COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

January 20, 2016

Board Meeting

Agenda

- Approval of Minutes from the December 16, 2015 Meeting
- Executive Director's Report
- Update on HPC Committee Assignments
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Schedule of Next Meeting (March 2, 2016)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on December 16, 2015, as presented.

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January 20 Meeting: Agenda

1. Update on HPC Committee Assignments

2. Cost Trends and Market Performance Updates
   - Update on Material Change Notices
   - Discussion of 2015 Cost Trends Report: Provider Price Variation
   - Discussion of Recommendations from the 2015 Cost Trends Report

3. Community Health Care Investment and Consumer Involvement Updates
   - Approval of Program Design for Health Care Innovation Investment Program
   - Approval of Program Design for HPC's Telemedicine Pilot Program

CHART Investment Program: Phase 2 launch update

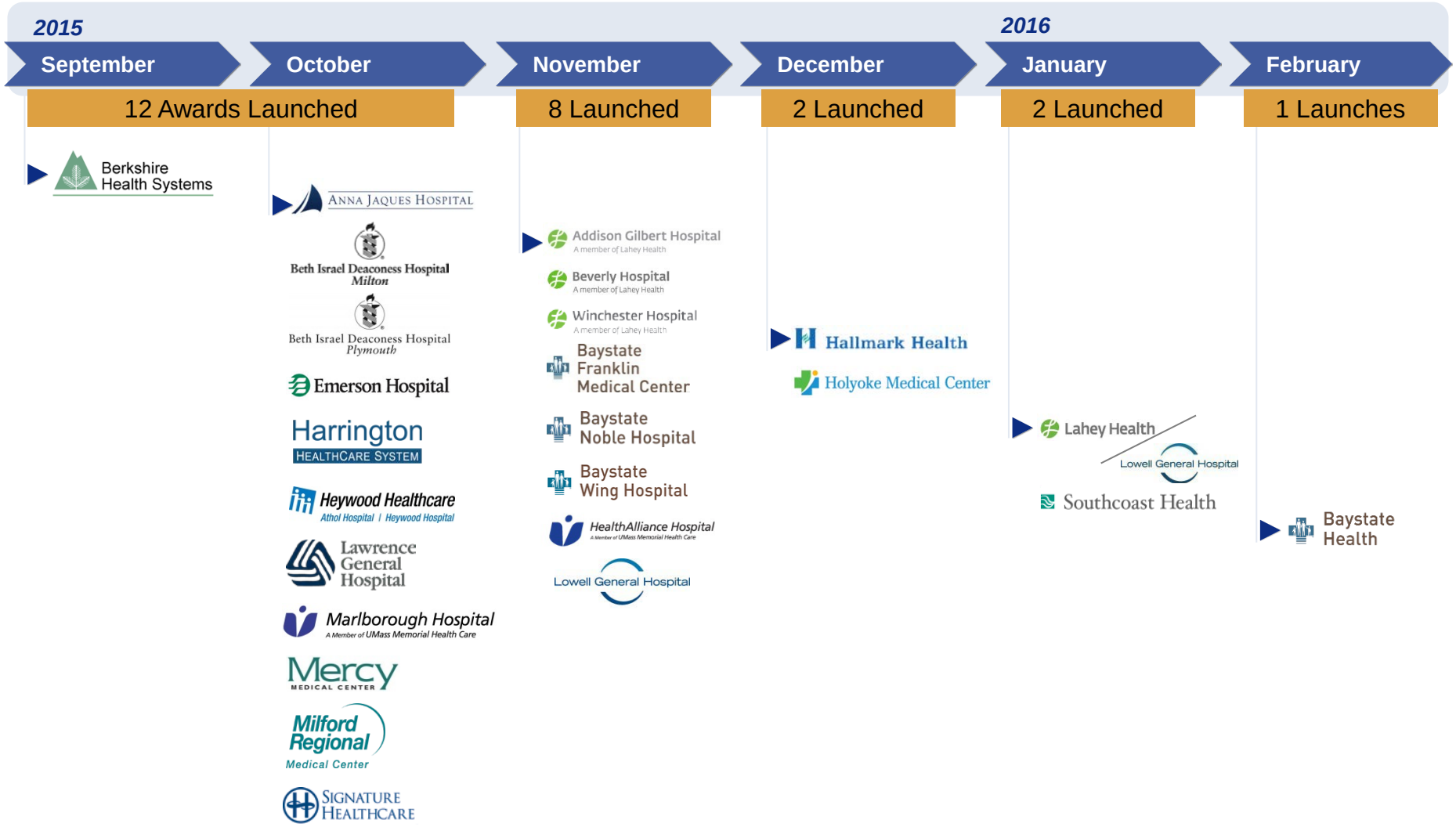

CHART Phase 2: Activities and supports

CHART Phase 2 Newsletter

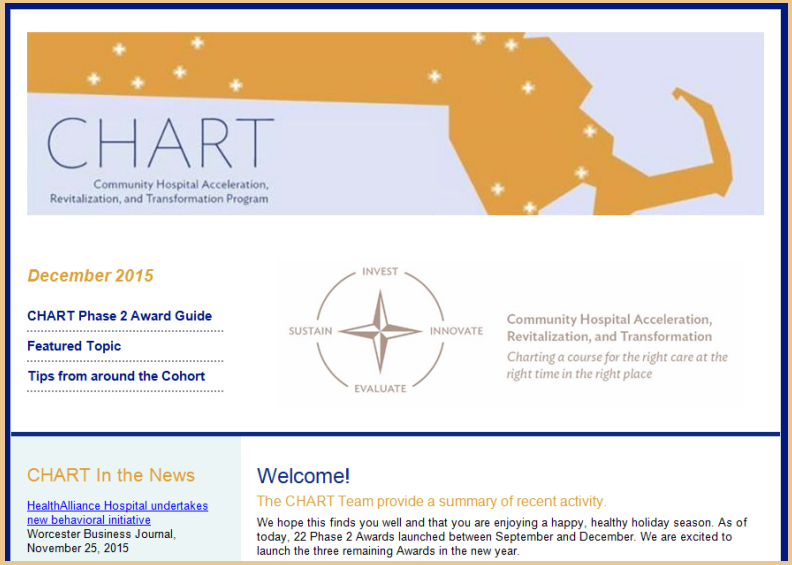
CHART
Community Hospital Acceleration, Revitalization, and Transformation Program

December 2015

CHART Phase 2 Award Guide

Featured Topic

Tips from around the Cohort

INVEST
SUSTAIN
INNOVATE
EVALUATE

Community Hospital Acceleration, Revitalization, and Transformation

Charting a course for the right care at the right time in the right place

CHART In the News

HealthAlliance Hospital undertakes new behavioral initiative
Worcester Business Journal, November 25, 2015

Welcome!

The CHART Team provide a summary of recent activity.

We hope this finds you well and that you are enjoying a happy, healthy holiday season. As of today, 22 Phase 2 Awards launched between September and December. We are excited to launch the three remaining Awards in the new year.

12+

working meetings with strategic advisors each month

CHART lecture series with national experts

CHART Hospital Resource Page

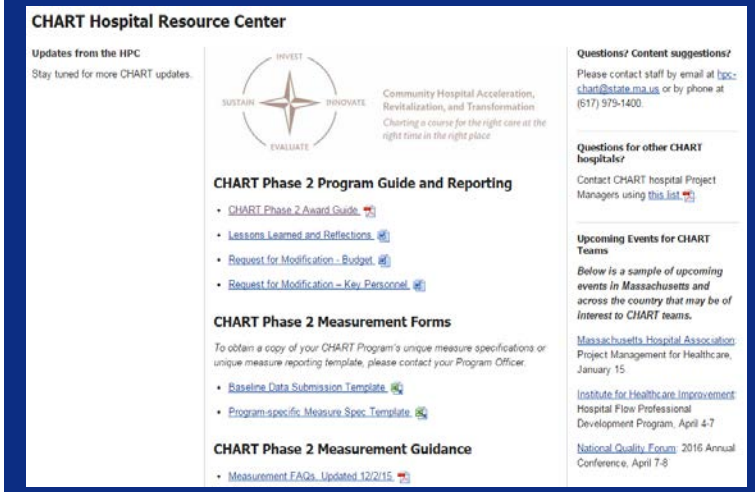
CHART Hospital Resource Center

Updates from the HPC

Stay tuned for more CHART updates.

INVEST
SUSTAIN
INNOVATE
EVALUATE

Community Hospital Acceleration, Revitalization, and Transformation

Charting a course for the right care at the right time in the right place

CHART Phase 2 Program Guide and Reporting

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

CHART Phase 2 Measurement Forms

To obtain a copy of your CHART Program's unique measure specifications or unique measure reporting template, please contact your Program Officer.

- Baseline Data Submission Template
- Program-specific Measure Spec Template

CHART Phase 2 Measurement Guidance

- Measurement FAQs, Updated 12/2/15

Questions? Content suggestions?

Please contact staff by email at hpc-chart@state.ma.us or by phone at (617) 979-1400.

Questions for other CHART hospitals?

Contact CHART hospital Project Managers using this list.

Upcoming Events for CHART Teams

Below is a sample of upcoming events in Massachusetts and across the country that may be of interest to CHART teams.

Massachusetts Hospital Association Project Management for Healthcare, January 15

Institute for Healthcare Improvement Hospital Flow Professional Development Program, April 4-7

National Quality Forum 2016 Annual Conference, April 7-8

Communities of Practice by Vocation

Quarterly regional convenings

Certification Programs

Patient-Centered Medical Home Certification Program

PCMH PRIME launched on January 1, 2016.
NCQA is currently accepting applications from eligible entities on its website.
HPC, in conjunction with NCQA, will continue to release communications on this program.
For more information, visit bit.ly/HPCPRIME

Accountable Care Organization Certification Program

HPC is accepting public comment on proposed ACO certification criteria through **Friday, January 29.**
Submit Comment: HPC-Certification@state.ma.us
or
Health Policy Commission
Attn: Catherine Harrison
50 Milk Street, 8th floor, Boston, MA 02109

All written or oral comments submitted to the HPC may be posted on the HPC's website and released in response to a request for public records. Please do not include any information in either written or oral comments that may lead to the identification of a patient, other than oneself.

January 20 Meeting: Proposed Votes

1. Minutes from December 16, 2015 Meeting
2. Committee Assignments
3. 2015 Cost Trends Report
4. Program Design for the Health Care Innovation Investment Program
5. Program Design for the HPC's Telemedicine Pilot Program

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Vote: Approving Committee Appointments

***Motion**:* That pursuant to section 4.1 of the By-Laws, the Commission hereby approves the following Committee appointments and directs each Committee that does not have a Chairperson to appoint a Chairperson at its next meeting:

Cost Trends and Market Performance
Dr. Cutler, Chair
Dr. Everett
Mr. Mastrogiovanni
Mr. Lord
Secretary Lepore

Quality Improvement and Patient Protection
Mr. Cohen, Chair
Dr. Allen
Dr. Everett
Ms. Turner
Secretary Sudders

Care Delivery and Payment System Transformation
Dr. Allen, Chair
Mr. Cohen
Dr. Cutler
Dr. Berwick
Secretary Sudders

Community Health Care Investment and Consumer Involvement
Dr. Berwick
Mr. Lord
Mr. Mastrogiovanni
Ms. Turner
Secretary Lepore

Administration and Finance
Dr. Altman, Chair
Mr. Lord
Mr. Mastrogiovanni
Ms. Turner
Secretary Lepore

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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	14	25%
Physician group merger, acquisition or network affiliation	12	22%
Acute hospital merger, acquisition or network affiliation	11	20%
Formation of a contracting entity	9	16%
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	5%
Affiliation between a provider and a carrier	1	2%

Update on notices of material change

Notices Received Since Last Commission Meeting

- Clinical affiliation between Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical Faculty Physicians, and MetroWest Medical Center (MWMC), under which the parties would expand MWMC service offerings and direct MWMC patients to BIDMC for tertiary/quaternary care.

- Clinical affiliation between Boston Children's Hospital (Children's), Mount Auburn Cambridge Independent Practice Association (MACIPA), and Mount Auburn Hospital, under which Children's would become the preferred pediatric academic medical center for MACIPA patients.

Elected Not to Proceed

- **Clinical affiliation between Atrius Health (Atrius) and Massachusetts Eye and Ear Infirmary**
  - Our analysis indicated that referral patterns for Atrius patients were not expected to shift significantly, and thus that there was limited scope for changes to health care spending.
  - We did not find evidence suggesting negative impacts on quality or access to care.

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Introduction

- As part of the 2015 Cost Trends Report series, the HPC is releasing a companion report on provider price variation, focused on the significant and persistent variation in prices paid by commercial insurers to different providers for the same sets of services.

- Chapter 224 charged the HPC with examining provider price variation and recommending solutions to address it.

- This Report provides an overview of previous work on provider price variation (by the HPC, AGO, CHIA and other national experts) and presents new data-driven analyses further detailing the issue of unwarranted price variation, including a rigorous examination of the factors associated with differing inpatient hospital prices.

Key findings

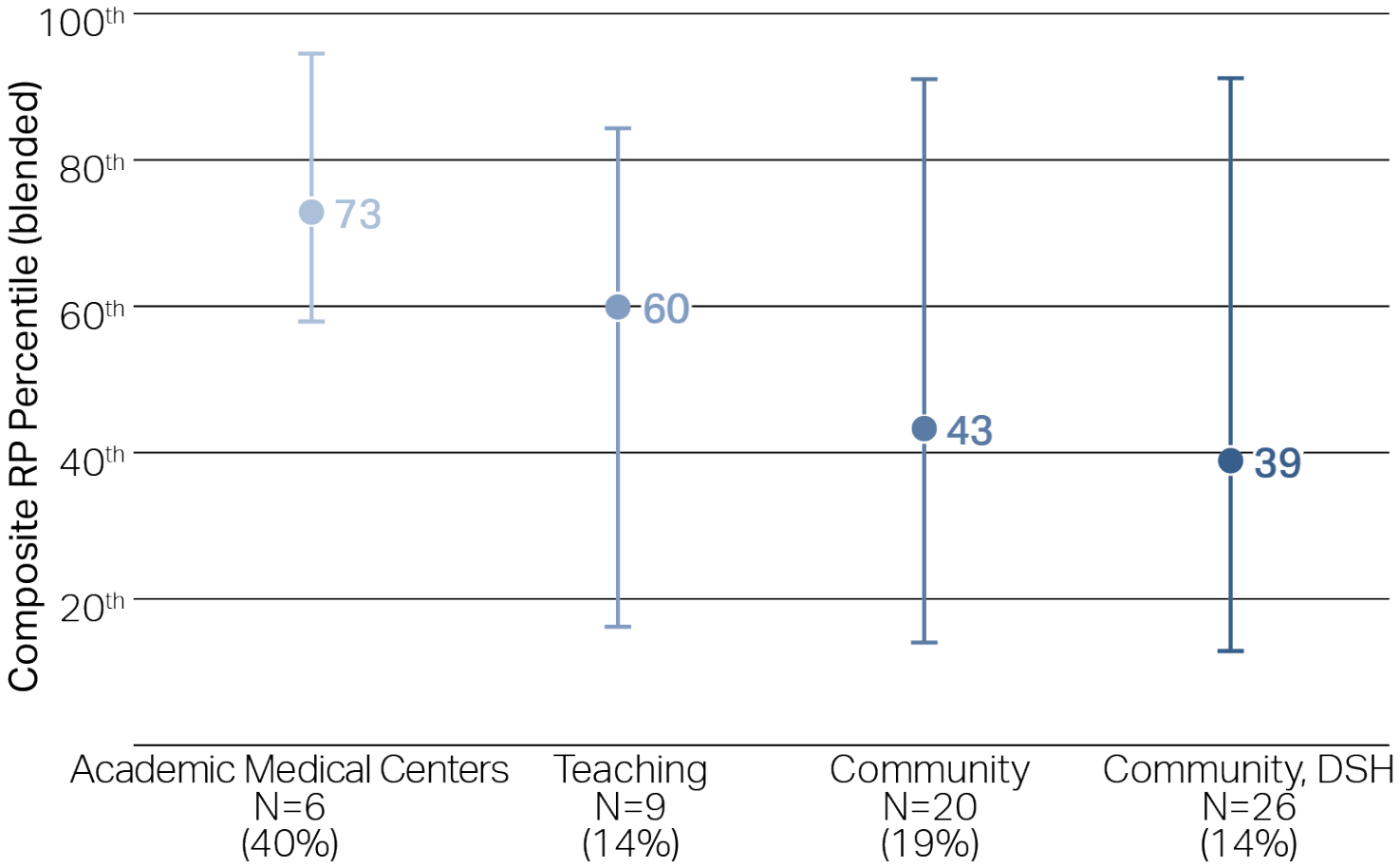
- Provider prices vary extensively for the same sets of services.
- Provider price variation has not diminished over time.
- Market leverage continues to be a significant driver of higher prices; higher hospital prices are not generally associated with higher quality or other value-based factors that provide benefit to the Commonwealth.
- While some variation in prices may be warranted to support activities that provide value to the Commonwealth (e.g. physician training), unwarranted variation in prices combined with the large share of volume at higher-priced providers results in increased health care spending and creates inequities in the distribution of health care resources.
- Other states have also found unwarranted variation in provider prices; however, in one state that limits hospital price variation to value-based factors, hospital prices for specific services vary less than in Massachusetts.
- Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue.

Multiple state agencies have documented extensive, unwarranted variation in hospital and physician prices in Massachusetts since 2010

- Multiple state agencies have found significant price variation among health care providers in the Commonwealth:
  - The Office of the Attorney General in 2010, 2011, 2013, and 2015
  - The Special Commission on Provider Price Reform in 2011
  - The Division of Health Care Finance and Policy in 2011 and the Center for Health Information and Analysis (CHIA) in 2012, 2013, and 2015
- In addition to variation in fee-for-service prices, multiple reports have documented extensive variation in prices paid under alternative payment methods, specifically global budget arrangements.
- Variation has not generally be found to be explained by differences in quality, patient acuity, or other common measures of value. Rather, past reports have found that higher prices are associated with market leverage.
- Previous reports have documented that hospital prices vary considerably not only across all Massachusetts hospitals, but also within hospital cohorts (AMC, teaching, community, community-DSH).

Hospital prices vary not only across all hospitals, but also within hospital cohorts

Acute Hospital Composite Relative Price Percentile by Hospital Cohort (2013)

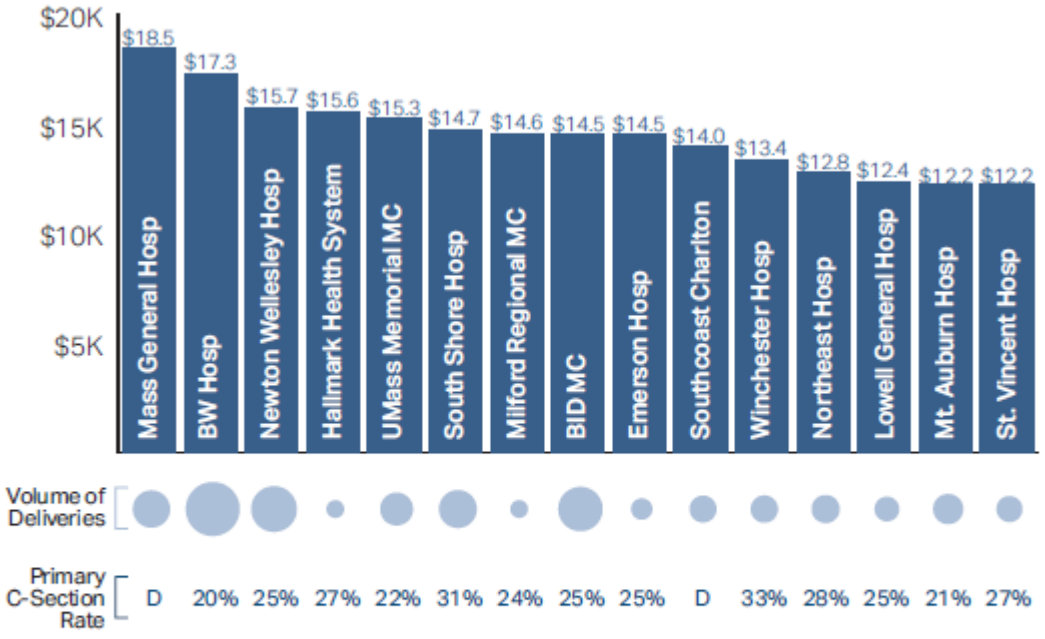


CHIA Hospital Relative Price Databook (2015).

The HPC has also found considerable variation in prices for common episodes of care

- As described in the 2014 and 2015 Cost Trends Reports, the HPC has found that spending levels for common episodes of care, such as hip and knee replacements and maternity care, vary considerably and such variation is not tied to differences in quality.
- Spending differences for these episodes are driven by variation in inpatient prices, rather than differences in utilization before or after the inpatient stay.
- The HPC has also found wide variation in prices paid for common outpatient laboratory tests.

Average Payments for Deliveries by Hospital

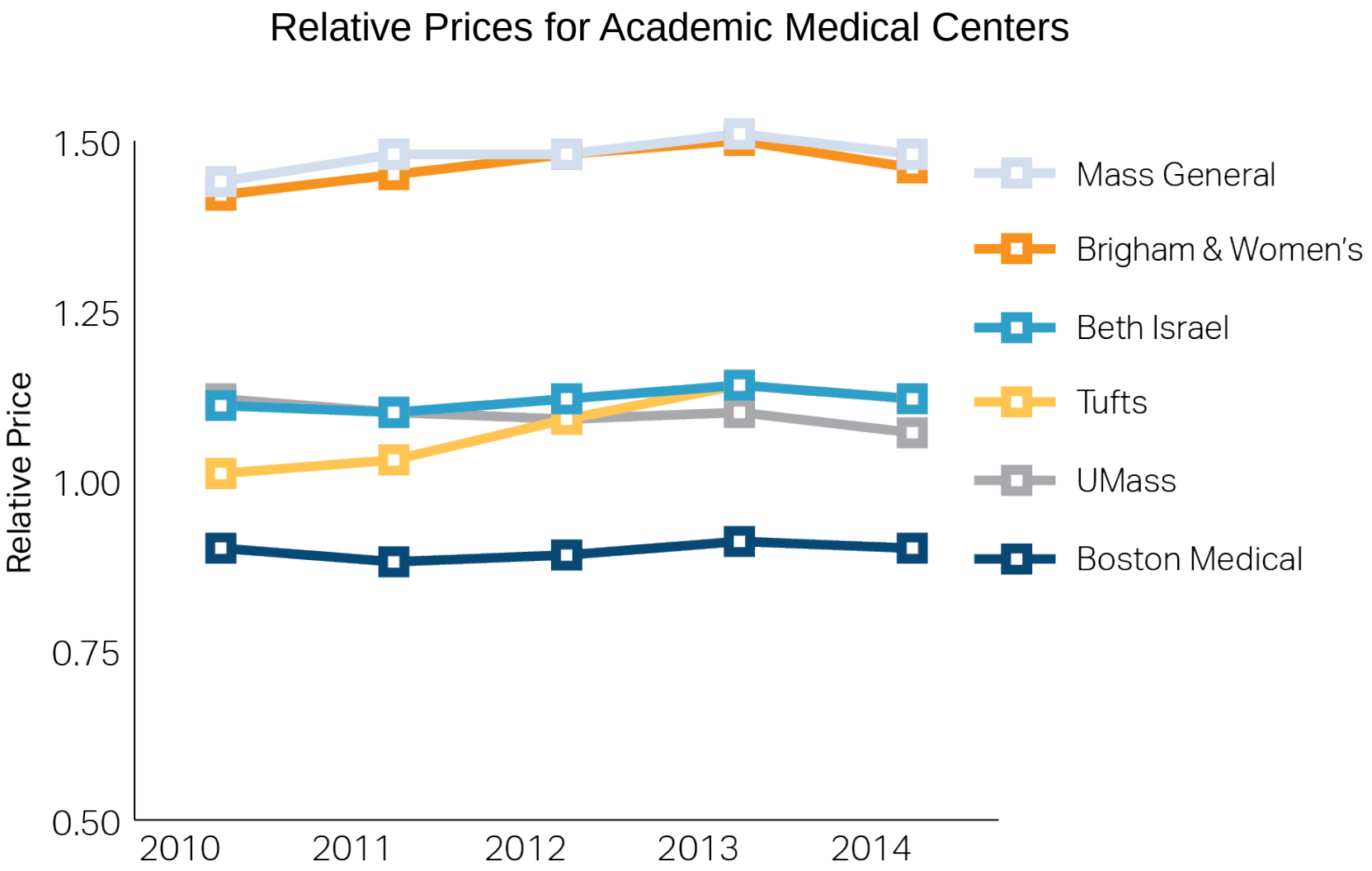


Note: This chart is limited to the 15 hospitals with the greatest number of normal deliveries paid by commercial payers in 2014. Both vaginal and C-section deliveries are included.

Source: HPC analysis of the Massachusetts All-Payer Claims Database, 2011-2012, HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database 2011-2012; Leapfrog group.

"D" indicates that the hospital declined to voluntarily submit rates.

Hospital price variation has not diminished over time, and hospital price positions generally remain consistent relative to the market



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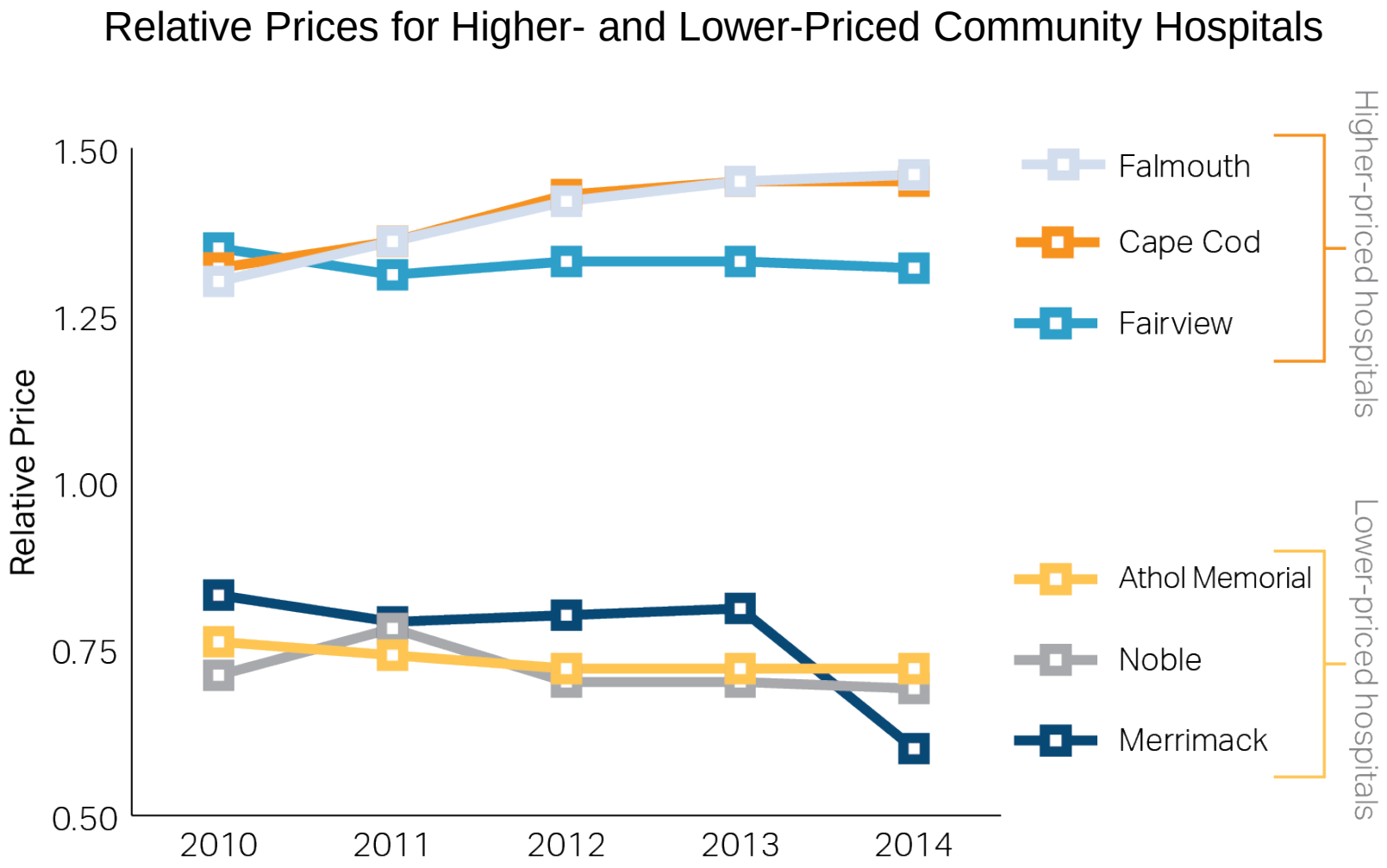
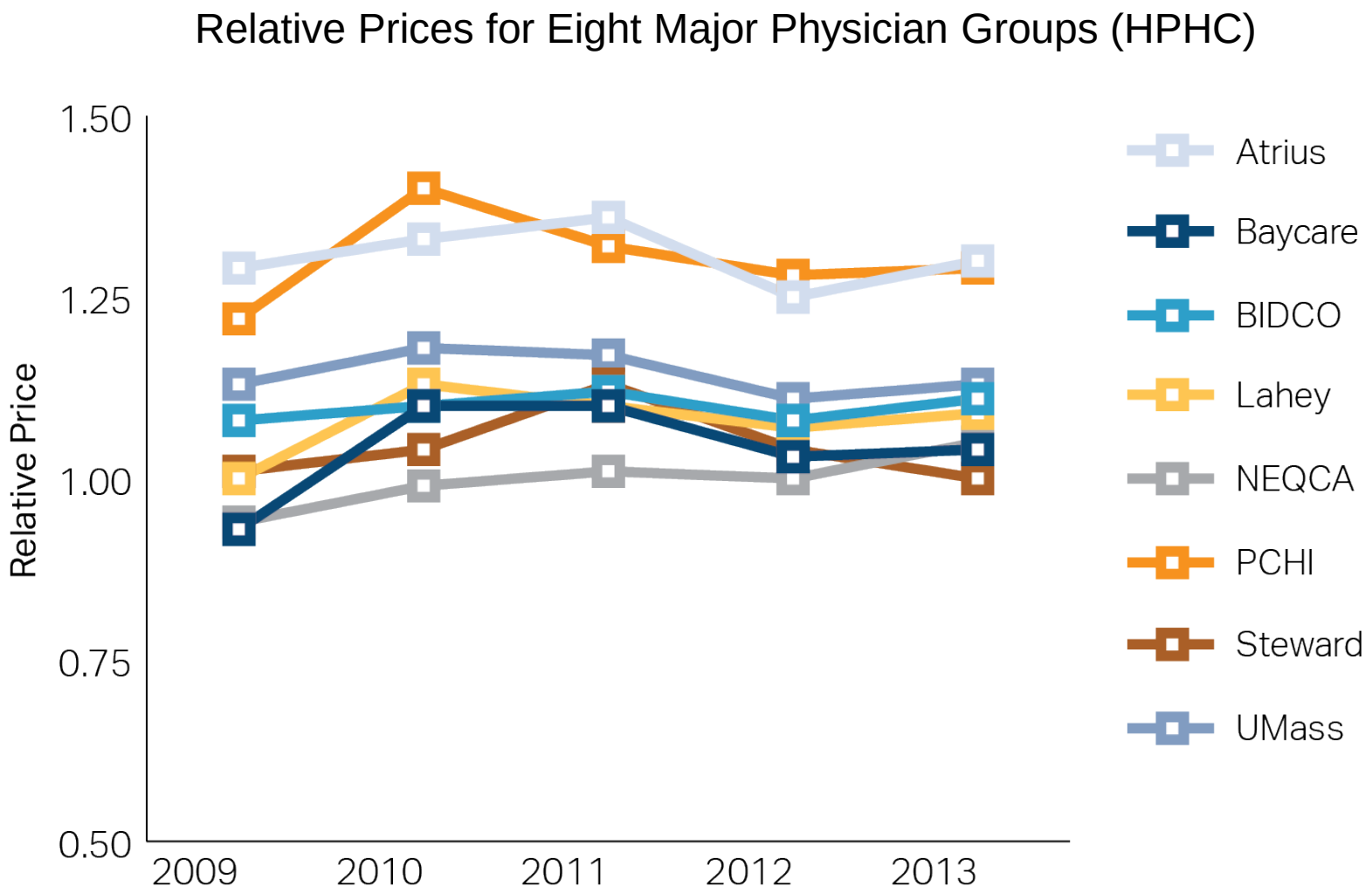
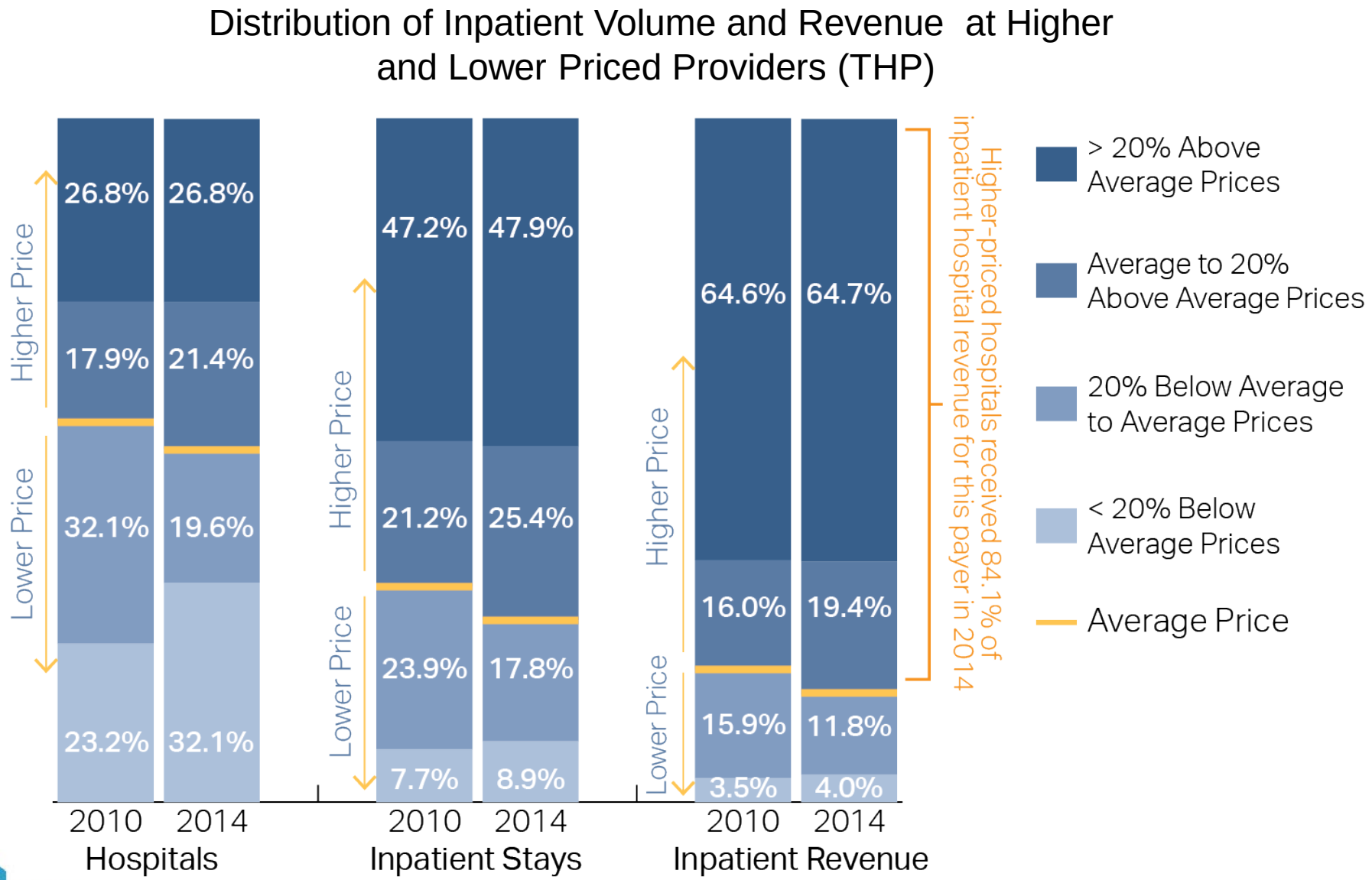


Physician price variation also has not diminished over time, and physician group price positions generally remain consistent relative to the market



Physicians affiliated with Children's Hospital Boston are not included in this chart. Throughout this five-year period, Children's was consistently the highest-priced physician group, with relative prices above 2.0 in all five years.

Higher healthcare spending is driven by both the higher prices some providers receive and the large volume at these higher-priced providers



The HPC found that a substantial portion of hospital price variation is associated with market structure, and not with quality

Factors associated with higher commercial prices (Holding all other factors equal)
Less competition
Larger system size (above a certain size)
Corporate affiliations with certain systems
Provision of higher-intensity (tertiary) services
Status as a teaching hospital

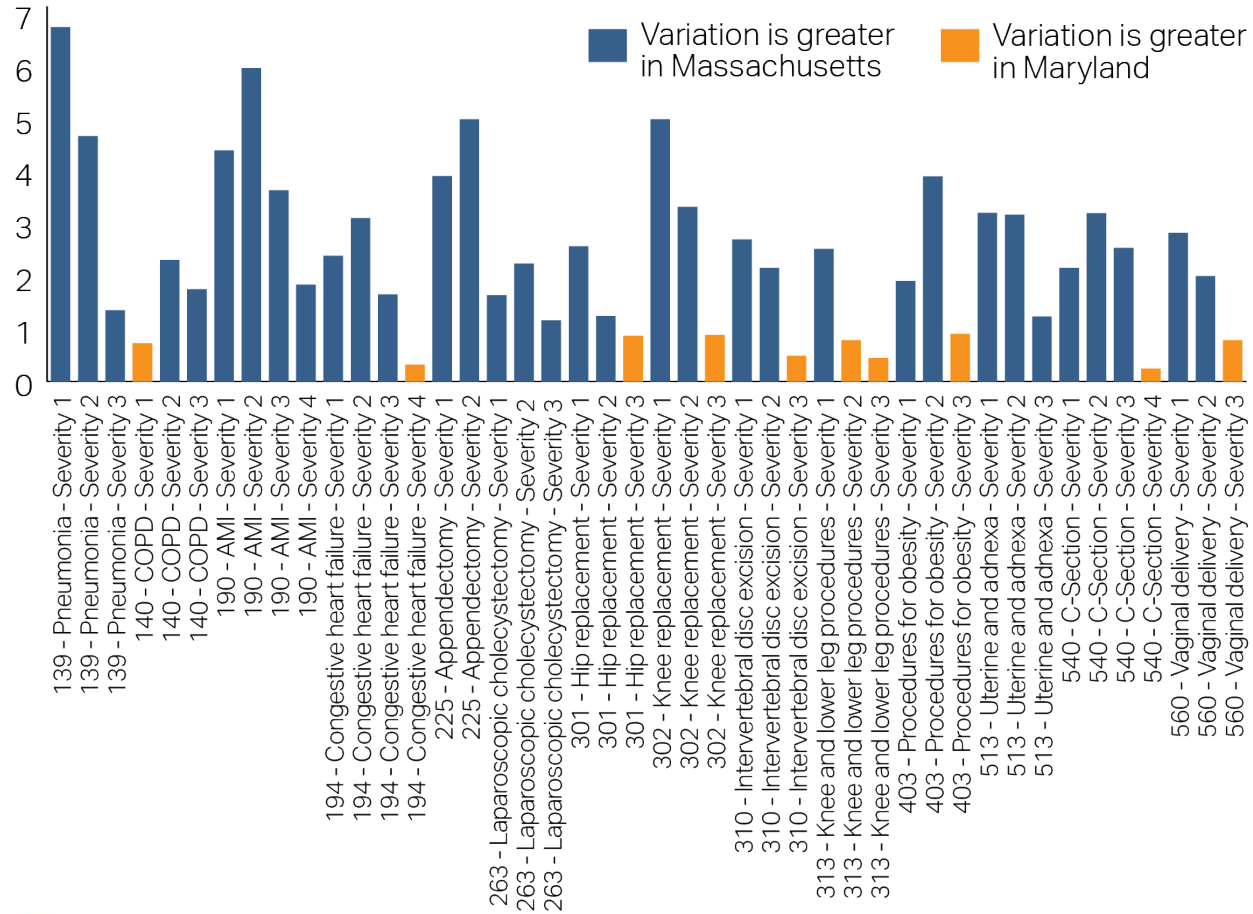
Factors associated with lower commercial prices (Holding all other factors equal)
More Medicare patients
More Medicaid patients
Corporate affiliations with certain systems

Factors not generally associated with commercial prices (Holding all other factors equal)
Quality
Mean income in the hospital's service area

HPC

Where price variation is restricted to value-based factors, it is lower than in Massachusetts

Ratio of Massachusetts Variation to Maryland Variation



- The HPC found that Massachusetts had more price variation than Maryland where hospital prices could only vary based on measures of value (e.g., patient acuity, teaching status, reasonable hospital costs, and level of uncompensated care).
- In 36 out of 44 DRG-severity-level pairs, Massachusetts prices varied more than Maryland.
- In 24 cases, MA hospitals showed **more than twice** as much variation as Maryland.
- For low severity pneumonia, Massachusetts had **nearly 7 times** the variation of Maryland.

HPC

Data from the Maryland Health Services Cost Review Commission

Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue

- Existing policy initiatives were not designed to directly reduce unwarranted price variation. For example:
  - The benchmark focuses on year-over-year growth, not the allocation of resources within the system;
  - Alternative payment methods are not likely to reduce price variation so long as global budgets are based on providers' historic spending levels.
- The need for action is reinforced by the extent of the price variation in the market. Price variation is extensive enough that it would take 16-19 years for some lower-priced hospitals in the three major commercial payer networks to reach the 2013 price level of the 75th percentile, even if they received annual 3.6% rate increases.

The HPC will continue data-driven analyses and convene stakeholders to discuss policy options to reduce unwarranted price variation

- The HPC will undertake additional research and analyses and promptly convene stakeholders (including the HPC Advisory Council) to present and discuss specific policy options to reduce unwarranted price variation in support of more sustainable and equitable health care system.

- Policy options for consideration include:

  - Policies to enhance healthcare market transparency and encourage consumers to use high-value providers for their care;

  - Limiting provider charges for emergency out-of-network services and those delivered by out-of-network providers located within in-network facilities;

  - Transitioning away from use of historic spending for setting global budgets; and

  - Limiting price variation to value-based factors that provide benefit to the Commonwealth

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2015 COST TRENDS REPORT

Massachusetts Health Policy Commission

Report topics and potential areas for recommendations

Report topics

Spending and the delivery system

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

Opportunities in quality & efficiency

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

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

HPC

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

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

4.8% rate of growth of THCE

1.6% percentage points due to drug spending

3.2% percentage points due to MassHealth *significant MassHealth enrollment growth due to ACA* (2.5 excluding drugs)

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

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

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

Conclusions from the 2015 Cost Trends report

1 2 3 4

There are significant opportunities to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options
2. **Promoting an efficient, high-quality health care delivery system,** centered on primary care, in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status
3. **Advancing alternative payment methods** that support and appropriately reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time

Fostering a value-based market

Proposed Recommendations and Selected HPC Commitments

1. Payers and employers should continue to enhance strategies that enable consumers to make high-value choices, including increasing transparency of comparative prices and quality.
2. The Commonwealth should enhance transparency of drug prices and spending, and payers should consider opportunities to maximize value
   - The Legislature should require increased transparency of drug pricing and rebates.
   - Payers should consider opportunities to maximize value and work with providers to develop appropriate treatment protocols and guidelines for new high cost drugs.
3. The Commonwealth should take action to improve consumer protection and market function related to out-of-network billing practices.
   - The Legislature should take steps to require consumer notice before out-of-network services are delivered, hold consumers harmless in cases of out-of-network emergency services, and establish a maximum reasonable price for such services.
4. The Commonwealth should take action to equalize payments for the same services between hospital outpatient departments and physician offices.
   - The Legislature should limit the types of provider locations that can bill as a hospital outpatient department.
   - Payers should implement site neutral payments for select services.
5. The Commonwealth should act to reduce unwarranted variation in provider prices.
   - The HPC will undertake additional research and analyses and will convene stakeholders to discuss specific policy options.

Promoting an efficient, high-quality delivery system

Proposed Recommendations and Selected HPC Commitments

6. The Commonwealth should continue to enhance community-based, integrated care and reduce unnecessary utilization of costly acute settings.
   - The Commonwealth should achieve a 20 per cent reduction in all-cause hospital readmissions by 2019.
   - A third of all primary care providers should be practicing within patient-centered medical homes and 20 percent of all primary care providers should be practicing within a HPC-certified PCMH Prime practice (medical homes with integrated behavioral health) by 2017.
   - The HPC will continue to pursue these goals in partnership with market participants through its PCMH and ACO certification programs, CHART and other investment programs, and through direct technical assistance.
7. To improve access to low-cost, high-quality care, particularly for low income and underserved populations, the Massachusetts Legislature should remove scope of practice restrictions for Advanced Practice Registered Nurses (APRNs).
8. The Commonwealth should be a national leader in use of enabling technologies to advance care delivery transformation through expansion of health information exchange, telehealth, and other digital health innovations.

Advancing alternative payment methods

Proposed Recommendations and Selected HPC Commitments

9. Payers and providers should continue to focus on increasing the adoption and effectiveness of alternative payment methods (APMs):
   - APMs for commercial HMO patients – goal: 80% by 2017
   - APMs for commercial PPO patients – goal: 33% by 2017
   - Implement bundled payment in selected cases
   - Reduce disparities in payment levels
   - Include behavioral health and long-term services and supports
10. The Commonwealth should develop alternative payment models to catalyze delivery system reform in MassHealth.
    - Developing a comprehensive care delivery and payment reform model that promotes coordination of care, improves population health, integrates both behavioral health and long-term services and supports, and enhances accountability for total cost of care is a top priority for the Executive Office of Health and Human Services. HPC strongly supports these efforts.
11. Payers and providers should seek to align technical aspects of their global budget contracts, including quality measures, risk adjustment methods, and reports to providers.
    - The HPC plans to collaborate with stakeholders in 2016 to pursue such alignment.

Enhancing transparency and data availability

Proposed Recommendations and Selected HPC Commitments

12. The Commonwealth should develop a coordinated quality strategy that is aligned across public agencies and market participants.

- The Legislature should refine the current process for developing the Standard Quality Measure Set (SQMS) to allow for the designation of limited sets of high priority measures for specific uses such as global budgets, PCMH/ACO certification, consumer transparency, and tiered or limited network product design.

13. CHIA should continue to improve and document its data resources and develop key spending measures.

Vote: Issuing Annual Cost Trends Report

Motion: That, pursuant to section 8(g) of chapter 6D of the Massachusetts General Laws, the Commission hereby issues the attached annual report on cost trends.

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  - Approval of Program Design for HPC's Telemedicine Pilot Program
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Discussion Preview: Health Care Innovation Investment Program

Agenda Topic

Discussion of Program Design for Health Care Innovation Investment Initiative

Description

Staff will present for consideration by the Board a proposed program design endorsed by the CHICI Committee for investments to foster innovation in health care payment and service delivery. The proposed design addresses eight high priority challenges for cost containment, and encourages payers and an array of providers to participate and to partner with each other and other stakeholders.

Key Questions for Discussion and Consideration

Does the proposed program design meet HPC's goals for these investments?

Are there particular outcomes of interest for the Board as staff prepare the RFP announcement?

What supports should the HPC offer to awardees (e.g. technical assistance)?

Decision Points

Vote requested. Commissioners will be asked to authorize the Executive Director to release a Request for Proposals in early February based upon the proposal for program design and to provide feedback on priorities for RFP development.

HCII in statute

Establishment of the Health Care Innovation Investment Program

- M.G.L. c. 6D § 7. Funded by revenue from **gaming licensing fees** through the Health Care Payment Reform Trust Fund
- Total amount of **$6 million from** Health Care Payment Reform Trust Fund
  - May be **supplemented** through Distressed Hospital Trust Fund for **CHART hospitals**
- **Competitive** proposal process to receive funds
- Broad eligibility criteria (*any **payer or provider***)

Purpose of the Health Care Innovation Investment Program

- To **foster innovation** in health care **payment** and service **delivery**
- To **align** with and **enhance** existing funding streams in Mass. (e.g., DSTI, CHART, MeHI, CMMI, etc.)
- To support and further efforts to meet the **health care cost growth benchmark**
- To improve **quality** of the delivery system
- **Diverse uses** include incentives, investments, technical assistance, evaluation assistance or partnerships

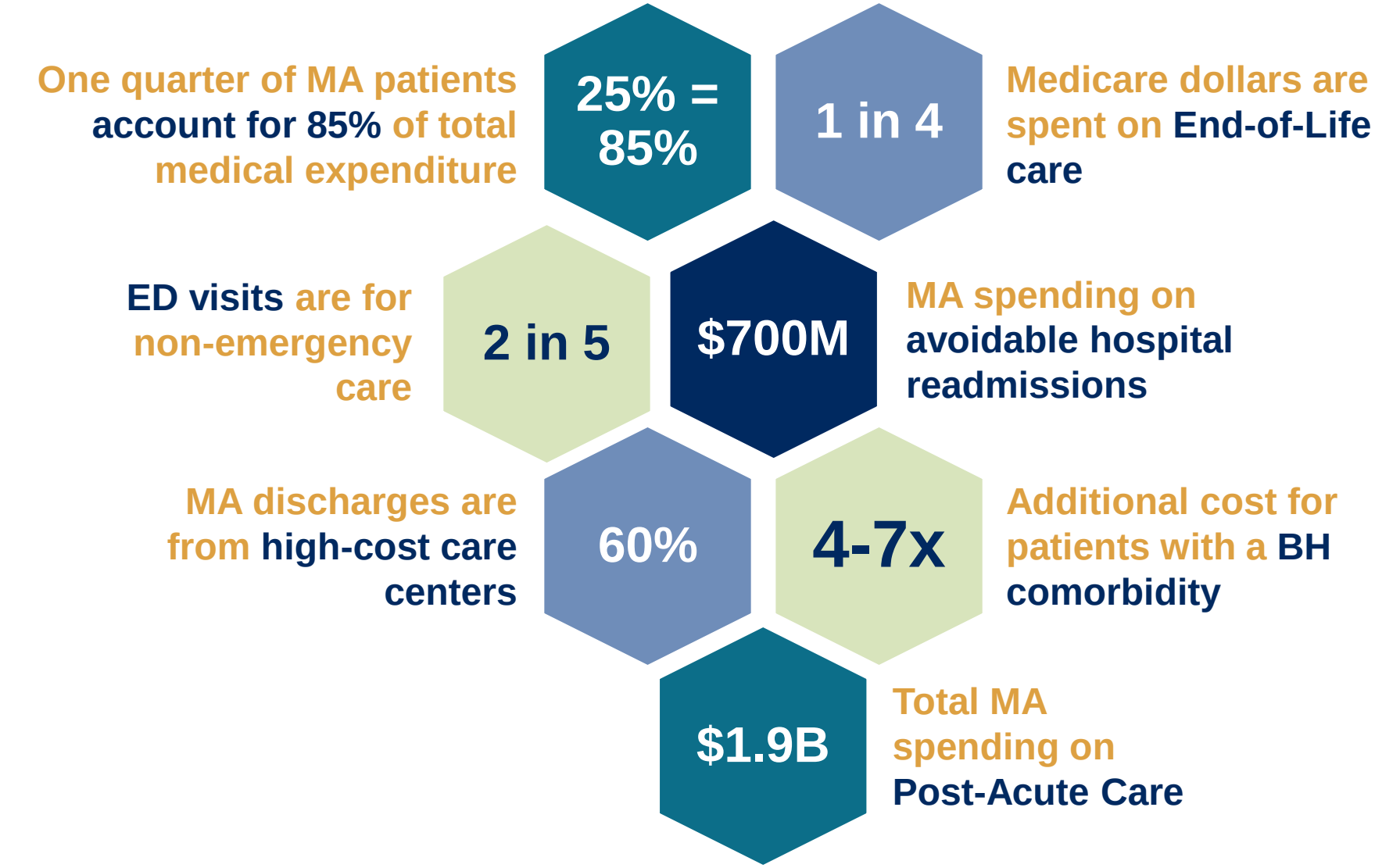
Health Care Innovation Investment Program

*The **HCII Program:** Focusing patient-centered innovation on Massachusetts' most complex health care cost challenges through investment in validated, emerging models*

Partnership	*Engage in meaningful collaboration to meet patients' needs* • Payers • Employers • Technology Partners • Providers • Social Services • Researchers
Sustainability	*Bring promising delivery and payment innovations to-scale to advance Accountable Care* • Rapid cycle measurement and improvement • Policy-focused evaluation
Costs	*Demonstrate rapid cost savings impact* • Measurable savings within 18 months of operations

HPC

Primary cost drivers in Massachusetts identified by HPC



HPC 2014 Cost Trends Report
HPC July 2014 Cost Trends Supplement
HPC 2015 Annual Cost Trends Hearing – AGO Report

HCII Round 1 proposed challenge areas

The HPC outlined inclusion criteria through which 8 Challenges were identified as potential domains applicants may elect to target in their Proposals.

Need	Innovation Opportunity
Persistent health challenge and a significant cost driver	**Limited existing market progress, despite strategic importance and promising emerging solutions**

Challenge		Challenge	
SDH	Meet the health-related social needs of high-risk/high-cost patients	Cost Variation	Reduce cost variability in hip/knee replacements, deliveries, and other high-variability episodes of care
BHI	Integrate behavioral health care (including substance use disorders) with physical health services for high-risk / high-cost patients	PAC	Improve hospital discharge planning to reduce over-utilization of high-intensity post-acute care (PAC) settings as well as improve efficiency and transitions of care within and between PAC providers
Value-Informed Choices: Purchasers	Increase value-informed choices by purchasers (including both employers and consumers) that optimize patient preferences	ACP & EOL	Support patients in receiving care that is consistent with their goals and values at the end of life (EOL) such as advanced care planning (ACP)
Value-Informed Choices: Providers	Increase value-informed choices by providers that address high-cost tests, drugs, devices, and referrals	Site & Scope of Care	Expand scope of care of paramedical and medical providers who can most efficiently care for high-risk / high-cost patients in community settings (e.g., through care models, partnerships, or tech)

HPC

A unique feature of the proposed program design is to require partnerships that utilize multi-stakeholder approaches to address cost challenges

Patients' health needs and approaches to address health system challenges can be best addressed through partnership between organizations spanning service types.

Partnerships required for award eligibility
Strength of partnerships will be a competitive factor in selection.

Applications will detail how proposed partnerships will collaborate, make decisions, and optimize efficiencies in order to address cost challenge(s).

Examples of strong partnerships may include:

A payer and a provider collaborating to test an innovative payment arrangement to implement a new model for supporting care at the end of life

A health system and a social services provider collaborating to meet the housing or other SDH needs of high risk patients

A payer and a researcher partnering to test a new analytics approach or to provide enhanced evaluation

A professional association and payers / providers partnering to address practice pattern variation and waste

A provider, an employer, and a technology partner to test a model of direct-to-consumer telemedicine offerings to increase employee access to behavioral health services

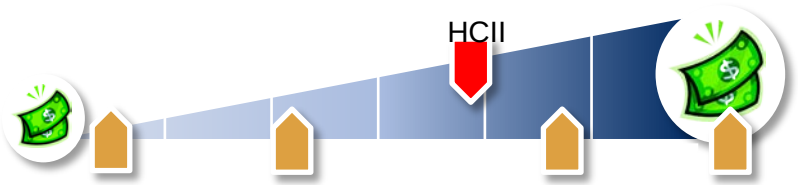
HPC

* Technology firms only selling a product or service to an eligible applicant will not be considered a "technology partner" for the purposes of this program. Partnering vendors will need to demonstrate a collaborative approach to testing an innovative delivery approach, analytic model, tool or other solution.

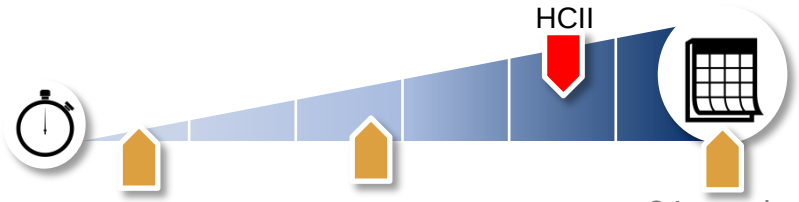
HCII Round 1 award size and duration

Other key design considerations have been made based on comparable grant and investment programs in the marketplace.

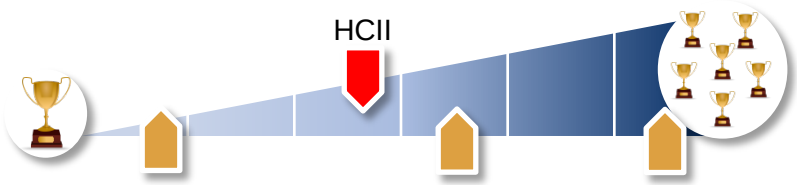
Max HCII Award **Cap**: $750k per award



HCII Award **Max Duration**: 18 Months



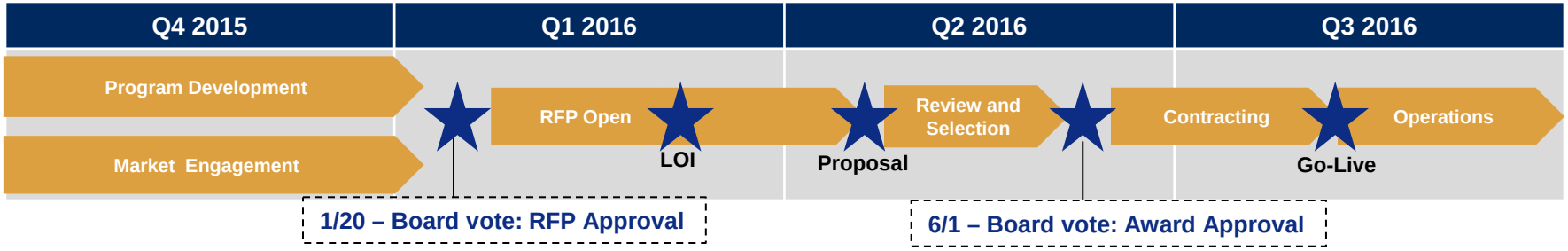
HCII Number of Awards: 8-12 Awards



$5M investment opportunity*

* Funds from the Distressed Hospital Trust Fund may be used to supplement investments from the Health Care Payment Reform Trust Fund for eligible entities (CHART hospitals) selected for awards)

HCII Round 1 RFP Milestones



	RFP Release	LOIs Due	Proposals Due	Review & Selection
RFP Milestones	**Early February**	**Early March (~5 weeks)**	**Mid April (~5 weeks)**	**June 1**
Description of RFP Framework and Major Activity	RFP will include easy-to-read supporting documents describing each Challenge and detailing select innovative models with a promising evidence base of cost savings	LOIs are required for eligibility, but nonbinding in content. LOIs will describe Applicants' approach to domains including: •Contemplated partnerships •Selected challenge and proposed innovation •Policy relevance for system-wide sustainability •Measurable goal •Estimated funding request •Interest in partnerships with other entities for HPC publication	Applicants who submit or are named in an LOI may submit a Proposal. Proposals will be reviewed based on criteria including: •Impact •Need •Sustainability •Partnerships •Operational Feasibility •"Innovativeness" •Synergy with other state programs	Proposals will be reviewed by a Review Committee consisting of •HPC Commissioners •HPC Staff •Representatives of Massachusetts state agencies •Other subject matter experts
HPC Support	HPC hosts 1-2 Info Sessions	•**Mid-March** – Publish applicant names, challenges, and partnership interests •HPC hosts 2 Info Sessions	N/A	HPC Announces Awards after Board Approval

HCII RFP development summary

	Recommendation	Considerations
Eligible Applicants	• Any **Payer or Provider** (includes a broad array of provider types) • Applicants **must propose partnership**	• The HPC seeks to engage a diverse array of market participants and encourage meaningful partnerships
Award Cap, Duration, and Opportunity	• **$750k award cap** o $500k per year of operations; up to 18 months of operations • **$5 million** total opportunity	• Generate impact while maximizing the number of innovations being funded • Generate measurable outcomes without 'overfunding' beyond HCII's targeted innovation lifecycle phases
Investment Focus	**Globally-emerging**, but **locally relevant** solutions addressing the most **persistent challenges** facing the state	• Minimize risk and achieve cost savings within short timeframe • Combine learnings of HPC programs and research with stakeholder feedback
Matching or In-Kind Funds	• Require **matching/in-kind** funds • No minimum amount, though **relative contribution** amount will be a **competitive factor** in selection	• Validate strategic importance of project to applicants without unfairly burdening smaller applicants
Application Process	• Require submission of a (nonbinding) **Letter of Intent (LOI)** as prerequisite to Proposal • HPC to release companion illustrations of the **best emerging innovations** with a promising **evidence base of cost savings**	• Gain foresight into the field prior to Proposal submission • Make program goals and process accessible to a wide variety of applicants
Selection Factors	• **Impact** - Cost Savings, Quality, and Access • **Evidence Base** Strength • **Innovativeness** – Partnership, Process, Tools • Sustainability • Operational **Feasibility**	• Promote highly competitive process to identify leading edge evidence-based innovations with strongest cost-saving potential • Emphasize value of multi-stakeholder partnerships • Maximize impact on cost savings while prioritizing policy-relevant solutions
Required Activities	• **Measurement** o Patient- and Provider-reported measures o Rapid-cycle improvement	• Emphasize scalability by requiring customer-centric approaches to evaluation • Require rapid cycle evaluation to encourage learning and potential for transference

Vote: approve proposed program design and authorize issuance of RFP

Motion: That the Commission hereby approves the proposal for an investment program to foster innovation in health care payment and service delivery to reduce total health care spending, 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.

Agenda

- Approval of Minutes from the December 16, 2015 Meeting
- Executive Director's Report
- Update on HPC Committee Assignments
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
  - Approval of Program Design for Health Care Innovation Investment Program
  - **Approval of Program Design for HPC's Telemedicine Pilot Program**
- Schedule of Next Meeting (March 2, 2016)

Discussion Preview: Telemedicine Pilot Program

Agenda Topic

Discussion of Program Design for Telemedicine Pilot Program

Description

In July, the legislature directed the HPC to conduct a regional pilot to study the impact of using telemedicine for consultation, diagnosis, and treatment. Staff will present a proposed program design for consideration by the Board as endorsed by the CHICI Committee. The proposed design considers key cost and access challenges in Massachusetts and focuses on successful applications of telemedicine for reducing readmissions of patients from post-acute settings and enhancing access to behavioral health care for high-need populations and geographies. The proposed design is for two awards of up to $500,000 each, with a total commitment of $1,000,000 (extending the legislative mandate by one award).

Key Questions for Discussion and Consideration

Does the proposed program design meet HPC's goals for these investments?

Are there particular outcomes of interest for the Board as staff prepare the RFP announcement?

What supports should the HPC offer to awardees (e.g. technical assistance)?

Decision Points

Vote requested. Commissioners will be asked to authorize the Executive Director to release a Request for Proposals in early February based upon the proposal for program design and to provide feedback on priorities for RFP development.

Telemedicine Pilot

A 1-year regional pilot program to further the development and utilization of telemedicine in the commonwealth

$1,000,000 → **Community-based providers and telehealth suppliers**

Summary of Pilot

- The HPC is to develop and implement a one-year **regional telemedicine pilot** program to advance use of telemedicine in Massachusetts
  - The pilot shall incentivize the use of **community-based providers** and the delivery of patient care in a **community setting**
- To foster partnership, the pilot should **facilitate collaboration** between participating community providers and teaching hospitals
- Pilot is to be evaluated on cost savings, access, patient satisfaction, patient flow and quality of care by HPC

Pilot Aims

1. Demonstrate **potential** of telemedicine to address critical behavioral health access challenges in three high-need target populations
2. Demonstrate effectiveness of multi-stakeholder collaboration to serve these populations
3. Inform policy development to support care delivery and payment reform

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Application; Awardee Selection; Pilot Development Implementation, and Rapid-Cycle Testing		Testing & Evaluation

Sustainability

Source: HPC Telehealth Pilot Language – Section 161

Telemedicine pilot design framework

Pressing Behavioral Health Needs	HPC focuses investment on high priority behavioral health access needs in Massachusetts

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Innovative, Provider-Driven Care Models	Providers compete to identify high-leverage models of care to address one or more target populations of interest utilizing telemedicine. Proposed models are tailored to local needs but emphasize scalability (low cost of intervention and high replicability)

High Impact Telemedicine Pilot

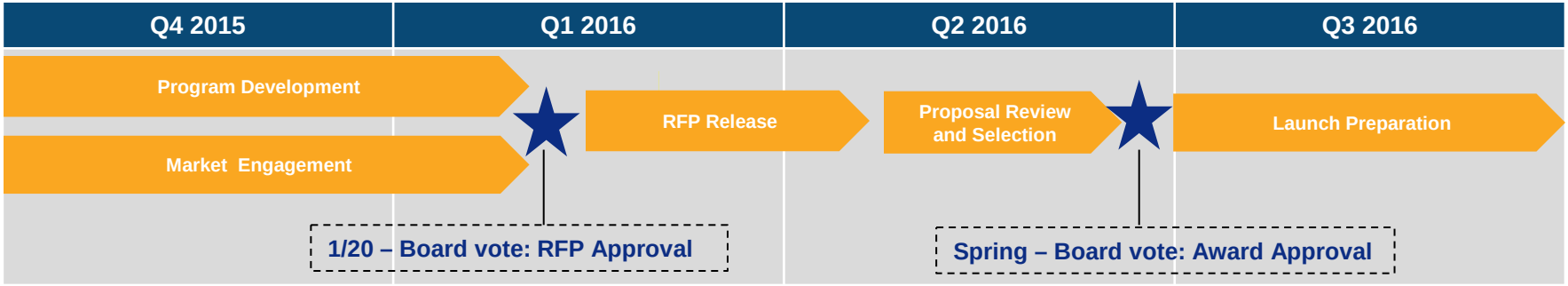
Program design provides three target populations of interest. Applicants must propose innovative uses of telemedicine to address the needs of one or more of these populations

Target Population	Relevant Data Point	Potential Use Cases
Pediatric patients with BH conditions	3,261 Discharges of patients between the ages of 10-19 spent at least 8 hours in an emergency department in 2014 for a mental health condition	**PROVIDER-PATIENT*** • Behavioral health integration in pediatric practices • Expanded access to school-based BH services
Patients aging in place with BH conditions	20% of the 65+ population suffers from a mental health disorder. Greatest segment of prescriptions with abuse potential are among adults aged 51-70	**PROVIDER – PATIENT** • Direct in-home tele-behavioral health clinical services (med management and counseling) • Facilitated in-home tele-behavioral health with ASAP or VNA augmented with tele-BH provider
Patients with substance use disorder	1,256 estimated opioid-related deaths in 2014, a 88% increase over 2012 (n=668) and a 38% increase over cases for 2013 (n=911).	**PROVIDER – PATIENT** • 'Reverse integration' of emergency medical care into detox facilities to reduce acute care transfers **PROVIDER TELECONSULTS** • Consult service for addiction providers to support PCPs in MAT

HPC

Telemedicine pilot timeline

The HPC anticipates releasing an RFP for the telemedicine pilot in late January 2016, with subsequent awardee selection and program launch in late Spring 2016



	Goal Setting	Program Design	Implementation
Activities	☑ Assess statutory framework for pilot and its goals ☑ Meet with subject matter experts and stakeholders on program design considerations ☑ Review reimbursement and regulatory landscape in MA ☑ Scan MA for existing pilots and at-scale programs	☑ Announce funding priority areas to providers ☑ Lock proposal selection criteria ☐ Release RFP & host information sessions ☐ Receive and review proposals ☐ Board selection of awardee Next Steps	☐ Finalize pilot design, measurable goals, and contract requirements with awardee(s) ☐ Distribute pilot funding ☐ Support pilot implementation as needed and monitor performance ☐ Conduct evaluation
Output	• Program Goals • Current Landscape	• RFP development • Proposal process • Awardee selection	• Operational planning • Performance monitoring • Evaluation

RFP development summary

	Recommendation	Considerations
Eligible Applicants	• Any **provider** • A single entity may apply on behalf of a **consortium** of providers • Require some **level of collaboration** with a teaching hospital; no funding requirement	• The HPC seeks to engage a diverse array of market participants and encourage meaningful partnerships
Award Cap, Duration, and Opportunity	• **$500k** award **cap; $1M** total opportunity • Up to **two awards** • **18 months duration:** 6 month funded design period; 12 month implementation period	• Two regional awards • Integrated planning period (driven by awardee) for clinical protocol development, clinician engagement, etc.
Investment Focus	**Behavioral health** initiatives focused on **pediatric** BH needs, **homebound adults** with BH needs, and/or patients with **opioid use disorders**	• Combine high priority areas of focus with opportunities for provider innovation
Matching or In-Kind Funds	• Require **matching/in-kind** funds • No minimum amount, though **relative contribution** amount will be a **competitive factor** in selection	• Validate strategic importance of project to applicants without unfairly burdening smaller applicants
Application Process	• **Conventional**, brief proposal describing target population, measurable aim, driver diagram, operational model, budget, etc.	• Encourage competitive application pool
Selection Factors	• Level of access expansion OR cost savings (or both); evidence base for proposed model, including anticipated impact on patient experience and quality; demonstration of how pilot will improve operating efficiency and provider satisfaction; prior experience with telehealth; likelihood of sustainability;	• Prioritize anticipated impact, evidence of model, and applicant's past experience (and therefore likelihood of success) • Emphasize opportunities to scale successful models
Required Activities	• **Measurement** Applicants must indicate key outcomes of interest, measures to assess those outcomes, and include a plan for rapid-cycle evaluation	• Require rapid cycle evaluation to encourage learning and potential for transference • Maximize impact through multi-stakeholder partnerships

Vote: approve proposed program design and authorize issuance of RFP

Motion: That the Commission hereby approves the proposal for a pilot program to advance use of telemedicine services to enhance access to behavioral health care in the Commonwealth, 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.

Agenda

- Approval of Minutes from the December 16, 2015 Meeting
- Executive Director's Report
- Update on HPC Committee Assignments
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- **Schedule of Next Meeting (March 2, 2016)**

Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

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

Appendix

Program development to date: stakeholder input and feedback

HPC Board Meetings

- April 29, 2015
- **January 20, 2016**

CHICI Committee Meetings

- February 25, 2015
- April 15, 2015
- October 14, 2015
- December 2, 2015
- January 6, 2016

HPC Advisory Council Meetings

- March 18, 2015
- May 13, 2015
- January 13, 2016

HPC Staff Meetings with Stakeholders

Payers

- Blue Cross Blue Shield of Massachusetts
- Massachusetts Association of Health Plans
- MassHealth

Providers

- Atrius Health
- Boston Children's Hospital
- Boston Healthcare for the Homeless
- Brigham and Women's Hospital
- Commonwealth Care Alliance
- Lowell General Physician Hospital Organization
- Massachusetts Child Psychiatry Access Project (MCPAP)
- Massachusetts General Hospital

Communities of Practice

- American Telemedicine Association
- The Network for Excellence in Health Innovation (NeHI)

Government

- Cambridge Housing Authority
- Commonwealth Corporation
- Department of Public Health (DPH)
- Executive Office of Elder Affairs
- Executive Office of Health and Human Services
- MassHealth
- Massachusetts eHealth Institute (MeHI)

Research & Foundation

- BCBSMA Foundation
- Center for Health Care Strategies
- Harvard School of Public Health
- Institute for Healthcare Improvement
- RAND Corporation
- The Kraft Center for Community Health
- UCLA Global Lab for Innovation

Other Market Participants

- Aledade Health
- American Well
- Klio Health
- Patient Ping

…& 98 other market respondents to a public survey and all members of the HPC Advisory Council

HPC has engaged key health care innovation experts to support program design

Molly J Coye MD, MPH, MA

Strategic Advisor to the HPC

Dr Coye brings many years of experience in public health, government, large hospital systems, insurance companies, academia and nonprofits. Dr. Coye is **Social Entrepreneur in Residence** at NEHI. Previously she was **Chief Innovation Officer** for UCLA Health. Dr. Coye was also the **founder and CEO of the Health Technology Center** (HealthTech), a non-profit education and research organization established in 2000 that became the premier forecasting organization for emerging technologies in health care. Dr. Coye has also served as **Commissioner of Health** for the State of New Jersey, Director of the California State Department of Health Services, and Head of the Division of Public Health Practice at the Johns Hopkins School of Hygiene and Public Health.

Dr. Coye holds MD and MPH degrees from Johns Hopkins University and an MA in Chinese History from Stanford University.

HCII

Technical Advisory Group

The HPC has also assembled a 10-member Technical Advisory Group (TAG) to support final design and implementation of the Health Care Innovation Investment Program. The TAG consists of credible, established experts from relevant fields. TAG members are:

- **Dr. Karen Bell**, Independent Consultant
- **Dr. Karen Feinstein**, Jewish Healthcare Foundation
- **Scott Lambert**, Ascension Health's Innovations Accelerator Team
- **Eric Langshur**, AVIA
- **Dr. Thomas Lee**, Press Ganey Associates
- **Barbara Lubash**, Versant Ventures
- **Sheila Fifer PhD, MA,** NEHI
- **June Simmons**, Partners in Care Foundation
- **Laurence Stuntz**, Massachusetts eHealth Initiative
- **Dr. Krishna Udayakumar**, Global Innovation for Duke Medicine

HCII program development considerations

Chapter 224 provides guidance on program development process and framework but does not provide detailed specifications for use of funds

1. HPC shall **solicit ideas for payment and care delivery reforms** directly from providers, payers, research / educational institutions, community-based organizations and others
2. HPC must coordinate with other state grant makers
3. Investments must be **evaluated for cost and quality implications**
4. Chapter 224 encourages broad dissemination of learnings and incorporation of successes into ACO certification and state-administered payment reforms

Investments that catalyze care delivery and payment innovations

HCII investing in 'validated innovation'

Research on innovation emphasizes the opportunity for the HPC to focus investments in 'innovation' on 'adaptation' of emerging models rather than the 'invention' of new ones.

Innovation isn't "just about generating new ideas or finding new uses for the iPad. ...Lately, the innovation field has shifted its focus from the generation of ideas to rapid methods of running experiments to test them."

Innovation as Discipline, Not Fad
-David A. Asch, and Roy Rosin
The New England Journal of Medicine, August 19, 2015

"Providers need to actively seek out good ideas that have been tried and refined, bring those ideas home, and adapt them for local use."

Health Care Needs Less Innovation and More Imitation
-Anna M. Roth, and Thomas H. Lee
Harvard Business Review; November 19, 2014

"Good ideas themselves are not innovations; instead, they become innovations when the have economic impact, when they add [business and social] value."

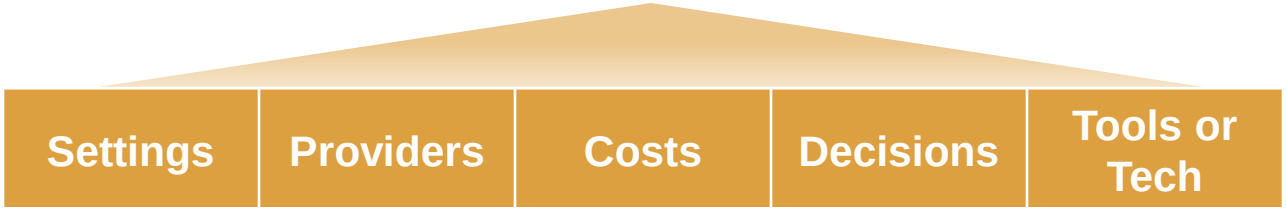
Permanent Innovation
-Langdon Morris
Innovation Academy Publishing; November 19, 2014

Drive sustainable market value by investing in adaptation of promising innovations from the field

HCII Round 1 challenge inclusion criteria

Initial draft challenges were determined by taking cost reduction as its defining goal, and synthesizing best practice approaches to innovation with stakeholder feedback. Those factors guiding challenge inclusion are below.

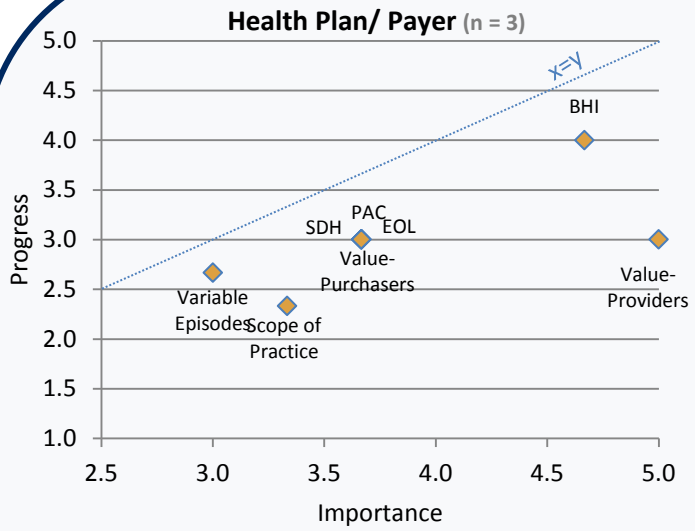
Need	Innovation Opportunity	Feasibility & Sustainability
• **Persistent health challenge** for people, especially the underserved, of Massachusetts • The challenge is a significant **cost driver** that threatens the benchmark and can be improved with equal or better quality	• Existing solutions have made **limited progress** • **Preliminary evidence** of innovation potential already exists • **Synergy** with other Commonwealth investments and certification programs • Demonstrable **market interest** in disruption, primarily through substantially and rapidly changing:	• Challenge is **actionable** by potential applicants • Potential for **sustainability**, translation, and scale • Responsive to interventions enough to demonstrate measurable impacts within approximately **18 months**

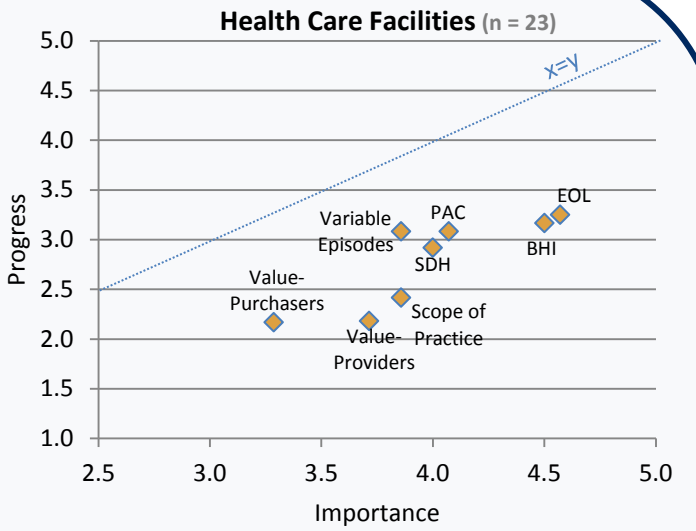


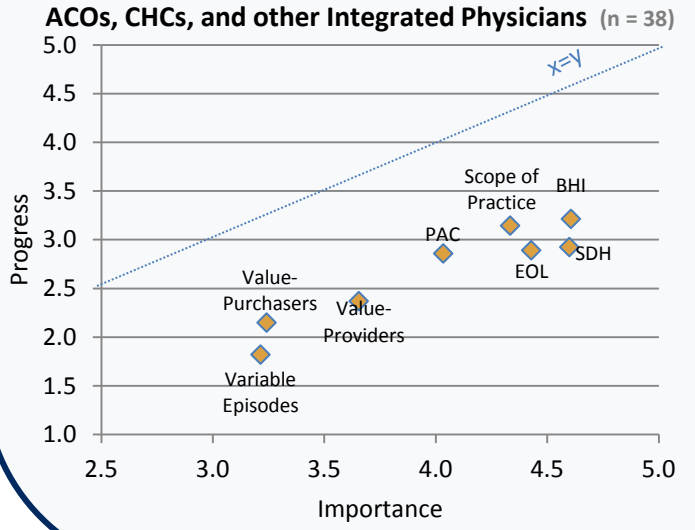
HCII Stakeholder Survey – importance vs progress by respondent type

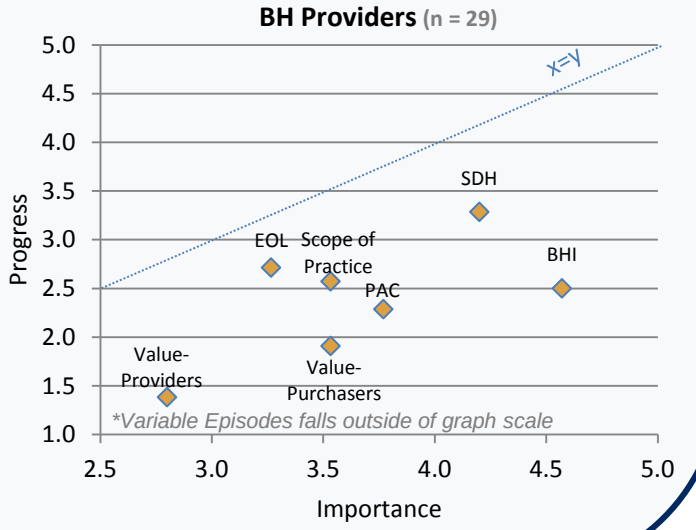
No respondent type indicated sufficient Progress in any Challenge.

BHI emerges as the only Challenge indicated as a top priority (≥4) across all respondent types, but great variability exists in all other domains.





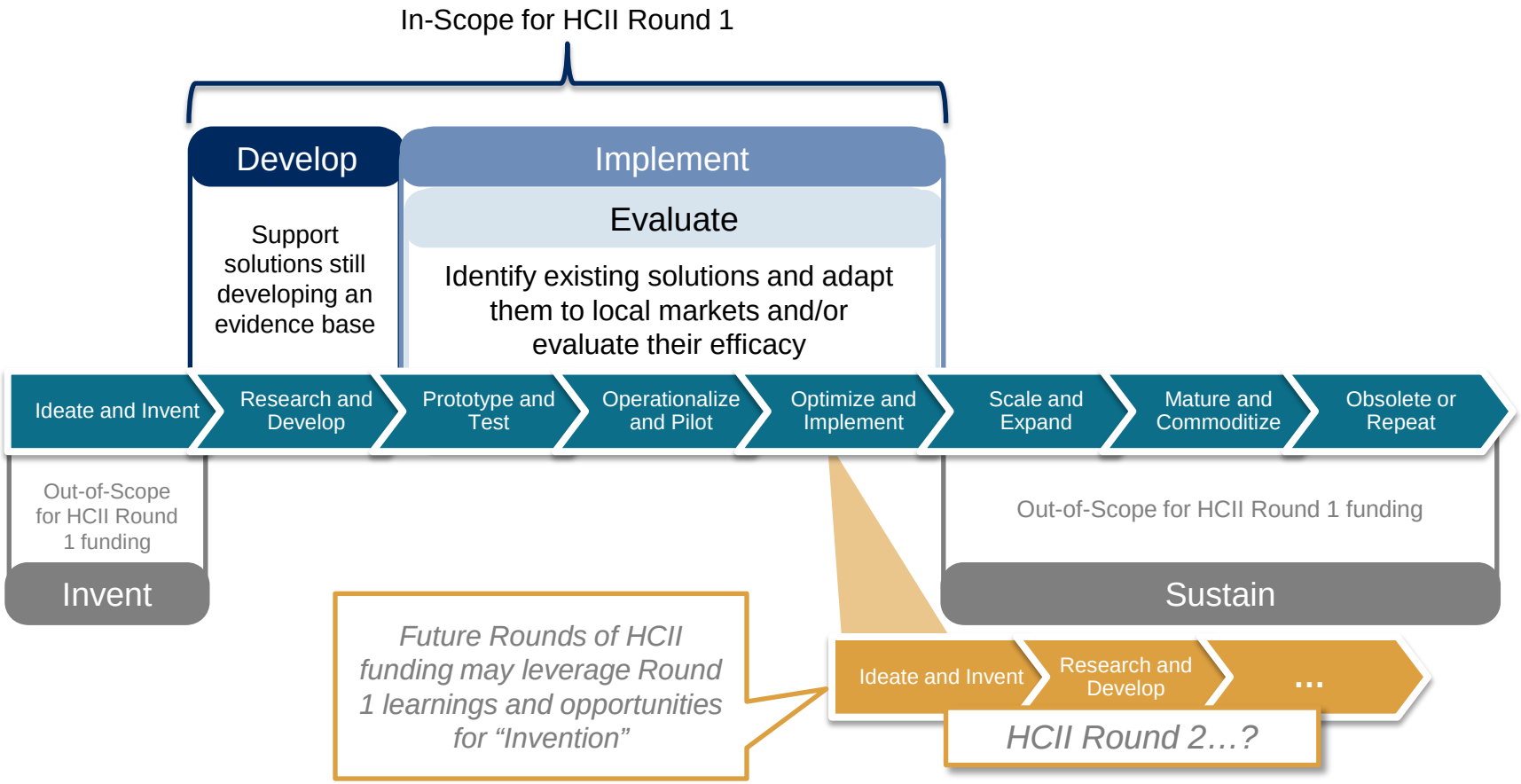




Where in the innovation life cycle can HCII be most effective?

HCII may use its funds to develop, implement, or evaluate promising models in payment and service delivery. Within this model framework, HCII Round 1 funding would focus on investment in rapid adoption of existing models with a preliminary evidence base.

1½ – 5-year "Innovation Lifecycle"



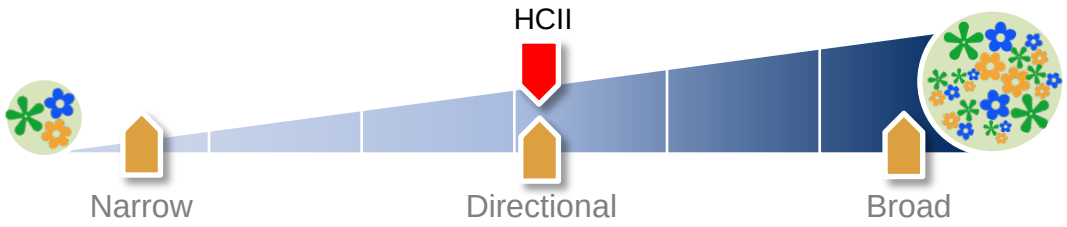
HCII Round 1 primary design choice: how should investments be focused?

Stakeholder recommendations were divided between prescribing a narrow focus for investment based on HPC priority areas and allowing a diverse swath of ideas to emerge.

Which framework will generate investments that achieve HCII's Primary Aim?

Primary Aim

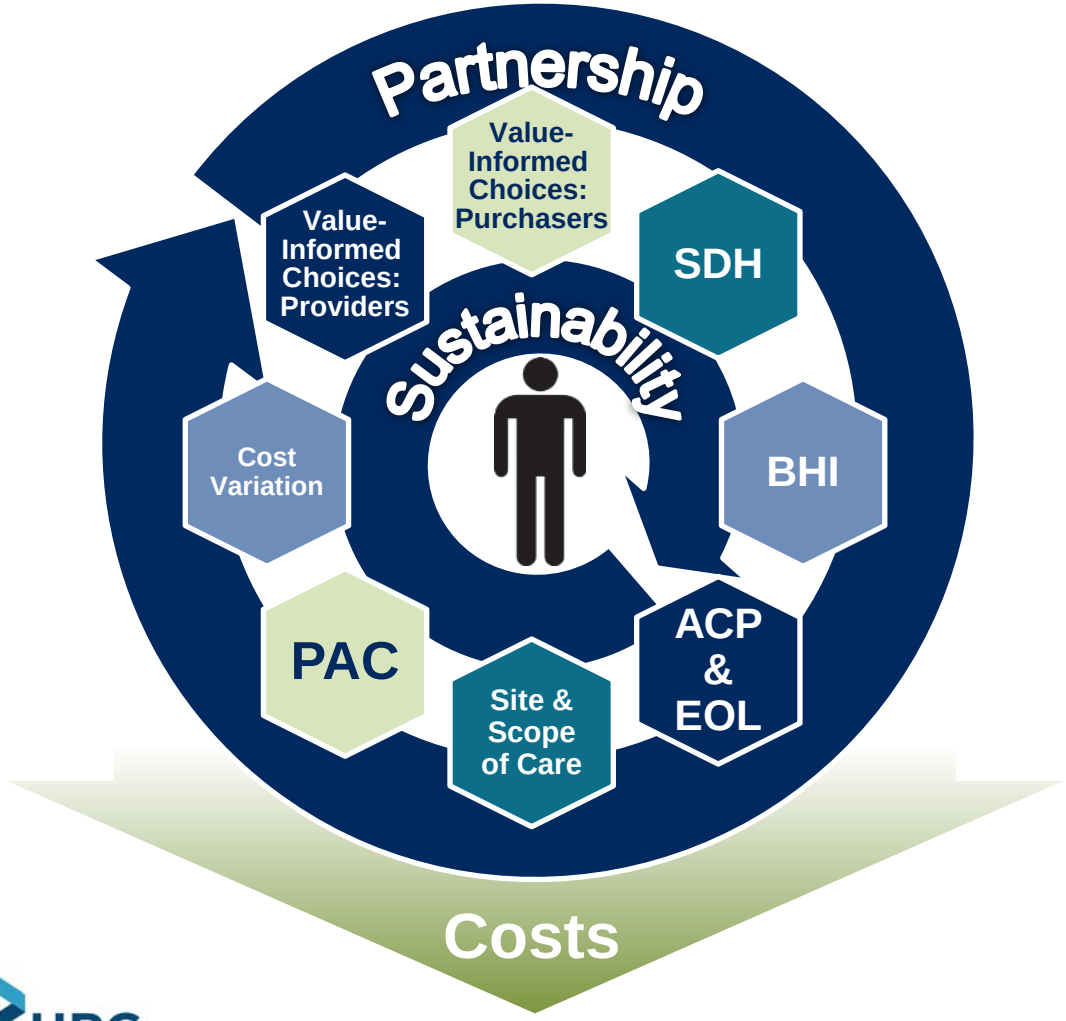
Demonstrably Reduce Growth of THCE



	Directive	Hybrid	"Let 100 Flowers Bloom"
	Allow only 2-3 models for Applicants to scale	*Allow Applicants to inform selection of challenges & models, but ultimately compete by adapting from a focused list*	*Allow Applicants to propose any innovations*
Pros	• Promotes concentrated impact on a specific issue • Builds shared learning community, evidence base, and scale opportunities	• Applicant viewpoints substantially inform models • Focuses effort on select challenges to maximize impact	• Allows broad Applicant choice • Facilitates creativity
Cons	• Drastically limits Applicant choice • Eliminates any potential for creative new models	• (More) complex process may not yield consensus • Emphasizes 'imitation' over 'invention'	• Substantial risk of diluted impact • Difficult to contrast Proposals for selection

HCII: Innovations Advancing Delivery and Payment Transformation

*The **HCII Program:** Focusing patient-centered innovation on Massachusetts' most complex health care cost challenges through investment in validated, emerging models*



Broad array of eligible Challenges	Capture innovations from a diverse swath of applicants

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Narrow selection criteria	Define rigorous requirements for high-quality innovation and partnership in order to achieve sustainable cost-reduction

HPC

HCII and Telemedicine: Aligned approaches to requirements and technical assistance

With minor Program-specific variation, HPC's HCII Program and Telemedicine Pilot approach investment through shared principles around measurement, technical assistance, and partnership.

Measurement	Applicants will propose **key outcomes**, **measures** to assess those outcomes, and a plan for **rapid-cycle evaluation** in order to: • Improve care for patients real-time • Encourage learning and knowledge transfer • Evaluate overall impact and effectiveness
Partnership	HPC will require **multi-stakeholder collaboration** to: • Maximize impact through interdisciplinary approaches enabled by multi-stakeholder partnerships • Strengthen partnerships in communities to meet patient needs
Technical Assistance	In order to meet program goals, the HPC may provide **limited, focused technical assistance** to Awardees to finalize project design, implementation, and/or evaluation

Goals of telemedicine pilot program

Payers, providers, and policymakers are interested in understanding the impact of using telemedicine for consultation, diagnosis, and treatment. Goals of piloted models may include:

1. Telemedicine should demonstrate **cost savings** and/or **enhance access to care**
2. Telemedicine should maintain or **improve patient experience** and **quality** of care
3. Telemedicine should **improve patient flow**
4. Telemedicine should **improve providers' operating efficiency** through optimal allocation of clinical staff among partnering sites and use of staff time
5. Telemedicine should enhance community-based care and **reduce the number of patients transferred for specialty evaluations** when appropriate care could be delivered at the originating setting
6. Telemedicine should **improve provider satisfaction**
7. Telemedicine care models should be closely linked back to primary providers to ensure **continuity of care**
8. Telemedicine should **not result in duplicative utilization** patterns and, where appropriate, should reduce overall utilization over an episode of care

Source: HPC Telehealth Pilot Language – Section 161; HPC Stakeholder Engagement

Local and regional examples of value of telemedicine

Two-Way Video Conferencing

Massachusetts General Hospital

MGH TelePsych *program allows patients to* receive personalized, convenient psychiatric care from their home, workplace or any private location

Berkshire Medical Center
Berkshire Health Systems

CHART funded

Utilize telehealth behavioral health visits to expand access to psychiatric services

Massachusetts circlehealth Emerson Hospital

Utilize telehealth visits to expand access to primary care

Provider-Provider Support

Beth Israel Deaconess Medical Center

ECHO Age links BIDMC geriatric specialists, neurologists and psychiatrists with providers in the community through a weekly teleconference to discuss cases and to co-develop treatment plans

MCPAP
Massachusetts Child Psychiatry Access Project

Telephonic consultations between child/adolescent psychiatrist and the pediatric PCP

Passive Remote Monitoring

Signature Healthcare

CHART funded

Homeward Bound, a CHART Phase 2 funded initiative, uses a combination of telemedicine and nurse-led home visits to support high-risk patients with COPD and CHF at home

Health Affairs

In the nursing home, a switch from on-call to telemedicine physician coverage during off hours resulted in fewer hospital admissions[2]

Active Remote Monitoring

NEHI New England Healthcare Institute

Intensivists promoting remote ICU care decreased mortality by more than 20 percent, decreased ICU lengths-of-stay by up to 30 percent, and reduced the costs of care[1,3]

UMassMemorial Health Care

Steward
Steward Health Care System

With tele-ICU, a clinician in one “command center” is able to remotely monitor, consult and care for ICU patients in multiple locations[3]

1. Kvedar J, Coye MJ, Everett W. *Connected Health: A Review Of Technologies And Strategies To Improve Patient Care With Telemedicine And Telehealth. Health Aff* February 2014 vol. 33 no. 2 194-199.
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Identification of a priority area for telemedicine pilot

HPC engaged in extensive dialogue with payers, providers, telemedicine experts, and state policy leaders to identify a single area of focus for the telemedicine pilot