Commonwealth of Massachusetts

Health Policy Commission

March 11, 2015

Board Meeting

Agenda

- Vice Chair Appointment
- Approval of Minutes from the January 20, 2015 Meeting
- Executive Director Report
- Cost Trends and Market Performance Update
- Community Health Care Investment and Consumer Involvement Update
- Quality Improvement and Patient Protection Update
- Care Delivery and Payment System Transformation Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (April 29, 2015)

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Vote: Vice Chair Appointment

Motion: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby appoints Dr. Wendy Everett to serve a one-year term as Vice Chairperson of the Health Policy Commission.

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on January 20, 2015, as presented.

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2015 Work Plan – Work Streams

Ongoing Policy Programs

Annual Cost Trends Report Research and Analysis
Behavioral Health Agenda
CHART Phase 2
Notices of Material Change
Cost and Market Impact Reviews
Office of Patient Protection
RPO: Initial Registration Part 1

New Policy Programs

ACO Certification Program, Model Payment, and Technical Assistance
PCMH Certification Program, Model Payment, and Technical Assistance
Health Care Innovation Investment Program
CHART Additional Investments and Technical Engagement Program
Performance Improvement Plans
Review of DoN/Essential Service Notices
RPO: Initial Registration Part 2
Transparency Initiatives (Episode-Level Spending/Price Variation)
Continued Work on 2014 Cost Trends Report Recommendations

2015 Work Plan – Publications and Regulations

Proposed 2015 Publications

Annual Reports
- HPC Business
- Office of Patient Protection
- Registration of Provider Organizations
- CHART

CHART
- Phase One Final Report
- Phase One Case Studies

Community Hospital Study
Cost and Market Impact Reviews
2016 Cost Trends Report
Substance Use Disorder Report
White Paper Series

Proposed 2015 Regulations/Guidance

ICU Nurse Staffing Regulation

ACO Certification Regulation

Interim Guidance on Performance Improvement Plans (PIP)

Updates to OPP Regulation

Interim Guidance on OPP RBPO/ACO Appeals Process

Updates to MCN Technical Bulletin

2015 Work Plan – Other Activities Based on 2014 Cost Trends Report Recommendations

- Develop MA's health system performance "**dashboard**"
- Promoting a Value-Based Market
  - Engage with payers, providers, and employers on advancing consumer-directed price **transparency** efforts
  - Engage with employers and payers – including the GIC – in efforts to enhance **value-based product design**
  - Develop approaches to **examine past transactions** and evaluate status of parties' commitments regarding cost, quality, and access
- Promoting a High Quality Delivery System
  - Support provider efforts to adopt appropriate tools and **share best practices** to improve quality and efficiency in the specific priority areas (i.e., PAC, readmissions, HCP, ED utilization)
  - Develop coordinated **technical assistance** program through HPC's investment and certification programs in these priority areas
  - Support MassHealth's development of a **Medicaid ACO** program and ensure alignment with the HPC ACO certification program
- Alternative Payment Methodologies
  - Engage with payers and providers to advance the adoption of effective **APMs**, including through the exploration of episode-based payments
  - Coordinate with other state agencies to align APM reporting and expand types of APMs reported
  - Coordinate with other state agencies to align quality measurement
- Behavioral Health
  - Coordinate **behavioral health integration** strategy with other state agencies
  - Support and strengthen the work of CHIA's behavioral health data task force

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  - Partners' Proposed Acquisitions of Hallmark Health System and Harbor Medical Associates
  - Health Care Cost Growth Benchmark Establishment **(VOTE)**
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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	11	32%
Acute hospital merger or acquisition	7	21%
Clinical affiliation	5	15%
Formation of contracting entity	4	12%
Acquisition of post-acute provider	3	9%
Change in ownership or merger of owned entities	3	9%
Affiliation between a provider and a carrier	1	3%

Update on notices of material change

Notices Received Since Last Commission Meeting

Description

Clinical affiliation between Dana-Farber Cancer Institute and Steward Health Care System, under which Dana-Farber would provide oncology services at the Steward Holy Family Hospital campus

Elected Not to Proceed

Description

Acquisition of Pentucket Medical Group by Partners HealthCare System

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Update on Partners’ Proposed Acquisitions of South Shore Hospital, Harbor Medical Associates, and Hallmark Health System

- On January 26, Attorney General Healey filed a Notice of Position with the court detailing a number of concerns regarding the parties’ proposed Consent Judgment, and noted that if the Consent Judgment were rejected, she would void the agreement with the parties and move to litigate the South Shore Hospital (SSH) acquisition.
- On January 29, Judge Sanders rejected the Consent Judgment on the basis that it was not in the public interest and would be difficult to enforce.
- On February 17, the parties notified the court that Partners had dropped its bid to acquire SSH and that the proposed acquisition of Hallmark Health System (Hallmark) remains under review.
- Partners has indicated it intends to proceed with the acquisition of Harbor Medical Associates (Harbor), the largest medical practice within the South Shore Physician Hospital Organization (SSPHO), which was not a party to the proposed Consent Judgment.

Final CMIR Report on South Shore Hospital and Harbor Medical Associates: Cost Impact Findings

The HPC found that Partners' acquisition of SSH and its affiliated physicians, including Harbor, would increase total medical spending by $23 to $26 million each year for the three major commercial payers due to increases in Harbor/SSPHO physician prices and shifts in referrals. These figures do not include the potentially significant cost impacts of any increased ability to leverage higher prices and other favorable contract terms or to add or increase facility fees.

Continued cost impacts of the Harbor Acquisition as originally proposed:

At Least $8 Million in Price Increases: As 65 Harbor physicians join Partners' contracts, we anticipate a permanent increase in physician prices amounting to at least an additional $8 million in annual spending. If Partners continues its past practice of adding facility fees to physician group services, there would be additional cost increases. Payers have expressed concern about their ability under current data systems to effectively monitor such practices.

$6-10 Million in Referral Pattern Impacts: We originally modeled a cost impact of up to $1.6 million per year as South Shore physicians began referring more like PCHI community physicians. If Partners proceeds with plans to recruit additional PCPs to Harbor, shifts in referral patterns will likely increase spending by an additional $5.8 to $9.0 million each year. This impact may be greater if Partners acquires Harbor *without* acquiring SSH because the newly recruited physicians may refer to higher-priced Partners hospitals more frequently than SSH.

Final CMIR Report on Hallmark Health System: Cost Impact Findings

The HPC found that this transaction would reinforce Partners' position as the provider with the highest share of inpatient and primary care services in its northeastern Massachusetts service areas. Over time, this transaction is anticipated to increase spending in northeastern Massachusetts by $15.5 million to $23 million per year for the three major commercial payers, which is not expected to be offset by commensurate savings from decreased utilization through population health management.

$16.1 Million in Physician and Hospital Price Increases: The HPC projected a permanent $6.8 million increase in annual spending due to increases in Hallmark's physician rates to those of Partners' employed or "integrated" physicians. If Partners seeks parity between Hallmark's hospital rates and those of its owned community hospitals, the HPC projected that spending would increase by an additional $9.3 million annually.

Up to $6.9 Million in Referral Pattern Impacts: The HPC also found that, contrary to the parties' claims, anticipated changes in referral patterns are unlikely to result in significant savings at current prices. If Hallmark's prices increase to those of Partners' owned providers, annual spending is anticipated to increase by up to $6.9 million due to shifts in referral patterns of both current Hallmark physicians as well as new physicians the parties plan to recruit.

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What is Potential Gross State Product?

Potential Gross State Product (PGSP)

Long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle

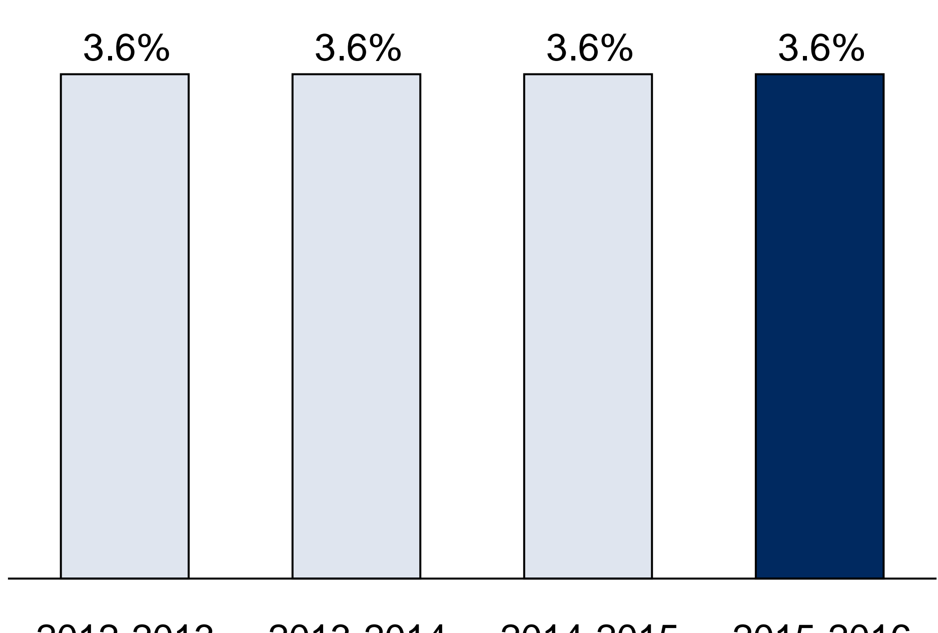
Process

- Section 30(b) of Chapter 224 requires the Secretary of Administration and Finance and the House and Senate Ways and Means Committees to set a benchmark for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is to be included in a joint resolution due by January 15th of each year
- The Commonwealth's estimate of PGSP was developed with input from outside economists, in consultation with Administration and Finance, the House and Senate Ways and Means Committees, the Department of Revenue Office of Tax Policy Analysis, and members of the Health Policy Commission

HPC's Role

- The PGSP estimate is used by the Health Policy Commission to establish the Commonwealth's health care cost growth benchmark
- For CY2013-2017, the benchmark must be equal to PGSP
- For CY2018-2022, the Commission may modify the benchmark at an amount equal to PGSP to minus 0.5 percent of PGSP

PGSP Estimate for 2015-2016



- The 2015-2016 estimate of 3.6% is within a range as discussed by stakeholders
- Estimates were informed by standard methodologies (e.g., Congressional Budget Office) as well as legislative intent to target the long-run average growth rate of the Commonwealth's economy

Vote: 2016 Health Care Cost Growth Benchmark

Motion: That, pursuant to by G.L. c. 6D, § 9, as determined jointly by the Secretary of Administration and Finance and the House and Senate Ways and Means Committees, the Commission hereby establishes the health care cost benchmark for calendar year 2016 as 3.6%.

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CHART Phase 1 by the numbers*

CHART Phase 1: $10M

162,000+
Patients impacted by Phase 1 initiatives

2,200+
Hospital employees trained

27 Hospitals | **260** Units
Primed for system transformation

92%
Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

308
Community partnerships formed or enhanced by awardees

400+
Hours of direct technical assistance to awardees

*Updated February 25, 2015

CHART Phase 1 evaluation products

A series of Phase 1 evaluation outputs are currently in development or complete

1. ***Complete* - Programmatic learnings to inform Phase 2:** HPC staff have continuously collated and captured key lessons to inform ongoing program development and hospital improvement efforts. These tools and approaches are actively being implemented in Phase 2, including directly informing the creation of the implementation planning period.

2. ***Complete* - CHART Leadership Summit Proceedings Paper:** Staff developed and released a proceedings paper on the Leadership Summit. Staff are working to finalize an aggregate report developed based on the assessments conducted by Safe & Reliable Healthcare for release.

3. **Case Studies on Key Themes:** HPC has commissioned up to six case studies of key themes in CHART Phase 1. Each will include multiple hospitals. Cases will be released on a rolling basis and will include topics such as: using data to understand a population and design an intervention, the importance of engaged leadership, and how to address social and behavioral drivers of hospital utilization.

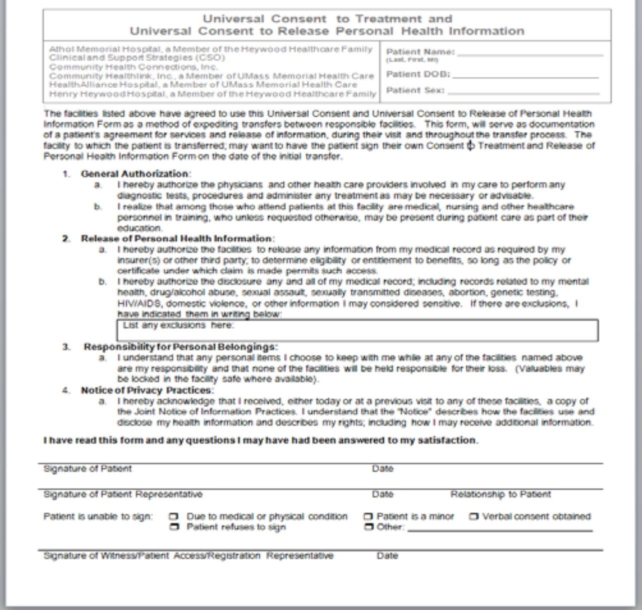
4. ***In progress* - Summative Evaluation Report:** Subsequent to receipt of all final reports and completion of the Phase 1 close out survey, the HPC will release a summative evaluation report on Phase 1. This is anticipated in Q1 2015.

Spotlight: North-Central Mass. regional behavioral health collaborative

These three awardees identified a need for sharing best practices and finding a common way to share information on frequent ED users with behavioral health comorbidities.

Athol, Heywood, and HealthAlliance created the Regional Behavioral Health Collaborative (RBHC) to develop best practices to improve early identification of mental illness and to increase access to behavioral health care among the North Central and North Quabbin communities.

- The hospitals invited community partners like Community Health Connections, Community HealthLink, Gardner Public Schools, and Athol Public Schools
- Created a universal patient consent form to enable efficient data sharing among institutions
- Created Regional Individualized ED Care Plan with the latest information on each patient who visits area organizations, **treating 471 high risk patients in total**



Universal Consent to Treatment and
Universal Consent to Release Personal Health Information

Athol Memorial Hospital, a Member of the Heywood Healthcare Family Clinical and Support Strategies (CSO) Community Health Connections, Inc. Community Healthlink, Inc., a Member of UMass Memorial Health Care HealthAlliance Hospital, a Member of UMass Memorial Health Care Henry Heywood Hospital, a Member of the Heywood Healthcare Family	Patient Name: (Last, First, MI) ______ Patient DOB: ______ Patient Sex: ______

The facilities listed above have agreed to use this Universal Consent and Universal Consent to Release of Personal Health Information Form as a method of expediting transfers between responsible facilities. This form, will serve as documentation of a patient's agreement for services and release of information, during their visit and throughout the transfer process. The facility to which the patient is transferred; may want to have the patient sign their own Consent to Treatment and Release of Personal Health Information Form on the date of the initial transfer.

1. **General Authorization:**
   a. I hereby authorize the physicians and other health care providers involved in my care to perform any diagnostic tests, procedures and administer any treatment as may be necessary or advisable.
   b. I realize that among those who attend patients at this facility are medical, nursing and other healthcare personnel in training, who unless requested otherwise, may be present during patient care as part of their education.
2. **Release of Personal Health Information:**
   a. I hereby authorize the facilities to release any information from my medical record as required by my insurer(s) or other third party; to determine eligibility or entitlement to benefits, so long as the policy or certificate under which claim is made permits such access.
   b. I hereby authorize the disclosure any and all of my medical record; including records related to my mental health, drug/alcohol abuse, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may considered sensitive. If there are exclusions, I have indicated them in writing below:
   List any exclusions here:
3. **Responsibility for Personal Belongings:**
   a. I understand that any personal items I choose to keep with me while at any of the facilities named above are my responsibility and that none of the facilities will be held responsible for their loss. (Valuables may be locked in the facility safe where available).
4. **Notice of Privacy Practices:**
   a. I hereby acknowledge that I received, either today or at a previous visit to any of these facilities, a copy of the Joint Notice of Information Practices. I understand that the "Notice" describes how the facilities use and disclose my health information and describes my rights; including how I may receive additional information.

I have read this form and any questions I may have had been answered to my satisfaction.

Signature of Patient Date

Signature of Patient Representative Date Relationship to Patient

Patient is unable to sign: ❒ Due to medical or physical condition ❒ Patient refuses to sign ❒ Patient is a minor ❒ Other: ______ ❒ Verbal consent obtained

Signature of Witness/Patient Access/Registration Representative Date

From ED to School

Provided school-based services, including community wrap-around, for 322 families

School-based BH program reached capacity within 4 weeks of implementation

- Home and school-based BH counseling
- Access to eye glasses
- Housing placement for homelessness and rental assistance for housing vulnerability
- Food supports/security

"[CHART] provided an opportunity to **collaborate on efforts to increase access**, strengthen **care coordination** and **improve the system of care** for both youth and individuals in crisis suffering from mental illness and addictions through the EDs…The relationships made or enhanced by our initial project's work hold promise for **great collaboration** in the years to come."

Spotlight: Telehealth to improve access and reduce cost in Western Mass.

Baystate Franklin Medical Center and Mary Lane's projects used telehealth to increase access to specialty medicine in the community setting.

Baystate Franklin Medical Center had 76 inpatient telehealth encounters between April 15 and September 15 in neurology, critical care, infectious disease, and geriatrics with the most encounters in neurology

Baystate Mary Lane Hospital had 40 telehealth encounters in outpatient neurology, inpatient speech, outpatient cardiology, and outpatient behavioral health

86% of patients were satisfied with their telehealth encounter at BFMC. Evaluation of cost impacts is ongoing

The wait time for the third next available appointment at BML went from 90 – 113 days for an in-person consult for neurology to 5 – 9 days for a telemedicine consult, and from 60-65 days to 3-23 days for cardiology

Zero adverse events have been reported

Spotlight: Building staff capacity for process improvement at Mercy Medical Center

Mercy Medical Center trained 251 staff in various aspects of Six Sigma, Just Culture, and Lean to enhance the culture of safety and improve hospital processes.*

$223,134

Phase 1 award for staff capability development

66

66 employees completed an 8-week Lean in Healthcare seminar

112

employees completed a two-day Just Culture training for managers

19

19 employees completed training in Culture of Safety

7

health system leaders completed the Six Sigma certificate training

47

senior leaders and key health system managers took part in a special day-long Lean in Health Care seminar

>75 individual improvement initiatives across Mercy Medical Center

Reduce Ortho LOS through Effective Equipment Management

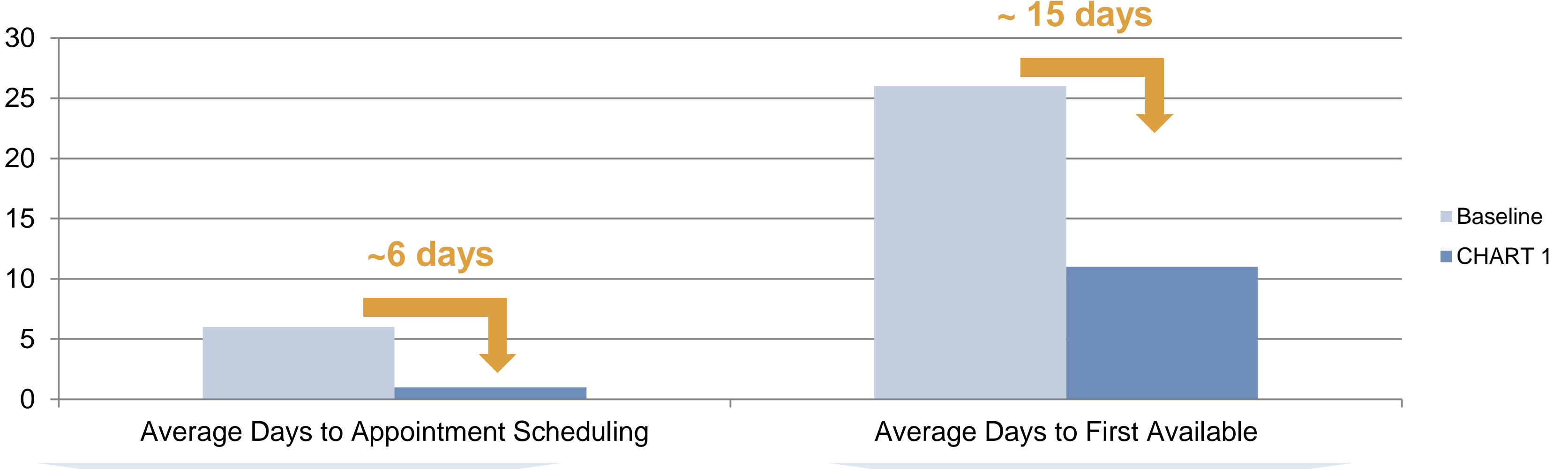
Reduced LOS from baseline of 3.24 days to 2.98 days

Improve Documentation of Assessment and Intervention to Ensure Appropriate Service Utilization

Improved compliance to >95% from baseline of 71.4% for target service line

Spotlight: Redesigning Harrington's behavioral health IT systems.

As the foundational step in a long-range behavioral health system redesign initiative at Harrington Memorial Hospital, IT systems were extensively redesigned to improve timely access to care



Reduced time for initial booking of follow up appointments from 5-7 days to <24 hours (for 100% of patients) resulting in greater certainty of follow up care

Reduced time for first available appointment from 21-30 days to 11 days resulting in more timely follow up care; seeking to reduce further through staff additions and CHART 2 enhancements

Through case studies, CHART hospitals can share learnings in improvement program design and operations with other organizations

- The HPC has engaged Health Management Associates (HMA) to highlight key themes from CHART Phase 1 projects through a series of case studies
- The HPC intends for the experiences and lessons exhibited in this series to assist other providers, the public, and policy makers in designing and promoting similar short-term, high-impact improvement initiatives in their communities and organizations
- Each case study will include multiple hospitals and will be released on a rolling basis

The first three case studies in the series are:

1. Use of Locally-Derived Data to Design, Develop and Implement Population Health Management Interventions
2. Deploying Effective Management Strategies to Drive Change
3. Strategies to Align Clinical and Non-clinical Care to Address Community's Behavioral and Social Needs

2

Deploying Effective Management Strategies to Drive Change

Background

- The health care industry as a whole has been slow in utilizing dedicated individuals with strong management experience and skills to lead projects, instead relying on clinical or technical staff with substantial other responsibilities
- In addition to strong project managers and processes, the success of individual initiatives depends on senior-level support
- Need and opportunity to develop middle-management was echoed throughout CHART Phase 1 activities and the Leadership Summit

CHART hospitals highlighted in Case Study 1

Deep leadership engagement directly supporting project staff as well as championing the project throughout the organization substantially removed roadblocks

HealthAlliance Hospital's project manager had substantial autonomy and sole responsibility to CHART implementation; flexed work schedule meet 24 hour nature of the ED

Signature Healthcare Brockton Hospital had multidisciplinary executive team champions to support institution-wide change

Key lessons learned

1. There is tremendous variation within and across hospitals in project management capacities; often success relies on skilled and dedicated individuals and not development of effective systems.
2. Many organizations are challenged to provide effective models for development of middle management, which has impacts on culture and performance
3. Project managers must have experience, credibility, and the technical expertise required for change management in a clinical setting
4. Sustained, organization-wide change requires leadership with both long term strategic vision and a hands-on approach, including executive sponsors who enable, support, and empower middle-management

Looking toward Phase 2

- CHART staff is strongly encouraging hospitals to assign a dedicated project manager with project management training and experience, to their Phase 2 projects; initiation payment funds are being focused towards early deployment of key project leaders
- The HPC has required a 10% time commitment from a senior operational and clinical leader for Phase 2 to ensure ongoing leadership engagement and buy-in

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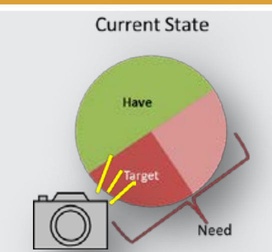
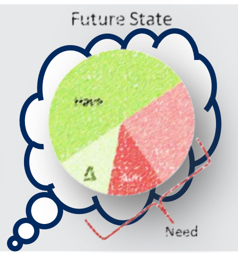
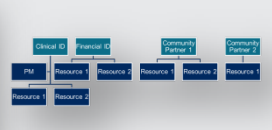
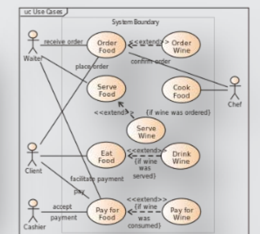
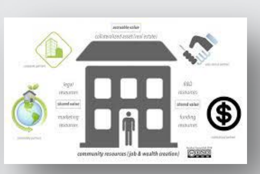
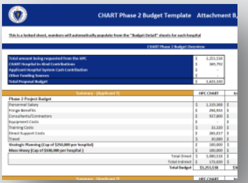
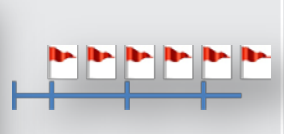
Overview of the Implementation Planning Period (IPP)

	1. Describe Current State	2. Verify Aim	3. Refine Service Model	4. Finalize Staffing Model	5. Develop Technology Req's	6. Develop Mass HIway cases
						
Activity Description	Utilize your data and patient interviews to be able to define your target population and describe the state of the measures you intend to affect	Using your baseline, quantify the specific impact your Initiatives will seek to have on the target population by the end of the Period of Performance	Design Initiatives that address the needs (i.e., Drivers) of the target population in order to achieve the Aim Statement	Specify the exact staffing model to support Phase 2 investments (service delivery, administrative, and leadership needs)	Specify lightweight technologies to be used to support achievement of Aim(s)	Specify intended uses of Mass HIway (to be further developed post-IPP)

	7. Define Scope of Strategic Plan	8. Describe Non-Service Investments	9. Develop Measurement Plan	10. Submit Final Budget	11. Extrapolate Project Milestones	12. Finalize Payment Schedule
						
Activity Description	Define broad goals for strategic planning, to be refined and subject to HPC approval after release of Community Hospital Study	Specify needs and requirements for service-delivery investments (e.g., training, capital, consultants, TA, etc.)	Finalize measurement plan (including validation of data sources and ability to collect measures) for standard and award-specific metrics	Specify final budget based on prior amendments and up to Board -approved award cap	Specify all project milestones (including goals and metrics where appropriate) to assess successful completion	Align disbursement schedule with project milestones including both process and achievement based payments

Staff and hospitals have found IPP to be valuable but also resource-intensive

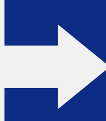
Intensive, collaborative planning requires resources but will yield:

1. Strong interventions with quantified, measureable aims
2. Clinical models employing best known practices
3. Strong opportunities for successful transformation
4. Sufficient time for marshalling effective resources both within and external to awardee hospitals
5. Appropriate, measured oversight with rapid-cycle improvement throughout period of performance

Investment in planning is investment in transformation

Staff are actively working in partnership with hospitals to resolve key implementation challenges

Challenge	Response
With competing priorities and limited resources, hospitals find it challenging to devote time and attention to clinical program design	Hospitals are being encouraged to use Implementation Planning to hire dedicated Project Managers
Data and analytics infrastructure is under-resourced at many hospitals	CHART contemplating ADT-enabled, technology solution
Hospitals seek technical assistance in core functional areas and key program domains	Technical assistance plan will provide responsive supports, many of have been fielded during IPP (e.g., regional convening)



During IPP the HPC reaches agreement with the awardee on services to be provided as well as clinical and non-clinical workflows

Measure	Total	Proportion of Total (%)
A. Total Discharges	7883	100%
B. Total Discharges to Post-Acute Care	3038	38.5%
C. Discharges to SNF/IRF/LTAC*	1542	50.8%
D. Discharges to Home Health	1496	49.2%
E. Discharges to Home	4395	55.8%
F. Discharges with Primary or Secondary BH Diagnosis	4269	54.2%
G. Total (adult non-OB) 30-day Readmissions	1094	13.9%
H. Readmissions Occurring <4 days of d/c	188	17.2%
I. Readmissions Occurring <10 days of d/c	477	43.6%
J. Readmissions with a Primary or Secondary BH Diagnosis	573	52.4%
K. Number of Patients with ≥4 Hospitalizations Past Year	234	---
L. Total Number of Discharges Among [K]	1182	15.0%
M. Total 30-day Readmissions Among [K]	526	48.1%
N. % of Discharges that Result in Readmissions Among [K]	---	44.5%

Example Only: Target Population Development

54%

behavioral health comorbidity among hospital discharges

48 % | **234** Patients

234 superutilizers drive readmission rate

A key output of IPP, CHART Phase 2 Aim Statements, are impactful and measurable

Reduce 30-day readmissions by 20% for patients with a history of recurrent acute care utilization, social complexity, and/or in need of palliative care, within two years

Reduce 30-day ED revisits by 10% for all ED patients with a primary or secondary BH diagnosis, and reduce 30-day readmissions by 20% for all high utilizers within two years

Aim Statements focus interventions and are the backbone of service models

Reduce 30-day readmissions by 20% for all med/surg patients discharged to SNF, home care, or palliative care; BH patients readmitted within 30 days; and all patients with two or more readmissions in the past six months, within two years

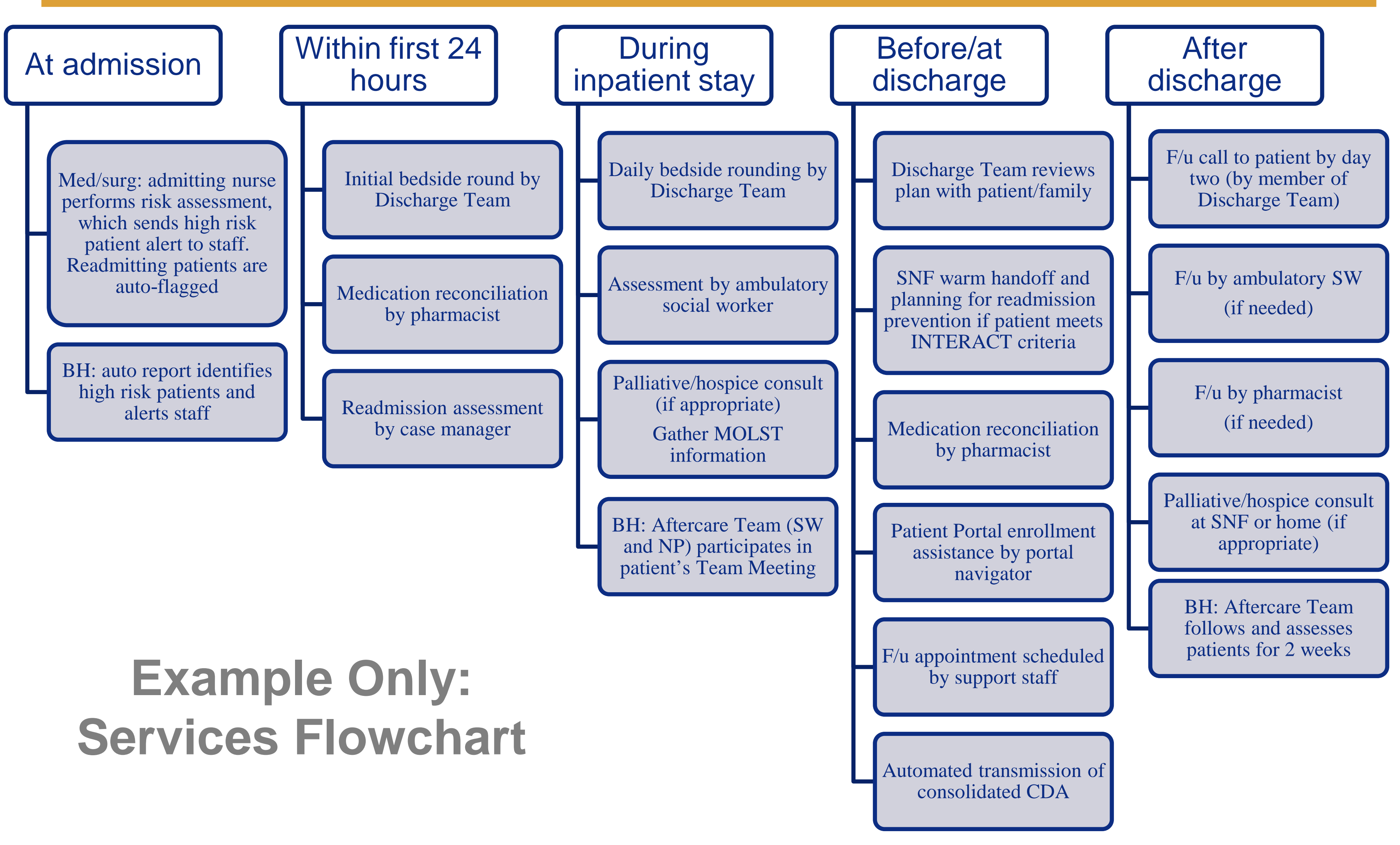
Reduce 30-day ED revisits and 30-day readmissions to inpatient psych by 25% for patients with BH conditions within two years

Example Only: Aim Statement Development

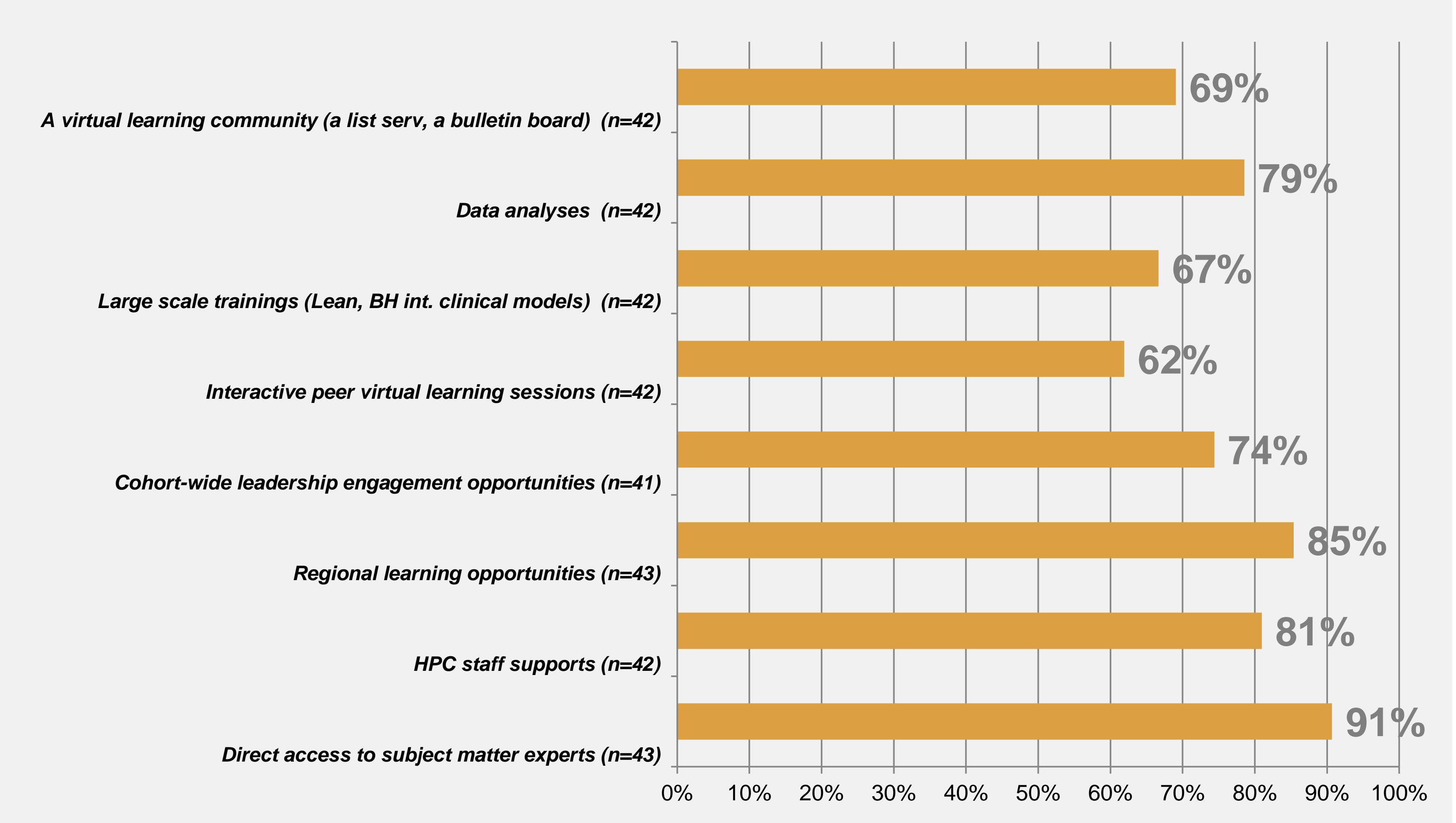
Vote: CHART Implementation Planning Period

Motion: That, pursuant to 958 CMR 5.07, the Board hereby authorizes the Executive Director to increase the overall award funding for each hospital participating in Phase 2 of the Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program by up to $100,000, provided that such additional funding shall be used to support additional Implementation Planning activities.

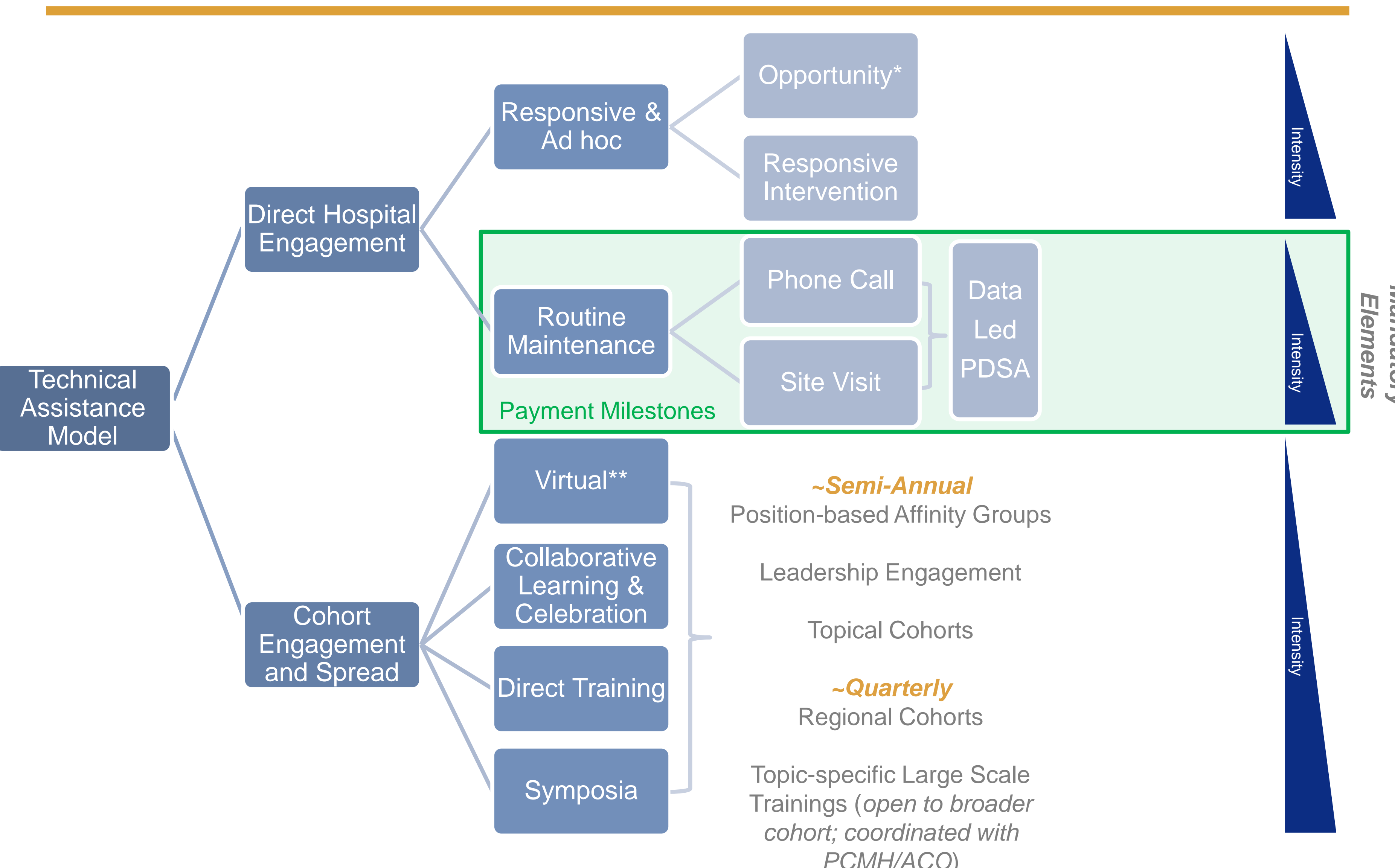
During IPP the HPC reaches agreement with the awardee on services to be provided as well as clinical and non-clinical workflows



Provider engagement and support



Modes for technical assistance and provider engagement



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

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

Technical assistance topics and necessary expertise

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

Potential Topics for Technical Assistance Activities

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

Necessary Content Expertise

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

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- Community Health Care Investment and Consumer Involvement Update
- **Quality Improvement and Patient Protection Update**
  - Quality Measures Relative to ICU Nurse Staffing Ratios
  - Office of Patient Protection (OPP) Role in Health Insurance Waiver Process
  - Risk-Bearing Provider Organizations (RBPO)
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Proposed Regulation 958 CMR 8.00: Timeline Update

January 20: HPC Board Meeting
Vote to advance proposed regulation to public comment and hearing process

March 4: QIPP Committee Meeting
Discussion and release of proposed quality measures for public comment

March 25: Public Hearing on proposed regulation
One Ashburton Place, 21st Floor, Boston, 12 PM

April 2 : Public Hearing on proposed regulation
Worcester State University, Blue Lounge, 486 Chandler Street, Worcester, 10 AM

April 6: Public Comment Period closes

April 28: QIPP Committee Meeting
Discussion of recommended final regulation and vote to advance final regulation

April 29: HPC Board Meeting
Discussion of recommended final regulation; vote to authorize final regulation

Summer 2015 – DPH develops and promulgates regulation governing certification and enforcement

**Certain dates subject to change*

Proposed Quality Measures Released for Public Comment

Based on extensive stakeholder input, consultation with experts, and internal research and analysis, the QIPP Committee advanced the following four proposed quality measures for public comment:

1. **Central line-associated blood stream infection (CLABSI)**
2. **Catheter-associated urinary tract infection (CAUTI)**
3. **Pressure ulcer prevalence (hospital acquired); and**
4. **Patient fall rate**

Proposed Regulation 958 CMR 8.00: Next Steps

- The proposed quality measures will be posted on the HPC's website and distributed to interested parties
- Public comment and testimony to be received at two public hearings
  - March 25, 2015 at 12 PM in Boston
  - April 2, 2015 at 10 AM in Worcester
- In advance of the hearings, HPC staff anticipate posting focus questions as well as guidelines for the public hearings on the HPC's website
- Written comments accepted until Monday, April 6, 2015 at 12:00 PM

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Office of Patient Protection: Program Update on Open Enrollment Waivers

- Massachusetts and federal law establish open enrollment periods to limit when consumers can buy individual or non-group insurance
- Mass. law provides additional rights for Mass. residents who missed the annual open enrollment period by creating a process to waive the open enrollment rules on a case-by-case basis (M.G.L. c. 176J, §4(a)(4))
- Consumers may apply for a waiver of the open enrollment period from the Office of Patient Protection
- OPP reviews waiver requests and typically grants open enrollment waivers to consumers who:
  - Are uninsured and did not intentionally forgo enrollment in health insurance, or
  - Lost insurance coverage but did not find out until after 60 days had passed, or
  - Other extenuating circumstances
- Many consumers do not need a waiver and may purchase insurance if they experience a qualifying event or special enrollment period, e.g.,
  - Eligible for MassHealth or subsidized insurance (income below 300% FPL), or
  - Lost insurance coverage within the past 60 days, or
  - Other qualifying events established by state or federal law (e.g., birth or adoption of child, marriage, new citizenship status, etc.; see 45 C.F.R. §155.420 and 956 CMR 12.10(5))

How consumers may purchase non-group insurance when enrollment is closed

Steps to apply for waiver and purchase insurance

1. Try to buy non-group insurance

- Apply to purchase insurance through the Health Connector, insurance company or insurance agent

2. Receive denial notice

- The insurer or Health Connector will send a denial letter, email or other notice and information about OPP waivers
- Consumer needs a copy of the denial notice to apply for a waiver

3. Apply for enrollment waiver

- Fill out waiver application form (available from insurer or on OPP website)
- Send completed waiver application form and denial notice to OPP
- No application fee

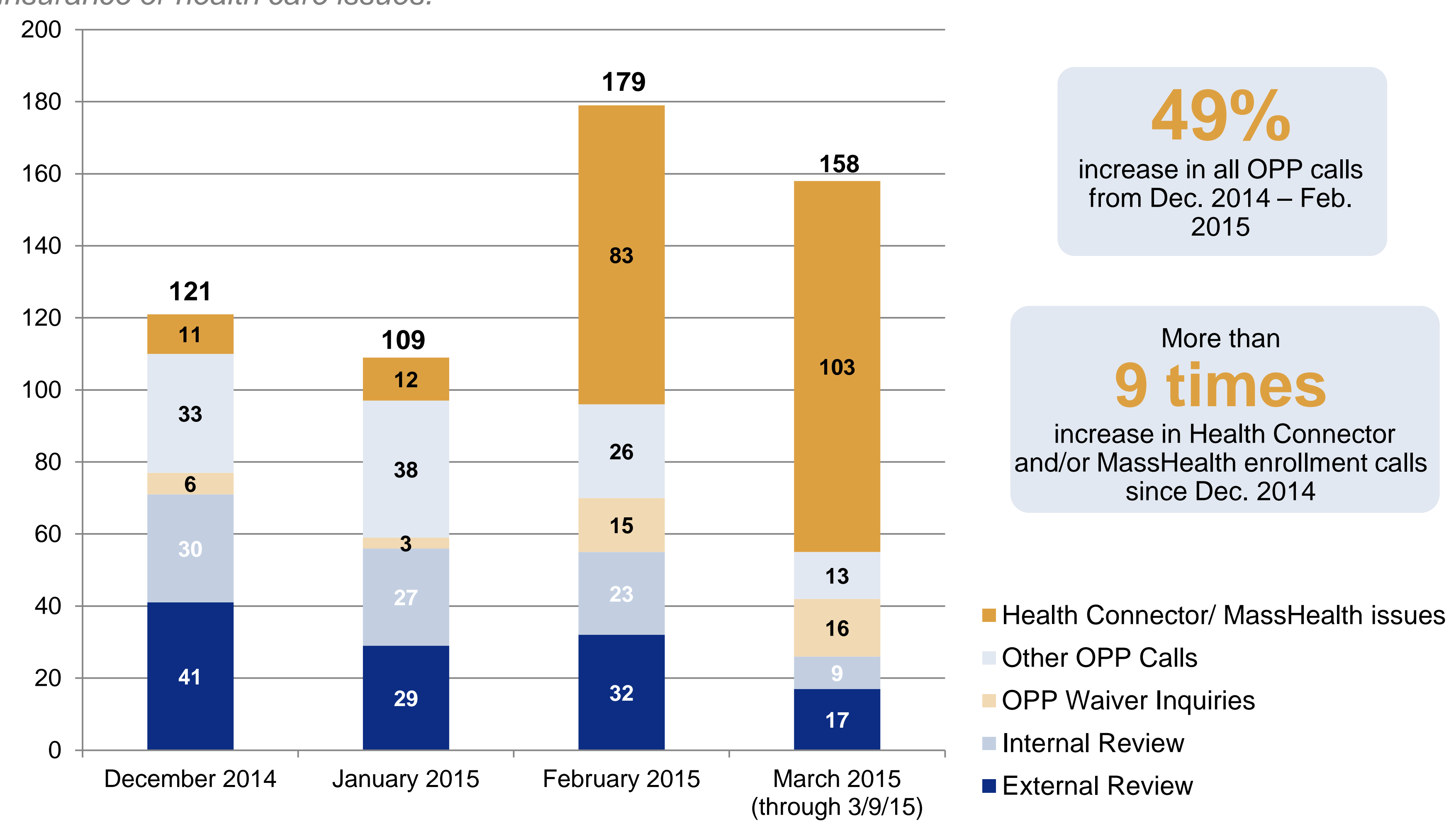
4. Return to insurer to purchase

- If consumer is eligible for a waiver, OPP will send a waiver letter within 30 days of receipt
- Take the waiver letter back to the insurer to buy insurance

Source: see 958 CMR 4.00.

Consumer phone calls to OPP, December 2014 through March 9, 2015

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



Source: Office of Patient Protection 2014 & 2015 Data

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  - Office of Patient Protection (OPP) Role in Health Insurance Waiver Process
  - **Consumer Appeals Process for RBPOs and ACOs**
- Care Delivery and Payment System Transformation Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (April 29, 2015)

Overview: Appeals Processes for RBPOs and ACOs

- **Chapter 224 requires the HPC to develop internal and external review processes for RBPOs and ACOs**
  - Office of Patient Protection (OPP) is directed to establish requirements for DOI-certified Risk Bearing Provider Organizations (RBPO) or HPC-certified Accountable Care Organizations (ACO) to implement processes for reviewing consumer grievances as well as an external review process to obtain third party review of such grievances.
- **Statutory requirement similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations**

Summary of statutes

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

Key considerations for development of regulation

- Applicable to RBPOs and ACOs
- Appeals processes available to patients for whom RBPO is at risk
- Process/locus of appeal within the RBPO, given different organizational structures
- Defining types of issues appropriate for internal review/external review
  - Identifying issues “not otherwise properly heard through” the consumer’s health plan or provider (i.e., disputes about coverage, medical necessity, BORIM issues)
- Defining standard for external review

Recommended Process

1 Provide Interim Guidance

- Given RBPO status of certification process, recommend issuing a Bulletin to RBPOs to advise them of the need to provide notice and opportunity for patients to file complaints
- Require collection and reporting of data on number and types of grievances filed for some period of time

2 Development of Regulation

- Review of Data
- Listening Session(s)

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- **Care Delivery and Payment System Transformation Update**
  - PCMH and ACO Certification Programs
- Administration and Finance Update
- Schedule of Next Commission Meeting (April 29, 2015)

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  - **PCMH and ACO Certification Programs**
- Administration and Finance Update
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PCMH Program Update

Certification Standards

- HPC released proposed PCMH certification standards for public comment. Responses are due on March 27, 2015.
- HPC hosted two focus groups prior to releasing standards for public comment
- HPC will host two stakeholder Q&A sessions during the public comment period
  - March 18, 2015, 4-5 PM
  - March 23, 2015, 2-3 PM
- Continued discussion with stakeholders through focus groups and one-on-one meetings
- Proposed standards to be finalized during the April 29, 2015 board meeting

Model payment

- Development of overall policy framework (key principles, approach, timeline) is underway
- Focus groups on policy framework next week
  - March 16, 2015, 12-2 PM
  - March 17, 2015, 2-4 PM
- Further discussion at CDPST on April 1, 2015 and at the board meeting on April 29, 2015

ACO certification: Key takeaways from expert input

Certification – General Thoughts

- Current evidence on link between capabilities and performance is thin
- Exceptions:
  - Leadership: essential (but hard to regulate)
  - Insurance oversight if risk bearing
  - Performance reporting (so we know how they are doing)
- Remarkable diversity in current models; over-specification likely harmful
- However, certification can help address ACOs "in name only"

Minimum standards

- Align with MSSP to extent possible
- Encourage systems to move to all-payer ACO contracts
- Consider standardized reporting on structure, contracts, capabilities
- Protections against stinting and dumping – i.e., what ACOs should not do
- Building blocks: information flow, risk stratification, effective transitions, gap analysis, team based care, process improvement (team); provider feedback (individual)

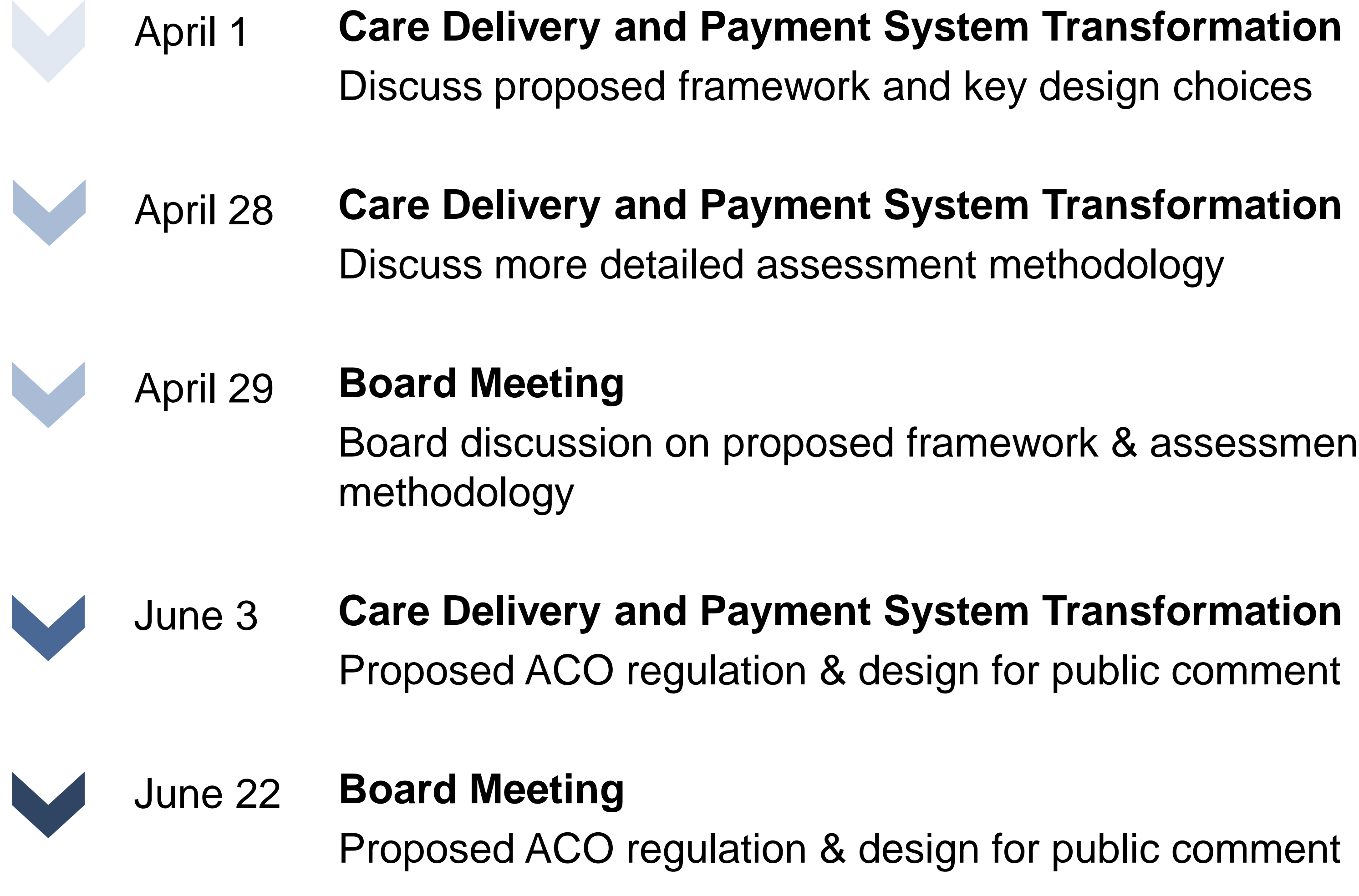
More advanced ACOs

- Link levels to:
  - Proportion of primary care patients under ACO model
  - Degree of risk bearing
  - Ability to report on advanced measures (PROMs, health risk)
  - Price reductions for remaining FFS contracts

What else can the HPC do?

- Payment model concordance (push other payers)
- Standardized data collection; link to performance tracking
- Design the certification process to accelerate learning
  - Use assessments to identify peer-coaching opportunities
  - Technical support, access to evidence
  - Data support

ACO Certification: Next Steps



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HPC Lease Amendment: 50 Milk Street

Current Space

Proposed Expansion

Vote: Lease Amendment

Motion: That, pursuant to G.L. c. 6D, § 3(d), the Commission hereby authorizes the Executive Director to execute and deliver an amendment to the HPC's lease for additional, contiguous office space to meet the space needs of the Health Policy Commission for a term of ten 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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Vote: Commending Karen Tseng

Motion*:* That, in recognition of her exceptional service to the Health Policy Commission as Director of Policy for Market Performance and her remarkable contribution on behalf of the Commonwealth to enhancing health care market transparency by leading the Commission's seminal cost and market impact reviews and building a strong analytic framework and team on which the Commission can continue its work consistent with the exceptionally high standards she set, the Board hereby commends Karen Tseng and wishes her well in her new position as Chief of the Health Care Division in the Office of Attorney General Maura Healey.

Contact Information

For more information about the Health Policy Commission:

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