Health Policy Commission

Board Meeting

April 16, 2014

Agenda

- Approval of Minutes from March 5, 2014 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Administration and Finance Update
- Schedule of Next Commission Meeting

Agenda

- **Approval of Minutes from March 5, 2014 Meeting**
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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on March 5, 2014, as presented.

Agenda

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Upcoming Meetings

Tuesday, April 29, 2014
Cost Trends and Market Performance (CTMP) Committee
9:30 AM
Two Boylston Street, Daley Room, 5th Floor, Boston, MA

Thursday, May 22, 2014
Health Policy Commission (HPC) Board Meeting
2:00 PM
Gardner Auditorium, State House, Boston, MA

Wednesday, June 4, 2014
Community Health Care Investment and Consumer Involvement (CHICI) Committee
9:30 AM
Two Boylston Street, Daley Room, 5th Floor, Boston, MA

Cost Trends and Market Performance (CTMP) Committee
11:00 AM
Two Boylston Street, Daley Room, 5th Floor, Boston, MA

Wednesday, June 11, 2014
Quality Improvement and Patient Protection (QIPP) Committee
9:30 AM
Two Boylston Street, Daley Room, 5th Floor, Boston, MA

Care Delivery and Payment System Reform (CDPSR) Committee
11:00 AM
Two Boylston Street, Daley Room, 5th Floor, Boston, MA

2014 Expected Activities at the HPC

Q1

• CMIR Report: PHS/SSH/Harbor	✓
• Final OPP Regulation	✓
• Health Care Cost Growth Benchmark for 2015	✓
• PCMH Certification Standards	In Development
• CHART Phase 2 Framework	In Development
• Behavioral Health Agenda	✓

Q2

• CMIR Preliminary Report: Lahey/Winchester	✓
• CHART Phase 2 RFP	In Development
• Material Change Notices (MCN) Regulation Development	
• Final PCMH Program Framework	
• APCD Almanac Publication w/CHIA	
• CMIR Final Report: Lahey/Winchester	

Q3

- Final RPO Regulation
- Proposed MCN Regulation
- Summer Supplemental Cost Trends Report
- PCMH Demonstration Program Launch
- Planning for Annual Cost Trends Hearing
- CMIR Report: PHS/Hallmark

Agenda

- Approval of Minutes from March 5, 2014 Meeting
- Executive Director Report
- **Care Delivery and Payment System Transformation**
  - Patient-Centered Medical Home (PCMH) Certification Program
- Quality Improvement and Patient Protection
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Administration and Finance Update
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- Approval of Minutes from March 5, 2014 Meeting
- Executive Director Report
- Care Delivery and Payment System Transformation
  - **Patient-Centered Medical Home (PCMH) Certification Program**
- Quality Improvement and Patient Protection
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Overview of feedback from public comment period/listening session

- Public comment period: March 5, 2014 – April 4, 2014
  - Listening session: March 18, 2014

- Participation: 38 organizations (physician groups, health plans, stakeholder organizations) provided feedback

- Program design:
  - Address suggestions regarding placement of criteria within each tier
  - Streamline certification process
  - Focus on community integration
  - Focus on performance and transparency for validation
  - Consider a simplified approach for third party certification
  - Consider expanding pilot size
  - Clarify criteria used to select practices for the demonstration
  - Incorporate flexibility into program design to accommodate practices of varying sizes, specialties, and geographic locations

Overview of feedback from public comment period/listening session

- Measurement:
  - Engage stakeholders
  - Consider CAHPS and MHQP to measure patient experience
  - Use uniform clinical quality measures and a standardized reporting framework
  - Focus on outcomes, not process, measures

- Payer engagement:
  - Questions about payer involvement and roles
  - Considerations around enhanced payment

- Stakeholder involvement:
  - Continue to involve stakeholders throughout process, especially around measurement and validation

Certification requirements: measurement and validation

- Considerations around measurement
  - Process vs. outcomes measures
  - Alignment with other programs (e.g., Meaningful Use, SQAC, CHIPRA, PCPR)
  - Reporting considerations

- Strategies for validation and measurement
  - Focus on high value elements
  - Framework for linking criteria, validation, and measures

Examples of HPC PCMH certification requirements

Proposed Standard	Proposed Criteria	Proposed Definition	Proposed Validation Requirement
Care coordination	Identify high-priority conditions	The practice identifies high-priority conditions for their patient populations, including conditions (e.g., obesity) related to unhealthy behaviors or a mental health or substance use condition.	1. Written definition of high-risk patients. 2. Methodology used to identify high-risk patients. 3. Copy of risk stratification for at-risk, high-risk and complex care patients from at least the past three months for selected clinical focus areas (numerator and denominator for selected clinical focus areas).
Enhanced access & communication	Optimize timely access to appropriate services	Patients have access to appropriate routine/urgent care and clinical advice during and outside of usual office hours, as appropriate to the patient needs and preferences, with the option of enhanced modes of care communication, including telephonic and electronic access (e.g., secure messaging via email).	1. Copy of the practice's written plan for access and patient communications. 2. Reports of five separate patient visit days within the past month showing same-day access and response times, compared with practice policy. 3. Five examples within the past month of after-hours access to clinical advice in patient records. 4. Report with frequency of non-traditional encounters over the past month.
Resource stewardship	Tracking over and under-utilization	The practice monitors over-utilization of high cost clinical services (e.g. emergency department visits, MRI testing, etc.) and under-utilization of appropriate services (e.g. age-appropriate immunizations and implementation of effective preventive care guidelines) through a quality improvement strategy and process that includes regular review and evaluation of performance data as well as HEDIS results and external quality reporting data.	1. Process/procedure for monitoring over-utilization ***and*** under-utilization of services, including a description of the practice's QI strategy and implementation that specifically addresses both over and under-utilization. 2. Report showing results of monitoring and QI for over and under-utilization for at least the past six months.

Next steps (April – July 2014)

- Revise criteria for PCMH certification based on feedback and public comment
  - Consider two levels of certification
  - Consider approach to third party recognition
  - Continued engagement with technical advisors to inform criteria
- Propose measures and validation tools for criteria for stakeholder engagement and public comment
- Continue to work with payers, purchasers, and providers to share goals on HPC approach for primary care transformation

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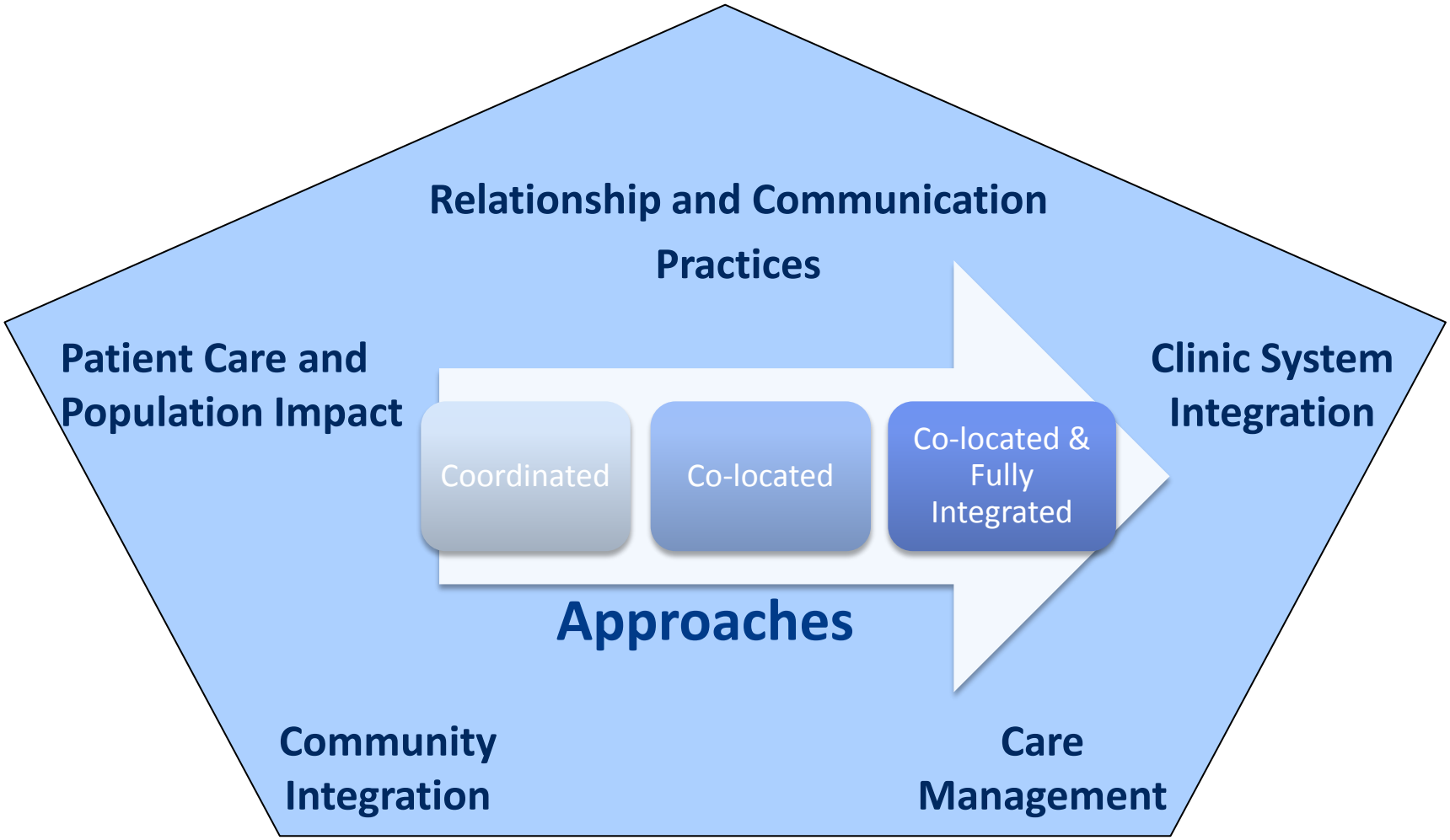
Joint committee meeting on behavioral health integration

- QIPP and CDPST convened a joint meeting on April 9, 2014
  - Purpose of the meeting was to further discuss BH integration and inform HPC's BH agenda

- Presentation by Judith Steinberg, MD, MPH and Alexander Blount, EdD of UMass Medical School
  - Provided background on national, regional, and state-based efforts
  - Described BH integration elements (e.g., community integration, care management) and approaches (e.g., coordinated, co-located, co-located and fully integrated)
  - Outlined challenges to integrating BH and PC (e.g., reimbursement issues, training needs for PC and BH providers, barriers to accessing treatment)
  - Reviewed taskforce recommendations

- Presentation by Nancy Paull, CEO of Stanley Street Treatment and Resources (SSTAR)
  - Provided an overview of a non-profit health care and social service agency's comprehensive efforts to integrate primary care and behavioral health

Behavioral health integration: approaches and elements



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- **Cost Trends and Market Performance**
  - Material Change Notices (MCN)
  - Preliminary Report on Cost and Market Impact Review
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Frequency
Physician group affiliation or acquisition	31%
Acute hospital acquisition	23%
Clinical affiliation	19%
Acquisition of post-acute provider	12%
Change in ownership or merger of owned entities	12%
Formation of contracting entity	5%

Pending Notices

Notices pending decision

Description
Acquisition of Wing Memorial Hospital by Baystate Medical Center
Clinical affiliation between Dana-Farber Cancer Institute and St. Elizabeth's Medical Center
Clinical affiliation between Beth Israel Deaconess Medical Center (BIDMC) and New England Baptist Hospital
Merger of Steward Merrimack Valley Hospital into Steward Holy Family Hospital

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Overview of cost and market impact reviews

- Provider changes, including consolidations and alignments, have been shown to impact health care system performance and total medical spending
- Chapter 224 directs the HPC to track “material change[s] to [the] operations or governance structure” of provider organizations and to engage in a more comprehensive review of transactions anticipated to have a significant impact on health care costs or market functioning
- CMIRs promote transparency and accountability in engaging in market changes, and encourage market participants to minimize negative impacts and enhance positive outcomes of any given material change

Process for cost and market impact reviews

Inputs

- Data and documents:
  - Parties' production
  - Publicly available information
  - Data from payers, providers, and other market stakeholders
- Support from expert consultants
- Feedback from Commissioners
- Information gathered is exempted from public records law, but the HPC may engage in a balancing test and disclose information in a CMIR report

Outputs

- Issuance of a preliminary report with factual findings
- Feedback from parties and other market participants
- Final report issued 30 or more days after preliminary report
- Proposed change may be completed 30 or more days after issuance of final report
- Potential referral to Massachusetts Attorney General's Office

Description of the parties

Lahey Health System

- Founded in May 2012 through the merger of Lahey Clinic and Northeast Health System
- Lahey has the following general acute care hospitals:
  - Lahey Hospital and Medical Center in Burlington and Peabody (LHMC) (327 beds)
  - Beverly Hospital in Beverly (223 beds)
  - Addison Gilbert Hospital in Gloucester (79 beds)
- Lahey also owns non-acute operations:
  - BayRidge Hospital in Lynn (psychiatric, 62 beds)
  - Two outpatient centers in Danvers and Lexington
  - Lahey Behavioral Health Services and Lahey Health Senior Care

Winchester Hospital

- Not-for-profit community hospital in Winchester, MA (189 beds)
- 21 satellites, including an ambulatory surgery center, endoscopy center, new outpatient center, home health, and outpatient imaging services
- Clinical Affiliations with Tufts MC, BIDMC, Children's, and McLean
- Owns Winchester Physician Associates (WPA): ~85 employed physicians (50 PCPs)
  - WPA is a member of Highland IPA (Highland), which is a member of NEQCA
  - For many payers, including BCBS and HPHC, WPA/Highland contract through NEQCA; for some smaller payers, Highland contracts directly with payers on behalf of WPA

Source: Lahey and Winchester Financial Statements

Overview of Lahey – Winchester transaction

Lahey – Winchester

- On Sept. 27, 2013, Lahey and Winchester executed an Affiliation Agreement for Winchester to become a fully-integrated, community-based member of Lahey Health System
- The agreement includes a one-time $35M investment for health information technology and a five-year capital commitment

Goal of Transaction

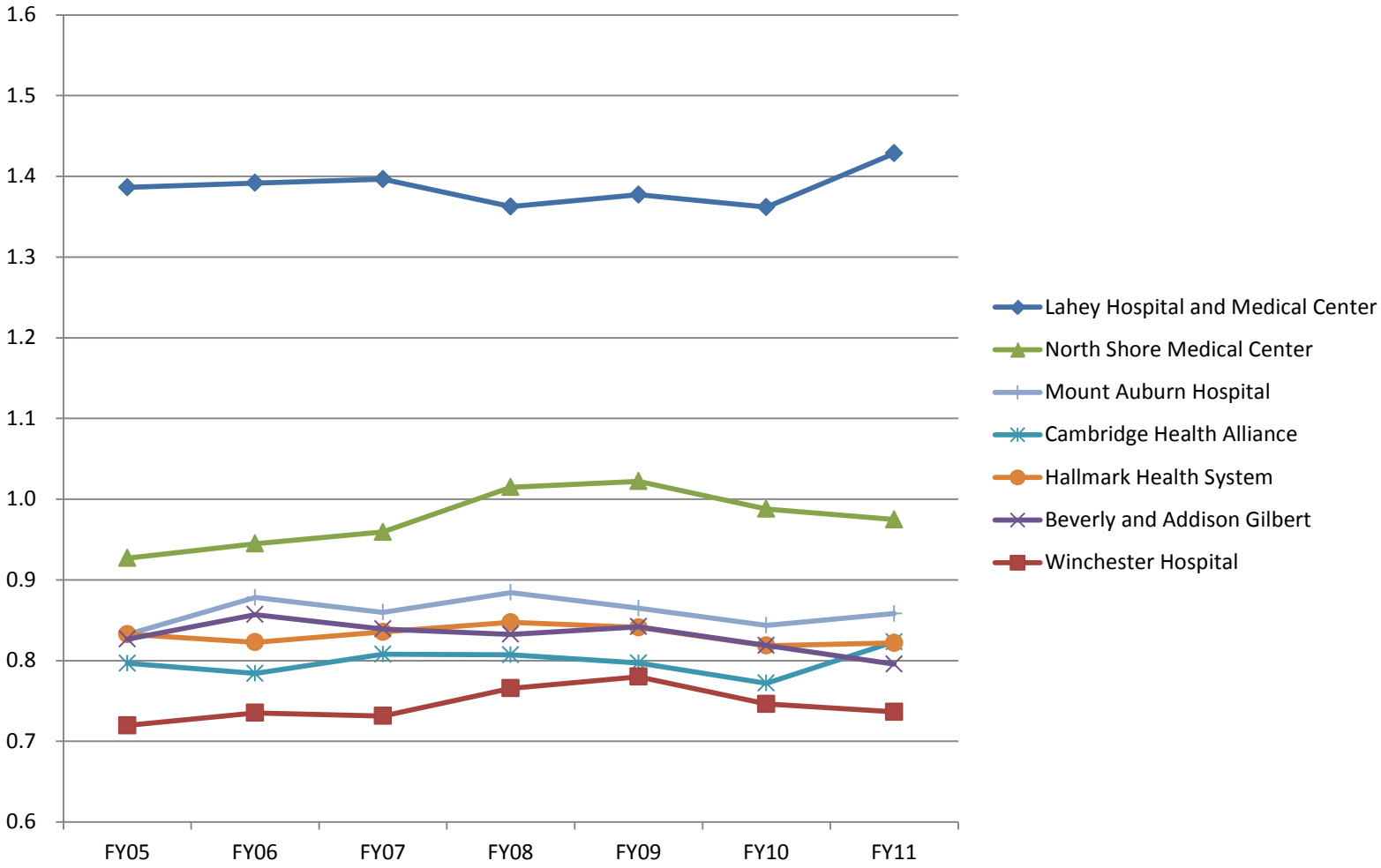
- To create an independent health care system north of Boston able to provide "locally based, high quality clinical services . . . in lower cost community settings."

Source: Application by Winchester Hospital for Determination of Need under 105 C.M.R. 100.600-603 for Change of Ownership of Winchester Hospital (Oct. 25, 2013).

Lahey Hospital & Medical Center provides a tertiary mix of services

Case mix index (CMI) for LHMC compared to area hospitals

2005-2011



Source: CHIA Acute Hospital Case Mix Adjusted Discharges, 2005-2011

Structuring an impact review

	Baseline Review	Impact Analysis
Costs	✓	✓
Quality and Care Delivery	✓	✓
Access	✓	✓

Structuring an impact review

	Baseline Review	Impact Analysis
Costs	✓	
Quality and Care Delivery		
Access		

Cost and financial metrics examined

- Financial ratios
- Relative prices
- Total medical expenses
- Market share

Lahey and Winchester are in strong financial condition

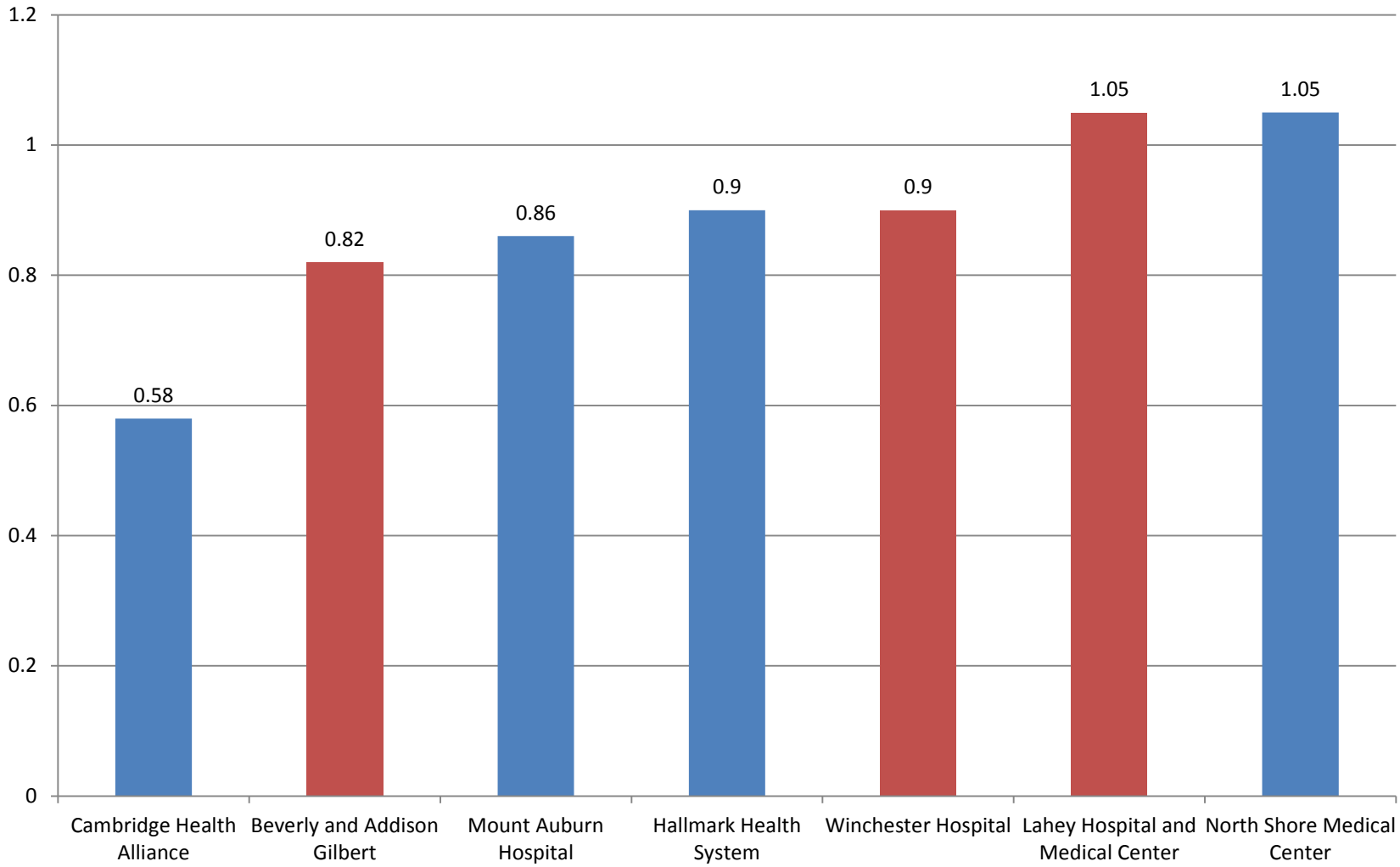
- Lahey is the fifth largest provider system in MA by net patient service revenue
- Lahey's operating margin has averaged 3.2% over the last three years, higher than that of the larger MA provider systems
- Winchester's operating margin has averaged a stable 2% over the last three years; its total net assets are higher than those of some area community hospitals, but lower than others

Source: Lahey and Winchester Financial Statements

Lahey and Winchester are medium priced compared to area hospitals

Relative prices for Lahey hospitals and Winchester Hospital compared to area hospitals

HPHC 2012

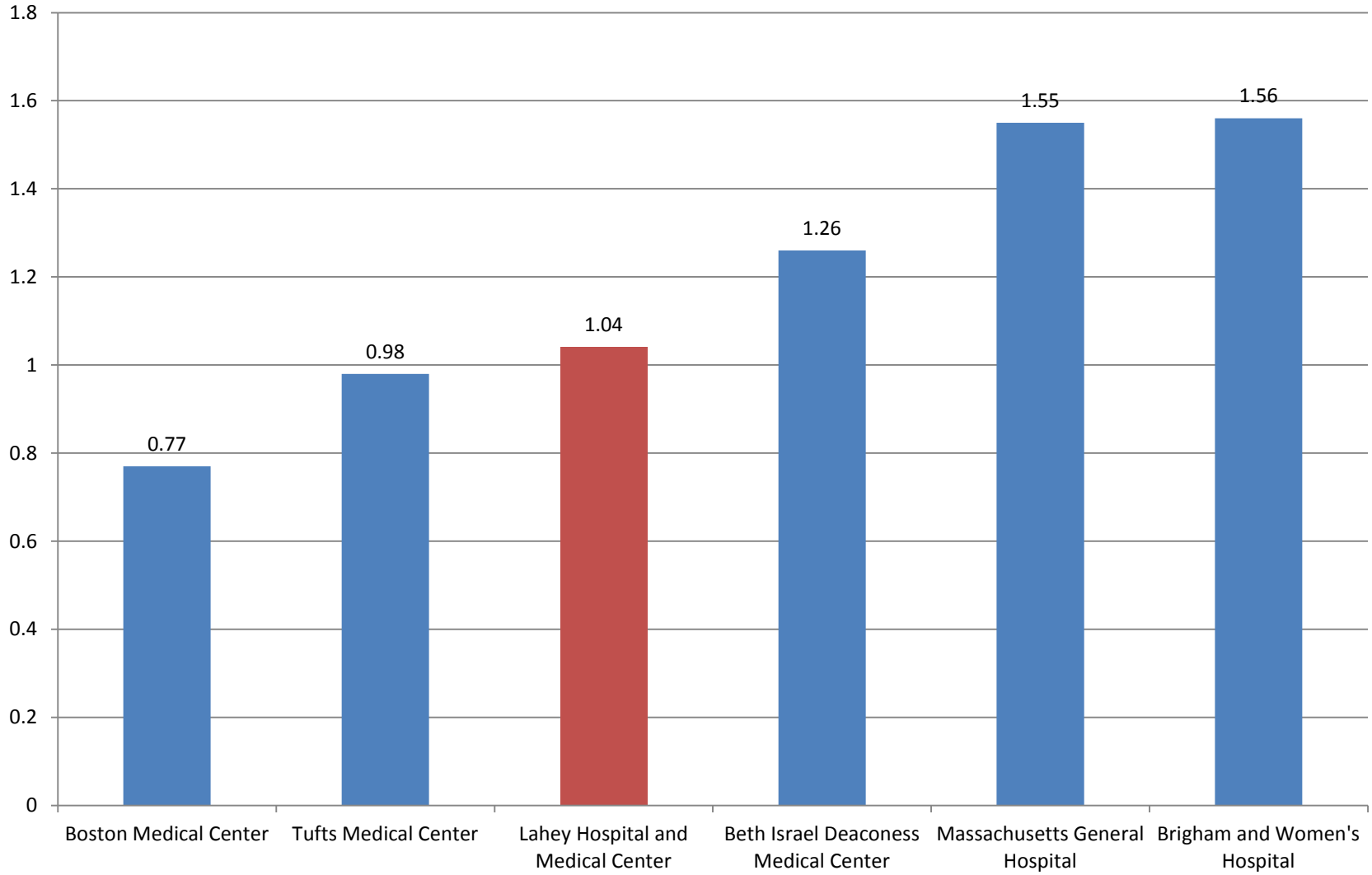


Source: CHIA *2012 Relative Prices, APM, and TME by Payer Databook*

LHMC is low to medium priced compared to Boston AMCs

Relative prices for LHMC compared to Boston AMCs

THP 2012

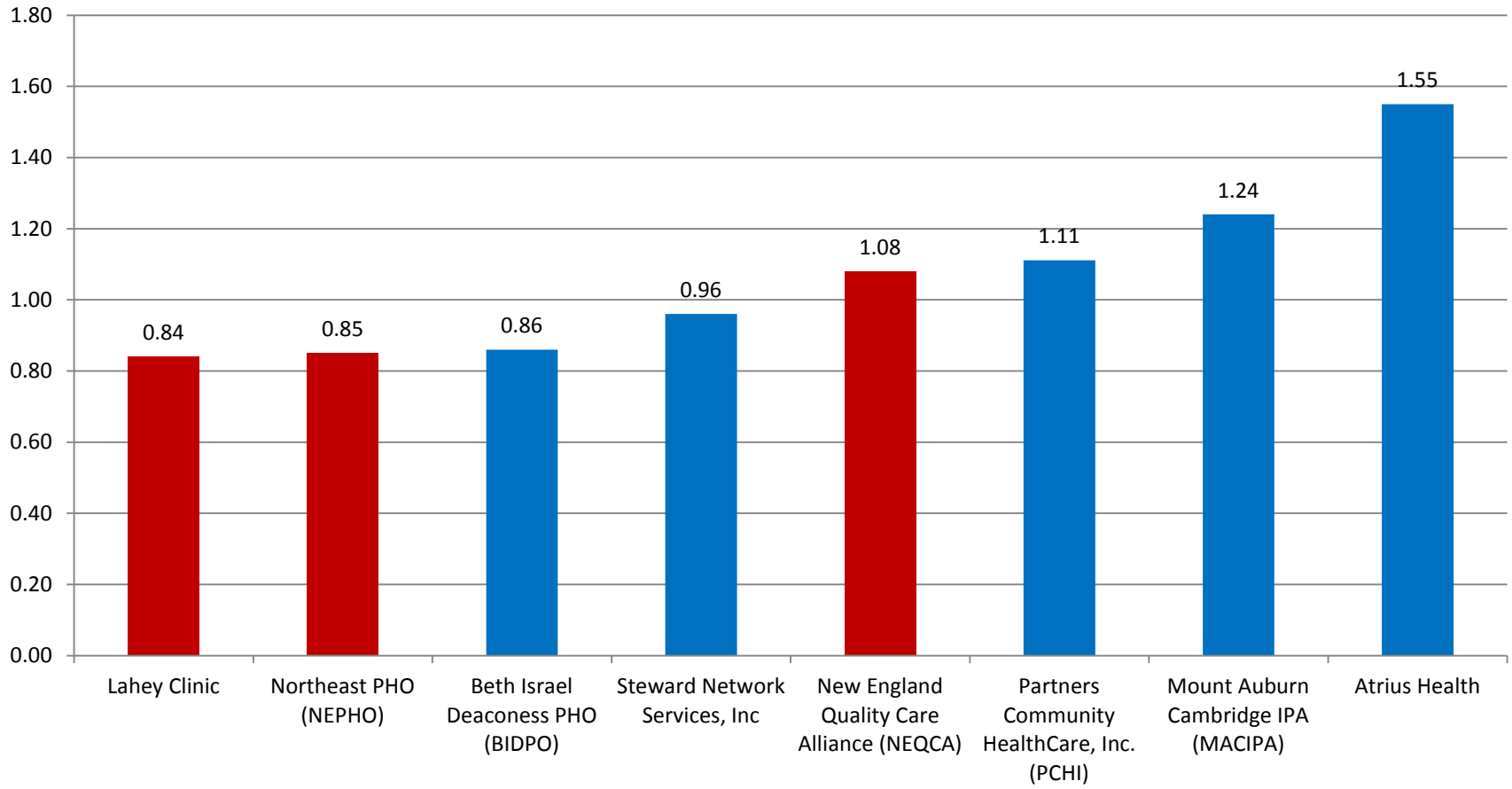


Source: CHIA *2012 Relative Prices, APM, and TME by Payer Databook*

WPA receives higher physician prices than Lahey for the largest payer

Relative prices for WPA (a member of NEQCA) compared to area physician groups

BCBS 2011

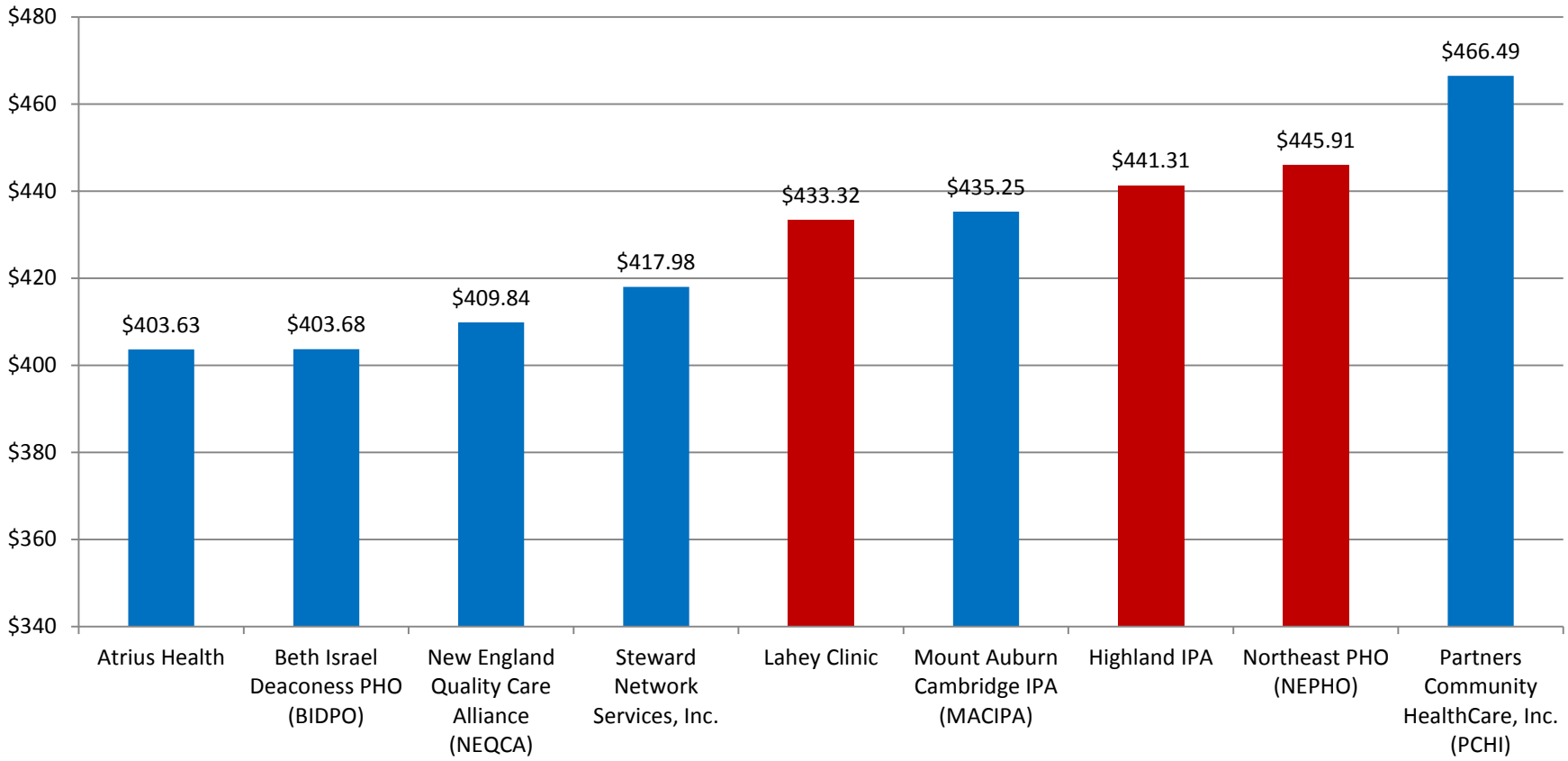


Source: CHIA *2012 Relative Prices, APM, and TME by Payer Databook*

Lahey Clinic's TME is usually lower than NEPHO's and WPA's

Health status adjusted TME of Lahey, NEPHO & WPA compared to area provider groups

THP 2012

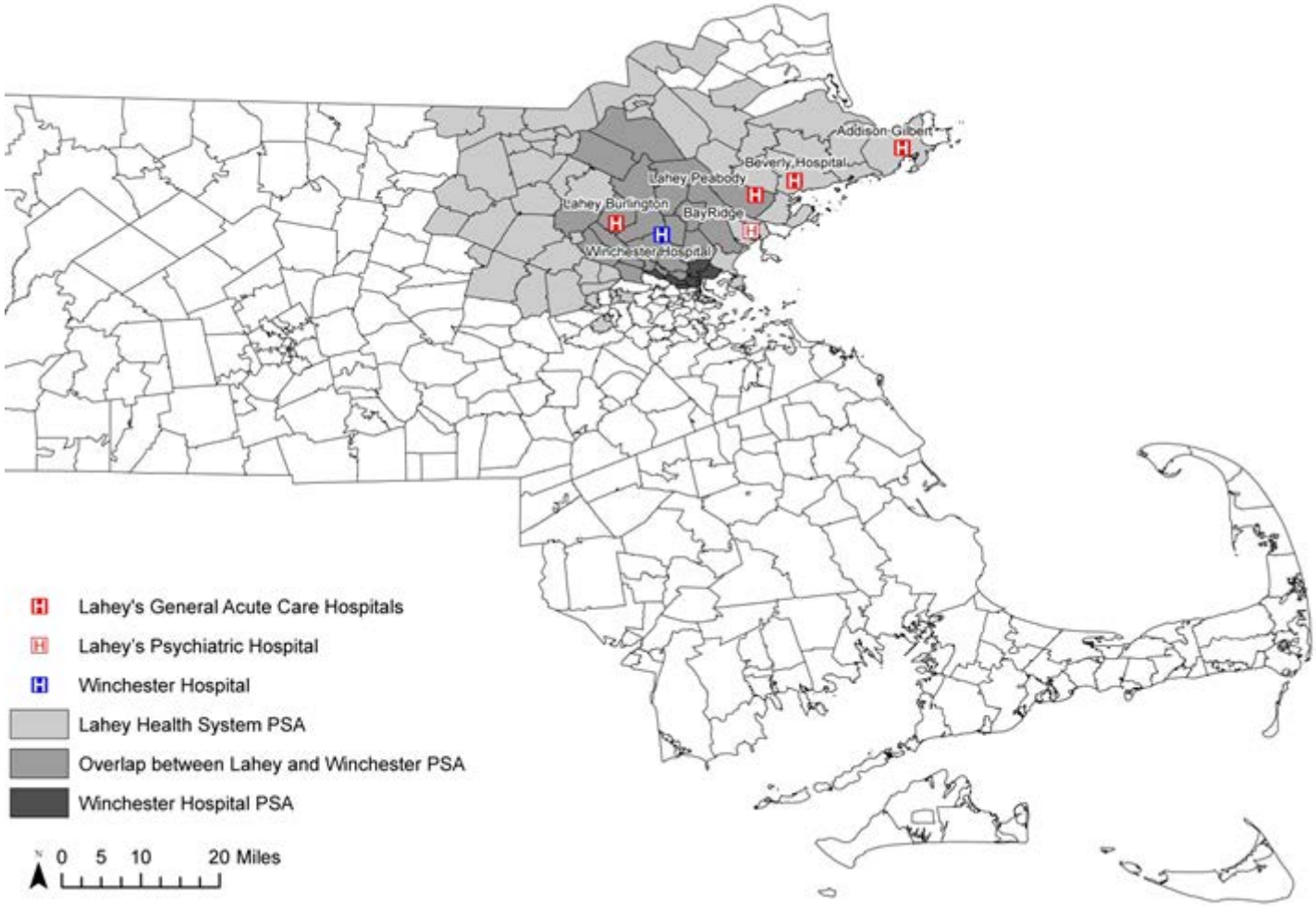


Source: CHIA *2012 Physician Group TME Databook*

Lahey hospitals and Winchester Hospital are located north of Boston

Primary service areas (PSAs) of Lahey hospitals and Winchester Hospital

2012 hospital discharges



Source: MHDC *Inpatient Discharge Database, 2012; Coordinate System: HCS WGS1984 WGS 1984*

Winchester and Lahey have the second and third largest shares of commercial discharges in Winchester's PSA

Commercial inpatient market share in Winchester's PSA

2012 hospital discharges

Hospital System	Commercial Discharges	Market Share
Partners	8,854 – 11,286	31.5% - 40.2%*
Winchester	**4,322**	**15.4%**
Lahey	**2,632**	**9.4%**
Beth Israel Deaconess	2,612 – 3,483	9.3% - 12.4%*
Mount Auburn	2,392	8.5%

*Range depends on whether contractual affiliates are included as part of the system

Source: MHDC *Inpatient Discharge Database, 2012*

Winchester and Lahey have the second and third largest shares of commercial PCP services in Winchester's primary care PSA

Commercial PCP market share in Winchester's primary care PSA
2011 BCBS physician claims

Physician Group	Revenue-Based Shares	Volume-Based Shares (Visits)
Partners	26%	22%
Winchester Physician Associates	**18%**	**18%**
Lahey	**11%**	**13%**
NEQCA	11%	11%
Atrius	7%	5%
BIDCO	6%	6%

Source: CHIA *All Payer Claims Database, 2011 (HPC Analysis)*

Principal findings

- The parties are in strong financial condition
- The parties' hospital prices are generally in the medium range compared to other hospitals
- The parties' physician prices and health status adjusted TME are generally in the low to medium range compared to other physician groups
- The parties have moderately strong market share

Structuring an impact review

	Baseline Review	Impact Analysis
Costs		
Quality and Care Delivery	✓	
Access		

Quality and care delivery metrics examined

- 90+ measures of inpatient and outpatient care
  - Structures of quality
  - Process measures
  - Outcome measures
  - Patient experience
- Examined over time, across providers, and within provider systems
- Compared parties to each other, to area providers, and to national and statewide benchmarks

Hospital performance

- LHMC exceeds state average performance on 71% of inpatient quality measures, and Beverly exceeds the state average on 74%
- Winchester exceeds the state average performance on 61% of inpatient measures
- Each of the parties' hospitals outperforms the others on certain measures, but these were small differences among generally high-performing hospitals

Physician performance

- In the outpatient setting, Lahey Clinic and NEPHO outperform the state average on process measures, while Highland's performance (including WPA) was in line with the average

- On patient experience measures, the parties' practice groups perform in line with the state average

Principal findings

- Lahey and Winchester have strong quality performance compared with national and state benchmarks
- Each party performs slightly higher than the other on certain measures, but these are small differences between generally high-performing providers

Structuring an impact review

	Baseline Review	Impact Analysis
Costs		
Quality and Care Delivery		
Access	✓	

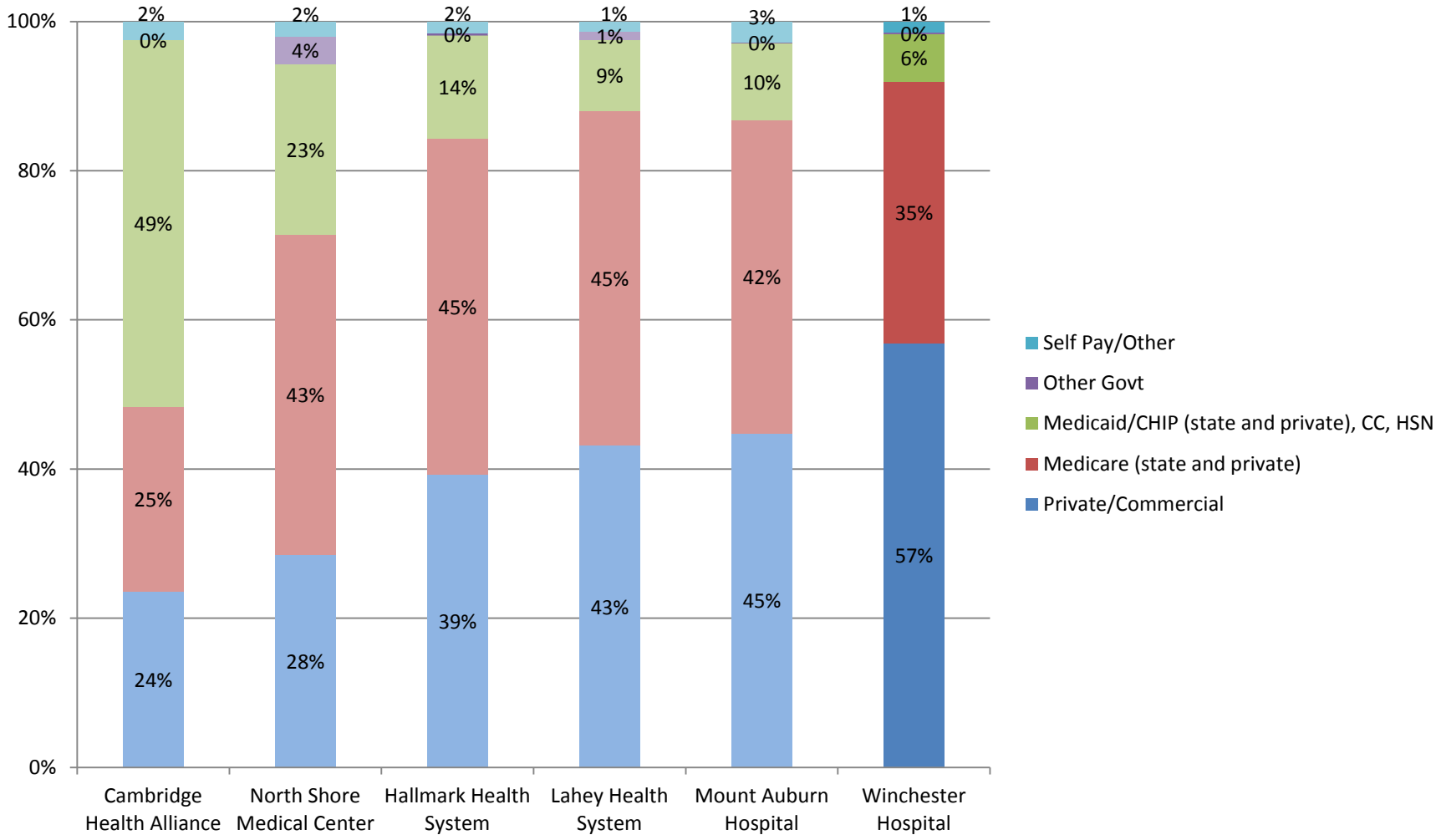
Metrics examined

- Hospital inpatient and outpatient payer mix by revenue, and inpatient payer mix by discharges
- Hospital inpatient service mix by discharges in each of the parties' PSAs

Winchester has the highest commercial payer mix and lowest Medicaid mix among area hospitals

Payer mix of Winchester Hospital compared to area hospitals

FY12 inpatient + outpatient GPSR

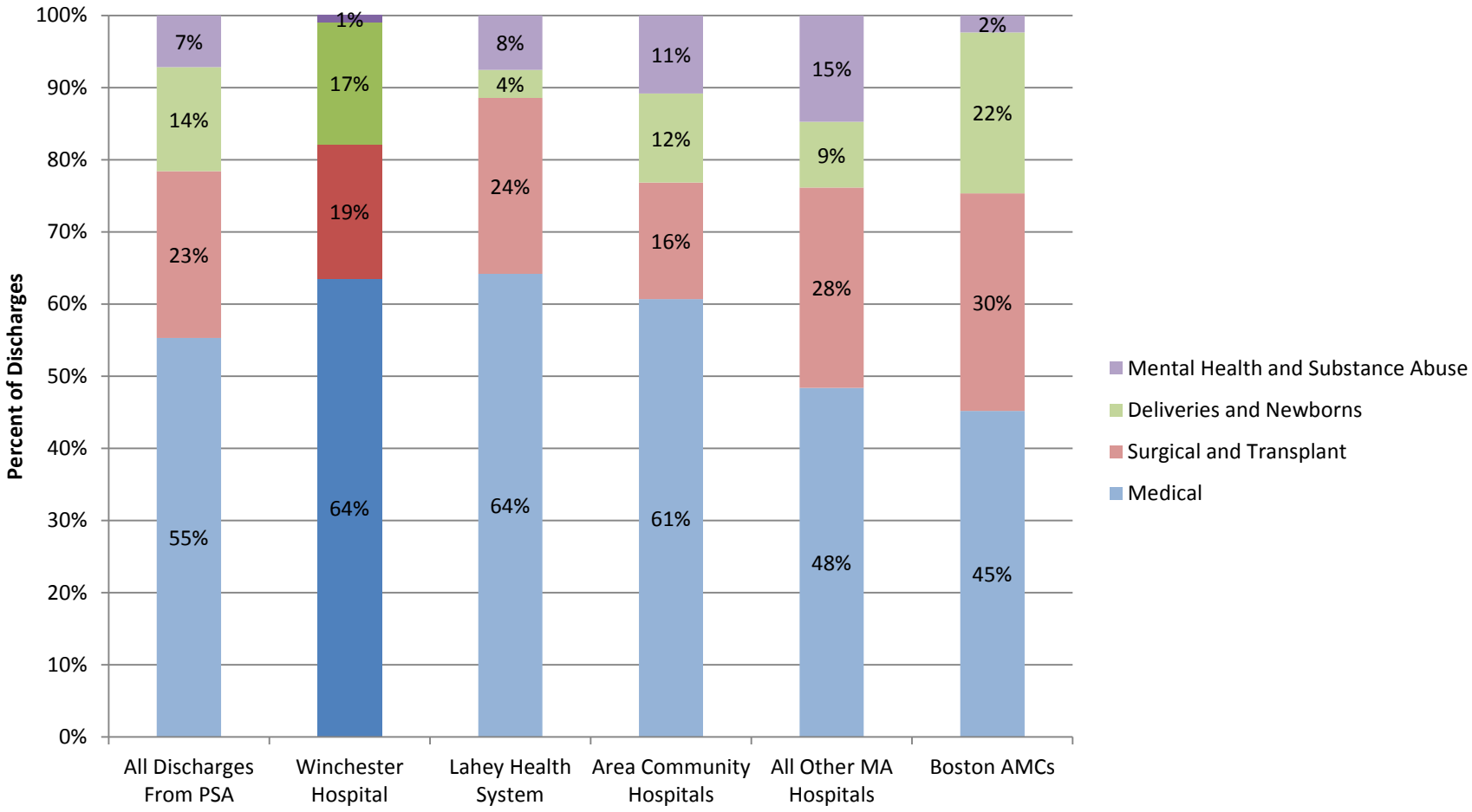


Source: CTR. FOR HEALTH INFO. & ANALYSIS, *Hospital Data on Gross Patient Service Revenue, FY10-FY12 (HPC Analysis).*

Winchester provides a smaller share of behavioral health discharges and a larger share of deliveries than other area hospitals

Inpatient service mix of residents in Winchester Hospital's PSA

2012 hospital discharges



Area Community Hospitals: Cambridge Health Alliance, Hallmark, Mount Auburn, and North Shore MC

Source: MHDC *Inpatient Discharge Database, 2012*

Principal findings

- Winchester Hospital has a higher commercial payer mix and lower Medicaid mix than other area hospitals
- Winchester provides a smaller share of behavioral health discharges and a larger share of deliveries than other area hospitals

Structuring an impact review

	Baseline Review	Impact Analysis
Costs		✓
Quality and Care Delivery		
Access		

Questions examined

- Will prices change?
- Will care shift to higher or lower priced providers?
- Will market leverage increase?

As WPA physicians join Lahey's payer contracts, changes in physician prices could decrease total medical spending

Potential changes in spending for BCBS, HPHC, THP & Aetna based on 2011 relative price data

WPA Patient Population	Annual Cost Impact
HMO/POS patients	($1.7 million dollars)
PPO/Indemnity patients	$0.3 million dollars
Total annual impact to medical spending	**($1.4 million dollars)**

Source: CHIA *2012 Relative Prices, APM, and TME by Payer Databook*

Modeling impact of changes in WPA care referral patterns

- Central claim of the parties is that the transaction will result in cost savings due to shifts in care from higher-priced Boston AMCs to Lahey hospitals
- Northeast case study:
  - Referral patterns of NEPHO patients before and after the Lahey-Northeast merger
  - Saw shifts from higher-priced Boston AMCs and from lower-priced community hospitals
  - Overall, one year post-merger, shifts in referral patterns of NEPHO patients were relatively **cost-neutral**

Potential upper bound savings from changes in WPA care referral patterns

Hospital	Proportion of Care Shifted from Boston AMCs
Winchester	18.9%
LHMC	11.0%
Beverly	3.9%
Total	**33.8%**

WPA Care Shifted from Boston AMCs to Lahey Hospitals	Potential Savings
Inpatient	($630,000)
Outpatient	($650,000)
Total	**($1,280,000)**

DOJ/FTC merger guidelines thresholds

HHI threshold guidelines

Post-Merger Market	HHI	Change in HHI	Presumption
Moderately concentrated	1,500 to 2,500	> 100	**Potentially raises significant competitive concerns and often warrants scrutiny**
Highly concentrated	> 2,500	100 to 200	**Potentially raises significant competitive concerns and often warrants scrutiny**
		> 200	**Presumed to be likely to enhance market power**

Changes in concentration in the parties' PSAs result in moderately concentrated markets that potentially raise competitive concerns

Example: Changes in HHIs in Winchester's PSA 2012 discharges	
Pre-Merger HHI	1,590
Post-Merger HHI	1,879
HHI Change	**+288[1]**

[1] Figure reflects rounding of decimals

Source: MHDC Inpatient Discharge Database, 2012

Diversion analysis supports market share findings that Lahey & Winchester are direct competitors, but not each other's closest substitute

- For **Lahey**, Partners is its closest substitute
  - 54% of discharges would shift to Partners hospitals
    - MGH is LHMC's closest substitute
  - 8% of discharges would switch to Winchester Hospital
    - Winchester is LHMC's third closest substitute (after MGH and BWH)

- For **Winchester**, Partners is its closest substitute
  - 37.2% of discharges would shift to Partners hospitals
    - MGH is Winchester's closest substitute
  - 16.7% of discharges would switch to a Lahey hospital
    - LHMC is Winchester's second closest substitute

Source: MHDC Inpatient Discharge Database, 2012

Principal findings

- As WPA physicians join Lahey's payer contracts, changes in physician prices could decrease total medical spending.
- Utilization of LHMC is anticipated to increase as a result of the transaction, which will lower total medical spending if this increased LHMC volume is drawn from higher-priced as opposed to lower-priced competitors.

At the same time:

- The commercial inpatient market will become moderately more concentrated, potentially increasing the ability of the resulting system to leverage higher prices.
- Total medical spending will increase if facility fees are increased or added to services delivered in Winchester physician office settings.

Structuring an impact review

	Baseline Review	Impact Analysis
Costs		
Quality and Care Delivery		✓
Access		

Questions examined

- Are there differences in the parties' historic quality performance that are likely to drive transaction-specific quality improvement?
- What have the parties described as the role of this transaction in supporting population health management?

The parties' historic performance on quality measures and in risk contracts do not clearly indicate that the transaction itself is instrumental to driving improvements

- Some potential for quality improvements in certain areas, but we would not necessarily expect meaningful improvement in the parties' overall quality based on historic differences in their performance
- Winchester physicians already participate successfully in risk contracts; no clear indication that the transaction would drive clinical efficiencies under these contracts
- Both parties started Medicare Shared Savings ACOs in 2013, for which performance data is not yet available

Principal findings

- There is potential for improving clinical quality through the parties' stated plan of exchanging best practices in care delivery.
- However, given Lahey and Winchester's comparably strong historic performance, and their established experience managing populations through risk-based payments, it is unclear that this corporate acquisition is instrumental to raising the parties' clinical quality.

Structuring an impact review

	Baseline Review	Impact Analysis
Costs		
Quality and Care Delivery		
Access		✓

Principal findings

- Lahey has described its plans to integrate behavioral health services into patient centered medical homes, both for its current system and eventually for Winchester.
- The parties have not shared any specific plans to make service line changes at Winchester Hospital, or to increase its mix of inpatient behavioral health services.

Conclusions

Cost Impact: For the four major commercial payers studied, we modeled cost savings of up to $2.7 million per year as a result of potential decreases in WPA physician prices and shifts in utilization from higher-priced hospitals to Lahey facilities. However, these savings depend on the resulting system not raising its prices relative to other providers, or adding facility fees.

Care Delivery Impact: The parties' stated plan to improve clinical quality through the exchange of best practices demonstrates potential for improving care delivery and health outcomes. However, given Lahey and Winchester's strong overall quality performance, and their established experience managing populations through risk-based payments, it is unclear how this transaction is instrumental to raising their existing care delivery performance.

Access Impact: Lahey proposes to integrate behavioral health services into some Winchester physician practices in 2015. At the same time, Lahey and Winchester have not proposed specific changes in hospital services that would cause the HPC to anticipate changes to their existing inpatient service mix and payer mix trends.

Next steps

- Per M.G.L. c. 6D, § 13, the HPC issues a preliminary report
- The parties have 30 days to respond to our findings
- The Commission issues a final report
- The parties may not close the transactions until at least 30 days following the issuance of the final report

Vote: Preliminary Report on Cost and Market Impact Review

Motion: That pursuant to section 13 of chapter 6D of the Massachusetts General Laws, the Commission hereby approves and authorizes the issuance of the attached preliminary report on the cost and market impact review of the proposed acquisitions of Winchester Hospital and all of its subsidiaries by Lahey Health System.

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- Schedule of Next Commission Meeting

CHART Phase 1 projects are underway

Phase 1 Status Report

- HPC staff have conducted site visits at **9 CHART hospitals**, with 2 scheduled in the coming months. Staff anticipate conducting site visits at all funded hospitals during Phase 1.
- Staff are conducting **regular monthly calls with CHART hospitals** for updates on milestones and project work, problem identification, and provision of limited technical assistance as needed
- Phase 1 projects are generally **proceeding well**:
  - Where applicable, HPC staff are able to **coordinate efforts of teams** at different CHART hospitals engaged in similar efforts
  - Hospitals report **considerable excitement and enthusiasm** for CHART efforts
  - In some cases, projects are **delayed due to hiring challenges** or overly ambitious timeline
- Staff have **formalized the coordinating/oversight role of MeHI** for the six IT-heavy Phase 1 awards
- **Staff are engaged in ongoing coordination of CHART activities with key partners** *(e.g. Prevention and Wellness Trust Fund, Infrastructure and Capacity Building Grants, Workforce Development Trust, DSTI, MeHI e-Health investments, SIM, etc.)*

Phased approach promotes learning and improvement

- Staff conducted a survey to **assess the Phase 1 application process from CHART hospitals' perspective** to inform optimized Phase 2 process.
- HPC sent the survey to pertinent staff at each hospital. HPC received 22 responses from grant writers, program directors, and executive level sponsors.

Topic Area	Quantitative Findings	Qualitative Findings	Phase 2 Considerations
Clarity of Application Materials	• 81% of respondents found the materials to be Very Clear or Clear overall	• Hospitals requested more guidance upfront regarding allowable costs, CHART priorities, hospital staff responsibilities, etc.	• Staff will provide more concrete guidelines in Phase 2 around these specific topics
Ease of Use of Materials	• Only 45-63% of materials were rated Very Easy or Easy to Use	• Requested additional administrative functions to facilitate ease of use	• Staff has purchased new online application system for Phase 2 that will significantly improve this process
Appropriateness and Applicability of Materials	• 95% of respondents said the application asked the right questions to understand their hospital's vision for its CHART project	• Hospitals felt that some questions, e.g. selecting metrics, should be a more iterative process, to be finalized over the first several weeks of project implementation	• Staff proposes 90-120 day planning period for Phase 2 awardees
Revision Process	• 81% of respondents said the process was clear and efficient	• Respondents appreciated the amount of time they had to implement changes	• HPC will consider similar process using online application process in Phase 2
Timeline	• Average request for Phase 2 application timeline was **6-8 weeks**	• Hospitals consistently reported needing more time than was given in Phase 1 (**7 weeks**)	• HPC is contemplating a sequenced approach to application, taking into consideration hospital feedback

Key events involving CHART hospitals

CHART hospital landscape

- **North Adams Regional Hospital** is currently closed. Efforts are ongoing to provide for some continuation of services at this site.
- Lahey Health System has proposed an acquisition of **Winchester Hospital** and its operating affiliates.
- Partners HealthCare System has proposed an acquisition of Hallmark Health System, which operates **Lawrence Memorial Hospital** and **Melrose-Wakefield Hospital**.
- Lower Merrimack Valley Physician Hospital Organization, which is comprised of **Anna Jaques Hospital** and Whittier Independent Practice Association is seeking to join Beth Israel Deaconess Care Organization (BIDCO).
- **Baystate Health** is seeking to acquire **Wing Memorial Hospital**, which is currently owned by UMass Memorial Health Care.
- Tufts Medical Center is seeking to create an integrated system with **Circle Health (Lowell General Hospital)**

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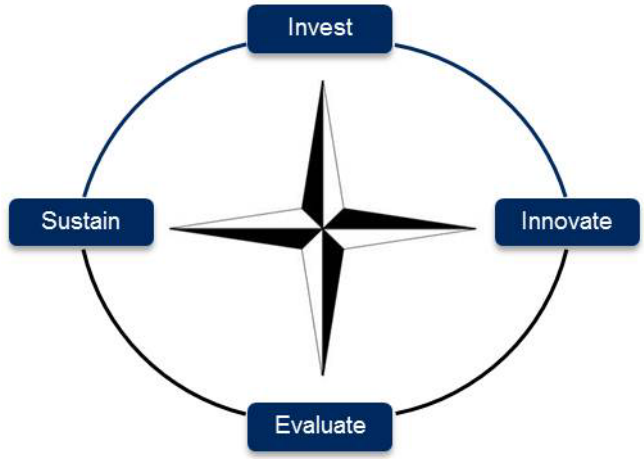
Key decision points for Phase 2

- Size of total opportunity
- Structure of tier(s) & caps
- Specificity of project focus
- Funding model(s)
- Ensuring accountability
- Leveraging partnerships
- Connection with future phases

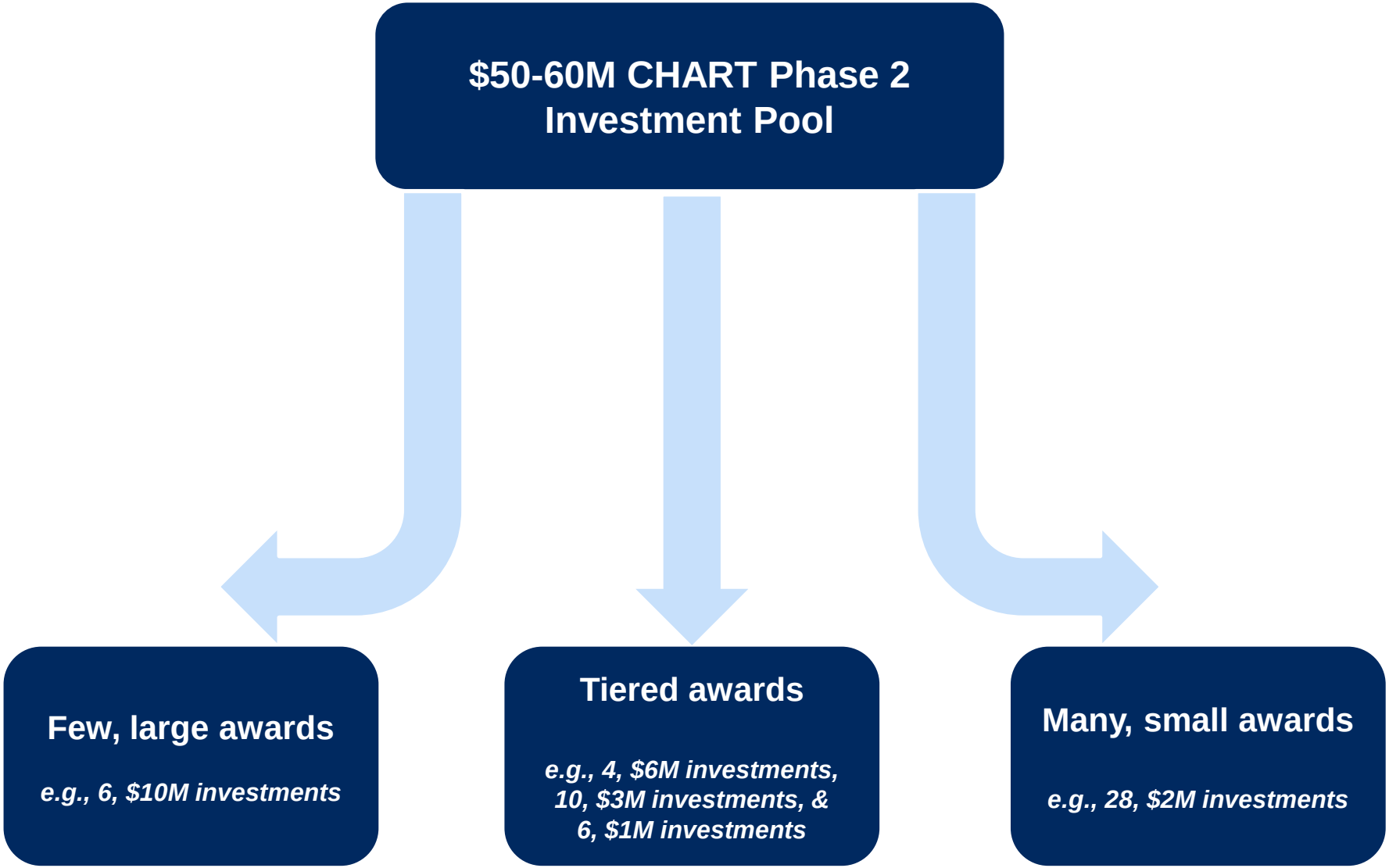


CHICI endorsed in prior meeting
Discussion today
Future discussions

CHART Phase 2 development balances competing aims and pressures

Challenge	Proposed Approach
▪ Should CHART prioritize **evidence-based** established interventions or **innovative** emerging approaches?	▪ CHICI discussed a balanced approach with opportunities across the risk / impact spectrum
▪ How should CHART reconcile **broad statutory and regulatory goals** with the opportunity for focused, deep **impact**?	▪ To **maximize impact**, CHICI discussed a narrowed set of proposal aims for deep impact, only including aims likely to reduce healthcare cost growth.
▪ Should CHART require **standardization** of approaches to facilitate enhanced technical assistance and learnings between hospitals?	▪ CHART should balance a **standardization of aims** to maximize impact while **promoting hospital-specific mechanisms**/approaches to project implementation
▪ Should payments be based on **process** (protecting the financial health of CHART hospitals) or **outcomes** (providing the right incentives)?	▪ A **hybrid award and payment structure** shares risk between CHART program and hospitals, mindful of varied financial strength.
▪ How should CHART consider programs benefiting patients **today** that may not persist in the absence of **payment reform**?	▪ Consistent with goals of Chapter 224, Phase 2 pairs **care delivery reforms** that will be supported and enhanced by increased penetration of APMs with **process improvement and capacity development** that will maximize hospital efficiency and quality even in a FFS environment

Multiple potential models exist for spreading investments across CHART hospitals



Proposed CHART Phase 2 combines standardized aims with flexibility for hospitals approaches

Structure of tier(s) & caps	Funding model(s)
Specificity of project focus	Ensuring accountability

- Program focus on supporting achievement of **health care cost growth benchmark*)***
  - **Three standardized aims** drive deep impact across the Commonwealth, with flexibility of implementation approach and the overarching goal of transformation toward accountable care
  - Emphasis on **emerging technologies** to support achievement of aims
  - **Additional aim of strategic planning** to facilitate CHART hospitals' efforts to advance their ability to provide efficient, effective care and meet community needs in an evolving healthcare environment

3 +1+1

- Award sizes tied to factors such as **community need, hospital financial status, financial impact, and patient impact**, with payments tied to **milestones and outcomes**
- Proposals will include **mechanism** to address the aim, the **value proposition** to the hospital and to the Commonwealth, and **estimate of impact**. The detailed implementation work plan will be developed in the first 90-120 days
- **Standardized metrics** ensure accountability

In Proposed Phase 2 approach, hospitals propose mechanisms to meet specified aims, with the overarching goal to drive transformation toward accountable care

Support Achievement of Cost Growth Benchmark

Three outcome-based aims for implementation during 2-year grant period

Maximize appropriate hospital use	▪ Hot-spotting and population health management approaches to reduce acute care hospital utilization *(emergency department and inpatient)* ▪ Targeted reduction of readmissions after hospital -> SNF care transition ▪ Enhance discharge planning and emergency department interventions	
Hospital-wide process improvement	▪ Reduce costs through improved efficiency (e.g., Lean management applied on a system-wide basis) ▪ Improve safety and reliability of clinical processes (e.g., implementation of checklists) ▪ Reduce costs through improved financial management (e.g., cost accounting)	3
Enhancing behavioral health care	▪ Reduce emergency department boarding of patients with mental health and substance use disorders ▪ Integrate inpatient behavioral and physical health workflows ▪ Build hospital ←→ community networks for maximizing coordination of BH services	

Focus on emerging technologies to enhance impact

+

Connected health	▪ Connect to and use the Mass HIway *(required)* ▪ Increase specialty capacity at lower-cost sites of care through telemedicine to reduce preventable outmigration and maximize home-based care ▪ Use mobile technologies to facilitate achievement of outcome-based aims	1

One planning option, as a standalone grant or in conjunction with project tracks above

+

Strategic planning	▪ CHART hospitals may propose efforts to engage in strategic and operational planning to advance their ability to provide efficient, effective care and meet community need in an evolving healthcare environment	1

Hospitals combine programs to reduce unnecessary utilization with efforts to improve operational efficiency, quality, and connectivity – Example 1

1 Each hospital's proposal covers one or more domains

ILLUSTRATIVE PROPOSAL

	Maximize appropriate hospital use	▪ Emergency Department-based High Risk Care Team links community PCMHs and hospital-based case management services ▪ High need patients tagged in EHR
3	*Hospital-wide process improvement*	
	Enhancing behavioral health care	
+		
1	**Connected health**	▪ Connection to and utilization of Mass HIway for exchange of information with local PCMH
+		
1	**Strategic planning**	▪ Strategic planning initiative focused on maximizing community access to care and reducing use of the emergency department by high need patients.

2 All hospitals complete common CHART activities

Awardees must complete a common set of requisite activities, supporting many domains of transformation, including, e.g.:

- Operational Key Performance Indicator (KPI) Benchmarking
- Mass HIway connection and use
- …

Hospitals combine programs to reduce unnecessary utilization with efforts to improve operational efficiency, quality, and connectivity – Example 2

1 Each hospital's proposal covers one or more domains

ILLUSTRATIVE PROPOSAL

Maximize appropriate hospital use

3 **Hospital-wide process improvement**

- Lean management initiative championed by CEO
- Reduce Catheter-Associated Urinary Tract Infections (CAUTI)

+ **Enhancing behavioral health care**

- Co-locating behavioral health case managers in emergency department
- Building community-based collaborative to coordinate care for high-risk recidivists

1 **Connected health**

- Telepsychiatry pilot in collaboration with other CHART hospitals
- Connection to and utilization of Mass HIway

+ **Strategic planning** **1**

- Strategic planning initiative focused on reducing inpatient radiology capacity and shifting infrastructure to urgent care center

2 All hospitals complete common CHART activities

Awardees must complete a common set of requisite activities, supporting many domains of transformation, including, e.g.:

- Operational Key Performance Indicator (KPI) Benchmarking
- Mass HIway connection and use
- …

Hospitals combine programs to reduce unnecessary utilization with efforts to improve operational efficiency, quality, and connectivity – Example 3

1 Each hospital's proposal covers one or more domains

ILLUSTRATIVE PROPOSAL

Maximize appropriate hospital use

3 **Hospital-wide process improvement**

- Development of supply-chain management and cost accounting processes to minimize inefficiency
- Implementation of surgical checklist program in all ICUs

Enhancing behavioral health care

+ 1 **Connected health**

- Pilot of mobile device application to assess functional status of SNF patients (INTERACT)
- Connection to and utilization of Mass HIway

+ 1 **Strategic planning**

- Strategic planning initiative to enhance the hospital's ability to plan for provision of efficient, effective care that meets its community's evolving needs

2 All hospitals complete common CHART activities

Awardees must complete a common set of requisite activities, supporting many domains of transformation, including, e.g.:

- Operational Key Performance Indicator (KPI) Benchmarking
- Mass HIway connection and use
- …

Phase 2 application process

Key decision points for CHART Phase 2

Size of total opportunity	▪ **$50-60 million** total opportunity ▪ Tiered, multi-year opportunities with awards stratified across hospitals
Structure of tier(s) & caps	▪ Award caps tied to factors such as **community need, hospital financial status, financial impact, and patient impact**
Specificity of project focus	▪ Three key project domains with a fourth area of innovation ▪ A fifth opportunity for applicants to engage in targeted planning efforts
Funding model(s)	▪ **Initiation** payment; ongoing base payments for **milestones**; bonus payments for **achievement** (e.g., process and outcomes)
Ensuring accountability	▪ **Standardized metrics** and streamlined reporting framework; strong continuation of **leadership/management** development focus
Leveraging partnerships	▪ Appropriate community **partnerships** required (e.g., SNFs, Community Based Organizations, other provider organizations, etc.)
Requisite Activities	▪ All awardees must engage in a series of **participation requirements** (e.g., joining Mass HIWay, etc.)

3 +1+1

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  - CHART Administrative Budget for FY14
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  - Office Space Lease
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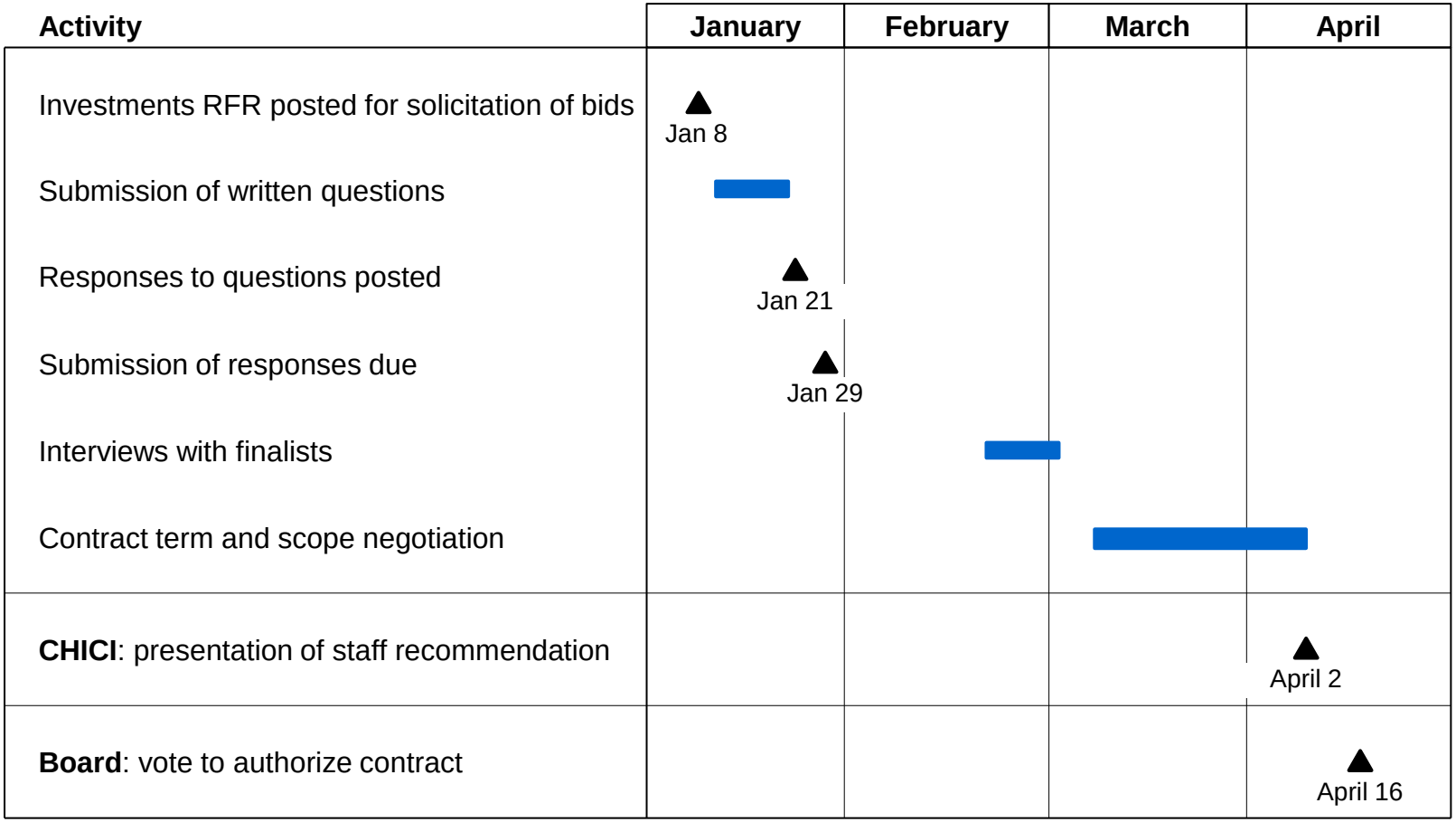
The scope of this procurement was based on five deliverables, for which a series of potential contractors were evaluated

1	**Hospital TA**	▪ Development of a Phase 2 technical assistance plan ▪ Supporting hospital-specific needs ▪ Instituting cohort-wide collaboratives
2	**Culture surveys**	▪ Implementing culture surveys and analyzing results ▪ Hospital-specific needs assessment and project work ▪ Hospital-specific activities for improvement
3	**Management survey**	▪ Assessment of hospital leadership and management capability and capacity ▪ Quantitative and qualitative approaches
4	**Leadership academy**	▪ Cohort-wide 1-2 day leadership session on data, best practices, and areas for improvement ▪ Phase 2 focused
5	**Strategy and evaluation**	▪ Support future HPC evaluation efforts ▪ Support HPC strategic design and development of CHART

A total of ten firms responded, with a blend of proposed scope of work. Some proposed engagement in as few as one deliverable, while others proposed all deliverables

HPC engaged in a thorough procurement process



10 bidders were scored on 8 evaluation criteria

Evaluation criteria used

Criteria	Value
Demonstrated MA provider expertise	20
Quality of proposed strategy for each pertinent activity	20
Demonstrated subject matter experience and expertise	15
Educational, professional qualifications	10
Demonstrated ability to meet rapid deadlines with excellent results	5
Overall quality of response	5
Best price/value	20
Supplier diversity plan	5

Summary of applicants and selection process

- The HPC received 10 bids from prospective contractors, who proposed to address one or more of the HPC's sought services
- A review committee composed of HPC staff and experts reviewed and scored each application on the basis of programmatic and financial factors
- Scores ranged from 31/100 to 85/100 *(the proposed awardee)*
- Interviews were conducted with the three highest bidders, from which staff began a process of negotiating a scope of work and total award value with the proposed awardee.
- Additionally, one applicant was selected for a modest contract to support development of technical assistance approaches for future phases

Based on our review of the proposals, we recommend Safe & Reliable to lead culture survey work

Summary of results for 3 finalists

	Evaluation score	Cost $ 000s
S & R	85	**$525***
Finalist #2	80	$1,300
Finalist #3	70	$658

Rationale for Safe & Reliable

- Demonstrated understanding of HPC needs and objectives
- Experience working with hospitals to improve culture and proven track record as clinician-leaders
- Highest evaluation score of pertinent applicants
- Able to articulate approaches to deal with unique and complex challenges facing community hospitals
- Ability to negotiate with HPC to modify scope to meet budget constraints

Our final recommendation is Safe & Reliable Healthcare

* Represents final negotiated rate; includes both fixed rate and hourly components

Safe & Reliable Summary

Conduct Scan of Hospital-Specific Culture Work To-Date

- Collate and examine results of previously conducted culture surveys and assess baseline improvement work
- Provide hospital specific recommendations on whether prior surveys are sufficient
- *Hospitals with insufficient data, determine most appropriate next step:* define sampling technique and support hospitals in fielding and interpreting survey
- *Hospitals with sufficient data:* identify opportunities for improvement and leadership academy programming

Conduct Site Visits to Assess Culture & Leadership Capacity

- Adapt/customize SocioTechnic approach to CHART hospital needs
- Brief hospital leadership on site visit objectives and conduct interviews
- Team includes clinical leaders, culture/QI experts, and operations experts
- Analyze site-visit results and culture data and develop aggregate and hospital-specific mixed methods reports with companion memos with areas for improvement

Development of CHART Leadership Academy

- Develop a 1-2 day leadership academy curriculum with HPC staff
  - Principles/skills of QI
  - Strategic ops planning for system improvement
  - Change management
- Tailor curriculum with 'sounding board' of 5-7 hospital attendees
- Develop a renewable/adaptable curriculum for future HPC use
- Evaluation impact of leadership academy

Contract includes fixed cost and hourly rate components, with an option to renew on a rate-basis for up to five years

Vote: Consideration of Professional Services Contract

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the Executive Director is hereby authorized to execute a contract with Safe & Reliable Healthcare to further support implementation of activities related to the Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program, for an amount up to no more than $525,000 through December 31, 2014, subject to further agreement on terms deemed advisable by the Executive Director.

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Distressed Hospital Trust Fund and CHART administrative budget

- **FY14:** July 1, 2013 - June 30, 2014
- The balance at the beginning of FY14 was $40.29 million, the entire amount of the first installment of the industry assessment deposited in the Distressed Hospital Trust Fund.
- In January 2014 the Board authorized $10 million in Phase 1 awards to 28 hospitals. Of this amount, 80% will be distributed in FY14 ($8M) and the final 20% in FY15 ($2M).
- According to c. 224, 10% of the amounts held in the fund are available for administrative costs.
- Administrative costs related to the CHART investment program in FY14, include:
  - Salary and benefits for program staff, including fiscal and legal support, for work related to CHART
  - Expert assistance in Phase 1 and Phase 2 program development, including Phase 1 grant review
  - Contracted services on behalf of awardees, including technical assistance, leadership and capacity survey, and other awardee engagement and support (including services provided by Safe and Reliable Healthcare)
  - General administrative costs
- The FY14 proposed administrative spending for CHART is **$594,307**. This represents approximately 1.5% of available funds in the Trust Fund in FY14.

FY14 Distressed Hospital Trust Fund and CHART administrative budget

CHART FY14 Proposed Administrative Budget		
Salary and Benefits	$	224,507
Professional Services	$	325,000
General Administrative Costs	$	44,800
Total	**$**	**594,307**
% of Available Funds in DHTF		**1.5%**

Vote: CHART Administrative Budget for FY14

Motion: That the Commission hereby accepts and approves the administrative budget for the CHART investment program in fiscal year 2014 as reviewed by the Administrative and Finance Committee on February 19, 2014 and presented and attached hereto, and authorizes the Executive Director to expend these budgeted funds from the Distressed Hospital Trust Fund.

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Vote: Market Review Contract Extension

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 Bates White for an additional amount of $100,000 through June 30, 2014, for economic expertise in support of the Commission's ongoing measuring and monitoring of provider relationships and market changes, subject to further agreement on terms deemed advisable by the Executive Director.

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Vote: Office Space Lease

Motion: That, pursuant to G.L. c. 6D, § 3(d), the Executive Director is hereby authorized to execute and deliver a lease for office space in downtown Boston to meet the space needs of the Health Policy Commission for a term of seven years, containing such terms and provisions as he shall deem advisable, the definitive form of such lease to be evidenced conclusively by his execution of the lease and any supporting documents.

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Contact Information

For more information about the Health Policy Commission:

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