# Health Policy Commission

Board Meeting

March 5, 2014

# Agenda

- Approval of Minutes from February 19, 2014 Meeting
- Presentation by the State Ethics Commission
- Executive Director Report
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Schedule of Next Commission Meeting

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# Vote: Approving Minutes

**Motion**: That the Commission hereby approves the minutes of the Commission meeting held on February 19, 2014, as presented.

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# CHART Hospital Visits


**Pictured (left to right):** Senator Michael J. Rodrigues (D-Westport), Representative Carol Fiola (D-Fall River), Representative Patricia A. Haddad (D-Somerset), Speaker Pro Tempore, HPC Commissioner Paul Hattis, Keith A. Hovan President and CEO Southcoast Health System and Southcoast Hospitals Group, Representative Paul Schmid (D-Westport), and Representative Alan Silvia (D-Fall River).

# Upcoming Meetings

**Tuesday, March 18, 2014**
Care Delivery and Payment System Transformation (CDPST) Committee Meeting
Public Hearing on Patient-Centered Medical Homes Certification Program
12:00PM – 1:30PM
Daley Room, Two Boylston Street, Boston, MA

**Wednesday, April 2, 2014**
Community Health Care Investment and Consumer Involvement (CHICI) Committee Meeting
9:30AM – 11:00AM
Daley Room, Two Boylston Street, Boston, MA

Cost Trends and Market Performance (CTMP) Committee Meeting
11:00AM – 12:30PM
Daley Room, Two Boylston Street, Boston, MA

**Wednesday, April 9, 2014**
Quality Improvement and Patient Protection (QIPP) Committee Meeting
9:30AM – 11:00AM
Daley Room, Two Boylston Street, Boston, MA

Care Delivery and Payment System Transformation (CDPST) Committee Meeting
11:00AM – 12:30PM
Daley Room, Two Boylston Street, Boston, MA

# 2014 Expected Activities at the HPC

## Q1

- CMIR Report: PHS/SSH/Harbor
- Final OPP Regulation
- Health Care Cost Growth Benchmark for 2015
- PCMH Certification Standards
- CHART Phase 2 Framework
- Behavioral Health Agenda

## Q2

- CHART Phase 2 RFP
- Material Change Notices (MCN) Regulation Development
- Final PCMH Program Framework
- APCD Almanac Publication w/CHIA
- CMIR Report: Lahey/Winchester

## Q3

- Final RPO Regulation
- Proposed MCN Regulation
- Summer Supplemental Cost Trends Report
- PCMH Demonstration Program Launch
- Planning for Annual Cost Trends Hearing
- CMIR Report: PHS/Hallmark

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  - **PCMH Certification Model**
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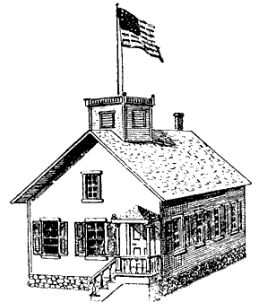
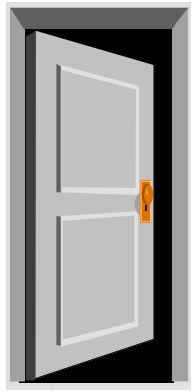
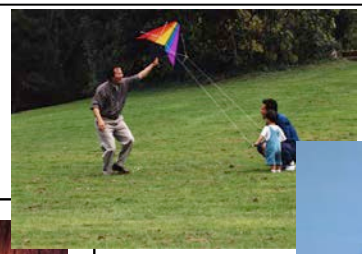
# The Medical Home



PROTECT

Quality

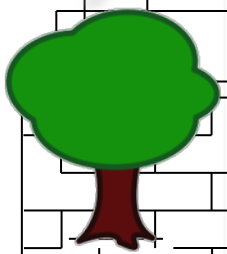


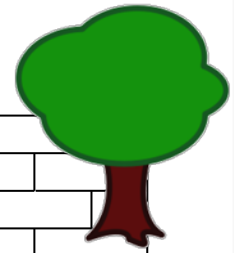


Relationship

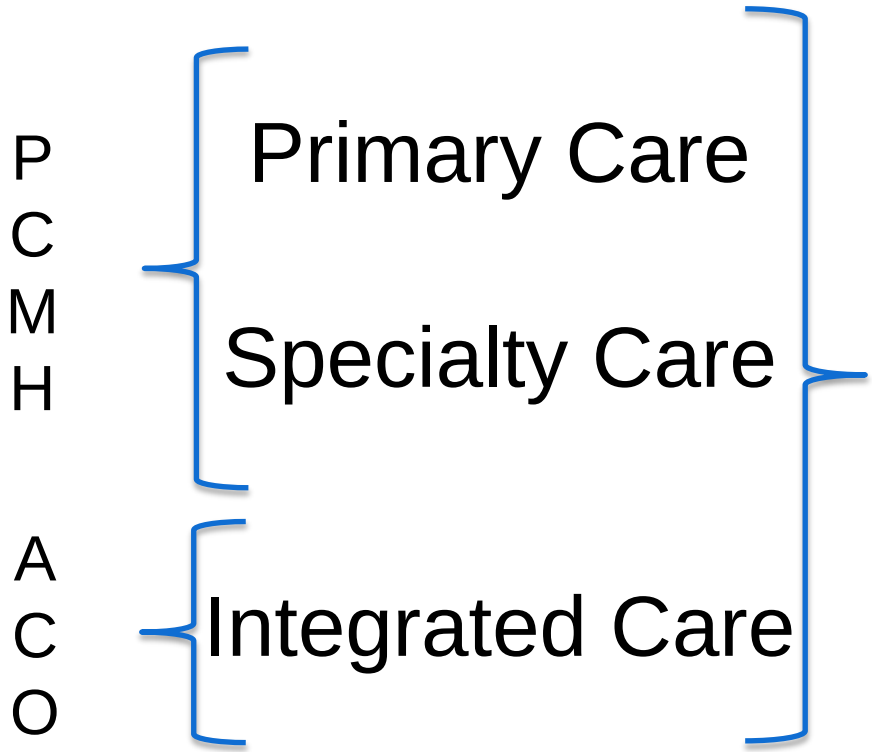
Support

FOUNDATION





# HPC PCMH/ACO Certification : *patient-centered* accountable care




**Accountable Care Certification**

*A unified framework for promoting, validating and monitoring the adoption and impact of accountable care in the Commonwealth*

# HPC PCMH Certification: three-pronged approach

1. **Standardize criteria for accountable care**: certify practices demonstrating progress in implementing the PCMH care model, as measured by the number of capabilities implemented and in active use across domains

2. **Align payment with PCMH capabilities**: leverage the efforts of multiple payers to support implementation of high-value elements of accountable care and align payment incentives over time to support transformation

3. **Evaluate the impact on cost and quality:** assess the impact of the HPC PCMH certification program, as measured by quality, utilization and efficiency of care provided at certified practices, and disseminate best practices

**Transform Primary Care**

# General approach to implementation

- ***Phased approach to implementation***: demonstration (2014-2015), evaluation, scaled roll-out

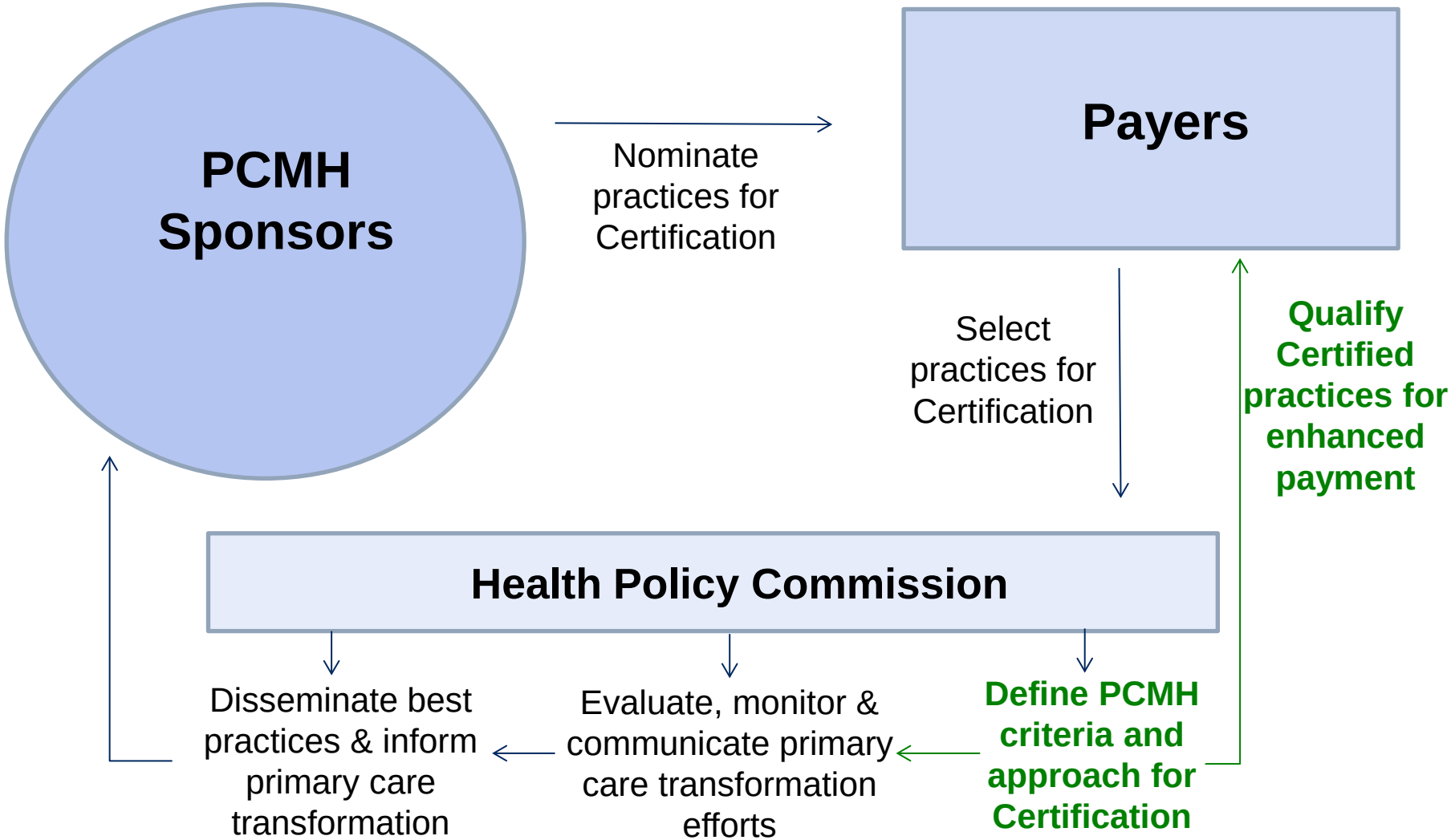
- Work with primary care transformation sponsors (organizations/entities committed to PCMH implementation) and health plans to ***select practices for certification***

- Create an objective approach to ***assess practice transformation*** ("certify" performance & "validate" functional capabilities)

- Line up existing payment models (side-by-side) to understand if any ***natural harmonization*** can be accomplished – align incentives and promote more effective payment models over time

- Use certification results, APCD and other data to assess impact on ***cost and quality*** – contribute to the evidence-base and inform future efforts

# HPC PCMH Certification Model



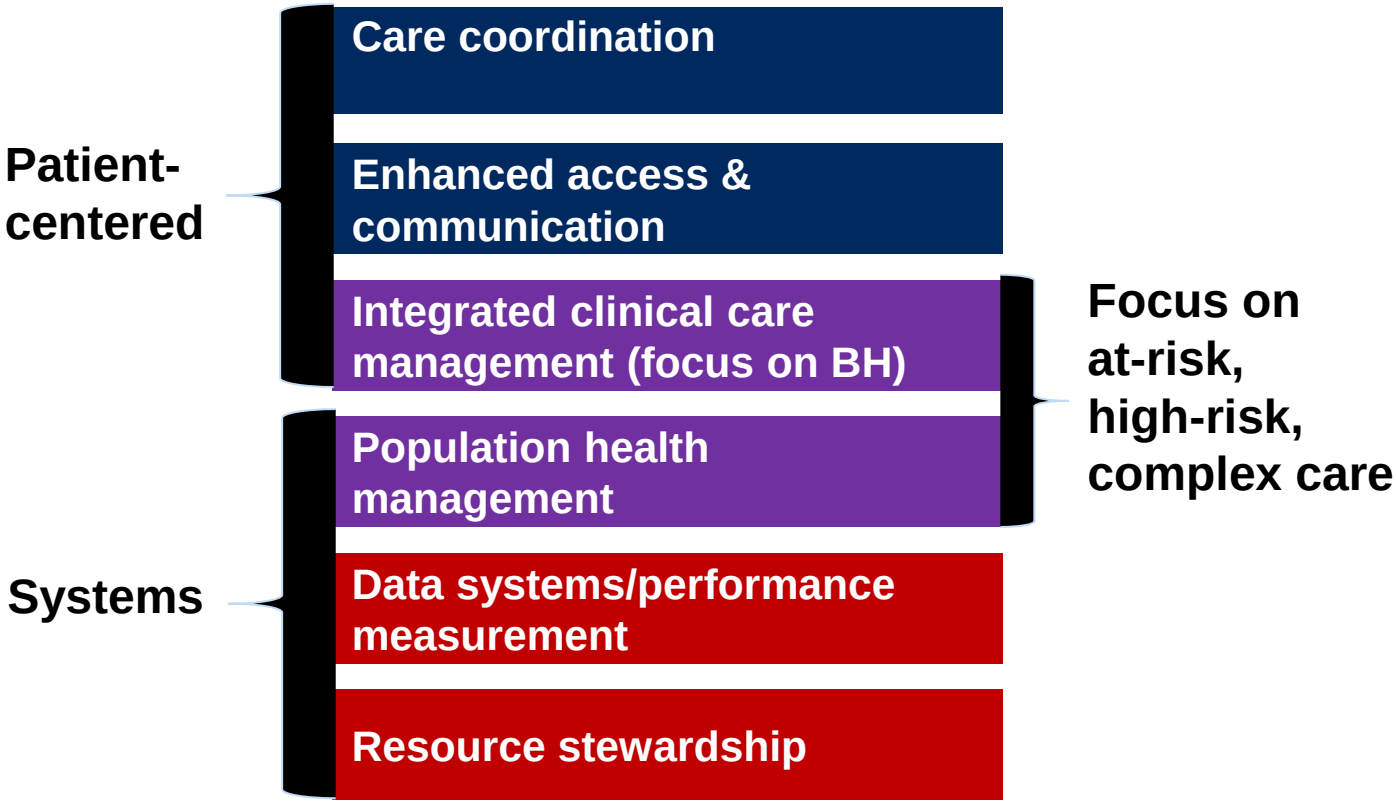
## Value Proposition: link advanced primary care to enhanced payment

*HPC will use the Certification pathway as a performance-based gateway to qualify practices for enhanced payment and assess the impact on value-based care*

# HPC Accountable Care Standards – local & national alignment

- National certification standards
- Payer/purchaser advanced primary care requirements
- Local primary care transformation initiatives
- Practice setting applications (pediatric, behavioral health, specialty practice)
- HPC behavioral health integration pathway (joint Committee discussion with QIPP)

# Proposed PCMH Certification Standards




**6 Standards**

**Pathway: Basic, Advanced, Optimal**

**45 Criteria: 15 criteria for each level of Pathway**

# Value of HPC PCMH Certification

**Participating Payers**

- Use common set of accountable care standards to qualify practices for enhanced payment
- Access to neutral body (HPC) to conduct certification and assess performance, validate PCMH capabilities, and evaluate impact

**Participating Practices**

- Participate in FREE, streamlined process for Certification (online application, limited performance data, on-site review)
- PCMH Pathway provides “on-ramp” for progressive levels of advanced primary care (Basic, Advanced, Optimal)
- Opportunity to qualify for enhanced payment

**Health Policy Commission**

- Focus on high-value, evidence-based criteria (6 standards and 45 criteria) - NCQA has 6 standards, 27 elements and 153 factors)
- Conduct detailed assessment of performance & capabilities
- Monitor status of PCMH certification and evaluate impact
- Advance high-quality, cost effective care delivery models
- Facilitate learning, contribute to the evidence-base, and disseminate best practices

# MA PCMH Certification – Phase I: Demonstration

1. Collaborate with primary care sponsors to use accountable care criteria to inform PCMH implementation efforts
2. Engage payers to use common set of core criteria as gateway for PCMH payment
3. Validate practice capability on PCMH Pathway to qualify practices for enhanced payment
4. Assess the impact of various payment models on the adoption of high-value elements and the impact on cost & quality
5. Inform value-based care considerations and primary care transformation efforts through transparent data on comparative results

# Next Steps (March – June 2014)

- Public comment period for proposed PCMH criteria (March)
- Finalize clinical focus areas and menu of clinical quality and utilization measures (high cost clinical conditions and population health priorities)
- Joint meeting with QIPP to develop and plan for behavioral health integration (April 9th)
- Develop guidelines for evaluating practices (performance reporting and validation of functional capabilities)
- Confirm payers and sponsor organization(s) for 2014 PCMH Demonstration (expected to begin by Q3 2014)
- Convene payers, purchasers and health systems to share goals on HPC approach for primary care transformation

# PCMH Public Comment Period

**Proposed Patient Centered Medical Home Certification Criteria**

Posted on HPC website: mass.gov/hpc

Public Comment Period
March 5 – April 4, 2014

Public Meeting
March 18, 2014
Two Boylston Street, 5th Floor, Boston, MA
12:00PM – 1:30PM

**Please submit comments to HPC at HPC-PCMH@state.ma.us**

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# 2014 Behavioral Health Agenda

Chapter 224 sets a broad vision for a more affordable, effective and accountable health care system in Massachusetts. The successful integration of behavioral health care is essential for realizing the goals of improving outcomes and containing long-term cost growth.

The Health Policy Commission, through its various policy Committees, should work to ensure that behavioral health issues are appropriately considered and addressed in the spectrum of initiatives led by the Commission.

# 2014 Behavioral Health Agenda

Despite a history of progressive state policies and a commitment by many health care providers and payers, there are a number of persistent barriers to behavioral health integration in Massachusetts. As identified by the Behavioral Health Task Force these barriers include, but are not limited to:

1. Reimbursement issues, including lack of equity, restrictive billing policies, and non-aligned payment systems;
2. Regulations that are based on historically separate systems of physical health and behavioral health;
3. Difficulty accessing behavioral health treatment;
4. The need for significant training and education of both primary care and behavioral health providers;
5. Lack of interoperability and connection of the behavioral health system to electronic health records; and,
6. Privacy and data-sharing concerns.

**For discussion:**

How can the HPC work to address these barriers in 2014?

# 2014 Behavioral Health Agenda

| | Planned HPC activities for 2014 |
|---|---|
| **Promoting clinical standards through accountable care models** | ▪ The development of behavioral health (BH) criteria and standards to be included in the PCMH program (joint effort of the CDPST and QIPP committees); the development of evaluation and measurement metrics for BH in the PCHM setting; and the engagement of payers on payment support for BH services. Focus will shift to developing the ACO certification program in Q3 and Q4 of 2014. |
| **Promoting clinical models through investment** | ▪ Providing CHART awardees a number of capacity-building opportunities through training, leadership assessment, and technical assistance; overseeing and evaluating Phase One projects, including the dissemination of lessons learned and best practices; developing and implementing the Phase Two CHART investment opportunity in which we plan to provide significant, strategic investments in targeted areas of HPC focus. |
| **Research, evaluation, and analysis** | ▪ Extend analysis of high-need patients to the MassHealth population; coordinate with the work of the Public Payer Commission as it pertains to behavioral health; other on-going research and analysis in areas of interest to the Commission Board; and monitor research of others in this area. |
| **Capacity and needs assessment (Health planning)** | ▪ On-going participation of the HPC ED in council activities; collaboration between the Council and the HPC's QIPP Committee to develop key questions and an analytic approach; HPC staff providing in-kind support to the Council. |
| **Public forum for policy discussion** | ▪ Focused discussions and deliberations by the QIPP committee and other stakeholders and experts as appropriate on the challenges and opportunities for behavioral health integration; receive periodic updates on the progress of the HPC and by other state agencies in implementing key Chapter 224 strategies for advancing integration (i.e. the DOI/AGO on parity issues, DMH, and the Public Payer Reimbursement Commission.) |

# Next Steps

Next steps: What are the priorities for the QIPP Committee for 2014?

**Upcoming activities for QIPP include:**

- Joint meeting of QIPP and CDPST to: 1) consider behavioral health criteria and standards to be included in the PCMH certification program, and 2) receive an update from MassHealth on the integration of behavioral health in the PCPR program
- Invite representatives of the Health Planning Council to provide an update and discuss opportunities for aligned work in 2014
- Invite representatives of the Division of Insurance to provide an update on the parity regulations mandated by c. 224 and the first report on parity certification
- Inventory behavioral health initiatives and map to the Behavioral Health Task Force report

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# What is Potential Gross State Product?

**Potential Gross State Product (PGSP)**
Long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle

## Legislation

- Section 30(b) of Chapter 224 requires the Secretary of Administration and Finance and the House and Senate Ways and Means Committees to set a benchmark for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is to be included in a joint resolution due by January 15th of each year
- The PGSP estimate is used by the Health Policy Commission to establish the Commonwealth's health care cost growth benchmark

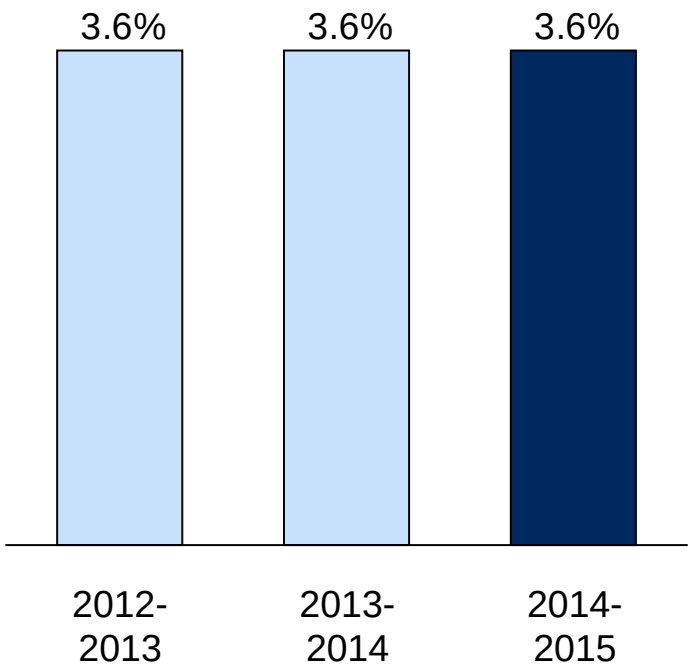
## Process

- The Commonwealth's estimate of PGSP was developed with input from outside economists, in consultation with Administration and Finance, the House and Senate Ways and Means Committees, the Department of Revenue Office of Tax Policy Analysis, and members of the Health Policy Commission
- Consistent with existing practices:
  - Builds on Consensus Revenue process
  - Uses the same assumptions as other fiscal policy benchmarks (Long-Term Fiscal Policy Framework)
  - Developed with stakeholder input

# PGSP Estimate for 2014-2015

**Potential Gross State Product (PGSP)**

Percent growth




- The 2014-2015 estimate of 3.6% is within a range of discussed by stakeholders
- Estimates were informed by standard methodologies (e.g. Congressional Budget Office) as well as legislative intent to target the long-run average growth rate of the Commonwealth's economy
- The range reflects a consensus around two key technical issues:
  - *Real growth*: How to account for under-investment in capital during the recession
  - *Inflation*: Agreement to use Fed's 2.0% target for the inflation assumption and monitor going forward

# Vote: Establishing the Health Care Cost Growth Benchmark for 2015

**Motion**: That, pursuant to by G.L. c. 6D, § 9, as determined jointly by the Secretary of Administration and Finance and the House and Senate Ways and Means Committees, the Commission hereby establishes the health care cost benchmark for calendar year 2015 as 3.6%.

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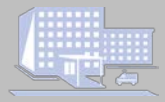
# Findings from the 2013 cost trends report (1/2)

- Per capita spending in Massachusetts is the **highest of any state** in the U.S., crowding out other priorities for consumers, businesses, and government
  - Over the past decade, Massachusetts health care spending has **grown much faster than the national average**, driven primarily by faster growth in commercial prices
  - Massachusetts residents continue to **use health care services at a higher rate** than the nation, especially in **hospital care and long-term care**, although the difference between Massachusetts and the U.S. average has been stable over the past decade

- While **spending growth in Massachusetts since 2009** has slowed in line with slower national growth, sustaining lower growth rates will **require concentrated effort**
  - Past periods of slow health care growth in Massachusetts, such as the 1990s, have been followed by **sustained periods of higher growth**
  - While observed growth rates for individual payers are low, the statewide growth rate is higher, **driven by enrollment shifts among payers** due to trends such as the aging of the population

# Findings from the 2013 cost trends report (2/2)



**Hospital operating expenses**

- The operating expenses that hospitals incur for inpatient care **differ by thousands of dollars per discharge**, even after adjusting for regional wages and complexity of care provided
- Some hospitals deliver **high-quality care with lower operating expenses**, while many higher-expense hospitals achieve lower quality performance
- Hospitals able to negotiate **high commercial rates have high operating expenses** and cover losses they experience on public payer business with income from their higher commercial revenue, while hospitals with more limited revenue must maintain lower operating expenses

**Wasteful spending**

- In 2012, an estimated **$14.7 to $26.9 billion (21 to 39 percent)** of health care expenditures in Massachusetts are estimated to be wasteful, reflecting both clinical and structural opportunities
- There are **opportunities to reduce wasteful spending** in preventable hospital readmissions, unnecessary emergency department visits, health care-associated infections, early elective inductions, and unnecessary imaging for lower back pain

**High-cost patients**

- In 2010, five percent of patients accounted **for nearly half of all spending** among both the Medicare and commercial populations in Massachusetts
- Certain characteristics differed between high-cost patients and the rest of the population:
  - A number of **conditions occurred more often** among high-cost patients, and high-cost patients generally had more clinical conditions than the rest of the population
  - The **interaction of conditions increased spending** more than the individual condition contributions
  - There is **modest regional variation** in the concentration of high-cost patients
  - **Lower-income zip codes** have a higher concentration of high-cost patients
- Persistently high-cost patients – those who remain high-cost in consecutive years – represent **29 percent of high-cost patients** and 15 to 20 percent of total spending

# 2013 report conclusion and action steps

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

**For discussion:**

How can the Commonwealth follow up on these conclusions?

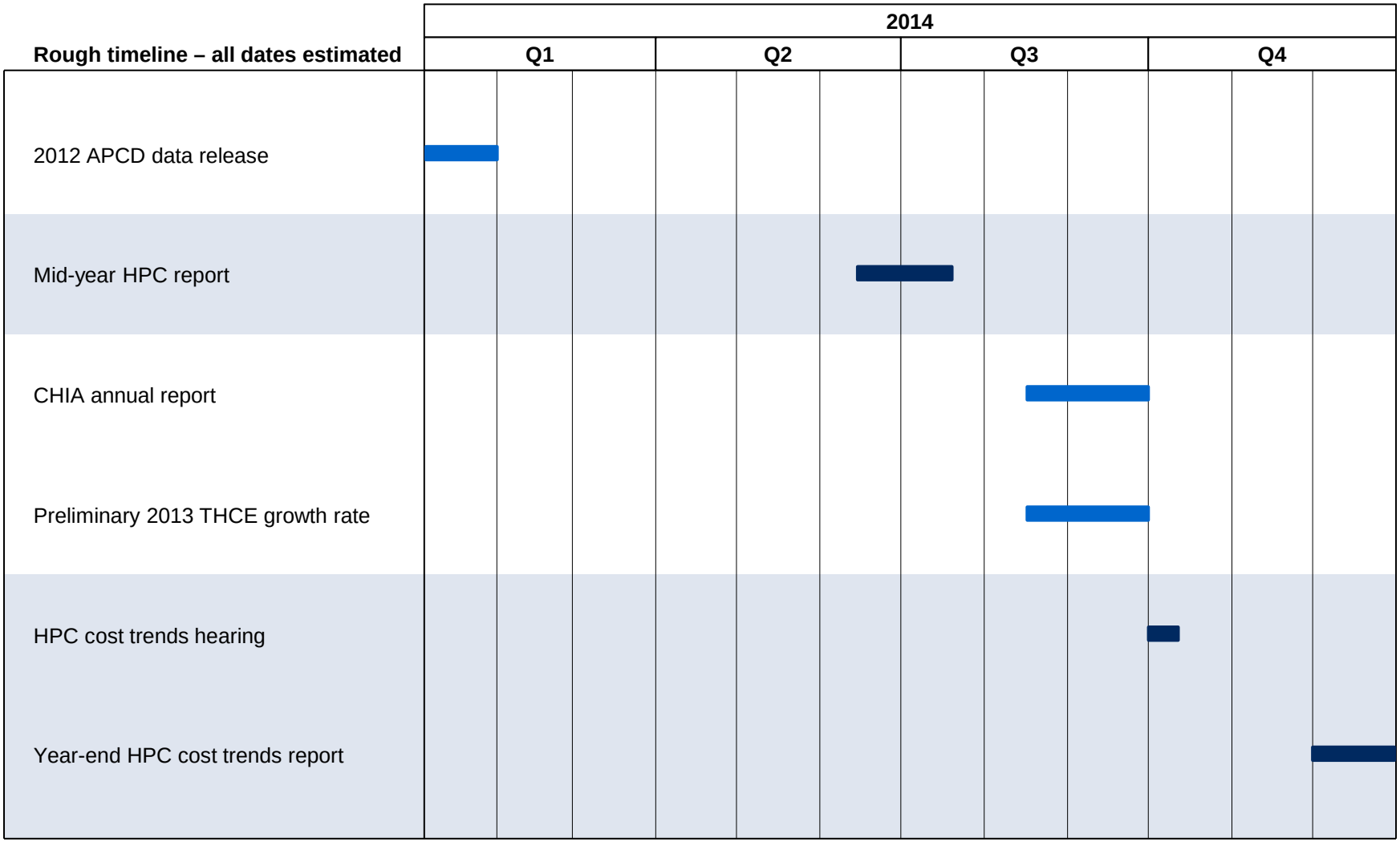
# Areas of opportunity identified in 2013 report: state agency activities

| | Activities of state agencies |
|---|---|
| **1 Fostering a value-based market** | ▪ Health plan and provider price transparency tools (Multi-agency)<br>▪ Evaluation of market changes and cost and market impact reviews (HPC)<br>▪ Promotion of value-oriented health insurance purchasing and innovative product design (GIC, Connector, DOI)<br>▪ Health resource planning and Determination of Need activities (EOHHS, DPH)<br>▪ Consumer health information website with cost and quality information (CHIA, OCABR)<br>▪ Oversight and enforcement of health care market competition (AGO) |
| **2 Promoting an efficient, high-quality health care delivery system** | ▪ Patient-centered medical home (PCMH) and ACO certification programs (HPC)<br>▪ Investment programs for community hospitals, DSH hospitals, CHCs, and community-based prevention/wellness (HPC, EOHHS, DPH)<br>▪ Integrated care delivery models with aligned payment for public programs (EOHHS, GIC)<br>▪ Evaluation of new care delivery models (HPC, CHIA, EOHHS)<br>▪ Primary care workforce development and training programs (DPH, EOLWD)<br>▪ Integration of behavioral health services (Multi-agency)<br>▪ Public payer commission (EOHHS) |
| **3 Advancing alternative payment methods** | ▪ Primary care payment reform initiative (EOHHS)<br>▪ Integrated risk-bearing provider organization requirements (GIC)<br>▪ Risk-bearing provider organization certification (DOI)<br>▪ Evaluation of alternative payment methodologies in new care delivery models (HPC, CHIA, EOHHS)<br>▪ Dual-eligible “One Care” program (EOHHS)<br>▪ State Innovation Model grant activities (Multi-agency) |
| **4 Enhancing transparency and data availability** | ▪ APCD development and provider portal (CHIA)<br>▪ Interoperable health record dissemination and health information exchange (eHealth Institute, EOHHS)<br>▪ Registration of provider organizations (HPC, CHIA)<br>▪ Hospital profile reports (CHIA)<br>▪ Cost trends reporting and annual hearings (HPC, CHIA, AGO) |

# Preliminary 2014 research agenda extending from 2013 cost trends report

| | |
|---|---|
| **Basic profile** | ▪ Medicaid (payer)<br>▪ Long-term care and home health (service category)<br>▪ Behavioral health care (clinical area)<br>▪ Care for children (population segment)<br>▪ Disparities in access and care delivery<br>▪ Product design and trends |
| **Hospital operating expenses** | ▪ Deepening analysis of particular areas of hospital expenses (e.g., capital expenses)<br>▪ Extending analysis to additional provider types |
| **Wasteful spending** | ▪ Ongoing tracking of performance in reducing wasteful spending<br>– Preventable readmissions<br>– Unnecessary ED visits |
| **High-cost patients** | ▪ Extending analysis to MassHealth population<br>▪ Identifying meaningful segments within high-cost patient population |
| **Provider mix** | ▪ Profiling care provided in the Massachusetts market (discharges, episodes)<br>▪ Analysis of potential cost impact of provider mix changes for a common set of discharges and/or episodes |

# Timeline for 2014



# Next steps

**Goal: Support HPC's mission to develop evidence-based policy**

- Solicit feedback from commissioners, committees, board, and advisory council
- Validate and analyze 2009-2012 APCD data
- Catalog other research to leverage the efforts and findings of other institutions, including:
  - Public institutions, including CHIA, MassHealth, GIC, DOI, DPH, and DMH
  - Chapter 224 commissions, including health planning council, public payer commission, and provider price variation commission
  - Private organizations, including academics, stakeholders, foundations, and research organizations

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# Types of Transactions Noticed

**2013 to Present**

| Type of Transaction | Frequency |
|---|---|
| Physician group affiliation or acquisition | 36% |
| Acute hospital acquisition | 23% |
| Acquisition of post-acute provider | 14% |
| Clinical affiliation | 14% |
| Change in ownership | 9% |
| Formation of contracting entity | 5% |

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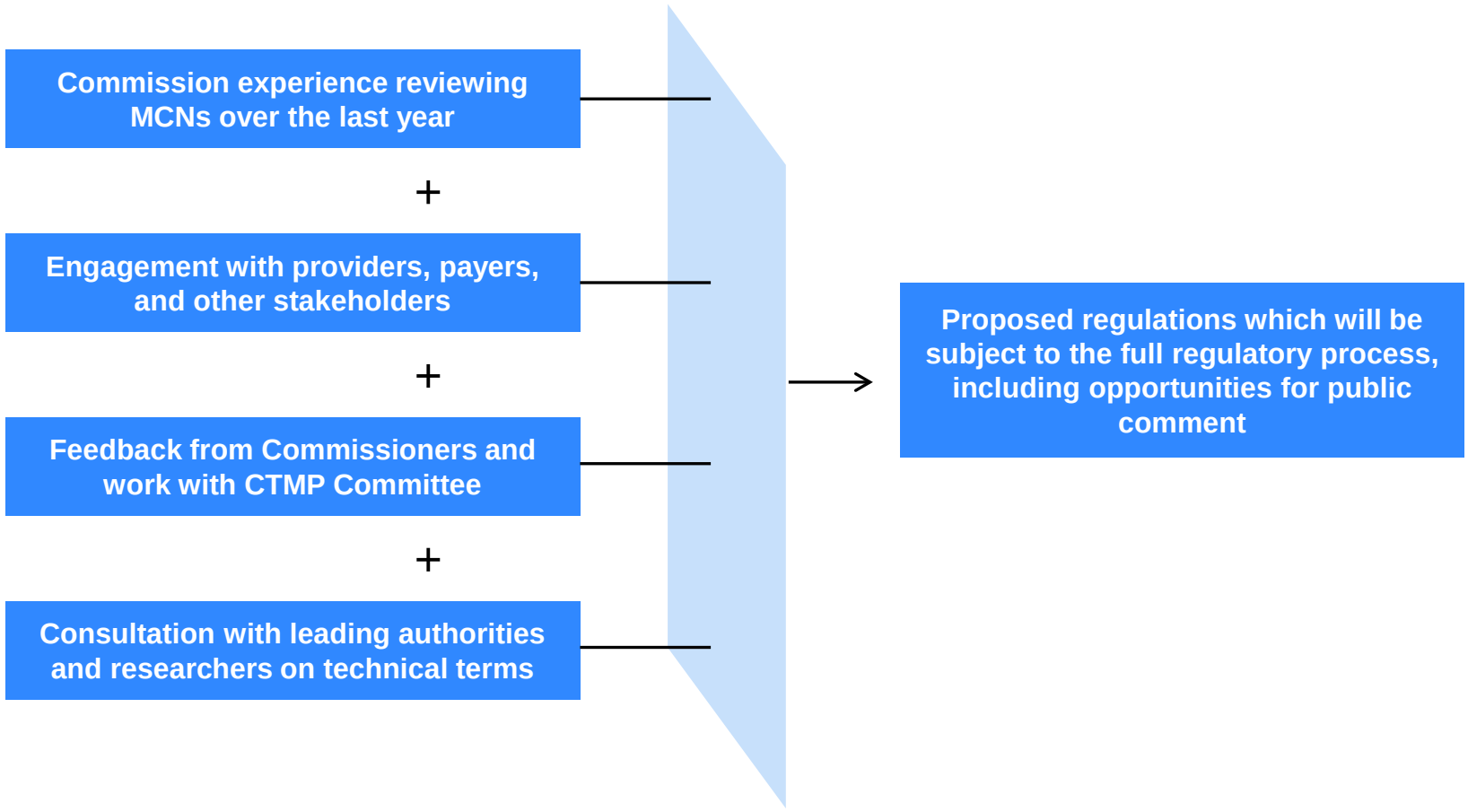
# Update on Material Change Notice Regulations

- Interim Guidance issued March 12, 2013 currently governs the filing of material change notices.
- The HPC is required to define a number of terms by regulation:  e.g., primary service areas, dispersed service areas, dominant market share, materially higher prices, materially higher health status adjusted total medical expenses.
- The HPC is tracking toward issuing regulations to codify these definitions and a final process for filing material change notices.

# Process for Developing MCN Regulations



# Primary and Dispersed Service Areas

- “Primary Service Area” and “Dispersed Service Area” are metrics by which the HPC may evaluate Material Change Notices, and serve as the geographic area in which cost, quality, and access factors may be evaluated.
- Service areas are well-vetted and established in economic literature as important tools for evaluating market effects.
- Dispersed service areas are a newer concept than primary service areas, but provide important insight into the impact of multi-provider health systems, factors purchasers/employers consider when choosing health plans, and health plan pricing.

# Primary and Dispersed Service Areas

- Presented a proposed definition of Primary Service Areas for hospitals, which is based on inpatient discharges, and which is very similar to existing methodologies used by market participants and other government agencies (DOJ/FTC).
- Discussed a potential approach for defining Dispersed Service Areas for multi-hospital systems based on the union of the Primary Service Areas for the system's hospitals.

# Next steps

- Modeling definitions of other statutory terms (materially higher price and total medical expenses, dominant market share) (Winter 2014)
- Working closely with experts and stakeholders (ongoing)
- Proposing regulations, which will be subject to the full regulatory process, including opportunities for stakeholder feedback through a public hearing and written comments (Spring - Summer 2014)

# Agenda

- Approval of Minutes from February 19, 2014 Meeting
- Presentation by the State Ethics Commission
- Executive Director Report
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Cost Trends and Market Performance
- **Community Health Care Investment and Consumer Involvement**
  - CHART Evaluation and Phase 2 Framework
- Schedule of Next Commission Meeting

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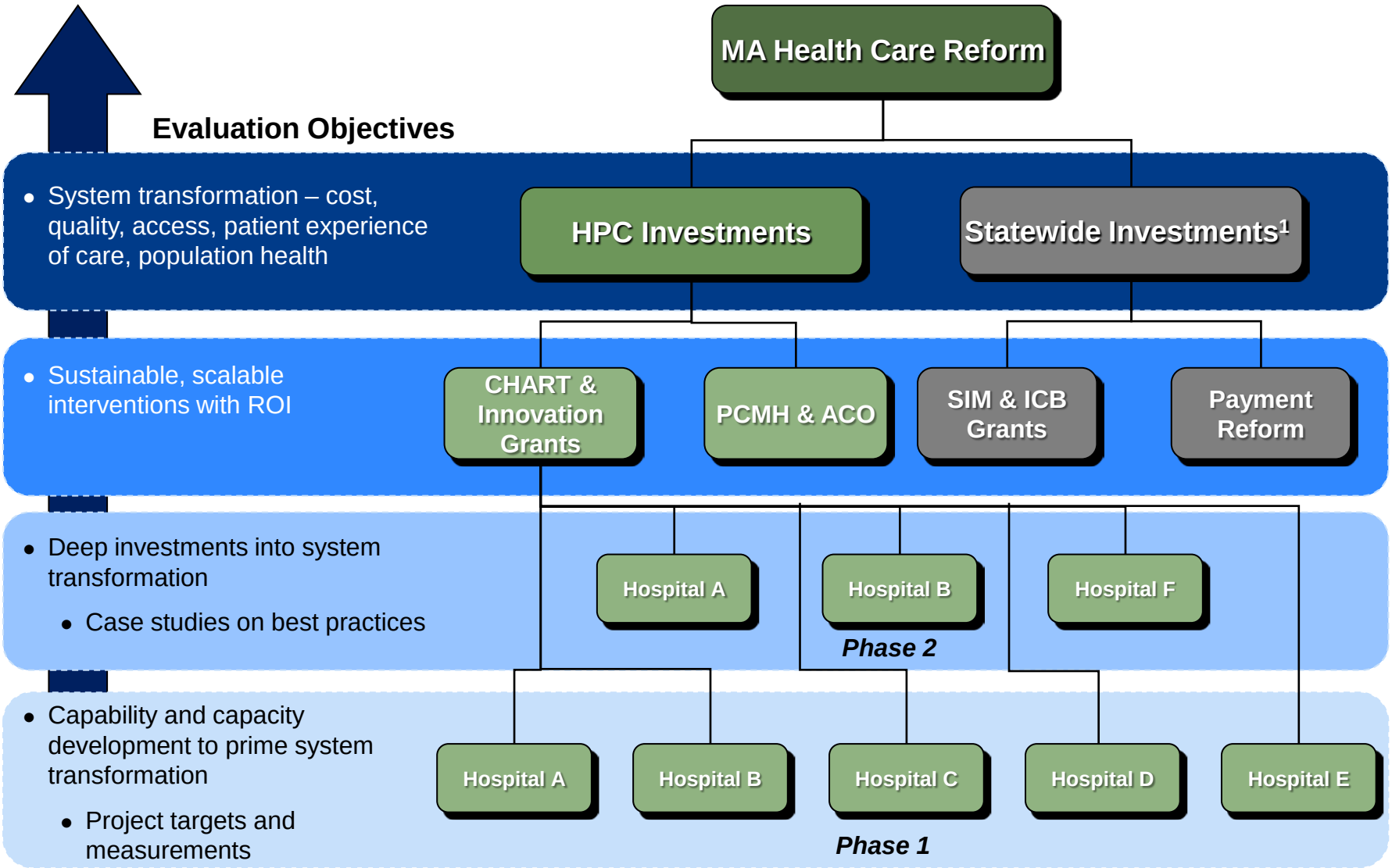
# General evaluation framework

*Develop CHART evaluation within a wider context*




[1] Examples only – HPC anticipates developing evaluation framework in the context of many activities across the Commonwealth, including all Chapter 224 investments

# Approach to Phase 1 Evaluation

## Evaluation goals

- The evaluation will draw upon CHART program documents, existing hospital reports, and limited additional data collection from participating institutions.

- The overall HPC Care Delivery Evaluation Framework has three broad purposes:
  - To assess the efficacy of the investment program in achieving specific **quantitative and qualitative goals**, including the **ROI, sustainability and scalability** of specific projects
  - To advance **knowledge** regarding opportunities, challenges, and best practices for **healthcare organizations that seek to transform** care delivery
  - To support a **culture of measurement, accountability, and continuous improvement** within participating hospitals and the HPC

- The Phase 1 evaluation has five more narrow aims:
  - To **assess the progress and output of each specific CHART Phase 1 investment**
  - To establish a **baseline understanding** on the capability and capacity of participating hospitals
  - To identify **best practices and foster shared learning** among participating hospitals
  - To strengthen HPC's **grant stewardship** practices, through documentation and reflection.
  - To **inform the development of future HPC investments and care delivery policy**

# Phase 1 Evaluation: Data sources and evaluation outputs


**A HPC Driven Metrics**

1. HPC will assign metrics for evaluation of proposed investment priorities
   a) Publically available data sources
   b) Focus groups and cohort surveys
2. Awardee feedback on Phase 1 administration will be solicited and incorporated

**B Menu of Metrics (SQMS, CMMI)**

Phase 2

1. HPC will assign metrics for evaluation of proposed investment priorities
   a) Baseline scenarios
   b) Industry and/or organization benchmarks
2. Applicants will choose from a menu of metrics to be evaluated for success

**C Applicant Driven Metrics**

1. HPC received milestones, metrics, and targets for evaluation for each proposal
2. Awardees proposed metrics as related to program objectives
   a) Baseline scenarios
   b) Industry and/or organization benchmarks

1 Baseline findings: hospital performance and program structure (Summer 2014)

2 Phase 1 evaluation report (Winter 2015)

# Looking from Phase 1 to Phase 2

## Phase 1: Fall 2013 – Foundational Activities to Prime System Transformation

- 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: Spring 2014 – Driving System Transformation

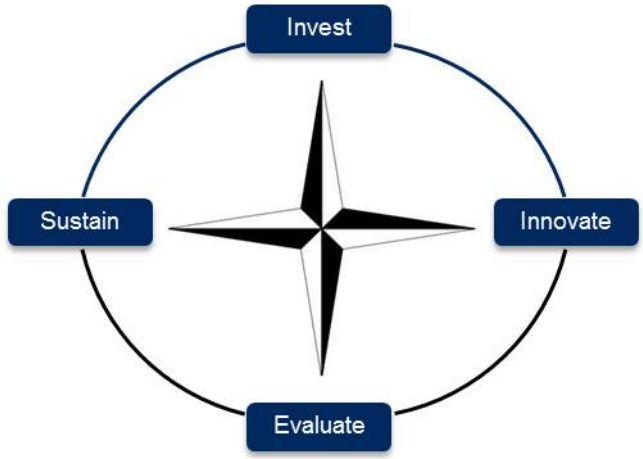
- Deeper investment in limited set of hospitals – competitive application process
  - **Multi-year, system or service line** transformations in **Commission-identified areas of focus**
  - **Testing models** of system transformation
- **Opportunities for 'all-play' engagements** – Pay for Success, or similar – non-competitive
- Close engagement between awardees and HPC

*Ongoing program development*

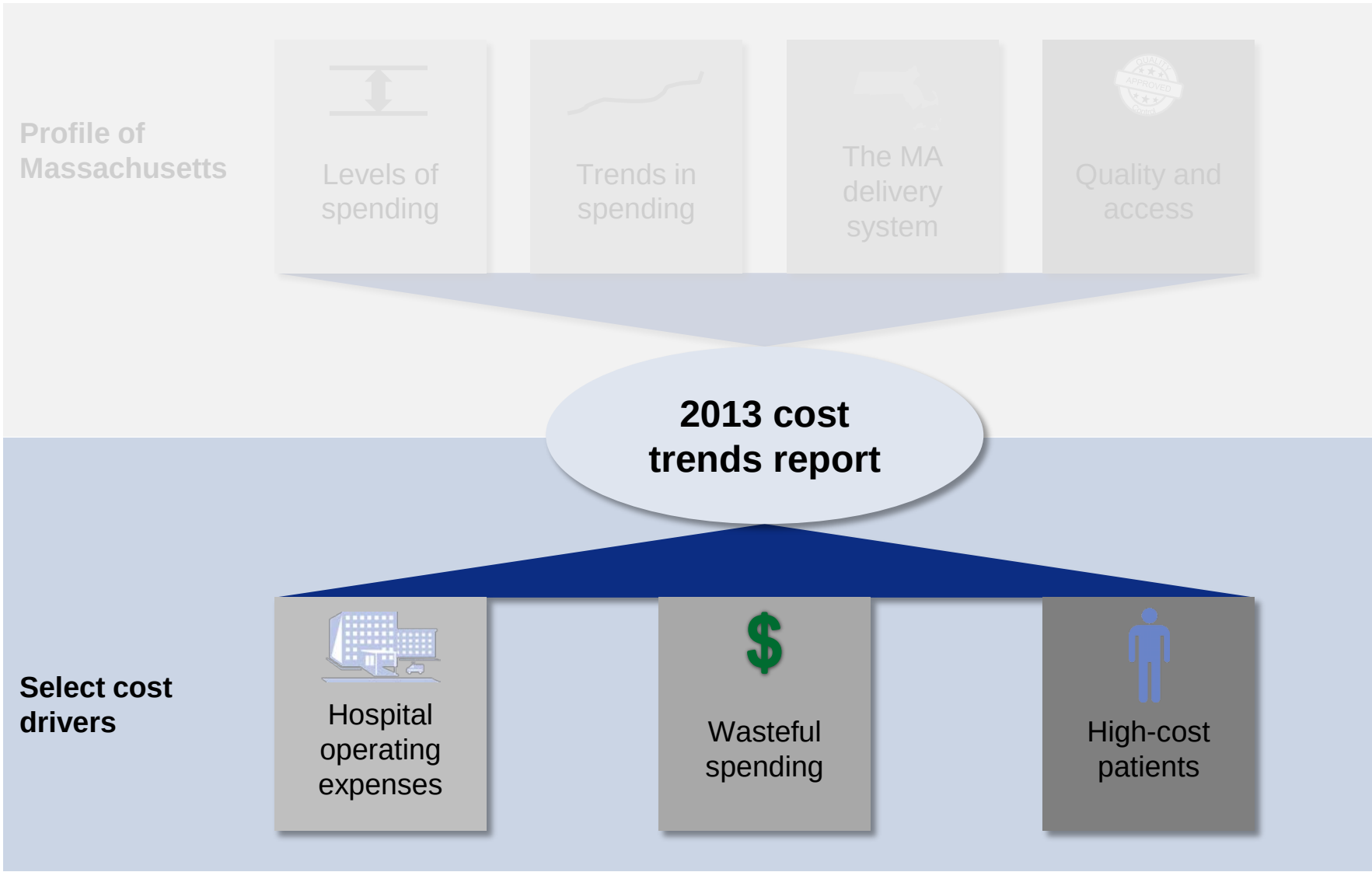
QI, Collaboration, and Leadership Engagement
Measurement & Evaluation
HPC Partnership with Awardees

# Key Decision Points for Phase 2

- Size of total opportunity
- Structure of tier(s) & caps
- Specificity of project focus
- Funding model(s)
- Ensuring accountability
- Leveraging partnerships
- Connection with future phases



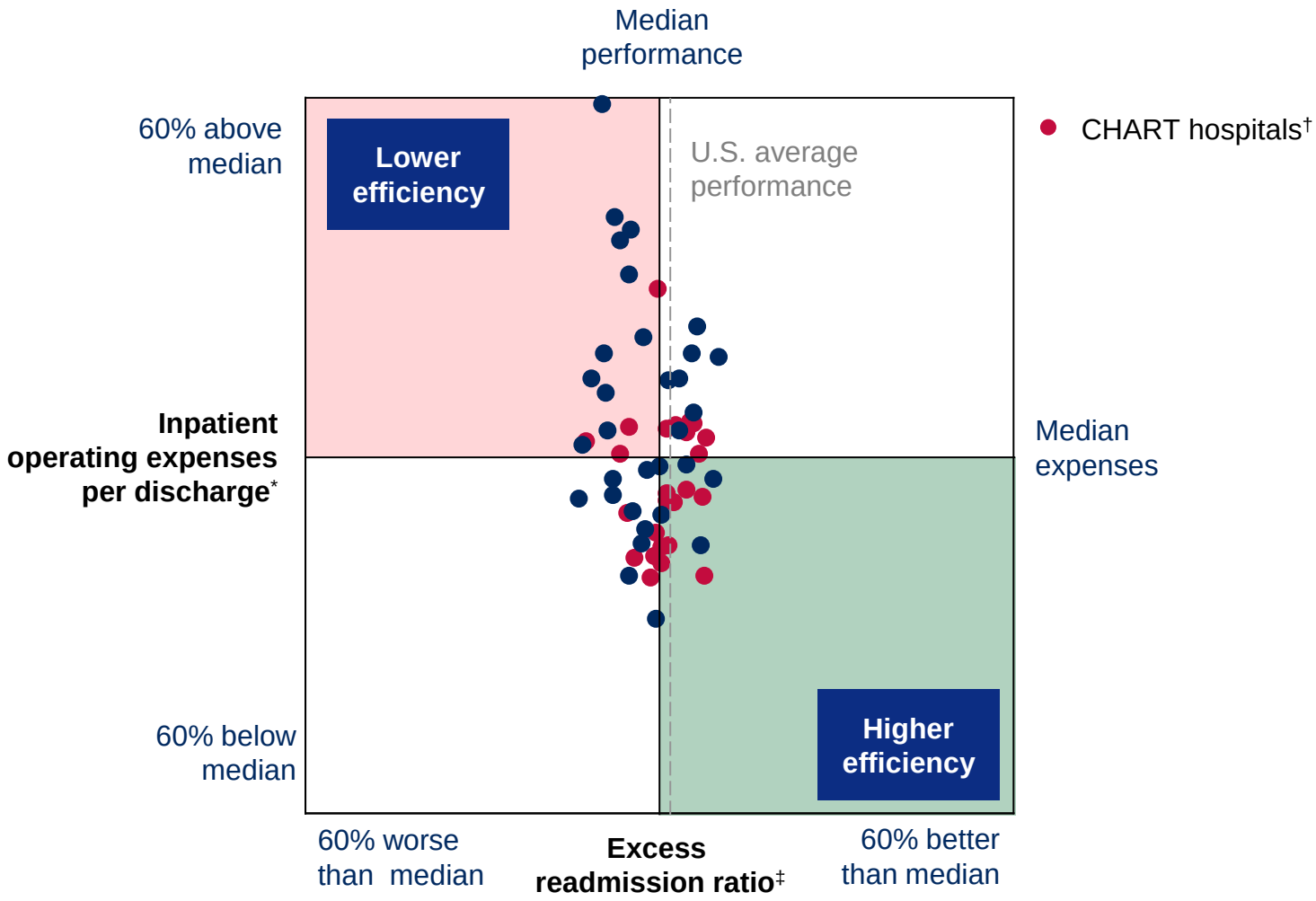
# The 2013 Cost Trends Report outlined a series of barriers to reform consistent with those identified in CHART development




**Source:** 2013 Cost Trends Report

# Quality performance relative to inpatient operating expenses per admission

## Excess readmission ratio versus dollars per case mix adjusted discharge*




* 2012 inpatient patient service expenses divided by inpatient discharges. Adjusted for hospital case mix index (CHIA 2011) and area wage index (CMS 2012).

† Athol Memorial Hospital and Shriners Hospital are not displayed, as data were not available for measures shown.

‡ Composite of risk-standardized 30-day Medicare excess readmission ratios for acute myocardial infarction, heart failure, and pneumonia (2009-2011). The composite rate is a weighted average of the three condition-specific rates.

**Source:** Center for Health Information and Analysis; Center for Medicare & Medicaid Services; HPC analysis

# The 2013 Cost Trends Report also describes a series of applicable remedies

## HOSPITAL OPERATING EXPENSES

## WASTEFUL SPENDING

## HIGH-COST PATIENTS

**What solutions could be applied by CHART hospitals to drive improvement across these domains?**

***(examples only)***

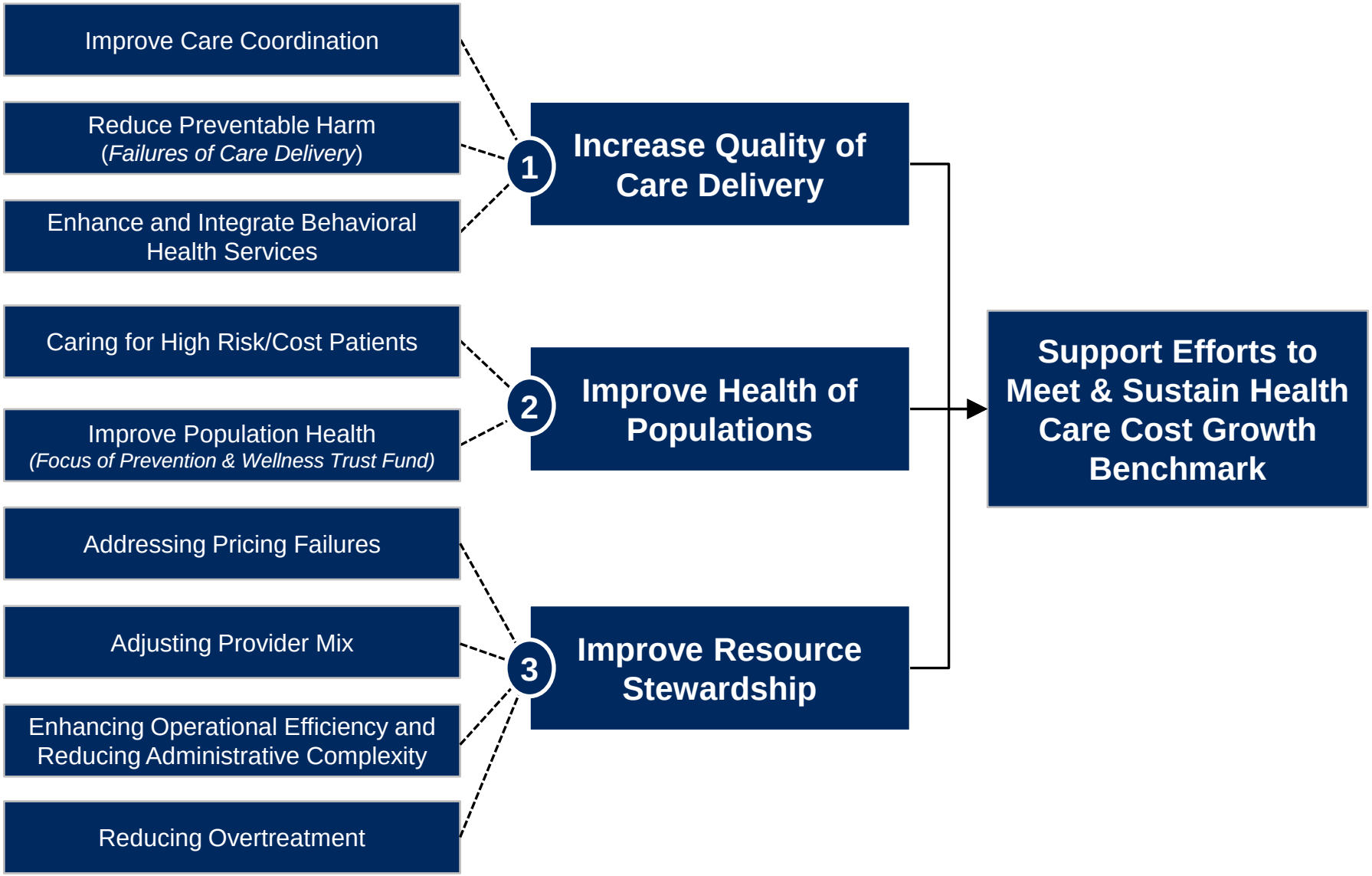
- Lean / Six Sigma *(general process improvement)*
- Time driven activity-based costing
- Implementing management best practices and coordinated leadership approaches
- Reducing administrative complexity

- Top-of-license work
- Reducing excessive Labor and Delivery spending (early elective deliveries; C-sections)
- Reducing Inappropriate imaging
- Reducing preventable harm
- Investing in Choosing Wisely initiatives

- Reducing inappropriate hospital use through care management / hot-spotting
- Ensuring access to and integration of behavioral health services
- Investment in analytics for identification of prevalence and modeling persistence

**Source:** 2013 Cost Trends Report

# Preliminary discussion of goal setting for Phase 2



# Preliminary Discussion of Scope of Phase 2

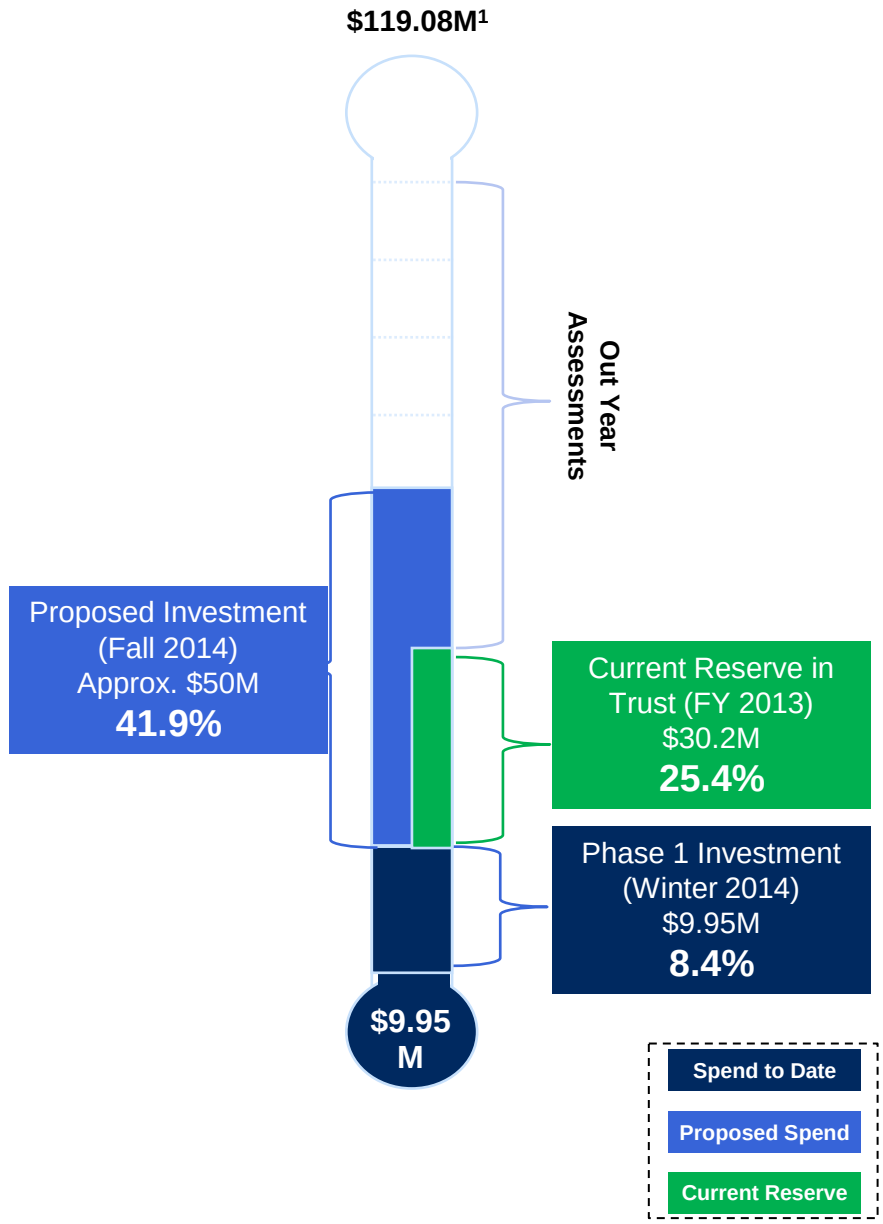
## Fund allocation and preliminary program structure

- Staff propose a **total funding of approximately $50M** with two tiers:
  - Large scale transformation awards: **multi-year awards** (highly selective):
    - *Innovative approaches to care delivery and hospital operations*
    - *Required parallel engagement in care delivery enhancement and operating efficiency improvement*
  - Focused intervention awards: **multi-year** awards (numerous):
    - *Evidence based models, clinical or operational*
    - *Potential opportunity for pooled investments across awardees (e.g. regional investments*
- **Funds flow should promote accountability** through one or more payment models, including, e.g., P4P (milestone based process or outcome payments), shared savings, etc.
- A central theme should be **community-focused, collaborative approaches** to care delivery transformation

# Next Steps

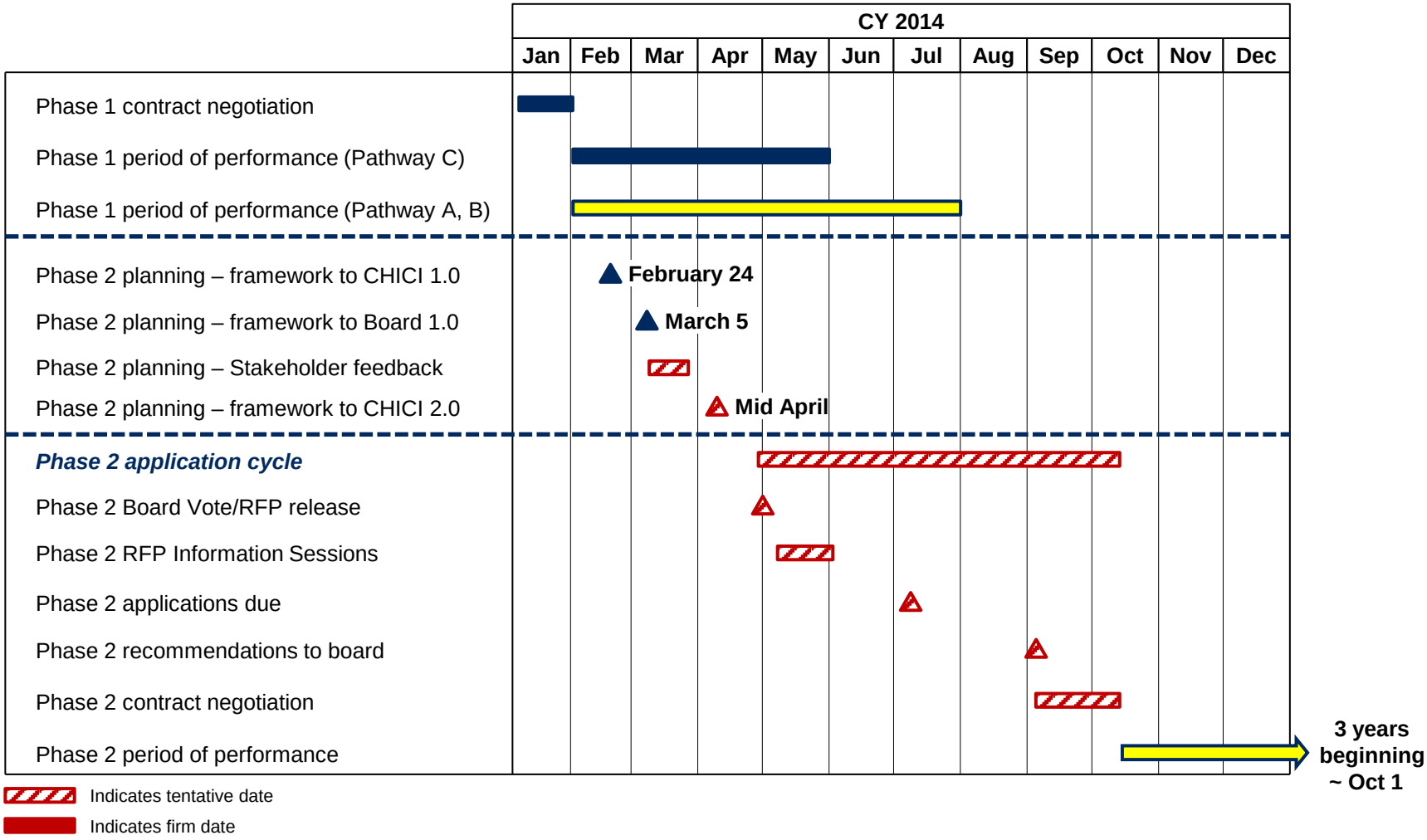
## Staff activities and Committee engagement

- Staff to continue developing Phase 2 framework, including:
  - Increased specificity of tiers
  - Comprehensive analysis of CHART communities and hospitals
  - Adapting administrative framework to early lessons learned from Phase 1
  - Evaluating evidence base regarding potential payment models
- Staff to present updated framework to Board for consideration in March, followed by stakeholder engagement process
- Staff to evaluate approaches to achieving economies of scale relative to CHART projects (e.g., centralized data analytics resources)
- Staff to conduct site visits with awardees early in Phase 1, to build strong relationships and engagement
- Staff to continue goal-setting activities, including framework of quantitative targets for Committee consideration




[1]Distressed Hospital Trust funding pool after mitigation for select health systems

# CHART Phase 1 and Phase 2 timeline



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# Contact Information

For more information about the Health Policy Commission:

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