MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Advisory Council

May 9, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Presentation: Executive Director's Report
- Presentation: Market Oversight and Transparency
- Presentation: Care Delivery Transformation
- Discussion: HPC Priorities for 2018
- Schedule of Next Meeting: July 11, 2018

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- **Presentation: Executive Director's Report**
  - New Board Policy Committees
  - Agency Administration and Finance
  - 2019 Health Care Cost Growth Benchmark
  - Upcoming Public Sessions
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Chapter 224 of the Acts of 2012 established the HPC and a target for reducing health care spending growth in Massachusetts.

Chapter 224 of the Acts of 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

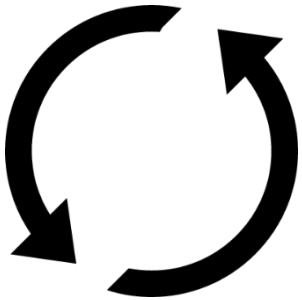
A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for the people of the Commonwealth.

HPC

The HPC, in collaboration with others, promotes and monitors priority policy outcomes that contribute to the goal and vision of Chapter 224.

Strengthen market functioning and system transparency

in which payers and providers openly compete, providers are supported and equitably rewarded for providing high-quality and affordable services, and health system performance is transparent in order to implement reforms and evaluate performance over time.



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

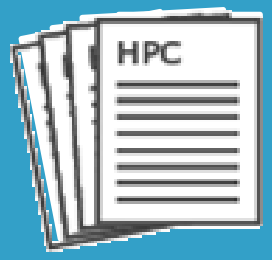
Promoting an efficient, high-quality system with aligned incentives

that reduces spending and improves health by delivering coordinated, patient-centered and efficient health care that accounts for patients' behavioral, social, and medical needs through the support of aligned incentives between providers, employers and consumers.

The HPC employs four core strategies to advance the policy priority outcomes.

RESEARCH AND REPORT

INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS



CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

MONITOR AND INFORM TO ASSURE MARKET PERFORMANCE

PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

New committee structure aligned with priority policy outcomes

MARKET OVERSIGHT AND TRANSPARENCY

Primary Policy Aim: *Strengthen market functioning and system transparency*

Committee Members

Dr. David Cutler (Chair)
Dr. Wendy Everett
Mr. Richard Lord
Mr. Renato Mastrogiovanni
Secretary Michael Heffernan or Designee

Focus Areas

- Evaluation of market changes (e.g., MCNs/CMIRs)
- Benchmark establishment and monitoring
- Performance Improvement Plans (PIPs)
- Post-transaction reviews
- Registration of Provider Organizations (RPO)
- Research (e.g., pharmaceutical spending, out of network billing, facility fees, provider price variation)

HPC

New committee structure aligned with priority policy outcomes

CARE DELIVERY TRANSFORMATION

Primary Policy Aim: *Promote an efficient, high-quality system with aligned incentives*

Committee Members

Mr. Martin Cohen (Chair)
Dr. Donald Berwick
Mr. Timothy Foley
Secretary Marylou Sudders or Designee
Dr. Chris Kryder

Focus Areas

- Certification programs (ACO, PCMH)
- Investment programs (CHART, HCII, new investments)
- Learning and dissemination activities
- Program evaluation
- Alternative payment methods expansion
- Quality measurement alignment and improvement
- Office of Patient Protection (OPP)
- Research (e.g., avoidable acute care utilization, behavioral health integration, opioid epidemic)

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HPC Line-Item: FY19 Budget Proposals

For FY19, the HPC requested a modest 3% increase to the operating account. The state budget is to be finalized by July 1, 2018.

State Budget Process

Governor's FY19 Budget Proposal
1450-1200: *For the operation of the Health Policy Commission*... $8,540,451

House FY19 Budget Proposal
1450-1200: *For the operation of the Health Policy Commission*... $8,769,931

Senate FY19 Budget Proposal
1450-1200: *For the operation of the Health Policy Commission*... Finalized May 2018

Final State Budget
1450-1200: *For the operation of the Health Policy Commission*... Finalized July 2018

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MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK

March 28, 2018

Summary of Testimony

Organization	Position
1199 SEIU	3.1%
Association for Behavioral Health Care	3.1%
Associated Industries of Massachusetts	3.1%
Atrius Health	3.1%
Beth Israel Deaconess Care Organization	3.1%
Conference of Boston Teaching Hospitals	3.1%
Greater Boston Interfaith Organization	3.1%
Health Care for All	3.1%
Home Care Alliance of Massachusetts	No formal position
Lahey Health	No formal position
Lawrence General Hospital	3.1%
Massachusetts Association of Behavioral Health Systems	No formal position
Massachusetts Association of Health Plans	3.1%
Massachusetts Business Roundtable	No formal position
Massachusetts Health and Hospital Association	3.1%
Massachusetts Nurses Association	3.1%
Massachusetts Taxpayers Foundation	3.1%
Mental Health Legal Advisors Committee	No formal position
National Federation of Independent Business	No formal position
Retailers Association of Massachusetts	3.1%
Steward Health Care System, LLC	3.1%

The HPC Board Voted Unanimously to Establish the 2019 Health Care Cost Growth Benchmark at 3.1%

- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state's long-term economic growth rate:
  - Health care cost growth benchmark for 2013 - 2017 equals **3.6%**
  - Health care cost growth benchmark for 2017 - 2019 equals **3.1%**

- If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:
- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Net cost of private health insurance

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Save the Date

THURSDAY

May 17, 2018

8:00AM

UMass Club
One Beacon Street, 32nd Floor
Boston, MA 02108

MASSACHUSETTS
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HPC SPECIAL EVENT

Partnering to Address the Social Determinants of Health: *What Works?*

Join the HPC for a special event to explore how partnerships between health care providers and community stakeholders work to address health-related social needs. The morning will feature nationally-recognized experts and panels of Massachusetts health care leaders focused on the practical and policy approaches for supporting such partnerships. Coffee and a light breakfast will be provided. Register now (link below) and visit the HPC's website (www.mass.gov/HPC) for more information.

Reserve your seat: tinyurl.com/HPCAddressingSDH

Public Hearing on RBPO/ACO Patient Appeals Regulation

Public Hearing

Friday, May 25, 2018
9:30 AM
50 Milk Street, 8th Floor

The HPC is conducting a public hearing on the PROPOSED regulation on Risk-bearing Provider Organization and Accountable Care Organization Appeals

Parties will have 5 minutes to offer comments. Written testimony and comments will also be accepted until **5:00 PM on Friday, May 25** to HPC-Testimony@mass.gov.

For more information, please visit **https://www.mass.gov/service-details/hpc-regulations-and-guidance**

HPC

Save the Date

OCTOBER 15 & 16, 2018

THE HEALTH POLICY COMMISSION'S 6TH ANNUAL
HEALTH CARE COST TRENDS HEARING

The annual health care cost trends hearing is a public event at which policymakers and researchers convene to address challenges and discuss opportunities for improving care and reducing costs in the Commonwealth's health care sector. The prominent, two-day hearing features live testimony from top health care executives, industry leaders, and government officials. Questions are posed from Massachusetts and national health care experts about the state's performance under the Health Care Cost Growth Benchmark, the drivers of health care costs, and other health care reform efforts.

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Cost Trends Research and Reports: Revised Design Approach

Previous Approach

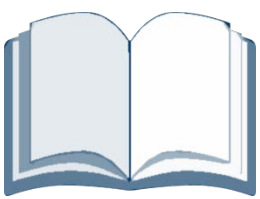
1 ANNUAL REPORT
- ~80-100 pages • Primarily narrative
- 10-12 fully written chapters

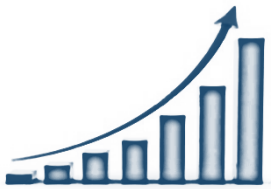
1-2 SUPPLEMENTAL PUBLICATIONS
Full written reports

Revised Approach

1 ANNUAL REPORT
- ~50 pages • Narrative and visual
- 3-4 fully written chapters
- 3-4 graphical chart packs
- Online interactive content utilizing data visualization tools (Tableau)

6-8 SUPPLEMENTAL PUBLICATIONS
Varying types
(Policy Briefs, Chart Packs, DataPoints)

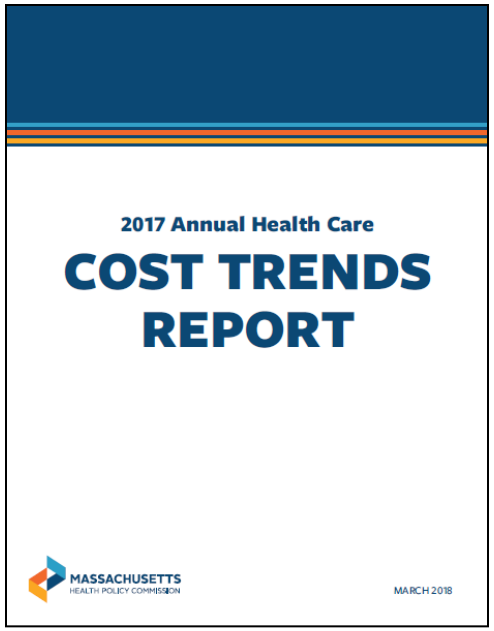




Goal

Advance the HPC's mission to publicly report on health care system performance by producing a variety of reports and publications that are visually-appealing, engaging, and accessible to a wide range of audiences.

The 2017 report includes material in two publications, a narrative written report and a graphical chartpack.



Written Report Focus Areas:

- Trends in Spending and Care Delivery
- Hospital Outpatient Department Spending
- Provider Organization Performance Variation
- Policy Recommendations

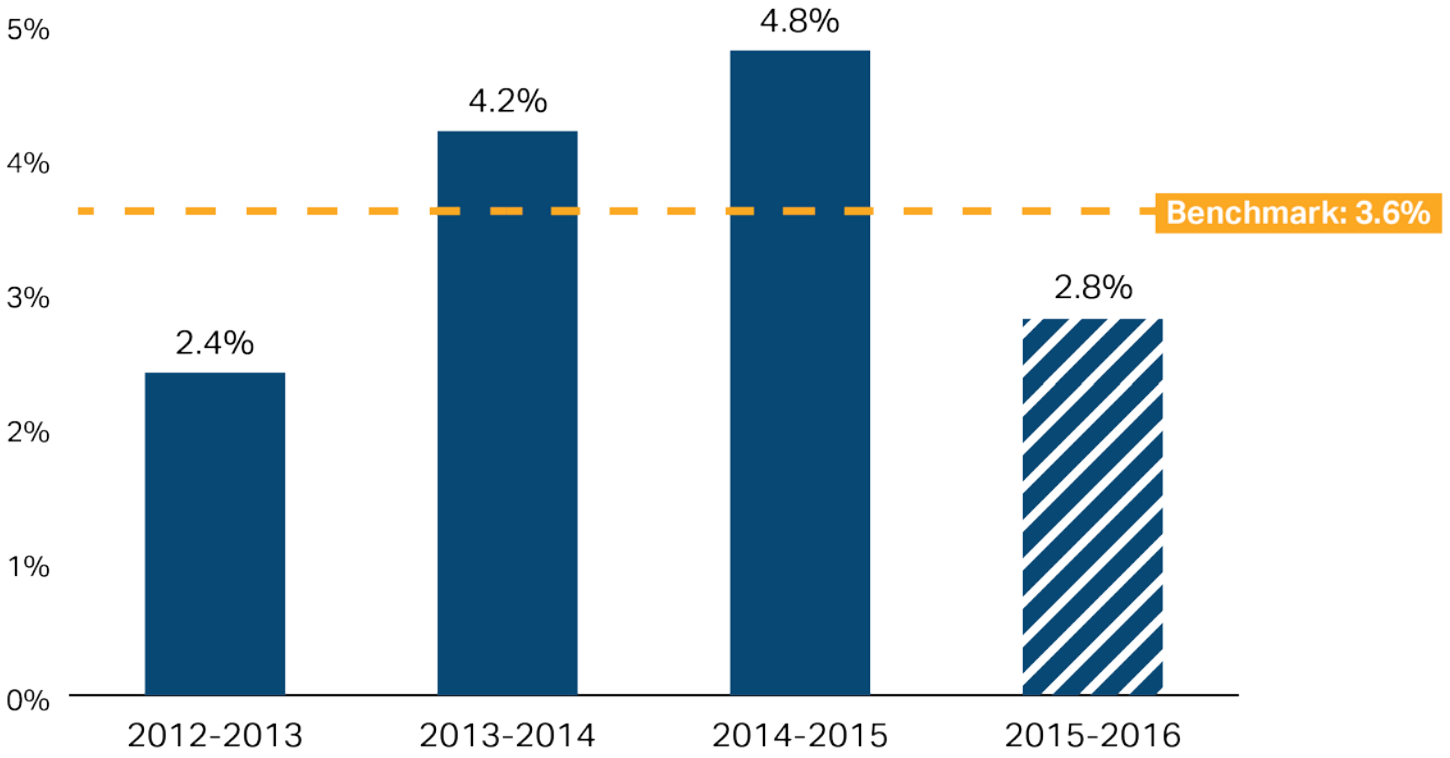
Chartpack Focus Areas:

- Hospital Utilization
- Post-Acute Care
- Alternative Payment Methods
- Demand-Side Incentives

HPC

Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate

Annual per-capita total health care expenditure growth in Massachusetts, 2012-2016

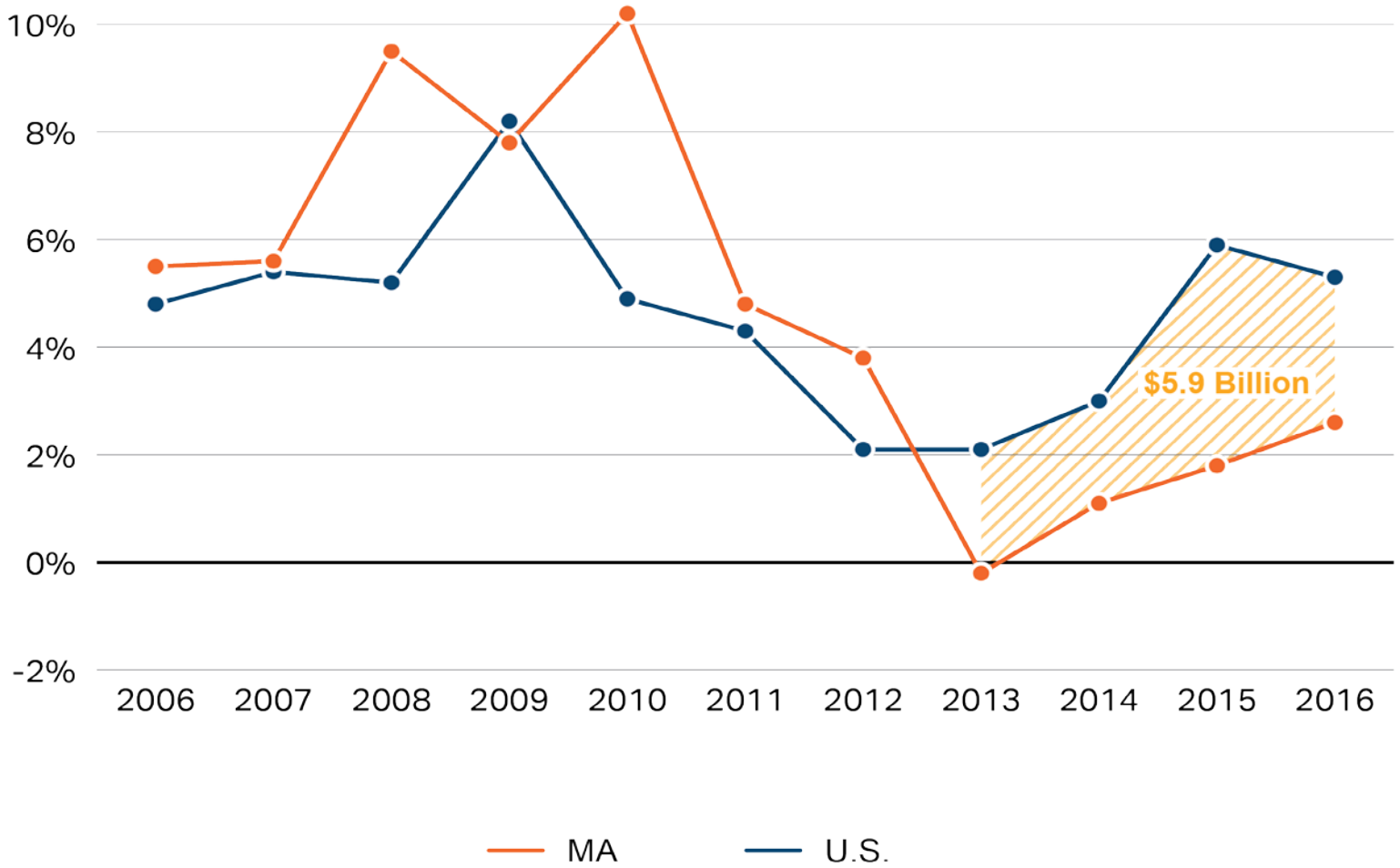


Average annual spending growth from 2012-2016: 3.55%

Notes: 2015-2016 growth is preliminary. All other years represent final data.
Sources: Center for Health Information and Analysis, Total Health Care Expenditures

In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance spending from previous year, per enrollee, MA and the U.S.

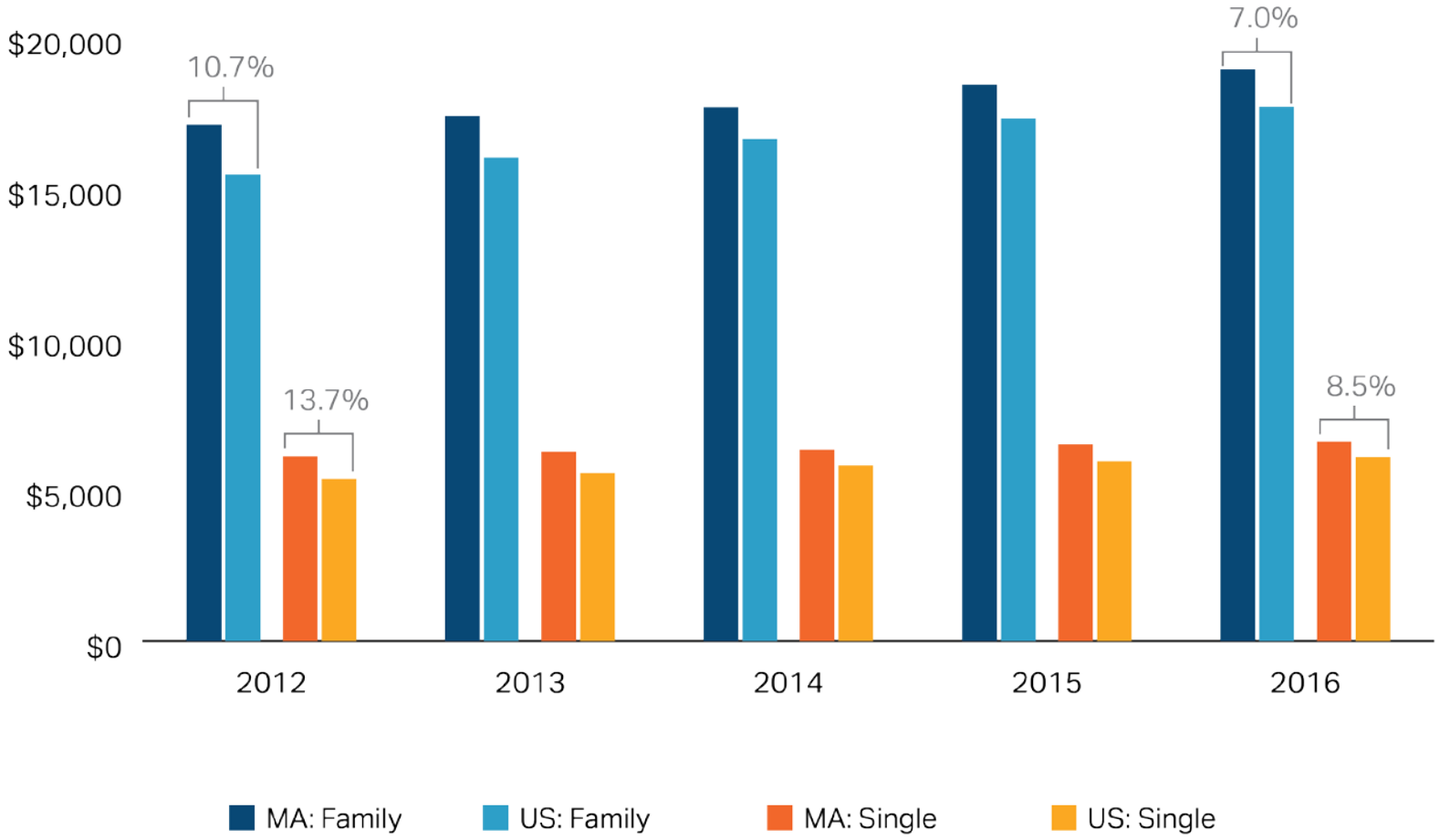


Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Sources: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (2015-2016)

For both families and individuals, the difference between MA and the U.S. premiums narrowed between 2012 and 2016

Annual employer sponsored health insurance premiums, single and family coverage



Family premiums in Massachusetts averaged $19,000 in 2016, $21,085 including typical cost-sharing

Sources: HPC analysis of Medical Expenditures Panel Survey data, 2012 - 2016

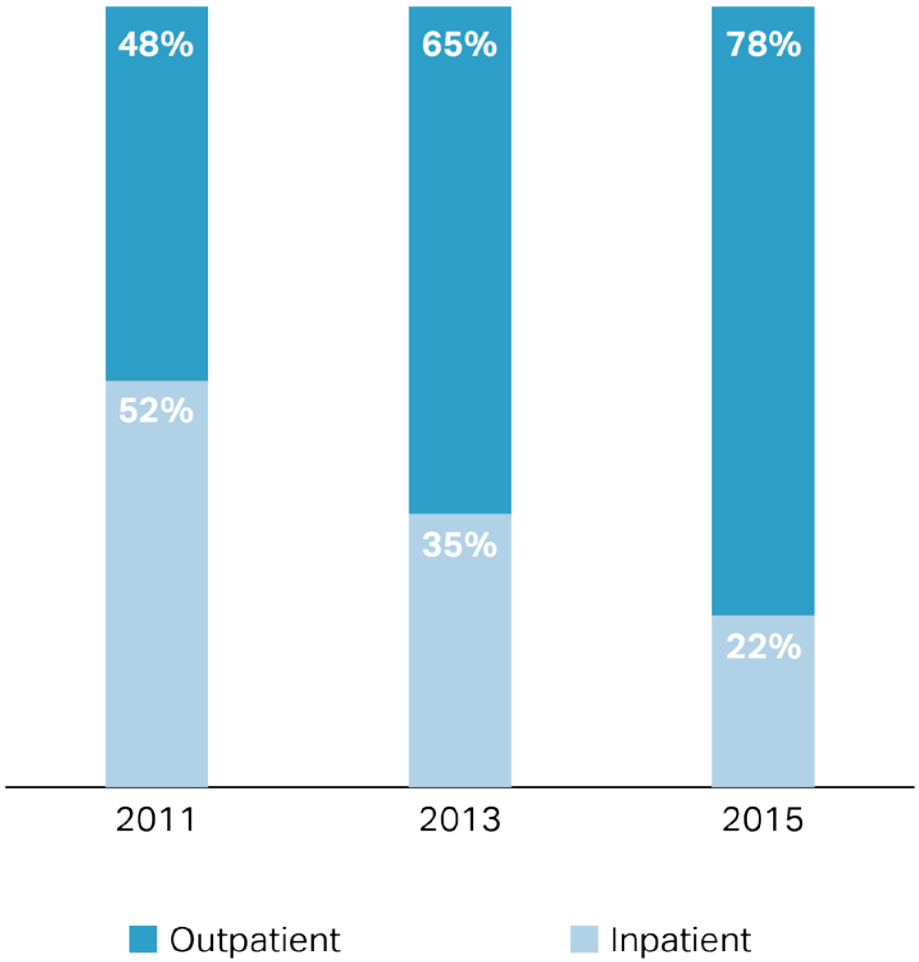
Trends in hospital outpatient spending

- Hospital outpatient is a high-growth area of spending, with 5.3% growth in 2016
- Shifts in setting of care are an important dynamic in hospital outpatient spending:
  - Services have shifted from inpatient to outpatient, while others have shifted from the community to outpatient

Prices for the same service in hospital outpatient departments are typically higher than in community settings because outpatient services charge both a professional fee and a facility fee

Surgery procedures are shifting from hospital inpatient to hospital outpatient settings for high volume 'crossover' procedures

Share of volume by setting for laparoscopic cholecystectomy, laparoscopic appendectomy, arthrodesis, laparoscopic total hysterectomy, and laparoscopic vaginal hysterectomy, 2011 - 2015

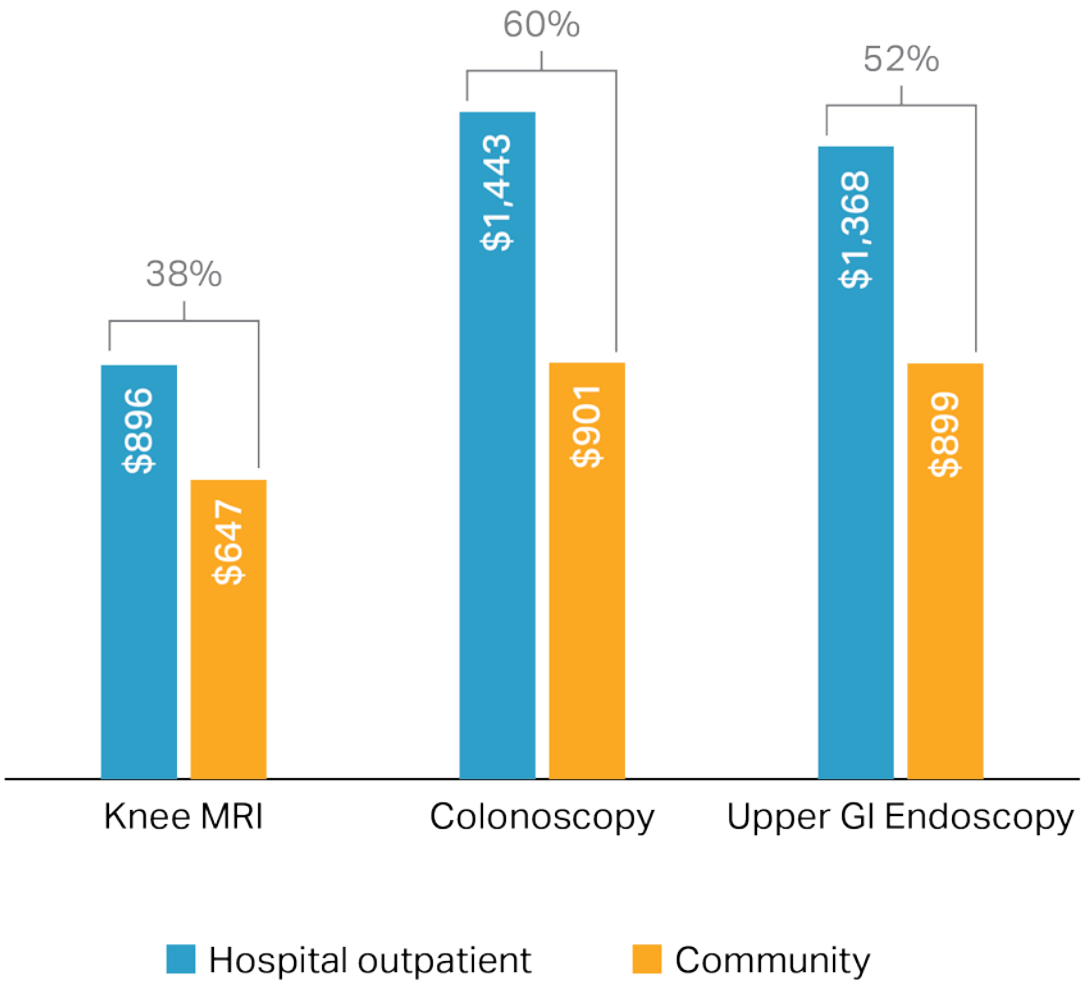


Notes: The five major cross-over procedures were identified as the highest-volume procedures billed by surgeons in 2013 where at least 10 percent of the surgeries occurred at an inpatient hospital and at least 10 percent occurred in an outpatient setting. Spending includes insurer and enrollee payments for the facility portion of the surgical procedure.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2011-2015

Commercial prices remain significantly higher in the hospital outpatient setting than in community settings across common procedures in 2015

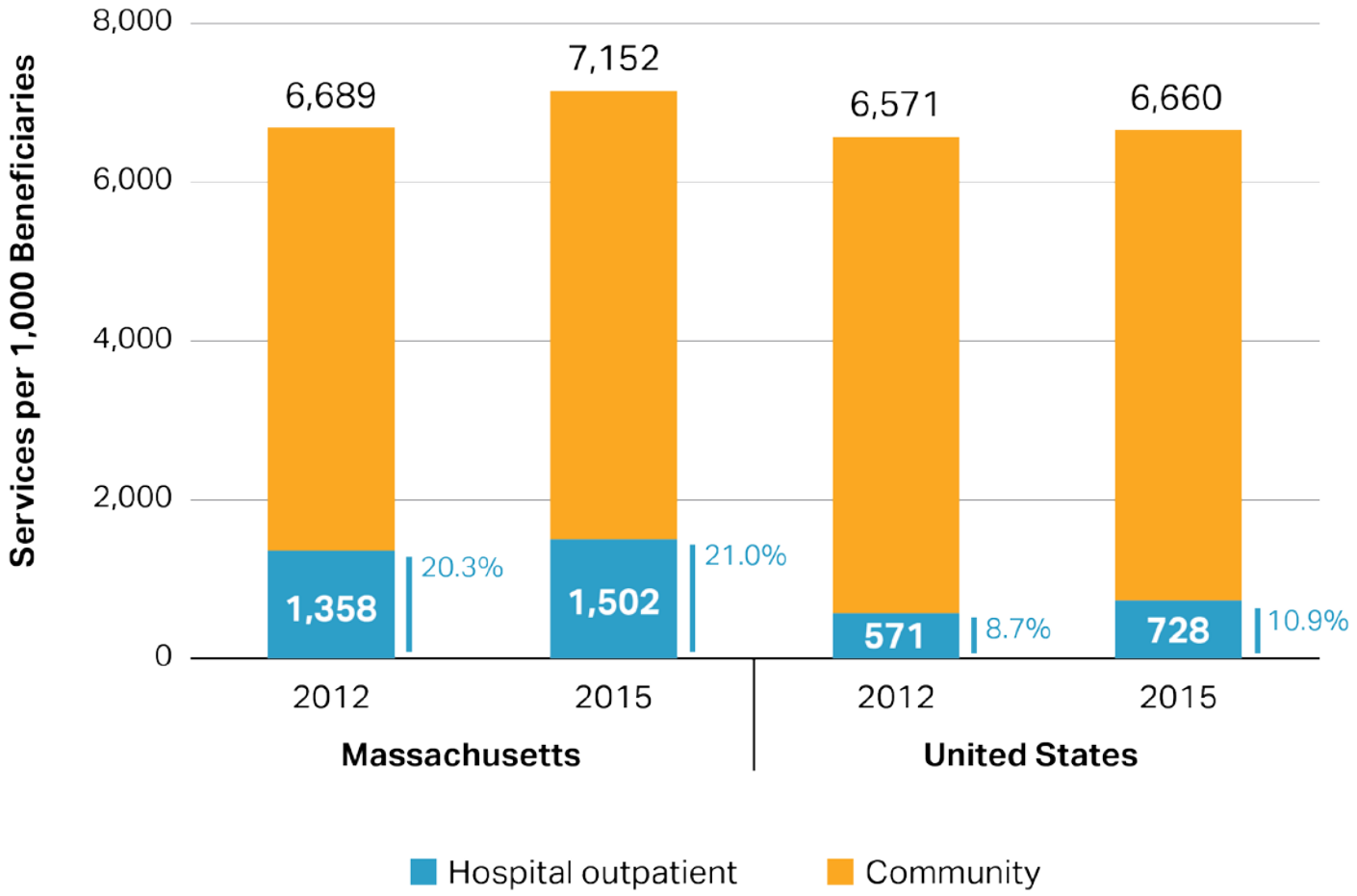
Mean commercial price in hospital outpatient versus community settings, 2015



Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2013-2015

In Medicare, MA uses hospital outpatient for routine office visits at twice the national rate

Services per 1,000 beneficiaries by setting for Evaluation and Management visits (99211 - 99215), 2012 and 2015



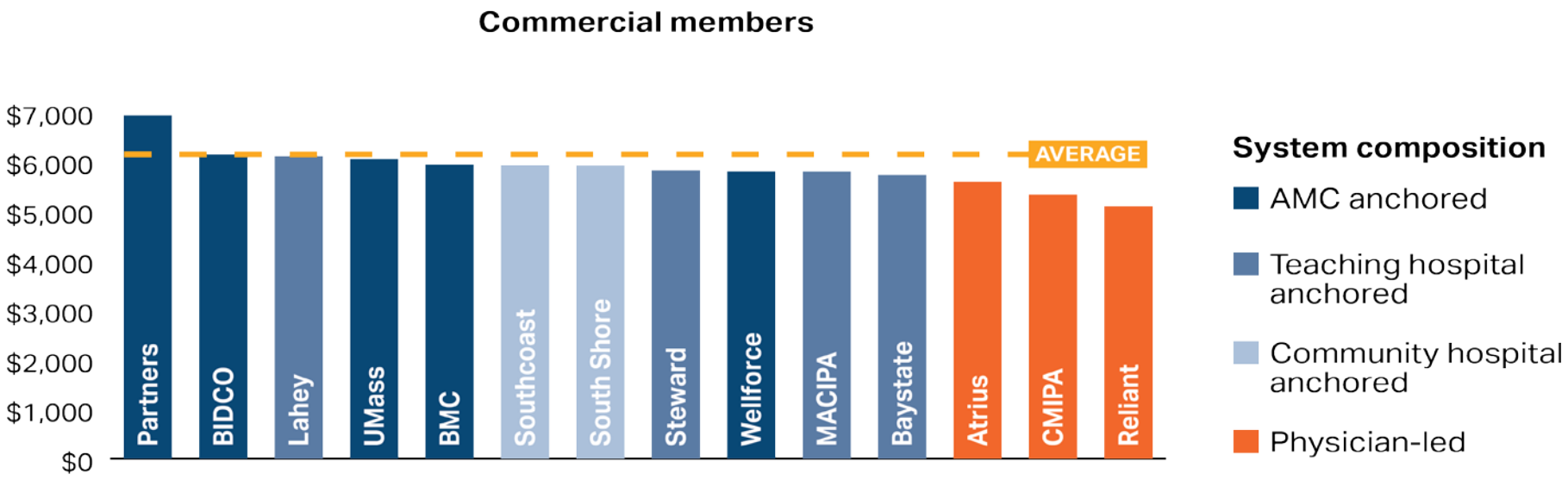
Notes: Prices reflect Medicare allowed amount for services. Professional services paid under the Medicare physician fee schedule (MPFS). Facility fees paid under the Outpatient Prospective Payment System (OPPS). The Current Procedural Terminology codes used for Evaluation and Management visits are 99211-99215. The Healthcare Common Procedure Code Set code for this example under OPPS is G0463. Hospital outpatient category includes settings for which Medicare reimburses professional services at a facility rate.

Sources: Center for Medicare and Medicaid Services, Medicare Physician and Other Supplier Public Use File, 2012-2015

Member spending in the highest-cost organization was 36% higher than in the lowest-cost organization

Average commercial PMPY spending, by provider organization, 2014

Risk adjusted



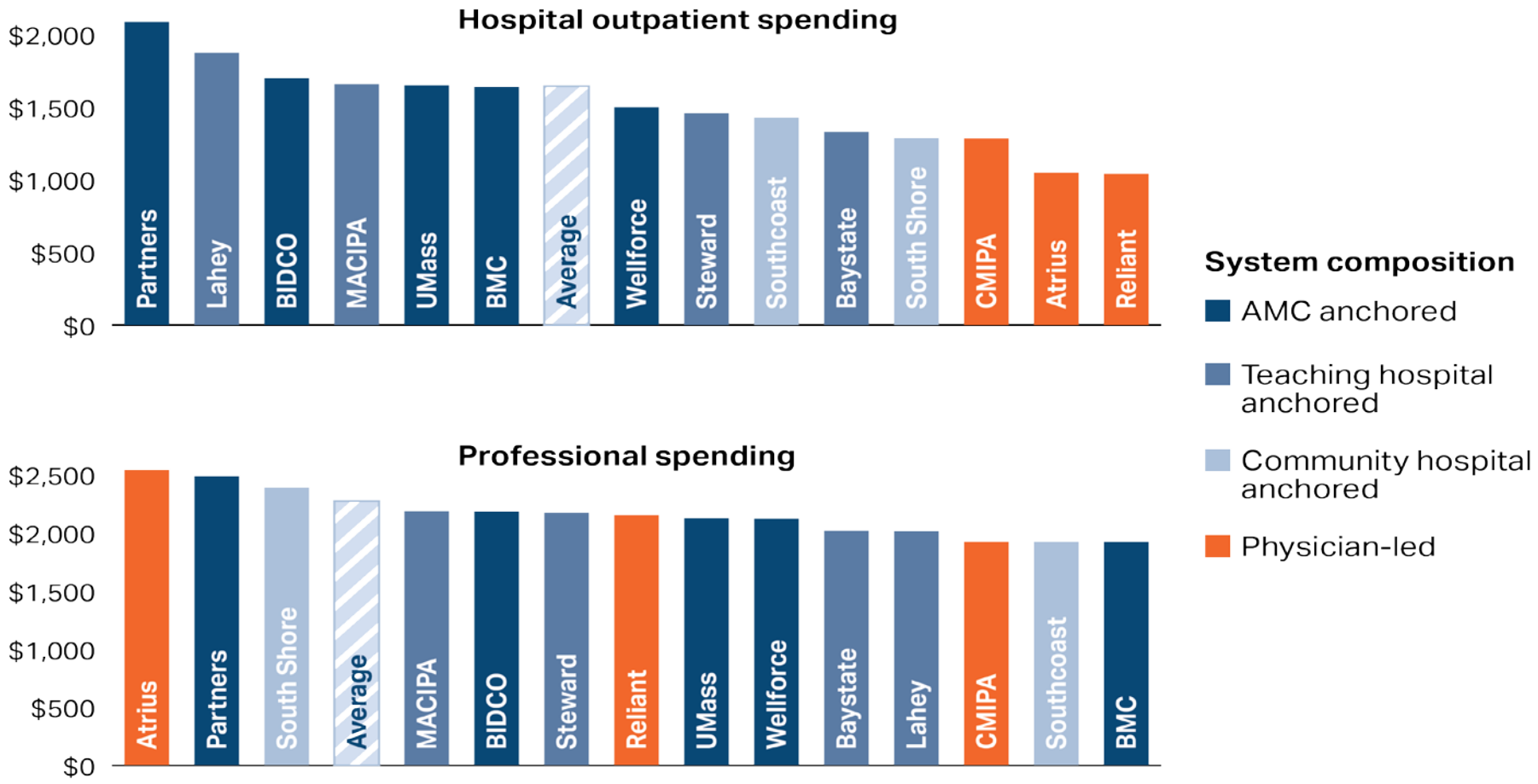
Notes: PMPY= per member per year, PCP= primary care provider, AMC= academic medical center. Spending adjusted using ACG risk-adjuster applied to claims data. Data includes only adults over the age of 18. Commercial payers include Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. MassHealth includes only MCO enrollees who had coverage through BMC HealthNet, Neighborhood Health Plan, or Network Health/Tufts. Members in the MassHealth Medical Security Program (MSP) were excluded. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registry of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

Differences in professional and outpatient spending suggest some substitution based on site-of-service

Average commercial PMPY spending, by provider organization, by category of spending, 2014

Risk adjusted



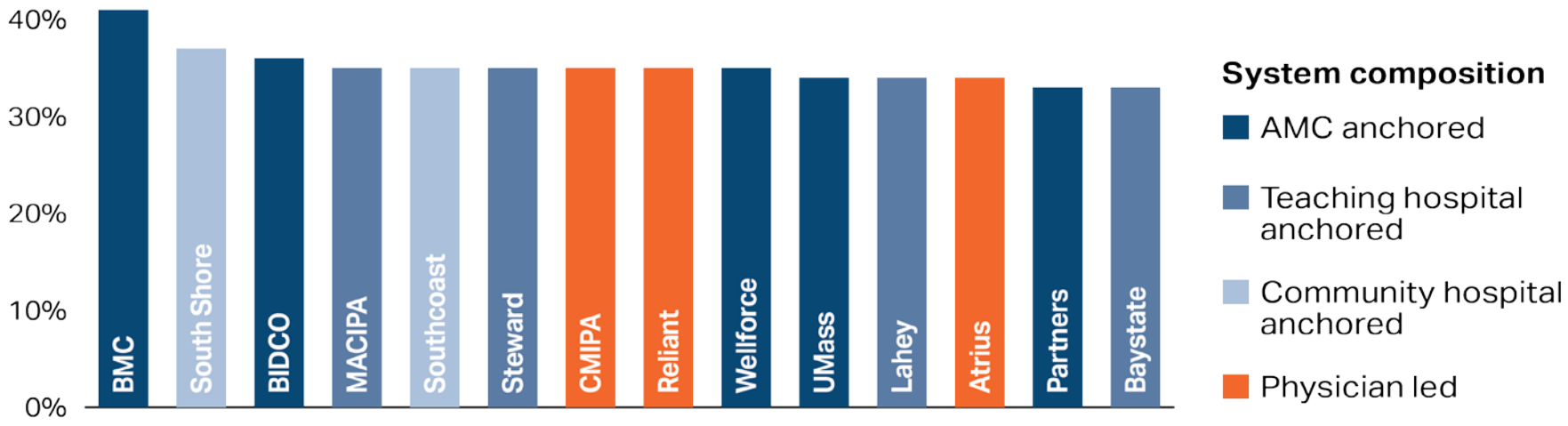
Notes: PMPY= per member per year, PCP= primary care provider, AMC= academic medical center. Spending adjusted using ACG risk-adjuster applied to claims data. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

The percentage of ED visits that were potentially avoidable varied by organization from 41% to 33%

Percent of ED visits that were potentially avoidable, by provider organization, 2014

Risk and demographic adjusted



Notes: ED= emergency department; PCP= primary care provider, AMC= academic medical center. Adjusted avoidable ED visits by provider group were defined according to the NYU Billings Algorithm and calculated after adjusting for the following patient characteristics: risk score, median community income, area deprivation index, fully insured (commercial patients only), age, gender, and payer. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

HPC DataPoints showcases brief overviews and interactive graphics on relevant health policy topics.

Issue #5: Quality Measure Misalignment in MA

- The three largest MA commercial payers vary in their scope of quality measure use in APM contracts; one payer reported use of 26 measures in at least ten APM contracts while the others reported use of over 40 measures in at least ten APM contracts.

- Only 17 quality measures are used in at least ten APM contracts by all three payers, including two common outcome measures.

Issue #6: Provider Organization Performance Variation

- After adjusting for differing health needs, spending for patients in the highest-cost organization was 32 percent higher than in the lowest-cost organization.

- The greatest variation across provider groups occurs in the hospital outpatient spending category, where the highest-cost provider organization for hospital outpatient spending, Partners ($1,963), is twice as expensive as the lowest-cost provider organization, Reliant ($974).

Issue #7: Variation in Imaging Spending

- Massachusetts ranks as the 4th highest spending state for imaging services with $892 in annual costs per Medicare beneficiary, 14 percent higher than the U.S. average. This is a contributing factor to higher overall health care costs in Massachusetts.

- Massachusetts has relatively high facility use for imaging procedures, ranking 18th among states. Prices are typically more than twice as high when the service is provided in a hospital outpatient department or other facility, compared to the same service performed in a doctor's office or other non-facility setting.

UPCOMING Issue #8: Urgent Care Centers

HPC

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Opportunities for Improving Care and Reducing Spending

Background on 2018 Opportunities

- In order to inform the consideration of whether to modify the health care cost growth benchmark, the HPC identified a set of specific opportunities for improvement and modeled potential health care spending reduction estimates for each one.
- The limited set of seven scenarios is based on specific policy recommendations and targets described in the 2017 Cost Trends Report. This should **not** be considered an exhaustive list of potential areas for reducing health care spending.
- These illustrative, **"what-if"** scenarios are intended to provide the HPC's Board, the Legislature, market participants, and the public with a greater understanding of the scope and scale of different savings opportunities.
- This year, the model includes five-year estimates from 2018 to 2022 and separate estimates for commercial spending, Medicare, and MassHealth, where applicable.

List of 2018 Spending Reduction Scenarios

1. Reduce Hospital Readmissions
2. Reduce Institutional Post-Acute Care
3. Reduce Avoidable Emergency Department Use
4. Shift Community-Appropriate Inpatient Care to Community Hospitals
5. Implement Site-Neutral Payment for Hospital Outpatient Services
6. Reduce Prescription Drug Price Growth
7. Increase Adoption of Alternative Payment Methods

HPC

Hospital Readmissions

BACKGROUND

- Massachusetts all-payer hospital readmissions rates *increased* in 2014 and 2015 while the national average has been falling
  - Massachusetts' Medicare readmission rate was 10th highest in the US in 2015 at 18.2% versus 16.8% in the rest of the nation

ESTIMATE TARGET AND SCOPE

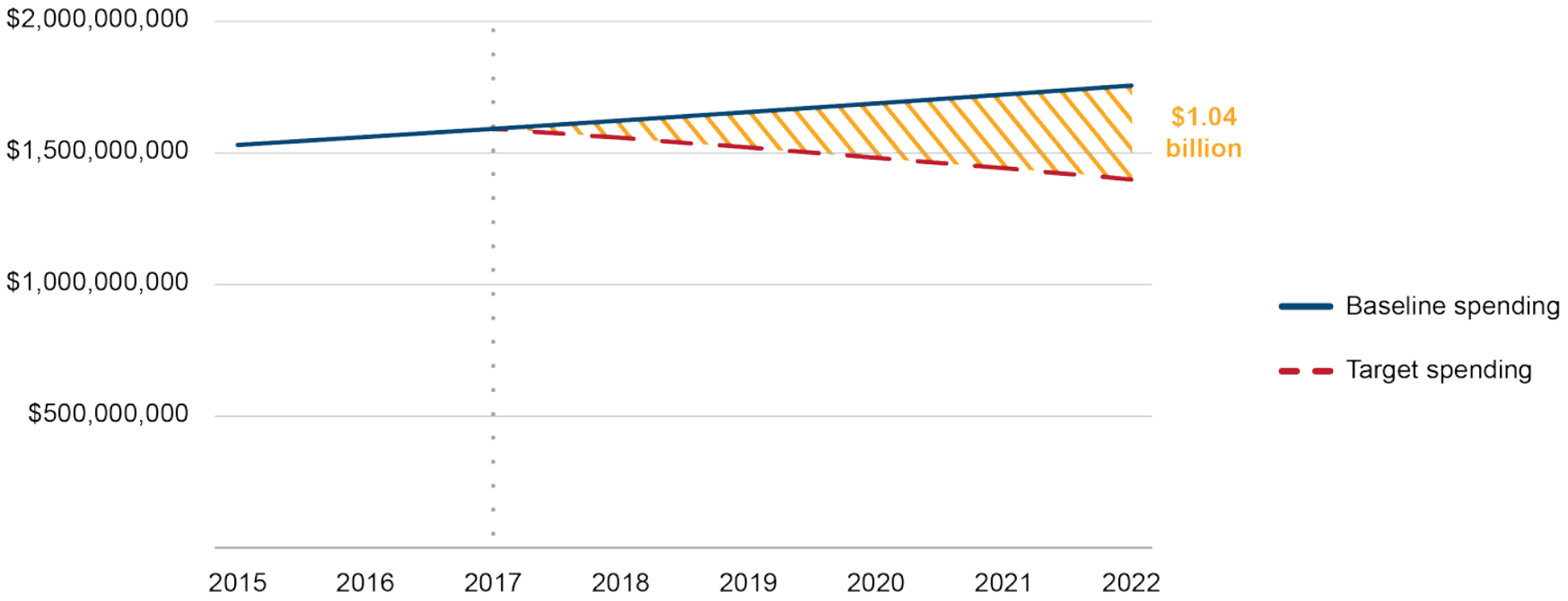
- ***Reduce all-payer readmissions gradually such that the 2022 readmissions rate is 20% below the 2015 rate***
- Scope: All discharges

KEY ASSUMPTIONS

- Baseline: readmission rates hold steady for all payers from 2015 onward
- Assume that rates for Medicare, Commercial, and MassHealth each drop by 20% from their 2015 levels

HPC

Reducing hospital readmissions by 20% would save $1.04 billion over five years



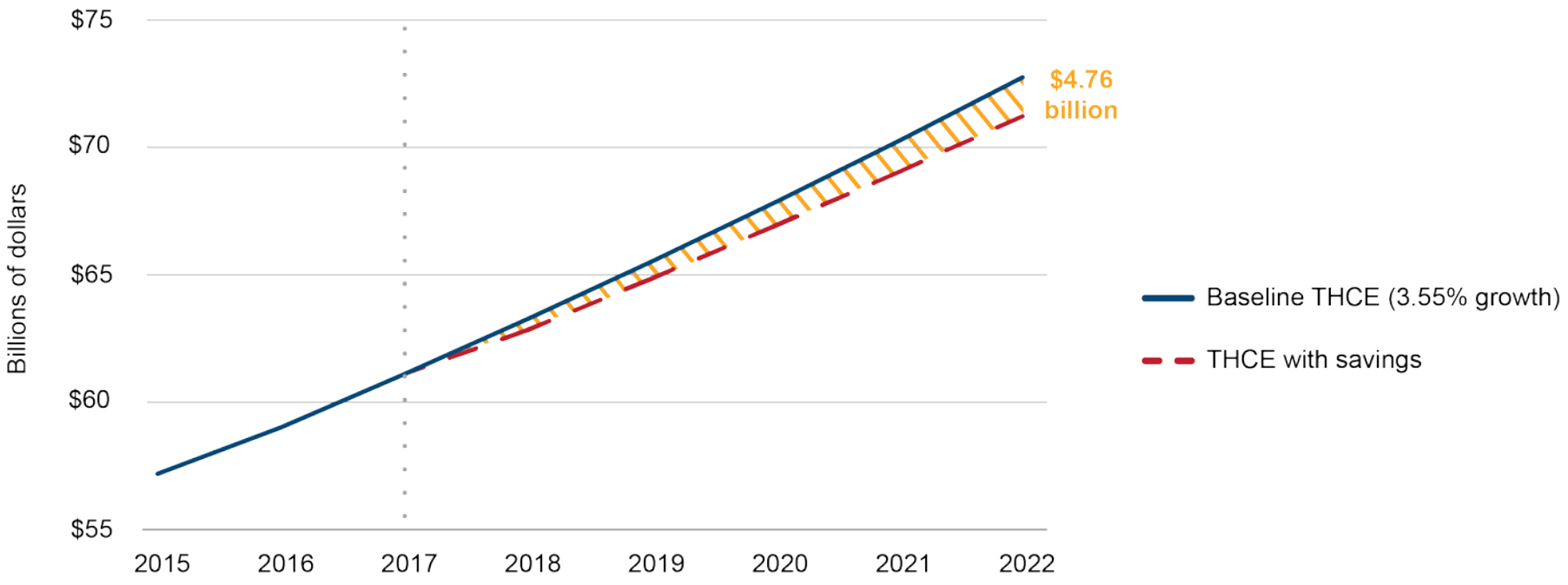
All-Payer

	2018	2019	2020	2021	2022	Total
Total Savings	$66,041,768	$134,704,966	$206,070,783	$280,222,749	$357,246,803	**$1,044,287,069**

Total savings over five years exceeds $4.7 billion

Measure	2018 savings	2019 savings	2020 savings	2021 savings	2022 savings	5 year savings
Readmissions	$66.0m	$134.7m	$206.1m	$280.2m	$357.2m	$1.04b
PAC	$88.7m	$178.6m	$270.9m	$365.7m	$462.9m	$1.37b
Avoidable ED	$22.2m	$46.5m	$70.0m	$94.1m	$119.0m	$351.7m
Outpatient	$195.1m	$202.8m	$210.8m	$219.1m	$227.7m	$1.06b
CADs	$13.5m	$27.4m	$41.8m	$56.7m	$72.0m	$211.4m
Drugs	$43.4m	$44.5m	$46.0m	$47.4m	$49.2m	$230.5m
APMs	$3.9m	$30.9m	$74.8m	$150.4m	$234.6m	$494.6m
Net savings	**$432.7m**	**$665.5m**	**$920.4m**	**$1.21b**	**$1.52b**	**$4.76b**
Commercial savings	*$291.6m*	*$379.5m*	*$484.8m*	*$623.6m*	*$773.3m*	*$2.55b*

Compared to recent performance, achieving the combined savings would reduce THCE by $1.5 billion (2.1%) in 2022



All-Payer

	2018	2019	2020	2021	2022
Baseline THCE (3.55% growth)	$63.3 billion	$65.5 billion	$67.8 billion	$70.3 billion	$72.7 billion
Savings as a percentage of THCE	0.7%	1.0%	1.4%	1.7%	2.1%

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MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Presentation: Executive Director's Report
- Presentation: Market Oversight and Transparency
- **Presentation: Care Delivery Transformation**
  - ACO Certification Program
  - SHIFT-Care Challenge
- Discussion: HPC Priorities for 2018
- Schedule of Next Meeting: July 11, 2018

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PCMH PRIME Certification: Participating Practices

Since January 1, 2016 program launch:

79 practices
are PCMH PRIME Certified

Recently certified practices include: Glen P. Bombardier, M.D.

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

1 practice
applying for NCQA PCMH Recognition and PCMH PRIME concurrently

98 Total Practices Participating

ACO Certification: Reporting on Key Learnings

The HPC will create and publish **six briefs based on ACO Certification data**, approximately 2-5 pages each, organized by **topic areas most salient to stakeholder interests**. Briefs will be issued **~ every 3 months**. Each brief will stand alone, but together they will tell a comprehensive story. Briefs will be **descriptive**, but also **analytical**, pointing to policy implications as appropriate.

Brief #1: Intro to Accountable Care Orgs in Massachusetts	Brief #2: How do ACOs Manage Population Health, esp. BH and SDH?	Brief #3: How Do ACOs Manage Their Performance Under Risk Contracts?	Brief #4: How are ACOs Governed?	Brief #5: How are ACOs Delivering Patient-Centered Care?	Brief #6: How do ACOs Coordinate Care?
Intro to the ACO Certification program; background, key terms, intro to this series of briefs Certification in context of the Massachusetts ACO landscape ACO profiles, using some other public data such as RPO	What methods do ACOs use for risk stratification? What kinds of BH and SDH programs do ACOs offer? How/do ACOs use Community Health Needs Assessments to inform population health management strategies?	What are the characteristics of ACO risk contracts? How much risk are ACOs taking on? What are ACOs' approaches to quality measurement and performance improvement? What are ACOs' approaches to distributing and/or investing shared savings?	What do the governance structures of ACOs look like? How alike or unique are they? Do governance structures differ between hospital-anchored and physician-led ACOs? How are different ACO Participants represented in leadership roles?	How do ACOs involve patients in their decision-making processes? How do the ACOs assess the needs and preferences of their patient population? What do ACOs do in areas such as patient-centered advanced illness care, community-based programs, etc.?	How do ACOs provide coordinated care across the continuum of services and providers? What technologies do ACOs employ to facilitate information sharing across the continuum? What do non-ACO Participant partnerships look like?

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Now Available: Brief #1, “Introduction to ACOs in MA”

MASSACHUSETTS HEALTH POLICY COMMISSION

APRIL 2018

ACO POLICY BRIEF

Transforming Care: An Introduction to Accountable Care Organizations in Massachusetts

ACOs are groups of health care providers who come together to provide patient-centered, coordinated care, with the goal of improving quality and reducing costs.

ACOs typically include **PCPs**, through which patients are attributed to the ACO.

In 2017, the Massachusetts Health Policy Commission (HPC) launched a first-in-the-nation set of statewide standards for accountable care organizations (ACOs). ACOs are groups of physicians, hospitals, and other health care providers who come together to provide patient-centered, coordinated care to their patients, with the goal of improving quality and reducing health care spending growth. The HPC certified 17 ACOs in Massachusetts that met those standards through an application process.

This brief is the first in a series of written reports and other resources that the HPC will issue regarding the landscape of certified Massachusetts ACOs based on the information submitted by applicants for ACO Certification, combined with other publicly available information. The purpose of this new series of policy briefs is to provide policymakers, health care providers, payers and purchasers, researchers, and other members of the interested public with new information and insights regarding the characteristics of certified ACOs. Topics that will be examined include how they are organized and governed, how they set and implement quality improvement strategies, their experience managing patients under risk contracts, and other key features. In providing increased transparency about the landscape of HPC-certified ACOs through this series, the HPC aims to support health care providers in their ongoing efforts to improve the quality and efficiency of patient care, support the formulation of sound policy that further bolsters those endeavors, and generally contribute to public understanding of the evolving care delivery system in Massachusetts.

This first brief provides background information on the ACO model in Massachusetts and the HPC ACO Certification program, and some key facts about the certified ACOs, which will be explored in greater detail in subsequent briefs.[1]

THE ACO MODEL IN MASSACHUSETTS

While HPC ACO Certification is a new program, providers and payers both in Massachusetts and nationally have been testing and evolving various accountable care delivery and contracting approaches over the past decade. The term “ACO” is generally used to mean a group of health care providers that contracts with a payer to assume responsibility for the delivery of care to its attributed patients, and for those patients’ health outcomes.[2,3] ACOs contract with payers under payment models other than fee-for-service (so-called “alternative payment methods,” or APMs), in which the ACO is typically accountable for spending against a budget and may earn financial incentives for meeting agreed-upon quality performance targets. Contracts with “shared savings” or “upside risk” allow an ACO to share in any cost savings generated. In contracts with “downside” or “two-sided” risk, an ACO is responsible for paying some share of losses, depending on quality targets, if it fails to meet a budget.

The types of providers participating in an ACO can vary widely from one ACO to the next. ACOs typically include primary care providers (PCPs), through which patients

HEALTH POLICY COMMISSION ACO CERTIFIED – 2017 –

ACO Policy Brief | 1

The first brief provides background information on the HPC-certified ACOs, and highlights key facts about them, such as:

- Approximately 1.9 million commercial or Medicare patients in Massachusetts are served by HPC-certified ACOs.
- The 17 HPC-certified ACOs hold a total of 66 commercial risk contracts, 17 MassHealth risk contracts, and 11 Medicare risk contracts.
- Over 80% of ACOs have at least one hospital as an ACO participant.

Visit the HPC’s Transforming Care website to read the full brief.

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SHIFT-Care, the HPC's new $10 million investment opportunity, received 36 proposals totaling over $24 million

FUNDING TRACK 1: Addressing social determinants of health

Support for innovative models that **address social determinants of health** for complex patients in order to prevent a future acute care hospital visit or stay.

Proposed partners include: Legal services providers, hospitals, VNAs, housing authorities, outpatient service providers.

11 Applicants requested funding of $7 million

FUNDING TRACK 2a: Addressing behavioral health needs

Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay.

Proposed partners include: Police departments, primary care practices, Councils on Aging, rehabilitation centers.

10 Applicants requested funding of $7 million

FUNDING TRACK 2b: Enhancing opioid use disorder treatment

Section 178 of ch. 133 of the Acts of 2016 directed the HPC to invest not more than $3 million to support hospitals in further testing **ED initiated pharmacologic treatment for SUD**.

Proposed partners include: Outpatient OUD service providers, sheriff's departments, universities, municipalities.

15 Applicants requested funding of $9.6 million

HPC

SHIFT-Care Challenge Applicants by the Numbers

The HPC received proposals from a diverse range of entities including 16 CHART hospitals, 11 ACOs/ACO participants, and 8 HCII awardees.*

	Applicants	Avg partners	Requested HPC Funding	Proposed In-Kind Funding	Total Initiative Costs
TRACK 1	11	~5 per application (59 total)	Avg: $636K Total: $6,956,919	Avg: $453K Total: $4,539,886	$11,631,622
TRACK 2a	10	~4 per application (41 total)	Avg: $693K Total: $6,939837	Avg: $385K Total: $2,852,522	$9,792,359
TRACK 2b	15	~3 per application (48 total)	Avg: $694K Total: $10,415,722	Avg: $293K Total: $4,407,597	$14,823,319
Total	**36**	**148**	**$24,312,479**	**$11,934,820**	**$36,247,299**

*Note: ACO/ACO Participant s excludes Applicants that are hospitals

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2018 Meetings and Contact Information

Board Meetings

Wednesday, July 18, 2018
Wednesday, September 12, 2018
Thursday, December 13, 2018

Committee Meetings

Wednesday, June 13, 2018
Wednesday, October 3, 2018
Wednesday, November 28, 2018

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@mass.gov

Special Events

Thursday, May 17, 2018: Partnering to Address the Social Determinants of Health: *What Works?*
Friday, May 25, 2018: Public Hearing on RBPO/ACO Patient Appeals Regulation
Monday and Tuesday, October 15 and 16, 2018: Cost Trends Hearing