MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

March 29, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the February 8, 2017 Meeting
- Commissioner Updates
- 2018 Health Care Cost Growth Benchmark
- Cost Trends and Market Performance
- Executive Director’s Report
- Schedule of Next Board Meeting (May 10, 2017)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on February 8, 2017 as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Call to Order
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  - Vice Chair Appointment (VOTE)
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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Vice Chair Appointment

MOTION: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby re-appoints Dr. Wendy Everett to serve a one-year term as Vice Chairperson of the Health Policy Commission.

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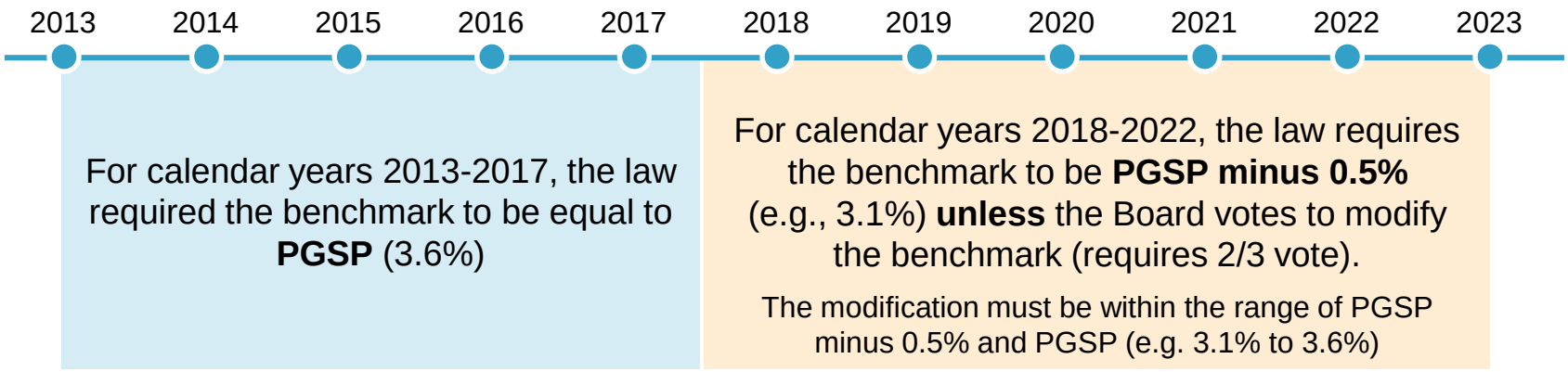
Benchmark Modification Process Overview

- For the first time, in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for calendar year 2018)**, pursuant to a public hearing process and engagement with the Legislature.

- The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January 15 (when the PGSP is established in the consensus revenue process) and April 15.



- "For calendar years 2018 through 2022, if the commission determines that an adjustment in the health care cost growth benchmark is **reasonably warranted**...the board of the commission may modify the health care cost growth benchmark…" between -0.5 and PGSP

Benchmark Modification Process – Key Steps

HPC ROLE

- HPC Board must hold a **public hearing** prior to making any modification of the benchmark
- Hearing must consider testimony, information, and data on whether modification of the benchmark is appropriate:
  - **Data**: CHIA annual report, other CHIA data, or other data considered by the Board
  - **Information**: "health care provider, provider organization, and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system"
  - **Testimony**: representative sample of providers, provider organizations, payers and other parties determined by HPC
  - The Joint Committee on Health Care Financing may participate in the hearing
- Following a potential vote to modify, the HPC Board **must submit notice** of its intent to modify the benchmark to the Joint Committee

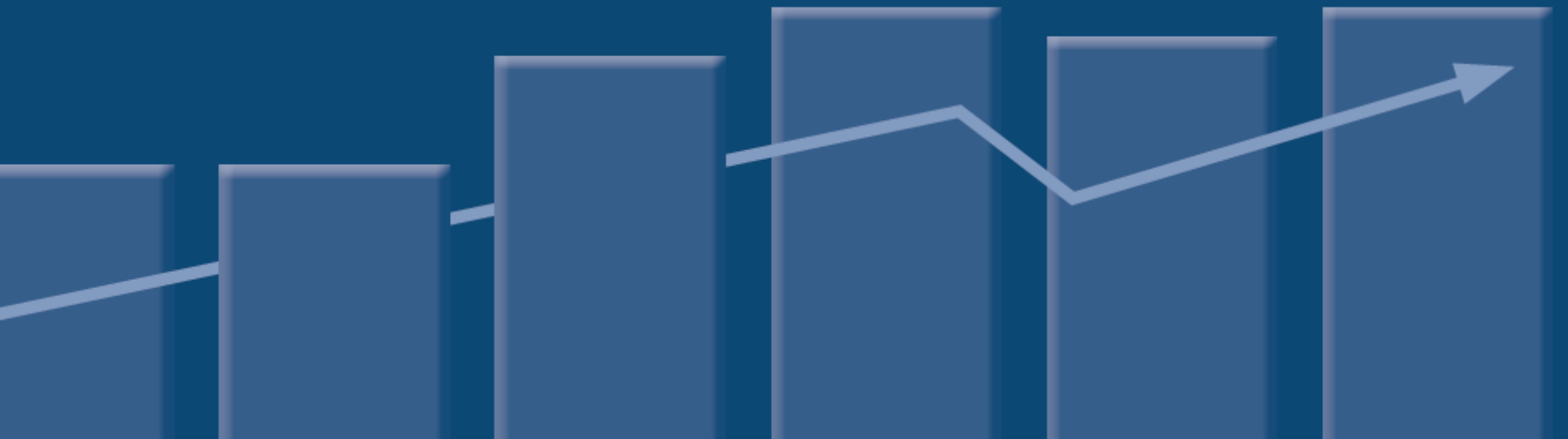
LEGISLATIVE PROCESS

- Joint Committee must hold a public hearing within 30 days of notice
- Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing
- General Court must act within 45 days of public hearing or the HPC Board's modification of the benchmark takes effect

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK



By the Numbers

HPC BENCHMARK MODIFICATION HEARING

1ST

MEMBERS OF JOINT COMMITTEE ON HEALTH CARE FINANCING

14

12

ORGANIZATIONS PROVIDED ORAL TESTIMONY

19

ORGANIZATIONS SUBMITTED WRITTEN TESTIMONY

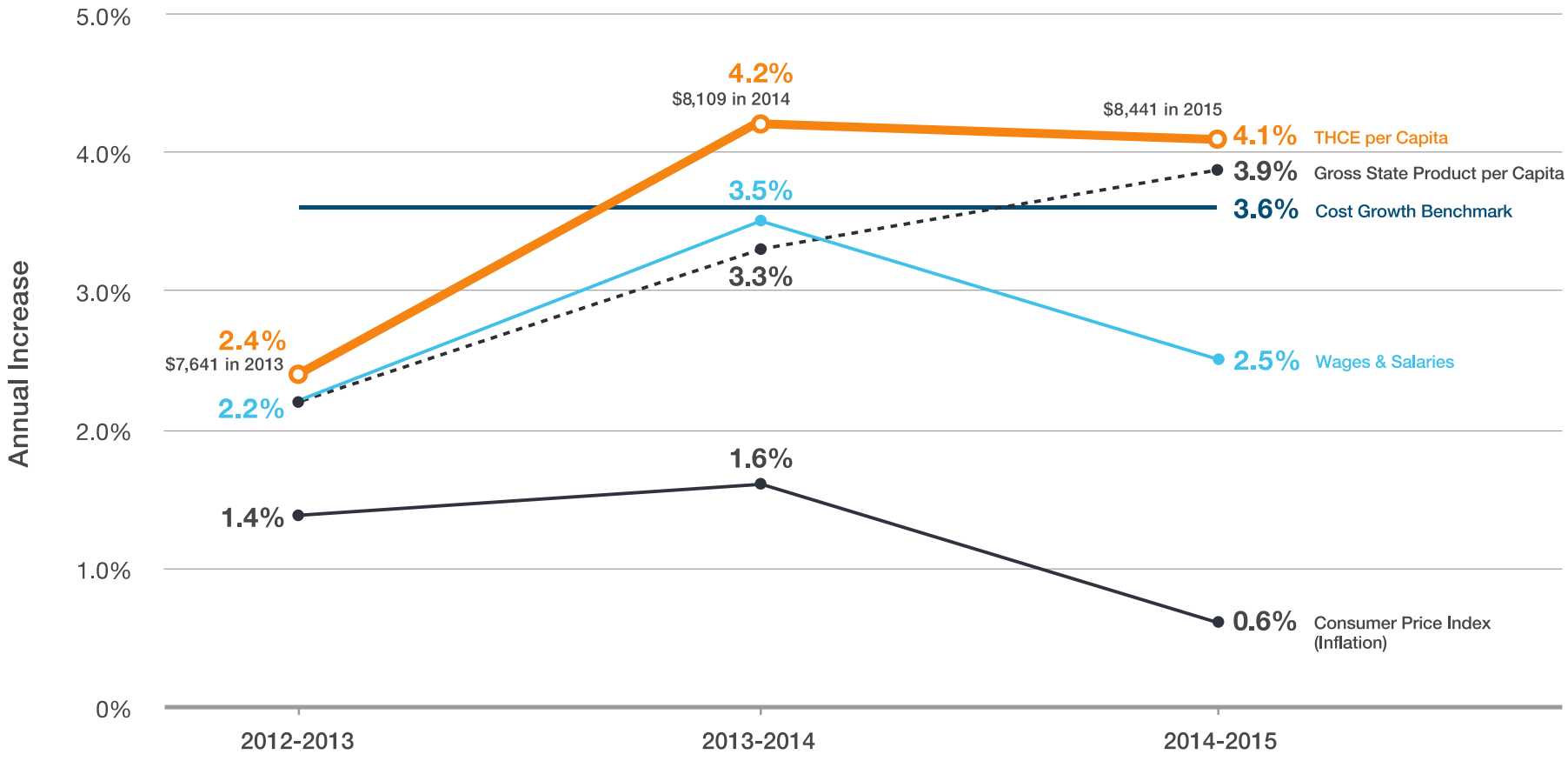
HPC

Factors to Consider in Determination of Whether an Adjustment is Reasonably Warranted

1. Massachusetts' health system performance to date
2. Impact of enrollment and demographic changes on performance
3. Opportunities for and barriers to additional savings in Massachusetts
4. Financial impact of modifying the benchmark
5. Significant changes to the state or federal health care landscape
6. Role of the benchmark in the HPC's statutory responsibilities
7. Feedback from market participants and interested parties

HPC

Total Health Care Expenditures in the Commonwealth, 2012-2015



Sources:
THCE: Payer reported data to CHIA and other public sources; Cost Growth Benchmark: Health Policy Commission; Gross State Product: U.S. Bureau of Economic Analysis; Consumer Price Index: Bureau of Labor Statistics; Wages and Salaries: Bureau of Labor Statistics

Population Aging

- The Massachusetts population is aging

	2011	2015	2019
Average age	38.8 years	39.4 years	40.2 years
% of state residents 65+	13.9%	15.4%	17.0%

- Older residents have higher spending

Age	0-18	19-44	45-64	65-84	85+
Average PMPY spending	$3,394	$4,260	$9,091	$16,123	$30,972

- Relative population aging contributes consistently to notable TME growth

	2012-2015	2016-2019
TME growth per year due to relative aging	+0.5%	+0.6%

Notes: Resident spending by age bracket are national CMS estimates.

Estimated opportunity for savings for improving care and reducing costs

SCENARIO	'LOW' SAVINGS	'HIGH' SAVINGS
I. Shift community-appropriate inpatient care to community hospitals	$43m	$86m
II. Reduce hospital readmissions	$61m	$245m
III. Reduce avoidable emergency department use	$12m	$24m
IV. Reduce use of institutional post-acute care	$47m	$186m
V. Adjust premiums based on primary care provider total medical expenditures	$36m	$72m
VI. Increase participation in alternative payment methodologies	$23m	$68m
VII. Reduce rate of growth in prescription drug spending	$57m	$113m
Total	**$279 million (~0.5% THCE)**	**$794 million (~1.3% THCE)**

HPC

Key Takeaways

1 Massachusetts' health system performance to date

Presentations

- Per capita THCE growth has outpaced the growth of wages, inflation, and actual economic growth
- Hospital and professional spending accounted for 55% of total spending increases from 2013 – 2015
- Pharmacy spending was the fastest growing type of service
- Total national health expenditures (not per capita) grew at about 5% each year from 2014 through 2016

Public Testimony

- Spending growth has not been constant across sectors of the health care system or across spending categories
- The HPC should look at these differential growth rates when contemplating requiring a PIP

Key Takeaways

2 Impact of enrollment and demographic changes on performance

Presentations

- The aging population alone will cause per capita THCE growth of approximately 0.6% each year through 2019

Public Testimony

- The aging population is likely to increase costs and demand for certain services, such as home health
- These costs reflect increased utilization of needed services, which may be considered positive spending

3 Opportunities for and barriers to additional savings in Massachusetts

Presentations

- Massachusetts could save between 0.5% and 1.3% of THCE without jeopardizing quality by achieving some of the of the recommendations in the 2016 Cost Trends Report

Public Testimony

- Massachusetts can achieve savings through a variety of strategies:
  - Reducing waste
  - Optimizing the use of high-value providers
  - Supporting value-based insurance design

HPC

Key Takeaways

4 Financial impact of modifying the benchmark

Presentations

- Increasing the benchmark from 3.1% to 3.6% would allow approximately $300 million in additional spending
- Health care affordability continues to be a threat to low and middle income residents

Public Testimony

- Rising health care costs place a serious economic burden on employers, individuals, and families
- Health care costs are crowding out other areas of spending in Massachusetts

Key Takeaways

5 Significant changes to the state or federal health care landscape

Presentations

- Potential federal health care changes may impact both national and Massachusetts spending

Public Testimony

- Payers and providers are facing an unprecedented level of uncertainty at the state and federal level
- Some argued that this uncertainty weighs in favor of giving providers and payers more flexibility to adapt with a higher benchmark
- Others argued that these changes create even greater urgency to find effective cost control mechanisms and advocated for a lower benchmark

Key Takeaways

6 Role of the benchmark in the HPC's statutory responsibilities

Presentations

- CHIA refers entities to the HPC whose HSA TME growth is "excessive" and who "threaten the benchmark"
- The HPC reviews each referred entity and has discretion to require a PIP or conduct a CMIR

Public Testimony

- A lower benchmark could mean an increase in the number of organizations referred to the HPC for a potential PIP or CMIR
- The HPC should consider the impact of costs that are largely outside of entities' control, such as drug spending and labor costs, before requiring a PIP

7 Feedback from market participants and interested parties

Public Testimony

- Just over half of the organizations advocated for a specific growth rate, while some chose to only submit factors and data for the HPC's consideration
- 10 out of the 11 organizations that took a formal position recommended the HPC keep the statutory 3.1% benchmark.

Summary of Public Testimony

Organization	Position
1199SEIU United Healthcare Workers East	No formal position
American Nurses Association Massachusetts	No formal position
Associated Industries of Massachusetts	3.1%
Association of Developmental Disabilities Providers	Concerned with 3.1%
Beth Israel Deaconess Care Organization	No formal position
Conference of Boston Teaching Hospitals	No formal position
Greater Boston Interfaith Organization	3.1%
Health Care for All	3.1%
Kathleen Keough, Ph.D. RN-BC	3.1%
Massachusetts Association of Health Plans	3.1%
Massachusetts Council of Community Hospitals	3.1%
Massachusetts Health and Hospital Association	3.1%, with caveats
Massachusetts Medical Society	3.6%
Massachusetts Nurses Association	No formal position
Massachusetts Senior Care Association	No formal position
Massachusetts Taxpayers Foundation	3.1%
Mental Health Legal Advisor Committee	No formal position
Retailers Association of Massachusetts	3.1%
Steward Health Care System	3.1%

MASSACHUSETTS
HEALTH POLICY COMMISSION

POTENTIAL VOTE: 2018 Health Care Cost Growth Benchmark

MOTION: That, pursuant to G.L. c. 6D, § 9, based on Potential State Gross Product as determined jointly by the Secretary of Administration and Finance and the House and Senate Ways and Means Committees, the Commission hereby establishes the health care cost growth benchmark for calendar year 2018 as ____%.

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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	18	24%
Physician group merger, acquisition, or network affiliation	18	24%
Acute hospital merger, acquisition, or network affiliation	15	20%
Formation of a contracting entity	13	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	6	8%
Change in ownership or merger of corporately affiliated entities	5	7%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- Proposed acquisition of First Psychiatric Planners d/b/a **Bournewood Hospital (Bournewood)**, a for-profit psychiatric hospital located in Brookline, by **Alita Care**, a for-profit Delaware company that owns and operates residential and outpatient behavioral health treatment facilities in eight states, including one in Massachusetts.
  - Our analysis suggested limited scope for changes in health care spending, given that no substantial changes in Bournewood's services or operations are expected as a result of the transaction.
  - We did not find any evidence suggesting negative impacts on quality or access.
- Proposed formation of a new contracting entity by **Berkshire Health System (BHS)**, Partnership for Health in the Berkshires (PHB), to contract on behalf of BHS (including Berkshire Medical Center), physicians affiliated with BHS, and certain other physicians practicing in Berkshire County.
  - Our analysis indicated little difference in physician rates between BHS and independent Berkshire physicians, but the potential for an increase in market share for BHS as physicians join PHB.
  - However, BHS stated that it has no plans to seek price increases for these physicians as a result of this new affiliation, and would cooperate with the HPC on any future evaluation of this transaction. Given this commitment, our analysis suggested limited scope for changes in health care spending.
  - We did not find any evidence suggesting negative impacts on quality or access.

Elected Not to Proceed

- Proposed clinical affiliation between **UMass Memorial Health Care** and **Dana-Farber Cancer Institute (DFCI)**, under which UMass Memorial Medical Center (UMass) would become a member of the Dana-Farber Cancer Care Collaborative and DFCI would provide certain consulting, educational, and clinical support services to UMass and its patients.
  - Our analysis suggested limited scope for changes in health care spending, given that the transaction is not likely to significantly impact referral patterns for medical oncology services.
  - We did not find any evidence suggesting negative impacts on quality or access.

- Proposed acquisition of **PMG Physician Associates (PMG)**, a 19-physician practice in the greater Plymouth area, by **Atrius Health**. PMG consists largely of primary care physicians and currently contracts through Beth Israel Deaconess Care Organization (BIDCO).
  - Our analysis suggested some potential for increased spending as PMG leaves BIDCO and joins Atrius contracts, although price and TME differentials between Atrius and BIDCO have been decreasing over time.
  - However, the transaction is anticipated to decrease primary care market concentration in PMG's service area.
  - We did not find any evidence suggesting negative impacts on quality or access.

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Performance Improvement Plans: Purpose

PIPs are one of the key mechanisms by which the HPC can **enforce the benchmark** and ensure accountability to the Commonwealth's cost containment goals.

PIPs provide an opportunity for the HPC and for payers and providers undergoing a PIP to **understand the drivers** of its cost growth, and to **pursue best practices** to address them.

The PIP process enables entities to **explore options to reduce cost growth** such as changing pricing or referral practices or implementing care delivery reform.

Entities undergoing a PIP will **provide updates to the HPC** on their progress and will have the opportunity to **receive consultation and technical assistance** from the HPC.

Overview of Regulatory Process

Mar.	Released interim guidance
Nov.	Board declines to require a PIP based on the 2015 CHIA list
Dec.	Discussed draft regulation and forms with CTMP
Jan.	Expert and stakeholder outreach on drafts
Jan.	Further discussion with CTMP, vote on advancement to Board
Mar.	Discussion with Board and vote to release drafts for public comment
Mar.	Public hearing, public comments, and updates to drafts as appropriate
Mar.	CTMP Vote to advance regulation to Board
TODAY	**Full Board vote to issue final regulation**

HPC

Comments and Proposed Updates to Regulation

Testimony Received From

Beth Israel Deaconess Care Organization
Blue Cross Blue Shield of Massachusetts
Massachusetts Association of Health Plans
Partners HealthCare System
Steward Health Care System

Section	Comment	Recommendation
10.04(3) and (4)	Entities should have the chance, before a public Board vote for a PIP, to: • **Review data** relied upon by HPC; and • **Meet with HPC.**	**Add to section 10.04:** Prior to the Board vote, the entity will receive written notice, the opportunity to review data relied upon by the HPC, and the opportunity to meet with the Executive Director.
10.08(8)	The notice that HPC has denied an extension request should **include the reasons for the denial.**	**Add clause to 10.08(8)** stating that the denial notice will include "the reason for the denial."

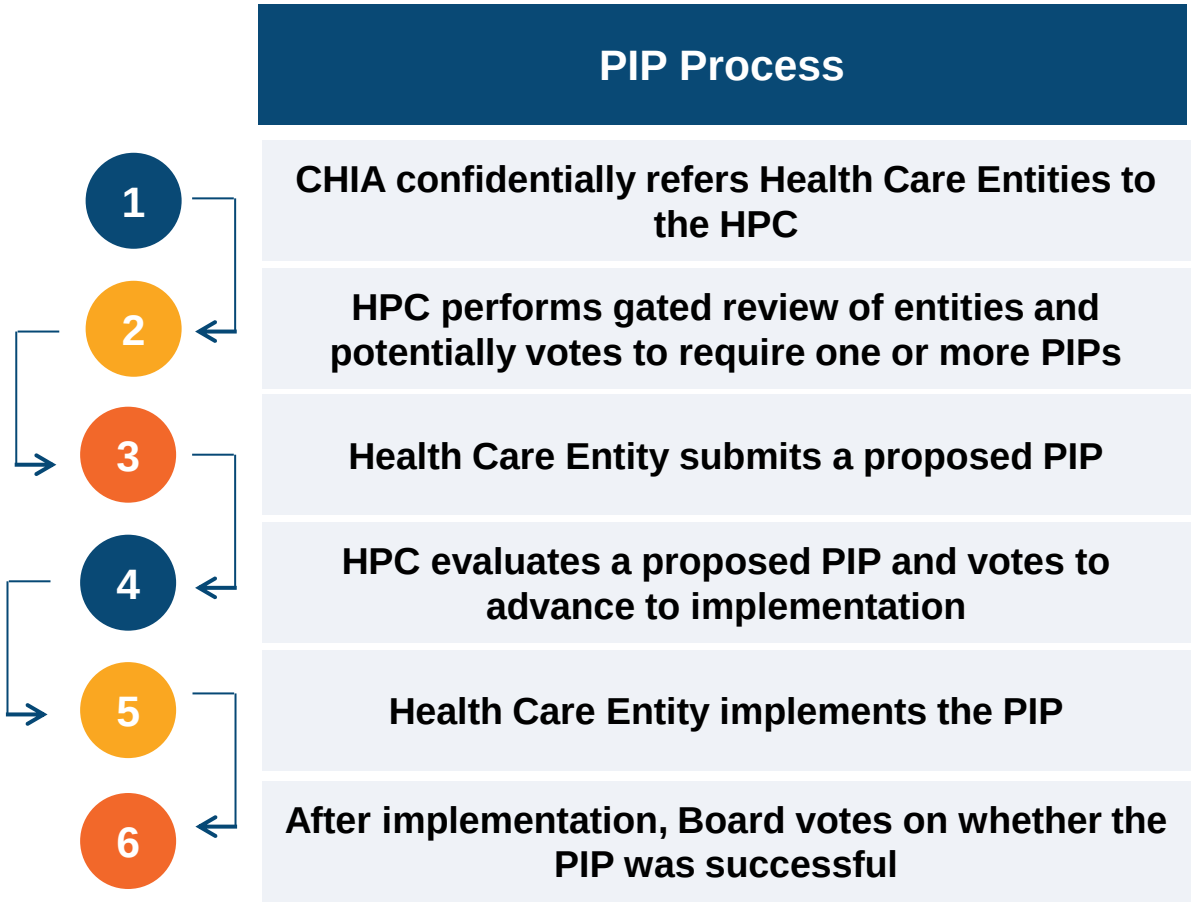
Comments and Proposed Updates to Regulation

Section	Comment	Recommendation
10.04(1)	Articulate a **clear, numerical standard** for the "significant concern" that would justify a PIP.	**No change.** The analysis should accommodate a variety of entities and case-by-case review.
10.04(2) **10.10(2)** **10.13(3)**	Add **additional, more specific factors** for determining whether to: • Require a PIP; • Approve or deny a proposed PIP; or • Deem a PIP successfully implemented.	**Add to 10.04(2)(d) , (f) and (i):** **"**Payer mix," "cost structure," and "any other factors the Commission considers relevant." Other suggested factors can be considered under the existing factors.
10.10(5)	The notification that a PIP proposal was unacceptable or incomplete should be by **both hardcopy and electronic copy.**	**No change.** 958 CMR 10.10(5) states that the HPC will notify the entity.

Other Proposed Changes to Regulation

Section	Issue	Recommendation
10.16	Draft regulation unintentionally omits the requirement of a **Board vote to initiate a CMIR** on named provider organizations, and does not grant the opportunity to review the HPC's data and meet with the HPC.	**Add 10.16(2):** The entity may review the HPC's data and meet with the HPC prior to a Board vote. **Add 10.16(3): "**The Commission shall determine whether to initiate a Cost and Market Impact Review by vote of the Board."

Performance Improvement Plans: Overview



Proposed Implementation Process

Step 1: Identification by CHIA

Provided to Commissioners	The final confidential list of entities identified by CHIA
Board Input	Comments or recommendations regarding the list

Step 2: Requirement to File a PIP

Provided to Commissioners	a) Results of the review process b) Recommendations to conclude the review process or request additional information from an entity c) Summary and analysis of additional information received d) Notice of any meeting scheduled with an entity
Board Input	Comments or recommendations regarding the review and requests for additional information
Board Vote	Whether to require a PIP

Proposed Implementation Process

Step 3: Extensions or Waivers

Provided to Commissioners	a) Entities' waiver/extension requests, including supporting information b) Whether the ED has granted an extension request of ≤ 45 days
Board Vote	To grant an extension of >45 days or a waiver

Step 4: Approval of Proposed PIP

Provided to Commissioners	a) Information related to the development of the PIP proposal b) Staff analysis of the PIP proposal c) Any additional information provided by the entity
Board Input	Comments or recommendations regarding a PIP proposal
Board Vote	To approve a proposed PIP

Proposed Implementation Process

Step 5: Implementation of PIP

Provided to Commissioners	a) Reports on the implementation, reporting, and monitoring of the PIP at Commission meetings b) Other periodic reports c) Any proposed amendments
Board Vote	To approve significant proposed amendments

Step 6: Conclusion of PIP

Provided to Commissioners	Information related to the conclusion of the PIP
Board Vote	To determine whether the PIP was successful

Proposed Implementation Process

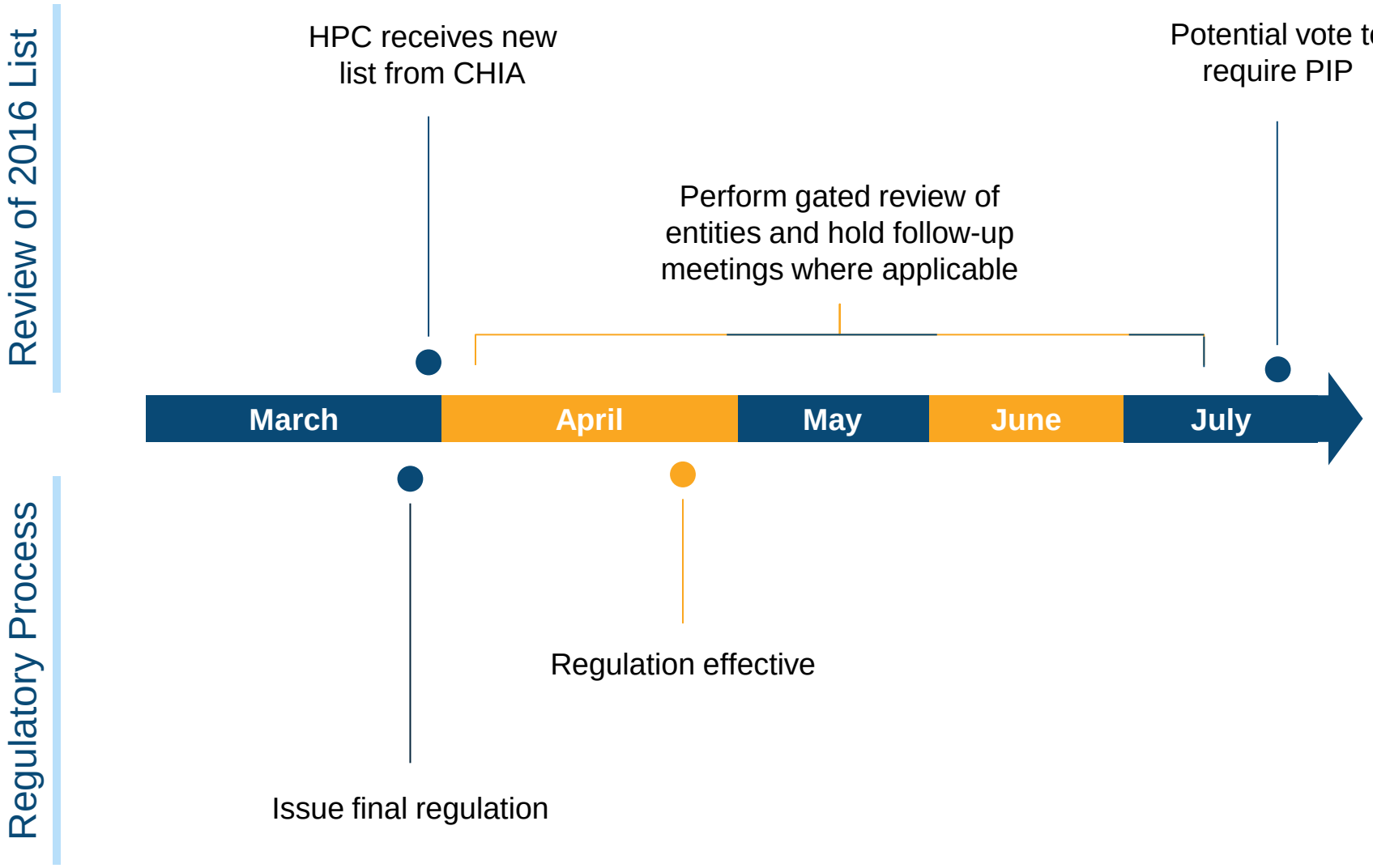
Step 7: Assessment of Penalty

Provided to Commissioners	a) All information relevant to a determination whether to assess a civil penalty b) Notice of any hearing afforded the entity
Board Vote	To assess a civil penalty to an entity of not more than $500,000

Step 8: Initiation of CMIR

Provided to Commissioners	a) All information relevant to a determination whether to initiate a CMIR b) Recommendations to request additional information from an entity c) Summary and analysis of additional information received d) Notice of any meeting scheduled with an entity
Board Input	Comments or recommendations regarding requests for additional information
Board Vote	To determine whether to initiate a CMIR

Next Steps



All dates are approximate.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Final Regulation on Performance Improvement Plans

MOTION: That the Commission hereby approves and issues the attached FINAL regulation on performance improvement plans, 958 CMR 10.00, pursuant to M.G.L. c. 6D, § 10 and § 13.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Policy on Process for PIPs and CMIRs

MOTION: That the Commission hereby approves and adopts the attached Policy on Process for Initiating Performance Improvement Plans and Cost and Market Impact Reviews pursuant to 958 CMR 10.00.

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  - Office of Patient Protection
  - Care Delivery Certification Programs
  - HCII Program
  - CHART Investment Program
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The HPC is charged in statute with advancing four policy priority outcomes.

Fostering a value-based market	in which payers and providers openly compete, and providers are supported and equitably rewarded for providing high-quality and affordable services.
Advancing aligned and effective financial models	for providers to deliver high-quality, cost effective care and for consumers and employers to make high-value choices for their care and insurance coverage.
Promoting an efficient, high-quality system	that improves health by delivering coordinated, patient-centered health care that accounts for patients' behavioral, social, and medical needs.
Enhancing transparency	of health care system performance in order for health care stakeholders and agencies to successfully implement reforms and evaluate performance over time.

Development and Promotion of Policy to Advance the HPC's Mission: Four Core Strategies

RESEARCH AND REPORT

INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS

CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

MONITOR AND INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE

PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

2016 Cost Trends Report: Recommendations to Advance the Priority Policy Outcomes

FOSTERING A VALUE-BASED MARKET

1. Health Care Equity and Affordability*
2. Pharmaceutical Spending*
3. Out-of-Network Billing *
4. Provider Price Variation*
5. Facility Fees
6. Community-Appropriate Care*

PROMOTING AN EFFICIENT, HIGH-QUALITY SYSTEM

7. Unnecessary Hospital Use and Other Institutional Care*
8. Substance Use Disorder Treatment
9. Adherence to Evidence-Based Care

ADVANCING ALIGNED AND EFFECTIVE FINANCIAL MODELS

10. Adoption of Alternative Payment Models (APMs)*
11. Alignment and Improvement of APMs
12. Demand-Side Incentives

ENHANCING TRANSPARENCY

13. Data and Measurement*

HPC * Identified by Board members at the February 8, 2017 Board meeting as potential high-impact activities.

Estimated Opportunities for Savings for Improving Care and Reducing Costs

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II. Reduce hospital readmissions	$61m	$245m
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HPC

Proposed Framework for Board Discussion on May 10, 2017

Board discussion on policy priorities for 2017-2018

Focus and align HPC activities towards that strategic direction

Proposed approach:

1. **Map** how current and planned HPC activities align with priority policy outcomes.
2. **Identify and focus** on the HPC's activities and strategies that can best be leveraged to achieve the priority policy outcomes.
3. **Define metrics and targets** to hold the health care market's performance accountable to meeting the priority policy outcomes.
4. Consider **new ideas** that align with the HPC's mission and statutory mandate.

Save the Date

MONDAY
April 10, 2017
11:30AM

UMass Club
One Beacon Street, 32nd Floor
Boston, MA 02108

MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC SPECIAL EVENT

Consumer Preferences, Hospital Choices, and Demand-Side Incentives

The HPC is hosting a special event to release new findings and discuss consumer preferences, hospital choices, and demand-side incentives. With funding from the Robert Wood Johnson Foundation, HPC staff, in conjunction with researchers from Tufts Medical School, conducted research to evaluate a patient's choice of community hospitals versus academic medical centers. Researchers from Harvard University will also present on a recent study they conducted on the impact of tiered network health plans on hospital choice and overall spending. The event will culminate with a stakeholder panel discussion.

Reserve your seat: tinyurl.com/HPCConsumerPreference

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Office of Patient Protection: External review process

Process for consumer with a fully-insured Mass. health plan, after pursuing internal review

1. Consumer receives 2nd denial from carrier	2. Consumer requests external review	3. Independent external review	4. Next steps
▪ Consumer receives written denial notice/final adverse determination from carrier ▪ External review if **medical necessity** ▪ Consumer may request expedited external review ▪ Consumer may request continuation of coverage	▪ Deadline: 4 months from the date the insured receives the final adverse determination ▪ Submit completed external review form, copy of final adverse or adverse determination & $25 fee if applicable, any supporting documents	▪ OPP reviews for eligibility ▪ If eligible, OPP sends to external review agency (ERA) ▪ ERA requests file from carrier ▪ ERA applies Mass. medical necessity standard ▪ Standard: 45 days ▪ Expedited: 72 hours	▪ ERA may uphold, overturn, or partially overturn ▪ ERA sends written decision to insured, representative, OPP, carrier ▪ Carrier must respond within 5 days, implement without delay ▪ Final and binding decision

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  - Office of Patient Protection
  - **Care Delivery Certification Programs**
  - HCII Program
  - CHART Investment Program
- Schedule of Next Board Meeting (May 10, 2017)

PCMH PRIME Participation Update

Since January 1, 2016 program launch

35 practices
are PCMH PRIME Certified

42 practices
are on the **Pathway to PCMH PRIME**

1 practices
are working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

78 Practices Participating

ACO Certification Program Recent Milestones

Beta Launch

Kickoff and Training Meeting

March 16

3 ACOs

Program Overview Webinar

March 22

~60

stakeholder attendees

ACO Certification Program Timeline

April 27, 2016 – *HPC Board approved final ACO Certification Criteria*

May 2016 – March 2017 – *HPC developed detailed requirements and application system*

March 2017 – June 2017 – Beta Launch for application system testing

Mid-June 2017 *(TBD)* **–** Application system open for all Applicants

October 1, 2017 – Application submission deadline for MassHealth ACOs

Rolling to December 1, 2017 – HPC issues certification decisions

HPC expects to issue decisions within 60 days of application receipt

Certification decisions are valid for 2 years

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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HPC's Health Care Innovation Investment Program: Preparation Period Update

The Health Care Innovation Investment Program is investing $11.3M in innovative projects that further the HPC's goal of **better health and better care at a lower cost** across the Commonwealth.

Health Care Innovation Investment Program
Round 1 – Three Pathways

- Targeted Cost Challenge Investments
- Telemedicine Pilots
- Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions

	Lower Costs	Greater Access	Better Outcomes
Primary Goal:			
Target Populations:	8 diverse cost challenge areas: SDH, BHI, VIC-Purchasers, VIC-Providers, Practice Pattern Variation, PAC, SAI & EOL, Site & Scope of Care	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Opioid-addicted mothers and substance-exposed newborns 
Number of Initiatives:	10	4	6

By the Numbers: Targeted Cost Challenge Investments

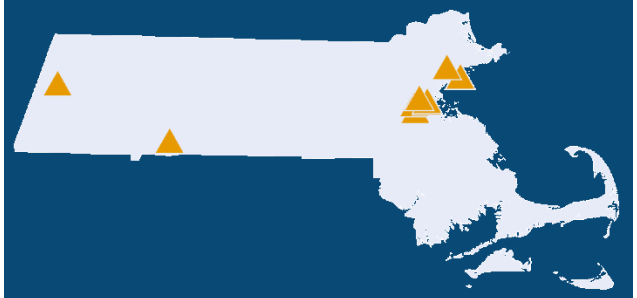
62
Organizations
(hospital, pharmacy, housing) collaborating on projects

Hospice and Palliative Care
Social Services
Academic Medical Centers
Community Hospitals
Home Care
Behavioral Health
Health Plans
Police and Judicial
Housing
Paramedicine & EMS
Pharmacy
Technology Firms
Researchers

10 initiatives
Funded by the HPC

5 out of 8
Targeted cost challenge areas awarded

Initiatives span the Commonwealth:
From the Berkshires to Boston



$6,600,000
HPC funding

>5,500 patients
will be targeted, from children, to homeless families, to older adults

50% of Preparation Period complete

>$40M
estimated impact in health care cost savings

HPC

By the Numbers: Telemedicine Pilots and NAS Interventions

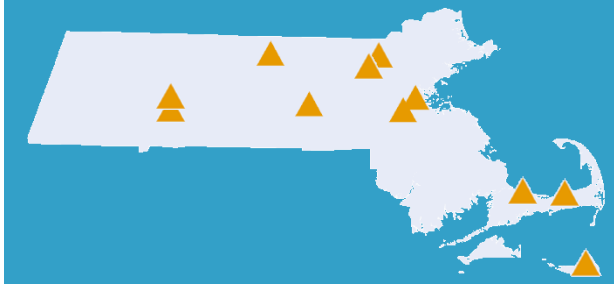
Telemedicine

4 initiatives
Funded by the HPC

$1,700,000
HPC funding

21 Organizations
(e.g. hospitals, schools, primary care practices) collaborating

Initiatives span the Commonwealth:
From the Holyoke to Cape Cod



Serve 900 patients
with Behavioral Health needs

60% of Preparation Period complete

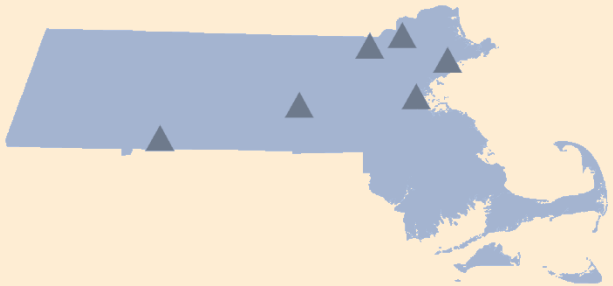
Neonatal Abstinence Syndrome Interventions

6 initiatives
Funded by the HPC

$3,000,000
HPC funding

59 Organizations
(e.g. hospitals, primary care practices, behavioral health providers) collaborating

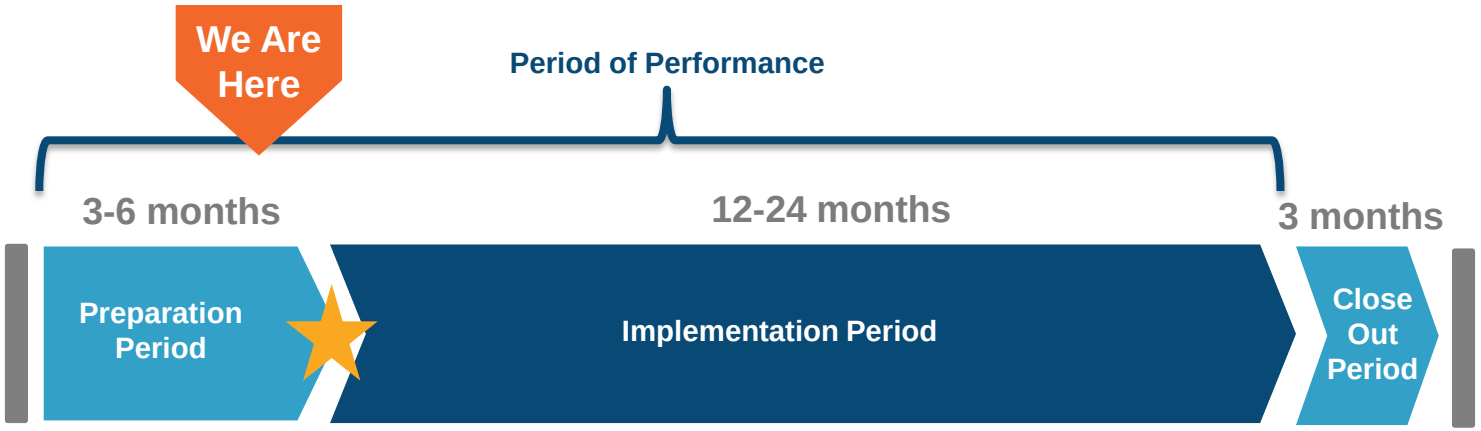
Initiatives span the Commonwealth:
From the Springfield to Middlesex County



>450 infants with NAS
treated in 2015 by HPC's proposed awardees

2 Initiatives Launched

HCII Program Timeline and Next Steps



Most Awardees are currently preparing for launch

- Hiring staff
- Creating protocols, deploying education and training
- Implementing technology
- Establishing governance structures and agreements
- Preparing measurement & self-assessment plans

MASSACHUSETTS
HEALTH POLICY COMMISSION

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CHART Phase 2: Progress as of March 2017

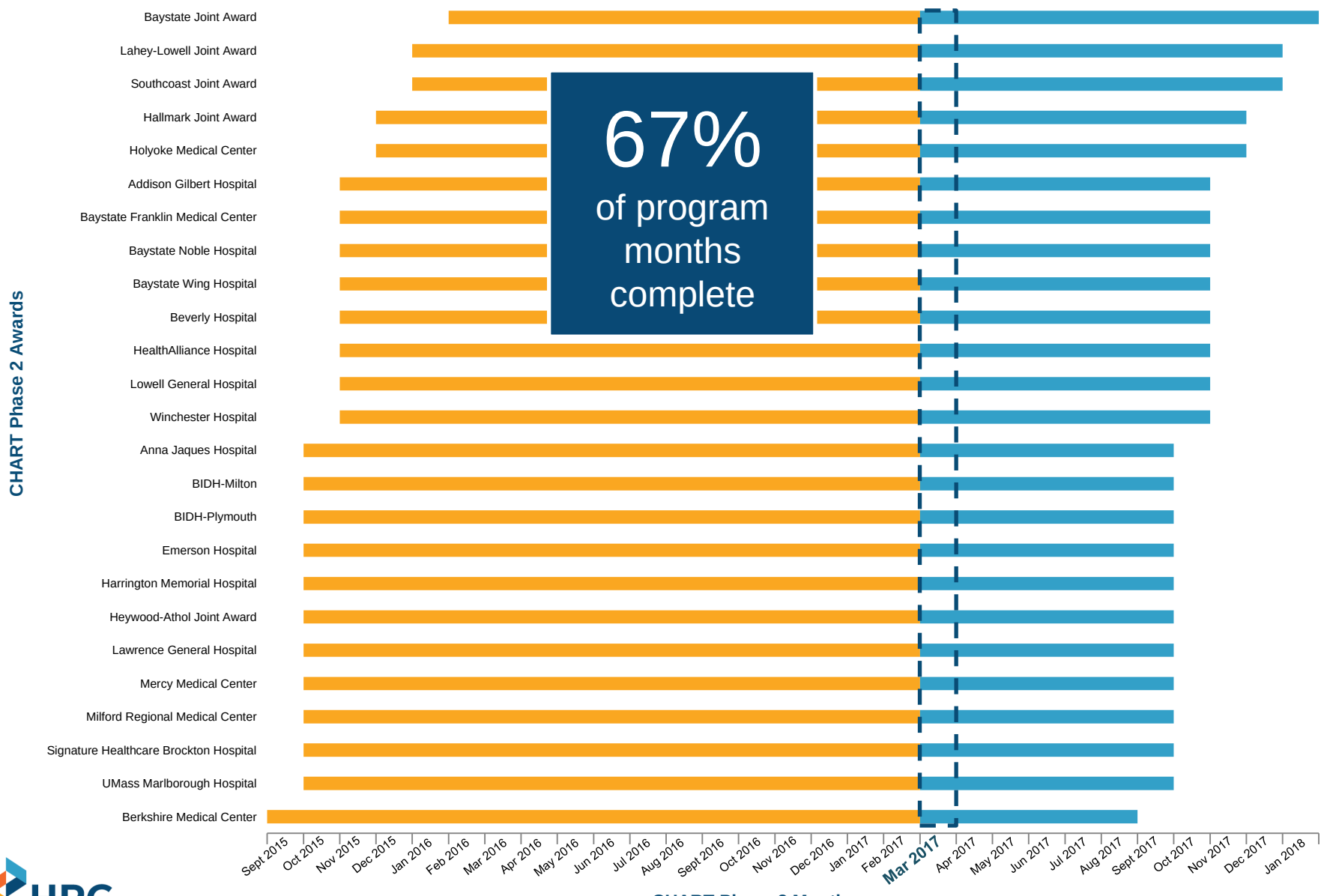


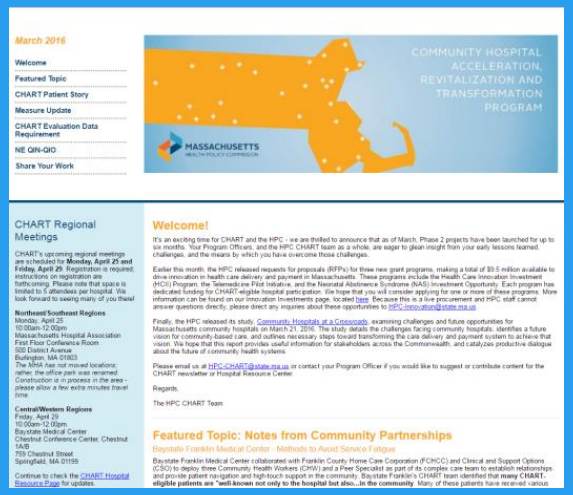
CHART Phase 2: Activities since program launch[1]

11
regional meetings
with
600+
hospital and community provider attendees

210+
technical assistance working meetings

600+
hours of coaching phone calls

15
CHART newsletters


March 2016

Welcome
Featured Topic
CHART Patient Story
Measure Update
CHART Evaluation Data Requirement
NE QIN-QIO
Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM
MASSACHUSETTS

CHART Regional Meetings

Welcome!

Featured Topic: Notes from Community Partnerships

3,012 unique visits to the CHART hospital resource page

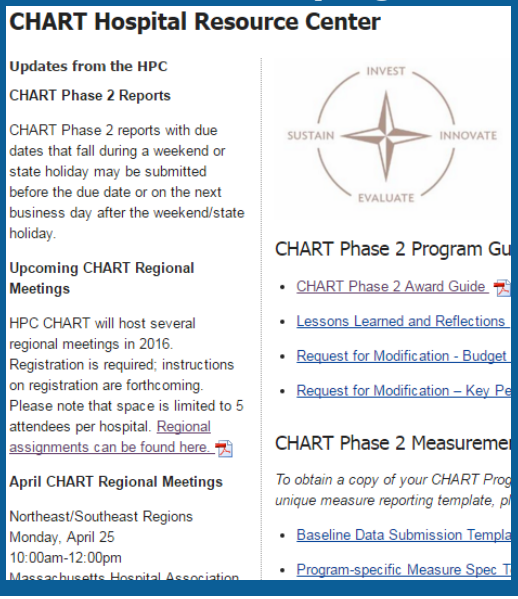


CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

HPC CHART will host several regional meetings in 2016. Registration is required; instructions on registration are forthcoming. Please note that space is limited to 5 attendees per hospital. Regional assignments can be found here.

April CHART Regional Meetings

Northeast/Southeast Regions
Monday, April 25
10:00am-12:00pm
Massachusetts Hospital Association

INVEST
SUSTAIN
INNOVATE
EVALUATE

CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide
- Lessons Learned and Reflections
- Request for Modification - Budget
- Request for Modification – Key Pe

CHART Phase 2 Measuremer

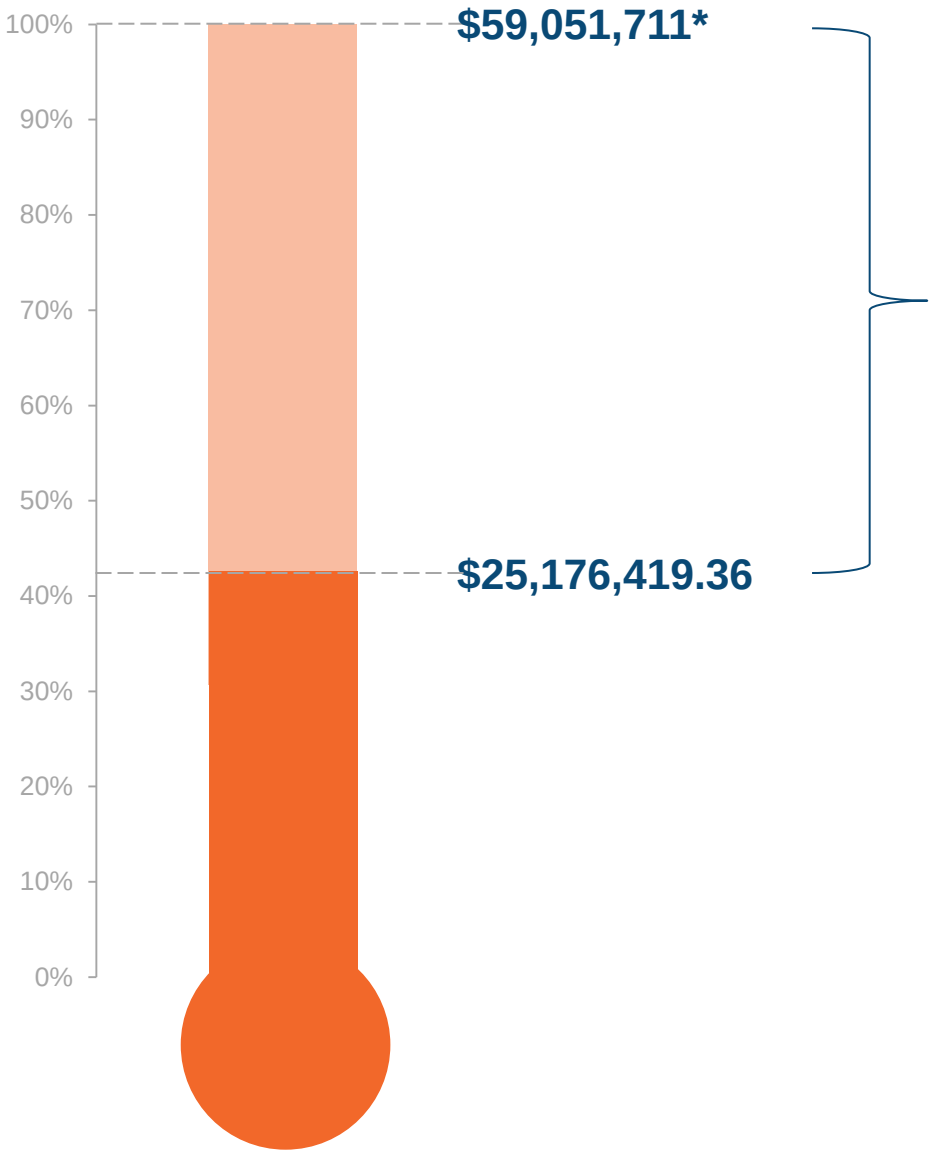
To obtain a copy of your CHART Prog unique measure reporting template, pl

- Baseline Data Submission Templa
- Program-specific Measure Spec T

375+
data reports received

[1] Updated through March 9, 2016. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

CHART Phase 2: The HPC has disbursed $25.2M to date



Remaining
$33,875,291.64
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

HPC

Updated March 9, 2017

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

CHART Phase 2 Evaluation Timeline

February 2017 – Hospital Survey Results

March 2017 – Baseline Summary Report

April 2017 – Awardee Memos

July 2017 – Interim Report

April 2018 – Patient Perspective Study Report

May 2018 - Awardee memos 2

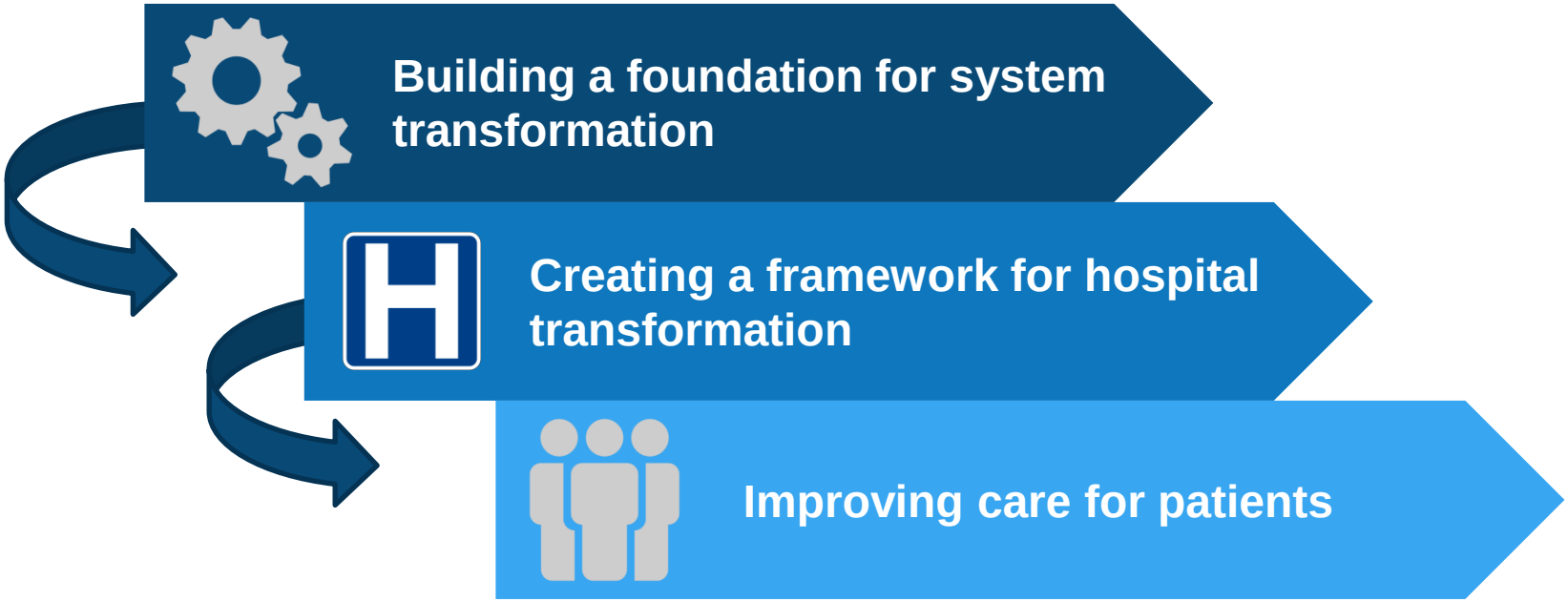
October 2018 - Theme Reports

January 2019 – Final summative Report

HPC

CHART Investment Priorities

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



Looking from Phase 1 to Phase 2 to Phase 3

Phase 1: Foundational Activities to Prime System Transformation $9.2M	Phase 2: Driving System Transformation $60M	Phase 3: Sustaining System Transformation Approx. $20M
▪ Modest investment with many eligible hospitals receiving funds	▪ Deeper investment in hospitals over a 2-year period of performance	▪ Support the successful transition to a sustainability model supported by market incentives and alternative payment models, including the MassHealth ACO program
▪ Short-term, high-need expenditures	▪ Focused areas for care transformation	▪ Continue and enhance the work of promising interventions from Phase 2
▪ Participation not requisite for receipt of Phase 2 funds nor a guarantee of Phase 2 award	▪ Data-driven approach	▪ Strengthen relationships with community partners
▪ Identified need to assess capability and capacity of participating institutions	▪ Outcomes-oriented aims and targets	▪ In-kind contributions from hospitals/systems
▪ Opportunity to promote engagement and foster learning	▪ Close engagement between awardees and HPC, with substantial technical assistance	▪ Alignment with MassHealth's DSRIP funding and programmatic goals

HPC

Stakeholder Input to Date

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

Preliminary Proposal for Structure of CHART Phase 3 as Discussed at March 25 CHICI Meeting

THEME

Enhancing and ensuring sustainability of community-focused, collaborative approaches to care delivery transformation and the successful adoption of alternative payment models, including the MassHealth ACO program

FUNDING

Proposed total funding of approximately $20M

FOCUS AREAS

Two pathways:

1. Limited bridge funding to continue promising interventions from Phase 2. Awards would be selective and would require hospital financial support, with a continued focus on:
   - Reducing unnecessary hospital utilization (readmissions, ED visits, ED Boarding, etc.)
   - Addressing whole patient needs with multi-disciplinary care teams
   - Identifying and engaging in real time with complex patients
   - Addressing social determinants of health
   - Strengthening community partnerships
2. Funding to support the successful adoption of alternative payment models, including strong alignment with the MassHealth ACO program, through continued capacity-building activities in various areas. For example:
   - Analytics/risk stratification expertise
   - Data exchange
   - Legal support for community partnership contracting
   - Business planning

Preliminary Proposal for Structure of CHART Phase 3 (continued)

COMPETITIVE FACTORS

- Solid sustainability plan
- Required in-kind funds from hospitals/systems to promote sustainability
- Supportive, but not duplicative, of DSRIP goals
- Participation in risk contracts with substantive quality measures and/or partnership with a provider organization seeking HPC ACO certification in 2017
- Performance in Phase 2
- Demonstration of understanding of the drivers of utilization
- Collaborative multi-disciplinary team approach to care delivery
- Strong relationships with community partners

OUTCOMES

- Address at least one or all of the HPC's key target areas for reducing unnecessary utilization and improving quality:
  - Reduce all-cause 30-day hospital readmissions
  - Increase the integration of behavioral health into primary care
  - Reduce the rate of discharge to institutional care following hospitalization
  - Reduce the rate of behavioral health related ED utilization

Next Steps

HPC to continue developing Phase 3 design, including:

- Comprehensive stakeholder engagement
- Increased specificity of focus areas and targets
- Adapting administrative framework to reflect early lessons learned from Phases 1 and 2
- Review of CHART Phase 2 performance at the one year mark

HPC to continue goal-setting activities, including evaluation framework and performance targets

Present RFR to Board on May 10, 2017, with planned release following Board vote

Proposed CHART Phase 3 Timeline

	Jan. 2017	Feb. 2017	March 2017	April 2017	May 2017	June 2017	July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec./ Jan. 2018
Design discussion	Advisory Meeting	Board meeting	CHICI meeting									
Stakeholder engagement												
Procurement and evaluation development												
RFR vote and release					Board meeting and RFR release		Respon ses due					
Board vote on Awardees									Board meeting			
Majority of Phase 2 Awards end										Phase 2 Ending		
Contracting												
Launch												★

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Contact Information

For more information about the Health Policy Commission:

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Follow us: @Mass_HPC

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