MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Meeting of the Care Delivery and Payment System Transformation and Quality Improvement and Patient Protection Committees

June 7, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- Certification Programs Update
- Bailit Health's Design Recommendations for ACO Technical Assistance Program
- ACO Certification Spotlight: Community Care Cooperative
- Schedule of Next Meeting (July 19, 2017)

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- Call to Order
- **Approval of Minutes**
  - Joint CDPST/QIPP Meeting: April 26, 2017 **(VOTE)**
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VOTE: Approving Minutes

MOTION: That the joint Committee hereby approves the minutes of the joint CDPST/QIPP Committee meeting held on April 26, 2017, as presented.

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Practices Participating in PCMH PRIME

37 practices
are PCMH PRIME Certified

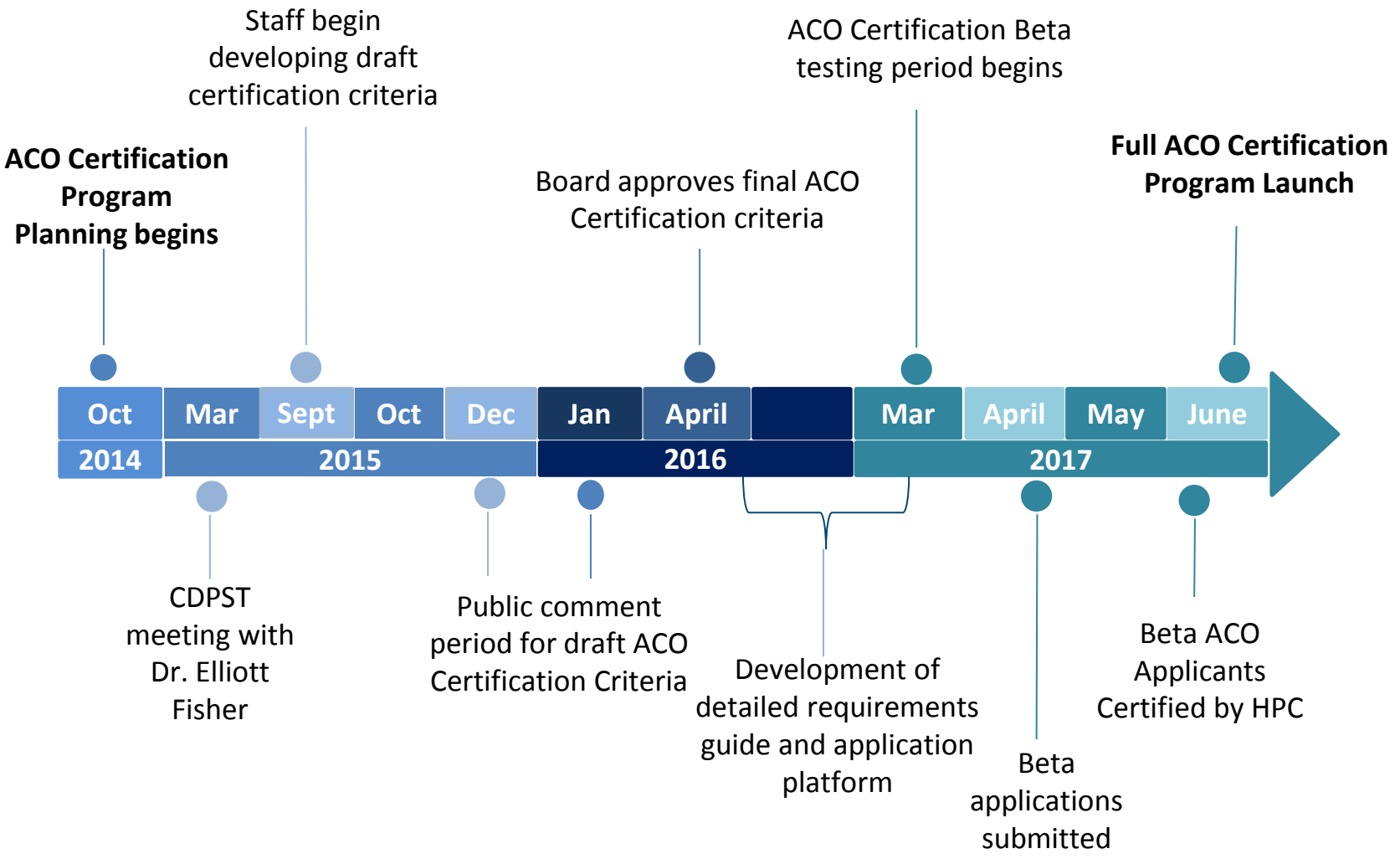
Recently Certified practices include:
Lowell Community Health Center
Manet Community Health Center, North Quincy

58 practices
are on the **Pathway to PCMH PRIME**

1 practices
are working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

96 Total Practices Participating

ACO Certification Program: Key Milestones to Date



Beta Launch Results

Congratulations and thank you to…

Community Care Cooperative (C3)

Boston Accountable Care Organization (BACO)

Beta Launch Experience

Beta Launch Activities

- ACOs received detailed application requirements and technical instructions
- Assistance included weekly office hours, individual troubleshooting
- Applications submitted in April and reviewed by the HPC

Feedback and Lessons Learned

- ACOs had a small number of questions regarding the certification criteria and documentation requirements, which were addressed by phone or email
- Users of the OnBase application system found initial training helpful, but most needed individual assistance later on
- ACOs needed 1-2 weeks longer than the original 5-week timeframe to complete the application

Full Launch Plans

Finalized Application Requirements and Platform User Guide (PUG) issued June 2

2 in-person trainings in June, and **1 webinar in July** for application system users

1:1 calls with ACOs to address PUG questions

Application system go-live ~June 15

Ongoing support to ACOs through weekly office hours, dedicated email, and individual calls as needed

Next Steps

Mid-June 2017 – Application system open for all Applicants

October 1, 2017 – Application submission deadline for MassHealth ACOs

Rolling to December 1, 2017 – HPC issues certification decisions

HPC expects to issue decision within 60 days of application receipt

Certification decisions are valid until December 31, 2019

2018 – Analyze and report on information received, implement technical assistance program, re-open application system as needed, etc.

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ACO Certification Technical Assistance

- **Accelerate delivery organization care transformation** towards value-based care delivery and development of core ACO competencies through discrete and targeted investments
- **Promote alignment** with other TA and investment programs at HPC (CHART TA, CHART Phase 3) and MA more broadly (MassHealth DSRIP TA)
- Focus TA offerings on areas covered within **HPC ACO Certification domains**

~$2 million in funding over 3 years

ACO TA Needs Assessment - Process

Strategic Consultation

- HPC contracted with Bailit Health to conduct a TA needs assessment of MA ACOs and develop recommendations for the HPC ACO TA program.

Methodology

- **Interviews** with four Massachusetts ACOs and two payers

- Communication with **industry experts on available TA resources** for MA ACOs

- **Meeting with MassHealth** to discuss TA for ACOs through DSRIP funding and to solicit feedback more broadly

Bailit Health's ACO TA Program Design Recommendations

- In April 2017, Bailit Health presented to a joint meeting of the Care Delivery and Payment System Transformation and Quality Improvement and Patient Protection Committees

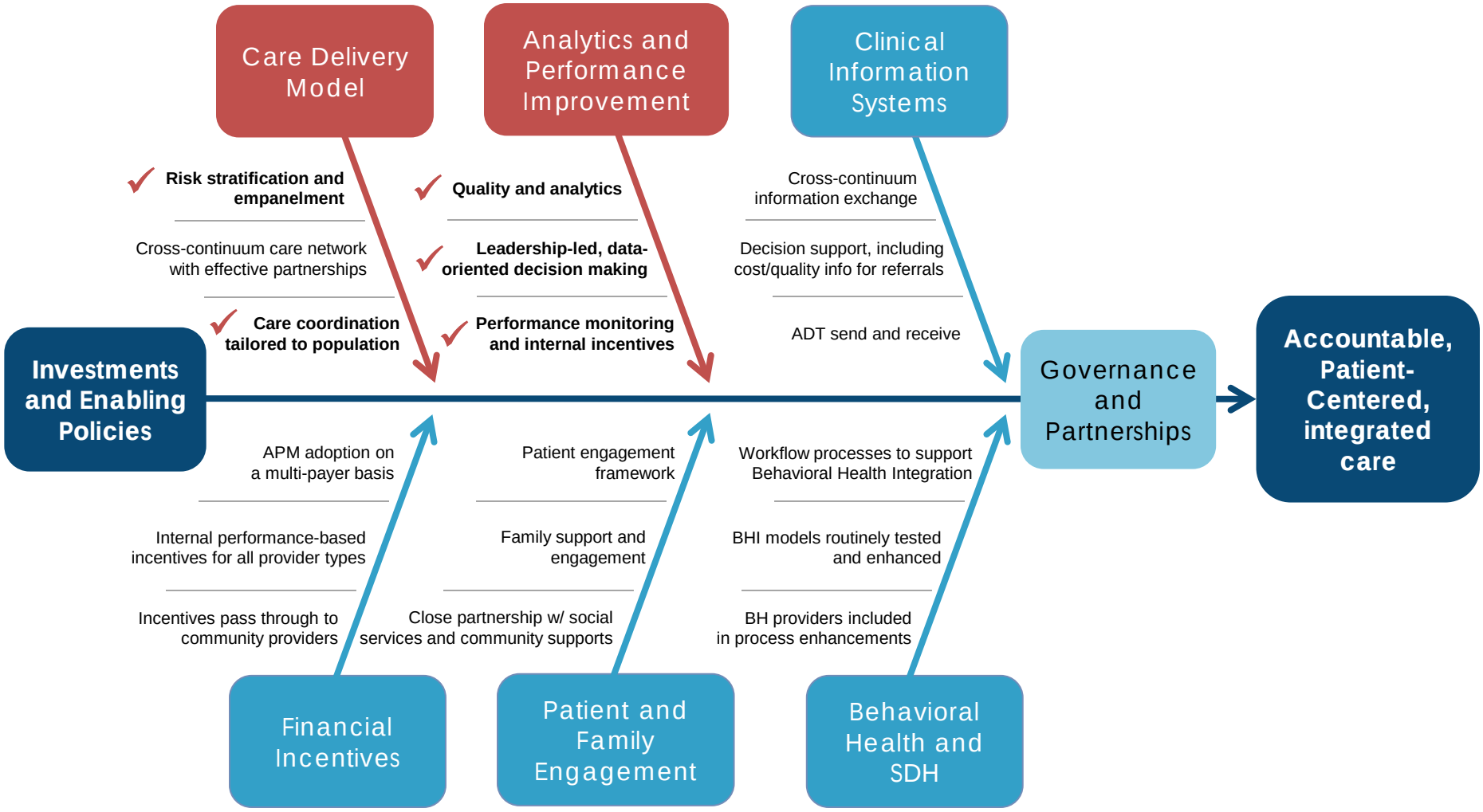
Priority Areas

- HPC should prioritize TA on **central core competencies** an ACO must develop and sustain in order to operate.
- HPC should target the following priority areas for TA based on the interview findings, and our experience and recommendations of others nationally regarding ACOs:
  - Strategies and methods for analyzing data for the purpose of care management
  - Strategies and methods for care management of high-risk patients

Priority Considerations

- HPC should consider these factors in **prioritizing TA investment in ACOs:**
  - participation in the HPC ACO Certification program
  - experience as an ACO
  - capacity and resources

Context for Proposed TA Program Priority Areas



Bailit Health's Recommendations for Operationalizing the HPC ACO TA Program: Grant Program

- The HPC should structure the ACO technical support as a **grant program** whereby ACOs apply for funding to support capacity development in one or both of the priority areas
- Grants should fund **ACO work including any contracts with consulting subject matter experts**
- Total amount of each grant should **not exceed $150,000**
- Grant/project period should **not exceed 18 months**
- ACOs should use the HPC grant funds to support **new work** only, and not previously procured and/or currently contracted work

HPC

bailit health

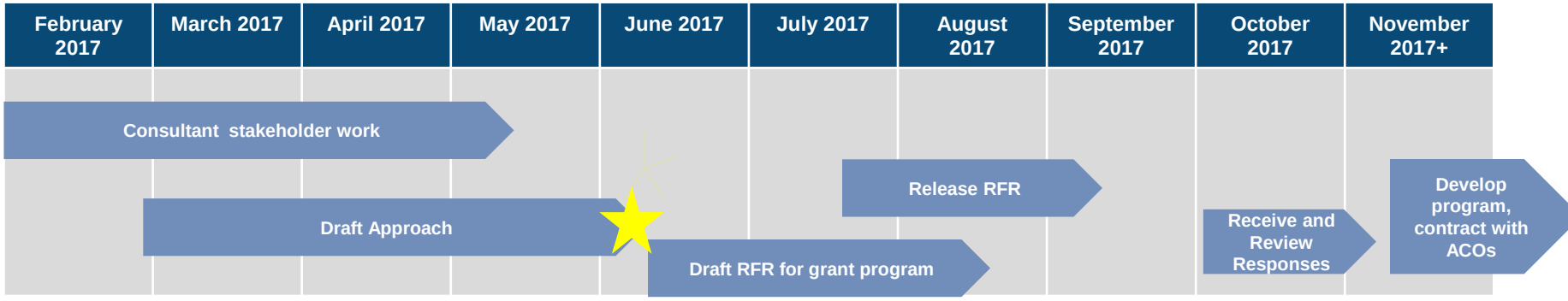
Bailit Health's Recommendations for Operationalizing the ACO TA Program: Application Requirements

- The application process and reporting requirements should be **minimally burdensome** without compromising program integrity
- If the ACO is working with a **proposed contractor** at the time of the application, they should submit to the HPC a copy of the contractor-proposed scope of work and budget
- ACOs should be permitted to **apply for support in both priority areas** on one application, but the total maximum allowable grant amount should remain $150,000 per ACO
- ACOs should be required to submit a **report to the HPC at the end of the funding period** documenting how they met their stated TA goals and objectives

Bailit Health's Recommendations for Operationalizing the ACO TA Program: Other Considerations

- HPC staff should **continue to work closely with MassHealth** to coordinate ACO TA development and communication to ACOs
- HPC should **communicate to ACOs the TA opportunity and its parameters as early as possible** so ACOs can strategically plan and coordinate responses to both the HPC and MassHealth
- HPC should attempt to **accelerate the timing of the TA program** implementation so ACOs can soon access support as they ramp up operations

ACO TA timeline and next steps



	Goal Setting and Design	Procurement	Implementation
Activities	☑ Meet with subject matter experts and stakeholders on program design considerations ☑ Align with other TA efforts at state and federal levels ☐ Discuss final TA framework, at CDPST	☐ Draft RFR ☐ Release RFR ☐ Receive and review proposals ☐ Selection of ACO TA proposals	☐ Finalize program design, measurable goals, and contract requirements ☐ Begin TA program ☐ Support program implementation as needed and monitor performance
Output	• Program Goals • Current Landscape	• RFR development • Proposal process • ACO TA proposal selection	• Operational planning • Program monitoring

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COMMUNITY
CARE COOPERATIVE

Meeting with Health Policy Commission

Care Delivery and Payment System Transformation

Our Corporate Members

NSCH
NORTH SHORE COMMUNITY HEALTH

THE DIMOCK CENTER

Hilltown Community Health Center

FENWAY HEALTH

HPC

Community Care Cooperative

- A little bit about how this all got started….

Community Care Cooperative

- Community Care Cooperative, Inc., or C3, is a new 501(c)(3) ACO health care organization, organized to take responsibility for managing the cost and quality of health care for attributed MassHealth members
- Unlike all other established and emerging ACOs in the Commonwealth, our model is a Federally Qualified Health Center (FQHC), primary care-based ACO
  - We have not found another FQHC-ACO in the country organized to take two-sided total cost of care (TCOC) risk
  - Therefore, our ACO is uniquely positioned to revolutionize the cost and quality equation for the Massachusetts Medicaid program

Primary Care ACOs (Model B): Summary of Key Highlights

What we love	Why we love it
Stand alone, independent ACO	We make all financial and business decisions We decide how and where DSRIP is spent – no quibbling! No core business conflicts
Performance risk, not insurance risk	Things like PMPY beneficiary capping & carving-out of anomalous market events decrease financial risks and create more actuarial stability
PCC Plan is benefit plan and network administrator	Members have access to full PCC hospital and specialist network; administrative simplicity; fixed unit cost pricing
PCP monogamy	Our PCPs only participate with us, ensuring scale and reducing need for marketing efforts
Members attribute based on PCP history and are assigned to C3 in a special enrollment	There will be an opt-out period, and then a 12-month lock-in
Experienced-based-to-Market budget setting over time	Establishing a rational starting point and a future that rewards us for the historic and continue value that we provide

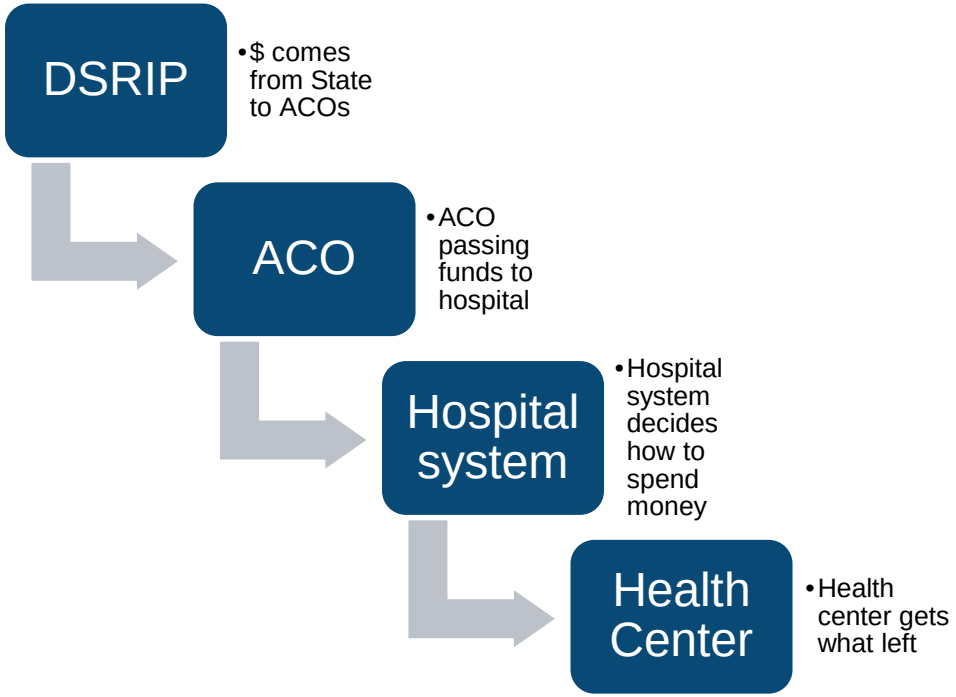
Why We Think an FQHC-based ACO Is a Really Good Idea

- American Journal of Public Health published an article Nov 2016:
- Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings
- Robert S. Nocon, Sang Mee Lee, Ravi Sharma, Quyen Ngo-Metzger, Dana B. Mukamel, Yue Gao, Laura M. White, Leiyu Shi, Marshall H. Chin, Neda Laiteerapong, and Elbert S. Huang (doi: 10.2105/AJPH.2016.303341)
- Objectives. To compare health care use and spending of Medicaid enrollees seen at federally qualified health centers versus non–health center settings in a context of significant growth.
- Methods. Using fee-for-service Medicaid claims from 13 states in 2009, we compared patients receiving the majority of their primary care in federally qualified health centers with propensity score–matched comparison groups receiving primary care in other settings.
- **Results. We found that health center patients had lower use and spending than did non–health center patients across all services, with 22% fewer visits and 33% lower spending on specialty care and 25% fewer admissions and 27% lower spending on inpatient care. Total spending was 24% lower for health center patients.**
- Conclusions. Our analysis of 2009 Medicaid claims, which includes the largest sample of states and more recent data than do previous multistate claims studies, demonstrates that the health center program has provided a cost-efficient setting for primary care for Medicaid enrollees. (Am J Public Health. Published online ahead of print September 15, 2016: e1–e9. doi:10.2105/AJPH.2016.303341)

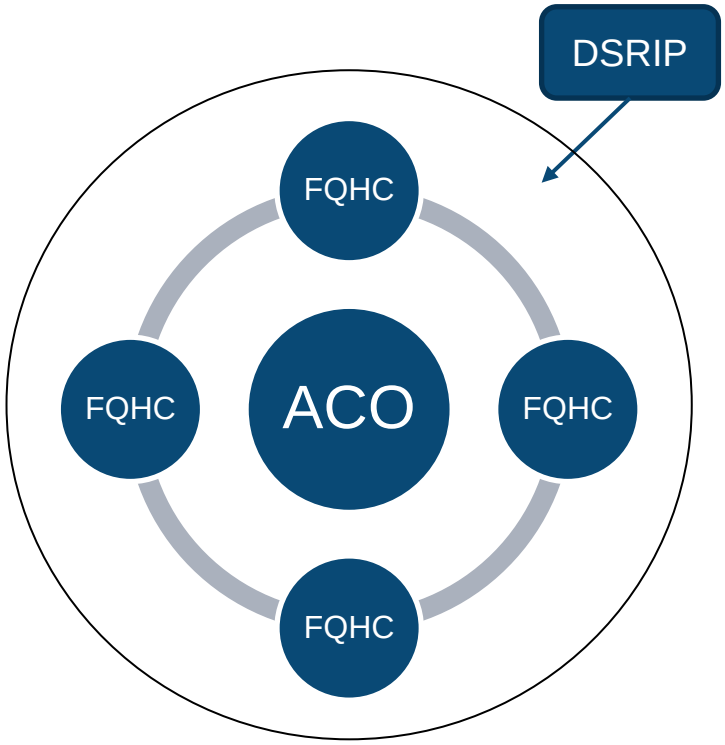
Why Do FQHCs Like C3?

- Best chance at financial success
- Best strategy to preserve health center autonomy

Typical Model



C3 Model



Vision, Mission & Strategy

Vision	• Transforming the health of underserved communities
Mission	• To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve
Strategy	• Improve health outcomes and decrease cost trends through community-based innovation

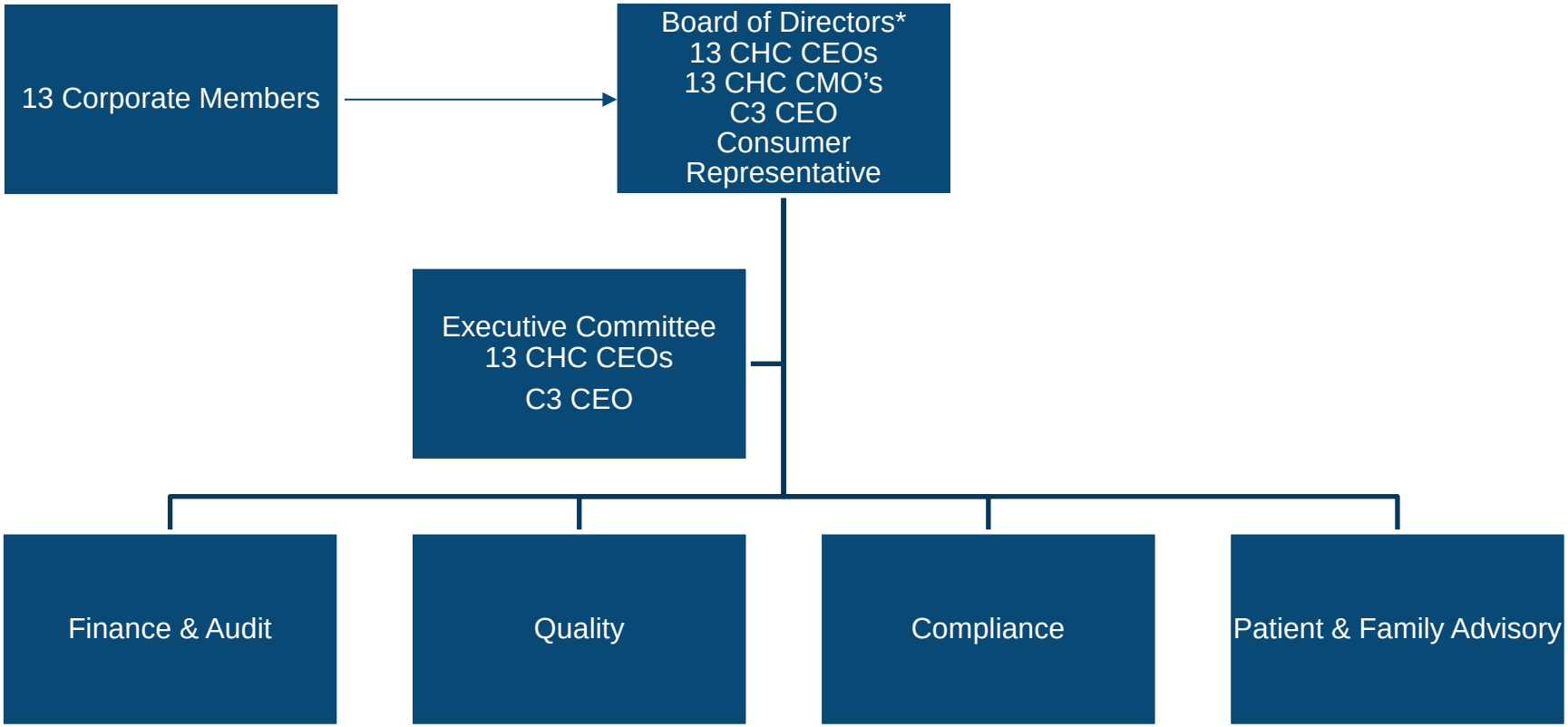
What We Want To Achieve

- Transform primary care through direct financial investment and deep technical support to create a long-term plan for financial sustainability
- Re-draft the narrative to focus on real methods and systems to achieve cost control and quality improvement in health care
  - e.g.: primary care design; social health; not bricks and mortar
- Move beyond “medicalization” of care to efforts aimed at truly improving people’s lives
  - Just look at the data
- A collaborative environment where we have moved from “if you’ve seen one health center, you’ve seen one health center” to a national model of producing real cost and quality results on value-based payments through *collaboration*
- Improved quality for work-life for PCPs
- True community-based efforts at addressing the impacts of poverty on individuals, families and communities

Why We Think Our Strategy Can Work

- As a health center-based ACO, we do not face the core existential issue that traditional system ACO must overcome to achieve cost savings targets
- This allows us to leverage a whole new approach to managing the cost and quality of vulnerable populations
- Our care model is designed to de-medicalize an approach to health, wellness and happiness
  - Moving from “health care” to “health” for vulnerable populations
  - Meaningful whole person care: highly integrated physical & behavioral health
  - More engagement of community partners
  - More focus on alleviating social impediments to health, wellness & happiness
- We have already created “a coalition of the willing” locally and nationally of organizations that want to support our efforts
  - We have also received numerous inquiries from throughout the country

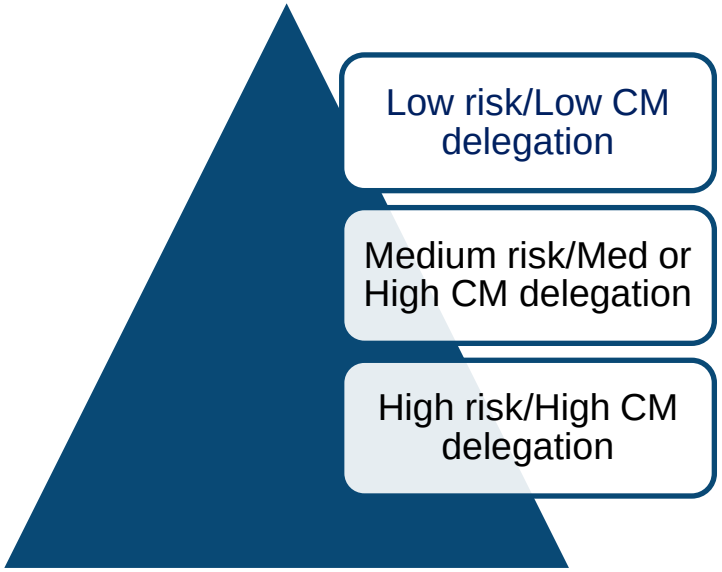
Governance Structure



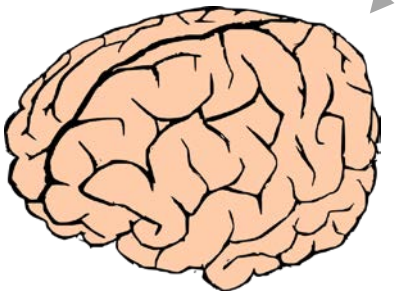
* One member, one vote

Internal Financial Architecture (IFA)
Scope & Guiding Principles

- Our IFA methodology includes creating sub risk units at the health center level, while retaining aspects of socialization within the collective
- This allows us to customize and match the amount of risk a health center takes to their experience, capabilities and financial position
  - These systems also ensure that the company is financially sound
- In order to create the best matches with starting point capacities of our health centers (financial and care management), we have three IFA offerings



Using Data to Help Us Provide the Right Care at the Right Time



Patient screens

EHR

SDoH data

Claims

ADT & Auth alerts

"The Main Brain"

Data Warehouse with a Rules-based engine

Performance Analytics

Cost & Quality performance information

Risk of Big Events

Complex Care

Risk of Re-admissions

Transitions of Care

Care & Social Needs

Care Coordination

Gaps in Quality & Care

Population Health & Risk Adjustment

HPC

C3 Full ACO Model of Care: An Overview

Key principles:

- Building on our key strength of the integrated PCMH for 95% of the care, 95% of the time
- Surrounding the PCMH with proven care management and population health programs
- Using data and analytics to provide the right care at the right time
- Achieving long term sustainability through savings on TCOC and quality improvement

Policy Interests for Discussion Today

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Contact Information

For more information about the Health Policy Commission:

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