



Commonwealth of Massachusetts  
Office of the State Auditor  
Suzanne M. Bump

*Making government work better*

Official Audit Report – Issued April 25, 2017

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## Community Hospital Acceleration, Revitalization, and Transformation Program—Phase 1

For the period January 1, 2014 through December 31, 2014





Commonwealth of Massachusetts  
Office of the State Auditor  
Suzanne M. Bump

*Making government work better*

April 25, 2017

Mr. David Seltz, Executive Director  
Health Policy Commission  
50 Milk Street, Eighth Floor  
Boston, MA 02109

Dear Mr. Seltz:

I am pleased to provide this performance audit of Phase 1 of the Health Policy Commission's Community Hospital Acceleration, Revitalization, and Transformation Program. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2014 through December 31, 2014. My audit staff discussed the contents of this report with management of the commission, whose comments are reflected in this report.

I would also like to express my appreciation to the Health Policy Commission for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMBump".

Suzanne M. Bump  
Auditor of the Commonwealth

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## LIST OF ABBREVIATIONS

CHART	Community Hospital Acceleration, Revitalization, and Transformation
CHIA	Center for Health Information and Analysis
CMR	Code of Massachusetts Regulations
DHTF	Distressed Hospital Trust Fund
HPC	Health Policy Commission
MMARS	Massachusetts Management Accounting and Reporting System
NARH	North Adams Regional Hospital
OSA	Office of the State Auditor

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## EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) is required by Chapter 224 of the Acts of 2012 (An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation) to review financial and programmatic effects of Chapter 224 and present findings and recommendations to the Legislature by March 31, 2017.<sup>1</sup> The Legislature enacted this law to align the state's healthcare-delivery system with the federal Affordable Care Act of 2010,<sup>2</sup> improve the quality of healthcare, and reduce rising healthcare costs. In addition to assessing the aforesaid effects of this legislation, OSA is conducting a series of audits related to different agency initiatives established by Chapter 224, including the activities of the Health Policy Commission (HPC), a newly established agency.

As part of this effort, and in accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, OSA has conducted a performance audit of HPC's<sup>3</sup> Community Hospital Acceleration, Revitalization, and Transformation (CHART) Program Phase 1 grants. The funding for the CHART Program is provided by the Distressed Hospital Trust Fund, established by Section 2GGGG of Chapter 29 of the General Laws to provide grants to certain nonprofit community hospitals. The fund is financed by public and private sources, grants and donations, interest earned on revenue, and funds from other sources.

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1. This date was later changed to June 30, 2017.
  2. On March 23, 2010 and March 30, 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, respectively. These two separate pieces of legislation are referred to as the Affordable Care Act. The purposes of the Affordable Care Act are to expand medical coverage to millions of Americans who would not or could not buy health insurance or who are underinsured and to improve the quality of healthcare services.
  3. Generally accepted government auditing standards require that organizations be free from organizational impairments to independence with respect to the entities they audit. Under Section 2(b) of Chapter 6D of the General Laws, HPC's board consists of 11 members, 3 of whom are appointed by the State Auditor. This disclosure is made for informational purposes only, and this circumstance did not interfere with our ability to perform our audit work and report its results impartially.

Below is a summary of our findings and recommendations, with links to each page listed.

<b>Finding 1</b> <b>Page <a href="#">8</a></b>	\$9 million in Phase 1 grants under the CHART Program provided limited measurable results.
<b>Recommendations</b> <b>Page <a href="#">10</a></b>	<ol style="list-style-type: none"> <li>1. HPC should ensure that future grants are administered in a manner that ensures that measurable outcomes can be achieved within the grant period. This administration should include, among other things, performing detailed reviews of all future CHART grant proposals to ensure that funds are only awarded for projects that can produce measurable results within that period.</li> <li>2. HPC should ensure that it documents, in its board minutes, its formal responses to all questions and concerns raised by its board members.</li> </ol>
<b>Finding 2</b> <b>Page <a href="#">13</a></b>	HPC did not properly document that it assessed the financial health of grant applicants.
<b>Recommendations</b> <b>Page <a href="#">15</a></b>	<ol style="list-style-type: none"> <li>1. HPC should develop policies and procedures for documenting and retaining its financial health assessments and evaluations that include an examination of key financial and economic performance indicators.</li> <li>2. HPC should retain documentation of its review of each grant applicant's most recent independent audited financial statements and other disclosures as part of its assessment process.</li> </ol>
<b>Finding 3</b> <b>Page <a href="#">16</a></b>	HPC did not provide adequate financial oversight to grantees; this resulted in \$9,204 of undocumented expenses.
<b>Recommendation</b> <b>Page <a href="#">18</a></b>	HPC should ensure that its compliance monitoring program includes a requirement for hospitals to retain, and provide to HPC on request, all applicable supporting documentation for grant expenditures in a standardized reporting format developed by HPC.
<b>Finding 4</b> <b>Page <a href="#">19</a></b>	HPC paid \$418,600 for consulting services that were of limited use to hospitals.
<b>Recommendation</b> <b>Page <a href="#">21</a></b>	HPC should ensure that all consultant deliverables intended to benefit CHART hospitals are valuable, accurate, and shared with hospital officials.
<b>Finding 5</b> <b>Page <a href="#">23</a></b>	HPC did not provide annual reports on CHART expenditures to the Legislature.
<b>Recommendation</b> <b>Page <a href="#">24</a></b>	HPC should establish policies and procedures to ensure that it provides the required annual report to the Legislature, including detailing all expenditures and resulting benefits of the CHART Program.

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## OVERVIEW OF AUDITED ENTITY

The Health Policy Commission (HPC) was established in 2012 by the Commonwealth’s healthcare cost containment law, Section 6D of Chapter 224 of the Acts of 2012. Under Chapter 6D of the Massachusetts General Laws, HPC is an independent state agency overseen by an 11-member board. This board, by law, consists of experts from various healthcare sectors, including healthcare finance and administration, primary care, consumer advocacy, behavioral health, and the healthcare workforce. HPC’s mission is to improve the quality, and reduce the cost, of healthcare across Massachusetts through independent policy and programs aimed at promoting healthcare innovation, accountability, and transparency. As part of this mission, HPC is responsible for administering all grants under the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Program from the Distressed Hospital Trust Fund (DHTF) under Section 2GGGG of Chapter 29 of the General Laws.

### CHART Program

Through the CHART Program, HPC plans to invest \$120 million in multi-phased grants to qualified community hospitals throughout Massachusetts. Funding for the CHART Program comes from assessments against large health systems and commercial insurers, as required by Chapter 224. To be eligible for CHART funding, community hospitals must be nonprofit, non-teaching hospitals with relative prices below the statewide median relative price.<sup>4</sup> According to HPC’s report “Community Hospital Acceleration, Revitalization, and Transformation Program Phase 1—Foundational Investments for Transformation,” the goals of the CHART Program are as follows:

- to advance healthcare coordination and delivery
- to expand electronic health record use and coordination among providers
- to increase the use of alternative payment methods<sup>5</sup> and accountable care organizations<sup>6</sup>
- to improve patient safety, access to behavioral-health services, and partnerships between hospitals and community-based providers/organizations

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4. According to the website of the Center for Health Information and Analysis, “Relative price is a calculated metric that measures provider price variation in the Massachusetts health care market. It allows for comparison of different provider prices within a payer’s network for a standard mix of insurance products.”

5. These are alternatives to the more common method of paying for healthcare, the fee-for-service method. They include options such as paying a healthcare provider a set amount for all the services that s/he will provide to a particular member, rather than paying for each service as it occurs.

6. Accountable care organizations are groups of healthcare providers that are accountable for the cost and quality of their members’ health care. They provide a range of medical services based on the provider groups’ capabilities.

## **CHART Phase 1**

In October 2013, HPC published a request for proposals for CHART Phase 1 grants, making \$10 million available to community hospitals. Based on the responses, HPC awarded grants to 28 community hospitals in February 2014. Of the total amount available, HPC awarded approximately \$9 million to hospitals. HPC officials informed us that Phase 1 grants are foundational investments in hospitals that fall within three award types: (1) reducing hospital readmissions, (2) minimizing the use of emergency departments, and (3) advancing healthcare technology. Some of the projects that Phase 1 grants funded included upgrades to electronic medical recordkeeping systems, development of physician guidelines for prescribing opioids, and implementation of new technologies to identify and redirect frequent users of emergency departments. Although some hospitals completed Phase 1 work in the six-month grant period (February 2014 through July 2014), 19 hospitals required time extensions of one to six months to complete projects. HPC hosted a one-day leadership summit in September 2014 for hospital executives to share project results and lessons learned from the Phase 1 grant process.

## **Future CHART Phases**

In October 2014, HPC selected 25 hospitals or hospital health systems to participate in CHART Phase 2 and executed contracts in November 2014 totaling approximately \$60 million. Phase 2 was intended to continue transforming CHART hospitals with projects focusing on the following three areas, according to HPC's website:

- maximizing appropriate hospital use through reduction of readmissions or reduction of emergency-department use
- enhancing behavioral-health care
- improving hospital-wide (or system-wide) processes to reduce waste and improve quality and safety

Implementation of Phase 2 was staggered through summer 2016 and was expected to be complete by January 2017; however, that completion date was subsequently extended to September 2017.

HPC is currently planning Phase 3 and additional future grant phases to disburse the remainder of the \$120 million.

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## AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of the Health Policy Commission’s (HPC’s) Community Hospital Acceleration, Revitalization, and Transformation (CHART) Program for the period January 1, 2014 through December 31, 2014.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objectives	Conclusion
1. Did HPC administer CHART Phase 1 in accordance with state laws, rules, and regulations and in such a manner as to ensure that grantees’ expenditures were in accordance with final approved grant proposals?	<b>No; see Findings <u>1</u>, <u>3</u>, <u>4</u>, and <u>5</u></b>
2. Did HPC award CHART grants to financially viable community hospitals?	<b>Partially; see Finding <u>2</u></b>

To achieve our audit objectives, we reviewed applicable state laws, rules, and regulations; HPC’s published documents; and meeting minutes related to the CHART Program from HPC’s board of commissioners and its Committee for Community Health Care Investment and Consumer Involvement. We also conducted interviews with HPC and grantee officials regarding the CHART Program’s Phase 1 grant expenditures, initiatives, and programmatic successes.

We gained an understanding of the key processes and controls that were significant to our audit objectives through interviews and observations. We tested the controls for the audit objective related to proper administration of CHART Phase 1 for proper design and effectiveness. However, because HPC could not give us adequate documentation that it properly assessed the financial health of grant

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applicants, we could not test the effectiveness of this control. We still achieved our audit objective by expanding our audit procedures to reflect a higher level of risk.

We judgmentally selected a nonstatistical sample of 7 out of the 28 hospitals, giving consideration to state region<sup>7</sup> and award type, including 1 hospital that we believed was of interest—North Adams Regional Hospital (NARH)—because it ceased operations 38 days after receiving its CHART grant. We met with officials from the remaining selected hospitals (officials from NARH were no longer available) to gain an understanding of their CHART grant projects, including established targets, project implementation, and results. Since this sample was nonstatistical, we did not extrapolate any errors to the population.

For each sampled hospital, we reviewed all grant expenditures, including supporting documentation for each expenditure. We compared the expenditures to the approved grant proposals and each hospital's grant budget reconciliation reports, which detailed budgeted and actual amounts of grant funds spent. For the hospital that closed approximately one month after receiving grant funds, we compared all the grant expenditures the hospital used up to the date of closure (totaling \$40,876) to the budget reconciliation report it submitted to HPC.

We also conducted interviews with HPC officials to determine whether HPC assessed the financial viability of each hospital that was awarded a CHART Phase 1 grant and the procedures it performed to conduct these assessments as required by its governing law. We reviewed supporting data that were provided by the Center for Health Information and Analysis (CHIA)<sup>8</sup> and used by HPC to assess hospitals' financial viability. In addition, we evaluated the extent to which HPC analyzed the CHIA data when performing these assessments.

We obtained and examined all executed contracts and award letters for each sampled CHART hospital. Additionally, we examined all operational responses (grant applications) prepared by all CHART applicants, with particular focus on disclosures made by hospital administrators on the financial stability/instability of the hospitals, planned reporting and metrics for each proposed project, and other pertinent background information disclosed in the application.

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7. This was based on the Executive Office of Health and Human Services' established region codes.

8. CHIA is an independent state agency created by Chapter 224 of the Acts of 2012, pursuant to Chapter 12C of the General Laws, whose mission is to obtain, record, and report information about the quality, affordability, use, access, and outcomes of the Commonwealth's healthcare system.

To assess the reliability of data, we queried from the state’s Massachusetts Management Accounting and Reporting System (MMARS) all payments made to Phase 1 grantees and compared these payments to those reported in HPC’s publication “Community Hospital Acceleration, Revitalization, and Transformation Program Phase 1—Foundational Investments for Transformation.” Based on our most recent data-reliability assessment of MMARS, dated April 8, 2014,<sup>9</sup> and our current comparison of source documentation with MMARS information, we determined that the information obtained from MMARS for our audit period was sufficiently reliable for the purposes of our audit work. Additionally, we assessed the reliability of each hospital’s reporting of grant funds used by comparing the reported amounts to those in MMARS, as well as to supporting invoices and other calculations hospitals provided in relation to grant expenditures. Based on the procedures performed, we determined that the data obtained were sufficiently reliable for the purposes of this report.

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9. As part of this assessment, we tested general information-technology controls for system design and effectiveness. We tested for accessibility of programs and data, as well as system change management policies and procedures for applications, configurations, jobs, and infrastructure.

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## DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

### **1. \$9 million in Phase 1 grants under the Community Hospital Acceleration, Revitalization, and Transformation Program provided limited measurable results.**

The Health Policy Commission (HPC) awarded Community Hospital Acceleration, Revitalization, and Transformation Program (CHART) Phase 1 grants totaling \$9,074,098 to 28 acute-care hospitals to be used during the six-month Phase 1 grant period, February 1, 2014 through July 31, 2014. Under their grant agreements, hospitals were supposed to produce measurable results for improving healthcare delivery systems and reducing healthcare costs. However, HPC did not adequately assess whether hospitals would have sufficient time and resources, such as required staffing, to complete Phase 1 projects successfully. As a result, the Commonwealth did not receive a measurable return on its grant funding investment at all of these hospitals.

During the CHART Phase 1 planning process, HPC allowed hospitals to develop grant projects to provide more efficient and effective healthcare for the specific needs of their communities. However, although some hospitals fully or partially completed projects with measurable results, others did not. Specifically, as reported by HPC in its 2015 report "Community Hospital Acceleration, Revitalization, and Transformation Program Phase 1—Foundational Investments for Transformation," only 5 CHART hospitals met all of their targets;<sup>10</sup> 18 met some of their targets, but not all; and the other 5 did not produce any measurable results.

For example, one hospital received grant funds to partner with a healthcare analytics company. Through this project, the hospital transferred claim data, which the partner company analyzed to identify high-risk patients who were most likely to require expensive treatments and acute-care inpatient visits. The hospital planned to use this information to improve patient case management, prevent costly treatments, and reduce inpatient stays. However, as noted in its grant proposal, the hospital estimated that just the integration and installation of this system would take at least six months; it did not expect measurable results in the first phase (meaning that results would be available in Phase 2). This hospital applied for Phase 2 grant funds to continue this project, but HPC denied this request because it did not focus specifically on hospital readmissions, a Phase 2 CHART initiative. Hospital officials stated that the goal of this project was to prevent any admissions, including readmissions. They expressed frustration

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10. "Targets" in this context are measurable results of completed grant projects.

with HPC because of the time spent implementing this project and then having to change focus in Phase 2 to readmissions only.

## Authoritative Guidance

Section 2GGGG(e) of Chapter 29 of the Massachusetts General Laws requires HPC to do the following before awarding grants:

*In reviewing the grant applications, the commission shall consider . . . the anticipated return on investment, as measured by improved health care coordination and a reduction in health care costs.*

To administer these grants properly, HPC should have ensured that hospitals had sufficient time and resources to achieve their goals within the grant period.

## Reasons for Limited Measurable Results

During our audit, HPC officials stated that they did not expect the shorter-term CHART Phase 1 grants to produce measurable results in every case because the grants were essentially intended to build a foundation for future programs and expenditures that would lead to measurable results, rather than delivering results in themselves. In its response to our draft of this report, HPC stated,

*The HPC fully expected, and publicly reported on, variability in success of the Phase 1 investment initiatives. The variability may be attributed, in part, to some hospitals designing goals that likely were too aggressive or aspirational given the established timeline.*

Hospital officials we met with told us they were led to believe that they could complete Phase 1 projects using Phase 2 grant funds. We confirmed this during our reviews of grant applications, where grantee hospitals listed metrics as measurable during CHART Phase 2, left metrics blank, or listed them as "N/A" or "TBD." However, HPC changed the direction of CHART Phase 2 by narrowing the project scope and patient population, which in many cases did not allow hospitals to complete Phase 1 projects that did not match up to the new Phase 2 scope. We also confirmed this with officials at the sampled hospitals.

During HPC board meetings, one HPC board member expressed concerns that the regulations<sup>11</sup> governing the procedures and criteria used to award and administer CHART grants were too broad and did not specifically define how grant funds should be used to lower costs and increase quality (i.e., produce measurable results). Another board member raised concerns about the brevity of the Phase 1

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11. The board member was referring to Section 5 of Title 958 of the Code of Massachusetts Regulations.

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program implementation timeline. HPC did not address these concerns formally as part of its monthly board meetings, so we do not have sufficient evidence to consider whether the concerns were addressed. Thus HPC may not have sufficiently considered whether it gave hospitals enough time to implement Phase 1 projects effectively and to ensure that projects could produce measurable outcomes within the six-month grant period.

Finally, in its report on the outcomes of the Phase 1 grant program ("Community Hospital Acceleration, Revitalization, and Transformation Program Phase 1—Foundational Investments for Transformation"), HPC reported that many hospitals failed to achieve measurable results and attributed this failure to "a variety of reasons including **the Phase 1 time frame being too short** to meet a target, slower than anticipated launch of initiatives and the setting of **unrealistic targets** to begin with" [emphasis added].

## Recommendations

1. HPC should ensure that future grants are administered in a manner that guarantees that measurable outcomes can be achieved within the grant period. This administration should include, among other things, performing detailed reviews of all future CHART grant proposals to ensure that funds are only awarded for projects that can produce measurable results within that period.
2. HPC should ensure that it documents, in its board minutes, its formal responses to all questions and concerns raised by its board members.

## Auditee's Response

*While the Health Policy Commission (HPC) concurs with the Auditor's general recommendation that grant programs should be designed to enable awardees to be as successful as possible during a grant period, we respectfully disagree with the conclusion that the HPC failed to administer the Phase 1 grants properly. . . .*

*The intent of the DHTF is important context for any assessment of CHART. As a cornerstone strategy of its health care reform legislative package in 2012, the legislature established the DHTF to support and sustain the Commonwealth's financially challenged community hospitals, despite inherent risk, recognizing that these low-resourced hospitals lack sufficient resources to develop the capabilities necessary to succeed in a rapidly changing health care environment.*

*To administer the \$120 million Fund, the HPC designed a multi-phased program, with a first phase of \$9.07 million in awards to 28 hospitals focusing on capability development. This was a policy decision made unanimously by the Board in the exercise of discretion squarely within the mandate of M.G.L. c. 29, §2GGGG. The Board's 11 members deliberated on the design and execution of Phase 1 and ultimately voted in unanimous support of the program design and award amounts. The phased approach, which the HPC clearly communicated to all hospitals, allowed hospitals in Phase 1, through short-term, high-need projects, to build a foundation for*

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*broader transformation in future phases. The effectiveness of Phase 1 must be determined in the context of the multi-phase approach.*

*There is no requirement, statutory or otherwise, that all projects funded from the DHTF must meet 100% of the project's measurable goals or targets. M.G.L. c. 29 §2GGGG(e) simply requires that the HPC "consider, among other factors . . . the anticipated return on investment" of a grant proposal, and the HPC considered these statutory factors accordingly when reviewing applications. The HPC fully expected, and publicly reported on, variability in success of the Phase 1 investment initiatives. The variability may be attributed, in part, to some hospitals designing goals that likely were too aggressive or aspirational given the established timeline, as highlighted in the HPC's Phase 1 report, "Community Hospital Acceleration, Revitalization, and Transformation Program; Phase 1—Foundational Investments for Transformation" ("the Phase 1 report").*

*As documented in the Phase 1 report, however, Phase 1 produced numerous successes, including the reduction in opioid prescription use at one hospital and the launch of three training programs and reduction in the length of stay for orthopedic patients at another hospital. Overall, Phase 1 funds supported the training of more than 2,300 hospital personnel in multiple disciplines across the cohort of hospitals, which the hospitals are leveraging in Phase 2. Twenty-three of the 28 hospitals met at least some of their targets and produced measurable results. The overwhelming majority of hospitals—87% of respondents to an anonymous survey administered by the HPC—reported that they believed CHART Phase 1 moved their organization along the path to system transformation. Further, Phase 1 allowed the HPC to assess capability among the cohort of hospitals, foster engagement, and build a foundation for transformation, which enabled a rich and robust selection and implementation of Phase 2. The targets designed by the hospitals are only one metric of success; the overall goals and objectives of the program are another. The HPC accomplished its goals in Phase 1, and Phase 2 has continued this engagement and close partnership while supporting further transformation.*

## **Auditor's Reply**

Although some of the hospitals' projects produced measurable results, there were just as many that did not. A number of the grantee applications listed no metrics on their applications, so success or failure could not be fully measured. For example, the metrics and reporting sections of some grant applications were left blank or not fully completed; some included language such as "TBD"; "N/A"; "All the metrics to measure performance are qualitative, not quantitative"; "The projects are not expected to yield any patient clinical outcomes or cost savings [efficiencies] during the grant period"; and "Measurable results are not expected in the first Phase." The fact that HPC did not require all grantees to be held to the same standards of achieving some type of measurable results leads us to believe that it could have done a better job of administering the CHART Program.

We do not argue with HPC's assertion that Section 2GGGG(e) of Chapter 29 of the General Laws does not specifically require grantees to meet 100% of a project's measurable goals or targets, but it does require HPC to consider the anticipated return on investment. We question how the HPC could effectively assess a project's potential return on investment when the project proposal does not include measurable goals or outcomes that can be used for this purpose. Further, it should be noted that HPC's own regulations under Section 5.05 of Title 958 of the Code of Massachusetts Regulations (CMR) require all grant applicants to submit, among other things, the following:

4. *A plan that defines specific goals for improving the efficiency and effectiveness of the hospital's care over a multi-year period;*
5. *The programs the Applicant shall use to meet the goals, and the evidence-base for these programs where applicable . . .*
7. *A plan for sustaining any investments after the expiration of grant funds.*

This was not the case for all the grant applicants in Phase I.

In its response, HPC refers to a survey completed by CHART hospitals, which concludes that 87% of the respondents believed that CHART Phase 1 helped to move their hospitals "along the path to system transformation." It is reasonable to expect that hospitals that received grant funding and responded to this survey would respond favorably, but it should be noted that some hospitals provided critical comments about the way HPC administered the grant process. For example, some hospital administrators felt that HPC could better support them in future CHART phases in the following ways:

- *The staff assessing our proposal in the planning stage should consider visiting our site to see first hand what we are facing to better understand our ability to evolve. This cannot be discerned over the phone.*
- *Continued funding over time for transformation. We will not be "finished" when the next project is completed. Feedback and support during the design phase of establishing projects might have helped with organization and project selection.*
- *More flexibility to adjust in the projects. More clarity up front on reporting and requirements so that this data can be collected along the way rather than going back to gather information, also would allow for better project planning.*
- *More content experts who have been successful in the initiatives to guide the teams so the reshaping of the grant to the dollars does not compromise the original intentions.*
- *Please be flexible with the organizations. We found that our initial assumptions were incorrect and we had to re-structure for better results. Flexibility is key to learning both what does and does not work! Allowing for learning is essential.*

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Another issue with HPC's administration of this grant program is that it changed direction on the Phase 2 project goals and did not clarify to its grant recipients that Phase 1 had a limited grant period. Moreover, HPC accepted several hospitals' project proposals even when the hospitals disclosed that they planned to use grant funds in Phase 2 to continue their Phase 1 projects. This was a disservice to those hospitals, whose projects were discontinued because of HPC's change of the focus of Phase 2 grants.

Finally, HPC states that all 11 members of its board ultimately voted on the design and project awards. Although this may be true, board members expressed concern over certain aspects of the project at various times, as noted in our report. For example, at the January 8, 2014 board meeting, one board member expressed concern about the fact that the final grantee reporting content requirements were not yet clarified, stating that reporting typically drives the progression of grantee projects. Other concerns expressed by board members, such as the shortness of Phase 1, are also detailed in this report.

## **2. HPC did not properly document that it assessed the financial health of grant applicants.**

HPC could not provide documentation to substantiate that it properly assessed the financial health of hospitals before awarding CHART Phase I grants. Because HPC did not ensure that its financial assessment activities were properly documented, there is a higher-than-acceptable risk that assessments are not being performed or are inadequate in that staff members may not be performing all of the financial analysis required by HPC regulations.<sup>12</sup> This might put grant funds at risk of loss or misuse by hospitals that may not be financially viable, may be forced to use the funds for purposes other than those intended under the grant, and/or may have to cease operating.

For example, one Phase 1 grant awardee, North Adams Regional Hospital (NARH), received \$316,248 from HPC on February 18, 2014 and then ceased operations 38 days later, on March 28, 2014. NARH disclosed indicators of financial instability to HPC in its grant proposal, stating that its parent company, Berkshire Health Systems, had filed for bankruptcy in 2011. NARH's former director of Finance stated at a November 1, 2013 public hearing (103 days before NARH received Phase 1 grant funds) that NARH only had 20 days of cash on hand, that it was not financially healthy, and that its finances were in what he described as a desperate state. The statement about cash on hand was repeated in NARH's grant

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12. Section 5.06 of Title 958 of the CMR requires HPC to "take into account days cash on hand, net working capital and earnings before income tax, payer mix, uncompensated care, and depreciation and amortization, and access to working capital, using data reported to the [Center for Health Information and Analysis]" and "the anticipated return on investment, as measured by improved health care coordination."

application signed December 10, 2013. Also, a member of HPC's board of commissioners stated at an April 16, 2014 board meeting that there were early warning signs of NARH's closure: financial problems had caused NARH to close Greylock Pavilion, its psychiatric facility (often the first type of facility that hospitals must close when they are financially distressed). This closure occurred in November 2013, before grants were funded.

HPC did give us data it had requested from the Center for Health Information and Analysis (CHIA), but did not provide evidence that it had used these data to calculate all the information that the regulations required it to analyze to assess the financial viability of grant applicants. HPC also did not provide evidence that it had considered the parent-company bankruptcy disclosure in NARH's grant proposal, contacted NARH officials to discuss the financial instability reported to HPC in December 2013, or obtained hospital financial statements for additional reviews.

### **Authoritative Guidance**

Section 2GGGG(e) of Chapter 29 of the General Laws requires that HPC do the following before awarding grants:

*In reviewing the grant applications, the commission shall consider, among other factors: (1) the financial health of the qualified acute hospital and the demonstrated need for investment, taking into account all resources available to the particular provider including the relationship or affiliation of the particular provider to a health care delivery system and the capacity of the system [parent company] to provide financial support for the acute hospital.*

### **Reasons for Insufficient Assessments**

HPC stated that it assessed the financial health of CHART grant applicants by considering financial information provided in applicant proposals and by consulting with CHIA on hospitals' financial health. (State law requires HPC to work with CHIA to review financial figures when assessing the financial health of each grant applicant before awarding grants.) However, HPC did not provide us with sufficient documentation to substantiate this assertion. In addition, HPC had not developed any policies and procedures for evaluating financial data provided by CHIA and grant applicants. Finally, when we requested evidence that HPC had obtained and reviewed grant applicants' most recent audited financial statements or other independent financial disclosures, HPC did not provide it.

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## Recommendations

1. HPC should develop policies and procedures for documenting and retaining its financial health assessments and evaluations that include an examination of key financial and economic performance indicators.
2. HPC should retain documentation of its review of each grant applicant's most recent independent audited financial statements and other disclosures as part of its assessment process.

## Auditee's Response

*The HPC properly evaluated and scored all Phase 1 applications in accordance with the DHTF statute (M.G.L. c. 29, § 2GGGG), CHART regulation (958 CMR 5.00 et seq.), and the Phase 1 Request for Proposals, considering each hospital's financial health and demonstrated need for investment, among several other statutory factors, when reviewing applications. Neither the DHTF statute nor the CHART regulation requires the HPC to award funds only to "financially viable" hospitals. In fact, the DHTF is specifically designed and intended to provide financial support to the Commonwealth's struggling community hospitals. These community hospitals are a crucial part of the Massachusetts health care system, and they face enormous challenges to transform the way they deliver care, as documented in a comprehensive research study of the community hospital landscape published by the HPC in March 2016: *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System*.*

*The HPC evaluated both "financial health" and "financial need" as factors in selection and award of the Phase 1 funding. Using data provided by CHIA and commercially available sources for regional benchmarks (Optum Almanac), the HPC assessed four factors of financial need—Medicaid payer mix, average age of physical plant, total net assets, and operating expense ratio. These factors were calculated for all participating hospitals and were carefully considered and scored as aspects of decision making. The HPC also assessed financial health by reviewing the most recent data available from the Center for Health Information and Analysis (CHIA) and the audited financial statements available on the Attorney General's website. After analyzing all of this data, HPC staff scored each proposal on demonstrated need and financial health, among other factors, as reflected on the Phase 1 score sheet for each hospital.*

*Based on available data, North Adams Regional Hospital (NARH) was not among the most financially "distressed" hospitals, with three hospitals (who also received Phase 1 funds) all reporting negative net assets in FY12, and NARH reporting positive net assets. NARH had been engaged in a strategic improvement process starting in 2012, and the award to NARH accounted for the hospital's financial status, as it was intended to support the hospital in establishing meaningful community-based (non-hospital) services to ensure continuity of care if a conversion of that facility occurred. The closure of NARH was precipitous and surprised the community, staff, and lawmakers. While many individuals reflected in hindsight that NARH faced significant financial challenges, leading state officials, including the Secretary of Health and Human Services and the Secretary of Administration and Finance, voted along with every commissioner to authorize the Phase 1 award for NARH. Upon NARH's closure and bankruptcy filing, HPC suspended its contract and confirmed with the Attorney General's Office that the HPC could not*

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*recover any of the CHART funds paid to NARH given the superior claims of secured creditors and extent of NARH's liabilities.*

*The Auditor's recommendation #1 was in fact executed in full by the HPC during Phase 1 (see score sheets). Likewise, the HPC reviewed audited financial statements as per Recommendation #2 and will continue to do so going forward. Consistent with the Auditor's recommendation, the HPC also will more thoroughly document its policies and procedures related to its assessment of financial health and demonstrated need.*

## **Auditor's Reply**

HPC asserts that it properly assessed the financial health of all grant applicants but agreed with the Office of the State Auditor (OSA) that it could have done a better job of documenting these assessments. However, during our audit fieldwork, despite repeated requests, HPC only provided limited documentation that it had properly assessed the financial health of all CHART Phase 1 hospitals. The documentation did not include an analysis of all financial indicators as discussed in the regulations, and HPC could not provide some of the information it said it used to evaluate these hospitals. At the end of our audit fieldwork, HPC did give us copies of its hospital "score sheets," but since information was not provided when requested during the audit, OSA personnel could not adequately assess the accuracy of these documents.

In its response, HPC states that based on its analysis of the financial data it developed and financial data that were provided to it, NARH was not the only hospital that was financially distressed. It also states that the idea behind funding projects at these distressed hospitals is to help revitalize and transform them. However, OSA disagrees that HPC should not be faulted for making a bad investment, because HPC knew on December 10, 2013, the date NARH signed the grant application, that NARH was in severe financial distress. In this application, NARH specifically stated that it had only 20 days of cash on hand and that its parent company, Berkshire Health Systems, was not in a position to provide any financial support because of its own bankruptcy. Therefore, it should not have been a surprise to HPC when NARH ultimately ceased operating.

### **3. HPC did not provide adequate financial oversight to grantees; this resulted in \$9,204 of undocumented expenses.**

HPC did not develop policies and procedures to review grant expenditures periodically and ensure that hospitals used CHART Phase 1 grants in accordance with the grant terms and conditions. In addition, HPC extended some hospitals' grant periods, but did not require a final reporting of expenditures that

covered the extension periods. As a result, two hospitals we visited had inaccurately reported their use of grant funds. Specifically, one hospital was approved to spend \$9,000 on scanners/technology equipment, but reallocated this money to other grant line items without HPC's knowledge or approval. A second hospital could not substantiate \$204 of IT licensing purchases.

Also, HPC did not develop a standardized reporting format for hospitals to use to make a periodic and final detailed report on their use of funds. This led to hospitals either creating their own spreadsheets to report use of funds, or reporting expenses in memo format. This resulted in disorganized and unclear financial disclosures, which could have caused HPC to draw incorrect conclusions on the proper use of grant funds.

### **Authoritative Guidance**

Section 2GGGG(i) of Chapter 29 of the General Laws requires the following in order to ensure proper use of grant funds:

*The commission shall develop guidelines for an annual review of the progress being made by each grantee. . . . In the event that any recipient of grant monies from this trust does not utilize funding in a manner consistent with the approved grant application, the recipient shall be required to repay to the commission all or some portion, as determined by the commission, of the grant funds previously provided to the recipient under this section.*

Additionally, HPC's executive director is required, under 958 CMR 5.08(3)(a), to ensure that all grant contracts include details of the following:

*any financial, programmatic, technical or other reporting appropriate to monitor and evaluate the funded activities, including ongoing milestones, an annual progress review as applicable for multi-year grants, and an evaluation process.*

Appropriate monitoring would include reviewing a final accounting of funds spent during any grant extensions.

In addition, without standardized reporting among CHART hospitals, HPC cannot effectively evaluate and monitor how individual hospitals use grant funds, including whether any recoveries of misspent funds may be necessary.

## Reason for Inadequate Reporting

HPC did not establish formal reporting requirements before funding the grants. Monthly board minutes from January 8, 2014 indicate that one commissioner voiced concern that HPC was funding grants without giving hospitals final details on what it would require each hospital to report. The commissioner was concerned because reporting typically drives the performance of the grant obligation.

When we discussed the lack of formalized grant reporting requirements with HPC officials, they indicated that HPC was developing a comprehensive compliance monitoring program for future CHART grant awards. They stated that part of this plan is to require hospitals to provide quarterly financial reporting in a standardized format.

## Recommendation

HPC should ensure that its compliance monitoring program includes a requirement for hospitals to retain, and provide to HPC on request, all applicable supporting documentation for grant expenditures in a standardized reporting format developed by HPC.

## Auditee's Response

*The HPC appreciates the Auditor's feedback and responds that the HPC made a policy decision to rely on a final financial accounting with an attestation from the hospital, balancing the \$500,000 award cap, the total scope of awards, and available resources. Before receiving final payment from the HPC, along with submission of a final reconciled budget, each hospital was required to certify, under the penalties of perjury, that it had completed its project in accordance with all requirements, and all payments received from the HPC "have been and will be used for performance, costs, and expenses authorized by the terms of the CHART Phase 1 Contract documents."*

*We appreciate the Auditor's identification of \$9,204 of expenses at two hospitals that were not approved in advance or could not be substantiated (approximately 0.1% of disbursed CHART Phase 1 funds). The HPC has confirmed that the hospital reallocated the \$9,000 that was not spent on scanner technology as originally approved, to more intensely engage personnel already identified and approved in the budget, an appropriate purpose consistent with the goals of Phase 1.*

*The Auditor's recommendation aligns with the financial monitoring program that the HPC has implemented for Phase 2. Even before the Auditor commenced this performance audit, the HPC had begun implementing a comprehensive financial monitoring program for the nearly \$60 million Phase 2 funds, which includes requirements for hospitals to report regularly to the HPC in a standardized format and retain applicable supporting documentation.*

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## Auditor's Reply

In its response, HPC states that it relied on each hospital's certification that all CHART grant payments received were used in accordance with each approved project. However, OSA believes that HPC should not have solely relied on hospital certifications to ensure that grant funds were appropriately expended. It should have developed policies and procedures to require supporting documentation, including a standardized final report comparing the budget to actual grant expenditures, so that it could verify certifications made by hospital officials. This would also allow HPC to take a more active role in monitoring hospitals' use of grant funds.

Although the amounts we identified as inaccurately reported were a small percentage of the total CHART funds spent across the program (approximately 0.1%), they represent a deficiency in HPC's monitoring process that could result in more significant problems if not addressed. If HPC does not develop a monitoring process or require standardized reporting from CHART hospitals, it cannot effectively evaluate and monitor how individual hospitals use grant funds, including whether any recoveries of misspent funds may be necessary.

HPC states that the funds in question were ultimately used for a purpose that was consistent with Phase 1 activities. However, from our review of supporting documentation and materials provided to us by HPC, we could not verify how these funds were actually used. Additionally, in our report, we stated that one sampled hospital's reported use of funds was not the final reporting that HPC required, since HPC allowed the hospital to extend its project deadlines. Because of this confusion, HPC did not have full knowledge of whether all grant funds were properly expended until we brought this problem to its attention. Without effective oversight of hospital grant expenditures, there is a risk that hospitals could inaccurately report amounts spent for grant projects, without HPC's knowledge, as noted in the two examples above.

### **4. HPC paid \$418,600 for consulting services that were of limited use to hospitals.**

HPC spent \$418,600 for consulting services that provided limited value to hospitals that received CHART grants. HPC hired a consultant (Safe & Reliable Healthcare LLC of Evergreen, Colorado) to perform certain tasks, including the following:

- conducting on-site interviews with selected hospital staff members from various departments to assess their perceptions related to patient safety
- assessing hospitals' previously conducted patient safety culture surveys<sup>13</sup> or, in cases where surveys had not been completed, conducting similar surveys
- reviewing both interview and survey results to identify strengths and opportunities for improvement for each hospital
- conveying this information to hospital officials both verbally and in report format

HPC intended this consultant to help hospitals that received CHART grants identify administrative and operational issues and provide recommendations to resolve these issues. However, it did not ensure that the consultant gathered sufficient information that would be useful in identifying areas for improvement. When we met with officials at six hospitals to determine the effectiveness of the consultant work, they all stated that the consultant did not identify organizational problems hospitals were experiencing, such as high staff turnover, bullying, patient safety issues, and deficiencies in the proper reporting of incidents involving patients.

The consultant combined the results of the interviews and survey data into reports for each hospital. However, HPC did not provide the hospitals with these reports.

Although HPC spent \$418,600 for this consultant, and hospitals that received CHART grants committed staff resources, time, and money to assist the consultant, many officials at the hospitals we visited told us they received virtually no meaningful feedback on the areas reviewed under this contract.

## Authoritative Guidance

According to HPC's contract with the consultant, it was required to deliver the following, among other things, to HPC:

- *For hospitals with sufficient data: identify opportunities for improvement. . . .*
- *Analyze site-visit results and culture data and develop aggregate and hospital-specific mixed methods reports with companion memos for areas of improvement.*

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13. Patient safety culture surveys are questionnaires completed by hospital personnel to help hospital administrators assess staff opinions on patient safety in their hospitals and to help raise awareness of the importance of patients' welfare.

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To receive value from this contract, HPC should have ensured that the consultant identified opportunities for improvement and should have shared the consultant's results with each hospital to allow hospitals to make any appropriate improvements.

### **Reasons for Issue**

The above-quoted contract required the consultant to provide the listed deliverables to HPC, not directly to hospitals. HPC officials stated that the consultant did provide the listed deliverables to them, but neither the consultant nor HPC shared the information with the hospitals. HPC officials told us they had not passed the information on because they believed the consultant had already provided valuable feedback to the hospitals verbally.

### **Recommendation**

HPC should ensure that all consultant deliverables intended to benefit CHART hospitals are valuable, accurate, and shared with hospital officials.

### **Auditee's Response**

*While the HPC generally agrees with the Auditor's recommendation as a guiding principle, it does not believe that this recommendation is applicable to the Safe and Reliable Healthcare (SRH) contract, because both the CHART hospitals and the HPC derived substantial value from SRH, and SRH produced the required deliverables to the satisfaction of the HPC.*

*Pursuant to its contract with the HPC, SRH conducted day-long interviews at each hospital to understand the context in which hospital staff work. At the end of each on-site visit, SRH conducted a debriefing session with the hospital's senior leadership group to validate findings and provide feedback for improvement. SRH also either reviewed or conducted a culture survey at each hospital and examined each hospital's data for performance trends and compared it with on-site assessments. SRH made specific recommendations to the cohort of CHART hospitals, as detailed on pages 46 and 47 of the Phase 1 report. SRH also prepared hospital-specific reports of the culture surveys for the HPC, which were used to inform technical assistance for CHART hospitals and program design. Finally, SRH organized and led the Leadership Summit, a gathering of 175 hospital senior executives, directors, and managers, for which presentation content was directly informed by the on-site assessments and culture surveys. SRH completed its contractual deliverables to the satisfaction of the HPC.*

*Further, CHART hospitals overall rated SRH's work highly. At the conclusion of Phase 1, 81% of respondents to an anonymous survey found the culture survey to be valuable, while 76% found the SRH site visits to be valuable. Likewise, after the Leadership Summit and shortly before the close of Phase 1, respondents to two separate anonymous surveys replied favorably about both the CHART program and SRH's performance. 92% of respondents indicated that the Leadership*

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*Summit was a valuable mode of technical assistance. These survey results, copies of which have been provided to the Auditor, directly contradict the Auditor's finding, which appears to be derived from the comments of one or two hospital officials.*

## **Auditor's Reply**

We do not dispute that the leadership summit may have been successful. However, the statement that CHART hospitals received substantial value from SRH's consulting contract is not consistent with what we heard from officials at all six of the hospitals we visited. On the contrary, as illustrated below, hospital officials generally indicated that that they believed SRH provided little or no value to CHART hospitals:

- An official at one hospital stated that SRH provided no value to the hospital; the official did not understand how SRH received a high rating from other hospital officials in the feedback survey conducted by HPC.
- Many hospital officials stated that they had received no reports from SRH other than a one-page pictorial summary at the leadership summit.
- Many hospital officials stated that no SRH feedback was used to implement changes at their hospitals.
- An official at one hospital stated that the hospital did not want SRH to conduct an on-site assessment, since it contracted with another consultant for similar work. The official also stated that the hospital had not received any reports from SRH to date and that SRH was not helpful to the hospital.
- An official at one hospital stated that SRH's verbal feedback and minimal recommendations were not useful to the hospital.
- An official at one hospital stated that SRH did not provide any reports after its assessment; the hospital only received a verbal debriefing and did not find it helpful for instituting any management change.
- An official at one hospital stated that the hospital received no value from SRH's consultant work.
- An official at one hospital stated that the hospital received more value from a free online article written by Dr. Frankel of SRH than from the survey and staff interviews conducted at the hospital.
- An official at one hospital stated that the culture safety surveys conducted by SRH were the same as free online surveys available through the Agency for Healthcare Research and Quality within the US Department of Health and Human Services, which can be analyzed and compared nationally to other hospitals' results.

Although the anonymous survey results cited by HPC did show some general satisfaction with the work conducted by the consultant, our interviews with sampled hospital officials indicated that hospitals had problems with both the process used by the consultant and the results of its work.

In its response, HPC stated that SRH met all requirements in its contract. However, this is not the case: neither SRH nor HPC provided hospitals with aggregate and hospital-specific mixed-methods reports with companion memos for areas of improvement, which were agreed-upon deliverables in their contract.

## **5. HPC did not provide annual reports on CHART expenditures to the Legislature.**

During our audit period, HPC did not submit its required annual report on the Distressed Hospital Trust Fund. Therefore, the Legislature did not receive a proper accounting of the expenditures and resulting benefits of CHART grants.

### **Authoritative Guidance**

Section 2GGGG(j) of Chapter 29 of the General Laws states,

*The commission shall, annually on or before January 31, report on expenditures from the Distressed Hospital Trust Fund. . . . The report shall be provided to the chairpersons of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the commission's website.*

Within the report, HPC is required to detail CHART administrative costs, grant expenditures, grantee activities, and resulting benefits to the Commonwealth.

### **Reason for Noncompliance**

HPC does not have policies and procedures to ensure annual reporting on CHART expenditures to the Legislature. HPC officials did not provide a reason that annual reports were not issued, but told us that detailed information about CHART activities and expenditures is shared at public meetings, on HPC's website, and to the Legislature, upon request. Although this practice helps to provide open disclosures to the public, it does not comply with HPC's legal requirement.

## Recommendation

HPC should establish policies and procedures to ensure that it provides the required annual report to the Legislature, including detailing all expenditures and resulting benefits of the CHART Program.

## Auditee's Response

*The HPC is committed to full transparency regarding expenditures from the Distressed Hospital Trust Fund (DHTF). Since it began operations in 2013, the HPC has provided detailed information about its activities and trust fund expenditures, including information on the expenditures from the DHTF and the CHART investment program, at its frequent public meetings, on its website, and to legislators. Funds were first collected into the DHTF in June, 2013, and the HPC did not make any payments to CHART hospitals until February, 2014. The HPC provided information on DHTF revenue and expenditures to both the House and Senate Committees on Ways and Means annually from 2014–2016 and to other legislators as requested. In 2016, the HPC developed the format of the HPC's Annual Business Report to publish comprehensive information about HPC activities, including expenditures on CHART. The HPC will continue to use this format going forward and will publish the Annual Business Report on its website and, consistent with the Auditor's recommendation, ensure that copies are provided to the legislature.*

## Auditor's Reply

In its response, HPC states it has published an annual business report on its website and has also informed members of the Legislature of the CHART Program's revenue and administrative costs in order to comply with the reporting requirement. However, this does not fulfill HPC's statutory responsibility to file annual written reports with the chairpersons of the house and senate committees on ways and means and the joint committee on healthcare financing. Further, it should be noted that the report on HPC's website does not include all mandated disclosures, such as an itemized list of CHART fund expenditures, a description of CHART grant activities, and detailed results of the evaluation of the effectiveness of these activities. According to its response, HPC is taking measures to address our concerns in this area.