MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Committee Meeting
CTMP and CHICI

May 31, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes
- Presentation: Center for Health Information and Analysis
- Market Oversight: Performance Improvement Plans
- Strategic Investment Programs: Learning and Dissemination Strategy
- CHART Phase 2: Evaluation Program Update
- CHART Phase 3: Final Program Design Discussion
- Schedule of Next Meeting: July 5, 2017

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes: CHICI 2/24/16

MOTION: That the Committee hereby approves the minutes of the joint CHICI/CTMP meeting held on February 24, 2016, as presented.

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes: CHICI 3/22/17

MOTION: That the Committee hereby approves the minutes of the CHICI meeting held on March 22, 2017, as presented.

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes: CTMP 3/29/17

MOTION: That the Committee hereby approves the minutes of the CTMP meeting held on March 29, 2017, as presented.

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HEALTH POLICY COMMISSION

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Agenda

1. **Relative Price**

    - RP as used to determine hospital eligibility for payments from the Community Hospital Reinvestment Trust Fund

    - Key findings from CHIA's recent publication *Provider Price Variation in the Massachusetts Health Care Market*

2. **Review new methodology** for identifying entities with cost growth that is considered excessive for confidential referral to the HPC

3. **Overview of CHIA's Current Priorities**

Requirement to Develop Statewide Relative Price

- In May 2016, the Massachusetts Legislature enacted c. 29, § 2TTTT, establishing the Community Hospital Reinvestment Trust Fund
- This section required that "To be eligible to receive payment from the fund, an acute care hospital shall … not be a hospital with relative prices that are at or above 120 per cent of the statewide median relative price, as determined by the center for health information analysis"
- Previously, CHIA's relative price measure was payer-specific, this requirement necessitated development of a new statewide RP methodology
- In developing the statewide relative price measure, CHIA collaborated with actuarial consultants and our sister state agencies
- Solicited public comment during fall 2016
- Final method published on CHIA's website January 2017

Statewide Relative Price Methodology

- **Cross-Payer Relativities**
  - Blend each hospital's inpatient adjusted base rate across payers, weighted by each payer's share of a hospital's inpatient payments
  - Blend each hospital's outpatient RP values across payers, weighted by each payer's share of a hospital's outpatient payments
  - Convert each hospital's cross-payer inpatient ABR and outpatient RP to statewide relativities based on the average amounts across hospitals
- **Statewide Relative Price (S-RP)**
  - Blend each hospital's cross-payer inpatient and outpatient statewide relative values into a single S-RP based on the inpatient/outpatient share of payments for each hospital

CY15 Commercial S-RP Results

Measure	Results
Range of S-RP Values	0.681 – 1.960
Median S-RP	0.934
120 Percent of Median S-RP	1.121
Acute Care Hospitals Eligible	53 (84%)
Acute Care Hospitals Ineligible	10 (16%)

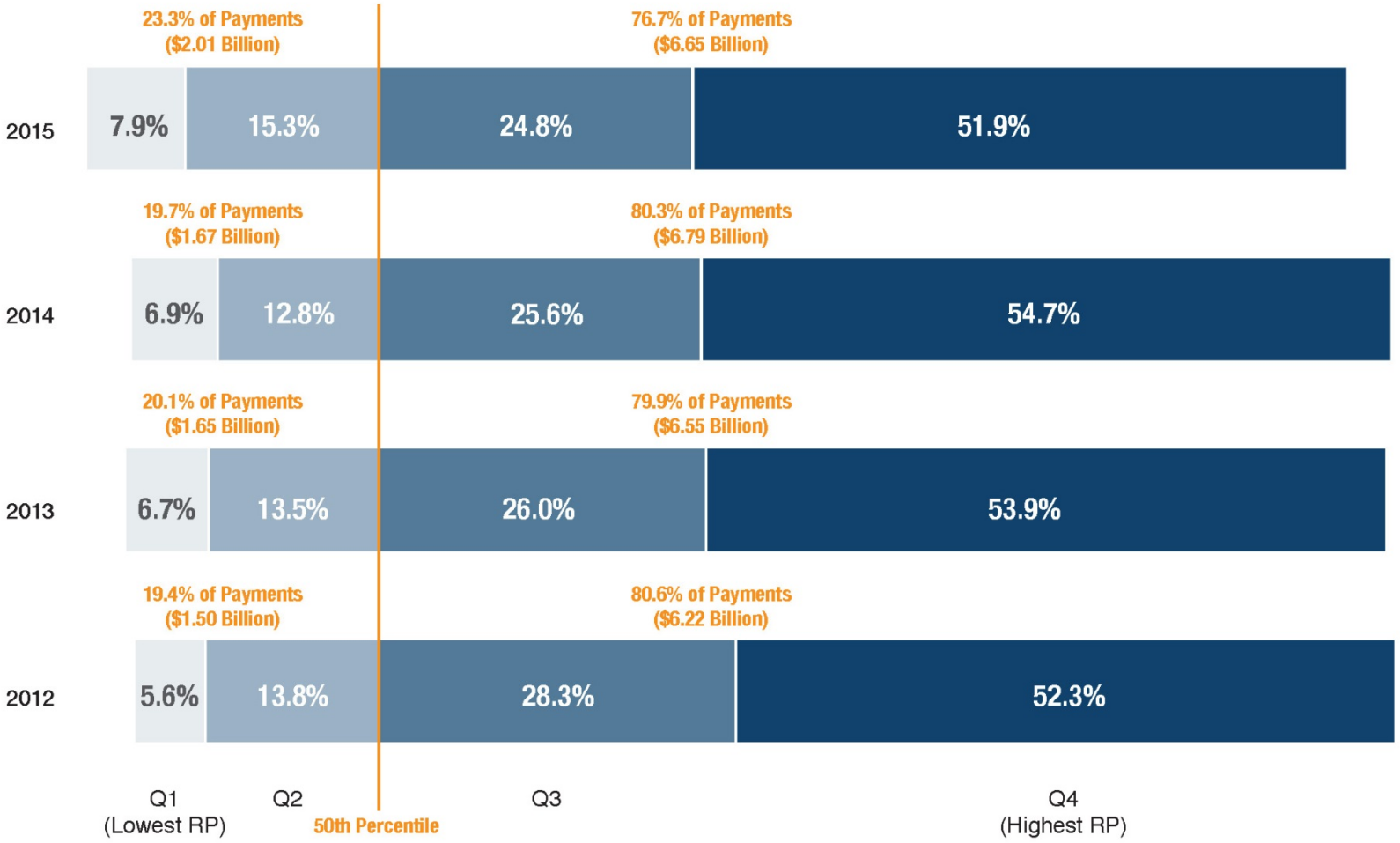
Provider Price Variation in the Massachusetts Health Care Market

2017 Relative Price Report

- In May 2017 CHIA published the most recent version of *Provider Price Variation in the Massachusetts Commercial Market*
  - Examined relative prices for acute hospitals using 2015 data and for physician groups using 2014 data
  - Measured performance using traditional RP calculations to examine the level of spending by RP quartile over time
  - Measured performance using S-RP to facilitate current year, cross-payer analysis of acute hospital relative price levels

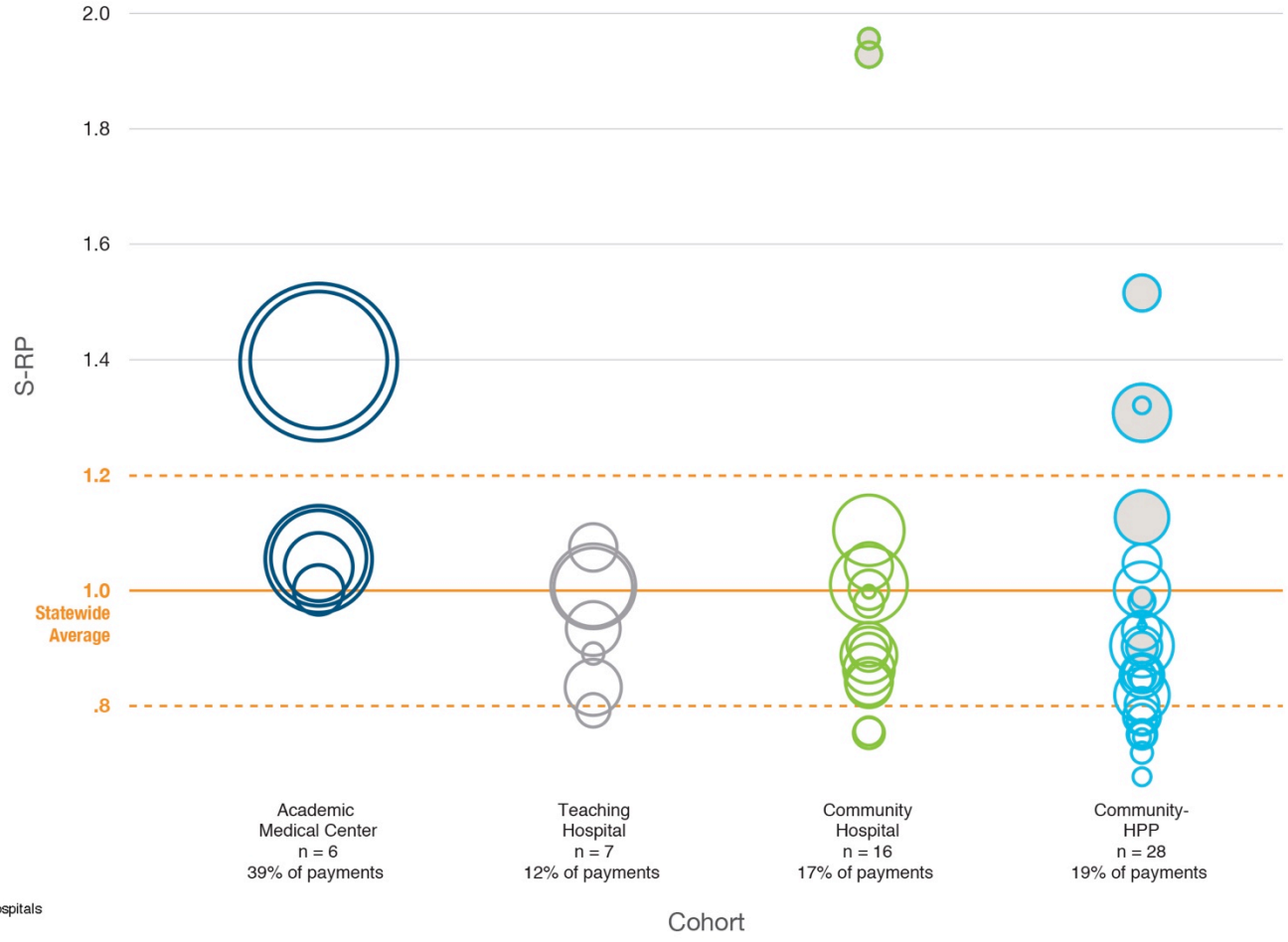
Commercial Payments by Acute Hospital RP Quartile

Key Finding: Spending continues to be concentrated among acute hospitals with higher relative prices in 2015, but the proportion of spending for higher RP hospitals has decreased slightly over time



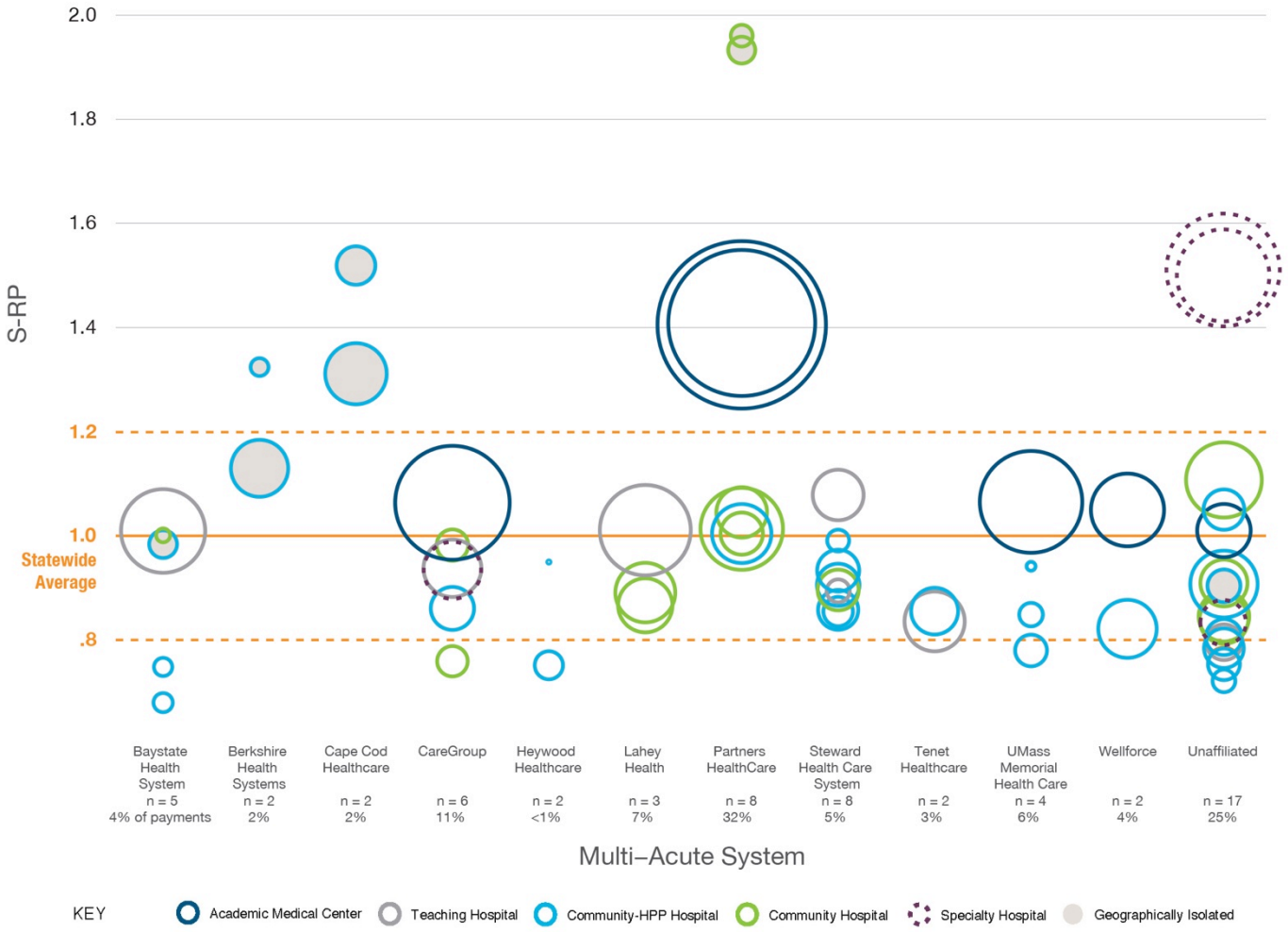
Commercial Statewide Relative Price by Acute Hospital Cohort

Key Finding: Consistent with past years, Academic Medical Centers had the highest commercial S-RPs among hospital cohorts in 2015, while community-high public payer hospitals tended to have the lowest



Commercial Statewide Relative Price by Acute Hospital System

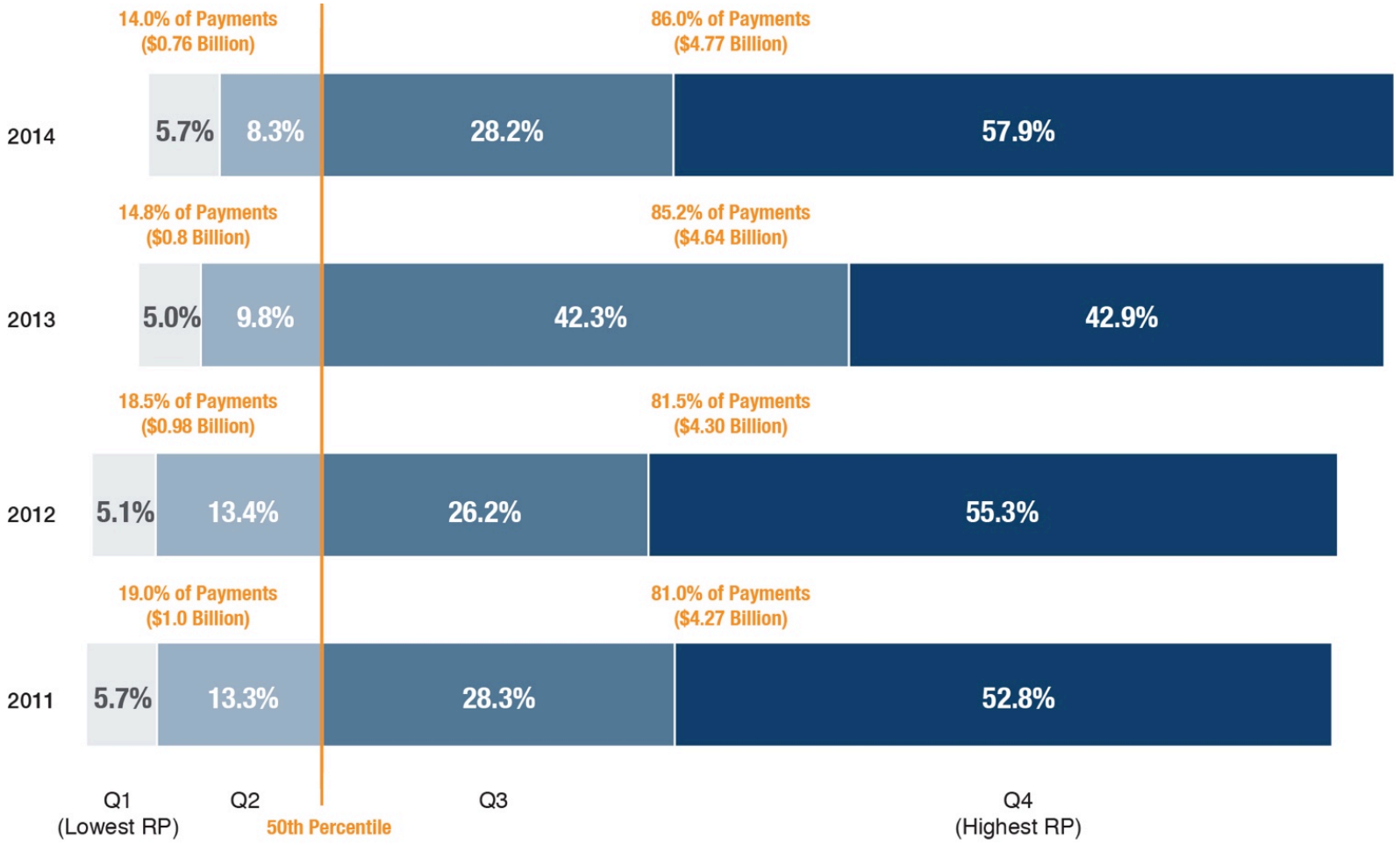
Key Finding: In general, hospitals that were affiliated with larger health systems and/or geographically isolated, or specialty hospitals tended to have higher S-RPs in 2015



CHIA.

Commercial Payments by Physician Group RP Quartile

Key Finding: The share of commercial payments to higher-priced physician groups increased from 81% in 2011 to 86% in 2014

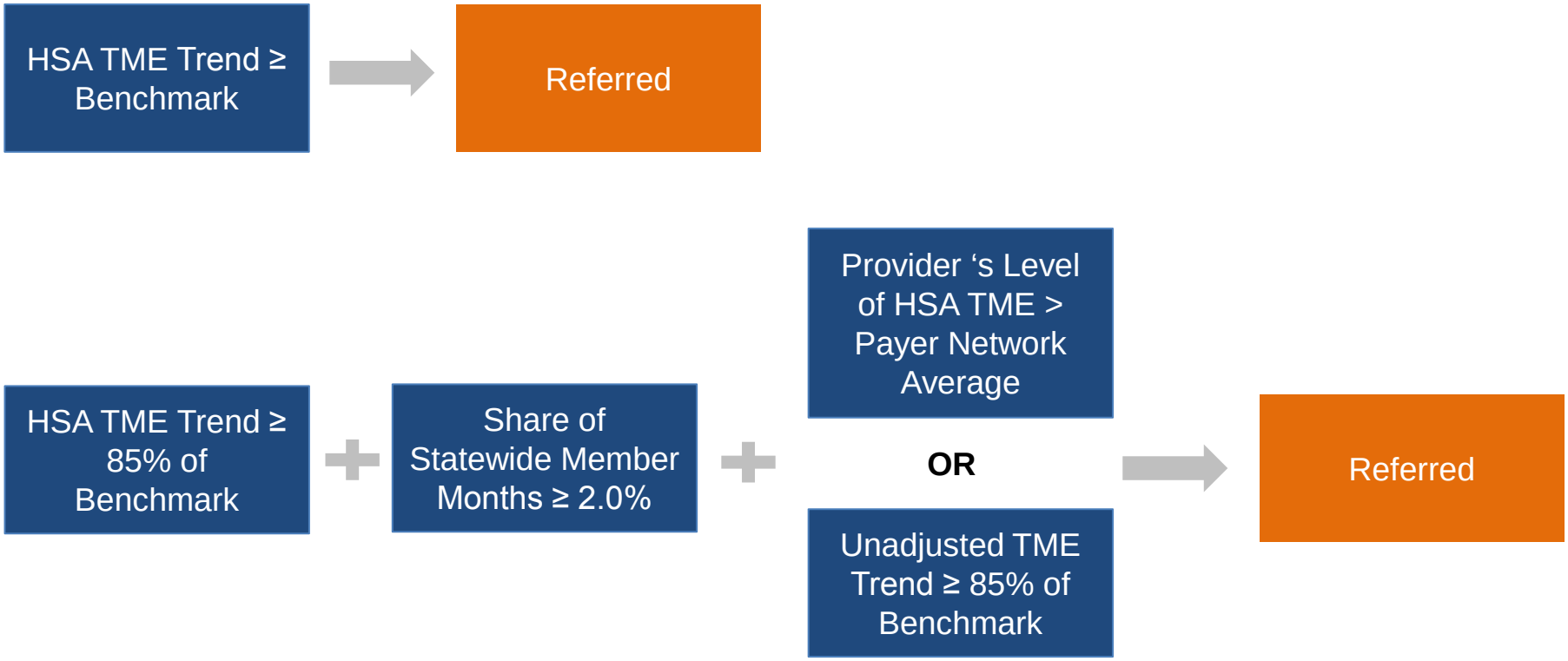


Confidential Referral of Entities to the HPC

Confidential Referral of Entities to the HPC

- CHIA is required by Ch. 224 to confidentially refer to the HPC health care entities:
  - "whose increase in health status adjusted total medical expense (HSA TME) is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark"
- The HPC may require referred entities to implement a performance improvement plan (PIP)
- In prior years, CHIA referred entities based solely on whether their health status adjusted (HSA) TME growth exceeded the benchmark
- To build a more robust rubric for referral, CHIA developed and issued a proposed methodology for public comment during Fall 2016

Proposed Referral Logic of Payers and Physician Groups



Comments Received from Stakeholders

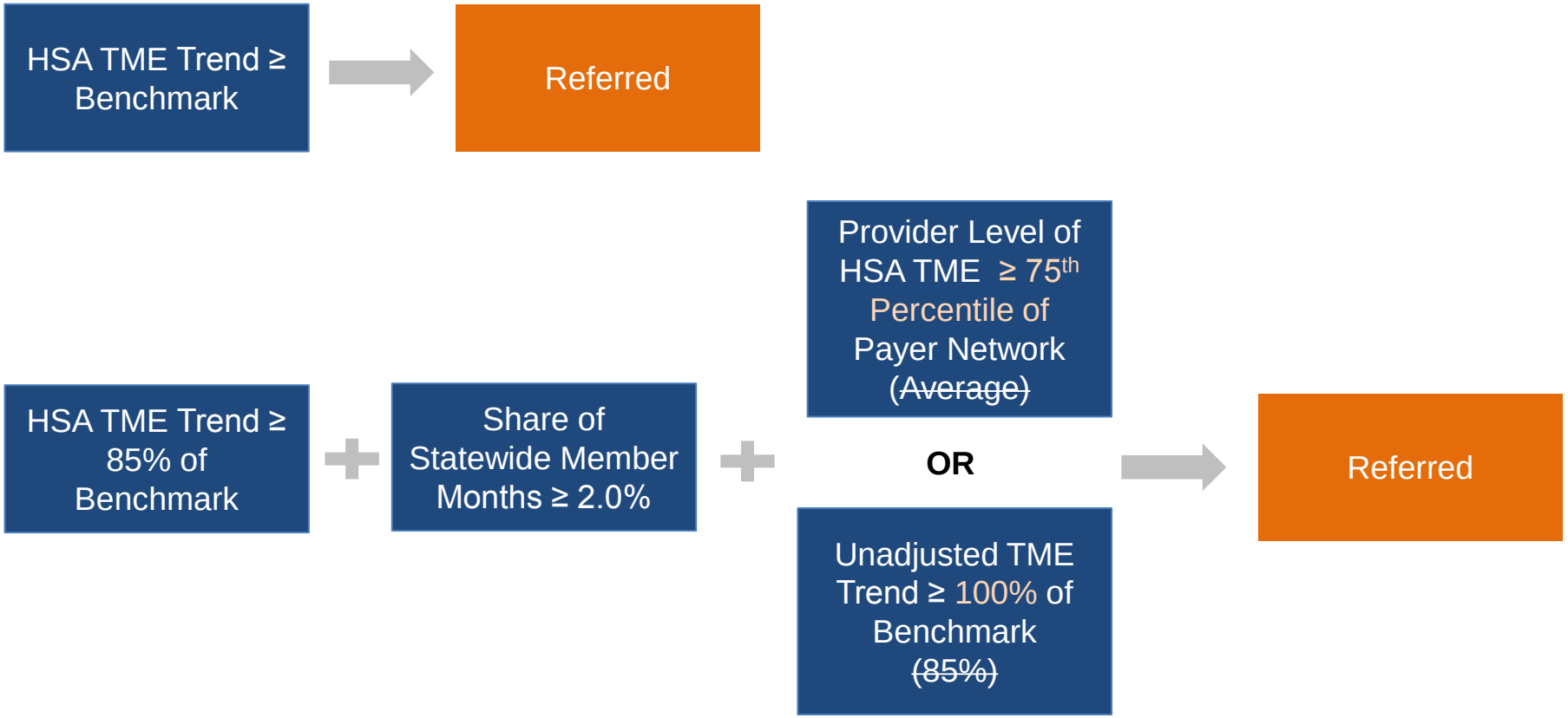
- CHIA received comments on the proposed confidential referral methodology from the AGO, providers[1], payers[2], and industry representatives[3]

- The primary comments received and responded to in the final referral methodology are as follows:

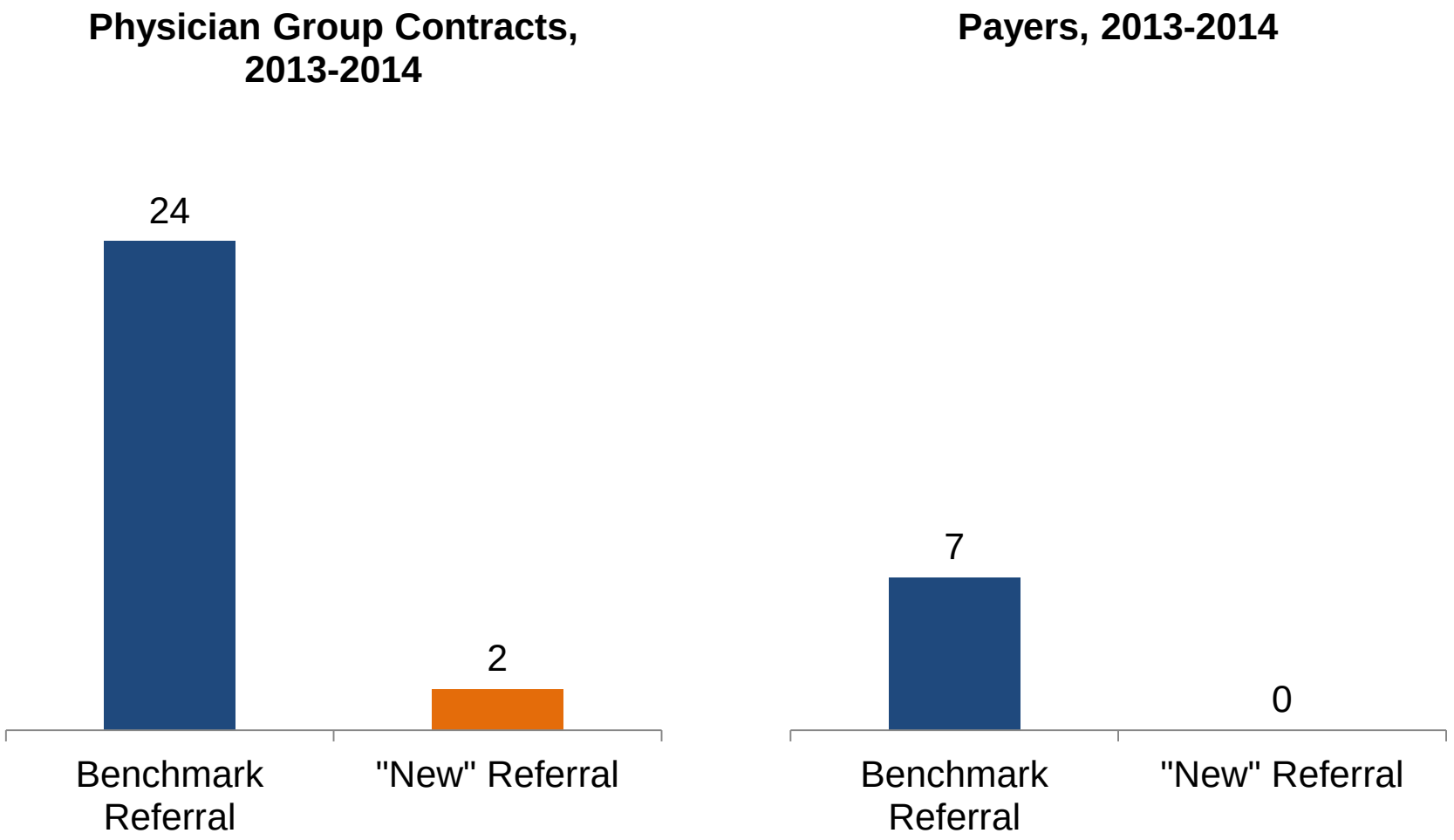
Comment Category	CHIA Response
Concern regarding use of preliminary data	Only use final TME data
Opposition to use of 85 percent threshold for adjusted and unadjusted TME	Assess unadjusted TME growth against 100% of benchmark
Opposition to use of network average HSA TME as threshold and proposal to increase to higher relative level within network	Assess HSA TME against 75th percentile for payer network

1. CHIA received comments from the following provider organizations: Atrius, BIDCO, MACIPA, Partners, Steward, Sturdy, and UMass.
2. CHIA received comments from the following payer organizations: BCBSMA and Harvard Pilgrim.
3. CHIA received comments from the following industry representatives: MHA, MAHP, and MMS.

Final Referral Logic for Payers and Physician Groups



Referral by Benchmark-Only and Additional New Gate



Note: Both “new” provider group contract referrals would have been referred under both the network HSA TME percentile and unadjusted TME growth standards. One of the two “new” provider group contracts was for Commercial members and one was for Medicare Advantage members

CHIA.

Confidential Referral of Entities to the HPC

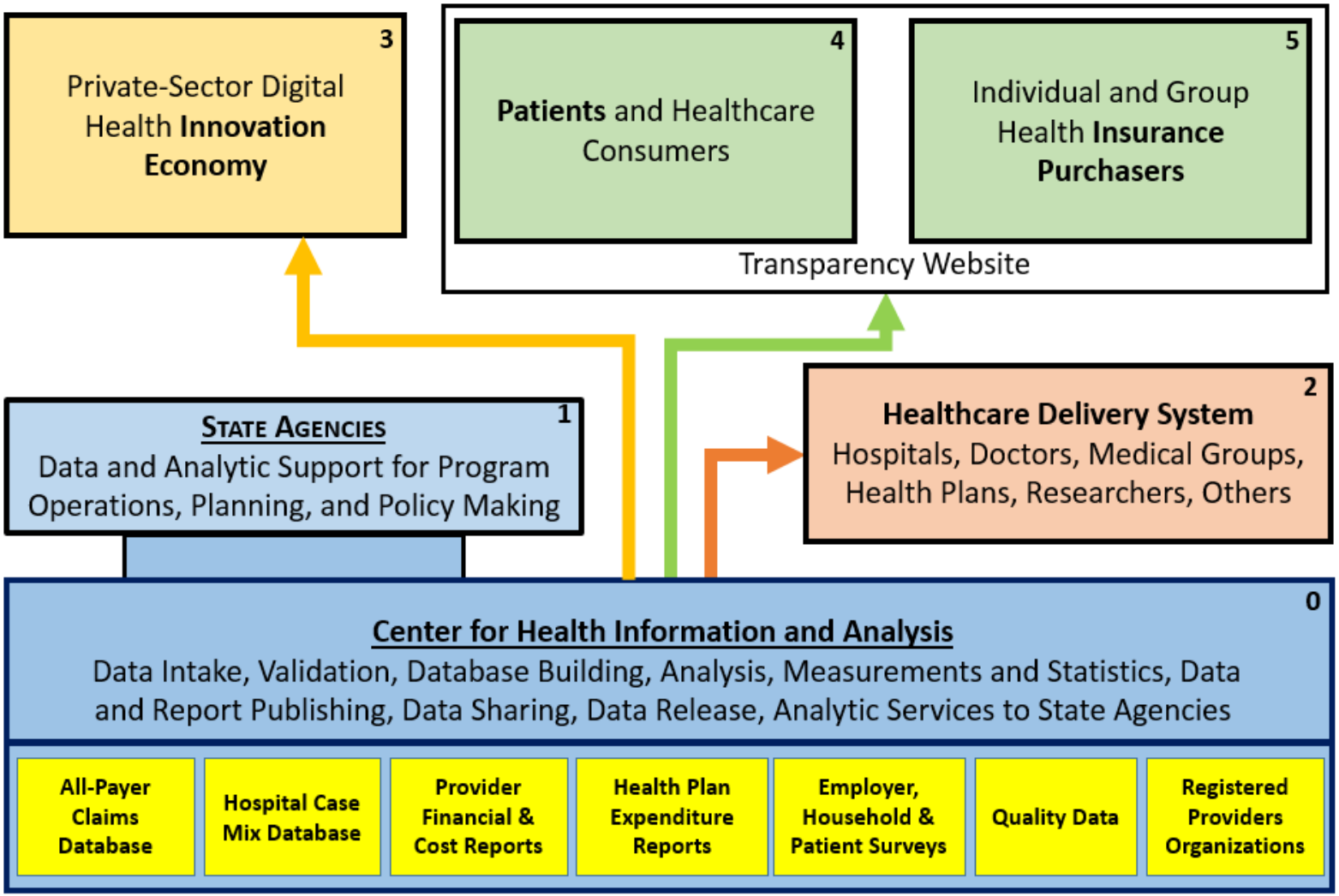
- When CHIA refers an entity we include information to facilitate understanding the growth rate in context including
  - Health status adjusted TME level and rate of change both overall and by cost category[1]
  - Relative health status adjusted TME level compared to other provider groups within a given payer network
  - Unadjusted TME level and rate of change both overall and by cost category
  - Member months level and rate of change

1. Cost categories include inpatient hospital, outpatient hospital, professional physician, other professional, pharmacy, other medical, and non-claims expenditures.

Questions?

Overview of CHIA's Current Priorities

CHIA's Stakeholder Ecosystem



CHIA's Major Publications

- Performance of the Massachusetts Health Care System: Annual Report
- Provider Relative Price Report
- Massachusetts Hospital Profiles
- CHIA Standard Statistics
- Massachusetts Health Insurance Survey
- Massachusetts Employer Survey
- A Focus on Provider Quality: Annual Report
- Hospital-Wide Adult All-Payer Readmissions in Massachusetts
- Hospital-Specific Readmissions Report
- Massachusetts Health Care Coverage: Enrollment Trends
- Mandated Benefit Reviews
- Massachusetts Acute Hospital Financial Performance

CHIA Data Collection — Areas for Investigation

- Pharmaceutical Costs
- Behavioral Health
- Substance Use
- Quality Measurement and Reporting
- Real-time/HIE data
- Clinical Data
- Data Linking
- Social Determinants
- Disparities in Care
- Practice Pattern Variations
- Predictive Analytics

CHIA's Transparency Website — Overview

- Target audience is consumers and small employers
- Will also serve providers, payers, and policymakers
- Agile, phased approach with Phase 1 going live in Fall 2017
- Being developed in close collaboration with state agencies and private stakeholders
- Multiple pricing views: relative price, and payer and provider-specific, procedure level pricing
- Will include quality and safety information
- Consumer educational materials and tools, including plan choice and links to health plan pricing tools
- Small business educational materials and tools
- Provider and health plan transparency compliance support
- CHIA's entire public data archive available via API

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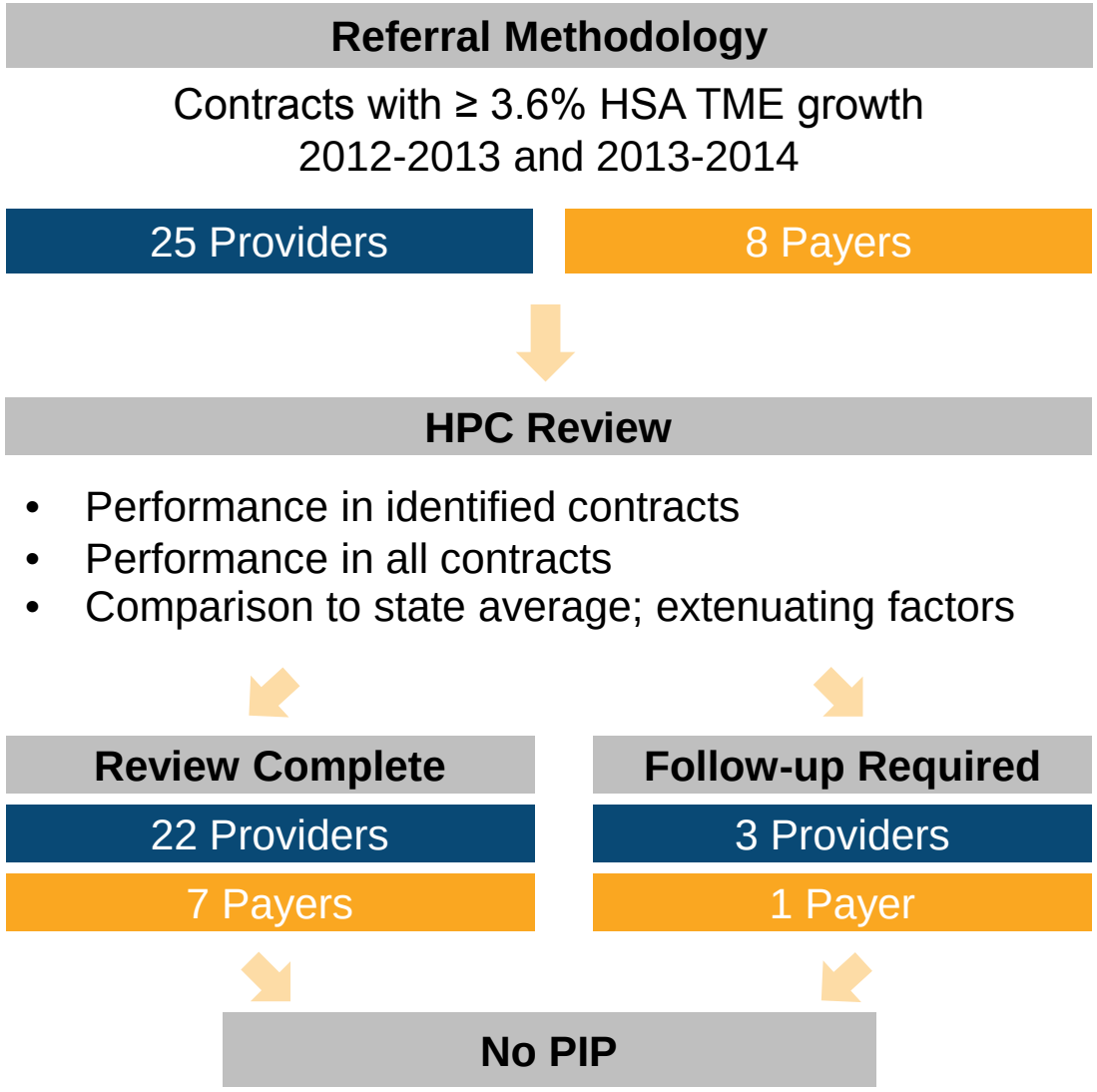
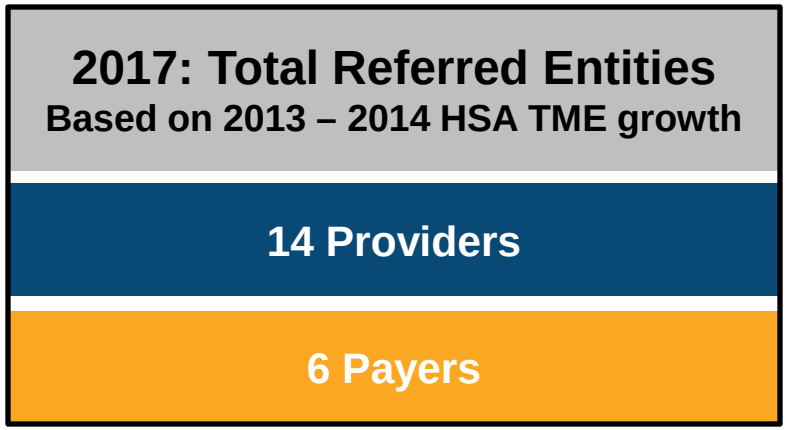
Recap of 2016 PIPs Review Process



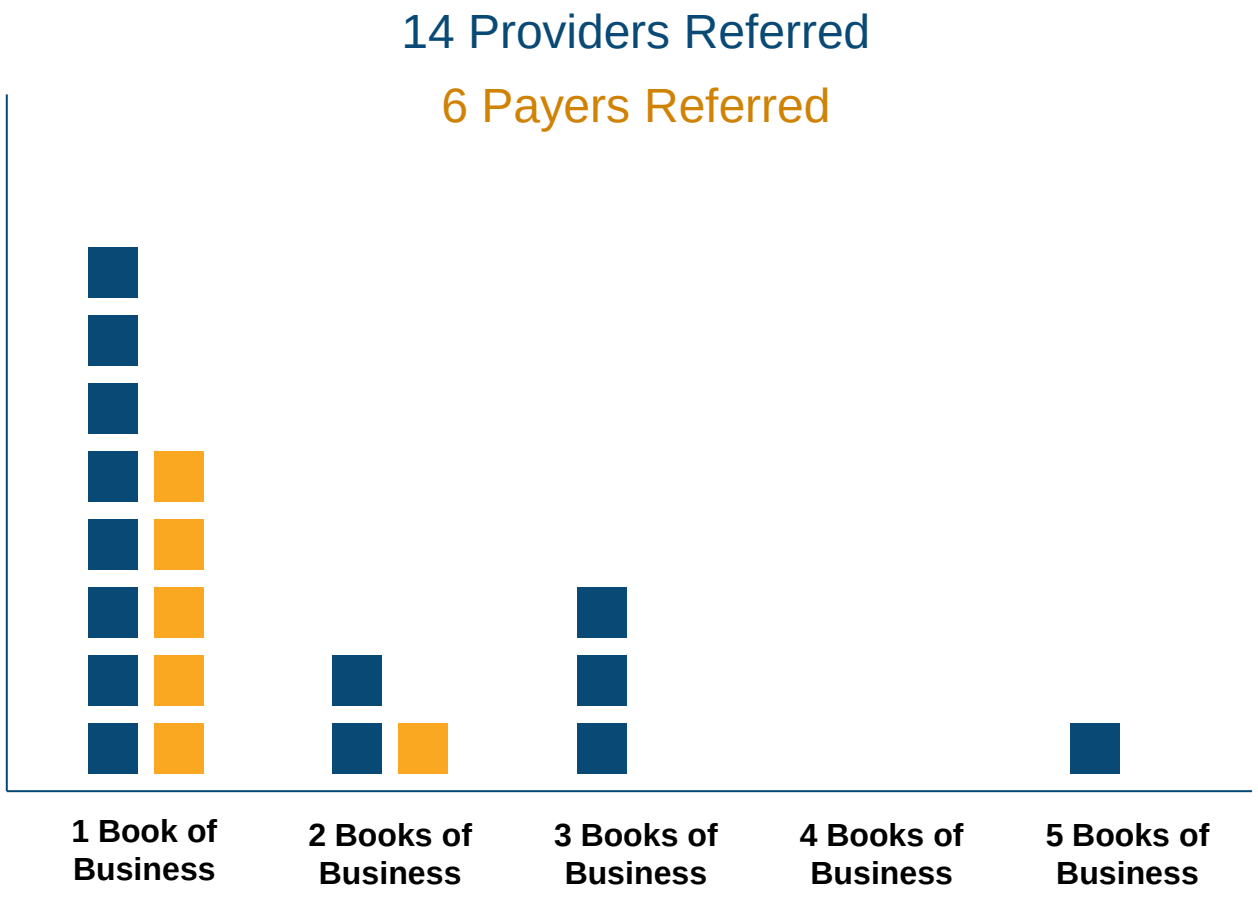
Overview of 2017 Named Entity List

Basis of Referral

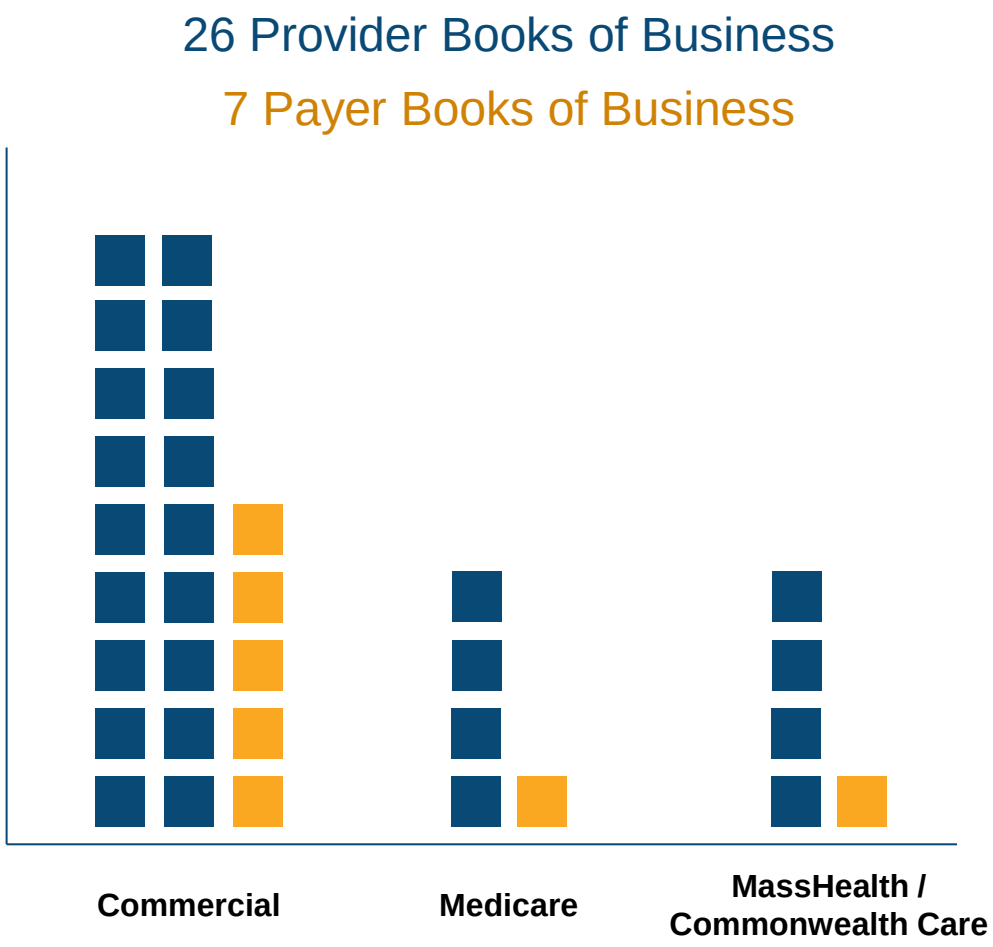
- Per its new methodology, CHIA only refers payers and providers based on their final TME data; this year's list is based on entities' **2013 – 2014 trend**.
- There are approximately 50% fewer providers on the CHIA list this year; this is likely due to the fact that the list is based on only one year of trend, rather than two.



The majority of providers and payers were referred for their performance in a single book of business.



Providers and payers were referred most frequently for their commercial spending growth.

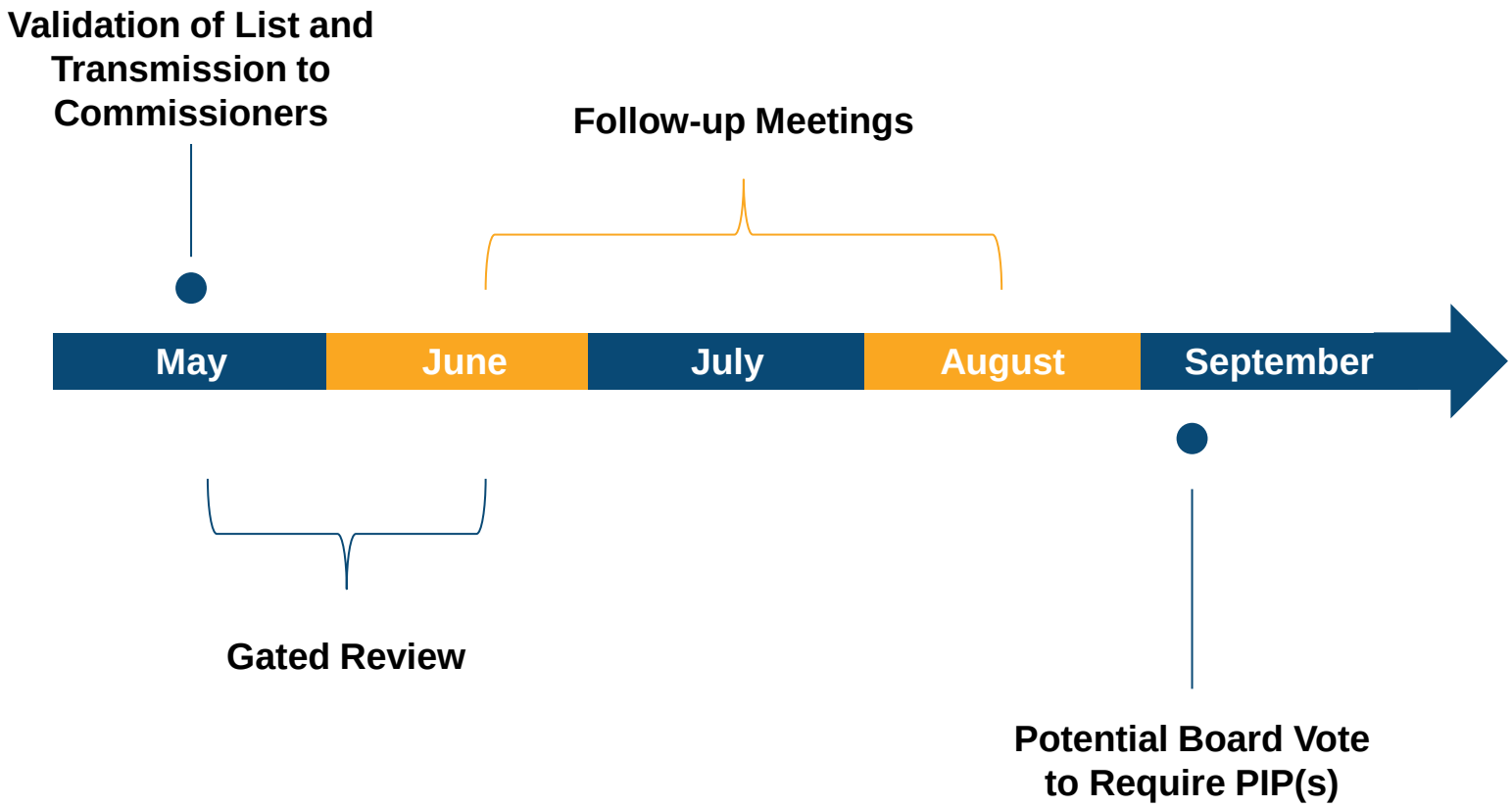


Next Steps in 2017 Review Process

Send validated CHIA list to Commissioners	▪ Commissioners provide initial thoughts/feedback
HPC staff perform gated review	▪ Staff share results with Commissioners ▪ Commissioners provide feedback/recommendations
Follow-up meetings with select entities	▪ HPC meets with entities to discuss their performance ▪ Staff share findings with Commissioners ▪ Commissioners provide feedback/recommendations
Potential Board vote to require PIP(s)	▪ Commissioners deliberate and vote in an Executive Session on whether to require PIP(s)

PIPs Timeline

Commissioner Engagement Throughout



All dates are approximate

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HPC's role in supporting Learning and Dissemination (L+D)

Learning and Dissemination will support the HPC's mission:

To advance a more transparent, accountable, and innovative health care system through our investment and certification programs and independent policy leadership.

HPC's role in supporting L+D: Activities will focus on lessons from HPC Certification and Investment programs

Vision of Accountable Care: A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement through the support of alternative payments.

Certification Programs

Accountable Care Organization (ACO) Certification

Patient-Centered Medical Home Certification (PCMH PRIME)

Investment Programs

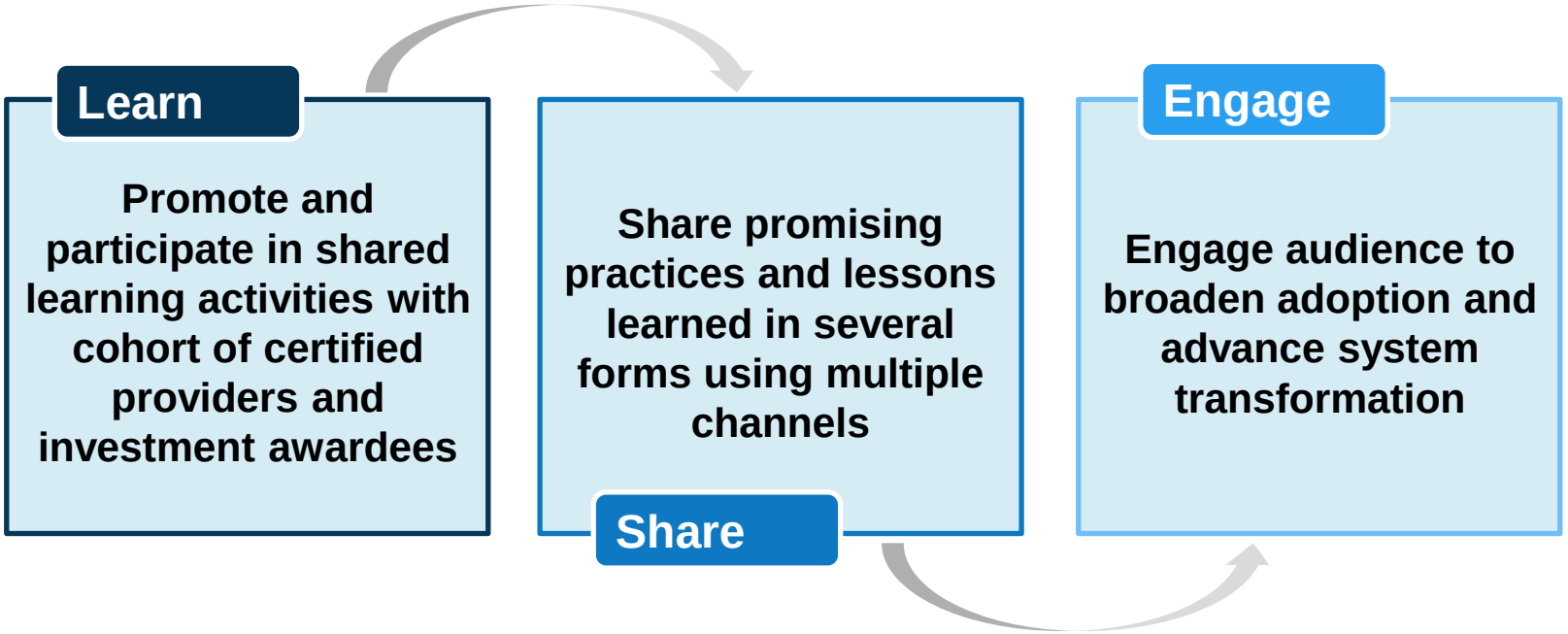
Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program

Health Care Innovation Investment (HCII) Program

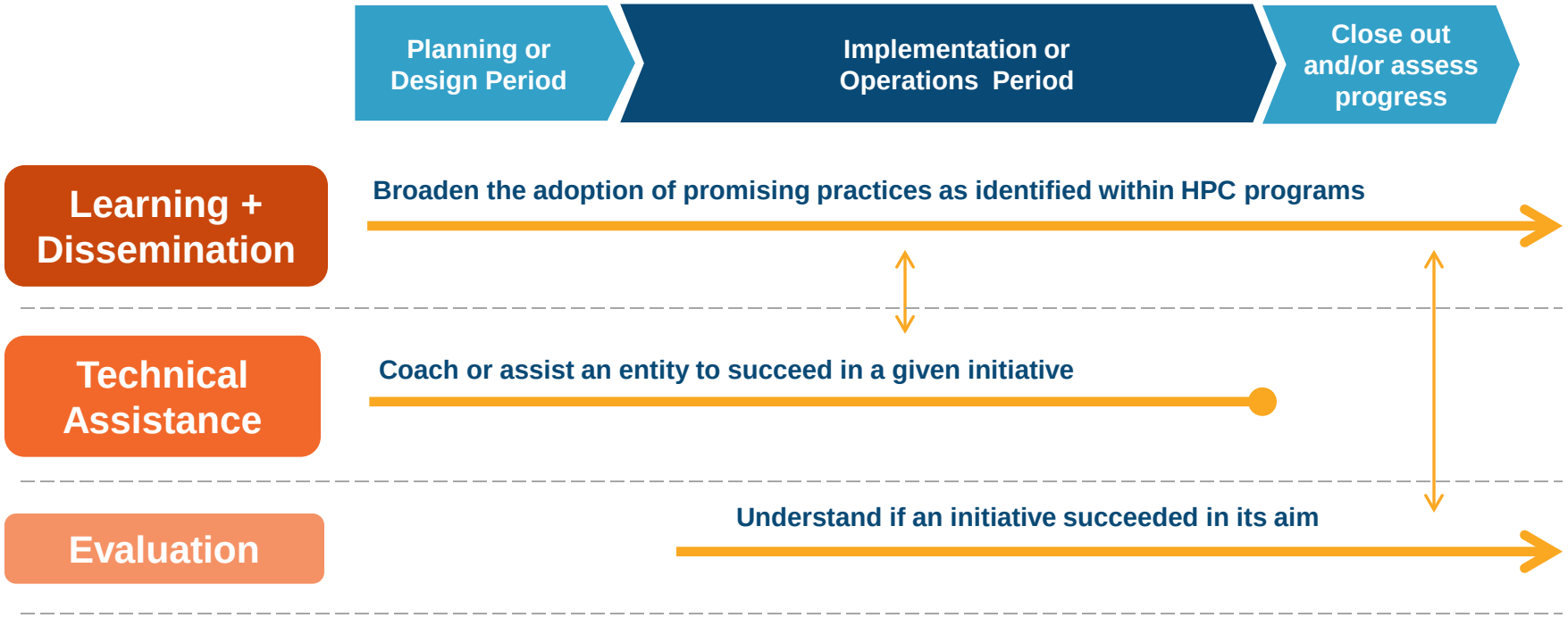
HPC's role in supporting L+D: Learn, share, and engage

Goals

1. To curate and share **practical approaches, effective models, sustainable practices, and lessons learned** with providers, payers, state government agencies, and policymakers.
2. To become a **trusted source** for market participants and other stakeholders to find **practical information to achieve the triple aim**.



TA, Evaluation, and L+D – although distinct functions – should feed and complement each other



Example L+D goals: HPC certification programs

L+D Goals:
Learn from stakeholder engagement, literature, and partnerships to identify certification standards

L+D Goals:
Disseminate information on program feasibility, working with partners (as applicable), and the mechanics of establishing certification programs

L+D Goals:
Learn promising practices, challenge areas, and lessons learned during implementation; disseminate learnings in real time

Example L+D goals: HPC investments

L+D Goals:
Support preparation and planning by promoting relevant learnings from within and outside of the investment awardee cohort

L+D Goals:
Facilitate rapid cycle learning and adaptation for awardees; learn from awardee experience while program is live

L+D Goals:
Refine and disseminate learning to generate impact outside of HPC investment programs

L+D best practices: Brief literature review

1. Dissemination is a communication process.
   - Push: top-down (or lateral) approach
   - Pull: consumer actively seeking out information

2. Target audiences with intentional messages and formats by understanding audience groups and needs.
   - Accounting for audience technical knowledge, time available, and competing demands for their attention

3. Messages should be repeated, consistent, and communicated through multiple channels that foster dialogue.
   - Web: webinars, e-newsletter, online trainings
   - Print: manuals, case studies, policy briefs, tool kits, publications
   - Face-to-face: conferences, workshops, trainings

4. Distribute messages through networks that connect people and organizations.
   - Community, facility, regional, national levels
   - TA providers, inter-organizational task force, government agencies

Sources: Esposito, D. et al. (2015). PCORI Dissemination and Implementation Framework. *Washington, DC: Patient-Centered Outcomes Research Institute*. Macoubrie, J., & Harrison, C. (2013). Human Services Research Dissemination: What Works? OPRE Report # 2013-09, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Wilson, P. et al. (2010). Disseminating research findings: what should researchers do? A systematic scoping review of conceptual frameworks. *Implementation Science*.

L+D survey and subject matter expert interviews: Process

Survey

The HPC distributed a survey in April 2017 to a broad group of stakeholders across the Commonwealth to gain insight in to the needs of our audiences.

65	57%	11%	69%	17%
responses	represent medical providers	represent behavioral health providers	hold management or leadership positions	hold patient-facing roles

Subject matter expert interviews

Throughout May 2017, HPC conducted interviews with subject matter experts, nationally and in Massachusetts, to gather information on best practices in learning and dissemination.

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Institute *for* Healthcare Improvement

FOUNDATION MASSACHUSETTS

Connecticut Health FOUNDATION
Changing Systems, Improving Lives.

CHCS
Center for Health Care Strategies, Inc.

L+D survey and subject matter expert interviews: Key findings

1. Stakeholders express a desire to learn about **a wide range of topics** for both the HPC's certification and investment programs. Subject matter experts suggest **retaining flexibility** in prioritizing topics to be responsive to audience needs.

2. Stakeholders require that information be **diffused in multiple ways and through multiple channels**. Subject matter experts recommend a **multi-layered approach** to sharing information, tailoring and repackaging based on the specific needs of a given audience.

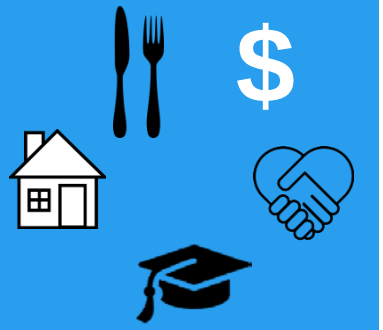
3. Stakeholders find the most value in **succinct and practical information** on tools, methods, and models. Subject matter experts validate this finding, suggesting that practical information should be **reinforced by evidence**.

Summary of findings: Topics and flexibility

- *There is **broad interest in a wide range of topics**.*
- *The HPC should **retain flexibility** in featured topics to be responsive to stakeholder need.*

Topics relating to **behavioral health**[1] are among the highest rated across all respondents

86% of respondents noted interest[2] in programs to address **social determinants of health**



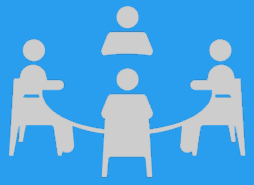
"We learned that **we have to be more flexible and nimble in what we disseminate** because we can't know ahead of time what [learnings] will be generated." – *Subject matter expert*

[1] "Integration of BH providers within primary care practices" (84%); "Care management for patients with BH conditions" (84%); "Evidence-based decision support for BH conditions" (84%); and "Programs to address BH" (89%).

[2] "Very interested" or "extremely interested."

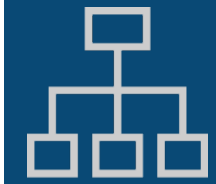
Summary of findings: Mode, channels, and approach

- *Information should be **diffused in multiple ways and through multiple channels**.*
- *The HPC should **deploy a multi-layered approach** to sharing information.*



84%

of respondents find
peer to peer learning
to be very useful[1] in planning and implementing care delivery redesign projects



77%

of respondents find
practical tools and technical resources
to be very useful[1]

Respondents also express strong interest in
program results and evaluation findings

"We've learned from our stakeholders that **there's value in a 'layered approach.'** Give them the blog, the fact sheet, the at-a-glance program matrix, and then something that dives deeper." – *Subject matter expert*

"**Use multiple methods of communication**: briefs and executive summaries…long reports…and follow up with blogs and infographics. Think about how to use personal connections to disseminate via partners and networks." – *Subject matter expert*

[1] "Very useful" or "extremely useful."

Summary of findings: Practical information supplemented by evidence

- *There is **value in succinct and practical information**.*
- *Practical information should be **reinforced by evidence**.*

"[The] key is to link right amount of time to the topic and **provide really useful information and not a lot of fluff**."
– ACO executive

77%
of respondents find
practical tools and technical resources
to be very useful[1]

Respondents also noted value in
academic publications
across organization and role types

"[We like] **slide decks that tell a story** – a summary that catches they eye."

"What are the 3–4 key recommendations? **Simple, clear, compelling**."

"Start with initial information that [you] can get out quickly, and then **[introduce] more expansive analysis down the road**."

[1] "Very useful" or "extremely useful."

L+D milestones and next steps

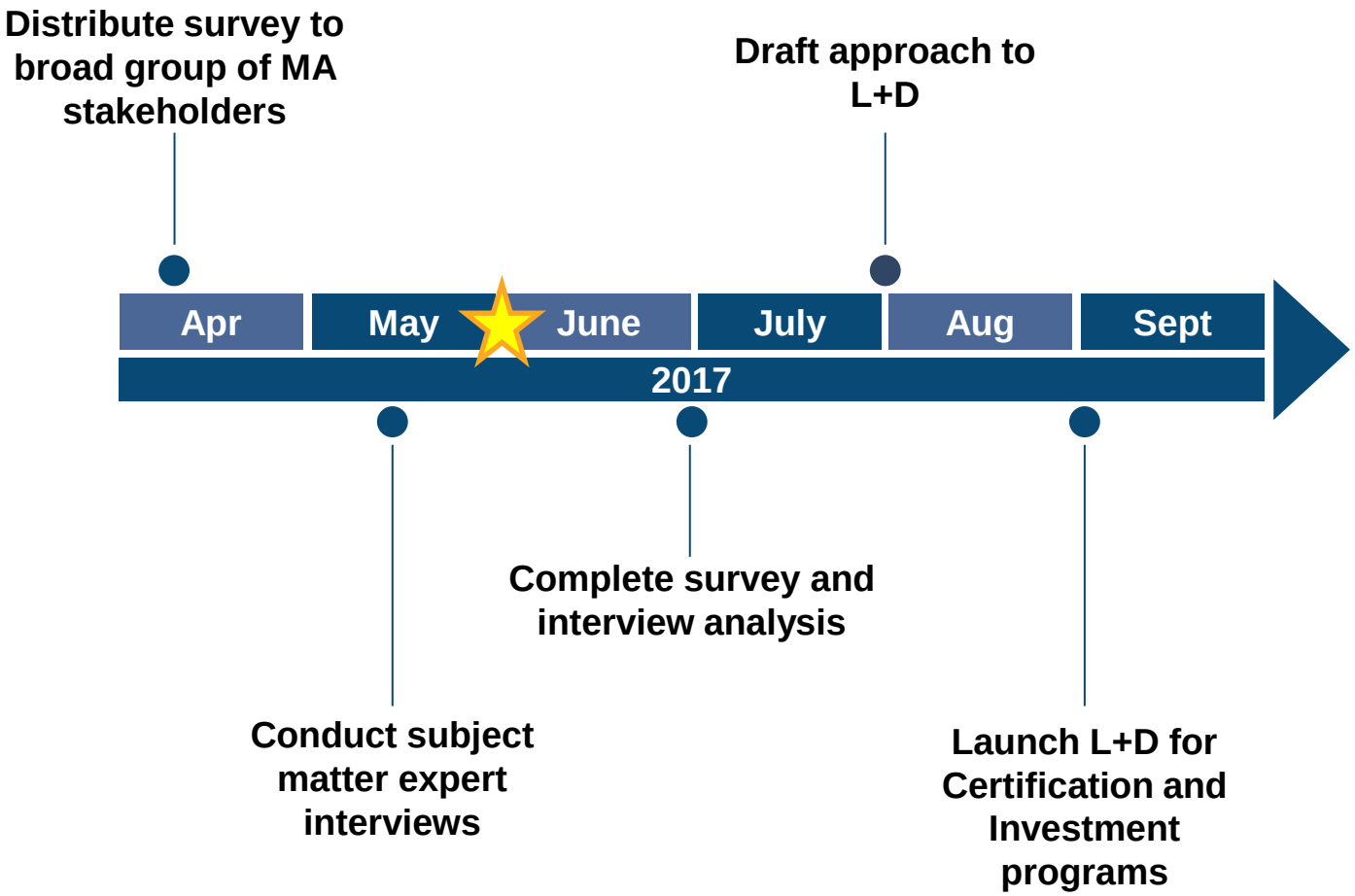


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CHART Phase 2 Evaluation: Building insight into care delivery and hospital transformation

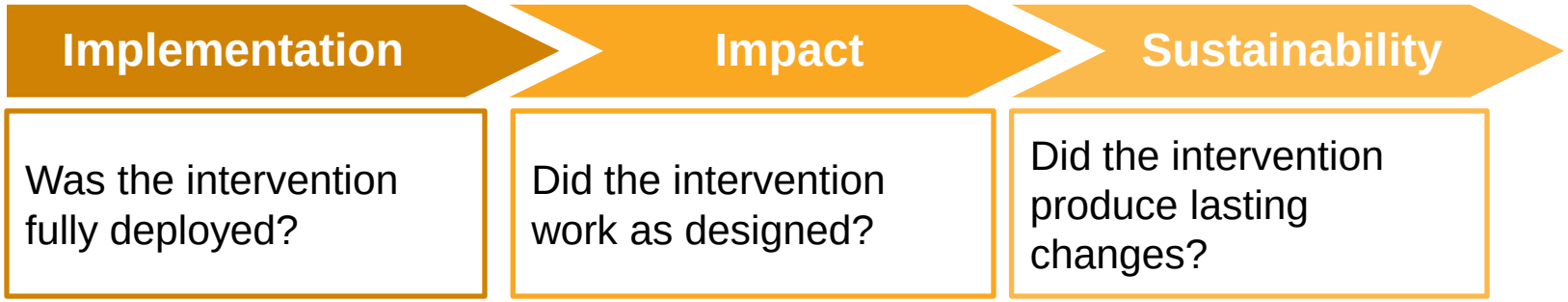
Evaluation goals

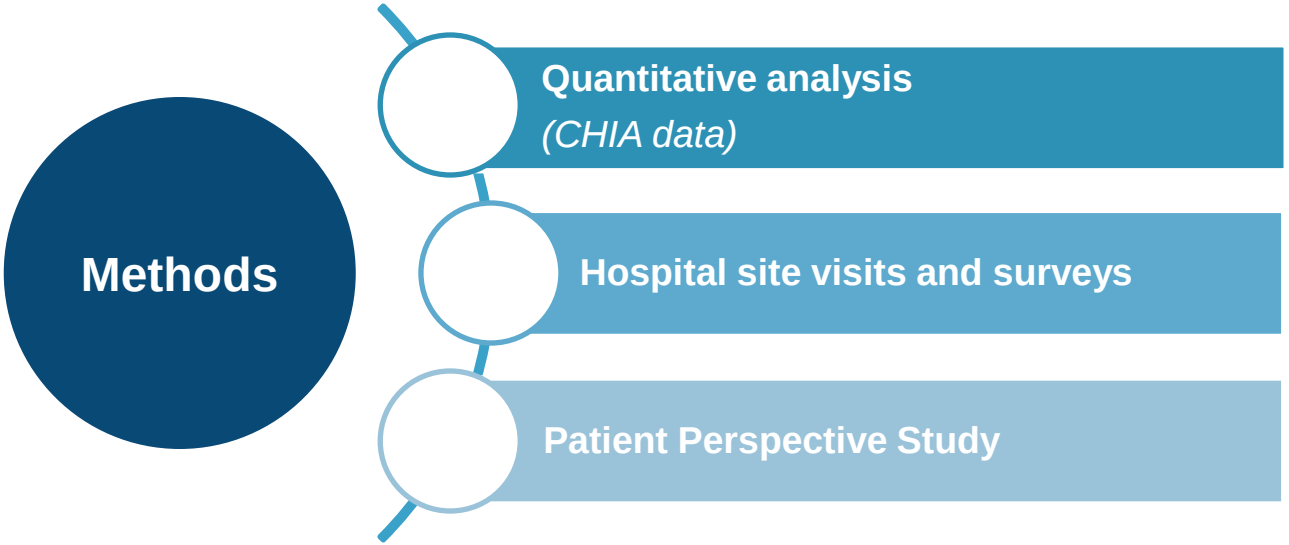
in partnership with

BU School of Public Health

HPC

CHART Phase 2 Evaluation: Assessing performance of a forward-looking investment





Framework adapted from Berry SH, Concannon TW, Gonzalez Morganti K, et al. CMS innovation center health care innovation awards: Evaluation plan. RAND Corporation, 2013.

HPC engagement with CHART hospitals

100% are Satisfied or Extremely satisfied with the responsiveness of their HPC Program Officer.

100% Agree or Strongly Agree that TA meetings with the strategic advisor were helpful.

"Collaborative learning opportunities have been huge in the success of our program." *Hospital Program Manager*

89% Agree or Strongly Agree that "*My hospital is in a better position to achieve its CHART Phase 2 goals because of the TA and programmatic support we have received from the HPC.*"

Respondents found HPC TA especially helpful in the areas of:

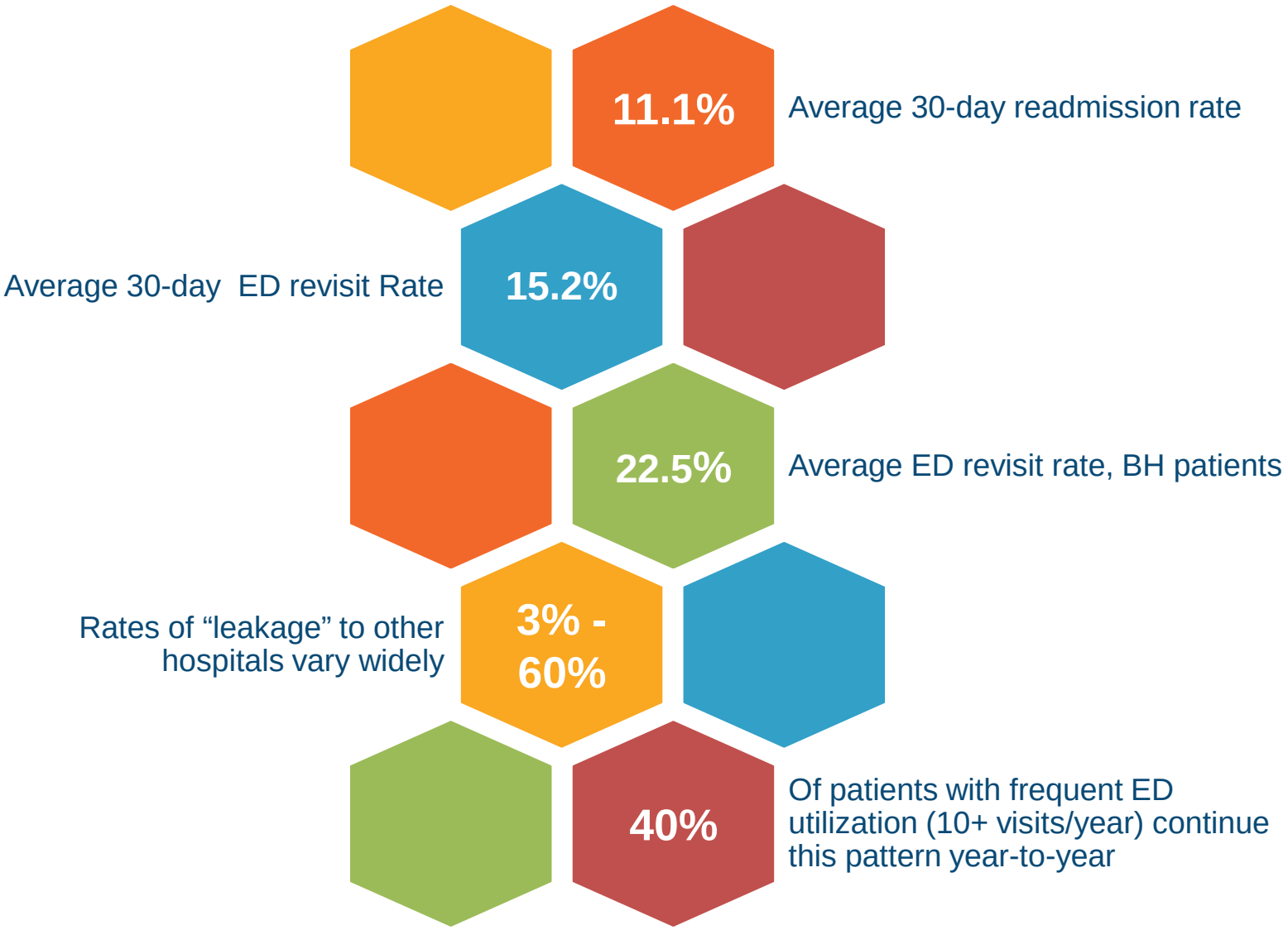
- Measurement & Analysis (90%)
- In-hospital clinical processes (84%)
- Post-acute follow-up (84%)
- Case-finding (69%)

Other forms of TA also described as helpful:

- Regional convenings (95%)
- Statewide convening (89%)
- CHART newsletter (90%)
- CHART resource page (79%)

Survey of program managers/investment directors at CHART Phase 2 hospitals taken in March 2017. 19 Responses out of a possible 30 were received.

Baseline statistics: Utilization at CHART hospitals prior to Phase 2



Baseline Summary, derived from CHIA Case Mix Data for the two years before launch of CHART Phase 2. BH patients refers to patients identified as having any BH diagnosis, whether primary or not.

Institutional context: Hospital-wide practices

92% of hospitals have behavioral health and medical providers co-located in the ED

But just **27%** say collaboration of BH and medical providers is standard in their ED

100% have hired new staff for care coordination as part of CHART Phase 2

67% have hired new staff for data analytics

26% routinely assess inappropriate use of the ED and act on the data

30% say they have a fully developed program to reduce readmissions

93% use telehealth to care for some patients

41% use automated flags to encourage hospice or palliative consults

37% use a single EHR across the hospital

CHART hospitals collaborate with:

Long-term care providers	**97%**
Police/Fire	**70%**
BH providers	**67%**
Social services	**67%**
Schools	**33%**

Organization Survey of hospitals participating in CHART Phase 2, conducted November 2016– Jan 2017. Respondents were asked about hospital-wide practices, not specifically the CHART program unless indicated.

Institutional context: Data and analytics at CHART hospitals

Most CHART hospitals report that they are able to:

- Electronically transmit and track medications sent to pharmacies
- Automatically inform primary care physicians when a patient is admitted or discharged (ENS)
- Use patient registries for chronic disease and high utilization
- Integrate some patient data from providers outside their system

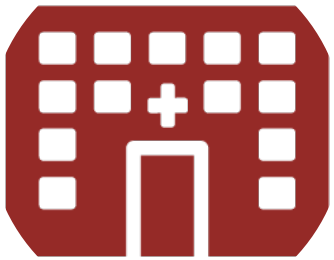
CHART hospitals report mixed or limited ability to:

- Use predictive risk assessment and stratification
- Use patient registries for behavioral health
- Use patient portals or secure email/text to communicate with patients
- Share referral and follow-up information with specialists electronically

Organization Survey of hospitals participating in CHART Phase 2, conducted November 2016-Jan 2017. Respondents were asked about hospital-wide practices, not specifically the CHART program unless indicated.

Community partnerships in CHART Phase 2 Initiatives

Frequently named as "most critical" for achieving aims of CHART Phase 2



- BH Providers
  - SUD/SMI Outpatient
- Post-acute
  - SNF
  - Elder services
  - Home care
- Social
  - Housing
  - Food

Unique and innovative partnerships

- Hospice
- Pharmacy
- Transportation
- Court / DA's Office

Organizational Survey of hospitals participating in CHART Phase 2, conducted November 2016-Jan 2017. Respondents were asked to list "*the most critical community partners (to achieving your primary and secondary aims) involved in CHART initiatives at your hospital.*"

Timeline of CHART Phase 2 Evaluation

February 2017 – Hospital Survey Results ✓

March 2017 – Baseline Summary Report ✓

June 2017 – Awardee Memos

August 2017 – Interim Report

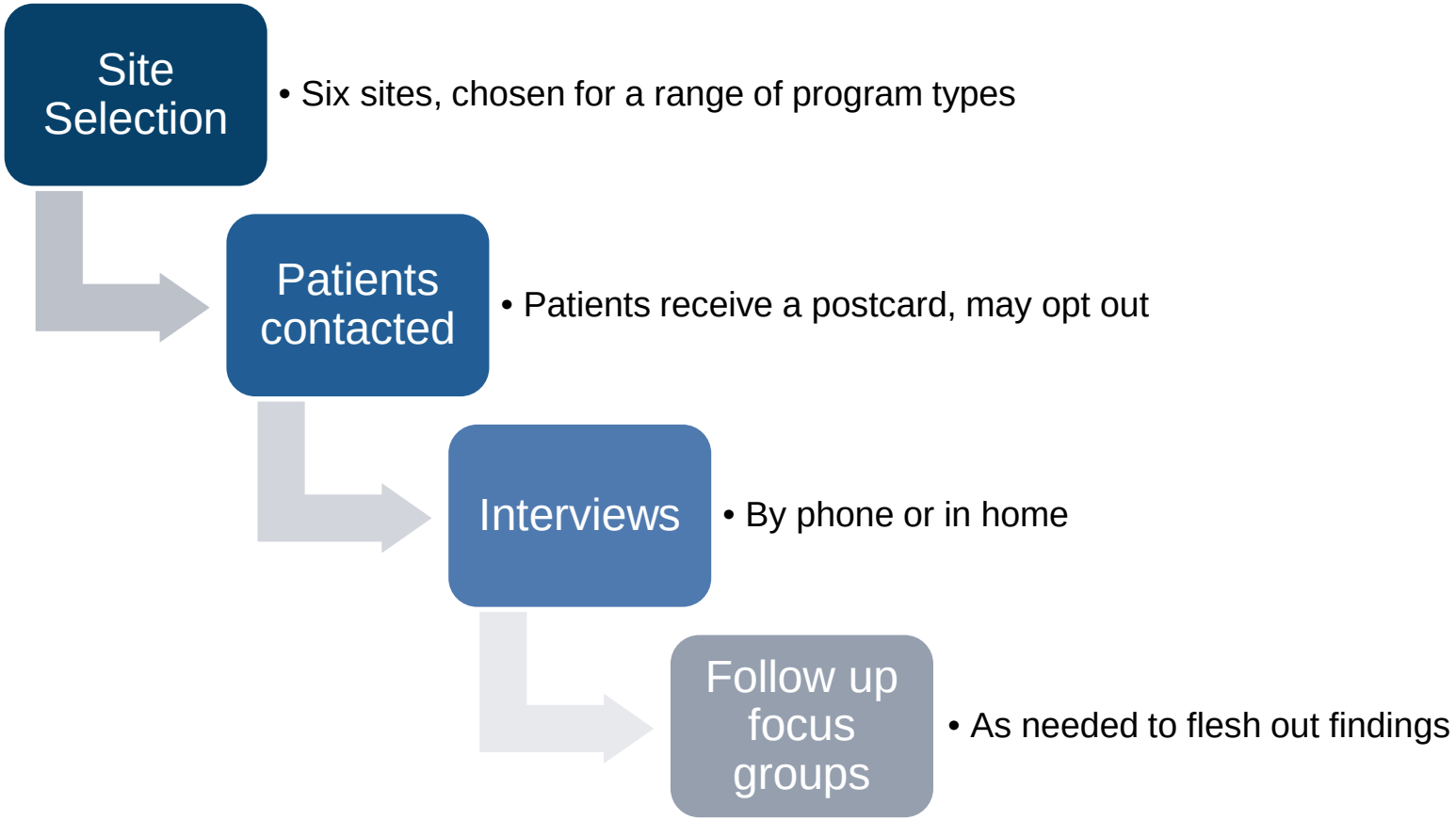
April 2018 – Patient Perspective Study Report

May 2018 - Awardee memos 2

October 2018 - Theme Reports

January 2019 – Final summative Report

Patient Perspective Study



The plan for the Patient Perspective Study was approved by the BUSPH / Boston Medical Center IRB on 3/17/2017, IRB # H-36026.

Potential topics for theme reports

Care delivery transformation

- Composition of complex care teams
- Moving services out of the hospital: Training and deployment of community health workers
- Characteristics of successful partnerships with community-based providers
  - SNFs
  - Social services
- Integration of palliative care
- Evolving role of pharmacists

CHART hospital transformation

- Role of CHART hospitals within ACOs
- Case-finding and target population selection
- HIT for population health management
- Community impact and health equity

Case studies of particularly successful or unique programs

Evaluation of CHART Phase 3

All Awardees

- ACO Readiness
  - Nature and degree of risk
  - Information flow
  - Population health management activities
- BHI
- Community Partnerships

Pathway 1

- Hospital reporting
  - Utilization
  - Service delivery
  - Payer mix
  - Referrals
- Mixed methods
  - Quantitative analysis of CHIA data
  - Interviews & Surveys
  - Patient perspective study

Pathway 2

- Hospital reporting
  - Small set of process metrics by project

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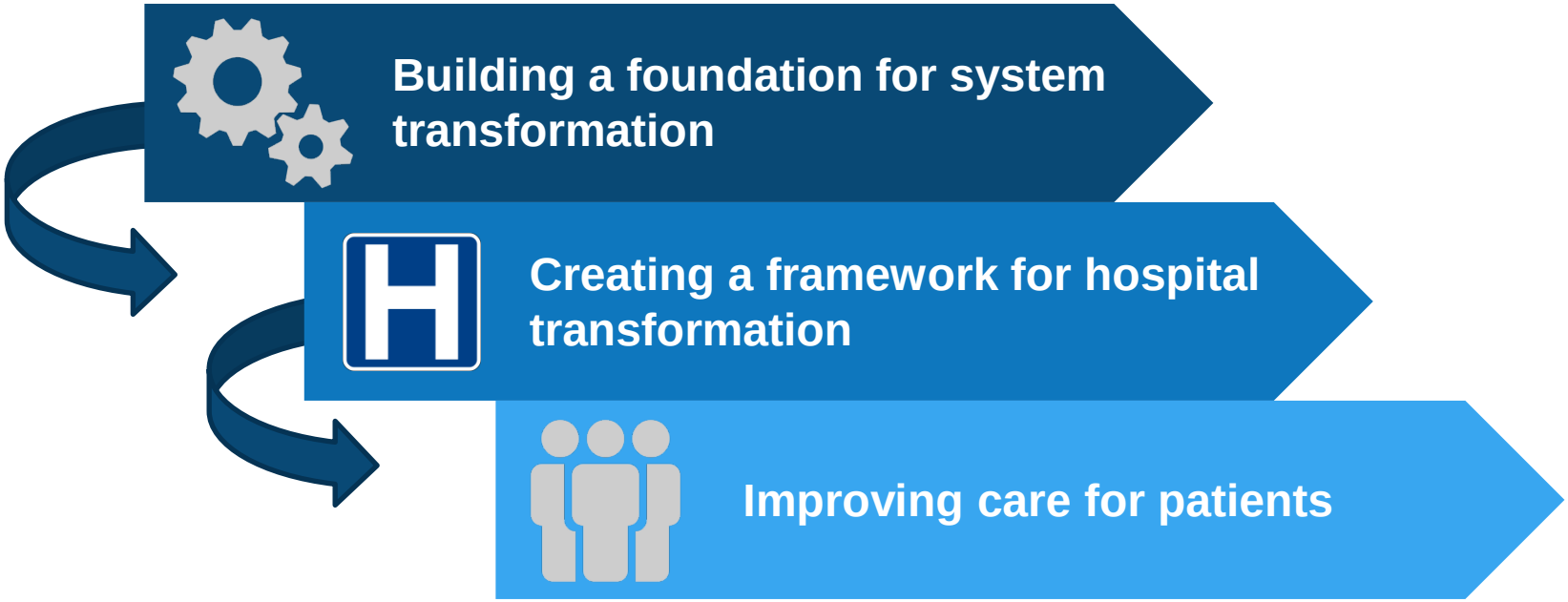
AGENDA

- Approval of Minutes
- Presentation: Center for Health Information and Analysis
- Market Oversight: Performance Improvement Plans
- Strategic Investment Programs: Learning and Dissemination Strategy
- CHART Phase 2: Evaluation Program Update
- **CHART Phase 3: Final Program Design Discussion**
- Schedule of Next Meeting: July 5, 2017

CHART Investment Priorities

CHART investment priorities are structured to support transformation at the system, hospital, and patient care levels.

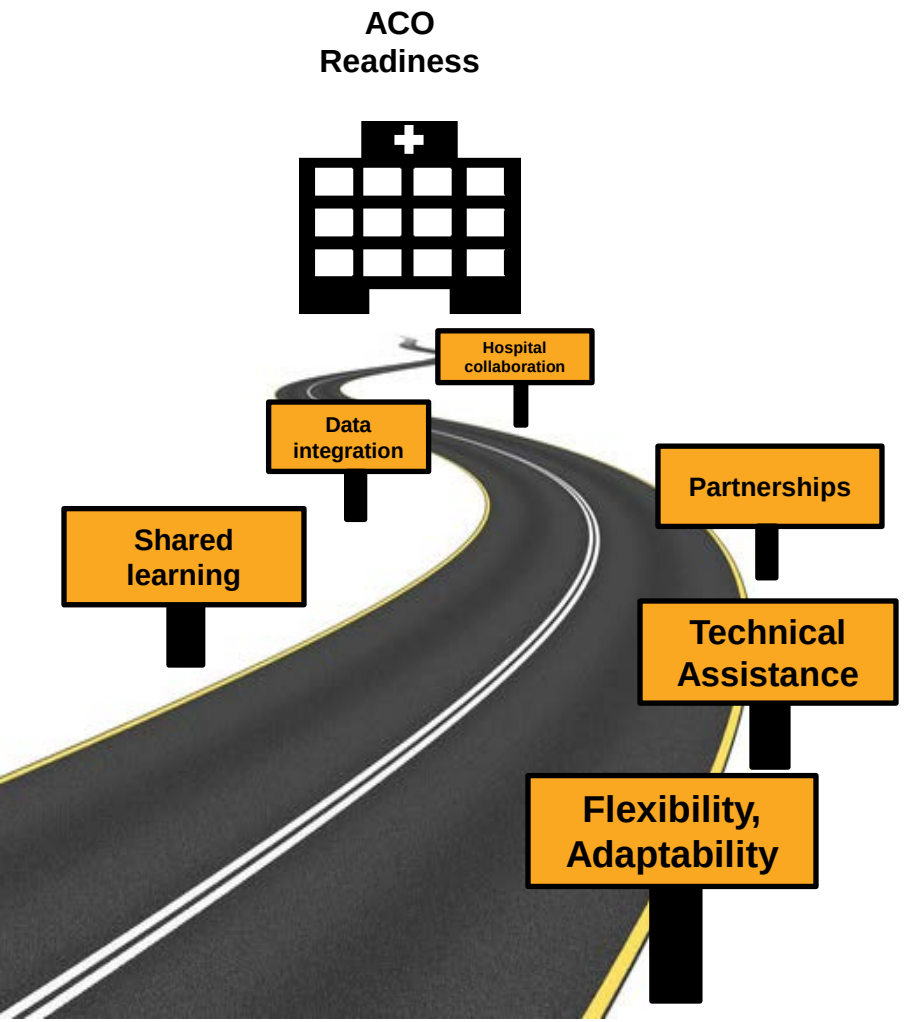


Working towards a community-based health care system

"*I don't see any future for community hospitals…I think there's a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care].*"

COMMUNITY HOSPITAL CEO

CHART supports community hospitals as they advance toward accountable care readiness



Flexibility and adaptability
Programs use models of continuous improvement to iterate on their clinical models

Technical assistance
In-person, site-specific performance coaching by care delivery transformation experts and HPC staff

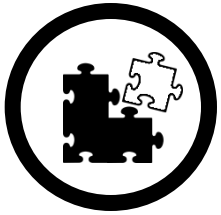
Shared learning
Awardees engage in shared learning and group problem-solving through regional and statewide convenings

Partnerships
Community partnership and stakeholder engagement are key components to program models

Data integration
Emphasis on reporting and tracking of outcomes for continuous quality improvement

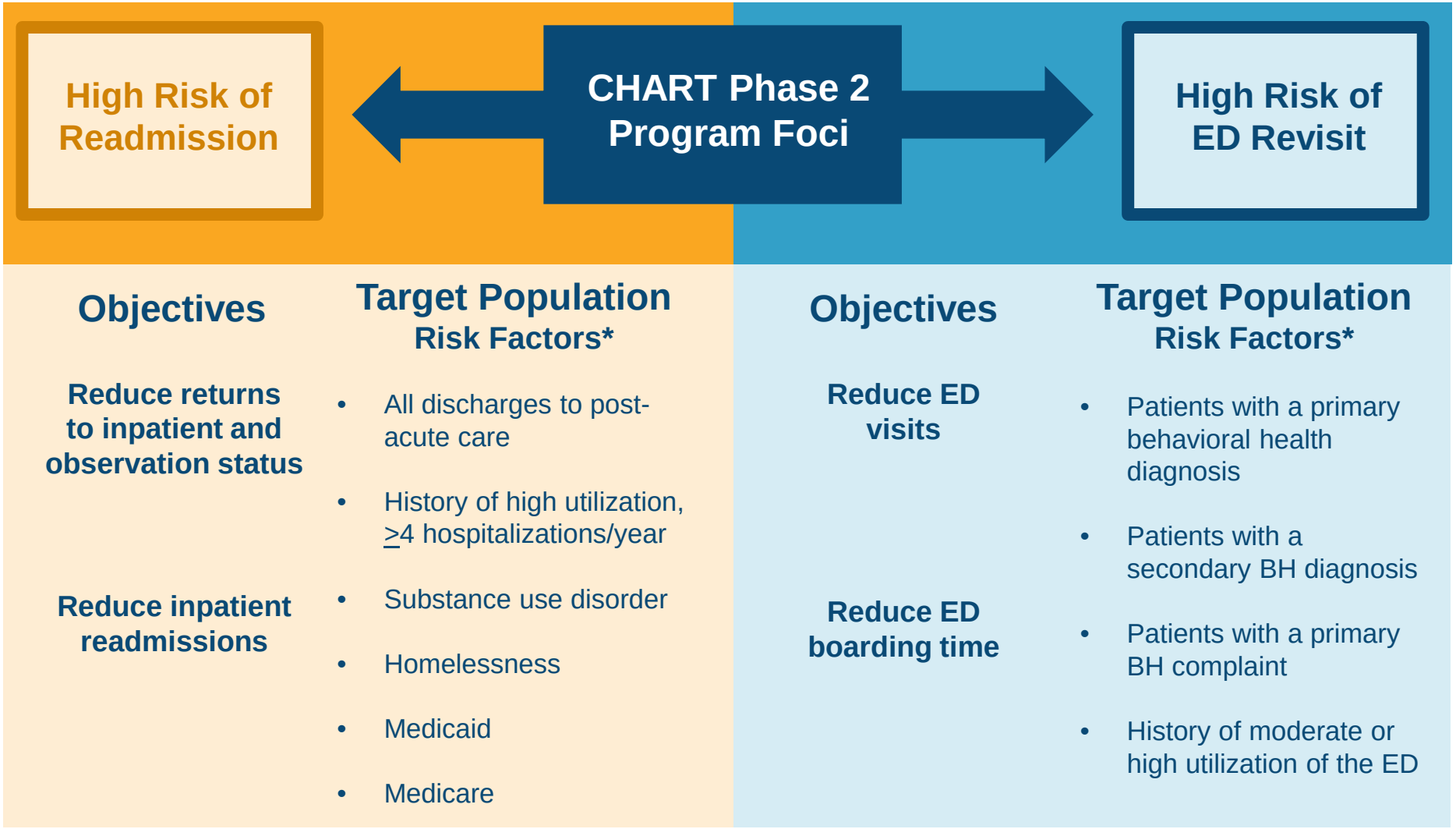
Hospital collaboration
Programs composed of hospital leadership, clinical, and non-clinical staff representing many departments

CHART innovation highlights

Traditional care	vs.	Transformed care through CHART
Hospital-centric, medical model		Whole-person continuum of care
Focus on in-hospital care		Sustained community engagement
Specialization in silos		Collaboration extends beyond silos
Data use limited		Enabling technology investment

Adapted from The Visual Miscellaneum, David McCandless

CHART Phase 2 programs focus primarily on patients with a high risk of hospitalization and/or a high risk of ED revisits



*Note: These are examples only and are not an exhaustive representation of all CHART Phase 2 target population risk factors and aim statements.

CHART Phase 2 target populations by awardee

High Risk of Readmission	High Risk of ED Revisit
15 Awardees	10 Awardees
Addison Gilbert Hospital	Anna Jaques Hospital*
Anna Jaques Hospital*	Baystate Franklin Medical Center*
Baystate Franklin Medical Center*	BIDH–Milton
Baystate Noble Hospital	BIDH–Plymouth*
Baystate Wing Hospital	Hallmark Health System
Berkshire Medical Center	Harrington Memorial Hospital
Beverly Hospital	Heywood-Athol Joint Award
BIDH–Plymouth*	Holyoke Medical Center
Emerson Hospital	Lahey-Lowell Joint Award
Lawrence General Hospital	Mercy Medical Center
Lowell General Hospital	UMass Memorial HealthAlliance Hospital
Marlborough Hospital	
Milford Regional Medical Center	
Signature Healthcare Brockton Hospital	
Southcoast Hospitals Group	
Winchester Hospital	

*BIDH–Plymouth, BIDH-Franklin and Anna Jaques Hospital have two Aim Statements and/or two corresponding target populations.

Note: The Baystate Joint Award is not included as it has a unique target population and aim statement that does not fall into either category listed above.

CHART Phase 2: Results to date

CHART-funded FTEs[1]

10 staff =

13 FTEs
Care Coordinators

24 FTEs
Patient Navigators

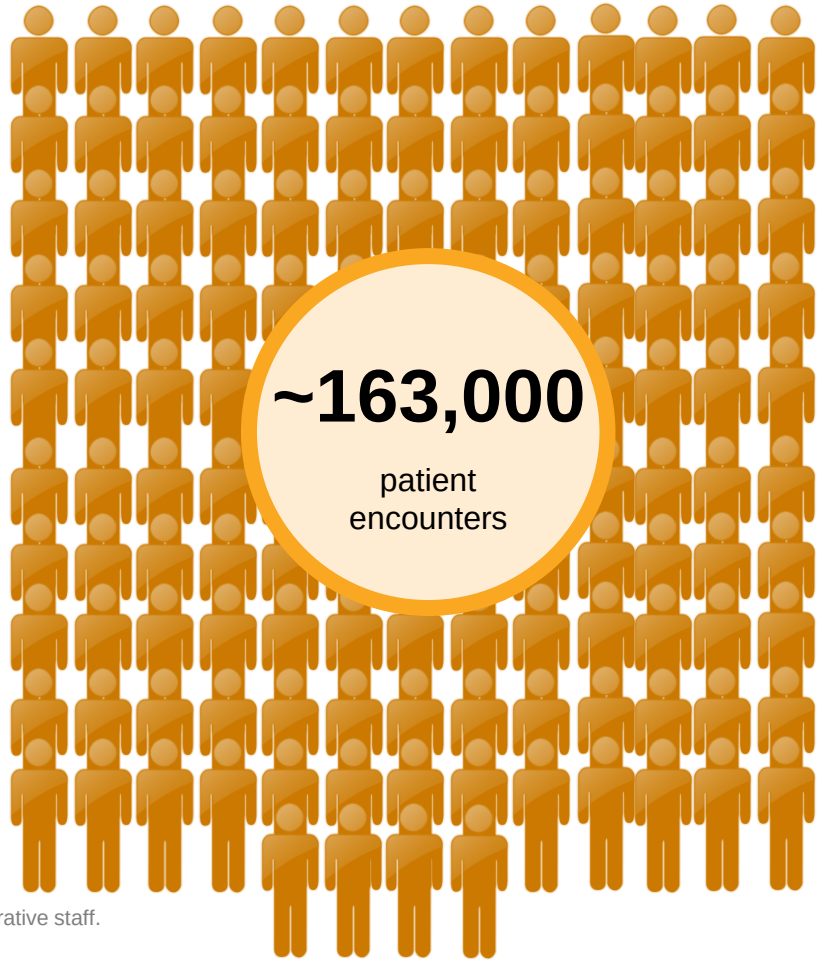
47 FTEs
Social Workers

54 FTEs
Community Health Workers

91 FTEs
Other Support Specialties and Clinical Staff

CHART-eligible encounters[2]

= 1,000 patient encounters



[1]Includes patient-facing staff only. Patient facing staff are supported by administrative staff.
[2]Based on reports received from CHART Phase 2 awardees.
Note: Last updated May 23, 2017

Looking from Phase 1 to Phase 2 to Phase 3

2013 — QI, Collaboration, and Leadership Engagement; Measurement and Evaluation; Partnership — 2018

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. $15M - $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

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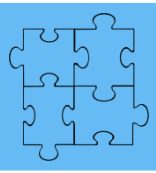
CHART Phase 3 design components

1. Award size and duration

2. Goals and Pathways

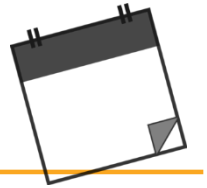
3. Performance measures

4. Financial support and sustainability



5. Competitive factors

CHART Phase 3: Award size and duration



Total funding

$15,000,000 to $20,000,000

Individual awards

$500,000 – up to $1,500,000

Pathway 1: Up to $1,000,000

Pathway 2: Up to $500,000

Duration

18 months

CHART Phase 3: Goals and pathways

Goals of CHART Phase 3

- Reduce unnecessary hospital utilization and improve quality
- Enhance behavioral health care
- Establish strong relationships with community partner(s)
- Support the development of the capabilities necessary to participate in ACO models and transition to APMs

In order to support these goals, **there will be 2 pathways for which CHART-eligible hospitals can apply for one or both**:

Pathway 1

Limited bridge funding to continue promising CHART Phase 2 initiatives that have reduced unnecessary hospital utilization and improved quality.

Pathway 2

Funding of projects to support the development of the capabilities necessary to function as a high-performing partner in an ACO and to transition to APMs.

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CHART Phase 3: Pathway 1

Pathway 1

Limited bridge funding to continue interventions from Phase 2 that have shown **promise in reducing unnecessary hospital utilization, improving quality of care, and offering a path to sustainability under APMs**.

Awards would be selective and would require hospital financial support and community partnership, with a continued focus on:

- Addressing whole person needs with a multi-disciplinary care team
- Identifying and engaging in real time with complex patients
- Addressing social determinants of health
- Increasing post-acute care coordination
- Strengthening community partnerships

HPC

CHART Phase 3: Pathway 2

Pathway 2

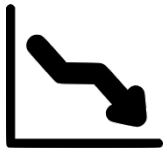
Funding investments necessary to **enhance and build the competencies** required for hospitals to function as **high-performing participants in ACOs and transition to APMs**.

Proposed work will address one or more components of ACO readiness:

- Technology
- Community partner planning
- Hospital planning for participation in ACO (e.g., data analytics planning, planning for participation in ACO governance)

HPC

CHART Phase 3: Performance measures



Pathway 1

Outcomes related to **reducing unnecessary utilization and improving quality** by addressing at least one or all of the HPC's key target areas for:

- **Reducing all-cause 30-day hospital readmissions**
- **Reducing the rate of behavioral health related ED utilization**
- **Reducing ED Boarding**

Pathway 2

Planning and implementation related **deliverables and milestones specific to ACO readiness** project(s) in one or more of the following categories:

- **Technology**
- **Community partner planning and implementation**
- **Hospital planning for participation in an ACO**

CHART Phase 3: HPC financial support and sustainability

Require **in-kind contributions** from hospitals/ systems to **lessen financial reliance on the HPC**

For every CHART-eligible expense in the Award, the **CHART hospital will be reimbursed at 70%** (i.e., CHART hospital is responsible for 30%)

Require **sustainability plans** to ensure continuation beyond Phase 3

CHART Phase 3: Competitive factors

Competitive factors

1. Solid **sustainability plan**
2. **Participation in risk contracts** with substantive quality measures and/ or partnership with a provider organization seeking HPC ACO certification in 2017
3. **Performance** in CHART Phase 2
4. Demonstration of **understanding of the drivers of utilization**
5. Collaborative **multi-disciplinary team approach** to care delivery
6. Strong relationships with **community partners**

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Proposed CHART Phase 3 timeline

June 14, 2017 – Release RFP

June 27, 2017 – Information session held by HPC staff (webinar)

July 26, 2017 – Deadline for submission of written questions (by 3:00pm)

August 9, 2017 – Deadline for submission of Proposal (by 3:00pm)

November 2017 – Awardees selected

January 2018 – Projected Contract execution

January 2018–June 2019 – Period of Performance

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Contact Information

For more information about the Health Policy Commission:

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

Appendix

Proposal for Structure of CHART Phase 3

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 $15M to $20M
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 for Pathway 1	▪ 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 – Reduce the rate of behavioral health related ED utilization – Reduce ED Boarding – Reduce the rate of discharge to institutional care following hospitalization

HPC

Proposal for Structure of CHART Phase 3 (continued)

FOCUS AREAS

Two pathways for which Applicants can apply for one or both:

Pathway 1
-$1,000,000 award cap. 30% in-kind contribution required.
-Limited bridge funding to continue interventions from Phase 2 that have shown promise in reducing unnecessary hospital utilization, improving quality of care, and offering a path to sustainability under alternative payment methods
-Awards would be selective and would require hospital financial support and community partnership, with a continued focus on:

- Addressing whole patient needs with multi-disciplinary care teams
- Identifying and engaging in real time with complex patients
- Addressing social determinants of health
- Increasing post-acute care coordination
- Strengthening community partnerships

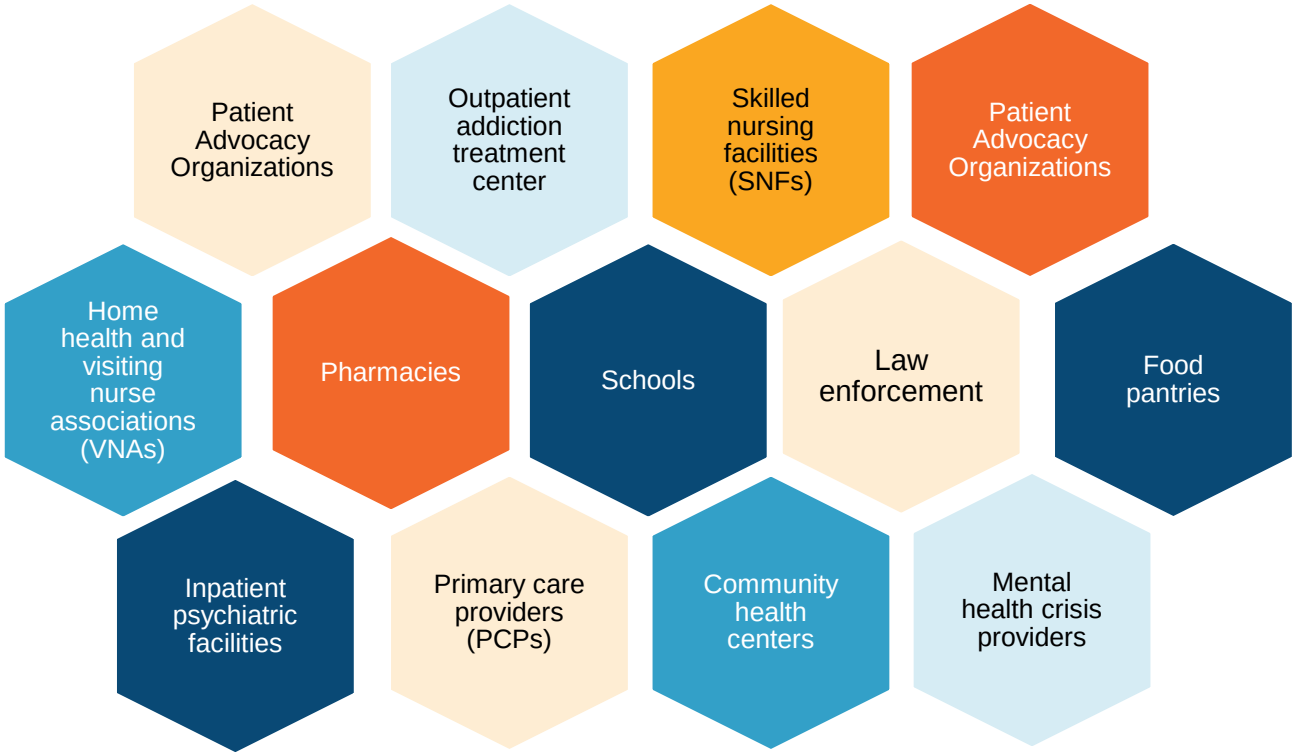
Pathway 2
-$500,000 award cap. 30% in-kind contribution required.
-Funding investments necessary to enhance and build the competencies required for hospitals to function as high-performing participants in Accountable Care Organizations and transition to alternative payment methods
-Proposed work will address one or more components of ACO readiness:

- Technology
- Community partner planning
- Hospital planning for participation in ACO (e.g. data analytics planning, planning for participation in ACO governance)

CHART 3: Hardwiring community partnerships

HPC defines community partner as those medical and non-medical community services with whom the hospitals share in the care of patients that they serve.

Community partners can include, but are not limited to:



Stakeholder Feedback

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