Care Delivery and Payment System Transformation Committee

Health Policy Commission

August 13, 2014

Agenda

- Approval of minutes from July 2, 2014, meeting
- Discussion of Cost Trends Report
- Discussion of the HPC Accountable Care Organization Certification Program
- Presentation by Boston Medical Center
- Schedule of Next Committee Meeting (October 29, 2014)

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Vote: Approving minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on July 2, 2014, as presented.

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Topics in the July 2014 Supplement

LONG-TERM CARE AND HOME HEALTH

Highlights from 2013 report

- In 2009, Massachusetts spent 72% more per capita on long-term care and home health than the U.S. average

July 2014 findings

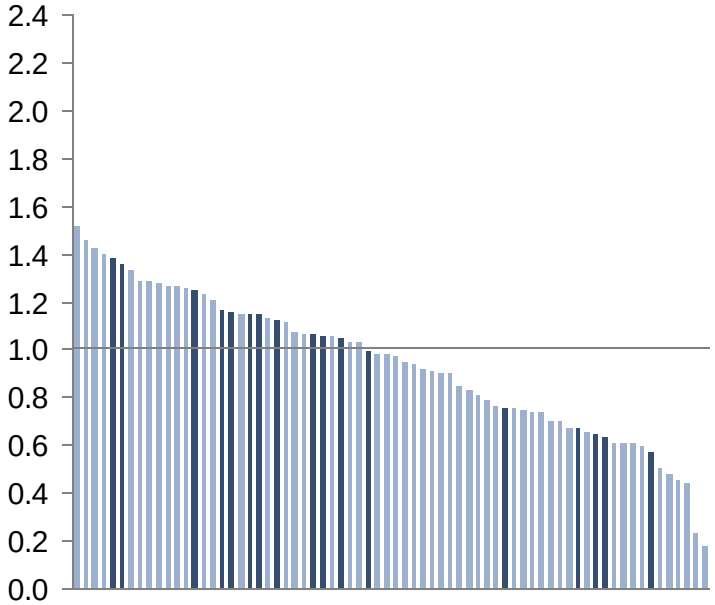
- The age of the population and Massachusetts price levels contribute to higher spending on long-term care, but there is also a large utilization difference not accounted for by demographics
- Nursing home residents covered by MassHealth have a lower average level of disability than the U.S. average for Medicaid nursing home residents
- After a hospitalization, the average Massachusetts resident is relatively more likely to be discharged to post-acute care, and rates of discharge to post-acute care vary widely across Massachusetts hospitals

Massachusetts hospitals vary widely in their rate of post-acute care use and in the setting selected

Long-term care and home health

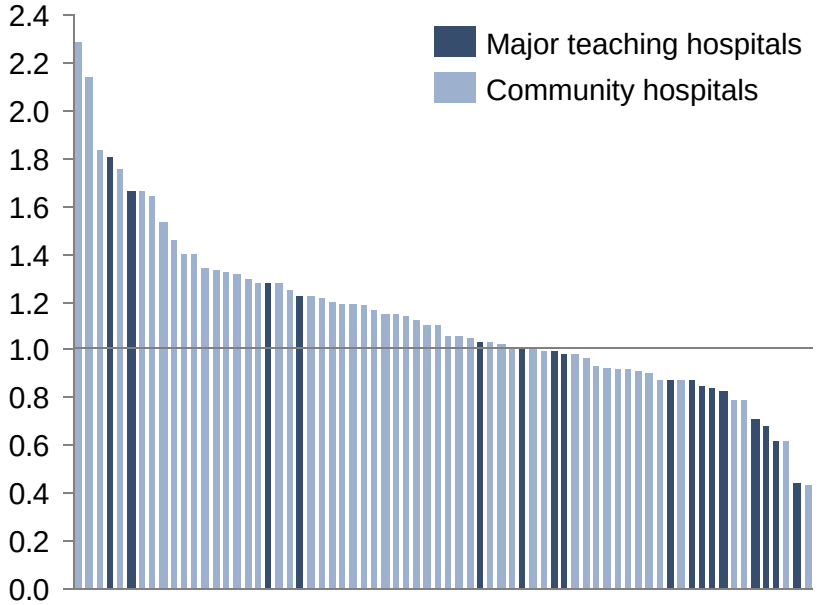
RATES OF DISCHARGE TO POST-ACUTE CARE

Adjusted rate of discharge to nursing facilities and home health, 2012*



RATES OF USE OF NURSING FACILITIES AS POST-ACUTE CARE SETTING

Adjusted rate of use of nursing facility as setting for post-acute care,†, 2012*



* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the state average rate equal to 1.0.

† Discharge to nursing facility as a proportion of total discharges to either nursing facility or home health.

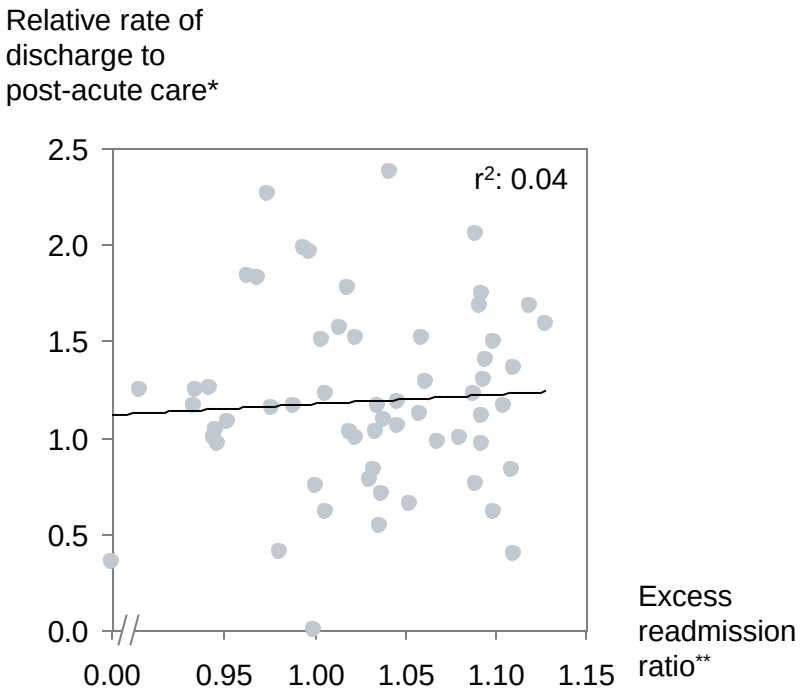
SOURCE: Center for Health Information and Analysis; HPC analysis

Massachusetts hospitals' rates of discharge to post-acute care do not correlate with their readmissions rates or average lengths of stay

Long-term care and home health

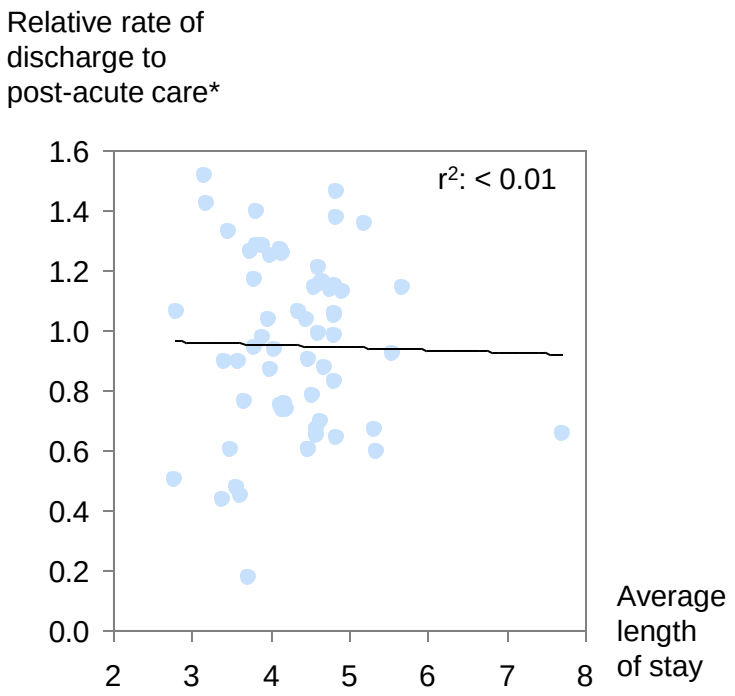
RATES OF DISCHARGE TO POST-ACUTE CARE AND EXCESS READMISSION RATIOS BY HOSPITAL

Massachusetts general acute hospitals, 2012



RATES OF DISCHARGE TO POST-ACUTE CARE AND AVERAGE LENGTHS OF STAY BY HOSPITAL

Massachusetts general acute hospitals, 2012



* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the statewide average equal to 1.0.

† Composite of risk-standardized 30-day Medicare excess readmission ratios for acute myocardial infarction, heart failure, and pneumonia (2009-2011). The composite rate is a weighted average of the three condition-specific rates. 1.0 represents national average.

SOURCE: Center for Health Information and Analysis; Centers for Medicare & Medicaid Services; HPC analysis

Topics in the July 2014 supplement

PROFILE OF INPATIENT CARE IN MASSACHUSETTS

Highlights from 2013 report

- Massachusetts has a 10 percent higher rate of inpatient admissions than the national average, adjusted for age differences
- 40% of Massachusetts Medicare discharges were at major teaching hospitals in 2011, compared to 16% nationwide

July 2014 findings

- Massachusetts' higher rate of inpatient admissions is concentrated in the medical service category, and there is room for continued improvement in reducing the rate of hospitalization for ambulatory care-sensitive conditions
- Many Massachusetts residents leave their home region to seek inpatient care in Boston, a pattern that is more pronounced among those with commercial insurance and residents of higher-income communities

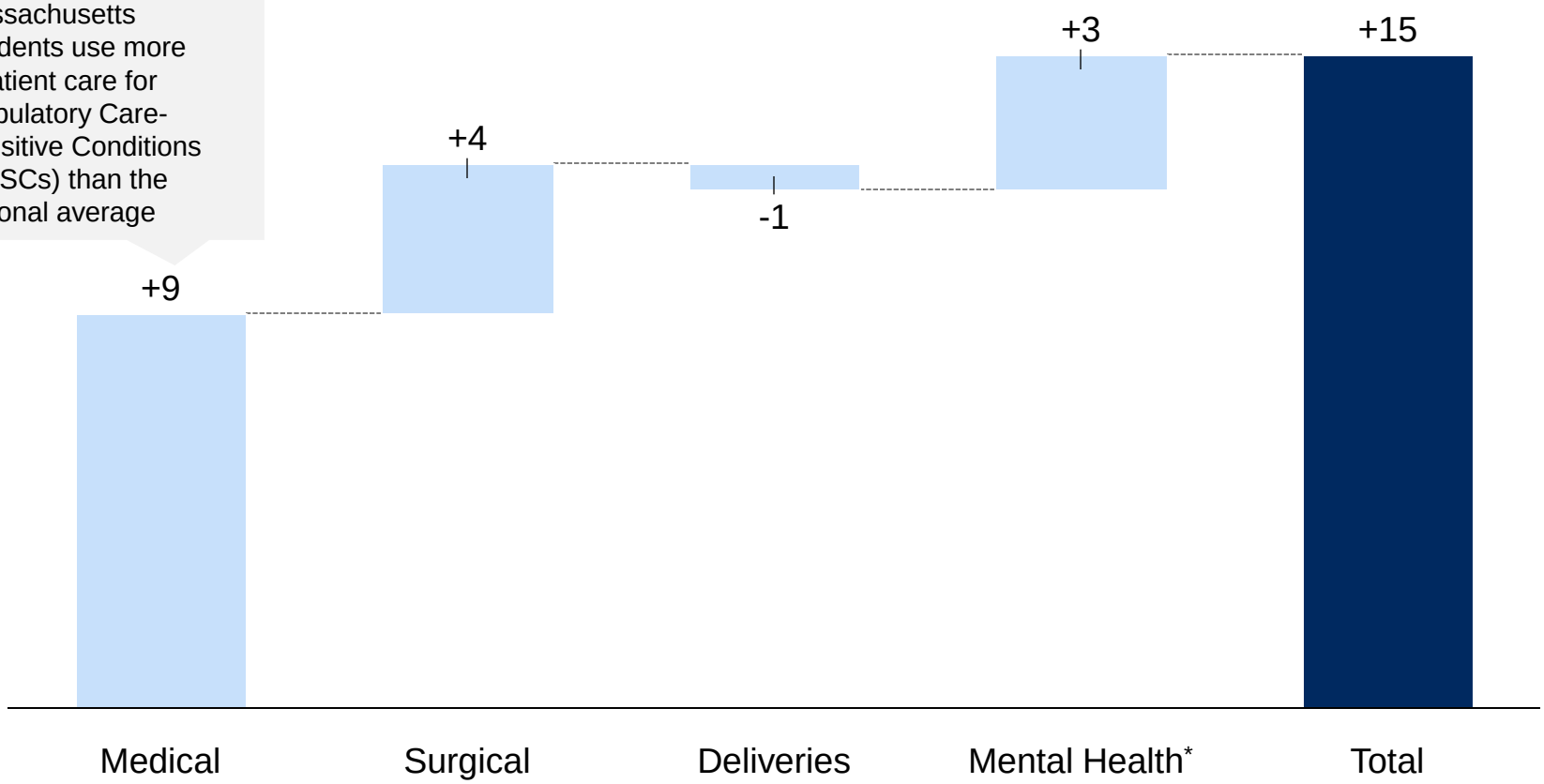
Massachusetts' higher use of inpatient care is concentrated among medical discharges

Profile of inpatient care

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

Inpatient discharges per 1,000 persons, 2011

Massachusetts residents use more inpatient care for Ambulatory Care-Sensitive Conditions (ACSCs) than the national average



* Based on discharges in general acute hospitals. Data exclude discharges in specialty psychiatric hospitals.

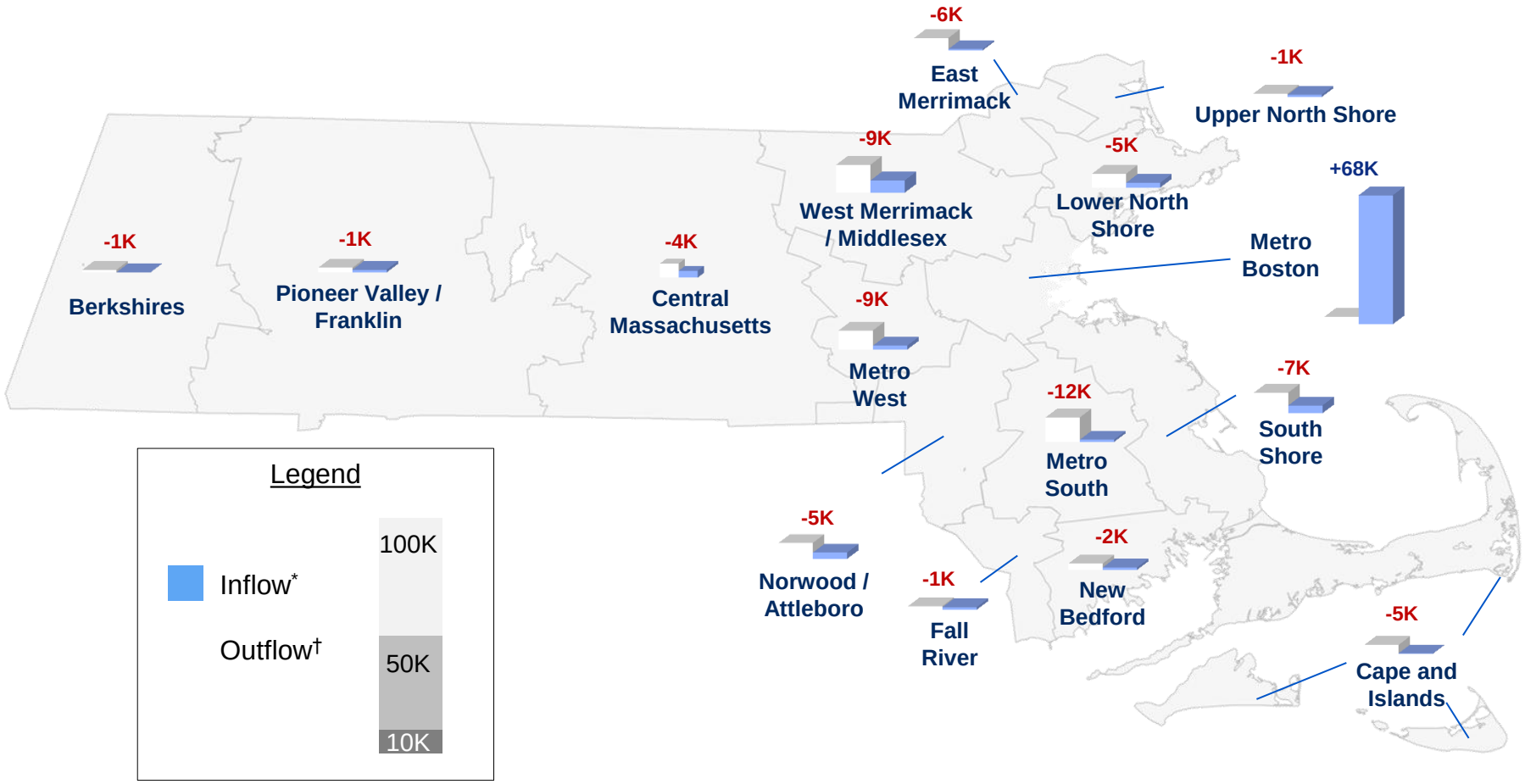
SOURCE: Agency for Healthcare Research and Quality, Kaiser Family Foundation, American Hospital Association

Most Massachusetts residents who leave their home region for inpatient care seek their care in Metro Boston

Profile of inpatient care

DISCHARGES FLOWS IN AND OUT OF MASSACHUSETTS REGIONS

Number of inpatient discharges for non-emergency, non-transfer volume, 2012



* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
SOURCE: Center for Health Information and Analysis; HPC analysis

Topics in the July 2014 supplement

ALTERNATIVE PAYMENT METHODS

Highlights from 2013 report

- Medicare and commercial payers in Massachusetts have increasingly adopted alternative payment methods that establish a global budget for provider organizations

July 2014 findings

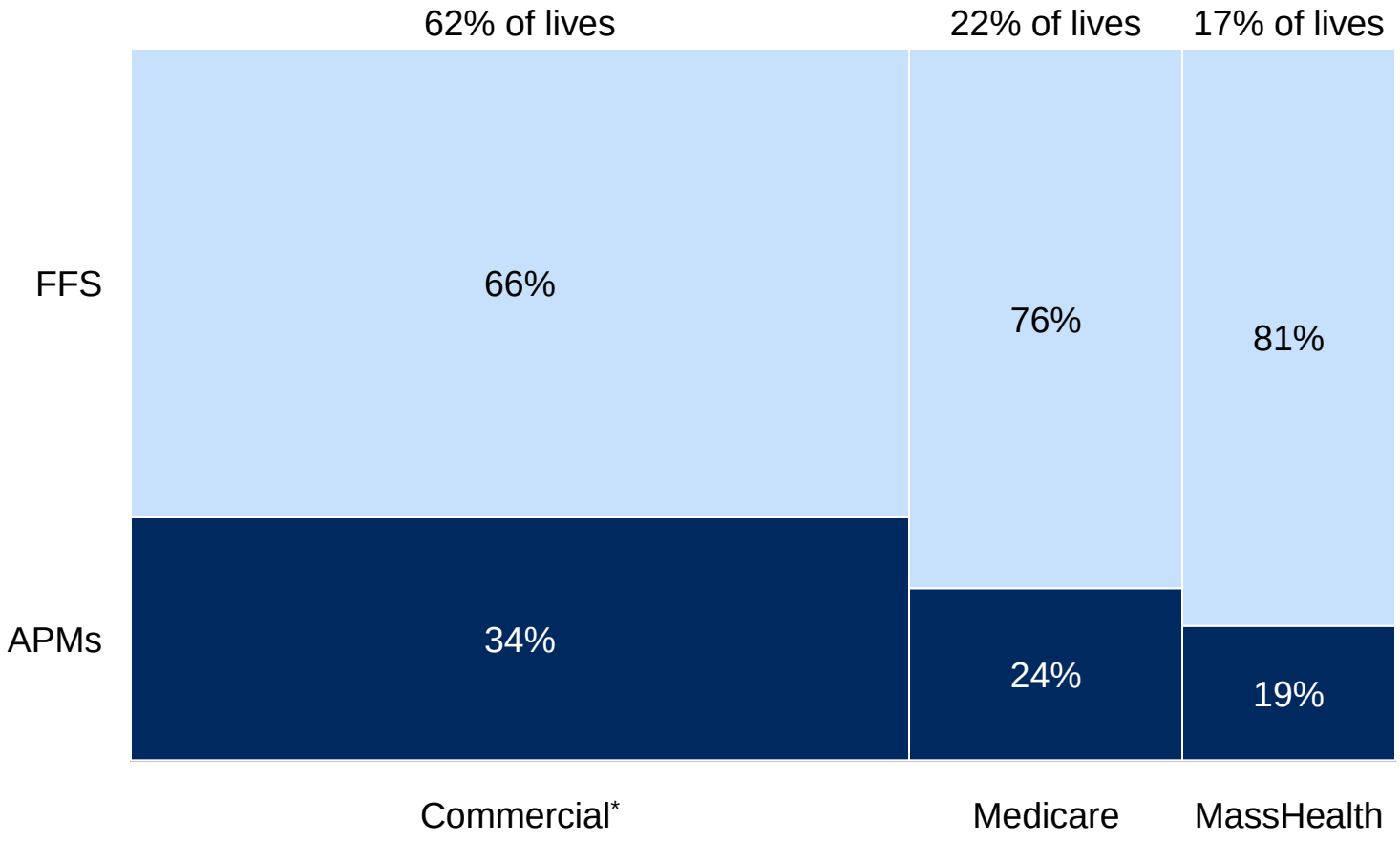
- At the end of 2012, alternative payment methods covered 29 percent of insured Massachusetts residents
- Opportunities exist to expand APM coverage and strengthen implementation

Across all payers, 29 percent of Massachusetts residents were covered by global budget APMs in 2012

Alternative payment methods

ALTERNATIVE PAYMENT METHOD COVERAGE BY PAYER TYPE

Percent of members/beneficiaries covered by global budget APMs, 2012



29%

of members were covered by APMs across commercial, Medicare, and MassHealth populations

* Includes Commonwealth Care

SOURCE: Center for Health Information and Analysis; MassHealth; Centers for Medicare & Medicaid Services; HPC analysis

Opportunities exist to expand APM coverage and strengthen implementation

Alternative payment methods

Expansion in APM coverage

Enrolling additional provider organizations	▪ Transition of commercial contracts from fee-for-service arrangements to shared savings or risk-based global budgets ▪ Growth in provider participation in Medicare demonstrations ▪ Expanded adoption of APMs for MassHealth (e.g. PCPR initiative, waiver)
Expanding commercial APMs to PPO members	▪ Review and improvement of methods for attribution of PPO members to primary care providers ▪ Examination of barriers slowing implementation of attribution methodology required for adoption of APMs for PPO members

Improvements in APM implementation

Improving global budget-based models	▪ Review and evaluation of varied approaches to payment model design and implementation (e.g. level of risk sharing, quality measures and incentives, services covered, requirements for stop-loss insurance) ▪ Identification of opportunities for increased alignment ▪ Examination of how incentives flow to individuals within provider organizations
Considering models outside of global budgets	▪ Innovation to enable care delivery organizations without aligned primary care providers - such as specialist physician groups without primary care providers – to move away from fee-for-service payment ▪ Review of models in other states (e.g., Arkansas episodes of care, Maryland total patient revenue)

Topics in the July 2014 supplement

INCOME-BASED DISPARITIES IN PREVENTABLE HOSPITAL ADMISSIONS

Highlights from 2013 report

- There was an estimated $700 million in spending associated with potentially preventable hospital readmissions in 2009

July 2014 findings

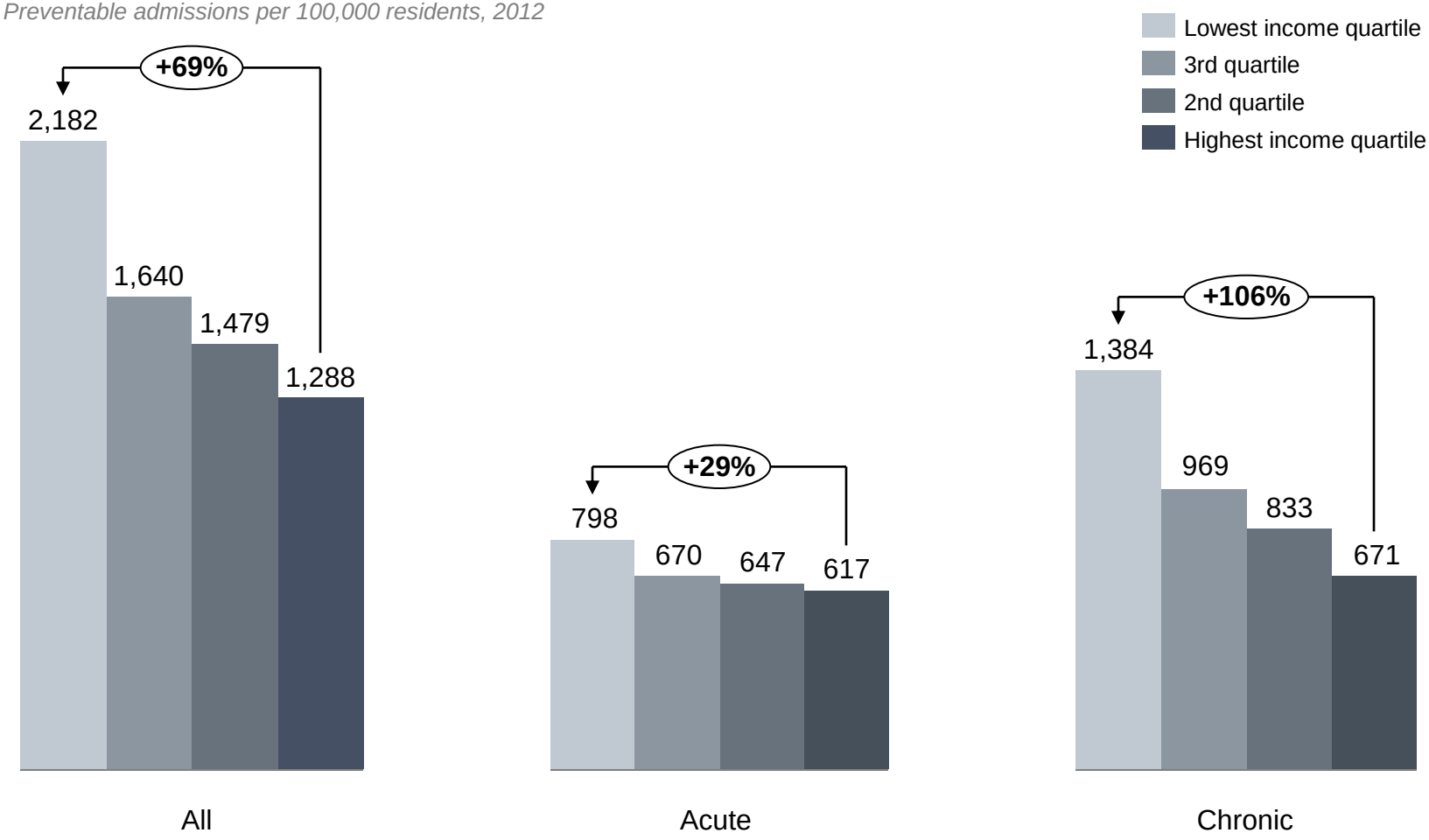
- Rates of preventable admission are much higher in lower-income communities than in higher-income communities, suggesting an opportunity to improve outcomes and reduce cost through targeted community supports and improved ambulatory care
- Income-based disparities in rates of preventable admissions are especially high for chronic conditions such as COPD, asthma, and diabetes

Rates of preventable admission are markedly higher in lower-income communities than in higher-income communities

Preventable hospitalizations

RATES OF PREVENTABLE HOSPITAL ADMISSIONS BY INCOME QUARTILE*

Preventable admissions per 100,000 residents, 2012



* Income was estimated using the median household income for the patient's zip code. Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

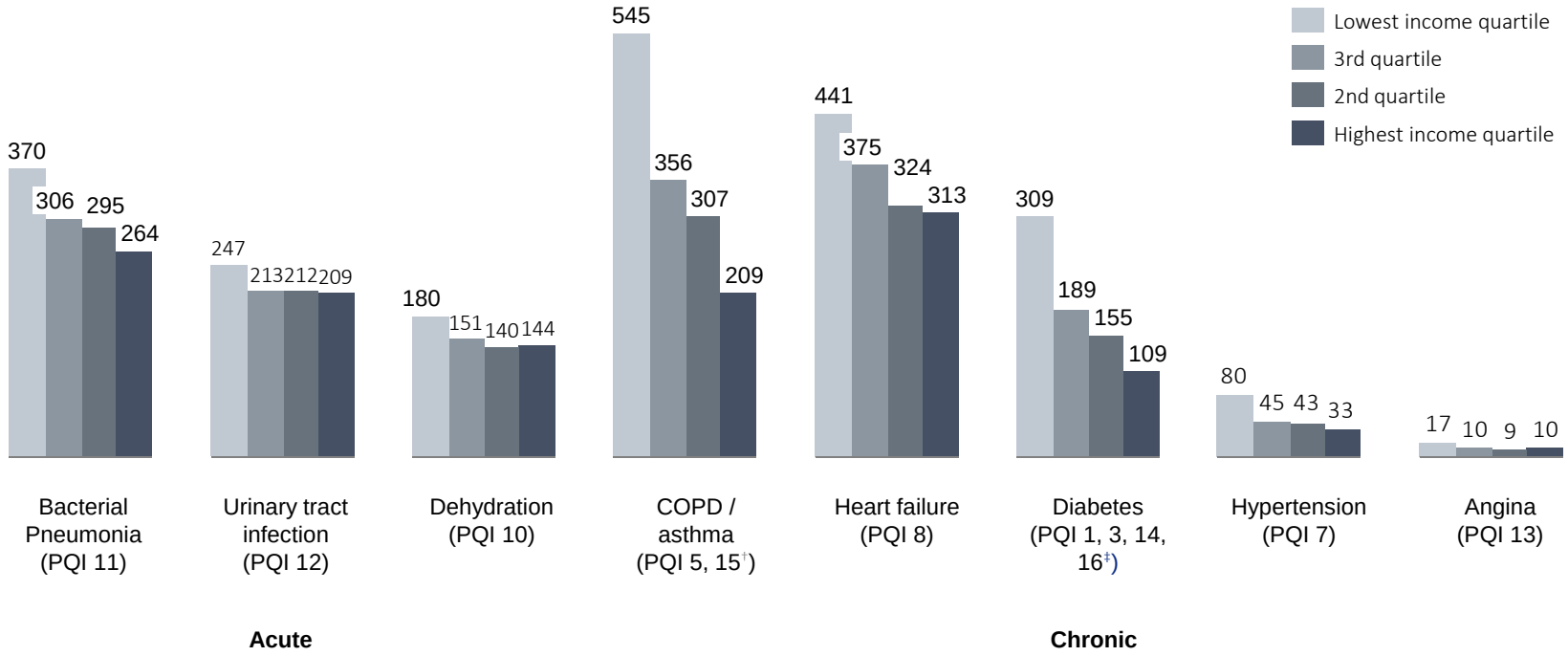
Source: Center for Health Information and Analysis; HPC analysis

Chronic conditions like COPD, asthma, and diabetes have the largest differences in rates of preventable hospital admissions by income

Preventable hospitalizations

RATES OF PREVENTABLE ADMISSIONS FOR ACUTE AND CHRONIC CONDITIONS BY INCOME QUARTILE*

Preventable admissions per 100,000 residents, 2012



* Income was estimated using the median household income for the patient's zip code. Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

† Composite of PQI 5 (COPD or asthma in older adults) and PQI 15 (asthma in younger adults)

‡ Composite of PQI 1 (short-term complications for diabetes), PQI 3 (long-term complications for diabetes), PQI 14 (uncontrolled diabetes), and PQI 16 (amputation among diabetes)

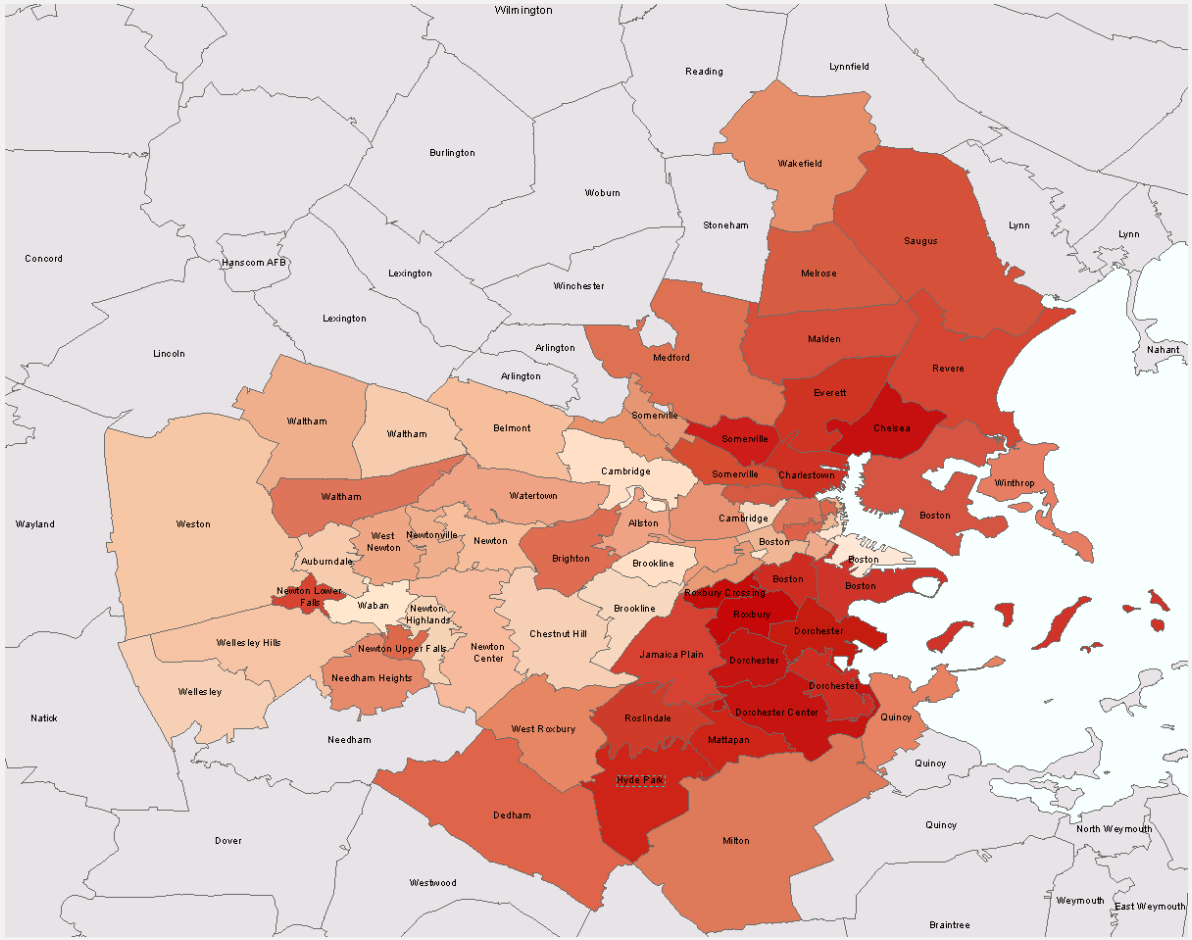
Source: Center for Health Information and Analysis; HPC analysis

Rates of preventable hospital admissions can vary dramatically between communities within a metropolitan area

Preventable hospitalizations

METRO BOSTON EXAMPLE: RATES OF PREVENTABLE ADMISSIONS BY ZIP CODE*

Preventable admissions per 100,000 residents, 2012



2,800 preventable admissions per 100,000 residents

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* Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

Source: Center for Health Information and Analysis; HPC analysis

Recommendations from July Report and HPC's Plans to Address Them

	Recommendations in July 2014 Cost Trends Supplement	HPC plans for remainder of 2014
Value-based market	• **HPC** will study impact of new insurance products and increased cost-sharing	• HPC December cost trends report and October hearing
	• If **providers** grow, they should pursue lower cost settings	• HPC cost and market impact reviews
	• **HPC** will examine flows to AMCs and identify policy solutions	• HPC community hospital study and October cost trends hearing
Efficient, high-quality, patient centered delivery system	• **Hospitals** should work to optimize PAC, including care coordination and transitions for BH patients • Where applicable. **HPC** will support via CHART	• CHART Phase 2 • HPC December cost trends report and October hearing
	• **Payers and providers** should continue to pursue BH integration • **HPC** will support via its certification programs	• CHART Phase 2 • HPC PCMH and ACO work • HPC December cost trends report and October hearing
Advancing APMs	• **HPC** will study APMs to evaluate effectiveness and identify opportunities for improvement	• CHART Phase 2 • HPC December cost trends report and October hearing • HPC PCMH and ACO work
	• **Payers** should review, improve, and align attribution • **HPC** will explore opportunities to accelerate progress	• October cost trends hearing • HPC working together with CHIA and market participants on this topic
Transparency and data	• **CHIA** should convene state agencies to strengthen transparency, data, and measurement for behavioral health	• HPC December cost trends report • RPO program
	• **CHIA** should extend TME measurement to PPO populations, using an agreed-upon method for attribution • **HPC** will seek to work with CHIA to design measures of contribution to spending growth for additional provider types	• HPC October cost trends hearing • HPC working together with CHIA and market participants on this topic

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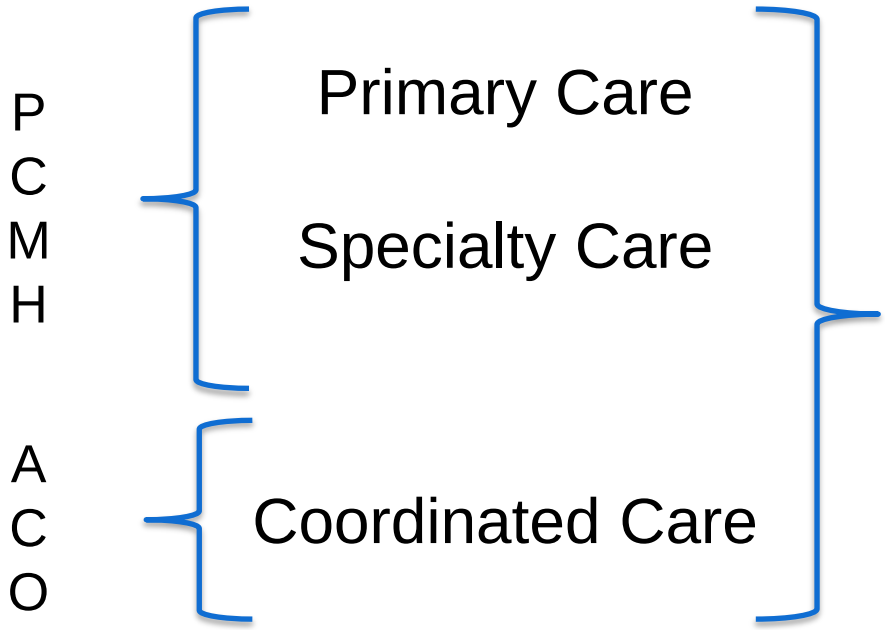
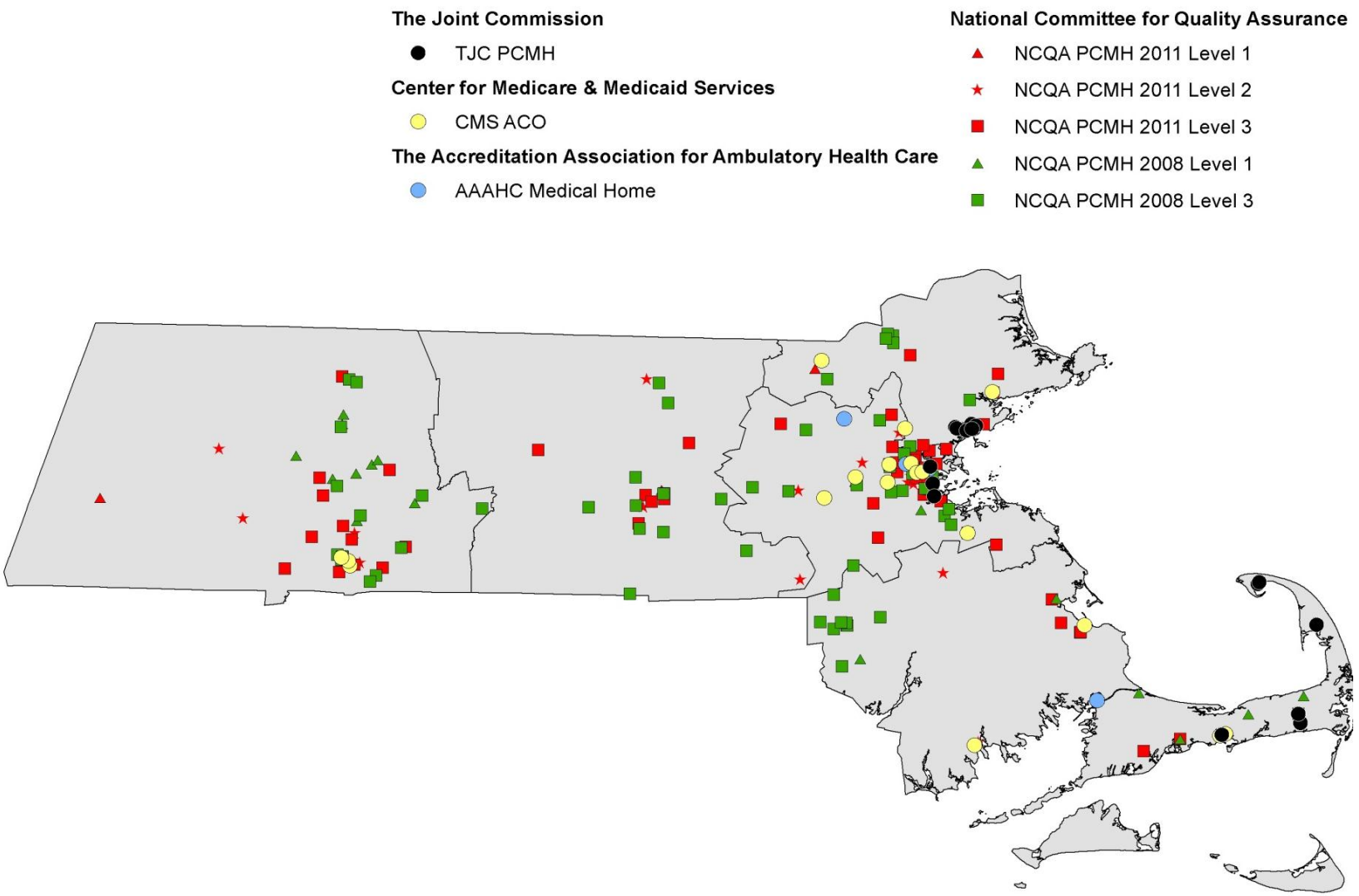
Framework for accountable care



Accountable Care Certification

A unified framework for promoting, validating and monitoring the adoption and impact of accountable care in the Commonwealth

Massachusetts Medical Homes and ACOs



Source: Primary address of PCMH accredited practice sites and CMS ACOs in MA

What is ACO?

CMS Definition

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** (or potential losses) it achieves.

Defining ACOs in Chapter 224

Statutory Definition	Chapter 224 defines an “Accountable Care Organization” or “ACO,” as a provider organization certified under section 15.
HPC’s Authority	The legislation grants the HPC broad authority to establish a process for certifying certain provider organizations as ACOs.
Goals of ACO Certification	The underlying goals of the ACO certification process is to encourage the adoption of coordinated care delivery systems in the commonwealth for the purpose of cost containment, quality improvement and patient protection.

Statutory Responsibilities

In developing an ACO certification process, Chapter 224 charges the HPC with the following responsibilities:

- **Developing and implementing** standards for voluntary certification of registered provider organizations to be certified as ACOs;
- Creating a designation process for **Model ACOs** for ACOs that have demonstrated excellence in adopting the best practices for quality improvement, cost containment and patient protections;
- Establishing a **review process** for aggrieved providers that are denied approval by an ACO as a provider of free-standing ancillary services for ACO patients.

Minimum Certification Standards

1. Be organized or registered as a separate legal entity from its ACO participants;
2. Have a governance structure that includes an administrative officer, a medical officer, and patient or consumer representation;
3. Receive reimbursements or compensation from alternative payment methodologies;
4. Have functional capabilities to coordinate financial payments amongst its providers;
5. Have significant implementation of interoperable health information technology, as determined by the commission, for the purposes of care delivery coordination and population management;

Minimum Certification Standards (Cont.)

6. Develop and file an internal appeals plan as required for risk-bearing provider organizations; provided, that the plan is approved by the office of patient protection; and that the plan is included as part of a membership packet for newly enrolled individuals;

7. Provide medically necessary services across the care continuum including behavioral and physical health services, as determined by the commission through regulations, internally or through contractual agreements; provided, that any medically necessary service that is not internally available shall be provided to a patient through services outside the ACO;

8. Implement systems that allow ACO participants to report the pricing of services, as defined by the commission through regulations; further provided that ACO participants shall have the ability to provide patients with relevant price information when contemplating their care and potential referrals;

9. Obtain a risk certificate from the division of insurance;

10. Shall engage patients in shared decision-making, including, but not limited to, shared-decision making on palliative care and long-term care services and supports.

Additional Standards & Goals for ACOs

In developing additional standards for ACO certification, the HPC will consider the following goals for ACOs:

- reduce the growth of health status adjusted total medical expenses over time;
- improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures;
- ensure patient access to health care services across the care continuum;
- promote alternative payment methodologies;
- improve access to certain primary care services;
- improve access to health care services and quality of care for vulnerable populations;
- promote the integration of mental health, substance use disorder and behavioral health services with primary care services;
- promote patient-centeredness;
- adopt certain health information technology, data analysis functions and performance management programs;
- demonstrate excellence in the area of managing chronic disease and care coordination;

Additional Standards & Goals for ACOs (Cont.)

- promote protocols for provider integration, both with providers within and outside of the provider organization;
- promote community-based wellness programs and community health workers;
- promote the health and well being of children, including, but not limited to, improving access to pediatric care, and mental and behavioral health services;
- promote worker training programs and skills training opportunities for employees of the provider organization; and
- adopt certain governance structure standards, including standards related to financial conflicts of interest and transparency.

Model ACOs

- The HPC is required to establish a designation process for Model ACOs that have demonstrated excellence in adopting the best practices for:
  - ✓ Quality improvement
  - ✓ Cost containment
  - ✓ Patient protections
- In developing a standard of excellence, the HPC will consider the standards and goals highlighted on the previous slides.
- To the extent that state-funded health insurance providers contract directly with providers, Model ACOs may be eligible for priority contracting for the delivery of publicly funded health services.

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Contact information

For more information about the Health Policy Commission:

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