COMMONWEALTH OF MASSACHUSETTS

# HEALTH POLICY COMMISSION

July 22, 2015

Board Meeting

# Agenda

- Approval of Minutes from the June 10, 2015 Meeting
- Chair Report
- Executive Director Report
- Cost Trends and Market Performance Update
- Care Delivery and Payment System Transformation Update
- Quality Improvement and Patient Protection Update
- Community Health Care Investment and Consumer Involvement Update
- Administration and Finance Update
- Schedule of Next Commission Meeting (September 9, 2015)

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# Vote: Approving Minutes

**Motion**: That the Commission hereby approves the minutes of the Commission meeting held on June 10, 2015, as presented.

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# HPC 2015 Summer Fellows

**Adrienne Anderson**
*Yale University, MPH*
Substance Use Disorder Report

**Sharone Assa**
*Harvard School of Public Health*
Office of the General Counsel

**Emma Gaquin**
*George Washington University, BA/MPP*
Office of the Chief of Staff

**Rachel Goldstein**
*Brown School of Medicine, MD/MPH*
Substance Exposed Newborns

**Sarah Hijaz**
*Tufts Public Health Program, DrPH*
Provider Price Variation

**Nina Jolani**
*Northeastern University, MS Health Informatics*
Health Information Exchanges

**Katherine Kilrain**
*Suffolk Sayer School of Management*
Registration of Provider Organizations

**Emma Sandoe**
*Harvard University, PhD Health Policy*
Long Term Care

**Mubeen Shakir**
*Oxford University, MPP*
PCMH Technical Assistance

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# Connecticut's new health care law

**Public Act No. 15-146, *An act concerning hospitals, insurers and health care consumers***, was signed into law by Connecticut Governor Dan Malloy on June 30, 2015. The law includes significant provisions that will impact Connecticut insurance companies, hospitals, physicians and health care consumers.


A number of the provisions in Connecticut's new law reflect, and in some cases directly parallel, the Health Policy Commission's statutory charges and health care policy efforts. HPC staff have been, and will continue to be, in communication with various Connecticut staffers to facilitate mutual information sharing.

# Overview of key provisions

**Study of Cost Containment in Other States**

- The law charges the **Health Care Cabinet** with **studying health care cost containment models in other states,** including Massachusetts, to "identify successful practices and programs that may be implemented" in Connecticut
- The Cabinet must **submit a report** to the General Assembly no later than December 1, 2016 documenting the study findings and including **recommendations for administrative, regulatory and policy changes** that will provide for:
  - A framework for monitoring and responding to health care cost growth on a provider and state-wide basis (may include benchmarks or limits), identification of providers exceeding such benchmarks or limits, and provision of assistance for providers to meet benchmarks or to hold providers accountable;
  - Mechanisms to identify and mitigate factors that contribute to cost growth as well as price disparity between providers of similar services (including, e.g., consolidation, integration);
  - The authority to implement and monitor delivery system reforms designed to promote value-based care and improved health outcomes;
  - The development and promotion of insurance contracting standards and products that reward value-based care and promote the utilization of low-cost, high-quality providers; **and**
  - Implementation of other policies to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care

**Revision of Certificate of Need (CON) Process & Establishment of Cost and Market Impact Reviews**

- The law **revises the CON process** with respect to applications involving hospital ownership transfer
- The law also **establishes a cost and market impact review (CMIR) process** to be conducted by the Office of Health Care Access (OHCA) division within the Department of Public Health
- Beginning with CON applications involving transfer of hospital ownership filed on or after December 1, 2015, OHCA **shall conduct a CMIR in each case** where (1) a CON application involves the transfer of ownership of a hospital, and (2) the purchaser is a hospital or hospital system that had greater than $1.5 billion in net patient revenue for FY13, or any person that is organized or operated for profit

# Overview of key provisions, continued

**Community Hospital Financing Report**

- Connecticut's Health and Educational Facilities Authority **(CHEFA)**, in consultation with other state entities, must **consider financing options** to enable **community hospitals** to engage in activities (including the acquisition of medical equipment, updating of information technology, and the renovation or acquisition of health care facilities) in order to improve their ability to effectively serve the community, support infrastructure investments, improve affordability and quality of care, and improve access, among other stated purposes
- CHEFA must **report** recommendations to the General Assembly no later than **January 1, 2016**

**Study of Price Variation**

- The Insurance Commissioner **shall convene a working group** to study the rising costs of health care, including but not limited to, increases in the prices charged for services, the variation in such prices among providers, the impact on such prices and variation of reimbursement rates paid by carriers, and the impact of price variation on the state (as payer and provider), premiums, and out-of-pocket costs
- A **report to the General Assembly**, no later than January 1, 2016, will contain **recommendations**; may include expanding or modifying limitations on facility fees, establishing a reasonable maximum provider price variation limit, and establishing a state-wide median rate for certain services and procedures, among others

**Out-of-Network Billing & "Surprise Bills"**

- The law contains **restrictions around billing** for emergency services by an out-of-network provider, as well as for "surprise bills;" outlines the limitations for costs to the insured and reimbursement by carriers
- A **"surprise bill"** is defined as a bill for nonemergency health care services received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by such out-of-network provider at an in-network facility, during a service/procedure performed by an in-network provider or during a service/ procedure previously approved or authorized by the carrier and the insured did not knowingly elect to obtain those services from that out-of-network provider

**Promotion of Tiered Networks**

- The law requires the CT Health Insurance Exchange to **encourage carriers to offer tiered** network plans and requires the exchange to **offer any such tiered plans through the exchange**

# Overview of key provisions, continued

**Facility Fees**

- The law imposes **additional requirements regarding facility fees**, including new requirements for billing statements that include facility fees (including the clear identification of the fee as a facility fee, a statement that the facility fee is intended to cover the hospital's or health system's operational expenses, and a phone number the patient may use to request a reduction of the facility fee or any other portion of the bill)
- The law also imposes **certain limitations on the actual facility fees collected**; if a transaction results in the establishment of a hospital-based facility at which facility fees will "likely be billed," the hospital or health system that is the purchaser must notify patients served by the purchased facility in the last 3 years; may not collect a facility fee until at least 30 days after the notice is mailed (or a copy of the notice is filed with OHCA)
  - However, beginning in 2017, facility fees are not allowed for certain outpatient physician office visits
- Hospitals and health systems will **report annually** to the Commissioner of Public Health regarding facility fees

**Transparency & Consumer Protection**

- The law creates a **number of new mechanisms** for health care consumers to learn about their health care costs, quality, and provider networks, including:
  - The CT Health Insurance Exchange must **establish and maintain a consumer health information website** to assist consumers in making informed decisions concerning their care
  - Prior to any scheduled admission, procedure or service, for nonemergency care, each health care provider shall **determine whether the patient is covered** under a health insurance policy; there are patient notification requirements if a patient is uninsured or the provider is out-of-network
  - New requirements for providers regarding plan acceptance and carrier updates to provider directories
- The law also expands practices considered **unfair trade practices** under the CT Unfair Trade Practice Act

**Notification of Referrals to Affiliated Providers**

- Each health care provider that **refers a patient to an affiliated health care provider must notify** the patient in writing that the providers are affiliated
- Providers must inform the patient that s/he is **not required to see the affiliated provider** and provide information about the patient's carrier for the patient to obtain information regarding in-network providers and estimated out-of-pocket costs for the referred service

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# Types of transactions noticed

**April 2013 to Present**

| Type of Transaction | Number of Transactions | Frequency |
|---|---|---|
| Physician group merger, acquisition or network affiliation | 12 | 27% |
| Acute hospital merger, acquisition or network affiliation | 8 | 18% |
| Clinical affiliation | 8 | 18% |
| Formation of a contracting entity | 7 | 16% |
| Merger, acquisition or network affiliation of other provider type (e.g. post-acute) | 5 | 11% |
| Change in ownership or merger of corporately affiliated entities | 3 | 7% |
| Affiliation between a provider and a carrier | 1 | 2% |

# Update on notices of material change

**Notices Received Since Last Commission Meeting**

- Clinical affiliation between Children's Hospital Corporation and Boston Medical Center to consolidate and restate existing arrangements to share pediatric specialist physician services
- Clinical affiliation between Children's Hospital Corporation and Lahey Health System to designate Children's as the preferred pediatric academic medical center for Lahey's risk patients
- Acquisition of Braintree Rehabilitation Hospital and New England Rehabilitation Hospital by HealthSouth Acquisition Holdings

# Update on notices of material change

## Elected Not to Proceed

- **Affiliation between UMass Memorial Health Care (UMass) and Quest Diagnostics Massachusetts (Quest MA)**
  - We found that UMass' purchase of a minority share of Quest MA will not substantively impact either organization's operation of clinical laboratory or anatomic pathology services.
  - We do not anticipate negative impacts on cost, quality, access to care, or the competitive market.
- **Acquisition of South Shore Medical Center by South Shore Physician Ambulatory Enterprise, an affiliate of South Shore Hospital**
  - Our analysis indicates that SSMC's prices and referral patterns are unlikely to change in a manner that would increase health care costs.
  - We also do not anticipate negative impacts on quality, access to care, or the competitive market.
- **Two joint ventures by Shields Health Care Group (Shields) to operate and contract for PET/CT diagnostic imaging clinics, one with Sturdy Memorial Hospital and one with Signature Healthcare Brockton Hospital**
  - Based on analysis of the APCD, we found that Shields PET/CT rates are comparable to those of the hospitals' current imaging providers, and the volume of services involved is relatively small. We therefore do not expect a significant cost or market impact as a result of the transaction.
  - We also do not anticipate a negative impact on quality or access to care.

# Updates to MCN and CMIR Process

This month, the HPC made the following updates:

- Released an FAQ clarifying timing and filing requirements for certain types of transactions requiring Notice
- Reorganized the MCN/CMIR website to make it more user-friendly
- Created a listserv for interested stakeholders to receive notice both when we receive MCNs and when we make determinations of whether or not to initiate a CMIR

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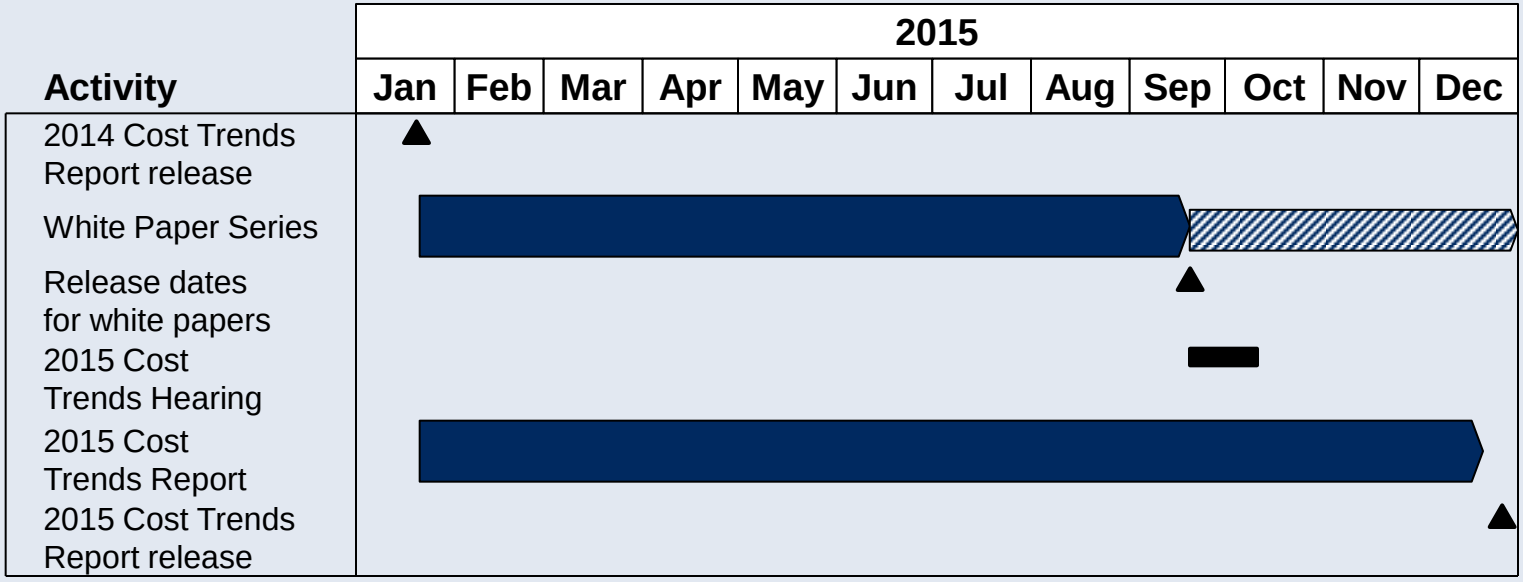
# Overview of 2015 Cost Trends Report

- HPC's third Annual Cost Trends Report
- 2015 Report will focus on new topic areas as well as progress over time
  - We will discuss progress in Massachusetts and broader national trends
  - Various chapters will discuss behavioral health and MassHealth; these will be cross-cutting themes
- Report emphasis and recommendations will vary according to state performance relative to benchmark and evidence regarding cost drivers
- HPC also continues research for white paper topics:
  - High-cost drug spending, primary care access and preventable hospital use, employer perspectives/insurance markets, scope of practice



# Draft outline for 2015 Cost Trends Report

## Trends in spending and delivery

- Benchmark– spending trends in MA and US
- Components of spending growth within MA
- Trends in provider markets
- Employer premium trends
- Access – financial and geographic
- Quality of care

## Progress in aligning incentives

- Payment Reform – trends in MA and US
  - ACOs, global payment, shared savings, P4Q
  - Bundled payments
  - Multi-payer alignment on APMs
  - Providers' needs for data and alignment
- Demand-side incentives
  - Network design, cost-sharing, reference pricing
  - Price transparency

## Opportunities to increase quality and efficiency

- *Price variation*
  - Maternity spending, lab tests
- *Opportunities to improve acute care use*
  - Preventable admissions, readmissions, ED use
- *Opportunities for improvement across non-acute needs*
  - Serious illness and end of life care
  - Post-acute care
  - Medicaid and long-term care

## Recommendations

- Dashboard (summary of current performance and areas for improvement)
- Recommendations from new and previously reported topic areas

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# 2015 Health Care Cost Trends Hearing

Commonwealth of Massachusetts

## Health Policy Commission

# 2015 Health Care Cost Trends Hearing

*An annual public examination of health care cost trends and drivers, featuring witness testimony and discussion with national experts on the challenges and opportunities within the Commonwealth's health care system.*

## October 5 & 6, 2015

Suffolk University Law School

120 Tremont Street, Boston, MA

# 2015 Health Care Cost Trends Hearing: Draft Agenda

## Day 1: October 5, 2015

**Opening Remarks:** State officials

**Keynote Remarks:** Governor Charlie Baker (invited)

**Presentation:** CHIA

**Policy Focus**: Challenges to the cost growth benchmark
- **Expert speaker:** TBD
- **Panel 1**: Challenges to the benchmark
  - Sub-themes: drug costs, waste

**Lunch Break**

**Presentation**

**Policy Focus:** Innovations to promote patient-centered care
- **Expert speaker:** TBD
- **Panel 2A**: Care delivery innovation (urgent care/Minute Clinics, telemedicine, scope of practice)
- **Panel 2B**: Meeting providers' needs for data and alignment
  - Subthemes: care integration, behavioral health, payer/provider reporting, EHR interoperability

**Closing Remarks and Public Comment**

## Day 2: October 6, 2015

**Opening remarks:** State officials

**Keynote Remarks:** Attorney General Maura Healey (confirmed)

**Policy Focus**: Market structure to promote value
- **Expert speaker:** Leemore Dafny, PhD (confirmed)
- **Panel 3**: Retrospective on past market transactions (provider)

**Lunch Break**

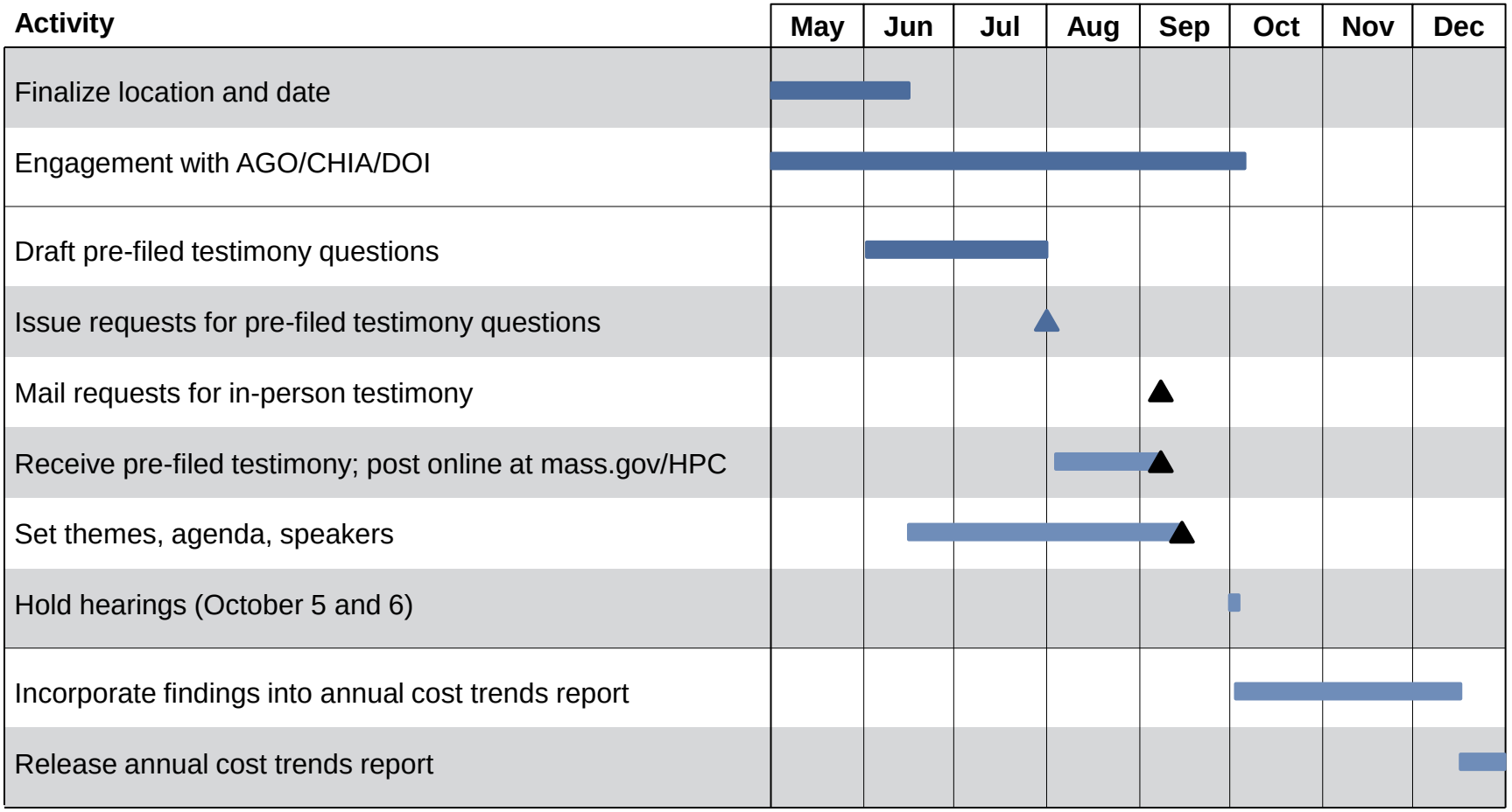
**Presentation:** Office of the Attorney General on Limited/Tiered Network Products

**Policy Focus:** The role of payers in promoting value
- **Expert speaker:** TBD (CA expert on reference pricing)
- **Panel 4A:** Payment reform progress (APMs)/price variation (payer)
- **Panel 4B:** Product and market design – harnessing the power of purchasers and consumers (payer/employer)
  - Sub-themes: employer perspectives, consumer price transparency tools

**Panel 5**: Reflections on Evidence (payer/provider)

**Closing Remarks and Public Comment**

# Tentative Timeline: Cost Trends Hearing and Report



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# PCMH Certification: Response to public comment & focus groups

**Pathway structure**:

- Practices believe NCQA's baseline recognition requirements are difficult to achieve, requiring **significant resources** to change practice workflows, and adding an additional layer of **administrative burden**

**Feasibility of proposed HPC domains**:

- Practices are not currently demonstrating advanced primary care in all four HPC domains, and most would **advocate for fewer required domains** so practices can allocate resources and efforts appropriately

- Domains considered to be more aspirational vs. attainable in the short term

  - *Resource Stewardship:* Difficulty identifying high-risk patients for care management and **capturing necessary levels of utilization data**

  - *Patient Experience:* Concerns with validity and cost of doing patient surveys at small practices

  - *Behavioral Health Integration:* Concerns with **maintaining agreements** with behavioral health providers and **requirements to screen** for additional conditions, given lack of access to behavioral health providers

  - *Population Health Management:* Concerns with **immunization measurement** and concerns with **barriers to accessing and managing data** requirements

**PCMH concepts in the individual practice vs. system of care (ACO)**:

- PCMH activities are most efficiently performed at different levels of care (e.g., within a larger system; practice setting with centralized support; by the practice alone). Recognizing this, HPC will seize the **opportunity to link PCMH and ACO standards**.

# PCMH Certification: Next steps

**Program Design**

Finalize certification design and work with NCQA

**Operational Planning**

Finalize operationalization plan for program implementation

**Technical Assistance**

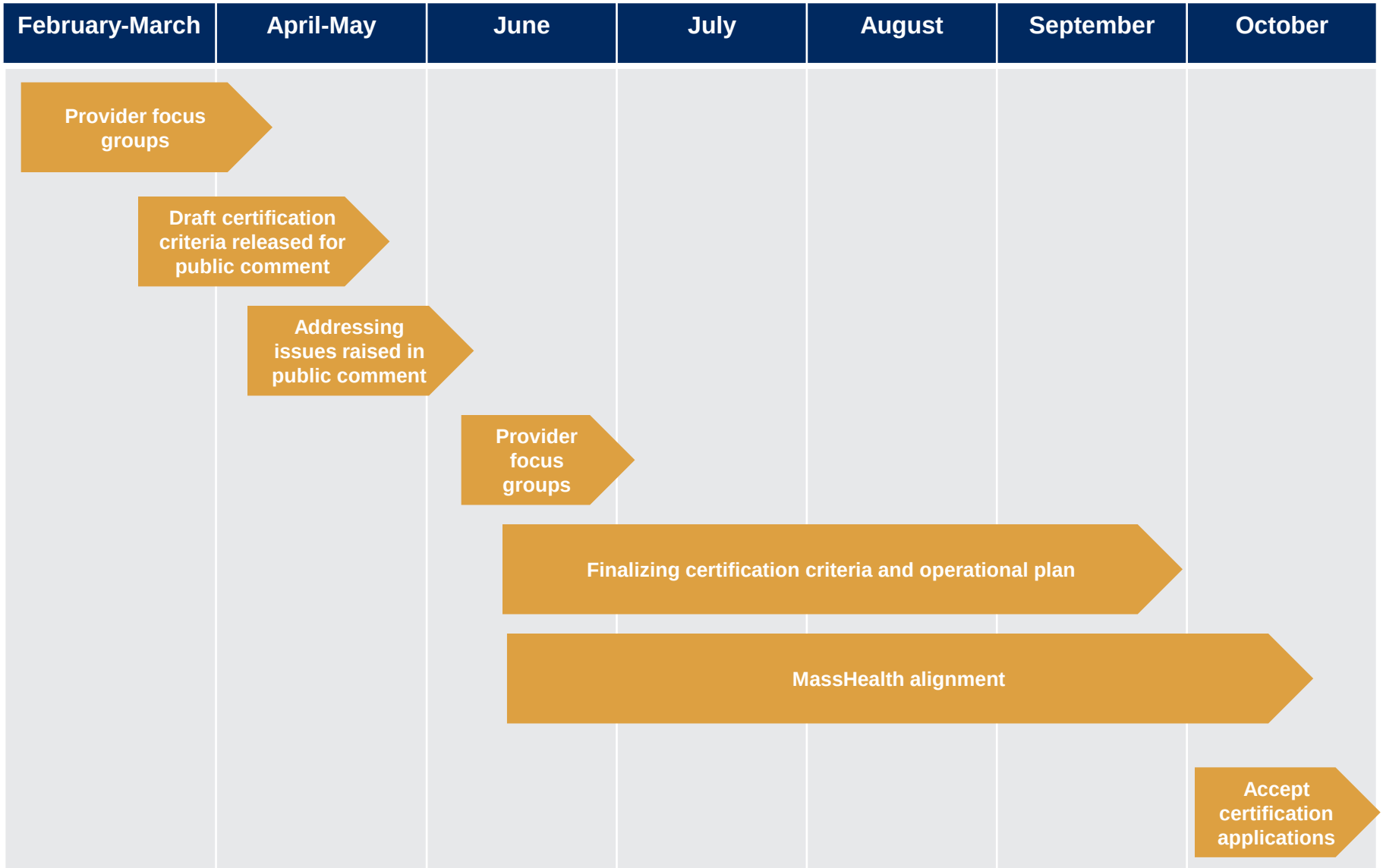
Design and implement technical assistance to promote behavioral health integration into primary care

**Additional Program Development**

Marketing / branding / data & benchmarking support

Alignment with MassHealth payment reform efforts

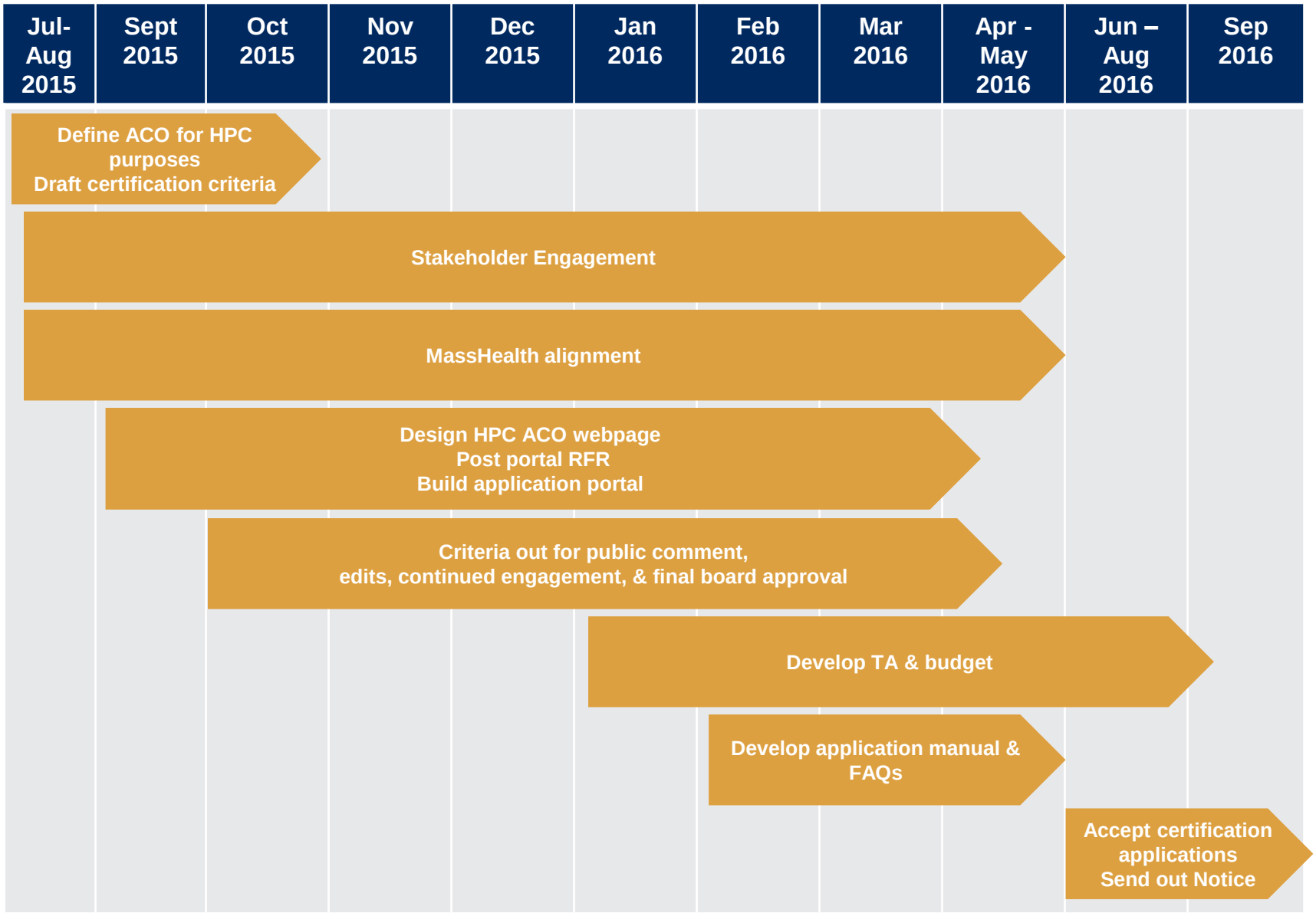
# PCMH Certification: Timeline



# ACO Certification: Process update

| | |
|---|---|
| **Operational Planning** | ▪ HPC is drafting **plan for operationalizing** ACO certification program<br>▪ Operational plan will delineate processes for evaluating applications, technical assistance platform, marketing, and auditing |
| **Refining criteria** | ▪ HPC will continue to **engage stakeholders**, including providers, patients and payers, to obtain feedback on the feasibility, efficacy, and impact of proposed ACO criteria and requirements<br>▪ HPC will work with **consultants** to advise on refining ACO criteria, modeling of TME analysis, and developing quality measure set for evaluating ACOs at **initial certification** and **re-certification** |
| **Interagency collaboration** | ▪ HPC is collaborating with **MassHealth** and **GIC** throughout the development of ACO criteria and program implementation in order to align with their payment reform efforts<br>▪ HPC also plans to work closely with **DMH** and **DPH** to foster interagency feedback and collaboration towards developing the ACO certification program |

# ACO Certification: Timeline



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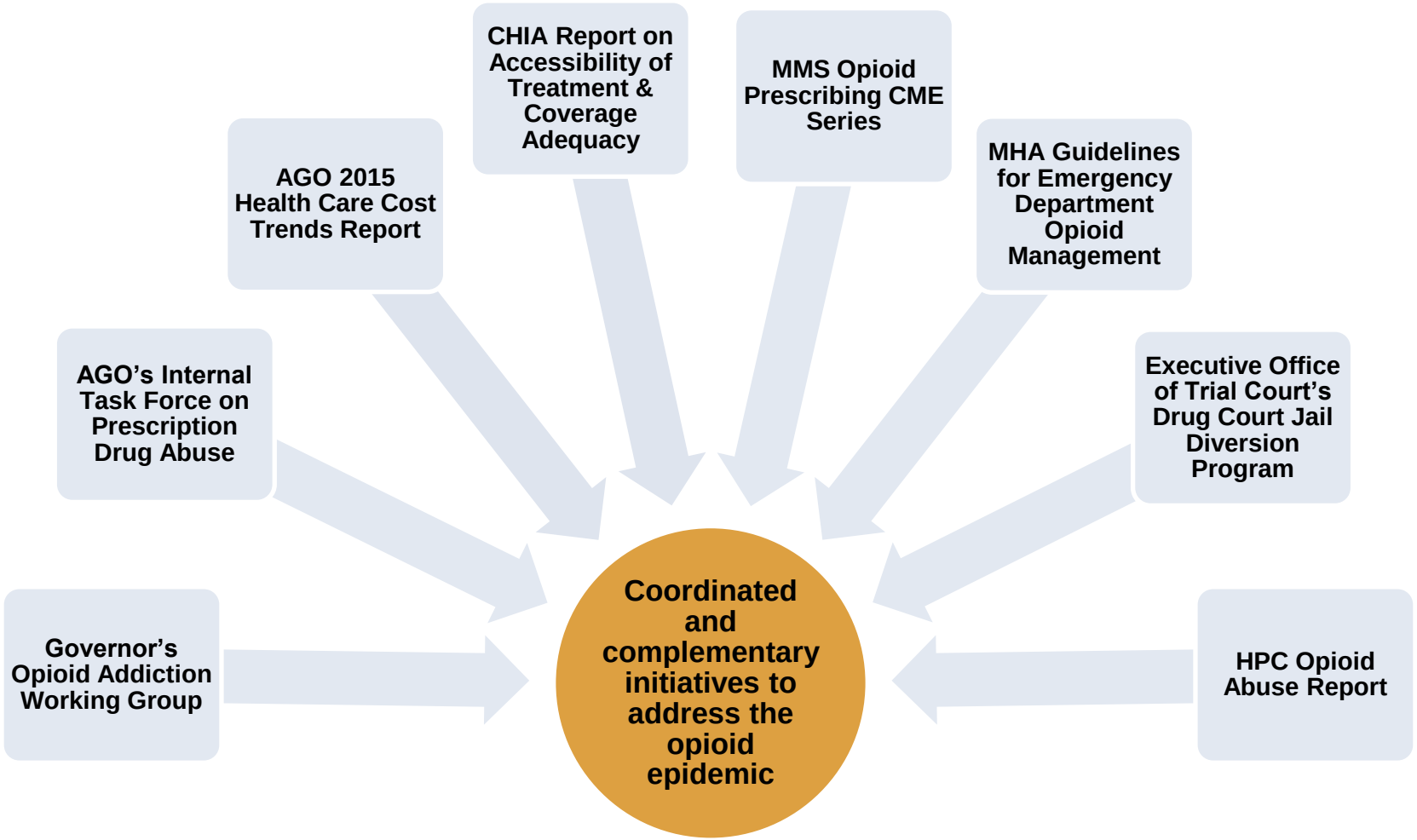
# Substance Use Disorder Report: HPC report statutory mandate

In 2014, the Legislature passed a comprehensive health care law, ch. 258 of the Acts of 2014, *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*.

Recognizing the HPC's unique mission and role in developing and promoting evidence-based health policy that improves the **transparency, accountability, efficacy, and efficiency** of our health care system, ch.258 charged the HPC to put forward recommendations on:

1. Improving the adequacy of coverage by public and private payers where necessary;
2. Improving the availability of opioid therapy where inadequate; and,
3. Identifying the need for further analyses by CHIA.

# Substance Use Disorder Report:
# Major activities in the Commonwealth relating to opioid abuse



# Substance Use Disorder Report: Principles guiding HPC's opioid abuse report development

HPC's recommendations will be **objective, data-driven, and evidence-based**, drawing on leading state & national policies, emerging best practices, published literature, and input from a wide spectrum of experts and stakeholders. Recommendations will be focused and actionable, reflecting the statutory charge from the Legislature.

**HPC seeks alignment and consistency with other Massachusetts activities, and aims to further contribute to policy around opioid abuse by:**

1. Providing new research, data, or evidence to support and inform legislative action;
2. Supplementing previous reports with new or more *specific and actionable* recommendations, based on our research & analysis;
3. Identifying strategic opportunities for care delivery/payment reforms for substance use disorder treatment that are likely to result in reduced spending and improved quality/access (consistent with HPC's overall mission);
4. Drawing on our experience with investment & technical assistance programs (e.g., CHART hospital initiatives to reduce opioid prescribing);
5. Recommending specific data needs and further analyses to be addressed by CHIA, DPH, HPC, and other government actors.

For the past six months, the HPC has conducted research, interviewed stakeholders, surveyed providers, and attended public sessions related to the opioid epidemic.

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# Opiate Exposed Newborns: Neonatal abstinence syndrome (NAS)

- Neonatal abstinence syndrome (NAS) is a clinical diagnosis resulting from the abrupt discontinuation of exposure to substances in utero (e.g., methadone, opioid pain relievers, buprenorphine, heroin)
- Clinical presentation: tremors, irritability, high-pitched, excessive crying, diarrhea (seizures present in 2-11% of infants with NAS)
- NAS is rarely fatal; it results in short-term morbidity and prolonged hospital stays
- Average length of hospitalization in the United States is **16 days**, though reported length of stay (LOS) ranges from **9 – 79 days**

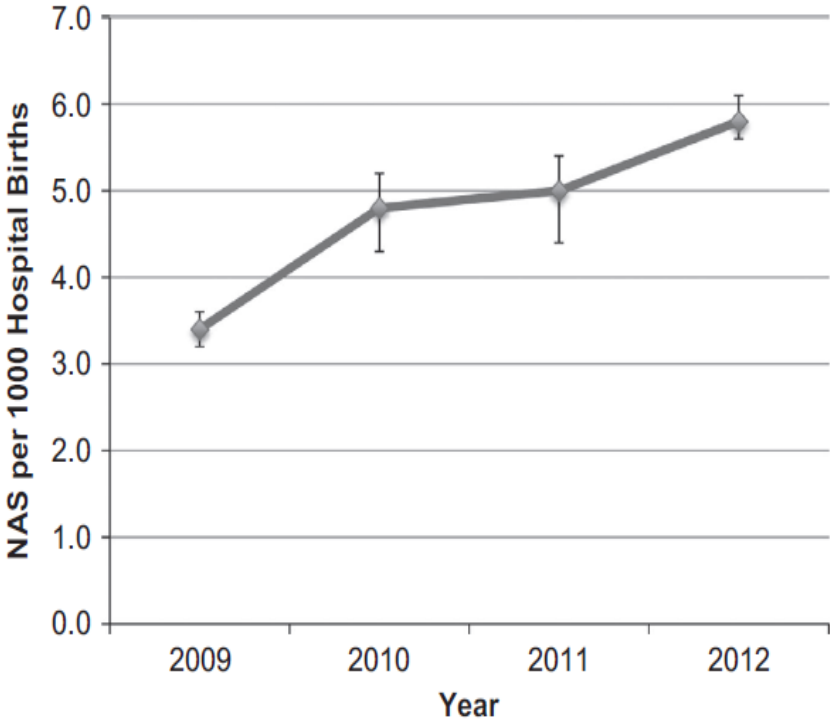
Kocherlakota, P. Neonatal abstinence syndrome. Pediatrics 2014;134(2):547-561.

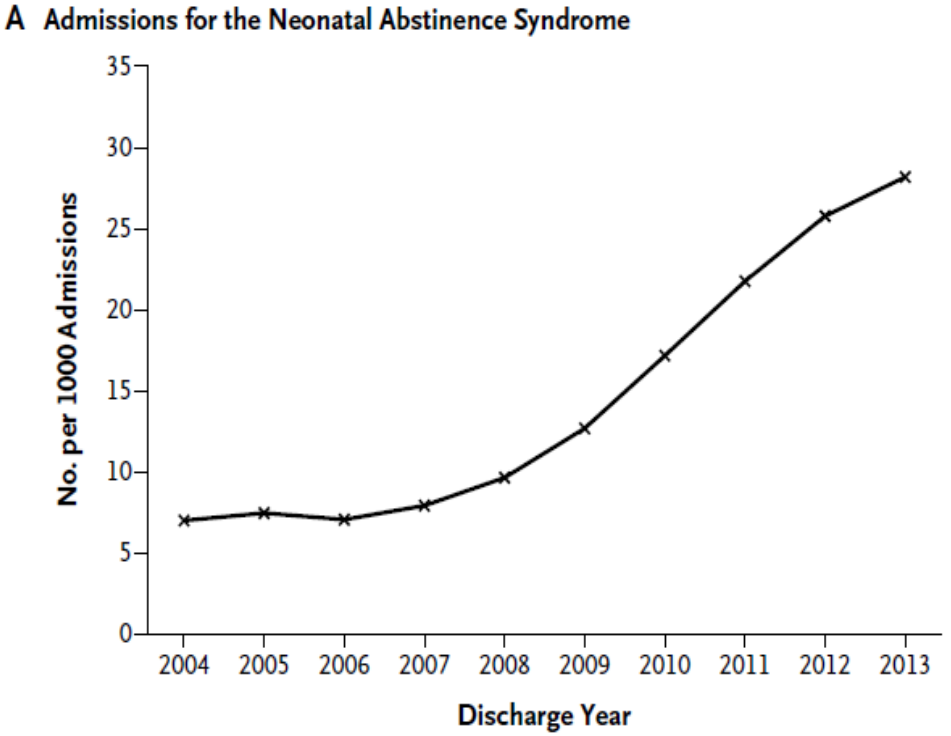
Asti L, Magers J, Keels E, Wispe J, McClead R. A quality improvement project to reduce length of stay for neonatal abstinence syndrome. Pediatrics 2015; 135(6):e1494 – e1500.

# Opiate Exposed Newborns:
# Incidence of NAS is increasing nationwide

**Proportion of hospital births that are NAS related increased 5 fold -** from 1.20 / 1000 to 5.58 / 1000 hospital births / year (2000-2012).

**Proportion of NICU stays that are NAS related increased 3 fold -** increased from 7 / 1000 to 27 / 1000 (2004-2013).



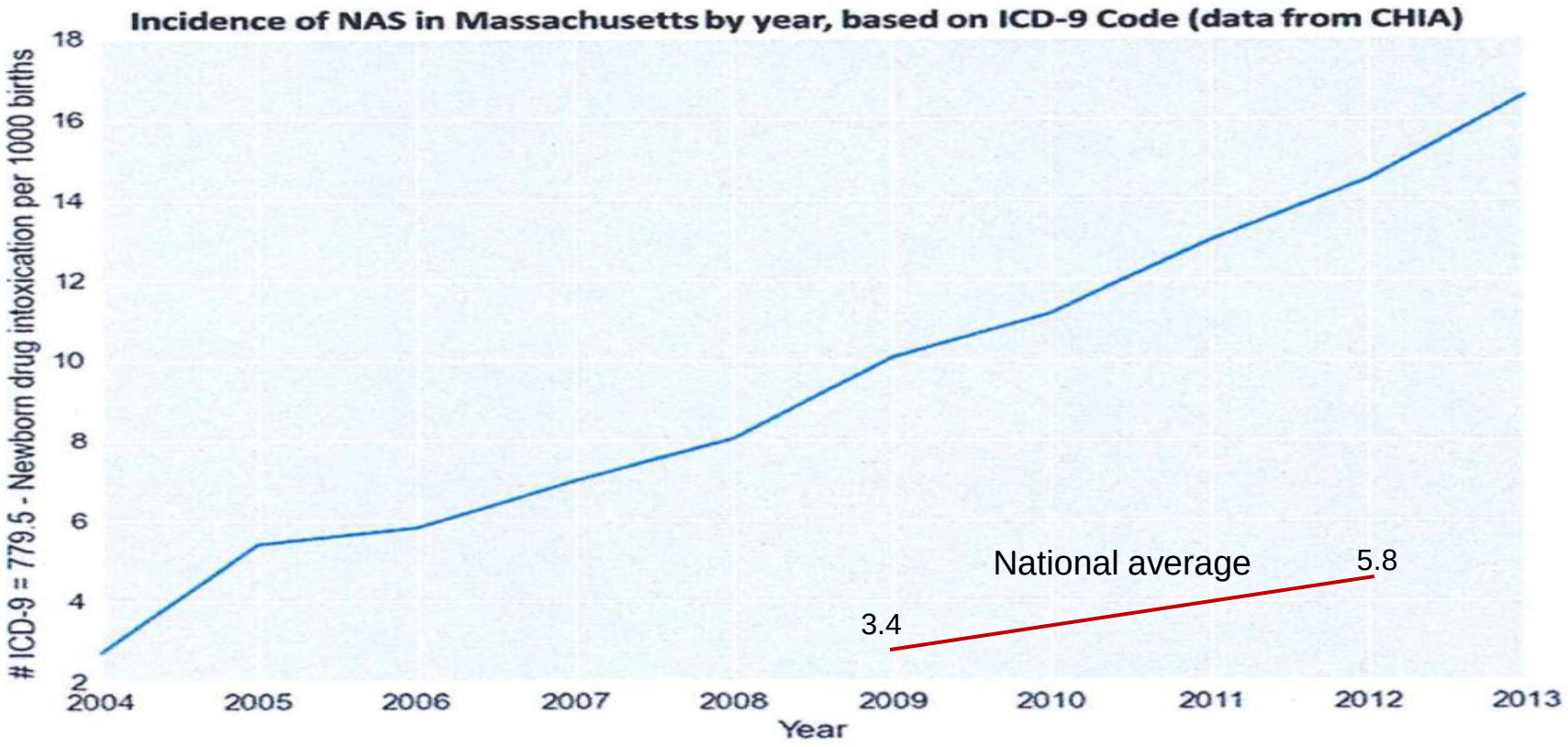

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

Tolia V, et al. Increasing incidence of the neonatal abstinence syndrome in U.S. Neonatal ICUs. N Engl J Med 2015;372:2118 – 2126.

# Opiate Exposed Newborns:
# Incidence of NAS is increasing in Massachusetts

- **2004 – 2013**: Incidence increased from <3 / 1000 hospital births to **>16 / 1000 hospital births** per year

- **MA rate of NAS was triple the national average** in 2009

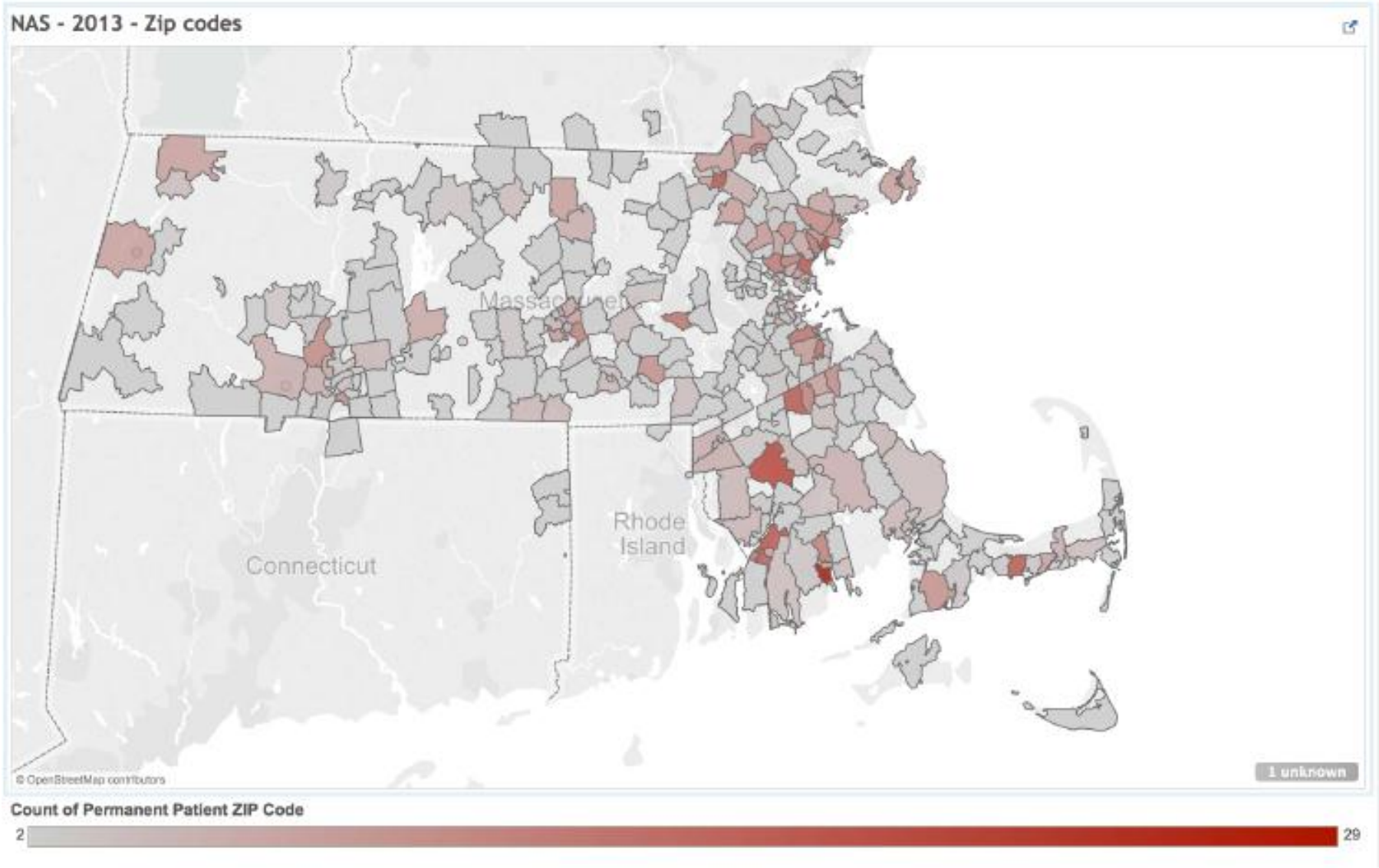




Gupta M and Picarillo A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. neoQIC. January 2015. PowerPoint presentation.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

# Opiate Exposed Newborns:
# Incidence of NAS in Massachusetts in 2013 (location by patient zip code)




Gupta M and Picarillo A. Direct communication with authors. July 10, 2015.

# Opiate Exposed Newborns: Short-term morbidity of NAS

Newborns with NAS are more likely to have complications compared with all other US hospital births.

**Premature Birth (gestational age <37 weeks)**
*2.6 – 3.4 times more likely*

**Low Birthweight <2,500g**
*19.1% vs 7.0%*

**Seizures**
*2.3% vs 0.1%*

**Respiratory Diagnoses**
*30.9% vs 8.9%*

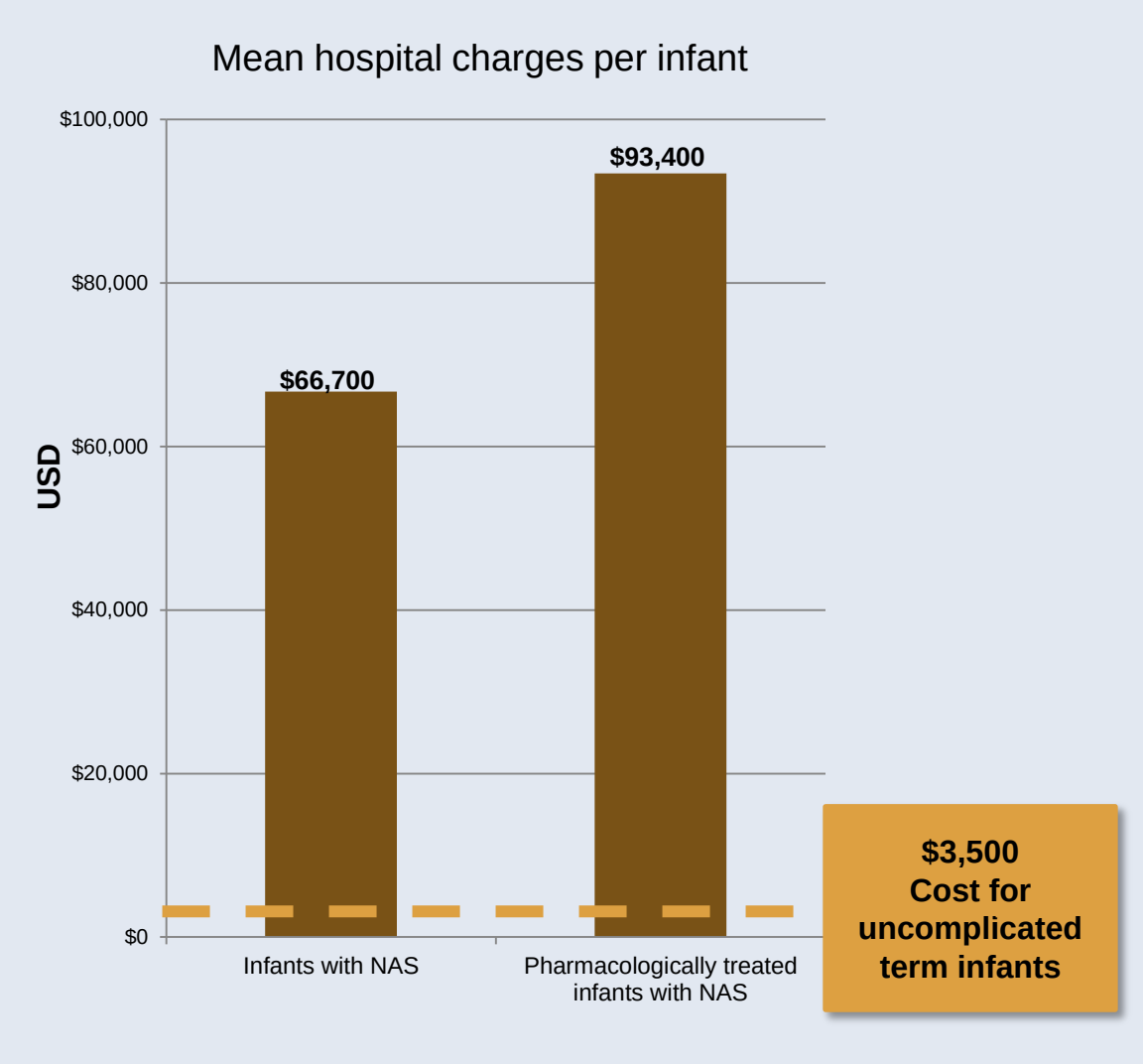
**Feeding Difficulties**
*18.1% vs 2.8%*

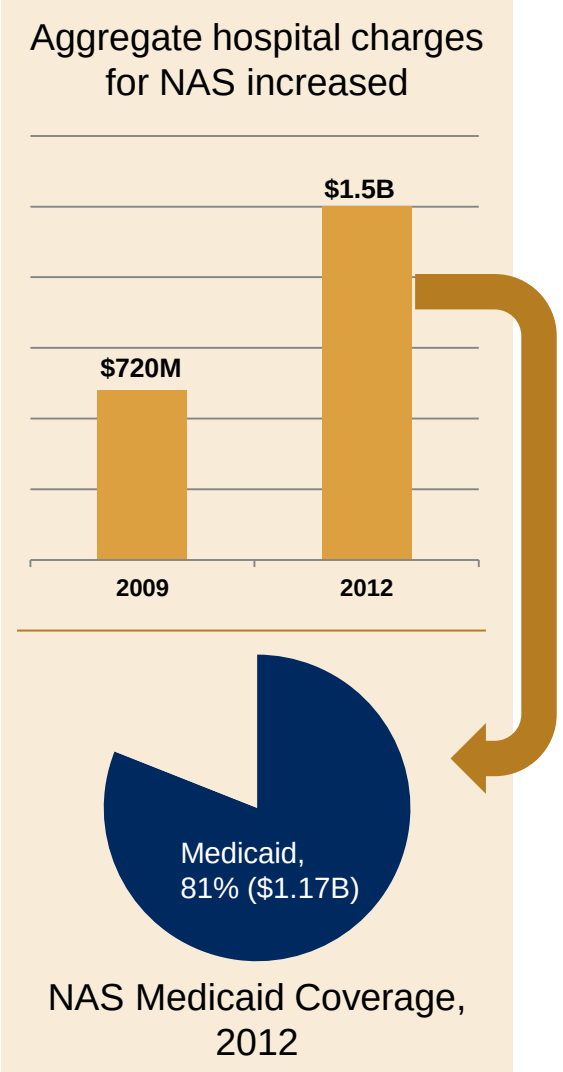
Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Creanga A, Sabel J, Yo J, *et al*. Maternal drug use and its effect on neonates: A population-based study in Washington State. Obstet Gynecol 2012;119(5):924-33.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

# Opiate Exposed Newborns: Costs of NAS





Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

# Opiate Exposed Newborns:
# Intervention opportunities exist across settings and time

**Family Planning**

- Integrated care (primary care, contraception, SUD treatment available in one setting)

**Pre-natal**

- Methadone / buprenorphine maintenance (vs. IV drug use)
- Wrap-around social services and coordinated multidisciplinary care

**Post-natal**

- Lower acuity of care (NICU → Special care nursery → pediatric floor)
- Rooming-in (mothers and babies together in the hospital)
- QI projects to decrease length of stay (staff training, breastfeeding)
- Wrap-around social services and coordinated multidisciplinary care

**Childhood**

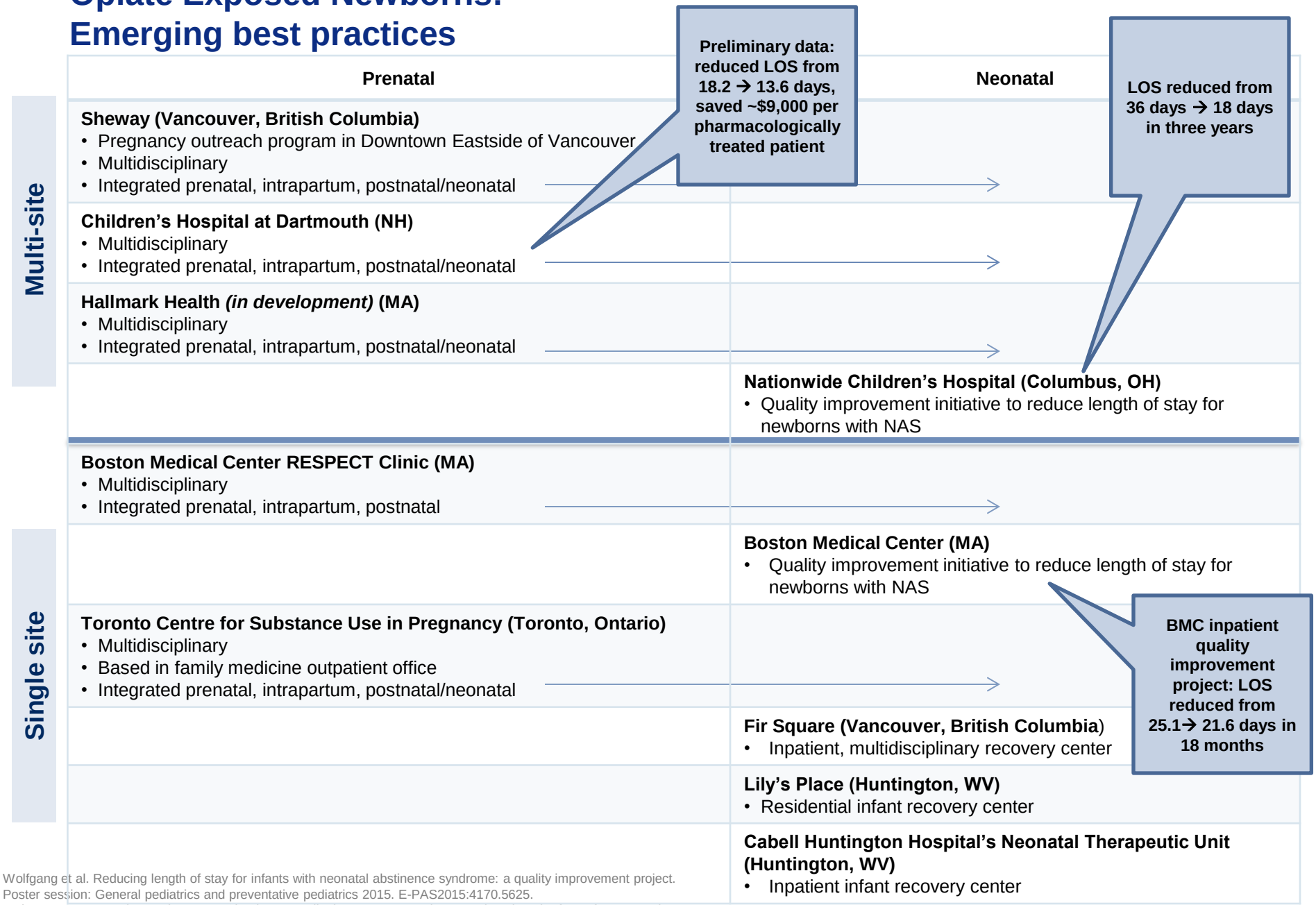
- Wrap-around social services and coordinated multidisciplinary care
- Early intervention

# Opiate Exposed Newborns: Emerging best practices

| | Prenatal | Neonatal |
|---|---|---|
| Multi-site | **Sheway (Vancouver, British Columbia)**<br>• Pregnancy outreach program in Downtown Eastside of Vancouver<br>• Multidisciplinary<br>• Integrated prenatal, intrapartum, postnatal/neonatal → | |
| Multi-site | **Children's Hospital at Dartmouth (NH)**<br>• Multidisciplinary<br>• Integrated prenatal, intrapartum, postnatal/neonatal → | |
| Multi-site | **Hallmark Health *(in development)* (MA)**<br>• Multidisciplinary<br>• Integrated prenatal, intrapartum, postnatal/neonatal → | |
| Multi-site | | **Nationwide Children's Hospital (Columbus, OH)**<br>• Quality improvement initiative to reduce length of stay for newborns with NAS |
| Single site | **Boston Medical Center RESPECT Clinic (MA)**<br>• Multidisciplinary<br>• Integrated prenatal, intrapartum, postnatal → | |
| Single site | | **Boston Medical Center (MA)**<br>• Quality improvement initiative to reduce length of stay for newborns with NAS |
| Single site | **Toronto Centre for Substance Use in Pregnancy (Toronto, Ontario)**<br>• Multidisciplinary<br>• Based in family medicine outpatient office<br>• Integrated prenatal, intrapartum, postnatal/neonatal → | |
| Single site | | **Fir Square (Vancouver, British Columbia)**<br>• Inpatient, multidisciplinary recovery center |
| Single site | | **Lily's Place (Huntington, WV)**<br>• Residential infant recovery center |
| Single site | | **Cabell Huntington Hospital's Neonatal Therapeutic Unit (Huntington, WV)**<br>• Inpatient infant recovery center |

Wolfgang et al. Reducing length of stay for infants with neonatal abstinence syndrome: a quality improvement project. Poster session: General pediatrics and preventative pediatrics 2015. E-PAS2015:4170.5625.
Asti L, Magers J, Keels E, Wispe J, McClead R. A quality improvement project to reduce length of stay for neonatal abstinence syndrome. Pediatrics 2015; 135(6):e1494 – e1500.

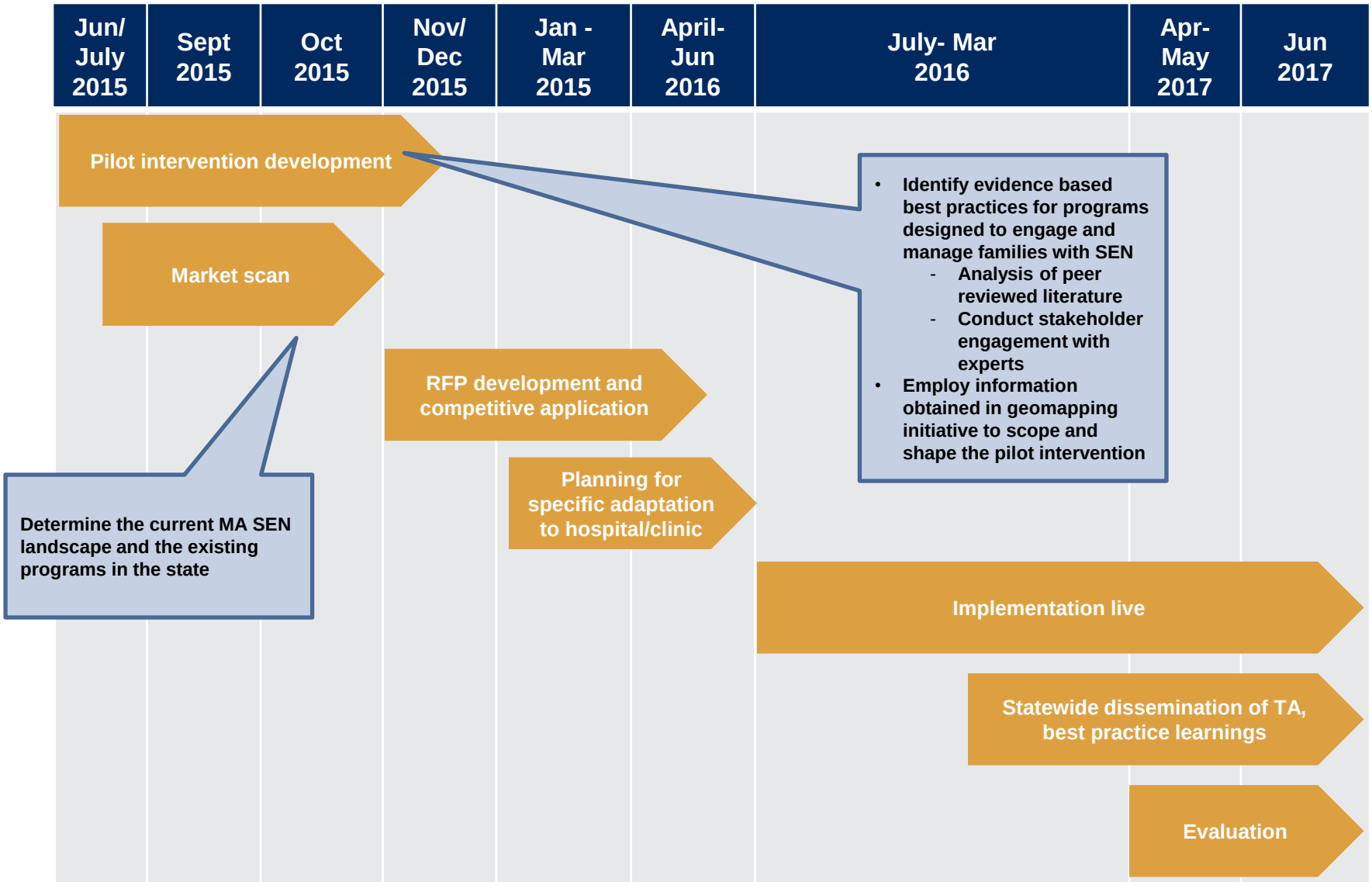
# Opiate Exposed Newborns: Emerging best practices





Wolfgang et al. Reducing length of stay for infants with neonatal abstinence syndrome: a quality improvement project. Poster session: General pediatrics and preventative pediatrics 2015. E-PAS2015:4170.5625.
Asti L, Magers J, Keels E, Wispe J, McClead R. A quality improvement project to reduce length of stay for neonatal abstinence syndrome. Pediatrics 2015; 135(6):e1494 – e1500.

# Opiate Exposed Newborns:
# Pilot development timeline (all dates are estimates)



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  - CHART Phase 2 Status
  - CHART Phase 2 Technical Assistance
- Administration and Finance Update
- Schedule of Next Commission Meeting (September 9, 2015)

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# PHASE TWO

## 28 Hospitals, 24 Months, $60M

**640+**
Hours of direct technical assistance for Awardees during IPP, alone

**81%**
Of CHART Hospital respondents found HPC Staff support helpful

# CHART Phase 2: Implementation Planning by the numbers*

**7** Regional Convenings

**31** Site visits

**25+**

Expert advisor and HPC staff intensive working meetings with hospitals

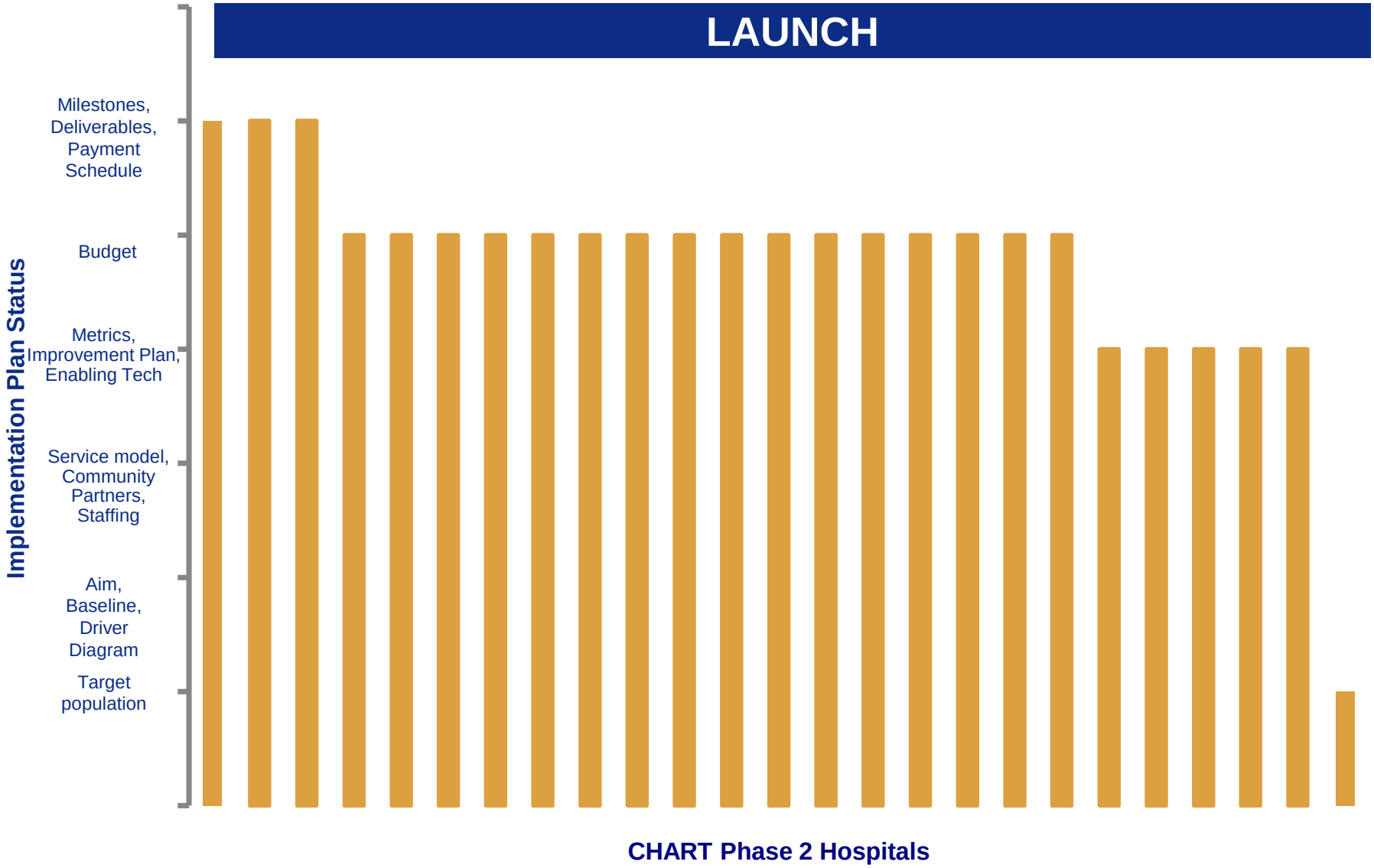
**640+**

Hours of coaching calls

*and counting*

*Updated July 21, 2015

# Implementation Plan status update by hospital




*Updated July 17, 2015

# Implementation Planning continues, with hospitals in varied stages; all but one target population specified (with continued adaptation)

| | | | | |
|---|---|---|---|---|
| **High utilizers**<br>Anna Jaques Hospital | **High utilizers**<br>Southcoast Joint Award | **High utilizers with BH**<br>Beverly Hospital | **All ED BH**<br>Mercy Medical Center | **Socially complex; BH; life-limiting conditions**<br>Baystate Wing Hospital |
| **High utilizers**<br>Baystate Franklin Medical Center | **High utilizers; discharges to PAC**<br>Winchester Hospital | **High utilizers with BH**<br>Addison Gilbert Hospital | **All ED BH**<br>Holyoke Medical Center | **Social and/or medical complexity**<br>Lawrence General Hospital |
| **High utilizers**<br>Lowell General Hospital | **High utilizers; discharges to SNF**<br>Baystate Noble Hospital | **High utilizers with BH**<br>Lahey-Lowell Joint Award | **All ED BH; BH EMS calls**<br>BIDH-Milton | **All admissions; low acuity ED visits 3-11pm**<br>Signature Healthcare Brockton Hospital |
| **High utilizers**<br>Marlborough Hospital | **High utilizers; high risk & those at risk of HU**<br>Emerson Hospital | **High utilizers; ED Narcan reversals; OB+SUD**<br>Hallmark Joint Award | **Primary BH; dual eligibles**<br>BIDH-Plymouth | **Residents of underserved catchment area**<br>Berkshire Medical Center |
| **High utilizers**<br>Milford Regional Medical Center | **High utilizers; all BH ED; students**<br>Heywood-Athol-HealthAlliance | **All ED BH**<br>HealthAlliance Hospital | **All BH and SUD**<br>Harrington Memorial Hospital | ***In progress***<br>Baystate Joint Award |

SUBJECT TO CHANGE

High utilizers | Social and behavioral factors | Other criteria | *In progress*

# All grantees must commit to quantifiable, outcome-based Aim Statements

*Primary aim statements are grouped in to three primary categories:*

1. Sixteen hospitals will **reduce readmissions by a median goal of 20%** for their target populations, within two years

2. Five hospitals will **reduce ED revisits by a median goal of 20%** for their target populations, within two years

3. Three hospitals will **reduce ED LOS by a median goal of 20%** for their target populations, within two years

SUBJECT TO CHANGE

CHART hospitals can have more than one measureable aim. Not all secondary aims are included in this slide.

# Data will drive program accountability and performance improvement

1. Standard cohort-wide and tailored program-specific measures will be reported monthly
2. Reporting will inform coaching and technical assistance
3. Hospitals are accountable for achieving measurable Aim Statements
4. HPC plans to engage an external evaluation firm to measure impact (cost savings, quality/access improvements, capacity improvements) and help quantify “return-on-investment”

# Example: Addison Gilbert Hospital and Beverly Hospital

Beverly Hospital
Addison Gilbert Hospital
Members of Lahey Health

| | |
|---|---|
| Award | $1.27 million to Addison Gilbert Hospital and $2.5 million to Beverly Hospital |
| Aim | Reduce 30-day readmissions for patients with a personal history of recurrent acute care utilization, social complexity, and/or in need of palliative care by 20% by the end of the 2-year period of performance |
| Target Population | Inpatient high utilizers (4+ discharges / year); social complexity (active BH; legal, housing, food, transportation services); palliative care |
| Primary Drivers | 1. Improve hospital-based care;<br>2. Deploy complex care team;<br>3. Leverage technology |
| Service Model | Complex care team (pharmacist, social worker, nurse practitioner, pharmacy tech, navigator); individual care plans; referral to palliative care and hospice; linkage to PCP |
| Enabling Tech | High Risk Intervention Team will use Loopback for care coordination and analytics |

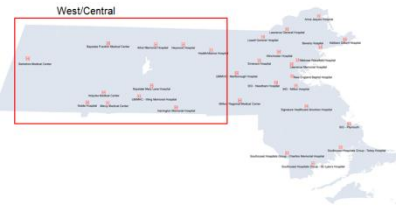
SUBJECT TO CHANGE

# Example: Berkshire Medical Center

Berkshire Medical Center
BERKSHIRE HEALTH SYSTEMS

| | |
|---|---|
| Award | $3 million |
| Aim | Reduce 30-day readmissions by 20% for all discharges of Northern Berkshire County residents by the end of the 2-year period of performance |
| Target Population | Total discharges from BMC of Northern Berkshire County residents |
| Primary Drivers | 1. Care navigation<br>2. Address social issues that lead to high utilization<br>3. Provide enhanced care for chronic illnesses<br>4. Increase access to BH care<br>5. Leverage technology to drive improvement |
| Service Model | Partner with community-based social services; comprehensive care plans; care coordination; Behavioral Health Aftercare Team; chronic illness support; nutrition support; electronic patient navigation |
| Enabling Tech | Care Director: Care coordination team will use Allscripts Care Director to view and modify care plans |

SUBJECT TO CHANGE



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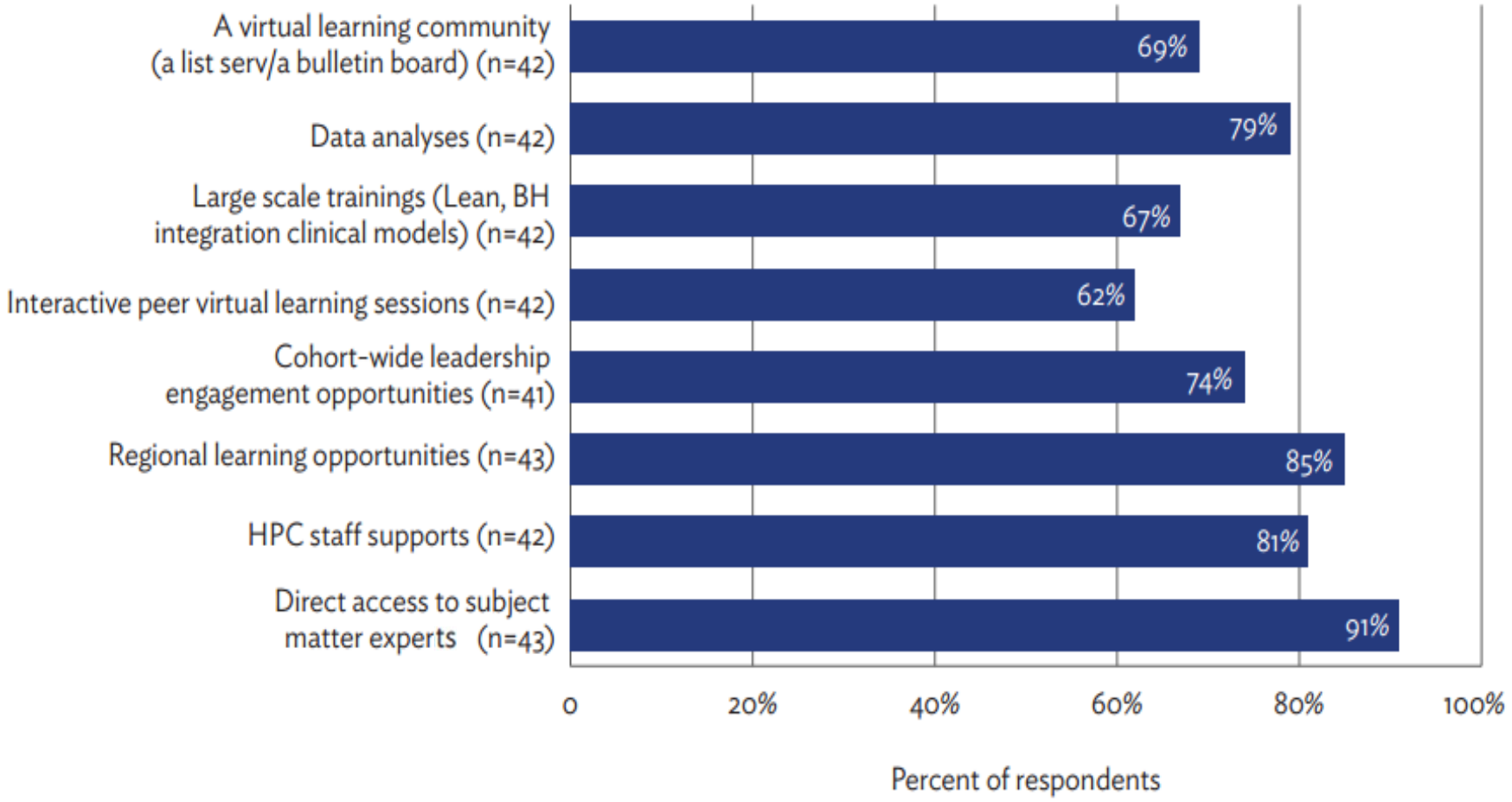
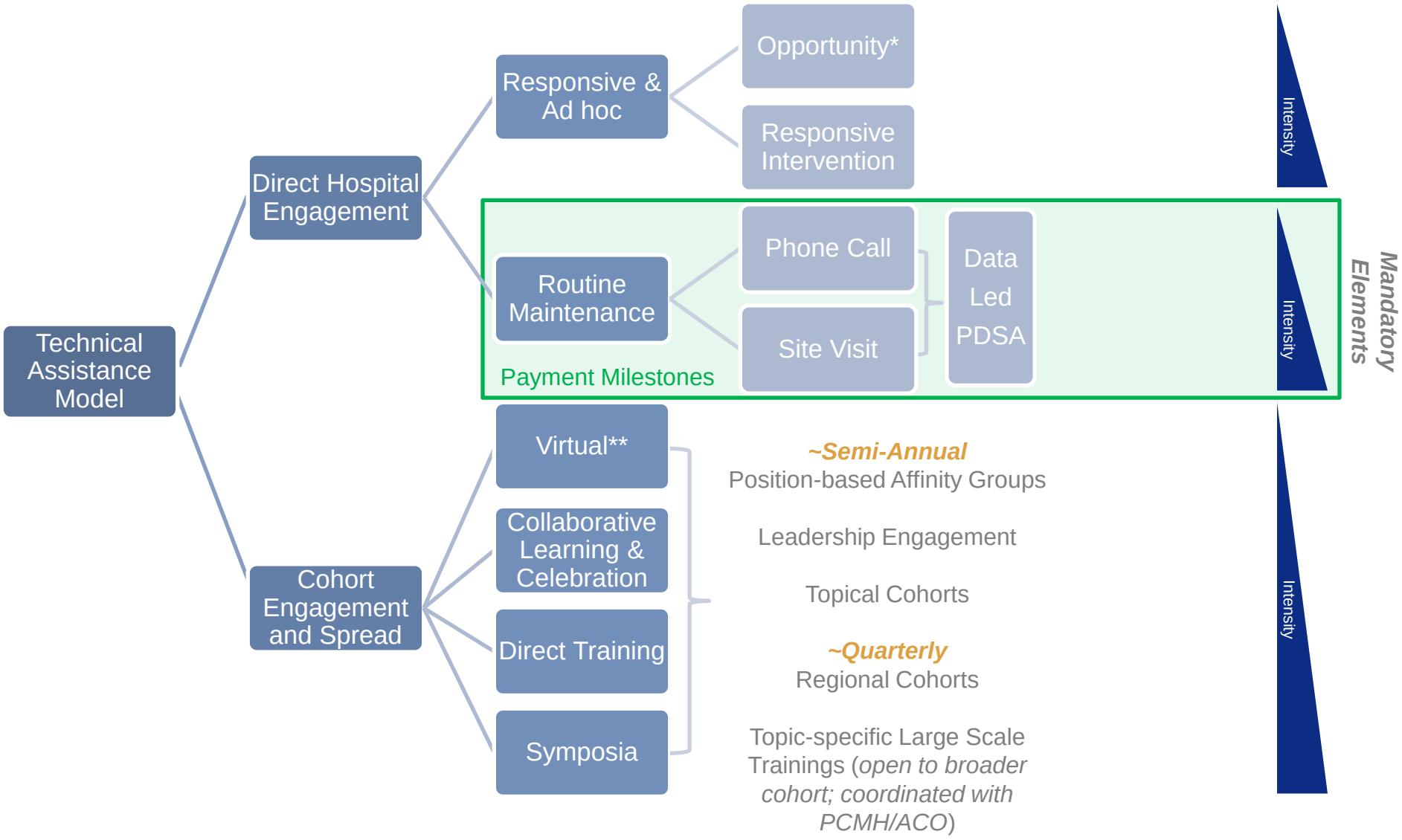
# Provider engagement and support

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



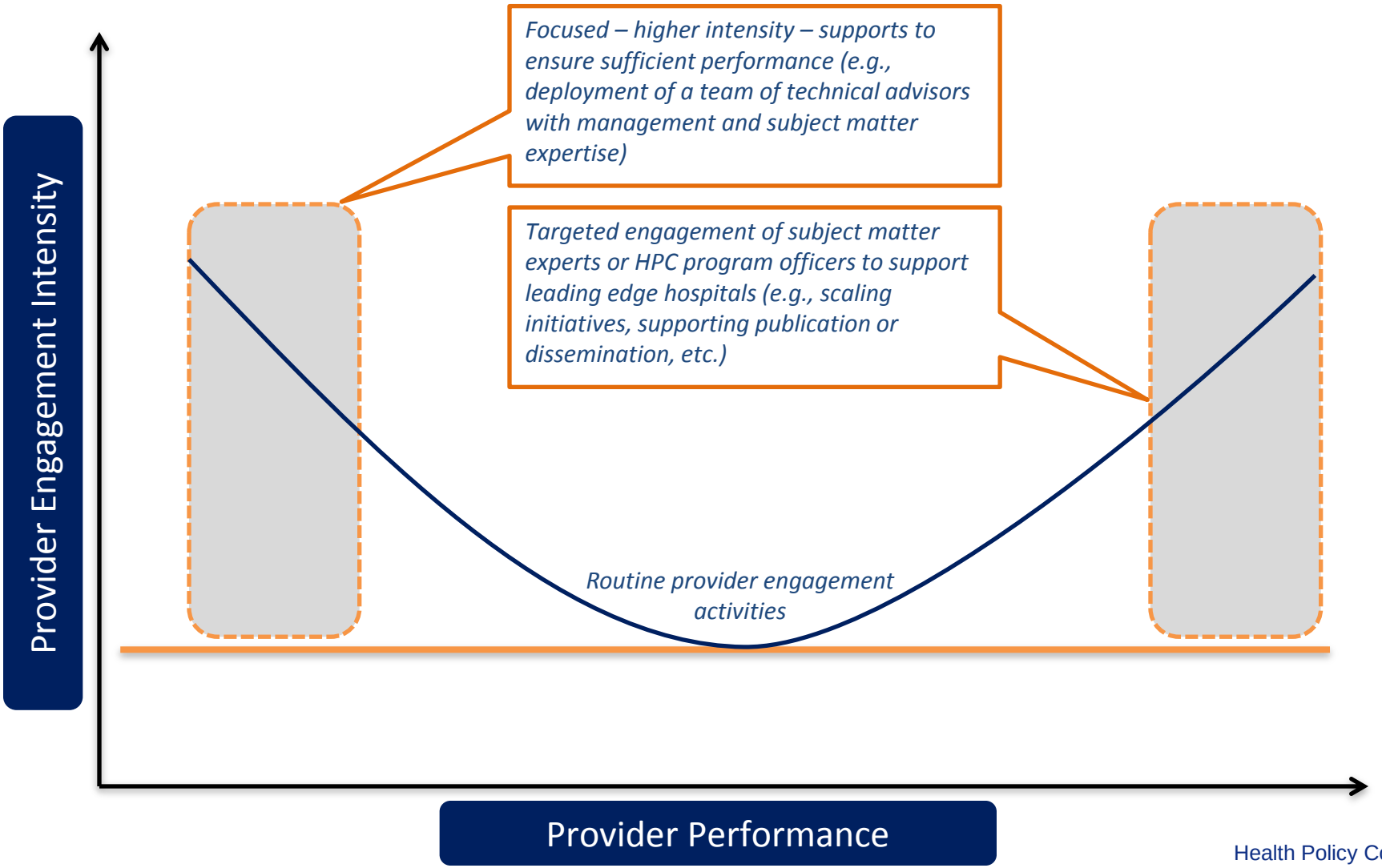
# Modes for technical assistance and provider engagement




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

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

# Provider engagement intensity will be stratified across the cohort based upon opportunity for maximal benefit from engagement



# Technical assistance approaches

| State-wide meetings | Regional convenings | Site visits | Training opportunities | Calls with staff and TA experts | Leadership engagement |
|---|---|---|---|---|---|

**HPC will hold two statewide meetings in CHART 2**

- *Launch Meeting:* Initial meeting focusing on content and peer sharing will kick-off the performance phase of the program
- *Interim Meeting* (open to public): Interim statewide meeting will be held focused on highlighting success, challenges, and best practices on individual, hospital-specific, and regional levels.

| State-wide meetings | Regional convenings | Site visits | Training opportunities | Calls with staff and TA experts | Leadership engagement |
|---|---|---|---|---|---|

**Regional convenings will be a cornerstone of peer learning**

- Peer-peer learning; discussion of local success and operational factors associated with effective implementation
- Discussion of local partnerships and community-based organization engagement
- Linkage with models and programs tied to CHART initiatives that are effective elsewhere
- Some regional meetings will be segmented into affinity groups (e.g., clinical leadership, operational leadership, frontline staff, community partners, etc.)

# Technical assistance approaches

State-wide meetings | Regional convenings | **Site visits** | Training opportunities | Calls with staff and TA experts | Leadership engagement

**Site visits will be a key opportunity for executive engagement**

- At a minimum, staff will conduct site visits at each Phase 2 CHART hospital biannually. Visits will generally include:
  - A meeting with the executive team to review progress and overall project implementation (data dashboard review).
  - Discussions with implementation teams on tests of change, implementation barriers, appropriate adaptation and overall project progress.

CHART hospitals with insufficient progress will likely require additional site visits and other touch points. Higher performing hospitals may also have increased touch points to harvest successful practices, stimulate activity at other hospitals and to build momentum in the entire group.

State-wide meetings | Regional convenings | Site visits | **Training opportunities** | Calls with staff and TA experts | Leadership engagement

**Trainings will bolster skills of front-line staff, managers, and leadership**

- HPC anticipates hosting 1-2 trainings annually. All trainings will be in-person but will be recorded and made available on the CHART program website. Trainings available to CHART hospitals and PCMH or ACO certified entities / those pursuing certification.
- HPC will seek to partner with other organizations in the market

# Technical assistance approaches

| State-wide meetings | Regional convenings | Site visits | Training opportunities | **Calls with staff and TA experts** | Leadership engagement |
|---|---|---|---|---|---|

**HPC will continue frequent virtual contact with multiple purposes**

- *Performance Management Calls:* Approximately monthly performance management calls led by Program Officer(s) to review activities and progress and discuss methods to overcome barriers. Semi-structured to review operational data, payment and other reporting issues
- *Coaching Calls*: Approximately monthly expert coaching calls with Program Officer(s) and Senior Advisors (content experts) to review activities and progress and discuss methods to overcome barriers.

| State-wide meetings | Regional convenings | Site visits | Training opportunities | Calls with staff and TA experts | **Leadership engagement** |
|---|---|---|---|---|---|

**HPC will seek opportunities to engage current and emerging leaders**

- *Current leadership* engagement activities would focus on the C-Suite and assumes more interaction and dialogue among the leaders (with networking for the CEOs, CMOs, CNOs, CFOs, and COOs). These activities would create an environment where current senior leaders engage more deeply on healthcare transformation as it applies to CHART
- *Emerging leader* activities to take mid-level, business line and other thought leaders and provides a structured curriculum that heavily links to the CHART project activities at each organization. Focused on building leadership capability and to sustain momentum after the current investments expire.

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  - HPC Fiscal Year 2016 Budget
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# State Fiscal Year 2016 Budget

**$250,000** Pilot for Substance Exposed Newborns

- Provides funds for the HPC, in coordination with DPH, to develop a pilot program to implement a model of post-natal supports for families with substance exposed newborns at up to three regional sites in the Commonwealth.
- The scope of services will include obstetrics and gynecology, pediatrics, behavioral health, social work, early intervention, and social services to provide full family care.

**$100,000** Pilot on Narcan Training

- Provides funds for the HPC, in coordination with DPH, to develop a training and technical assistance program to improve and expand the capacity and ability of primary care providers, including those seeking certification as a PCMH, to prescribe Narcan.
- Providers who participate in this pilot program may receive a supply of Narcan for use in their practices.

**$250,000** Behavioral Health Technical Assistance for HPC's Patient-Centered Medical Homes

- Provides funds for the HPC to administer a program to support behavioral health integration within patient-centered medical homes.
- The program will support efforts to build the infrastructure necessary to initiate or expand the provision of behavioral health care services in the primary care setting in the form of training, education, technical assistance or grants.

**$250,000** Paramedicine Pilot Administered by the HPC in the Quincy Area

- Provides funds for the HPC to develop a pilot program to triage behavioral health patients in the Quincy area affected by the recent closure of Quincy Medical Center.

# State Fiscal Year 2016 Budget

**$500,000** Telemedicine Pilot Administered by the HPC

- Directs the HPC to implement a one year regional pilot program to further the development of telemedicine in the Commonwealth.
- The program will incentivize the use of community-based providers and the delivery of patient care in a community setting and facilitate collaboration between participating community providers and teaching hospitals.
- Funded through the Distressed Hospital Trust Fund.

**Outside Section** Confidentiality Language for CHART, PCMH, ACO, and other HPC Programs

- Protects the confidentiality of non-public clinical, financial, strategic or operational documents provided to the HPC in connection with its statutory care delivery, quality improvement or performance improvement programs while allowing the HPC to provide summary reports and conduct evaluations.

**Outside Section** New CHIA Oversight Council

- Establishes a CHIA Oversight Council and names the Executive Director of the HPC as a member.
- The Council develops the CHIA budget, reviews manages its administrative expenses, and develops annual research and analysis priorities.
- The Secretary of Health and Human Services, the Secretary of Administration and Finance, and the Commissioner of Insurance are also named ex-officio members of the Council. The Chair is elected.

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# HPC Budget Overview – FY16 Recommendation

## Chapter 224 Background

- Chapter 224 of the Acts of 2012 (Ch.224) dedicated one-time, non-tax, revenues to be administered by the HPC through assessments on certain health care market participants and a portion of casino gaming licenses.*
- These funds, allocated to the **Health Care Payment Reform Trust Fund (HCPRTF)** and the **Distressed Hospital Trust Fund (DHTF)**, collectively support the HPC operations, policy programs, professional services, investment programs, market monitoring, and provider engagement initiatives necessary to promote *a more affordable, effective, and accountable health care system in Massachusetts*.
- These one-time revenues were designed to provide a multi-year "***glide-path***" for the HPC to build capacity, make phased investments in care delivery/payment system transformation, and develop objective, evidence-based programs and policies.

## FY16 Budget Recommendation

The recommended operating budgets for both Trust Funds will support on-going HPC activities and the implementation of Ch.224-mandated responsibilities in FY16. The proposed budgets will be fully supported by existing Trust Fund balances *not* by any new assessments or by the state's General Fund.

| | |
|---|---|
| Recommended HCPRTF: | **$10,478,252** |
| Recommended DHTF: | **$2,997,192** |
| *Recommended Combined:* | ***$13,475,444*** |

This budgetary recommendation is consistent with the multi-year plan for HPC programmatic and operational development. As the agency approaches full staffing and full program implementation in FY16, it is anticipated that HPC operating expenses will reach **steady-state** in future fiscal years.

*Assessed health plans and hospitals are prohibited by law from passing the cost of this assessment onto consumers in the form of premiums or provider price increases.

# HPC Budget Overview – FY16 Background

## Background for FY16 Budget Proposal Development

- Since its establishment in 2012, the HPC has aimed to be a model of cost-effective, efficient, transparent, high-performing government. The HPC has closed every fiscal year **under** Board-approved budgets.
- In FY15, the HPC is projected to finish **under** the Board-approved operating budget by more than **$500,000** and roll over this surplus, along with other positive Trust Fund balances, into FY16.
- The FY16 budget proposal has been developed over many months and through many consultative meetings with HPC Board members, including the members of the ANF committee.
- It reflects both known costs (e.g. rent) and projected costs (e.g. professional services) based on the **best information available**. However, the fact that HPC is doing groundbreaking, "first-in-the-nation" work with little or no historical precedent continues to provide some unpredictability to future operational/budgetary needs.

## Principles for FY16 Budget Proposal Development

- New investments are **limited**, **targeted**, and **essential**.
- The budget contains **limited** funding for new staff positions and professional services, which are **targeted** for new or enhanced HPC activities **essential** to meet our statutory responsibilities in FY16, e.g. care delivery and payment reform initiatives; performance improvement plans; technical assistance for CHART hospitals; behavioral health integration initiatives; and the enhancement of the APCD to include medicaid claims and BH-carveout data.
- The budget proposal continues a practice of balancing employed staff with contracted consultants, recognizing the need to supplement staff with highly-skilled, nationally-recognized experts such as economists, actuaries, clinicians, auditors, claims analysts, accountants, in order to continue to meet the rigorously high standard set for developing HPC publications, programs and policies.

# HPC Budget Overview – Looking Forward

## HPC Operations

– Absent any further legislative action, FY16 will be the **final year** of collections for the Ch.224 one-time assessment on certain hospitals and health plans. In addition to the Trusts administered by the HPC, this assessment also provides funds to the Prevention and Wellness Trust Fund and the e-Health Institute Trust Fund.

– The sunset of this provision will **significantly reduce** the required assessments on these hospitals (~$15M/annually) and all health insurance plans operating in Massachusetts (~$40M/annually) beginning in FY17.

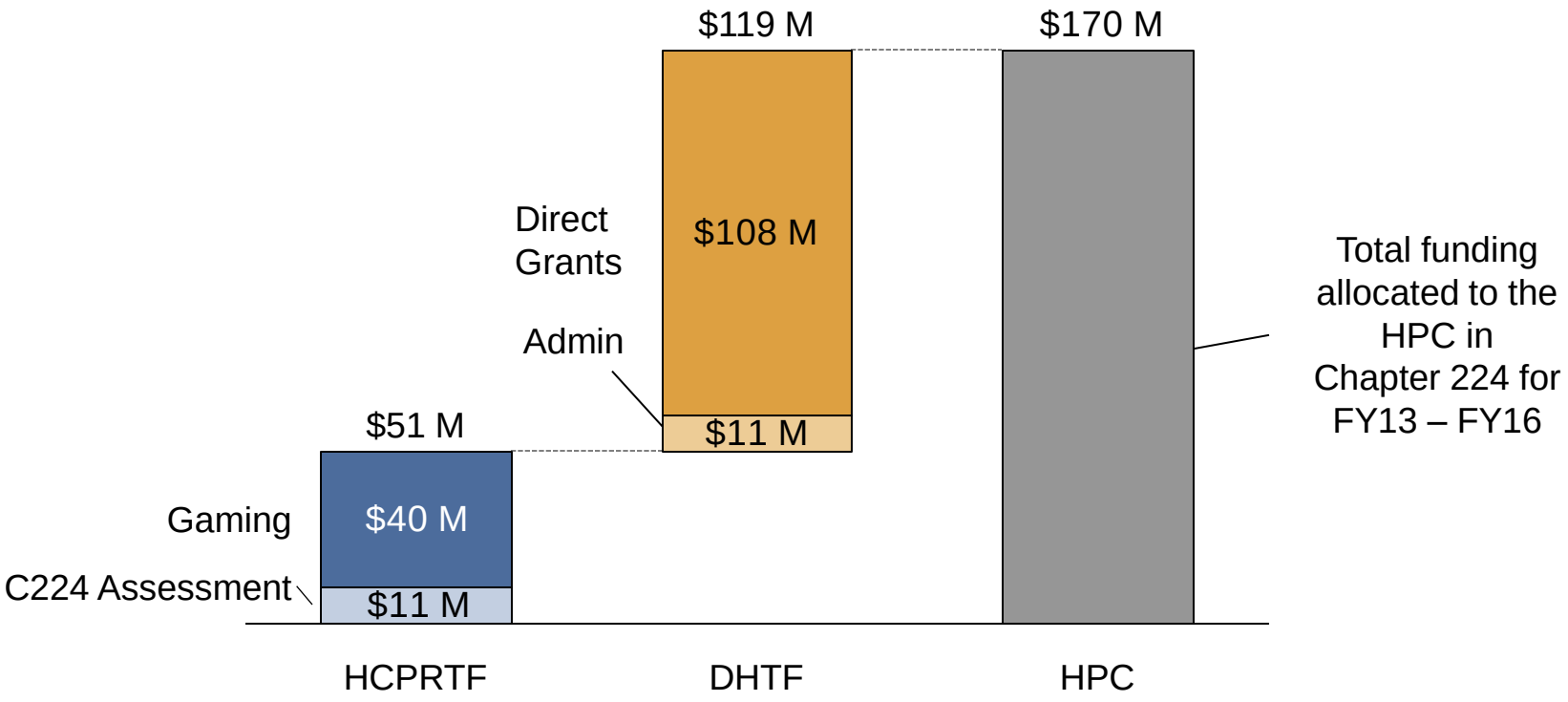
– As for the HPC, beginning in FY17, HPC operations and programs (less expenses related to the CHART Investment Program- see below) will be funded by a new annual assessment on hospitals, surgery centers, and health plans.

– This will be similar to the current financing mechanism for the Center for Health Information and Analysis (CHIA). As the HPC approaches full staffing and full program implementation in FY16, it is anticipated that HPC operating expenses will reach **steady-state** in future fiscal years.

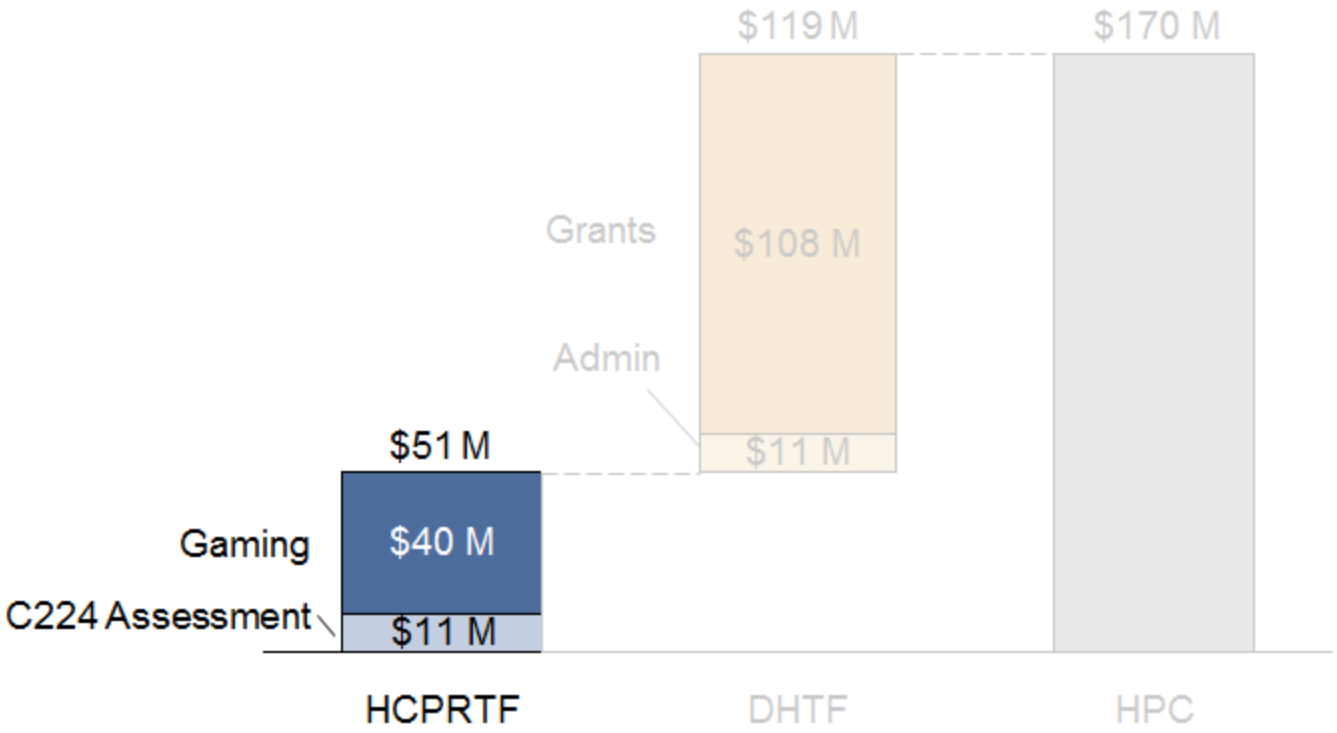
## CHART Investment Program

- Phased CHART investments will continue over the next few years, however, absent any financial replenishment, the current funding will likely be exhausted in FY18. If this program winds down, the operational costs of the program will likewise be phased-out.

# Ch. 224 envisioned a four year implementation “glide path” for the HPC with dedicated one-time funds

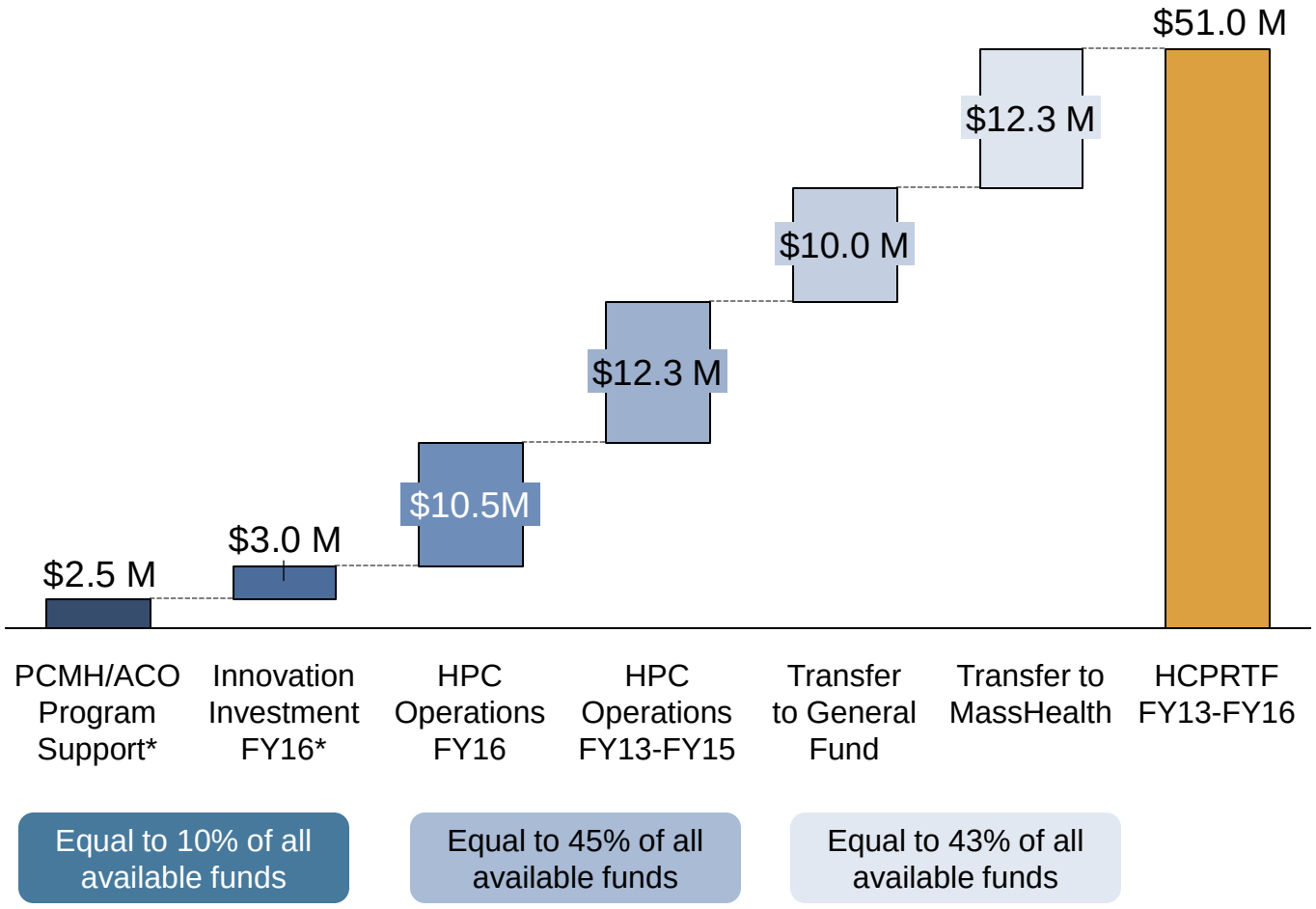


# Ch. 224 allocated $51M to the HCPRTF for HPC operations, health care innovation investments, and direct provider supports.



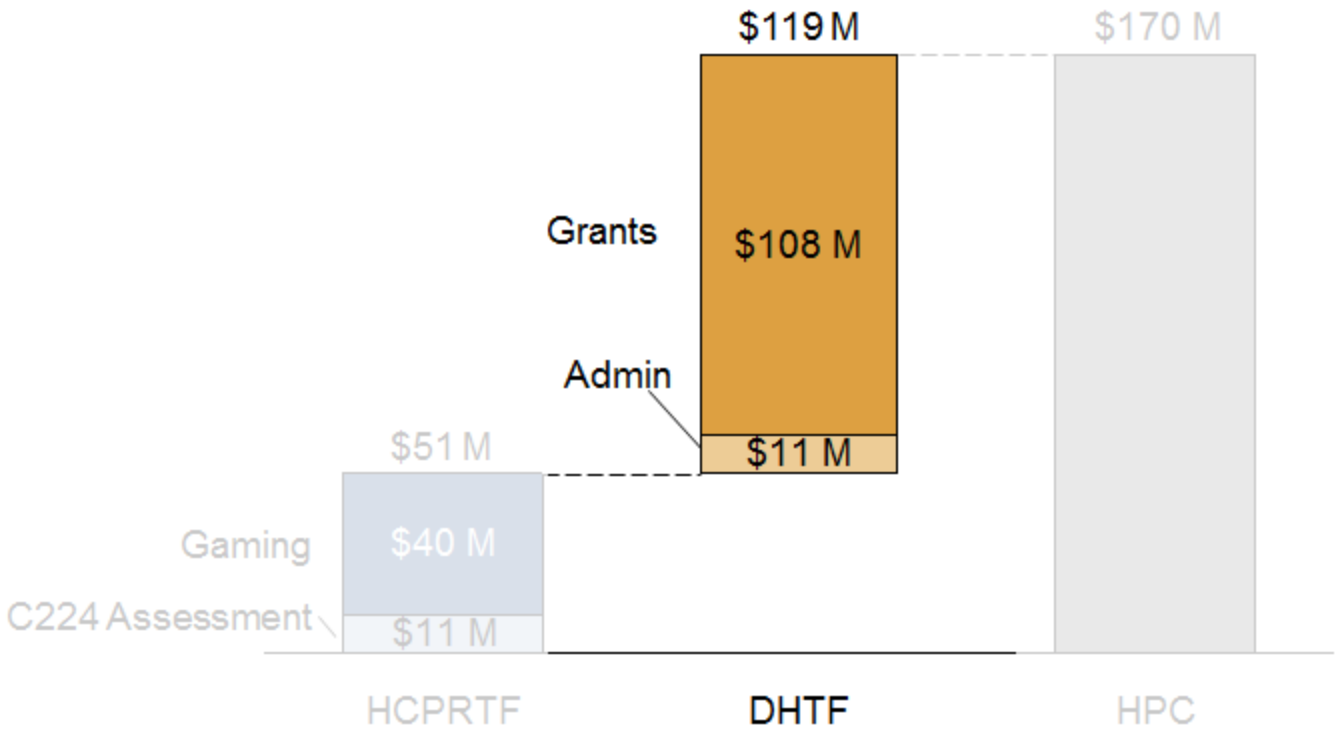
# By FY17, the current balance of the HCPRTF will be nearly fully expended for transfers to the state budget, operations, and innovation investments/supports

Beginning in FY17, HPC operations will be funded by an annual assessment on acute care hospitals, surgery centers, and health plans.

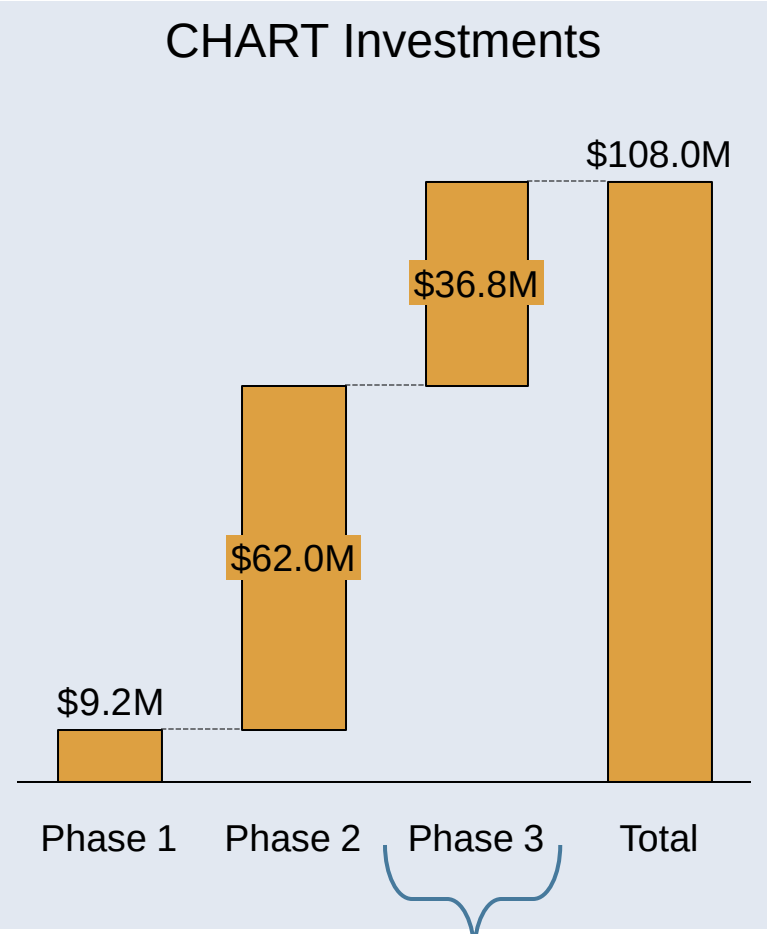



*Subject to board approval in FY16.

# The CHART Investment Program has a budget of $119M for operations and investments.



# The $119M assessment that funds CHART is budgeted for the five year duration of the program with the most spend in Phase 2 (FY16/FY17).



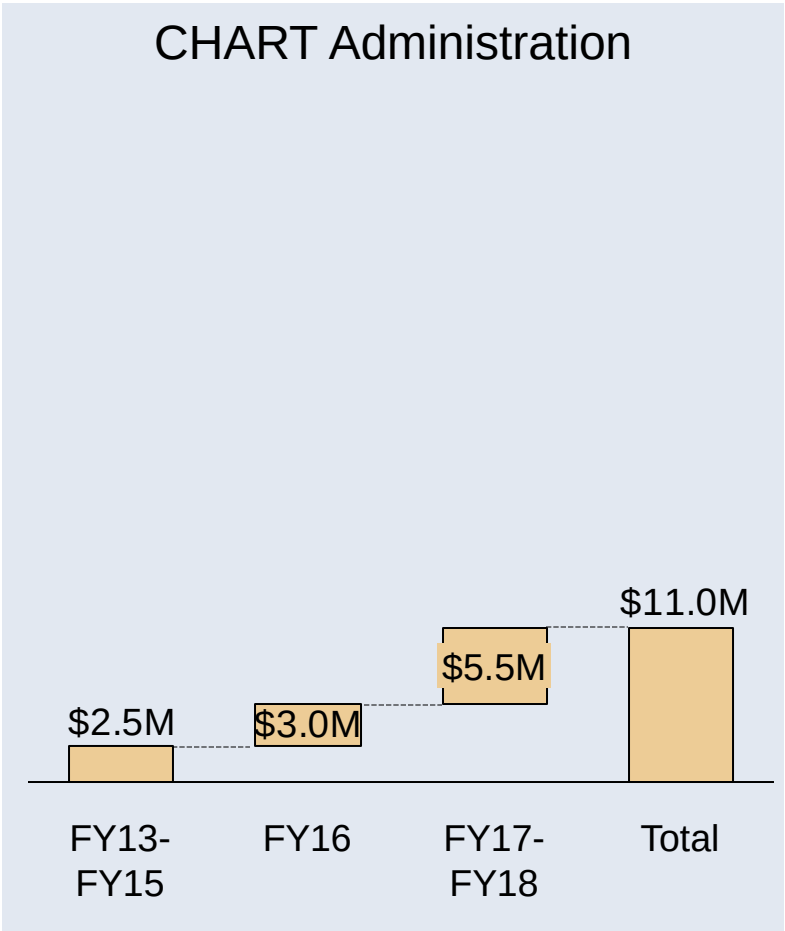
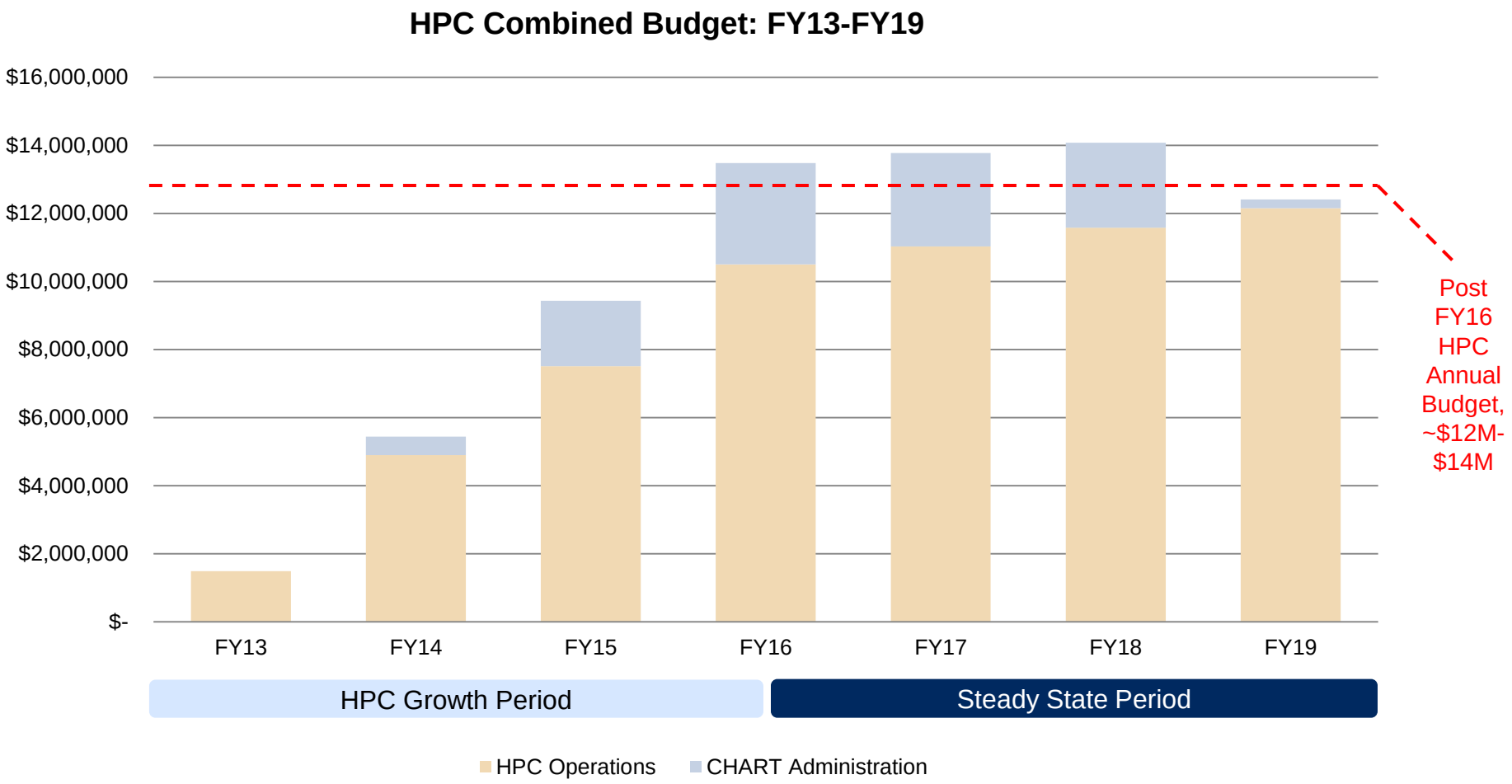
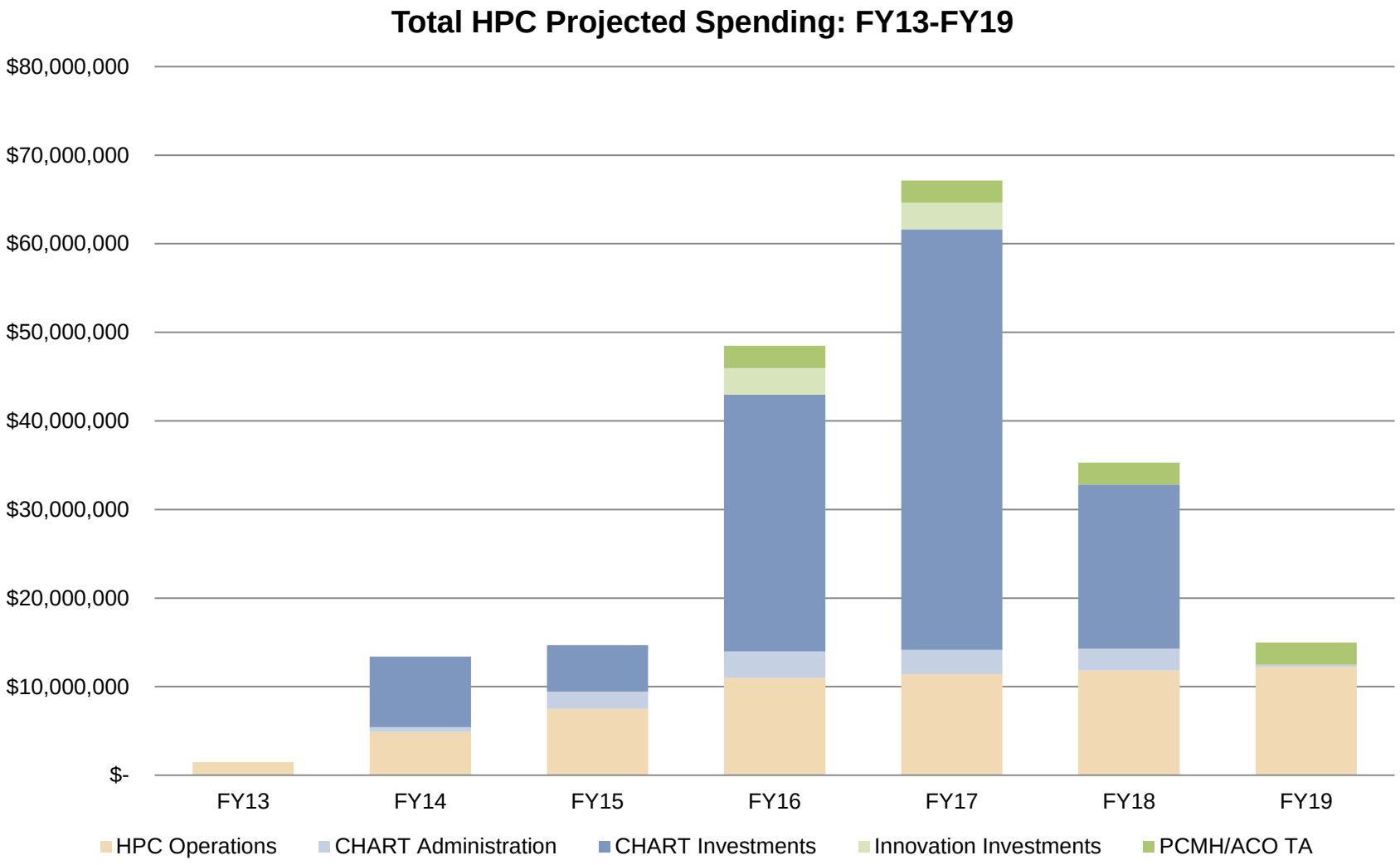




CHART Phase 3 will be developed in close collaboration with efforts by MassHealth to promote new community-based, coordinated care delivery models similar to ACOs.

# Looking forward: HCPRTF and DHTF operating expenses are anticipated to reach steady-state moving forward



# Looking forward: the HPC plans significant market investments to spur innovation and accelerate health care system transformation



# FY16 HPC Budget Summary

## FY16 Summary: July 1, 2015 – June 30, 2016

The recommended operating budgets for both Trust Funds will support on-going HPC activities and the implementation of new Ch.224 initiatives in FY16. The proposed budgets will be fully supported by **existing Trust Fund balances** *not* by any new assessments or by the General Fund.

*Recommended HCPRTF: $10,478,252*

*Recommended DHTF: $2,997,192*

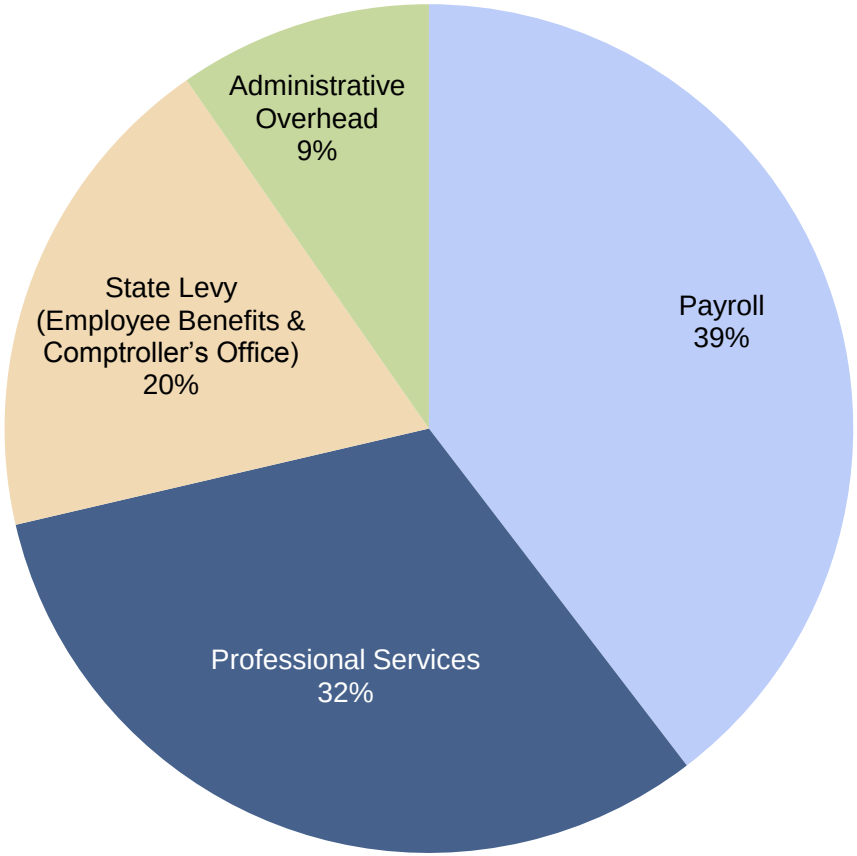
*Recommended Combined:* **$13,475,444**

## Key Variances from FY15:

- Spending for payroll is **$1.8M** above FY15 actual spending. Of this amount, **88%** or $1.6M, is needed just to maintain current positions due to the annualized cost of HPC's rolling hiring strategy. Funding for newly identified staff is extremely limited(~$200K). Full staffing expected by end of FY16.
- Spending for state- mandated levies is **$1.15M** higher than FY15 actual spending, primarily due to the annualized cost of the 10% fee to the Comptroller's Office and an increase in the fringe/benefit rate paid to the General Fund.
- Spending for professional services and interagency service agreements is **$870K** above FY15 actual spending. This increase is primarily due to enhanced technical assistance supports for CHART hospitals, spending necessary for the PCHM/ACO program launch, increased funding for APCD analytic services, and professional economic/actuarial consultants for the development of guidance/regulations relative to Performance Improvement Plans (PIPs).
- Overall overhead and admin/IT spending is **$165K** higher than FY15 actual spending, primarily due to the annualized rent at 50 Milk.

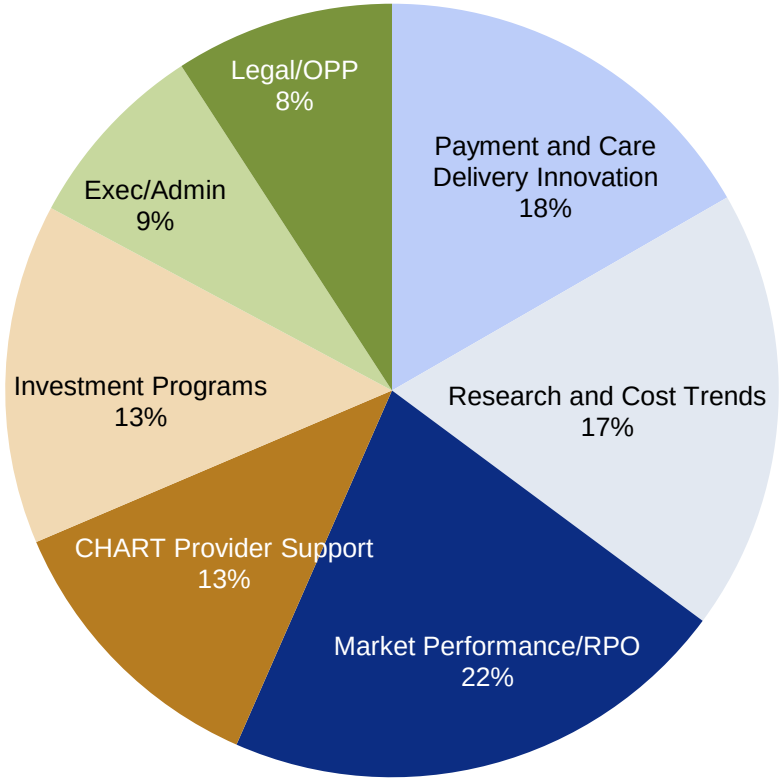
# FY16 Budget Recommendation – Spending Graphs

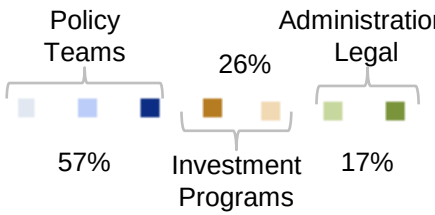
## Total Proposed Spending by General Category (FY16)



# FY16 Budget Recommendation – Spending Graphs

## Total Proposed Spending by Program Category (FY16)*




*Includes employed staff and contracted expert spending

# FY16 Budget – Outstanding Questions

**What is the impact of the final FY16 State Budget?**

- The final FY16 state budget contains additional funding for several innovative pilot programs to be administered by the HPC related to enhancing behavioral health integration within our PCMH program, addressing the opioid crisis, and expanding the use of telemedicine. As the final state budget was signed just last Friday, the impact of this initiatives on the HPC operating budget (if any) is still in development.

**What is the final design of the PCHM/ACO Certification programs?**

- The recommended FY16 budget contains funding to support the launch and administration of the PCMH/ACO certification programs based on the **best information available**. Significant design and program choices remain, however, especially for ACO certification, that may impact final operational costs. Additionally, the level of technical assistance and engagement supports (data, training, shared resources, convening) has yet to be determined and will be subject to Board approval in FY16.

**How much support will CHIA provide for APCD analytic work?**

- As directed by the Board in April, the HPC Executive Director is consulting with the CHIA Executive Director on potential financial support for the HPC's analytic work with the APCD. A final agreement on a shared scope of work has not yet been executed, but is expected.

**Status of "Performance Improvement Plans" in 2016?**

- As noted above, 2016 is the first year the HPC is authorized to implement "performance improvement plans (PIPs)" on provider organizations and payers that excessively contributed to cost growth in the Commonwealth. The proposed budget accounts for the analytic modeling and professional services required to develop the process and substance of PIPs. However, the extent to which the HPC decides to require payers/providers to propose and implement PIPs in FY16 is unknown at this time and may have a further impact on the HPC budget.

# FY16 Proposed Budget – Summary of Expenditures

| FY16 -Combined | FY15 Final Projection | FY16 Proposed | Variance |
|---|---|---|---|
| *Estimated Expenditures* | | | |
| Payroll | $ 3,510,708 | $ 5,323,435 | $ 1,812,727 |
| Mandated Assessment (Employee Benefits) | $ 1,013,190 | $ 1,573,378 | $ 560,188 |
| Mandated Assessment (State Comptroller) | $ 390,019 | $ 972,643 | $ 582,624 |
| Rent | $ 327,989 | $ 652,988 | $ 324,999 |
| Professional Services | $ 3,208,000 | $ 4,253,000 | $ 1,045,000 |
| CHIA ISA for RPO | $ 315,000 | $ 147,000 | $ (168,000) |
| IT Infrastructure and Services | $ 200,000 | $ 230,000 | $ 30,000 |
| Administrative Expenses | $ 283,000 | $ 323,000 | $ 40,000 |
| Office Relocation (One-Time) | $ 235,000 | $ - | $ (235,000) |
| Total | $ 9,482,906 | $ 13,475,444 | $ 3,992,538 |

# FY16 Proposed Budget – Summary of Expenditures

| FY16 -HCPR | FY15 Final Projection | FY16 Proposed | Variance |
|---|---|---|---|
| *Estimated Expenditures* | | | |
| Payroll | $ 2,950,243 | $ 4,448,313 | $ 1,498,070 |
| Mandated Assessment (Employee Benefits) | $ 851,440 | $ 1,318,018 | $ 466,578 |
| Mandated Assessment (State Comptroller) | $ 306,738 | $ 739,831 | $ 433,093 |
| Rent | $ 278,791 | $ 555,040 | $ 276,249 |
| Professional Services | $ 2,255,000 | $ 2,800,000 | $ 545,000 |
| CHIA ISA for RPO | $ 315,000 | $ 147,000 | $ (168,000) |
| IT Infrastructure and Services | $ 165,750 | $ 195,500 | $ 29,750 |
| Administrative Expenses | $ 240,550 | $ 274,550 | $ 34,000 |
| Office Relocation (One-Time) | $ 200,000 | $ - | $ (200,000) |
| Total | $ 7,563,512 | $ 10,478,252 | $ 2,914,740 |

| FY16 -DHTF | FY15 Final Projection | FY16 Proposed | Variance |
|---|---|---|---|
| *Estimated Expenditures* | | | |
| Payroll | $ 560,464 | $ 875,122 | $ 314,658 |
| Mandated Assessment (Employee Benefits) | $ 161,750 | $ 255,360 | $ 93,610 |
| Mandated Assessment (State Comptroller) | $ 83,281 | $ 232,812 | $ 149,531 |
| Rent | $ 49,198 | $ 97,948 | $ 48,750 |
| Professional Services | $ 953,000 | $ 1,453,000 | $ 500,000 |
| CHIA ISA for RPO | $ - | $ - | $ - |
| IT Infrastructure and Services | $ 34,250 | $ 34,500 | $ 250 |
| Administrative Expenses | $ 42,450 | $ 48,450 | $ 6,000 |
| Office Relocation (One-Time) | $ 35,000 | $ - | $ (35,000) |
| Total | $ 1,919,394 | $ 2,997,192 | $ 1,077,798 |

# Vote: Authorizing Fiscal Year 2016 Budget

**Motion:** That the Commission hereby accepts and approves the Commission's total operating budget for fiscal year 2016, as presented and attached hereto, and authorizes the Executive Director to expend these budgeted funds.

# Agenda

- Approval of Minutes from the June 10, 2015 Meeting
- Chair Report
- Executive Director Report
- Cost Trends and Market Performance Update
- Care Delivery and Payment System Transformation Update
- Quality Improvement and Patient Protection Update
- Community Health Care Investment and Consumer Involvement Update
- Administration and Finance Update
- **Schedule of Next Commission Meeting (September 9, 2015)**

# Contact Information

For more information about the Health Policy Commission:

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