Health Policy Commission

Board Meeting

May 22, 2014

Agenda

- Approval of Minutes from April 16, 2014 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Cost Trends and Market Performance
- 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 April 16, 2014, as presented.

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- **Care Delivery and Payment System Transformation**
  - Update on Patient-Centered Medical Home Certification Program
  - Update on Registration of Provider Organization Program
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HPC approach to PCHM certification

- Focus on high-value elements
  - Behavioral health integration
  - Population health
  - Resource stewardship

- Create a streamlined certification process that minimizes practice and provider burden while ensuring practices fully meet standards for being a patient-centered medical home

- Include an on-site validation process for certifying practices

- Align measurement with MA payers other state/federal programs

- Ensure a meaningful PCMH program that fulfills Commonwealth obligations
  - Other state provisions tied to certification (e.g., potential for practices to get preferred contracting; Infrastructure & Capacity Building Grants RFR provides option for gap analysis toward certification)

- HPC evaluation of certification results to access impact and contribute to evidence-base and inform future efforts

- Based on public comment feedback, incorporate 2 adjustments to program design:
  - Include a fast track certification process for third-party accredited organizations to become HPC-certified (align focus areas with national standards – NCQA, JC, AAAHC, URAC)
  - Adopt a 2-tier certification pathway

Revised PCMH certification pathway

Integrated BH across all standards

Standard	Advanced (24 criteria)	Advanced Plus (12 criteria)
Care coordination	▪ Team-based care ▪ Care transition management ▪ Referral/specialty care tracking and follow-up ▪ Test tracking and follow-up	▪ Care coordination oversight ▪ Active and ongoing communication among care team
Enhanced access & communication	▪ Optimize timely access to the appropriate services ▪ Collaborative decision making ▪ End of life care/advanced care planning ▪ Self-care support ▪ Culturally and linguistically appropriate services ▪ System for inquiries and prescription refills	▪ Active patient engagement ▪ Support patient/family/caregiver self-management
Population health management	▪ Empanel all patients to PCP/care team ▪ Comprehensive health assessment ▪ Identify high-priority health conditions ▪ System for stratifying at-risk, high-risk, complex care patients ▪ Use care reminders for preventive/follow-up care	▪ Care management pathways appropriate to risk status ▪ Apply evidence-based guidelines to provide evidence-based population health care
Integrated clinical care management	▪ Integrated care planning for complex/high-risk patients ▪ Care management for complex/high-risk patients	▪ Utilize/integrate community-based resources to provide community supports and services for high-risk patients ▪ Use evidence-based, objective measures to assess and address cognitive, emotional, and behavioral functioning and monitor health status
Quality improvement infrastructure	▪ Use certified EHR (meet core requirements for MU) ▪ QI training, implementation, and demonstration ▪ Measure experience of care ▪ Demonstrate patient/family/caregiver engagement in QI	▪ Improve experience of care ▪ Improve clinical quality and utilization
Resource stewardship	▪ Monitor and track practice patterns and variations in care delivery within the practice ▪ Track over- and under-utilization ▪ Track and monitor preferred use of specialty care/ancillary services	▪ Implement waste reduction initiatives ▪ Address and implement protocols for use of specialty care/ancillary services

Process update

- Continue to revise & refine 2-tier certification pathway and definitions based on public and expert feedback
  - Principles for inclusion of criteria:
    - High-value
    - Evidence-based
    - Attainable for a wide variety of practices

- Further develop a simplified process for third-party accredited organizations to become HPC PCMH certified

- Continue to engage stakeholders on measurement and validation and release updated criteria and definitions

- Develop a plan to market, communicate, and promote HPC PCMH certification

- Clarify principles of and process for HPC certification prior to beginning of demonstration period

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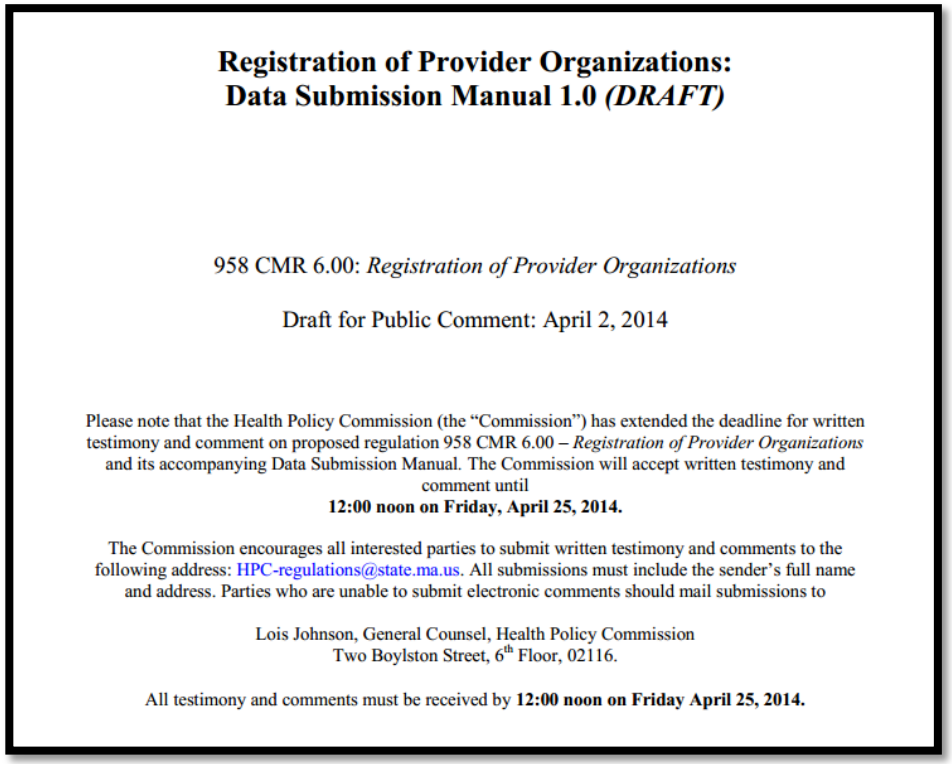
Release of Data Submission Manual

- HPC released a draft Data Submission Manual (DSM) for public comment on April 2, 2014
- The DSM describes each data element that RPOs will have to submit and the options that providers will have (e.g. manual entry, file upload) for submitting that information
- The DSM was developed through a collaborative process with other state agencies, including CHIA and DOI, as well as provider and payer stakeholders
- Stakeholders were encouraged to provide comment on the DSM in addition to their comment on the regulation during the public comment period



Registration of Provider Organizations:
Data Submission Manual 1.0 *(DRAFT)*

958 CMR 6.00: *Registration of Provider Organizations*

Draft for Public Comment: April 2, 2014

Please note that the Health Policy Commission (the "Commission") has extended the deadline for written testimony and comment on proposed regulation 958 CMR 6.00 – *Registration of Provider Organizations* and its accompanying Data Submission Manual. The Commission will accept written testimony and comment until
12:00 noon on Friday, April 25, 2014.

The Commission encourages all interested parties to submit written testimony and comments to the following address: HPC-regulations@state.ma.us. All submissions must include the sender's full name and address. Parties who are unable to submit electronic comments should mail submissions to

Lois Johnson, General Counsel, Health Policy Commission
Two Boylston Street, 6th Floor, 02116.

All testimony and comments must be received by **12:00 noon on Friday April 25, 2014.**

Summary of public comment

Public Comment Period: January 8 – April 25, 2014

- Public Comment period closed on Friday, April 25, 2014
- Feedback was solicited on proposed regulation and draft Data Submission Manual
- HPC received comment throughout the process, and has already incorporated some feedback received in early 2014
- 17 total comments received:

  - Atrius Health (2 comments)
  - Baystate Health
  - Beth Israel Deaconess Care Organization
  - Blue Cross Blue Shield
  - Boston Medical Center
  - Conference Of Boston Teaching Hospitals
  - Emerson Hospital
  - Lahey Health System
  - Mass Association of Health Plans
  - Mass Health Quality Partners
  - Mass Hospital Association (2 comments)
  - Mass Medical Society
  - Mass Society of Optometrists
  - Mount Auburn Hospital
  - Mount Auburn Cambridge Independent Practice Association
  - Steward Health Care System
  - Sturdy Memorial Hospital

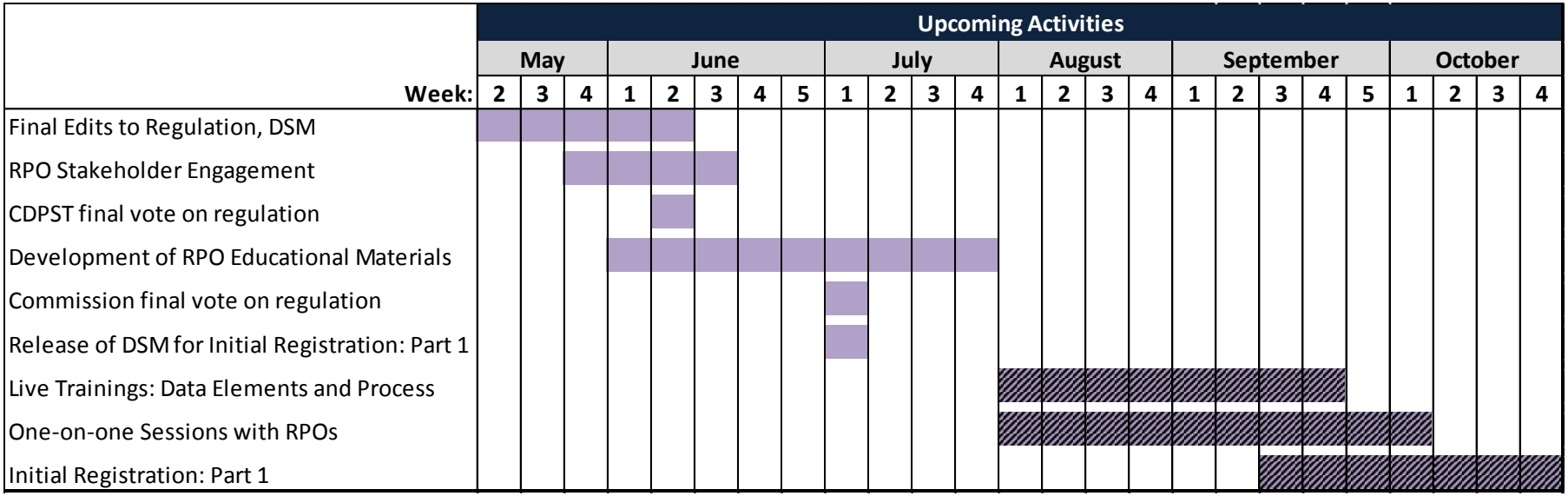
High-level themes in public comment

Comment	HPC Analysis
Broad support for HPC proposal to split Initial Registration into two stages	Phasing in requirements will minimize burden and confusion; Staff propose implementing this change in the final regulation
Requests for additional time to complete registration requirements	To ensure implementation of this new program is smooth, staff is considering optimal timelines to balance the need to move registration forward while giving providers ample time to complete submission
Requests for additional clarity, examples, and training from HPC	To ensure clarity and understanding, staff are developing a rollout approach which includes live trainings, webinars and one-on-one meetings with RPOs prior to Initial Registration: Part 1
Requests for addition of : • Appeals process • Process to request extension	Staff is considering amendments to the draft regulation relative to incorporating administrative processes for appeal of a denied registration and extension of time for submission of required materials
Questions regarding the types of changes that an RPO would have to report in-between biannual registration cycles	Staff is considering options for requiring notification of substantial changes that aligns with parallel filing requirements, e.g., any change triggering a Material Change Notice, any change requiring a Determination of Need filing, or any change affecting an essential service

High-level themes in public comment, continued

Comment	Analysis
Concerns about administrative burden	• Staff is working closely with CHIA and DOI to align processes and minimize duplication • Staff is working on identifying common variables used by other agencies and available information to link datasets automatically, thereby reducing the amount of information to be entered manually • Staff continues to develop templates that will allow for streamlined upload of large sets of information (e.g. lists of facilities) without manual entry • Staff continues to assess usefulness of developing forms or templates that large RPOs can use to solicit uniform information from their corporate and contractual relationships, when that information is not readily available • Staff continues to consider all suggestions on proposed formats, processes or question language that would make information easier to collect and will continue to coordinate with the provider community accordingly

Implementation timeline *(dates not finalized)*



- Development of RPO Submission Platform progressing on schedule
- Focus of summer months on providing training and education to RPOs:
  - Live trainings
  - Webinars
  - One-on-one meetings
- RPO Program is on track to receive Initial Registration: Part 1 materials in Fall 2014.
- Continued coordination with CHIA (RPO) and DOI (launch of RBPO) to ensure alignment

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Proposed framework for CHART Phase 2 investments

Robust public development process balanced diverse perspectives

- Reflects learning from many stakeholders, including:
  - market participants, including payers, providers, and purchasers
  - local and national content experts
  - diverse array of investors (private sector grant making/investment entities, other states and federal government, payers, etc)
  - HPC Advisory Council members
  - Extensive HPC Committee and Commission deliberation
- Reflects a strong basis in accountability with an early focus on evaluation
- Reflects the feedback of hospitals for precision of aims while allowing implementation flexibility
- Provides flexibility to optimize impact
- Promotes innovation and incentivizes regional partnerships, both among hospitals and with community based organizations

Key design elements for CHART Phase 2

1	**Size of total opportunity**	• **$50-60 million** total opportunity • Tiered, multi-year opportunities with awards stratified across hospitals
2	**Structure of tier(s) & caps**	• Hospital award cap of **$6M/2 years** tied to factors such as **community need, hospital financial status, financial impact, and patient impact**
3	**Specificity of project focus**	• **3 outcome-oriented project domains; behavioral health emphasized** • Required technology innovation and targeted strategic planning efforts
4	**Funding model(s)**	• **Initiation payment ($100K);** ongoing base payments for **milestones (at least 50%);** bonus payments for **achievement (up to 50%); required system contribution** where pertinent
5	**Ensuring accountability**	• **Standardized metrics** and streamlined reporting framework; strong continuation of **leadership/management/culture** development focus
6	**Leveraging partnerships**	• Appropriate **community partnerships** required (e.g., SNFs, CBOs, provider organizations, etc); **Joint hospital proposals** encouraged
7	**Requisite Activities**	• All awardees must engage in a series of **participation requirements** (joining Mass HIWay, participating in TA, evaluation, etc.)

Proposed CHART Phase 2 combines standardized aims with implementation flexibility

Goal: Supporting sustainable achievement of **health care cost growth benchmark**

CHART Phase 2: Driving transformation to accountable care

Aligned outcomes; flexible implementation	Emerging technologies	Strategic planning
• **Three standardized outcome-oriented aims** drive deep impact across the Commonwealth, with flexibility in hospital-specific implementation approaches and the overarching goal of transformation toward accountable care	• Minimum requirement of joining and using **MassHIway** • Emphasis on using **emerging technologies** to support and enhance achievement of outcome-oriented aims	• **Strategic planning requirement** to facilitate CHART hospitals' efforts to advance their ability to provide efficient, effective care and meet community needs in an evolving healthcare environment

Academic Medical Center-based health systems will be required to provide contributions to support project implementation in their community hospitals

Proposals will include **mechanisms** to address the aim, the **value proposition** to the hospital and to the Commonwealth, and **estimate of impact**. The detailed implementation work plan will be developed in the first 90-120 days

In Phase 2, hospitals propose mechanisms to meet specified aims, with the overarching goal to drive transformation toward accountable care

CHART Phase 2: Driving transformation to accountable care

Support sustainability of outcomes-based aims

Enhance impact of outcome-based aims

Outcome-based aims

Each hospital chooses one or more

Maximize appropriate hospital use	Enhance behavioral health care	Improve hospital-wide processes to reduce waste and improve safety
Maximize appropriate use of community hospitals through strategies that retain appropriate volume (e.g., reduction of outmigration to tertiary care facilities), reduce avoidable use of hospitals (e.g., PHM, ED use and readmission reduction, etc), and right-size hospital capacity (e.g., reconfiguration or closure of services)	Improve care for patients with behavioral health needs (both mental health and substance use disorders) in communities served by CHART hospitals, including both hospital and community-based initiatives	Reduce hospital costs and improve reliability through approaches that maximize efficiency as well as those that enhance safety and harm reduction

Emerging technologies

Connected health	Maximize use of effective or emerging technologies and innovative application of lightweight tools to promote efficient, interconnected health care delivery

Strategic planning

Strategic planning	Empower CHART hospitals to engage in long term (5-10 year) planning initiatives to facilitate transformation of community hospitals to meet evolving community needs; enhance efforts to sustain CHART Phase 2 activities

Example: Hospital combines programs to reduce unnecessary utilization with efforts to improve behavioral health and information connectivity

Each hospital's proposal for CHART Phase 2 is comprised of:

Hospital specific proposal activities
(Covers one or more CHART defined domains)

- **A** Maximize appropriate hospital use
- **A** Enhance behavioral health care
- *Improve hospital-wide processes to reduce waste and improve safety*
- **B** Connected health
- **C** Strategic planning

ILLUSTRATIVE PROPOSAL

A
- *Intervention:* Emergency Department-based High Risk Care Team links patients to community based providers (including PCMHs, behavioral health and other supportive services)
- *Target Population:* patients with 3 or more ED visits or hospitalizations in the last 12 months
- *Outcome:* reduced avoidable ED use and readmissions by 20% among served patients

B
- Development of Mass HIway use cases for exchange of info with local PCMH & PAC
- High need patients tagged in EHR
- Cloud based individualized care plan available to cross-continuum providers

C
- Strategic planning initiative to: 1) build sustainable community-based infrastructure to reduce ED use by high need patients and 2) address the fixed and variable cost impact of volume reduction on the hospital

Common activities
(All hospitals complete these)

- Awardees must complete a common set of requisite activities, supporting many domains of transformation, including, e.g.:
  - Operational Key Performance Indicator (KPI) Benchmarking
  - Mass HIway connection and use
  - Deep engagement in Executive Leadership Academy, management practice and culture-oriented activities, and potential learning collaboratives

Community collaboration will be a strong emphasis of all Phase 2 projects

Substantial selection preference will be given to applicants that partner with community-based organizations (CBOs) to provide appropriate services across the continuum of care. Partnerships may be formal or informal, financial or in-kind, new or a strengthening of an existing partnership

Partner Characteristics

Potential community-based partners will depend on the nature of the project, but may include: SNFs, home health agencies, ASAPs, physician practices, schools, public health agencies, community mental health centers, faith-based organizations, etc.

Key Characteristics

- Partners should be those entities with the most overlap with the hospital in caring for the target patient population (e.g., most common senders/receivers of patients)
- Partners should represent an opportunity for close collaboration between a CHART hospital and community providers caring for the patients it serves
- Partnerships should be established early to allow shared development of applications/intervention approaches

Partnership Examples

There are many examples in care delivery transformation models in which hospital-community collaboration is a critical factor (e.g., 3026 Community-based care transitions programs, STAAR, etc)

Examples

- Referring post-treatment chemo patients to community-based chronic disease services
- Using community-based patient navigators to identify and support high-risk patients (hotspotting)
- Making pharmacists available at the worksite to provide employees with medication therapy management,
- Linking elder services with clinical care providers to enhance care transitions

Hospital-hospital collaborative proposals are strongly encouraged

CHART hospital

Each CHART hospital may participate in up to 2 proposals (up to one of each type below)

Joint Applications

- Proposals with other hospitals (whether otherwise affiliated or non-affiliated)
- The joint application pathway is intended to facilitate collaboration across both affiliated and non-affiliated CHART hospitals. Joint applications may be an opportunity to maximize impact of community oriented projects or achieve efficiency through coordinated acquisition of tools/trainings, etc. One hospital should serve as the **primary applicant**
- **Examples**
  - A regional collaborative approach to identification and management of high-risk, high-cost patients
  - A coordinated approach to Lean Management through a shared training and support model that optimizes impact through shared analytics capacity
  - A regional or statewide bulk-purchasing collaborative that optimize impact through scale
  - A statewide approach to telemedicine in low-access settings that optimizes impact

Hospital-Specific Proposals

- One hospital
- The hospital-specific proposal allows an applicant to focus on unique needs of an individual institution, whether or not that hospital is also participating in a collaborative model.

The per hospital cap on grants of $6M will be cumulative across both proposals

Core Activities

"Each Awardee will be responsible for a series of participation requirements focused on supporting interconnectivity of health information, supporting collaboration and shared learning, enhancement of leadership and management practices, and evaluation."

- Joining and using the Mass HIway
  - Both Direct Messaging and Query & Retrieve services
- Strategic and operational planning
- Benchmarking of key performance indicators
- Coordinated use of tools, platforms, and approaches
- Learning, improvement, and diffusion
  - Continuation of the executive leadership program
  - Facilitate communication between Awardees and the HPC,
  - Provide opportunities for resources in areas of mutual challenge for Awardees, and
  - Enable best practice sharing within Awardee cohort

SOURCE: http://mehi.masstech.org/health-information-exchange-0/mass-hiway

Core Activities – strategic planning

"CHART hospitals may propose efforts to engage in strategic and operational planning to advance their ability to provide efficient, effective care and meet community need in an evolving healthcare environment"

- Phase 2 strategic planning will empower CHART hospitals to engage in long term (5-10 year) planning initiatives to facilitate revisioning the pathway necessary for transformation of community hospital to meet evolving community needs
  - Planning may be as limited as sustainability planning of CHART-funded activities
  - Planning may be bold and visionary, including:
    - shifting (increasing, decreasing, or changing) hospital service availability to meet community need
    - developing community-based approaches to care
    - developing models and partnerships to support accountability/bearing risk

Phase 2 application process

Approximate timeline		Application step	Parties involved
May 2014	1	Board Approval of RFR/Framework	HPC board
Jun 2014	2	RFP Release	CHART team
Jul 2014	3	Letter of Intent (Prospectus) Due	Interested Hospitals
Sep 2014	4	Full Proposal Due	
Oct 2014	5	Review & Selection	CHART team*
Oct 2014	6	Health Policy Commission Vote	HPC board
Nov 2014	7	Contracts Executed	CHART team
Dec 2014	8	90-120 Day Planning Period Begins	Grantees and CHART team
Feb 2015 – *Jun 2017*	9	Full Implementation begins (~2 years)	Grantees and CHART team

*Review & Selection includes Chair-designated Commissioners, HPC staff, and key content experts

Working framework for Phase 2 application process

The application process will occur in two steps, a short prospectus followed by a full proposal

Prospectus

The prospectus is intended to a be a brief (5-7 pages), directional and non-binding proposal giving the HPC insight into the applicant's proposed intervention, and allowing early feedback.

Key Elements

- Selected aim(s): *appropriate hospital use, behavioral health, process improvement*
- A description of nature and size of target population(s)
- A description of nature and scope of proposed intervention(s)
- A description of proposed partners
- An estimate of investment request and an estimate of net impact

HPC feedback

Full Proposal

The full proposal will include expanded details described in the prospectus, as well as select additional information.

Key Elements

- Qualitative and/or quantitative description of community or organizational need for intervention
- Description of target population, including numbers of patients, utilization patterns
- Description of intervention(s) for each aim and target population, estimated impact of strategy and a driver diagram describing the relation of interventions to aim (s)
- Impact/investment template with narrative detail

CHART Phase 2 award disbursement model

Funding model	▪ **Initiation** payment; ongoing base payments for **milestones**; segment of payments for **achievement** (e.g., process and outcomes)
Award caps	▪ Hospitals may apply for **up to $6M** ▪ Hospital-specific awards tied to factors such as **community need, hospital financial status, financial impact, and patient impact** ▪ Hospitals may apply for **up to $100,000** over two years to support meeting **HIWay implementation requirements** ▪ Hospitals may apply for up to **$250,000** to support **Strategic Planning requirements**. – Scope expectations will be commensurate with award size
Initiation Payment	▪ Hospitals will receive a **flat $100,000 initiation payment** at the time of contract execution for the 90-120 day Operational Planning Period
Strategy Payment	▪ Hospitals will receive strategic planning payments in **two lump sums,** 50% upon initiation of planning and 50% upon completion
Gate Payments	▪ **At least 50% of the balance** of each hospital's award will be segmented equally for quarterly milestone based **'gate' payments**
Achievement Payments	▪ **Up to 50% of the balance of each hospital's award** will be segmented equally for biennial **achievement payments** (processes and outcomes); **level of risk will vary with size and impact of award**

Selection factors – Qualified Acute Hospitals as of May 22, 2014

Phase 2 eligibility list

- Anna Jaques Hospital
- Athol Memorial Hospital
- Baystate Franklin Medical Center
- Baystate Mary Lane Hospital
- Beth Israel Deaconess Hospital - Milton
- Beth Israel Deaconess Hospital - Needham
- Beth Israel Deaconess Hospital - Plymouth
- Circle Health - Lowell General Hospital
- Emerson Hospital
- Harrington Memorial Hospital
- Hallmark Health – Lawrence Memorial Hospital
- Hallmark Health – Melrose Wakefield Hospital
- Heywood Hospital
- Holyoke Medical Center
- Lahey Health - Beverly Hospital
- Lahey Health - Addison Gilbert Hospital
- Lawrence General Hospital
- Mercy Medical Center
- Milford Regional Medical Center
- New England Baptist Hospital
- Noble Hospital
- Shriners Hospital - Boston
- Signature Brockton Hospital
- Southcoast Hospitals Group - Charlton Memorial Hospital
- Southcoast Hospitals Group - St. Luke's Hospital
- Southcoast Hospitals Group - Tobey Hospital
- UMass Memorial – HealthAlliance Hospital
- UMass Memorial - Marlborough Hospital
- UMass Memorial - Wing Memorial Hospital
- Winchester Hospital

[1] *As calculated from calendar year 2012 CHIA data*

Selection factors

Selection and relative award of implementation grants should be tied to a variety of factors

- **Impact of the proposal (25 points)**
  - Measurable community/patient impact; alignment with hospital's aims for system transformation
  - Extent of potential for supporting future transformation activities (scale and sustainability)
  - Alignment and synergy with ongoing investments in the Commonwealth
- **Community need and engagement (25 points)**
  - Extent to which the proposal meets an identified geographic/population need
  - Relative community need (financial, socioeconomic, and health status)
  - Presence and strength of community collaborations (partnerships)
- **Hospital financial status and operational capacity (30 points)**
  - Applicant's financial health and payer mix, access to resources, and level of system contribution
  - Hospital Phase 1 performance, if applicable
  - Leadership and management (clinical and operational) engagement and capability
- **Financial return and cost efficiency of the proposal (20 points)**
  - Financial ROI of the proposal
  - Cost efficiency of the proposed budget

HPC community hospital study - background

From Community Hospital to Community Health

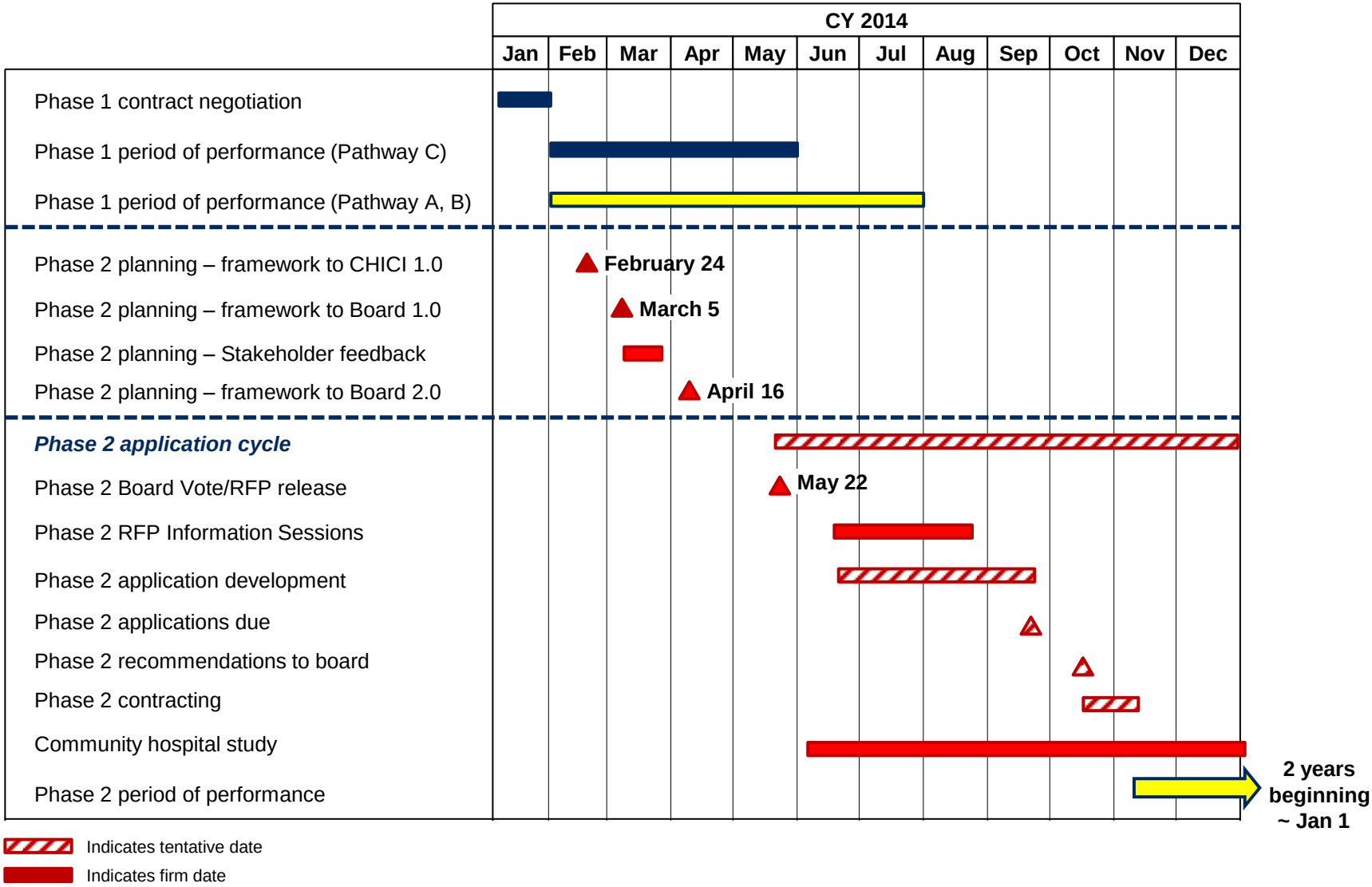
- Hospitals and health systems in Massachusetts are facing an unprecedented impetus to transform care delivery structures and approaches
  - Shifts in reimbursement models and funding pressures
  - Shifting demographics of Commonwealth's residents
  - General trend from inpatient to outpatient care
- No comprehensive set of vetted approaches exists to guide hospital transformation.
- Community hospitals, as small organizations, can be particularly sensitive to such change.
- Massachusetts is at the cusp of delivery system transformation, and effective, action-oriented planning is necessary to ensure that hospital resources are distributed to meet current and future community need
- Such analysis will support the HPC in sustainable achievement of the health care cost growth benchmark and the CHART Investment program among other policy priorities; continued development of scope and approach of this study will be discussed at CHICI Committee, Commission, and Advisory Council meetings in coming months
- This study would be conducted in close coordination with the Secretary of EOHHS, Commissioner of DPH and the Health Planning Council to inform many areas of work in the Commonwealth, and will take into account feedback from stakeholders

HPC community hospital study – broad concept *(in development)*

From Community Hospital to Community Health: Goals

- To develop an action-oriented report on the future of community hospitals in Massachusetts, including analysis of baseline status, community need, and opportunity for community hospital transformation (with a toolkit to support overcoming common barriers to change)
  - To identify **challenges to transformation** in community hospitals
  - To examine the **experience of key stakeholders** to inform solutions to these challenges and identify innovations that can work in the Commonwealth to help the **CHART program drive transformation** in an eligible community hospital
  - To identify and develop resources and approaches that support hospitals' **Phase 2 strategic planning efforts**
  - To support HPC funding prioritization and hospital proposals for **future phases of CHART**
  - To conduct an analysis of acute care supply and to **identify opportunities to right-size capacity** through the CHART program and other policy approaches

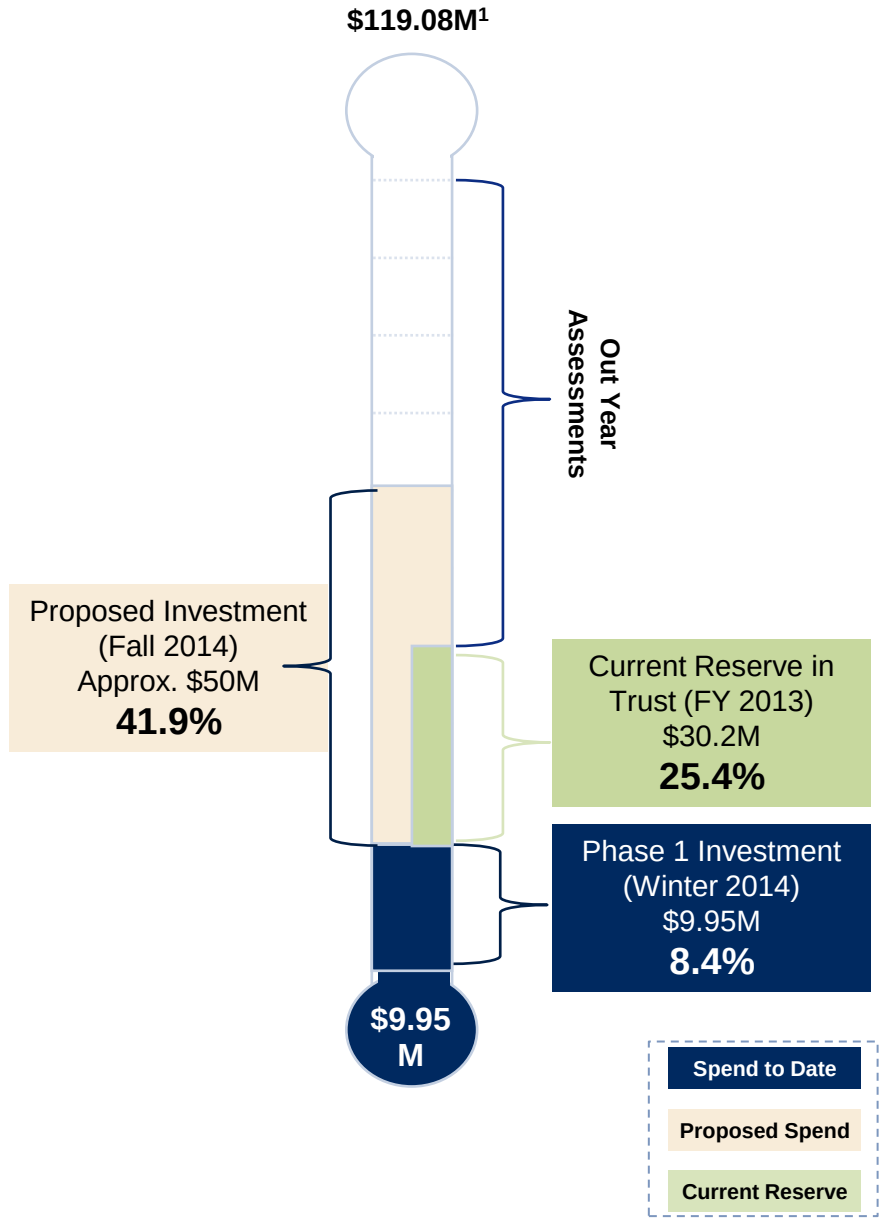
CHART Phase 1 and Phase 2 timeline



Next Steps

Staff activities and Committee engagement

- **Finalize RFP** and requisite application materials
- **Release RFP** in early June 2014
- **Finalize administrative protocols** for review and evaluation of applications
- Continue activities for engagement with applicants / awardees throughout the funding lifecycle and conclusion of Phase 1, to continue to **foster strong relationships** and **partnership**
- **Continue development of HPC capacity** to support operational implementation
- **Continue coordination of CHART activities with key partners** (e.g. Prevention and Wellness Trust Fund, Infrastructure and Capacity Building Grants, MeHI e-Health investments, SIM, etc.)
- Continued development of **community hospital study;** discussion at **next CHICI meeting**



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

Vote: Authorizing the Issuance of a RFP

Motion: That the Commission hereby authorizes the Executive Director to issue a Request for Proposals (RFP) for Phase 2 of the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program, in accordance with the framework described to the Commission, pursuant to 958 CMR 5.04.

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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	8	32%
Acute hospital acquisition	6	24%
Clinical affiliation	4	16%
Change in ownership or merger of owned entities	3	12%
Acquisition of post-acute provider	2	8%
Formation of contracting entity	2	8%

Note: May not sum to 100% due to rounding

Pending Notices

Pending decision
Description
Acquisition of Wing Memorial Hospital by Baystate Medical Center
Merger of Merrimack Valley Hospital into Steward Holy Family Hospital
Contractual affiliation between Beth Israel Deaconess Care Organization and Lawrence General Hospital
Formation of an accountable care organization by Boston Medical Center (BMC) and five community health centers affiliated with BMC

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  - Material Change Notices
  - **Final Report on Cost and Market Impact Review**
- Schedule of Next Commission Meeting

Lahey-Winchester Cost and Market Impact Review

Preliminary Report & Response

- Preliminary Report on Lahey-Winchester transaction issued April 16, 2014.
- Written response from Lahey and Winchester received on May 1.
- HPC analyzed the parties' response.
  - Discussed the response with the parties.
  - Reviewed with our experts.
  - Incorporated feedback from Commissioners.

Final Report

- The HPC now issues this Final Report, which reflects consideration and analysis of the parties' response.
- The parties' response and the HPC's analysis of that response are attached as Exhibits A and B to the Final Report.
- Based on our analysis and the parties' written response, the HPC declines to refer its CMIR review to the Massachusetts Attorney General's Office.
- The proposed transaction may not be finalized until 30 days after issuance of the Final Report.

Final Report: Key Findings

Cost Impact: For the four major commercial payers studied, we modeled cost savings of up to $2.7 million per year as a result of potential decreases in WPA physician prices and shifts in utilization from higher-priced hospitals to Lahey facilities. However, these savings depend on the resulting system not raising its prices relative to other providers, or adding facility fees.

Care Delivery Impact: The parties' stated plan to improve clinical quality through the exchange of best practices demonstrates potential for improving care delivery and health outcomes. However, given Lahey and Winchester's strong overall quality performance, and their established experience managing populations through risk-based payments, it is unclear how this transaction is instrumental to raising their existing care delivery performance.

Access Impact: Lahey proposes to integrate behavioral health services into some Winchester physician practices in 2015. At the same time, Lahey and Winchester have not proposed specific changes in hospital services that would cause the HPC to anticipate changes to their existing inpatient service mix and payer mix trends.

Two Concerns from the Preliminary Report

Market Leverage

- The merger of two financially strong direct competitors may reinforce the market strength of the resulting system, increasing the system's ability over time to leverage higher prices and other favorable contract terms in negotiations with commercial payers.

Facility Fees

- If Lahey adds or increases facility fees for Winchester's outpatient or ancillary services, total medical spending will increase.

Market Leverage

Parties' Response:

- The parties generally agree with the HPC's conclusion that market concentration will increase moderately, indicating a potential for (but not a presumption of) increased market leverage to raise prices.
- The parties emphasize this potentiality is offset by two considerations:
  - The parties' own business model, which is premised on being the lower-priced, high-quality option; and
  - The realities of a marketplace with increased transparency and oversight, particularly under Chapter 224.

Parties' Commitment to Health Care Market Transparency:

- The parties have reiterated their commitment to full cooperation with the HPC as we monitor their progress toward the goals of this transaction.
- We look forward to working together to provide greater transparency and accountability regarding the performance of the Massachusetts health care market, including, e.g.:
  - Requesting testimony in connection with the HPC's annual cost trends hearings
  - Working with providers to implement performance improvement plans
  - Conducting future CMIRs

Facility Fees

Parties' Response

- The parties affirm that "Lahey has no plans to convert WPA outpatient physician practices or Winchester freestanding facilities to hospital-based practices post-acquisition."

Parties' Commitment to Health Care Market Transparency

- It will be important to verify that billing for Winchester's joint venture services is included in the parties' commitment not to add or increase facility fees.

Final Report: Conclusion

Based on our analysis, the findings in the Final Report regarding the parties and the proposed transaction, and the parties' written response, the HPC declines to refer the Final Report to the Massachusetts Attorney General's Office pursuant to MASS. GEN. LAWS c. 6D.

Vote: Issuance of a Final Report for Cost and Market Impact Review

Motion: That pursuant to section 13 of chapter 6D of the Massachusetts General Laws, the Commission hereby approves and authorizes the issuance of the attached final report on the cost and market impact review of the proposed acquisition of Winchester Hospital by Lahey Health System.

Agenda

- Approval of Minutes from April 16, 2014 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Cost Trends and Market Performance
- **Schedule of Next Commission Meeting (July 2, 2014)**

Contact Information

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