



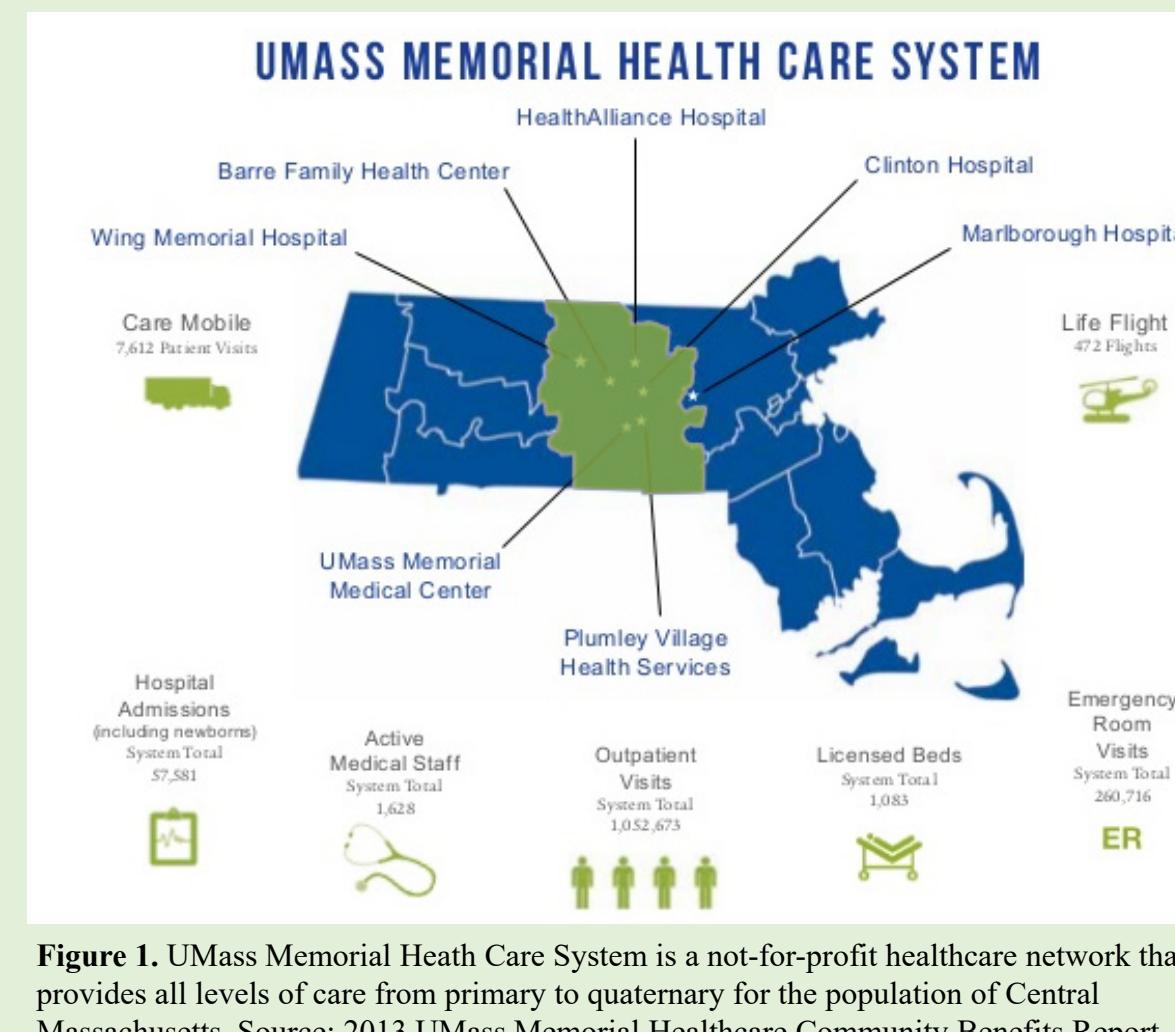
**UMASS  
MEDICAL  
SCHOOL**

# Transforming Health Systems through Payment Reform

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## Population: Medicaid beneficiaries of Central MA



**MassHealth state program overview**

- MA public health insurance for low income residents under the age of 65, consists of Medicaid and CHIP
- 1.85M members (~ 25% of state population)
- Costs \$16.1B (~ 40% of state budget)
- Spending is high and growing rapidly (MA spend is 31% above national average for state Medicaid programs)

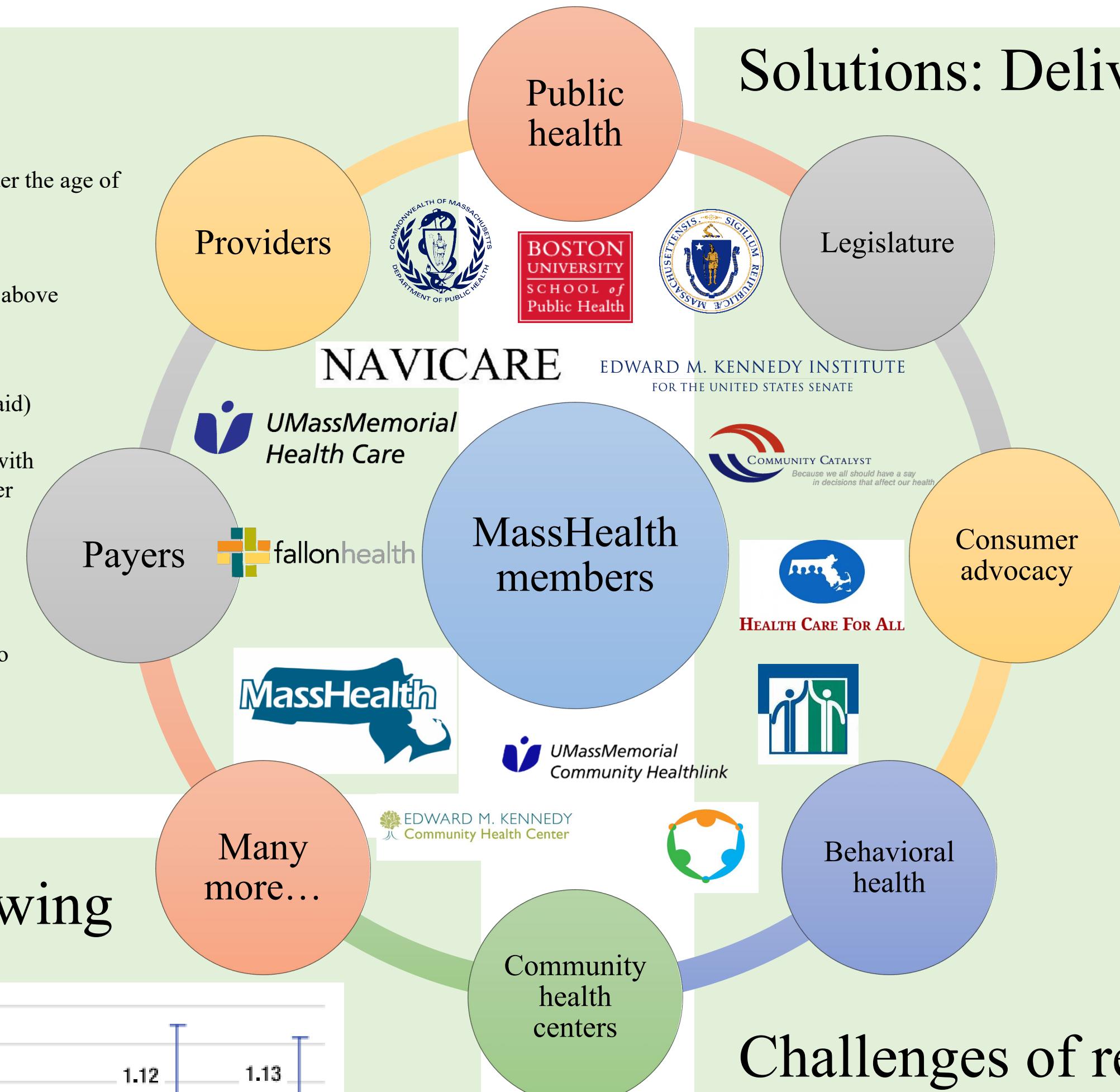
**Population served (city of Worcester)**

- 41.4% receive public health insurance (Medicare, Medicaid)
- 30% of children under age 18 live below poverty line
- Growing diversity – Hispanics, Vietnamese, Portuguese with refugee population from Bhutan, Burma, Liberia and other African nations

Source: 2010 U.S. Census Data

**UMass Memorial Healthcare (UMMHC)**

- Largest healthcare system in central New England
- Only Safety Net provider in the region; largest provider to uninsured outside Boston
- Partners with community agencies to connect medically underserved to health insurance and other resources



## Problem: MassHealth costs are high and rapidly growing

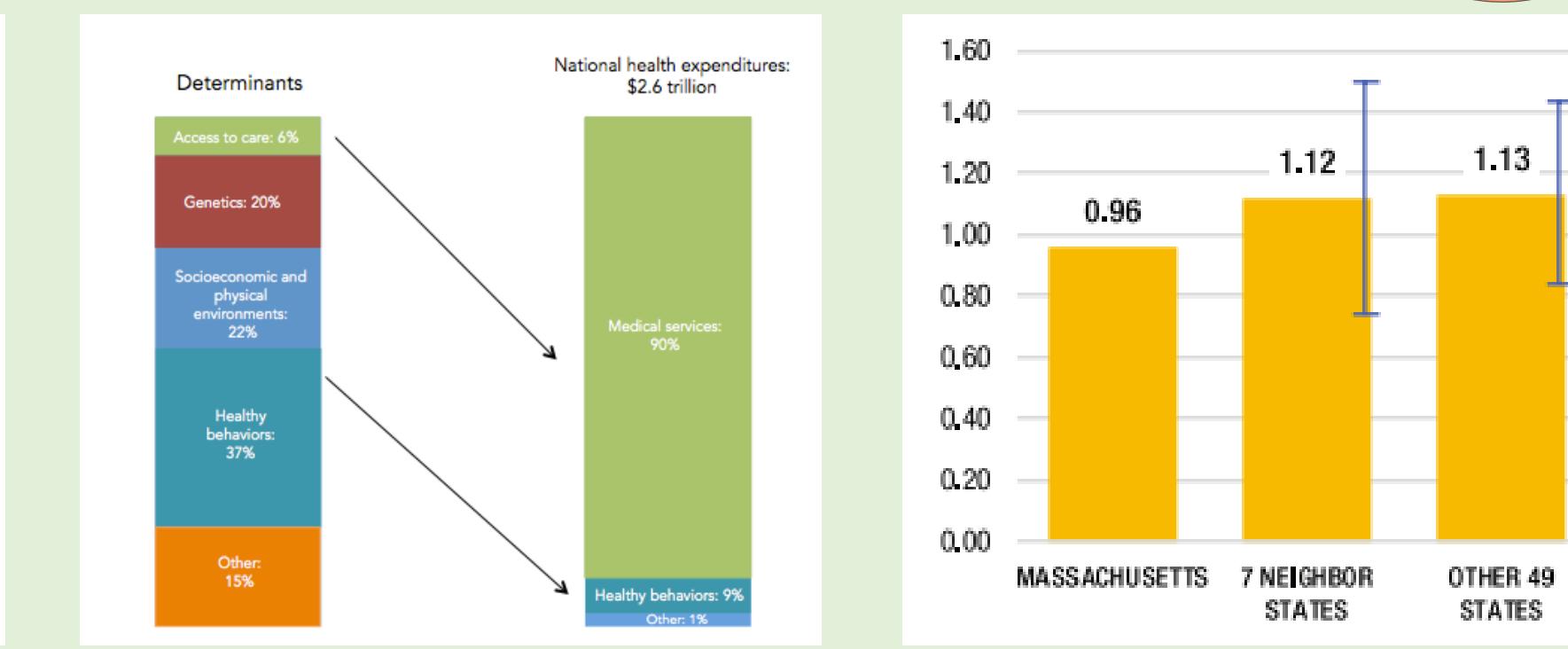
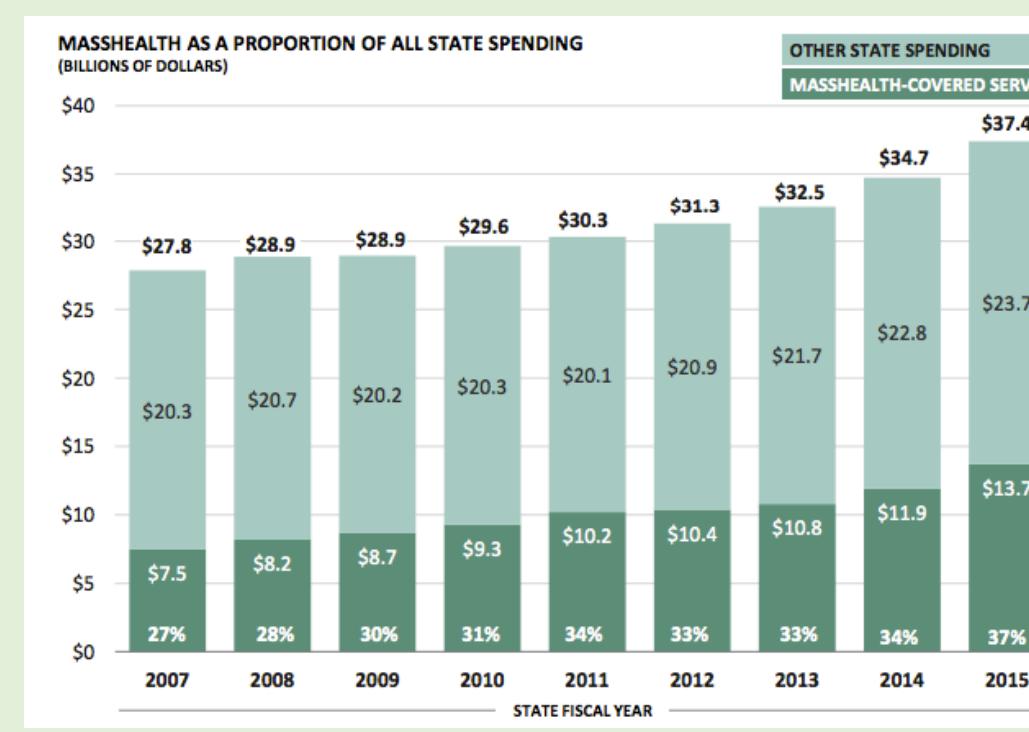
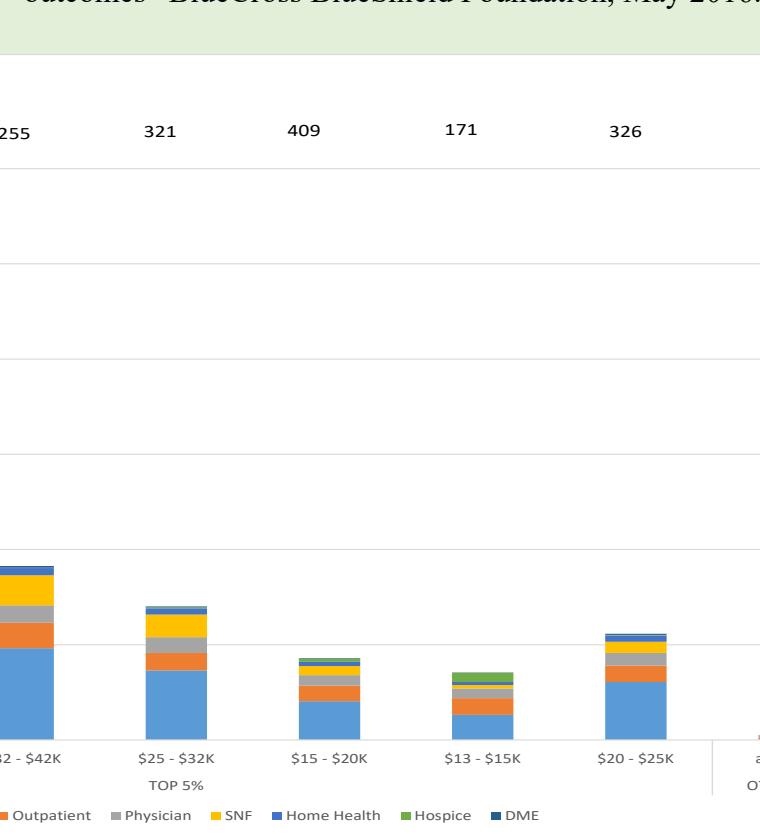


Figure 4. Social service to total health care spending ratio (2009). Source: "Healthcare and social service spending and outcomes" BlueCross BlueShield Foundation, May 2016.



### MassHealth represents an increasing fraction of the state budget

- MassHealth costs are 37% of overall state budget and have grown 15.1% (FY2014 to FY15), while other state spending increased by only 3.8%

### Crowd-out effect

- Increased spending on medical services “crowds out” dollars left to spend on services that impact social determinants of health (housing, education, transportation, healthy behaviors, etc.)
- Nationally, 90% of health expenditures is spent on medical services, while only 9% allocated to address healthy behaviors
- MA spends less on social services than total health care expenditure and has the lowest social service to total health care spending ratio of all US states

### Medicaid cost drivers

- Medicaid members have the highest rates of ED visits of any payer group (0.89 visits per year per member). Medicaid inpatient admission is the most costly of all payer groups (\$1,300 loss per admission). Potential strategy would target emergency & inpatient.
- Top 5% of members responsible for 50% of Medicaid expenditure

## Solutions: Delivery system transformation and payment reform

### Achieving the Triple Aim – Population health focus

- Better health for populations
- Better care for patients
- Lower costs

### Medicaid Accountable Care Organization (ACO)

- In July 2017, MassHealth will move its Medicaid providers into the ACO model, affecting 1.2M members
- ACOs will be accountable for both quality and total cost of care for all members, including behavioral health and long-term services and supports
- ACO model incentivizes hospitals to create partnerships with community health organizations to integrate medical and health-related social services
- Delivery System Reform Incentive Plan (DSRIP)** federal funding will allow Medicaid to invest \$1.8B over 5 years into ACO infrastructure development
- UMMHC named an ACO pilot site (6 total)

### UMMHC adapting to a value-based payment model

- Transition from fee-for-service (volume-based) to value-based payment model
- Focus on value-added care through alignment of evidence-based quality measures with compensation

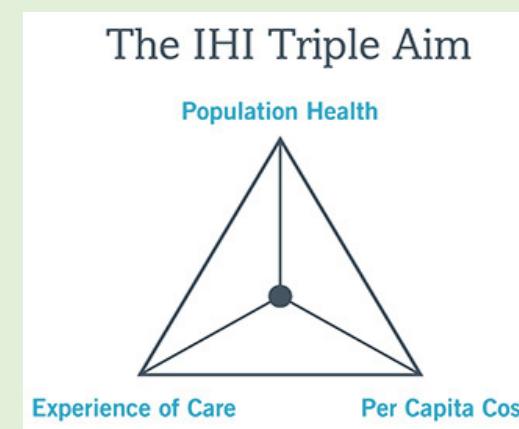


Figure 6. The Triple Aim. Source: Institute for Healthcare Improvement (IHI).

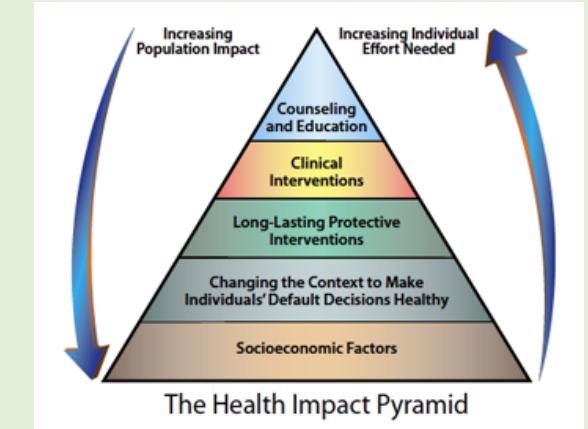


Figure 7. The Health Impact Pyramid. Source: Colorado Medical Society.

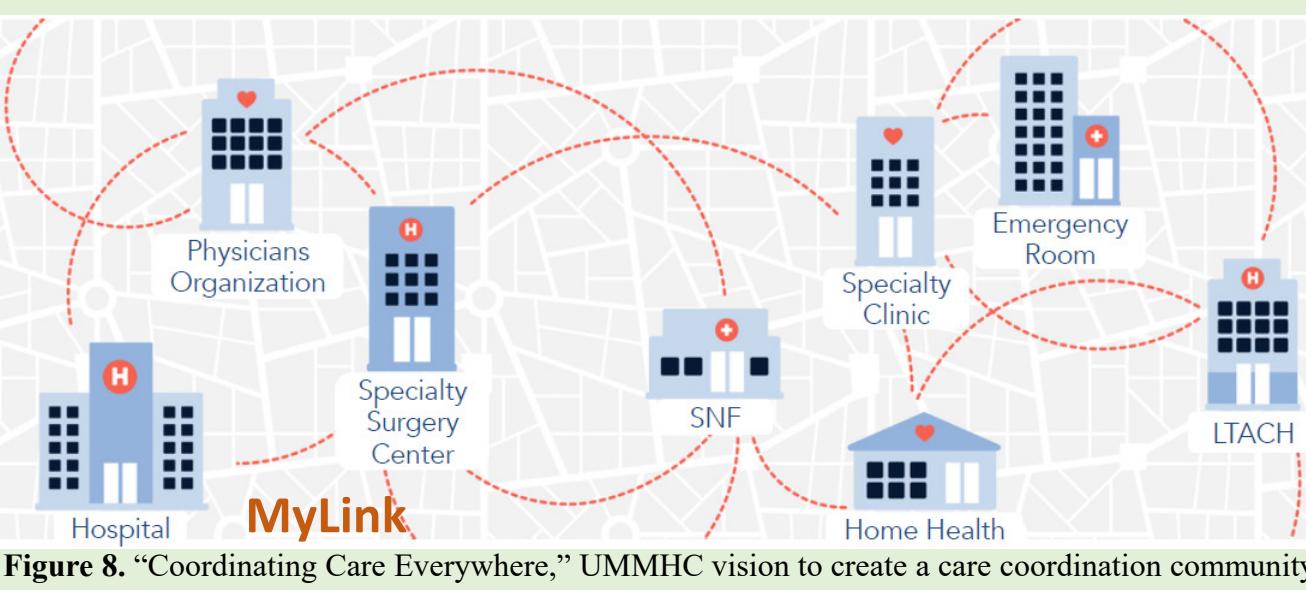


Figure 8. "Coordinating Care Everywhere," UMMHC vision to create a care coordination community across Central MA. MyLink program run by Community Healthlink (UMMHC behavioral health service) targets high users of the Emergency Room (more than 10 visits per year) to reduce costs and improve patient care coordination.

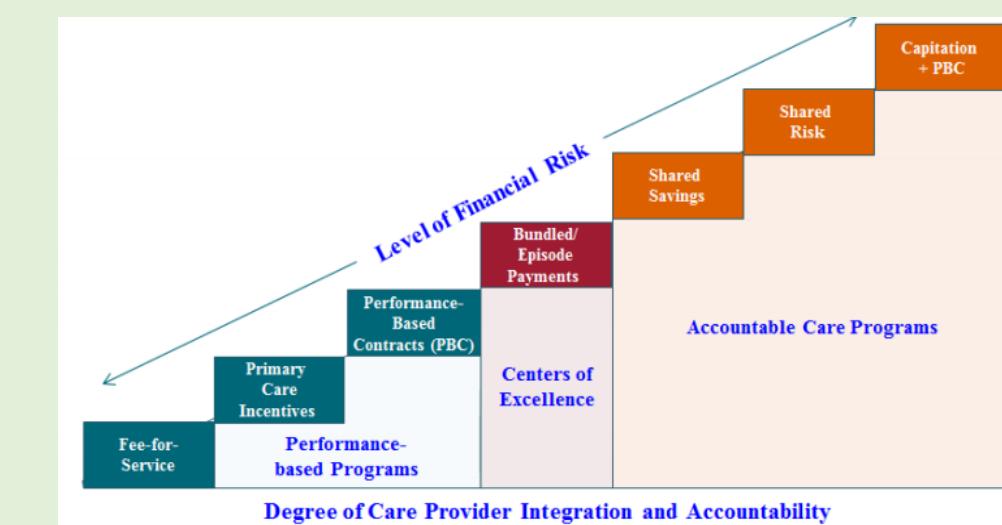
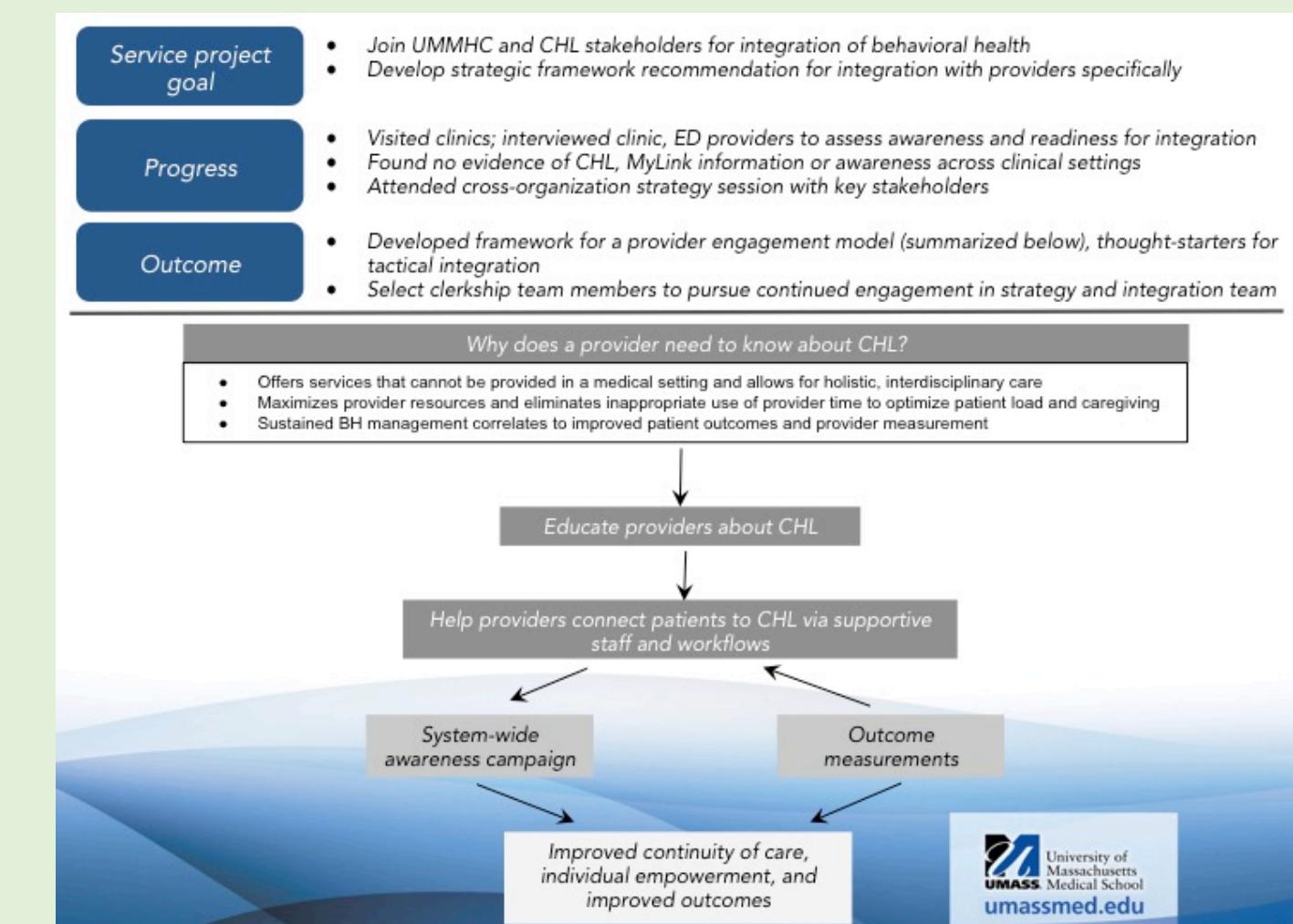


Figure 9. Transition from fee-for-service to value-based payment systems. Note that as integration and accountability increase so does financial risk. Source: Arizona Health Care Cost Containment System.

## Challenges of reform

- Sustainability and scalability: dependence on DSRIP funds, community health workforce
- Tying quality to compensation: ineffective measures
- Increasing focus on addressing social determinants of health, particularly housing and homelessness

## Service Project: Connecting patients to CHL



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