The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

DANIEL TSAI
Assistant Secretary for
MassHealth

Tel: (617) 573-1600
Fax: (617) 573-1891
www.mass.gov/eohhs

March 16, 2016

Chairman Stephen M. Brewer
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133

Chairman Brian S. Dempsey
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Dear Chairman Brewer and Chairman Dempsey:

Appropriation 1595-1067, *Delivery System Transformation Initiatives Trust Fund*, provides incentive payments to eligible hospitals for delivery system transformation activities as approved under MassHealth's section 1115 Demonstration waiver. In accordance with this line item, I am writing to report on: (i) the payments made to each hospital; (ii) the investments each hospital has made with this funding; and (iii) the hospitals' performance on the quality measures assessed under the Delivery System Transformation Initiatives program. This report will focus on the progress made in state fiscal year (SFY) 2015, as the original report submitted in July 2014 focused on SFY 2013 and 2014.

I. Overview of Delivery System Transformation Initiatives

Delivery System Transformation Initiatives (DSTI) is an incentive payment program to support eligible safety net hospitals' investments in delivery system transformation initiatives that aim to enhance the quality of care, improve population health, and lower health care costs. In addition, DSTI supports these safety net providers' investments in the infrastructure and capacities necessary to participate in alternative payment arrangements that hold providers accountable for the quality and cost of care. DSTI was originally authorized under MassHealth's section 1115 Demonstration Waiver for SFY 2012-2014, and was renewed under the current 1115 Waiver for SFY 2015-2017.

Up to $690.9 million in incentive payments are available to participating hospitals over three years during the current reauthorization period (SFY2015-2017). In order to earn DSTI payments, each hospital must meet the performance goals outlined in its three-year transformation plan as approved by

the Executive Office of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS). DSTI is jointly supported by the Commonwealth and CMS.

When DSTI was developed, the hospitals deemed eligible to participate were those Massachusetts acute hospitals with a payer mix where the proportion of the hospital's revenues from Medicaid was at least one standard deviation above the statewide average and the proportion of the hospital's revenues from commercial payers was at least one standard deviation below the statewide average. Based on these criteria, seven hospitals qualified to participate in DSTI. These are:

1. Boston Medical Center
2. Cambridge Health Alliance
3. Holyoke Medical Center Inc.
4. Lawrence General Hospital
5. Mercy Medical Center
6. Signature Healthcare Brockton Hospital
7. Steward Carney Hospital

MassHealth's most recent 1115 Demonstration renewal, which included authority for DSTI, was approved on October 30, 2014. In 2014 and 2015, MassHealth worked with CMS and participating hospitals to update the existing "Master DSTI Plan" and hospital-specific plans, outlining a set of transformation projects and associated performance metrics within each of the following categories:

1. Development of an integrated delivery system built on Patient-Centered Medical Home principles;
2. Implementation of innovative care models to improve quality of care and health outcomes;
3. Development of capabilities necessary to implement alternative payment models;

4A. Outcomes and improvement measures related to category 1-3 projects; and

4B. Population-focused health outcome improvements.

Each participating hospital selected at least six projects from the Master DSTI Plan with associated milestones and metrics by which hospital performance would be measured. Many hospitals are continuing projects started in the first DSTI period, with the expectation that these projects would need to expand and build upon the work that had already been accomplished. Hospitals also added new projects. A significant addition to the DSTI program involved the incorporation of robust outcome and improvement measures (categories 4A and 4B). By SFY 2017, 20 percent of DSTI funding will be at risk based on the hospitals' performance on these measures.

CMS approved the Master Plan and hospital-specific plans on October 30, 2015, and hospitals received their first payments for hospital plan approval under the new waiver in November 2015. Hospitals received payments for achieving metrics associated with SFY 2015 in November and December 2015. Hospitals report on their progress and receive incentive payments on a semi-annual basis, and MassHealth continues to work with the hospitals to track their progress and provide ongoing technical assistance as needed.

II. Hospital Payments To Date

Under the terms of the 1115 Demonstration, each hospital is eligible to earn a specified maximum amount of incentive payments. Each hospital is eligible for a share of the total $690.6 million pool according to the relative volume of care the hospital provides for MassHealth patients. Potential DSTI funding is allocated under the demonstration as follows.

Total Potential DSTI Funding By Hospital FY15-17				
	FY15	FY16	FY17	Total
	(all figures in millions)			
Boston Medical Center	$113.9	$113.9	$113.9	$341.7
Cambridge Health Alliance[1]	$49.3	$49.3	$49.3	$147.9
Holyoke Medical Center	$8.9	$8.9	$8.9	$26.7
Lawrence General Hospital	$15.8	$15.8	$15.8	$47.4
Mercy Medical Center	$16.7	$16.7	$16.7	$50.1
Signature Healthcare Brockton Hospital	$18.3	$18.3	$18.3	$54.9
Steward Carney Hospital	$7.0	$7.0	$7.0	$21.0
Total (millions)	$230.2	$230.2	$230.2	$690.6

To date, DSTI hospitals have received incentive payments associated with the achievement of metrics in SFY 2012, SFY 2013, SFY 2014, and SFY 2015. In the current DSTI term, all hospitals achieved all of the metrics for SFY 2015. The table below specifies the payments made to hospitals to date.

		DSTI Payments As Of February 2016								
		June 2012	August 2012	March-May 2013	August 2013	March 2014	September 2014	November 2015 (plan approval)	November and December 2015	Total (as of February 2016)
		(all figures in millions)								
Boston Medical Center		$51.8	$51.8	$43.5	$60.0	$26.9	$76.6	$25.8	$77.6	$414.1
Cambridge Health Alliance		$22.4	$22.4	$22.6	$22.2	$22.4	$22.4	$11.2	$33.6	$179.3
Holyoke Medical Center		$4.1	$4.1	$5.6	$2.5	$7.1	$1.0	$2.0	$6.1	$32.5
Lawrence General Hospital		$7.2	$7.2	$7.1	$7.3	$7.0	$7.3	$3.6	$10.8	$57.7
Mercy Medical Center		$7.6	$7.6	$8.0	$7.1	$6.9	$8.3	$3.8	$11.4	$60.8
Signature Healthcare Brockton Hospital		$8.4	$8.4	$8.7	$7.9	$8.5	$8.1	$4.1	$12.5	$66.8
Steward Carney		$3.2	$3.1	$2.0	$3.5	$3.0	$2.3	$1.6	$4.8	$23.6

[1] Cambridge Health Alliance (CHA), as a public institution, funds the non-federal share (50%) of its DSTI incentive payments through inter-governmental transfer. No General Funds are expended for CHA's DSTI payments.

Hospital									
Total (millions)	$104.7	$104.6	$97.6	$110.5	$81.9	$126.3	$52.3	$157.0	$835.3

III. Investments Supported By DSTI

Each participating hospital is required to undertake initiatives in each of four categories.

Category 1: Development of an integrated delivery system built on Patient-Centered Medical Home principles: Initiatives in this category focus on the foundational elements of delivery system change, including advancing the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include:

i. Investments in communication systems to improve information exchange and coordination between hospitals and medical home sites;
ii. Integration of physical and behavioral health care;
iii. Development of integrated care networks across the continuum of care;
iv. Investments in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Category 2: Improved Health Outcomes and Quality: Initiatives in this category focus on development, implementation and expansion of innovative care models which have the potential to make significant demonstrated improvements in patient experience, cost and care management. Examples include:

i. Implementation of Enterprise-wide Care Management or Chronic Care Management initiatives, which may include implementation and use of disease management registries
ii. Improvement of care transitions, and coordination of care across inpatient, outpatient, post-acute care, and home care settings
iii. Adoption of Process Improvement Methodologies to improve safety, quality, and efficiency

Category 3: Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability. Initiatives in this category focus on building the core capacities to participate successfully in alternative payment models in which providers assume accountability for the cost and quality of care, such as shared savings, shared risk, or global budget arrangements. Examples include:

i. Enhancement of Performance Improvement and Reporting Capabilities
ii. Development of enhanced infrastructure and operating and systems capabilities that would support new integrated care networks and alternative payment models to manage within new delivery and payment models
iii. Development of risk stratification capabilities/functionalities

Category 4A: At-risk outcomes and improvement measures related to category 1-3 projects. In this category, hospitals must choose at least six measures from an approved measure slate, of which at least two must be outcomes measures. In SFY15, hospitals reported their baselines on these measures. In SFY16, 10% of hospitals' payment will be at risk based on their performance on these measures, and in SFY17 12.5% will be at risk.

Category 4B: Population-Focused Improvements. In this category, hospitals report on a set of population-focused health outcome measures. In SFY15 and SFY16, hospitals track and

report their performance. In SFY17, 7.5% of hospitals' payment will be at risk based on their performance on these measures..

Each hospital selected a unique set of initiatives from among the categories above and submitted a hospital-specific three-year transformation plan to MassHealth and CMS for approval. All hospitals are required to participate in a Learning Collaborative to advance collective learning in the transformation process. A summary of each hospital's initiatives is provided below.

Boston Medical Center
Category 1: Development of a Fully Integrated Delivery System
1.1 PCMH and Behavioral Health Integration
Category 2: Improved Health Outcomes & Quality
2.1 Project RED Expansion: Improving Care Transitions
2.2 Open Access Clinic and Comprehensive Diabetes Management Program for High Risk Patients
2.3 Super Utilizers
2.4 Choosing Wisely
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 ACO Expansion
3.2 Participate in Learning Collaborative

Cambridge Health Alliance
Category 1: Development of a Fully Integrated Delivery System
1.1 Expand Patient-Centered Medical Home Model
Category 2: Improved Health Outcomes & Quality
2.1 System-Wide Expansion of Primary Care- Based System of Complex Care Management
2.2 Improve Care Transitions
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Population Health Management Capabilities
3.2 Elder Service Plan: Expand Model to Manage Care for complex, Dual Eligibles Patient Populations
3.3 Participate in Learning Collaborative

Holyoke Medical Center
Category 1: Development of a Fully Integrated Delivery System
1.1 Integrate Physical Health and Behavioral Health Medicines
1.2 Establish a Patient Call Center
Category 2: Improved Health Outcomes & Quality
2.1 Implement Improvements in Care Transition
2.2 Improve the Management of Patients with Identified Chronic Disease Diabetes
2.2Improve the Management of Patients with Chronic Disease Chronic Obstructive Pulmonary Disease (COPD)/Heart Failure (HF)
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Establish an Enterprise-wide Strategy for Information Management and Business Intelligence
3.2 Participate in a Learning Collaborative

Lawrence General Hospital
Category 1: Development of a Fully Integrated Delivery System
1.1 Develop Integrated Acute and Post-Acute Network across the continuum of care
1.2 Establish Health Data Exchange Capability to Facilitate Integrated Patient Care
Category 2: Improved Health Outcomes & Quality
2.1 Implement Improvements in Care Transitions
2.2 Clinical Pharmacy Program to Transform Medication Safety and Quality
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Develop an Integrated Care Organization to Enhance Capacity to Respond to Alternative Payment Systems
3.2 Develop Governance, Administrative, and Operational Capacities to Accept Global Payments/Alternative Payment
3.3 Participate in a Learning Collaborative

Mercy Medical Center
Category 1: Development of a Fully Integrated Delivery System
1.1 Integrating Primary Care into a Behavioral Health Hospital
Category 2: Improved Health Outcomes & Quality
2.1 Align New Organizational Structures, Human Systems and IT Infrastructure to Improve Health Outcomes and Quality
2.2 Develop Patient-Centered Care Transitions for Patients at the Highest Risk of Readmission
2.3 Develop Alternative Care Delivery Models for Patients Who Seek Non-Emergent Emergency Department Care
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Develop a Clinically-Integrated High-Value Network to Enhance Capacity to Respond to Alternate Payment Systems
3.2 Develop Administrative, Organizational and Clinical Capacities to Manage the Care of Complex Patient Populations
3.3 Participate in Learning Collaborative

Signature Healthcare Brockton Hospital
Category 1: Development of a Fully Integrated Delivery System
1.1 Depression Screening and Intervention for Patients with Chronic Medical Conditions through Integration of Physical and Behavioral Health
Category 2: Improved Health Outcomes & Quality
2.1 Chronic Disease Management: Blood Pressure Control in High Risk Populations
2.2 Improving Current Practices of Medication Reconciliation at Points of Transition of Care
2.3 High Risk Population Care Coordination Program
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Hospital-outpatient linked 360 Patient Care Management Program for Managed Care/Medicaid Patients
3.2 Risk Stratification to Reduce Readmissions in a Community-Based Integrated Delivery System
3.3 Participation in a Learning Collaborative

Steward Carney Hospital
Category 1: Development of a Fully Integrated Delivery System
1.1 Implement Patient Navigation Services
1.2 Integrate Physical and Behavioral Health
Category 2: Improved Health Outcomes & Quality
2.1 Enhance Patient Transitions
2.2 Implement Process Improvement Methodologies to Improve Safety, Quality, and Efficiency
Category 3: Ability to Participate in Alternative Payment Arrangements
3.1 Implement Global Payment Arrangements
3.2 Participate in a Learning Collaborative

I am grateful for your continued support of the MassHealth program and the DSTI program in particular. Please feel free to contact John May at 617-573-1763 should you have any questions about this report.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth

cc: EOHHS Secretary Marylou Sudders