Paying for Serious Illness Care Under a Global Budget: Opportunities and Challenges

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MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

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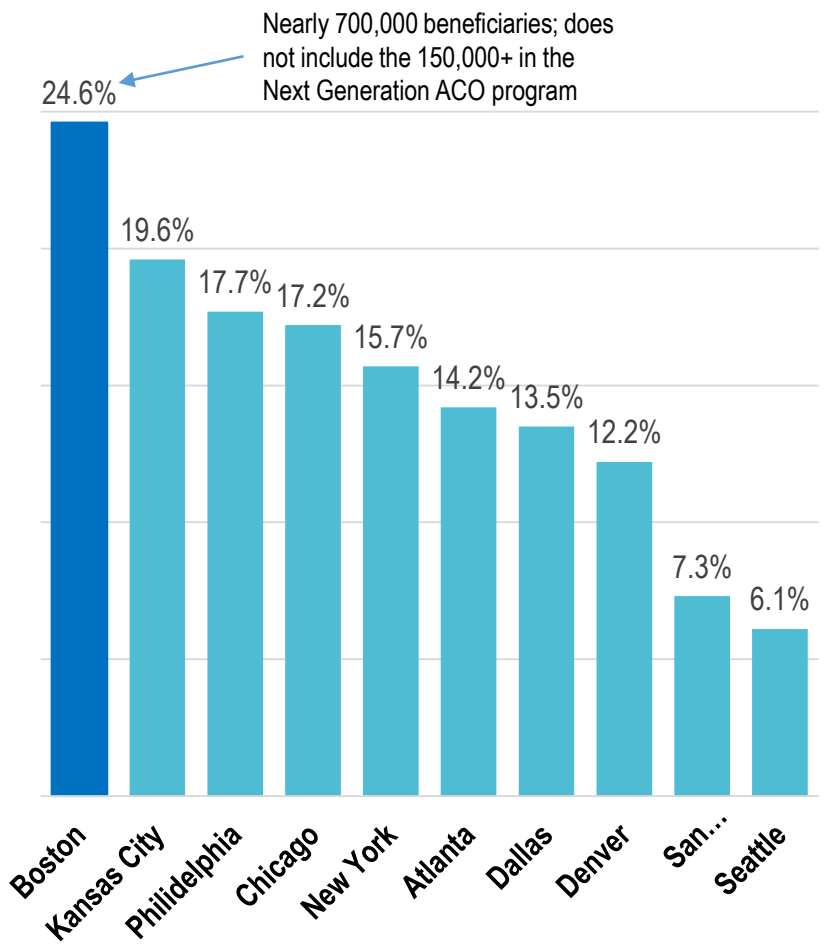
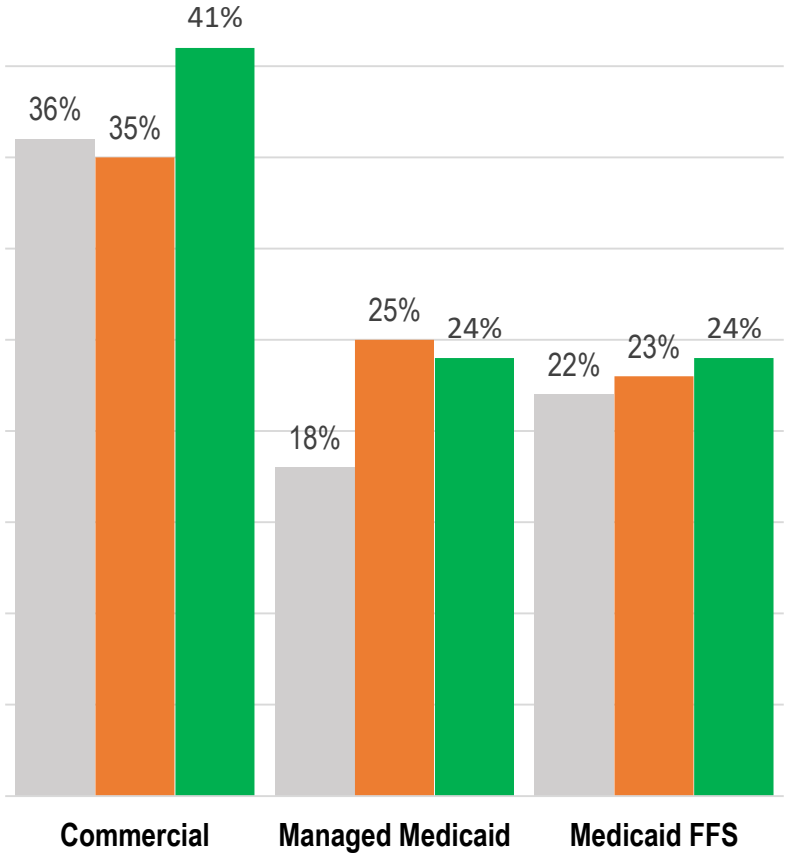
High rates of global payment adoption across payers and programs in Massachusetts

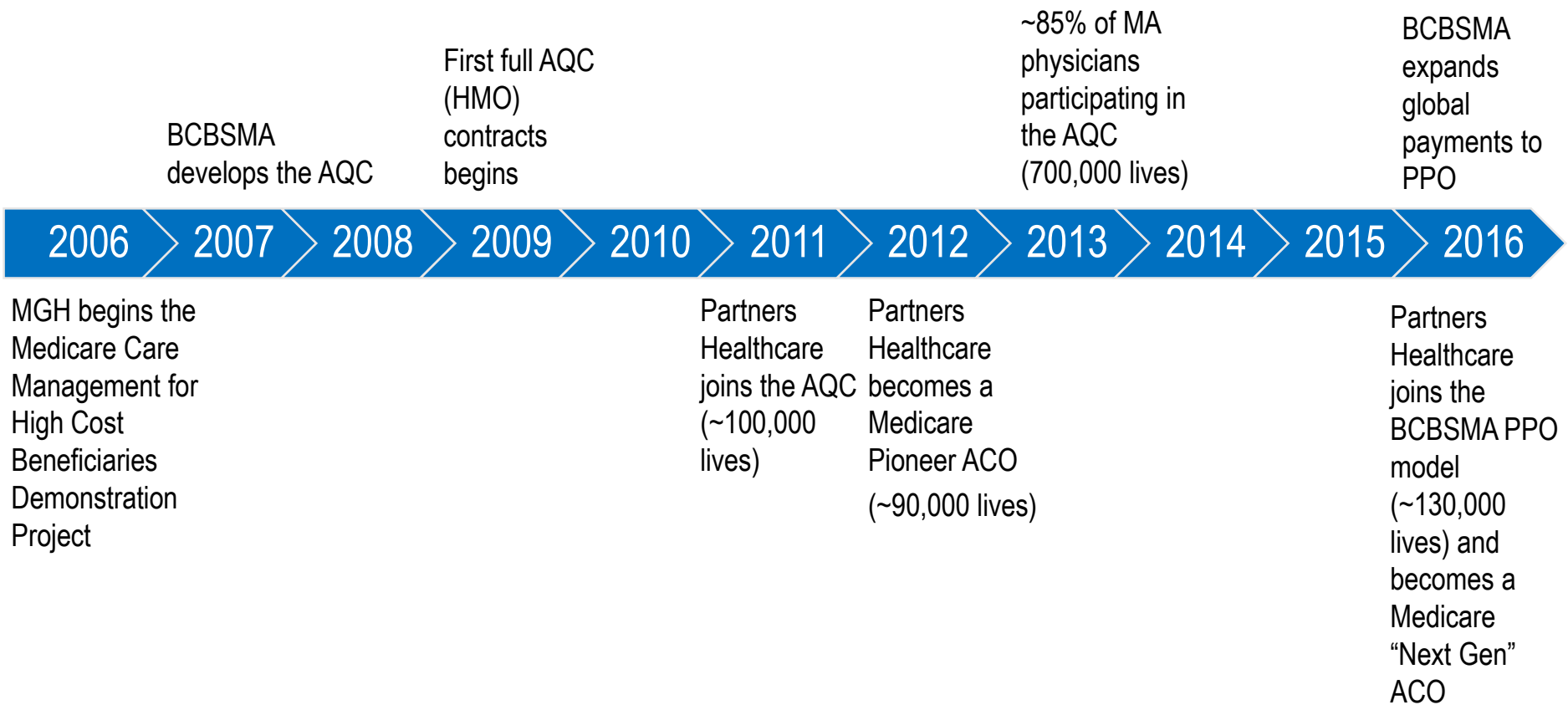
Share of regional Medicare beneficiaries cared for under the Medicare Share Savings ACO Program



Share of members whose care was paid for under a global payment arrangement



Global payment models in Massachusetts: the view from BCBSMA and MGH/Partners



BCBSMA's Alternative Quality Contract (AQC)

Global Budget

- Covers all medical services
- Health status adjusted
- Based on historical claims
- Shared risk
- Declining trend

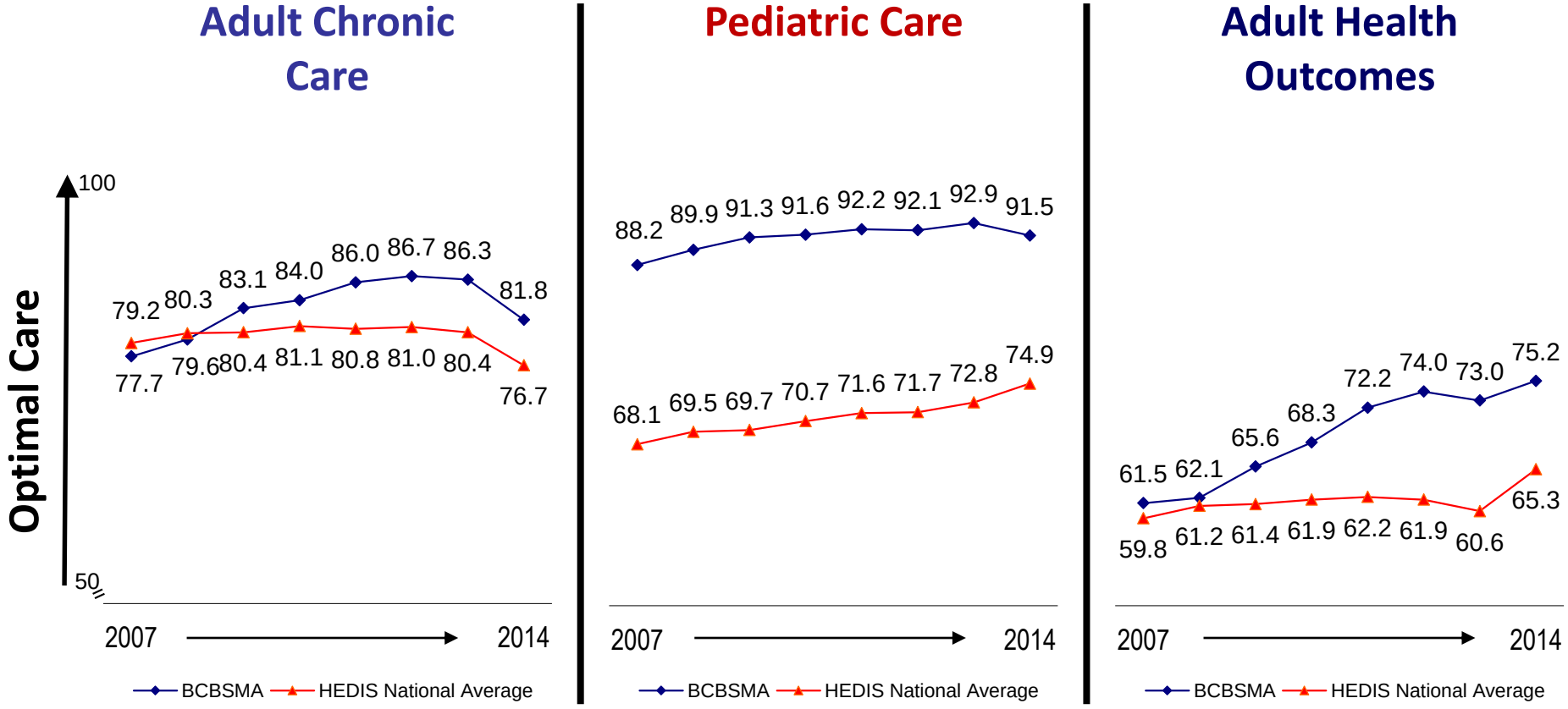
Quality Incentives

- Ambulatory and hospital
- Significant earning potential
- Nationally accepted measures

Long-Term Contract

- 5-year agreement
- Sustained partnership
- Supports ongoing investment

Results Under the AQC: Dramatic Increases in Quality



These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first two scores are based on the delivery of evidence-based care to adults with chronic illness and to children, including appropriate tests, services, and preventive care. The third score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC's pioneering achievements. In 2014, the LDL-C measure was dropped from the HEDIS National Average calculation.

Results Under the AQC: Accelerating Cost Savings

Formal Academic Evaluation: Year 3 & 4 Results

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Changes in Health Care Spending and Quality 4 Years into Global Payment

Zirui Song, M.D., Ph.D., Sherri Rose, Ph.D., ...

"As compared with similar populations in other states, Massachusetts AQC enrollees had lower spending growth and generally greater quality improvements in the period 2009 through 2012…The AQC experience may be useful to policy-makers, insurers and providers embarking on payment reform. Although it is still early, these results suggest that a two-sided global budget model may serve as a foundation for slowing spending and improving quality."

Savings Associated with the AQC Relative to Control Group, 2009-2012

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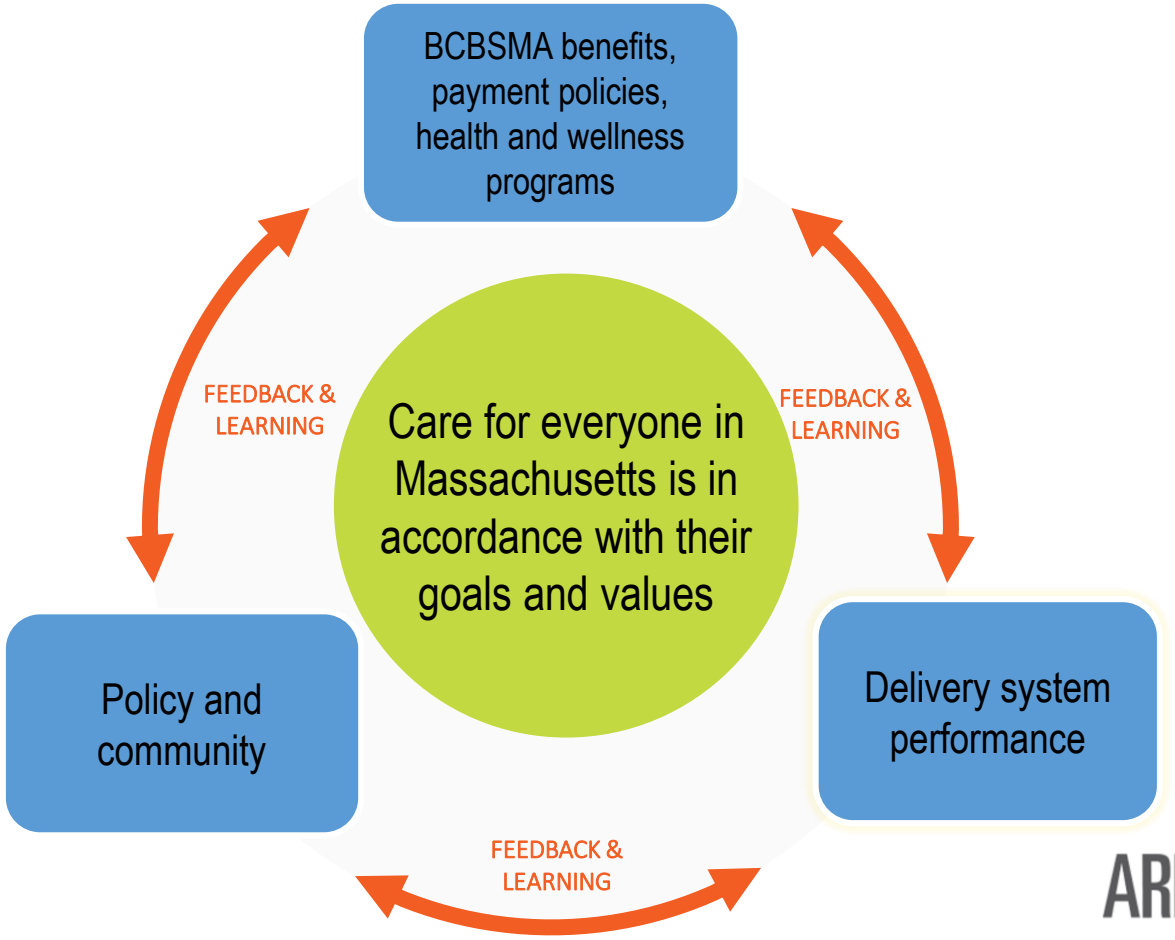
Notes: (1) Calculated based on combined PCP and SCP participation as of December of each year.

Source: Song Z, et al. Changes in Health Care Spending and Quality 4 Years into Global Payment. *The New England Journal of Medicine*. 2014.

Supporting High Quality Serious Illness Care in a Global Payment Environment



MASSACHUSETTS COALITION FOR SERIOUS ILLNESS CARE

ARIADNE LABS

MGH's Home Based Palliative Care Program Pilot (2014)

Care Team/ Model

- MD
- 3 NPs
- Social worker
- Home visits for symptom management and advance care planning discussions; frequency determined by need
- Discharged after hospice enrollment

Population

- Partners attributed ACO/risk patients (Medicare and commercial)
- Already part of the Integrated Care Management Program (high cost, high need)

Financing

- FFS billing by clinicians covering ~50% of program costs
- Supplemented by population health budget (ACO)

Final Pilot Financial Analysis Revealed Significant Savings

$1,351 PMPM

Savings **compared to controls** in the last 6 months of life:

- Majority of savings from reduced inpatient use while in program
- Also saw increased hospice use and length of stay

$2,696

Net benefit per patient to the ACO

- After program cost and shared savings with payer (CMS)

Expansion – Geographic and Financial

Home Based Palliative Care Program

Geographic Territory

Boston Neighborhoods

Allston
Back Bay
Bay Village
Beacon Hill
Brighton
Charlestown
Chinatown/Downtown
Dorchester
Downtown
East Boston
Fenway
Hyde Park*
Jamaica Plain
Mattapan
Mission Hill
North End
Roslindale*
Roxbury
South Boston
West End
West Roxbury*

*We will be expanding to these areas in January 2018

Lessons learned