COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

April 29, 2015

Board Meeting

Agenda

- Approval of Minutes from the March 11, 2015 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation Update
- Quality Improvement and Patient Protection Update
- Community Health Care Investment and Consumer Involvement Update
- Cost Trends and Market Performance Update
- Schedule of Next Commission Meeting (June 10, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on March 11, 2015, as presented.

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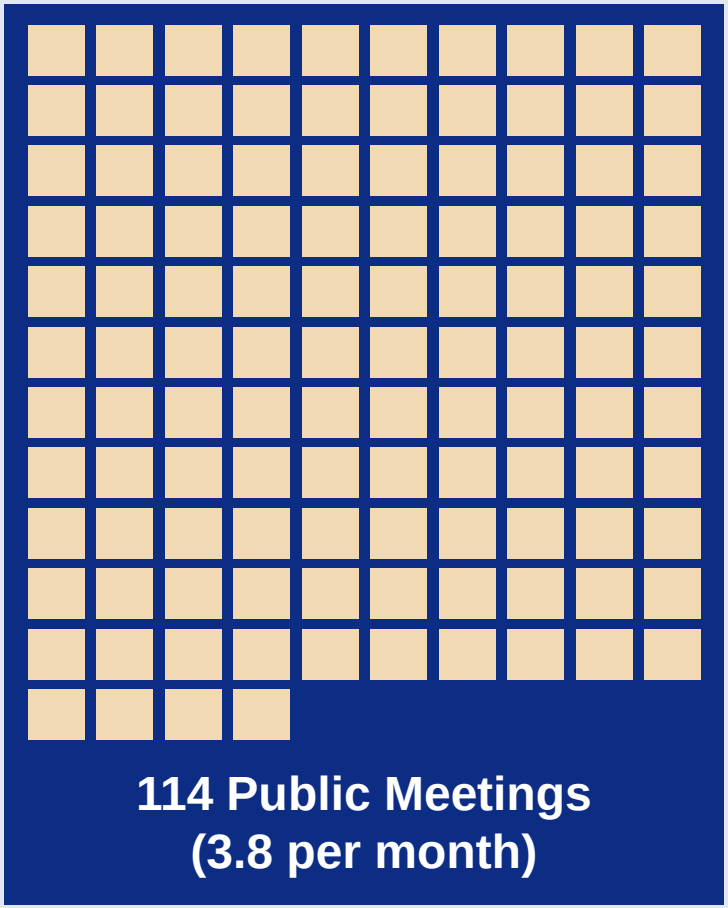
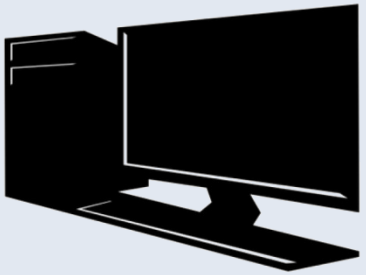
Public Engagement at 2.5 Years

11 Reports

291 Articles Mentioning HPC



114 Public Meetings (3.8 per month)



273,000 Unique Website Visits

300+ Executive Director Stakeholder Meetings

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  - HPC Certification Programs
  - Patient-Centered Medical Homes Model Payment
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ACO Certification: Principles for developing the program

ACO certification standards will:

- **Be compatible with existing Medicare ACO programs and MA commercial global budget contracts**
- **Be aligned with MassHealth ACO** program development requirements and timeline
- **Maintain flexibility** for market innovation while ensuring minimum standards for an efficient and high quality care delivery system
- Be **evidence-based**
- **Minimize unnecessary administrative burden** on providers

ACO Certification: Fundamental Construct of Certification

ACO certification design depends on the fundamental goals of this program:

Option 1: Wait and See (No tiers)	Option 2: Broad participation with some differentiation (single tier)	Option 3: Narrower participation, more differentiation (multiple tiers with scoring)
▪ Align requirements with CMS such that all existing ACOs are expected to meet standards	▪ Build in enhancements to CMS requirements while maintaining broad participation	▪ Build in enhancements to CMS requirements
▪ Do not differentiate amongst certified ACOs – everyone is either in or out	▪ Create a "pass or fail" assessment process in which ACOs are evaluated based on presence or absence of capabilities	▪ Create a scoring system that encourages broad participation at entry level, however, creates clear differentiation even amongst Pioneer and MSSPs (i.e., multiple tiers)
▪ Allows HPC to collect data, with the intent to define 'what works' later (through model ACO designation or re-certification)	▪ ACOs that also demonstrate historical success with lower TME and good quality metrics may be granted "gold star" status ***Current hypothesis***	

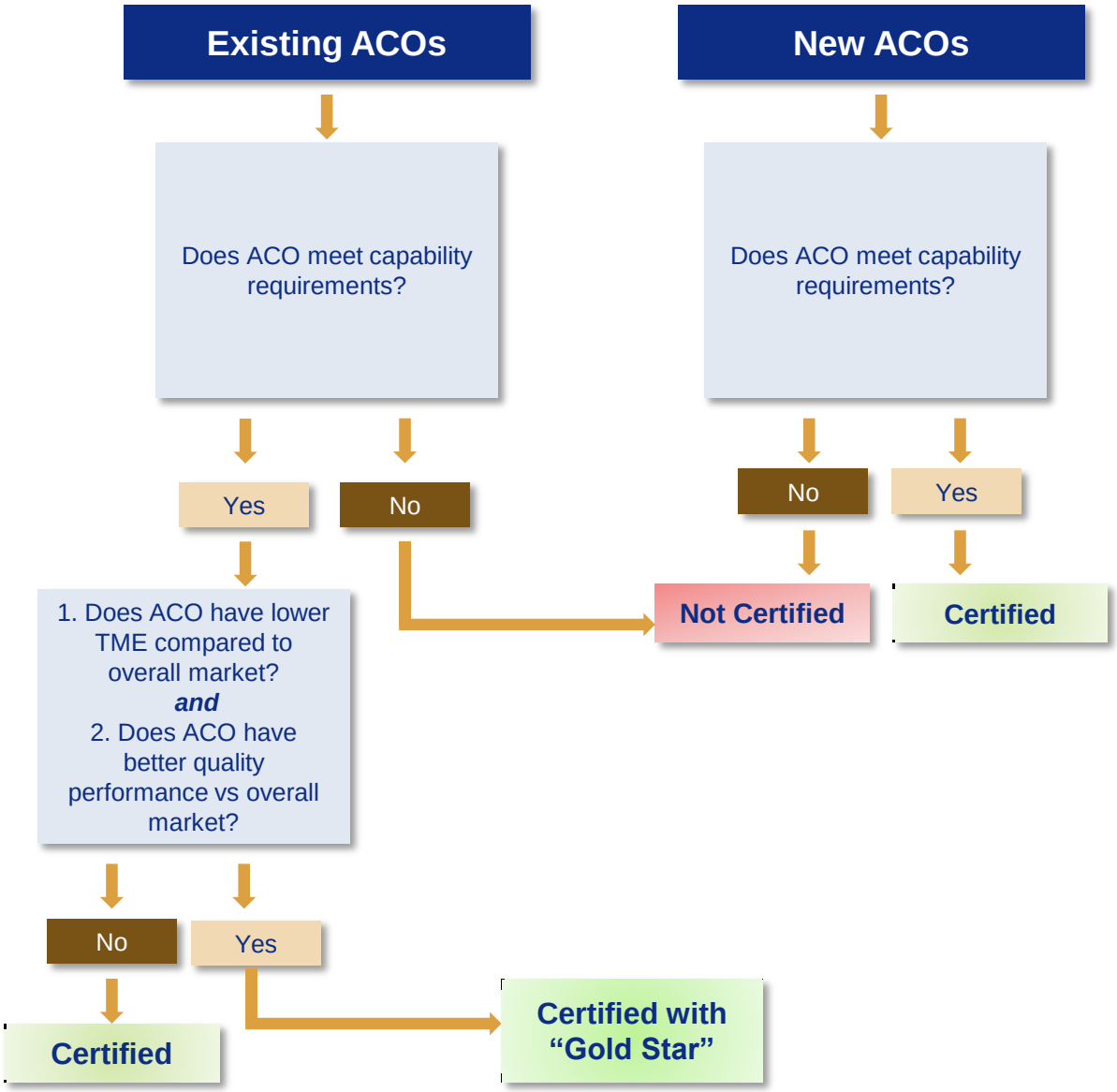
ACO Certification: Overall program structure

I ACO Certification Program	II Model ACO Designation	III Improving Market Efficiency

Mandatory requirements around legal structure, governance, patient protection, and market protection
 	
Proposed assessment:
✓ Capability-based framework across 5 domains (descriptive, not prescriptive)
✓ ACO must meet 50%+ of capabilities in each domain
 	
Existing ACOs with better TME & quality performance vs. peers will earn "gold star" recognition
✓ Intended to support payers, employers, and consumers in value based decision making
	▪ More heavily weighted towards outcome measures, e.g.,
	  ▪ Relative TME and TME growth (HMO and PPO)
	  ▪ Quality / Health Outcomes
	  ▪ Potentially preventable events (readmissions, avoidable ED visits, etc.)
	
	▪ HPC signal to the market key principles for model ACO designation
	
	▪ Standards will be refined over the course of 2-3 years
		▪ Model ACO payment
		▪ Model ACO contract
		▪ Model 'risk adjustment' methodology
		▪ Model performance reports (cost, utilization, quality)

Over time, the vision is:
- **To weigh certification standards more heavily towards outcome based metrics**
- **To incorporate 'Model ACO' criteria into the base certification standards**

ACO Certification: Pathways to Certification



ACO Certification: Overview of requirements for initial certification

Mandatory Requirements

A — Statutory Mandates

▪ Legal structure	▪ Separate legal entity (consistent with CMS requirements) except if ACO participants are part of the same legal entity ▪ If applicable, ACO must obtain an RBPO risk certification from DOI
▪ Governance	▪ Structure must include administrative officer, medical officer, and patient or consumer representative
▪ Coverage of Services	▪ ACO must provide services across the care continuum
▪ APM Adoption for Primary Care	▪ By the EOY2, ACO must have 40% of its revenue attributed to aligned PCPs coming from contracts with incentives based on total cost of care

B — Patient / Market Protection

▪ Patient Protection	▪ ACO must file an appeals plan with OPP for approval ▪ HPC will publicly report ACO performance on quality, including patient experience
▪ Market protections	▪ Application of state and federal antitrust laws to protect against anticompetitive behavior

Assessment

C — Capabilities

▪ Care Delivery Model	▪ Identification of patient health needs and targeted care delivery interventions based on population needs
▪ Analytics & Performance Improvement	▪ Ability to analyze and report on quality, utilization, and physician practice patterns
▪ Clinical Data Systems	▪ EHR and HIE capabilities, care decision support
▪ Financial Incentives	▪ APM adoption, including APM adoption for BH, specialty care, incentives within ACO
▪ Patient/Family Engagement	▪ Patient self-management resources, measure and improve on patient/family engagement and involvement

D — Transparency/ Reporting

- TME
- Quality / Health Outcomes
- Patient / Family Experience

ACO Certification: Overview of requirements over time for purposes of re-certification and Model ACO designation

		Initial Certification	Re-certification	Reporting/ Data collection	Model ACO
Mandatory Requirements	A Statutory Mandates				
	▪ Legal structure	X			
	▪ Governance	X			
	▪ Coverage of Services	X			
	▪ APM Adoption for Primary Care	X	X	X	
	B Patient / Market Protection				
	▪ Patient protection	X		X	
	▪ Market protections	X			
Assessment	C Capabilities				
	▪ (See previous page)	X		X	
	D Transparency/ Reporting				
	▪ TME (HMO only)	X		X	
	▪ TME (HMO and PPO)		X	X	X
	▪ Quality / Health Outcomes	X	X	X	X
	▪ Patient/Family Experience		X	X	X

"X" in gold indicates that the criteria is assessed at initial certification for purpose of "gold star" status only

ACO Certification: Proposed Capability Domains for Certification

Care Delivery Model	Analytics & Performance Improvement	Clinical Data Systems	Financial Incentives	Patient/Family Engagement
Risk Stratification & Empanelment	Cost & Utilization Analysis	EHR & Care Decision Support	APM Adoption	Patient/Family Engagement, & Self-Mgmt
Population Specific Interventions	Goals & Process for QI, PE, and Cost Containment	Real-time Information Exchange	Incentives within ACO	
Cross Continuum Network				
Care Coordination				

Behavioral Health is strongly integrated throughout entire structure

ACO must have at least 50% of the capabilities within each of the 5 domains

Number of capabilities	15	4	4	3	4

ACO Certification: Quality Measures

Compilation

When compiling list of potential quality measures to be included in both the PCMH and ACO certification programs, HPC considered the following:

- Alignment with: CMS ACO programs [MSSP, Pioneer, Next Generation], MassHealth, GIC
- Which payers were already collecting which measures
- Data sources HPC currently has access to: APCD, MHDC, MHQP
- Process v. Outcome measures (with preference for outcomes where feasible)

HPC has sought input from:

- Clinical consultant
- CHIA
- CMS

Barriers

The current list of proposed measures for the ACO and PCMH programs is just a small subset of data that CHIA already collects and reports from payers and providers; most of the measures are largely derived from MHQP's HEDIS measures

- MHQP collects data every year for patient satisfaction and every two years for clinical quality; data is at least two years old
- MHQP publicly reports 24 measures from the overall HEDIS measure set (75+ measures), but does anticipate expanding this list as early as Fall 2015
- MHQP only collects data for commercial populations & only for those practices with three or more physicians

Data is reported at the group level

- HPC wants the ability to attribute QMs to PCMH- & ACO-specific populations

Options

Given the limited access to data, HPC could do the following:

- Include only those HEDIS measures MHQP currently collects
- Work with CHIA to encourage prioritization of collecting additional HEDIS measures through MHQP, as well as data from other sources (e.g., collect 3-5 more metrics in Y1, more in Y2, etc.)
- Require ACOs to submit QMs directly to HPC
- Require payers to submit existing data to HPC

ACO Certification: Next Steps

- HPC will continue to **evolve the ACO certification program** through ongoing engagement with the CDPST Committee and the Board.

- Upcoming activities include:

  - Continue to engage with **stakeholders**, including providers and payers currently engaged in accountable care models, with the goal of obtaining feedback on overall ACO structure, domains, proposed criteria, reporting requirements, documentation validation, etc.

  - **Collaborate and align with MassHealth** on the development of its ACO program.

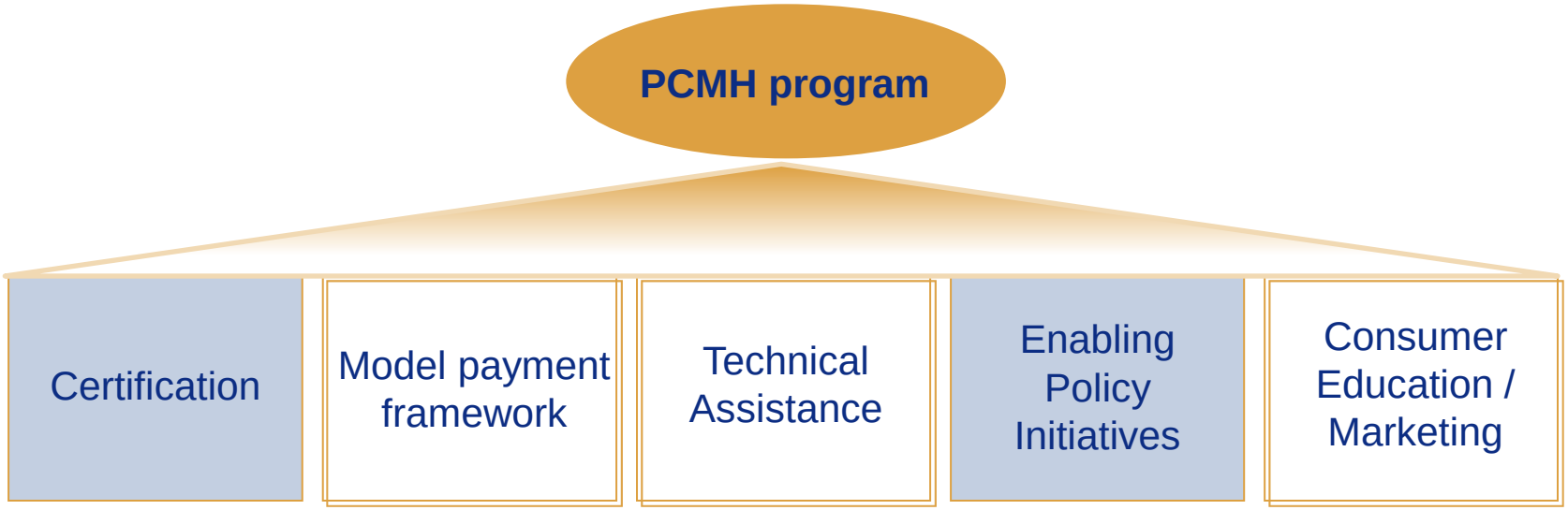
  - Work with **consultants** to evaluate the use of **TME** for a potential "goal star" designation.

  - Continue to **refine its list of Quality Measures** for PCMH and ACO programs, including the best **source(s) of data** as well as the **feasibility for reporting**.

  - Develop a **plan for operationalizing** ACO certification program

PCMH Certification: HPC's program will involve 5 key initiatives

Focus for today's discussion



PCMH Certification: Public comment period

- February 27 – April 10, 2015: The HPC sought public input on the proposed PCMH certification standards, as well as on other aspects of the HPC's programmatic design.
- The HPC received 40 written comment responses from a variety of stakeholders:

American Academy of Pediatrics (MA)	Connors Center for Women's Health and Biology	Lahey Health	MA Association of Family Physicians
Association of Behavioral Healthcare	DotHouse Health	MA ACOG	MHA
Atrius Health	Family Health Center of Worcester	MAHP	MHQP
Blue Cross Blue Shield of MA	Federation for Children with Special Needs	MA Child Health Quality Coalition	NEQCA
Boston Children's Hospital / CHICO	Fenway Health	MA Coalition of Nurse Practitioners	North Shore Community Health
Boston Medical Center	Health Care for All / MPHA	MA League of Community Health Centers	Planned Parenthood League of MA
Boston Public Health Commission	Hilltown Community Health Centers	MA Medical Society	Steward Health Care
Cambridge Health Alliance	Home Care Alliance of MA	MA Neuropsychological Society	UMASS Memorial / UMASS Medical School
Codman Square Health Center	The Joint Commission	MA Psychology Association	Upham's Corner Health Center
Conference of Boston Teaching Hospitals	Joseph M. Smith Community Health Center	MA School of Professional Psychology	Individual Comment

PCMH Certification: Synthesis of public comment

- General support for advancing primary care in Massachusetts and for HPC's priority domains (BHI, patient engagement, resource stewardship, population health)
- Big picture issues for further consideration:
  - **Pathway structure** (e.g., "grandfathering in" current practices, phasing in HPC requirements, and adjusting thresholds for HPC tiering as best practice and qualified practices)
  - **Measuring patient experience/patient engagement** with a standardized tool vs. multiple tools (e.g., strengths and weaknesses of given tools; value of consistency in measurement)
  - Practices' **access to timely utilization data** from payers (affects ability to meet HPC certification criteria)
  - **Financial support/payment reform to support non-FFS services that are central to becoming a PCMH** (e.g., patient outreach/education, care coordination, and care management services; need for infrastructure payments to support EHR adoption/interoperability)
  - **Concerns on administrative and financial burden** for providers
- Desire to have certification programs for specific populations, e.g., OB/GYN, pediatrics, and serious mental illness

PCMH Certification: Next steps

- Memo to CDPST Committee to be sent out May 1, 2015 that provides a comprehensive summary of the public comment with components that include:
    - Crosswalk of HPC Priority Factors with relevant comments
    - Thoughts on next steps for big picture issues
- CDPST Committee meeting on May 5, 2015 will include discussion on public comment and issues for consideration before standards are finalized.
- Additional round of stakeholder engagement in May 2015 to discuss public comment feedback and on potential refinements.
- Continue to coordinate with MassHealth to align primary-care based transformation initiatives (e.g. PCPRi)
- Working towards finalizing standards in July 2015.

PCMH Certification: Enabling Policy Initiatives

Issues:	Proposed solutions:	Next steps for HPC:
Lack of alignment of quality measures	SQAC process should be leveraged to develop standard PCMH quality and outcome measures	Present to SQAC recommendations on PCMH standard quality measures
Lack of standardized data reporting	Payers should provide timely and standardized reports to providers on quality and cost/utilization	• Engage with payers and providers to form a workgroup, with the goal to act within 2015 • Potential legislative action
Health information/ privacy issues	The Commonwealth should undertake a critical assessment of barriers to health information sharing between providers while ensuring individual privacy protection	Evaluate existing state laws and assess/disseminate provider “best” practices to facilitate appropriate information sharing across providers

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Statutory Background and Purpose of the Program

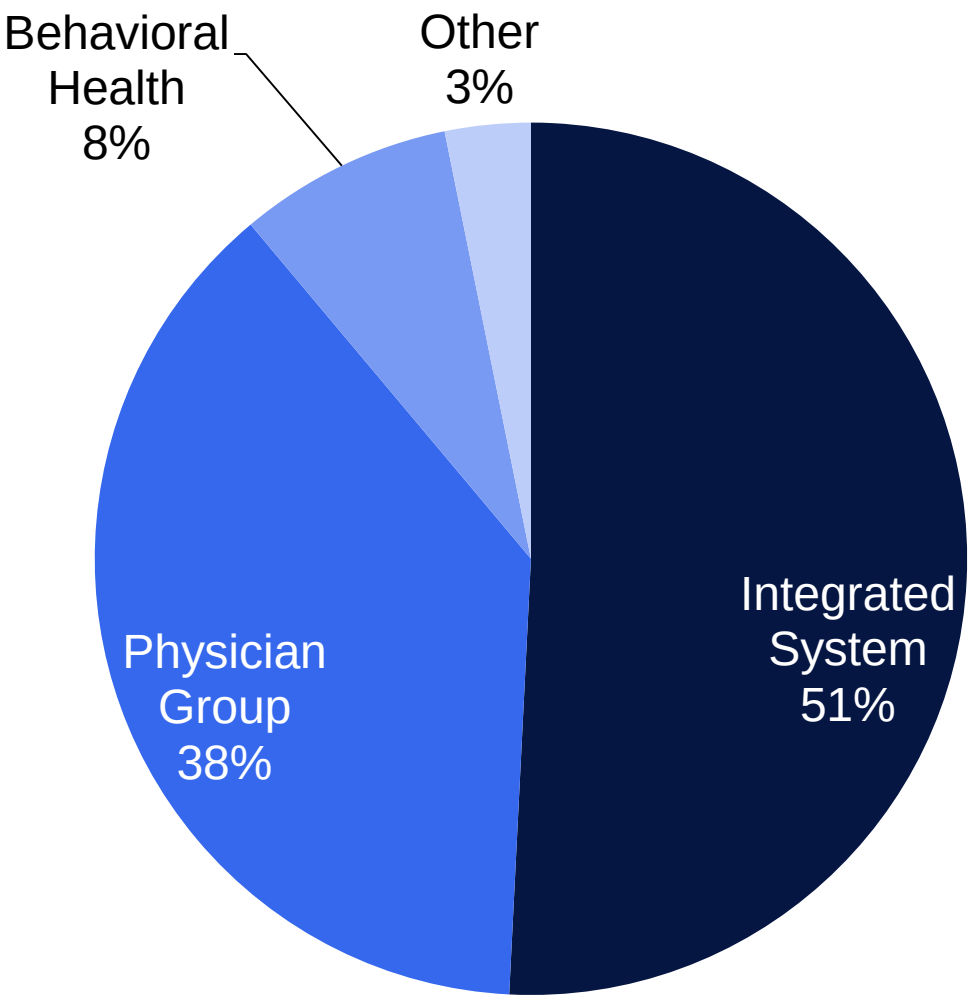
- Section 11 of chapter 6D of the General Laws requires the Health Policy Commission to “develop and administer a registration program for provider organizations.”
- RPO contributes to a foundation of information needed to support health care system monitoring and improvement. Regularly reported information on the health care delivery system is necessary to support:
  - Care delivery innovation
  - Evaluation of market changes
  - Health resource planning: assessing capacity, need, utilization
  - Tracking and analyzing system-wide and provider-specific trends

Structure of the Program

Summary of Applicants

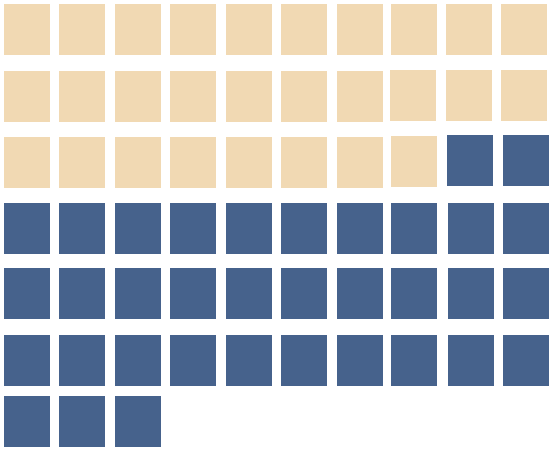
Submitted Applications	
Applications received on or before the 11/14 deadline	62
Applications received after the 11/14 deadline	16
Outstanding applications expected	4
Total applications received or expected as of 4/27	**82**
Applications Deemed Not Active or Otherwise Complete	
Corporate Affiliates of Registrants	15
Select RBPO Applicants Deemed Complete	4
Total applications deemed complete or not active	**19**
Total Anticipated Applications Moving to Part 2	
Total Anticipated Applications Moving to Part 2	**63**

Summary of Applicants: Organization Types



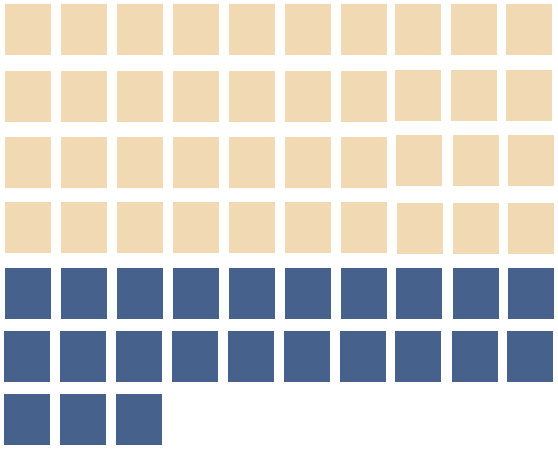
Disclaimer: The HPC has not completed its review of Part 1 materials. The information above is not considered final, is subject to change, and is not intended for use beyond discussion purposes.

Summary of Applicants: Risk-Bearing Provider Organizations and Abbreviated Applications



56%

Of registrants applied for a Risk Certificate or a Risk Certificate Waiver



37%

Of registrants applied to file an abbreviated application in Part 2

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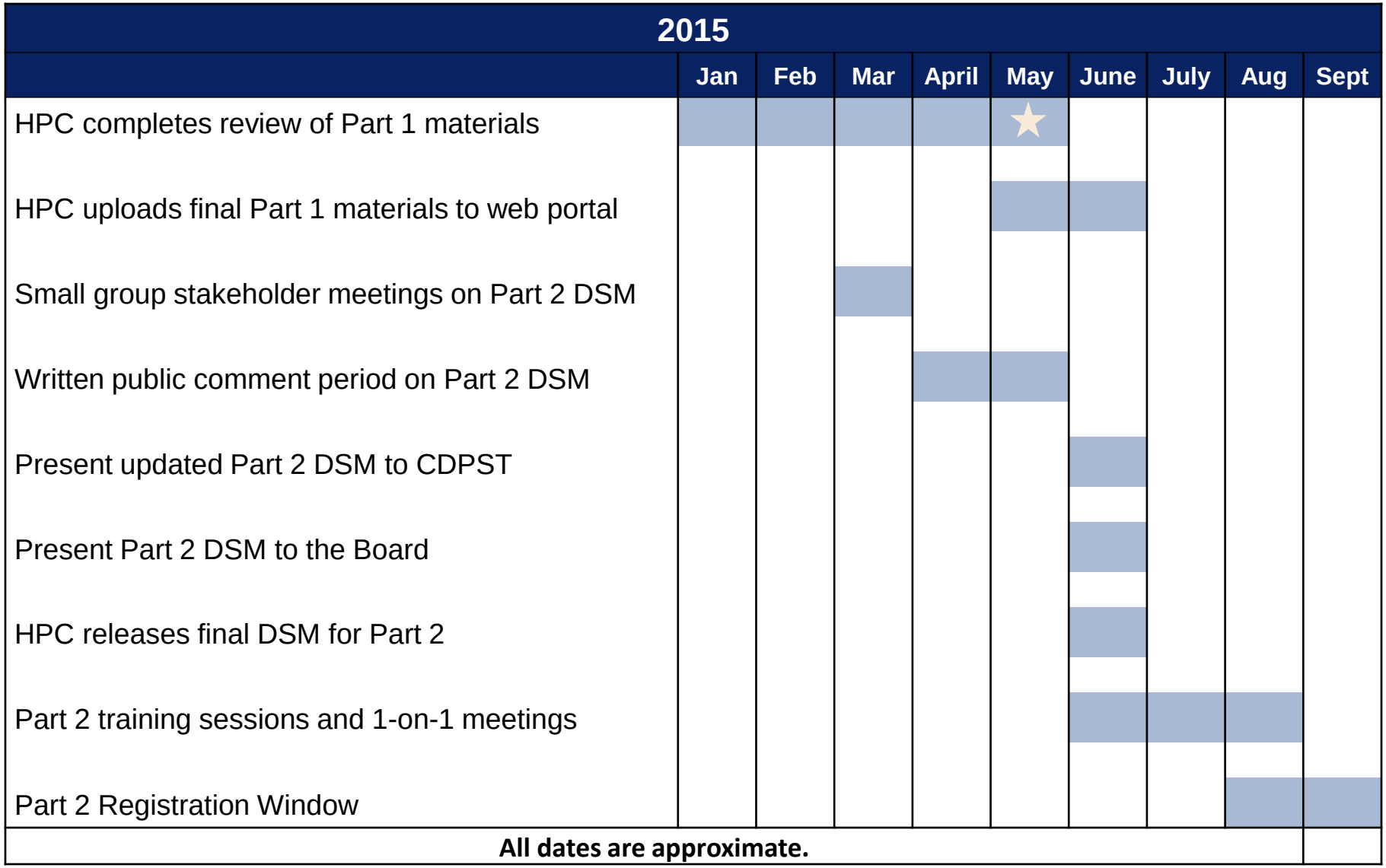
Part 2 Anticipated Process



Part 2 Categories of Information

Initial Registration: Part 2

Corporate Affiliations

Identifying information about each entity that the Provider Organization owns or controls, whether fully or partially

Facilities and Physicians

Location of and service availability at each licensed facility

Identifying information for each physician and medical group

Contracting Relationships

Description of the types of services and contracts that the Provider Organization offers

Identifying information about each of the Provider Organization's contracting affiliates

Clinical Affiliations

Description of the clinical relationships that acute care hospitals have with other Providers

Providing Feedback

The HPC released the draft Data Submission Manual for comment on Thursday, April 16. The HPC seeks input on the draft Data Submission Manual from registrants and interested parties.

Written comments can be sent to HPC-RPO@state.ma.us as either .PDF or Microsoft Word files. All comment must be received by **Friday, May 8, 2015 at 5:00pm**.

The document can be found at: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/registration-of-provider-organizations/initial-registration-part-2/

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Regulatory Development: Stakeholder Engagement/Feedback

Public Listening Sessions

- CHIA Daley Room October 29, 2014
- State House Gardner Auditorium November 19, 2014

HPC Staff ICU Visits

- Boston Children's Hospital
- Brigham and Women's Hospital
- Steward Morton Hospital & eICU campus

Feedback on Quality Measures

- HPC solicited feedback on quality measures on December 10, 2014
- Received 3 submissions

QIPP Committee Meetings

- August 13, 2014
- October 29, 2014
- December 10, 2014
- January 6, 2015
- March 4, 2015 (release of 4 proposed quality measures)

HPC Staff Meetings with Stakeholders

- Massachusetts Hospital Association
- Massachusetts Nurses Association
- American Nurses Association-MA Chapter
- Department of Public Health
- Organization of Nurse Leaders
- Quadramed (acuity tool vendor)
- Massachusetts Council of Community Hospitals
- Steward Health Care System
- Navigant Consulting Inc.
- Accenture
- DPH Shattuck Hospital

Release of Proposed Regulation 958 CMR 8.00

- Voted on by QIPP Committee January 6, 2015
- Voted on by HPC Board January 20, 2015

Public Hearings on Proposed Regulation

- Boston March 25, 2015
- Worcester April 2, 2015

Official Public Comment Period

- January 20, 2015 – April 13, 2015

**The original deadline for submission of public comment was extended by one week to April 13, 2015.*

958 CMR 8.00 – Public Comment Process By the Numbers

45

Parties who offered verbal testimony at public hearings

225+

Total people in attendance at public hearings

4+ **Hours of oral testimony**

48 **Written comments submitted***

Regulatory Timeline Update

January 6: QIPP Committee meeting

Vote to advance proposed regulation to HPC Board

January 20: HPC Board Meeting

Vote to advance proposed regulation to public comment and hearing process

March 4: QIPP Committee Meeting

Discussion and release of proposed quality measures for public comment

March/April: Public Hearings on proposed regulation

Two public hearings on proposed regulation in Boston and Worcester

April 13: Public Comment Period closes

May 20: QIPP Committee Meeting

Discussion of recommended final regulation and vote to advance final regulation

June 10: HPC Board Meeting

Discussion of recommended final regulation; vote to authorize final regulation

Fall 2015: DPH develops and promulgates regulation governing certification and enforcement

**Certain dates subject to change*

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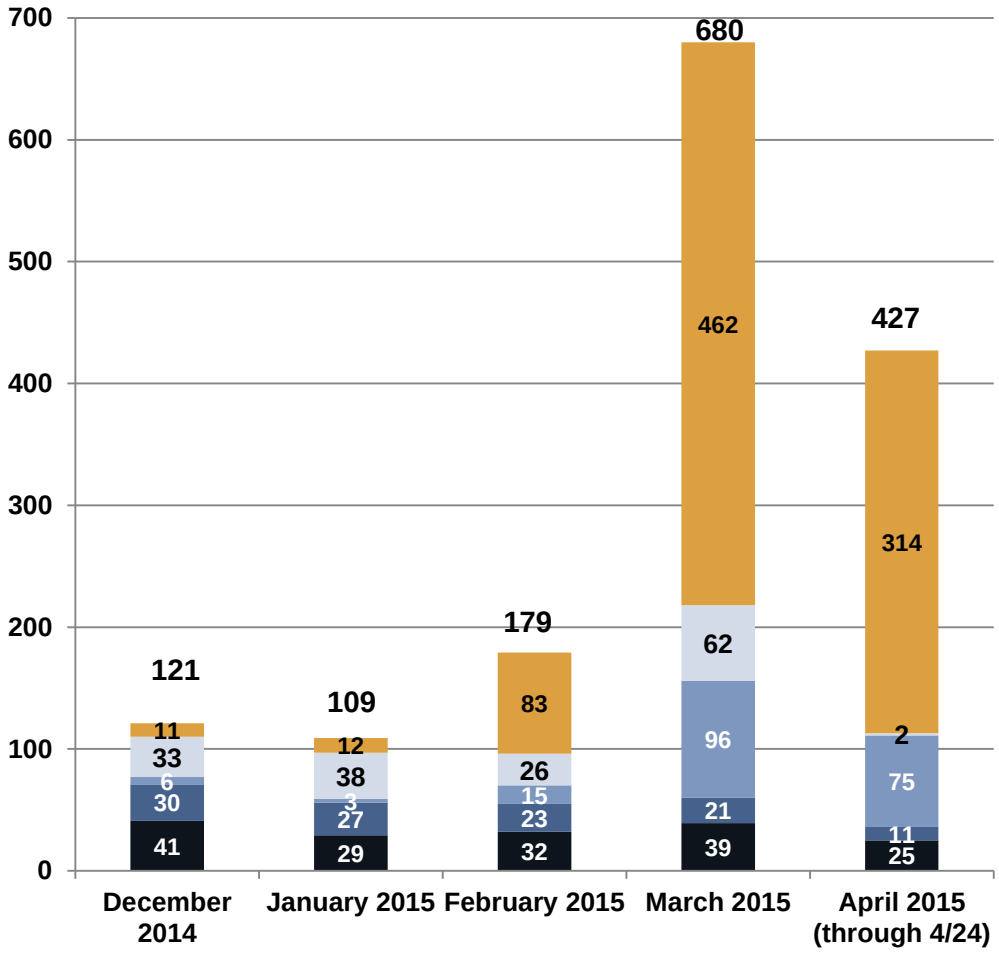
Office of Patient Protection: Program Update on Open Enrollment Waivers

- Massachusetts and federal law establish open enrollment periods to limit when consumers can buy individual or non-group insurance; waivers of the open enrollment period issued on a case-by-case basis by OPP (M.G.L. c. 176J, §4(a)(4))
- OPP typically grants open enrollment waivers to consumers who:
  - Are uninsured and did not intentionally forgo enrollment in health insurance, or
  - Unintentionally lost insurance coverage but did not find out until after 60 days had passed, or
  - Other extenuating circumstances
- Many consumers do not need a waiver and may purchase insurance if they experience a qualifying event or special enrollment period, e.g.,
  - Eligible for MassHealth or newly eligible for ConnectorCare subsidized insurance
  - Lost insurance coverage within the past 60 days
  - Other qualifying events established by state or federal law (e.g., birth or adoption of child, marriage, new citizenship status, etc.; see 45 C.F.R. §155.420 and 956 CMR 12.10(5))
  - Insurance carrier or Health Connector administrative error

Consumer phone calls to OPP December 2014 – April 24, 2015

Phone calls to OPP regarding health insurance enrollment issues related to the Health Connector and MassHealth, and other consumer inquiries regarding internal review, external reviews ,and other insurance or health care issues.



Health Connector & MassHealth category includes those eligible for MassHealth, and those who had temporary MassHealth but are no longer eligible (at least 50%)

Health Connector & MassHealth calls in one category because:

- **Issues may overlap**
- **OPP does not have detailed access to the callers' insurance status, only information provided by caller**

Source: 2014-2015 Office of Patient Protection Data

Working toward solutions

Health Connector

- Close collaboration with Health Connector and their customer service contractor, Dell.
- Health Connector and Dell have temporarily placed a Dell supervisor in the HPC offices to assist OPP with incoming phone calls and to identify the sources of misdirected referrals.
- OPP has helped to revise notices, online information, customer service scripts. Changes are being implemented but website changes will not take effect until May at the earliest.

MassHealth

- Close collaboration with MassHealth to troubleshoot.
- MassHealth has provided OPP with information to assist consumers.
  - MassHealth coverage extended through June 2015 for MassHealth redeterminations
  - Availability of in-person assistance and online information

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  - Health Care Innovation Investment Program
  - CHART Phase 1 Final Report
  - CHART Technical Assistance
  - CHART Contract
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  - CHART Phase 1 Final Report
  - CHART Technical Assistance
  - CHART Contract
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Health Care Innovation Investment Program (HCII)

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**
  - *May increase if 3rd gaming license is awarded*
- Unexpended funds may be rolled-over to the following year and do not revert to the General Fund
- **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

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

Program Development Considerations

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
5. Suggests potential funding priorities such as in safety-net and DSH providers, support for PIPs, employee wellness programs, evaluation of mobile health technologies and chronic disease management programs for rural health and underserved areas

Investments that catalyze care delivery and payment innovations

In 2015, HPC will release a first round of innovation funding (HCII.1)

Principles for HCII program development

- Design a program infrastructure that will support the testing of payment and care delivery models and provide opportunities to scale successful initiatives through further investments and policy
- Prioritize evidence-based approaches for evaluating and funding investments
- Engage in extensive dialogue with market participants to identify the highest-need areas for payment and care delivery reform that are not adequately addressed by policy, the market, or current investment programs
- Build a nimble approach to investment that maximizes impact of relatively small investments

$3M

Anticipated 2015-2016 Investment

Draft HCII.1 Goals

1. Generate multi-sector collaboration and engagement to advance innovations that will reduce health care costs

2. Address complex health care challenges by identifying, testing, and expanding promising solutions

HCII.1 Investment Options

The fund shall be used for the following purposes:
...foster innovation in health care payment and service delivery.
...establish a competitive process for health care entities to develop, implement or evaluate promising models in health care payment and health care service delivery

Develop	Implement	Evaluate
Present a problem to solve and focus funding on its potential solutions via a prize incentive	Identify and fund existing solutions that are proven to work and bring them to scale	Find organizations that are already developing solutions and evaluate their progress

Invest in a mix of approaches to span all stages of the innovation journey and manage the risk of innovation proportionate to the program priorities

HCII.1 Funding Mechanisms

	Example	*HPC Role*
Develop	Fund a challenge grant or technology development track, hosted and run by a partner, to generate potential solutions to a high-need health care problem	Transfer dollars to a partner to administer per joint requirements; Partner oversees, reinvests, and tests solutions with HPC as a strategic advisor
Implement	Identify a structural or operational partner problem that results in gaps in care for MassHealth patients; Fund and test an innovative model aimed to close the gap	Directly fund provider organization via competitive bid focused on innovative models and potentially source matching funds; Monitor performance and outcomes
Evaluate	Evaluate an innovative payment or care delivery approach (e.g., ED bypass) to understand implications for payment models and certification programs	Fund a 3rd party evaluation; Select pilots to be evaluated through multi-stakeholder partnership

HCII.1 Timeline

	Feb	March	April	May	June	July
Meetings	• CHICI 2/25	• Board 3/11 • Advisory Council 3/18	• CHICI 4/15 • Board 4/29 Goal Setting	• Advisory Council 5/13	• Board 6/10 Program Design	• Board 7/22 Program Design cont.

Goal Setting → **Program Design** → **Partnership**

Activities

Goal Setting

- ☑ Evaluate Ch. 224 and HPC governance structure to understand bounds/flexibility of the program
- ☑ Scan literature for public and private investment models
- ☐ Meet with state partners, funds and industry leadership to identify gaps in funding ecosystem

Current Focus

Program Design

- ☐ Decide funding approach
- ☐ Decide proposal selection criteria
- ☐ Define an operating model (with and without partnership)
- ☐ Define optimal funding and contracting vehicles

Partnership

- ☐ Select a partner organization with board approval
- ☐ Publically announce partnership
- ☐ Target marketing and outreach
- ☐ Design measurable goals for each segment of portfolio and program overall

Output

Goal Setting

- ***Program Goals***
- ***Program Priority Areas***

Program Design

- ***Funding Criteria***
- ***Mechanism for procurement***

Partnership

- ***Partner Selection***
- ***Program Announcement***

Launch Fall '15

Agenda

- Approval of Minutes from the March 11, 2015 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation Update
- Quality Improvement and Patient Protection Update
- Community Health Care Investment and Consumer Involvement Update
  - Health Care Innovation Investment Program
  - **CHART Phase 1 Final Report**
  - CHART Technical Assistance
  - CHART Contract
- Cost Trends and Market Performance Update
- Schedule of Next Commission Meeting (June 10, 2015)

CHART Phase 1 Report

Key Report Sections

1. Introduction to the CHART Investment Program
   - CHART Overview
   - Topline Impacts
2. CHART Program Goals and Theory of Change
3. HPC Investment Approach: Building a Foundation for Transformation
4. The CHART Hospital Engagement Model
   - High intensity partnership
5. Overview of Investment Priorities
   - Reducing Readmissions
   - Reducing Unnecessary Emergency Department Use
   - Enhancing Behavioral Health Care
   - Building Technology Foundations
6. Key Lessons Learned from Phase 1 Initiatives
7. Moving Into Phase 2: Applying Lessons to Enhance CHART

Overview of Phase 1 investments, impacts, lessons & implications

CHART Phase 1 topline impacts

CHART Phase 1: $9.2M

167,000+

Patients impacted by Phase 1 initiatives

2,300+

Hospital employees trained

27 Hospitals | **260** Units

Primed for system transformation

92%

Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

316

Community partnerships formed or enhanced by awardees

400+

Hours of direct technical assistance to awardees

Final Close Out: Updated April 27, 2015

CHART Phase 1 investments primed 27 hospitals for system transformation

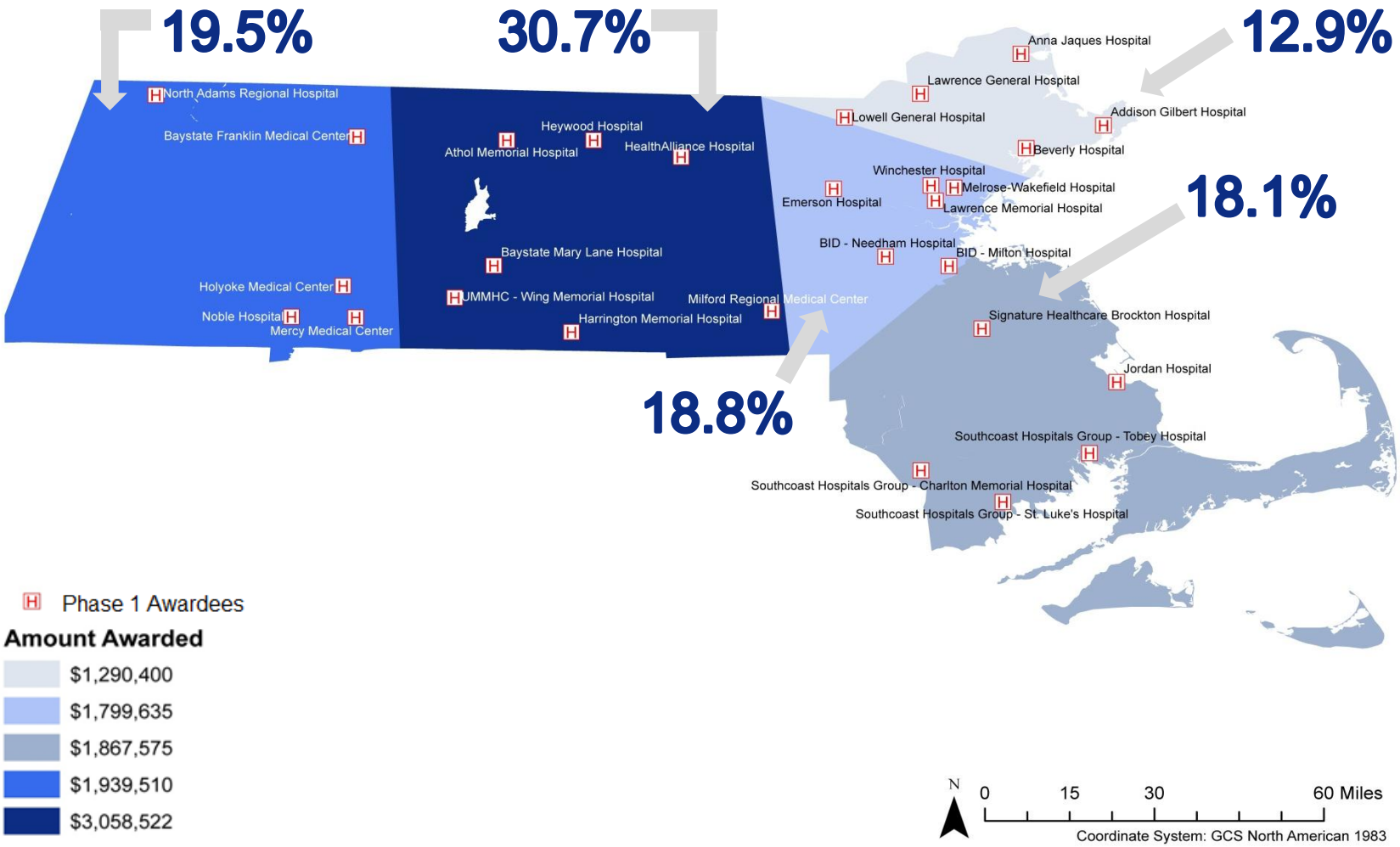
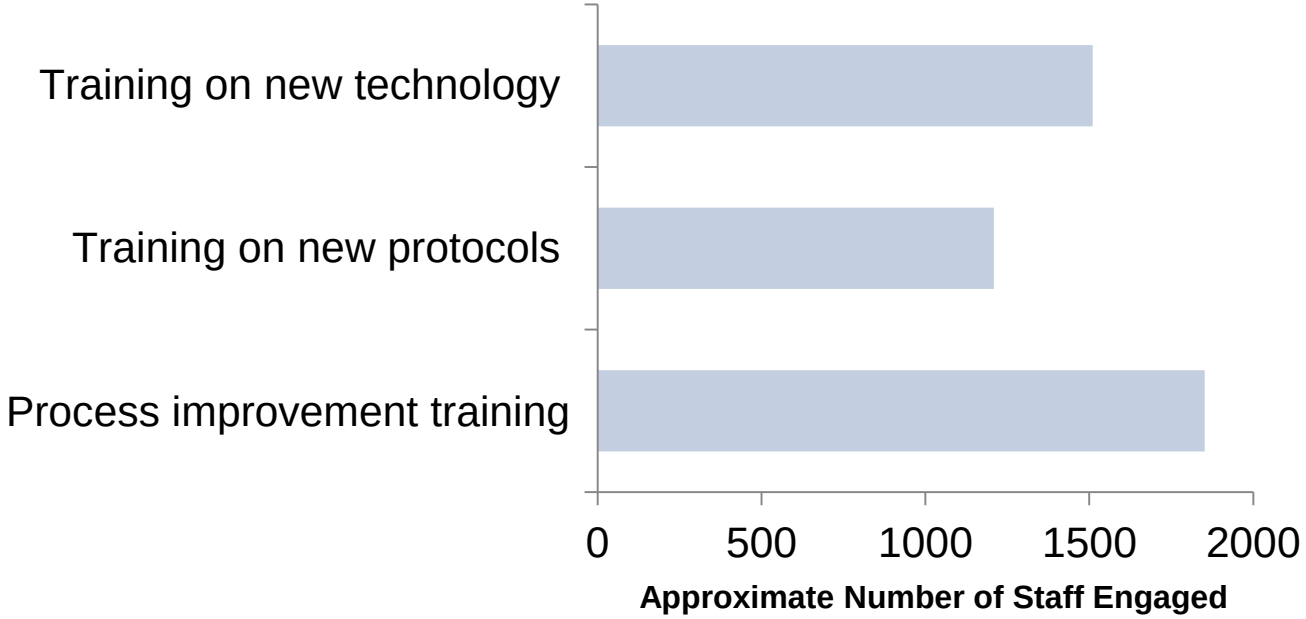


CHART Phase 1 investments trained over 2,300 hospital employees

CHART hospitals promoted staff development through trainings with a variety of areas of focus

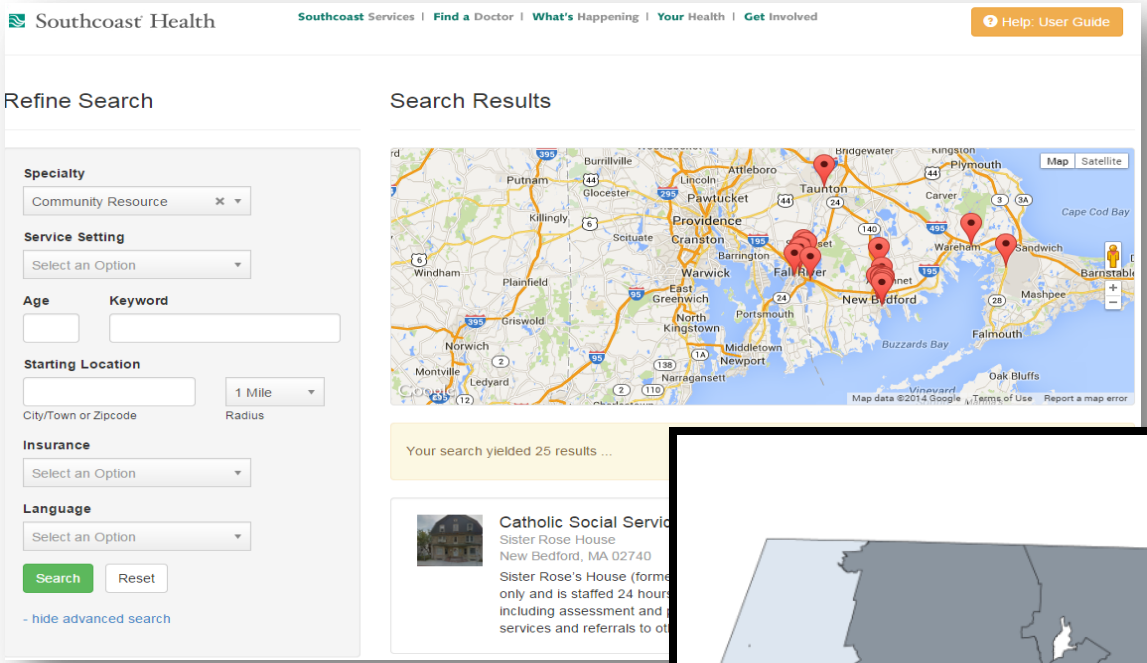


153 ED staff across the Hallmark hospitals adopted a new care protocol for back pain management to reduce opioid prescribing by 26% at Melrose-Wakefield and 43% at Lawrence Memorial, and increase PMP use from 1.5% to 60%

Mercy Medical Center trained 70 staff and executed more than 70 Lean improvement projects in five departments including team communication for care transitions and inpatient delay reduction

*Individual staff training numbers were reported by each hospital to the HPC in Phase 1 Final Reports.

CHART hospitals formed or enhanced more than 315 partnerships with medical practices, behavioral health providers, and community resources



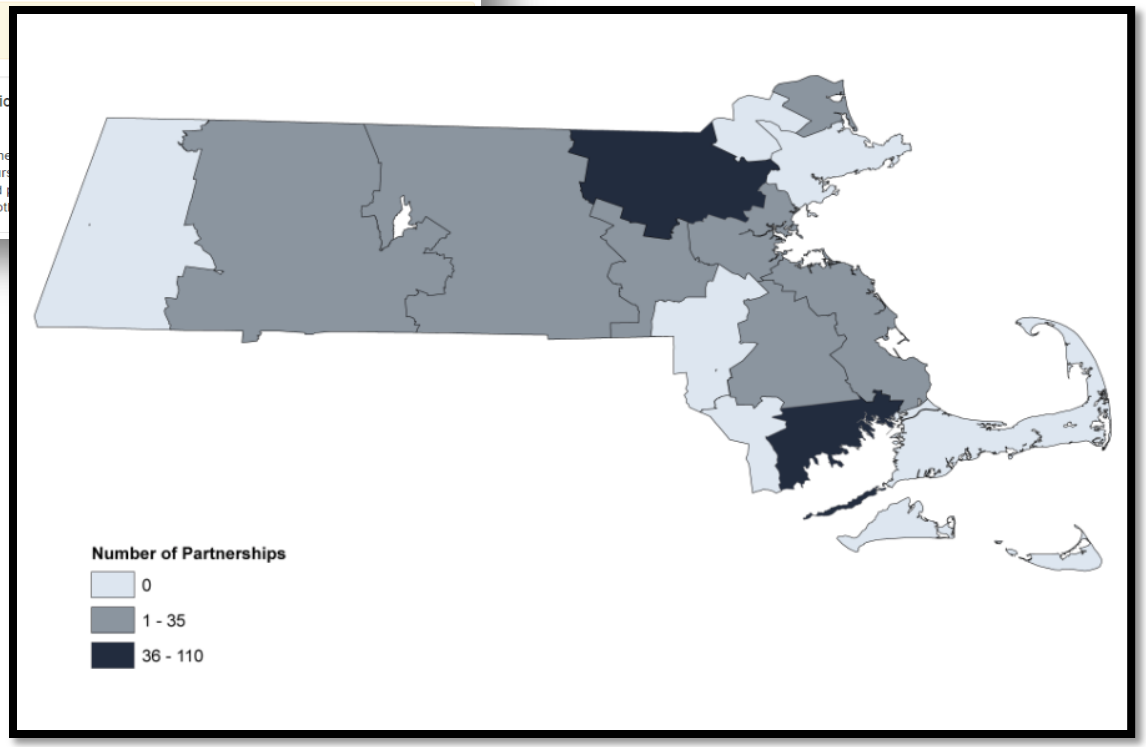


CHART Program delivered 450 hours of direct technical assistance

Monthly Calls	CHART program staff conducted calls with all hospitals for project updates, technical assistance, and setting expectations
Site Visits	CHART program staff conducted site visits at all awardee hospitals
Safe and Reliable	Safe and Reliable visited each hospital to assess the culture of the hospital and helped hospitals increase response rates to culture surveys
Learning Session	All CHART hospitals were invited to a learning session about reducing avoidable hospital utilization
Leadership Summit	CHART hospital leadership gathered to view new HPC analyses on hospital performance and discuss the imperative for transformation
Mass HIway and MeHI	MeHI offered TA on the monthly calls for 6 hospitals doing large technical projects

Ninety-two percent of Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

Investment priorities – reducing readmissions

Significance

In FY15, CMS will penalize 55 MA hospitals for higher-than-expected readmission rates

The HPC estimates wasteful spending on readmissions at about $700 million annually

Additional Highlighted Hospitals

Beth Israel Deaconess - Plymouth
Beverly Hospital
Lawrence General Hospital
Milford Regional Medical Center
Southcoast - Charlton Memorial Hospital
Southcoast - Tobey Hospital
Winchester Hospital

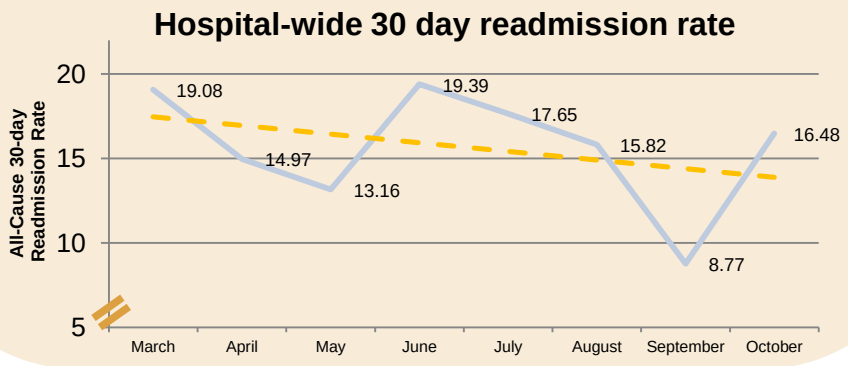
Spotlight – Addison Gilbert Hospital

Received $294,000 CHART Phase 1 Grant

Utilized funding to test implementation of a High Risk Intervention Team (HRIT)

HRIT provided patient education, medication management, and discharge planning to complex patients; reduced readmissions by

Addison Gilbert worked heavily with community partners such as The Healthy Gloucester Collaborative



Investment priorities – reducing unnecessary ED utilization

Significance

MA ranks 20th in the U.S. for highest rate of ED visits per 1,000 residents

The HPC found that almost half of ED visits in 2012 were avoidable

Additional Highlighted Hospitals

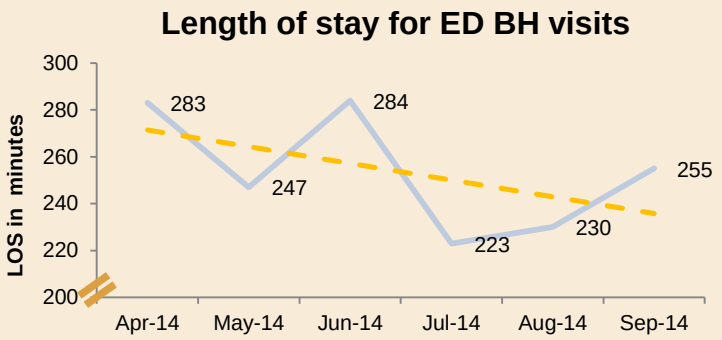
Athol Memorial Hospital
Beth Israel Deaconess - Needham
Heywood Hospital

Spotlight – HealthAlliance Hospital

Utilized CHART Phase 1 funds to develop a six-month ED Navigator Care Coordination Model for patients with serious mental illness to reduce ED length of stay with promising early indications

Intervention aimed at connecting all patients with a BH condition to a PCP, as well as increasing community collaboration for cross-continuum care

Partnered heavily with community organizations, such as local public schools and providers



Investment priorities – enhancing behavioral health care

Significance

Nearly 428,000 adults in MA struggle with a behavioral health condition

The number of opioid deaths increased 90% from 2000 to an average of 10.1 deaths per 100,000 residents in 2012

Additional Highlighted Hospitals

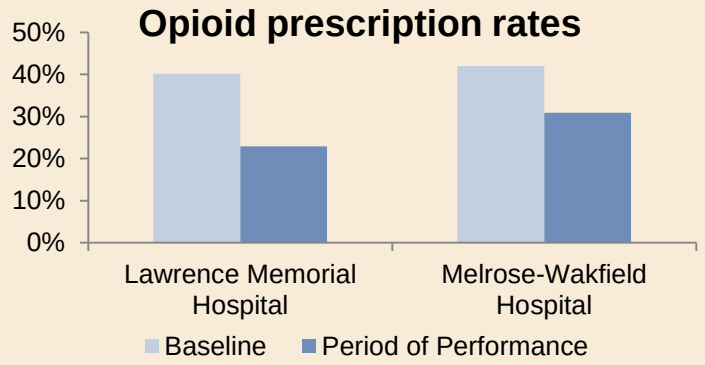
Athol Memorial Hospital
Heywood Hospital
Southcoast - St. Luke's Hospital

Spotlight – Hallmark Health System

Developed standardized clinical-practice guidelines for patients with lower back pain in EDs at member hospitals (Lawrence Memorial and Melrose-Wakefield)

Based guidelines upon extensive review of 1,100 patient medical records. Guidelines required providers to document reasons for imaging and opioid prescription

Created weekly provider and program dashboard to measure adherence to guidelines



Investment priorities – building technology foundations

Significance

Health information technology (HIT) initiatives are a means to collect, share, and analyze patient data to achieve high-quality, low-cost outcomes

89% of MA physicians and acute-care hospitals in MA utilize HIT, ranking the state among the highest in the nation

Hospitals to Highlight

Anna Jaques Hospital
Baystate Franklin Medical Center
Holyoke Medical Center
Lowell General Hospital
Noble Hospital
Signature Health Brockton

Spotlight – Baystate Mary Lane Hospital

Developed telemedicine programs in outpatient neurology, inpatient speech, inpatient and outpatient cardiology, and outpatient BH to increase patient access to specialty providers

Reduced overall patient waiting time for appointments to less than 20 days, versus over 80 days on average for in-person appointment

The wait time for the third next available appointment at BML went from 90 – 113 days for an in-person consult for neurology to 5 – 9 days for a telemedicine consult.

Key lessons learned from Phase 1 initiatives

Key Lessons

1. The composition of transformation teams is important
2. Process improvement is key to improving overall efficiency
3. Leadership and management must engage throughout the lifecycle of initiatives
4. Technology can lay the foundation for transformation
5. Data analysis is essential to measure performance and drive improvement
6. Community partnerships are challenging to build, but are essential to success in value-based health care
7. Sustaining low-cost options for acute care is critical for maintaining a value-based system

Directly informed Phase 2

Implications for Phase 2

Focus funding and attention on key priorities

Continue to provide enhanced technical assistance

Require and facilitate data collection, measurement, and overall hospital reporting

Engage deeply in program design

Support cross-functional composition of transformation teams

Implementation Planning

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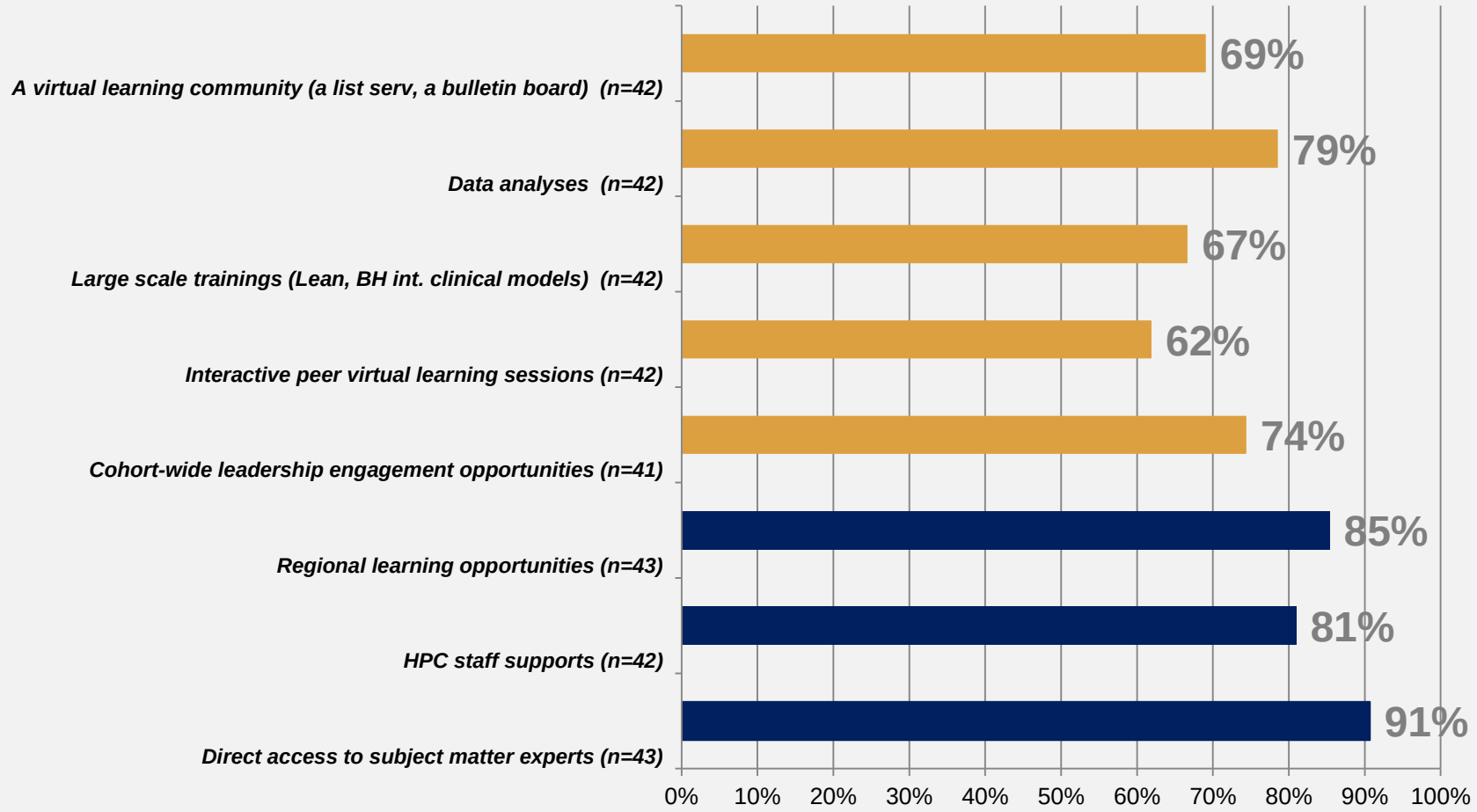
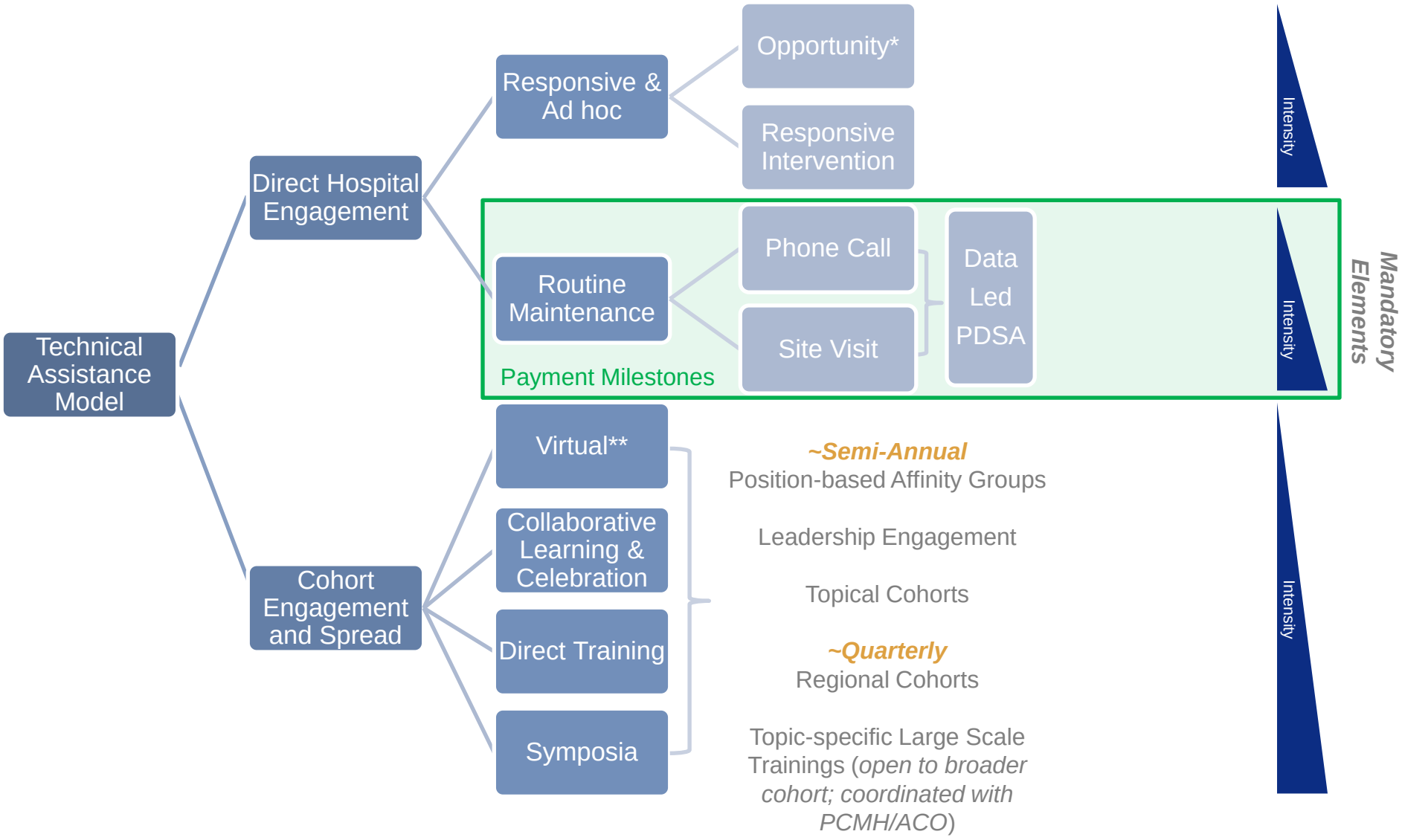
Provider engagement and support

Percent of respondents who agreed or strongly agreed that it would be helpful for the HPC to facilitate:



Modes for technical assistance and provider engagement



* Opportunities e.g., publication opportunities, pivot points for significant adaptation or enhancement, evolution of the scope and scale of interventions

** Virtual: **Passive** (content delivered to hospitals) or **Active** (facilitated)

Technical assistance topics and necessary expertise

Technical assistance will focus on themes of CHART investment and common topics necessary for hospital transformation

Potential Topics for Technical Assistance Activities

- *Performance improvement, e.g.,*
  - Applying improvement systems (Lean, Baldridge, Model for Improvement, etc.)
  - Data analytics and reporting
  - Team building with effective communication; physician and staff engagement
- *Achieving aims, e.g.,*
  - Reducing readmissions, ED visits, avoidable admissions
  - Identifying high-risk populations, including clinical, social and other factors
  - Behavioral health integration models
  - Chronic complex patients
- *Specific interventions, e.g.,*
  - BRIDGE and INTERACT models
  - Tele-behavioral health
  - Use of care navigators and community health workers
  - Developing community coalitions/partnerships

Necessary Content Expertise

- *Care delivery models*
  - Acute and chronic behavioral health management (including primary care integration)
  - ED care coordination with ambulatory providers
  - Community care models (e.g., accountable care communities, community health workers, regional “hot spotting”)
  - Care-coordination across the continuum
  - Hospital readmission reduction programs
  - Patient Centered Medical Home (Neighborhood)
  - Intensive Outpatient Care Programs (e.g., primary care based, case management based, partnership based)
- *Transformation prerequisites*
  - Cross cutting HIT topics (similar issues, not software specific discussions)
  - Hospital flow
  - Data analytics, data reporting to accelerate adoption, data mining for improvement
  - Project management
  - Improvement capacity building (target middle managers, improvement team leaders)

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CHART Phase 2 Implementation Planning by the numbers*

5 Regional Convenings

24 Site visits

20+

Expert advisor and HPC staff intensive working meetings with hospitals

475+

Hours of coaching calls

and counting

*Updated April 9, 2015

Vote: Approving staff recommendation for contract award

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws and vote of the Commission on October 16, 2013, the Commission hereby authorizes the Executive Director to amend its contract with Collaborative Healthcare Strategies for an additional amount of $175,000 through June 30, 2015, for expertise in support of the Commission's ongoing CHART Investment Program, subject to further agreement on terms deemed advisable by the Executive Director.

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- **Cost Trends and Market Performance Update**
  - HPC Whitepaper and Research Topics
  - All-Payer Claims Database Contract
- Schedule of Next Commission Meeting (June 10, 2015)

Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	11	30%
Acute hospital merger or acquisition	8	22%
Clinical affiliation	6	16%
Formation of contracting entity	5	14%
Acquisition of post-acute provider	3	8%
Change in ownership or merger of owned entities	3	8%
Affiliation between a provider and a carrier	1	3%

Update on notices of material change

Notices Received Since Last Commission Meeting

- Joint venture between UMass Memorial Health Care and Shields Health Care Group to open and negotiate contracts on behalf of a new ambulatory surgery center in Shrewsbury
- Acquisition of Noble Hospital and its affiliates by Baystate Health
- Clinical affiliation between Partners HealthCare and Steward Health Care System for provision of pediatric and newborn medicine services at certain Steward hospitals

Elected Not to Proceed

- Clinical affiliation between Dana-Farber Cancer Institute and Steward Health Care System for provision of oncology services at the Steward Holy Family Hospital campus

Transaction Completed

- Acquisition of Harbor Medical Associates, P.C. by Partners HealthCare System, Inc.

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  - **HPC Whitepaper and Research Topics**
  - All-Payer Claims Database Contract
- Schedule of Next Commission Meeting (June 10, 2015)

In 2015 cost trends research, the HPC will publish a series of "white papers" to complement the annual cost trends report

2015 Cost Trends Report

- Comprehensive report with market-wide view
  - Many descriptive analyses
  - Time trends and updates
  - National comparisons
  - Year-to-year continuity
  - May also include new or focused topics
- Publish one report at end of year

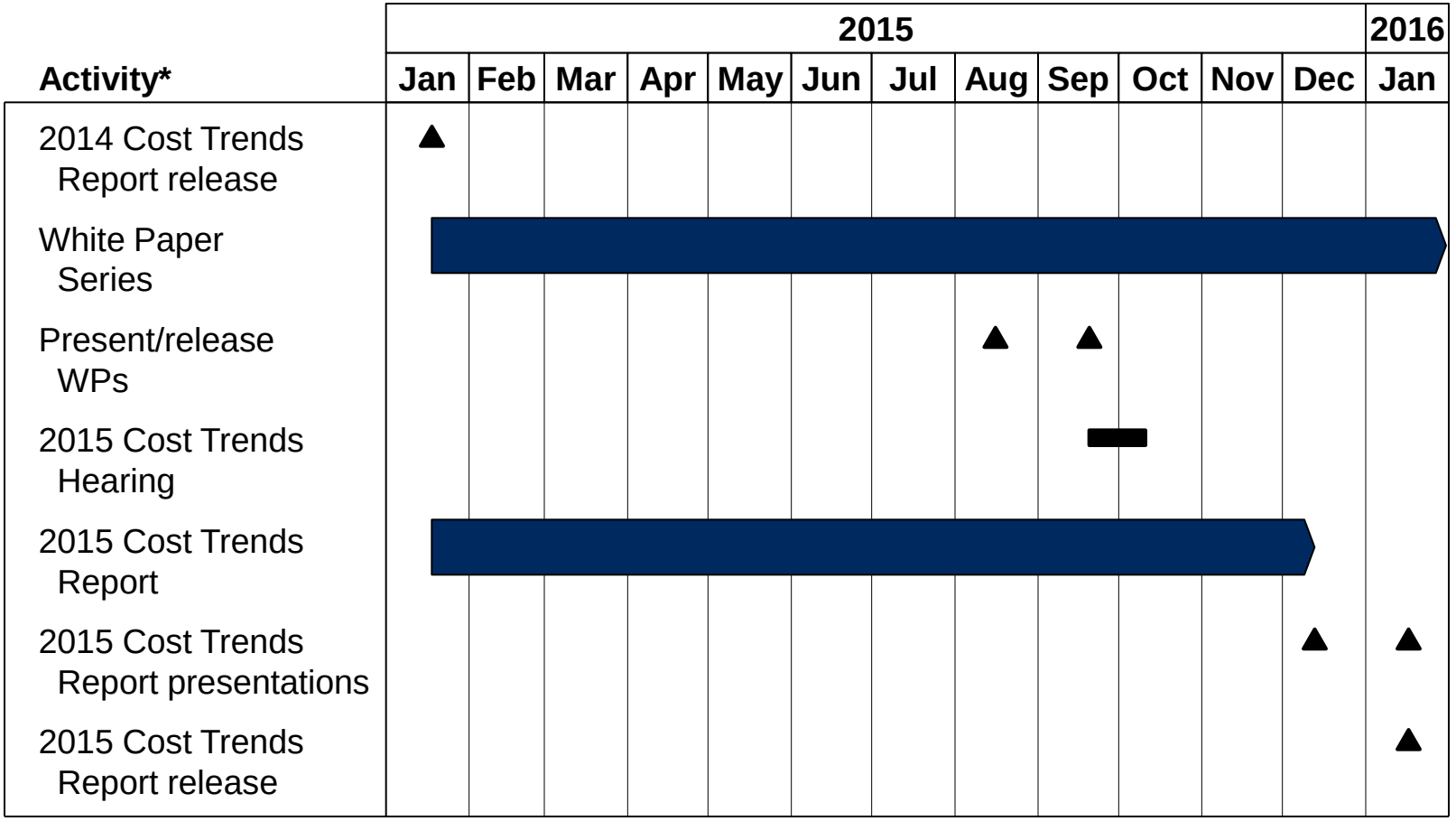
White Papers

- In-depth study of one issue
  - Examination of cause and effect
  - Often in partnership with outside researchers
  - Often oriented toward HPC policy and program priorities
  - More advanced analytic methods and/or original data collection
- Publish 2-3 white papers in 2015 on an occasional basis

Examine trends, drivers, opportunities, progress
Include evidence-based recommendations to increase quality and efficiency
Employ rigorous methods and objective analysis
Choose actionable, relevant topics, where HPC is uniquely positioned to contribute

HPC acts on findings with policy recommendations and strategic programs, e.g., technical assistance in priority areas.

2015 research timeline



*Preliminary and subject to change

2015 white papers – anticipated topics

- **Primary care access and preventable ED visits (white paper)**
  - Characterize patterns of preventable ED use (by region, population)
  - Assess relationship between ED use and multiple measures of primary care access (e.g. provider supply, retail clinics, urgent care, acceptance of MassHealth)
- **Employers and insurance markets (white paper)**
  - What are the barriers to adoption of tiered and limited network products, use of defined contribution strategies, use of transparency tools, and use of Connector?
- **High-cost drugs (policy brief)**
  - Potential cost impact, policy issues surrounding use in APMs
- **Policy responses to provider-level variation in spending (format TBD)**
  - Assess provider-level variation in episode-level spending, including role of both price and quantity
  - Foundation for future work on bundled payment, clinical improvement, and transparency

2015 cost trends report – anticipated topics

2015 Cost Trends Report

- Introduction
- Overview of system performance (“dashboard”)
- Trends in spending and care delivery
- Opportunities to increase quality and efficiency
  - Provider-level variation in spending and quality
  - Opportunities in care delivery
- Progress in key areas
  - APMs
  - Demand-side incentives
- Recommendations

New topic

Includes established topics, e.g. PAC, readmissions, ED use and new topics, e.g. end of life care

Maintains focus on data and transparency

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Statutory mandate for the Annual Cost Trends Report

Section 8g of Chapter 224 of the Acts of 2012

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

Required outputs

A. Concerning spending trends and underlying factors
B. Recommendations for strategies to increase efficiency
C. Legislative language necessary to implement recommendations

Data inputs

1. Hearings
2. Registration data
3. CHIA data / APCD
4. Any other information necessary to fulfill duties

HPC uses the APCD in cost trends research and other work

Cost trends research

- Aggregate trends in spending and utilization
- Factors of risk, quantity, and prices
- Drill-downs (e.g., out-of-pocket, service type, patient characteristics, region, episode)
- Special studies (e.g., high-cost patients)

Analysis of health care market functioning

- Defining service markets and analyzing market share
- Examining differences in price and utilization
- Analyzing cost and access impacts of proposed market transactions
- Developing analyses of the impacts of service expansions and closures

Other work

- Program evaluation (e.g., CHART evaluation)
- Payment design
- Developing measures of TME for different types of providers
- Etc.

HPC's pioneering work with APCD offers benefits to other agencies and researchers

Scope of work for analytic services procurement

Base task

1 **Aggregate trends in spending and utilization, for commercial and Medicare population**

- Includes
  - Classifying claims by category of service
  - Establishing counts of services (e.g., inpatient stays, outpatient visits)
  - Linking claims at person-level
  - Calculation of risk scores and linking other person-level variables
- The contractor will supply HPC with person-level files for additional in-depth work

Other potential tasks – to be awarded "as-needed"

2 **Trends in spending and utilization for MassHealth population**

- Initiate once CHIA/MassHealth establish and validate methods to calculate enrollment and PMPM spending with APCD

3 **Trends in quality and population health**

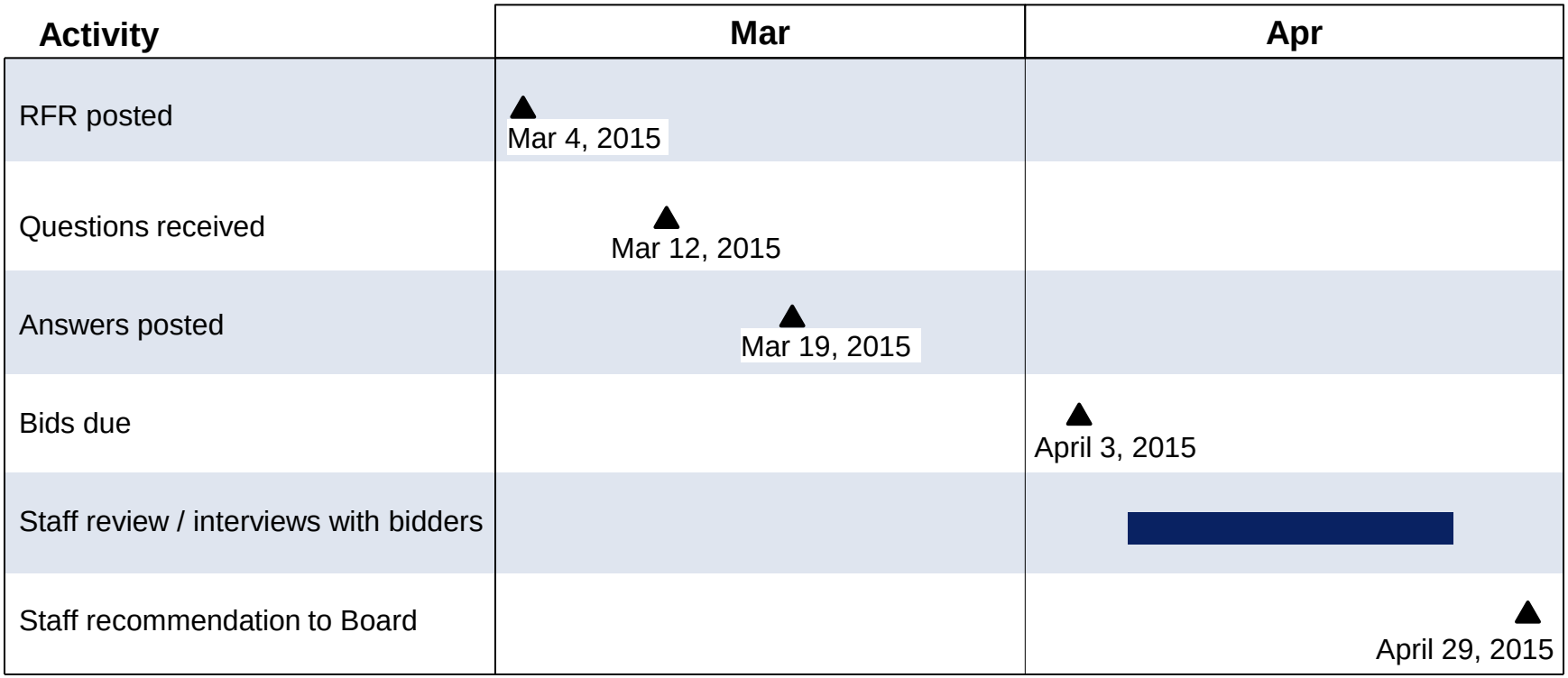
4 **Episode–level analysis**

- Classifying claims by episode and attributing episodes to provider
- The contractor will supply an episode-level file for additional in-depth work

5 **Other ad hoc work**

Contractor must both process data and assess its validity for HPC's analytic purposes – requires programming and research expertise. Must have strong quality assurance and documentation.

Analytic services procurement: timeline

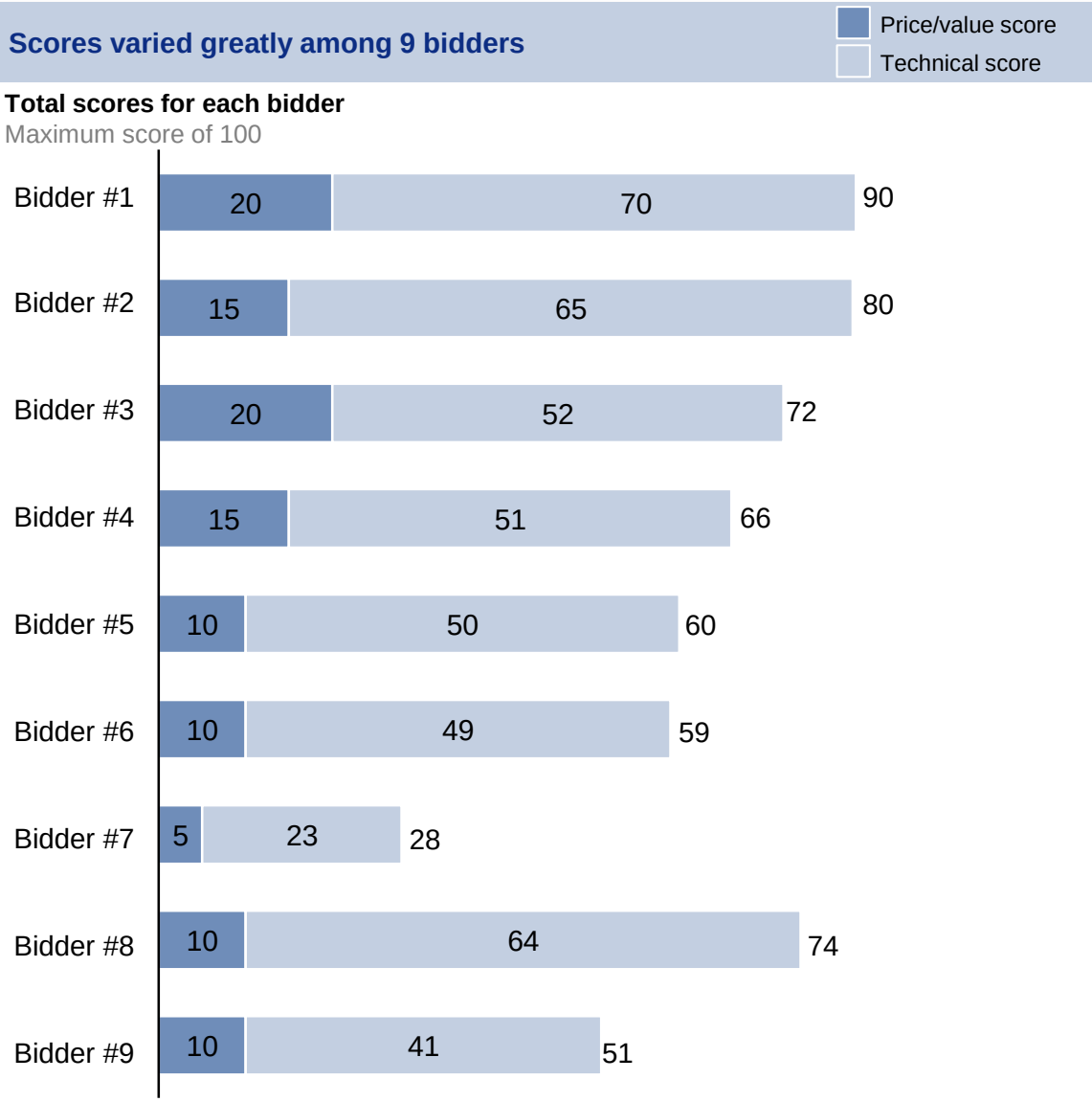


A total of nine firms responded to the RFR

Evaluation criteria used

Criteria	Value
Technical understanding of methods for analyses	10
Creative and feasible approaches to analyses	20
Demonstrated and relevant expertise / APCD experience	15
Educational, professional qualifications	10
Quality assurance	5
Strong project management plan	5
Supplier diversity plan	10
Price/value	25

Scores varied greatly among 9 bidders



Based on our review of the proposals, we recommend Mathematica Policy Research

Summary of results

	Evaluation score	Proposed Contract Cap	Proposed Budget Cap
Mathematica	90	**$300,000***	**$550,000****

Rationale for Mathematica Policy Research, Inc.

- Demonstrated understanding of HPC needs and objectives
- Offered creative and feasible approaches to analyses, potential thought partner for HPC
- Experience working with APCD
- Highest evaluation score
- Able to articulate a strong quality assurance process
- Strong project management plan

**Proposed contract cap pertains only to base task.

**Proposed budget cap includes base task ($300K), analysis of Mass Health data ($150K), and ad hoc analysis, potentially including quality, population health, episodes ($100K)

Vote: Endorsing staff recommendation for contract award

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the Commission hereby authorizes the Executive Director to enter into a contract with Mathematica Policy Research, Inc. ("Mathematica") for professional services to support analysis using the all-payer claims database maintained by the Commonwealth's Center for Health Information and Analysis, through June 30, 2016 for a total contract amount up to no more than $550,000, subject to further agreement on terms deemed advisable by the Executive Director, of trends in healthcare spending and utilization and additional analyses as needed to support the Commission's statutory responsibilities and directs the Executive Director to seek financial support from the Center for Health Information and Analysis through an inter-agency services agreement for the contract.

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Contact Information

For more information about the Health Policy Commission:

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