COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

December 16, 2015

Board Meeting

Agenda

- Approval of Minutes from the November 18, 2015 Meeting
- Annual Executive Director's Report and Commissioner Reflections
- Cost Trends and Market Performance
- Quality Improvement and Patient Protection
- Care Delivery and Payment System Transformation
- Community Health Care Investment and Consumer Involvement
- Schedule of Next Meeting (January 20, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on November 18, 2015, as presented.

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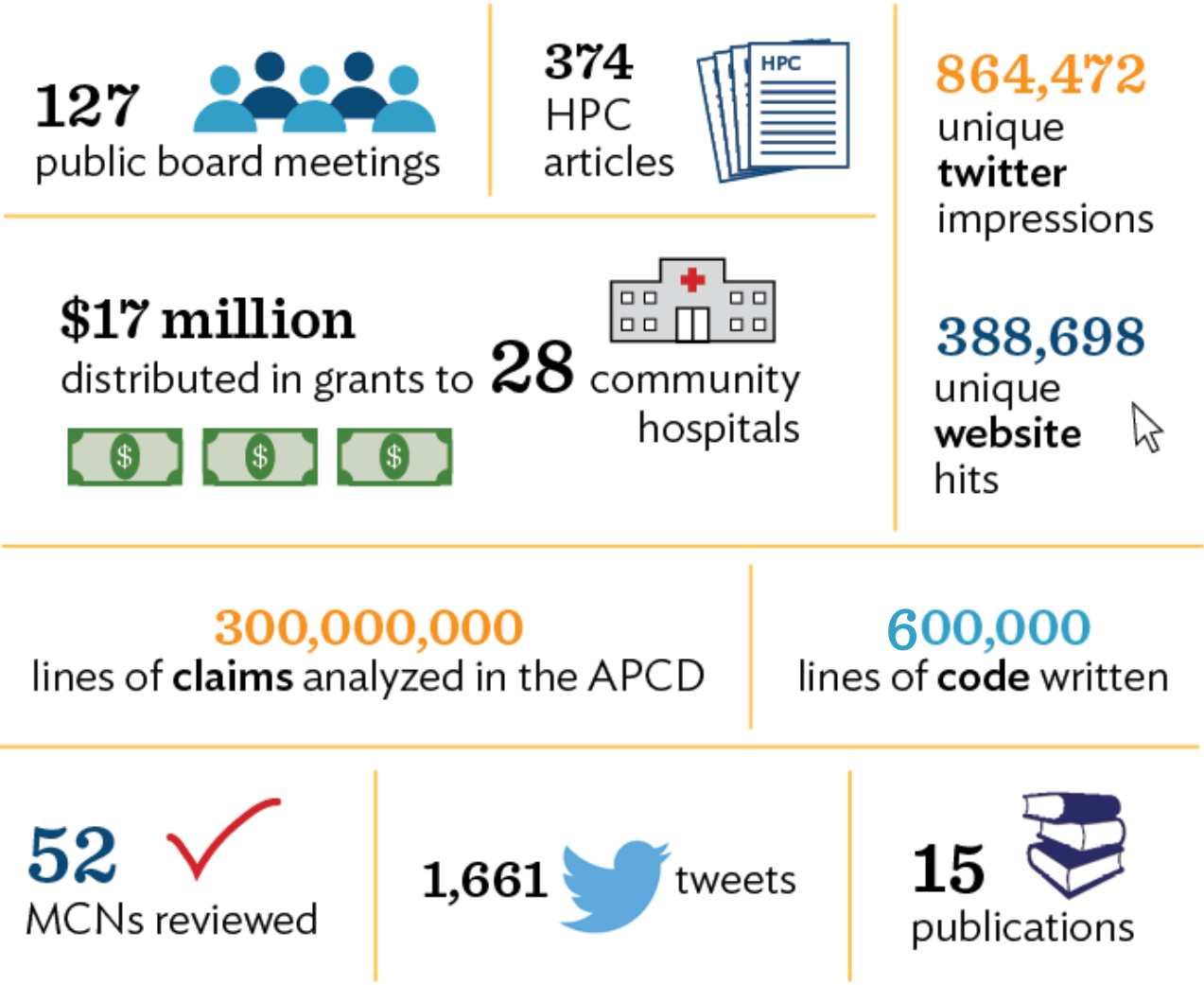
HPC by the Numbers: The First Three Years

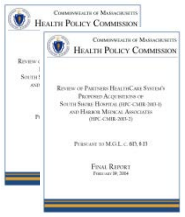


HPC by the Numbers: 2015 Policy Work

21
MCNs Reviewed

5
Reports Released

4
Regulations Approved



2
CMIRs Initiated

59
Registering Provider Organizations

1
Certification Program Finalized

30+
unique data sets in 2015 Cost Trends Findings

HPC by the Numbers: Investment Programs in 2015

CHART Investment Program

Phase 2 Implementation Planning Period
(28 hospitals)

TECHNICAL ASSISTANCE

1200 hours of coaching calls

71 working meetings/site visits

7 regional convenings

$500,000	Telemedicine Pilot
$100,000	PCP Narcan Training
$250,000	PCMH Behavioral Health Integration
$500,000	Neonatal Abstinence Syndrome Pilot
$1,250,000	Total Funding

Fiscal Year 2016 State Budget

Investment in the HPC

HPC by the Numbers: Consumer and Patient Support in 2015

In 2015, the Office of Patient Protection processed

3015

calls and emails from consumers seeking information on health insurance enrollment and appeals

325

External Review Cases filed by consumers seeking a determination of medically necessary

HPC by the Numbers: 2015 Cost Trends Hearing

4500+
attendees
550 in-person
4,000+ online

2
expert speakers

31
sworn witnesses from major payers & providers

70+
pre-filed testimony submissions

5
elected officials

HPC by the Numbers: Public Engagement in 2015

240,234
unique website hits

180
HPC articles

39
public meetings

1600+
attendees at public meetings throughout 2015

500+
meetings with over **100** different stakeholders

344
pages of minutes

14
newsletters

622
tweets

1
Completed Conference Center

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  - Update on Material Change Notices
  - Approval of Cost and Market Impact Reviews
  - Discussion of Preliminary Findings from the 2015 Cost Trends Report
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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group merger, acquisition or network affiliation	12	23%
Clinical affiliation	12	23%
Acute hospital merger, acquisition or network affiliation	11	21%
Formation of a contracting entity	9	17%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	5	9%
Change in ownership or merger of corporately affiliated entities	3	6%
Affiliation between a provider and a carrier	1	2%

Update on notices of material change

Notices Received Since Last Commission Meeting

- Clinical affiliation between Atrius Health (Atrius) and Massachusetts Eye and Ear Infirmary (MEEI) whereby MEEI and its affiliated physicians would become preferred specialty providers for Atrius clinicians.
- Joint venture between Shields Health Care Group and Partners HealthCare to operate a PET/CT diagnostic imaging clinic at Cooley Dickinson Hospital.

Elected Not to Proceed

- **Provider Partnership for Joint Contracting between Shields Health Care Group and Anna Jaques Hospital**
  - Our analysis indicated that this transaction would not likely result in substantial changes in volume or prices for PET/CT services at Anna Jaques Hospital, and therefore there was limited scope of increases to health care spending.
  - We did not find evidence suggesting negative impacts on quality or access to care.

Update on notices of material change (cont.)

Elected to Proceed with Cost and Market Impact Review (CMIR)

- **Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO), New England Baptist Hospital (NEBH), and New England Baptist Clinical Integration Organization (NEBCIO)**
  - NEBH and its affiliated physicians would become members of BIDCO beginning January 2016 and join BIDCO's commercial and public payer contracts
- **Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO) and MetroWest Medical Center (MWMC)**
  - MWMC would become a member of BIDCO beginning January 2016 and join BIDCO's commercial contracts; MWMC already participates in BIDCO's Pioneer ACO.

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Material Change Notice Review Process

Initial Review

- When the HPC receives a Notice, staff conduct a brief review and request any additional information required to complete the Notice.
- Once parties have responded and Notice is deemed complete, the HPC has 30 days to review the proposed transaction and inform the parties whether it merits further review.
- This 30-day review focuses on statutory factors for evaluating cost and market impact (e.g., changes to prices, total medical expenses and market share), to determine whether a proposed material change raises the potential for impacts to costs and market functioning that warrant examination and public consideration.

Proceeding to a CMIR

- If the HPC finds that the proposed transaction warrants further review, it provides notice to the parties that it is initiating a CMIR. The Commission then votes on whether to continue the CMIR at its next regular meeting.
- Of the 48 transactions for which the HPC has completed review, the HPC has conducted four CMIRs; it is proposing to continue two new CMIRs today.

Background on the parties

- **BIDCO** is an accountable care organization and clinically integrated payer contracting organization
  - Establishes contracts on behalf of members with commercial payers; also participates in the Pioneer ACO program
  - Includes 7 hospitals that collectively provide approximately 11% of all statewide discharges; second-largest share statewide
  - Includes approximately 2,400 physicians

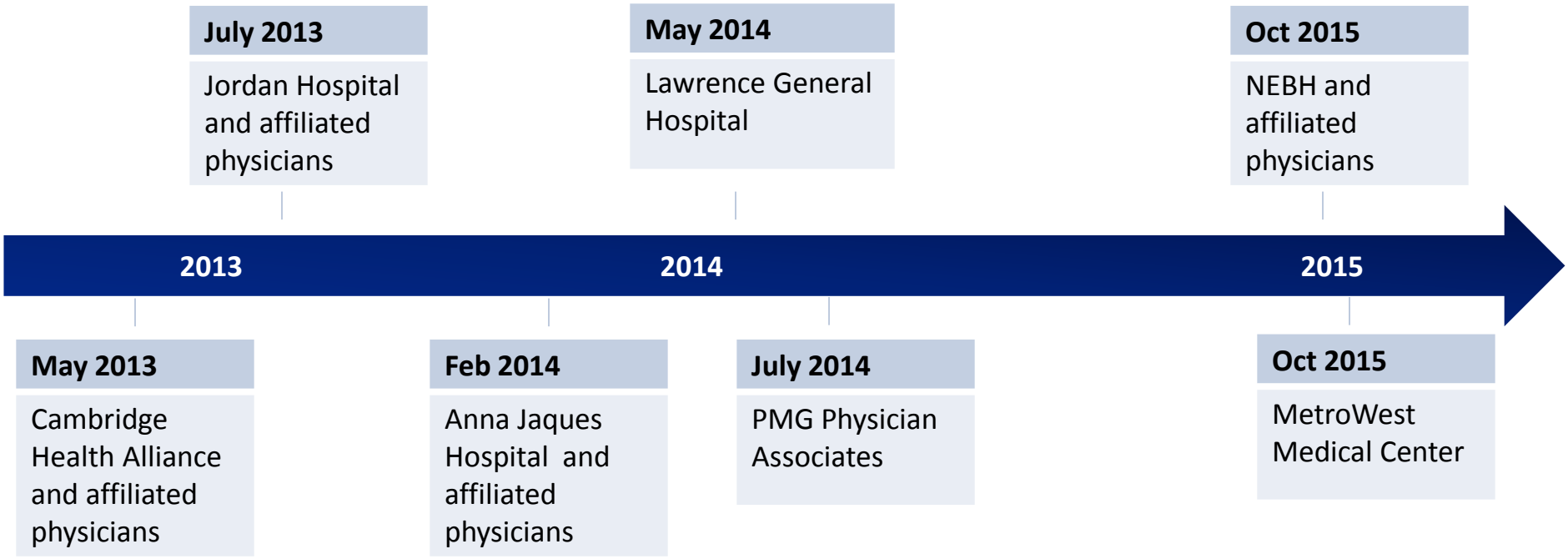
NEBH is an independent orthopedic specialty hospital; **NEBCIO** is its affiliated care management organization

- Non-profit specialty hospital with 118 beds, 5 outpatient locations, and affiliated physician group
- Specializes in orthopedic surgery and musculoskeletal diseases and disorders
- Teaching hospital affiliated with Tufts University School of Medicine; additional programs with the Harvard School of Public Health and Harvard Medical School
- Already clinically affiliated with Beth Israel Deaconess Medical Center and Harvard Medical Faculty Physicians (both members of BIDCO)

- **MetroWest** is a general acute care community hospital
  - For-profit community hospital with 284 beds at 2 campuses (Framingham and Natick)
  - Owned by Tenet Healthcare (purchased in 2013 along with St. Vincent Hospital)
  - Clinical Affiliate of Tufts Medical Center for tertiary services and Floating Hospital for pediatrics
  - Currently participates in BIDCO's Pioneer ACO

Growth of BIDCO since 2013

The HPC has received notice of 7 different BIDCO contacting affiliations, involving 6 hospitals and 5 physician groups since 2013



Basis and goals for reviews

- Over 2.5 years, the HPC has received 7 contracting affiliations involving BIDCO, involving 6 hospitals and 5 physician groups. The HPC's preliminary review of the two pending additional contracting affiliations raises important questions for review and public examination, including:
  - Potential for spending increases if contracted rates increase for NEBCIO physicians;
  - Potential for spending increases if Metrowest or NEBH hospital prices increase;
  - Potential for spending increases due to changes to referral patterns;
  - Potential for significantly increased market concentration in BIDCO's market share for inpatient services, as well as for orthopedic and musculoskeletal services in the service areas of NEBH, Metrowest, and the BIDCO hospitals; and
  - Potential impacts from NEBH's contracting exclusively through BIDCO on NEBH's standing as a high-quality, low-cost specialty provider in the market.

- At the same time, the parties describe plans to enhance care delivery and integrate clinical practices that they indicate will improve quality and lower costs.

- Conducting these CMIRs will enable us to objectively examine all aspects of the proposed transactions in order to better understand the impact of these transactions and the growth of the BIDCO system on costs and market functioning, including both the opportunities and challenges presented by the proposed changes.

Factors for review

The HPC will assess the potential impacts of the transactions based on a variety of statutory factors

A. The impact of the proposed transactions, considered in light of concurrent market developments, on **costs and market functioning** in Massachusetts, including:
   - Prices (e.g., for hospitals, physicians, and other providers, including fee-for-service, capitated, and other prices)
   - Total medical expenses ("TME")
   - Patient care referral patterns
   - Competing options for care delivery
   - Quality of and access to health care services

B. **Physician dynamics**, including the Parties' plans related to physician recruitment, compensation, and management

C. The Parties' **size and market position in the geographies they serve**, including market shares for relevant services

D. The Parties' **role in serving at-risk, underserved, and government payer populations**, and in **providing low- or negative-margin services**

E. The Parties' **plans for patient care management**, including the proposed integration of the Parties' clinical information systems, and the potential **impact of those plans on quality, costs, and market dynamics**

F. The impact of the proposed material change in light of **other prior and proposed health care transactions involving the parties**

G. Other factors concerning cost and market impact as the HPC may identify

Process for cost and market impact reviews

Inputs

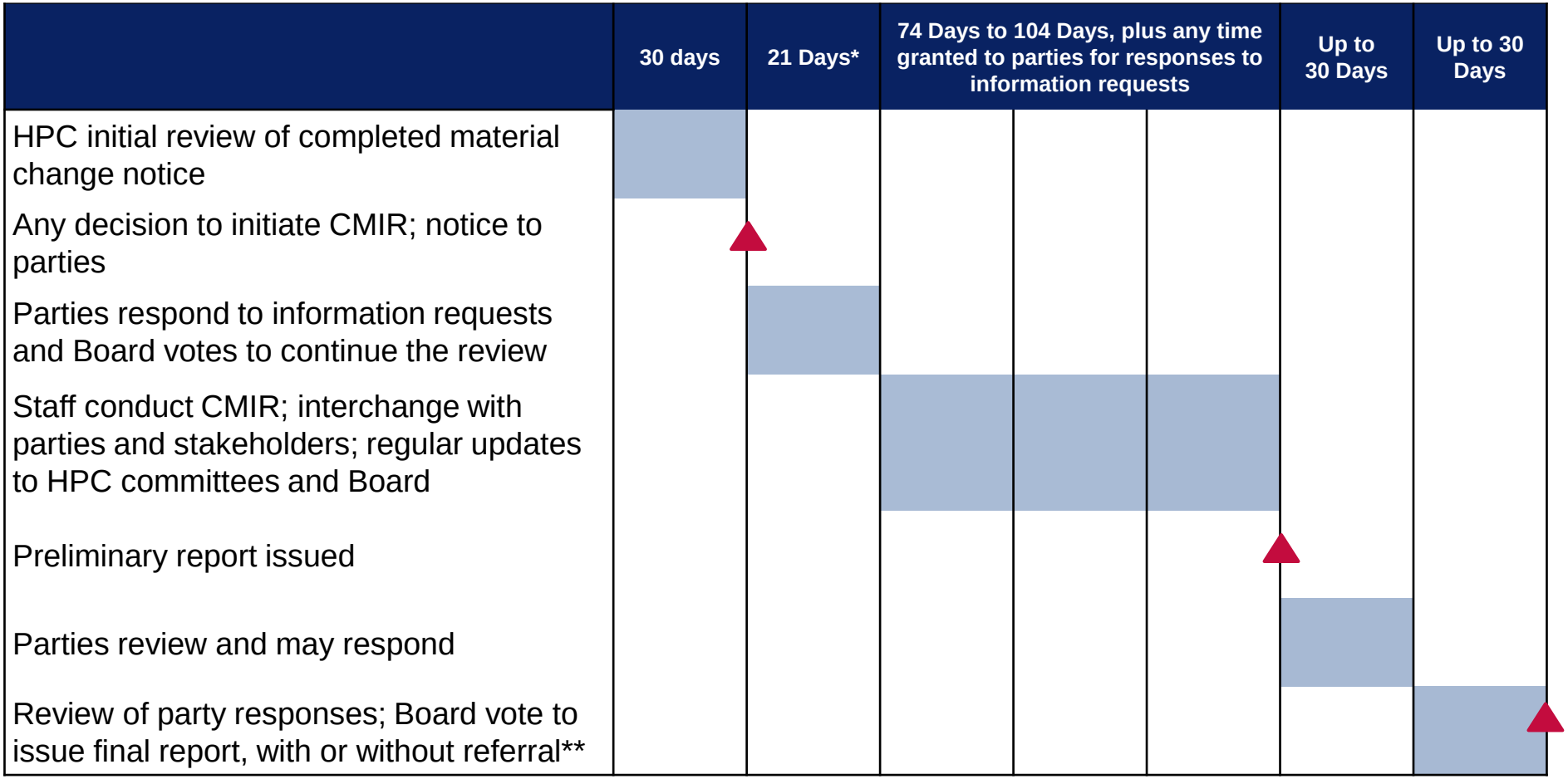
- Data and documents:
  - Parties' production
  - Publicly available information
  - Data from payers, providers, and other market stakeholders
- Support from expert consultants
- Feedback from Commissioners
- Information gathered is exempted from public records law, but the HPC may engage in a balancing test and disclose information in a CMIR report

Outputs

- Issuance of a preliminary report with factual findings
- Feedback from parties and other market participants
- Final report issued 30 or more days after preliminary report
- Proposed change may be completed 30 or more days after issuance of final report
- Potential referral to Massachusetts Attorney General's Office

CMIR process timeline

For these transactions, we intend to coordinate our reviews and to issue findings in a combined report (if the review timelines remain aligned)



*The parties may request extensions to this timeline which may likewise affect the timing of the report
**The parties must wait 30 days following the issuance of the final report to close the transaction

Vote: Authorizing the Continuation of CMIR #1

Motion: That the Commission hereby authorizes the continuation of the cost and market impact review of the proposed material change regarding the proposed contracting affiliation between Beth Israel Deaconess Physician Organization, LLC d/b/a Beth Israel Deaconess Care Organization, New England Baptist Hospital, and New England Baptist Clinical Integration Organization, LLC, pursuant to section 13 of chapter 6D of the Massachusetts General Laws and 958 CMR 7.00 et seq.

Vote: Authorizing the Continuation of CMIR #2

Motion: That the Commission hereby authorizes the continuation of the cost and market impact review of the proposed material change regarding the proposed contracting affiliation between Beth Israel Deaconess Physician Organization, LLC d/b/a Beth Israel Deaconess Care Organization and MetroWest Medical Center, pursuant to section 13 of chapter 6D of the Massachusetts General Laws and 958 CMR 7.00 *et seq*.

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2015 COST TRENDS REPORT

Massachusetts Health Policy Commission

Legislative mandate for HPC's annual cost trends report

Section 8g of Chapter 224 of the Acts of 2012

The commission shall compile an **annual report concerning spending trends and underlying factors**, along with any **recommendations for strategies to increase the efficiency of the health care system**. The report shall be based on the commission's analysis of information provided at the **hearings** by providers, provider organizations and insurers, **registration data** collected under section 11, **data collected by the Center for Health Information and Analysis** under sections 8, 9 and 10 of chapter 12C and **any other information the commission considers necessary to fulfill its duties under this section**, as further defined in regulations promulgated by the commission. The report shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include **any legislative language necessary to implement the recommendations**.

Required outputs

- **Annual report concerning spending trends and underlying factors**
- **Recommendations for strategies to increase efficiency**
- **Legislative language necessary to implement recommendations**

Data inputs

- **Hearings**
- **Registration data**
- **CHIA data**
- **Any other information necessary to fulfill duties**

Agenda

- **HPC Presentation**
  - Select findings concerning spending trends and underlying factors from the 2015 Cost Trends Report
- Board Discussion
  - Significance of findings
  - Recommendations for inclusion in the final report

Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
- Primary care access

Progress in aligning incentives

- APMs
- Demand-side incentives

Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
- Supporting efficient, high-quality care
- Advancing alternative payment methods, cultivating alignment
- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

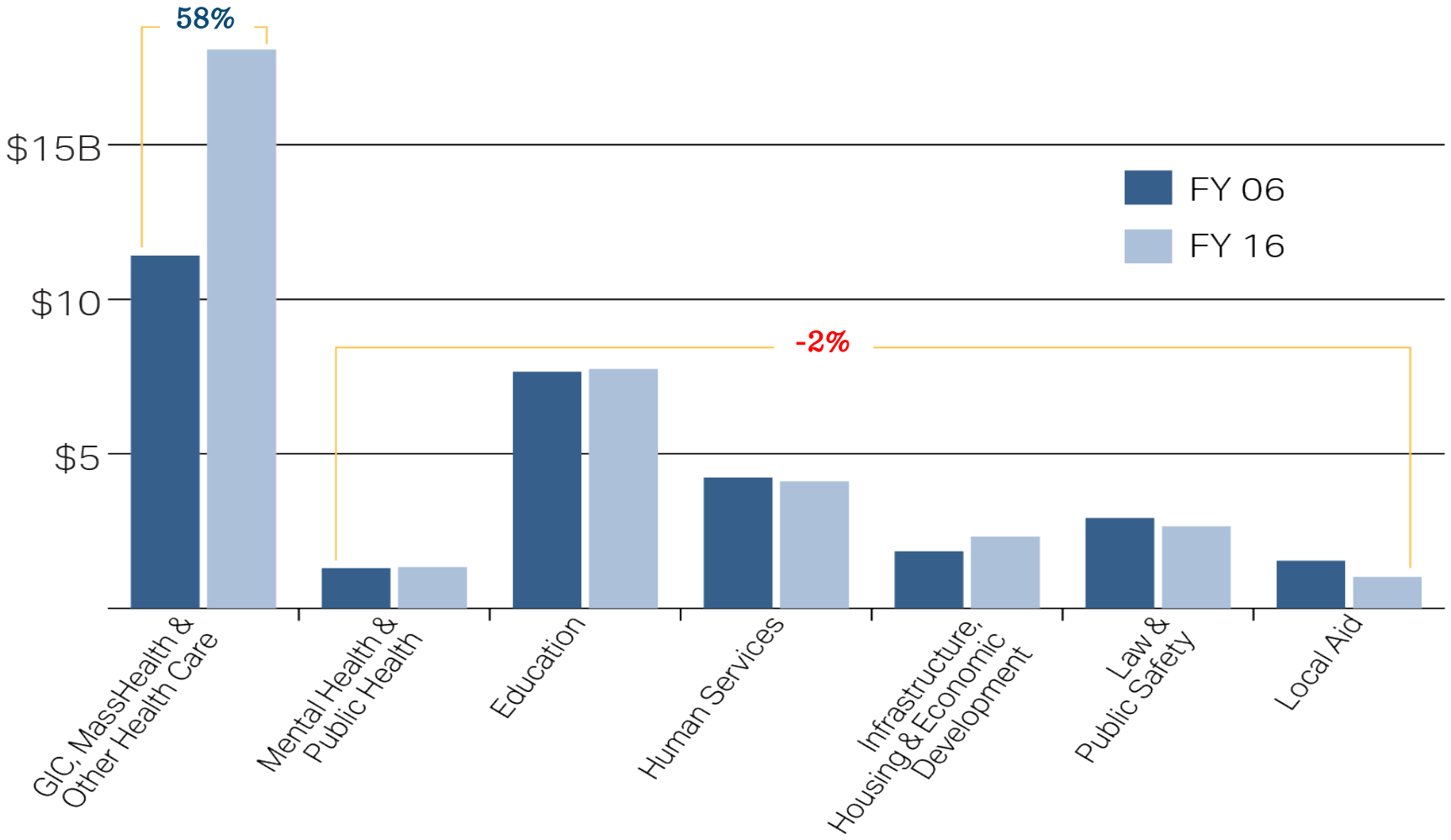
Opportunities to improve quality & efficiency

Progress in aligning incentives

- 2014 spending growth
- Prescription drug spending
- Hospital outpatient spending
- Trends in provider markets

Government health care spending crowds out other taxpayer-funded priorities

Inflation-adjusted budgeted dollars in Fiscal Year, in billions

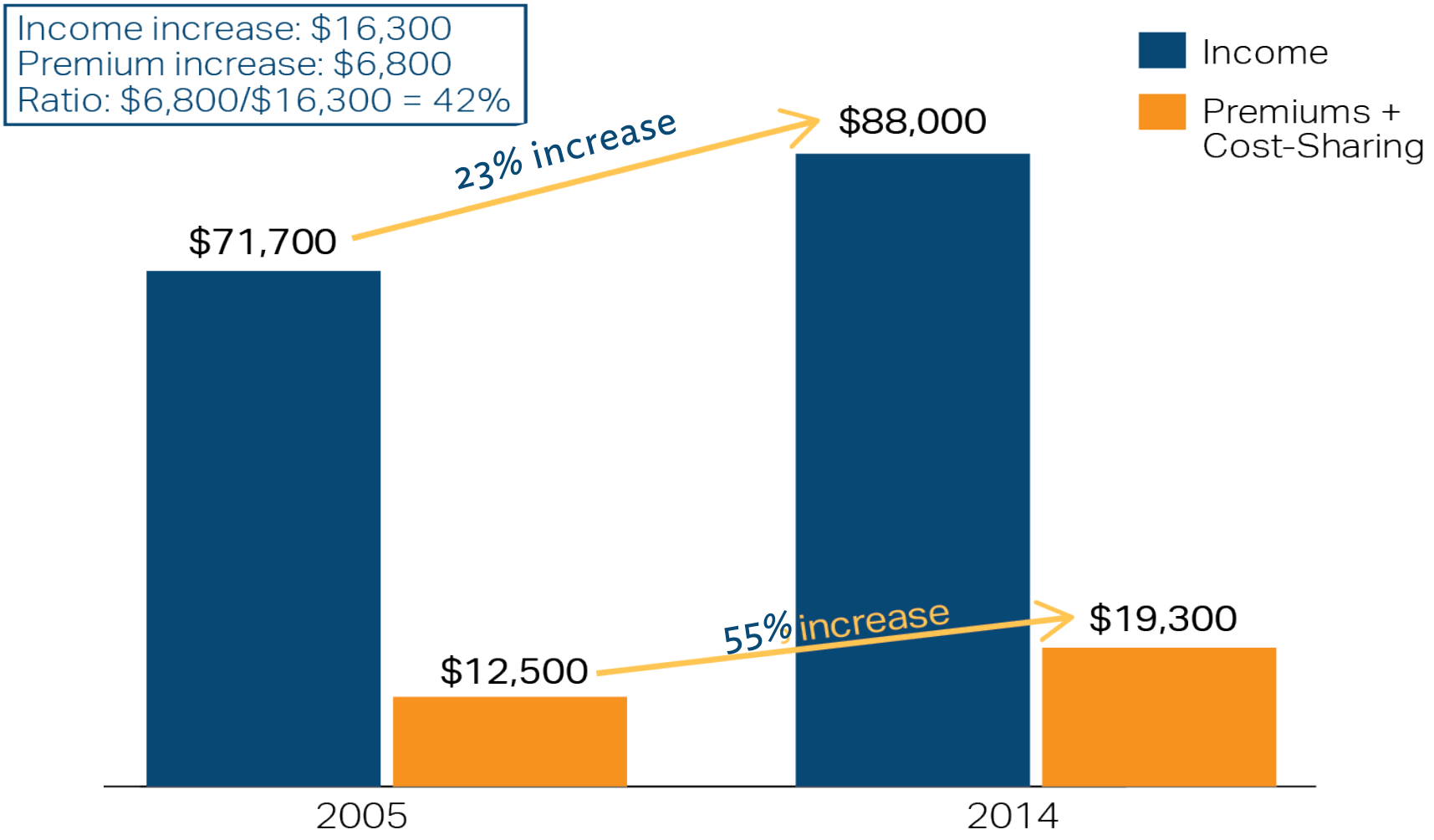


Note: Data are CPI-adjusted. Other health care includes operations funding and the ACA coverage expansion

Source: Massachusetts budget data obtained from massbudget.org

Increases in health insurance premiums have outpaced income gains, consuming over 40% of family income growth since 2005

Dollars in year shown



Note: Data are in nominal dollars. Includes cost-sharing

Source: American Community Survey (income data) , Agency for Healthcare Research and Quality (premiums) , and Center for Health Information and Analysis (cost-sharing)

Background

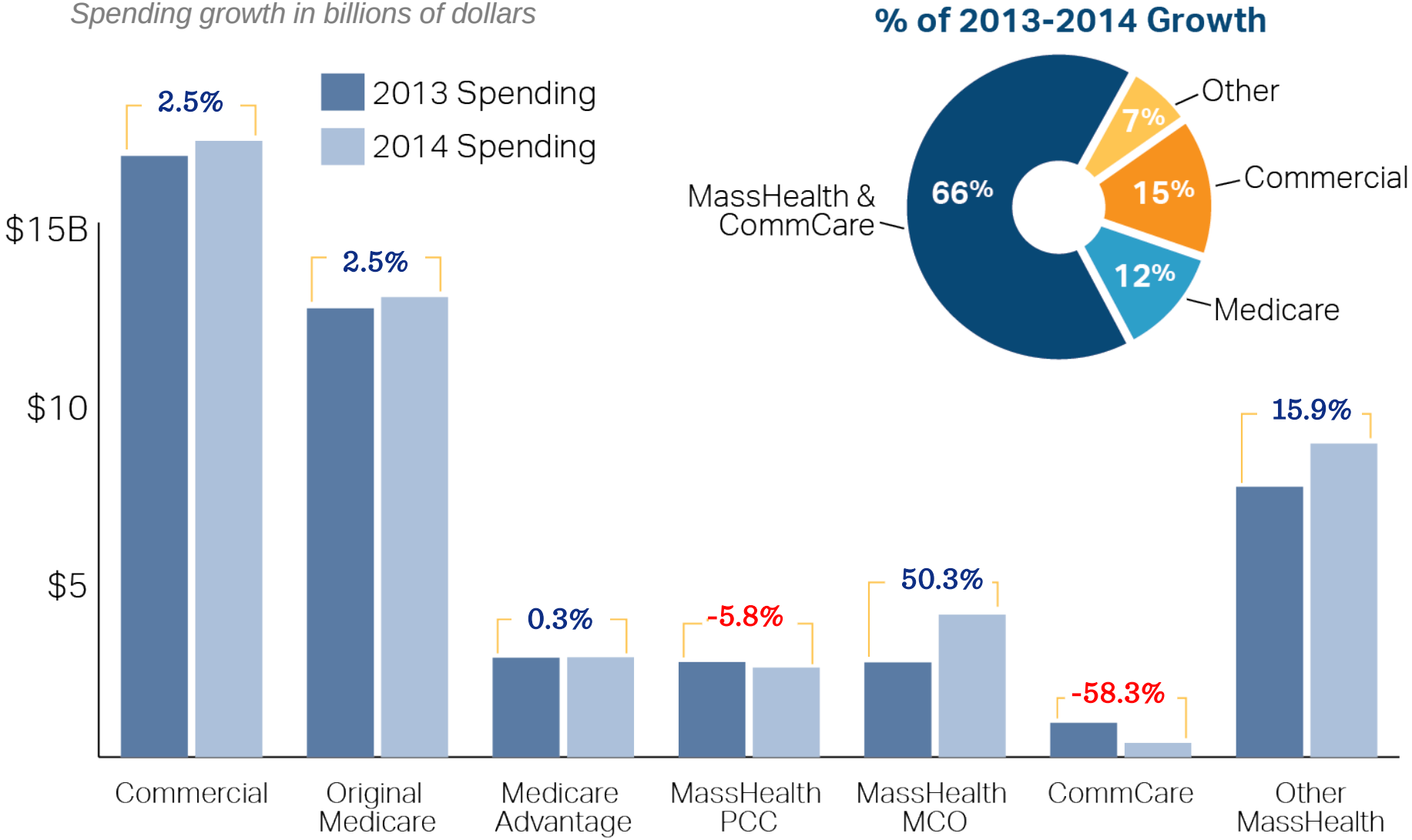
- Between 2013 and 2014, health care spending per resident (THCE) grew **4.8%**, exceeding the health care cost benchmark established by the HPC by 1.2 percentage points. In 2014, THCE in Massachusetts was $54 billion or **$8,010 per resident**.

- In 2014, commercial cost of health insurance coverage increased by **2.6%**, for both fully-insured premiums (+1.6%) and self-insured premium equivalents (+3.4%), while benefit levels remained constant.

- The final analysis of 2012- 2013 found that THCE grew 2.4%, or 1.2 percentage points below the 3.6% benchmark, and below comparable national averages.

MassHealth accounted for two-thirds of the 2013-2014 spending growth

Spending growth in billions of dollars

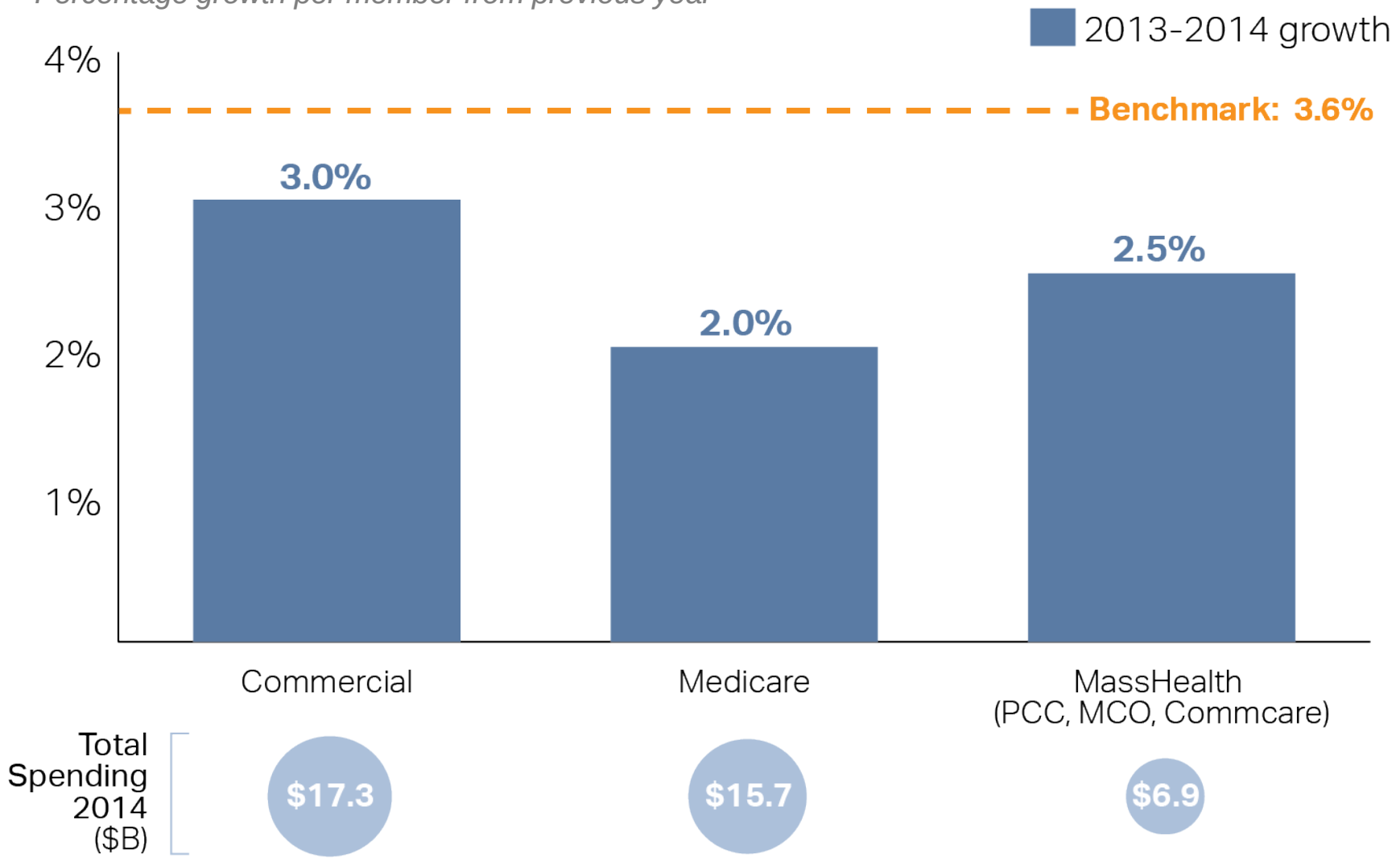


Note: Commercial spending includes reported full and partial claims data for residents insured by in-state carriers. About 600,000 residents with commercial insurance via out-of-state carriers are excluded . VA and some other minor payers not included in figure. MassHealth spending include all spending by EOHHS agencies on behalf of MassHealth members, including pass-through claims for DMH and DDS services, supplemental payments to hospitals, etc.

Source: Center for Health Information and Analysis, Total Health Care Expenditures

Per enrollee, all categories of spending grew at rates below the benchmark

Percentage growth per member from previous year

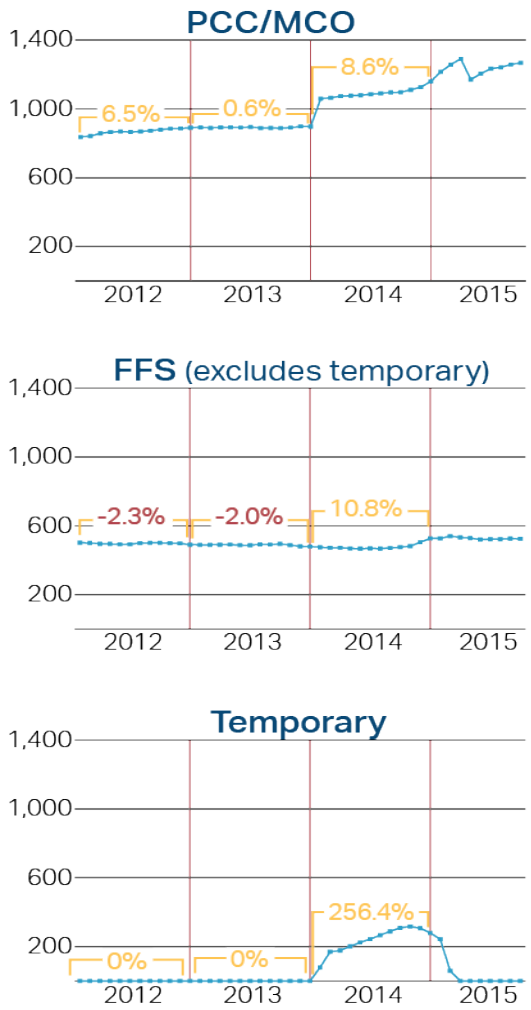


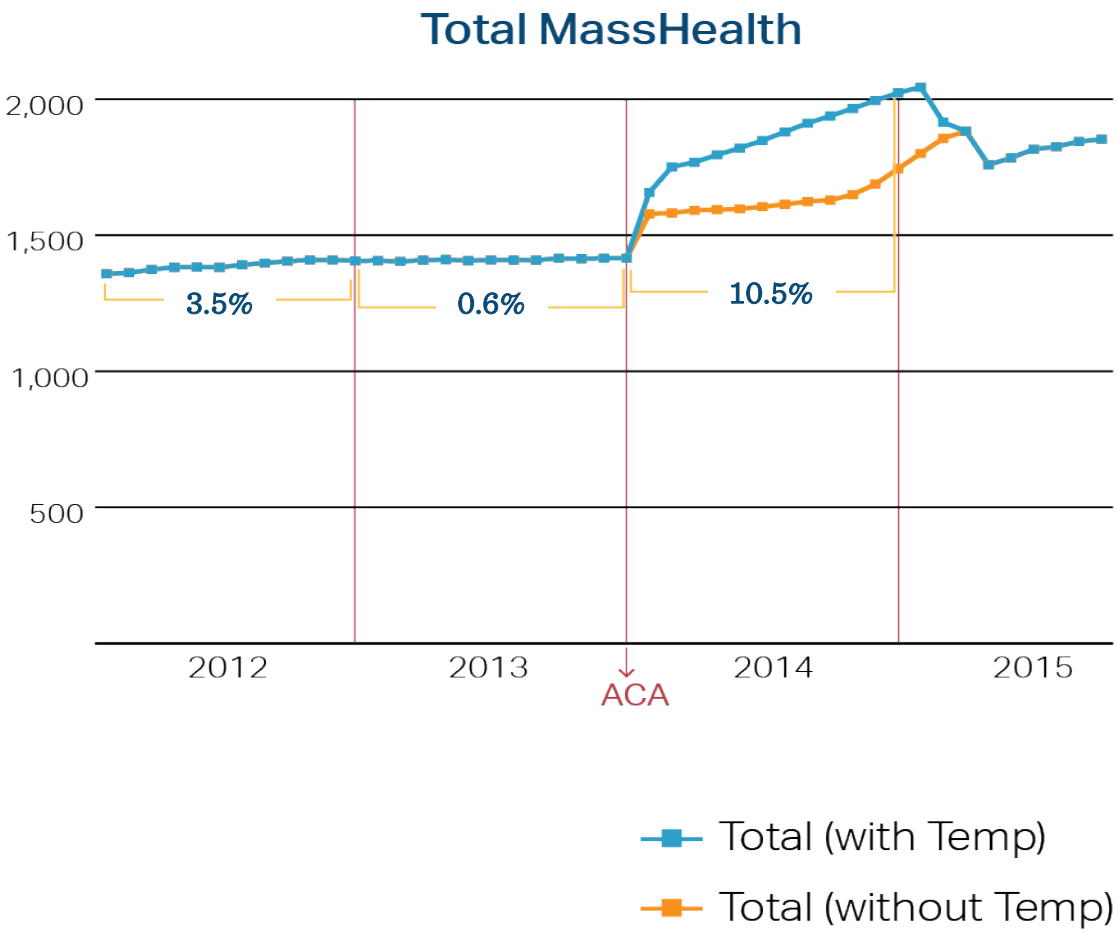
Note: MassHealth FFS not shown due to considerable enrollee flux in 2014 combined with the fact that much FFS spending is for individuals primarily covered (and already included) in the Commercial or Medicare populations

Source: Center for Health Information and Analysis, Total Health Care Expenditures

Baseline trends, the ACA, and a temporary program for 2014 Connector applicants all contributed to significant MassHealth enrollment growth

Enrollment (thousands)



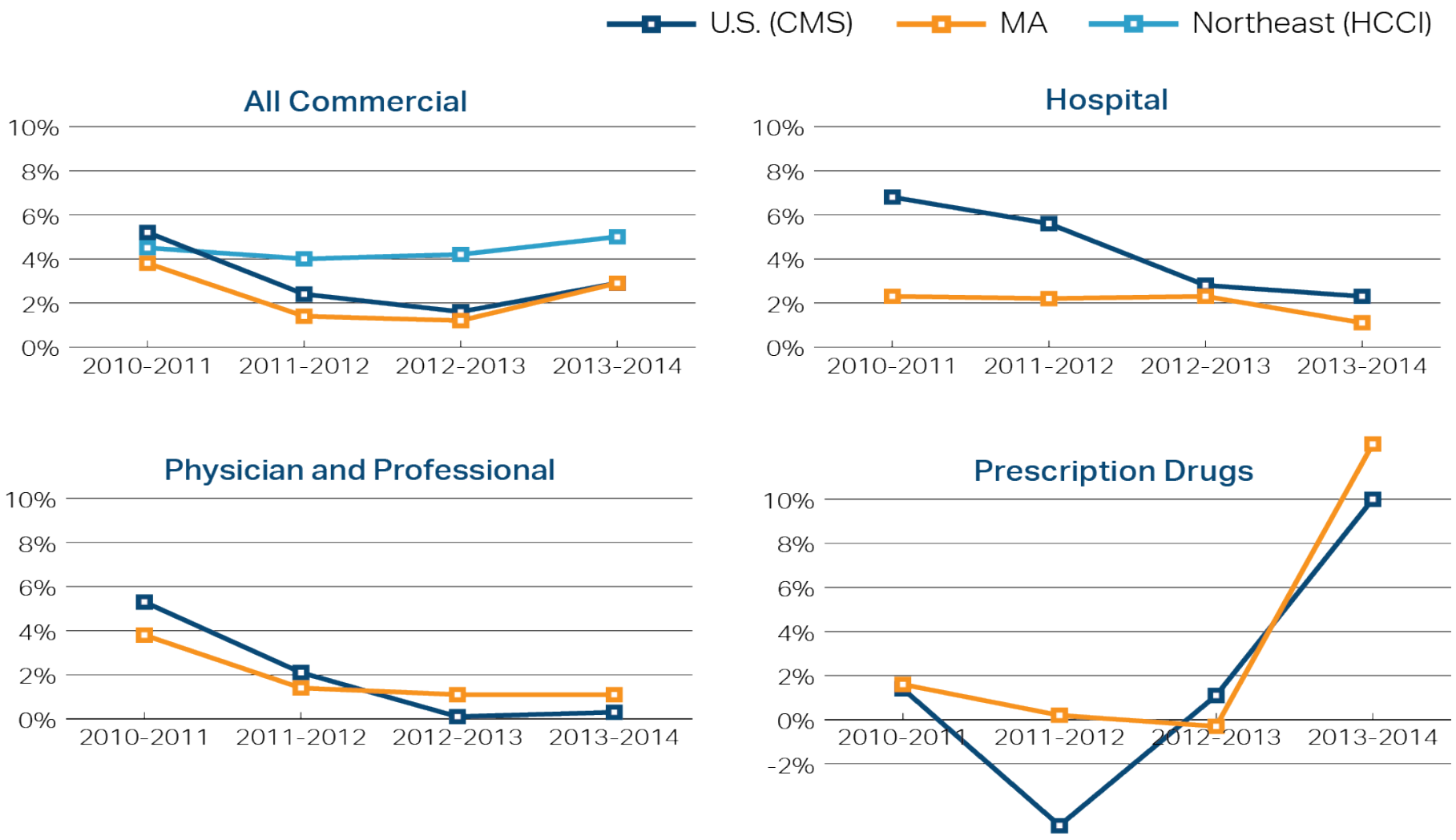


Note: The MassHealth Enrollment Snapshot and THCE define MassHealth enrollment differently. Approximately 2.4 million members months for individuals enrolled in the Health Safety Net, Children's Medical Security Plan, and DMH-only as well as CommCare-unenrolled are included in THCE but not the Enrollment Snapshot

Source: Center for Health Information and Analysis, Enrollment Snapshot

Commercial spending growth remained low in each category of spending with the exception of prescription drugs

Annual spending growth per member

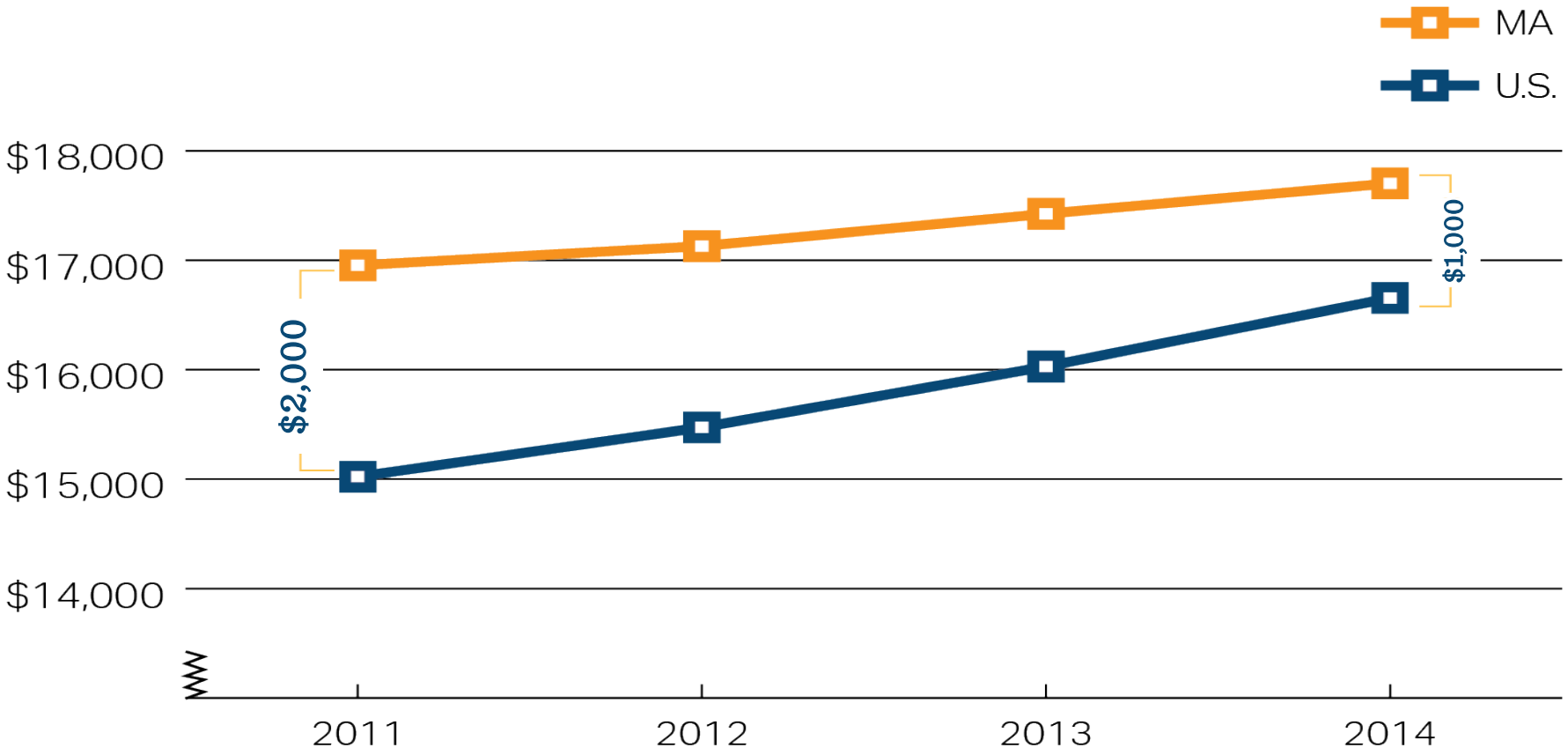


Note: Massachusetts data are for full-claims only. Drug spending figures do not account for manufacturer rebates, which affect spending level and growth

Source: U.S. Center for Medicare and Medicaid Services and Massachusetts Center for Health Information and Analysis

As a result of continued slow commercial spending growth, Massachusetts is closing the (family) premium gap with the rest of the US

Annual family premiums in nominal dollars, does not include cost-sharing



Note: Data include premiums for employer-sponsored private health insurance and account for both employer and employee contributions. Figures do not include cost-sharing

Source: Agency for Healthcare Quality and Research, Medical Expenditure Panel Survey

While premiums grew slowly, health care is still unaffordable for many

Family employer health insurance premiums plus cost-sharing in 2014 ($19,300) were:

- Greater than the annual full-time earnings of a minimum wage worker in Massachusetts ($16,640)
- 40% of the annual income of a family of four living at twice (200%) the federal poverty level

Cost sharing in 2015 grew faster than premiums

- Cost-sharing (copayments and deductibles) increased 4.9% overall in 2014
- The increase was slightly higher in the individual (5.0%) and self-insured (6.5%) markets

For many, out of pocket spending and medical debt were a burden

- 19% of residents paid more than $3,000 out of pocket for health care in 2014
- 17% of residents were paying off old medical bills: 9% of those owed more than $8,000
- 16.9% residents reported an unmet need for health care due to costs

Sources: Medical Expenditure Panel Survey, Center for Health Information and Analysis (Annual Report on the Performance of the Health Care System and Massachusetts Health Insurance Survey, 2014 and 2015)

Massachusetts health care spending growth in 2014

Summary

- MassHealth spending increased by 13% and accounted for two-thirds of the 4.8%; enrollment was an important driver
  - ACA (permanent) and operational difficulties at the Connector (temporary)
- *Per-capita* spending growth for each payer category remained below the benchmark
- Commercial hospital and physician spending grew 1% per capita
- The gap between Massachusetts family premiums and the U.S. average dropped from $2,000 in 2011 to $1,000 in 2014, yet affordability problems remain for many
- While commercial spending growth was relatively low overall, there were increases in prescription drugs, outpatient spending, and prices

Prescription drug spending

Background

- Prescription drug spending increased by 13% per capita in 2014. This category of service, across all payers including MassHealth, accounted for 1.6 percentage points of the 4.8% growth in THCE
  - Prescription drug spending accounted for 13.5% of THCE in 2014
  - Trends in Massachusetts mirror U.S. growth of 12% per capita between 2013 and 2014, after a decade of relatively low growth
  - Drug spending numbers do not include manufacturer rebates

- Many similar factors drive drug spending in Massachusetts as in the U.S. overall
  - Drug prices have a national nature through pharmacy benefit management companies (PBMs), although private payers can also negotiate independently with drug manufacturers for additional rebates
  - Distribution of prescriptions by payer is similar in Massachusetts and the U.S.

Notes: THCE: total health care expenditures.

Drivers of national pharmaceutical spending in 2014

1 New high-cost drugs

Sofosbuvir (Sovaldi) and other HCV drugs entered the market late 2013 and early 2014 at extremely high prices, e.g. $84,000 (list price) for 12-week treatment with Sofosbuvir

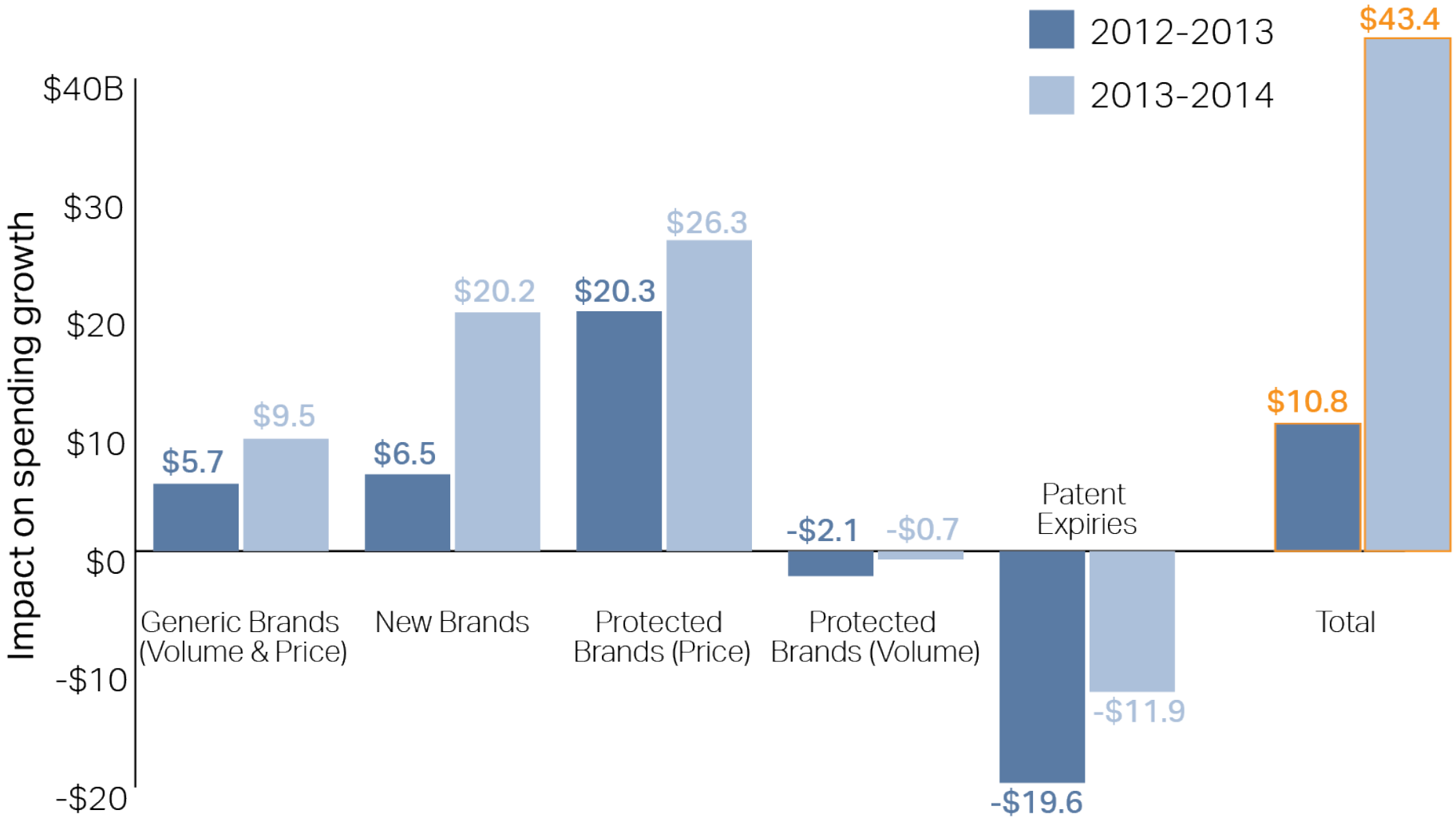
2 Large drug price increases

While price increases for brand-name drugs have the greatest impact on total spending, increases for some generics also impact spending and access

3 Low rate of patent expirations

Many factors led to increased nationwide drug spending in 2014

Components of U.S. spending growth for pharmacy and non-pharmacy drugs

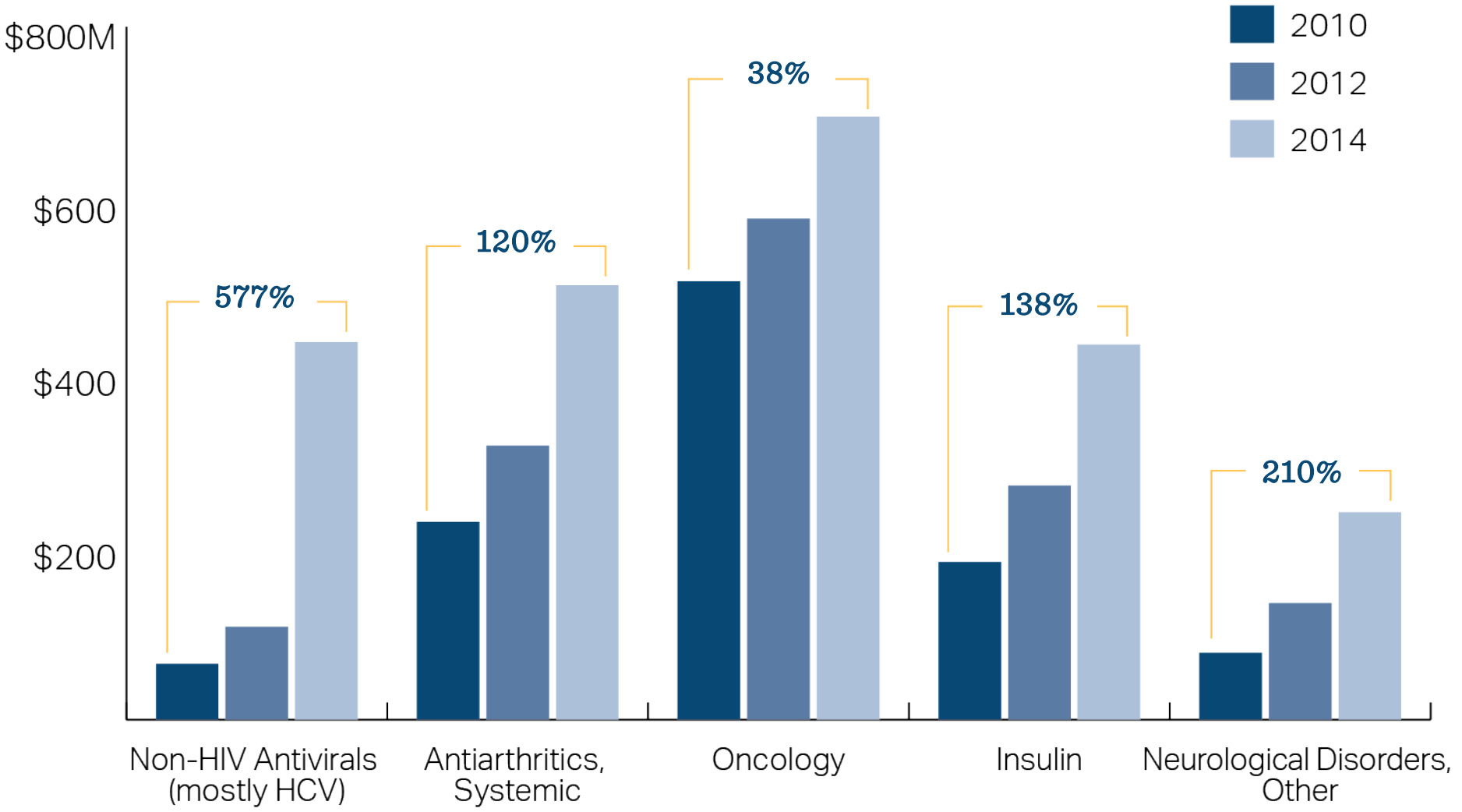


Note: Adjusted for rebates and discounts, protected brand price grew $11.8B in 2013 and $10.3B in 2014

Source: IMS, "Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014," April 2015

In Massachusetts, growth in drug spending was driven by hepatitis C drugs, but many other drug classes also had large spending increases

Annual spending for 5 drug classes with highest contribution to growth in 2014, millions of dollars



Note: Drug spending figures do not account for manufacturer rebates, which could affect both level and trend of spending

Source: Data from IMS Health Incorporated

Background

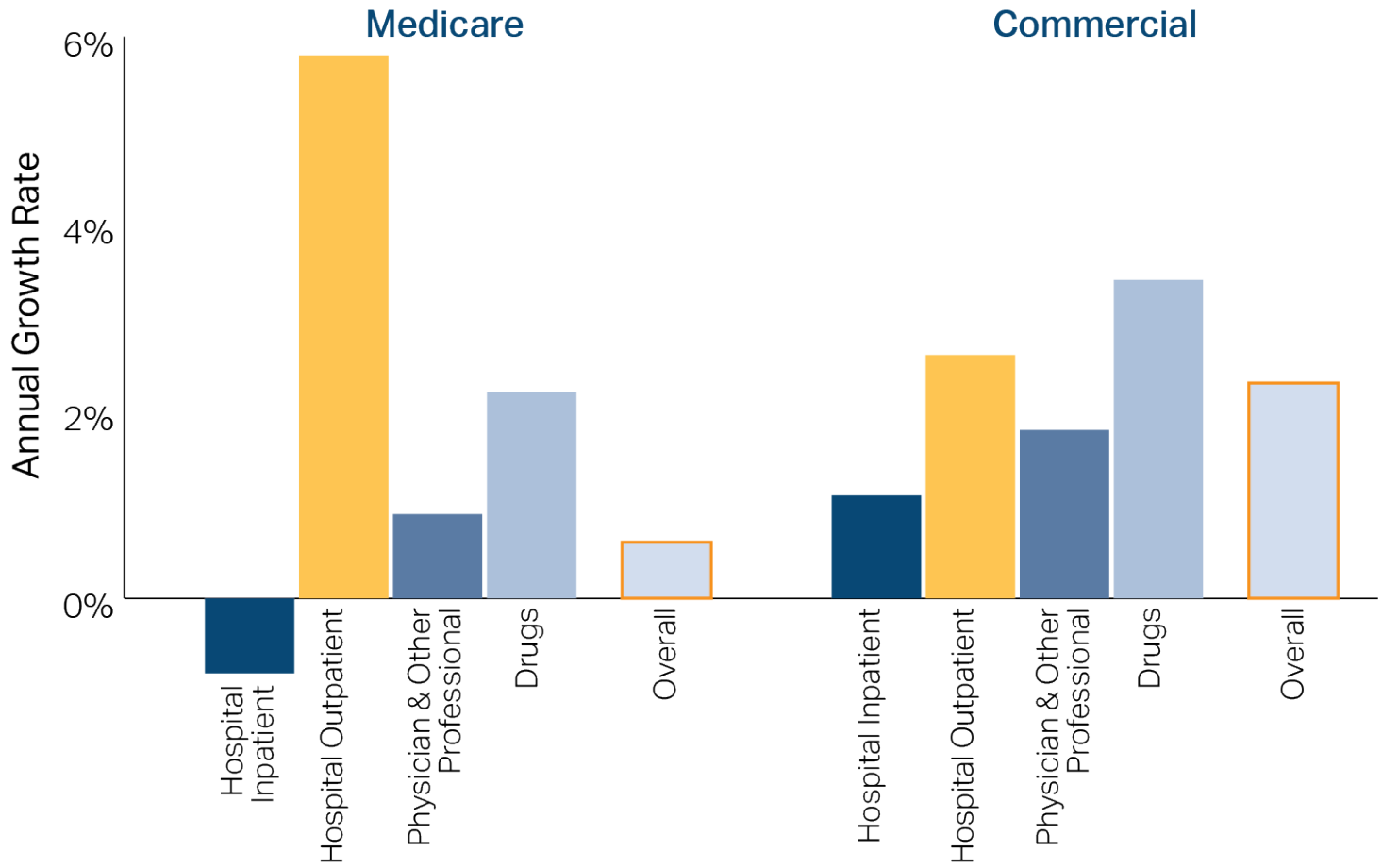
- Between 2010 and 2014, hospital outpatient spending had one of the fastest annual growth rates, for both Medicare (6%) and commercial (3%)
- In 2014, outpatient spending represented 24% of commercial spending and 15% of Medicare spending
- Our analysis compares trends in:
  - Hospital inpatient
  - Hospital outpatient
  - Community settings (non-hospital settings, primarily physician offices and freestanding facilities)

Some services have shifted from inpatient to outpatient, while others have shifted from the community to outpatient

Prices for the same service in hospital outpatient departments are typically higher than in community settings because outpatient services charge both a professional fee and a facility fee

Hospital outpatient spending in Massachusetts has consistently high annual growth

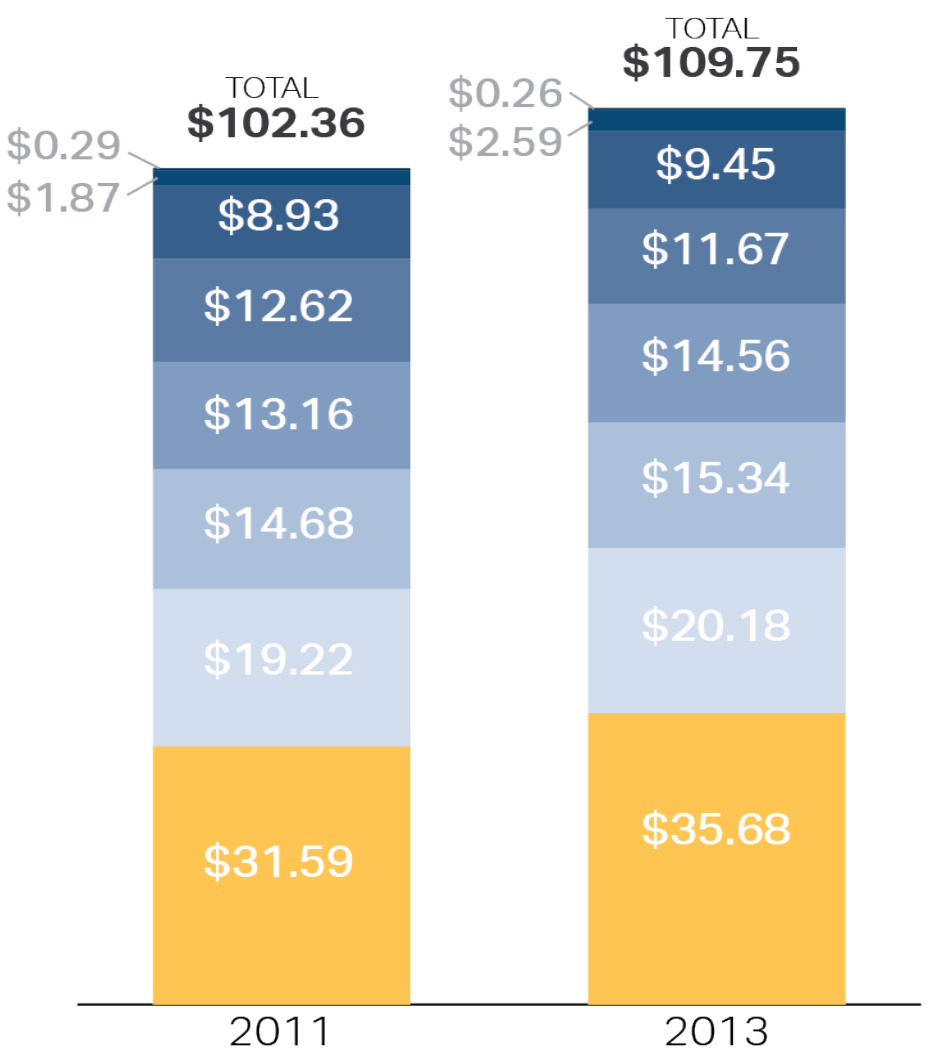
Average annual growth rate in spending, 2010-2014, by category



Source: Medicare Fee For Service spending data from the Center for Medicare and Medicaid Services and Commercial full-claims spending data from the Center for Health Information and Analysis and Kaiser Family Foundation, 2013

Among commercial payers, hospital outpatient spending growth has been driven by outpatient surgery

Per member per month spending



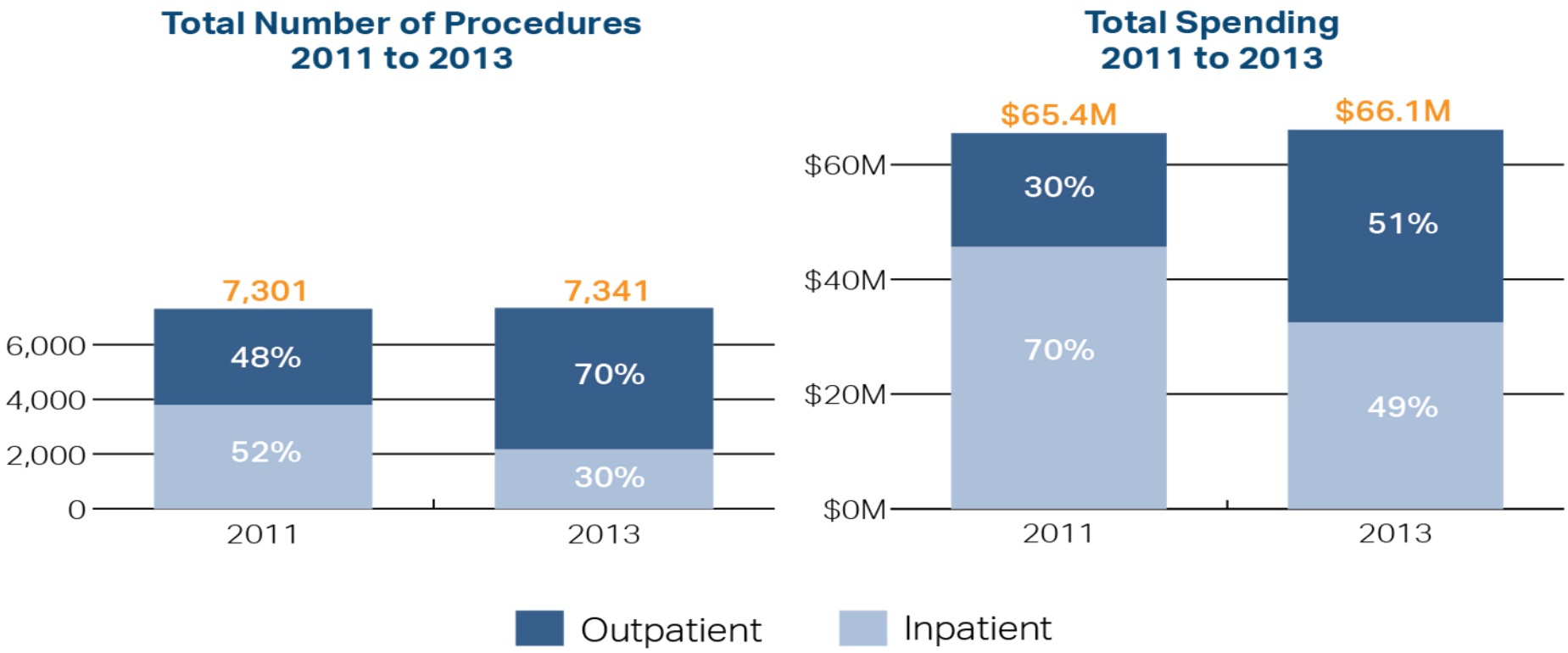
	Contribution to Growth, 2011-2013
Ancillary Services	0%
Observation Stays	10%
Administered Drugs	7%
Lab/Pathology	-13%
Emergency Room	19%
All Other Outpatient (excluding hospice)	9%
Radiology Services	13%
Outpatient Surgery	55%

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

Changes in site of care: Procedures are shifting from hospital inpatient to hospital outpatient

Volume and spending for laparoscopic cholecystectomy, laparoscopic appendectomy, arthrodesis, laparoscopic total hysterectomy, and laparoscopic vaginal hysterectomy, 2011 and 2013.

Analysis of 5 High Volume Crossover Surgical Procedures

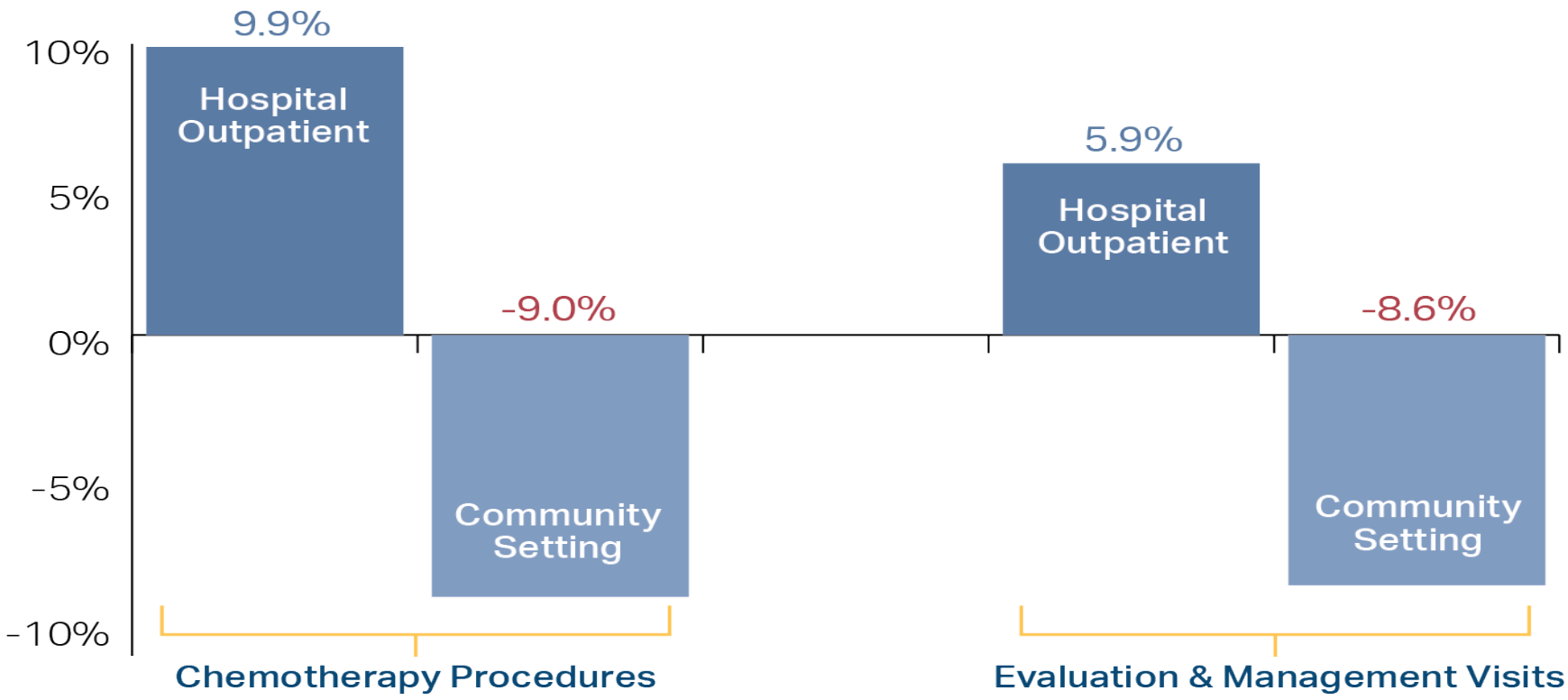


Note: The five major cross-over procedures were identified as the highest-volume procedures billed by surgeons in 2013 where at least 10 percent of the surgeries occurred at an inpatient hospital and at least 10 percent occurred in an outpatient setting. Total spending includes insurer and enrollee payments for the facility portion of the surgical procedure. Commercial FFS spending does not include capitated payments. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

Changes in site of care: Chemotherapy and E&M visits are shifting from community settings to hospital outpatient departments

Change in number of procedures per 1,000 member months, 2011 - 2013



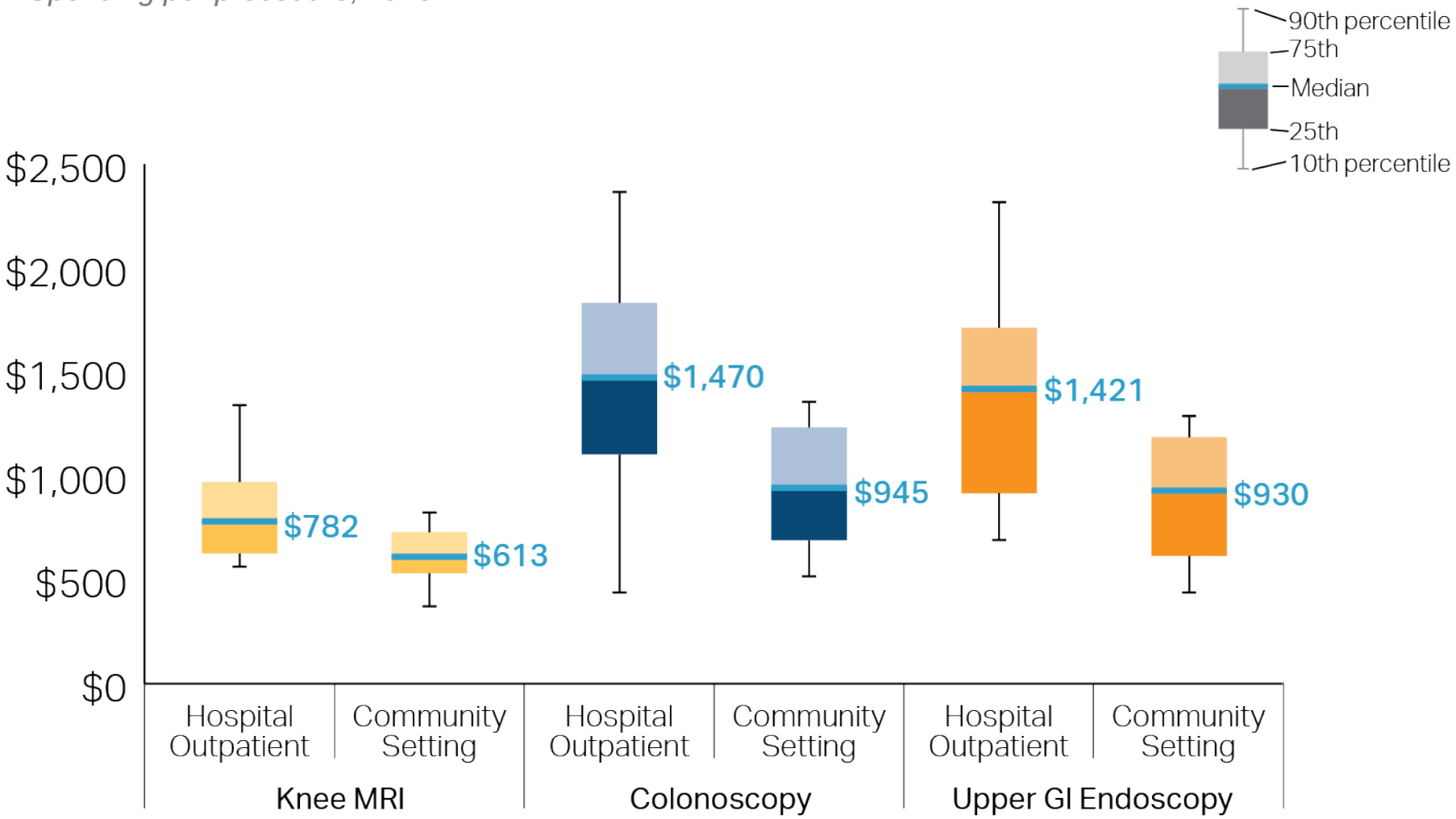
Outpatient prices are typically higher than in community settings:
for example, $298 vs $177 per procedure for chemotherapy administration in 2013*

Note: * Median price. Procedures with a missing site of service or non-community non-hospital outpatient site were excluded. Spending includes insurer and enrollee payments for both the facility and professional portion of the covered medical service, on all claim lines for the same patient on the same date with the same CPT procedure code. Commercial FFS spending does not include capitated payments. Community setting includes office, independent lab, urgent care, ambulatory surgical center, independent clinic, FQHC, public health clinic, walk-in retail health clinic, or rural health clinic. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

For common standard imaging and diagnostic procedures, hospital outpatient departments are more costly than community settings

Spending per procedure, 2013

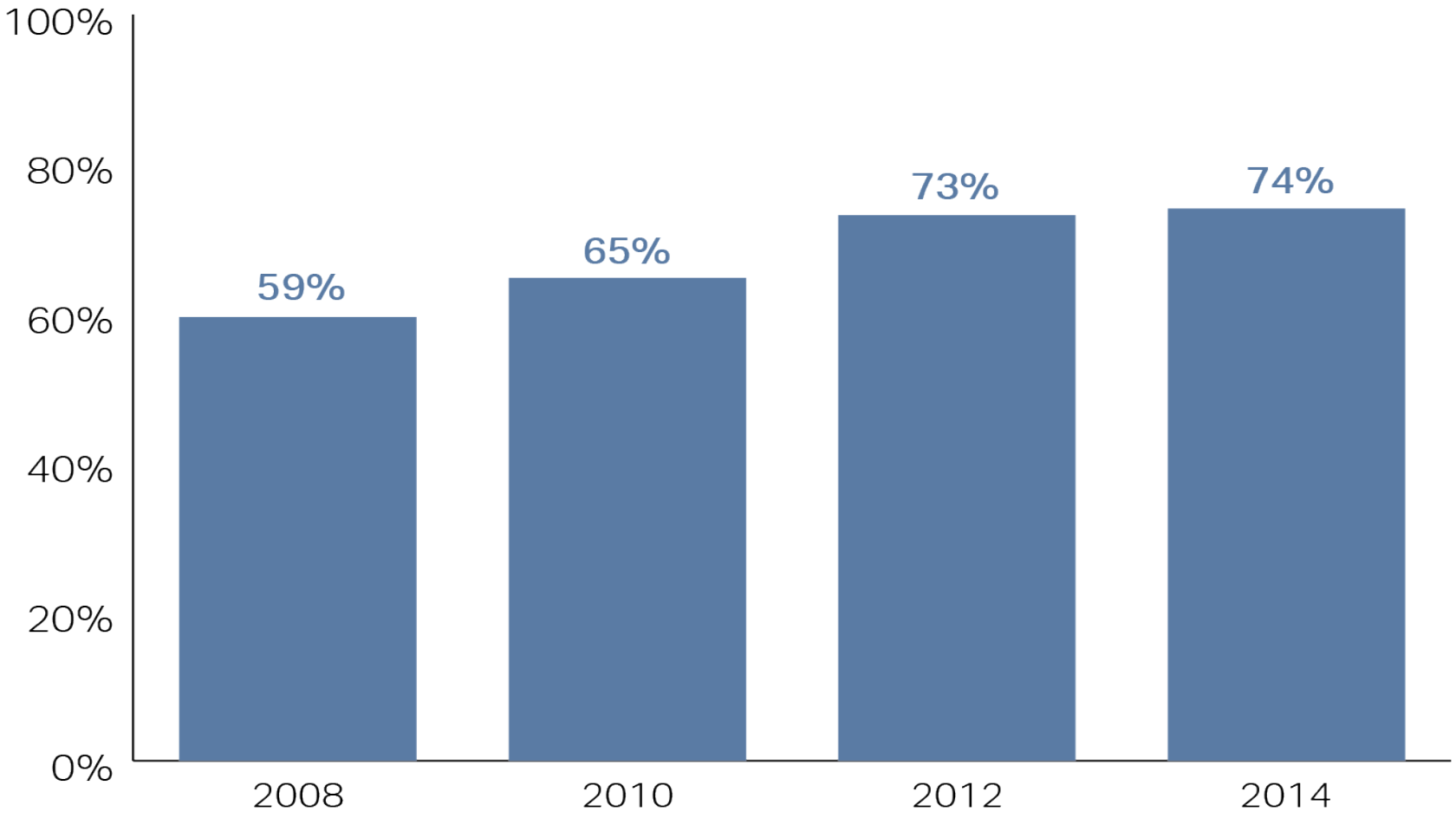


Note: Procedures with a missing site of service or non-community non-hospital outpatient site were excluded. Spending includes insurer and enrollee payments for both the facility and professional portion of the covered medical service, on all claim lines for the same patient on the same date with the same procedure code. Commercial FFS spending does not include capitated payments. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

PCP affiliations with the 8 largest provider systems have increased in recent years

Percentage of PCPs affiliated with one of the eight largest provider systems, 2008 - 2014



Note: Reflects PCPs associated with Partners Community Health Care, Beth Israel Deaconess Care Organization, Steward Health Care Network, New England Quality Care Alliance, Atrius Health, UMass Memorial Health Care, Baycare Health Partners, and Lahey Health System

Source: HPC analysis of data from Massachusetts Health Quality Partners

Summary

Drug spending

- In 2014, prescription drug spending increased by 13% per capita in 2014, accounting for 1.6% of the 4.8% growth in THCE per capita
- The 2014 spike was driven by both new high-cost drugs (including hepatitis C drugs), price increases, and a low rate of patent expirations; many trends point towards ongoing increases

Hospital outpatient spending

- Hospital outpatient spending is the fastest-growing category of care aside from the recent spike in prescription drug spending
- Some services (e.g. surgery) have shifted to outpatient departments from inpatient departments while others have shifted from community settings.
- 56% difference in median price of colonoscopy between hospital outpatient department and community setting

Provider market trends

- One driver of the shift from physician offices to outpatient departments may be the increasing share of physicians affiliated with large systems and the relicensing of physician offices as hospital outpatient departments

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

Opportunities to improve quality & efficiency

Progress in aligning incentives

- Variation in prices and spending among providers
- Avoidable hospital use
- Post-acute care
- Access to primary care

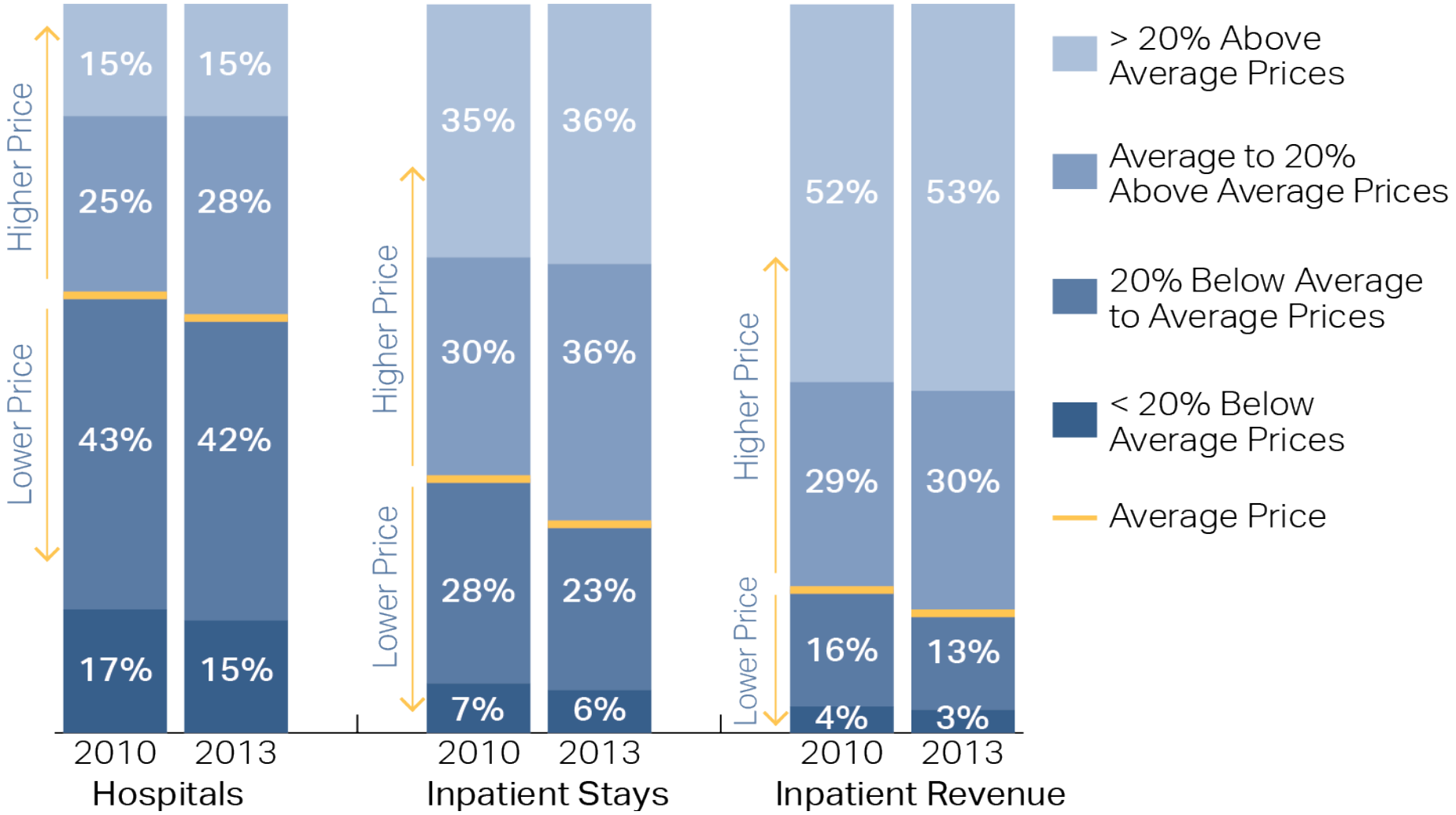
Variation in prices and spending among providers

Background

- Prices vary significantly among providers in Massachusetts and, in general, this variation is not related to quality
- Price variation, combined with increasing concentration of volume in high-cost providers, leads to higher spending
- In 2015 testimony, payers cited higher prices as the driver of spending growth
- Childbirth is the most common commercial inpatient procedure, accounting for one in six commercial hospital discharges

Higher-priced hospitals continue to receive a disproportionately high share of both inpatient admissions and inpatient revenue

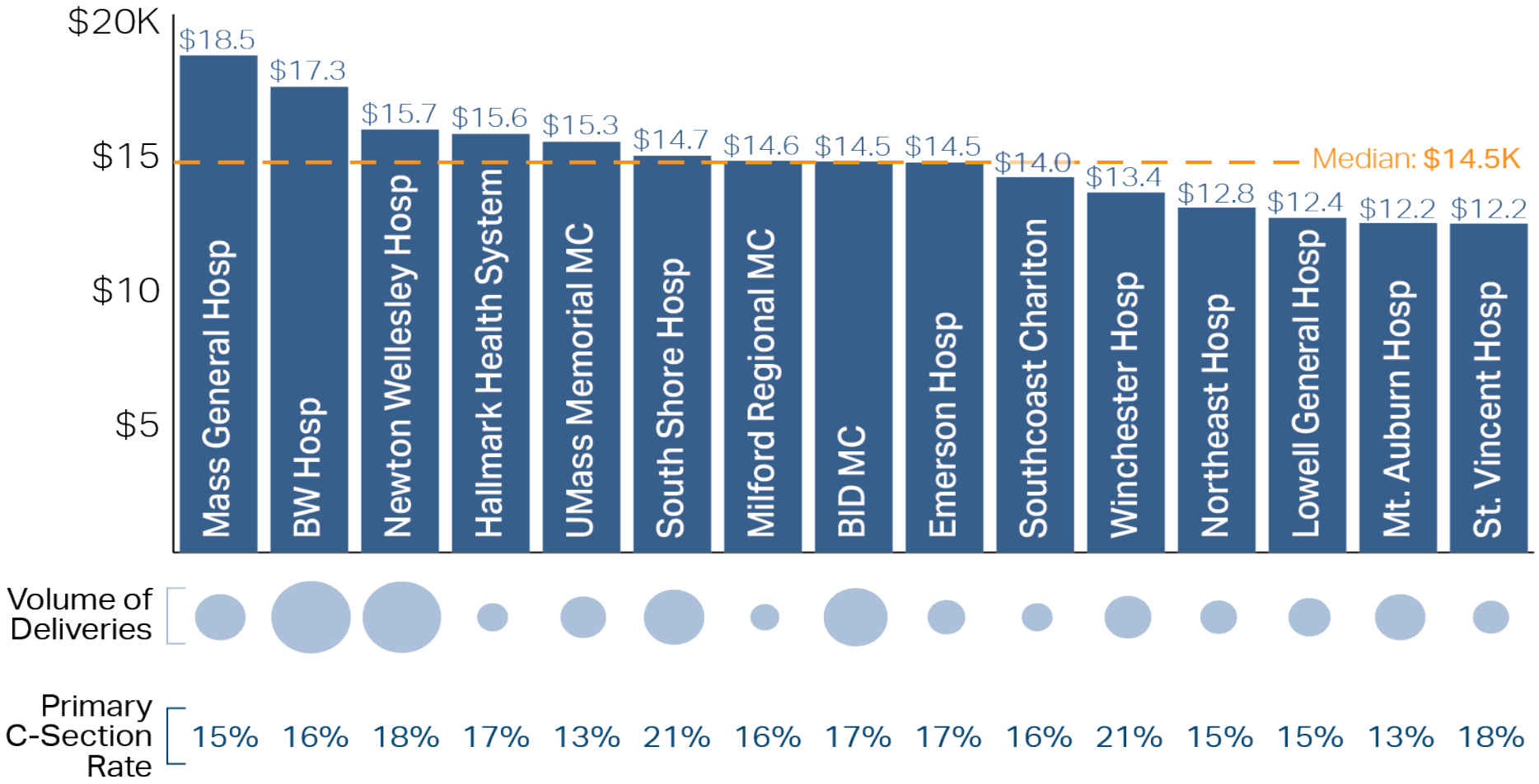
Inpatient spending, volume and prices for Blue Cross Blue Shield enrollees



Source: Center for Health Information and Analysis. Relative Price Data. Non-public file

Episode spending for low-risk pregnancies varied considerably among hospitals, with volume concentrated in higher-cost hospitals

Average total payment per pregnancy episode ($K), by hospital



Note: Displayed are the 15 hospitals with the highest volume, which accounted for 78% of deliveries. Spending includes both vaginal deliveries and C-sections. Spending data include low-risk, commercial deliveries only, while C-section rates include all payers

Source: HPC Analysis of All-Payer Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011- 2012, HPC analysis of CHIA hospital discharge database, 2014

Variation in prices and spending among providers

Summary

- Price variation is not decreasing nor is it self-correcting
- Inpatient stays remain concentrated in high-priced hospitals
- For low-risk pregnancies, spending for an episode of care varied from $12,200 at the least expensive hospital to $18,500 at the most expensive hospital, with variation largely driven by the price of the procedure

Avoidable hospital use / post-acute care

Background

- Hospital and post-acute care (PAC) use is higher in MA than in the U.S. overall
- Avoidable ED visits make up about half of all ED visits
- Hospitals vary in discharge practice patterns
  - While the "right" level of PAC use is not clear, higher use of institutional settings shows need for focus on optimizing care delivery

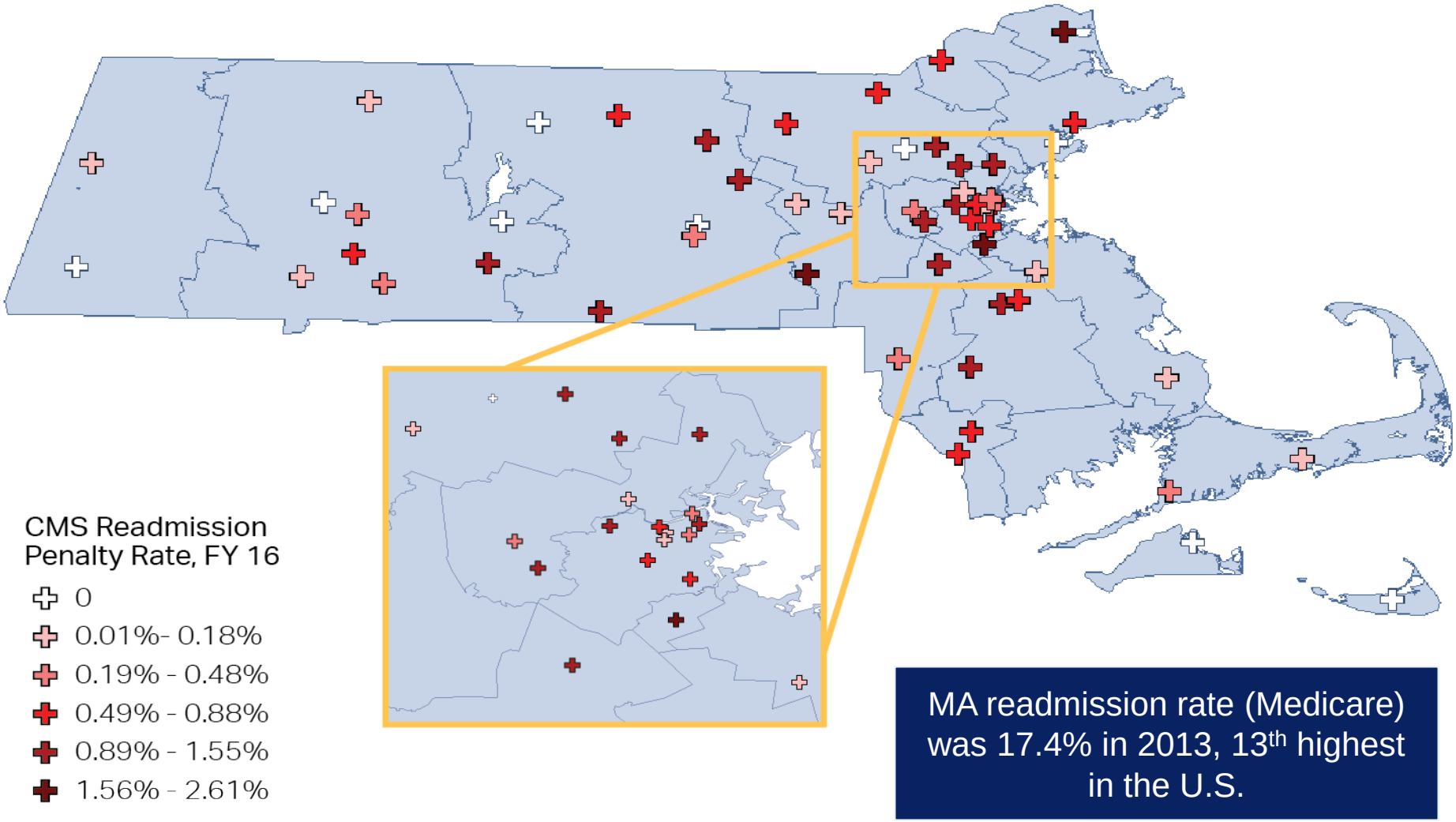
Hospital utilization in Massachusetts and the U.S., 2013 (visits per 1,000 residents)

	MA	U.S.	DIFFERENCE (%)	RANK (1=BEST)
Inpatient Admissions	118	106	11.3	36
Outpatient Visits	3,302	2,145	53.9	47
ED Visits	481	423	13.7	29

Source: HPC Cost Trends Report, 2014; Kaiser Family Foundation, accessed 2015

Medicare will penalize most hospitals in Massachusetts in FY 2016 for high readmission rates

CMS' FY 2016 Assessment Rate

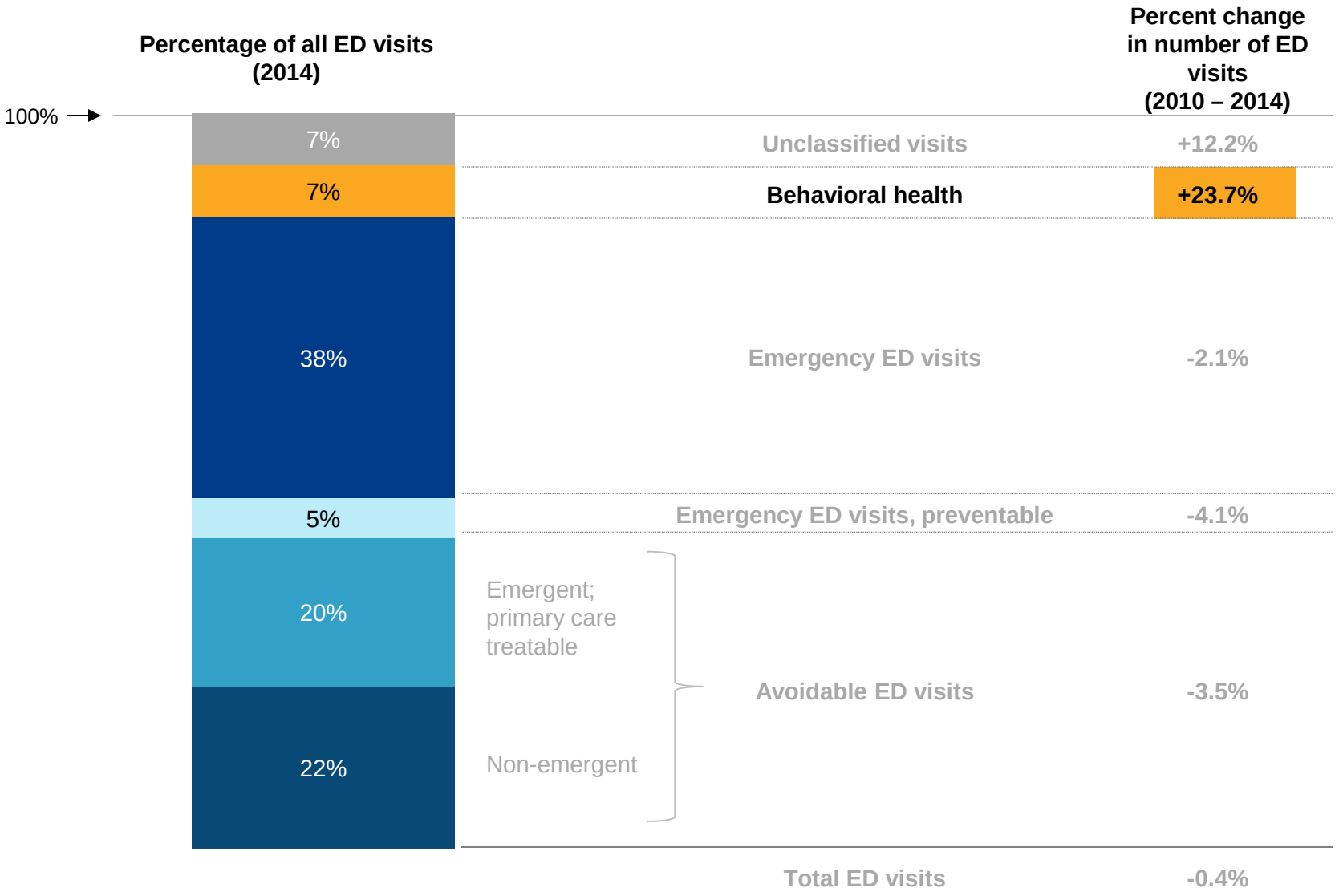


MA readmission rate (Medicare) was 17.4% in 2013, 13th highest in the U.S.

Note: Excludes Specialty and VA Hospitals

Source: Kaiser Family Foundation analysis of Centers for Medicare and Medicaid data, Institute of Medicine analysis of Centers for Medicare and Medicaid data

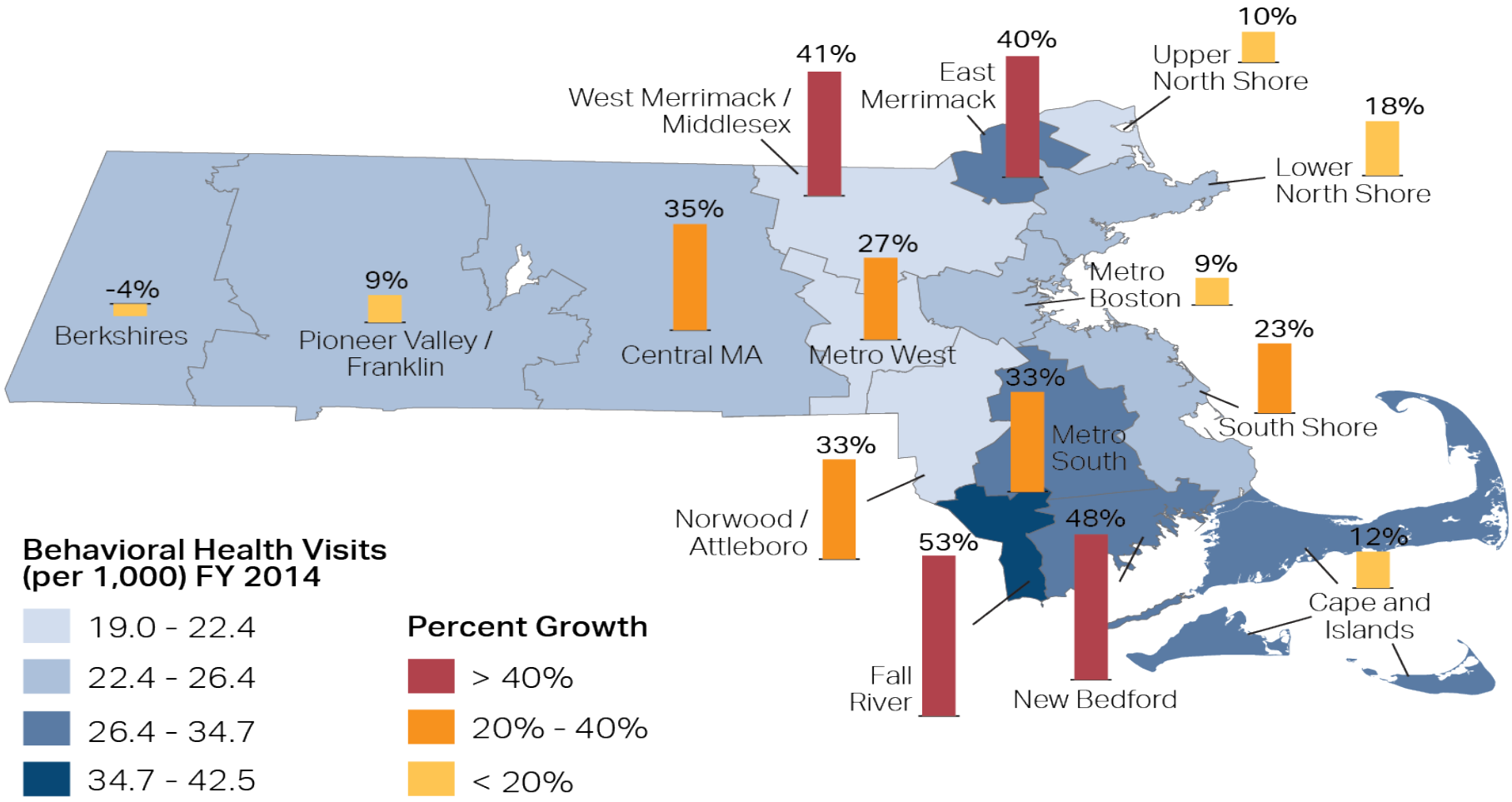
Primary behavioral health ED visits grew significantly between 2010 and 2014



Note: Definition for avoidable ED visits based on NYU Billings Algorithm

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2014

ED visits with a primary diagnosis of behavioral health increased sharply in a few regions between 2010 and 2014



Note: Behavioral health includes mental health and substance use disorder. All conditions are based on primary diagnosis. All rates are adjusted for age and sex

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis case mix ED database, FY2010-FY2014

The rate of use of institutional post-acute care was roughly constant from 2010-2014, though joint replacement has been shifting to home health

Probability of discharge, all DRGs, 2010-2014				
	2010	2012	2014	Change (percentage point) 2010-2014
Routine	58.5%	58.9%	57.4%	-1.1%
All PAC	41.3%	41.1%	42.5%	1.2%
Home Health	20.9%	21.2%	21.7%	0.8%
Institutional PAC	20.3%	19.7%	20.8%	0.5%

Probability of discharge, after joint replacement surgery (DRG 470), 2010-2014				
	2010	2012	2014	Change (percentage point) 2010-2014
Routine	3.8%	3.5%	4.7%	0.9%
All PAC	96.1%	96.5%	95.2%	-0.9%
Home Health	41.5%	46.7%	51.0%	9.5%
Institutional PAC	54.6%	49.8%	44.2%	-10.4%

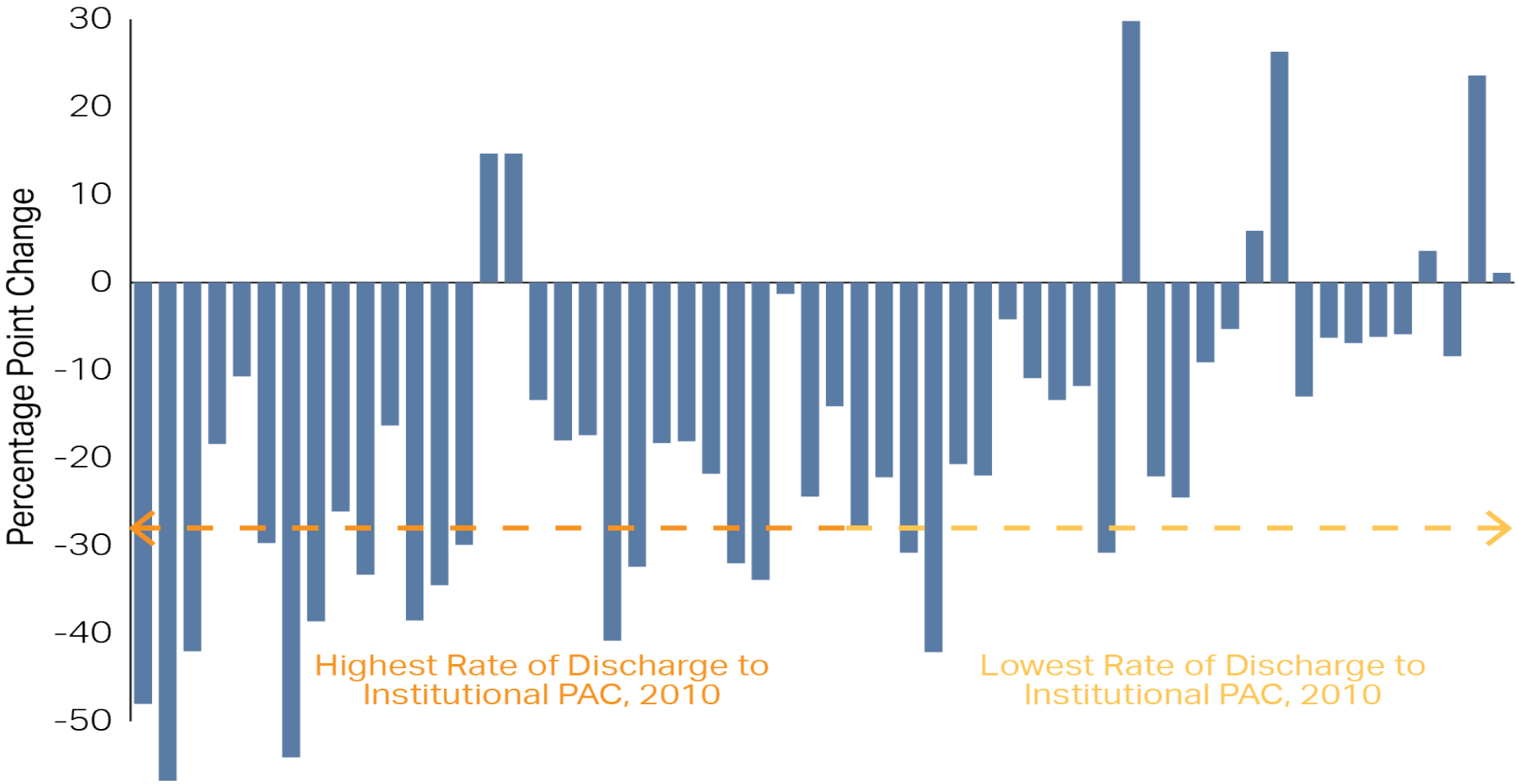
In 2012, 20% of MA patients were discharged to institutional PAC following an inpatient stay, compared to 17% to the U.S.

Note: All DRG analysis was adjusted for changes in case mix overtime

Source: HPC Analysis of Massachusetts Health Data Consortium inpatient discharge database, 2010-2014 and Healthcare Cost and Utilization Project (HCUP), 2012

For total joint replacement, 49 of 57 hospitals reduced use of institutional post-acute care between 2010 and 2014

Percentage point change in probability of discharge to institutional PAC, following joint replacement surgery, by hospital, 2010-2014



Note: Adjusted for age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Sample includes only adult patients who were discharged to routine care or some form of PAC. Specialty hospitals, except New England Baptist, were excluded

Source: HPC Analysis of Massachusetts Health Data Consortium, inpatient discharge database, 2010-2014

Summary

- Readmission rates improved slightly, but Medicare readmission rates remained worse than the national average, leading to high hospital penalties
- While overall ED use declined between 2010 and 2014, visits associated with a behavioral health diagnosis increased sharply
- Relative to the U.S., Massachusetts continued to use post-acute care at a high rate, but there were declines in institutional post-acute care use after total joint replacement

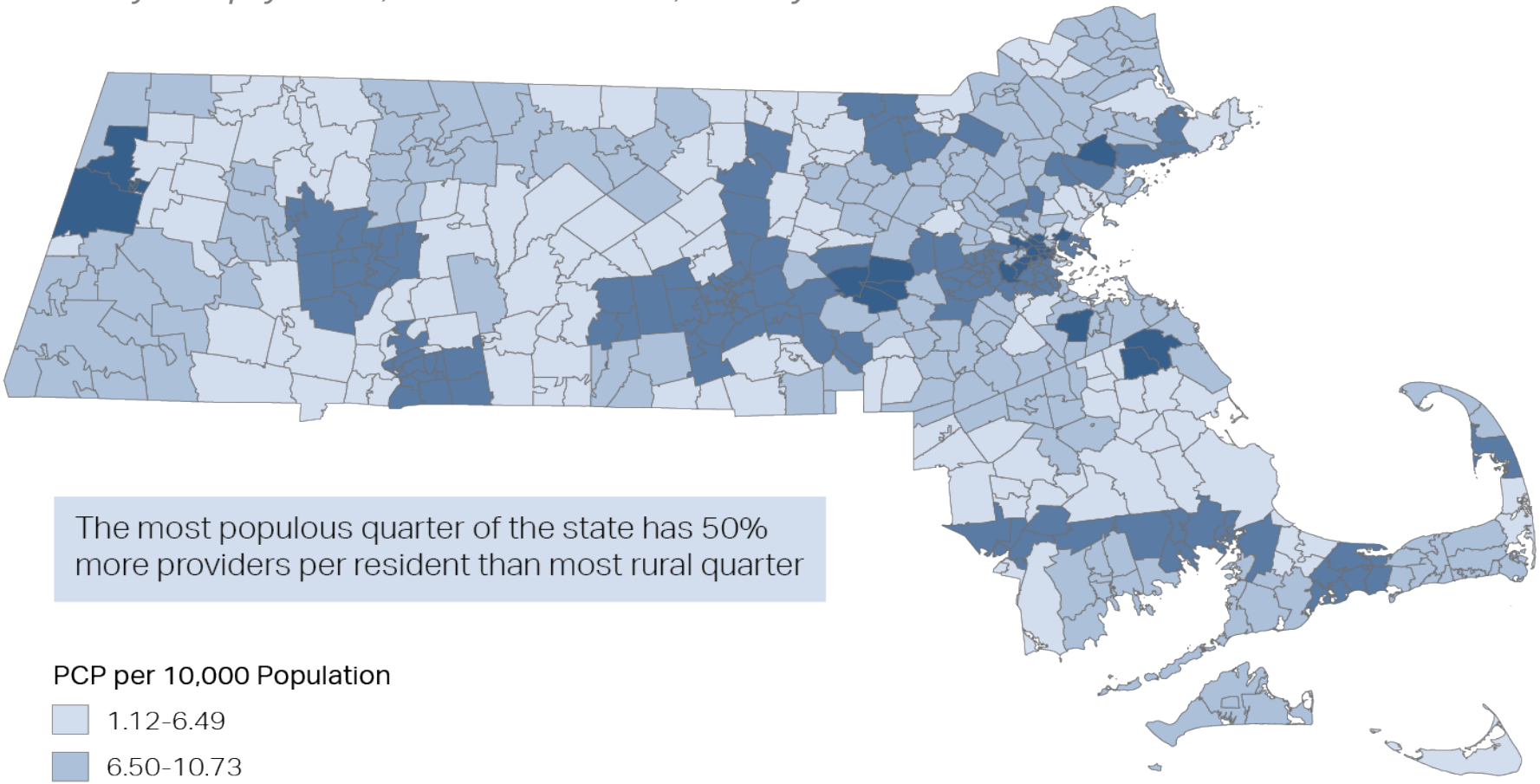
Background

- While Massachusetts has a large number of primary care physicians, 500,000 residents live in a federally-designated primary care professional shortage area
- Primary Care Nurse Practitioners (NPs) provide care at comparable quality at lower cost than physicians, and are more likely to practice in rural areas and to serve Medicaid patients
- Scope-of-practice restrictions are anti-competitive, hinder NP cost-effectiveness, add layers of unnecessary bureaucracy and can disrupt care
- Research has linked removal of such restrictions to greater NP supply and improved access to primary care

Source: Health Resources and Services Agency, Designated HPSA statistics, 2015

There is substantial variation in primary care providers per resident across Massachusetts

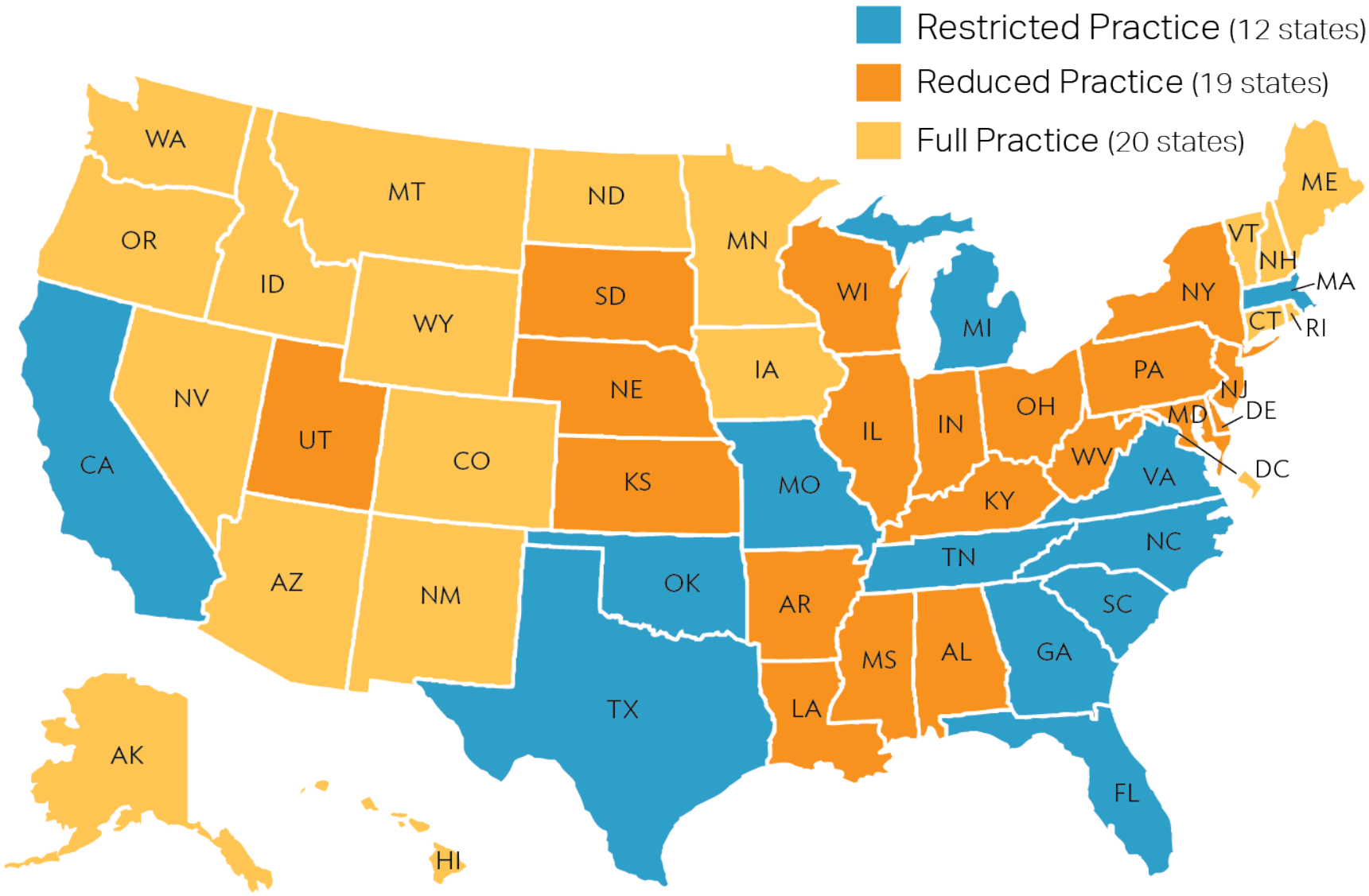
Primary care physicians, Nurse Practitioners, and Physician Assistants



Note: Massachusetts is divided into 158 regions called Primary Care Service Areas (PCSAs). These areas were developed by researchers associated with the Dartmouth Atlas and represent a geographic approximation of patients' travel patterns to obtain to primary care services. According to common practice, Nurse Practitioners and Physician Assistants weighted as equivalent to .75 relative to a physician. See technical appendix

Source: SK&A Office Based Physician Database, September 30, 2015 and Massachusetts Department of Public Health: Health Care Workforce Center

Massachusetts is one of the 12 most restrictive states for Nurse Practitioners, due to required physician supervision for prescribing drugs



Source: American Association of Nurse Practitioners, 2014

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

Opportunities to improve quality & efficiency

Progress in aligning incentives

Alternative payment methods

Demand-side incentives

Alternative payment methods (APMs)

Background

- Alternative payment methods offer incentives that support value and reward high-quality care
- In 2013, overall commercial APM coverage was 61% in HMOs, with high variation in rates by payer; only ~1% in PPOs
- To advance APMs, payer/provider coalition developed attribution method in 2014

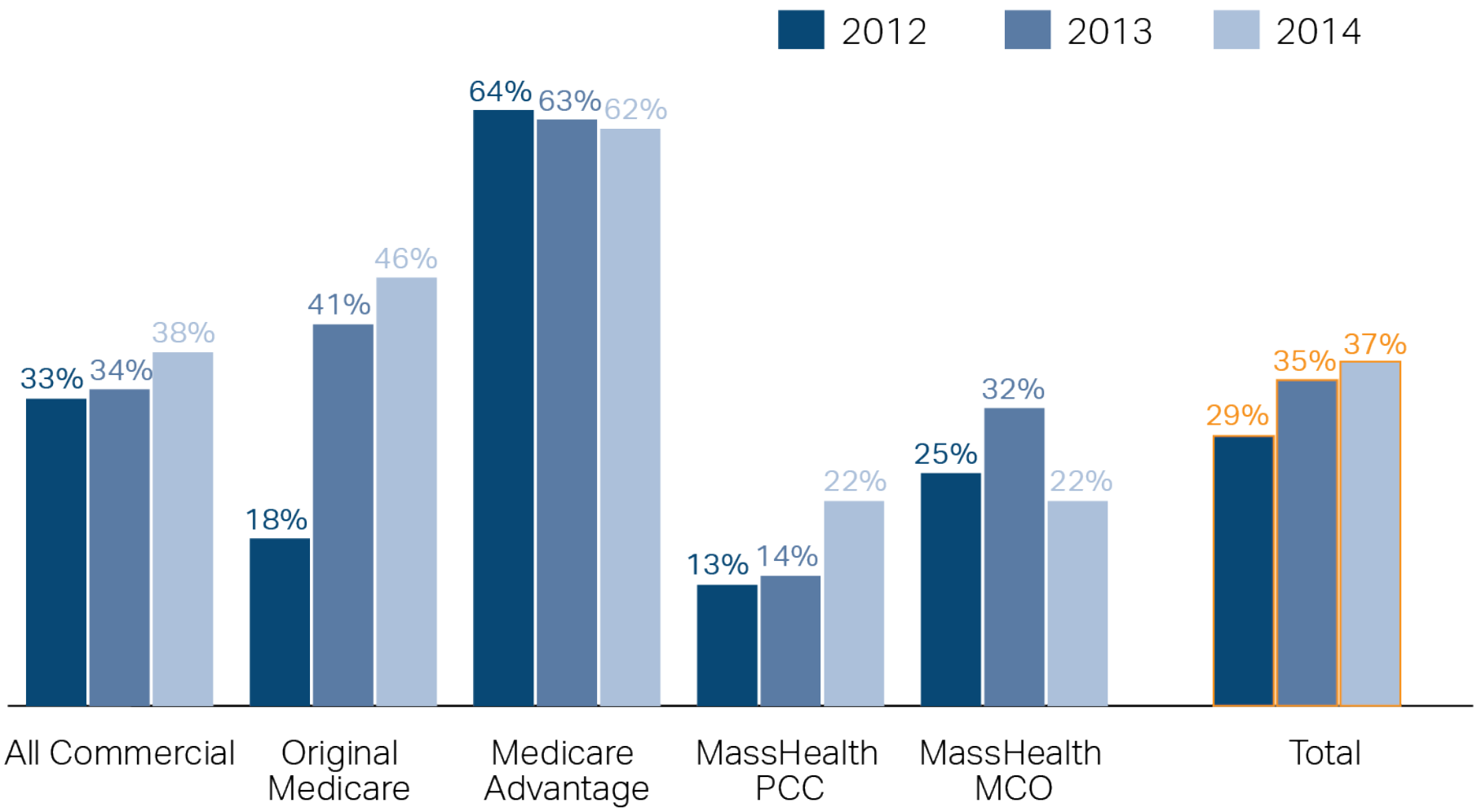
Recommendations in 2014 Cost Trends Report

- *APMs in HMO.* Each payer should use APMs for 60% of HMO lives in 2016
- *APMs in PPO.* Market should begin introducing APMs into PPOs in 2016, with goal of reaching one third of PPO lives in that year
- *Alignment*
- *BH.* APMs should include BH when possible
- *MassHealth.* MassHealth should continue progress towards at-scale care delivery and payment system reforms
- *Bundled payment*

Source: HPC Cost Trends Report, 2014

Statewide, the rate of APM coverage increased 8 percentage points between 2012 and 2014, with differences among payers

Percentage of covered lives in APMs across all payers



Note: See APM technical notes

Source: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other publicly-available Centers for Medicare & Medicaid Services data; MassHealth personal communication

Very little progress yet in PPO, although recent announcement from payer/provider coalition is promising

	HMO members as percent of all members	Percent of HMO members covered by APMs	PPO members as percent of all members	Percent of PPO members covered by APMs	Percent of all members covered by APMs
BCBS	53%	* 91%	47%	0%	48%
HPHC HPI	71%	* 65%	27%	0%	46%
Tufts/ Network	67%	* 60%	33%	11%	43%
Other	40%	33%	47%	2%	15%
Total	**55%**	**68%**	**42%**	**2%**	**37%**

* Met HMO coverage goal from 2014 Cost Trends Report

Source: CHIA 2015 Annual Report, and HPC analysis of CHIA 2015 Annual Report APM data book

Alternative payment methods (APMs)

Summary

- *APMs in HMO.* Three large commercial payers attained better than 60% coverage in 2014
- *APMs in PPO.* BCBS and four providers committed to extending APMs to PPO in 2016
- *BH.* More payers are including behavioral health spending in APM contracts
- *MassHealth.* MassHealth is engaged in an extensive stakeholder process to establish a strategy for at-scale care delivery/payment system reform – significant progress anticipated in 2016
- *Alignment.* At the hearings, providers continued to emphasize the need for progress, especially around risk adjustment and quality measurement
- *Bundled payment.* Limited offerings from payers. Mandatory bundled payments for select episodes from Medicare. Some use within provider systems.

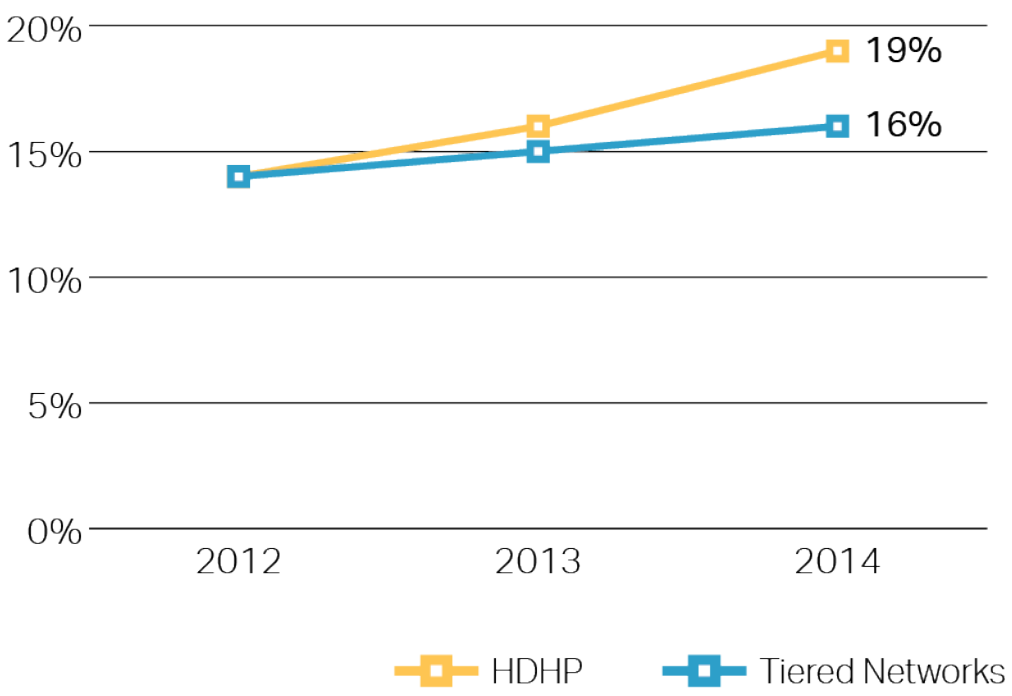
Demand-side incentives

Background

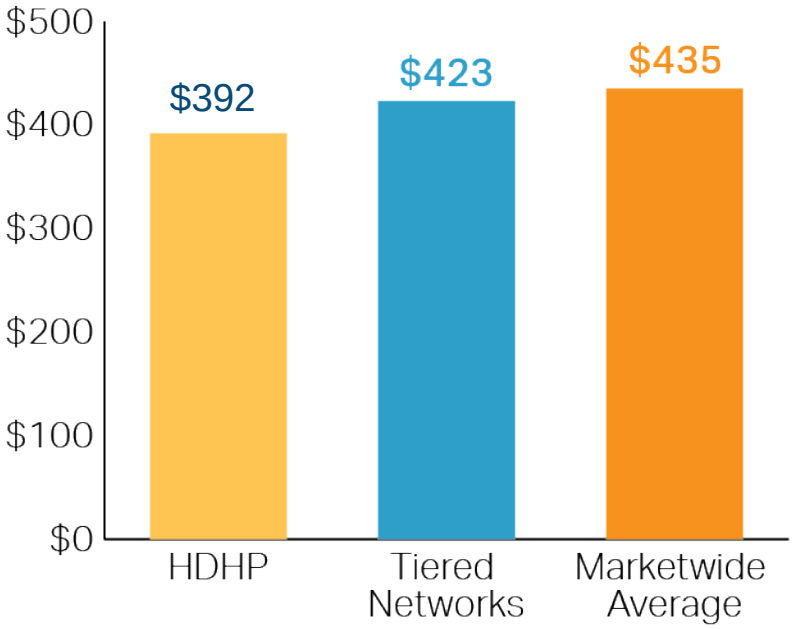
- Demand-side incentives complement supply-side incentives (APMs) by driving volume to high-value providers, products, and services
- Demand-side incentives may target employers or consumers
- Opportunities for demand-side incentives:
  - Choice of insurance plan
  - Choice of primary care provider
  - Choice of provider and care setting at the time of service use
- Tiered network plans identify high-value providers
  - Consumers pay less out-of-pocket when high-value providers are used
  - Premiums are also lower

Tiered network product growth is being outpaced by high deductible health plans

Uptake of Tiered Network and High Deductible Health Plans



2014 Monthly Premium, Per Person



Note: Premiums are for fully-insured products, net of medical loss ratio rebates and scaled to account for carved-out benefits. Cost-sharing is not included

Source: Center for Health Information and Analysis Enrollment and Source of funds data book released with the September 2015 Annual Report

Summary

- Efficacy of demand-side incentives and consumer engagement can be enhanced with:
  - Continued improvement in the transparency of price and quality information, that is accessible, understandable, and actionable by a wide range of consumers for a wide range of health care services and settings
  - Additional mechanisms for rewarding value
    - Cash back incentives
    - Incentives for choosing an efficient PCP or system
  - Larger cost differentials between tiers for tiered products
  - Opportunities for firms to offer multiple products, comparative information, and “defined contribution”
  - Reduced administrative complexity for firms and consumers

Future outlook – 2015 and beyond

- Reasons for concern
  - 6.3% premium growth in January 2016 in Massachusetts merged market
  - Higher U.S. spending growth through September, 2015
    - 5-6% overall; 8-9% for prescription drugs
  - Ongoing market consolidation
  - Continued high rates of readmissions, ED use, and PAC
- Reasons for optimism
  - Low rate of growth in hospital and physician services
  - Connector website is well-functioning and MassHealth enrollment growth has stabilized
  - Spread of APMs (PPO, MassHealth) may enhance providers' incentives to contain costs and improve quality

Source: Altarum Institute, Massachusetts Division of Insurance, Center for Health Information and Analysis

Agenda

- HPC Presentation
  - Select findings concerning spending trends and underlying factors from the 2015 Cost Trends Report
- **Board Discussion**
  - Significance of findings
  - Recommendations for inclusion in the final report

Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
- Primary care access

Progress in aligning incentives

- APMs
- Demand-side incentives

Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
- Supporting efficient, high-quality care
- Advancing alternative payment methods, cultivating alignment
- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure

Key statistics from the 2015 Cost Trends Report

2015 HPC Key Findings

$19,300
annual health insurance premium plus cost-sharing for typical family

1.0%
rate of growth of commercial spending on physician and hospital services

4.8% rate of growth of THCE

1.6% percentage points due to drug spending

3.2% percentage points due to MassHealth (2.5 excluding drugs)

74%
percent of PCPs affiliated with one of the 8 largest provider systems

$6,300
difference in spending between Mass General and Mt. Auburn for a low-risk pregnancy

56%
difference in price of colonoscopy between hospital outpatient department and community setting

~0
change in statewide rate of discharge to institutional post-acute care, 2010-2014

24% statewide growth in ED visits with a primary behavioral health diagnosis, 2010-2014

~50% growth in behavioral health ED visits in New Bedford and Fall River

68%
share of HMO lives covered by alternative payment models, 2014

2%
share of PPO lives covered by alternative payment models, 2014

49/57
number of hospitals that decreased their rate of discharge to institutional post-acute care after joint replacement surgery, 2010-2014

Agenda

- Approval of Minutes from the November 18, 2015 Meeting
- Annual Executive Director's Report and Commissioner Reflections
- Cost Trends and Market Performance
- **Quality Improvement and Patient Protection**
  - Discussion of Program Design for the HPC's Pilot on Neonatal Abstinence Syndrome
- Care Delivery and Payment System Transformation
- Community Health Care Investment and Consumer Involvement
- Schedule of Next Meeting (January 20, 2015)

Agenda

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- Schedule of Next Meeting (January 20, 2015)

Discussion Preview: Neonatal Abstinence Syndrome (NAS) Pilot Programs

Agenda Topic

Discussion and Vote of Program Design and RFP release for NAS Pilot Programs

Description

The legislature appropriated $500,000 for the HPC to conduct a pilot program to accelerate adoption of best practices around treatment of NAS. HPC is also proposing to contribute $3,000,000 from the Distressed Hospital Trust Fund to expand the reach of a DPH intervention that targets pregnancy and the first 6 months of the newborn's life. Staff will present a proposed RFP design based on program design considerations discussed with the Quality Improvement and Patient Protection Committee.

Key Questions for Discussion and Consideration

Are there any additional outcomes of interest the HPC should focus on as it finalizes the RFP announcement?

Are there any additional supports the HPC should offer to awardees (e.g. technical assistance)?

Decision Points

Vote requested. The board will be asked to endorse the proposal for a pilot program to enhance care for patients with neonatal abstinence syndrome and authorize the Executive Director to issue a Request for Proposals (RFP) to solicit competitive proposals.

Neonatal abstinence syndrome (NAS)

- Clinical diagnosis resulting from the abrupt discontinuation of exposure to substances in utero (e.g., methadone, opioid pain relievers, buprenorphine, heroin)
- Incidence and prevalence of NAS increasing rapidly in US, especially in MA
- In 2013 - 1,189 hospital discharges in MA with NAS code (21 disch. for other states)
- Average LOS = **16 days** (ranges from 9 – 79 days)

Newborns with NAS are more likely to have complications compared with all other US hospital births.

Premature birth (gestational age <37 weeks)
2.6 – 3.4 times more likely

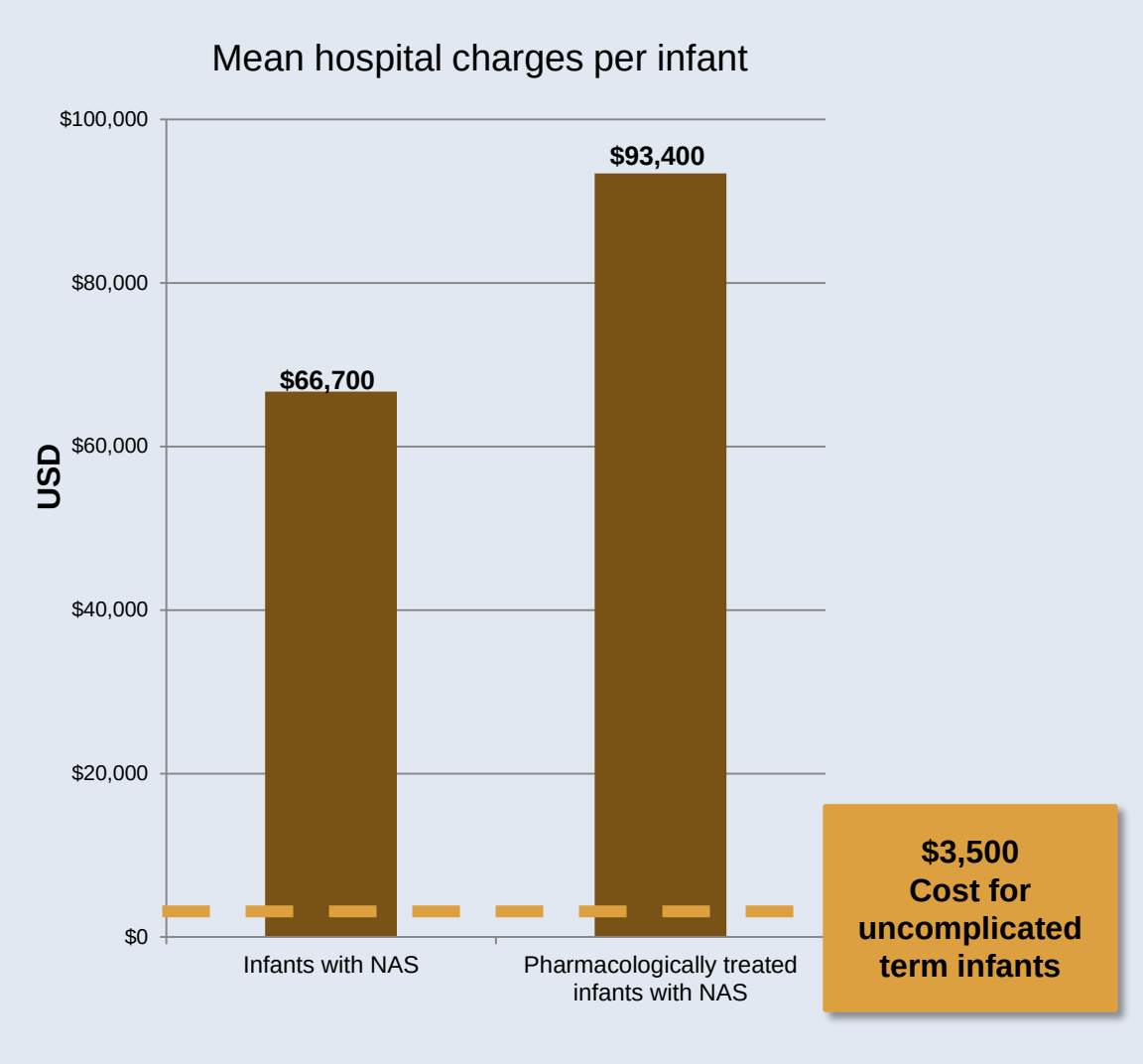
Low birthweight <2,500g
19.1% vs 7.0%

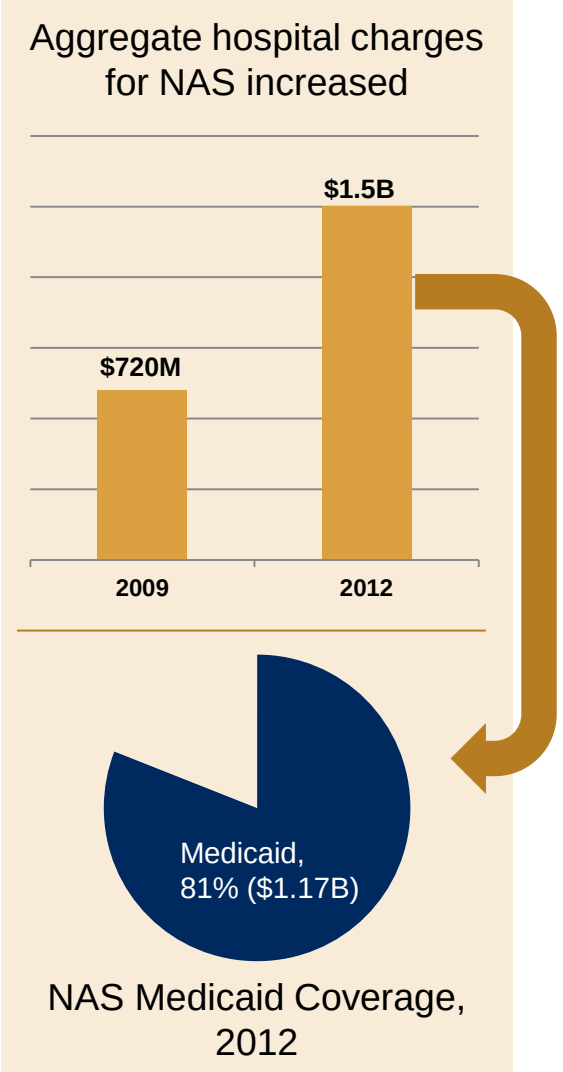
Seizures
2.3% vs 0.1%

Respiratory diagnoses
30.9% vs 8.9%

Feeding difficulties / Difficulty gaining weight
18.1% vs 2.8%

Costs of NAS nationwide

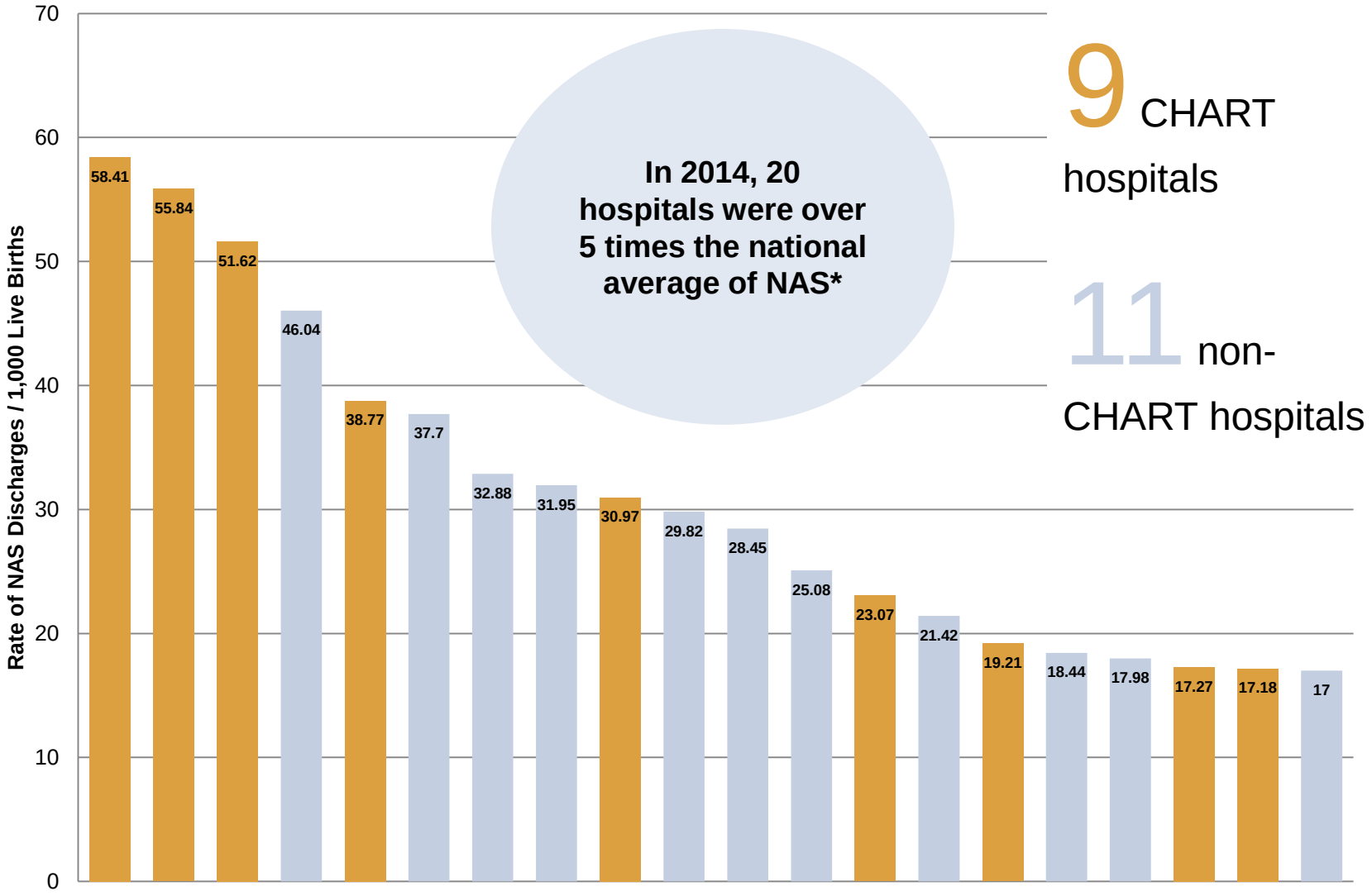




Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

Hospitals in Massachusetts are significantly impacted by increasing rate of NAS



*Per 2012 national average of 3.4/1000 births (eligibility criterion used by DPH for a federally funded initiative)

Source: Massachusetts Health Data Consortium (MDHC) 2014 hospital data

HPC pilot planning process

1. **Survey of best practices nationwide & internationally** (literature review; semi-structured interviews with providers)*
2. **Focus group** with MA providers, DPH, DMH, DCF and others to solicit feedback on pilot*
3. Consultation with the **Neonatal Quality Improvement Collaborative of Massachusetts (NeoQIC)**
4. Commissioner discussion at **QIPP committee meetings**, including endorsement of proposed program design
5. Participation in **DPH's NAS advisory council**

*See appendix for summary of literature review, interview, and focus group

HPC NAS pilot project overview

Based on scan of best practices, consultation with DPH, DCF, NeoQIC, and providers, staff proposes the following investment design:

Two categories of funding:

1 Inpatient quality improvement initiative

- non-CHART-eligible hospitals with at least 60 NAS births/year or > 5x the national NAS average
- up to $250,000 per award
- in-kind funding match will be a competitive factor

2 Inpatient quality improvement initiative and replication of DPH intervention (pregnancy & first 6 months of life)

- CHART-eligible hospitals with at least 60 NAS births/year or > 5x the national NAS average
- up to $1,000,000 per award

Applicants in both categories will propose **evidence-based interventions and protocols that drive towards reduced spending** (procurement will provide non-exhaustive list of examples)

Aligning with and expanding on DPH's initiative allows for interventions to be applied across broader spectrum of continuum

HPC Pilot Program
Funded through FY16 State Budget
$500,000

DPH "Moms Do Care"
Program Funded through a federal grant
$3,000,000

HPC Expansion
Funded through CHART Investment Program to expand on DPH work
$3,000,000

Evaluation and Technical Assistance Summary

Evaluation will track quantitative and qualitative metrics to identify process and program outcomes

- HPC's evaluation will be aligned with DPH's *Moms Do Care* evaluation as well as track inpatient specific data

Technical Assistance will be provided to hospital grantees via learning collaboratives, targeted training, and regional forums

- Regional forums will be open to all birthing hospitals (including non-grantees) to promote dissemination of best practices across the Commonwealth

RFP development summary

	HPC NAS Reserve $500,000	CHART Funds to extend DPH program up to $3,000,000
Eligible Applicants	Any non-CHART birthing hospital with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average	Any CHART birthing hospital with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average
Proposed Award Cap	Up to $250,000	Up to $1,000,000
Matching funds	In-kind funding match will be a competitive selection factor	NA
QI initiative	Describe quality improvement initiative that will reduce spending over 12 months	Describe quality improvement initiative that will reduce spending over 24 months
Internal/ External collaboration	• Describe plan to collaborate with outpatient providers (ob/gyn, primary care, pediatrics, addiction medicine) and procedure for creating first appointment prior to discharge	Describe plan to coordinate peer moms & identify outpatient providers for collaboration: • Ob/gyns, PCPs will participate in buprenorphine waiver trainings • Addiction medicine providers who will participate in training on treating women during pregnancy • Coordination with pediatricians, EI providers
Data collection	• Submit NAS discharge volume, reimbursements, and cost for June-Dec 2015 period • Describe plan to track QI measures throughout intervention	• Submit NAS discharge volume, reimbursements, and cost for June-Dec 2015 period • Describe plan to track QI measures throughout intervention
Existing NAS protocols	Applicants with existing protocols will be more competitive if proposal includes plan to participate in peer-peer learning sessions as the trainer	Applicants with existing protocols will be more competitive if proposal includes plan to participate in peer-peer learning sessions as the trainer

Vote: Approving Proposed Pilot Program Design and RFP Release

Motion: That the Commission hereby approves the proposal for a pilot program to accelerate adoption of best practices related to treatment and prevention of neonatal abstinence syndrome, as endorsed by the Quality Improvement and Patient Protection Committee, and authorizes the Executive Director to issue a Request for Proposals (RFP) to solicit competitive proposals according to the framework described in the documents presented and, as applicable, pursuant to 958 CMR 5.04.

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  - Update on Patient-Centered Medical Home Certification Program
- Community Health Care Investment and Consumer Involvement
- Schedule of Next Meeting (January 20, 2015)

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Discussion Preview: PCMH Certification Criteria

Agenda Topic

Patient-Centered Medical Home Certification Criteria Discussion

Description

Staff will present detail for each PCMH PRIME criteria, mapping to current NCQA standards and documentation requirements. Staff will also present an update on program operations to get ready for January 1 launch.

Key Questions for Discussion and Consideration

Feedback on the documentation requirements for the 5 new HPC only criteria.

Decision Points

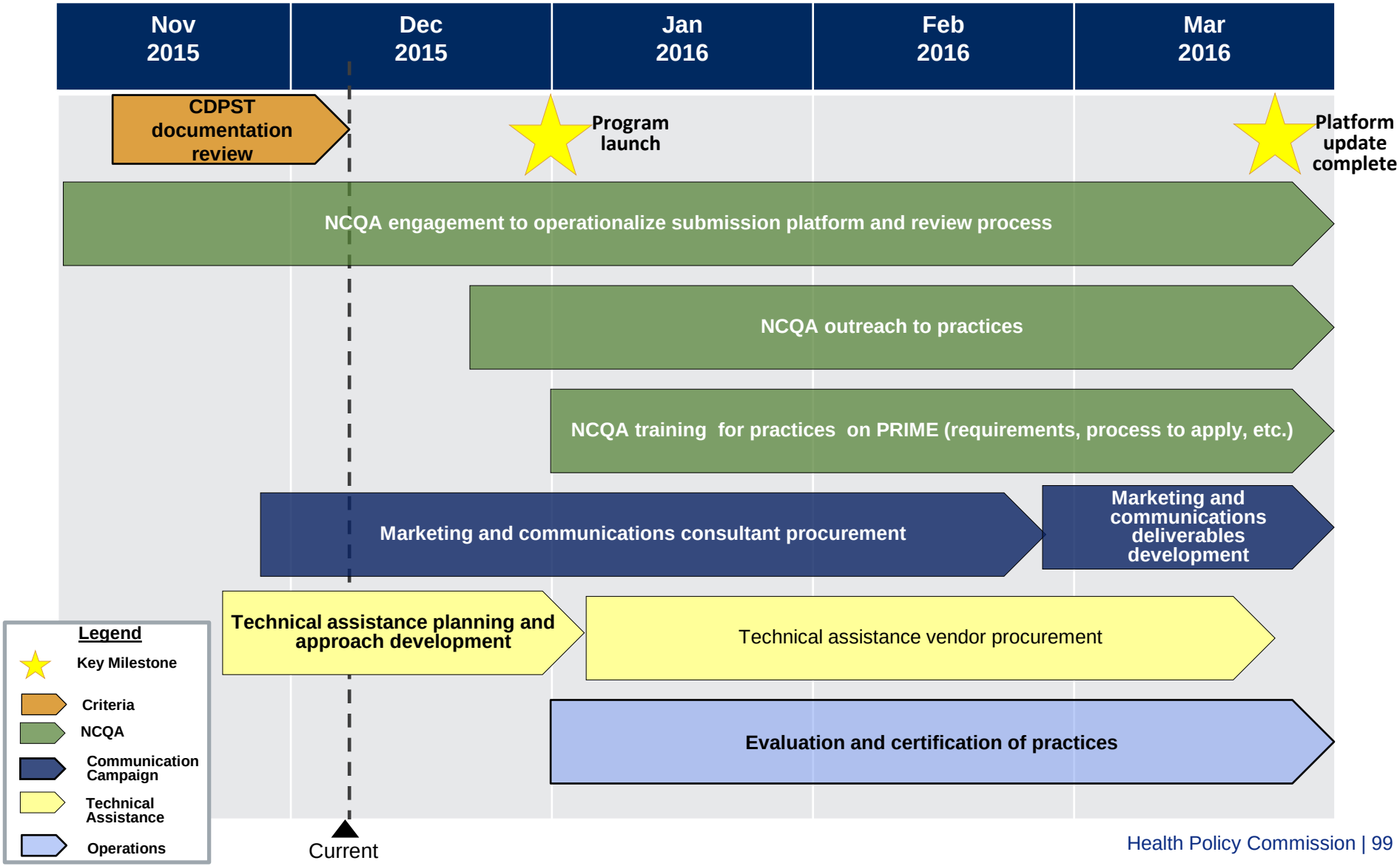
No votes proposed.

PCMH PRIME criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice **coordinates with behavioral healthcare providers** through formal agreements or has behavioral health providers located at the practice site.
2	The practice **integrates BHPs** within the practice
3	The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family.**
4	The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool.
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool.
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool.
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients).
8	The practice collects and regularly updates a comprehensive health assessment that includes postpartum depression screening for patients who have recently given birth using a standardized tool.
9	The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports.**
10	The practice implements clinical decision support following **evidence based guidelines** for a mental health and substance use disorder.
11	The practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions.
12	The practice has one or more providers in practice actively treating patients suffering from addiction with medication assisted treatment and appropriate counseling and behavioral therapies (directly or via referral)
13	If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health needs.

Proof of proficiency for criteria #2 automatically satisfies criteria #1

HPC PCMH PRIME operational plan



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Discussion Preview: Update on CHART Phase 2 Operations

Agenda Topic

Update on CHART Phase 2 Operations

Description

Staff will present an update on CHART Phase 2 planning and implementation progress to date. As of December 1, 2015, 22 of 25 CHART awards have launched. Holyoke Medical Center and Hallmark Health (Joint Award) launched on December 1. Staff will provide a brief overview of each award and commissioners will have an opportunity to ask about early successes and challenges.

Key Questions for Discussion and Consideration

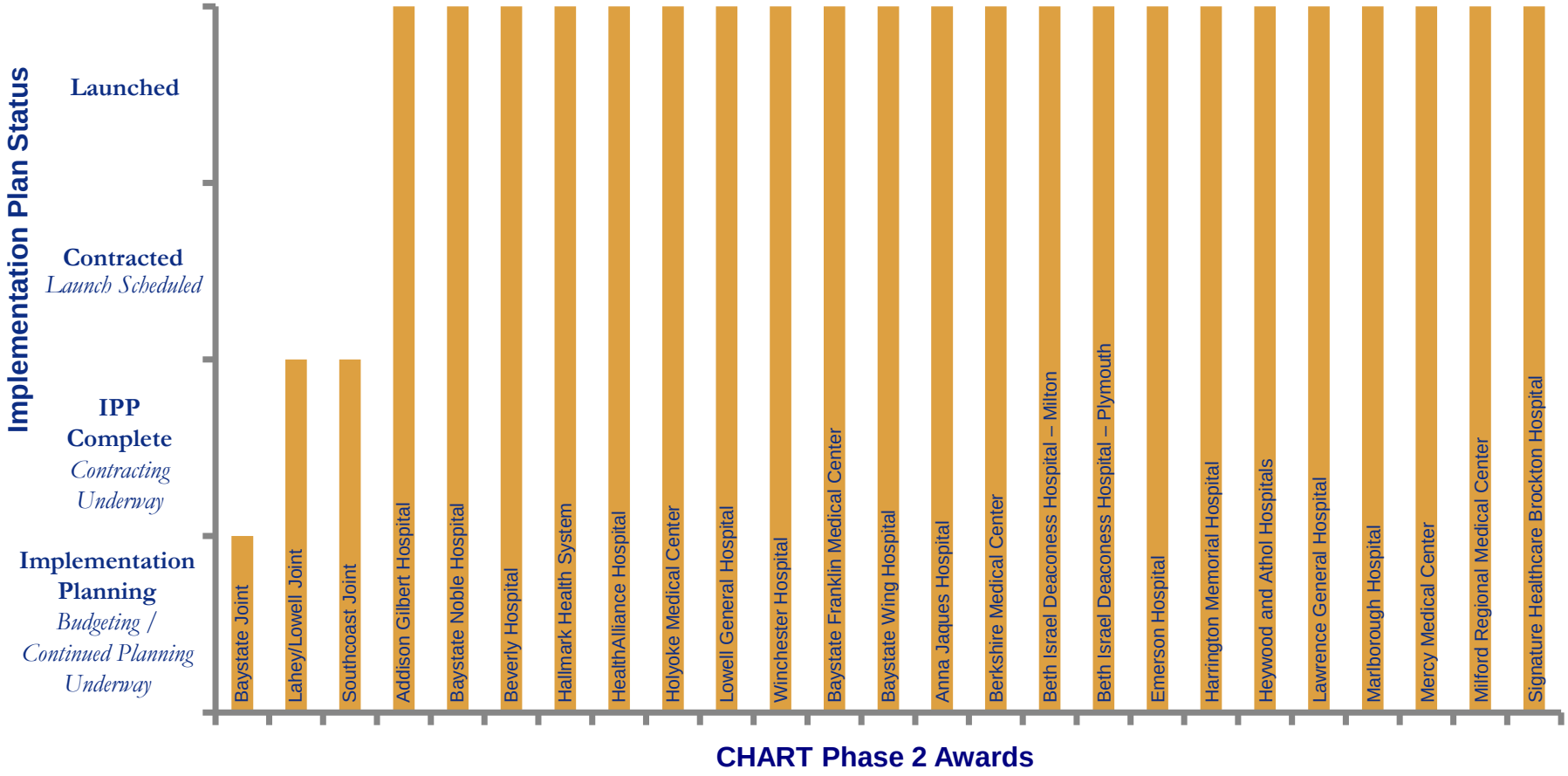
What updates on CHART Phase 2 hospital performance would be beneficial for the Committee to receive on a regular basis as hospitals move into operations?

Decision Points

No votes proposed. A full briefing on the first full quarter of performance will be provided in February 2016.

Implementation Plan status update

12 Awards launched in September and October; **8** Awards launched in November; **2** Awards launched in December; **3** Awards anticipated to launch in January



Two awards launched on December 1, both focused on enhancing behavioral health care and reducing ED utilization

Hallmark Health *$2,500,000*	Cross-setting, multi-disciplinary care team serving patients with a history of recurrent ED utilization or SUD, including specialized care for obstetric patients with active SUD to reduce ED utilization. Intensive outpatient BH treatment, care planning, and linkage to community resources.
Holyoke Medical Center *$3,900,000*	Cross-setting care teams serving patients with a history of recurrent ED utilization and BH diagnoses to reduce ED utilization. BH-trained ED RNs de-escalate, screen, and triage BH patients; multi-disciplinary outpatient clinic for intensive BH treatment, care planning, and linkage to community resources. Specialty ED capital project to improve care for BH patients

Holyoke Medical Center ER nurse manager calls expansion 'awesome'

"I felt bad for patients there because space is very tight, privacy is very difficult to achieve and we need to provide more dignity for people in the ED…In an area that is very busy, oftentimes what happens is the anxiety escalates and conditions get worse.

[The ED behavioral health wing] will address safety concerns [for patients with behavioral health conditions], but more importantly it will have an environment that de-escalates the anxiety, the issues [these patients] have.

Spiros Hatiras
President & CEO
Holyoke Medical Center

CHART-funded portion of the budget; in-kind and system contributions are additional

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Discussion Preview: CHART TA Contract

Agenda Topic

Approval of CHART Technical Assistance Contract Extension

Description

Staff will seek the Committee's endorsement of a proposed amendment to the Commission's contract with Collaborative Healthcare Strategies for an additional amount of up to $250,000 through June 30, 2016, for clinical expertise in ongoing support of the CHART Investment Program. Staff will present on the overall categories of professional services to support CHART and describe the role that Collaborative Healthcare Strategies fulfills in support of both CHART hospitals and the HPC.

Key Questions for Discussion and Consideration

What services does this contract provide for CHART hospitals?
Do CHART hospitals report value from these services?

Decision Points

Vote proposed. Commissioners will be asked to endorse the proposed contact amendment and recommend that the Board vote to approve it at the December 16, 2015 meeting

Overview of total professional services to support CHART investments

Relative Magnitude of HPC Professional Services Expenditures to Support CHART In FY16

Type of Professional Support	Description of Services	Aprox. Proportion of HPC Spending
Hospital Technical Assistance	Direct hospital support including one-on-one advising, regional meetings, training, subject matter expertise, and development of tools and content to support CHART hospitals	>50% Includes **Collaborative Health Strategies** and other contracts
HPC Strategic Consultation	Consultation supporting CHART program development and operations, including implementation planning, review and feedback on data and hospital reports, and development of tools to support hospital oversight	<25% Includes **Collaborative Health Strategies** and other contracts
Monitoring and Evaluation	Development and implementation of awardee monitoring tools (fiscal oversight) and an evaluation approach to garner learnings and assess impact of CHART investments	<25% Full funding to other contracts

More than half of total professional service budget projected to be spent on direct hospital support.

Vote: Approving Contract Extension

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the Executive Director is hereby authorized to amend the Commission's contract with Collaborative Healthcare Strategies for an additional amount of up to $250,000 through June 30, 2016, as endorsed by the Community Health Care Investment and Consumer Involvement Committee, for clinical expertise in ongoing support of the Commission's Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program, subject to further agreement on terms deemed advisable by the Executive Director.

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Contact Information

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