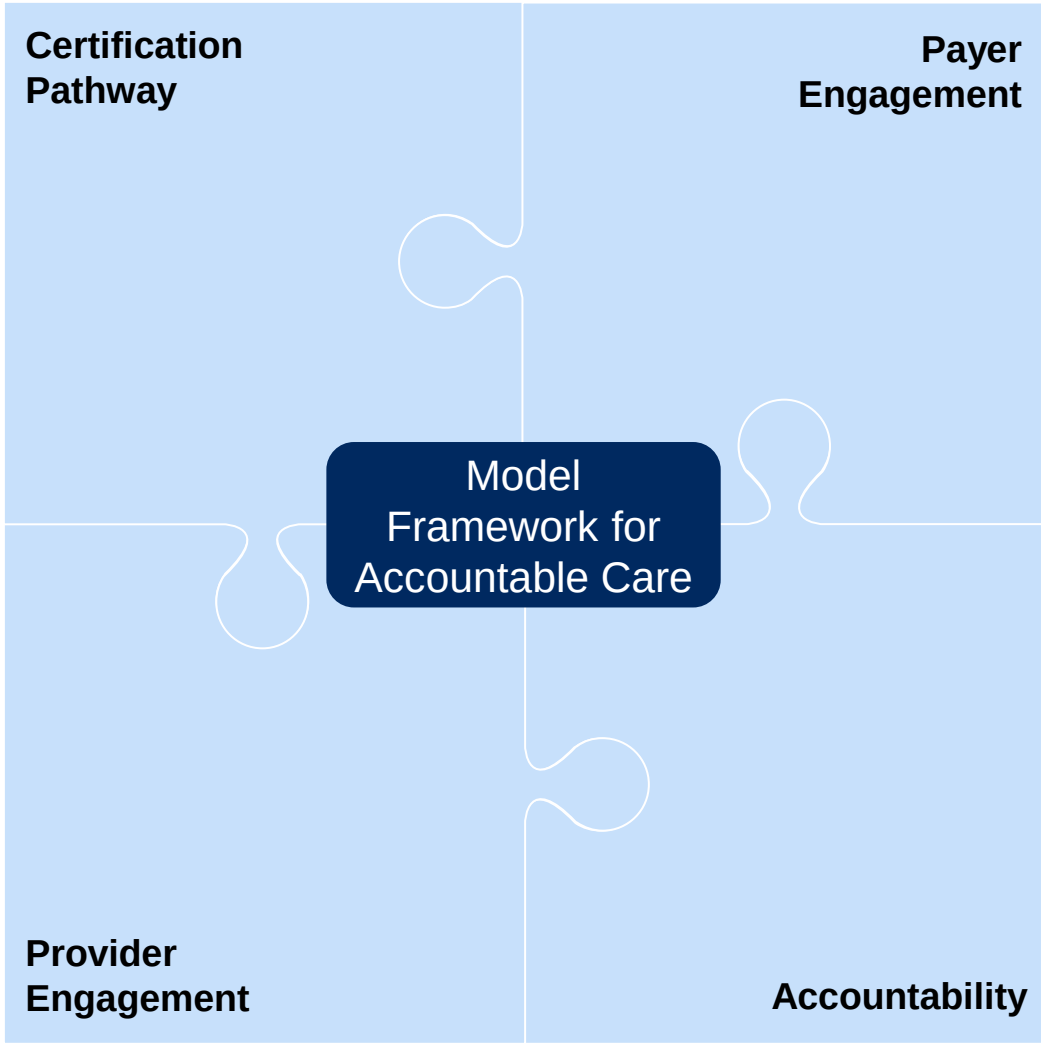
Core components of model framework



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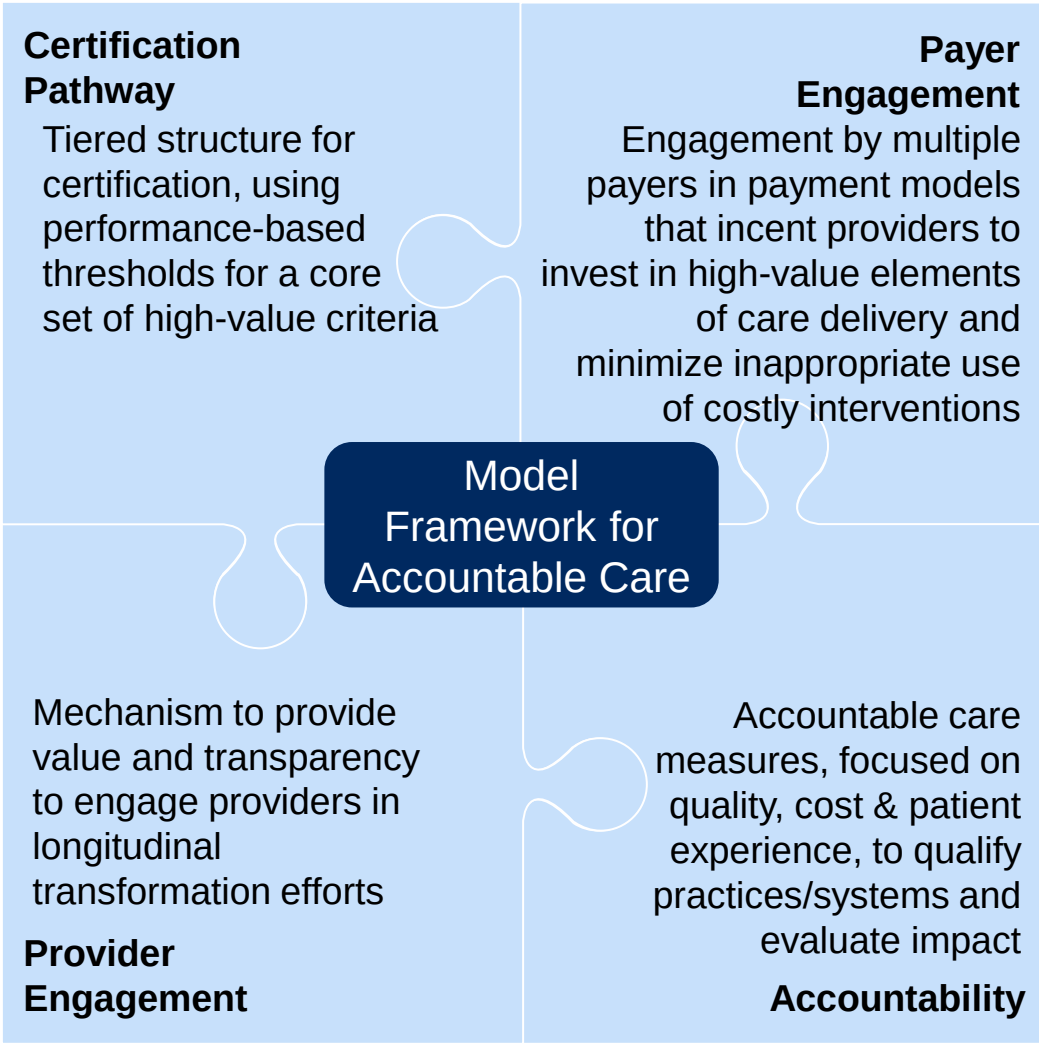
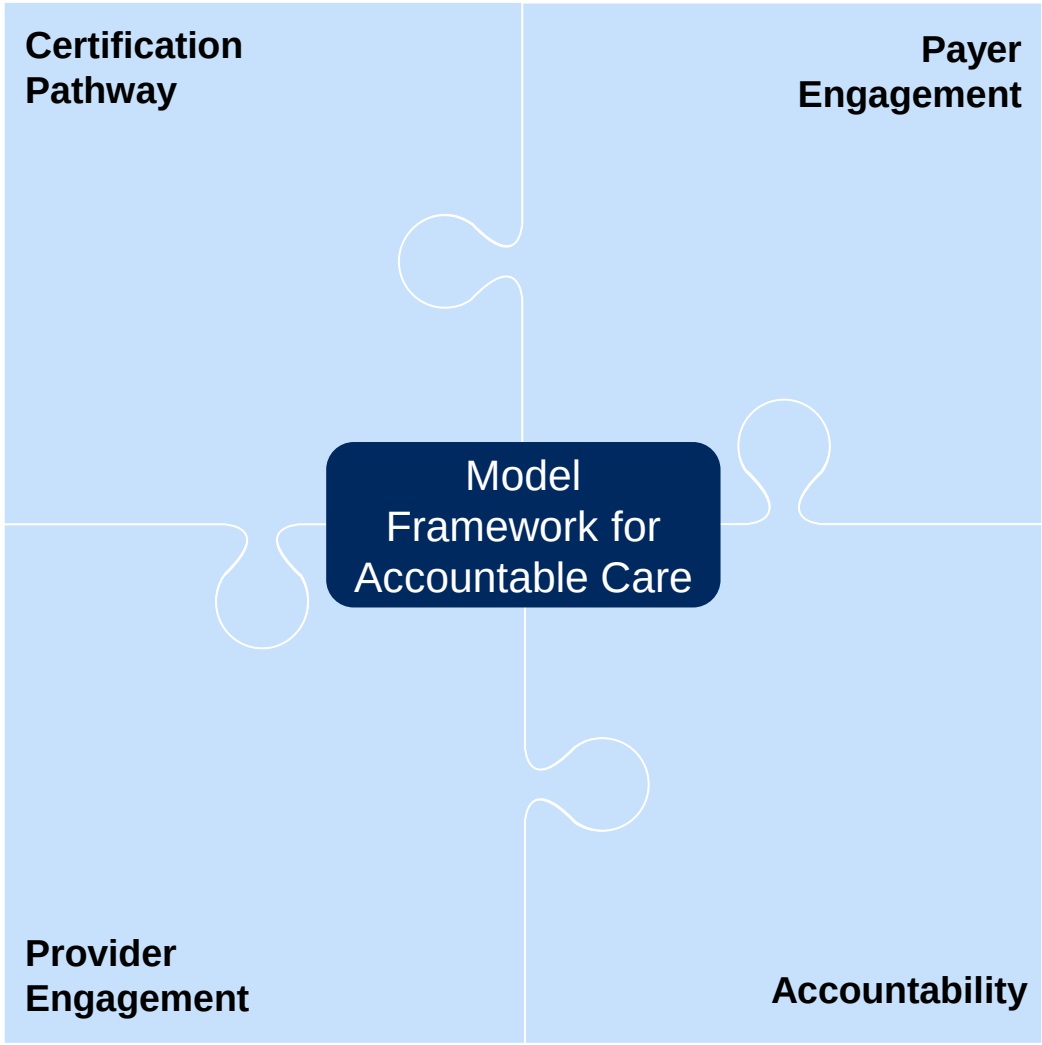


Desired outcome



Care Transformation

A more coordinated, patient-centered health care system that is value-based and performance-driven

Side-by-side components of typical PCMH and ACO (consideration of scale)

	PCMH	ACO
Key players	▪ Primary care practices, including PCPs, specialists, NP, pharmacists, PA, dieticians, SW, BH providers, complementary practitioners	▪ Hospitals ▪ Physician group practices ▪ Networks of individual practices ▪ Partnerships – hospitals/post-acute
Delivery structure	▪ Patient-provider relationship ▪ Physician-led practice ▪ Enhanced access to care ▪ Coordinated and integrated care ▪ Comprehensive continuous care	▪ Multiple providers ▪ Complete & timely info on pts/svcs ▪ Resources/support education/SMS Coordination across providers ▪ Collaboration with community based organizations
Required resources	▪ Electronic health records ▪ Resources for 24-hour care mgmt ▪ Behavioral health integration ▪ Liaison for prevention & treatment	▪ Technology and skills for population management and coordination of care
Accountability	▪ Rests primarily with primary care practice	▪ Joint accountability for care by all providers involved
Payment Structure	▪ FFS (enhanced payments) ▪ Shared savings/risk or bonus payments on quality targets	▪ Capitated/global payments for performance standards at expenditure benchmarks

Source: Adapted from Joshi, M. Patient Centered Medical Home: A Research Synthesis Report. AHA. 2010

Role of HPC

- Complement MassHealth and other local PCMH/ACO capacity-building initiatives
- Provide a value-added process for consumers and payers to define PCMH/ACO
- Adopt a performance-based approach for verification
- Monitor and evaluate the impact of PCMH/ACO on cost, quality, patient experience
- Recognize PCMH/ACO by other accrediting bodies, where appropriate, while providing a pathway for practices/systems to achieve performance-based Certification
- Identify, disseminate and invest in model care delivery innovations

Voluntary certification

- Certification requirements are met upon verification (application, self-assessment, performance results and site visit)
- Regular submission of performance data to maintain or progress on Certification pathway (tiers)
- Access to resources and milestones for Certification
- Engagement of partners/payers to incent practices to enter Certification “pathway”
- Transparency and communication of Certification to create value for providers, payers, and consumers

Lessons from state models (PCMH/ACO)

	Key principles and features	Considerations for HPC
Design	▪ Alignment with national standards ▪ Inclusion of behavioral health, specialists ▪ Multi-payer models ▪ Inclusion of resource stewardship/ accountable care ▪ Increasing expectations for HIT/ Meaningful Use	▪ Defining standards rigorous enough for transformation without presenting barriers to participation ▪ Integrating BH into standards and payment ▪ Inclusion of specialty and behavioral health providers ▪ Shared savings for targeted reductions in utilization ▪ Defining attribution for payment incentives
Administrative	▪ 2-3 year renewal process ▪ Annual maintenance of Certification ▪ Fees not typically applied ▪ Tiered structure for certification & payment ▪ Site visits for validation ▪ Dedicated resources/regionalization of transformation efforts ▪ Measurement: claims (cost and resource use), HEDIS (clinical quality), self-assessment (readiness), on-site audit tools (practice elements), patient experience data	▪ 2-year renewal process ▪ Regular maintenance of Certification ▪ Scale/regional rollout (pilots) ▪ Modeling high-value care delivery (best practices, technical assistance) ▪ Self-assessment on standards and milestones ▪ Verification: documentation requirements and/or performance data

Source: Colorado, Iowa, Maine, Michigan, Minnesota, Nebraska, New York, North Carolina, Oklahoma, Oregon, Vermont, Washington

Evidence on high value elements of accountable care

PCMH

High value: demonstrated impact on quality, cost and patient experience

- Care coordination
- Enhanced access
- Behavioral health integration
- Accessible, real-time data to manage performance and track patients
- Resource stewardship
- Integration & collaboration

ACO

HPC proposed medical home standards

Care coordination	Focuses on patients with chronic and complex care needs, involves the patient and family, aligns resources with population need, emphasizes community resources, and facilitates transitions across the continuum
Enhanced access & communication	Reflects appropriate, consistent and ongoing communication among the Medical Home and the patient/family/caregiver and provides continuous access to manage the patient's health care needs
Integrated clinical care management (focus on BH)	Integrates behavioral health, including substance use disorder and mental health, diagnostic and treatment considerations into comprehensive care management
Population health management	Includes capabilities for electronic searchable patient data to manage health care services, provide appropriate follow-up and identify gaps in patient care
Data Management/ HIE	Align MU criteria and maximize use and transmission of electronic data to support continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services
Resource stewardship	Commitment to efficiency of care by reducing unnecessary healthcare spending, reducing waste, addressing underutilization of services, and improving cost-effective use of health care services

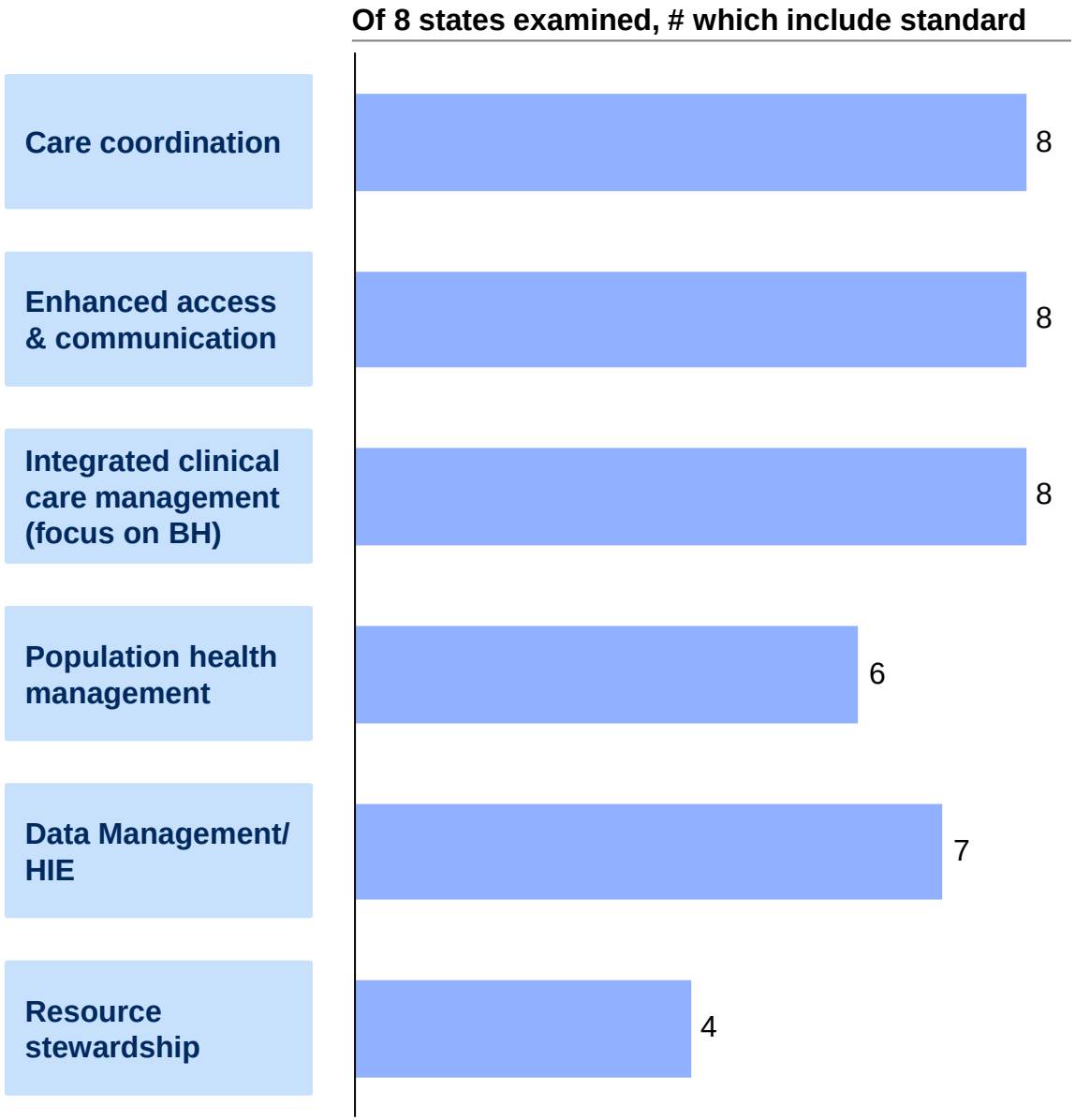
Tiered model framework

Tier 1 Basic	**Tier 2** Advanced	**Tier 3** Optimal
▪ Core structural components ▪ Minimal performance targets ▪ Basic HIT/perf. reporting ▪ Elements in place for integration & resource stewardship	▪ Advanced performance emphasizing outcomes ▪ Advanced care coordination staff and IT infrastructure ▪ High degree of integrated care delivery	▪ Increasingly high performance on cost, quality metrics ▪ Optimal HIT ▪ Fully integrated care

HPC alignment across proposed PCMH and ACO standards

	PCMH	ACO
Care coordination	✓	✓
Enhanced access & communication	✓	✓
Integrated clinical care management (focus on BH)	✓	✓
Population health management	✓	✓
Data Management/ HIE	✓	✓
Resource stewardship	✓	✓
Governance structure		✓
Financial risk arrangements		✓

HPC alignment with state-defined medical home standards



States examined

- Iowa
- Maine
- Michigan
- Minnesota
- Nebraska
- Oklahoma
- Oregon
- Washington

HPC alignment with national medical home accreditation standards

	NCQA	URAC	JC	AAAHC
Care coordination	✓	✓	✓	✓
Enhanced access & communication	✓	✓	✓	✓
Integrated clinical care management (focus on BH)	✓	✓	✓	✓
Population health management	✓	✓	✓	
Data Management/ HIE	✓	✓	✓	✓
Resource stewardship	▪ Proposed for 2014 standards			✓

Proposed NCQA 2014 PCMH Standards

Proposed NCQA Changes

- Further integration of behavioral health
- Focus on resource stewardship
- Encourage sustained commitment to CQI and PCMH transformation
- Expand emphasis on coordination and transitions in care
- Encourage appropriate shared decision making and incorporation of family, patient, and caregiver into care planning and self-management
- Maintain alignment with Meaningful Use requirements

Implications for HPC

- Integrating BH into standards and payment
- Include resource stewardship as standard for PCMH Certification
- Define integration and collaboration for PCMH validation
- Coordination of care criteria will include focus on care transitions
- Focus on integrated clinical care management
- Incorporate MU into HIT/HIE criteria

Source: NCQA PCMH Update: Draft Standards for Public Comment. July 22, 2013

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CDPSR committee discussion questions

1. HPC role
2. High-value components
3. Tiered pathway
4. Eligibility
5. Behavioral health integration
6. HIT/HIE
7. Measurement
8. Resource stewardship
9. Integration and collaboration
10. Validation process

1 HPC role

HPC seeks to establish a Certification program as a mechanism to validate performance on core high-value standards and criteria.

As HPC seeks to complement existing local and national PCMH capacity-building efforts, how can we be <u>best positioned</u> as a neutral body to validate Medical Homes and ultimately promote investments by payers in efficient, high-quality and cost-effective primary care transformation efforts in the Commonwealth?

2 High value components

One of the core principles of the proposed PCMH (and ACO) certification program, is the focus on high-value elements of care – those areas with the greatest impact on improving quality and patient experience, while reducing costs.

As we begin to understand and apply the evidence-base on high-value components of PCMH, we appreciate the opportunity to hear from the Committee on those elements that demonstrate measurable improvements in quality, cost and patient experience, and reaction to the proposed list of draft standards for HPC PCMH Certification (slide 12).

3 Tiered pathway

HPC seeks to provide a tiered pathway toward certification, with the aim of accelerating the adoption of medical home (beyond the current 10% of PCMH certified practices in MA)

What are some considerations for <u>tiered HPC Certification</u> with regard to setting thresholds for performance and recognizing the varying capabilities of providers, such as how to address criteria for small practices, or specialty providers, etc.?

4 Eligibility for PCMH certification

HPC is most interested in the opportunity to engage providers and health systems in sustained transformation toward integrated and accountable care. This includes the opportunity to work with a broad array of providers, practices and systems for PCMH and ACO certification.

As HPC seeks to design a generally applicable set of high-value standards, criteria and measures for PCMH Certification, we welcome feedback on the opportunity to include a wide array of eligible practices and providers, including specialty care and behavioral health providers.

5 Behavioral health integration

Integrating behavioral health with physical care is one of the key priorities in Chapter 224.

As we review the evidence and national best practices, we appreciate hearing from the Committee on recommended models and strategies for integrating behavioral health that are both measureable and impactful on key clinical, system, and efficiency outcomes.

In addition, we welcome opportunities to address payment alignment in the context of a potential behavioral health carve-out.

6 HIT/HIE

One of the key challenges for meeting and sustaining the necessary components for a Medical Home are investments by a practice/health system for staff, systems and infrastructure.

As HPC seeks to leverage and complement other HIT investments and MU reporting requirements, what do we need to consider for the varying degrees of HIT/HIE capacity currently in the market, as it relates to PCMH standards and certification?

7 Measurement

HPC aims to minimize the burden of reporting for prospective PCMH practices interested in the voluntary certification program. We hope to accomplish the performance-based component of validation by reviewing a core set of quality and utilization data currently reported by providers.

Are there other measurement considerations for collecting meaningful data on areas such as patient experience, integration and resource stewardship, without adding burden to providers?

8 Resource stewardship

Resource stewardship, or the appropriate allocation of resources, is a critical area of focus for high-quality and efficient medical homes. In addition, it's important to assure that the necessary and recommended care is delivered, and not omitted, for the best results.

How can HPC evaluate how practices are demonstrating resource stewardship, such as integrating Choosing Wisely or other practice models for addressing overuse/misuse/underuse?

9 Integration and collaboration

Collaboration among providers is a core attribute of accountable care. HPC is interested in considering structural features that may be assessed as part of the PCMH Certification process, particularly as we understand the capabilities of practices and health systems to achieve fully integrated care.

What aspects of collaboration and integration should HPC consider for PCMH Certification? These may include features such as shared risk arrangements, telemedicine agreements, co-location of services, etc.

10 Validation process

Our aim is to create a valid and objective approach for HPC Certification, while minimized the burden on providers and health systems. Ultimately, this will include a simplified application process, self-assessment of readiness, validation of performance data, and the potential for site visits to provide technical support and understand best practices that may be disseminated more broadly.

Keeping that goal in mind, what should we consider as we design an objective and reliable approach to validate PCMH performance?

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Program design considerations

Payment model design

- Better understand current landscape of payment model variation for PCMH and other primary care payment incentives
- Engage stakeholders to define tiered payment model design and parameters (MassHealth, MAHP, payers)
- Allow customization of payer incentive payments, across uniform standards and tiered performance thresholds
- Engage at least 2 payers for PCMH pilot
- Design evaluation of PCMH pilot (standards and payment models) to assess impact and inform implementation planning (roll-out)

Care model design

- Build on foundation of other MA health reform initiatives
- Consider community-based and regional opportunities to initiate PCMH certification program
- Establish pilot to test new models and build core foundation
- Solicit input from all interested parties and build stakeholder support
- Consider variations in model design for wider applicability

PCMH payment model should address drivers of accountable care

PCMH Payment model

Blended Hybrid Payment Model

(expanding upon the existing fee-for-service paradigm)

Key drivers of accountable care

Performance Standards

- Care coordination
- Enhanced access to care
- Integrated clinical CM (BH)
- Population-based management
- Real-time data tracking
- Resource stewardship

Payment models can be tailored to appropriate level of risk for providers

Example payment structures

- Pay-for-performance (e.g. quality incentives)
- Shared savings PCMH models
- MSSP ACOs
- Retrospective episode-based payment
- Global capitated payments
- Bundled payments for episodes

Care model program timeline (Year 1)

Q3 2013	Q4 2013	Q1 2014	Q2 2014
▪ HPC certification framework ▪ PCMH standards & criteria ▪ PCMH measures ▪ Payment model research ▪ Technical advisors	▪ Payment model design ▪ Reporting and monitoring methods ▪ Tiered pathway model ▪ PCMH Pilot & evaluation design	▪ Payer and practice engagement ▪ Training & technical assistance resources ▪ PCMH Pilot launch	▪ ACO standards & measures ▪ ACO program design ▪ Technical advisors ▪ PCMH Pilot evaluation (Phase I)

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Registered Provider Organizations – Three key aims

1. RPO **enhances transparency** of the health care marketplace in the Commonwealth by gathering information on the **composition, structure and relationships** among and within Massachusetts health care providers.

2. RPO **maps the provider delivery system**, including clinical affiliations, capacity, and market share, and monitors changes over time.

3. RPO creates a **centralized resource** for the Commonwealth and other stakeholders by compiling information about the provider market. RPO supports such functions as health resource planning, determinations of need, cost and market impact reviews, evaluation of health care cost trends, health system investments, and certification programs.

What does the HPC process look like?

Who must register?

- Any provider[1] or provider organization[2] that is a risk-bearing provider organization (as defined by DOI)
- Any provider or provider organization
  - with a patient panel greater than 15,000 and
  - which represents providers who collectively receive $25,000,000 or more in annual net patient service revenue from carriers or third-party administrators

Identifying RPOs

- DOI to provide list of RBPOs. All RBPOs to receive notification
- Any provider/provider organization determined to meet the NPSR threshold to receive notification
  - Including, e.g., hospitals, IPAs, PHOs, SNFs, CHCs
- Notified provider/provider organization is presumed to have a patient panel greater than 15,000
  - "Patient panel" defined to account for those facilities where a traditional patient panel is inapplicable
- Notified provider/provider organization registers as an RPO *or* provides compelling evidence of non-applicability

1 "Provider" is any person, corporation, partnership, governmental unit, state institution or any other entity qualified under the laws of the commonwealth to perform or provide health care services

2 "Provider organization" is any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services

Reporting requirements

Statutory mandates (HPC & CHIA)[1]

- **Organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations, parent entities, corporate affiliates, and community advisory boards**
- **Number of affiliated health care professional full-time equivalents and the number of professionals affiliated with or employed by the organization;**
- **Name and address of licensed facilities**
- Comprehensive financial statement
- Information on stop-loss insurance and any non-fee-for-service payment arrangements
- Information on clinical quality, care coordination and patient referral practices
- Information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions
- Information regarding charitable care and community benefit programs
- For risk-bearing provider organizations, a certificate from the division of insurance under chapter 176U

Additional reporting requirements

- **Such other information as HPC and CHIA consider appropriate**

1 M.G.L. Chapter 6D, Section 11 and M.G.L. Chapter 12C, Section 9

How do we plan to develop our regulations?

Principles

- Avoid duplication and promote administrative simplification through cross-agency collaboration and provider engagement
- Support DOI's Risk-bearing Provider Organization certification process
- Support cross-agency data needs, including e.g. health planning
- Coordinate with other agencies/entities
  - Center for Health Information and Analysis
  - Division of Insurance
  - Executive Office of Health and Human Services
  - Department of Public Health
  - MassHealth
  - Boards of Registration for health care providers

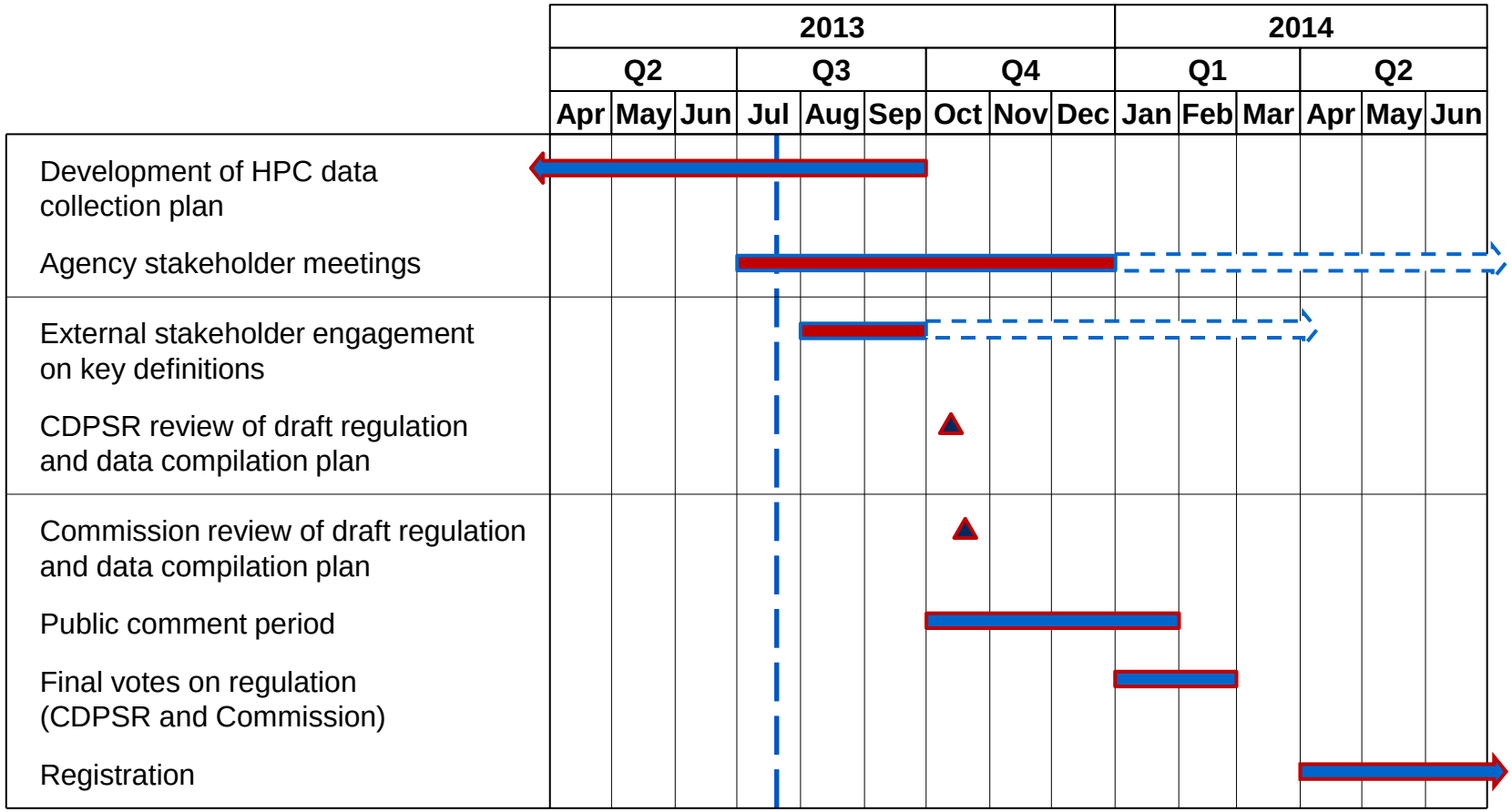
Work to date

- Joint DOI-HPC Listening Sessions
- Feedback Received
  - Different types of provider organizational structures, relationships with affiliated physicians
  - Nature of information ordinarily developed in the course of business, or reported to other agencies or health plans
- Ongoing collaboration with DOI and CHIA
  - Developing streamlined reporting mechanisms and ensuring consistency in definitions

RPO work plan

	Meet with Stakeholders	Build Consensus	Finalize Deliverables
Assessing HPC's Internal Needs	▪ Met with HPC directors to discuss RPO data	▪ Reach consensus on data elements to include in Phase 1 Implementation of RPO	▪ Data definitions compilation plan for HPC drafted
Assessing Other Agencies' Needs	▪ Meeting with sister agencies (especially CHIA) to discuss RPO data, and ensure administrative simplification	▪ Reach HPC/CHIA/DOI consensus on data elements and definitions to include in Phase 1	▪ Build additional elements into data compilation plan
Regulation	▪ Drafting regulation based on stakeholder input	▪ Circulate draft regulation among agencies (EOHHS, AGO, ANF, CHIA, DOI, DPH, others)	▪ RPO regulation to Committee for review → promulgation process
Implementation	▪ Developing implementation plan, including data collection infrastructure. Solicit input from stakeholders.	▪ Reach consensus on implementation plan among key agencies	▪ Develop collection mechanism and launch upon regulation promulgation

Draft RPO timeline



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Contact information

For more information about the Health Policy Commission:

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