COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Joint Committee Meeting

Cost Trends and Market Performance

Community Health Care Investment and Consumer Involvement

February 24, 2016

Agenda

- Approval of CTMP Minutes from January 13, 2016 Meeting (VOTE)
- Discussion of 2017 Health Care Cost Growth Benchmark (VOTE)
- Update on Interim Guidance for Performance Improvement Plans (VOTE)
- Presentation on Findings from the Community Hospital Study
- Approval of CHICI Minutes from January 6, 2016 Meeting (VOTE)
- Update on CHART Phase 2
- Discussion of the Evaluation Plan for CHART Phase 2
- Presentation from the Center for Health Information and Analysis on Hospital Readmissions
- Schedule of Next Committee Meeting

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Vote: Approving Minutes

Motion: That the Committee hereby approves the minutes of the Cost Trends and Market Performance Committee meeting held on January 13, 2016, as presented.

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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 7H 1/2 of Chapter 29 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 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 Health Policy Commission staff

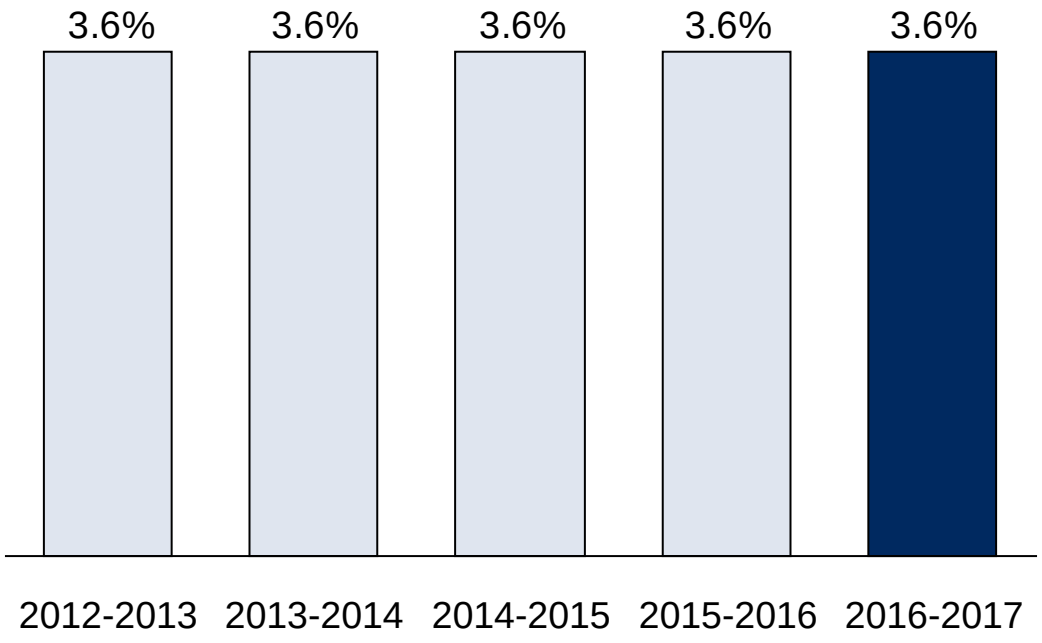
HPC's Role

- 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

PGSP Estimate for 2016-2017

Potential Gross State Product (PGSP)

Percent growth



- The 2016-2017 estimate of 3.6% is within a range as discussed by experts
- Estimates were informed by standard methodologies (e.g., Congressional Budget Office) as well as legislative intent to estimate the long-run average growth rate of the Commonwealth's economy

Vote: Approving 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 2017 as 3.6%.

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Discussion Preview: Performance Improvement Plans

Agenda Topic

Performance Improvement Plans: Proposed Process and Interim Guidance

Description

Staff will provide an update on the development of the process for Performance Improvement Plans, and will present proposed interim guidance for discussion. Staff will detail the HPC's recommended process for evaluating payers and providers, including discussion of the standard and factors to be reviewed. Staff will also discuss the HPC's authority to conduct cost and market impact reviews of CHIA-identified provider organizations.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to provide feedback as to the process and guidance for performance improvement plans.

Decision Points

Commissioners will be asked to endorse presentation of the proposed interim guidance to the full commission for a vote.

Overview of Performance Improvement Plans

- Performance Improvement Plans (PIPs) are a mechanism for the HPC to monitor and assist payers and providers whose cost growth may threaten the state benchmark.
- CHIA is required to provide to the HPC a confidential list of payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (HSA TME), is considered excessive and who threaten the benchmark.
- The HPC is required to provide confidential notice to all such payers and providers informing them that they have been identified by CHIA.
- After comprehensive analysis and review the HPC may require some of the identified payers and providers to file a PIP where the HPC has identified significant concerns about the entity's cost growth and found that the PIP process could result in meaningful, cost reducing reforms.
    - The HPC also has the option to conduct a cost and market impact review (CMIR) of any of the provider organizations identified by CHIA *if the state's total health care expenditures exceed the cost growth benchmark*.

CHIA Identification of Payers and Providers

CHIA is required to identify payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (HSA TME), is considered "excessive and who threaten the benchmark" (according to Chapter 224).

- This year, CHIA has interpreted this standard as payers and providers whose HSA TME growth is above 3.6%.
- The HSA TME metric accounts for variations in health status of a payer's full-claim members. This metric allows for a more refined comparison of TME trends between payers than looking at unadjusted TME alone.
  - Payer HSA TME represents total health care spending for members' care, adjusted by health status. Payer TME is reported for each book of business for a payer.
  - Provider group HSA TME represents the total health care spending of members whose plans require the selection of a primary care physician associated with a provider group (typically HMO or POS products), adjusted for health status. Provider TME is reported for each carrier/book of business for a provider.
- This year's list is based on the trend for 2012 and 2013 final data, as well as the trend for 2013 final and 2014 preliminary data.

Recommendation for Interim Guidance and Purpose

- Pending the adoption of final regulations, the HPC proposes to issue interim guidance to provide clarity for market participants about the PIPs process this year.

- The interim guidance provides direction with respect to the process for identifying payers and providers subject to PIPs, and for the submission, approval, and amendment of PIPs.

- The interim guidance closely tracks statutory requirements, but fills in key details (e.g. where the Board must vote, confidentiality protections), and clarifies certain statutory provisions.

- The development of the interim guidance has been informed by discussions with Commissioners, other state agencies, market participants, and subject matter experts. Stakeholders will have an additional opportunity to comment on the interim guidance in anticipation of the HPC issuing proposed regulations in the coming year.

- The regulatory process will provide further opportunity for public comment. The Commission's final regulations will supersede the requirements of the interim guidance and, accordingly, may differ.

Confidentiality

- **Identification by CHIA:** By statute, the list of identified payers and providers is confidential.
  - This list will be shared confidentially with commissioners.
  - The notices that will be sent to all identified entities will be confidential.

- **Recommendations for PIPs:** HPC staff will confidentially brief commissioners on its review analyses, findings, and recommendations in advance of a Board meeting/vote.
  - There will be a public Board vote for any payers or providers recommended for a PIP.
  - Any entity required to file a PIP will be identified on the HPC's website.

- **Information Provided to the HPC by Payers and Providers:** The HPC will not disclose confidential information or documents provided in connection with PIP activities without the entity's consent, except in summary form in evaluative reports (e.g., public reporting in summary form on PIP proposals, progress, and outcomes) or where the HPC believes that such disclosure should be made in the public interest after weighing privacy, trade secret or anticompetitive considerations. This applies to information provided:
  - In response to HPC requests during the review period;
  - In connection with a waiver request;
  - Within a PIP proposal;
  - During implementation reporting; and
  - For evaluation at the conclusion of a PIP.

Summary of Commissioner Votes

- ❑ Commissioner **Vote** to require a PIP and/or CMIR from any entity
- ❑ Commissioner **Vote** to approve/disapprove any requests for waiver from the requirement to file a PIP
- ❑ Commissioner **Vote** to approve/disapprove a proposed PIP from a payer/provider
- ❑ Commissioner **Vote** to approve/disapprove any significant proposed amendments during implementation
- ❑ Commissioner **Vote** to determine whether the PIP was successful
- ❑ Commissioner **Vote** to extend the implementation timetable, amend the PIP, or require the entity to enter into a new PIP if the PIP is determined unsuccessful
- ❑ Commissioner **Vote** to require a penalty if the entity fails to file or implement a PIP in good faith

Recommended Standard and Factors for Review

Standard: The HPC may require a PIP where, based on a review of factors described below,
1) the HPC identifies significant concerns about the entity's costs and
2) determines that a PIP could result in meaningful, cost-saving reforms.

Factors for review include, but are not limited to:

- Baseline spending and spending trends over time, including by service category;
- Pricing patterns and trends over time;
- Utilization patterns and trends over time;
- Population(s) served, product lines, and services provided;
- Size and market share;
- Financial condition, including administrative spending;
- Ongoing strategies or investments to improve efficiency or reduce spending growth over time; and
- Factors leading to increased costs that are outside the Health Care Entity's control.

While the same factors will be evaluated for both payers and providers, some of the underlying metrics examined may be unique to one or the other.

Payer and Provider Example Analysis

More Likely PIP

- **High baseline medical spending and rapid growth over a large population**
- **High and/or increasing relative price (providers) or price variation (payers)**
- **No obvious patient population issues warranting higher spending**

- **Low baseline medical spending, slower growth, and/or growth over a small population**
- **Low and/or decreasing relative price (providers) or price variation (payers)**
- **Identifiable patient population issues that might explain short term higher spending**

Less Likely PIP

**The HPC will examine these trends across all insurance categories and/or carriers*

Proposed Interim Guidance: Outline

1. Notice of Identification by CHIA
2. Standard for Requiring a PIP
3. Notice of Requirement to File a PIP
4. Timing for Responding to PIP Notice
5. Requests for Extension of Time
6. Requests for Waiver
7. PIP Proposals
8. Approval or Disapproval of a Proposed PIP
9. Implementation: Monitoring, Reporting, Amendments
10. Conclusion of Implementation Period
11. Confidentiality
12. Penalties
13. CMIR Process for CHIA-Identified Provider Organizations

Notice of Identification by CHIA; PIP Standard of Review

Notice of Identification by CHIA	▪ The statute requires the HPC to provide confidential written notice to each health care entity that is identified by CHIA. ▪ The notice will state the data relied upon by CHIA for identification of the entity. ▪ The notice will advise the entity that the HPC is evaluating the performance of that entity, that the HPC may request additional information from that entity, and the standards for requiring a PIP or initiating a CMIR.

Standard for Requiring a PIP	▪ The HPC may require any CHIA-identified health care entity to file a PIP where, based on a review of factors described below, the HPC identifies significant concerns about the entity's costs and determines that a PIP could result in meaningful, cost-saving reforms.
	▪ The HPC will determine whether to require a PIP based on a review of factors, including, but not limited to:
	  ▪ Baseline spending and spending trends over time, including by service category;
	  ▪ Pricing patterns and trends over time;
	  ▪ Utilization patterns and trends over time;
	  ▪ Population(s) served, product lines, and services provided;
	  ▪ Size and market share;
	  ▪ Financial condition, including administrative spending;
	  ▪ Ongoing strategies or investments to improve efficiency or reduce spending growth over time; and
	  ▪ Factors leading to increased costs that are outside the Health Care Entity's control.
	▪ The decision to require a PIP will require an affirmative vote of six members of the Commission.

PIP Notice; Timeline for Filing; Requests for Extension

Notice of Requirement to File a PIP	▪ The HPC will provide written notice to any health care entity from which it is requiring a PIP (PIP Notice). ▪ The PIP Notice will state the basis for the HPC's determination, the timing and process for filing a PIP, and the timing and process for filing a request for extension or waiver. ▪ All entities required to file a PIP will be identified on the HPC's website.

Timing for Responding to PIP Notice	▪ From receipt of PIP Notice, the entity must:
	  ▪ File a **proposed PIP** within 45 days;
	  ▪ File a **request for waiver** from the requirement to file a PIP within 45 days; or
	  ▪ File a **request for extension of time** to file a PIP or a waiver request within 15 days.

Requests for Extension of Time	▪ The HPC may extend the timeline for filing a PIP to provide sufficient time for the creation and submission of a plan that will be reasonably likely to successfully address the underlying cause(s) of the entity's cost growth. ▪ The entity must indicate requested length of extension. ▪ If approved, the HPC will notify the entity of the extended timeline. ▪ If the HPC declines the request, the entity will have 45 days to file a proposed PIP.

Waivers

Requests for Waiver

- The HPC may waive the requirement to file a PIP in light of all information received from the entity, based on a consideration of the following factors (taken directly from the statute):
  - the costs, price and utilization trends of the Health Care Entity over time, and any demonstrated improvement to reduce health status total medical expenses;
  - any ongoing strategies or investments that the Health Care Entity is implementing to improve future long-term efficiency and reduce cost growth;
  - whether the factors that led to increased costs for the Health Care Entity can reasonably be considered to be unanticipated and outside of the control of the entity (e.g., introduction of high-priced pharmaceuticals);
  - the overall financial condition of the Health Care Entity; and
  - any other factors the Commission considers relevant.
- The entity may submit any documentation or supporting evidence to the HPC to support its waiver request. The HPC may also require the entity to submit any other relevant information it deems necessary to consider the waiver request.
- A determination to waive the requirement to file a PIP will require an affirmative vote of six members of the Commission.
- If the HPC declines to waive, the entity will have 45 days to file a proposed PIP (the entity will have an opportunity to file request for extension of time if needed).

PIP Proposals; Approval/Disapproval Process

PIP Proposals	▪ The proposed PIP must be developed by the entity.
	
	▪ Must include, but need not be limited to:
	  ▪ Identification of the cause(s) of the entity's cost growth, with supporting analytic materials as applicable;
	  ▪ Specific strategies, adjustments, and action steps the entity proposes to implement to improve health care spending performance;
	  ▪ Specific identifiable and measurable expected outcomes, with a timetable for measurement, achievement, and reporting of such outcomes;
	  ▪ Any requests by the entity for implementation assistance from the Commission;
	  ▪ A timetable for implementation of 18 months or less; and
	  ▪ Any documentation necessary to support any claims or assertions contained in the proposal.
	
	▪ The HPC may publicly report in summary form upon the proposed PIP.

Approval or Disapproval of a Proposed PIP	▪ The HPC will approve a proposed PIP if it meets the criteria listed above, and if the HPC determines that the proposed PIP is reasonably likely to successfully address the underlying cause(s) of the entity's cost growth. ▪ If the HPC finds the proposed PIP unacceptable, it will provide up to 30 days for resubmission and will encourage the entity to consult with the HPC on the criteria that have not been met. ▪ Approval of a proposed PIP will require an affirmative vote of six members of the Commission.

Implementation; Conclusion of a PIP

Implementation	▪ The entity will be subject to compliance monitoring, and will be required to provide both public and confidential reports upon progress as specified in the approved PIP. ▪ The HPC may provide technical assistance as specified in the approved PIP. ▪ The entity may file requests to amend the PIP during implementation. Approval of significant amendments will require an affirmative vote of six members of the Commission.
Conclusion of a PIP	▪ Entities will be required to report on the outcome of the PIP, and the HPC may publicly report on the outcome in summary form. ▪ The HPC will determine, via affirmative vote ofsix members of the Commission, whether the PIP was successful. ▪ If the PIP is found unsuccessful, the HPC may extend the implementation timetable, request and/or approve amendments, or require the entity to submit a new PIP.

Confidentiality; Penalties

Confidentiality	▪ Unless otherwise specified in the statute or in the interim guidance, the HPC will keep confidential all nonpublic clinical, financial, strategic, or operational documents or information provided to the HPC in connection with PIP activities. ▪ The HPC will not disclose confidential information or documents without the entity's consent, except in summary form in evaluative reports (as referenced throughout the guidance), or where the HPC believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations.
Penalties	▪ The HPC may assess a civil penalty of no more than $500,000 if an entity 1) willfully neglects to timely file a PIP, 2) fails to file an acceptable PIP in good faith, 3) fails to implement a PIP in good faith, or 4) knowingly fails to provide information to the HPC required by PIP statute. ▪ The Commission shall determine whether to assess a penalty by affirmative vote of six members. ▪ The HPC will provide written notice to any entity that is assessed a penalty of the amount of the penalty, the reason(s) for assessing the penalty, and the right to request a hearing.

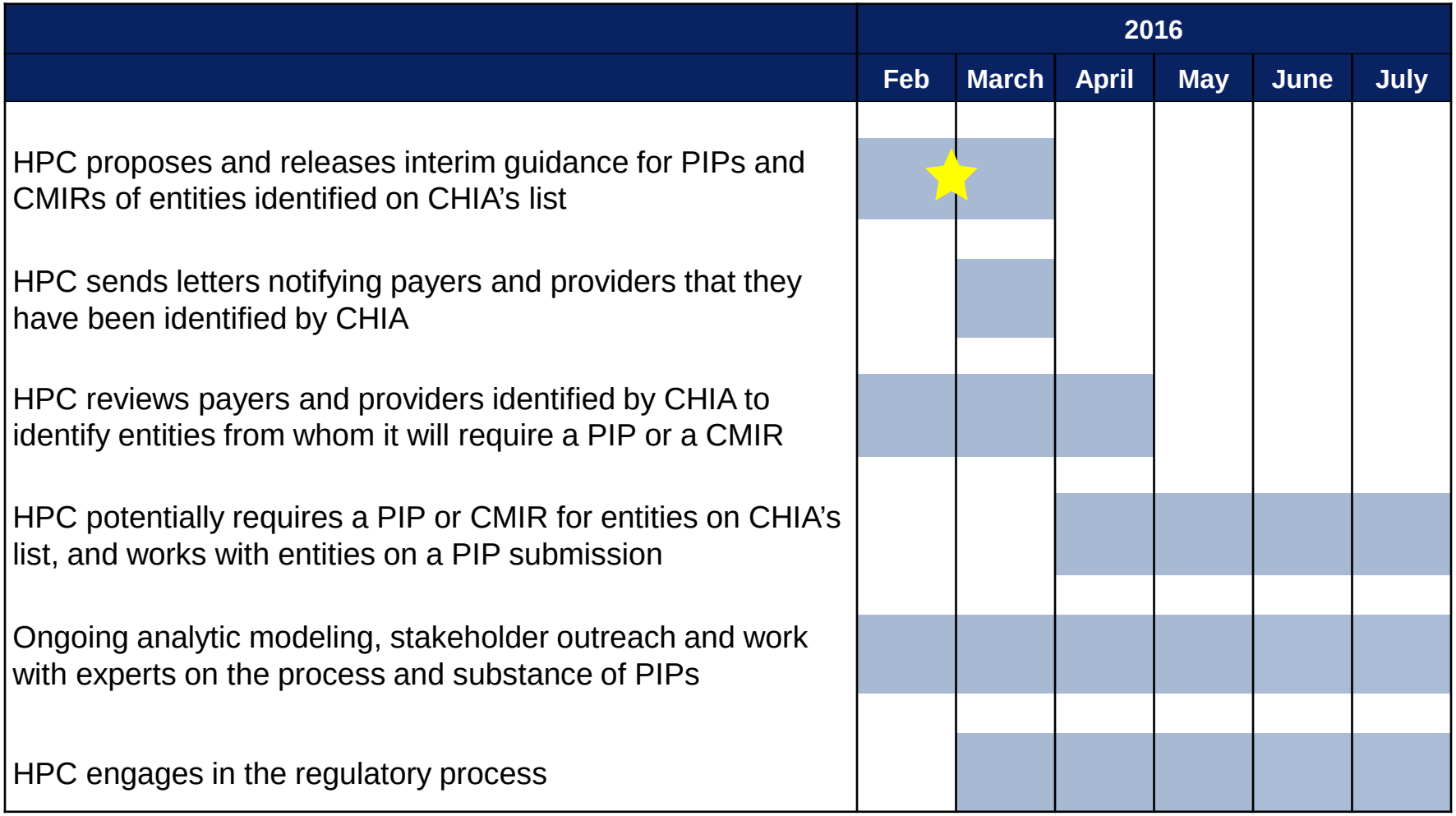
CMIRs of CHIA-Identified Provider Organizations

CMIR Process for CHIA-Identified Provider Organizations	▪ Only triggered when total health care expenditures exceed the health care cost growth benchmark in the previous calendar year. ▪ The HPC may conduct a CMIR of a CHIA-identified provider organization if the HPC determines that provider organization's performance has significantly impacted or is likely to significantly impact market functioning or the state's ability to meet the health care cost growth benchmark. ▪ The HPC will provide written notice to the CHIA-identified provider organization if the HPC decides to conduct a CMIR. ▪ The process for CMIRs of CHIA-identified provider organizations will be governed by M.G.L., chapter 6D, section 13, and 958 CMR 7.05 – 7.12; and 7.14, which govern CMIRs triggered by notices of material change.

PIPs vs CMIRs

	PIP	CMIR
When is HPC authority triggered?	Each year	Only in years when the total health care expenditures exceed the cost growth benchmark
To whom does it apply?	Payers and providers identified by CHIA	Providers identified by CHIA
When will the HPC require a PIP or a CMIR?	A PIP may be required where, based on a review of factors, the HPC identifies significant concerns about the entity's costs and determines that a PIP could result in meaningful, cost-saving reforms.	The HPC may conduct a CMIR where it determines that the provider organization's performance has significantly impacted or is likely to significantly impact market functioning or the state's ability to meet the health care cost growth benchmark.
What are the significant differences?	• Forward-looking • Most appropriate where cost drivers are evident and the HPC determines that an performance improvement intervention could effectively address the drivers	• Retrospective *and* forward-looking • Cost drivers may not be evident; investigatory in nature • Broader review: assesses impact of provider's performance on cost, market, quality, and access • HPC may require provider organizations to submit documents and information

Next Steps and Timeline for Performance Improvement Plans



Vote: Endorsing Interim Guidance

***Motion**:* That, pursuant to sections 10 and 13 of chapter 6D of the Massachusetts General Laws, the Cost Trends and Market Performance Committee hereby endorses the attached interim guidance for payers, providers, and provider organizations relative to performance improvement plans and cost and market impact reviews.

System-wide data update

Data needs	HPC and CHIA activities
Discharge data for psychiatric hospitals	• CHIA estimates project will take 13-18 months.
Validated MassHealth data from the APCD	• **CHIA has developed extensive tables related to enrollment and spending.** • **Tables will be foundation for joint CHIA/HPC project in 2016.**
APCD general	• APCD version 5.0 (2015 data) will be released 6/2016 (3 months run-out). • **CHIA has developed extensive tables related to enrollment and spending.**
TME for PPO	• CHIA planning new aggregate data collection
Measures of spending growth for hospitals and specialists	• **CHIA expects to solicit vendor to evaluate and recommend measures. HPC worked with CHIA to refine project.**
Quality data BH data	• CHIA is preparing its recommendations around reporting on behavioral health metrics for its June Oversight Council meeting. • **CHIA, HPC, and AGO working together to measure percentage of market covered by global APMs that include BH (part of APM data collection).**
Other new developments	• **CHIA assessing feasibility of collecting data on drug rebates – per HPC request.** • **HPC and CHIA discussing potential technical refinements to THCE calculation.** • **CHIA examining feasibility of collecting data on provider discounts.**

Notes: Bold text represent noteworthy developments since 01/13/016.

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Community Hospitals at a Crossroads

Findings from an Examination of the Massachusetts Health Care System

MASSACHUSETTS
HEALTH POLICY COMMISSION

Background of the report: building a path to a thriving, community-based health care system

The need for the report

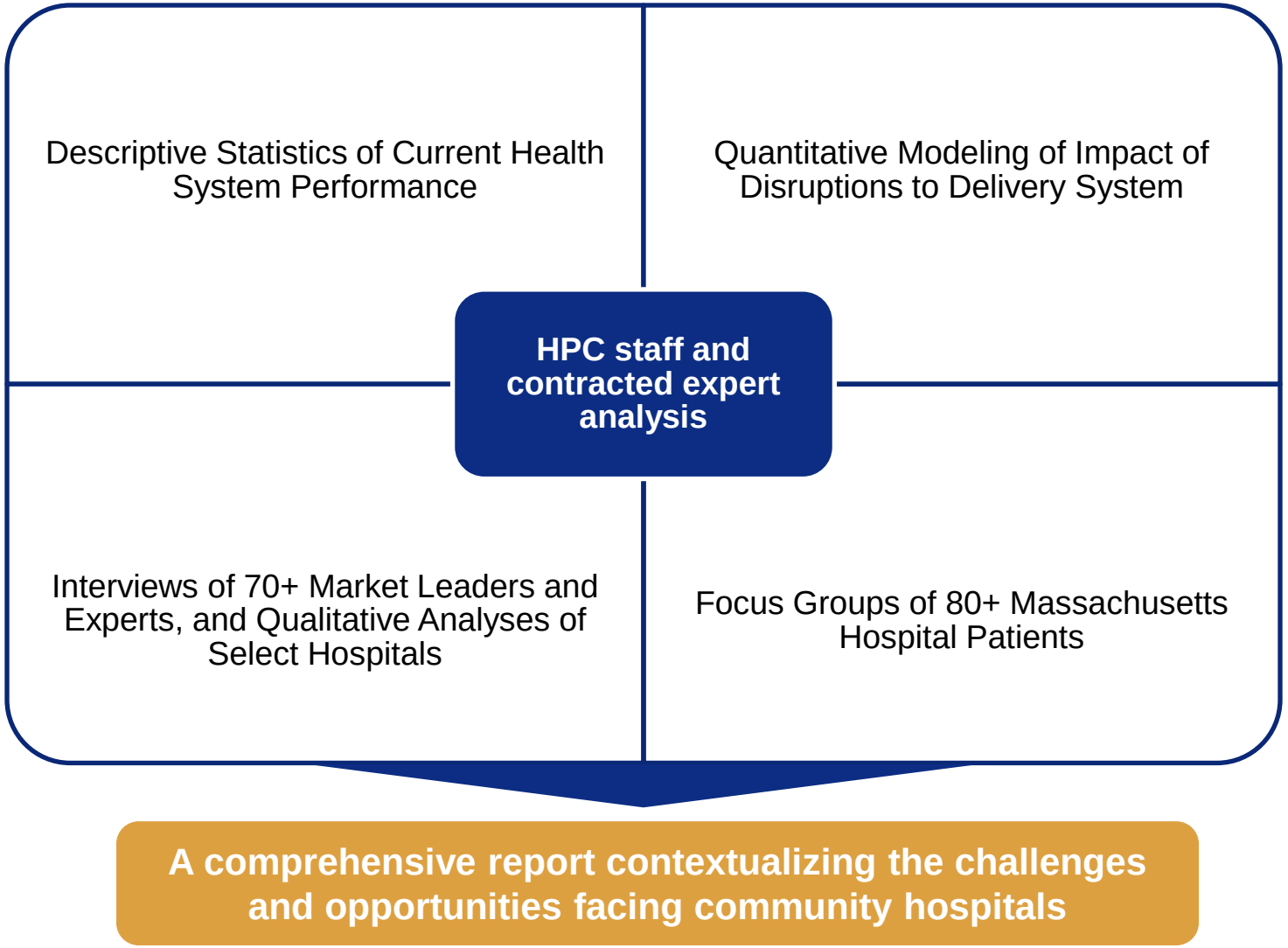
- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged **by current market and utilization trends,** as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- **To identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

> *"I don't see any future for community hospitals…I think there's a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care]."*
>
> *COMMUNITY HOSPITAL CEO*

Analytic components of the report



Key themes of the report

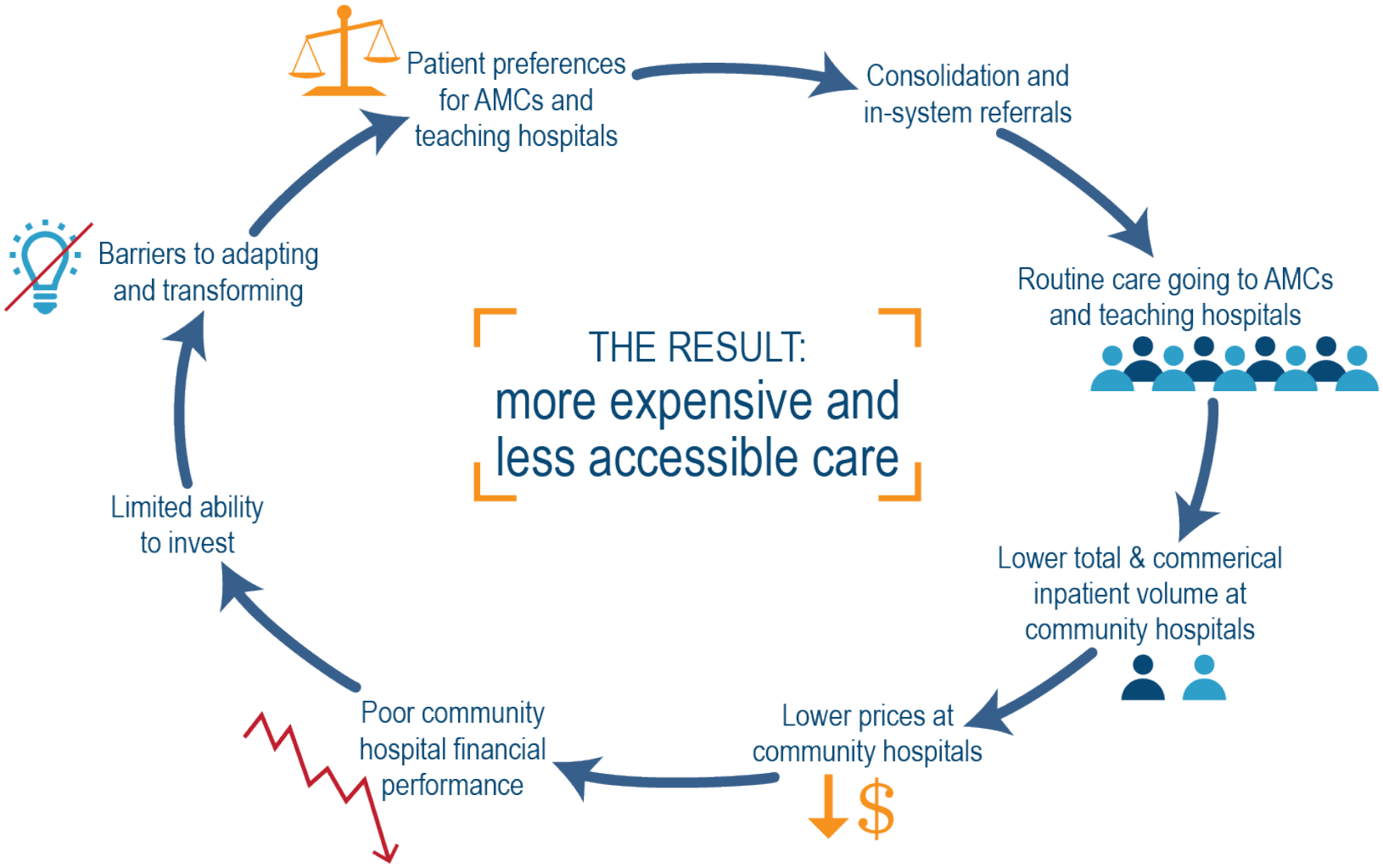
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

The traditional role and operational model for many community hospitals faces tremendous challenges

- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care

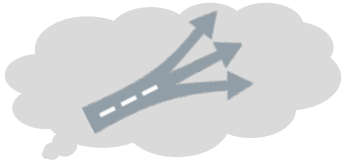


Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System

Overview | **Value** | **Challenges** | **Path Forward**

- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

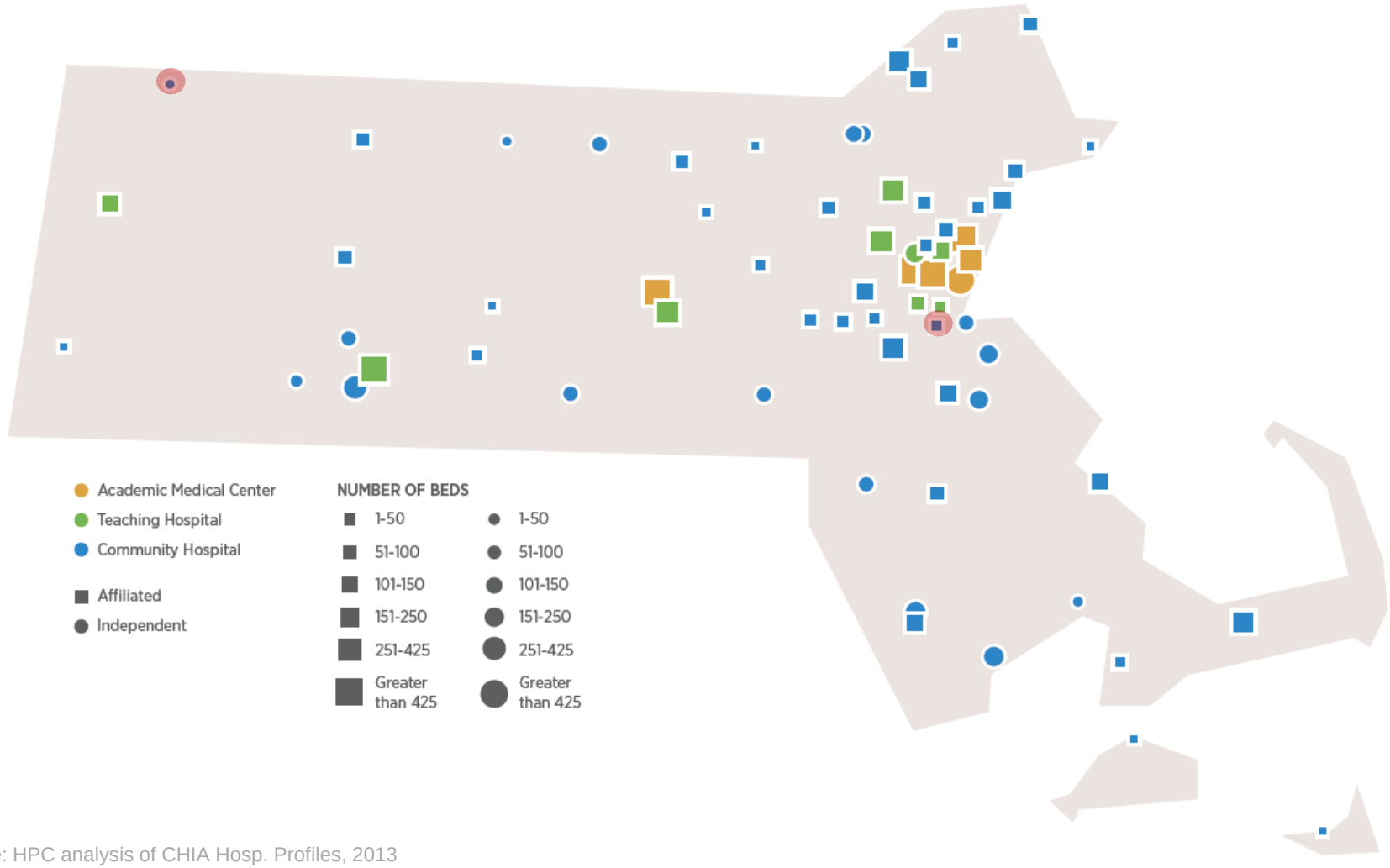
An overview of community hospitals in Massachusetts



Overview | Value | Challenges | Path Forward

- Key distinguishing features of community hospitals (geographic distribution, patient populations, services, financial condition)
- Key community hospital trends (transitions, consolidation and closure)

Community hospitals serve all parts of the Commonwealth



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Community hospitals at a glance

43
Community Hospitals

27 DSH | **18** non-DSH

7,518 | 52%
more than half of beds statewide
(19 – 556)

417,275 | 51.3%
more than half of discharges statewide
(556 – 40,303)

5.8 million | **42** %
outpatient visits

1.9 million | **65** %
2/3 of ED visits
(10,329 – 155,236)

64% community hospitals | **84%** AMCs
low occupancy rate
(29% – 74%)

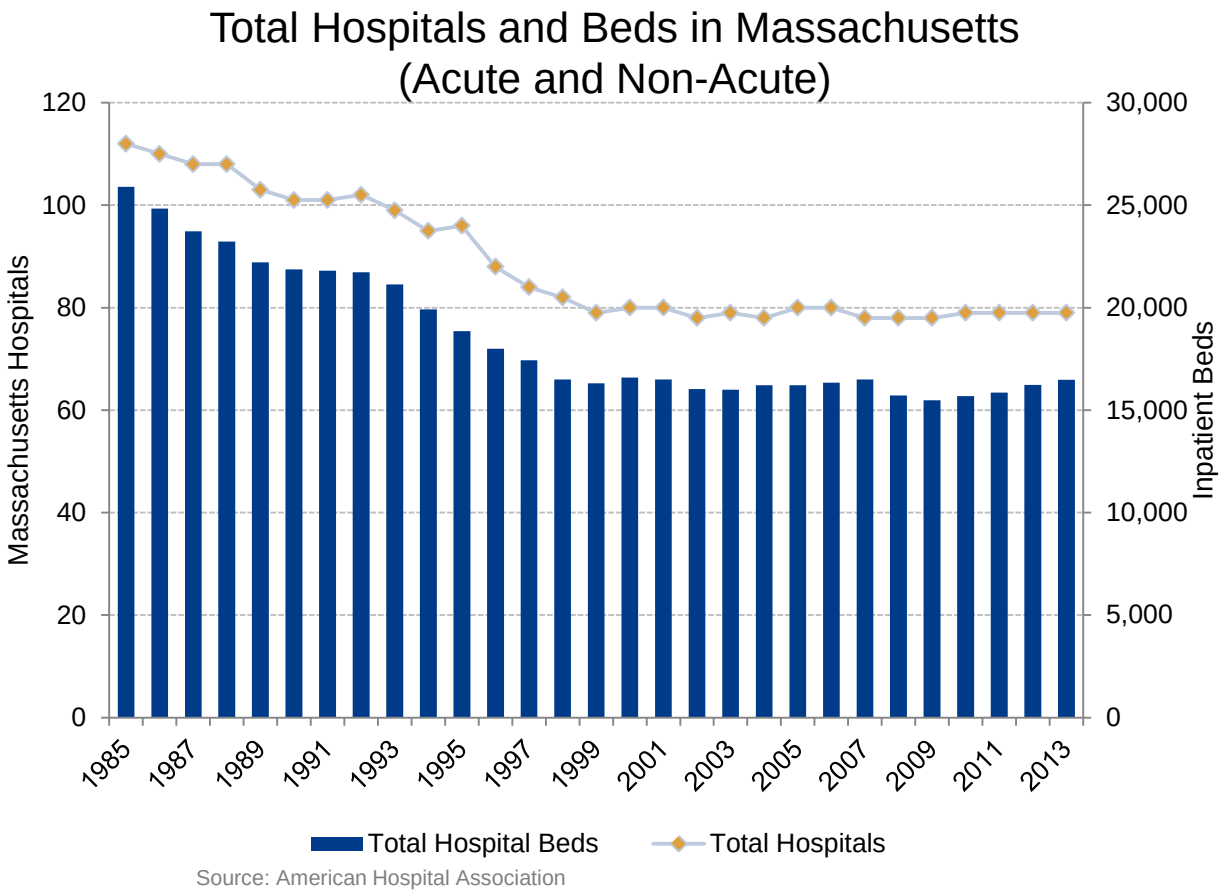
0.8 community hospitals | **1.33** AMCs
low case mix index
(0.60 – 0.93)

9.3 minutes | **+11** minutes
local patients drive 9.3 minutes on average to community hospitals; they would drive 11 minutes more on average to get to the next closest hospital

Older age of plant
Community hospitals generally have older physical plants than AMCs or teaching hospitals

Higher public payer mix
Community hospitals generally have disproportionately high shares of Medicaid and Medicare patients

Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



Source: American Hospital Association

Recent Conversions in Massachusetts Have Had Varied Impact

North Adams Regional Hospital

Steward Quincy Medical Center

Two Conversions Are Being Currently Contemplated

Baystate Mary Lane Hospital

Partners North Shore Medical Center – Union Hospital

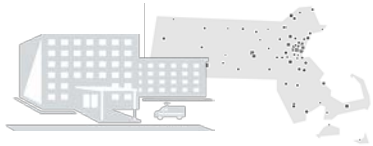
Hospital-related Material Change Notices since 2013

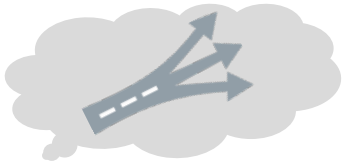
11
mergers or acquisitions of one hospital by another

16
new contracting or clinical relationships between hospitals

5
hospitals acquiring physician groups

The value of community hospitals to the health care system





Overview | **Value** | Challenges | Path Forward

Community-based care and access

- Care close to home / drive time analyses
- Patient populations / payer mix

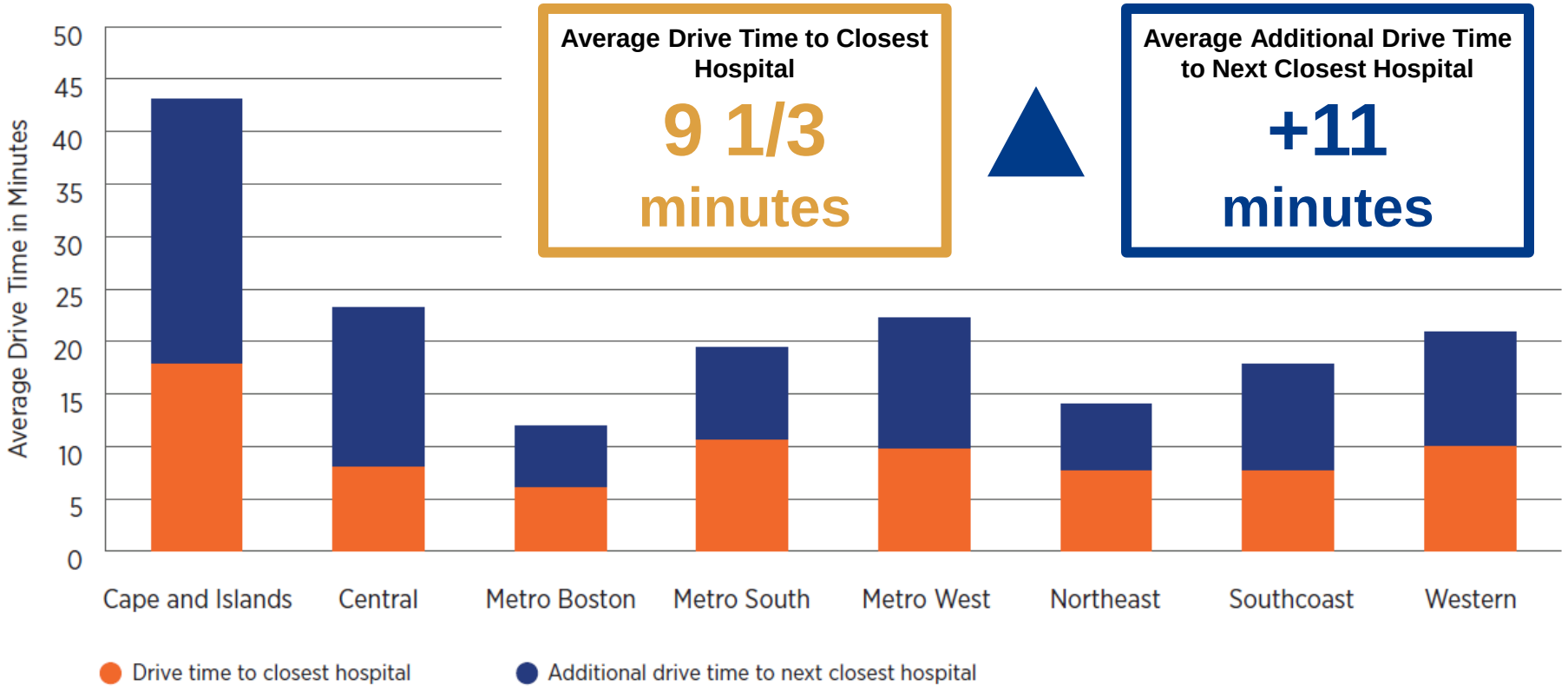
Quality and Efficiency

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

Community hospitals provide local access for local patients

Average Drive Times for Patients Using Their Local Community Hospital

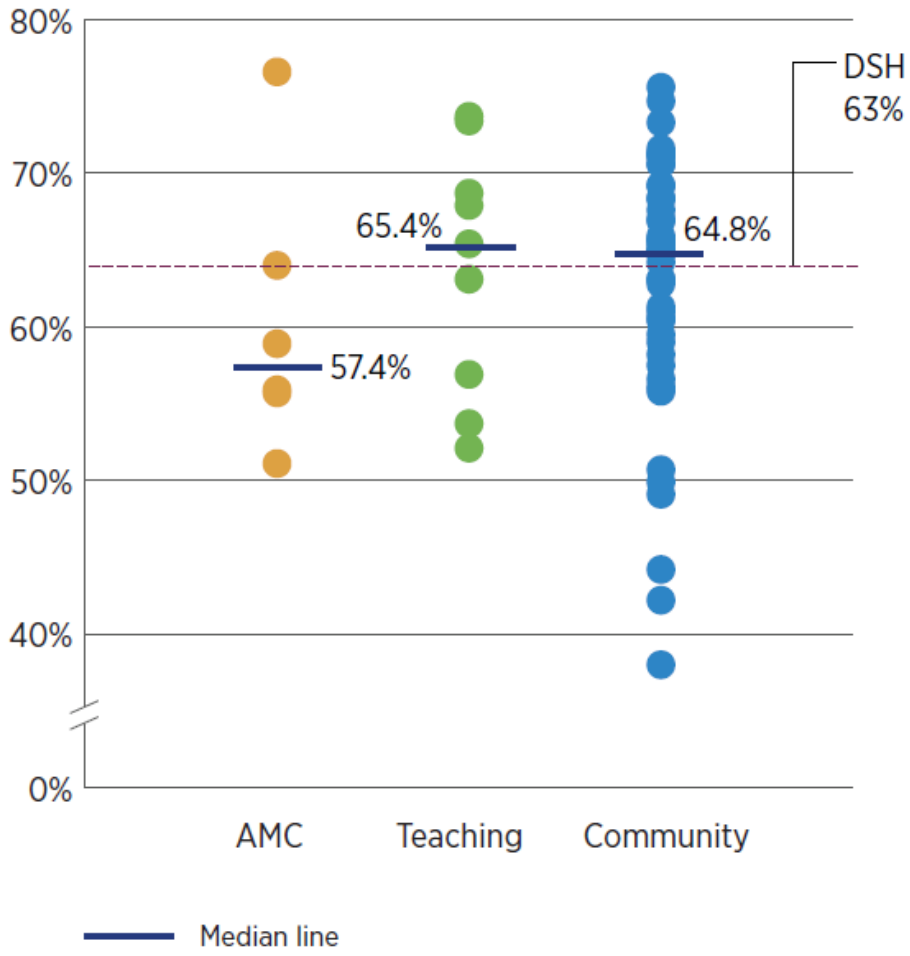
Analysis of patients who use their closest community hospital as a usual site of care



Source: HPC analysis of MHDC 2013 discharge data.
Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

Community hospitals serve a high proportion of vulnerable populations for whom access to care is often difficult, such as elders, individuals with disabilities, and individuals with low incomes

Percent of Hospital Gross Patient Revenue from Public Payers by Hospital Cohort, FY13



> *The community hospital plays a role as a cultural and social staple for the community that it serves. It's the place you're born at, that you grow up with, and get most of your basic care at…The state should ensure access to community-based, cost-effective care*
>
> *MASSACHUSETTS STATE LEGISLATOR*

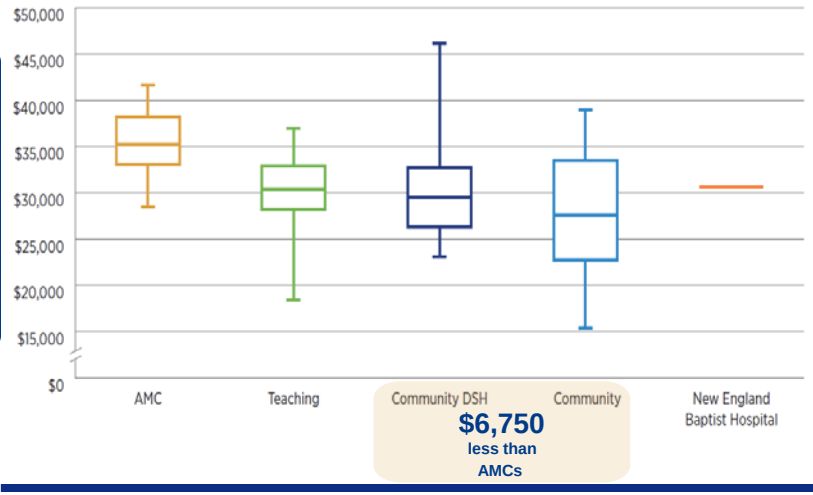
Source: HPC analysis of CHIA Acute Hosp. Databook, supra footnote 11, at Appendix D.
Note: Public payers include Medicate and Medicaid/MassHealth fee for service and managed care plans, Health Safety Net payments, and charges designated by hospitals as "other government."

Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

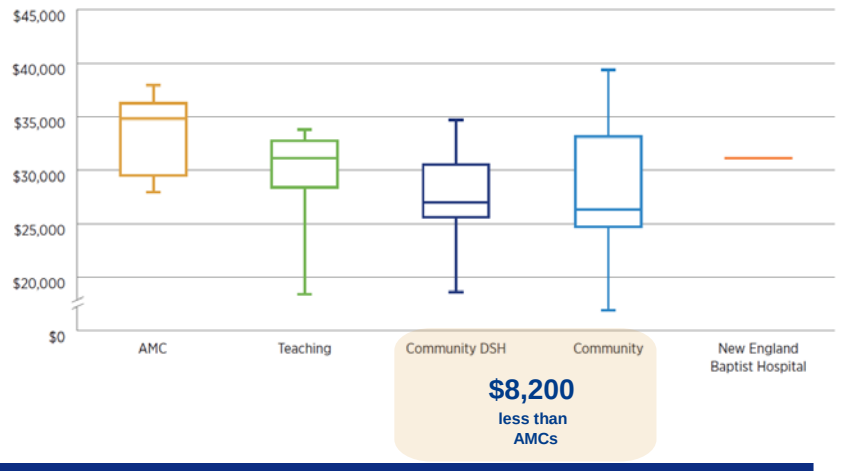
Orthopedics

Deliveries

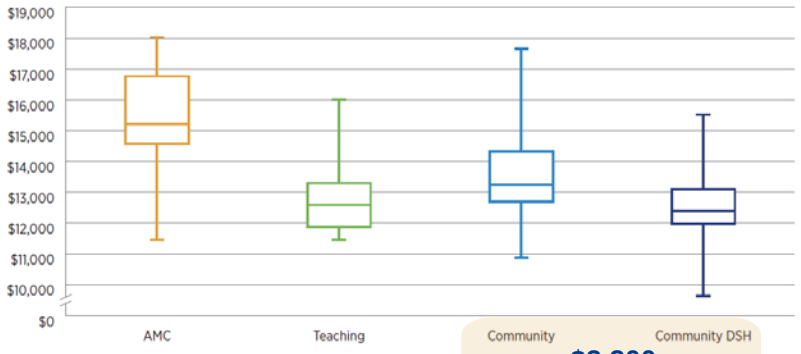
Hip Replacement



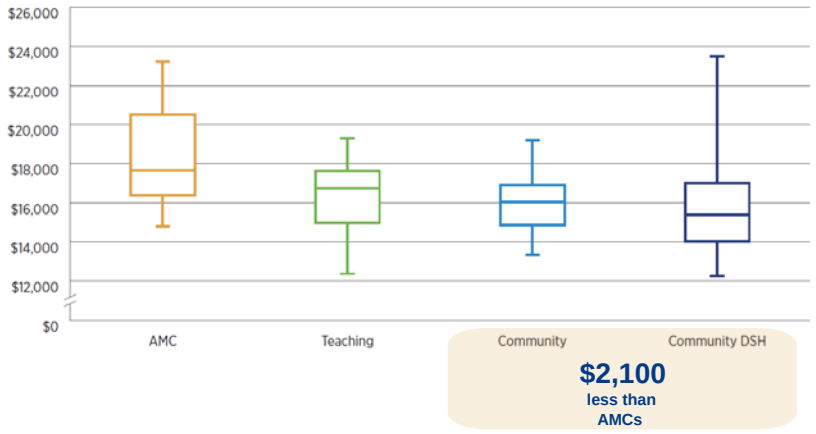
Knee Replacement



Pregnancy - Vaginal Delivery



Pregnancy - Caesarian Delivery

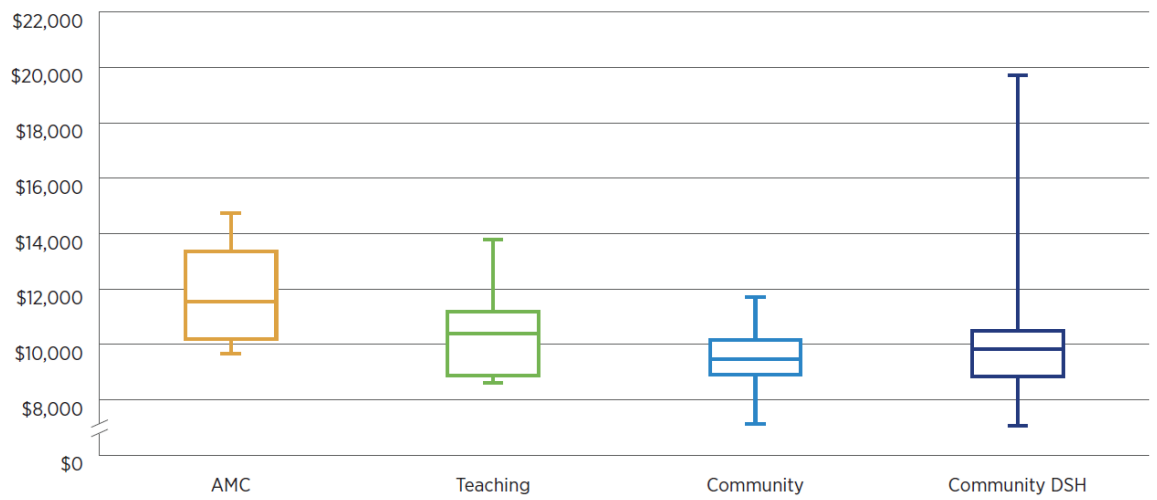


Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers but no cohort outperforms any other overall.

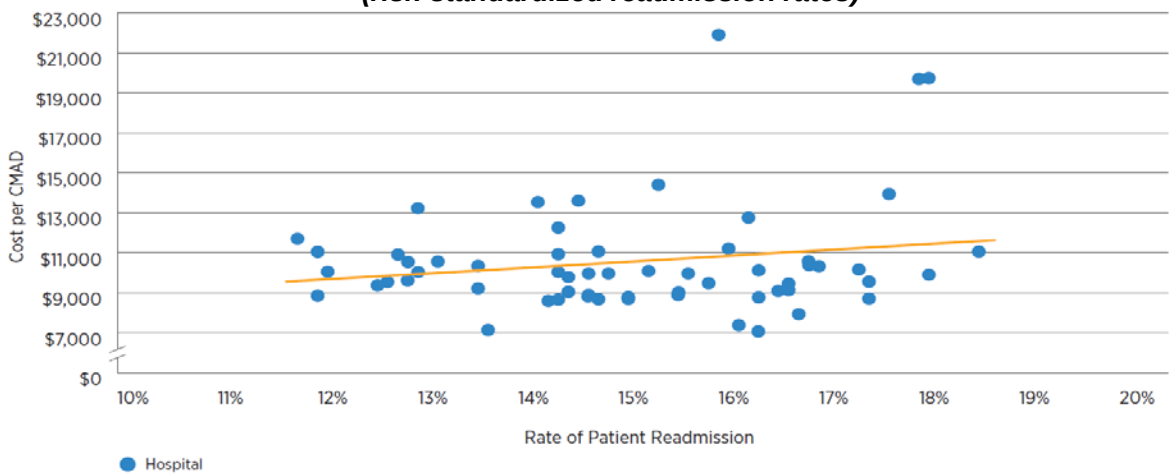
Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality
(risk-standardized readmission rates)



Source: HPC analysis of CHIA Hosp. Profiles, 2013; CHIA Focus on Provider Quality Databook, Jan 2015

On average, **community hospital costs are nearly $1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

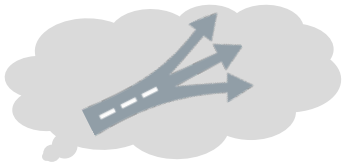
Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

Increases in health care spending on inpatient care would result from the closure of most community hospitals, due to commercial price variation

The HPC modeled where patients would likely seek care if community hospitals were to close and to estimate commercial spending impact.

- In most cases, a community hospital closure would **increase annual spending on inpatient care**
- **The majority of these increases would be less than $4 million**, due to the disproportionately low volume of commercially insured patients at many community hospitals
- Spending would increase by **more than $5 million for seven community hospitals**
  - The closure of **Lowell General Hospital** would cause the greatest increase: **over $16 million**
- Spending would actually **decrease** in the event of the closure of any of eight community hospitals, primarily those with higher relative prices
  - The greatest decreases in spending would result from **South Shore Hospital ($4.2 million annually)** or **Cooley-Dickinson Hospital ($2.8 million annually)** becoming unavailable

Challenges facing community hospitals



Overview | Value | **Challenges** | Path Forward

- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

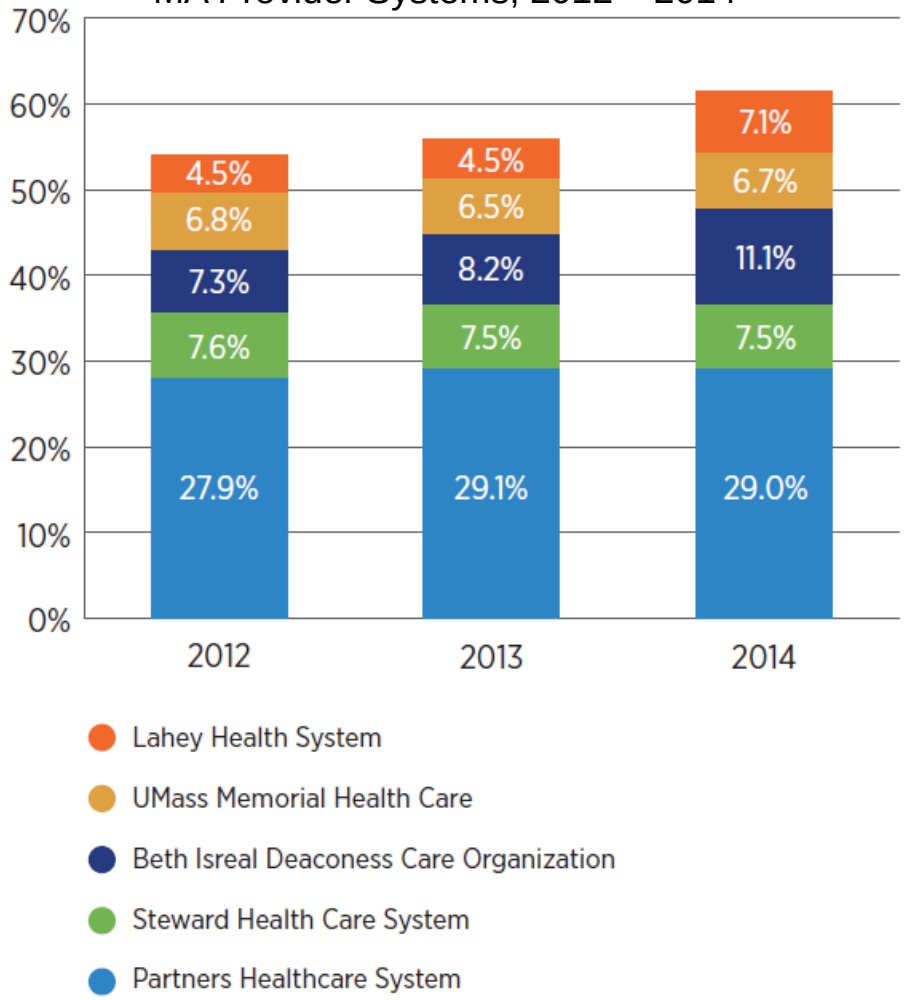
HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

> *"I guess it might be something in your psyche because I like brand-name products. So maybe that's what drives me to Boston."*
>
> *FOCUS GROUP PARTICIPANT*

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to "get their money's worth" from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

Increased consolidation of providers has driven referrals to large provider systems, including their anchor AMCs and teaching hospitals

Percent of Statewide Inpatient Discharges at the Five Largest MA Provider Systems, 2012 – 2014

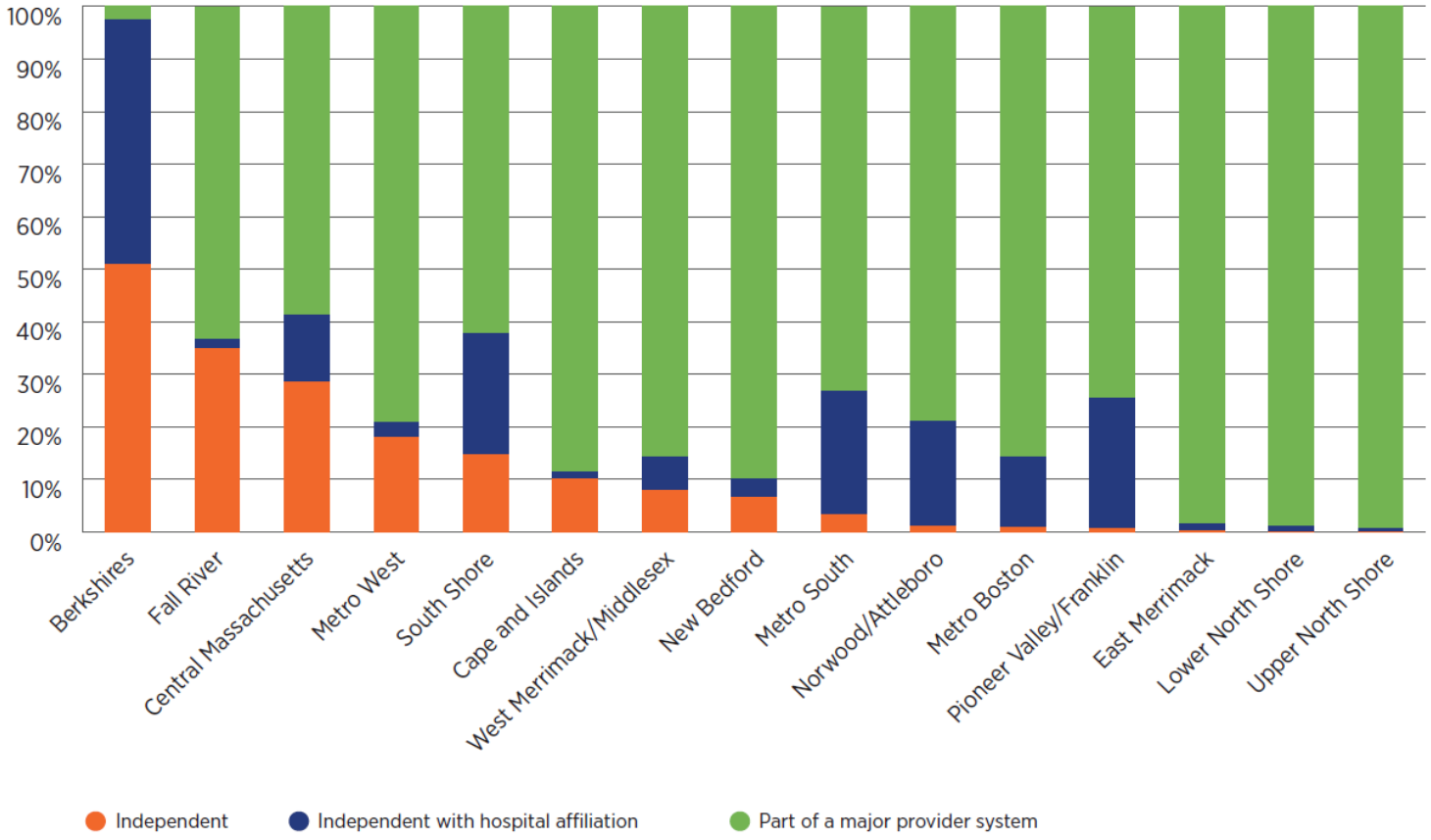


> *"Retaining primary care staff and specialists, 'the gatekeepers to volume' is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow"*
>
> *Synthesis of MASSACHUSETTS PROVIDER INTERVIEWS*

Source: HPC analysis of MHDC discharge data.
Note: Systems shown have the highest total net patient service revenue among providers in the Commonwealth.

Most primary care services are now delivered by physicians affiliated with major provider systems

Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



Percentage of PCPs Affiliated with Eight Largest Systems Grew from

62%

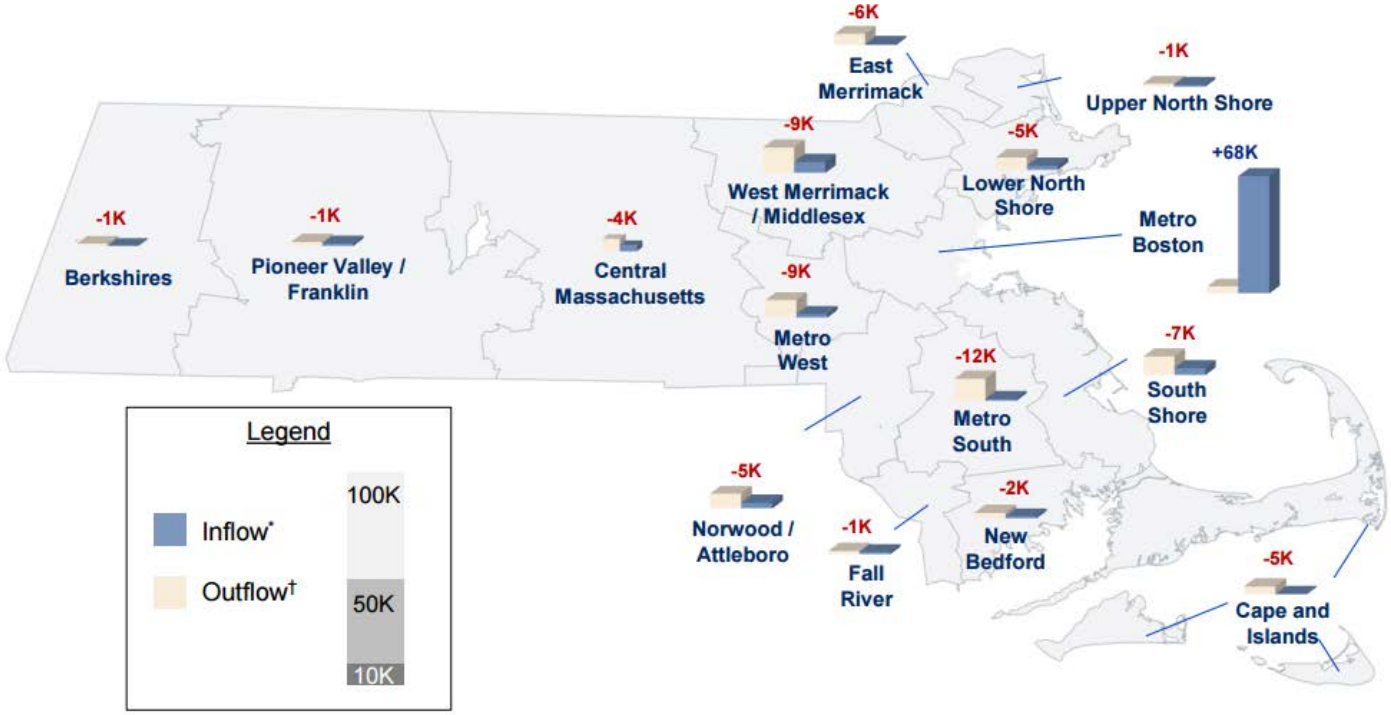
in 2008 to

76%

in 2014

Source: HPC analysis of 2012 APCD claims for BCBS and HPHC ; 2012 MHQP Master Provider Database.
Note: For the purposes of this analysis, major provider systems include Atrius Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lahey Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

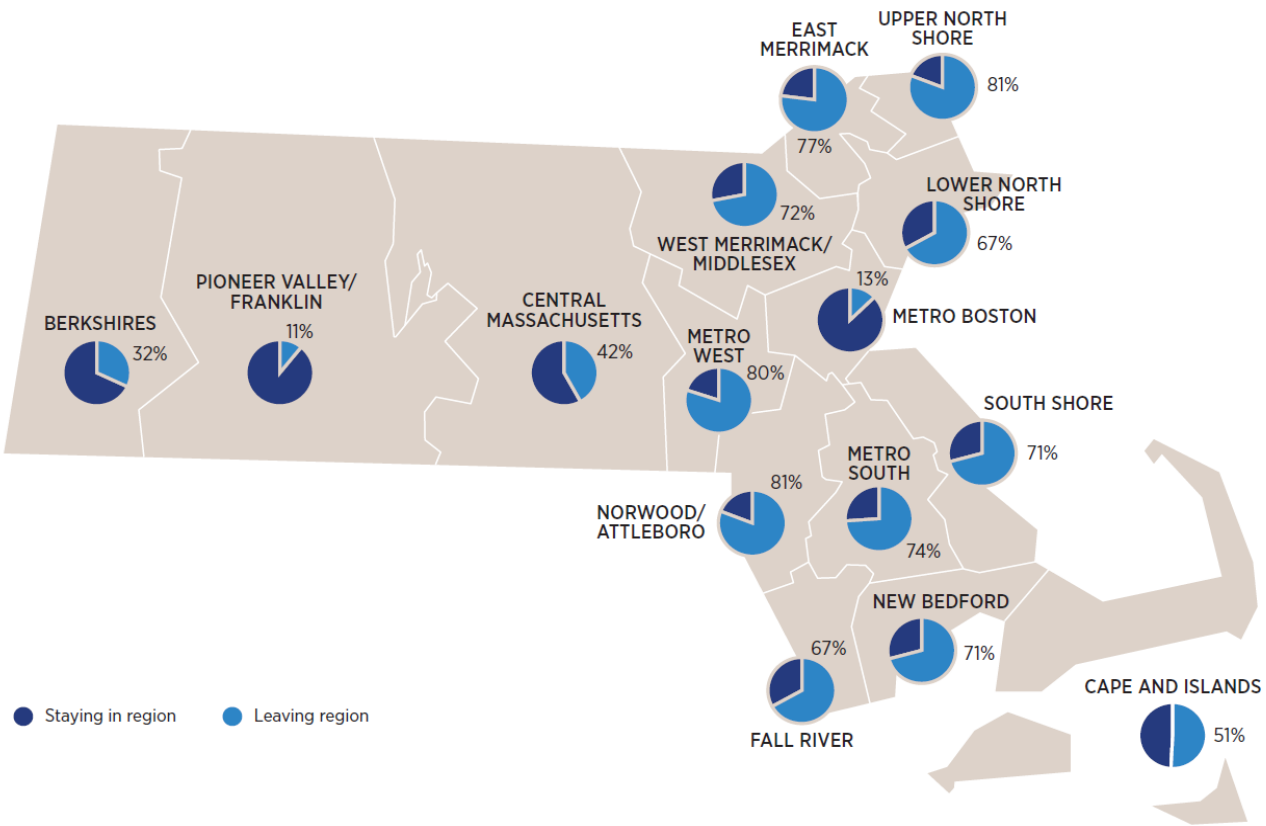
Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
Source: HPC Cost Trends Report, July 2014 Supplement

Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



74%→50%

change in proportion of all births in community hospitals from 1992 – 2012[1]

[1]Healthcare Equality and Affordability League, *Healthcare Inequality in Massachusetts: Breaking the Vicious Cycle*

6 hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

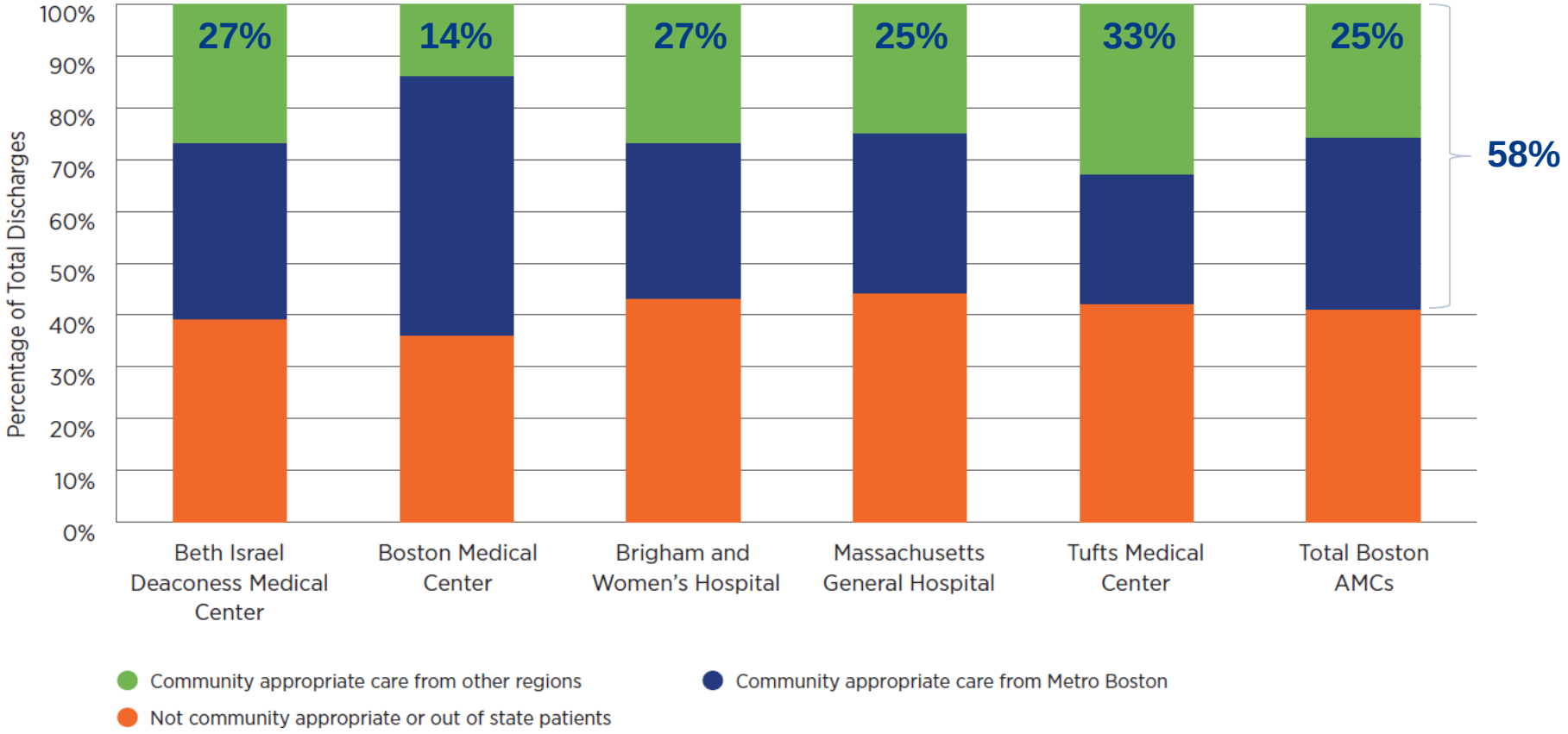
20%

of all low-risk births in the state

Source: HPC analysis of MHDC discharge data.

A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting

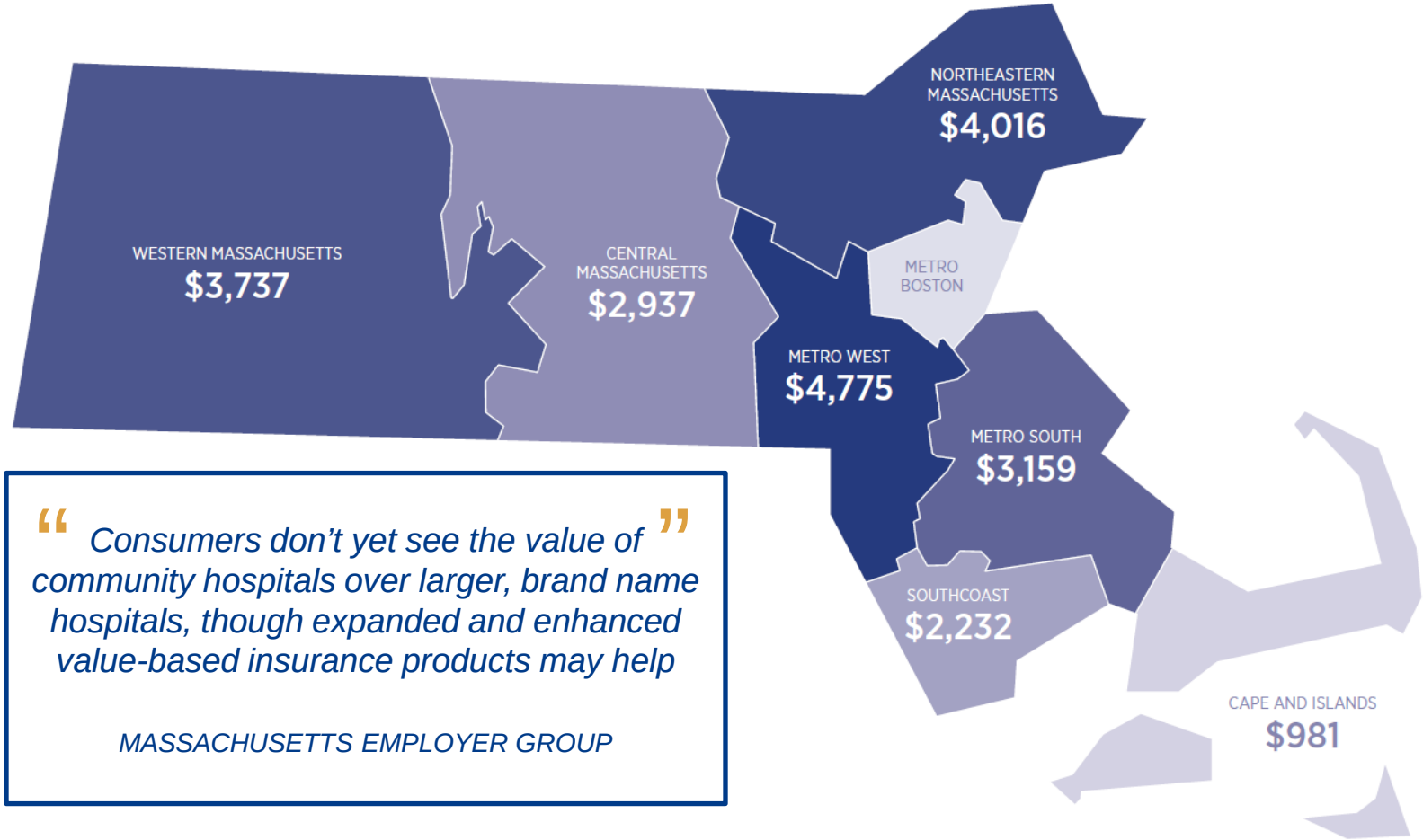
Inpatient Discharges at Boston AMCs, 2013
Community-Appropriate Volume as a Proportion of Total Volume



Source: HPC analysis of MHDC 2013 discharge data.
Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provide at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

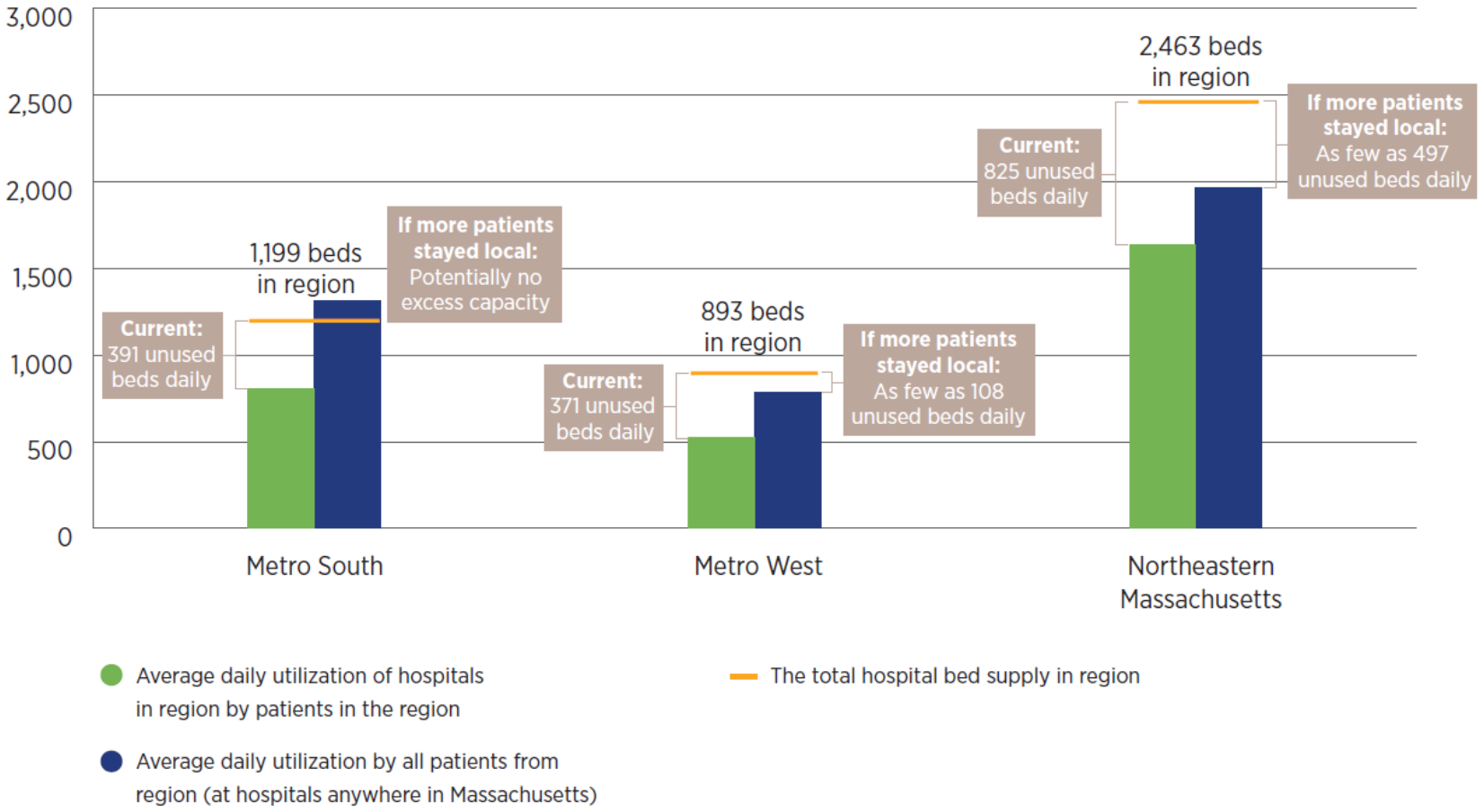


> *"Consumers don't yet see the value of community hospitals over larger, brand name hospitals, though expanded and enhanced value-based insurance products may help"*
>
> *MASSACHUSETTS EMPLOYER GROUP*

Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

In most regions, hospitals have the capacity to treat more patients locally

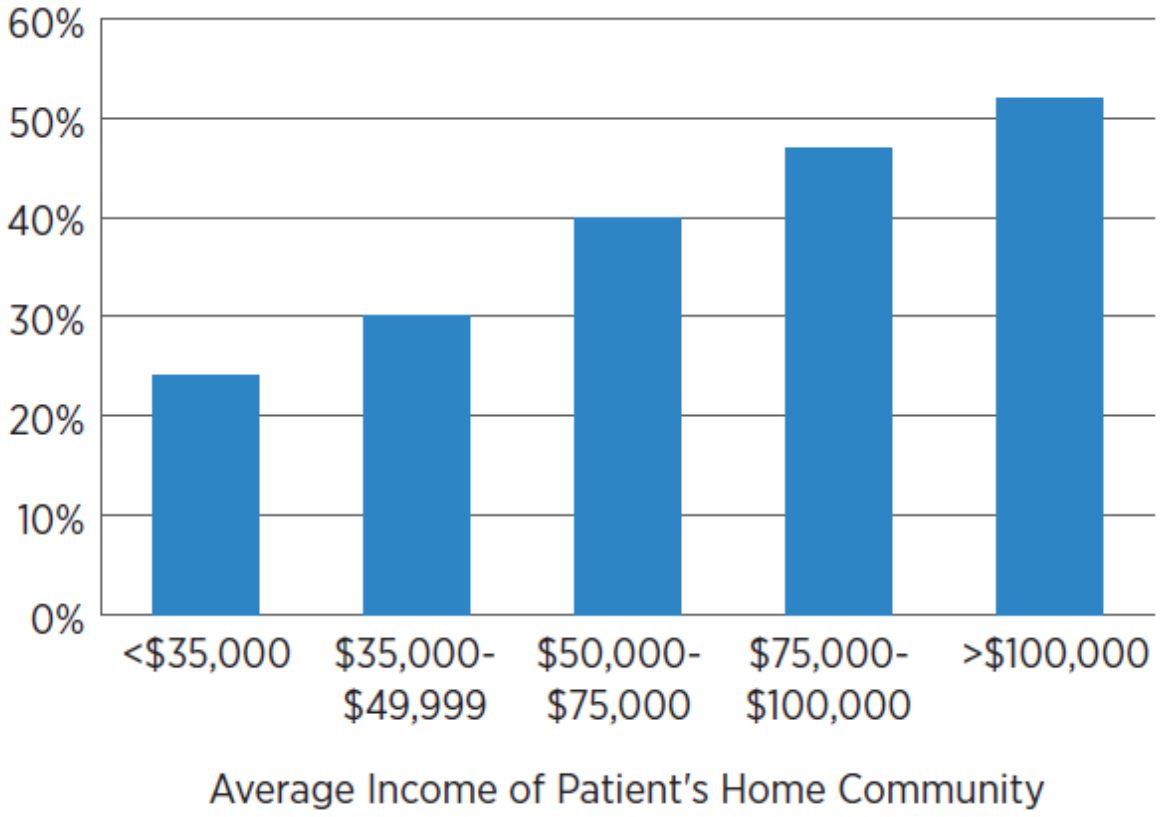
Average Use of Hospitals in Regions Neighboring Metro Boston
versus Average Use of All Hospitals by Region Residents, 2013



Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 403 reports.

Commercially insured patients and patients from wealthier communities are more likely to migrate to Boston for care

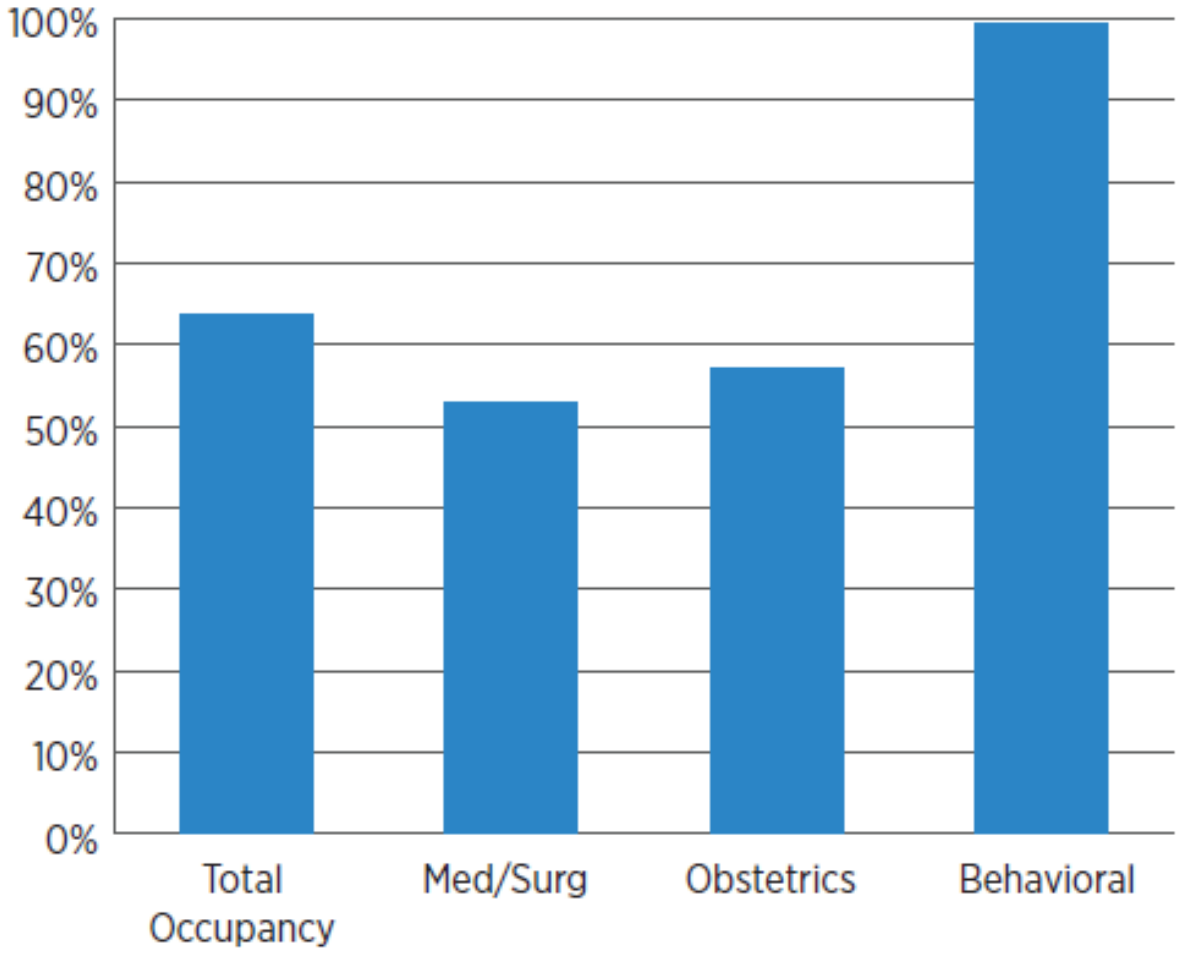
Probability that Patient will Travel Outside of His/Her Home Region for Inpatient Care, Based on Home Community Income



Source: HPC analysis of MHDC 2012 discharge data and U.S. Census Bureau American Community Survey data.

In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking low-margin services

Community Hospital Staffed Bed Occupancy Rate by Admission Type



Boarding of behavioral health patients in emergency departments increased by

40%

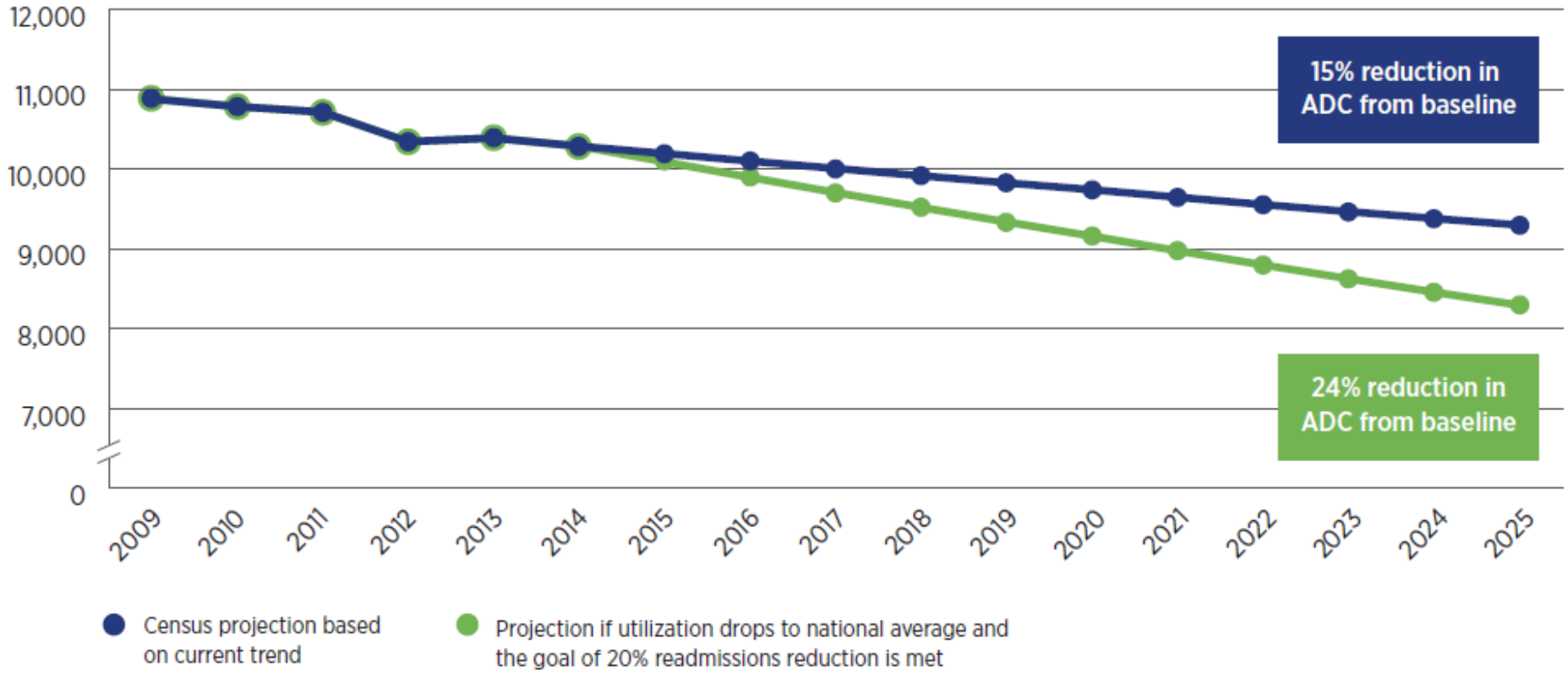
from 2012 - 2014

Source: HPC analysis of Department of Public Health data

Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 403 reports.

Declining inpatient utilization poses a structural challenge to the traditional community hospital model

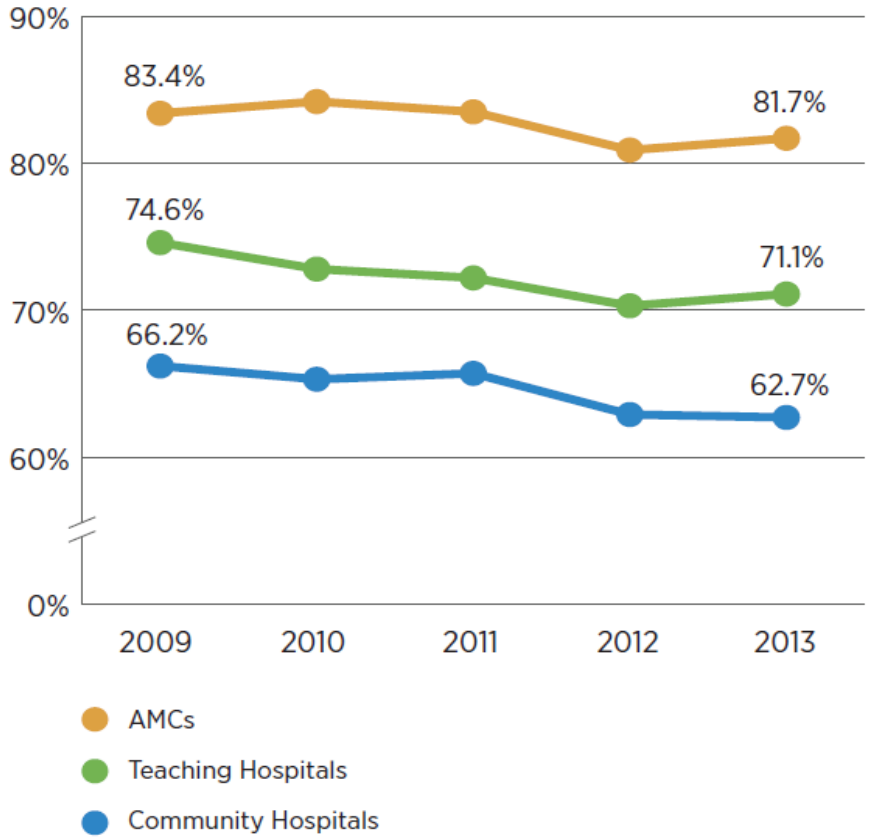
Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025



Sources: HPC analysis of MHDC discharge data, CHIA hospital 403 reports, AHA Hospital Statistics, and population data from the University of Massachusetts Donahue Institute.
Notes: Projection based on current trend assumes a continuation of recent utilization trends in major service categories, but does not take into account numerous other factors impacting utilization, e.g. the movement of more types of care from inpatient to outpatient settings. The alternate projection assumes a 10.2% reduction that would bring Massachusetts in line with national hospital utilization, and a 20% reduction in readmissions, reflecting goals of reducing unnecessary readmissions.

Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates

Total Inpatient Occupancy by Hospital Cohort, 2009 – 2013



Sources: HPC analysis of MHDC discharge data and CHIA hospital 403 reports.
Notes: Based on assessment of discharges and average patient length of stay compared to bed counts. Bed counts as of 2013. Bed types included are medical/surgical (including ICU), obstetrics, behavioral, and neonatology (normal newborn bassinets are excluded).

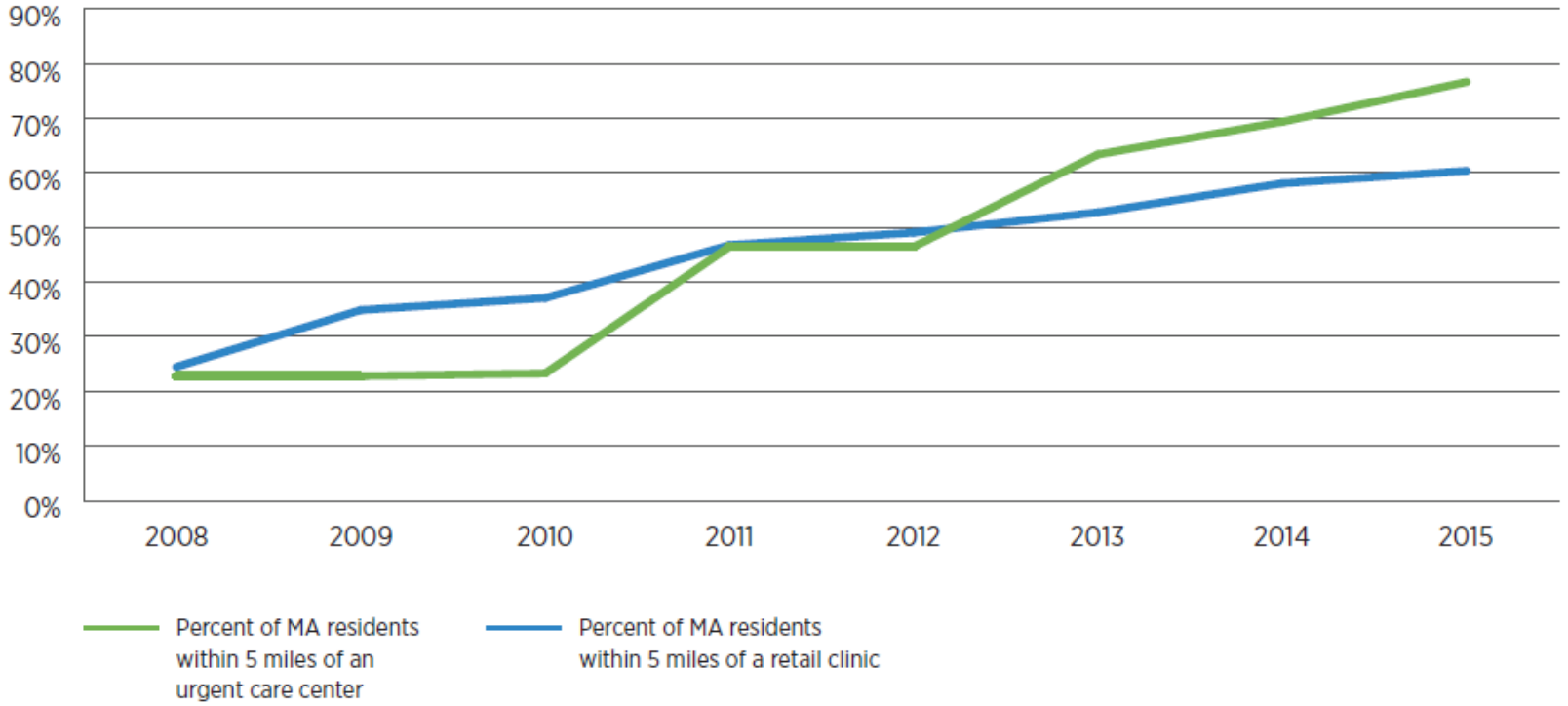
If current trend continues, community hospitals could face average occupancy rates of less than

50% within

10 years

Declining inpatient utilization is driven in part by growing accessibility of non-hospital health care providers

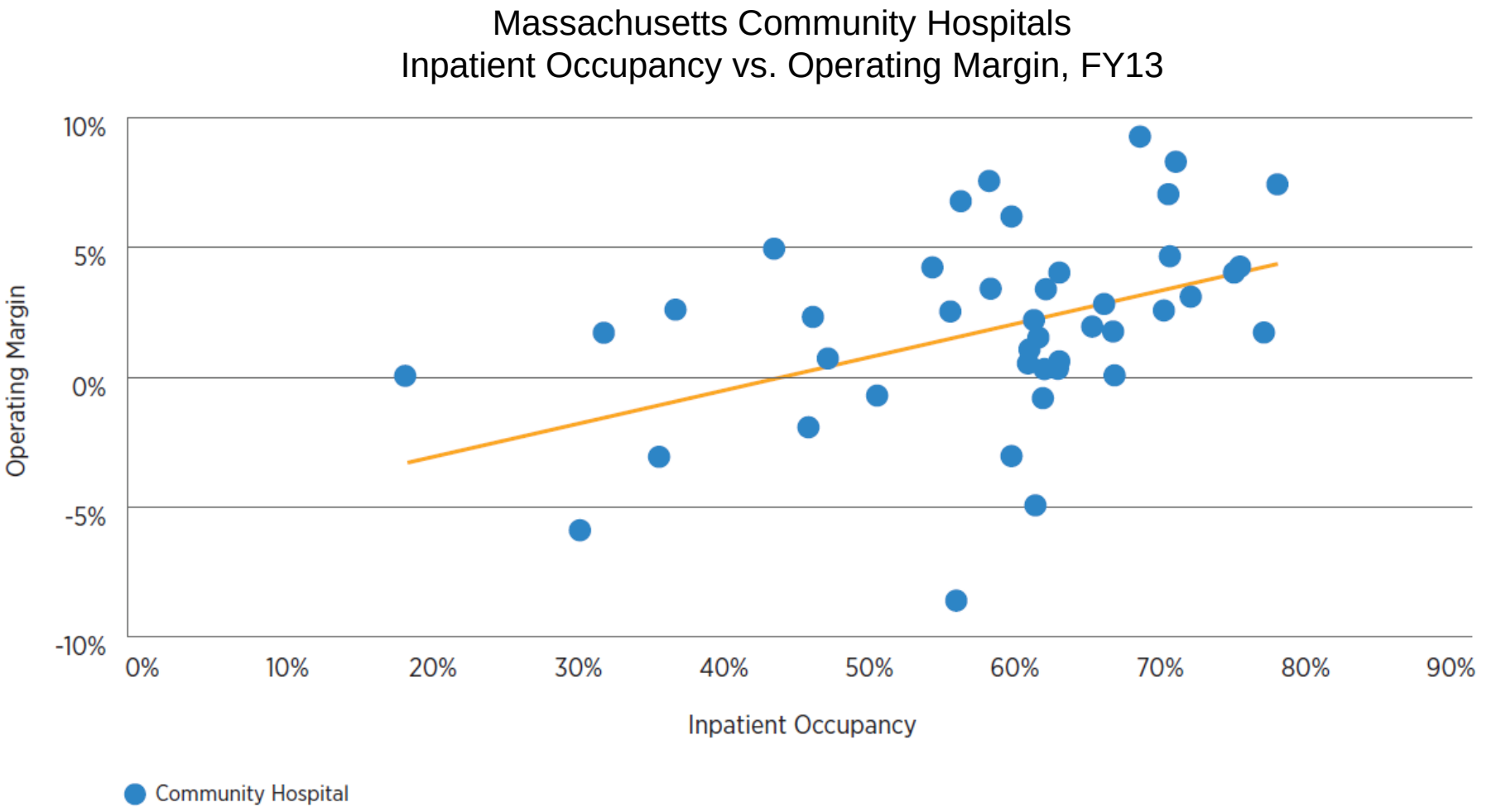
Percent of MA Residents Living Within 5 Miles of Retail Clinics and Urgent Care Centers



Sources: HPC analysis of DPH licensure data, SK&A health care claims database, and National Bureau of Economic Research Zip Code Distance Database.

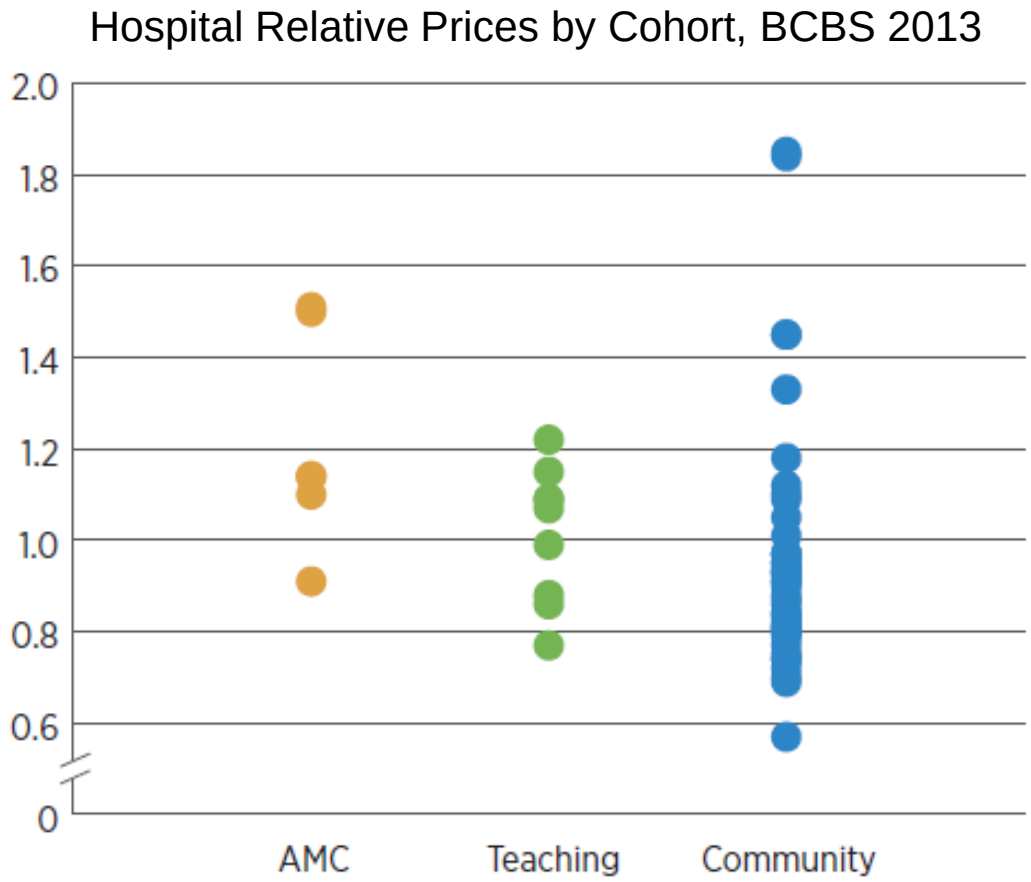
> *"When [they] opened an urgent care center down the block we saw an immediate and precipitous decline in ED volume, especially the commercially insured, non-acute patients. It might be good for costs in the short term, but if we cannot keep our ED open, then what's next?"*
>
> *COMMUNITY HOSPITAL CHIEF STRATEGY OFFICER*

Lower occupancy is associated with lower operating margins for community hospitals, and may threaten their financial stability



Sources: HPC analysis of CHIA Hosp. Profiles, 2013; MHDC 2013 discharge data; CHIA hospital 403 reports

Community hospitals tend to receive lower commercial relative prices than AMCs or teaching hospitals

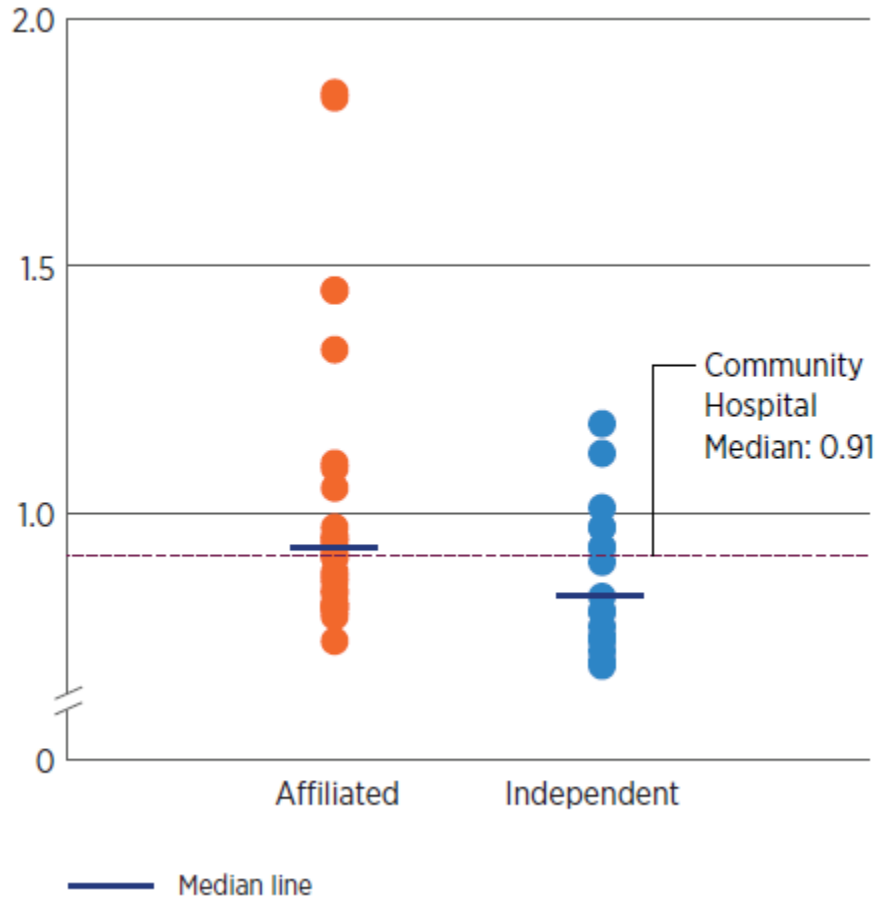


> *"The gap in prices, [which is] a reflection of the market power dynamics in the state, is probably the biggest threat to a lot of the community hospitals*
>
> *MASSACHUSETTS HEALTH INSURANCE LEADER*

Sources: HPC analysis of Ctr. For Health Info & Analysis, Provider Price Variation in the Massachusetts Health Care Market (calendar year 2013 data), Databook (Feb. 2015), [hereinafter CHIA 2013 RP Databook] available at http://chiamass.gov/assets/Uploads/relative-price-databook-2013.xlsx

Community hospitals affiliated with systems tend to have higher relative prices

Community Hospital Relative Prices and Affiliation Status, BCBS FY13



Source: HPC analysis of CHIA 2013 RP Databook
Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed

Hospital Commercial RP and Percent of Revenue from Public Payers by Cohort, BCBS FY13

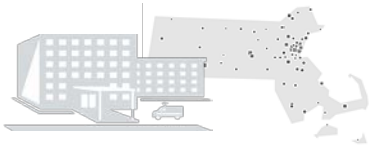
Source: HPC analysis of CHIA 2013 RP Databook and CHIA Hosp. Profiles, 2013

Market participants report facing additional barriers to transformation

To successfully meet challenges and adapt to a changing delivery and payment system, community hospitals must overcome barriers and utilize resources and capabilities that may not be readily available. Barriers reported to the HPC during stakeholder interviews include:

- Lack of **resources**, including financial resources and the ability to attract and retain new staff.
- Lack of needed **data and analytic support** to enable transformation efforts, including a lack of information about health needs and coordinated health planning.
- **Concern about change** by hospital governing bodies and community representatives.
- Challenges **aligning the interests of hospital labor and management** to more effectively pursue transformation efforts.
- Difficulty participating in **alternative payment models**, including challenges under current risk adjustment methodologies for hospitals serving patient populations with socioeconomic disadvantages.
- **Insufficient alignment** among programs designed to fund or assist transformation efforts.
- **Policy or regulatory frameworks** that limit deployment of new structures of care.

The path to a thriving community-based health care system



Overview | Value | Challenges | **Path Forward**

- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

Building a path to a thriving community-based health care system

Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings
- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs
- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

Fostering dialogue and developing an Action Plan

Community Hospitals at a Crossroads:
A Conversation to Foster a Sustainable Community Health System

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints.

The report findings are designed to spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government.

March 29, 2016 at 9:00AM at Suffolk University School of Law

The HPC Commissioners and staff will convene industry leaders and stakeholders to discuss findings from the report and its implications for transformation of the Commonwealth's community hospitals. Interested members of the public are invited to attend: register online at www.mass.gov/hpc

In collaboration with stakeholders, HPC will develop an Action Plan to address findings of the report. Action Plan recommendations will be oriented towards providers, payers, purchasers and policymakers

Community Hospitals at a Crossroads:
A Conversation to Foster a Sustainable Community Health System

Planning and support for community hospital transformation

Encouraging consumers to use high-value providers for their care

Creating a sustainable, accessible, and value-based payment system

> *"We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future"*
>
> *MASSACHUSETTS STATE LEGISLATOR*

Agenda

- Approval of CTMP Minutes from January 13, 2016 Meeting (VOTE)
- Discussion of 2017 Health Care Cost Growth Benchmark (VOTE)
- Update on Interim Guidance for Performance Improvement Plans
- Presentation on Findings from the Community Hospital Study
- **Approval of CHICI Minutes from January 6, 2016 Meeting (VOTE)**
- Update on CHART Phase 2
- Discussion of the Evaluation Plan for CHART Phase 2
- Presentation from the Center for Health Information and Analysis on Hospital Readmissions
- Schedule of Next Committee Meeting (April 13, 2016)

Vote: Approving Minutes

Motion: That the Committee hereby approves the minutes of the Community Health Care Investment and Consumer Involvement Committee meeting held on January 6, 2016, as presented.

Agenda

- Approval of CTMP Minutes from January 13, 2016 Meeting (VOTE)
- Discussion of 2017 Health Care Cost Growth Benchmark (VOTE)
- Update on Interim Guidance for Performance Improvement Plans
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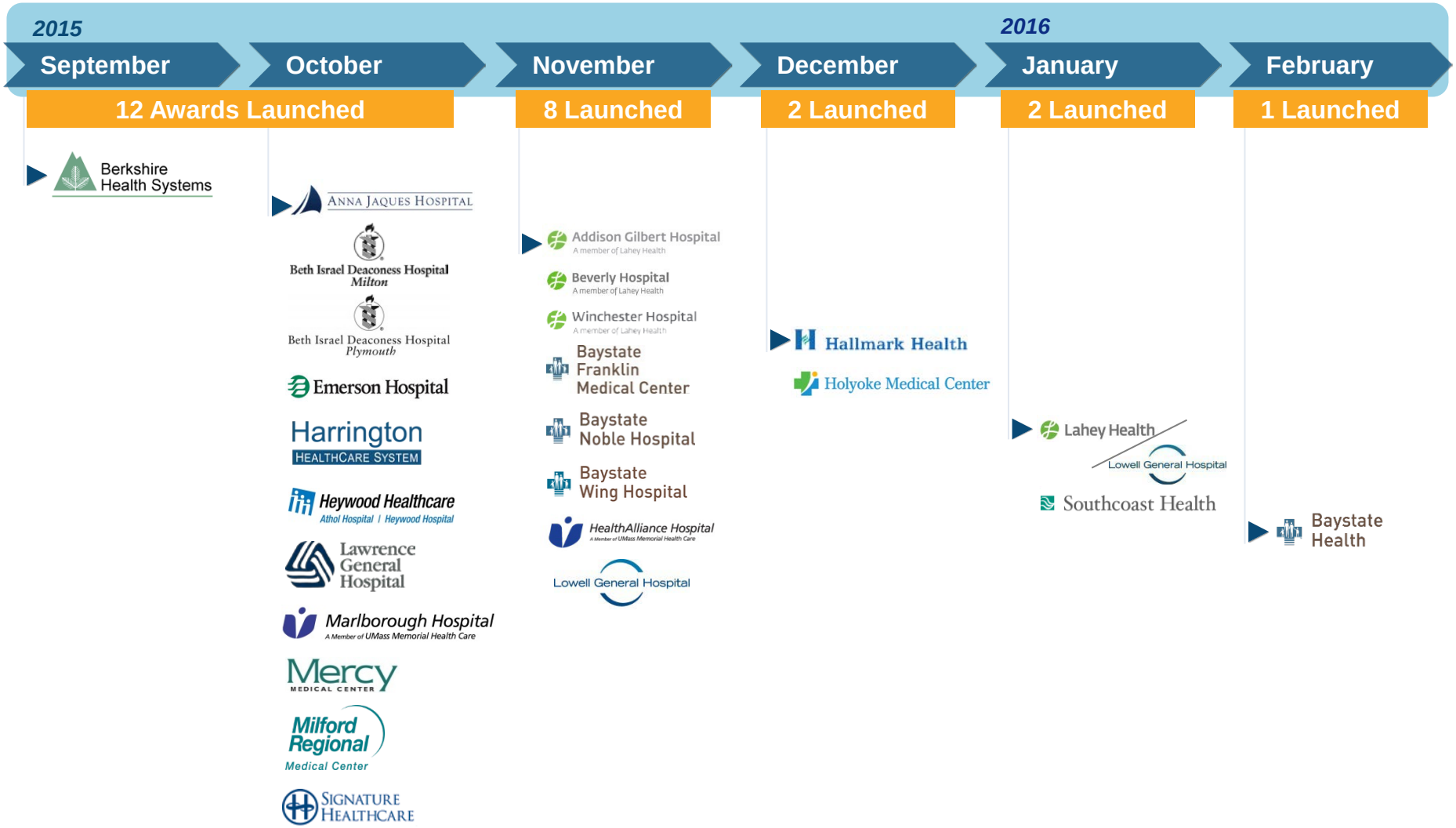
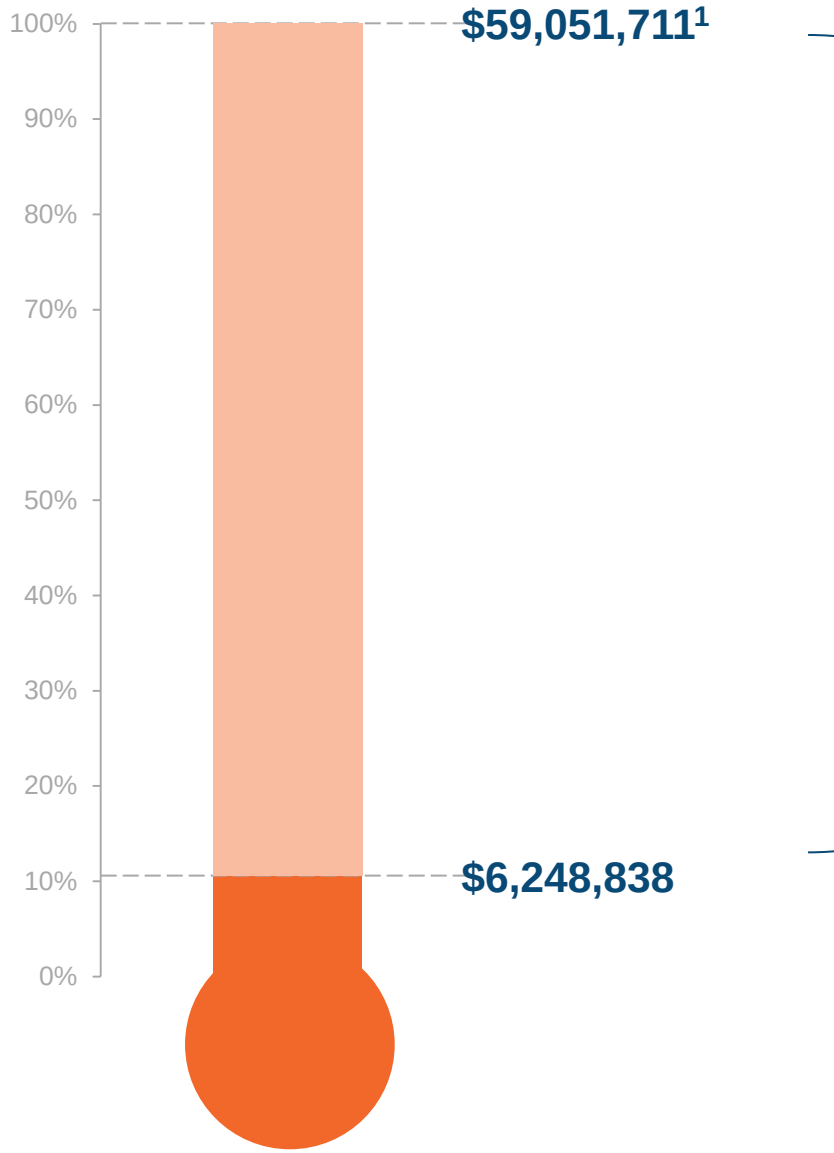
- Discussion of the Evaluation Plan for CHART Phase 2
- Presentation from the Center for Health Information and Analysis on Hospital Readmissions
- Schedule of Next Committee Meeting

CHART Phase 2: Launch update



Updated February 18, 2016

CHART Phase 2 Awards: The HPC has disbursed $6 million to date



Remaining
$52,802,873
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

Updated February 18, 2016

[1] Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

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Building insight into care delivery and hospital transformation

The Phase 2 evaluation will help us learn from any intervention's outcome by exploring its impact

Goals

TO ASSESS EFFICACY
of the investment program in achieving specific quantitative and qualitative goals, including the ROI, sustainability and scalability of specific projects

TO ADVANCE KNOWLEDGE
regarding opportunities, challenges, and best practices for healthcare organizations that seek to transform care delivery

TO ENHANCE CAPABILITY
of measurement, continuous improvement, and accountability, within participating hospitals and the HPC

Outputs

1. Documentation of what was accomplished in CHART Phase 2 at each hospital and across the program
2. Evidence on delivery transformation models to guide future investments strategies
3. Evidence to inform alternative payment models, regulatory structures, and other policy reforms

Pioneering 25 approaches to care delivery under a single program

25 Interventions

- Each hospital has designed a specific intervention in consultation with the HPC.
- The planned programs are different from the current way of providing care.

Hypothesis: ***The new model of care delivery will reduce avoidable hospital utilization.***

One CHART Program

- The HPC has designed an investment strategy that features active engagement during design, implementation, and delivery phases, with rapid cycle feedback.
- This investment strategy is also different from traditional methods of grantmaking.

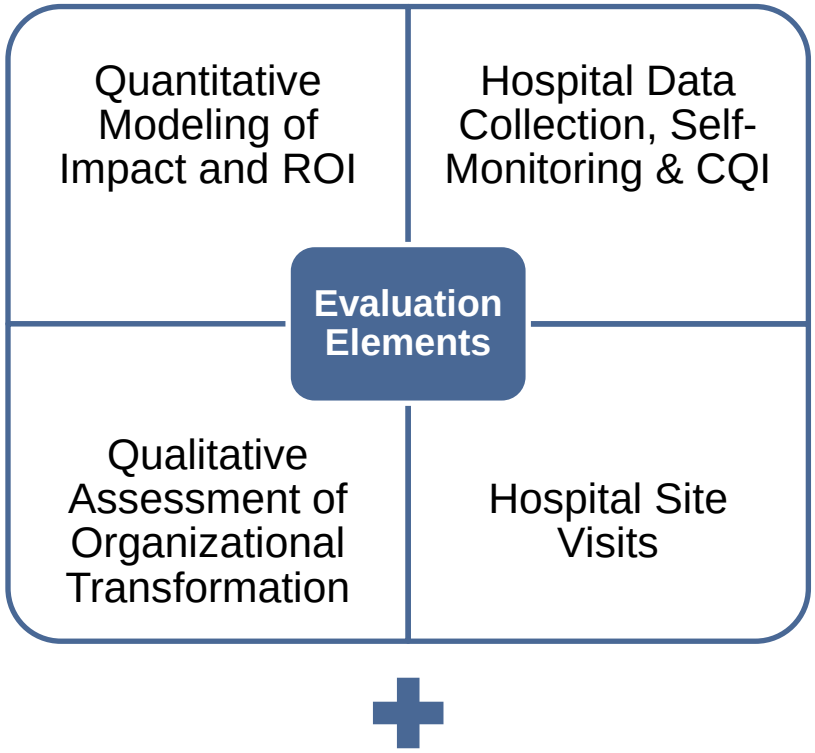
Hypothesis: ***Investing in community hospitals and partnering with them for program design and implementation will support hospital transformation towards high-value health care.***

Assessing performance of a forward-looking investment

	Was the intervention fully deployed?	Did the intervention work?	Did the intervention produce lasting changes?
Research questions	Did each hospital carry out the activities described in the implementation plan?	Was avoidable hospitalization reduced?	Did CHART hospitals move towards effective participation in accountable care?
	Was the CHART program as a whole implemented effectively?	Was patient-centered, integrated care delivery expanded?	Did CHART hospitals increase their capability for continuous improvement?
Methods	Qualitative Site visits, Doc review	Qualitative Site visits, Doc review	Qualitative Site visits, Org Survey
		Quantitative Pre-Post Analysis Difference-in-difference	Quantitative Return on Investment

Framework adapted from: Berry SH, Concannon TW, Gonzalez Morganti K, et al. Cms innovation center health care innovation awards: Evaluation plan. RAND Corporation. 2013.

Synthesizing primary and secondary information



HPC Ongoing Performance Monitoring and Awardee Engagement

Data Sources

Hospital Performance Dashboard
Quarterly dashboards bench-marking Awardee-reported quality and utilization measures, from hospital-reported data for all 25 Awardees.

Secondary Data Analyses
Analysis of secondary data from the CMD to measure key changes in hospital utilization and estimate return on investment (ROI) for the entire Phase 2 of the CHART Investment Program.

Site Visits
Two waves of site visits, interviews, and focus groups with hospital staff, and interviews or focus groups with community partners where appropriate.

Document Review
Document review of Awardee implementation plans, periodic reports, monthly data reports, and strategic plans.

Organizational Survey
An organizational survey with leaders in all 27 hospitals, conducted early in the CHART implementation period and again toward the end of the program.

Behavioral Health Integration Survey
A brief survey to assess changes in delivery of BH services.

CHART-TA Survey
A periodic survey of all 27 hospitals with a focus on Awardee feedback about CHART TA, services, and supports.

Periodic Feedback from the HPC Staff
Periodic interviews, and/or review of notes, with HPC staff and contractors about Awardee progress, barriers, and facilitators.

Public Data on Hospital Operations and Financial Health
Information from the HPC and CHIA will allow the evaluators to understand external factors affecting community hospitals in Massachusetts.

Balancing scientific rigor, cost and feasibility

The evaluation will pursue a mixed-methods approach to answer key research questions

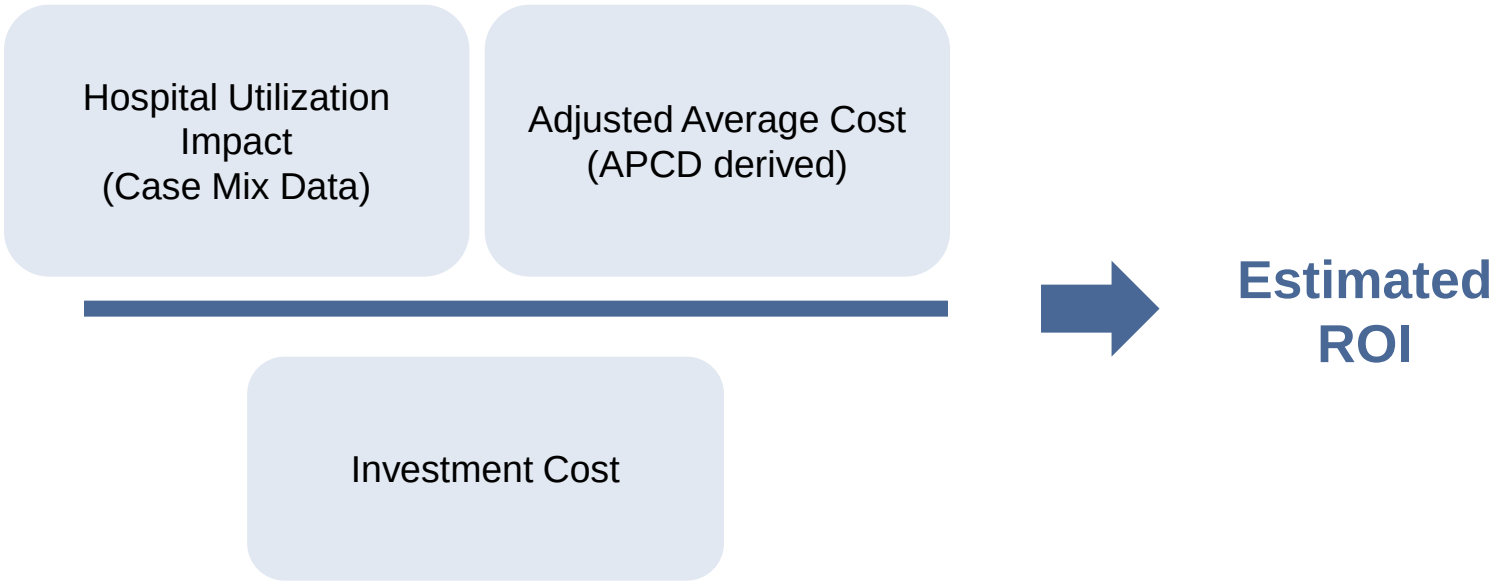
	Pre-post comparison	Difference-in-difference comparison	Randomized control trial
Capability	Measures change in performance over time	Identifies whether the site of intervention changed more than similar sites, supporting causal interpretation	Confidently attributes a change in performance to the intervention
Requirement	Any series of measurements	Large enough population for statistical significance Similar site for comparison	Randomization of intervention & controls
Solution	Each hospital	Selected large awards and groups of hospitals	
	All quantitative analyses supported by qualitative context to strengthen conclusions		

Measuring impact on utilization

	Each Hospital	Cross-Hospital
Metrics (examples)	Custom Metrics • Self-reported utilization • % of all ED pts who received SBIRT Screenings • % of pts enrolled in COACHH following Narcan reversal with 2+ visits for MAT of SUD	Global Metrics • 30-day ED revisits • 30-day ED revisits, primary BH diagnosis • 30-day readmissions • 30-day readmissions, target population
Data	Hospital-reported	Case Mix Data (CHIA)
Population	Customized Population	Standardized Population Intent-to-Treat

Measuring impact on cost

Estimated Savings = Avoided Hospitalizations X Average Cost of Episode



Listening to the hospitals

Hospital participation in the evaluation is critical for meaningful conclusions and recommendations. The evaluation design considers hospitals' time and availability in planning for data collection.

Evaluation Component	How	When
Site Visits	Interviews & focus groups of key program staff	• Late 2016 • Late 2017
Document Review	Analysis of hospital-submitted metrics, changes to implementation plans, program officer input	• Throughout
Technical Assistance Survey	Brief survey of program management staff	• Four times over two-year program period
Behavioral Health Integration Survey	Brief survey completed by one knowledgeable clinician	• Early 2016 • Late 2017
Organizational Survey	Brief survey completed by one knowledgeable executive	• Early 2016 • Late 2017
Post-Phase 2 Follow-up	Brief phone interview of key program staff	• One year after end of Phase 2

Documenting findings

Reports	
Baseline Report	• Program-wide summary of baseline status
Routine Performance Improvement Reports	• Dashboard summarizing hospital-reported metrics
Hospital Memos	• Synthesis of quantitative and qualitative analysis for each awardee • Summary of progress towards goals (first wave) • Documentation of challenges, successes, and lessons learned (second wave)
Interim Report	• Program-wide summary progress to date

Theme Reports	• In depth reports on topics affecting multiple hospitals
	  • Health Information Technology
	  • Workforce
	  • Other topics TBD

Final Summative Report	• Comprehensive report on the Phase 2 program

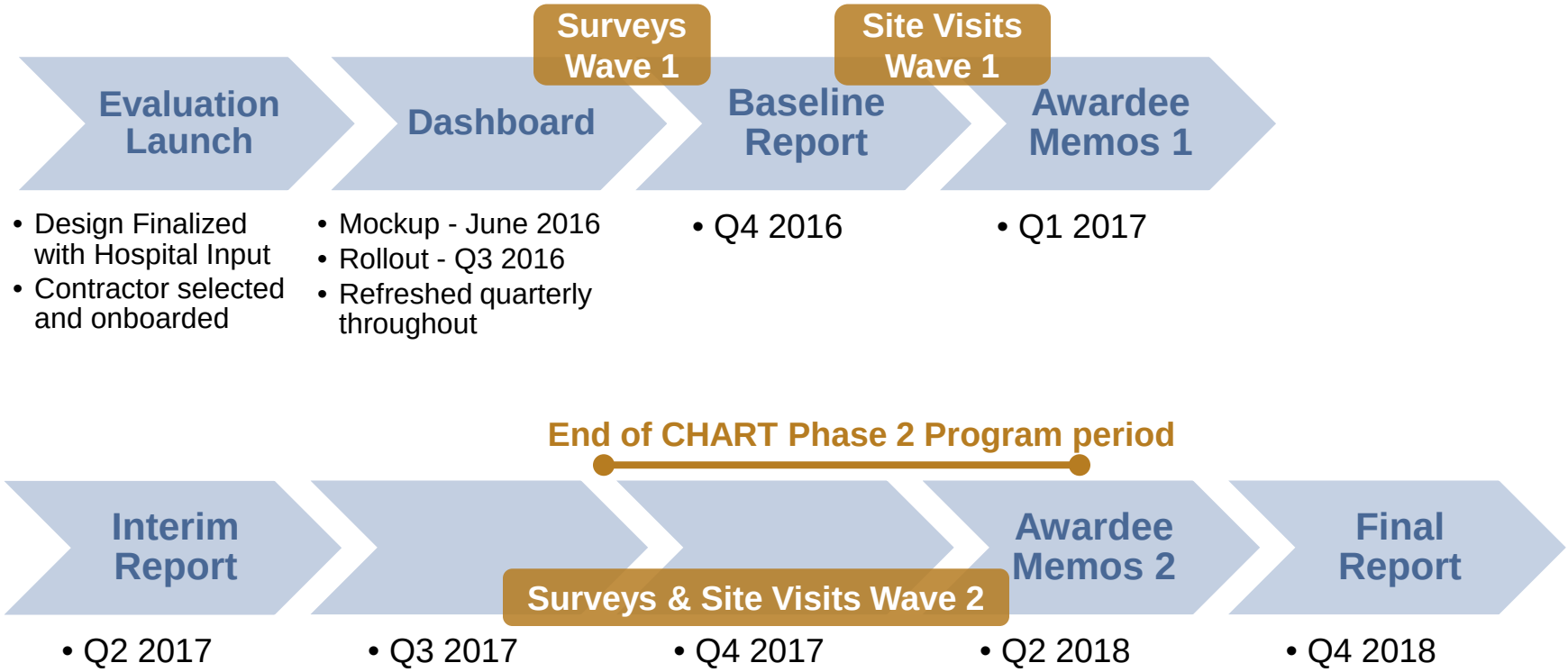
Leveraging the learning

The HPC will use the evaluation reports throughout the program period to inform project

During CHART Phase 2 Program Period
Improve TA
Provide feedback to hospitals
Identify challenges and create learning opportunities
Identify questions that need further study
After the CHART Phase 2 program period ends
Report to commission and legislature on results
Disseminate findings on program effectiveness and best practices
Guide future HPC investments
Make policy recommendations

Planning the evaluation

CHART Phase 2 evaluation timeline



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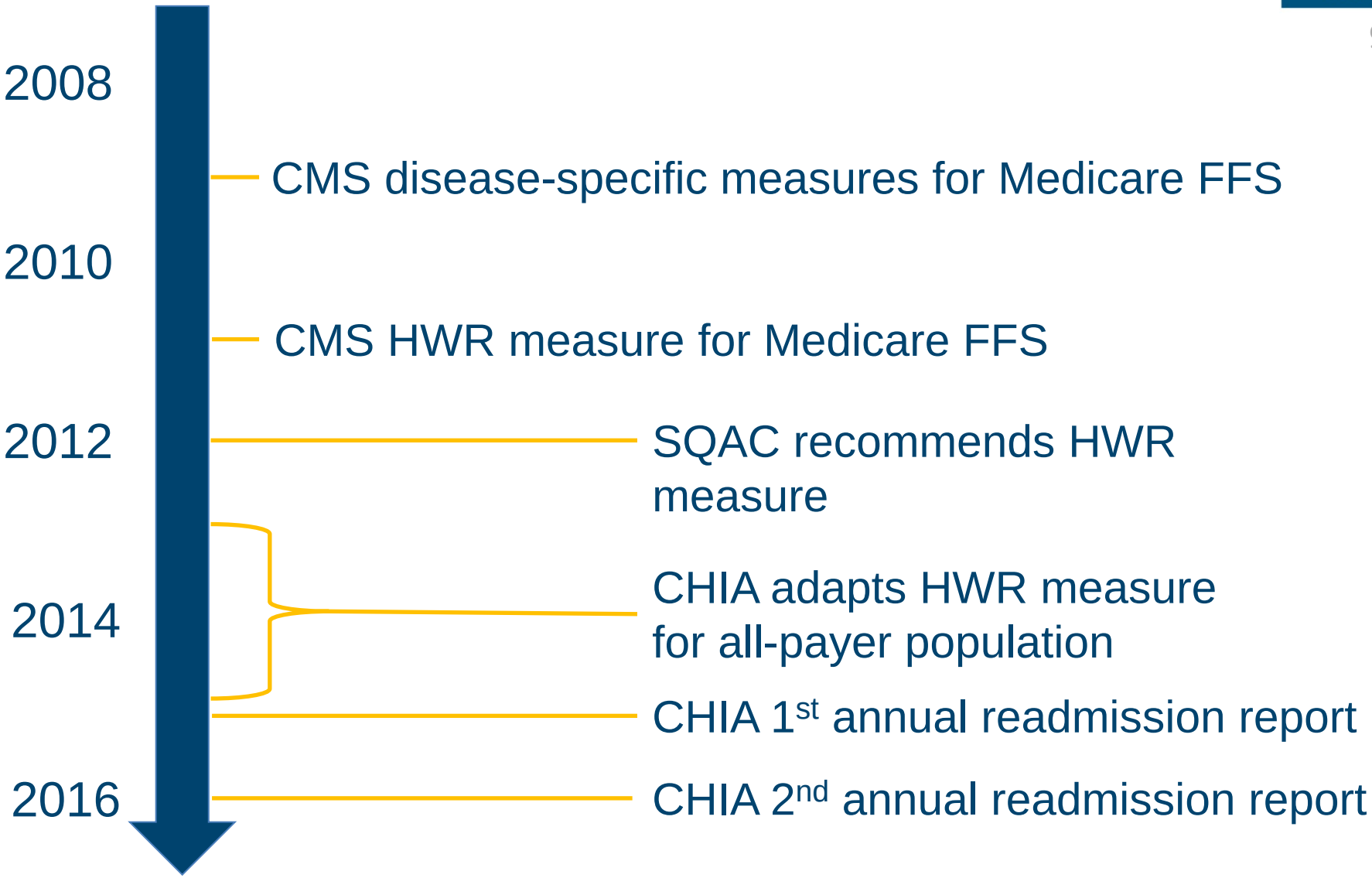
Hospital-Wide Adult All-Payer Readmissions in Massachusetts: 2011-2014

Community Health Care Investment &
Consumer Involvement Committee
Health Policy Commission

February 24, 2016

All-Payer Readmissions

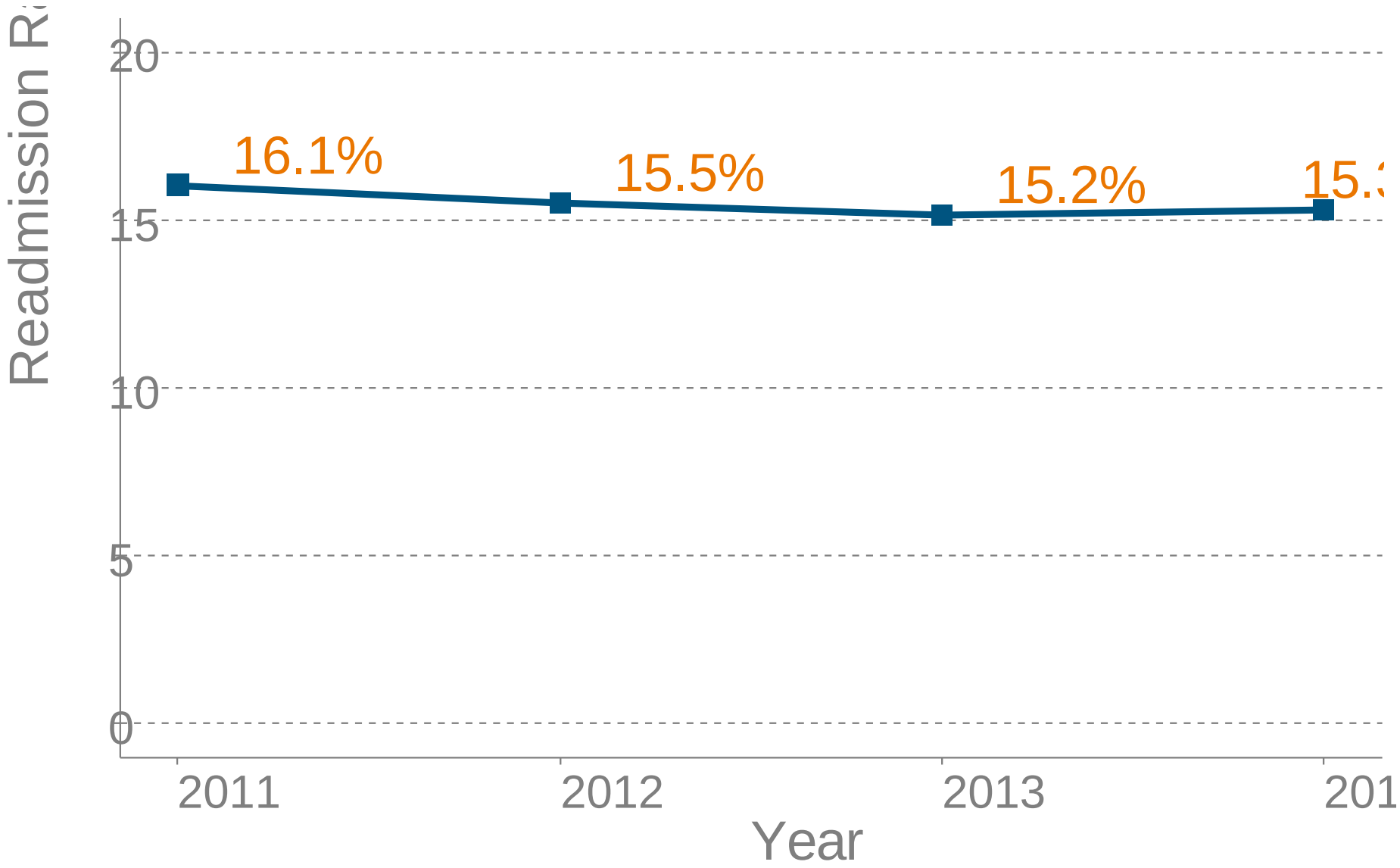


2nd Annual Readmissions Report

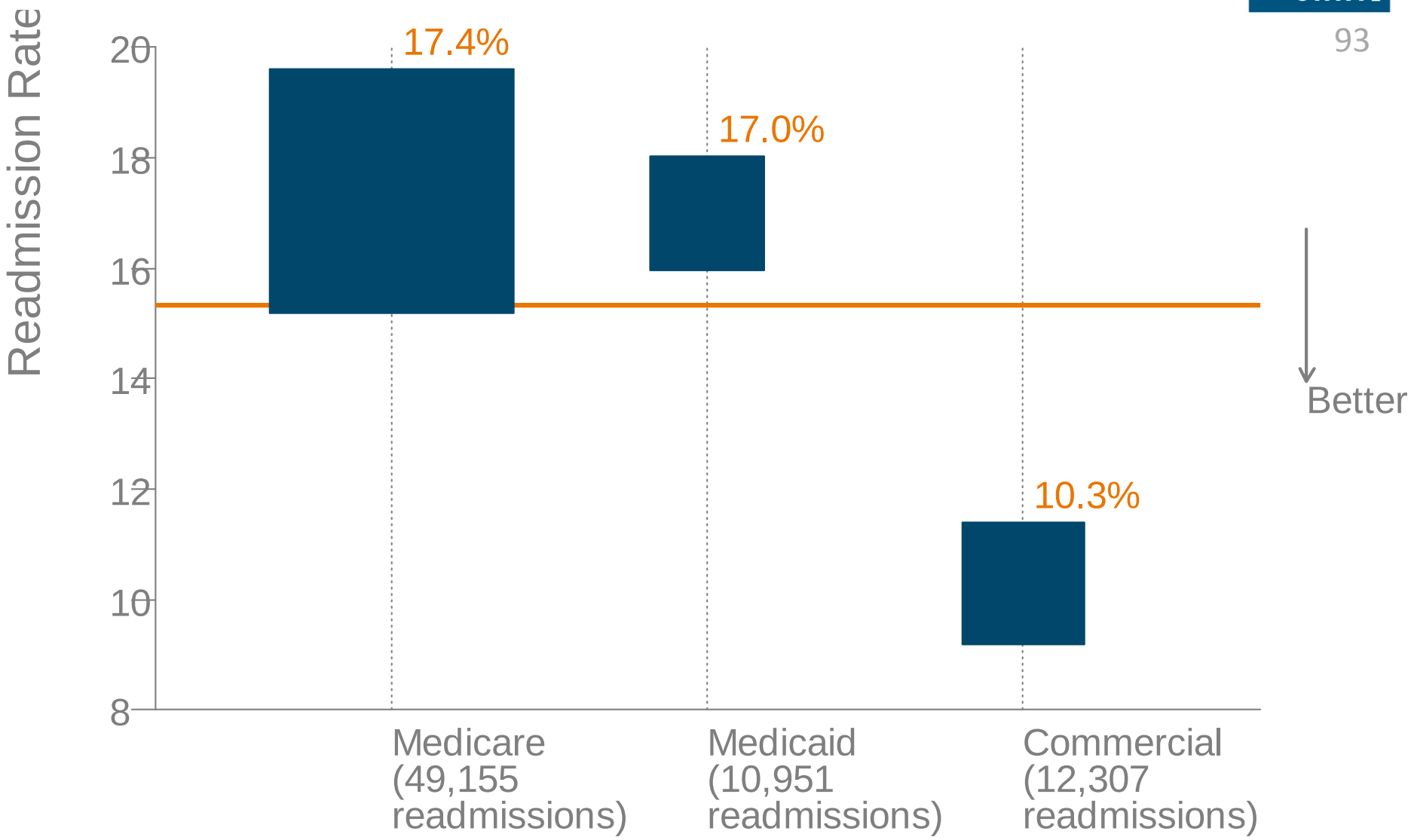
Highlights

- Statewide trend
- Readmissions by payer type & discharge setting
- Top readmission diagnoses
- Frequent users
- Readmissions by hospital & cohort

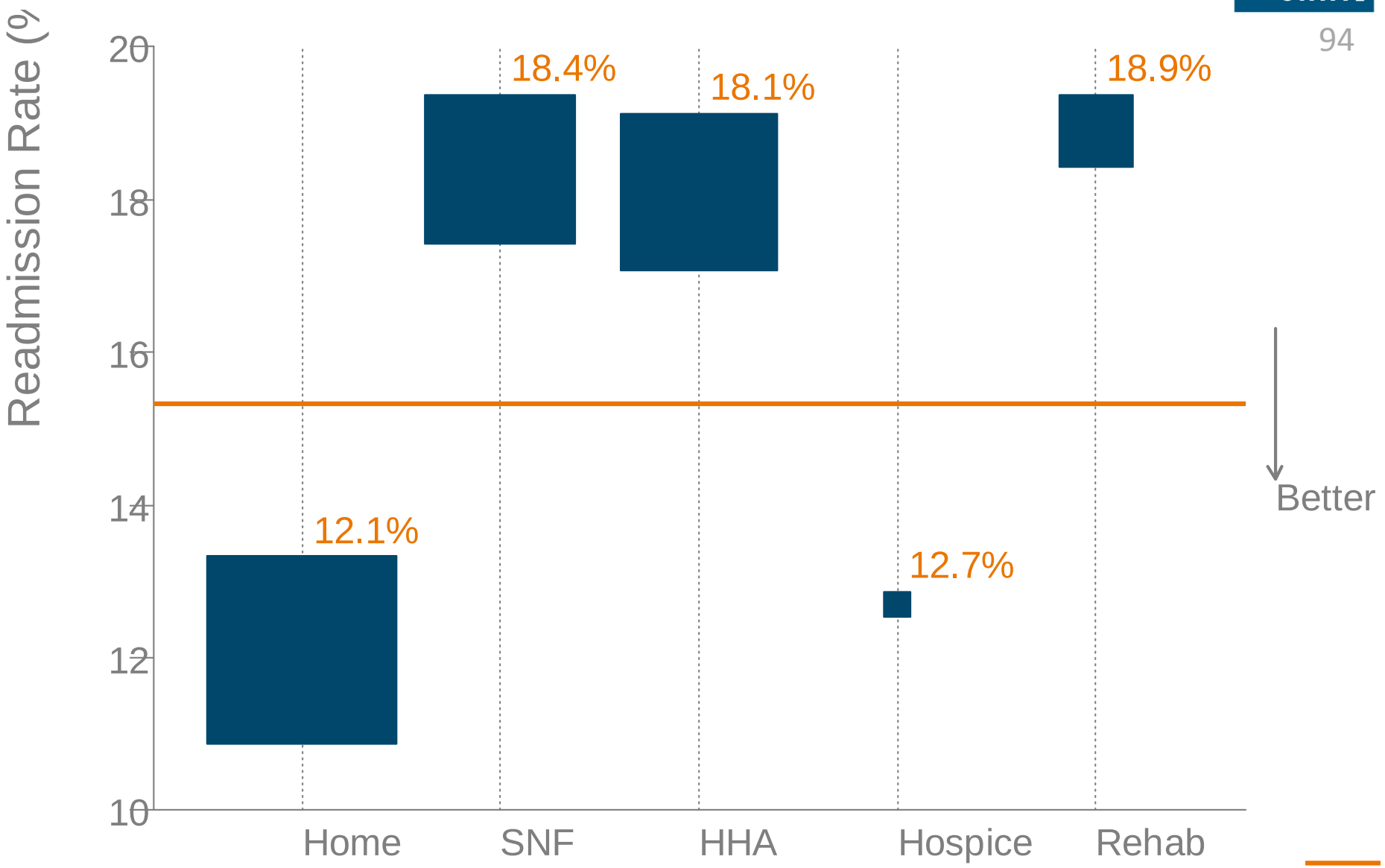
Trend in All-Payer Readmission Rate



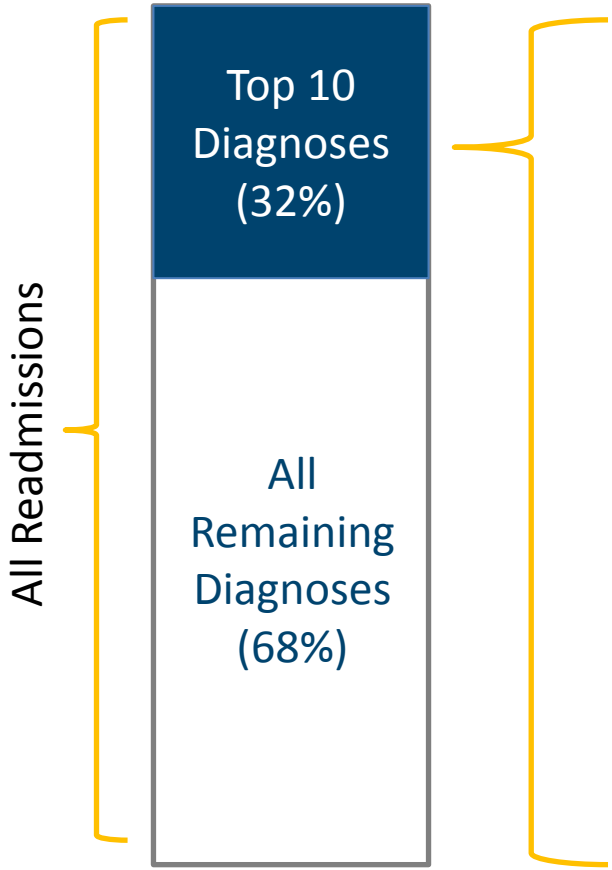
All-Payer Readmissions by Payer Type

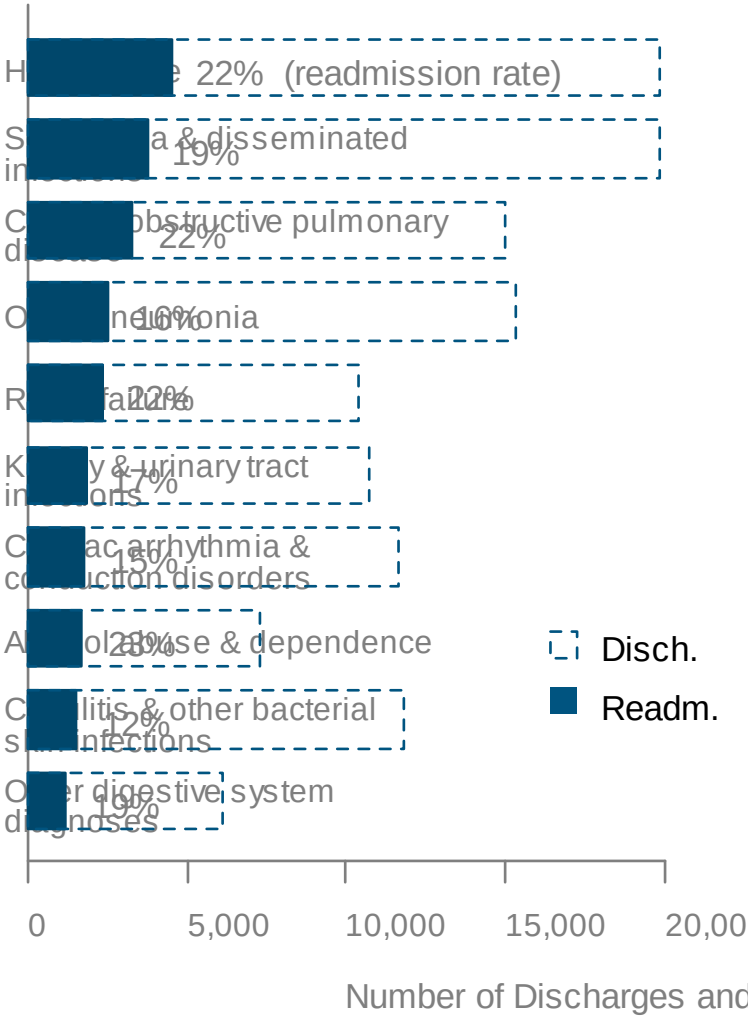


Readmissions by Discharge Setting

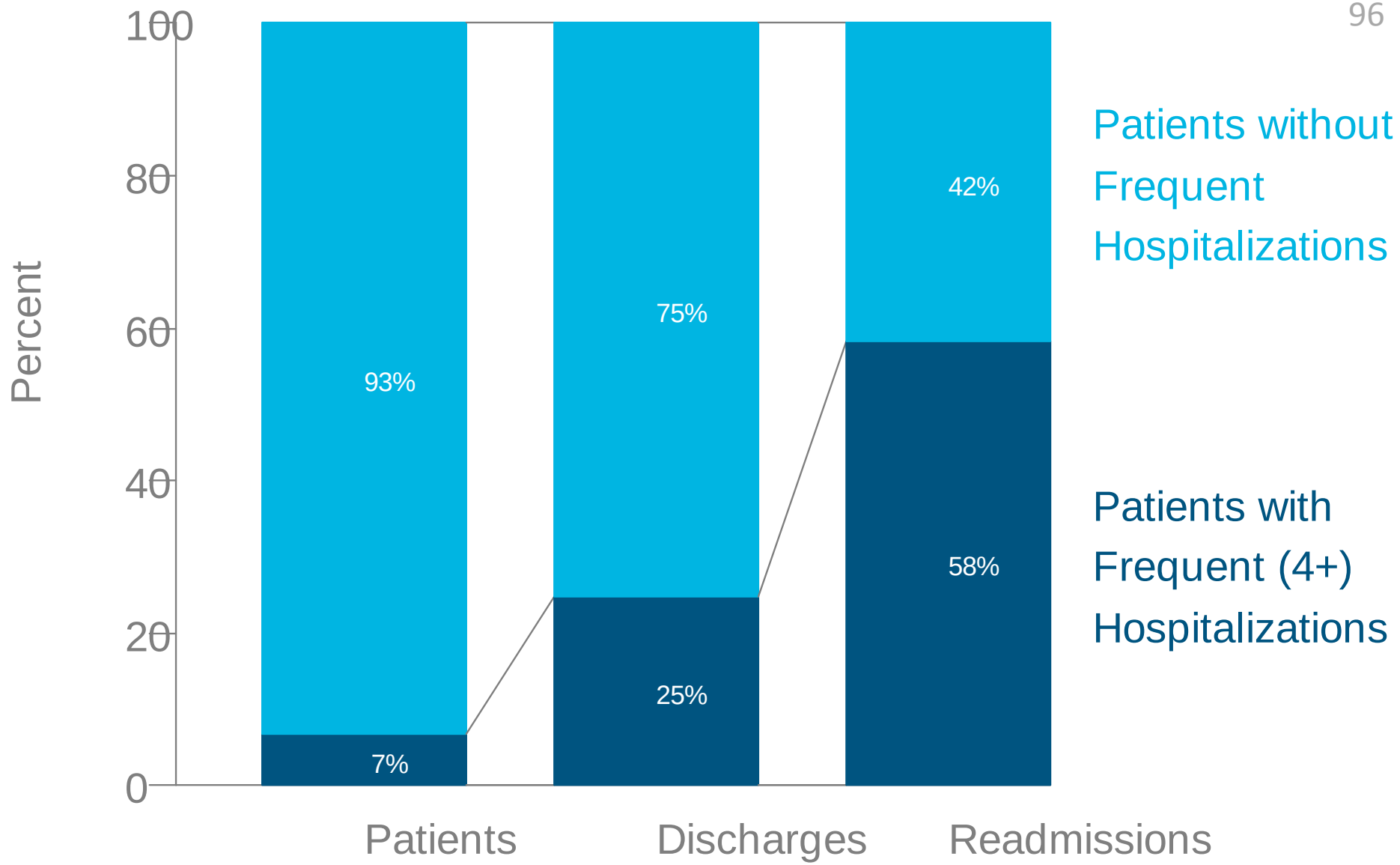


Top Readmissions Diagnoses

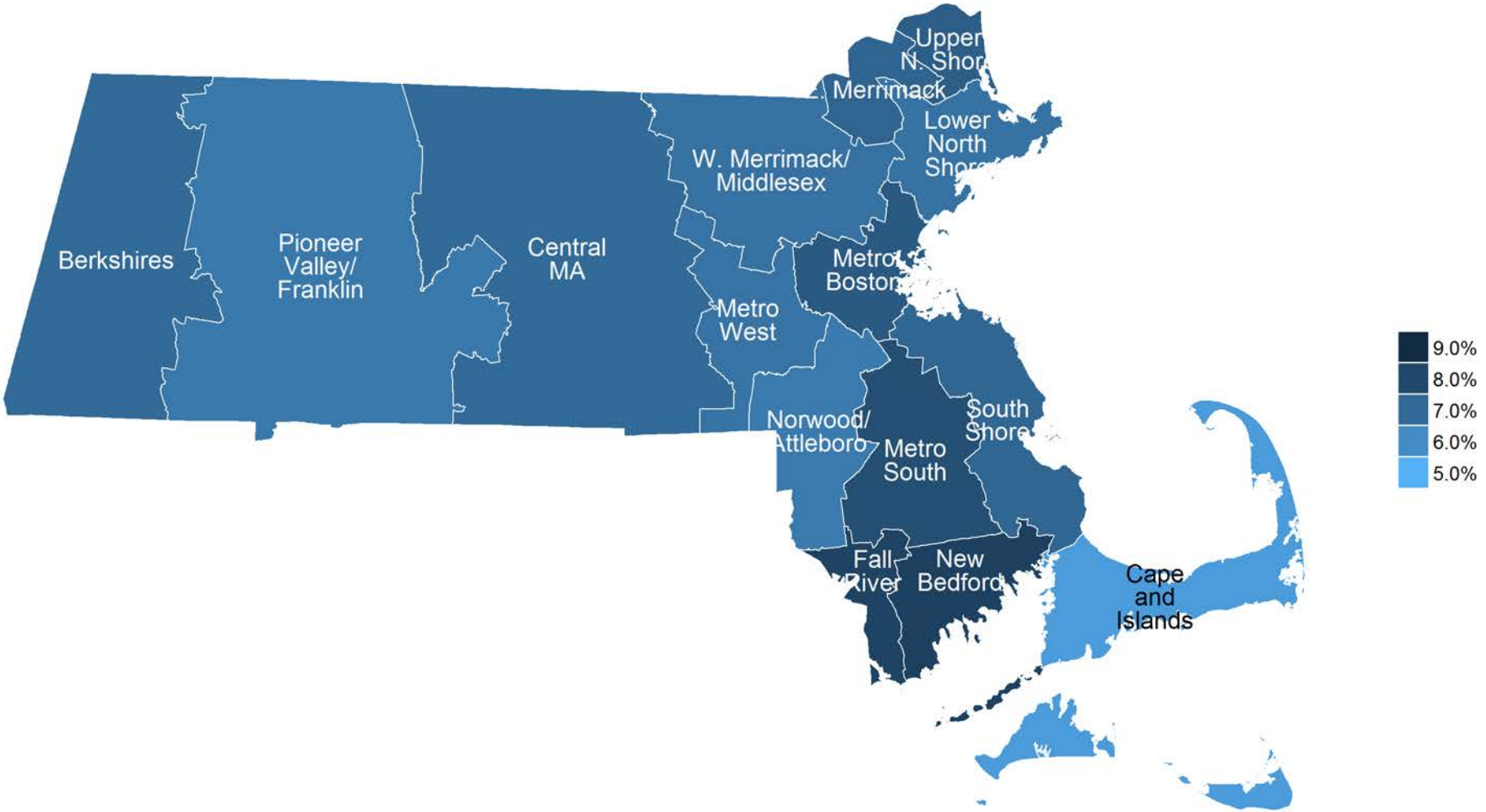




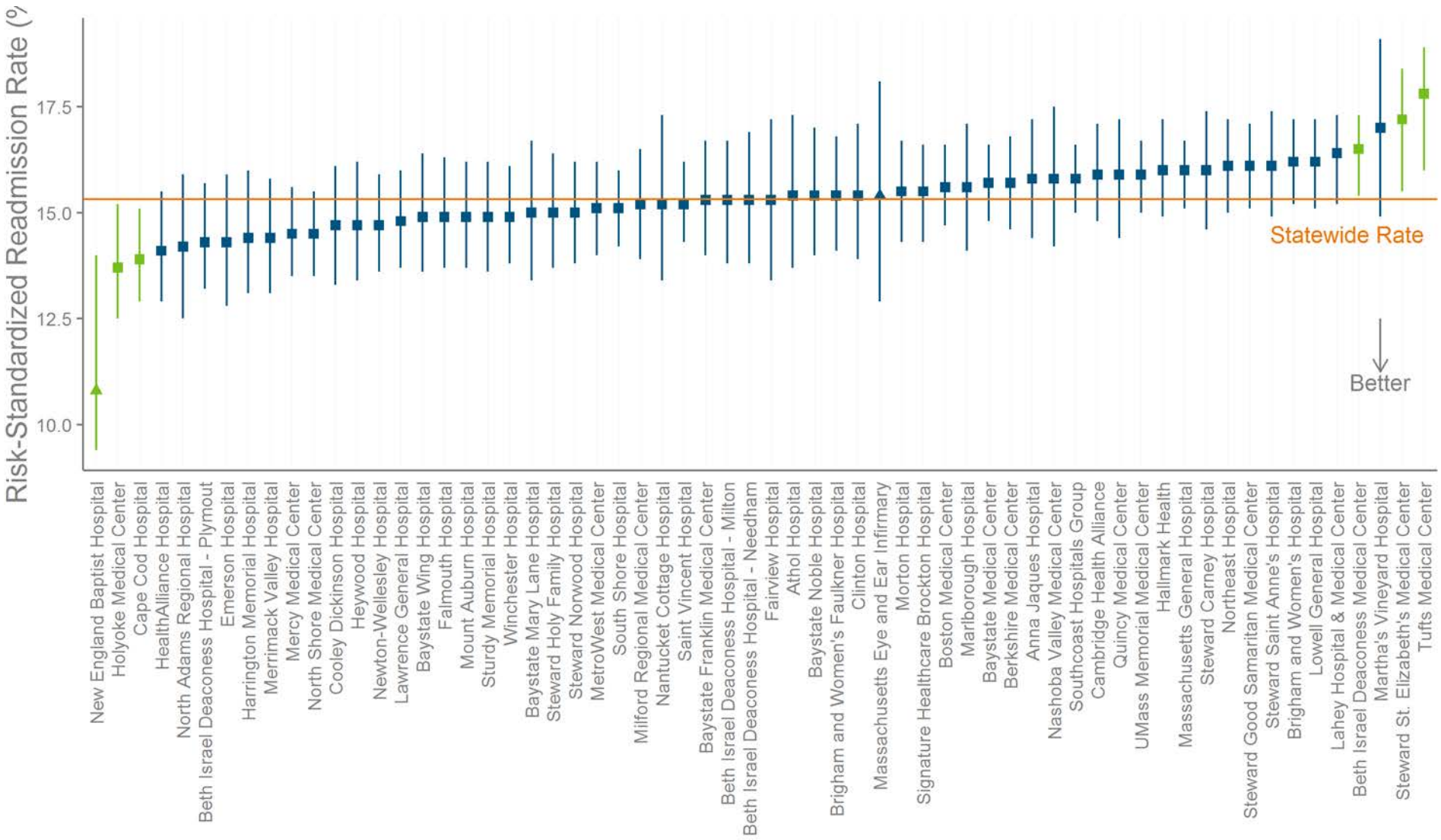
Frequent Users



Percentage of Frequent Users by Region



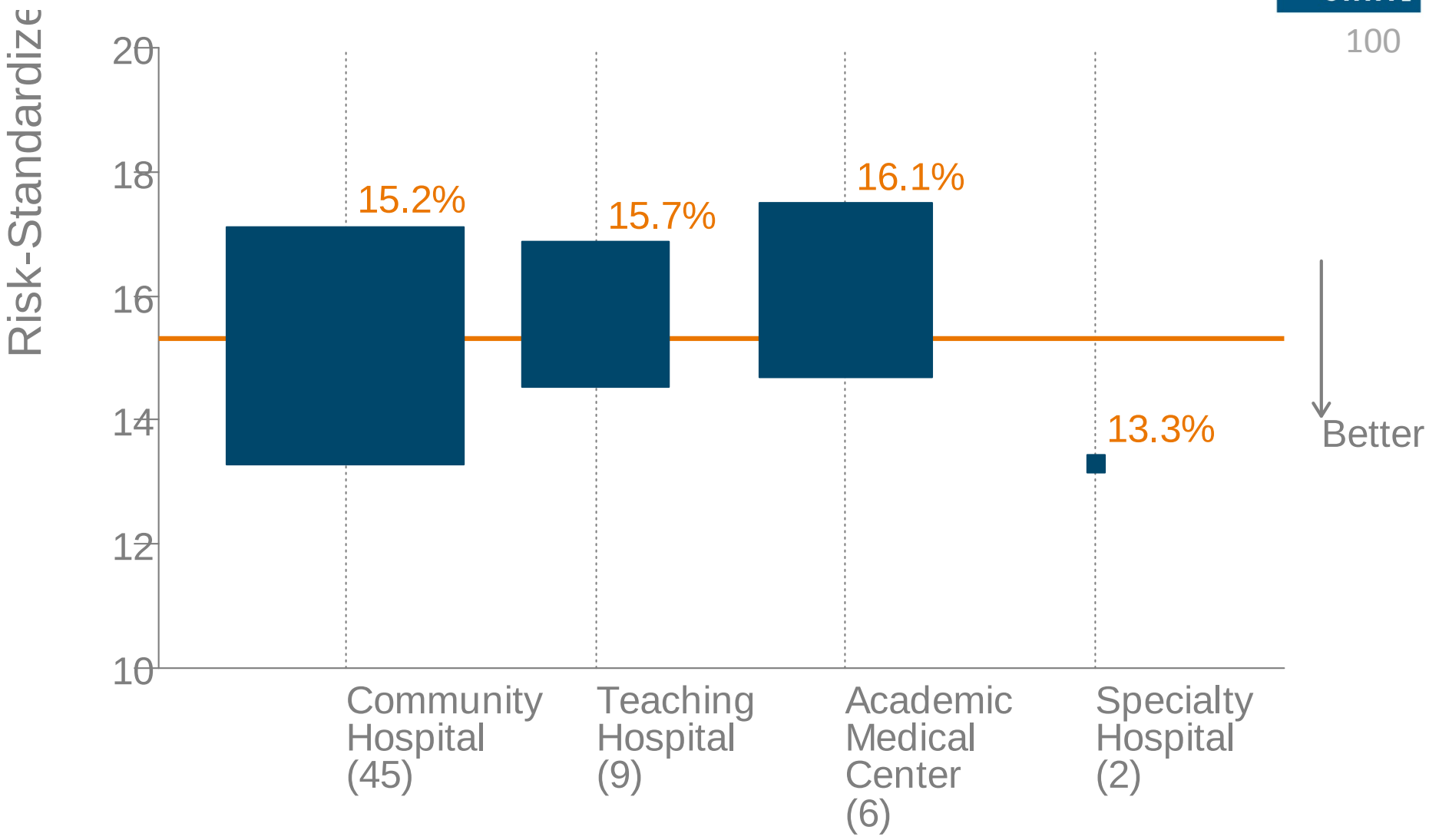
Risk-Standardized Rates (RSRRs) by Hospital



Consistency in Hospital RSRRs over Time

Risk-Standardized Readmission Rate Quartile	Hospitals	Median Risk-Standardized Readmission Rate in 2014
Highest quartile consistently across four years	Beth Israel Deaconess Medical Center Brigham and Women's Hospital Hallmark Health Northeast Hospital Steward St. Elizabeth's Medical Center Tufts Medical Center UMass Memorial Medical Center	16.2%
Lowest quartile consistently across four years	Cape Cod Hospital Emerson Hospital HealthAlliance Hospital Lawrence General Hospital North Shore Medical Center	14.3%

RSRRs by Hospital Cohort



Upcoming Reports

- Behavioral health readmissions (June ’16)
  - Behavioral health comorbidity and readmissions among acute care hospital patients
- Hospital-specific readmissions profiles (June ’16)
- State-wide readmissions report using SFY2015 data (December ’16)

Questions?

Contact:
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zi.zhang@state.ma.us

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Contact information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

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E-mail us: HPC-Info@state.ma.us