Health Policy Commission

Board Meeting

September 11, 2013

Agenda

- Approval of Minutes from July 25, 2013 Meeting
- Executive Director Report
- Community Health Care Investment and Consumer Involvement
- Care Delivery and Payment System Reform
- Quality Improvement and Patient Protection
- Cost Trends and Market Performance
- Schedule of Next Commission Meeting

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Vote: Approving minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on July 25, 2013, as presented.

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Update on the One-Time Assessment

Year One Collection

- Collection deadline June 30, 2013
  - Collected: $72,390,000 / $72,420,000
    - Outstanding: $30,000
- Hospitals: 100% collected
- Payers: 98% collected

Year One Totals:

Fund	Invoiced Amount	Amount Collected
Health Care Payment Reform	$3,740,000	$3,740,000
Distressed Hospital Trust	$40,300,000	$40,280,000
Prevention and Wellness Trust	$18,930,000	$18,920,000
eHealth Institute	$9,460,000	$9,460,000
Total	**$72,420,000**	**$72,390,000**

Update on the One-Time Assessment

Year Two Collection

- Collection deadline June 30, 2014
  - Anticipated: $47,870,000

Year Two Totals:	Fund	Invoiced Amount
	Health Care Payment Reform	$2,500,000
	Distressed Hospital Trust	$26,150,000
	Prevention and Wellness Trust	$12,650,000
	eHealth Institute	$6,070,000
	Total	**$47,870,000**

Upcoming meetings

HPC Advisory Council Meeting

When: Wednesday, September 25, 2013 from 12:00pm - 2:00pm

Where: Corcoran Jennison Building
150 Mount Vernon Street, 2nd Floor
Dorchester, MA 02125

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- Approval of Minutes from July 25, 2013 Meeting
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- **Community Health Care Investment and Consumer Involvement**
  - Approval of Final Regulation for the CHART Grant Program
  - Discussion of Framework for the CHART Grant Program
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Overview of 958 CMR 5.00: Investment program administration

- *Establishes key definitions to guide administration of the Fund*
  - Defines **eligibility criteria** based upon statute
- *Establishes application requirements and a process for development of RFPs*
  - Adopts **statutory requirements** and establishes structure for **further program development**
  - Creates process to issue RFPs
- *Establishes a framework for grant application, review and selection, and contractual requirements*
  - Adopts **statutory criteria** and creates a process to further refine criteria in the RFPs
  - Establishes a **process for review and selection** as well as contract execution

958 CMR 5.00 establishes program operating structure and process

RFP Development and Application

- Program framework approved by the Commission
- RFP(s) developed and released
  - Eligibility lists developed and released at time of RFP issuance
- Applications received and reviewed for completeness
- Complete applications from qualified applicants directed to review committee

Review, Selection, and Award

- All accepted applications reviewed by staff against criteria established in regulation and RFP
- Executive Director recommends investment recipients for approval by Commission
- Commission executes contract with selected awardees
- Award period begins

Monitoring, and Evaluation

- HPC staff monitor for contractual compliance
  - termination or amendment requires Commission action
  - material change triggers Commission review of eligibility
- HPC provides framework and oversight for evaluation

Entities providing comment

CHART Eligible Hospitals

- Anna Jacques Hospital (oral)
- Harrington Memorial Hospital

Non-Eligible Providers

- Atrius Health
- Berkshire Health System

Other Entities

- Health Care for All (oral & written)
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Hospital Association (MHA)
- National Alliance on Mental Illness (NAMI)
- Senator Brian A. Joyce

Key themes of comment received

Eligibility Criteria	▪ Broaden eligibility to include community-based teaching hospitals & hospitals with high Medicaid share ▪ Assign hospitals to systems and assess systems. Do not assess need/capacity of individual hospitals. ▪ Define “geographic need” to mean “geographically isolated hospitals.”
Program Framework	▪ A variety of comments, including: – Focus on critical services in needy communities – “go deep not broad” – Need is widespread - allow all hospitals access to funds ▪ Require strategic audits of all participants to ensure focus on reducing TME ▪ Award multiyear grants to promote sustainability. Emphasize dissemination & scalability ▪ Use fund to bolster ongoing investments/transformation activities (not new initiative)
Investment Priorities	▪ A variety of suggested priorities, including: – Behavioral health & integration of behavioral and physical health services – Care coordination & care transitions – Clinical-community linkages – Infrastructure enhancements – Increased efficiency and reduction in provider practice variation – Care for underserved populations – Culturally & linguistically appropriate services ▪ Some comments advocated for specific hospitals.

Proposed amendments to 958 CMR 5.00 (1/2)

	Proposed Change	Justification for Adoption
Technical Consistency	▪ Citations of regulations and Massachusetts General Laws aligned	▪ Provides clarity to market participants about intent and proper citation
Definitions	▪ Acute hospital definition added, consistent with CHIA and DPH ▪ Teaching hospital definition amended	▪ Provides clarity regarding eligible entities ▪ Aligns definition with intended source, MedPAC ▪ Collaboration with community based organizations
Application Requirements	▪ Added substantive language to clarify and more explicitly state goals of CHART investment program, including: – improving access and quality – enhancing care coordination – increasing behavioral health and primary care integration – promoting IT investments that enhance clinical care delivery, and especially efficiency – to facilitate appropriate and evidence based care and population health management, especially for vulnerable populations – increasing community-clinical linkages – promoting CLAS	▪ Provides clarity regarding the Commission's intent, signaling to market participants how the Commission anticipates prioritizing elements of care delivery transformation

Proposed amendments to 958 CMR 5.00 (2/2)

	Proposed Change	Justification for Adoption
RFPs	▪ Specified that a given RFP may address only one or several goals of the Commission as specified in the regulation	▪ Clarifies that the Commission anticipates a multi-phase approach to investments, including RFPs that may be broad or specific
Criteria for Grant Award	▪ Specified that applications for award must demonstrate the ability to meet the proposed interventions as consistent with the Commission's goals	▪ Signals the need for comprehensive demonstration of capability and capacity in applications
Review & Selection	▪ Provides for the Chairman of the Commission to nominate designees to review CHART investment applications with staff and to provide scoring recommendation	▪ Provides clarity as to staff-Commission roles and responsibilities with respect to application review
Grant Contract	▪ Specified that multi-year investments are allowable and expected	▪ Provides clarity of Commission's intent

Comments not recommended for adoption

	Proposed Change	Justification for Non-Adoption
Eligibility	▪ Allow teaching, community hospitals to be eligible	▪ Statute precludes such amendment
	▪ Define RP calculation to include Caid/Care FFS	▪ Statute precludes such amendment unless adopted by CHIA
	▪ Define “health care delivery system” and accordingly assess all applicants by system, not hospitals only	▪ Commission will examine the relationships of each entity, but a single regulatory definition will not provide clarity of purpose
	▪ Adopt definition of “geographically isolated hospital” to specify reference to geographic need in §5.06 (4).	▪ Review of geography should be comparing relative need, not a yes/no criterion
Program Framework	▪ Clarify in regulation intent relative to broad vs shallow investments	▪ Such clarification should be provided in RFPs, not regulation
	▪ Clarify in regulation that further investment in current initiatives is allowable	▪ Such clarification should be provided in RFPs, not regulation, and may not be applicable to all rounds of investment
Investment Priorities	▪ Add numerous varied references to priorities	▪ The Commission has made a number of changes to 958 CMR 5.03, but additional detail may be provided in RFPs
	▪ Invest in infrastructure vs stimulating policy changes	▪ CHART is an opportunity for varying investments by Community Hospital and as priorities and needs dictate, such a restriction is unnecessary and inconsistent with the Commission’s stated goals

Vote: Approving final regulation

Motion: That the Commission hereby approves and issues the attached final regulation on the administration of the distressed hospital trust fund, developed pursuant to section 2GGGG of Chapter 29 of the General Laws by the Commission's Community Health Care Investment and Consumer Involvement Committee, and directs staff to take all action necessary to promulgate said regulation.

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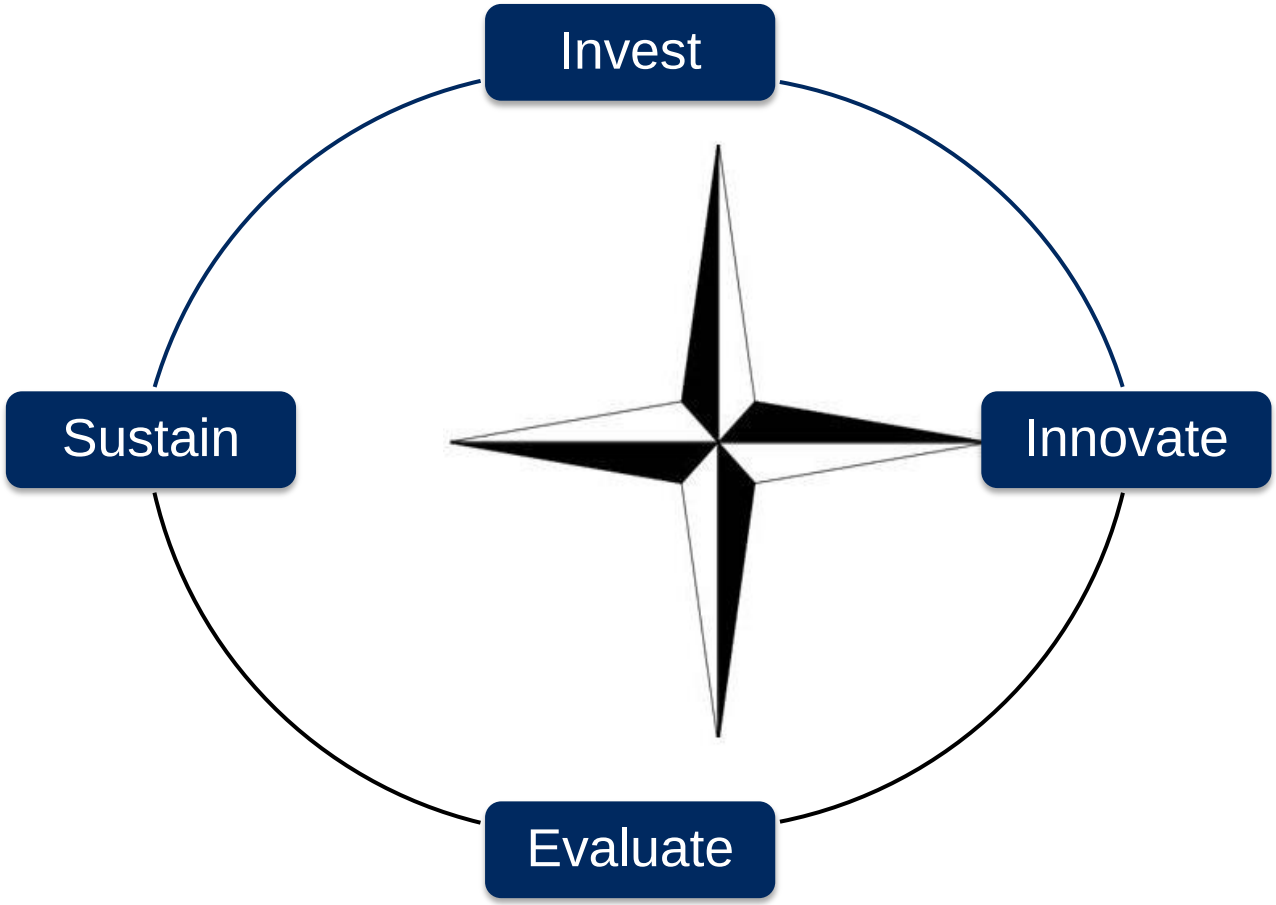
HPC CHART Investments: Status update

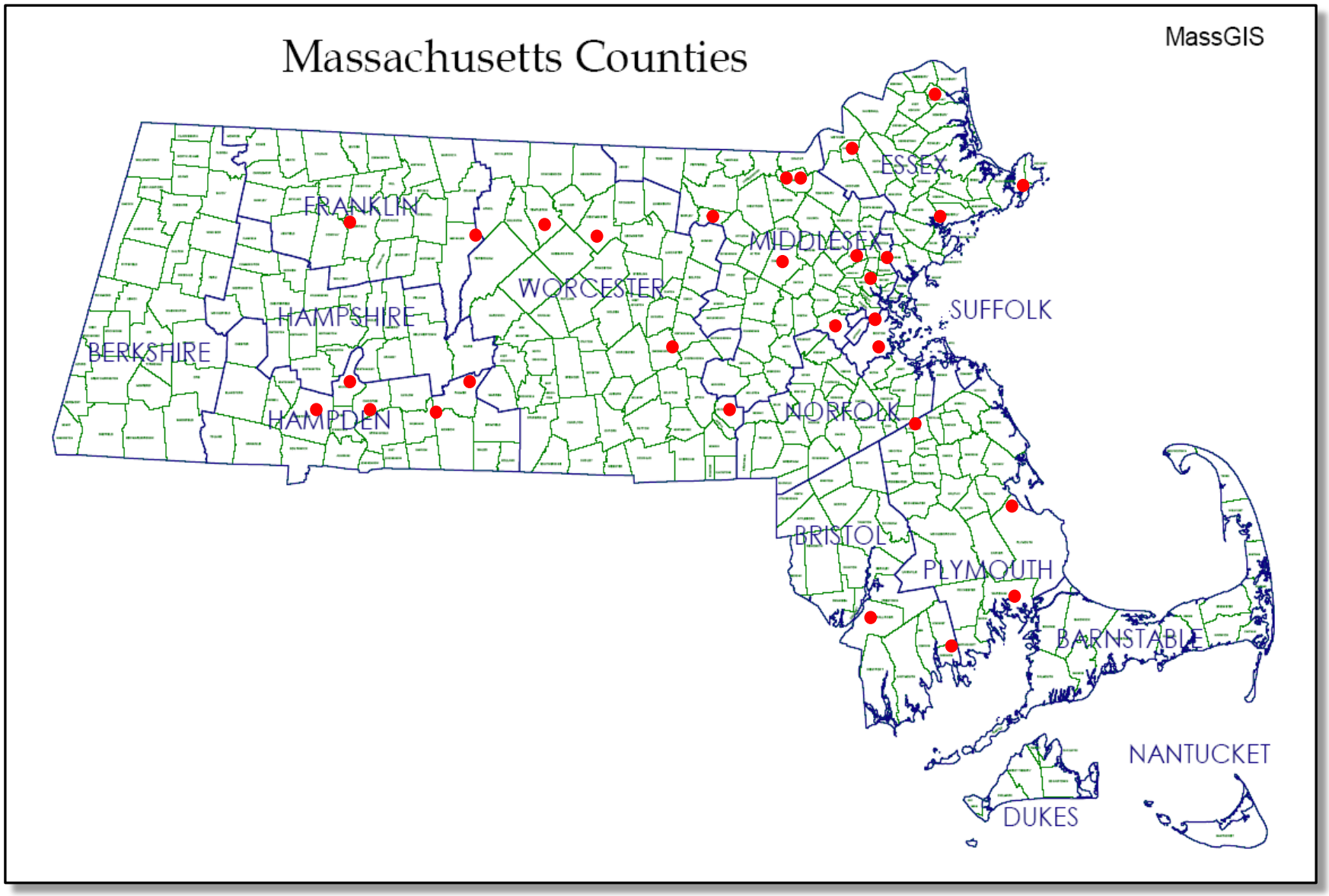


Consensus goals for CHART investments, from 958 CMR 5.00

Sustainable, Scalable Interventions with ROI

Efficient, Effective Care Delivery	Enhance care coordination, advance integration of behavioral and physical health services, promote evidence-based care practices and efficient care delivery, and provide culturally and linguistically appropriate services
Advance HIT Adoption	Enhance interoperable electronic health records systems and clinical support tools;
Advance HIE Spread	Accelerate the ability to electronically exchange information with other providers to ensure continuity of care and enhanced coordination across the continuum of providers and organizations in the community served by the Applicant
Increase APM Adoption	Enhance analysis performance management tools, including to promote transparency, to aggregate and analyze clinical data, and to facilitate appropriate care management, especially for vulnerable populations and those with complex health care needs;
Develop Capacity for ACO Cert.	Aid in the development of care practices and other operational standards necessary for certification as an accountable care organization
Improve Affordability & Quality	Enhance patient safety efforts, increase access to behavioral health services, and coordination between hospitals and community-based providers and organizations

Eligible hospitals *(effective 7/10/13 – subject to change)*



Proposed framework for Year 1 investments (1/3)

Development of Proposed Investment Approach

- Reflects **learning from many stakeholders**, including:
  - market participants
  - local and national content experts
  - **diverse array of investors** (private sector grant making/investment entities, other states and federal government, payers, etc.)
  - HPC Advisory Council

Considerations for Proposed Investment Approach

- Provide rapid investment to community hospitals with **identified needs**
- Allow for **ongoing development of a rigorous**, evidence-driven investment **strategy** for downstream opportunities
- Allow for continued development of HPC **staff capacity** to support investment program implementation

Proposed framework for Year 1 investments (2/3)

Phase 1: Fall 2013 – Foundational Activities to Prime System Transformation

- Modest investment with many eligible hospitals receiving funds
- Short term, high-need expenditures
- $~10M funding pool:
  - Awards of ~$250-$500K stratified by demonstrated financial need, capacity, capability, and potential impact
  - Focused on infrastructure investments to facilitate downstream delivery system transformation
  - Limited funding (e.g., ~$35K cap) for planning activities to provide staff capacity to minimize competitive advantages in downstream funding opportunities

Phase 2: Spring 2014 – Driving System Transformation

- Deeper investment in limited set of hospitals – competitive application process
- Multi-year, system or service line transformations in Commission-identified areas of focus
- ~$50+M funding pool:
  - Awards of varying size, stratified by demonstrated financial need, capacity, capability, and potential impact
  - Focused on system, population segment or service line transformations (e.g. reduction of ED boarding)
  - Varied potential funding and contractual models

Ongoing program development

Proposed framework for Year 1 investments (3/3)

Phase 1: Fall 2013

- Efficient, Effective Care Delivery
- Develop Capacity for ACO Cert.
- Improve Affordability & Quality
- Advance HIT Adoption
- Advance HIE Spread
- Increase APM Adoption

Phase 1 Investment Priorities

- Hospital-identified needs
- Clinical information flow between hospital and community-based providers
- Clinical triggers and flags
- IT based patient registries
- Limited planning funding

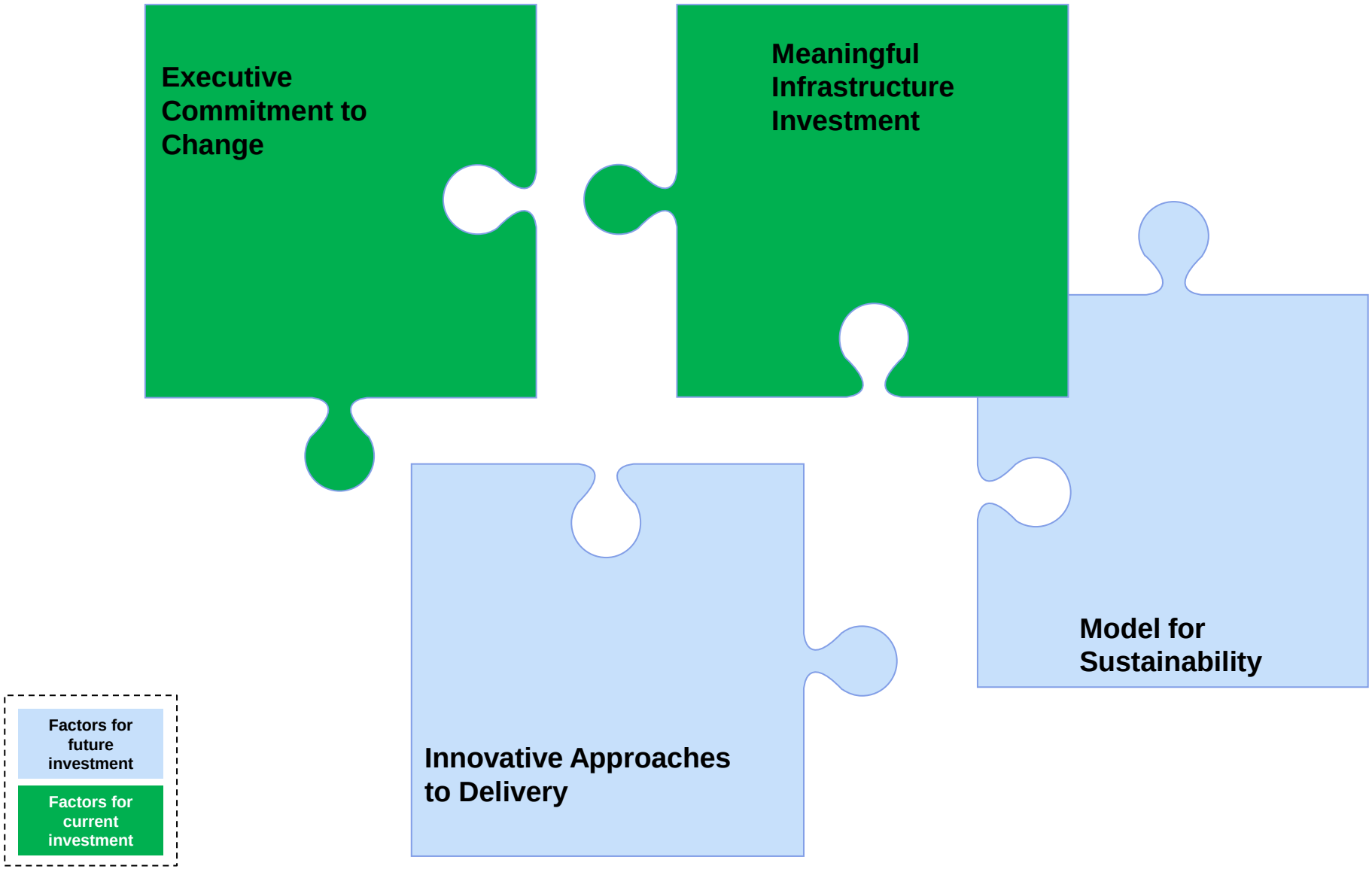
Considerations for proposed approach

Workflow focused – prioritize acquisition or implementation of **simple tools** that improve **quality, safety, coordination, and communication**

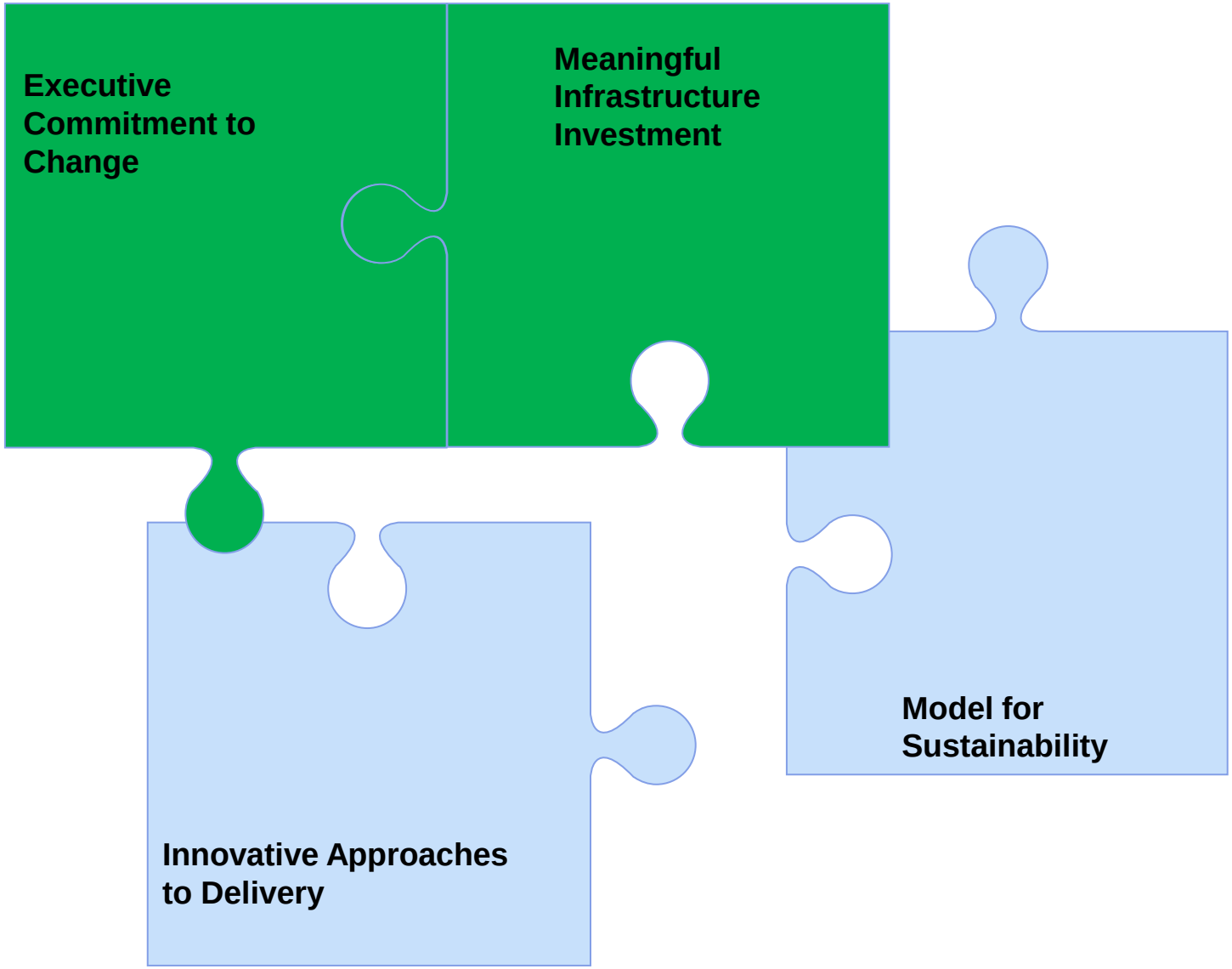
Early investment in f**oundations for change**

Low-risk, moderate return investments

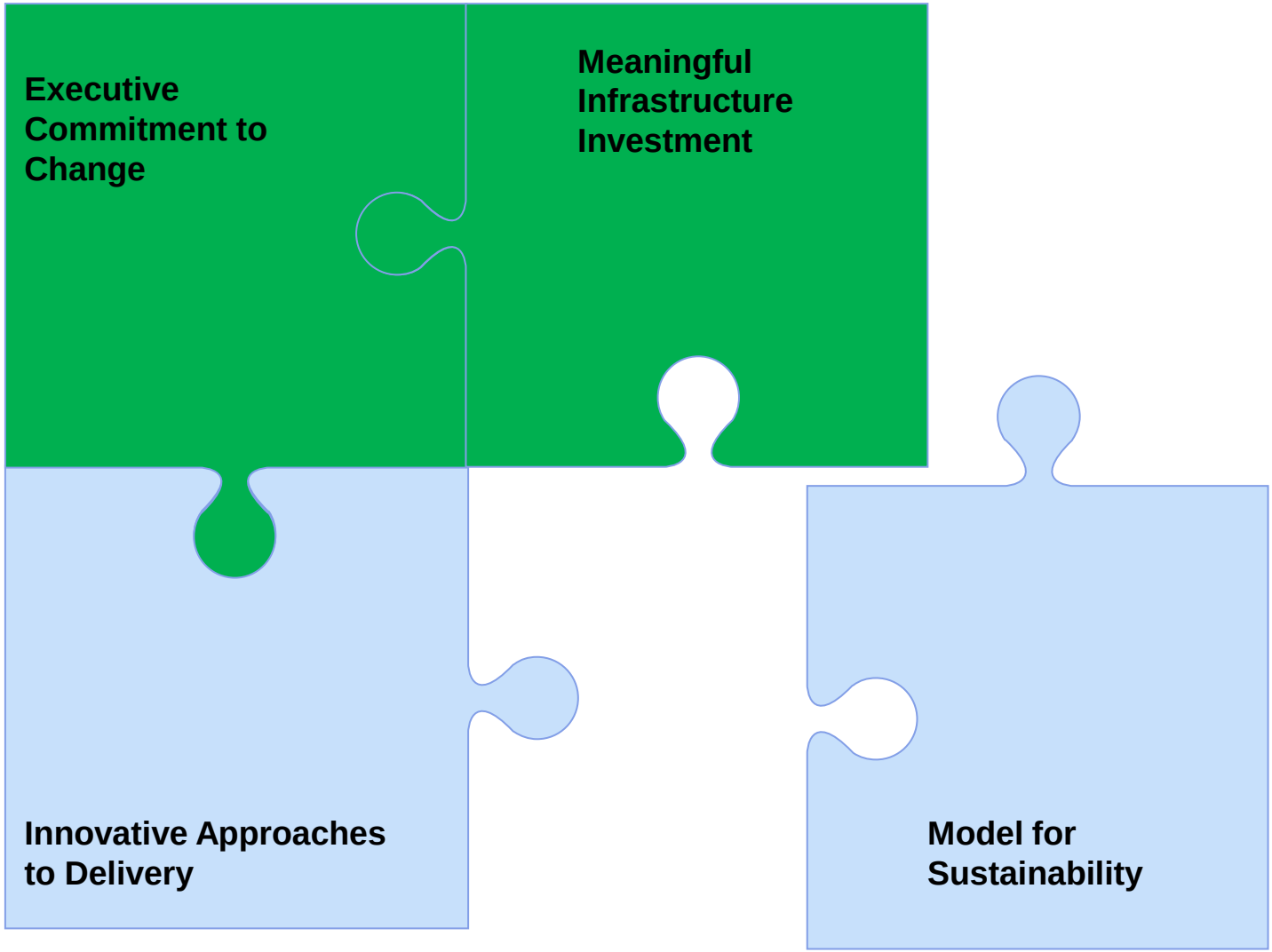
Necessary factors of change (1/4)



Necessary factors of change (2/4)



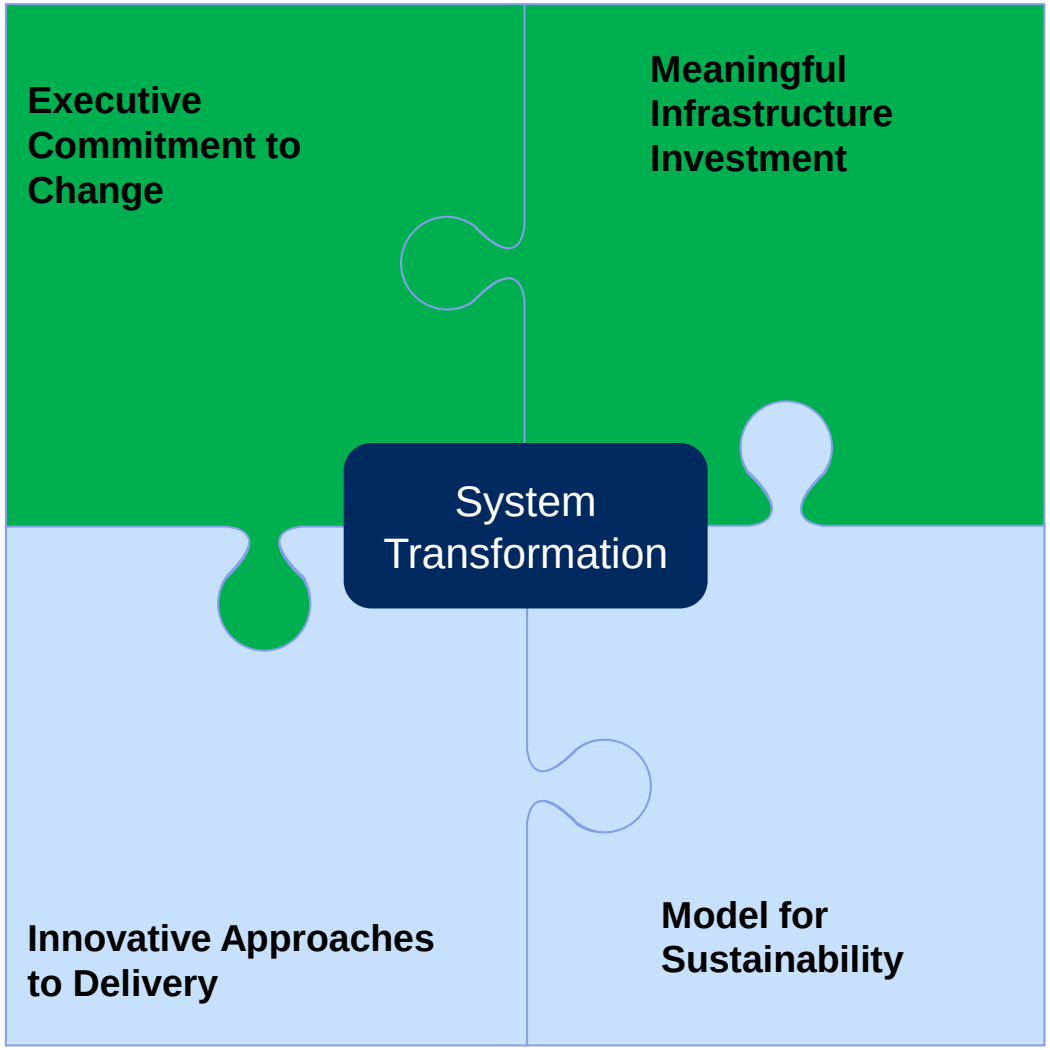
Necessary factors of change (3/4)



Factors for future investment

Factors for current investment

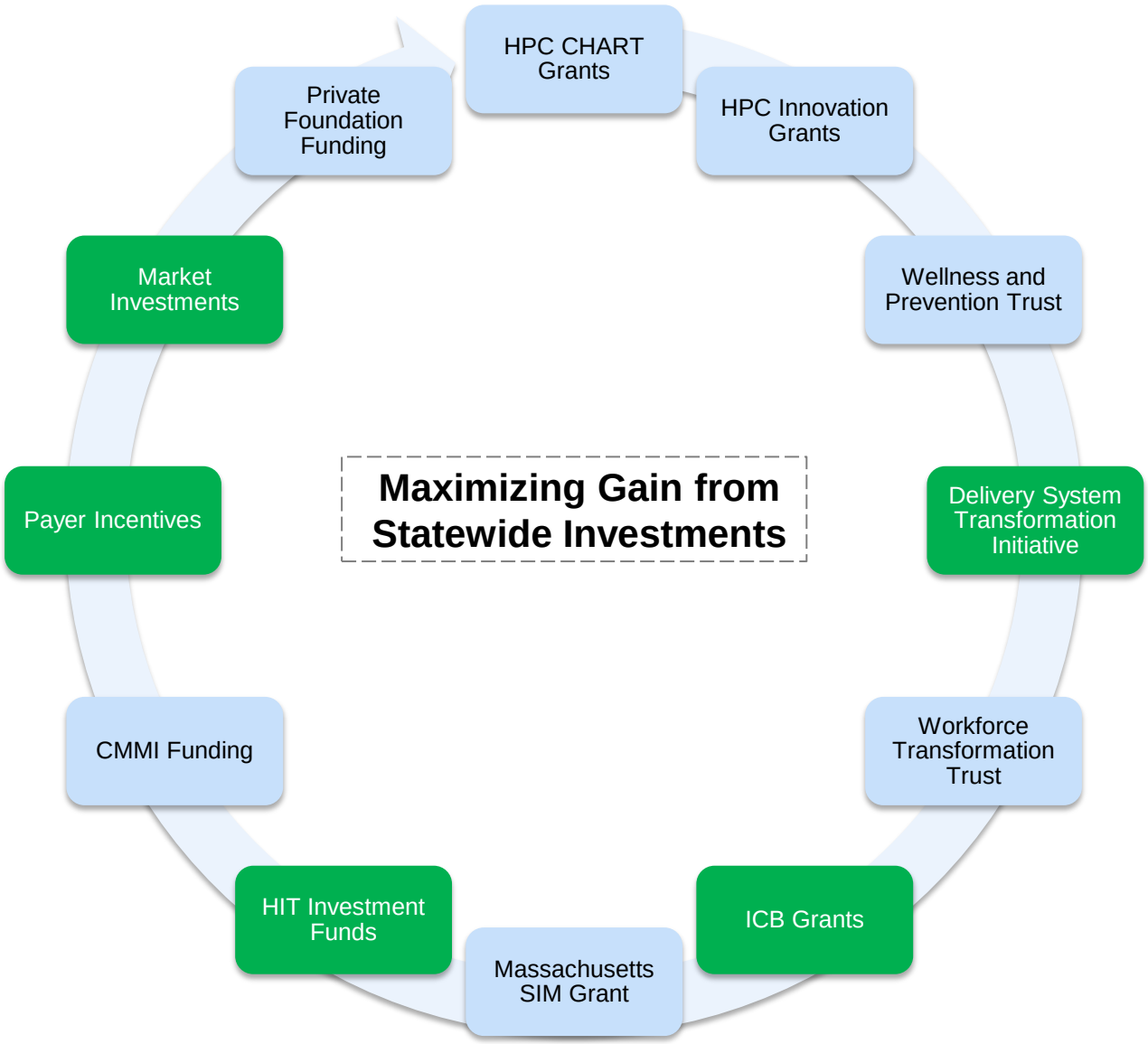
Necessary factors of change (4/4)



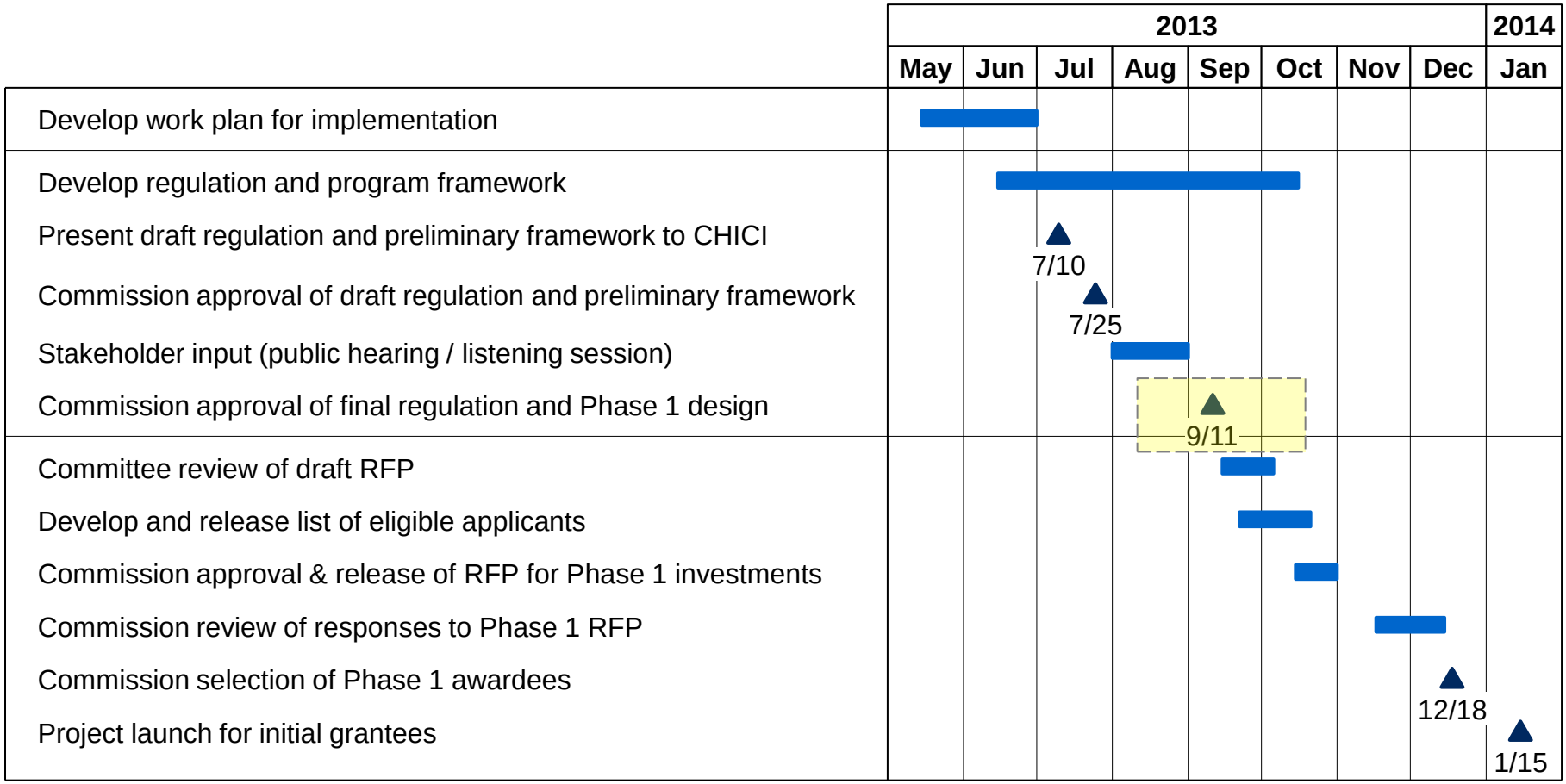
Factors for future investment

Factors for current investment

Alignment for Phase 1 with investments across agencies and programs



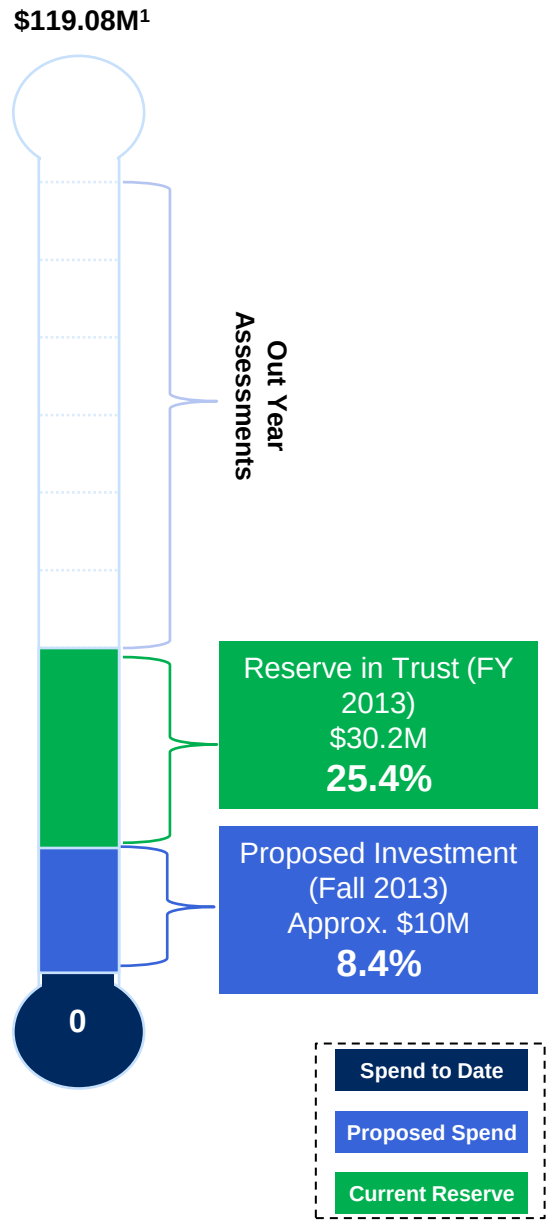
Anticipated six month timeline



Next steps

Staff activities and Committee engagement

- Develop **RFP and requisite application materials** (e.g. hospital capability assessment, executive engagement assessment, financial plan, operational plan, aims and drivers for improvement, evaluation metrics, etc)
- Apply **quantitative measures to selection criteria** to allow for stratifying investment across eligible hospitals (e.g. as a proportion of volume, payer mix, operating margin, cash reserves, prior investments, etc)
- Develop **administrative protocols** for review and evaluation of applications
- **Committee engagement** in RFP development
- Present **draft RFP to Commission** in October for approval
- Hire **Program Manager**
- **Ongoing development of full CHART framework**, building towards significant fund allocation in Spring 2014
- **Ongoing coordination of CHART activities with key partners** (e.g. Prevention and Wellness Trust Fund, Infrastructure and Capacity Building Grants, MeHI e-Health investments, etc)



[1]Distressed Hospital Trust funding pool after mitigation for select health systems

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Statutory obligations for PCMHs

Section 14 of Chapter 6D

The commission, in consultation with the office of Medicaid, shall develop[1] and implement standards of certification for PCMHs... Based on the following criteria: enhancing access… enabling utilization of… dedicated care coordinators… encouraging shared decision-making… [and] ensuring that PCMHs develop[2] and maintain appropriate comprehensive care plans for patients with complex or chronic conditions… Certification as a PCMH is voluntary. Primary care providers, behavioral health providers,[3] and specialty care providers certified by the commission as a PCMH shall renew their certification every 2 years… A primary care provider or specialty care provider certified as a PCMH shall have the ability to assess and provide or arrange for, and coordinate care with, mental health and substance abuse services. A behavioral health provider or specialty care provider certified as a PCMH shall have the ability to assess and provide or arrange for, and coordinate care with, primary care services,[4] to the extent determined by the commission… The commission, in consultation with the office of Medicaid, shall establish[5] a PCMH training for PCMHs to learn the core competencies of the PCMH model… The commission shall develop[6] a model payment system for PCMHs… The commission shall develop and distribute a directory of key existing referral systems and resources that can assist patients in obtaining housing, food, transportation, child care, elder services, long-term care services, peer services, and other community-based services.

2013 Amendment [7]

Amended chapter 224 to include priority for model PCMH practices

HPC Requirements

1. Develop and implement standards
2. Create a voluntary certification process that requires renewal every 2 years
3. Include behavioral health and specialty care providers
4. Establish training
5. Develop a model payment system
6. Develop and distribute a directory connecting patients to community-based services
7. Create a designation process for Model PCMHs

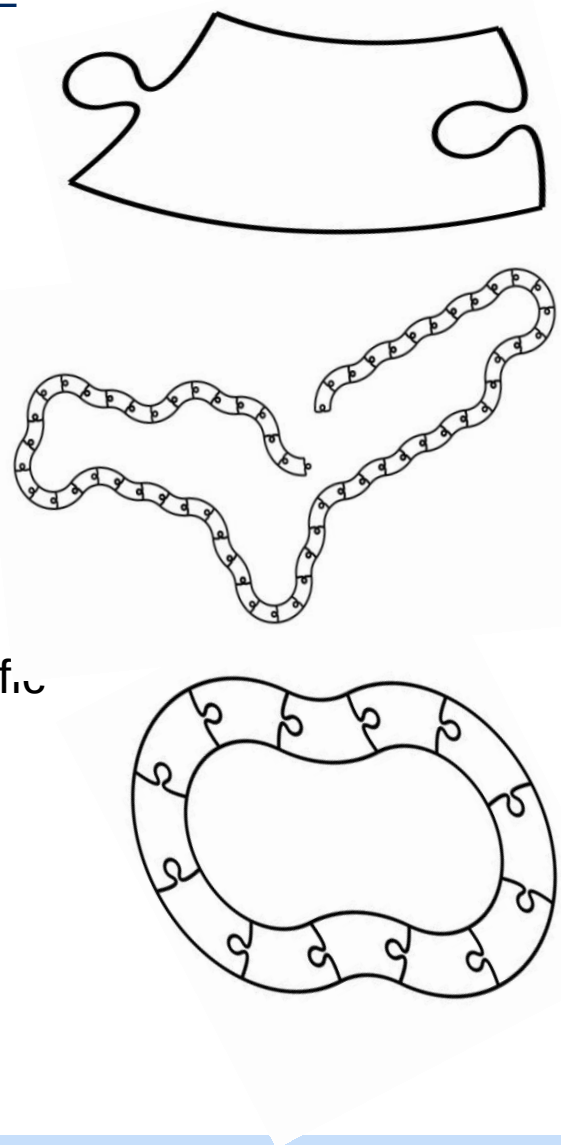
Statutory alignment of PCMH and ACO

Section 15(c)(5) of Chapter 6D

In developing additional standards for ACO certification, the commission shall consider the following goals for ACOs… to improve access to certain primary care services, including, but not limited to, by having **a demonstrated primary care and care coordination capacity and a minimum number of practices engaged in becoming patient-centered medical homes including certified patient-centered medical homes**.

Laying the “tracks” for PCMH in the Commonwealth

- Current status of PCMH certification
  - 159 accredited practices in MA (11%)
  - Approximately 3 new practices certified/month
  - Limited payer incentives for PCMH-specific certification (MassHealth), but other payers recognize PCMH-type attributes
- Opportunity to set direction for PCMH efforts in the Commonwealth
- Potential to impact quality and cost with focus on specific areas of PCMH capability and payer engagement



State PCMH certification models: Implications for HPC

State Models	HPC Considerations
▪ Varying state roles/involvement in standard selection and certification process	▪ Defining value of HPC certification to payers, providers (& level of rigor necessary to meet value expectations)
▪ Most work closely with public payers on enhanced payments for selected criteria	▪ Focus on specific criteria (focus areas): evidence-base and statutory requirements
▪ Those with more rigorous process have engagement from multiple payers	▪ Approach for measurement/ performance review
▪ Most have specific areas of focus, even if using national accreditation standards	▪ Considerations and resources for validation
▪ Strong state role in payment reform, analytics, monitoring and evaluation	▪ How choices for PCMH certification affect ACO program/opportunity
▪ Staff resources vary, though highest for provider training/education and on-site reviews	▪ Impact of standards selected and certification process on model payment design
▪ On-site reviews and practice facilitation perceived as highly valuable to PCMH sponsors & providers	▪ Partnering with others on capacity-building efforts

Key considerations for high-value, voluntary certification programs

Outstanding issues for certification

- Role of HPC
- Certification process
- Program resources
- Standards/focus areas

HPC role

Monitor	Monitor certification and impact of PCMH and ACO programs and payment models on quality, cost & access
Engage	Engage providers and payers to support adoption of functional capabilities at the practice level
Transform	Evaluate capabilities to define gaps, identify best practices, stimulate innovation, and measure impact

Considerations for approach: value vs. burden

- Participation by providers/payers
  - Perceived value of selected standards/accreditation body
  - Potential cost to providers (financial, administrative)
- Focus on behavioral health (minimal inclusion in national standards)
- Not all standards/elements considered “high-value”
- Measures, reporting, and analysis
- Opportunity for HPC to define focus areas to meet statutory requirements and focus on high-value elements for quality/cost

Certify and validate

Certification

Certification aims at assuring that the organization achieves a certain level of proficiency and that they agree to certain standards or criteria.

Process

Assurance of meeting standards or proficiency may be determined by:

- Application (response to specific criteria)
- Attestation or self-declaration of specific levels of proficiency
- Verification by 3rd party accrediting organization

HPC Example

- **Practice completes online application**
  - **Self assessment**
  - **Documentation requirements**
- **Practice attests to certification level or 3rd party certification**
- **HPC confirms national certification (if appropriate)**

Validation

The process of evaluating a system to determine whether the organization satisfies specified requirements (functional use of the capability).

Process

Evaluation of the specific standards and criteria may be accomplished by:

- Documentation review (i.e. policies, population reports)
- Performance review (specified measures)
- On-site survey (practice capabilities)

HPC Example

- **HPC reviews documentation and data**
- **HPC conducts site visit (if randomly selected)**
- **HPC awards practice certification and posts final status on website**

HPC options for certification and validation

	Pros	Cons
1. Certify national accreditation	▪ Minimize burden on HPC ▪ **Use nationally established standards** ▪ Align with requirements of local initiatives (PCMHI, PCPR)	▪ **Limitations of national standards** ▪ Need to encourage/include JC and NCQA programs for BH/spec certif. ▪ **Cost & time commitment by providers** ▪ Value of national standards by MA providers (90% without certification)
2. Validate national accreditation	▪ Opportunity to serve "validation" role (certified content experts for NCQA) ▪ **Value of validation to local partners & payers** ▪ Identify and disseminate best practices	▪ **Staffing resources for HPC to validate certification**
3. Add HPC-specific criteria	▪ Focus only on "high value" elements for certification ▪ **Include BH and specialty criteria – wider applicability** ▪ Monitor/evaluate high-value elements to assess impact	▪ **Added burden on providers for additional criteria and/or measurement (beyond national standards)** ▪ Program resources for validation
4. Focus on HPC-specific criteria for certification and validation	▪ **Directly align focus areas with national standards to certify practices with current accreditation** ▪ **Minimize cost/burden for other providers to pursue certification**	▪ **Stakeholder agreement on focus areas/ validation process** ▪ **Engaging payers and providers**

4. Focus on HPC-specific criteria for certification and validation

HPC Role/Implications

- Focus on high-value elements (focus areas)
- Recognize existing certification by third-party accrediting organization (align focus areas with national standards – NCQA, JC, AAAHC, URAC)
- Engage partners/payers to incent practices to enter Certification ”pathway”
- Provide communication and resources to define high-value elements and opportunities for certification
- Create tiered pathway for recognition, with clear milestones and approach for advancing on pathway
- Provide transparency of certification to create value for providers, payers and consumers (rating levels and definitions for purchasers)
- Engage with local partners for capacity-building efforts

HPC PCMH program implementation

Phase I: 18-24 months

- Engage payers to encourage participation
- Engage providers for voluntary certification
- Provide training / communications on HPC focus areas & milestones
- Evaluate engagement, impact (cost/quality), standards, payment models
- Program staff: program director, associate, 1-2 analysts, on-site survey staff/contractors

Phase II: Full scale roll out

- Review initial program evaluation
- Revise communications, program resources, approach to engagement, based on early results
- Expand practice and payer participation (as appropriate)
- Potential expansion of staff for communications, training, site visits
- Greater analytic capabilities – based on expanded participation and available data

Evidence on high value elements of accountable care

PCMH

- Care coordination
- Enhanced access
- Behavioral health integration
- Accessible, real-time data to manage performance and track patients
- Resource stewardship
- Integration & collaboration

ACO

High value: demonstrated impact on quality, cost and patient experience

HPC recommendations for certification framework

- **Role of HPC**
  - Engage providers and payers to stimulate adoption of selected PCMH criteria for enhanced payment
  - Monitor and evaluate impact of specific criteria on quality and cost to identify gaps, stimulate innovation, and measure impact
- **Standards/focus areas**
  - Focus on high-value elements of PCMH
  - Recognize existing certification with direct alignment of HPC focus areas to national standards
  - Minimize cost/burden to providers to participate
- **Certification process**
  - Practices submit application, self-assess level (or 3rd party certification)
  - HPC validates functional capabilities (application, performance, site visits)
  - Evaluate impact: program resources, engagement, quality/cost
- **Program resources**
  - Phased approach to initiation (Phase I: 18-24 months): multiple payers, 2-3 staff with contracted resources for site review (as needed)
  - Consider resources for performance review (quality/cost data)
  - Engage with local partners for capacity-building efforts

Key deliverables for HPC care model programs

Q3 2013	Q4 2013	Q1 2014	Q2 2014
▪ **HPC certification framework** ▪ PCMH focus areas & criteria ▪ PCMH measures ▪ Stakeholders/ technical advisor engagement	▪ Payer engagement ▪ Payment model design ▪ Reporting and monitoring methods ▪ PCMH pilot & evaluation design	▪ Practice engagement ▪ Training & technical assistance resources ▪ PCMH Phase I launch	▪ ACO standards & measures ▪ ACO program design ▪ Implement PCMH pilot

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  - Update on Office of Patient Protection Data
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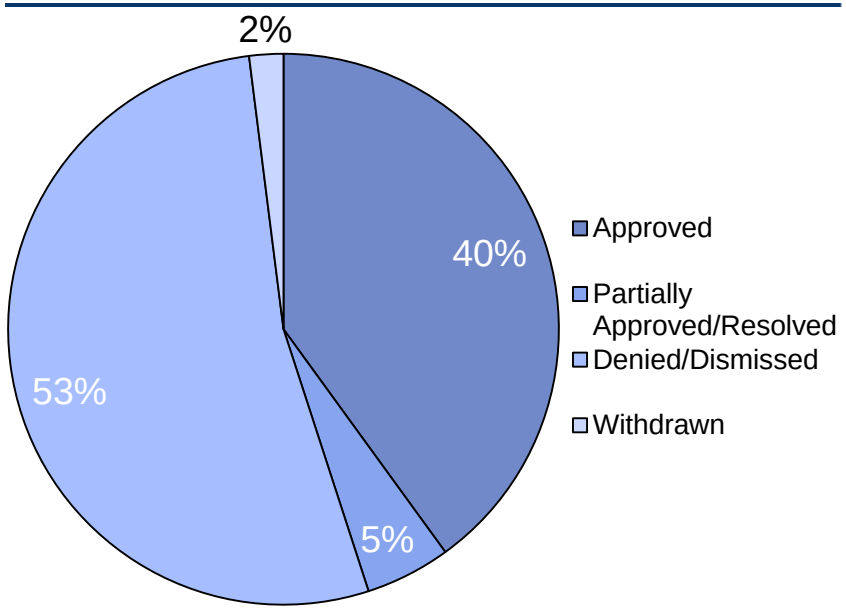
2012 Internal and External Reviews

Number of internal reviews*

12,783 total internal reviews

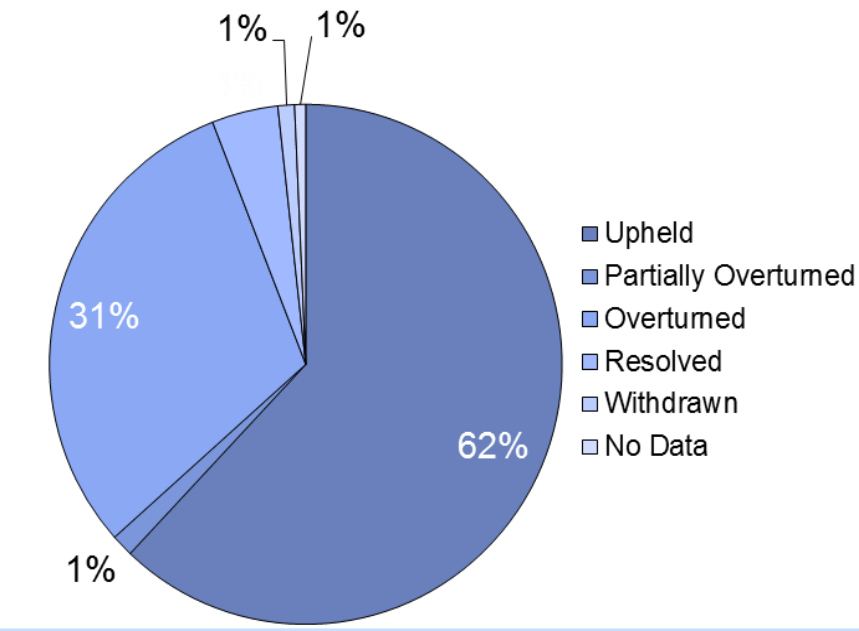
- 5,058 approved
- 570 partially approved or resolved
- 6,689 denied or dismissed
- 215 withdrawn



Number of external reviews*

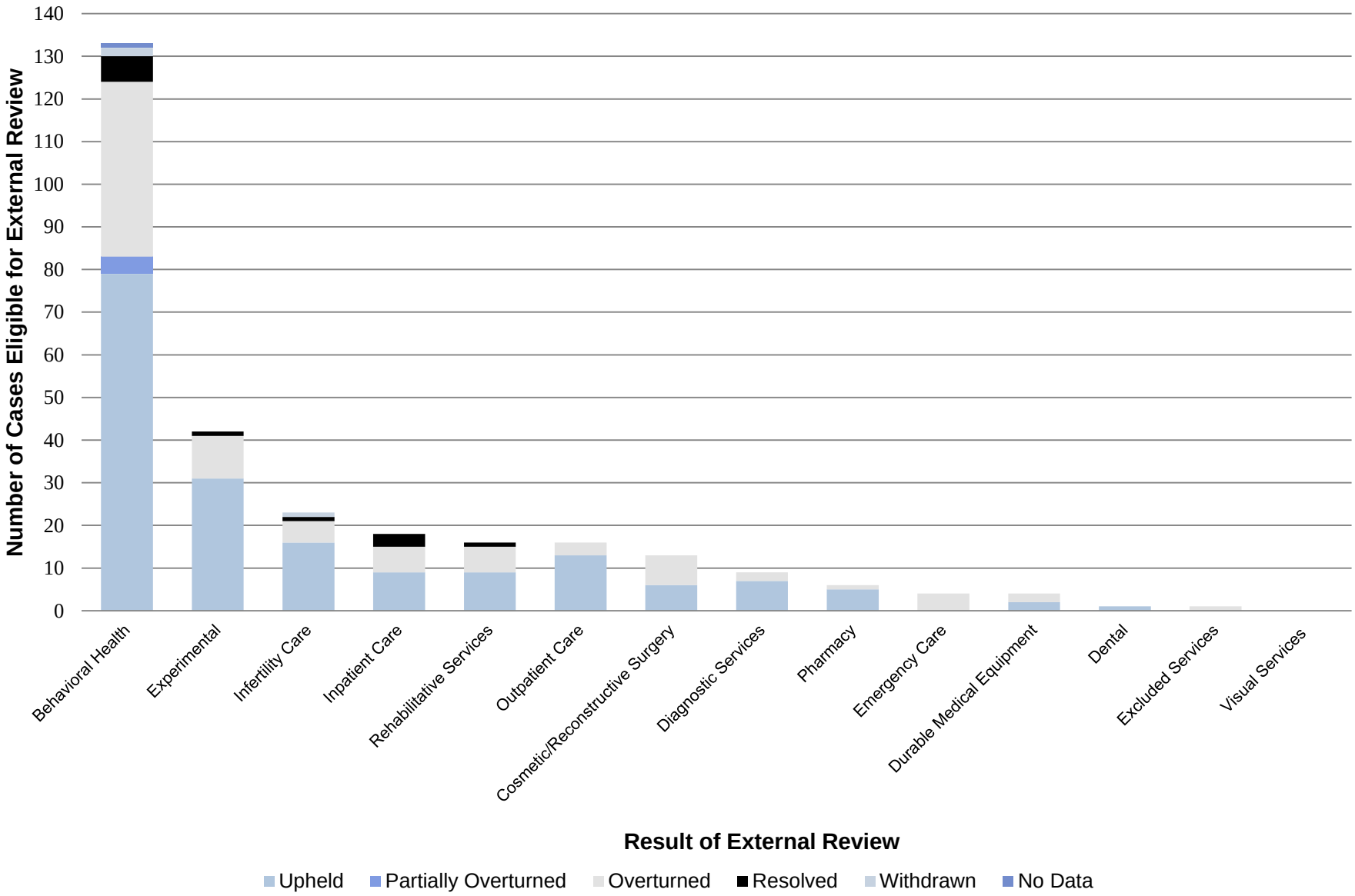
387 total requests for external review
- 287 eligible
- 100 ineligible

2012 Results for 287 eligible cases:
- 178 upheld
- 88 overturned
- 4 partially overturned
- 12 resolved
- 3 withdrawn
- 2 no data

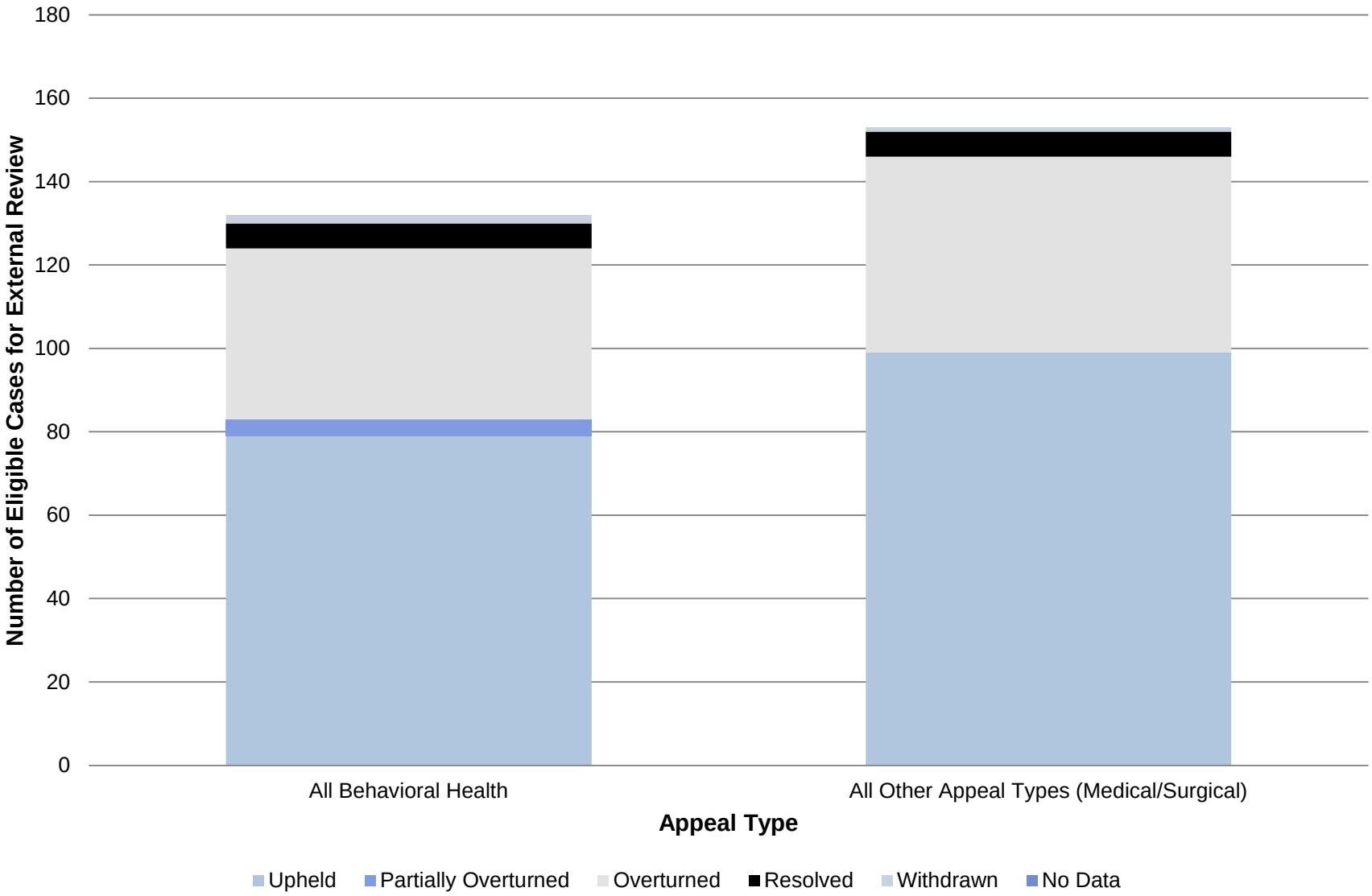


* Data as reported by carriers to OPP

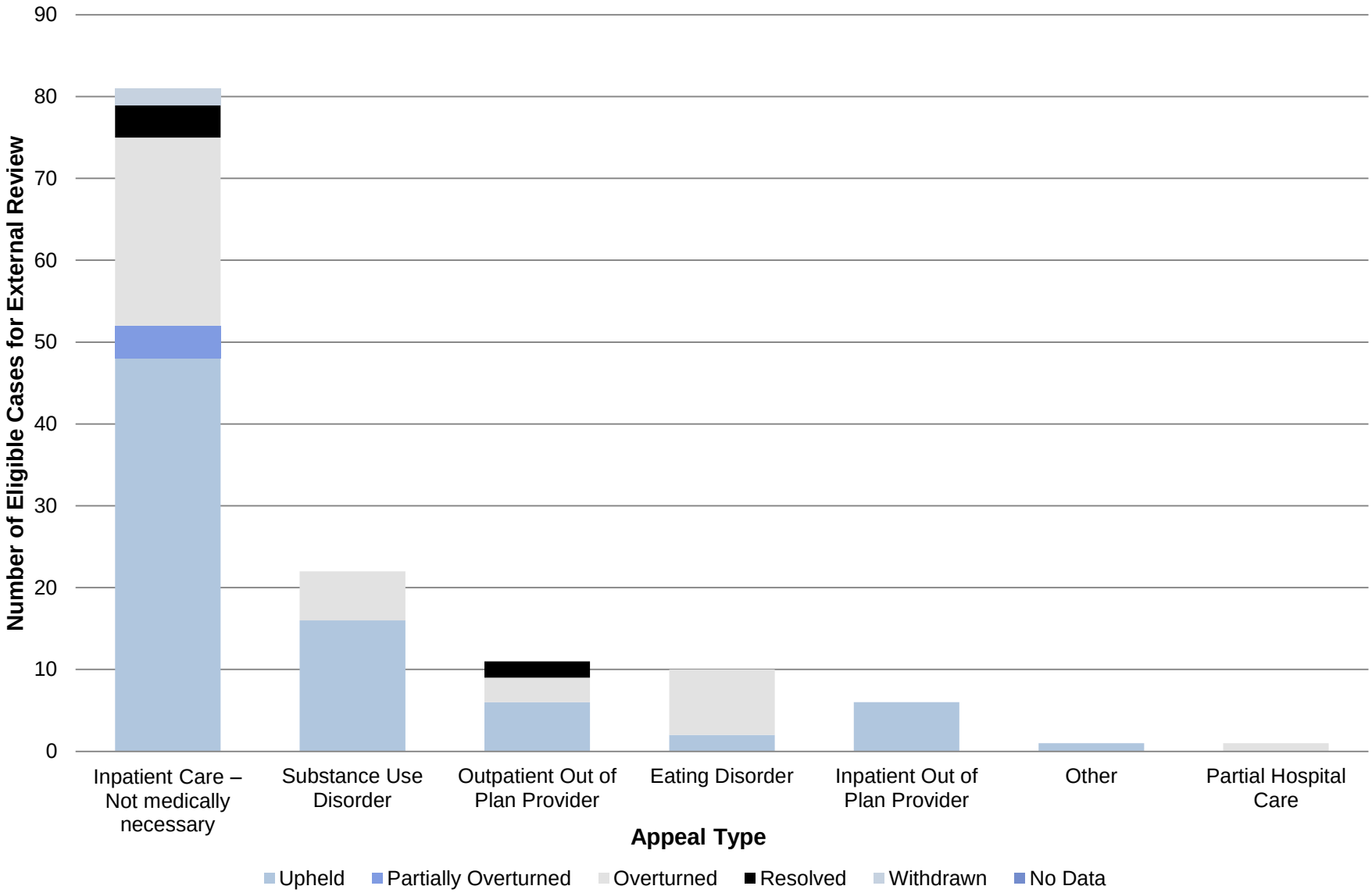
2012 Disposition of Cases Eligible for External Review



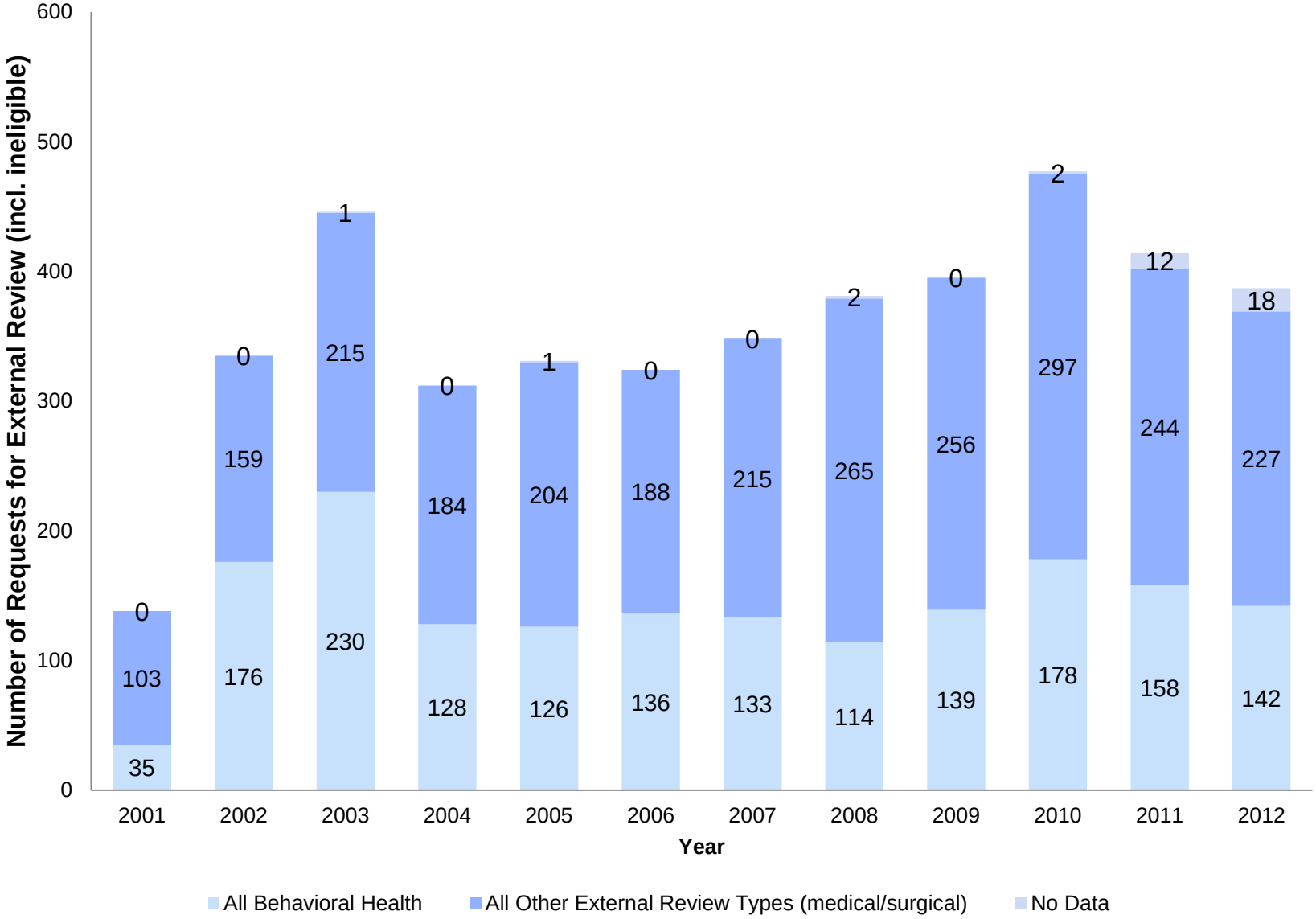
Comparison of 2012 Eligible External Reviews for Behavioral Health and All Other Appeal Types



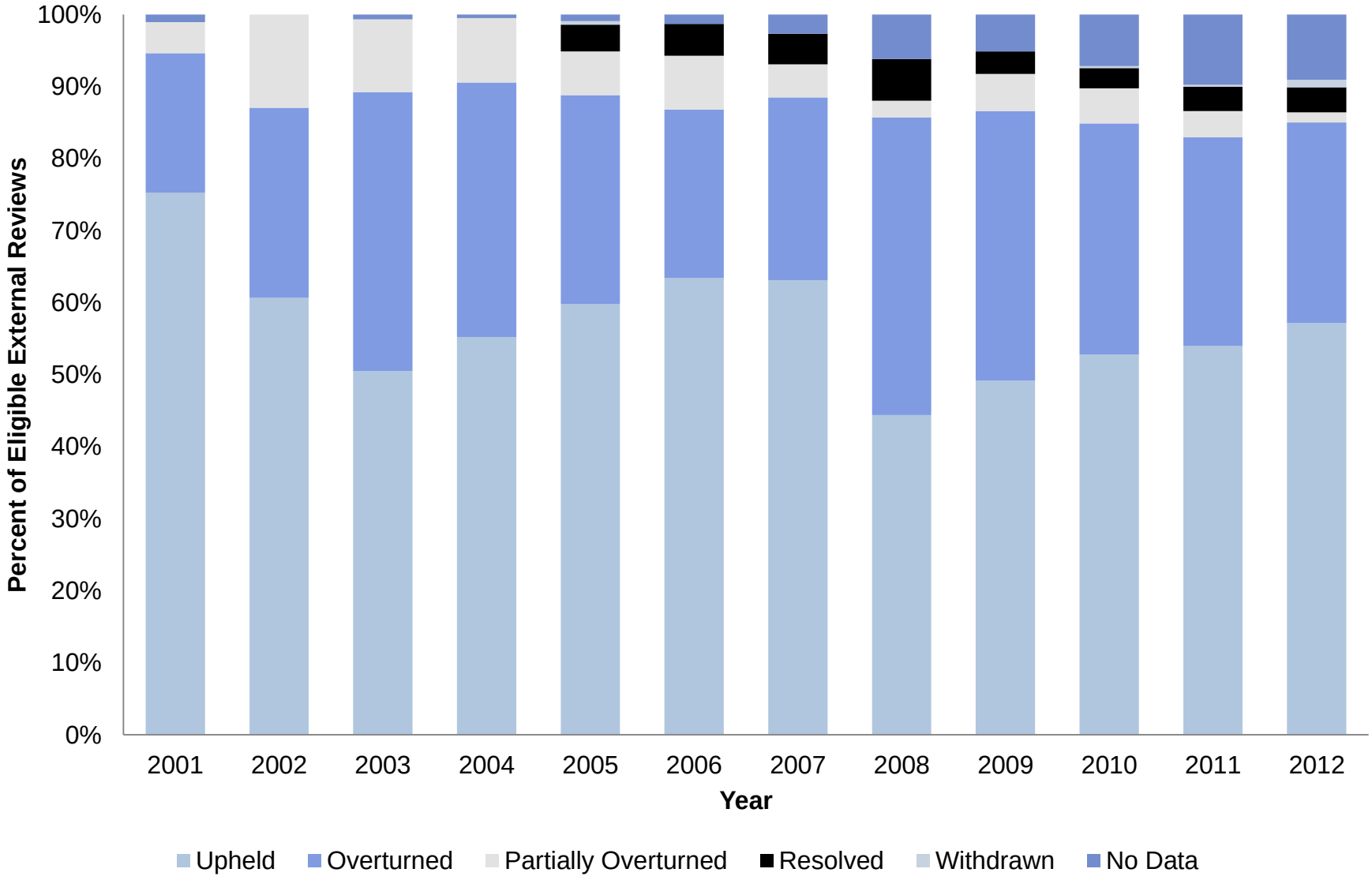
2012 Disposition of Behavioral Health Cases Eligible for External Review (by type of treatment or service)



2001-2012 External Review Requests:
Comparison of behavioral health with medical/surgical



Percent Outcomes of *Eligible* External Reviews, 2001-2012



Agenda

- Approval of Minutes from July 25, 2013 Meeting
- Executive Director Report
- Community Health Care Investment and Consumer Involvement
- Care Delivery and Payment System Reform
- Quality Improvement and Patient Protection
- **Cost Trends and Market Performance**
  - Update on Material Change Notices
  - Update on Annual Cost Trends Hearing (October)
- Schedule of Next Commission Meeting

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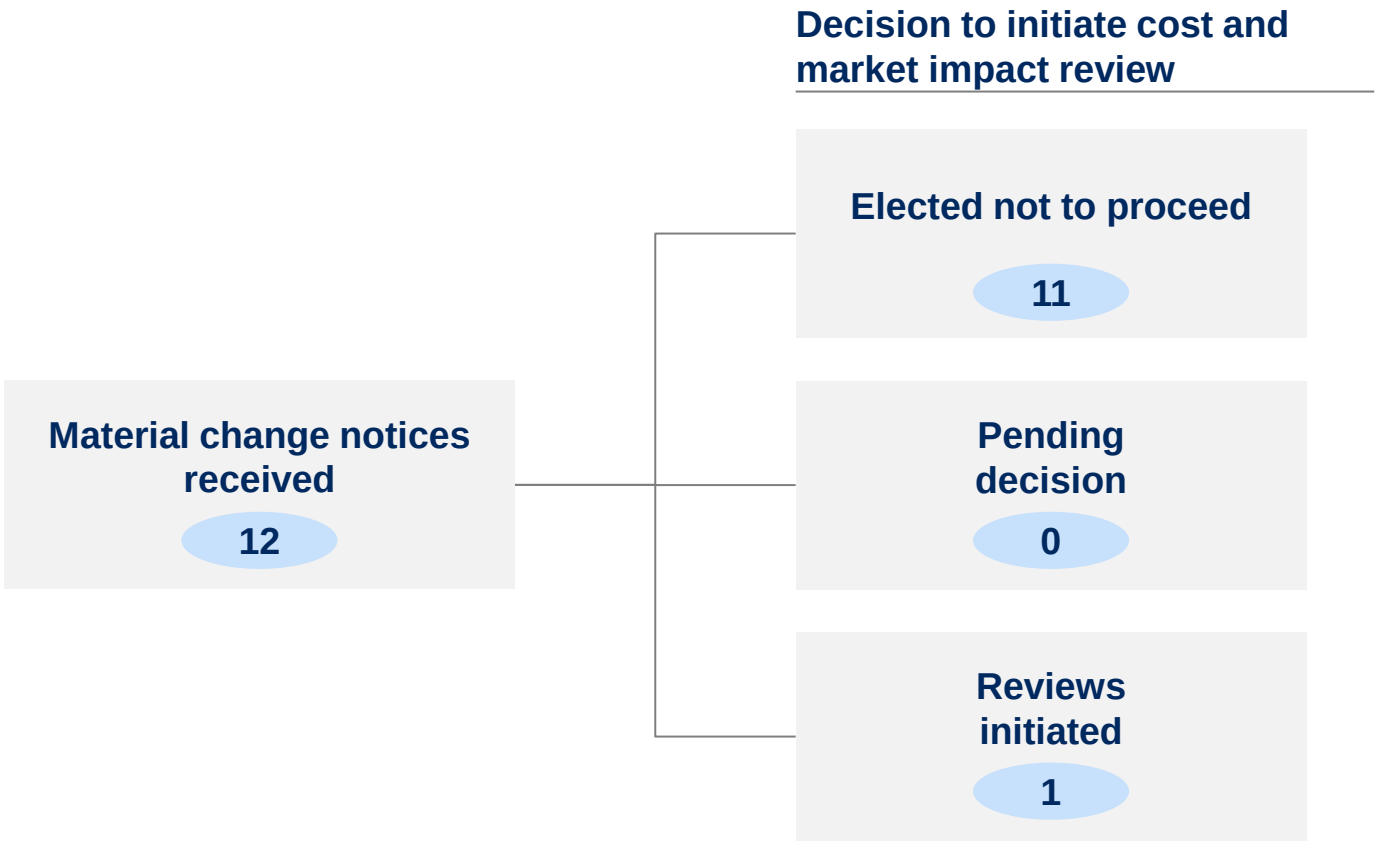
Amendment to M.G.L. 6D sec. 13

The commission shall issue its final report on the cost and market impact review within 185 days from the date that the provider or provider organization has submitted notice to the commission; provided that the provider or provider organization has certified substantial compliance with the commission's requests for data and information pursuant to subsection (c) within 21 days of the commission's notice, or by a later date set by mutual agreement of the provider or provider organization and the commission.

New timeline for completion of cost and market impact reviews

Notices received and reviews initiated

2013 YTD



Update on notices

Elected not to proceed since last Commission meeting

Description

- Acquisition of Jordan Hospital (Jordan) by Beth Israel Deaconess Medical Center (BIDMC), including corresponding clinical affiliations between Jordan and the Harvard Medical Faculty Physicians at BIDMC and between Jordan and Atrius Health.
- Network affiliations between Beth Israel Deaconess Care Organization (BIDCO) and Jordan and its affiliated physicians, and between BIDCO and Cambridge Health Alliance and its affiliated physicians.
- Change in ownership of Metrowest Medical Center and Saint Vincent Hospital.
- Acquisition of Visiting Nurse Association of Boston Foundation by Atrius Health's VNA Care Network Foundation.
- Network affiliation between New England Quality Care Alliance and Healthcare South.

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Annual Cost Trends Hearings – Legislative Mandate

Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center for health information and analysis under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system.

G.L. Chapter 6D, Section 8

SOURCE: Mass. General Laws

Objectives for the annual cost trends hearing

- Discuss stakeholders' observations of performance against the cost growth target
- Engage experts and witnesses to discuss particular challenges and opportunities in the Commonwealth
- Identify innovations that can work in the Commonwealth to help drive the HPC's core objectives
- Examine experience of stakeholders to inform the annual cost trends report

Witnesses testify under oath and are subject to questioning by the HPC, CHIA, and AGO

Witnesses to be called by statute

- At least 3 academic medical centers
- At least 3 disproportionate share hospitals
- Community hospitals from at least 3 separate regions of the commonwealth
- Freestanding ambulatory surgical centers from at least 3 separate regions of the commonwealth
- Community health centers from at least 3 separate regions of the commonwealth
- The 5 private health care payers with the highest enrollments in the commonwealth
- Any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program
- The group insurance commission
- At least 3 municipalities that have adopted chapter 32B
- At least 4 provider organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which has been certified as a model ACO, which shall be from diverse geographic regions of the commonwealth
- Any witness identified by the attorney general or the center

Topics to be covered by statute, including but not limited to…

- Payment systems
- Care delivery models
- Payer mix
- Factors underlying premium cost and rate increases
- Relation of reserves to premium costs
- Cost structures
- Utilization trends
- Reserve levels
- Quality improvement and care-coordination strategies
- Investments in health information technology
- Efforts to improve the efficiency of the delivery system
- Efforts to reduce the inappropriate or duplicative use of technology
- Efforts by the payer to increase consumer access to health care information
- Efforts by the payer to reduce the use of fee-for-service payment mechanisms

Overview of pre-filed testimony

- In order to meet our statutory requirements, and be consistent with past practice, the HPC, AGO, and CHIA sent written testimony questions to a representative sample of health care providers and payers.
- Selection process included a review of past respondents and input from Commissioners, the HPC Advisory Council, CHIA, and the AGO, as well as a consideration of size, geographic diversity, and unique market position.
  - 40 providers identified, including hospitals, community health centers, behavioral health providers, long-term care facilities, home care providers, ambulatory surgery centers, and physician organizations.
  - 12 payers identified, including non-profit and for-profit payers, and Medicaid managed care organizations.
  - 3 communities identified that have entered the Group Insurance Commission.
- A selection of these witnesses will also be called to provide in-person testimony at the hearings and answer direct questions from the Commissioners.

Topics covered in pre-filed testimony questions

- Providers and payers identified through this process have been asked to submit written responses to a number of questions. Questions may require narrative responses as well as data requests.
- Questions were selected based on a review of past inquiries and input from Commissioners, the Advisory Council, CHIA, and the AGO. A key consideration in developing the questions was minimizing the administrative burden on identified witnesses, while maximizing the value of the information collected.

Topics included in provider questions

- Reaction to the passage of chapter 224 of the acts of 2012, including the establishment of a health care cost growth benchmark
- Quality improvement and care coordination opportunities
- Provider price trends
- Behavioral health integration
- Adoption of alternative payment models
- Operational cost structure
- Consumer transparency
- Operating margin trends
- Risk contracting practices
- Population health management
- Health and wellness programs

Topics included in payer questions

- Reaction to the passage of chapter 224 of the acts of 2012, including the establishment of a health care cost growth benchmark
- Factors underlying premium cost and rate increases
- Quality improvement and care coordination opportunities
- Provider price trends
- Adoption of alternative payment models
- PCP attribution
- Member engagement on price and quality
- Impact of material changes on spending trends
- Consumer transparency
- Medical expenditure trends through Q1 of 2013
- Membership trends by product line
- Risk contracting practices
- Tiered and limited network products
- Health and wellness programs

Selection of witness panels

- A selection of witnesses (15-20) will be called to provide in-person testimony at the hearings and answer direct questions from the Commissioners. In addition, these witnesses will be asked to provide supplemental written testimony related to the topic of the panel. Invitations will be sent imminently.
- The witness selection process included input from Commissioners, a review of past witnesses, input from the HPC Advisory Council, input from CHIA, and input from the Attorney General's Office, as well as a consideration of size, geographic location, organization type, governance structure, and market position. A total of 55 organizations will be submitting pre-filed written testimony.

Cost trends hearing agenda

Day One

10/1

9:00 – 10:00AM	▪ Welcome and opening remarks
10:00 – 10:45AM	▪ CHIA presentation on health care access and cost trends in MA
10:45 – 11:00AM	▪ *Break*
11:00 – 11:30AM	▪ **Expert Presentation** (TBD)
11:30 – 1:00PM	▪ **Witness Panel:** Achieving sustainable statewide health care cost growth in MA – are we on track?
1:00 – 2:00PM	▪ *Lunch*
2:00 – 2:30PM	▪ **Expert Presentation** (K. Feinstein)
2:30 – 4:00PM	▪ **Witness Panel**: Advancing efficient, high-quality care through a more coordinated and accountable delivery system
4:00 – 4:30PM	▪ **Public Testimony**
4:30 – 5:00PM	▪ **Closing Remarks**

Day Two

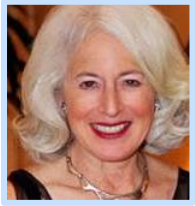
10/2

9:00 – 10:00AM	▪ Welcome and opening remarks
10:00 – 10:45AM	▪ AGO presentation on market structure and trends in MA
10:45 – 11:00AM	▪ *Break*
11:00 – 11:30PM	▪ **Expert Presentation** (P. Ginsburg)
11:30 – 1:00PM	▪ **Witness Panel:** Evaluating market structure and its impact on cost, quality and access
1:00 – 2:00PM	▪ *Lunch*
2:00 – 2:30PM	▪ **Expert Presentation** (S. Delblanco)
2:30 – 4:00PM	▪ **Witness Panel:** Empowering purchasers through greater transparency, information, incentives, and choice
4:00 – 4:30PM	▪ **Public Testimony**
4:30 - 5:00PM	▪ **Closing Remarks**

Confirmed expert speakers for cost trends hearing panels

Paul B. Ginsburg, Ph.D.
President, Center for Studying Health System Change (HSC)

- The non-partisan HSC informs policy makers and private decision makers about how local and national changes in the financing and delivery of health care affect people.
- Nationally recognized economist and health policy expert whose recent research topics include cost trends and drivers, Medicare provider payment policy and health care markets
- Founding executive director of the Medicare Payment Advisory Commission (MedPAC); formerly worked at RAND and as deputy assistant director of the Congressional Budget Office
- Ph.D., Economics, Harvard University



Karen Wolk Feinstein, Ph.D.

President & CEO
Jewish Healthcare Foundation,
Pittsburgh Regional Health
Initiative, Health Careers Futures

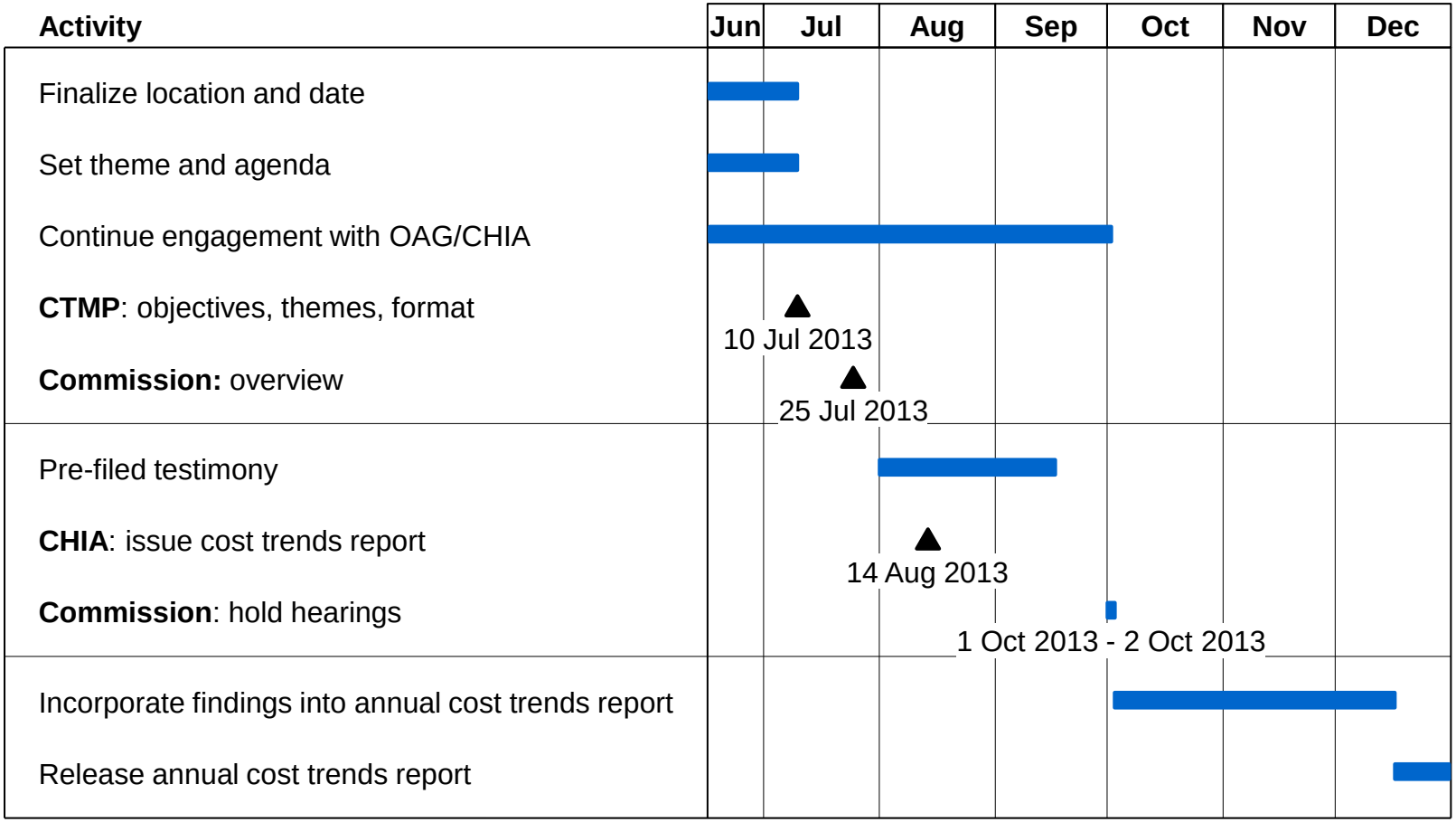
- Founder of Pittsburgh Regional Health Initiative, among the nation's first regional multi-stakeholder quality coalitions devoted to advancing efficiency, best practices and safety in health care
- National leader in health care quality improvement; author of numerous regional and national publications on quality and safety; previously served as editor of the Urban & Social Change Review
- Ph.D., Social Welfare Policies & Economics, Brandeis University
- MSW, Boston College

Suzanne F. Delbanco, Ph.D.

Executive Director
Catalyst for Payment Reform (CPR)

- CPR is a non-profit organization working for coordinated action among the largest purchasers of health care and health plans
- Founding CEO of The Leapfrog Group
- Ph.D., Public Policy, Goldman School of Policy
- M.P.H., School of Public Health, University of California, Berkeley

Timeline for cost trends hearing



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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