MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Advisory Council

January 18, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Presentation: Select Findings from the 2016 Cost Trends Report**
- Discussion: Process for Setting the 2018 Health Care Cost Growth Benchmark
- Discussion: CHART Phase 3 – Design and Timeline
- Presentation: Executive Director's Report

Key statistics from the 2016 Cost Trends Report

HPC Key Findings

4.1%
total health care expenditure growth between 2014 and 2015

6.0%
commercial health care spending per person in MA in excess of national average

30%
portion of income a typical family of 3 at three times the federal poverty level pays for health insurance premiums, copayments, and deductibles

$20,400
annual health insurance premium plus cost-sharing for typical family in MA in 2015

8.8%
per capita growth in commercial prescription drug spending, not factoring rebates

87%
growth in opioid related emergency department visits between 2011 and 2015

21%
approximate percent of commercial health care spending attributable to prescription and medical drugs combined in 2015

24.4%
rate of non-recommended imaging for lower back pain per 100 eligible cases

22.8%
portion of behavioral health related emergency department visits with a length of stay of more than 12 hours

4X
growth in percent of prescriptions with no cost sharing among women between 2012 and 2014 (3.2% to 13.4%)

+11,000
change in the number of inpatient admissions in Massachusetts in 2015 after 3 years of declines of over 20,000 per year

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Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- Affordability of care
- Prescription drug spending

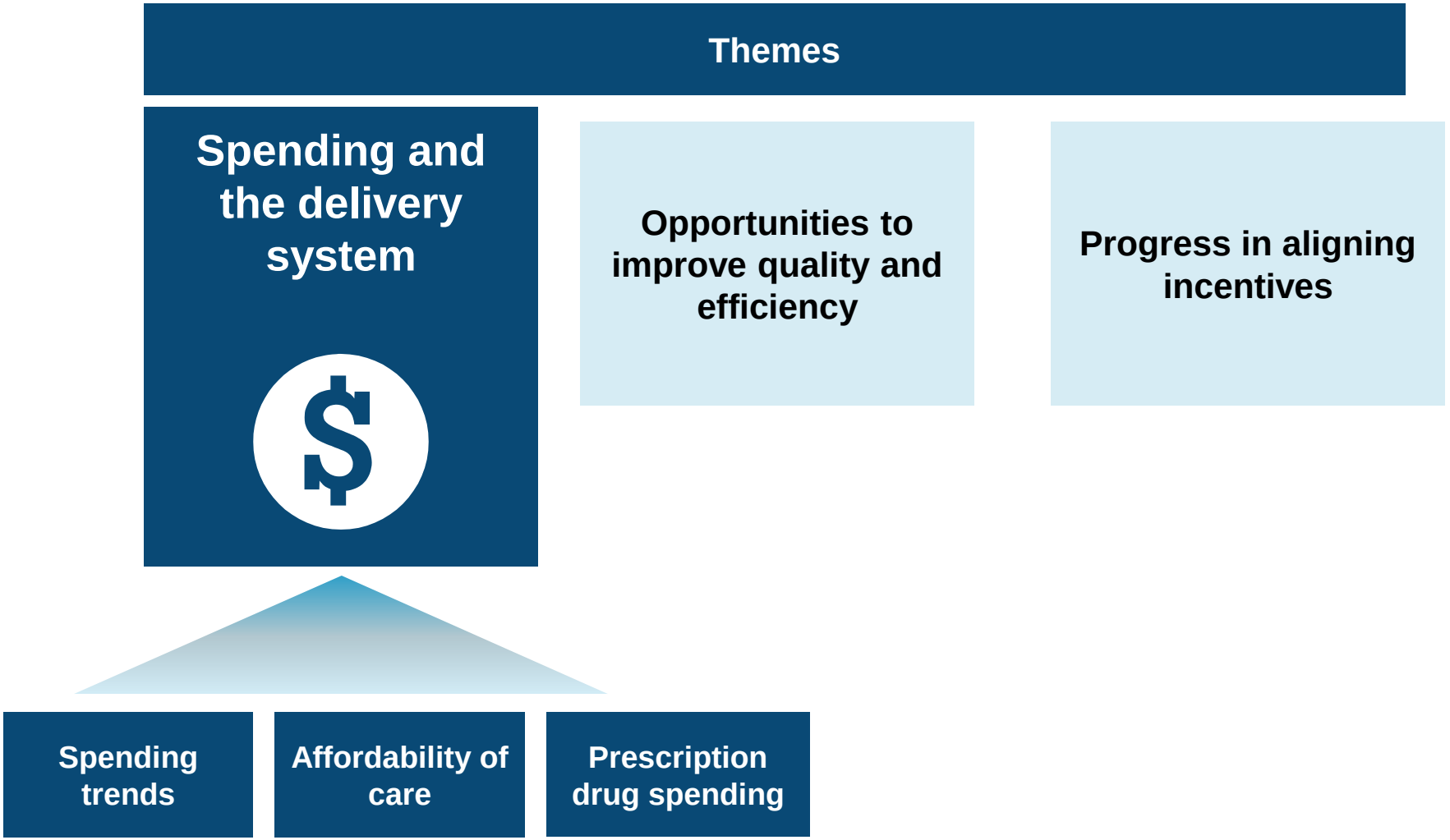
Opportunities to improve quality and efficiency

- Avoidable hospital utilization
- Post-acute care
- Variation in spending by primary care provider group

Progress in aligning incentives

- Alternative payment methods
- Demand-side incentives

Select findings from the 2016 Cost Trends Report



Massachusetts healthcare spending growth

Background

- After years of high growth in annual healthcare spending throughout the 2000s, Massachusetts spent more than any other state on health care per person in 2009
  - Medicare spending per capita was **9%** higher
  - Commercial premiums were **13%** higher

- Since 2012, the state (through the HPC) annually establishes a health care cost growth benchmark, as measured by growth in total health care expenditures (THCE) per capita. This target is based on projections of the state's long-term economic growth and has been set at **3.6%** annual growth through 2017

- Since 2012, the actual growth rates in THCE were:
  - 2012-2013: **2.4%**
  - 2013-2014: **4.2%**
  - 2014-2015 preliminary: **4.1%**

- Overall, between 2012-2015, the average growth rate in TCHE was **3.57%**

Growth in prescription drug spending, among other factors, contributed to exceeding the benchmark in 2015

Sector/spending category	Drivers of growth beyond benchmark rate, 2014-2015
Commercial	• Prescription drugs (**8.9%** growth, not factoring rebates)
Medicare (FFS)	• Prescription drugs (**10.9%** growth, not factoring rebates) • Home health care (**6.6%** growth)
MassHealth	• Prescription drugs (**9.1%** growth, not factoring rebates) • Long term services and supports (LTSS), particularly spending on home and community-based services
Other	• Medicare enrollment growth (Original Medicare, One Care and Senior Care Options) • Net cost of private health insurance

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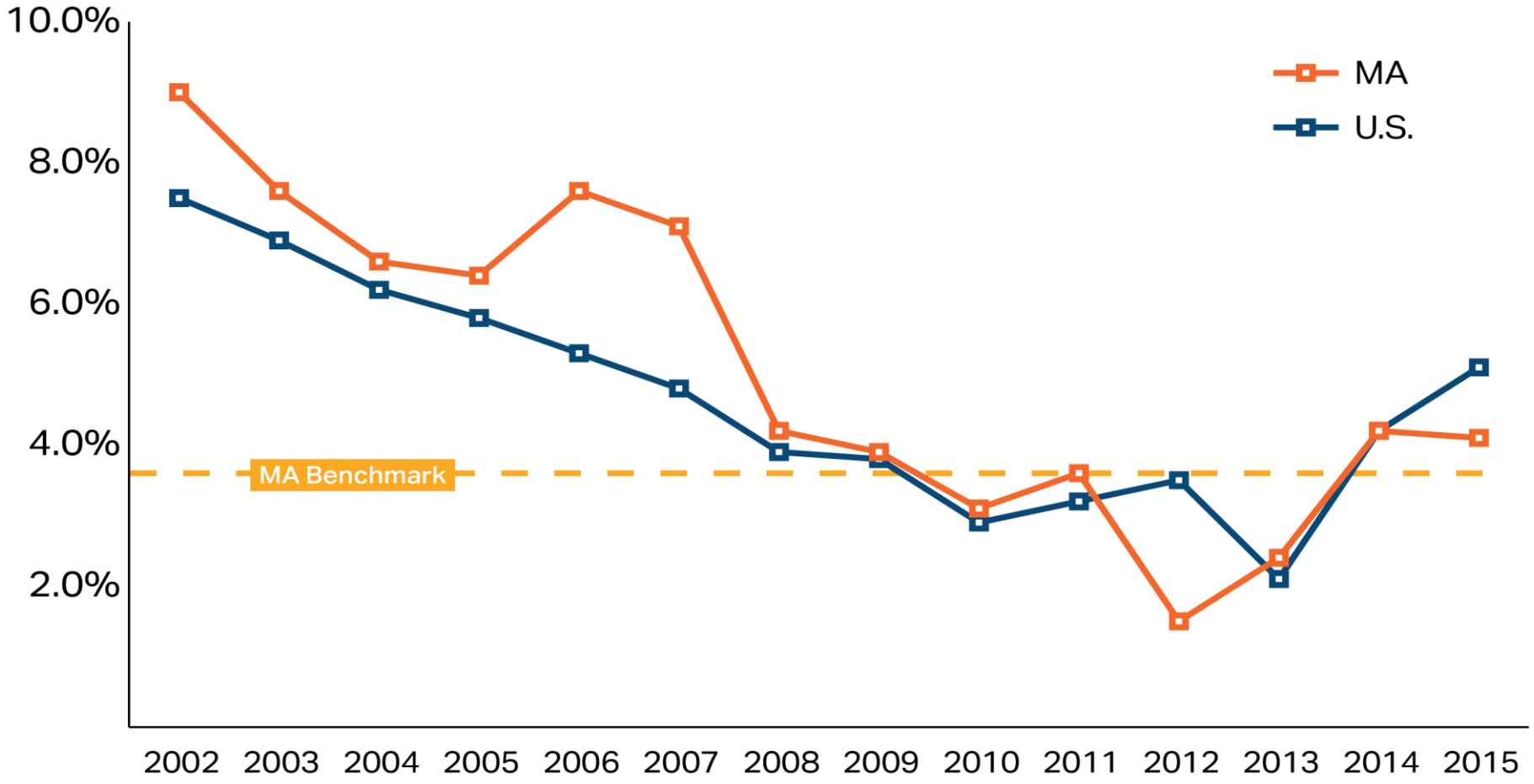
Note: Prescription drug figures under MassHealth include MCO, PCC and FFS spending only and exclude PACE, SCO and One Care. Prescription drug figures exclude impact of rebates. Growth figures provided are per member or per enrollee (Medicare drug spending is per Part D enrollee)
Sources: HPC analysis of Center for Health Information and Analysis 2016 Annual Report and July 2016 Enrollment Trends Report

Since 2009, total healthcare spending growth in Massachusetts has been near or below national growth

Annual growth in per capita healthcare spending, MA and the U.S., 2002-2015

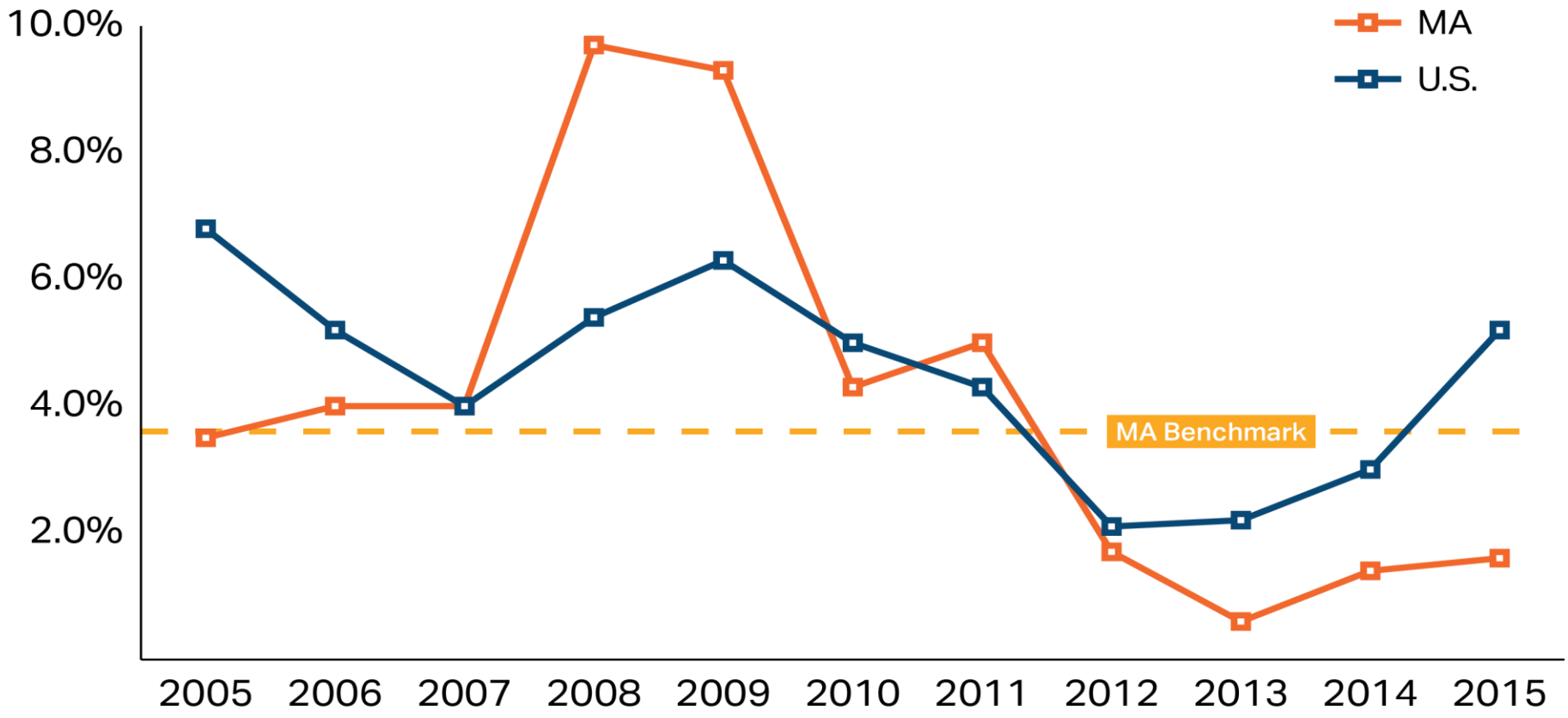


Note: U.S. data includes Massachusetts.

Sources: Centers for Medicare and Medicaid Services National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data, and State Healthcare Expenditure Accounts (U.S. 2002-2015 and MA 2002-2009); Center for Health Information and Analysis Annual Report THCE Databook (MA 2009-2015)

In recent years, commercial spending growth in Massachusetts has been consistently lower than national growth

Annual growth in commercial health insurance premium spending from previous year, per enrollee



Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only.
Sources: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts, Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2009); Center for Health Information and Analysis Annual Reports (MA 2009-2015)

Despite recent lower growth, spending per person in Massachusetts remains 6-7% higher than U.S. averages

Massachusetts per person spending in excess of U.S. averages, 2014 and 2015

	Overall	Inpatient hospital	Outpatient hospital	Physician	Post-acute care	Prescription drugs
Original Medicare (FFS)	6%	19%	24%	-9%	18%	1%

Commercial

- Milliman, Inc. (claims-based), 2014
  - **6%** overall (statewide)
    - **9%** Boston-area
- U.S. Agency for Healthcare Research and Quality (survey of employers), 2015
  - **6.5%** family premiums
  - **9.3%** single premiums

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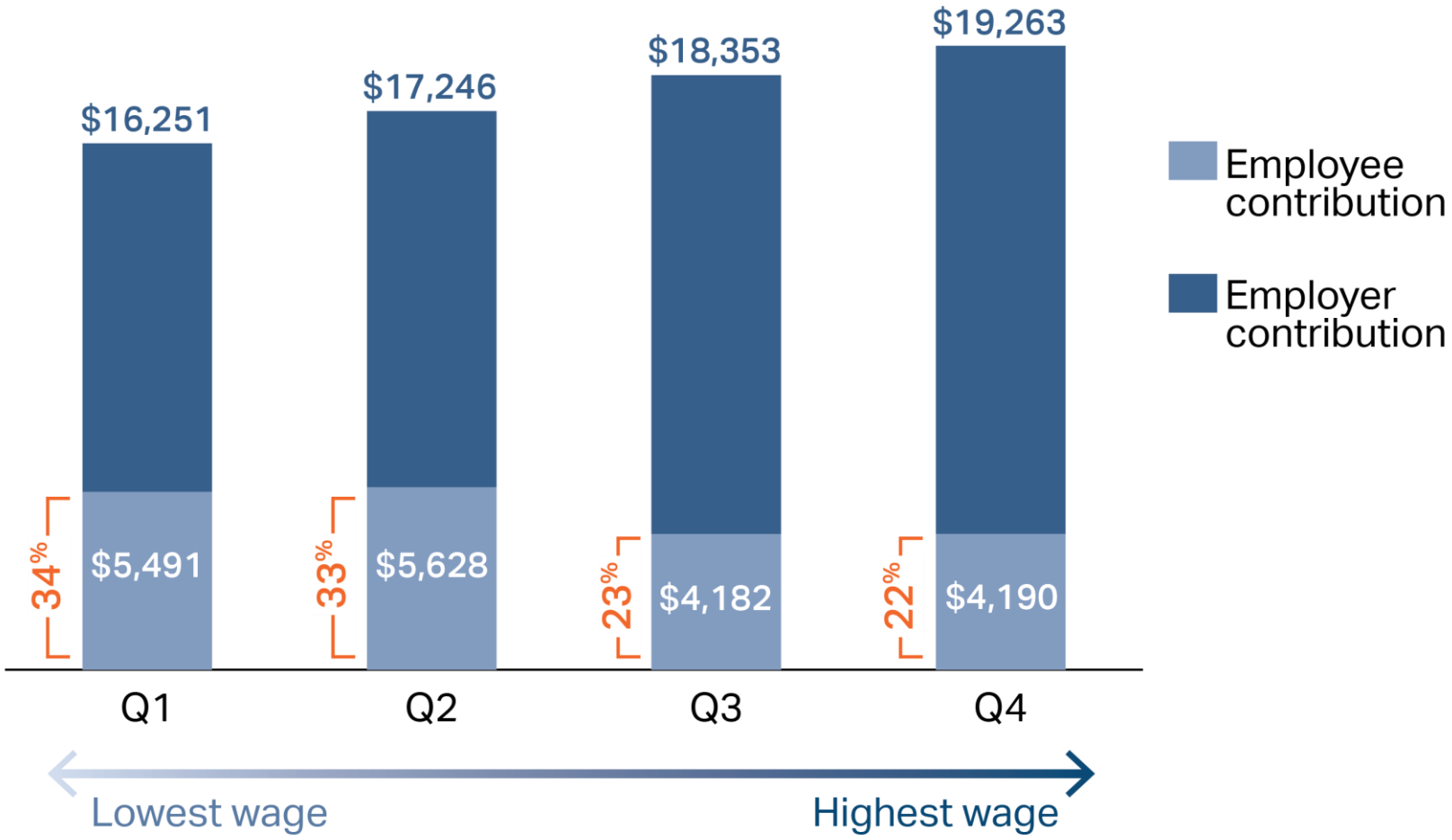
Sources: Centers for Medicare and Medicaid Services 2016 (Medicare); Milliman, Inc., 2014 and Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015 (commercial)

On average, health insurance premiums in Massachusetts are relatively similar for low- and high-wage employers, but the employee share is greater among lower-wage employers

Average family premiums and employee contributions, by wage quartile, 2015

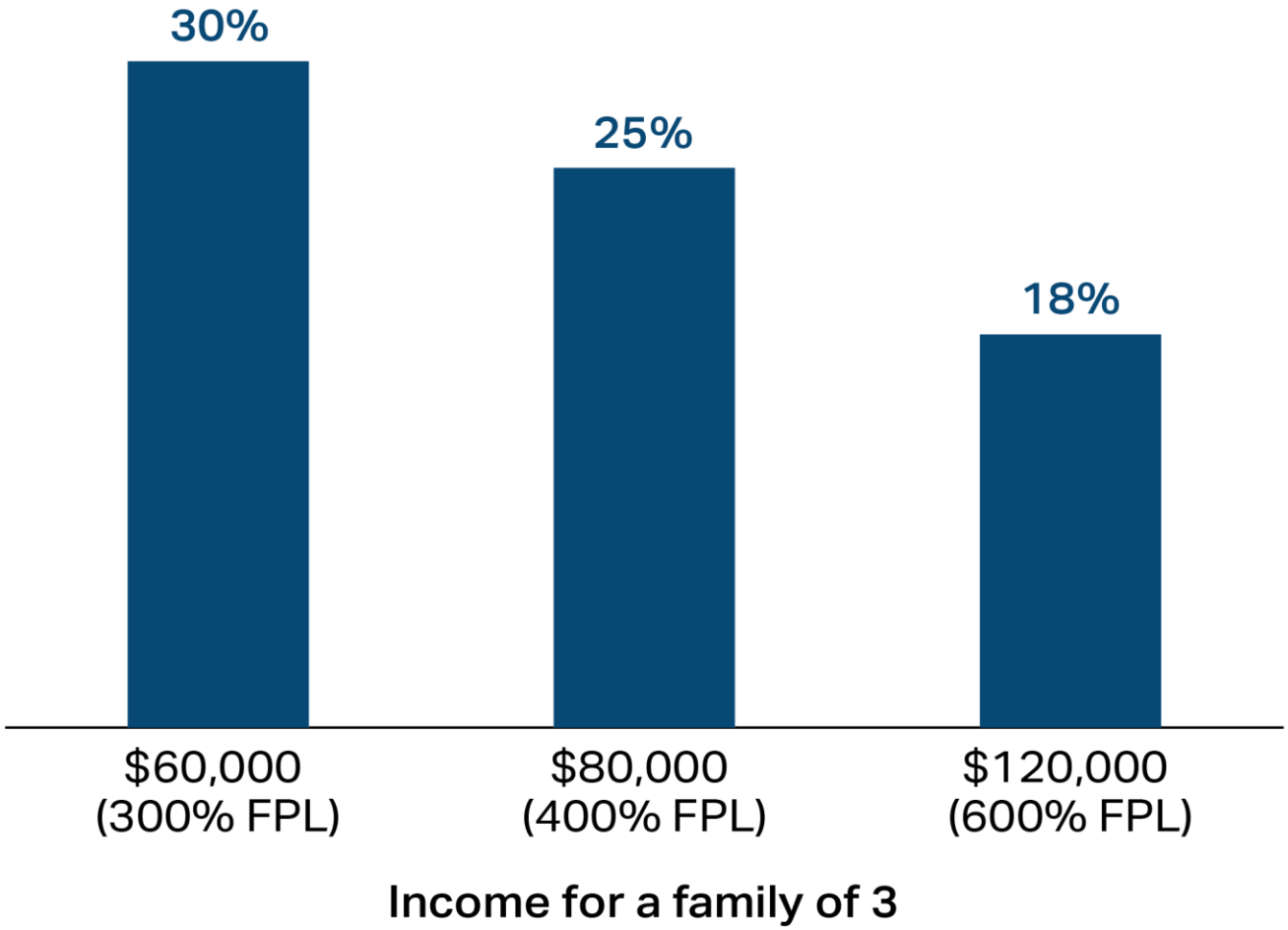


Average premium plus typical cost sharing was **$20,400** in 2015 while the average wage was **$64,116**

Source: Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015; Executive Office of Labor and Workforce Development 2015 Massachusetts Workforce and Labor Area Review

Massachusetts residents with low to middle incomes face a high burden of healthcare costs relative to income

Total healthcare spending relative to income for a family with employer-based coverage, 2015



Note: FPL= federal poverty level. Calculation assigns premium (including employer and employee contribution) for lowest-wage quartile employers (from private health insurance premium slide) to the 200% FPL family, the second highest-quartile to the 400% FPL family and the highest-quartile premium to the 600% FPL family. Cost sharing is assigned as a fixed proportion of the total premium using total cost sharing as reported by the Center for Health Information and Analysis. Calculations do not account for tax deductibility of employer-sponsored health insurance premiums or spending on health care outside of covered benefits.
Source: HPC analysis of Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015

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Prescription drug spending

Background

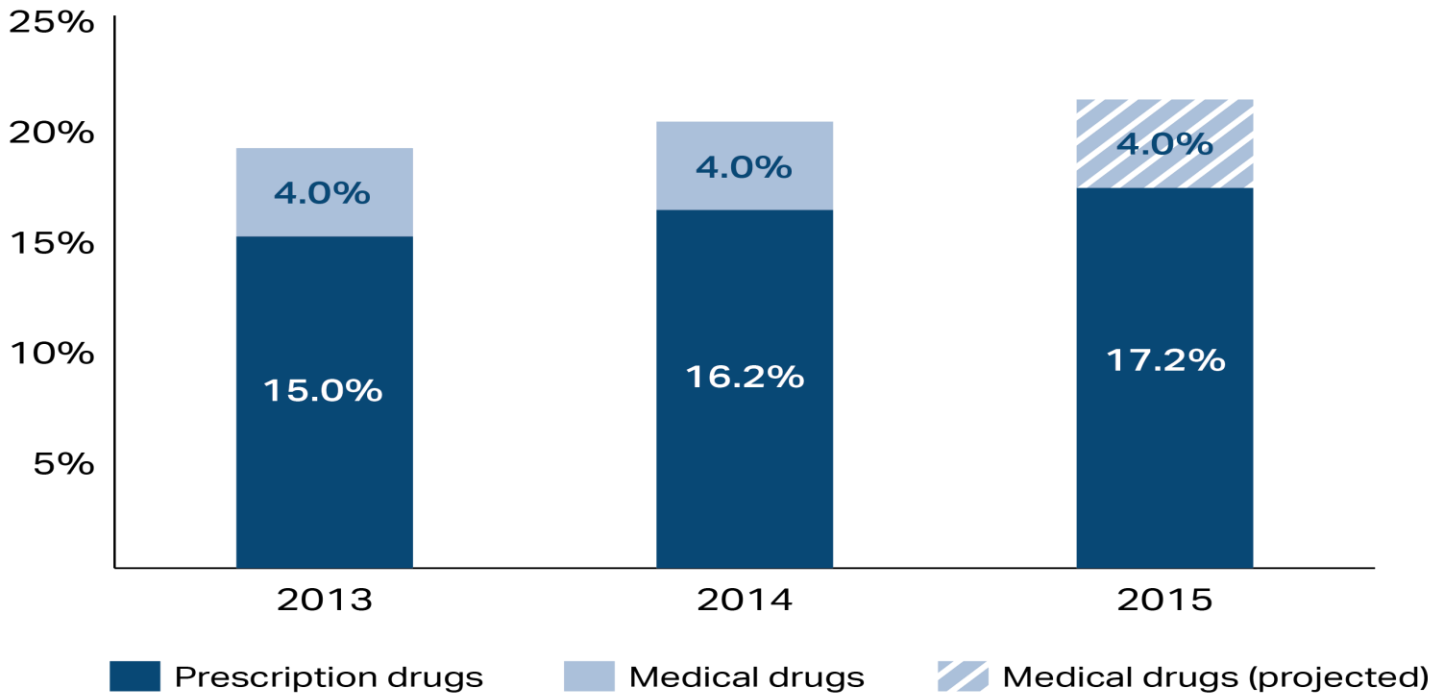
- For the second year in a row, prescription drug spending in Massachusetts exceeded historical growth rates (**10.2%** in 2015 and **13.5%** in 2014)
  - This growth is consistent with national trends
  - The entry of new high-cost drugs, price growth for existing drugs, and a low level of patent expirations remained the largest contributors to drug spending growth in 2015
- Commercial prescription drug spending grew **8.8%** per capita in 2015, down from **12.5%** in 2014
- The estimates above do not factor rebates, which affect both level and trend
  - AGO reports that commercial* per capita prescription drug spending growth in 2015 was two percentage points lower net of rebates: from **8.2%** to **6.1%**
- Even including rebates, growth in prescription drug spending exceeded spending growth in all other commercial categories of service

*Note: Analysis only includes five Massachusetts health plans.

Source: Office of the Attorney General. Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17. Boston (MA) : Office of the Attorney General; 2016 October 7

Medical and prescription drug spending combined comprise over 20% of commercial health spending in Massachusetts

Percent of commercial healthcare spending, by drug benefit type, 2013-2015

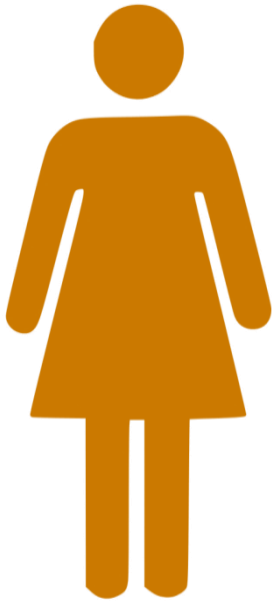


- Medical drugs are administered by providers (e.g. chemotherapeutic agents, flu vaccine)
- Medical drug spending grew **4%** per capita from 2013 to 2014, with ~ **6%** annual per capita growth from 2011 to 2014
- Combined medical and prescription drug spending represents a growing share of total health spending

Note: 2015 medical drug spending data is estimated based on 2013 and 2014 share of spending. Figures exclude impact of rebates.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014 (medical drug spending) and Center for Health Information and Analysis Annual Report TME Databooks (prescription drug spending)

From 2012-2014, cost sharing on prescription drugs decreased substantially for women, due in large part due to the ACA



Year	Women: Percent of claims with $0 cost sharing	Men: Percent of claims with $0 cost sharing
2012	3.2%	0.9%
2013	10.7%	1.6%
2014	13.4%	2.4%

- Many contraceptive methods are included under the ACA's mandatory coverage
- Average annual cost sharing particularly dropped for women from 2012 to 2014 – a **14%** decline ($205 to $176) versus a **4%** decline for men ($202 to $193)

Notes: PMPY= per member per year. Data include privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care who use the prescription drug benefit at least once in the calendar year. Figures exclude impact of rebates.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014

Select findings from the 2016 Cost Trends Report

Themes

Spending and the delivery system

Opportunities to improve quality & efficiency

Progress in aligning incentives

Avoidable hospital utilization

Post-acute care

Variation in spending by PCP group

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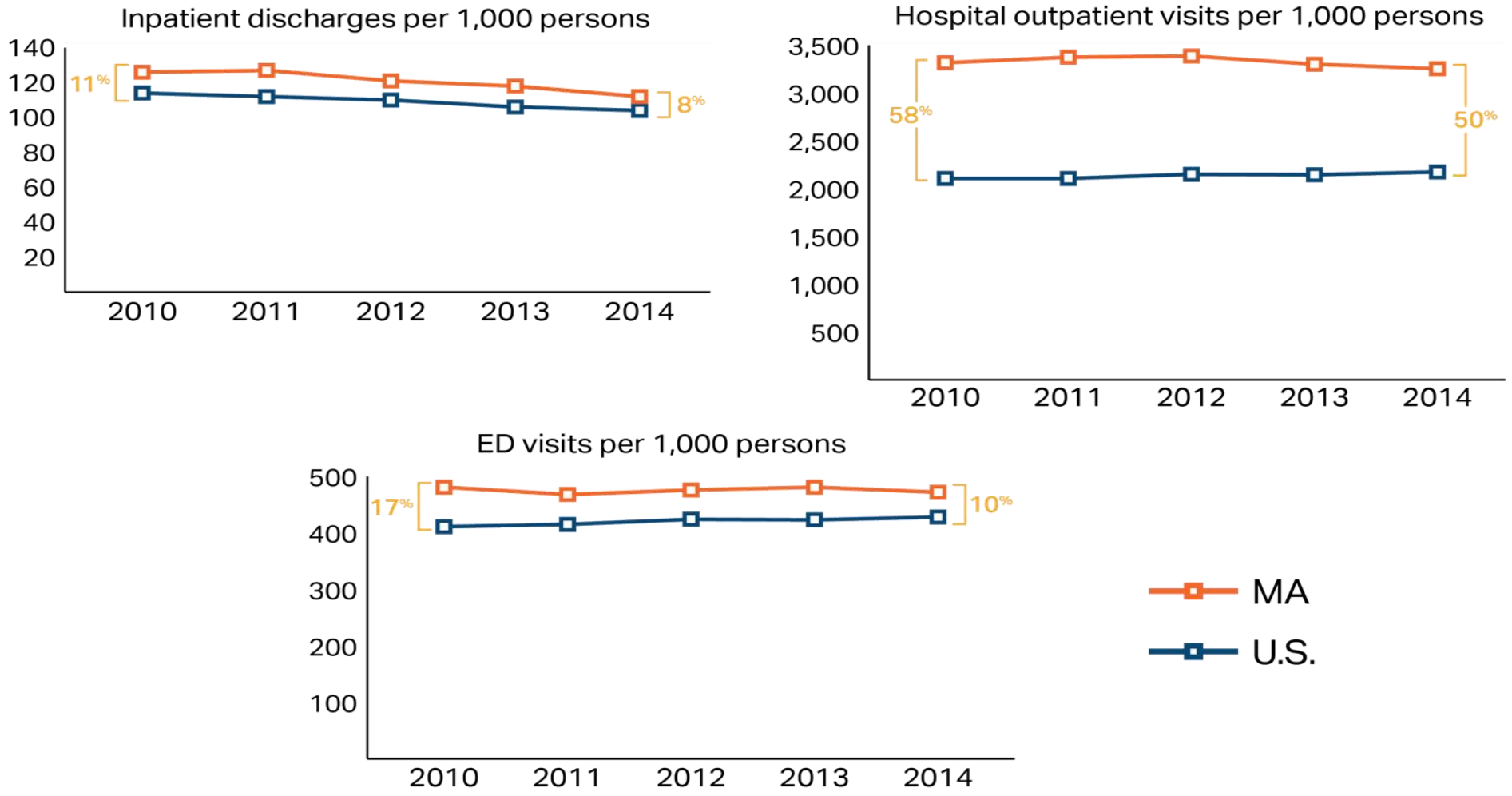
Hospital use in Massachusetts remains higher than national averages

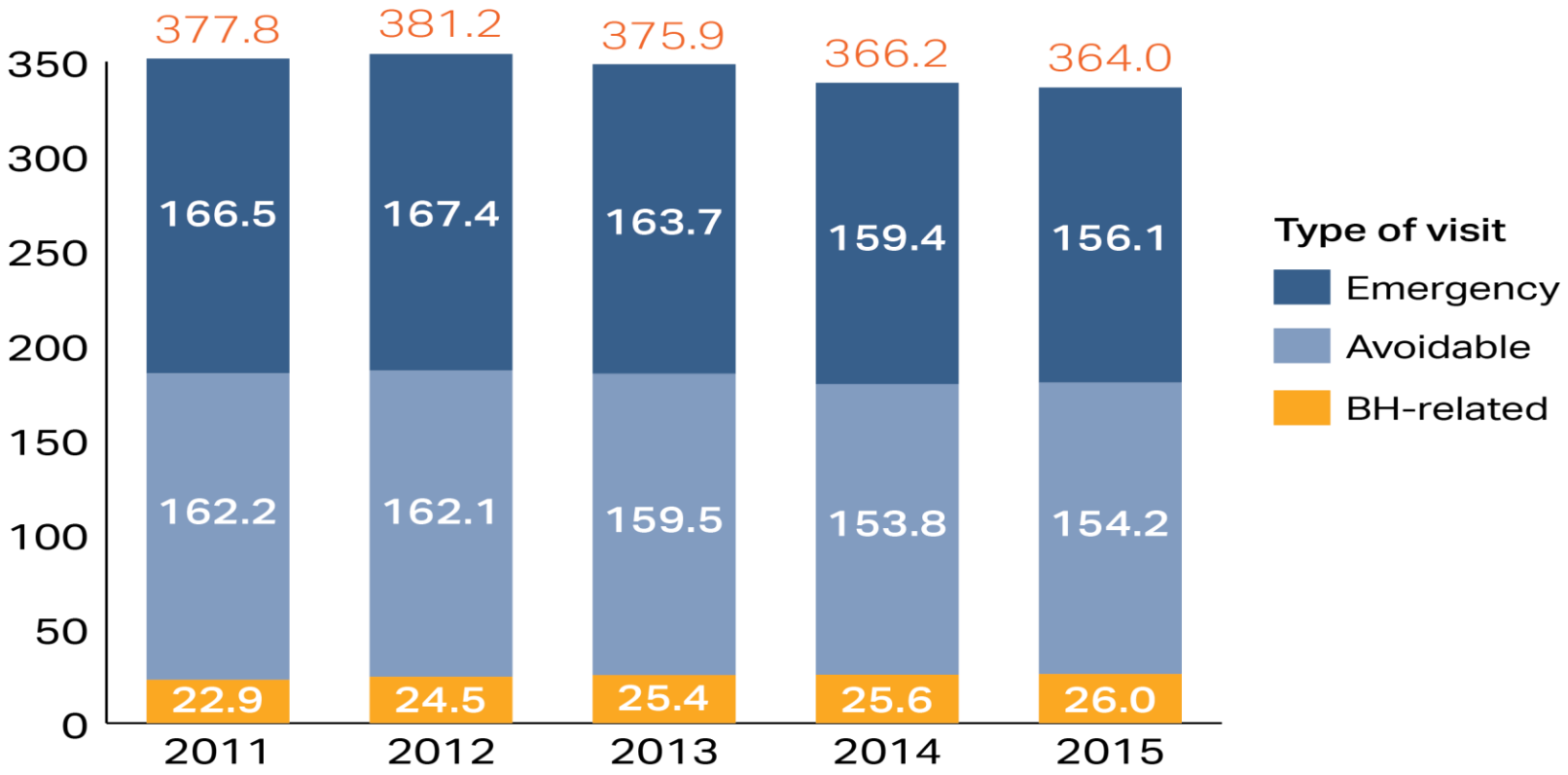
Hospital use in MA and U.S., per 1,000 population, 2010-2014



Note: ED= emergency department.
Source: Kaiser Family Foundation analysis of American Hospital Association data, 2010-2014

While ED visits have declined overall, behavioral health-related visits have increased steadily

ED visits by category, per 1,000 population, 2011-2015



The growth in BH-related ED visits was in part due to increases in opioid-related ED visits, which grew **87%** from 2011 to 2015

Notes: ED= emergency department; BH= behavioral health. The total ED rate (in orange above the bars) includes all categories of ED visits, including unclassed ED visits which are not shown here. Unclassified visits increased 5.7% during this time period. Definition of ED categories based on NYU Billings Algorithm categorization of a patient's primary diagnosis and are mutually exclusive. BH ED visits includes any discharge with a primary mental health, substance use disorder, or alcohol-related diagnosis code. Emergency visits include the Billings categories of emergency and emergent, ED care preventable; avoidable visits include the Billings categories of non-emergent and emergent, primary care treatable. Some non-Massachusetts residents are included in the number of ED visits. In 2015, 4% of all ED visits in Massachusetts were made by non-Massachusetts residents.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

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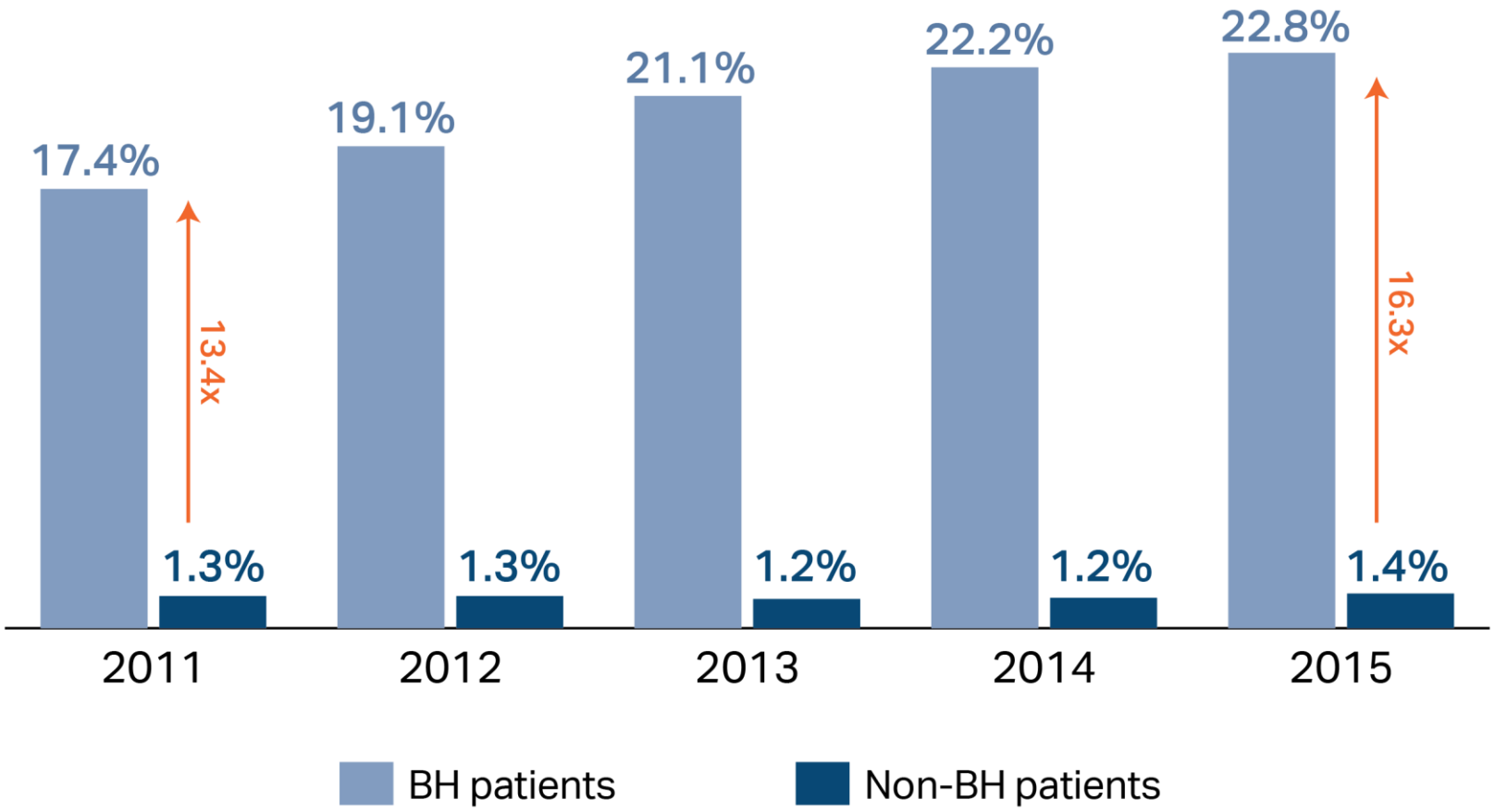
Behavioral health patients are increasingly more likely to have an extended length of stay in the ED

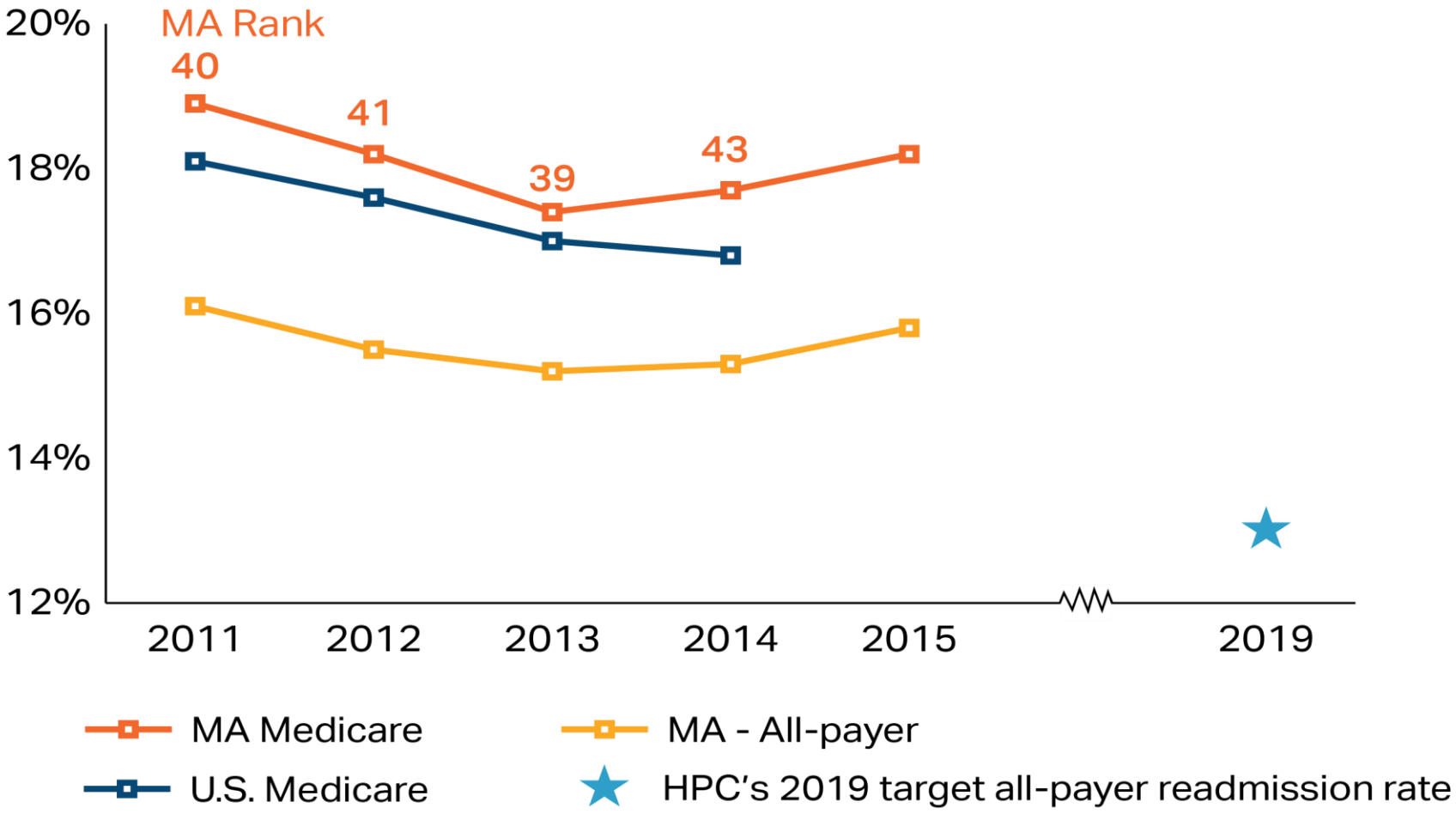
Percent of ED visits with a length of stay of more than 12 hours, by primary diagnosis type, 2011-2015



Notes: ED= emergency department; BH=behavioral health. BH ED visits identified using NYU Billings algorithm and include any discharge with a primary mental health, substance abuse, or alcohol-related diagnosis code. Length of stay is calculated as the difference between the point of registration and the point of admission or discharge.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

Massachusetts hospital readmissions began increasing in 2014 after a sustained decline

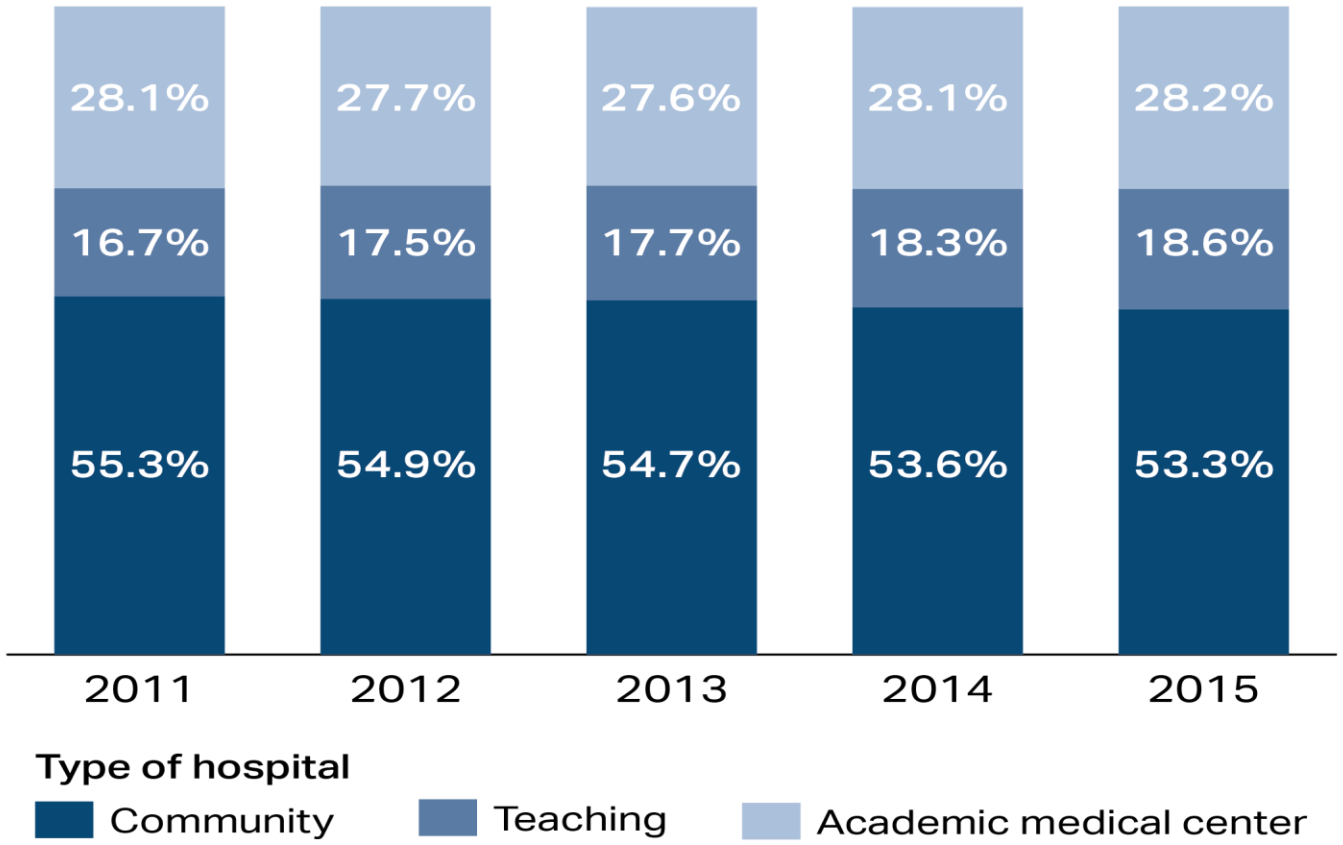
Thirty-day readmission rate, by payer, MA and the U.S., 2011-2014



Sources: Centers for Medicare and Medicaid Services (U.S. Medicare and MA Medicare 2011-2013); Center for Health Information and Analysis (all-payer and MA Medicare 2014-2015)

Inpatient care that could safely and effectively be provided in community hospitals is increasingly being provided by teaching hospitals

Share of community appropriate discharges, by hospital type, 2011-2015



Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis (CHIA) defines community hospitals as general acute care hospitals that do not support large teaching and research programs. Teaching hospitals are defined as hospitals that report at least 25 full-time equivalent medical school residents per one hundred inpatient beds in accordance with Medicare Payment Advisory Commission (MedPAC) guidelines. Academic medical centers are a subset of teaching hospitals characterized by (1) extensive research and teaching programs, (2) extensive resources for tertiary and quaternary care, (3) principal teaching hospitals for their respective medical schools, and (4) full service hospitals with case mix intensity greater than 5 percent above the statewide average.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

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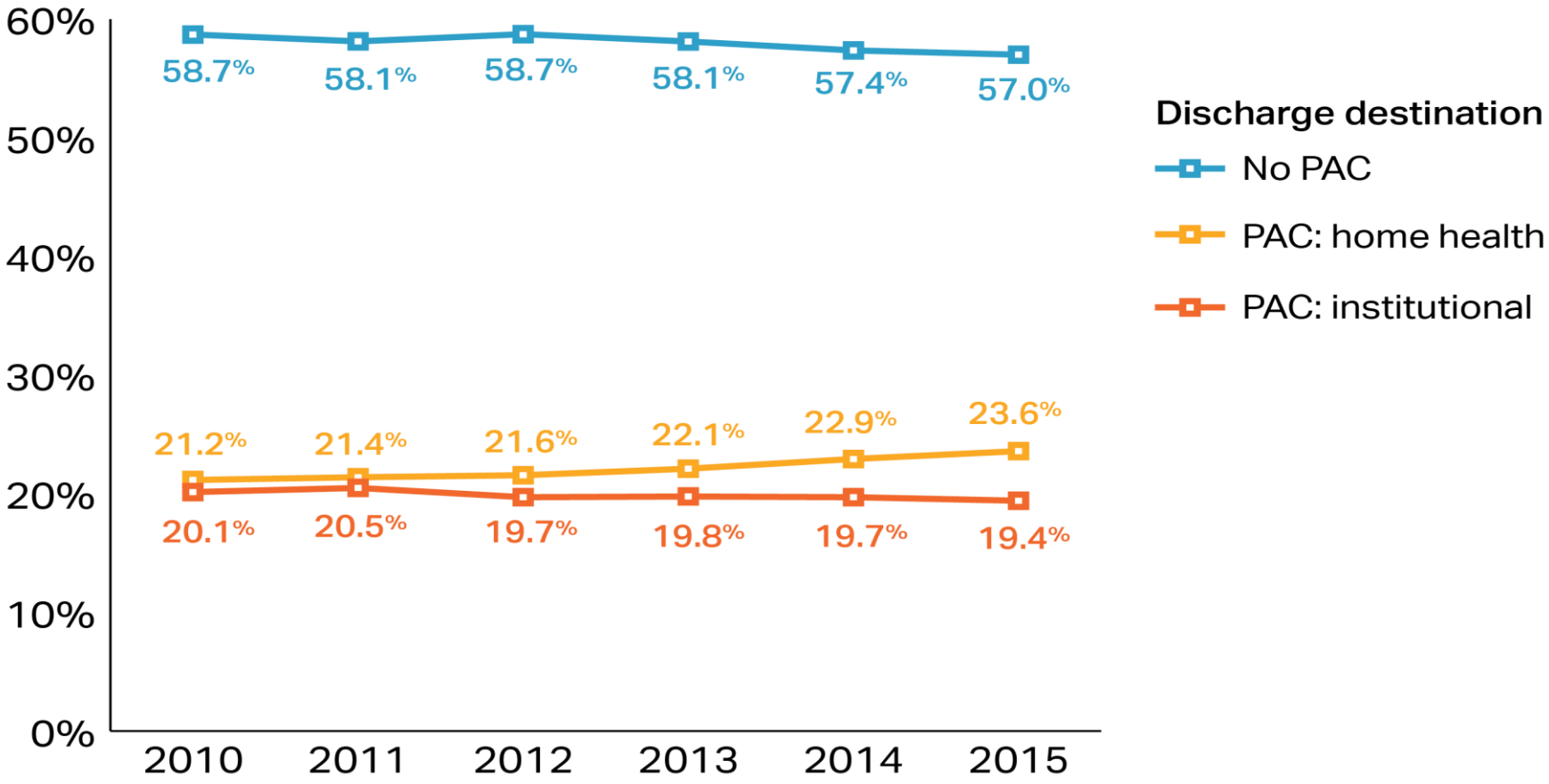
Since 2010, home health PAC use is increasing, while institutional PAC use remains fairly constant

Discharge destination following an inpatient admission, adjusted for DRG mix, 2010-2015



Notes: PAC= post-acute care. Data include adult patients who were discharged to routine care or some form of PAC. Discharges from hospitals that closed and specialty hospitals, except New England Baptist, were excluded. Discharges from UMass Memorial, Cape Cod, Marlborough, Clinton and Falmouth hospitals were excluded due to coding irregularities in the database. Institutional PAC settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Adjusted using ordinary least squares (OLS) regression to control for changes in mix of diagnosis-related groups (DRGs) over time.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2010-2015

Examining non-recommended care as an opportunity for improvement

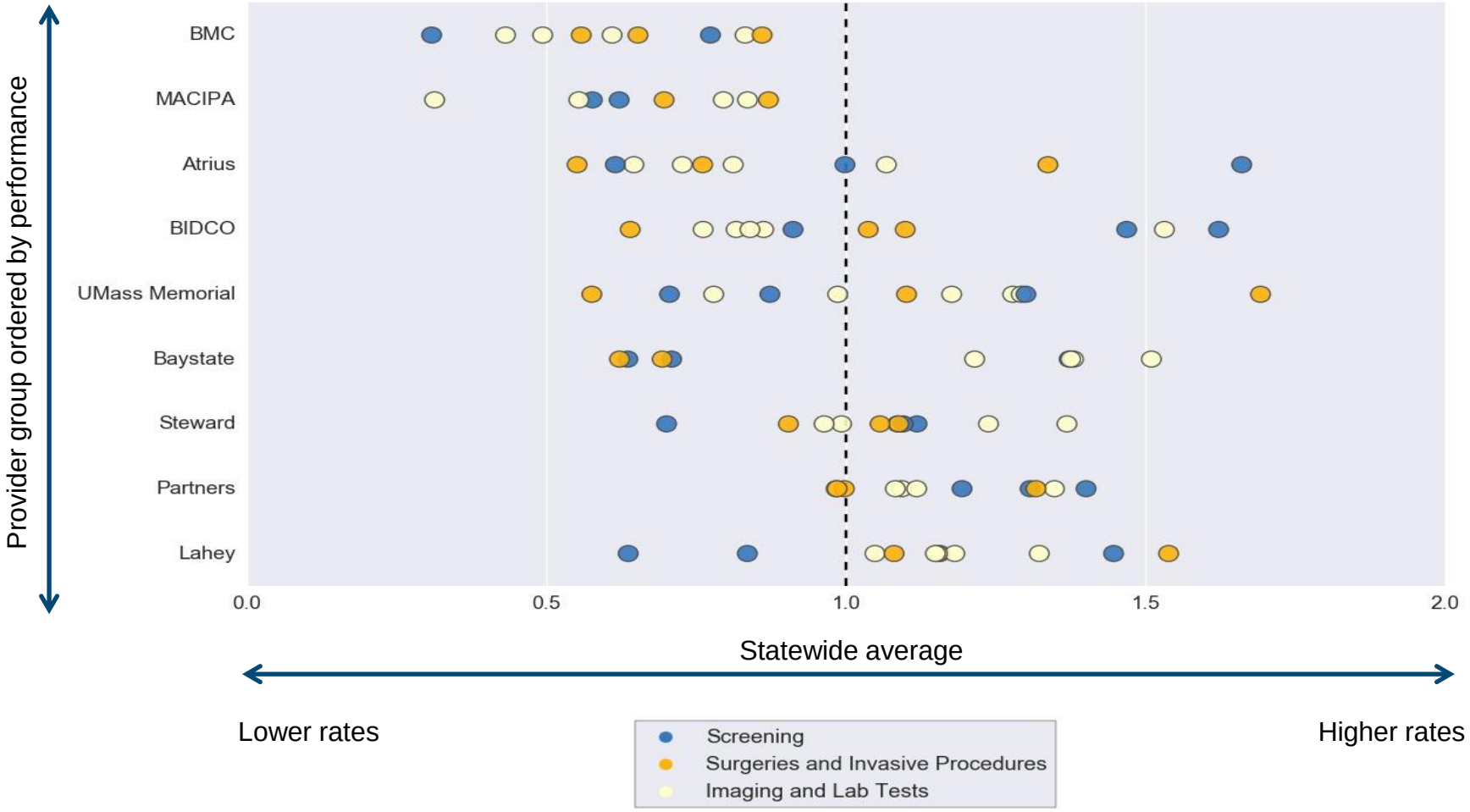
- This analysis was informed by the Choosing Wisely campaign, in which physician specialty groups defined wasteful or unnecessary screenings, procedures, and tests within their own specialty. Non-recommended care is alternatively referred to as "**low-value care**"

- Previous work has examined practice pattern variation by region and payer, while HPC's analysis also examines measures of utilization by primary care provider group
  - Through combination of the Massachusetts All-Payer Claims Database with the Registry of Provider Organizations dataset

- Methods to measure non-recommended care are based on previous studies care:
  - Rosenthal et. Al, "Choosing Wisely: prevalence and correlates of low-value health care services in the United States", *Journal of General Internal Medicine* (2015)
  - Schwartz et. Al, "Measuring low-value care in Medicare", *Journal of American Medical Association* (2016)

Some provider groups had consistently low or high rates of non-recommended care across measures

Rates of non-recommended care, by provider group relative to the statewide average (indexed to 1.0 for each measure), 2013

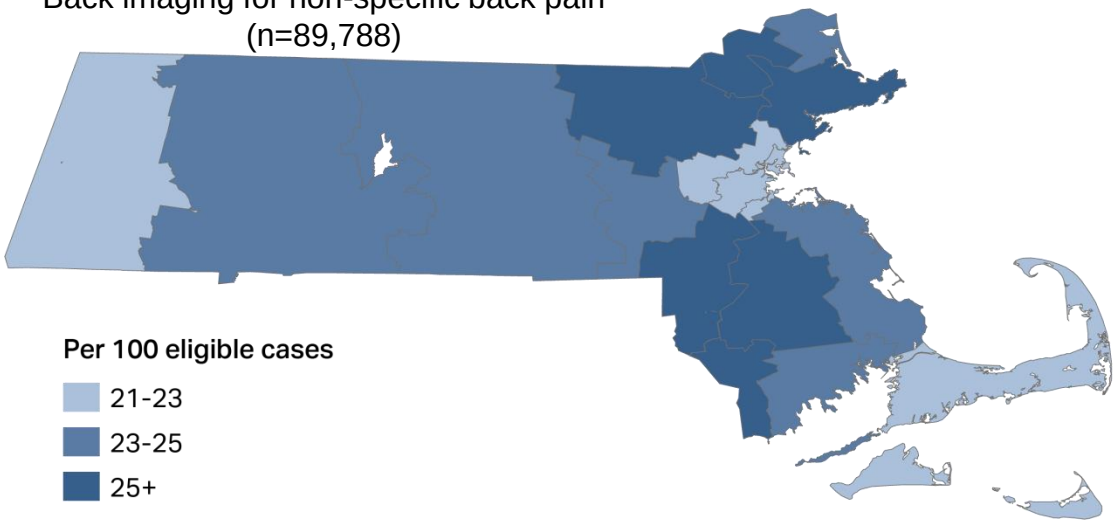


Notes: Analysis includes the same provider groups in the Total Medical Expenses (TME) analysis with the exception of NEQCA. Some measures are not reported for some organizations due to cell size limitations. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care.

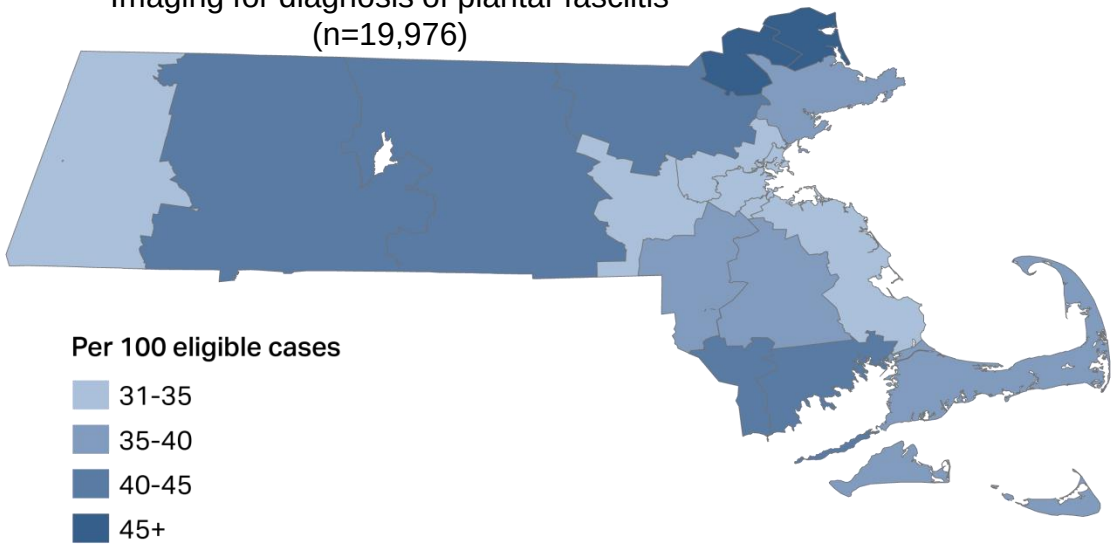
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2013 and Registry of Provider Organizations, 2016

Rates of non-recommended imaging vary by region

Back imaging for non-specific back pain
(n=89,788)



Imaging for diagnosis of plantar fasciitis
(n=19,976)



Notes: Analysis includes the same provider groups in the Total Medical Expenses (TME) analysis with the exception of NEQCA. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2013 and 2014

Select findings from the 2016 Cost Trends Report

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Alternative payment methods

Demand-side incentives

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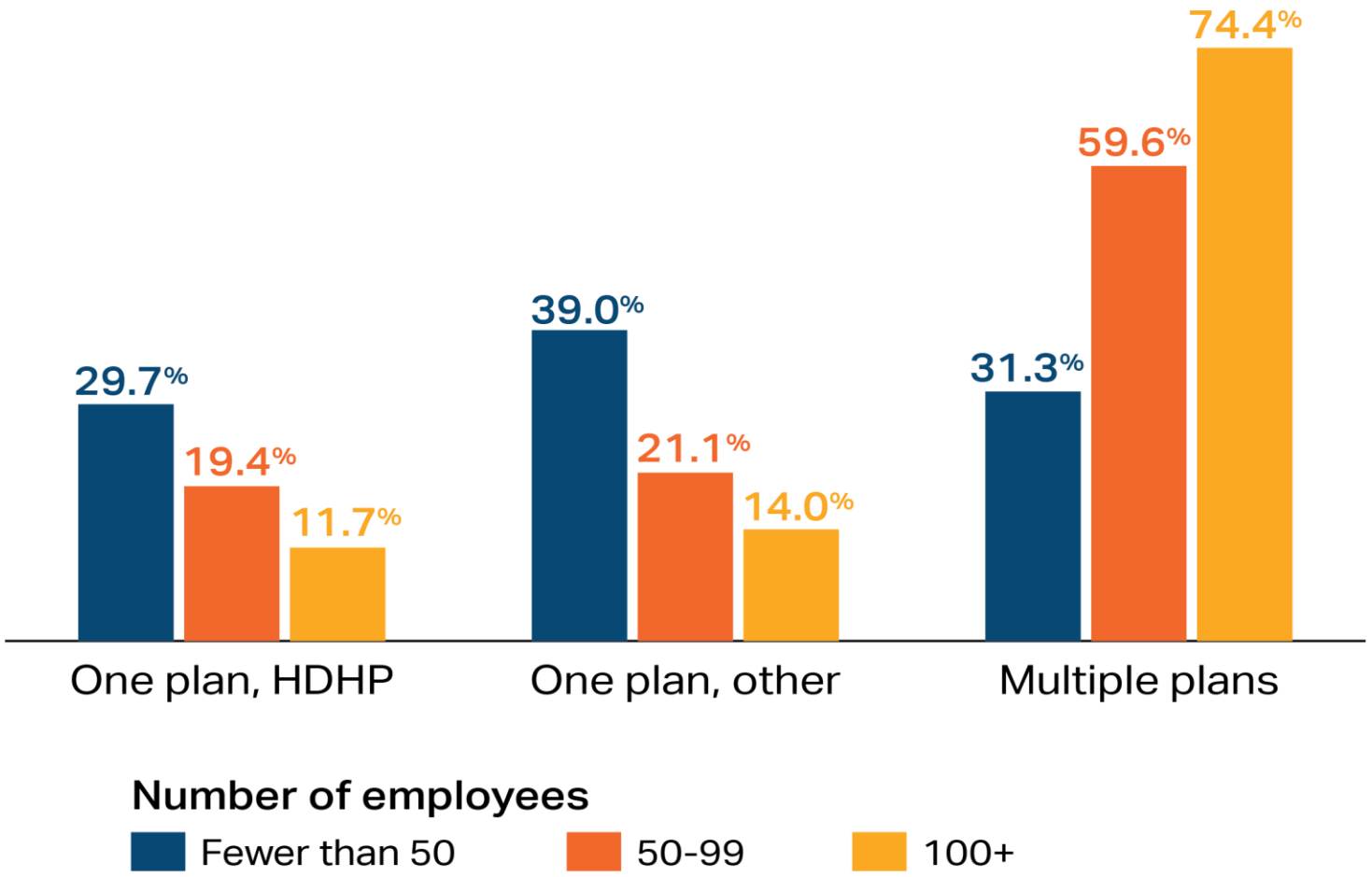
Background

- DSIs reduce healthcare spending and improve market functioning by encouraging individuals and employers to make value-based choices, including:
  - Tiered and limited network plans
  - Cash-back incentives and price transparency programs
  - Reference pricing products

- These mechanisms are enabled and fostered by:
  - Informed and activated employers and employees
  - Price and quality transparency
  - Competitive insurance markets such as exchanges

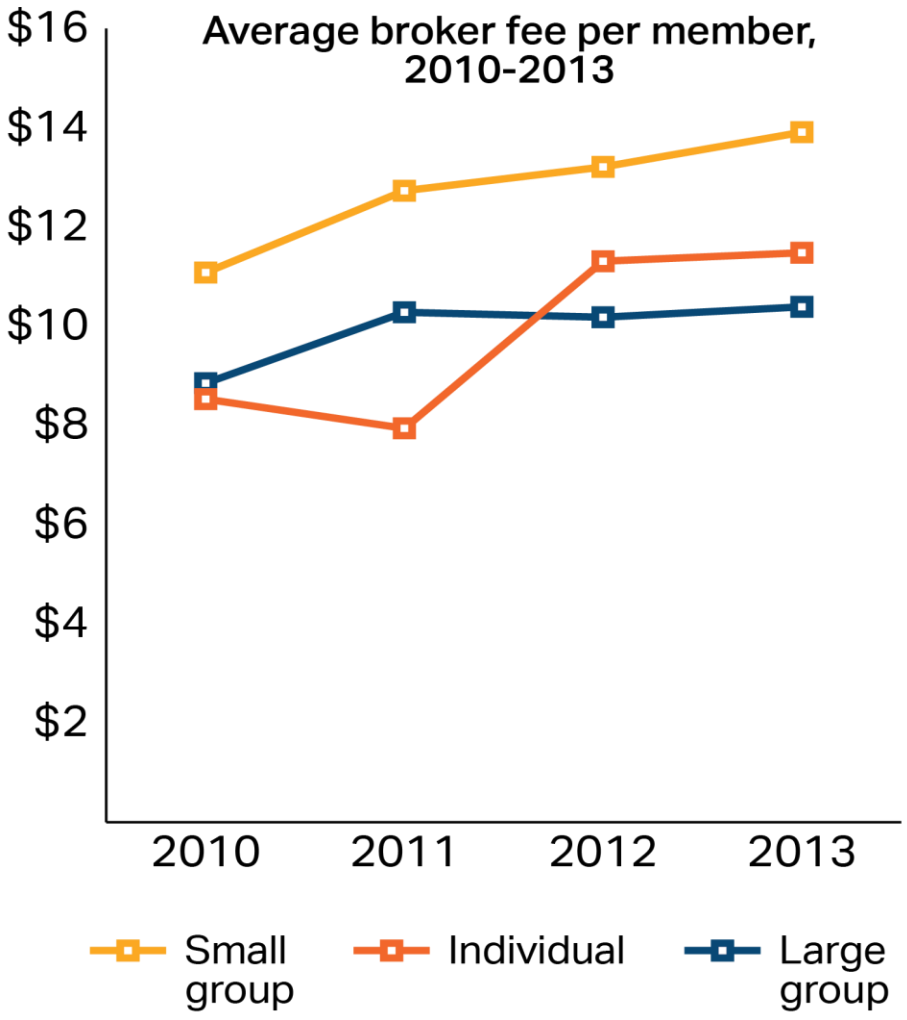
Most small group employees do not have a choice of plans

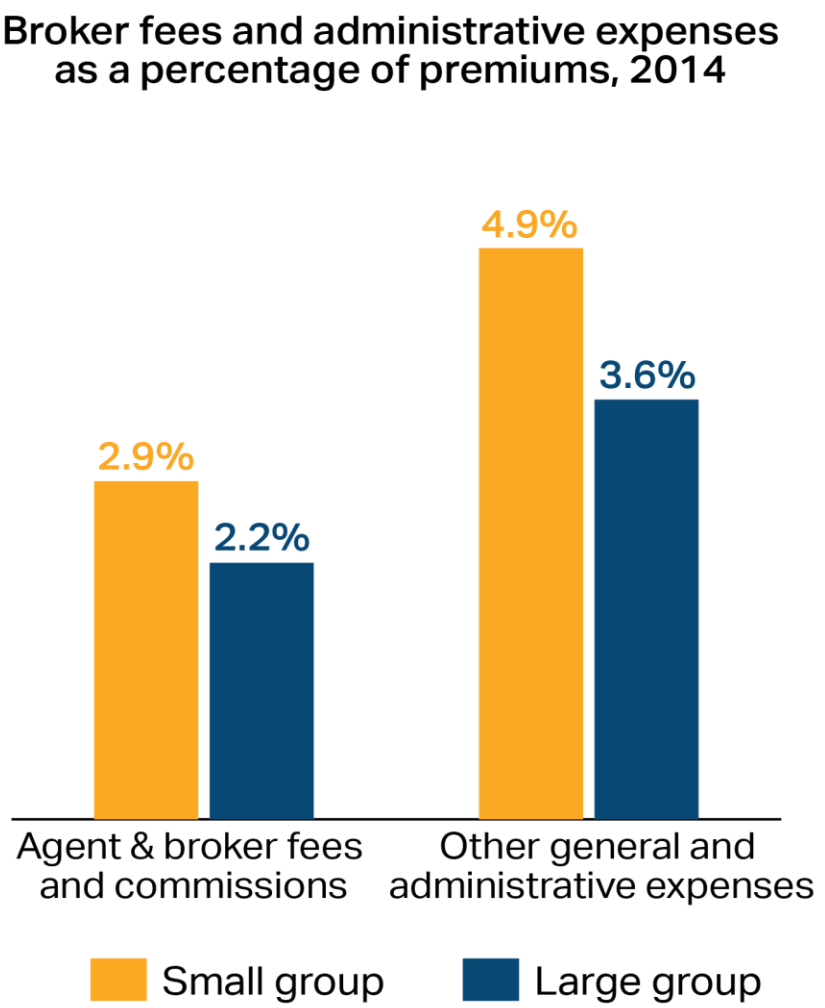
Among employees offered coverage by their firms, percent with plan choice by company size, 2014



Note: HDHP= high-deductible health plan.
Source: HPC analysis of Center for Health Information and Analysis Massachusetts Employer Survey, 2014

Small group employers pay more in broker fees and other insurance administrative costs

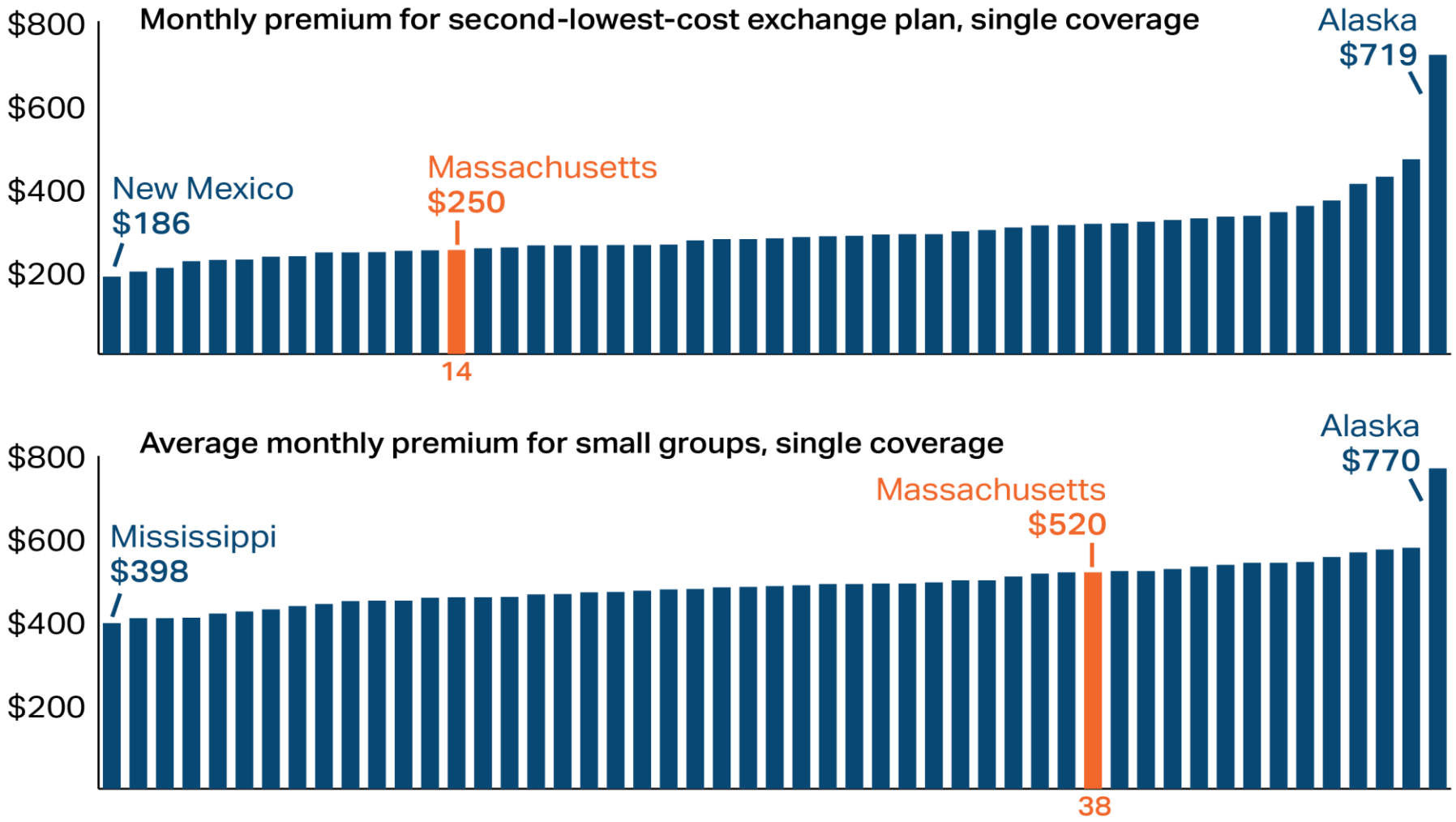




Notes: Graph on left defines small employers as those with fewer than 100 employees; graph on right defines small employers as those with fewer than 50 employees. In 2015, the vast majority (75%) of employees at firms with fewer than 100 employees were in firms with fewer than 50 employees.

Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates, 2010-2013

Massachusetts Health Connector premiums are below the national average, but employer based small-group premiums are higher



Notes: Top graph shows the average for the second-lowest silver plan premium for a 40 year old non-smoker earning $30,000 per year in the largest city in each state; bottom graph reflects the average monthly single premium for a private sector firm with fewer than 50 employees.

Sources: Kaiser Family Foundation, 2016 (top); Agency for Healthcare Research and Quality, 2015 (bottom)

2016 Cost Trends Report: summary of preliminary findings

Promising Developments

- Recent spending growth per person in Massachusetts continues to be below national rates; Massachusetts now spends about **6-7%** more on health care than other states, down from about **9-13%** more in 2009
- Overall, Massachusetts residents benefitted from lower prescription drug cost sharing from 2012-2014, due in large part to protections in the Affordable Care Act
- Early directional evidence suggests adoption of Alternative Payment Methods (APMs) may contribute to moderated spending growth for certain primary care provider groups
- Premiums for individual coverage offered through the Massachusetts Health Connector are below the U.S. average, unlike employer-based coverage

Challenging Developments

- Hospital utilization and readmissions increased in 2015 after years of decline
- Community appropriate care is continuing to increase at teaching hospitals
- While moderating somewhat in 2015, prescription drug spending in Massachusetts continues to grow more rapidly than any other category of service
- Rates of behavioral health-related ED use and ED boarding are increasing
- Post-acute care spending and utilization – particularly use of institutional care – remains high
- Growth in APM coverage stalled in 2015, though there are promising signs for 2016 and beyond
- Most small employers do not offer employees choice of insurance plan and pay higher broker/administrative fees

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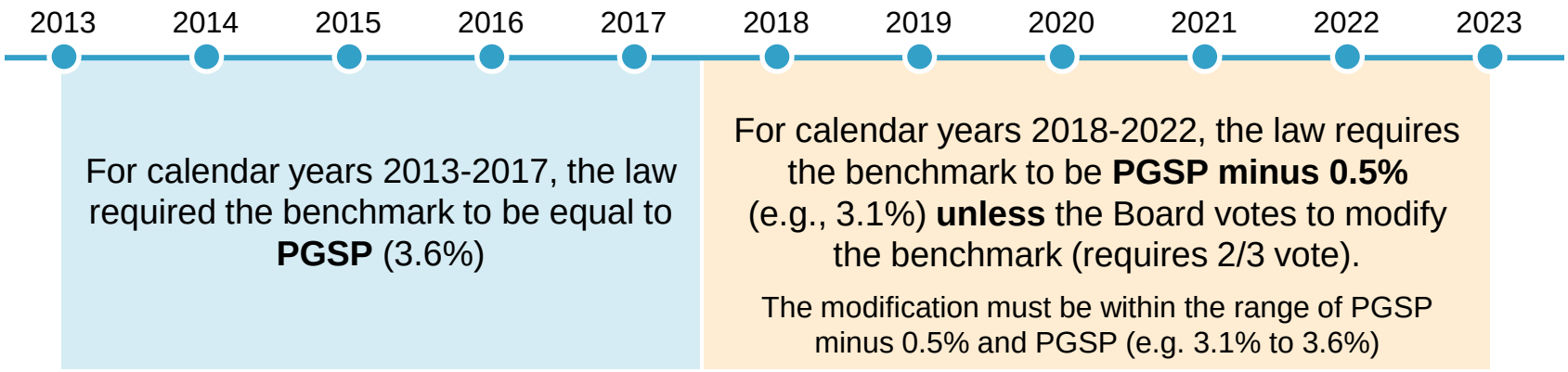
Benchmark Modification Process Overview

- For the first time, in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for calendar year 2018)**, pursuant to a public hearing process and engagement with the Legislature.

- The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January 15 (when the PGSP is established in the consensus revenue process) and April 15.



- The law requires an extensive notice and hearing process prior to modification and gives the Legislature an opportunity to take legislative action to change the benchmark and "override" any Board action to modify the benchmark.

Benchmark Modification Process – Key Steps

HPC Role

- HPC Board must hold a **public hearing** prior to making any modification of the benchmark
- Hearing must consider testimony, information, and data on whether modification of the benchmark is appropriate:
  - **Data**: CHIA annual report, other CHIA data, or other data considered by the Board
  - **Information**: "health care provider, provider organization, and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system"
  - **Testimony**: representative sample of providers, provider organizations, payers and other parties determined by HPC
  - The Joint Committee on Health Care Financing may participate in the hearing
- Following a potential vote to modify, the HPC Board **must submit notice** of its intent to modify the benchmark to the Joint Committee

Legislative Process

- Joint Committee must hold a public hearing within 30 days of notice
- Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing
- General Court must act within 45 days of public hearing or the HPC Board's modification of the benchmark takes effect

Benchmark Modification Process - *Proposed Timeline*

January 11, 2017

Board discusses process for potential modification of benchmark for calendar year 2018 which by operation of law will be PGSP minus 0.5% unless the board votes to modify; Board authorizes ED to submit notice of hearing on *potential* modification of benchmark to Joint Committee on Health Care Financing and schedule a hearing, providing 45 days notice to Joint Committee

January 15, 2017

Benchmark established in consensus revenue process

February 8, 2017

Board discussion of hearing, factors to be considered in potential modification

March 8, 2017

Board hearing on potential modification of benchmark

March 28, 2017

Board votes whether to modify benchmark; if Board votes to modify, submit notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2017

Statutory deadline for Board to set benchmark

April 2017

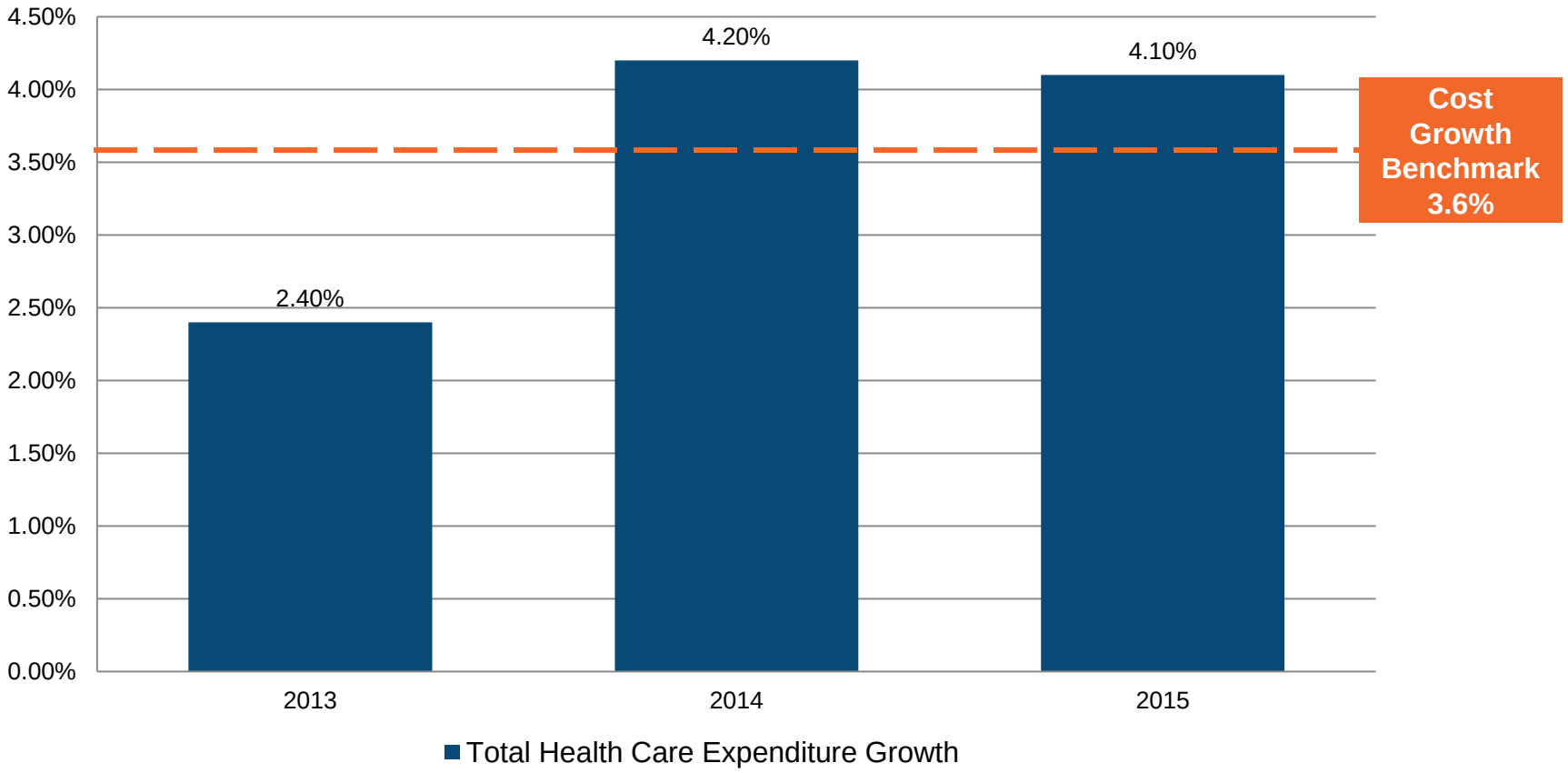
Joint Committee holds a hearing within 30 days of notice (between March 29 and April 29)

May 2017

Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; legislature has 45 days from hearing to enact legislation which may establish benchmark; if not legislation, then Board vote to modify takes effect

HPC

Performance Against the Benchmark to Date



2013-2015
Average Growth Rate: 3.57%

HPC

Benchmark Modification Process – Discussion

1. What factors should the HPC consider in determining whether to modify the CY 2018 benchmark?

2. What information (data, testimony, expert input) should the HPC consider in determining whether modification of the benchmark is appropriate?

3. What role does the Commonwealth's benchmark play in your own organization's performance?

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Presentation: Select Findings from the 2016 Cost Trends Report
- Discussion: Process for Setting the 2018 Health Care Cost Growth Benchmark
- **Discussion: CHART Phase 3 – Design and Timeline**
- Presentation: Executive Director's Report

Programmatic Goals of CHART

Background

- Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program is a $120 million reinvestment program funded by an assessment on large health systems and commercial insurers
- Aim of program is to make phased investments for certain Massachusetts community hospitals to successfully engage in health system transformation and to enhance their delivery of efficient, effective care

Overarching Goals of CHART

- **Promote** care coordination, integration, and delivery transformations
- **Advance** electronic health records adoption and information exchange among providers
- **Increase** alternative payment methods and accountable care organizations
- **Enhance** patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations

CHART Goals and Investments

CHART Phase 1

Goal Support capacity building through short term, high-need expenditures

Awards $10 million was awarded to 28 community hospitals in October 2013

CHART Phase 2

Goal Incentivize care delivery transformation towards readiness for effective participation in accountable care models through a focus on one or more of the following primary aims:

- Maximize appropriate hospital use
- Enhance behavioral health care
- Improve hospital-wide (or system-wide) processes to reduce waste and improve quality and safety

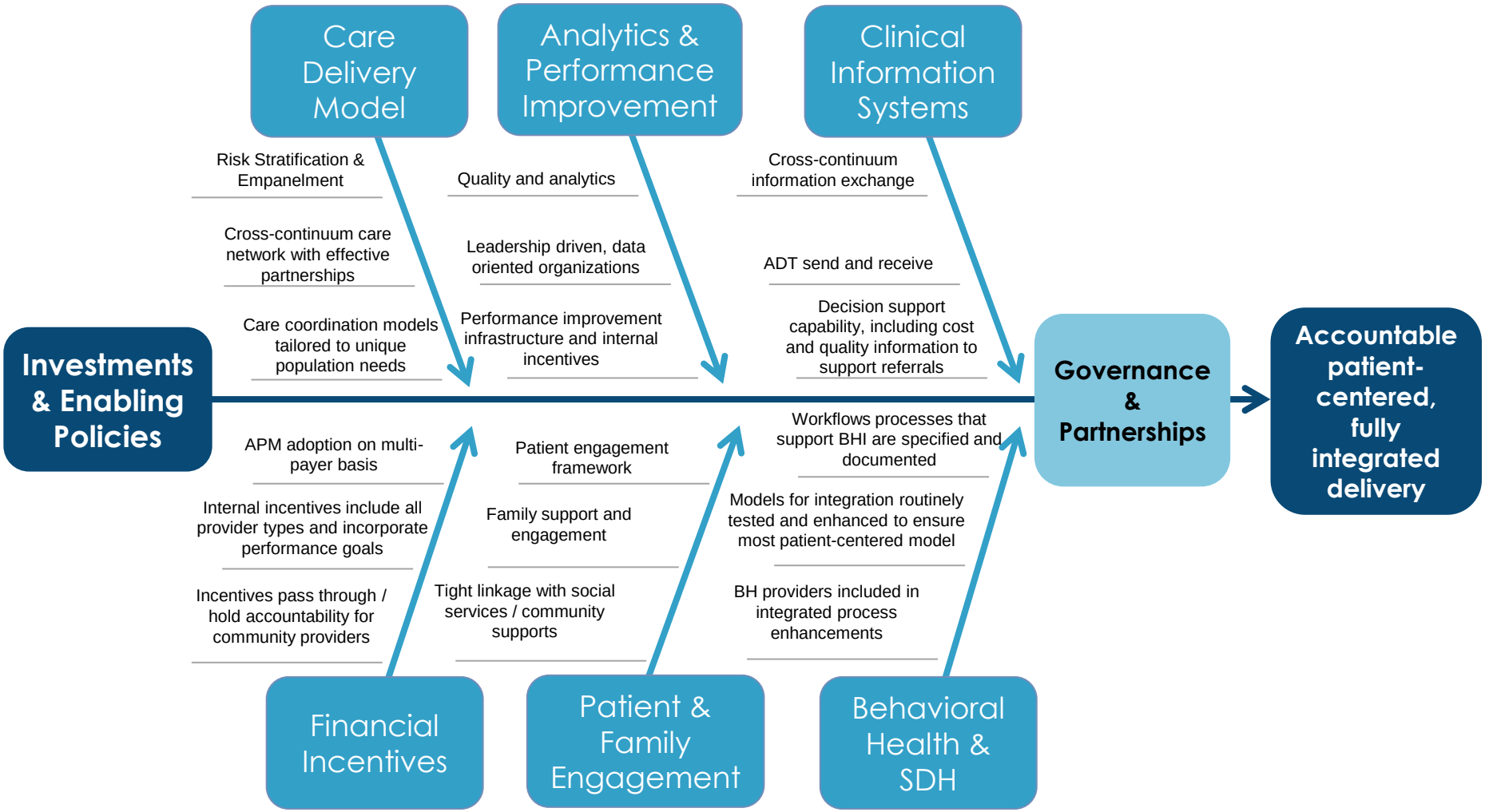
Awards $60 million was awarded to 25 community hospital awardees in October 2014.

CHART Phase 3

Goal *Proposed* Provide a bridge to payment reform in part by enhancing and hardwiring successful Phase 2 programs with a continued emphasis on Community Partnerships

Awards $20 million available to be awarded in October 2017 *(target date)*

Health System Capabilities Necessary for Accountable Care



Looking from Phase 1 to Phase 2 to Phase 3

Phase 1: Foundational Activities to Prime System Transformation

- Modest investment with many eligible hospitals receiving funds
- Short term, high-need expenditures
- Participation not requisite for receipt of Phase 2 funds nor a guarantee of Phase 2 award
- Identified need to assess capability and capacity of participating institutions
- Opportunity to promote engagement and foster learning

Phase 2: Driving System Transformation

- Deeper investment in hospitals over a 2 year period of performance
- Competitive application process
- Focused areas for care transformation
- Data driven approach
- Outcomes oriented aims and targets
- Close engagement between awardees and HPC, with substantial technical assistance

Phase 3: Sustaining System Transformation

- Ensure program sustainability post grant funding and support the successful adoption of alternative payment models, including the MassHealth ACO program
- Continue and expand the work of proven interventions from Phase 2
- Hardwire relationships with community partners
- Matching or in-kind contributions from hospitals/systems
- Alignment with MassHealth's DSRIP funding and programmatic goals
- Lessening engagement between awardees and HPC

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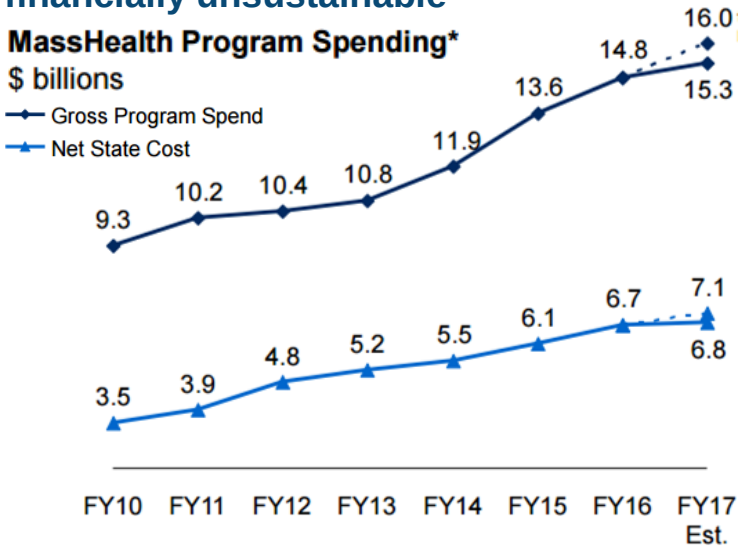
Delivery System Reform Incentive Program (DSRIP) Overview

Current MassHealth FFS system is financially unsustainable



Source: MassHealth Delivery System Restructuring: Overview, April 14, 2016

Key features of program

- **Care delivery and payment reform** to improve population health and care coordination through movement toward ACO model
- **Integration of physical and behavioral health** care by requiring ACOs to form linkages with state-certified BH and LTSS Community Partners (CPs)
- **Ability for ACOs to provide and seek reimbursement for "flexible services"** that address social determinants of health

Pilot ACOs (Dec 2016-Nov 2017)*

- 6 Pilot ACOs for 12-month period
- ACOs contract with MassHealth to provide care for PCC plan members

Full ACO Program (Jan 2017 - Dec 2022)*

- 20-25 full program ACOs for 5-year contract period
- 3 types of ACOs, all HPC certified

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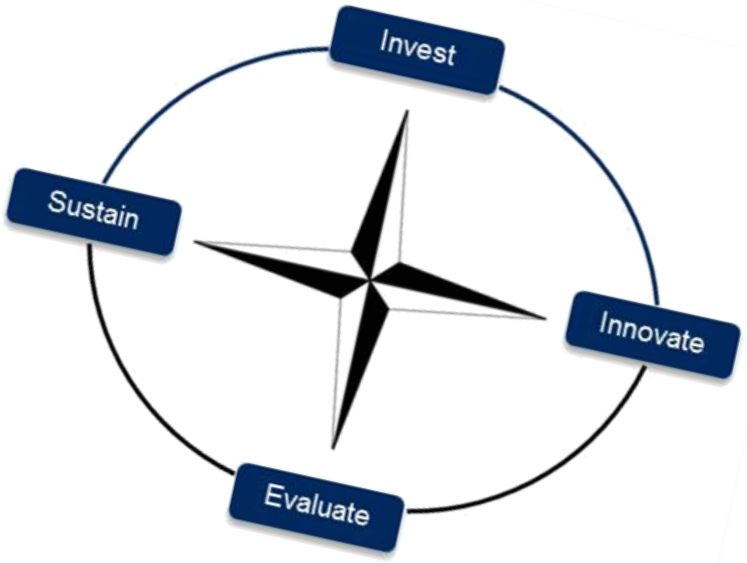
*see appendix for detailed timeline

Key Decision Points for Phase 3

- Size of total opportunity and caps
- Duration of award
- Focus areas
- Performance targets
- Sustainability



Decision: Award size and Duration

HPC Proposal: CHART Phase 3

Total Funding	$20,000,000
Individual Awards	$500,000 - $2,000,000
Duration	12-18 months

CHART Phase 1

Total Funding	$10,000,000
Individual Awards	$65,000 - $500,000
Duration	9 months

CHART Phase 2

Total Funding	$60,000,000
Individual Awards	$900,000 - $8,000,000
Duration	27 months

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Decision: Focus Areas and Performance Targets

HPC Proposal: CHART Phase 3

Hardwire proven interventions from Phase 2 and ensure successful adoption of alternative payment models; continued focus on reduction in readmissions and avoidable ED use

	Phase 1	Phase 2
Goal	Support capacity building through short term, high-need expenditures	Incentivize care delivery transformation towards readiness for effective participation in accountable care models through a focus on one or more of the following primary aims:
Pathway/ Primary Aim	• Implementation of pilot projects to improve quality of care and/or reduce cost • Building capability or capacity that aligns with the goals of better health, better health care, and lower costs • Meaningful operational and business planning activities to yield a strategic vision and plan for system transformation.	• Maximize appropriate hospital use • Enhance behavioral health care • Improve hospital-wide (or system-wide) processes to reduce waste and improve quality and safety
Metrics	Proposed by Applicants and approved by the HPC, with a focus on metrics that have a continuous improvement method of measurement and operational metrics to demonstrate efficient, effective implementation	Metrics include targets aligned with Primary Aim(s): • Reduce Readmissions • Reduce ED utilization • Reduce lower acuity adult tertiary transfers • Reduce excess ED Boarding for long stay BH patients

Decision: HPC Financial Support

HPC Proposal: CHART Phase 3

Require matching or in-kind contributions from hospitals/systems to lessen financial reliance on HPC

Phase 1

The HPC seeks to use Phase 1 of the CHART Investment Program to fund short-term, high-need foundational activities to prime system transformation

Phase 2

HPC requires the following:

- For Awardees that are part of a health system and have a teaching hospital, the System must make a contribution to the Award
- A majority of Awardees have In Kind Contributions from their hospitals
- Undertake Strategic Planning, with funding of $50K from the HPC, to engage in planning, at a minimum, to ensure sustainability of the CHART Phase 2 initiative(s)

Preliminary discussion of Scope of Phase 3

HPC Proposal: CHART Phase 3

Preliminary structure proposal for discussion

THEME

Scaling and ensuring sustainability of **community-focused, collaborative approaches** to care delivery transformation and the successful adoption of alternative payment models, including the MassHealth ACO program

FUNDING

Staff propose a **total funding of approximately $20M**

FOCUS AREAS

Limited bridge funding to continue proven interventions from Phase 2. **Awards** would be highly selective, with a continued focus on :

- Reducing ED-use
- Reducing readmissions
- Increasing post-acute care coordination
- Strengthening community partnerships

Funding to support the successful adoption of alternative payment models, including the MassHealth ACO program, through continued capacity-building activities in three areas:

- Analytics/risk stratification expertise
- Data exchange
- Legal support for community partnership contracting

COMPETITIVE FACTORS

Required matching/in-kind funds from hospitals/systems **to ensure sustainability**
Ensure alignment with DSRIP funding and MassHealth payment reform programmatic goals

Next Steps

HPC to continue developing Phase 3 design, including:

- Comprehensive stakeholder engagement
- Increased specificity of focus areas and targets
- Adapting administrative framework to reflect early lessons learned from Phases 1 and 2
- Review of CHART Phase 2 performance at the one year mark

HPC to present updated framework to CHICI for consideration and input in February

HPC to continue goal-setting activities, including evaluation framework and performance targets, for Committee consideration

[1]Distressed Hospital Trust funding pool after mitigation for select health systems

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HPC by the Numbers: The First Four Years

166 public board meetings

634 HPC articles

1,403,272 unique **twitter** impressions

$46 million distributed in grants to **27** community hospitals

686,323 unique **website** hits

900,000,000 lines of **claims** analyzed in the APCD

1,000,000 lines of **code** written

71 MCNs reviewed

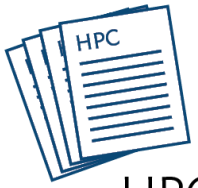
2,551 tweets

27 publications

HPC

HPC by the Numbers: Public Engagement in 2016

206,809
unique **website** hits



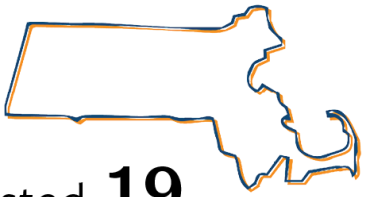
260
HPC articles

39
public meetings

2,120
attendees at **public meetings** throughout 2016

650+
meetings with over **200** different stakeholders

211
pages of minutes



hosted **19** **external meetings** for MA state agencies

21
newsletters

890
tweets

HPC

HPC by the Numbers: 2016 Policy Work

19
MCNs Reviewed

12
Reports Released

2
Regulations Approved

4
Investment Programs

60
Registering Provider Organizations

26
PCMH PRIME Certified Practices

8
unique data sets in 2016 Cost Trends Findings

HPC by the Numbers: Consumer and Patient Support in 2016

In 2016, the Office of Patient Protection processed

1241

calls and emails from consumers seeking information on health insurance enrollment and appeals

330

External Review Cases filed by consumers seeking a determination of medically necessary

HPC by the Numbers: 2016 Cost Trends Hearing

AUDIENCE

- Nearly 400 individuals in-person
- Over 2,700 individuals watching online
- Viewers came from the US, Germany, the Philippines, the UK, and Australia

WEBSITE

- 5,330 unique website visits
- 6.6% of all traffic to the Mass.Gov website
- The majority of people navigated to the Cost Trends Hearing agenda and materials

TWITTER

- 143 Official HPC Tweets
- 69,800 impressions (potential views by unique Twitter users)
- 32% outside of Massachusetts with 4% outside of the US
- 304 Retweets ⟶ 175 Likes ⟶ 50 Replies

MEDIA

- 25 unique articles across 14 major news outlets

Contact Information

For more information about the Health Policy Commission:

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

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us