MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Meeting of the Cost Trends and Market Performance and Community Health Care Investment and Consumer Involvement Committees

October 18, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- Future Care Delivery Investments: Design Discussion
- CHART Phase 2 Investment Program
- Health Care Innovation Investments (HCII)
- Research Presentation: Methodology for Community Appropriate Care and Expanded Review of Post-Transaction Impacts
- Schedule of Next Meeting (December 6, 2017)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the joint Committee hereby approves the minutes of the joint CTMP/CHICI Committee meeting held on July 5, 2017, as presented.

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Goals and principles of HPC's care delivery investments

Vision for Care Delivery Transformation

A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement and the support of alternative payment.

Goals of investments

- To **accelerate transformation** of care **for people, families and communities**
- Support successful achievement of **target aims (e.g., readmissions, ED use)**
- Promote **state policy priorities** (e.g., addressing the opioid epidemic, integrating behavioral health)

Principles of investments

- **Meet providers where they are**
- Promote a **system of learning** and **continuous improvement**
- **Align** HPC and state activities for care delivery transformation (e.g., MassHealth DSRIP TA)
- **Minimize** administrative burden to and reporting by providers
- **Encourage partnership** and collaboration with community partners

Proposal: Dedicate approximately $10 million from the HPC Trust Funds for the next round of investment

Health Care Payment Reform Trust Fund

- Primary Purposes:
  - Grants to providers and their partners to foster innovation in health care payment and service delivery through a competitive grant program (“Health Care Innovation Investment Program”)
  - Technical assistance and provider supports related to the PCMH/ACO certification programs

Distressed Hospital Trust Fund

- Primary Purpose:
  - Grants to low-priced community hospitals and their partners to reduce unnecessary hospital utilization and enhance behavioral health through the Community Hospital Acceleration, Revitalization, and Transformation Investment Program (CHART)

All investment programs are rigorously designed to further the Commonwealth’s goal of better health and better care at a lower cost

Proposal: Ground design proposal in experience with CHART and HCII

Proposed design components are informed by HPC's experience with **$80M of awards**, spread **over 75 awards**

CHART

HCII

Tracks	Leverage HPC research to identify narrow targets with demonstrated efficacy that have not yet been scaled, but allow applicants to propose diverse models of achieving aims
Performance measures	Maximize value by focusing on a parsimonious set of core measures, but allow applicants to propose additional initiative-specific measures
Award size & duration	Allow for variation in size and duration of awards, but cap to ensure monies are widely dispersed and outcomes are achievable
Financial support & sustainability	Require in-kind contributions and strong sustainability plans to maximize long term impact of investment
Competitive factors	Incent and reward partnerships that best meet patient needs and reinforce system accountability
Building the evidence base	There is utility in using investments to continue to build the evidence base/ return on investment case for innovative care models that integrate medical, behavioral and social needs.

HPC

Proposal: Next round of funding should focus on reducing avoidable acute care utilization

Next round of funding should focus on promoting an **efficient, high-quality healthcare delivery system** by investing in innovative ways to **reduce avoidable ED visits and inpatient readmissions**

ED visits

26%
of inpatient discharges were followed by a return to the ED within 30 days in SFY 2015*

42%
of all first ED revisits that occurred within 30 days of inpatient discharge occurred within 7 days of discharge*

Opioid-related ED utilization increased by
87%
from 2011-2015**

Patients with a primary BH diagnosis were
16.3 times
more likely to board than other patients in 2015**

Readmissions

41%
of commercial spending growth in 2015 was attributable to hospital care**

MA all payer unplanned readmissions has stayed at around
16%
for the past 5 years, while the national rate has declined***

In 2016, HPC recommended a reduction in all-cause all-payer 30-day readmissions to
<13%
by 2019**

Reducing readmissions to 13% would yield
$245 M
in savings****

* CHIA Emergency Department Visits After Inpatient Discharge in Massachusetts , July 2017: http://www.chiamass.gov/assets/docs/r/pubs/17/ed-visits-after-inpatient-report-2017.pdf
** HPC Annual Health Care Cost Trends Report 2016: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf
*** CHIA Performance of the Massachusetts Health Care System: Annual Report, September 2017: http://www.chiamass.gov/assets/2017-annual-report/2017-Annual-Report.pdf
**** HPC Benchmark Hearing, March 8, 2017, slide 29: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/testimony-regarding-modification-of-the-benchmark.html

HPC

The 2017 Cost Trends Hearings reinforced that avoidable acute care utilization is driving costs and poor quality in the Commonwealth.

Growth in health care expenditures is concentrated in complex patients vulnerable to social risks.[2,3]

69.2% of providers and

54.6% of payers submitted pre-filed testimony attesting that reducing unnecessary hospital utilization is a critical cost containment strategy.

Community appropriate inpatient care is increasingly being provided by teaching hospitals and AMCs.

The readmission rate for patients with a behavioral health diagnosis was

20.2%

in 2015[1]

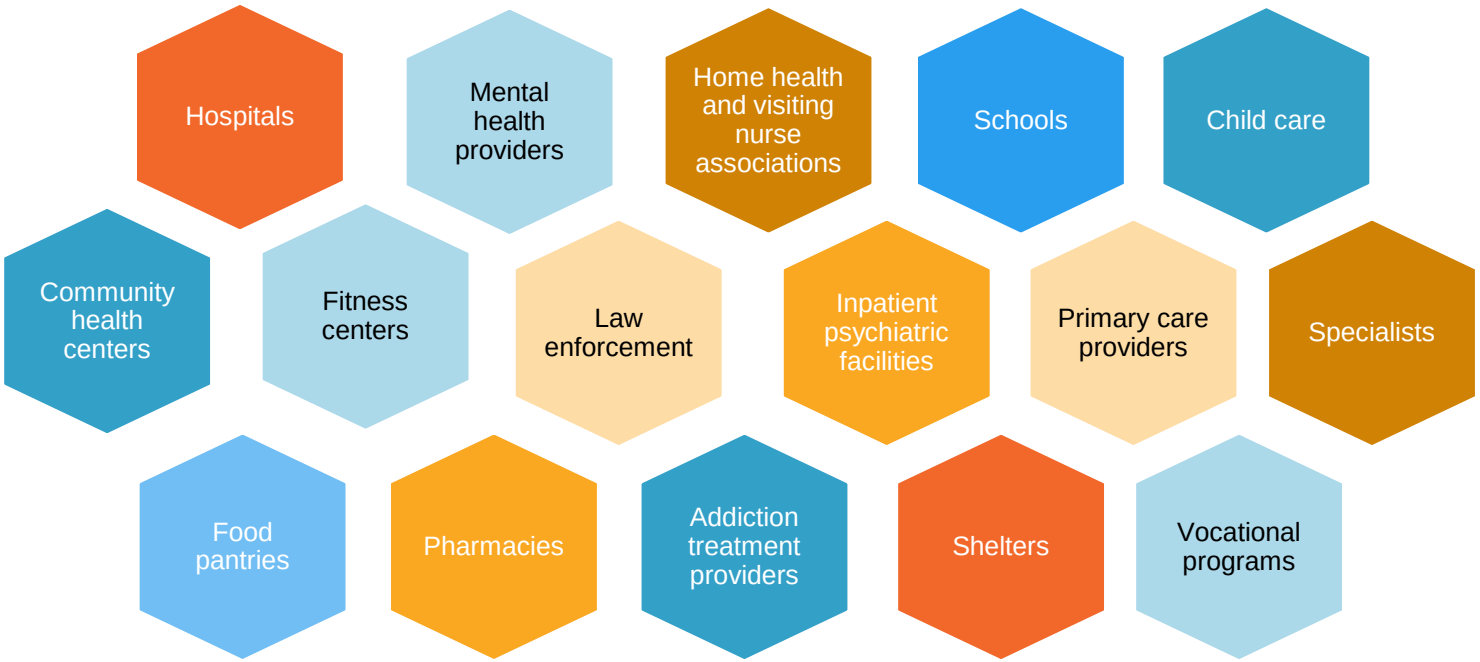
1 CHIA Hospital-Wide Adult All Payer Readmissions in Massachusetts, December 2016: http://www.chiamass.gov/assets/docs/r/pubs/16/Readmissions-Report-2016-12.pdf
2 United States Department of Health and Human Services: Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs A Report Required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. December 2016.
3 Presentation by Karen Joynt Maddox.

HPC

Proposal: Next round of funding should promote community based health care systems

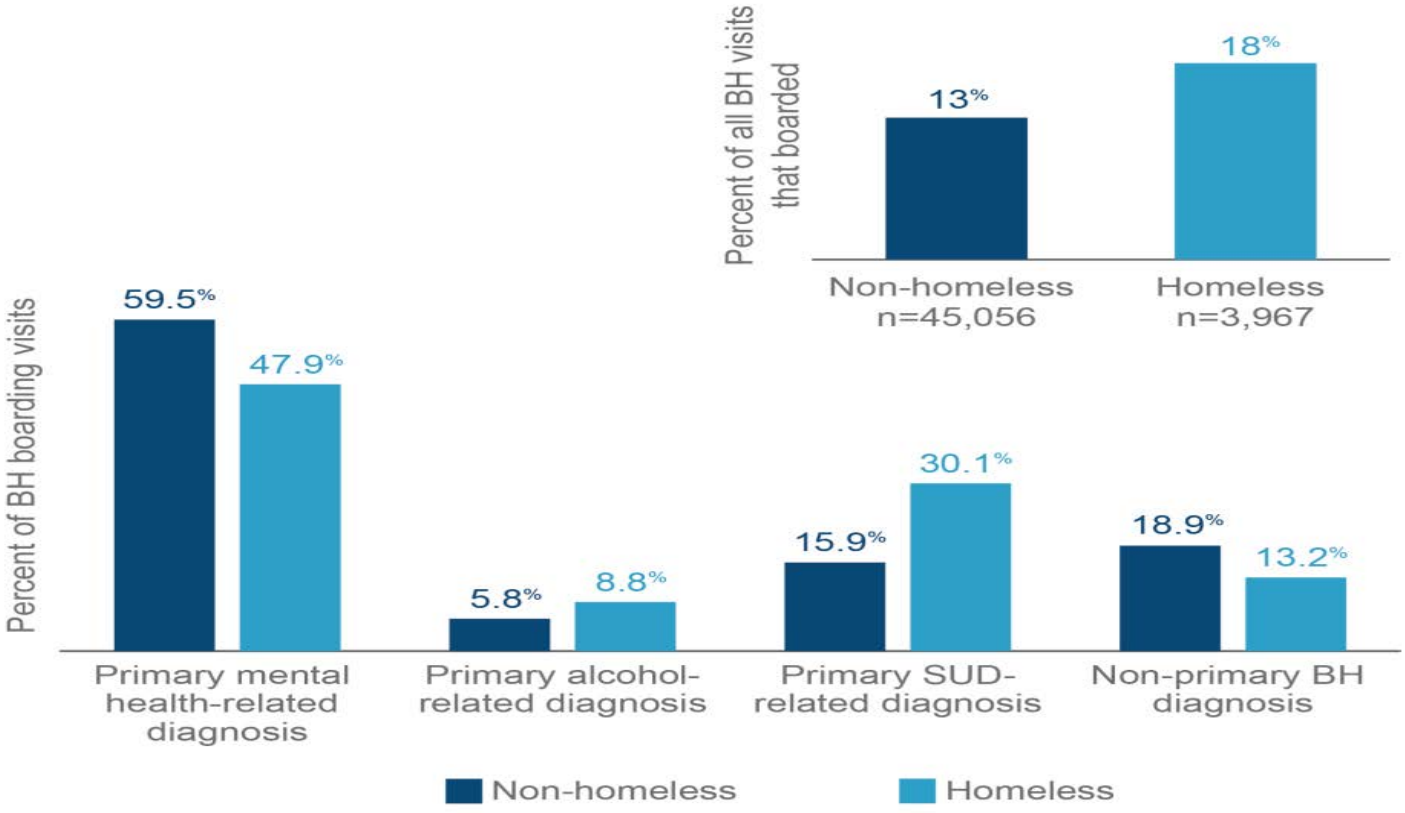
*"I don't see any future for community hospitals…I think there's a fantastic future for **community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future for health systems with a strong community hospital that breaks the mold** [of patient care]."*

- COMMUNITY HOSPITAL CEO



Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

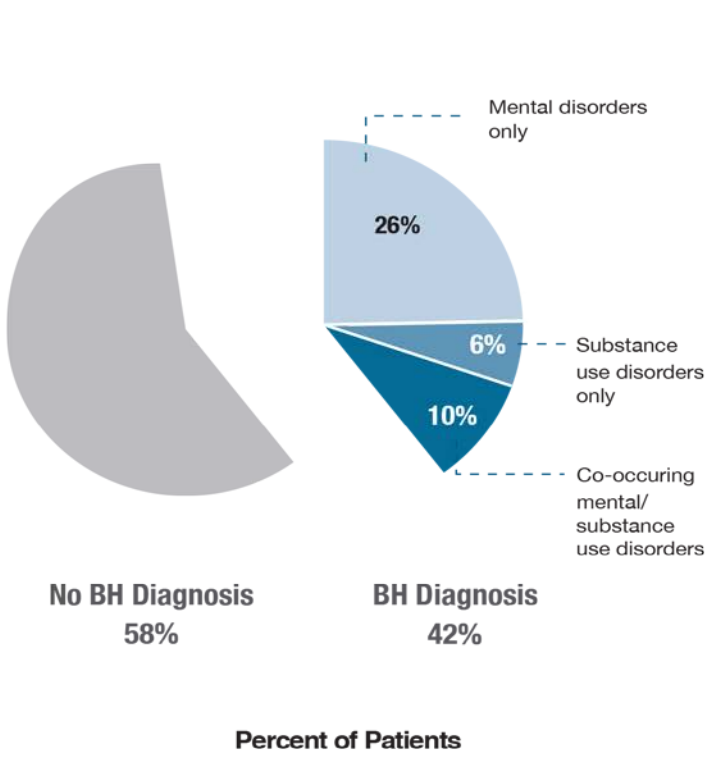
Evidence: Patients with unaddressed social complexities such as homelessness are more likely to utilize high cost and inefficient acute care treatment

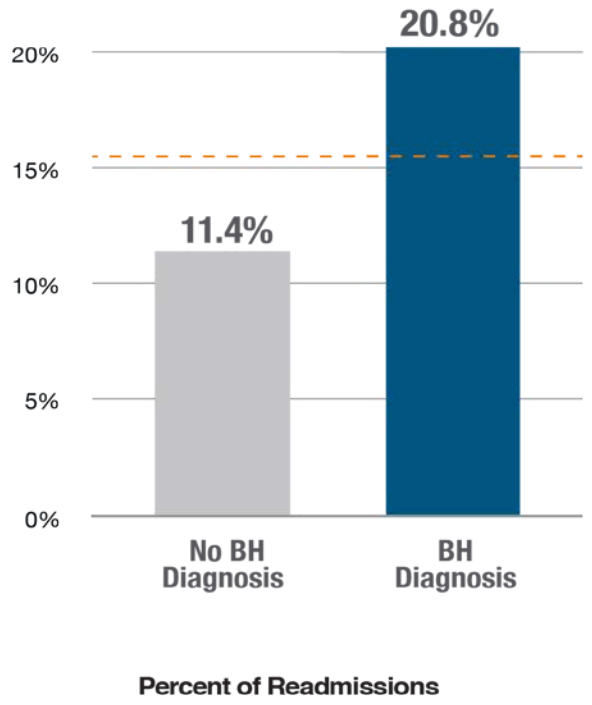


See appendix for additional data supporting rationale for track 1

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2015
Note: Emergency department (ED) boarding is definied as patients who had an ED stay of 12 or more hours from their time of arrival to their time of departure. BH ED visits identified using NYU Billings algorithm and include any discharge with a mental health, substance abuse, or alcohol-related diagnosis code.

Evidence: Patients with comorbid behavioral health diagnoses are more likely to be readmitted





In 2015, patients with a behavioral health comorbidity had a readmission rate of 20.8%, nearly twice that of those without a behavioral health diagnosis

HPC

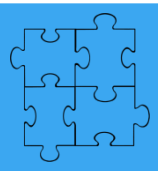
Graph and analyses created by the Center for Health Information and Analysis, using FY15 data (2017).

Proposed design components

1. Tracks

2. Award size and duration

3. Financial support and sustainability



4. Summary

Proposal: Two funding tracks to reduce avoidable acute care use

Funding track 1: through addressing social determinants of health

- Support for innovative models that **address social determinants of health** (e.g., respite care for patients experiencing housing instability at time of discharge) after an acute care visit or stay in order to prevent a future visit or stay
- **Partnership** with **social service providers / community based organizations required**

Funding track 2: through increasing access to real-time behavioral health care

- Support innovative care models to **increase access to real time behavioral health services**, (e.g. plans to **expand access** to 24/7 psychiatric assessment and short term prescribing, using **telemedicine** and/or **mobile integrated health**, and/or **other innovative strategies)**
- **Partnership** with **outpatient behavioral health providers required,** if applicant is a BH provider, partnership with medical care provider required

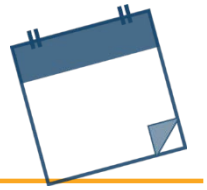
→ focus on opioid use disorder treatment

- Section 178 of ch. 133 of the Acts of 2016 directed the HPC to invest not more than $3M from the DHTF to support hospitals in further testing **ED initiated pharmacologic treatment for SUD**, with the goals of increasing rates of engagement and retention in evidence-based treatment
- **Eligible entities** would include hospitals with EDs; **partnership** with **outpatient providers required**

Eligible entities include HPC certified ACOs and their participants and/or CHART eligible hospitals*

**including provisionally certified ACOs*

Proposal: Award size and duration



Total funding

Up to $10,000,000

Individual awards*

Up to $750,000

Duration

18 – 24 months

*Any given awardee will receive maximum of one award (may apply for multiple tracks)

HPC

Proposal: Financial support and sustainability

- Require **in-kind contributions**
- For every eligible expense in the award, the **awardee will be reimbursed at 75%** (i.e., awardee is responsible for 25%)

Require **sustainability plans** to ensure continuation beyond grant cycle (no separate sustainability plan award)

Summary of new investment proposal

THEME	Enhancing and ensuring sustainability of community-based, collaborative approaches to care delivery transformation that drive reductions in avoidable acute care utilization
FUNDING	Proposed total funding of up to $10M
COMPETITIVE FACTORS	▪ Care model ▪ Impact ▪ Organizational leadership, strategy and demographics ▪ Evaluation
OUTCOMES	Address one or more of the HPC's key target areas for reducing avoidable acute care utilization and improving quality: ▪ Reduce all-cause 30-day hospital readmissions ▪ Reduce 30-day ED revisits ▪ Increase initiation of and engagement in OUD treatment

Next steps

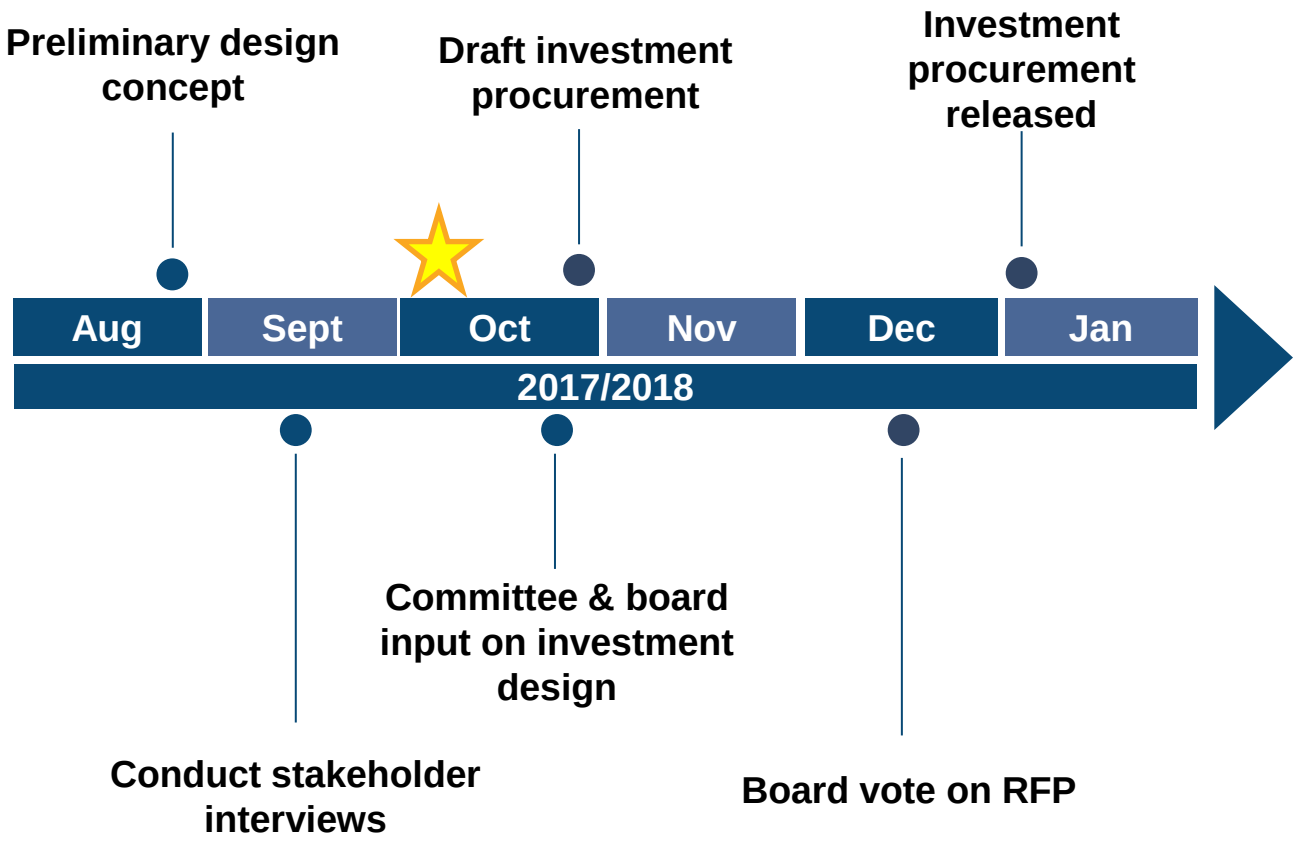

Preliminary design concept
Draft investment procurement
Investment procurement released
Aug
Sept
Oct
Nov
Dec
Jan
2017/2018
Committee & board input on investment design
Conduct stakeholder interviews
Board vote on RFP

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CHART Phase 2 Statewide Convening: October 16, 2017

> 250

attendees representing CHART hospitals, state government, payers, and providers

4 panels

Panel 1: ***Reducing readmissions for high risk patients***

Panel 2: ***Slowing the cycle of high utilization for multi-visit patients***

Panel 3: ***Improving care for behavioral health patients in the ED***

Panel 4: ***Lessons learned, capabilities developed, and the future***

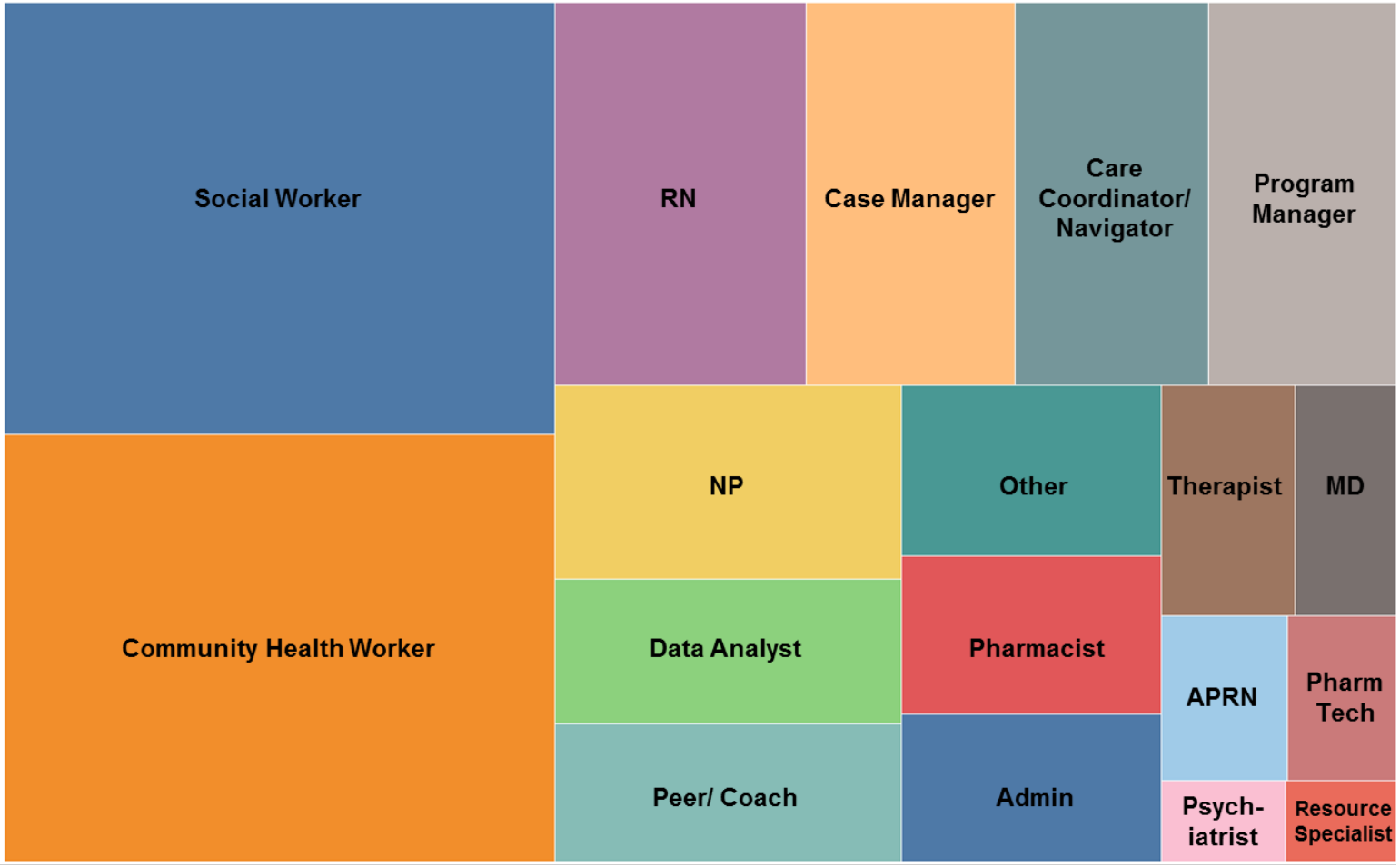
8

breakout sessions

CHART Phase 2 workforce: multidisciplinary and committed

CHART Phase 2

250 full-time equivalents engaging approximately 180,000 CHART-eligible acute encounters.[1]



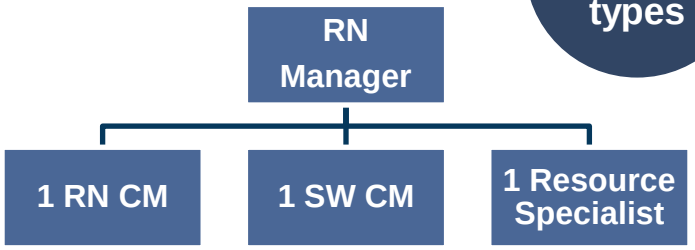
[1]Based on reports received from CHART Phase 2 awardees through September 2017.

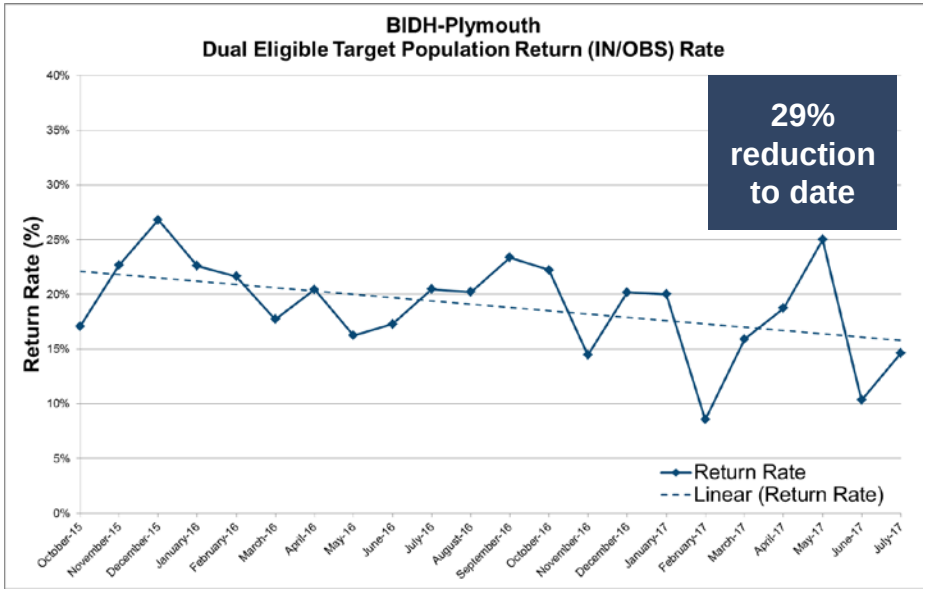
Example panel slide: BID – Plymouth
Reducing returns for high risk patients

Beth Israel Deaconess Hospital Plymouth

Team

4 FTEs
4 role types





Average volume

85
Discharges/ month

70 (82%)
Discharges served/ month

125 patients/ month

Success factors

- ✓ Transition from telephone to community outreach
- ✓ Co-management of patients
- ✓ Leverage Resource Specialist's skills
- ✓ Engage patients while hospitalized

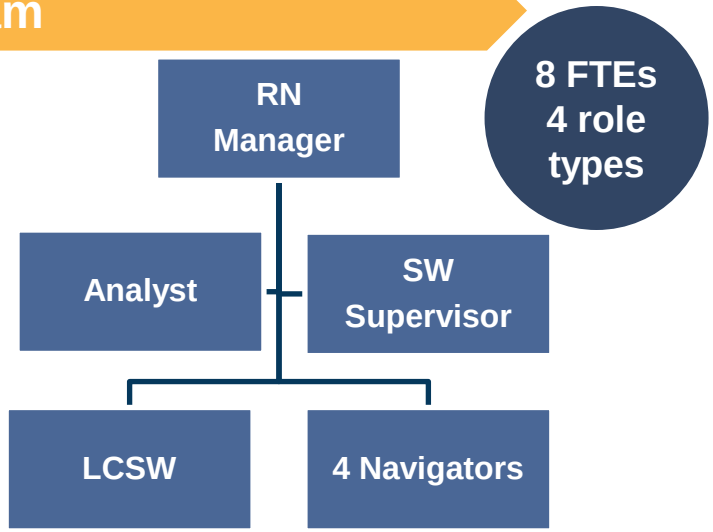
HPC

CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.

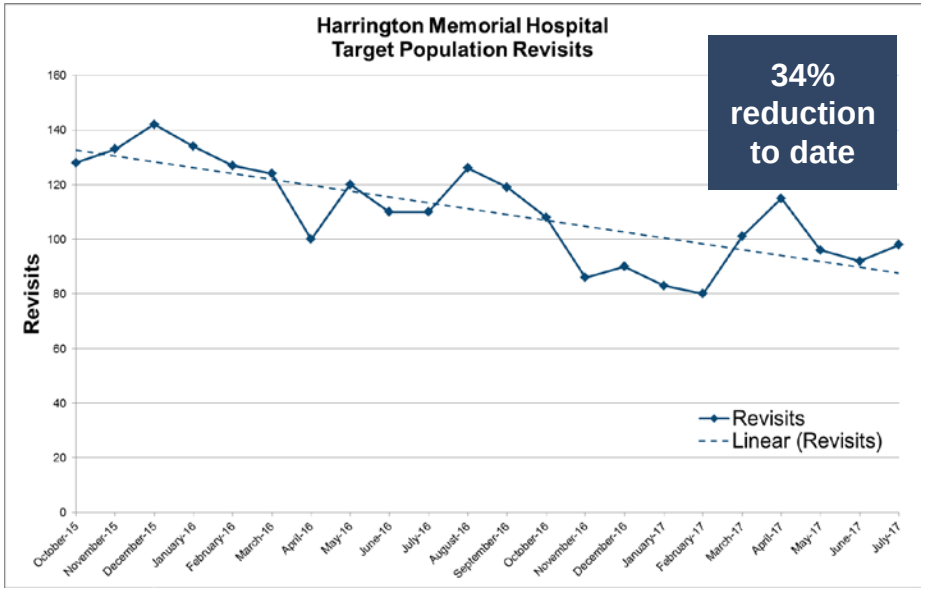
Example panel slide: Harrington Memorial Hospital
Improving care for behavioral health ED patients

Harrington HEALTHCARE SYSTEM

Team



8 FTEs 4 role types



34% reduction to date

Average volume

275
ED visits/ month

200 (73%)
ED visits served/ month

120 patients/ month

Success factors

- ✓ **Address patients' basic needs first**
- ✓ **Creatively leverage community resources**
- ✓ **Effective engagement tactics, frequent contact**
- ✓ **Adapt care model to achieve outcomes**
- ✓ **Drill down on data to understand impact**

HPC

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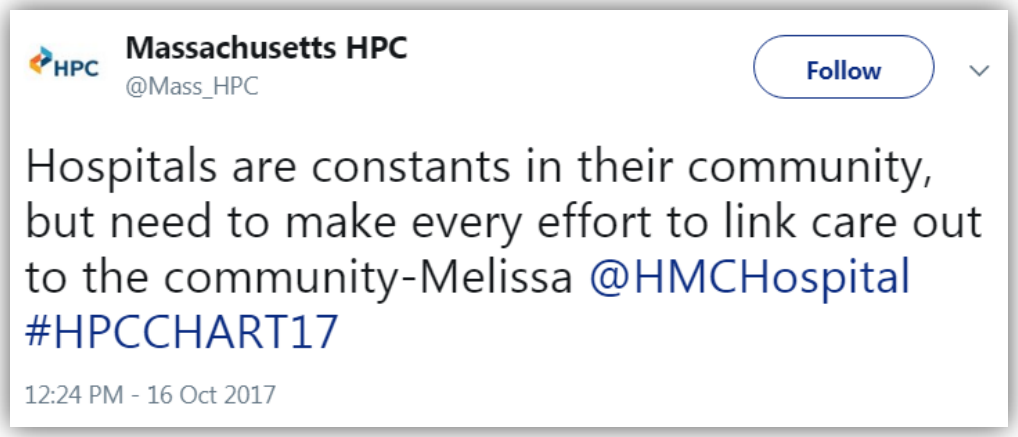
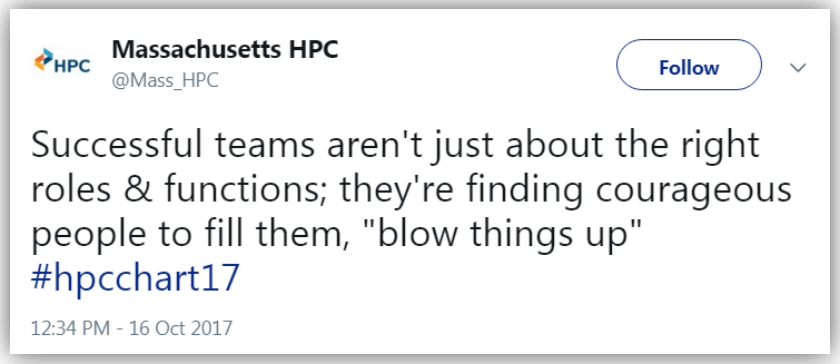
CHART Phase 2 teams are passionate about their work and eager to share their lessons learned with a broad group of stakeholders

"CHART allowed us to shift the paradigm from 'talk and tell' to "listen and ask."

Mary Beth Strauss, Winchester Hospital





"The CHW role is so important for the 'hand-holding' – we're all in this room because we have someone to hold our hands; our patients do not."

Lisa Brown, Lowell General Hospital

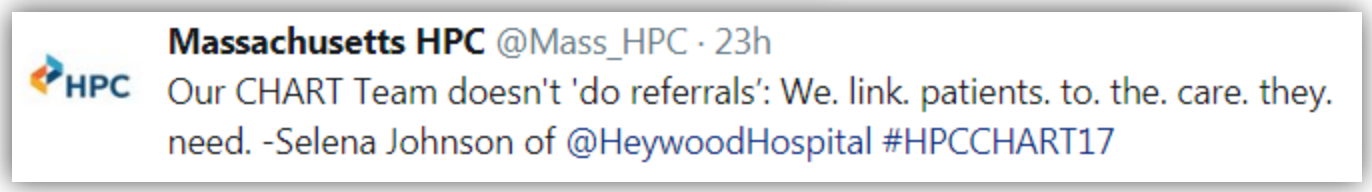


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CHART Phase 2: Progress as of October 2017

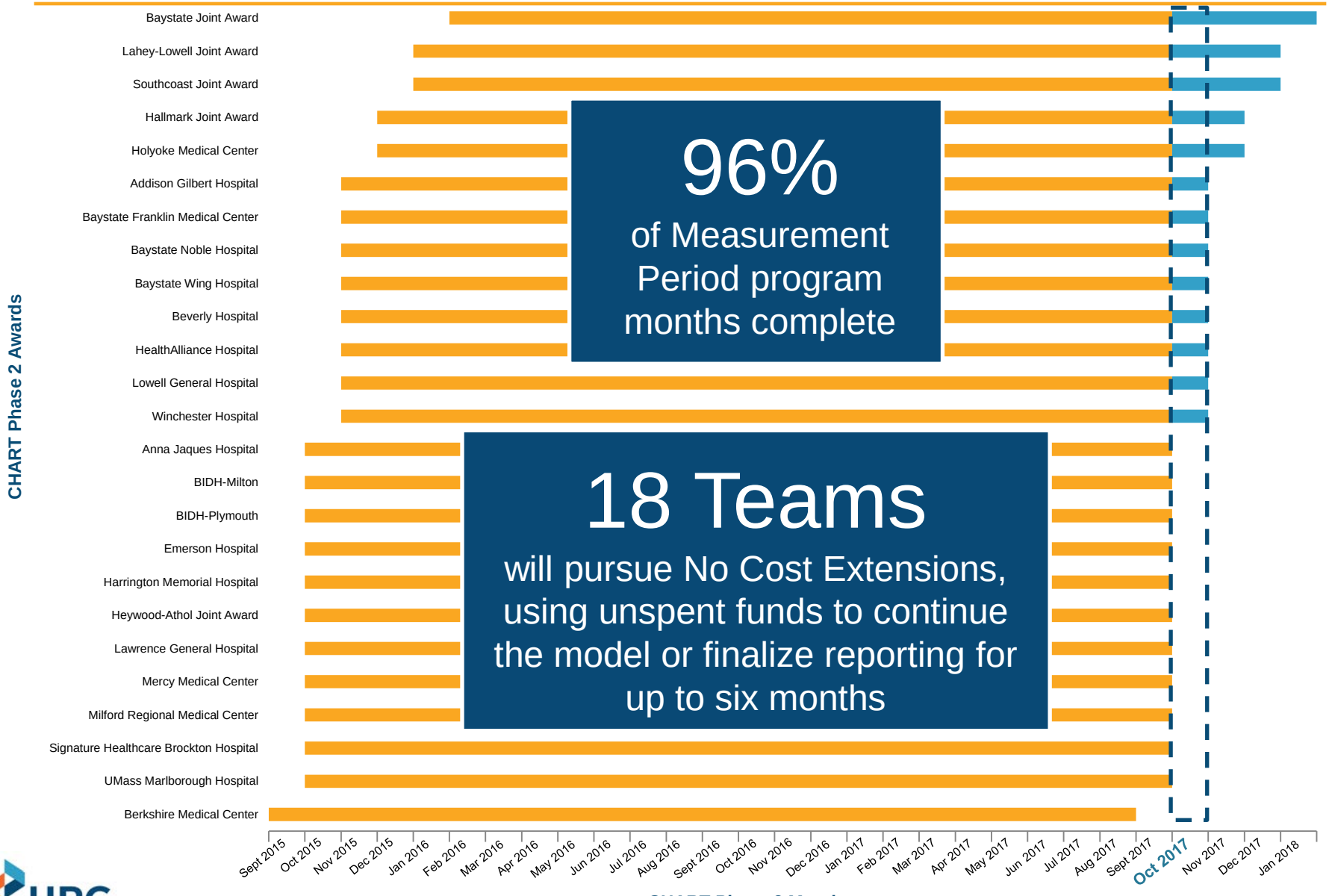


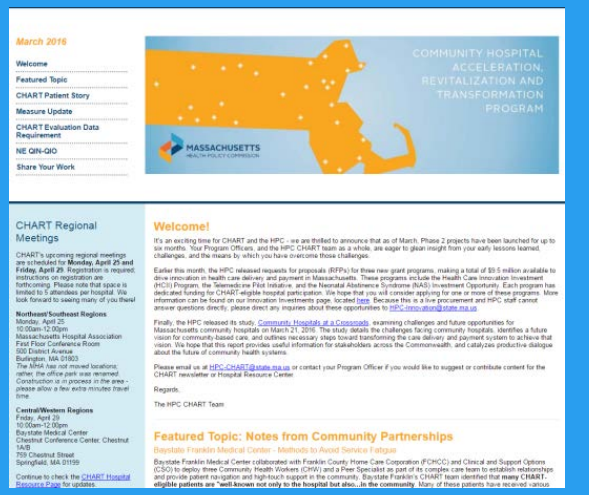
CHART Phase 2: Activities since program launch[1]

15
regional meetings
with
900+
hospital and community provider attendees

290+
technical assistance working meetings

865+
hours of coaching phone calls

21
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

3,523 unique visits to the CHART hospital resource page

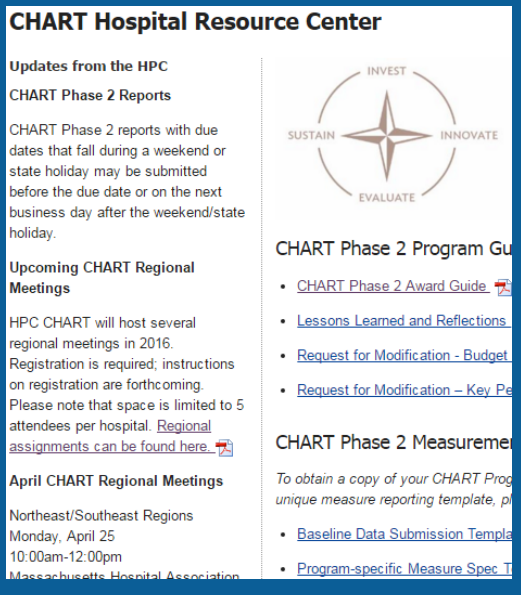


CHART Hospital Resource Center

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

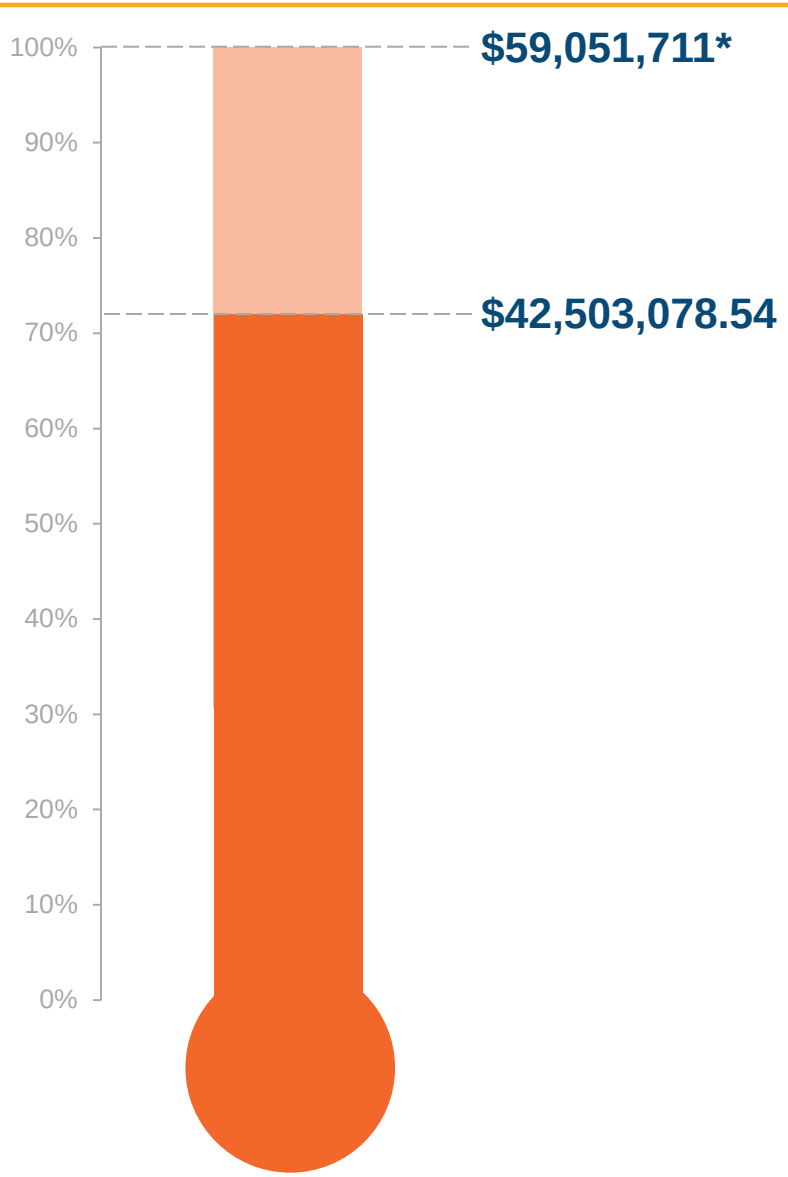
To obtain a copy of your CHART Prog unique measure reporting template, pl

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

550+
data reports received

[1] Updated through October 17, 2017. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

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



Remaining
$16,548,632.46
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

HPC

Updated October 12, 2017

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

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By the Numbers: Health Care Innovation Investment (HCII) Program

All 20 initiatives
funded by the HPC have launched

>100 organizations
collaborating to deliver care

220 initiative-specific measures
recording patient experience, provider experience, quality, process, and outcomes

~6,500 patients
will be served, including patients with SUD, chronic homelessness, and comorbid conditions

Awardees span the Commonwealth:
From the Berkshires to Boston

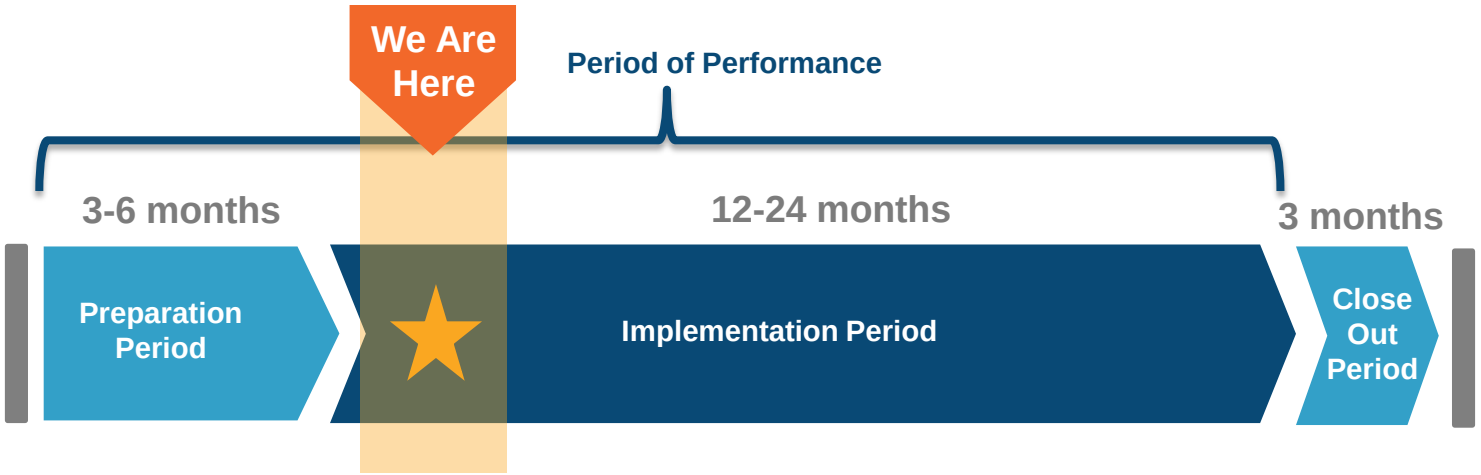
3 HCII newsletters

$40M
in estimated health care cost savings

Initiatives will deliver lower-cost care by shifting site and scope

HPC

HCII Program Timeline and Next Steps



Awardees are continuously enrolling patients in their target populations and delivering services, including:

- Assessing students for unmet behavioral health needs
- Expanding outreach on the streets to engage homeless patients
- Investigating new use cases for tele-psychiatry services
- Training physicians in holding advance care conversations with patients nearing the end of life

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Site of Care Changes after Hospital Acquisitions and Affiliations: Overview

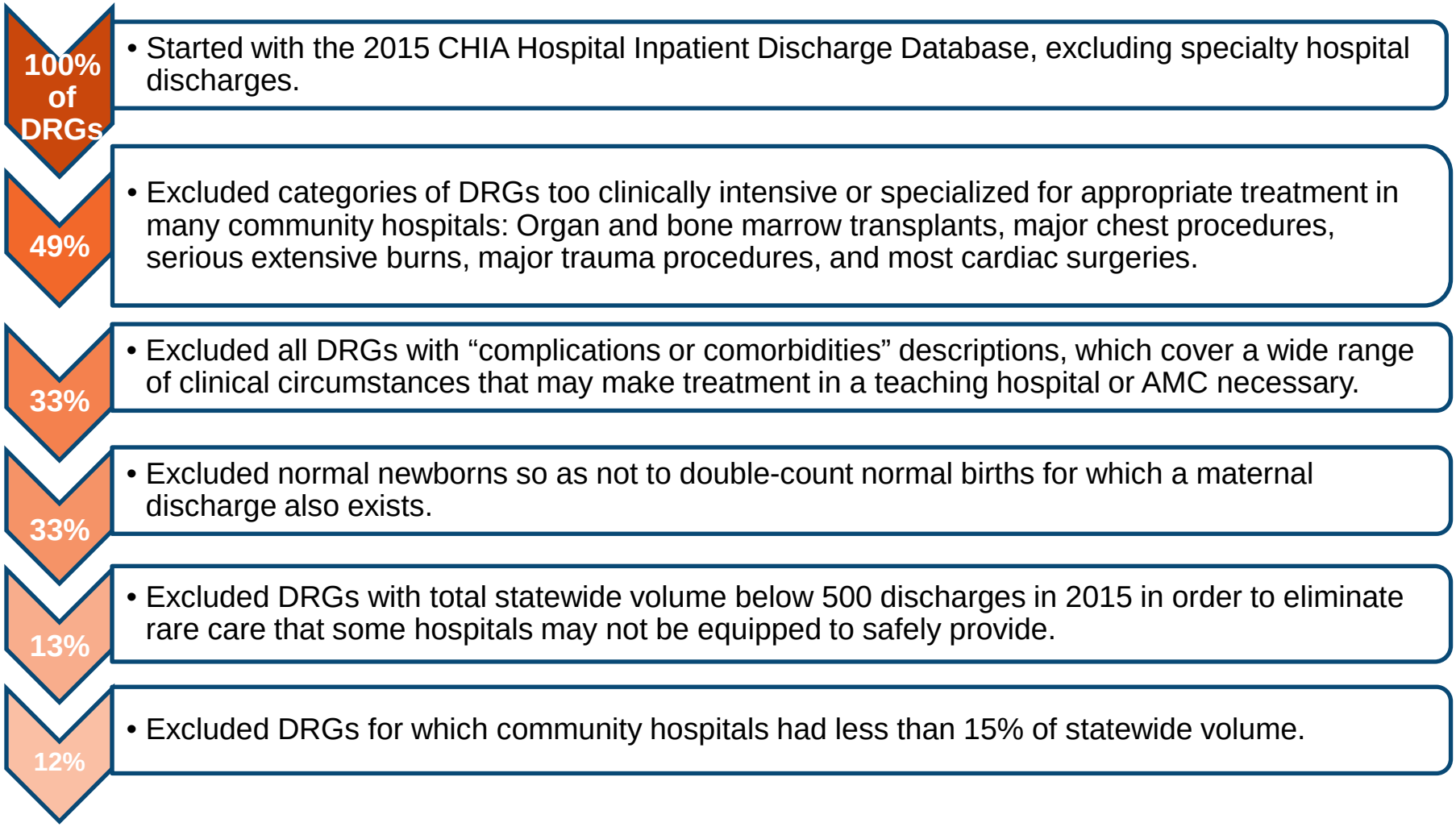
- To examine the effects of hospital acquisitions and affiliations on whether community-appropriate care remained in the community, the HPC analyzed:
  - the share of local patients receiving community-appropriate care at the focal hospital, before and after the transaction, and
  - the share of local patients receiving community-appropriate care at other hospitals, including academic medical centers (AMCs) and teaching hospitals, before and after the transaction.
- The HPC also examined changes in community hospitals' shares of local discharges *not* defined as community appropriate in order to better understand changes taking place at each hospital.

Notes: "Local patients" were defined as those residing within the primary service area (PSA) of the focal hospital, as defined in the HPC's Technical Bulletin for 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews, available at http://www.mass.gov/anf/docs/hpc/regs-and-notices/technical-bulletin-circ.pdf. Short time periods following transactions may prevent us from seeing their full impact. Observed trends may be impacted by factors not related to the transactions.
Source: 2009 to 2016 CHIA hospital discharge data.

Why Define Community-Appropriate Discharges?

- The HPC, in consultation with clinical experts, defined a set of discharges as “community appropriate” in order to identify and examine inpatient care that could be provided in most hospitals in the Commonwealth.
- Because most hospitals are able to provide these community-appropriate discharges (CADs), these discharges should be provided at high-value community hospitals whenever possible, consistent with the Triple Aim principle of providing the right care in the right place.
- Our method is designed to be conservative. We exclude some discharges that could appropriately be provided in *many* community hospitals, if they may not be appropriate for *nearly all* community hospitals in the Commonwealth.

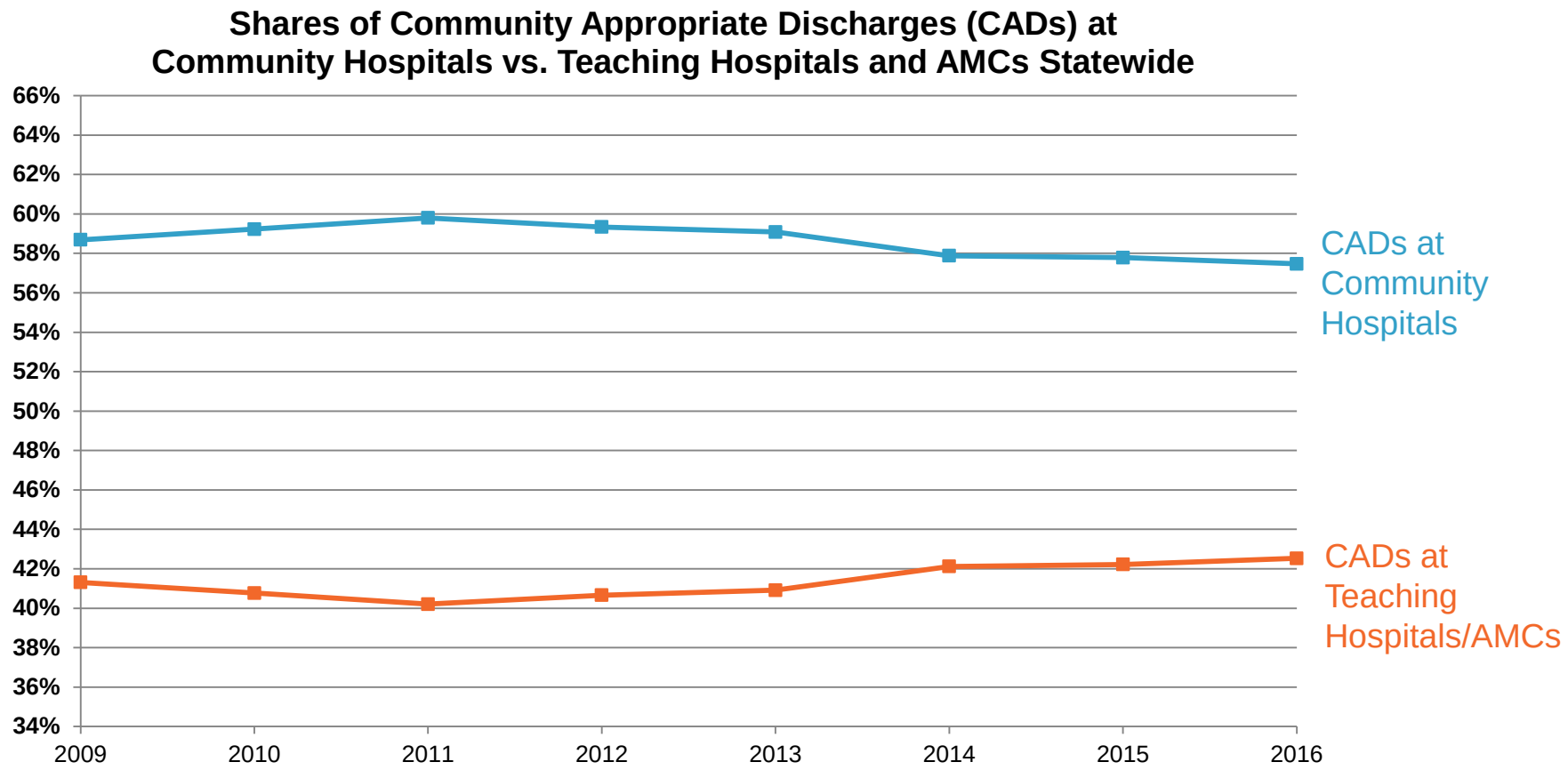
Identifying Community-Appropriate Discharges



94 DRGs classified as community-appropriate,
representing 41% of all acute hospital discharges in Massachusetts in 2015.

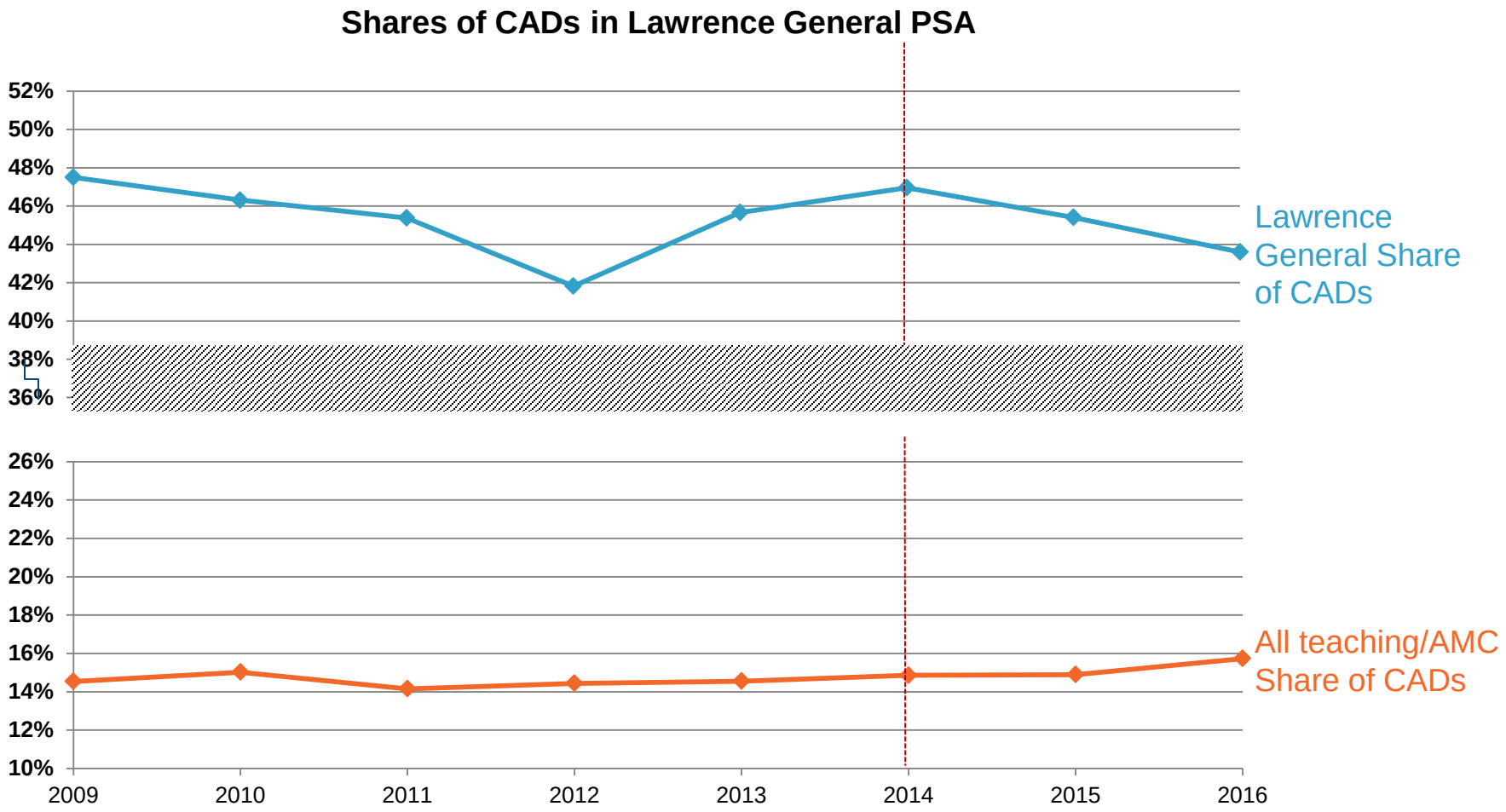
HPC

Community-appropriate inpatient care is increasingly being provided by teaching hospitals and AMCs.

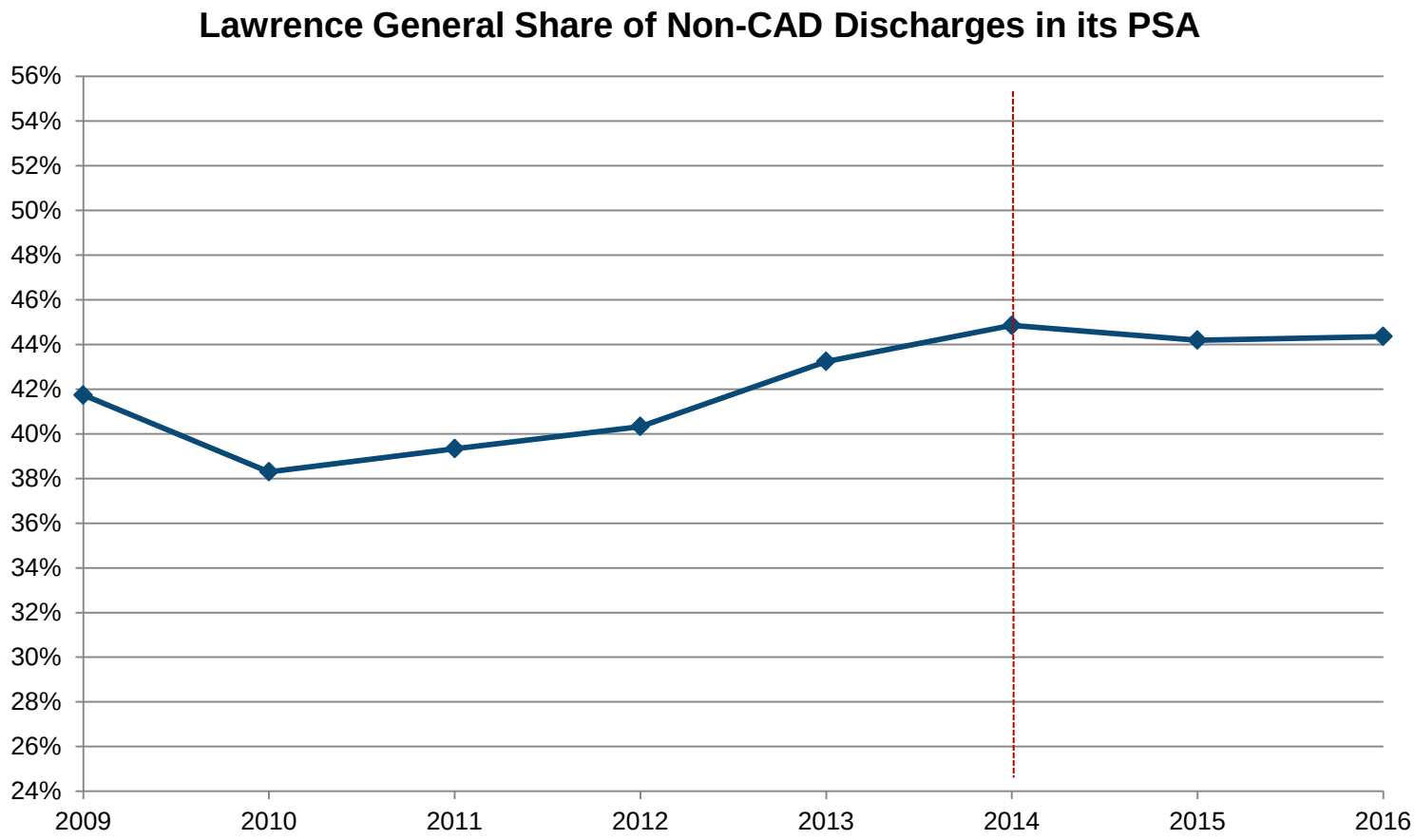


Few hospitals that were acquired or formed contracting affiliations appear to have reversed this trend.

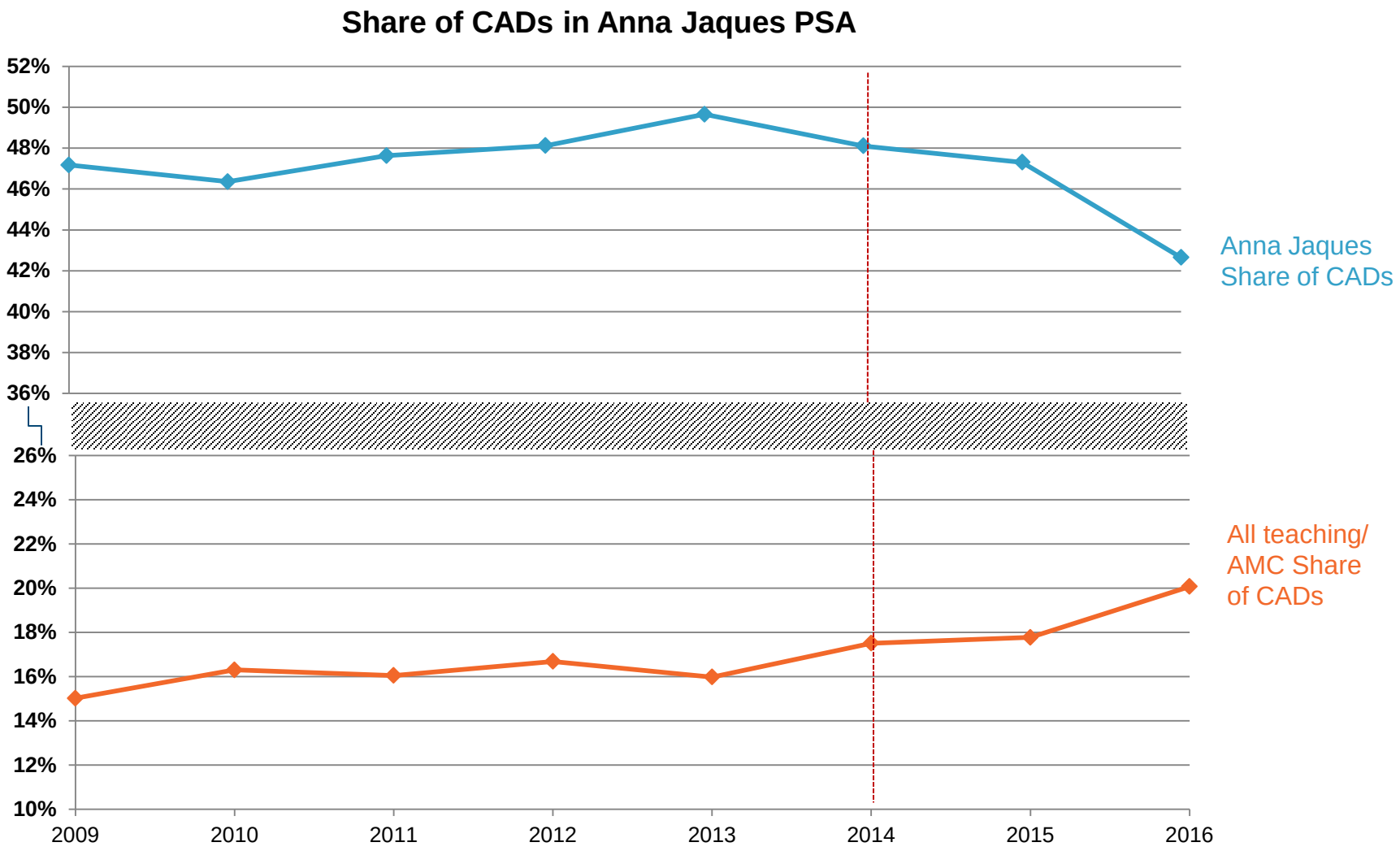
Lawrence General's share of local community-appropriate discharges declined faster than the statewide trend after it affiliated with BIDCO.



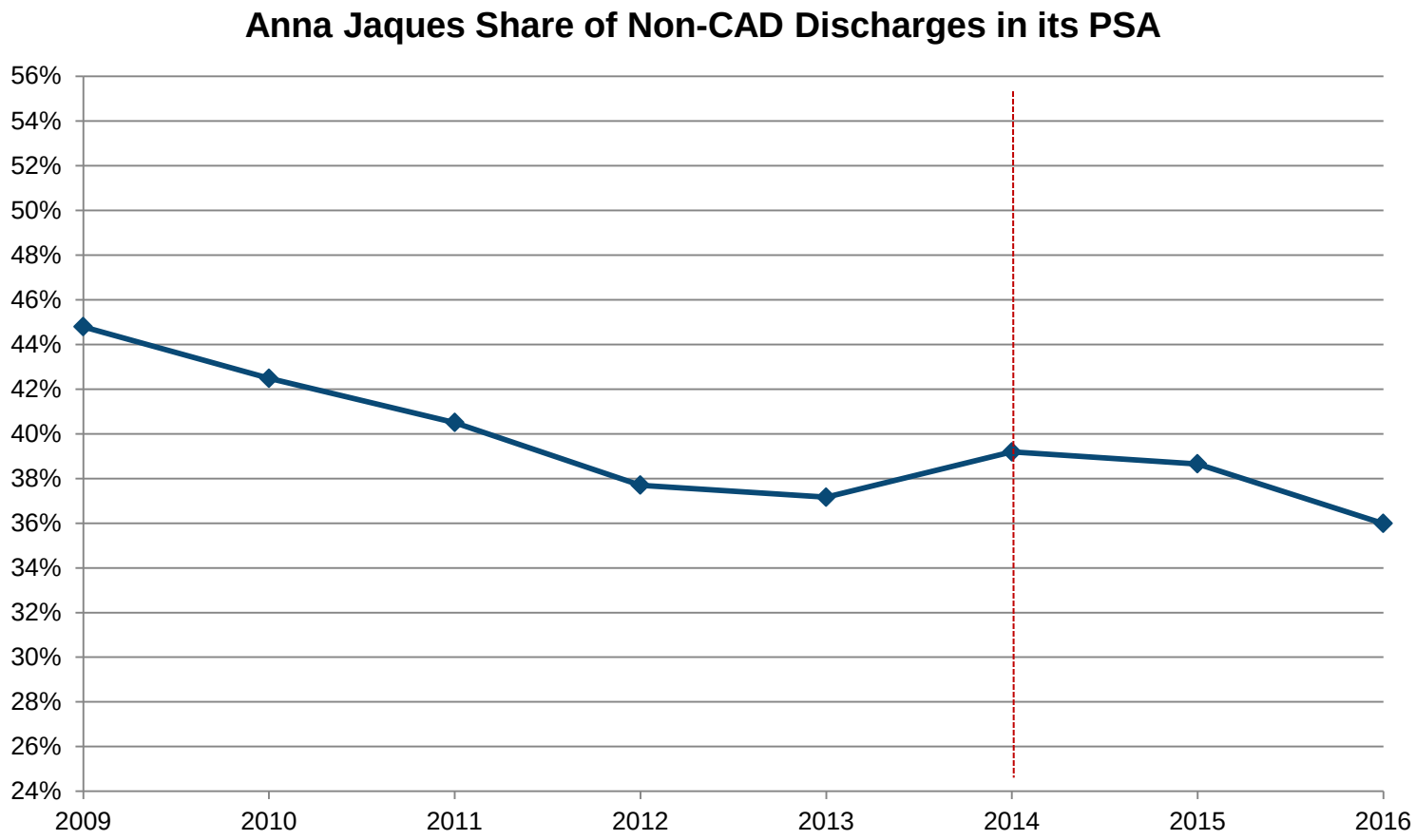
Lawrence General's share of other local discharges rose leading up to its affiliation with BIDCO and flattened afterwards.



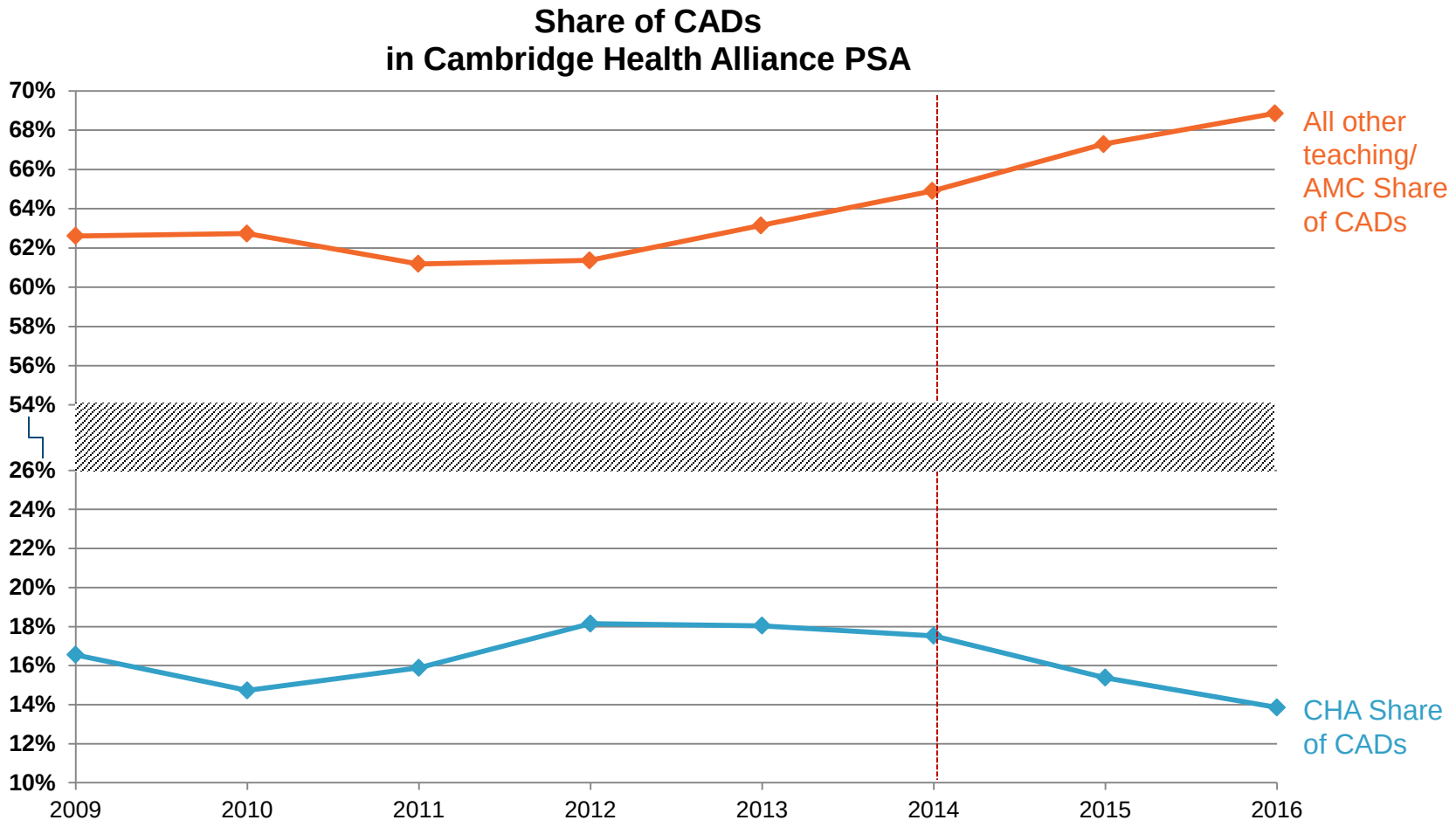
Anna Jaques' share of local community-appropriate discharges also declined faster than the statewide trend after affiliating with BIDCO.



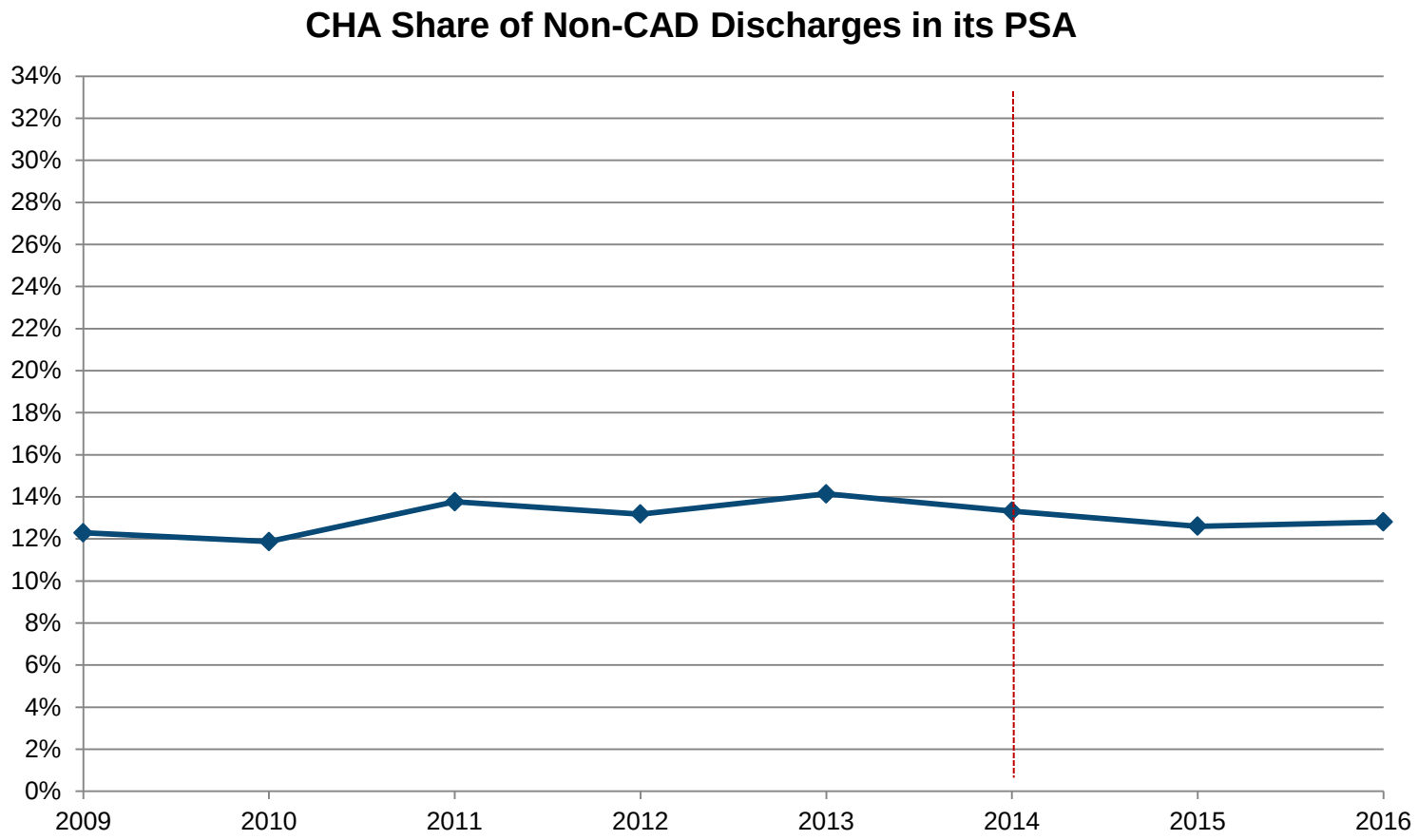
Anna Jaques' share of other local discharges also declined after its affiliation with BIDCO.



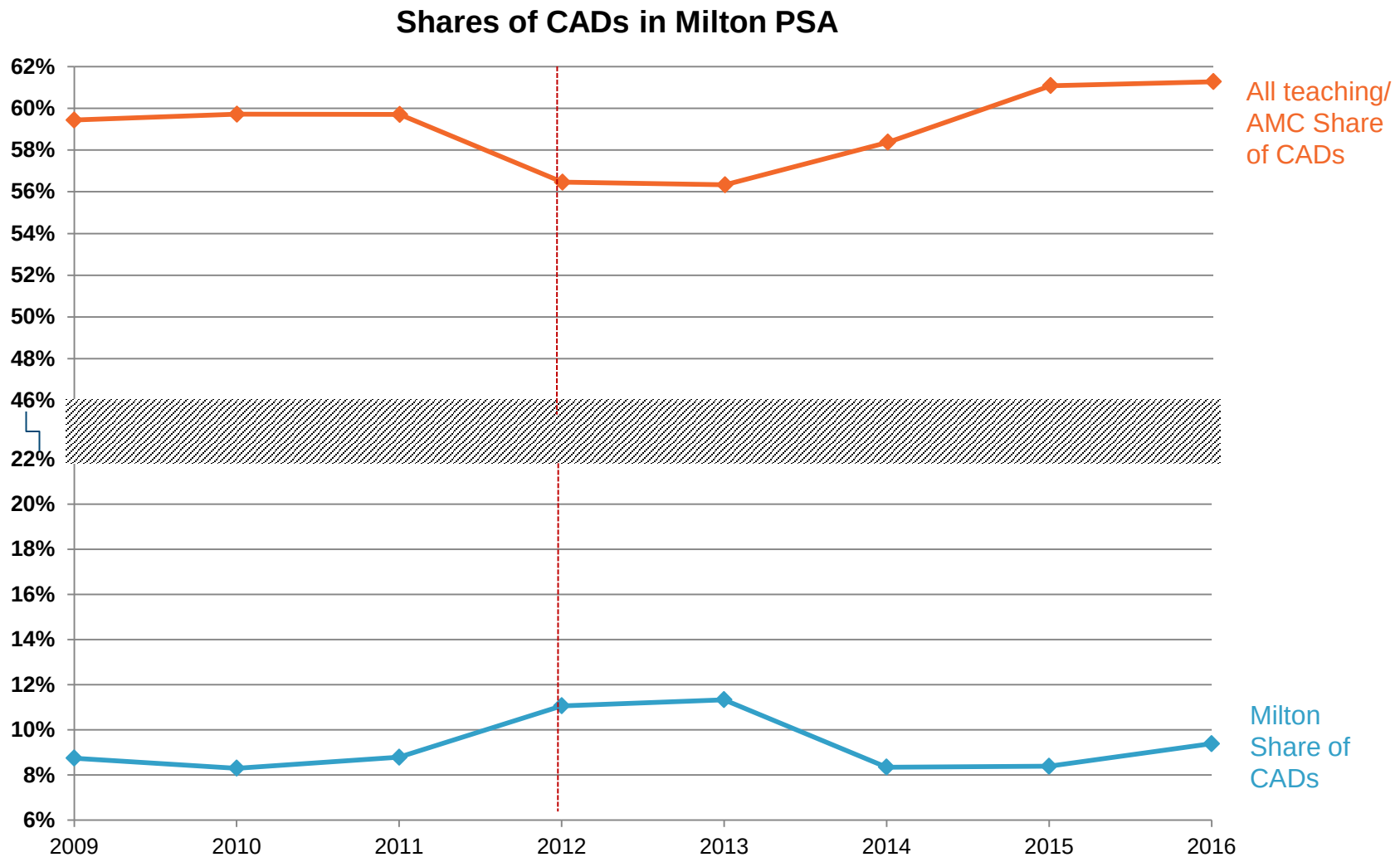
Cambridge Health Alliance's share of local community-appropriate discharges also fell faster than the statewide trend after affiliation with BIDCO.



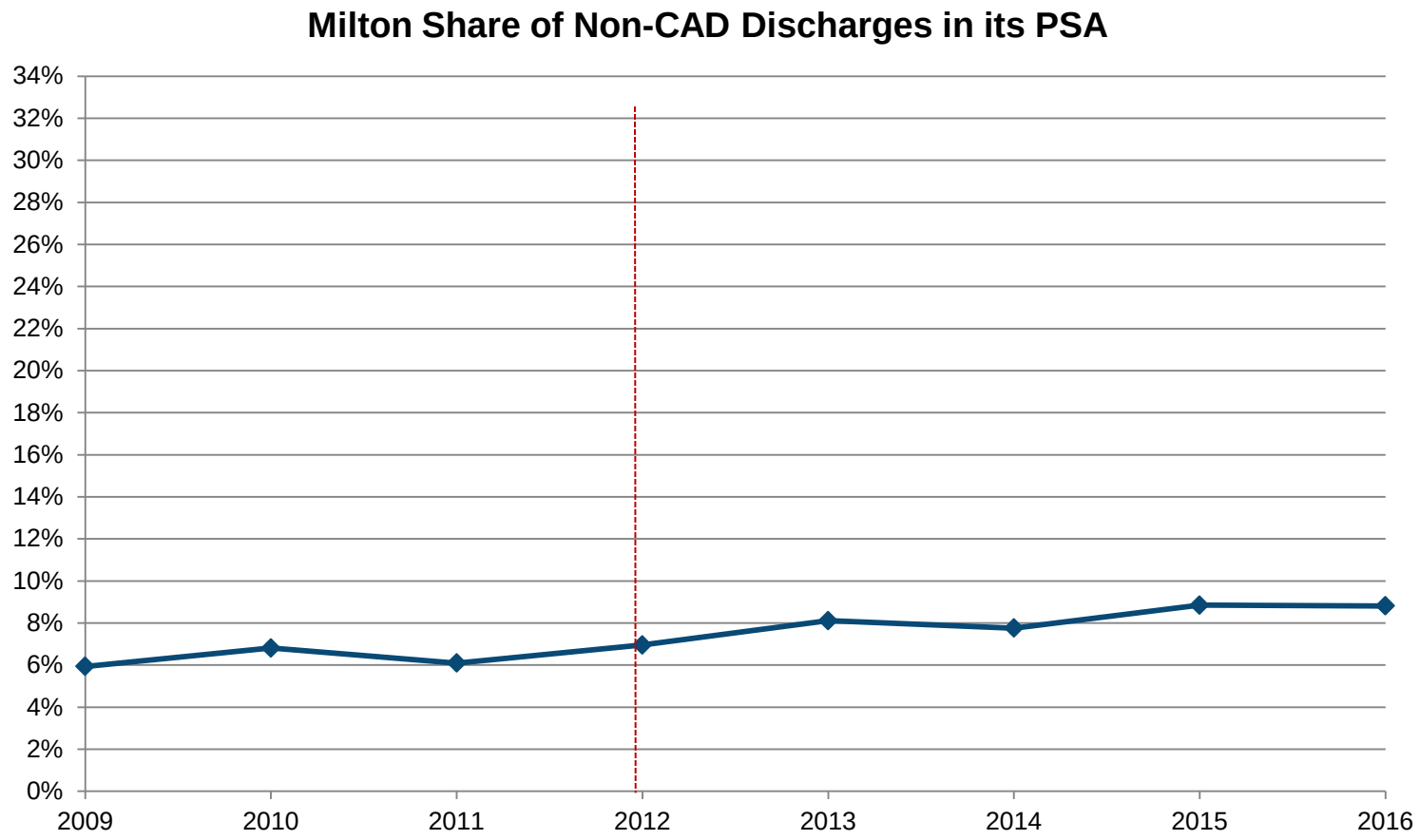
Cambridge Health Alliance's share of other local discharges decreased slightly after its affiliation with BIDCO.



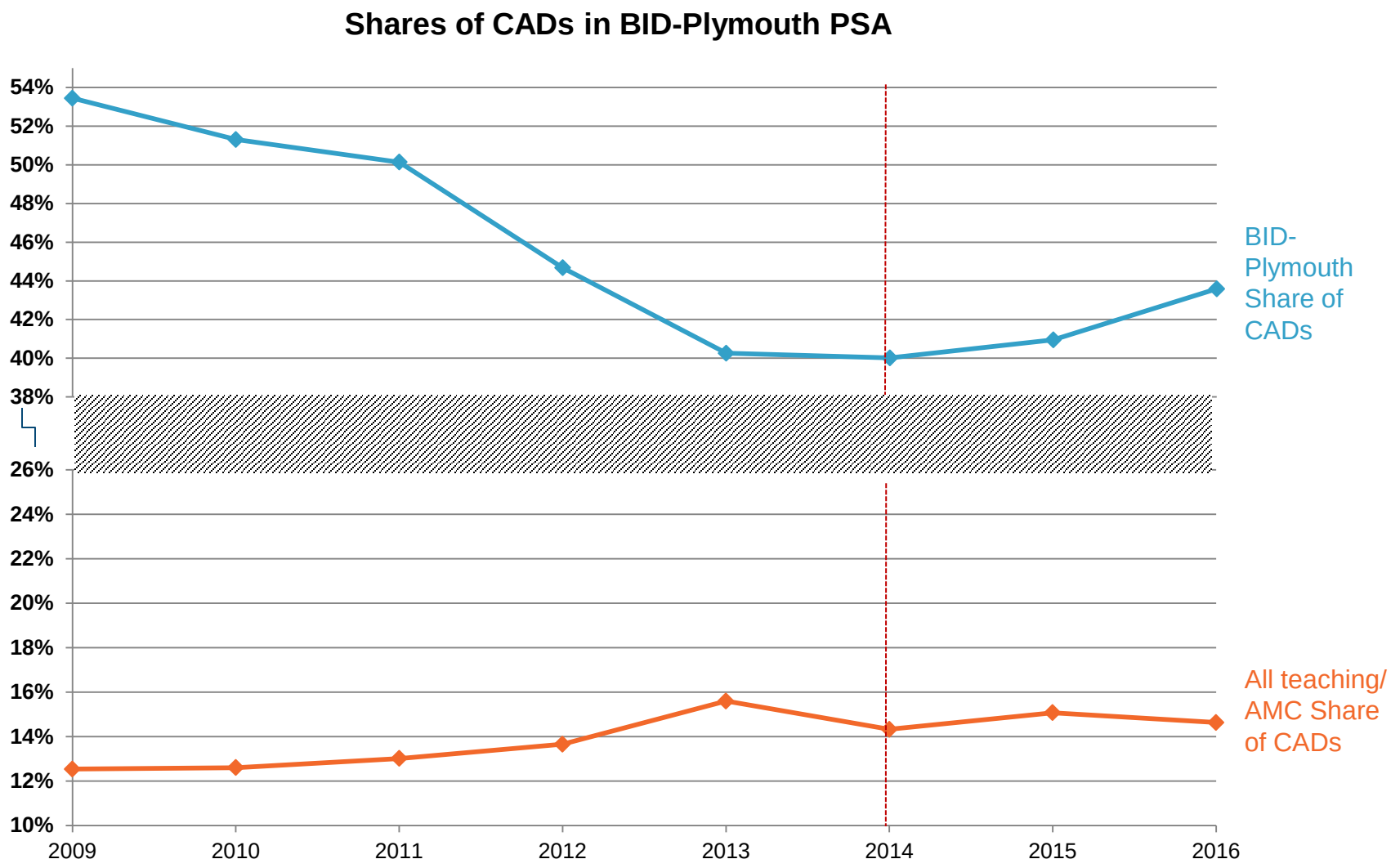
In contrast, BID-Milton did not generally lose shares of community-appropriate discharges after acquisition by BIDMC, though teaching hospitals and AMCs saw a larger share



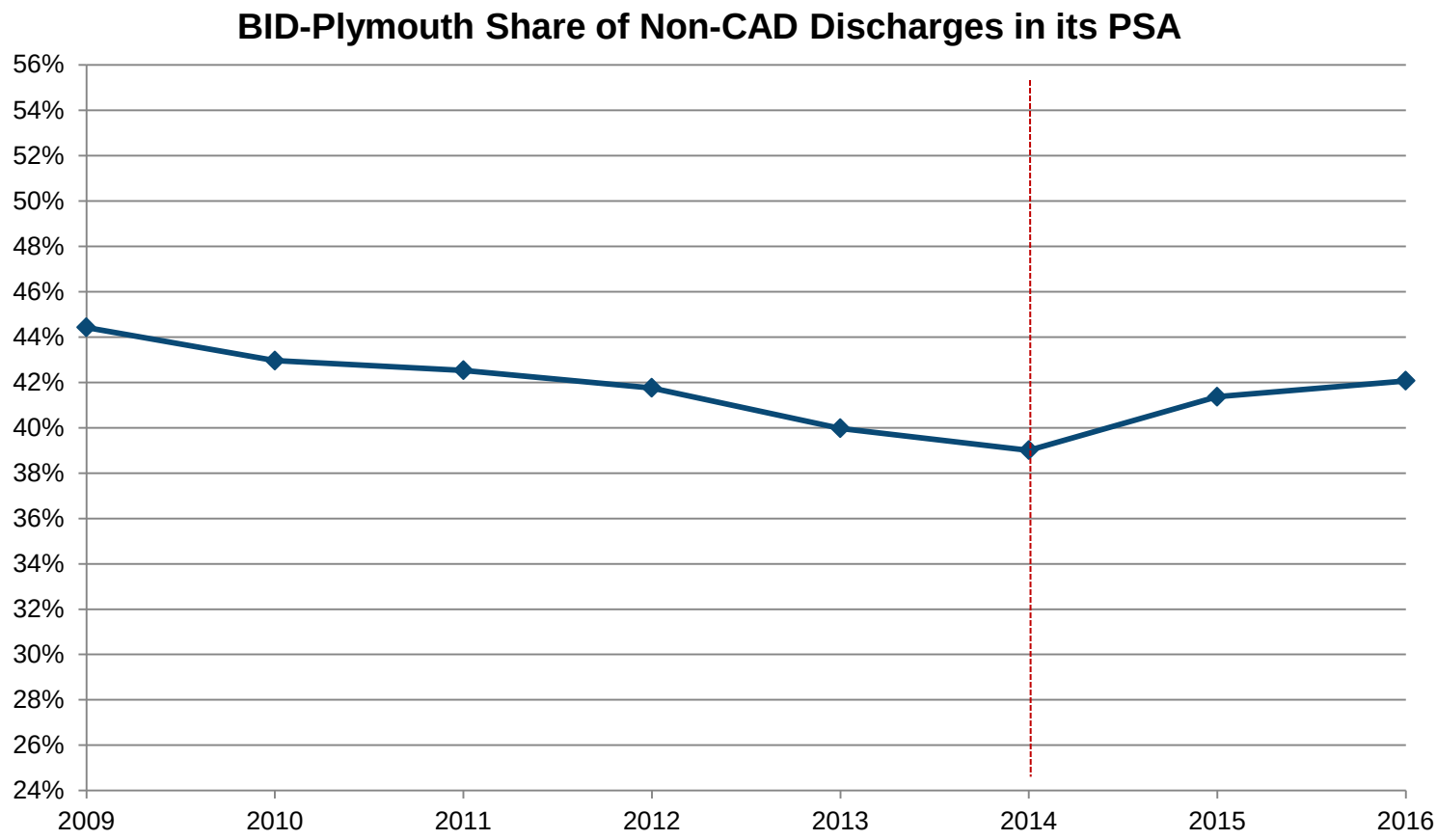
BID-Milton's share of other local discharges increased slightly after acquisition by BIDMC.



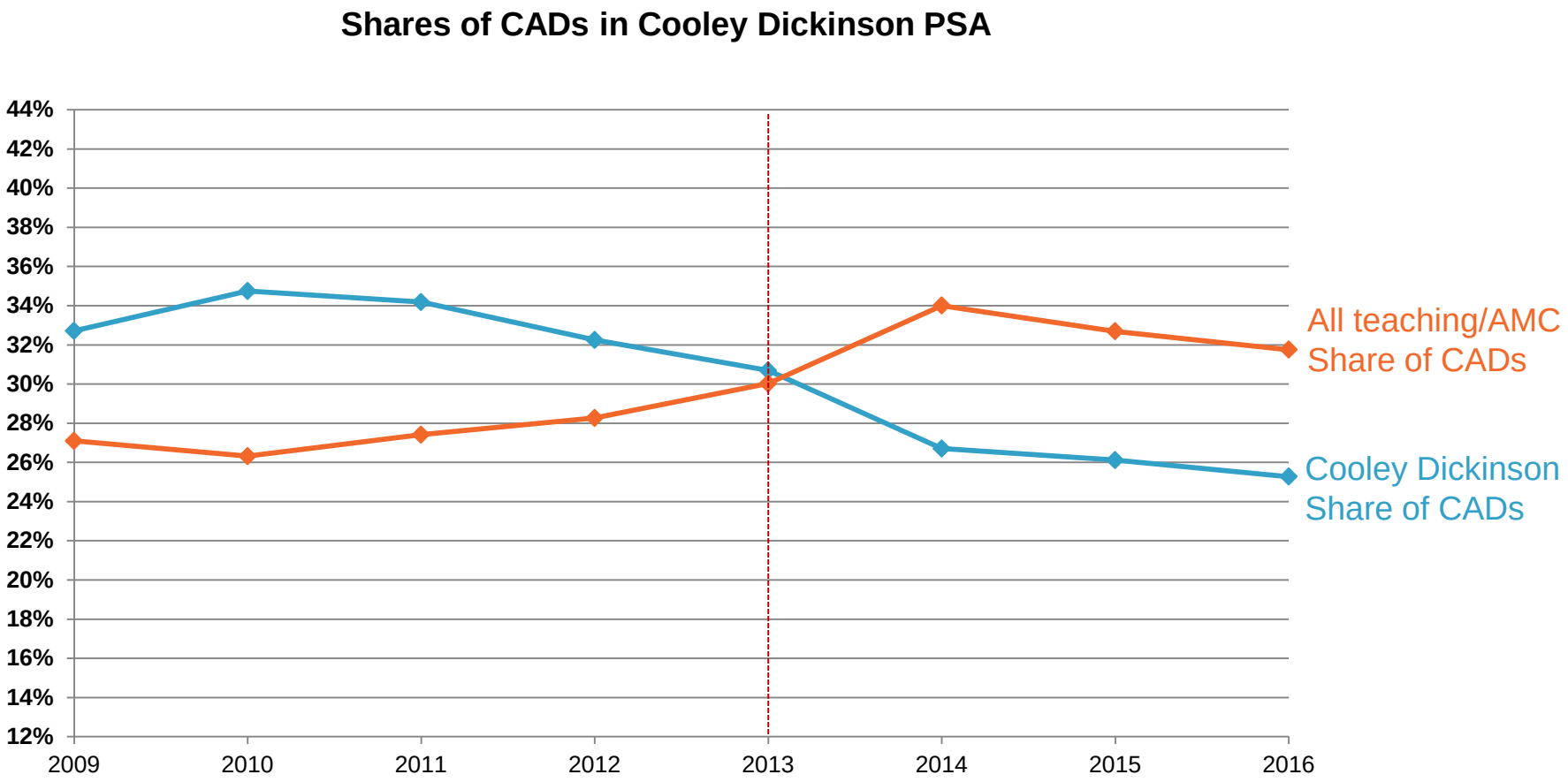
BID-Plymouth's shares of local community-appropriate discharges also began to rebound after acquisition by BIDMC.



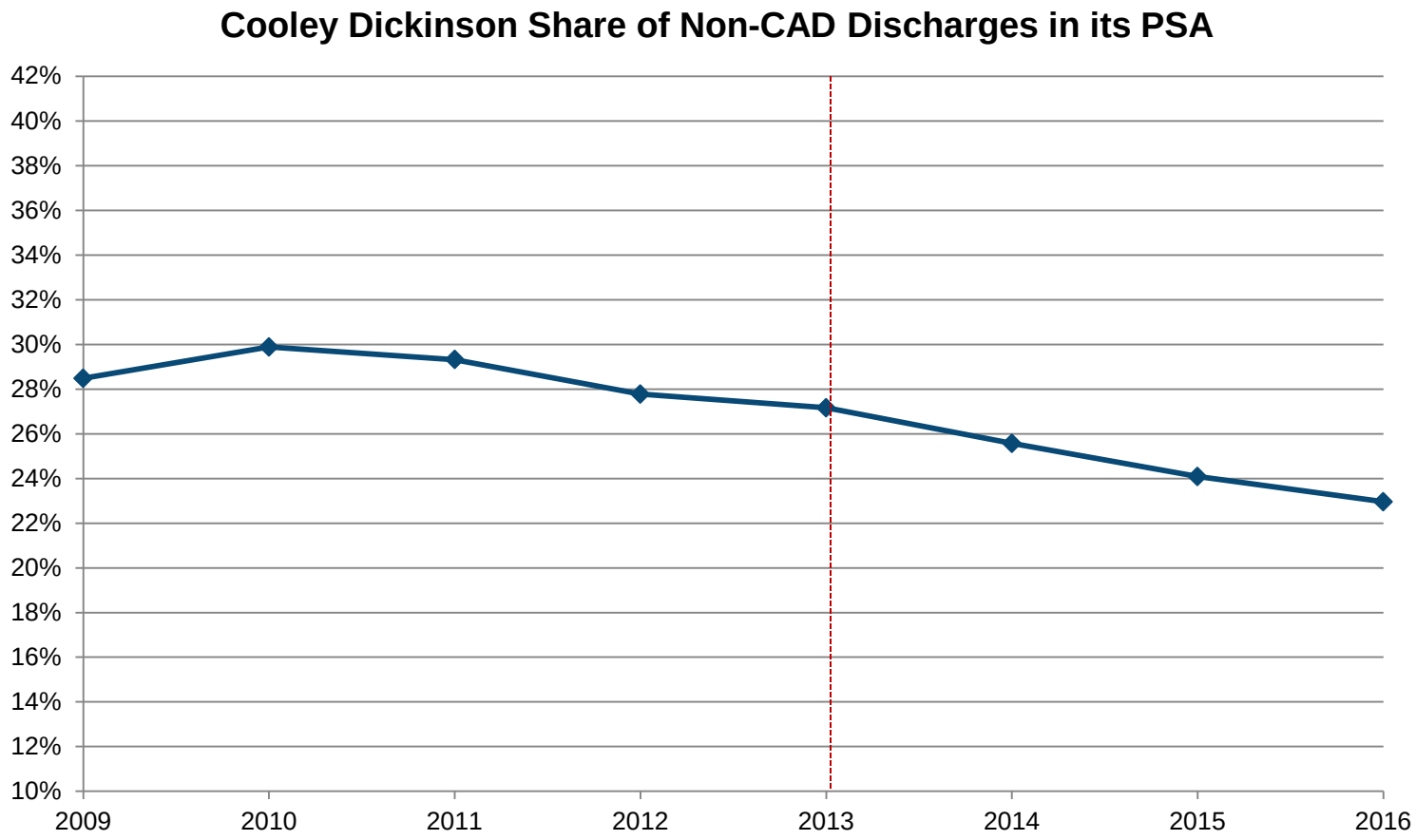
BID-Plymouth's share of other local discharges also began to rebound after acquisition by BIDMC.



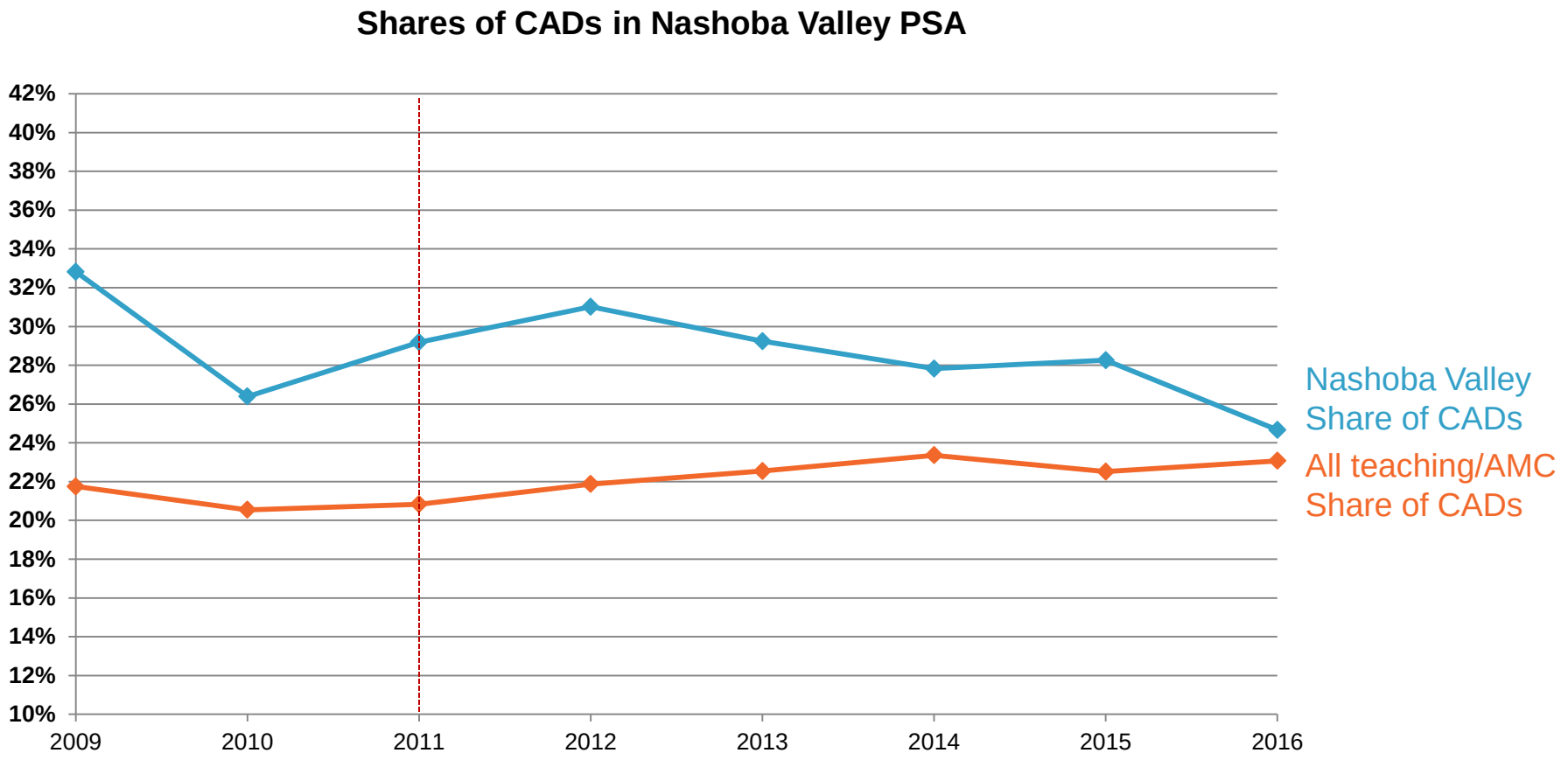
Cooley Dickinson's share of local community-appropriate discharges decreased faster than the statewide trend after it was acquired by Partners.



Cooley Dickinson's share of other local discharges also decreased before and after its affiliation with Partners, though less steeply.



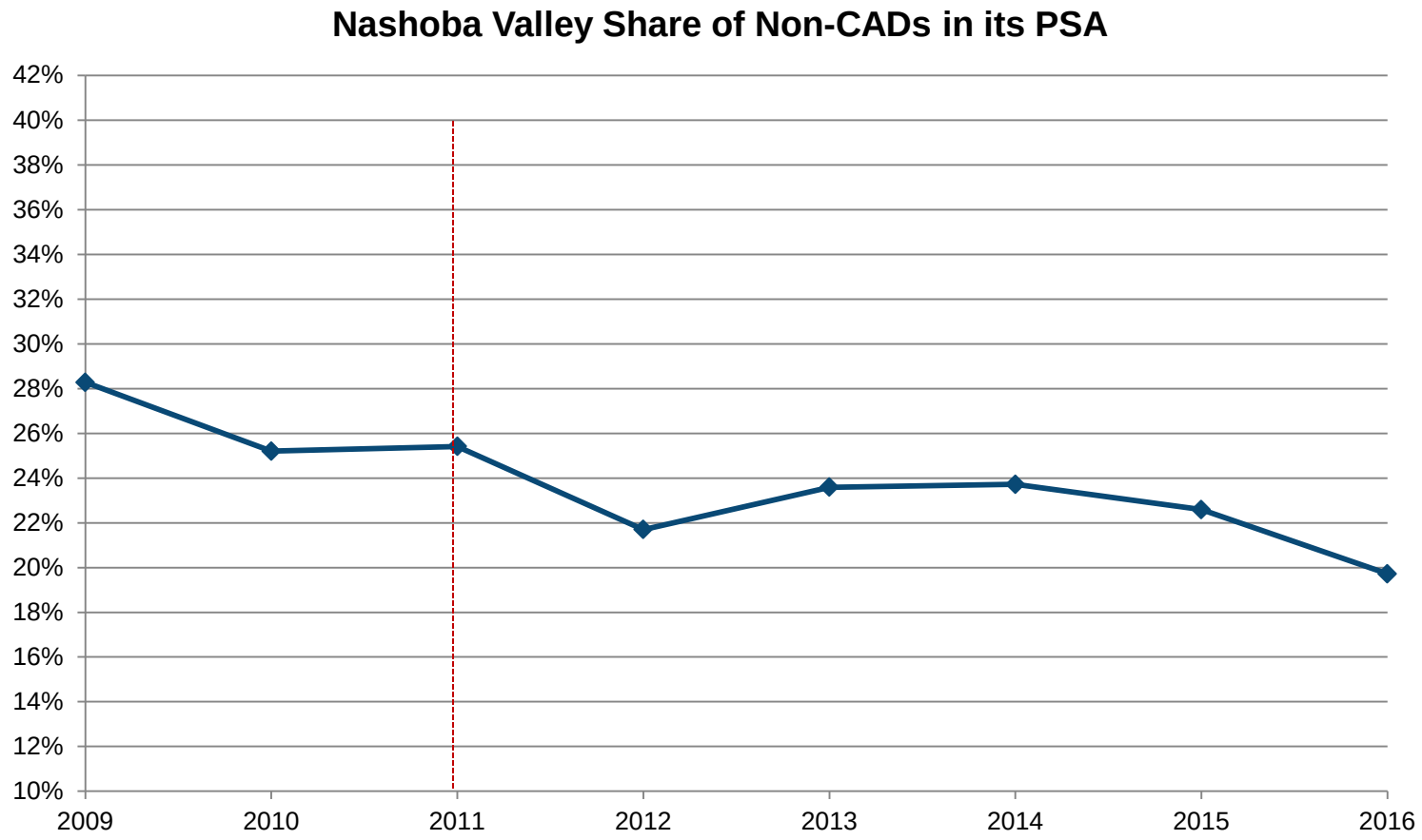
Nashoba Valley also lost shares of community-appropriate discharges in its local area after it was acquired by Steward.



Other Steward hospitals acquired in 2011 and 2012 – Merrimack Valley and Morton – experienced steeper declines in shares of community-appropriate discharges while teaching hospitals and AMCs gained shares.

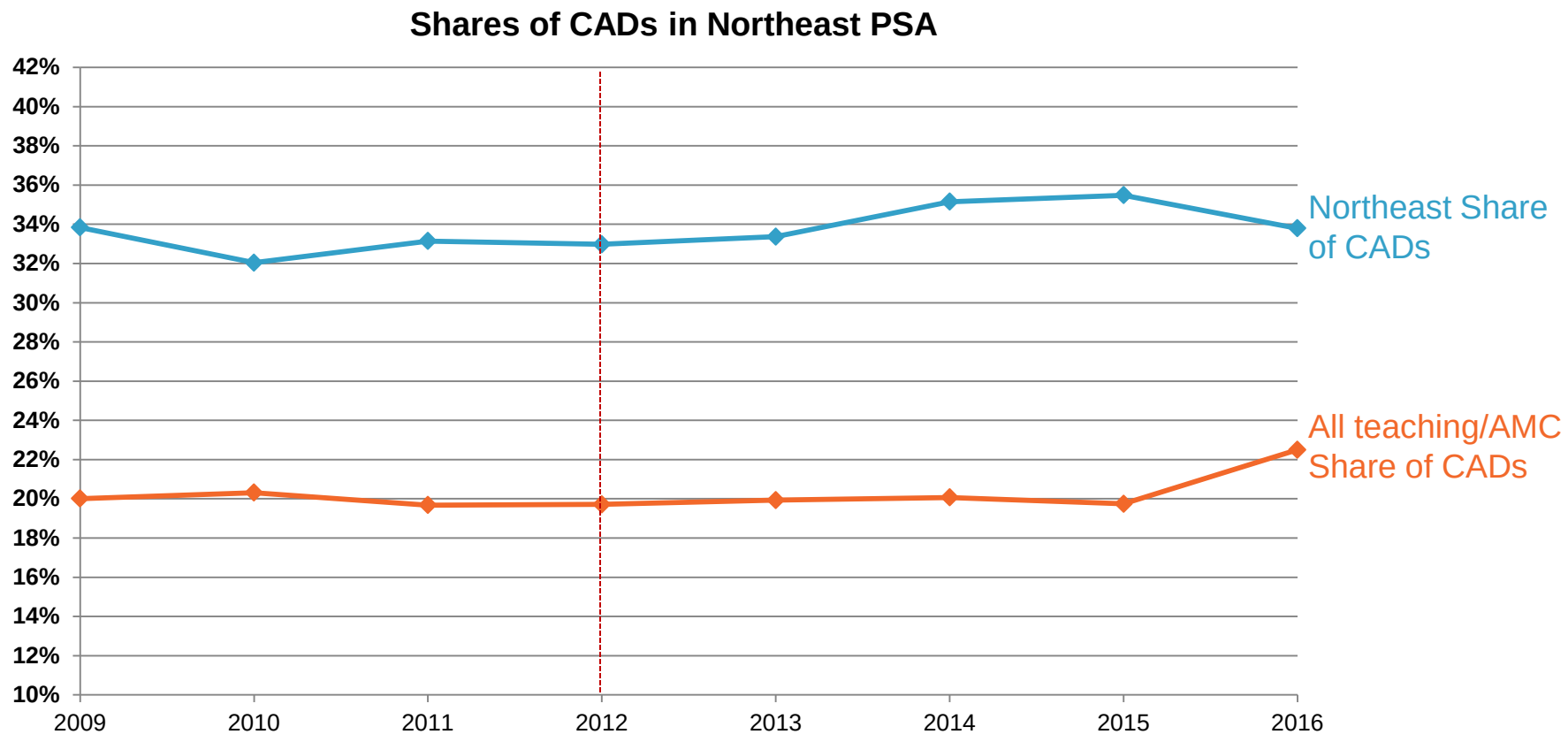
HPC

Nashoba Valley also lost shares of other local discharges after acquisition by Steward, at an even faster rate.



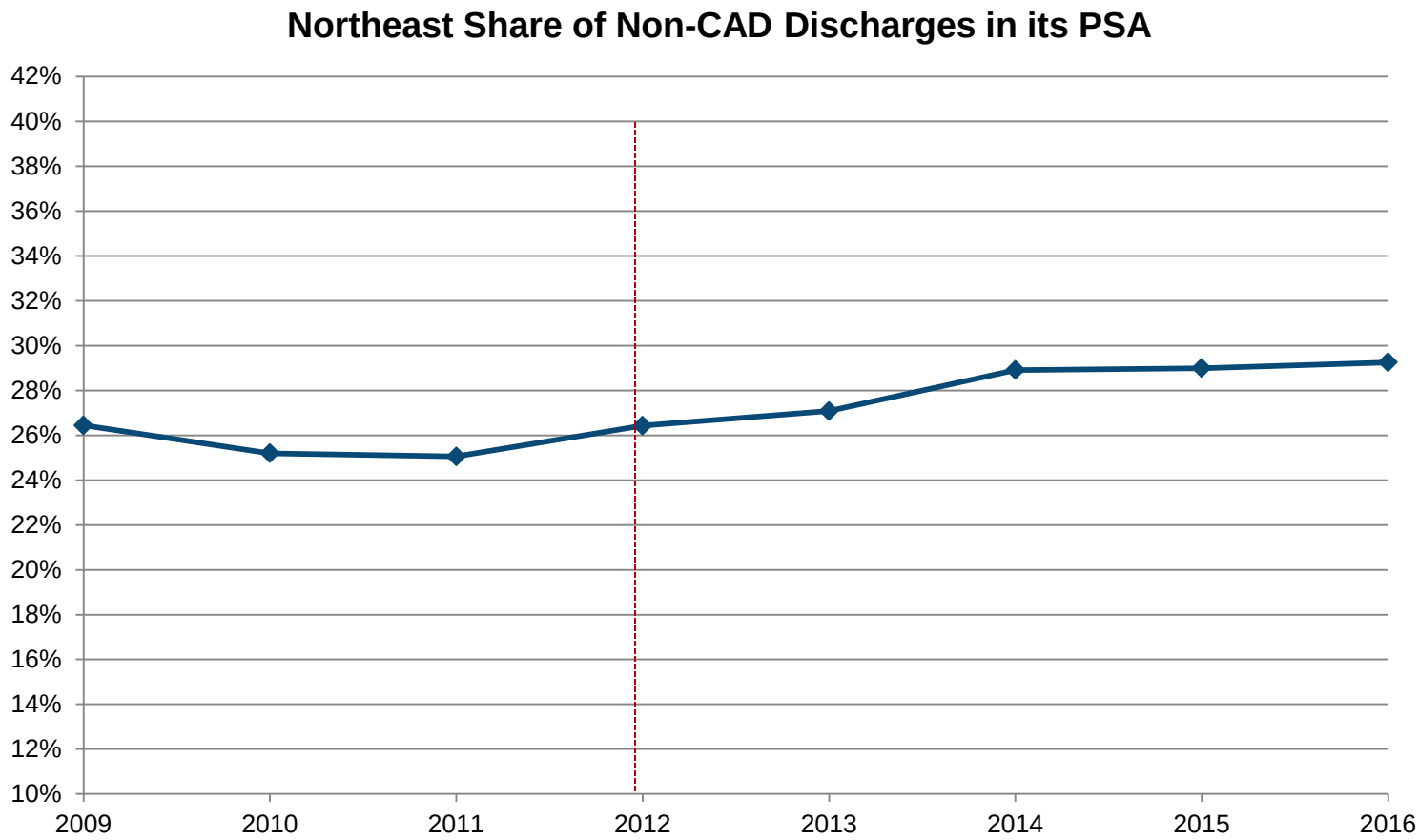
Neither Merrimack Valley nor Morton saw increases in their non-CAD shares.

Northeast Hospital did not experience the same decline in its share of community-appropriate discharges after acquisition by Lahey.

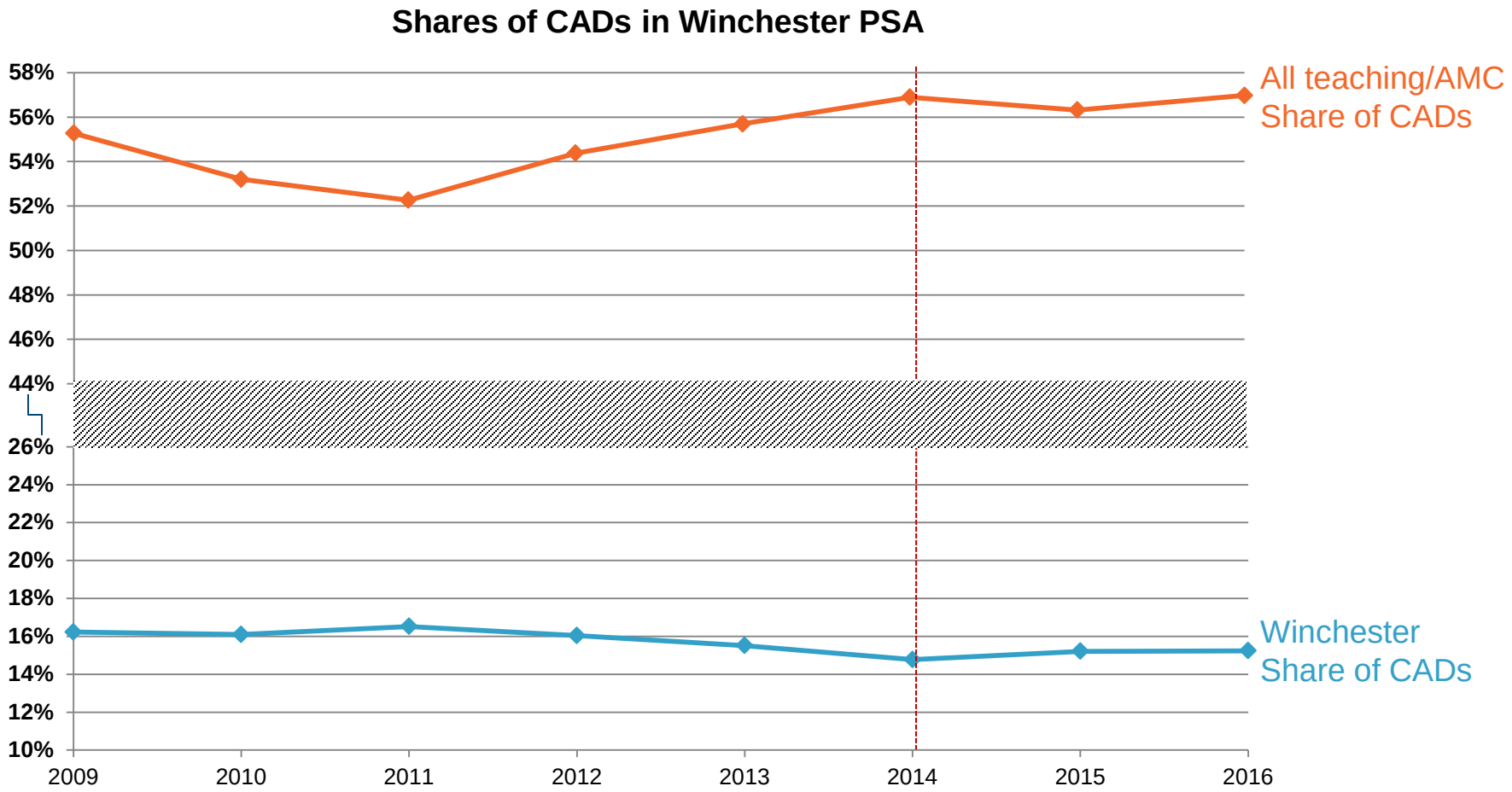


- The share of community-appropriate discharges at Northeast Hospital (Beverly Hospital and Addison-Gilbert) has **slightly increased** following acquisition by Lahey.
- Until 2016, the share of community-appropriate discharges at teaching hospitals and AMCs was also relatively stable.

Northeast Hospital also experienced a higher share of other local discharges after its affiliation with Lahey.

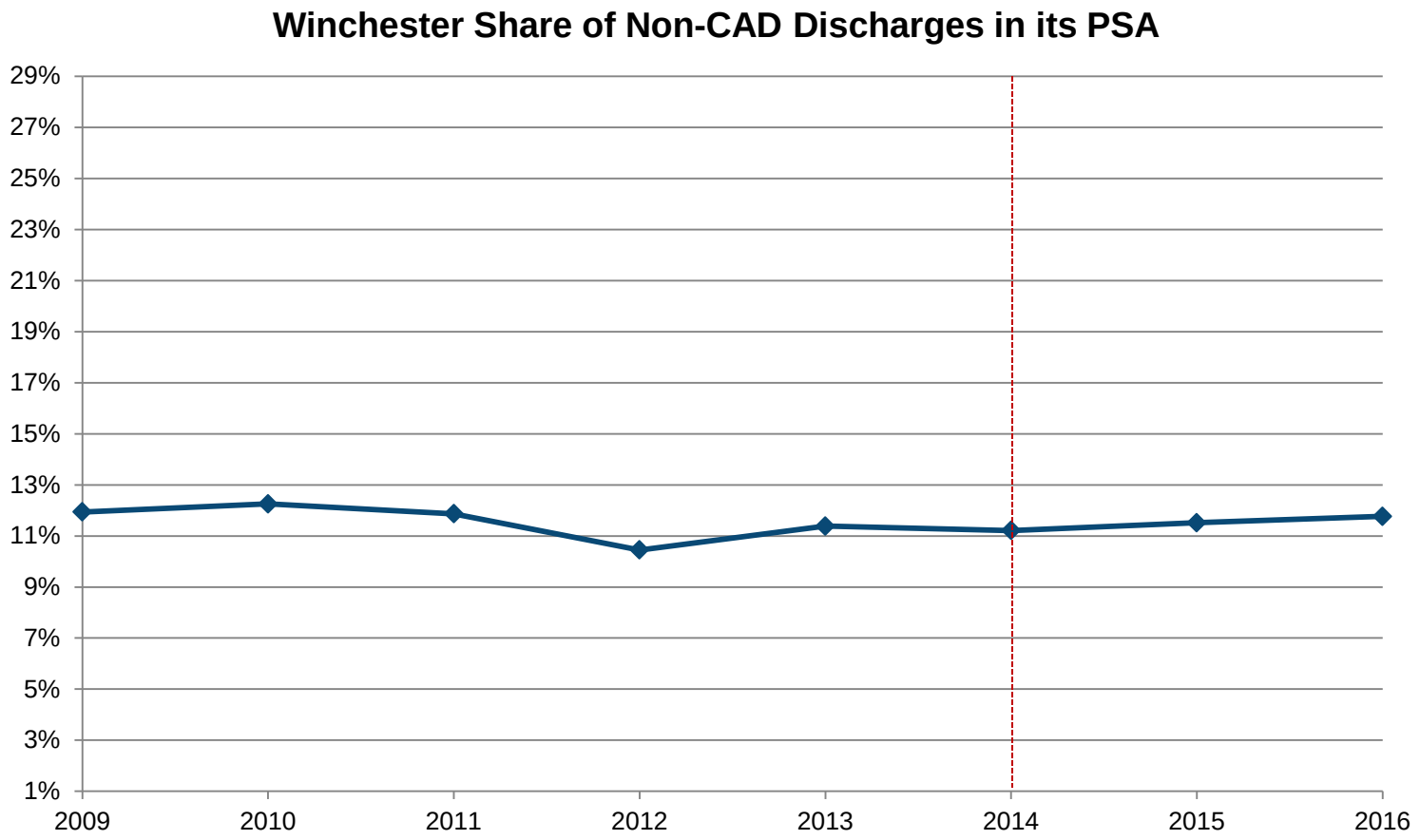


Similarly, Winchester Hospital did not have a decline in its share of community-appropriate discharges after it was acquired by Lahey.



- Winchester Hospital's share of community-appropriate discharges was decreasing before its acquisition by Lahey, but its share appears to have now stabilized and slightly increased.
- While AMCs and teaching hospitals gained a slightly larger share of CADs in this service area following Winchester's acquisition, it has also been slower than the statewide trend.

Winchester had a similarly slight increase in other local discharges after its affiliation with Lahey.



The HPC is monitoring a range of other performance metrics for those providers that have formed new corporate or contracting affiliations.

The HPC is continuing to monitor a range of metrics for providers that have new affiliations such as:

- Relative price and composite relative price percentile;
- Inpatient net patient service revenue per case mix adjusted discharge;
- Inpatient costs per case mix adjusted discharge;
- Case mix index;
- Occupancy rate;
- Payer mix;
- Nationally-recognized quality metrics;
- Total Medical Expenses for patients residing in the providers' primary service areas; and
- Total Medical Expenses by provider organization.

We look forward to reporting information about these and other performance metrics in the future.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- Future Care Delivery Investments: Design Discussion
- CHART Phase 2 Investment Program
- Health Care Innovation Investments (HCII)
- Research Presentation: Methodology for Community Appropriate Care and Expanded Review of Post-Transaction Impacts
- **Schedule of Next Meeting (December 6, 2017)**

Contact Information

For more information about the Health Policy Commission:

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