AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting
- Commissioner Updates
- 2018 Health Care Cost Growth Benchmark
- Cost Trends and Market Performance
- Executive Director’s Report
- Schedule of Next Board Meeting (May 10, 2017)
AGENDA

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**VOTE:** Approving Minutes

**MOTION:** That the Commission hereby approves the minutes of the Commission meeting held on February 8, 2017 as presented.
AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting

- Commissioner Updates
  - Vice Chair Appointment (VOTE)
- 2018 Health Care Cost Growth Benchmark
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AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting
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  - Vice Chair Appointment (VOTE)
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VOTE: Vice Chair Appointment

MOTION: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby re-appoints Dr. Wendy Everett to serve a one-year term as Vice Chairperson of the Health Policy Commission.
AGENDA

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For the first time, in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for calendar year 2018)**, pursuant to a public hearing process and engagement with the Legislature.

The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January 15 (when the PGSP is established in the consensus revenue process) and April 15.

For calendar years 2013-2017, the law required the benchmark to be equal to **PGSP (3.6%)**

For calendar years 2018-2022, the law requires the benchmark to be **PGSP minus 0.5%** (e.g., 3.1%) **unless** the Board votes to modify the benchmark (requires 2/3 vote).

The modification must be within the range of PGSP minus 0.5% and PGSP (e.g. 3.1% to 3.6%)

“For calendar years 2018 through 2022, if the commission determines that an adjustment in the health care cost growth benchmark is **reasonably warranted**...the board of the commission may modify the health care cost growth benchmark...” between -0.5 and PGSP
Benchmark Modification Process – Key Steps

HPC ROLE

- HPC Board must hold a public hearing prior to making any modification of the benchmark
- Hearing must consider testimony, information, and data on whether modification of the benchmark is appropriate:
  - **Data**: CHIA annual report, other CHIA data, or other data considered by the Board
  - **Information**: “health care provider, provider organization, and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth’s health care system”
  - **Testimony**: representative sample of providers, provider organizations, payers and other parties determined by HPC
  - The Joint Committee on Health Care Financing may participate in the hearing
- Following a potential vote to modify, the HPC Board **must submit notice** of its intent to modify the benchmark to the Joint Committee

LEGISLATIVE PROCESS

- Joint Committee must hold a public hearing within 30 days of notice
- Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing
- General Court must act within 45 days of public hearing or the HPC Board’s modification of the benchmark takes effect
HEARING ON THE POTENTIAL MODIFICATION OF THE HEALTH CARE COST GROWTH BENCHMARK
By the Numbers

**HPC BENCHMARK MODIFICATION HEARING**

1st

12 ORGANIZATIONS PROVIDED ORAL TESTIMONY

**MEMBERS OF JOINT COMMITTEE ON HEALTH CARE FINANCING**

14

19 ORGANIZATIONS SUBMITTED WRITTEN TESTIMONY
Factors to Consider in Determination of Whether an Adjustment is Reasonably Warranted

1. Massachusetts’ health system performance to date
2. Impact of enrollment and demographic changes on performance
3. Opportunities for and barriers to additional savings in Massachusetts
4. Financial impact of modifying the benchmark
5. Significant changes to the state or federal health care landscape
6. Role of the benchmark in the HPC’s statutory responsibilities
7. Feedback from market participants and interested parties
Total Health Care Expenditures in the Commonwealth, 2012-2015

Sources:
### Population Aging

- The Massachusetts population is aging

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2015</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>38.8 years</td>
<td>39.4 years</td>
<td>40.2 years</td>
</tr>
<tr>
<td>% of state residents 65+</td>
<td>13.9%</td>
<td>15.4%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

- Older residents have higher spending

<table>
<thead>
<tr>
<th>Age</th>
<th>0-18</th>
<th>19-44</th>
<th>45-64</th>
<th>65-84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average PMPY spending</td>
<td>$3,394</td>
<td>$4,260</td>
<td>$9,091</td>
<td>$16,123</td>
<td>$30,972</td>
</tr>
</tbody>
</table>

- Relative population aging contributes consistently to notable TME growth

<table>
<thead>
<tr>
<th>TME growth per year due to relative aging</th>
<th>2012-2015</th>
<th>2016-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+0.5%</td>
<td>+0.6%</td>
</tr>
</tbody>
</table>

Notes: Resident spending by age bracket are national CMS estimates.
## Estimated opportunity for savings for improving care and reducing costs

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>‘LOW’ SAVINGS</th>
<th>‘HIGH’ SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Shift community-appropriate inpatient care to community hospitals</td>
<td>$43m</td>
<td>$86m</td>
</tr>
<tr>
<td>II. Reduce hospital readmissions</td>
<td>$61m</td>
<td>$245m</td>
</tr>
<tr>
<td>III. Reduce avoidable emergency department use</td>
<td>$12m</td>
<td>$24m</td>
</tr>
<tr>
<td>IV. Reduce use of institutional post-acute care</td>
<td>$47m</td>
<td>$186m</td>
</tr>
<tr>
<td>V. Adjust premiums based on primary care provider total medical expenditures</td>
<td>$36m</td>
<td>$72m</td>
</tr>
<tr>
<td>VI. Increase participation in alternative payment methodologies</td>
<td>$23m</td>
<td>$68m</td>
</tr>
<tr>
<td>VII. Reduce rate of growth in prescription drug spending</td>
<td>$57m</td>
<td>$113m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$279 million</strong> (~0.5% THCE)</td>
<td><strong>$794 million</strong> (~1.3% THCE)</td>
</tr>
</tbody>
</table>
Massachusetts’ health system performance to date

**Presentations**

- Per capita THCE growth has outpaced the growth of wages, inflation, and actual economic growth
- Hospital and professional spending accounted for 55% of total spending increases from 2013 – 2015
- Pharmacy spending was the fastest growing type of service
- Total national health expenditures (not per capita) grew at about 5% each year from 2014 through 2016

**Public Testimony**

- Spending growth has not been constant across sectors of the health care system or across spending categories
- The HPC should look at these differential growth rates when contemplating requiring a PIP
Key Takeaways

2 Impact of enrollment and demographic changes on performance

- The aging population alone will cause per capita THCE growth of approximately 0.6% each year through 2019
- The aging population is likely to increase costs and demand for certain services, such as home health
- These costs reflect increased utilization of needed services, which may be considered positive spending

3 Opportunities for and barriers to additional savings in Massachusetts

- Massachusetts could save between 0.5% and 1.3% of THCE without jeopardizing quality by achieving some of the recommendations in the 2016 Cost Trends Report
- Massachusetts can achieve savings through a variety of strategies:
  - Reducing waste
  - Optimizing the use of high-value providers
  - Supporting value-based insurance design
# Key Takeaways

## Financial impact of modifying the benchmark

<table>
<thead>
<tr>
<th>Presentations</th>
<th>Public Testimony</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increasing the benchmark from 3.1% to 3.6% would allow approximately $300 million in additional spending</td>
<td>• Rising health care costs place a serious economic burden on employers, individuals, and families</td>
</tr>
<tr>
<td>• Health care affordability continues to be a threat to low and middle income residents</td>
<td>• Health care costs are crowding out other areas of spending in Massachusetts</td>
</tr>
</tbody>
</table>
### Key Takeaways

#### Significant changes to the state or federal health care landscape

<table>
<thead>
<tr>
<th>Presentations</th>
<th>Public Testimony</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Potential federal health care changes may impact both national and Massachusetts spending</td>
<td>• Payers and providers are facing an unprecedented level of uncertainty at the state and federal level</td>
</tr>
<tr>
<td></td>
<td>• Some argued that this uncertainty weighs in favor of giving providers and payers more flexibility to adapt with a higher benchmark</td>
</tr>
<tr>
<td></td>
<td>• Others argued that these changes create even greater urgency to find effective cost control mechanisms and advocated for a lower benchmark</td>
</tr>
</tbody>
</table>
# Key Takeaways

## Role of the benchmark in the HPC’s statutory responsibilities

<table>
<thead>
<tr>
<th>Presentations</th>
<th>Public Testimony</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CHIA refers entities to the HPC whose HSA TME growth is “excessive” and who “threaten the benchmark”</td>
<td>• A lower benchmark could mean an increase in the number of organizations referred to the HPC for a potential PIP or CMIR</td>
</tr>
<tr>
<td>• The HPC reviews each referred entity and has discretion to require a PIP or conduct a CMIR</td>
<td>• The HPC should consider the impact of costs that are largely outside of entities’ control, such as drug spending and labor costs, before requiring a PIP</td>
</tr>
</tbody>
</table>

## Feedback from market participants and interested parties

<table>
<thead>
<tr>
<th>Public Testimony</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Just over half of the organizations advocated for a specific growth rate, while some chose to only submit factors and data for the HPC’s consideration</td>
</tr>
<tr>
<td>• 10 out of the 11 organizations that took a formal position recommended the HPC keep the statutory 3.1% benchmark.</td>
</tr>
</tbody>
</table>
### Summary of Public Testimony

<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1199SEIU United Healthcare Workers East</td>
<td>No formal position</td>
</tr>
<tr>
<td>American Nurses Association Massachusetts</td>
<td>No formal position</td>
</tr>
<tr>
<td>Associated Industries of Massachusetts</td>
<td>3.1%</td>
</tr>
<tr>
<td>Association of Developmental Disabilities Providers</td>
<td>Concerned with 3.1%</td>
</tr>
<tr>
<td>Beth Israel Deaconess Care Organization</td>
<td>No formal position</td>
</tr>
<tr>
<td>Conference of Boston Teaching Hospitals</td>
<td>No formal position</td>
</tr>
<tr>
<td>Greater Boston Interfaith Organization</td>
<td>3.1%</td>
</tr>
<tr>
<td>Health Care for All</td>
<td>3.1%</td>
</tr>
<tr>
<td>Kathleen Keough, Ph.D. RN-BC</td>
<td>3.1%</td>
</tr>
<tr>
<td>Massachusetts Association of Health Plans</td>
<td>3.1%</td>
</tr>
<tr>
<td>Massachusetts Council of Community Hospitals</td>
<td>3.1%</td>
</tr>
<tr>
<td>Massachusetts Health and Hospital Association</td>
<td>3.1%, with caveats</td>
</tr>
<tr>
<td>Massachusetts Medical Society</td>
<td>3.6%</td>
</tr>
<tr>
<td>Massachusetts Nurses Association</td>
<td>No formal position</td>
</tr>
<tr>
<td>Massachusetts Senior Care Association</td>
<td>No formal position</td>
</tr>
<tr>
<td>Massachusetts Taxpayers Foundation</td>
<td>3.1%</td>
</tr>
<tr>
<td>Mental Health Legal Advisor Committee</td>
<td>No formal position</td>
</tr>
<tr>
<td>Retailers Association of Massachusetts</td>
<td>3.1%</td>
</tr>
<tr>
<td>Steward Health Care System</td>
<td>3.1%</td>
</tr>
</tbody>
</table>
POTENTIAL VOTE: 2018 Health Care Cost Growth Benchmark

MOTION: That, pursuant to G.L. c. 6D, § 9, based on Potential State Gross Product as determined jointly by the Secretary of Administration and Finance and the House and Senate Ways and Means Committees, the Commission hereby establishes the health care cost growth benchmark for calendar year 2018 as ____%.
AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting
- Commissioner Updates
- 2018 Health Care Cost Growth Benchmark

**Cost Trends and Market Performance**
  - Update on Notices of Material Change
  - Final Regulation and Process Governing PIPs (VOTE)
- Executive Director’s Report
- Schedule of Next Board Meeting (May 10, 2017)
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## Types of Transactions Noticed

### April 2013 to Present

<table>
<thead>
<tr>
<th>Type of Transaction</th>
<th>Number of Transactions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical affiliation</td>
<td>18</td>
<td>24%</td>
</tr>
<tr>
<td>Physician group merger, acquisition, or network affiliation</td>
<td>18</td>
<td>24%</td>
</tr>
<tr>
<td>Acute hospital merger, acquisition, or network affiliation</td>
<td>15</td>
<td>20%</td>
</tr>
<tr>
<td>Formation of a contracting entity</td>
<td>13</td>
<td>17%</td>
</tr>
<tr>
<td>Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>Change in ownership or merger of corporately affiliated entities</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>Affiliation between a provider and a carrier</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>
Elected Not to Proceed

Proposed acquisition of First Psychiatric Planners d/b/a **Bournewood Hospital (Bournewood)**, a for-profit psychiatric hospital located in Brookline, by **Alita Care**, a for-profit Delaware company that owns and operates residential and outpatient behavioral health treatment facilities in eight states, including one in Massachusetts.

- Our analysis suggested limited scope for changes in health care spending, given that no substantial changes in Bournewood’s services or operations are expected as a result of the transaction.
- We did not find any evidence suggesting negative impacts on quality or access.

Proposed formation of a new contracting entity by **Berkshire Health System (BHS)**, Partnership for Health in the Berkshires (PHB), to contract on behalf of BHS (including Berkshire Medical Center), physicians affiliated with BHS, and certain other physicians practicing in Berkshire County.

- Our analysis indicated little difference in physician rates between BHS and independent Berkshire physicians, but the potential for an increase in market share for BHS as physicians join PHB.
- However, BHS stated that it has no plans to seek price increases for these physicians as a result of this new affiliation, and would cooperate with the HPC on any future evaluation of this transaction. Given this commitment, our analysis suggested limited scope for changes in health care spending.
- We did not find any evidence suggesting negative impacts on quality or access.
Elected Not to Proceed

Proposed clinical affiliation between **UMass Memorial Health Care** and **Dana-Farber Cancer Institute (DFCI)**, under which UMass Memorial Medical Center (UMass) would become a member of the Dana-Farber Cancer Care Collaborative and DFCI would provide certain consulting, educational, and clinical support services to UMass and its patients.

- Our analysis suggested limited scope for changes in health care spending, given that the transaction is not likely to significantly impact referral patterns for medical oncology services.
- We did not find any evidence suggesting negative impacts on quality or access.

Proposed acquisition of **PMG Physician Associates (PMG)**, a 19-physician practice in the greater Plymouth area, by **Atrius Health**. PMG consists largely of primary care physicians and currently contracts through Beth Israel Deaconess Care Organization (BIDCO).

- Our analysis suggested some potential for increased spending as PMG leaves BIDCO and joins Atrius contracts, although price and TME differentials between Atrius and BIDCO have been decreasing over time.
- However, the transaction is anticipated to decrease primary care market concentration in PMG’s service area.
- We did not find any evidence suggesting negative impacts on quality or access.
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**Performance Improvement Plans: Purpose**

PIPs are one of the key mechanisms by which the HPC can **enforce the benchmark** and ensure accountability to the Commonwealth’s cost containment goals.

PIPs provide an opportunity for the HPC and for payers and providers undergoing a PIP to **understand the drivers** of its cost growth, and to **pursue best practices** to address them.

The PIP process enables entities to **explore options to reduce cost growth** such as changing pricing or referral practices or implementing care delivery reform.

Entities undergoing a PIP will **provide updates to the HPC** on their progress and will have the opportunity to **receive consultation and technical assistance** from the HPC.
### Overview of Regulatory Process

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar.</td>
<td>Released interim guidance</td>
</tr>
<tr>
<td>Nov.</td>
<td>Board declines to require a PIP based on the 2015 CHIA list</td>
</tr>
<tr>
<td>Dec.</td>
<td>Discussed draft regulation and forms with CTMP</td>
</tr>
<tr>
<td>Jan.</td>
<td>Expert and stakeholder outreach on drafts</td>
</tr>
<tr>
<td>Jan.</td>
<td>Further discussion with CTMP, vote on advancement to Board</td>
</tr>
<tr>
<td>Mar.</td>
<td>Discussion with Board and vote to release drafts for public comment</td>
</tr>
<tr>
<td>Mar.</td>
<td>Public hearing, public comments, and updates to drafts as appropriate</td>
</tr>
<tr>
<td>Mar.</td>
<td>CTMP Vote to advance regulation to Board</td>
</tr>
<tr>
<td>TODAY</td>
<td>Full Board vote to issue final regulation</td>
</tr>
</tbody>
</table>
## Comments and Proposed Updates to Regulation

### Testimony Received From

- Beth Israel Deaconess Care Organization
- Blue Cross Blue Shield of Massachusetts
- Massachusetts Association of Health Plans
- Partners HealthCare System
- Steward Health Care System

<table>
<thead>
<tr>
<th>Section</th>
<th>Comment</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.04(3) and (4)</td>
<td>Entities should have the chance, before a public Board vote for a PIP, to: • <strong>Review data</strong> relied upon by HPC; and • <strong>Meet with HPC.</strong></td>
<td><strong>Add to section 10.04:</strong> Prior to the Board vote, the entity will receive written notice, the opportunity to review data relied upon by the HPC, and the opportunity to meet with the Executive Director.</td>
</tr>
<tr>
<td>10.08(8)</td>
<td>The notice that HPC has denied an extension request should <strong>include the reasons for the denial.</strong></td>
<td><strong>Add clause to 10.08(8) stating that</strong> the denial notice will include “the reason for the denial.”</td>
</tr>
<tr>
<td>Section</td>
<td>Comment</td>
<td>Recommendation</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td>10.04(1)</td>
<td>Articulate a <strong>clear, numerical standard</strong> for the “significant concern” that would justify a PIP.</td>
<td><strong>No change.</strong> The analysis should accommodate a variety of entities and case-by-case review.</td>
</tr>
</tbody>
</table>
| 10.04(2) 10.10(2) 10.13(3) | Add **additional, more specific factors** for determining whether to:  
- Require a PIP;  
- Approve or deny a proposed PIP; or  
- Deem a PIP successfully implemented. | **Add to 10.04(2)(d), (f) and (i):** “Payer mix,” “cost structure,” and “any other factors the Commission considers relevant.”  
Other suggested factors can be considered under the existing factors. |
| 10.10(5) | The notification that a PIP proposal was unacceptable or incomplete should be by both hardcopy and electronic copy. | **No change.** 958 CMR 10.10(5) states that the HPC will notify the entity. |
### Other Proposed Changes to Regulation

<table>
<thead>
<tr>
<th>Section</th>
<th>Issue</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| 10.16   | Draft regulation unintentionally omits the requirement of a **Board vote to initiate a CMIR** on named provider organizations, and does not grant the opportunity to review the HPC’s data and meet with the HPC. | **Add 10.16(2):** The entity may review the HPC’s data and meet with the HPC prior to a Board vote.  
**Add 10.16(3):** “The Commission shall determine whether to initiate a Cost and Market Impact Review by vote of the Board.” |
Performance Improvement Plans: Overview

1. CHIA confidentially refers Health Care Entities to the HPC
2. HPC performs gated review of entities and potentially votes to require one or more PIPs
3. Health Care Entity submits a proposed PIP
4. HPC evaluates a proposed PIP and votes to advance to implementation
5. Health Care Entity implements the PIP
6. After implementation, Board votes on whether the PIP was successful
# Proposed Implementation Process

## Step 1: Identification by CHIA

<table>
<thead>
<tr>
<th>Provided to Commissioners</th>
<th>The final confidential list of entities identified by CHIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Input</td>
<td>Comments or recommendations regarding the list</td>
</tr>
</tbody>
</table>

## Step 2: Requirement to File a PIP

| Provided to Commissioners | a) Results of the review process  
|                          | b) Recommendations to conclude the review process or request additional information from an entity  
|                          | c) Summary and analysis of additional information received  
|                          | d) Notice of any meeting scheduled with an entity |
| Board Input              | Comments or recommendations regarding the review and requests for additional information |
| Board Vote               | Whether to require a PIP |
## Proposed Implementation Process

### Step 3: Extensions or Waivers

<table>
<thead>
<tr>
<th>Provided to Commissioners</th>
<th>Provided to Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Entities’ waiver/extension requests, including supporting information</td>
<td><strong>Board Vote</strong></td>
</tr>
<tr>
<td>b) Whether the ED has granted an extension request of $\leq 45$ days</td>
<td>To grant an extension of $&gt;45$ days or a waiver</td>
</tr>
</tbody>
</table>

### Step 4: Approval of Proposed PIP

<table>
<thead>
<tr>
<th>Provided to Commissioners</th>
<th>Provided to Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Information related to the development of the PIP proposal</td>
<td><strong>Board Input</strong></td>
</tr>
<tr>
<td>b) Staff analysis of the PIP proposal</td>
<td>Comments or recommendations regarding a PIP proposal</td>
</tr>
<tr>
<td>c) Any additional information provided by the entity</td>
<td><strong>Board Vote</strong></td>
</tr>
<tr>
<td></td>
<td>To approve a proposed PIP</td>
</tr>
</tbody>
</table>
Proposed Implementation Process

Step 5: Implementation of PIP

**Provided to Commissioners**

- a) Reports on the implementation, reporting, and monitoring of the PIP at Commission meetings
- b) Other periodic reports
- c) Any proposed amendments

**Board Vote**

To approve significant proposed amendments

Step 6: Conclusion of PIP

**Provided to Commissioners**

Information related to the conclusion of the PIP

**Board Vote**

To determine whether the PIP was successful
Proposed Implementation Process

Step 7: Assessment of Penalty

- Provided to Commissioners
  - a) All information relevant to a determination whether to assess a civil penalty
  - b) Notice of any hearing afforded the entity

- Board Vote
  - To assess a civil penalty to an entity of not more than $500,000

Step 8: Initiation of CMIR

- Provided to Commissioners
  - a) All information relevant to a determination whether to initiate a CMIR
  - b) Recommendations to request additional information from an entity
  - c) Summary and analysis of additional information received
  - d) Notice of any meeting scheduled with an entity

- Board Input
  - Comments or recommendations regarding requests for additional information

- Board Vote
  - To determine whether to initiate a CMIR
Next Steps

- March: HPC receives new list from CHIA
- April: Perform gated review of entities and hold follow-up meetings where applicable
- May: Issue final regulation
- June: Potential vote to require PIP
- July: Regulation effective

All dates are approximate.
VOTE: Final Regulation on Performance Improvement Plans

MOTION: That the Commission hereby approves and issues the attached FINAL regulation on performance improvement plans, 958 CMR 10.00, pursuant to M.G.L. c. 6D, § 10 and § 13.
VOTE: Policy on Process for PIPs and CMIRs

MOTION: That the Commission hereby approves and adopts the attached Policy on Process for Initiating Performance Improvement Plans and Cost and Market Impact Reviews pursuant to 958 CMR 10.00.
AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting
- Commissioner Updates
- 2018 Health Care Cost Growth Benchmark
- Cost Trends and Market Performance

Executive Director’s Report
- Strategic Priorities 2017-2018
- Office of Patient Protection
- Care Delivery Certification Programs
- HCII Program
- CHART Investment Program

Schedule of Next Board Meeting (May 10, 2017)
AGENDA

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- Schedule of Next Board Meeting (May 10, 2017)
The HPC is charged in statute with advancing four policy priority outcomes.

<table>
<thead>
<tr>
<th>Fostering a value-based market</th>
<th>in which payers and providers openly compete, and providers are supported and equitably rewarded for providing high-quality and affordable services.</th>
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</thead>
<tbody>
<tr>
<td>Advancing aligned and effective financial models</td>
<td>for providers to deliver high-quality, cost effective care and for consumers and employers to make high-value choices for their care and insurance coverage.</td>
</tr>
<tr>
<td>Promoting an efficient, high-quality system</td>
<td>that improves health by delivering coordinated, patient-centered health care that accounts for patients’ behavioral, social, and medical needs.</td>
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<tr>
<td>Enhancing transparency</td>
<td>of health care system performance in order for health care stakeholders and agencies to successfully implement reforms and evaluate performance over time.</td>
</tr>
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</table>
Development and Promotion of Policy to Advance the HPC’s Mission: Four Core Strategies

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 INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE

PARTNER
ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS
2016 Cost Trends Report: Recommendations to Advance the Priority Policy Outcomes

**FOSTERING A VALUE-BASED MARKET**

1. Health Care Equity and Affordability*
2. Pharmaceutical Spending*
3. Out-of-Network Billing *
4. Provider Price Variation*
5. Facility Fees
6. Community-Appropriate Care*

**PROMOTING AN EFFICIENT, HIGH-QUALITY SYSTEM**

7. Unnecessary Hospital Use and Other Institutional Care*
8. Substance Use Disorder Treatment
9. Adherence to Evidence-Based Care

**ADVANCING ALIGNED AND EFFECTIVE FINANCIAL MODELS**

10. Adoption of Alternative Payment Models (APMs)*
11. Alignment and Improvement of APMs
12. Demand-Side Incentives

**ENHANCING TRANSPARENCY**

13. Data and Measurement*

* Identified by Board members at the February 8, 2017 Board meeting as potential high-impact activities.
## Estimated Opportunities for Savings for Improving Care and Reducing Costs

<table>
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<tr>
<th>SCENARIO</th>
<th>‘LOW’ SAVINGS</th>
<th>‘HIGH’ SAVINGS</th>
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<tbody>
<tr>
<td>I. Shift community-appropriate inpatient care to community hospitals</td>
<td>$43m</td>
<td>$86m</td>
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<tr>
<td>II. Reduce hospital readmissions</td>
<td>$61m</td>
<td>$245m</td>
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<tr>
<td>III. Reduce avoidable emergency department use</td>
<td>$12m</td>
<td>$24m</td>
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<tr>
<td>IV. Reduce use of institutional post-acute care</td>
<td>$47m</td>
<td>$186m</td>
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<tr>
<td>V. Adjust premiums based on primary care provider total medical expenditures</td>
<td>$36m</td>
<td>$72m</td>
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<tr>
<td>VI. Increase participation in alternative payment methodologies</td>
<td>$23m</td>
<td>$68m</td>
</tr>
<tr>
<td>VII. Reduce rate of growth in prescription drug spending</td>
<td>$57m</td>
<td>$113m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$279 million (~0.5% THCE)</strong></td>
<td><strong>$794 million (~1.3% THCE)</strong></td>
</tr>
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</table>
Board discussion on policy priorities for 2017-2018

Focus and align HPC activities towards that strategic direction

Proposed approach:
1. **Map** how current and planned HPC activities align with priority policy outcomes.
2. **Identify and focus** on the HPC’s activities and strategies that can best be leveraged to achieve the priority policy outcomes.
3. **Define metrics and targets** to hold the health care market’s performance accountable to meeting the priority policy outcomes.
4. Consider **new ideas** that align with the HPC’s mission and statutory mandate.
Upcoming HPC Special Event

Save the Date

HPC SPECIAL EVENT

Consumer Preferences, Hospital Choices, and Demand-Side Incentives

The HPC is hosting a special event to release new findings and discuss consumer preferences, hospital choices, and demand-side incentives. With funding from the Robert Wood Johnson Foundation, HPC staff, in conjunction with researchers from Tufts Medical School, conducted research to evaluate a patient’s choice of community hospitals versus academic medical centers. Researchers from Harvard University will also present on a recent study they conducted on the impact of tiered network health plans on hospital choice and overall spending. The event will culminate with a stakeholder panel discussion.

Reserve your seat: tinyurl.com/HPCConsumerPreference
Call to Order

Approval of Minutes from the February 8, 2017 Meeting

Commissioner Updates

2018 Health Care Cost Growth Benchmark

Cost Trends and Market Performance

Executive Director’s Report
  – Strategic Priorities 2017-2018
  – **Office of Patient Protection**
    – Care Delivery Certification Programs
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Schedule of Next Board Meeting (May 10, 2017)
Office of Patient Protection: External review process

Process for consumer with a fully-insured Mass. health plan, after pursuing internal review

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<tbody>
<tr>
<td>Consumer receives written denial notice/final adverse determination from carrier</td>
<td>Deadline: 4 months from the date the insured receives the final adverse determination</td>
<td>OPP reviews for eligibility</td>
<td>ERA may uphold, overturn, or partially overturn</td>
</tr>
<tr>
<td>External review if medical necessity</td>
<td>Submit completed external review form, copy of final adverse or adverse determination &amp; $25 fee if applicable, any supporting documents</td>
<td>If eligible, OPP sends to external review agency (ERA)</td>
<td>ERA sends written decision to insured, representative, OPP, carrier</td>
</tr>
<tr>
<td>Consumer may request expedited external review</td>
<td></td>
<td>ERA requests file from carrier</td>
<td>Carrier must respond within 5 days, implement without delay</td>
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<tr>
<td>Consumer may request continuation of coverage</td>
<td></td>
<td>ERA applies Mass. medical necessity standard</td>
<td>Final and binding decision</td>
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<td>Standard: 45 days</td>
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<td>Expedited: 72 hours</td>
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- Schedule of Next Board Meeting (May 10, 2017)
PCMH PRIME Participation Update

Since January 1, 2016 program launch

35 practices are PCMH PRIME Certified

42 practices are on the Pathway to PCMH PRIME

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

78 Practices Participating
ACO Certification Program Recent Milestones

Beta Launch
Kickoff and Training Meeting
March 16

3 ACOs

Program Overview Webinar
March 22

~60 stakeholder attendees
ACO Certification Program Timeline

April 27, 2016 – HPC Board approved final ACO Certification Criteria

May 2016 – March 2017 – HPC developed detailed requirements and application system

March 2017 – June 2017 – Beta Launch for application system testing

Mid-June 2017 (TBD) – 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 decisions within 60 days of application receipt*

*Certification decisions are valid for 2 years*
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  - **HCII Program**
    - CHART Investment Program
- Schedule of Next Board Meeting (May 10, 2017)
HPC’s Health Care Innovation Investment Program: Preparation Period Update

The Health Care Innovation Investment Program is investing $11.3M in innovative projects that further the HPC’s goal of **better health and better care at a lower cost** across the Commonwealth.

**Health Care Innovation Investment Program**

**Round 1 – Three Pathways**

- Targeted Cost Challenge Investments
- Telemedicine Pilots
- Mother and Infant-Focused Neonatal Abstinence Neonatal Syndrome (NAS) Interventions

**Primary Goal:**
- **Lower Costs**
- **Greater Access**
- **Better Outcomes**

**Target Populations:**
- **8 diverse cost challenge areas:**
  - SDH
  - BHI
  - VIC-Providers
  - VIC-Purchasers
  - Practice Pattern Variation
  - PAC
  - SAI & EOL
  - Site & Scope of Care

**Number of Initiatives:**
- **Lower Costs:** 10
- **Greater Access:** 4
- **Better Outcomes:** 6

**Patients from the following categories with Behavioral Health needs:**
1. Children and Adolescents
2. Older Adults Aging in Place
3. Individuals with Substance Use Disorders (SUDs)

**Opioid-addicted mothers and substance-exposed newborns**
By the Numbers: Targeted Cost Challenge Investments

62 Organizations
(hospital, pharmacy, housing) collaborating on projects

10 initiatives
Funded by the HPC

5 out of 8
Targeted cost challenge areas awarded

Initiatives span the Commonwealth:
From the Berkshires to Boston

$6,600,000
HPC funding

>5,500 patients
will be targeted, from children, to homeless families, to older adults

50% of Preparation Period complete

>$40M
estimated impact in health care cost savings
By the Numbers: Telemedicine Pilots and NAS Interventions

**Telemedicine**

- **4 initiatives** Funded by the HPC
- **$1,700,000** HPC funding
- **21 Organizations** (e.g. hospitals, schools, primary care practices) collaborating
- Initiatives span the Commonwealth: From the Holyoke to Cape Cod

---

**Neonatal Abstinence Syndrome Interventions**

- **6 initiatives** Funded by the HPC
- **$3,000,000** HPC funding
- **59 Organizations** (e.g. hospitals, primary care practices, behavioral health providers) collaborating
- Initiatives span the Commonwealth: From the Springfield to Middlesex County
- >450 infants with NAS treated in 2015 by HPC’s proposed awardees

---

- **Serve 900 patients** with Behavioral Health needs
- **60%** of Preparation Period complete
- **2 Initiatives** Launched
Most Awardees are currently preparing for launch

- Hiring staff
- Creating protocols, deploying education and training
- Implementing technology
- Establishing governance structures and agreements
- Preparing measurement & self-assessment plans
AGENDA

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- Schedule of Next Board Meeting (May 10, 2017)
CHART Phase 2: Progress as of March 2017

67% of program months complete
CHART Phase 2: Activities since program launch

11 regional meetings

600+ hours of coaching phone calls

600+ hospital and community provider attendees

15 CHART newsletters

210+ technical assistance working meetings

3,012 unique visits to the CHART hospital resource page

375+ data reports received

Updated through March 9, 2016. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.
CHART Phase 2: The HPC has disbursed $25.2M to date

$59,051,711*

Remaining $33,875,291.64 is inclusive of $7,217,898 maximum outcome-based Achievement Payment opportunity

$25,176,419.36

Updated March 9, 2017

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.
CHART Phase 2 Evaluation Timeline

February 2017 – Hospital Survey Results

March 2017 – Baseline Summary Report

April 2017 – Awardee Memos

July 2017 – Interim Report

April 2018 – Patient Perspective Study Report

May 2018 - Awardee memos 2

October 2018 - Theme Reports

January 2019 – Final summative Report
CHART Investment Priorities

CHART investment priorities are structured to support transformation at the system, hospital, and patient care levels.
### Looking from Phase 1 to Phase 2 to Phase 3

<table>
<thead>
<tr>
<th>2013</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase 1: Foundational Activities to Prime System Transformation</strong> $9.2M</td>
<td><strong>QI, Collaboration, and Leadership Engagement</strong></td>
</tr>
<tr>
<td>Modest investment with many eligible hospitals receiving funds</td>
<td>Measurement and Evaluation Partnership</td>
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<tr>
<td>Short-term, high-need expenditures</td>
<td></td>
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<tr>
<td>Participation not requisite for receipt of Phase 2 funds nor a guarantee of Phase 2 award</td>
<td></td>
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<tr>
<td>Identified need to assess capability and capacity of participating institutions</td>
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<tr>
<td>Opportunity to promote engagement and foster learning</td>
<td><strong>Phase 2: Driving System Transformation</strong> $60M</td>
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<td><strong>Phase 2: Driving System Transformation</strong> $60M</td>
<td></td>
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<tr>
<td>Deeper investment in hospitals over a 2-year period of performance</td>
<td></td>
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<tr>
<td>Focused areas for care transformation</td>
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<tr>
<td>Data-driven approach</td>
<td></td>
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<tr>
<td>Outcomes-oriented aims and targets</td>
<td></td>
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<tr>
<td>Close engagement between awardees and HPC, with substantial technical assistance</td>
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<tr>
<td><strong>Phase 3: Sustaining System Transformation</strong> Approx. $20M</td>
<td></td>
</tr>
<tr>
<td>Support the successful transition to a sustainability model supported by market incentives and alternative payment models, including the MassHealth ACO program</td>
<td></td>
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<tr>
<td>Continue and enhance the work of promising interventions from Phase 2</td>
<td></td>
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<tr>
<td>Strengthen relationships with community partners</td>
<td></td>
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<tr>
<td>In-kind contributions from hospitals/systems</td>
<td></td>
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<tr>
<td>Alignment with MassHealth’s DSRIP funding and programmatic goals</td>
<td></td>
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</tbody>
</table>

**Phase 1: Foundational Activities to Prime System Transformation $9.2M**

- Modest investment with many eligible hospitals receiving funds
- Short-term, high-need expenditures
- Participation not requisite for receipt of Phase 2 funds nor a guarantee of Phase 2 award
- Identified need to assess capability and capacity of participating institutions
- Opportunity to promote engagement and foster learning

**Phase 2: Driving System Transformation $60M**

- Deeper investment in hospitals over a 2-year period of performance
- Focused areas for care transformation
- Data-driven approach
- Outcomes-oriented aims and targets
- Close engagement between awardees and HPC, with substantial technical assistance

**Phase 3: Sustaining System Transformation Approx. $20M**

- Support the successful transition to a sustainability model supported by market incentives and alternative payment models, including the MassHealth ACO program
- Continue and enhance the work of promising interventions from Phase 2
- Strengthen relationships with community partners
- In-kind contributions from hospitals/systems
- Alignment with MassHealth’s DSRIP funding and programmatic goals
Stakeholder Input to Date

Input received from current CHART hospitals, other agencies, experts, and community providers

- Strong support for goal of sustainability through alternative payment models
- Required community partnerships
- Importance of alignment with MassHealth ACO program/DSRIP
Preliminary Proposal for Structure of CHART Phase 3 as Discussed at March 25 CHICI Meeting

**THEME**
Enhancing and ensuring sustainability of community-focused, collaborative approaches to care delivery transformation and the successful adoption of alternative payment models, including the MassHealth ACO program

**FUNDING**
Proposed total funding of approximately $20M

**FOCUS AREAS**
Two pathways:
1. Limited bridge funding to continue promising interventions from Phase 2. Awards would be selective and would require hospital financial support, with a continued focus on:
   - Reducing unnecessary hospital utilization (readmissions, ED visits, ED Boarding, etc.)
   - Addressing whole patient needs with multi-disciplinary care teams
   - Identifying and engaging in real time with complex patients
   - Addressing social determinants of health
   - Strengthening community partnerships
2. Funding to support the successful adoption of alternative payment models, including strong alignment with the MassHealth ACO program, through continued capacity-building activities in various areas. For example:
   - Analytics/risk stratification expertise
   - Data exchange
   - Legal support for community partnership contracting
   - Business planning
Preliminary Proposal for Structure of CHART Phase 3 (continued)

COMPETITIVE FACTORS

- Solid sustainability plan
- Required in-kind funds from hospitals/systems to promote sustainability
- Supportive, but not duplicative, of DSRIP goals
- Participation in risk contracts with substantive quality measures and/or partnership with a provider organization seeking HPC ACO certification in 2017
- Performance in Phase 2
- Demonstration of understanding of the drivers of utilization
- Collaborative multi-disciplinary team approach to care delivery
- Strong relationships with community partners

OUTCOMES

- Address at least one or all of the HPC’s key target areas for reducing unnecessary utilization and improving quality:
  - Reduce all-cause 30-day hospital readmissions
  - Increase the integration of behavioral health into primary care
  - Reduce the rate of discharge to institutional care following hospitalization
  - Reduce the rate of behavioral health related ED utilization
Next Steps

HPC to continue developing Phase 3 design, including:
- Comprehensive stakeholder engagement
- Increased specificity of focus areas and targets
- Adapting administrative framework to reflect early lessons learned from Phases 1 and 2
- Review of CHART Phase 2 performance at the one year mark

HPC to continue goal-setting activities, including evaluation framework and performance targets

Present RFR to Board on May 10, 2017, with planned release following Board vote
### Proposed CHART Phase 3 Timeline

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<tr>
<td>Design discussion</td>
<td>Advisory Meeting</td>
<td>Board meeting</td>
<td>CHICI meeting</td>
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<td>Stakeholder engagement</td>
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<td>Procurement and evaluation development</td>
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<td>RFR vote and release</td>
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<td>Board meeting and RFR release</td>
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<td>Responses due</td>
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<td>Board vote on Awardees</td>
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<td>Board meeting</td>
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<td>Majority of Phase 2 Awards end</td>
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- **Phase 2 Ending**
AGENDA

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- Approval of Minutes from the February 8, 2017 Meeting
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- Executive Director’s Report
- **Schedule of Next Board Meeting**
Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us