CHA Cambridge Health Alliance

Cambridge Health Alliance

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Who We Are & Who We Serve

- CHA is the **only public hospital system in Massachusetts** and a teaching affiliate of **Harvard Medical School**, Harvard T.H. Chan School of **Public Health** and **Tufts University** School of Medicine
- Operates the **Cambridge Pubic Health Department**, **3 hospital campuses and employees over 500 providers**
- Serves over **475,000** residents of Cambridge, Somerville and Boston's Metro-North communities and:
  - 11,000 Inpatient discharges,
  - 100,000 Emergency Room visits,
  - 600,000 Ambulatory visits, and
  - 118,000 on the primary care panel
- **Business is 51% Medicaid, 25% Medicare and 24% Commercial and other**

ACO Moving To Population Health Management

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MassHealth

TUFTS Health Plan

Medicare.gov The Official U.S. Government Site for Medicare

Medicare Shared Savings

Commonwealth CARE alliance

Tufts Medicare Preferred

MASSACHUSETTS

Harvard Pilgrim HealthCare

- CHA has been in **Value Based Models (VBM) since 2009** and began to expand this effort materially in 2014
- CHA manages over **$440M in Total Medical Expense** in various VBM with on average a **50%/50% upside and downside risk** involving the following:
  - Medicaid ACO,
  - Medicare Shared Savings Plan,
  - Medicare Advantage,
  - Senior Care Options,
  - CHA's own Elder Services Plan, and
  - All major Commercial Plans
- CHA's has over **45%** of its business in VBM with risk structured as described above

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Massachusetts Context

- **2012 Health Reform Law** passed and created new regulatory bodies that oversee the healthcare industry in the state:
  - The **Center for Health Information & Analysis (CHIA),** to study healthcare services and costs,
  - The **Health Policy Commission (HPC)** to monitor healthcare spending, growth, recommend policy changes and to oversee healthcare delivery and payment reform, and
  - The existing **Division of Insurance (DOI)** but with new requirements for ACOs to be financially certified
- **1115 State Waiver - 2018** implementation of statewide **Medicaid ACO program** and efforts underway to address **Senior Care Options and Duals** populations by **2020**.

YIKES!

More Regulatory Requirements

Agency	Requirement	Purpose
Health Policy Commission	ACO Certification	HPC requirement to continue to participate in risk agreements, demonstrates capability to manage populations & risk
Health Policy Commission	Registered Provider Organization (RPO)	HPC tracking cost and quality performance to health care organizations and providers, feeds CHIA process
Division of Insurance	Risk-Bearing Provider Organization (RBPO)	DOI financial solvency and risk management capabilities, required to sign any risk agreement
Mass Health	ACPP Readiness Review & Contract Compliance	MH ongoing contract compliance reviews and testing
Mass Health & THPP	NCQA Accreditation: Case Management	Required certifications to accept delegated care management responsibility and more of the administrative PMPM from payors

- Regulatory, Certification and Mass Health contractual requirements resulting in **incremental investments** in staff and systems that are typically not required to operate in a VBM

Mass Health

Contractual Requirements

- **The Mass Health contract is a payor and provider partnership that requires:**
  - **Community and Population Assessments**
  - Significant **clinical integration** expectations
  - Improved **access to care** for primary care & behavioral health, provision of **culturally and linguistically** based services, greater access for **disabled** patients
  - Requirements for more ACO **clinical activities** (Comprehensive clinical assessments, Care Needs & Health Risk Assessments, Screening for Social Determinants of Health, Comprehensive care planning, between all clinical partners including (social services & agencies, community partners)
  - Newly established **quality measures** for social services, behavioral health, long term support services & community partners
  - **Financial planning** and reviews of financial plan

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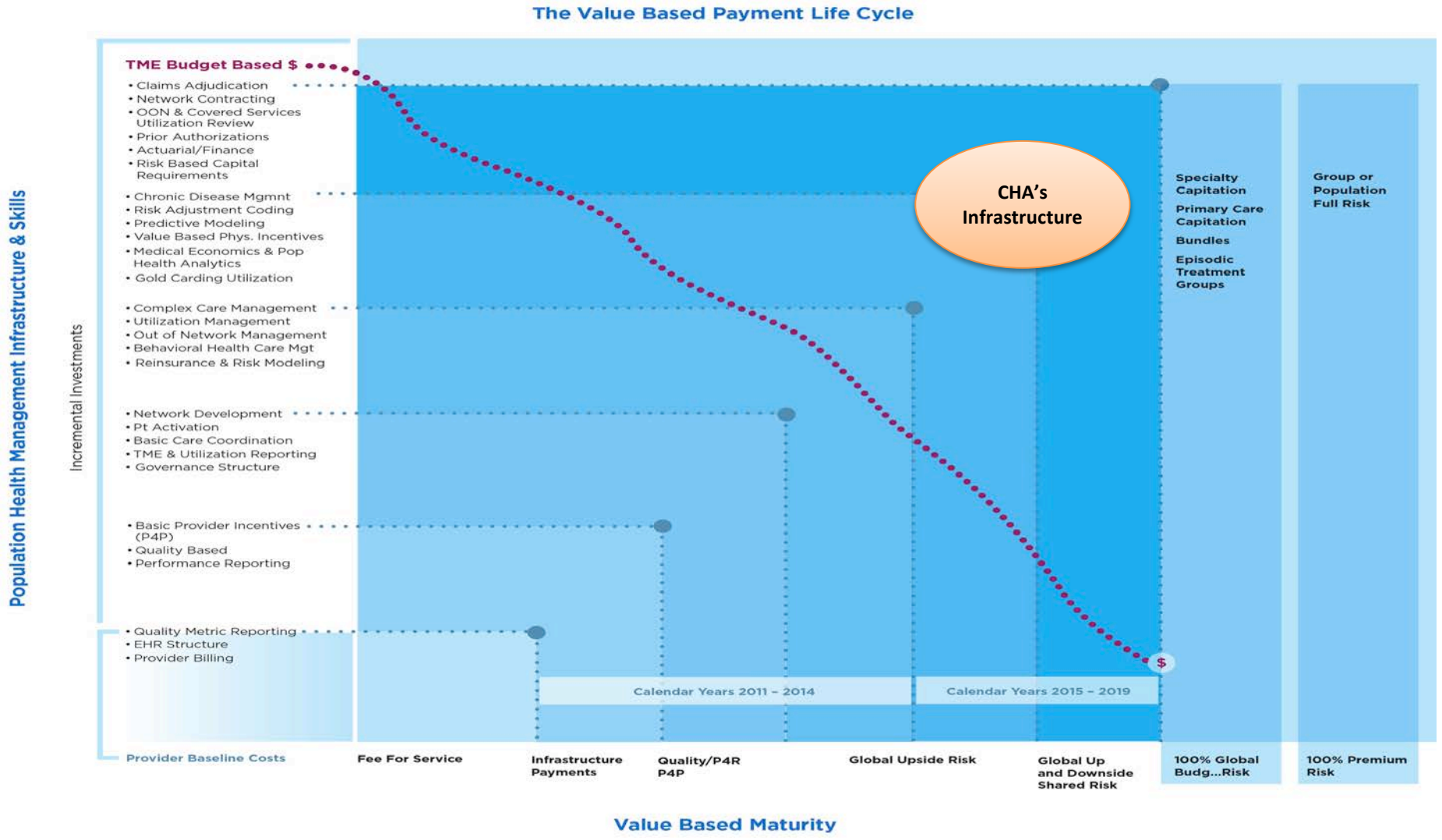
Infrastructure & Maturity



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Governance Structure

- **PHM Leadership reports** to CEO and CMO and provides regular feedback to CHA Board of Trustees, Strategic Planning & Finance Committees
- **Multiple Committees needed to achieve change** in an integrated delivery system that assumes significant risk under VBM:
  - Advanced Illness and Palliative Care
  - Contracting
  - Integrated Care Management
  - Medical Management
  - Network and Referral Management
  - Post Acute
  - Risk Adjustment & Coding
  - Utilization Management
  - Quality & Patient Experience

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Current Strategies

- **Expansion of efforts beyond traditional care and network management activities:**
  - Broader expansion of screenings for both **health and wellness and social determinants of health**
  - Expansion of **community partner relationships and investments** in services to resolve issues illuminated via social determinants screening. Initial efforts are addressing **food and housing insecurity**
  - Systemwide development of **evidence based guidelines** for common chronic conditions to reduce **unintended variation in care and improve outcomes:**
    - Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Depression, Diabetes, Hypertension, Substance Use Disorder (SUD)

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Population Health Management Current Struggles

- After years of operating in VBMs and having successful outcomes, now in a **"race to the bottom"** for Total Medical Expense (TME) Budgets
  - Current models are a **bridge strategy** to premium based risk
- Requiring the **pace of change** in an integrated delivery system to occur faster in order to be successful
- **Maturing PHM infrastructure and degree of VBM penetration** is impacting business today that isn't structured as VBM thus reducing the potential financial returns in the future
- Continued expansion of VBM and **pursuit of growth** in primary care panel for new unmanaged populations

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Lessons Learned

- **Building the infrastructure** and being effective with it always takes longer than anticipated
- Beware of the "**Data Abyss"**, new tools, new methods and more information hasn't proven to be helpful
- Risk stratification is no **"Silver Bullet"** and continued refreshing is required
- Recognition that **operational changes will need to occur at a faster pace** in order to continually improve performance on quality, patient experience and total cost of care
- Clinical **redesign requiring more medical leadership** than originally anticipated
- **CHANGE IS HARDER THAN YOU THINK!**

THANK YOU!