MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

July 24, 2019

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes
- Market Oversight and Transparency
- Care Delivery Transformation
- Executive Director's Report
- Executive Session (VOTE)
- Schedule of Next Meeting **(September 11, 2019)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- **Approval of Minutes**
  - October 10, 2018 CDT Committee Meeting
  - November 28, 2018 CDT Committee Meeting
  - May 1, 2019 Board Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- Executive Director's Report
- Executive Session (VOTE)
- Schedule of Next Meeting **(September 11, 2019)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the members of the Care Delivery Transformation Committee (CDT) hereby approves the minutes of the CDT meeting held on October 10, 2018 as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the members of the Care Delivery Transformation Committee (CDT) hereby approves the minutes of the CDT meeting held on November 28, 2018 as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on May 1, 2019 as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- **Market Oversight and Transparency**
  - Notices of Material Change
  - Review of Past Market Transactions
  - Reducing Administrative Complexity
- Care Delivery Transformation
- Executive Director's Report
- Executive Session (VOTE)
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Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	23	22%
Clinical affiliation	23	22%
Acute hospital merger, acquisition, or network affiliation	21	20%
Formation of a contracting entity	19	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	12	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

Notices Currently Under Review

Received Since 5/1

- Proposed contracting affiliation between **Sturdy Memorial Associates** and **South Shore Physician Hospital Organization**.

- Proposed partnership between **Baystate Health System** (Baystate) and **AmSurg Holdings** (AmSurg) under which the parties would acquire AmSurg's current 62% ownership interest in Pioneer Valley Surgicenter (PVS), an ambulatory surgery center located in Springfield.

- Proposed clinical affiliation between **Partners HealthCare System** (Partners) and **Boston Children's Hospital** (Children's) under which Brigham & Women's physicians would provide maternity care at a new integrated Maternal Fetal Care Center housed on Children's campus.

Elected Not to Proceed

Received Since 5/1

- Proposed contracting affiliation between **The Pediatric Physicians' Organization at Children's** (PPOC) and **Pediatric Associates of Brockton** (PAB) and **Woburn and North Andover Pediatric Associates** (WPA).
  - PPOC is a contracting network of pediatric primary care physicians. The network is owned by Children's, but participating physicians are not employed by Children's.
  - PAB and WPA are pediatric primary care practices that employ 9 and 17 physicians, respectively.
  - PAB and WPA currently contract through NEQCA. Under the proposed transaction, both practices would join PPOC contracts with commercial payers and participate in Children's MassHealth ACO.

Elected Not to Proceed, Cont.

- In its review, the HPC found some potential for modest spending increases based on differences in primary care prices between PPOC, PAB, and WPA.
- There could be additional spending impacts from changes in practice patterns, including an increase in referrals to Children's-affiliated providers.
    - However, PPOC does not currently require its primary care providers to refer to Children's or specialists affiliated with Children's; and
    - PPOC did not impose any referral requirement or provide any financial incentive for referrals on either WPA or PAB as a condition of joining the PPOC.
- The HPC has not reviewed evidence suggesting negative impacts on quality or access.

Elected Not to Proceed, Cont.

- Proposed transaction under which a number of anesthesiologists and certified registered nurse anesthetists who are currently employed by Anaesthesia Associates of Massachusetts (AAM) would be employed by **Associated Physicians of Harvard Medical Faculty Physicians** (APHMFP) and would contract through **Beth Israel Deaconess Care Organization** (BIDCO).
  - The analysis of this transaction suggested limited scope for increases in health care spending.
  - The HPC did not review evidence suggesting negative impacts on quality or access.

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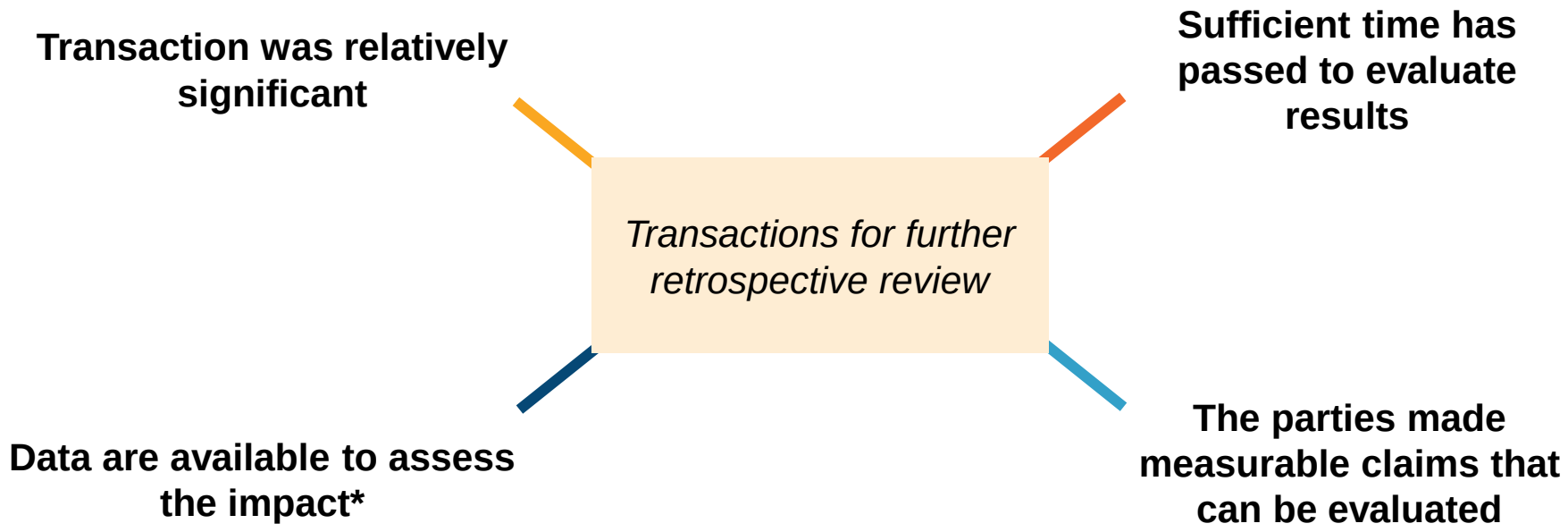
Criteria for Selecting Transactions for Retrospective Review

The HPC has reviewed **over 100 transactions** through the Material Change Notice process since 2013. The HPC is proposing conducting focused review of some of these transactions that have not yet been the subject of retrospective review (e.g., through a CMIR involving the parties).



*Key data for assessing transactions are only currently available through 2016. However, 2017 APCD and TME data are expected to be available later this year. Focused data requests to payers and/or providers may be necessary to supplement publicly available data sources.

Examples of Past HPC Retrospective Reviews: Beth Israel Lahey Health

- Last year, the HPC conducted a cost and market impact review (CMIR) of the formation of **Beth Israel Lahey Health** (BILH).
- The HPC's final CMIR report included findings on the results of prior transactions involving **Beth Israel Deaconess Medical Center**, **Beth Israel Deaconess Care Organization**, and **Lahey Health System**, including:
  - The degree to which the parties retained low-acuity care in community settings
  - Impacts on hospital and physician prices
  - Impacts on spending for the parties' primary care patients and for patients living near the parties' hospitals
  - Impacts on quality of care and access for patients
- Under BILH's agreements with the Determination of Need program and Attorney General, the HPC will receive regular updates on the progress and outcomes of the BILH merger, and will have the opportunity to review its impacts.
- Given the HPC's recent and future work monitoring the outcomes of BILH transactions, the HPC's work this year will focus on other noteworthy transactions for which data are available.

Transactions Proposed for Examination at this Time

- Merger between **Tufts Medical Center** and **Circle Health** (Lowell General) to form Wellforce
- Acquisition of **Hallmark Health** by **Wellforce**
- Acquisition of the **Commonwealth Hematology and Oncology** physician group by **Dana-Farber Cancer Institute**
- Acquisition of the **South Shore Medical Center** physician group by **South Shore Health System**
- Acquisition of the **Harbor Medical Associates** physician group by **Partners HealthCare System** (Partners)
- Clinical affiliation between **Partners** and **Steward Health Care** involving pediatric services at Steward hospitals

Rationale for Focusing on these Transactions

- **Data Availability**
  - Limited pre-transaction data for earlier transactions
  - Delays in availability of post-transaction data for more recent transactions
  - Limited data to examine impacts of out-of-state transactions

- **Significance of the Transaction**
  - Prioritizing transactions that involve a substantial change in the relationship between the parties
  - Prioritizing transactions that involve substantial changes to the market

- **Evaluation of Impacts**
  - HPC is still developing analytic tools to evaluate impacts of transactions involving certain provider types (e.g., home health, ancillary services, rehabilitation hospitals)
  - HPC analysis of commercial claims data has been limited to the three largest payers to-date; starting next year, the HPC will be able to analyze claims data for more commercial payers, increasing its ability to evaluate impacts of transactions in western MA, where other payers are more prevalent

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Administrative complexity drives up the cost of health care for patients and purchasers.

> In 2016, the United States spent nearly twice as much as 10 high-income countries on medical care.... Prices of labor and goods, including pharmaceuticals and devices, and **administrative costs appeared to be the main drivers** of the differences in spending.

Health Care Spending in the United States and Other High-Income Countries (2018)

Irene Papanicolas, PhD; Liana R. Woskie, MSc; Ashish K. Jha, MD, MPH

HPC

Massachusetts payers and providers believe that administrative complexity threatens the Commonwealth's ability to meet the benchmark.

The challenge of administrative complexity – and its unintended consequences – has been identified in pre-filed testimony before every annual cost trends hearing.

Examples from pre-filed testimony

- Provider credentialing
- Eligibility verification
- Prior authorization
- Claims submission, denials and appeals
- EHR integration, data-sharing, interoperability
- Government regulations, reporting requirement
- Duplicative care management programs
- Quality performance measurement
- Variation in risk contract terms

- Clinician confusion, discomfort, burn-out
- Decreased time with patients
- Distraction from other priorities
- Confusion and anxiety for patients

Some areas of administrative complexity add value; others do not.

Policy Recommendation:

The Commonwealth should take action to identify and address areas of administrative complexity **that add costs** to the health care system **without improving the value or accessibility of care**.

Potential markers of administrative complexity without value

- **Takes clinician time or attention away from patient care**
- **Driven or constrained by current technology and its limitations**
- **Must be repeated or done differently to accommodate non-standard forms or processes**
- **Costs outweigh financial benefits**

HPC

Proposed Principles for Selecting Focus Areas

1. Reducing complexity in this area would measurably reduce health care costs in Massachusetts **without jeopardizing quality or access**
2. Massachusetts **stakeholders have prioritized action** in this area
3. The issue can be addressed **at the state level**
4. Work in this area could **complement without duplicating** existing efforts

Proposed Principles for Selecting Focus Areas

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4. Work in this area could **complement without duplicating** existing efforts

HPC

Identifying Stakeholder Priorities

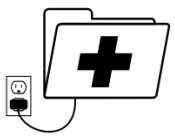
- The HPC has met with several individuals and organizations that are interested in reducing administrative complexity, including:

Payers	**Trade associations**	**Clearinghouses**
Providers	**Government agencies**	**Non-profits**

- Many are already working to reduce administrative complexity, on their own and/or collaboratively. Priority areas vary based on the strategic interests of the organization.
- The HPC distributed the **Reducing Administrative Complexity Advisory Council Survey** in May to more formally identify stakeholders' top priorities.
  - Respondents were asked to rate 12 areas as a **High**, **Medium**, or **Low** priority, rating no more than three areas as High priority.
- The HPC received 15 completed surveys.

Advisory Council Survey: Areas of Administrative Complexity

- Billing and Claims Processing
- Clinical Documentation and Coding
- Clinician Licensure
- EHR Interoperability
- Eligibility/Benefit Verification
- Prior Authorization
- Provider Credentialing
- Provider Directory Management
- Quality Measurement and Reporting
- Referral Management
- Variations in Benefit Design
- Variations in Payer-Provider Contract Terms



Advisory Council Survey: Results at a Glance

Billing and Claims Processing

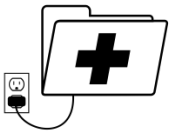
Provider Credentialing

Clinical Documentation and Coding

Provider Directory Management

Clinician Licensure

Quality Measurement and Reporting



EHR Interoperability

Referral Management

Eligibility/Benefit Verification

Variations in Benefit Design

Prior Authorization

Variations in Payer-Provider Contract Terms

Each of the top priority areas were identified by multiple types of organizations (i.e., a combination of payers, providers, employers, and patient advocates).

HPC

Key Themes from Advisory Council Survey Responses and Discussion

Credentialing

- Stakeholders often use the term “credentialing” to **refer to the broader process** of state licensure, controlled substances registration, and credentialing with payers and hospitals.
- Collectively, these processes **take significant time** and may create **access issues** when there are vacancies that need to be filled immediately.
- These processes also **pose financial challenges for providers**. A provider may choose to have a physician begin seeing patients once licensed, but before credentialing is complete. Yet, they cannot bill for services provided before the physician is credentialed with the health plan.
- Several providers reported having had **out-of-state physicians decline employment in Massachusetts** in order to work in another state with a shorter credentialing period.
- Policy solutions raised for consideration:
  - **Transition away from paper-based forms** and manual transmission methods
  - Massachusetts participation in the **Interstate Medical Licensure Compact**
  - Encourage payers with longer credentialing times to **adopt their peers’ best practices**
  - Development of a **centralized system** for hospital credentialing, comparable to HCAS for payers
  - Payer **delegation** of credentialing to providers

Key Themes from Advisory Council Survey Responses and Discussion

Prior Authorization

- The prior authorization process demands **significant time and resources** from providers, payers, and patients.
  - Payer ROI may not take into account **costs borne by providers and patients**.
  - Providers feel that **prior authorization burden has increased** over the last several years, including by requiring prior authorization for lower cost and routine services.
- Prior authorization requirements can lead to **delays and disruption in care**.
  - Changes in a patient's benefits or the specifics of a planned procedure can force the process to re-start from the beginning. Changes to a payer's formulary may require prior authorization before refills of existing medications.
- **DOI and the Mass Collaborative** have developed several **standardized prior authorization forms** (e.g., Medication, Imaging, Behavioral Health) that must be used pursuant to Chapter 224, and are continuing to develop forms for additional services.
- National health care industry leaders have signed a **Consensus Statement on Improving the Prior Authorization Process**.
- Policy solutions raised for consideration:
  - **Delegating prior authorization** to ACOs
  - Developing a **"gold carding"** system to reduce the need for prior authorization for some providers.

HPC

Key Themes from Advisory Council Survey Responses and Discussion

Variation in Benefit Design

- Payers offer **many different product types**, which also change over time, reflecting federal and state regulations, employers requesting specific policies/benefits or network designs, and cost control efforts.
- Variation in plans and plan design changes, as well as formulary changes, can **compromise a patient's ability to navigate the health care system and create confusion**.
  - These changes also create **difficulties for providers** in enrollment and benefit verification as well as billing and claims processing.
- However, efforts to limit variation could **reduce choice for employers and consumers**.
- Policy solutions raised for consideration:
  - Require a **common set of plan elements** that would apply to all products.

Advisory Council members noted that for all areas of administrative complexity, problems may be more acute for behavioral health patients and providers.

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HEALTH POLICY COMMISSION

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- **Care Delivery Transformation**
  - Awardee Spotlight: Boston Health Care for the Homeless Program
- Executive Director's Report
- Executive Session (VOTE)
- Schedule of Next Meeting **(September 11, 2019)**

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- Call to Order
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  - **Awardee Spotlight: Boston Health Care for the Homeless Program**
- Executive Director's Report
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Targeted Cost Challenge Investments Awardee: *Boston Health Care for the Homeless Program*

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Challenge Area	HPC Funding
Social Determinants of Health	**$750,000**

Partners

- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- The New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs

Total Initiative Cost

$919,085

Target Population

Highest cost MassHealth patients with high ED utilization (> 6 visits) and/or hospital utilization (> 2 admissions) in the most recent 6 months

Primary Aim

Reduce total number of emergency department visits and hospitalizations by 20%

Service Model

BHCHP will serve as a hub for a team of primary, acute, and specialty medical providers along with shelters and advocacy organizations to identify patients, track utilization, and provide intensive care coordination for patients whose needs span many types of services and providers

Evidence Base

- Yamhill Community Care Organization's Community Hub, Oregon
- Veteran's Health Administration's Homeless Patient Aligned Care Team Program

HPC

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM



Social Determinants of Health (SDH) Coordinated Care Hub for Homeless Adults

Barry Bock, CEO, BHCHP
Mary Takach, Sr. Health Policy Advisor, BHCHP
Kaitlyn McGary, SDH Nurse Navigator, BHCHP

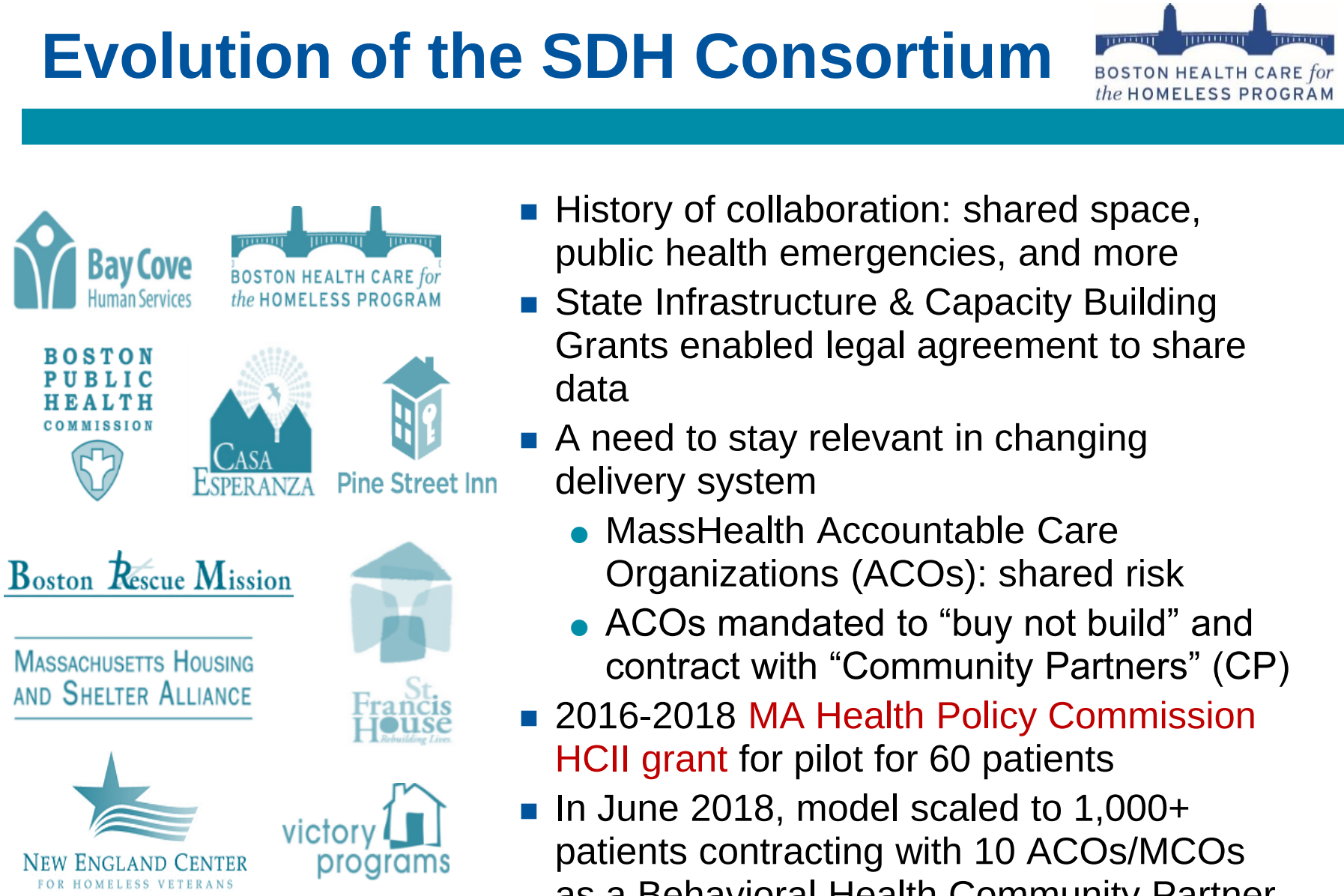
Health Policy Commission Board Meeting
50 Milk Street, Boston
July 24, 2019

BHCHP

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Since 1985, our mission has remained the same: to provide or assure access to the highest quality health care for all homeless individuals and families in the greater Boston area.

Evolution of the SDH Consortium



- History of collaboration: shared space, public health emergencies, and more
- State Infrastructure & Capacity Building Grants enabled legal agreement to share data
- A need to stay relevant in changing delivery system
  - MassHealth Accountable Care Organizations (ACOs): shared risk
  - ACOs mandated to "buy not build" and contract with "Community Partners" (CP)
- 2016-2018 MA Health Policy Commission HCII grant for pilot for 60 patients
- In June 2018, model scaled to 1,000+ patients contracting with 10 ACOs/MCOs as a Behavioral Health Community Partner

Pilot Overview

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

- Objective: Coordinate care across diverse agencies to better serve people experiencing homelessness, improve access to services that address SDH, and reduce avoidable ED and hospital utilization by 20%.
- Timeline: 2-year $750K grant: December 2016— 2018
- 18-month Implementation Phase began June 2017.
- Target Population: ~60 homeless MassHealth individuals with high costs/ high health care utilization.

Criteria for participation

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

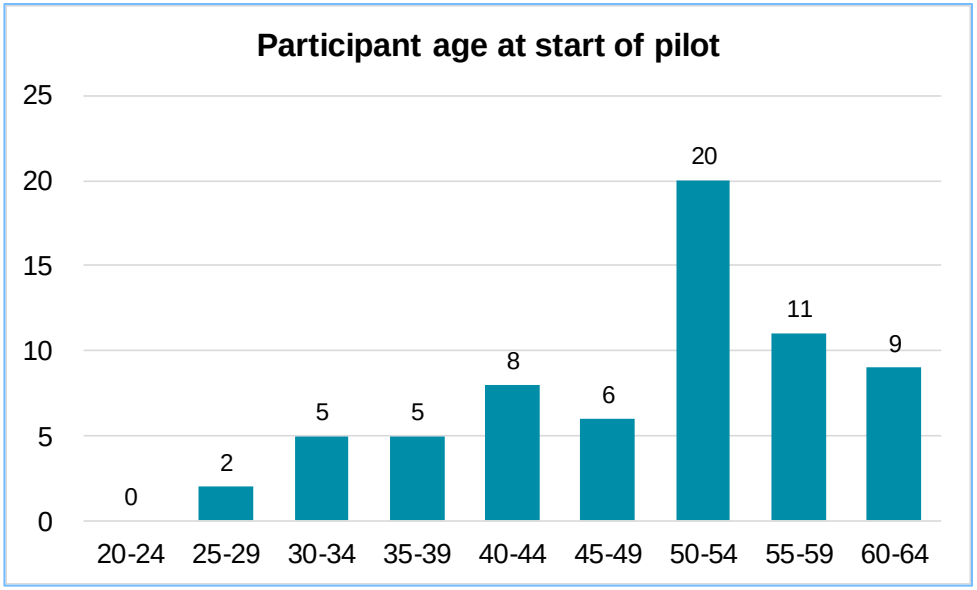
- The SDH Coordinated Care Hub pilot initiative targeted some of our most complex patients, using a claims-based approach
  - In the top 10% to 15% of cost for the most recent 12-month period, and
    - At least 6 ED visits in the most recent six months, OR
    - At least 2 inpatient admissions in the most recent six months
- We reviewed claims data every month and provided lists to the nurse navigator and case managers so that they could outreach to these high-cost, high-risk patients
- Actual metrics for participants in six months prior to identification:
  - Average of 13.7 ED visits
  - Average of 1.5 IP admissions

Target population demographics

- 76% male, 24% female,
- 70% white, 21% black, 9% unknown/not reported

- Average age at start of pilot: 49.1

	RACE				
GENDER	**White**	**Black**	**Unknown**	**Total**	***% of total***
Female	11	5	0	16	***24%***
Male	35	9	6	50	***76%***
Total	**46**	**14**	**6**	**66**	
% of total	***70%***	***21%***	***9%***		



Intervention

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Social Determinants of Health Coordinated Care Hub

for people experiencing homelessness

1 DEDICATED RESOURCES

15:1 client-to-staff ratio

- Recognizes challenge of engaging highest-risk clients
- Delegated case management based on existing relationships
- At least weekly encounters
- Support from BHCHP RN

2 SHARED INFORMATION TECHNOLOGY

Enhances communication with other agencies

- Shared care management platform
- Consent required from client

3 SHARED CARE PLANS

Client's goals are created by him or her and supported by team

4 CONNECTION TO PRIMARY CARE

- Regular communication with doctor/nurses
- Joint training and case conferencing
- Accompaniment to appointments

5 DATA TO HELP UNDERSTAND CLIENT'S NEEDS & SERVICE USE

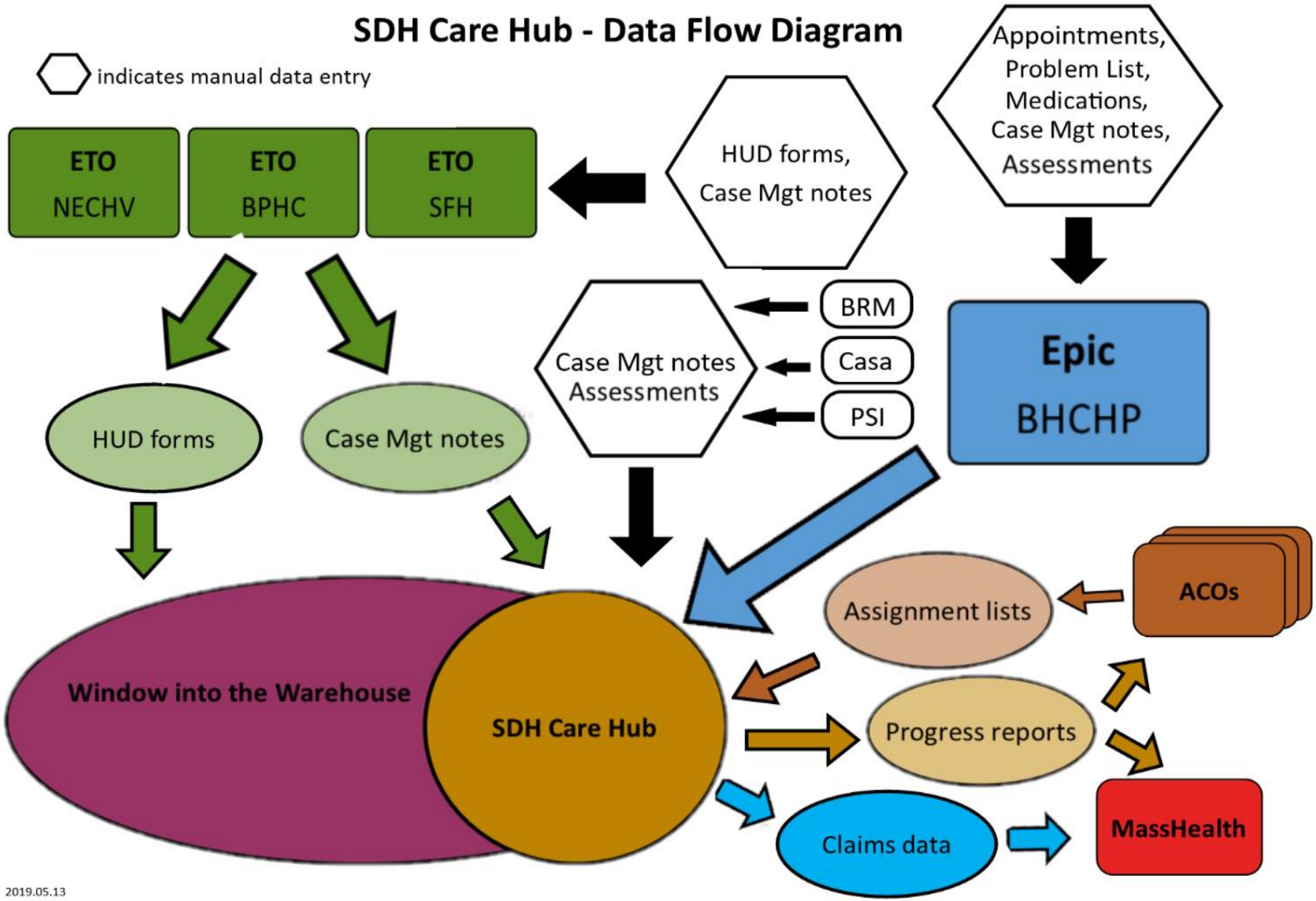
Information from Medicaid claims, EHR, PreManage ED, City of Boston, etc.

- Recent hospitalizations/ED visits
- Care management & housing, shelter stays

6 SUPPORT FROM HUB LEADERSHIP TEAM

Meets regularly to troubleshoot and strategize about progress and "pain points"

- Monthly dashboard
- May be able to prioritize housing, services, or leverage other resources


SDH Care Hub - Data Flow Diagram
indicates manual data entry
ETO NECHV
ETO BPHC
ETO SFH
HUD forms, Case Mgt notes
Appointments, Problem List, Medications, Case Mgt notes, Assessments
BRM
Casa
PSI
Case Mgt notes Assessments
Epic BHCHP
HUD forms
Case Mgt notes
Window into the Warehouse
SDH Care Hub
Assignment lists
ACOs
Progress reports
Claims data
MassHealth
2019.05.13

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

« My Patients « Client Search

[redacted]

Basic Info & Programs | History | File Uploads | Health

- Dashboard
- Care Plan
- Team Members
- Services
- Goals
- Files
- Metrics

[redacted]

Last Seen
1 day ago

Last Seen Location
Behavioral Health Community Partner, Confidential Project, and Female Day Program

Days in Last 3 Ye
479 homeless
479 literally home

Homeless Span
Jan 23, 2004 to May

SO, TH, and SH

Veteran:
No

Consent Form

CAS Client ID: 1827

Full HAN Release | Long-term Stayer | Chronically Homeless & in CAS View in CAS

Demographics

ID	Name	SSN	Age	Gender	Race	Ethnicity
Warehouse	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
DND						
Health						
DND						
DND						
BPHC						

Contact Information

No contact information on file

Current Program Enrollments

Entry
Aug 26, 2018
Jan 26, 2019

Case Manager

Name	Phone	Type
Mike Payne		Case Manager

Assessments

Assessment Type	Collection Date	Location
Project Annual Assessment	Jan 1, 2016	Shelter Services
Project Exit	Apr 27, 2018	Shelter Services
Project Start	Mar 6, 2019	Shelter Services

Residential Enrollments

	Program Name < Agency Name	Entry	Exit	Most Recent Day Served	Days S
				Totals:	
DND ES	Night Center < Bay Cove Human Services	Jan 26, 2019		Feb 25, 2019	

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

My Patients « Client Search

Client Healthcare Dashboard for [redacted]

Basic Info & Programs | HMIS -- | Dashboard | Care Plan | Team Members | Services | Goals | Files | Metrics

Patient Summary | Appointments | Problems | Medications

Patient Summary

[redacted]

6 Valid Qualifying Activities in May

SSN: [redacted] Medicaid ID: [redacted] Primary Care Provider: WISHIK-MILLER, GABRIEL R ACO: Boston Accountable Care Organization in partnership with BMC HealthNet Plan

Engagement Readiness & Forms

- ✓ Participation Form
- ✓ Release of Information form
- ✓ Self-Sufficiency Matrix
- ✓ Comprehensive Health Assessment
- ✓ PCTP Signed

Communication

Preferred Communication:

Demographics

AGE: [redacted] GENDER: [redacted] DISABILITY FLAG: Unknown

DOB: [redacted] RACE / ETHNICITY: [redacted] VETERAN STATUS:

Allergies

none

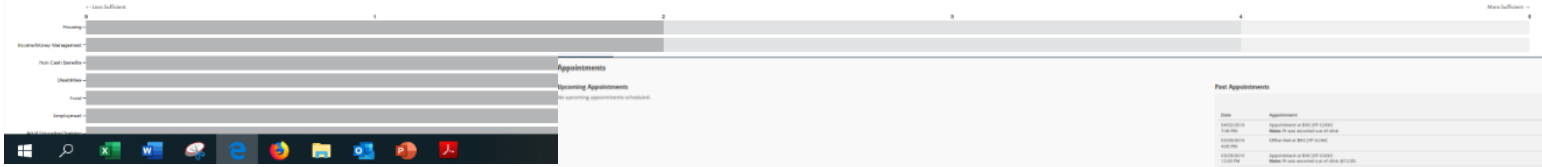
Advanced Directive

Would like to develop plan

[redacted]

Housing Status (August 2018 - April 2019)

Self Sufficiency Scores

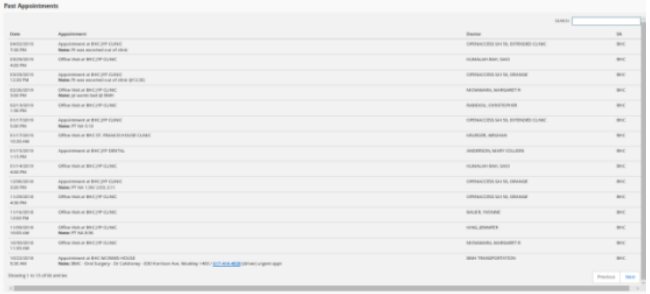


Appointments

Upcoming Appointments

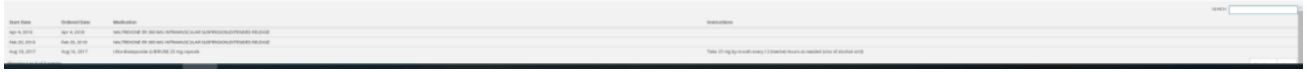
No upcoming appointments scheduled.

Past Appointments



Problems

Medications



BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

« My Patients « Client Search

Collaborative Care Plan for [redacted]

Basic Info & Programs | HMIS | Dashboard | **Care Plan** | Team Members | Services | Goals | Files | Metrics

Case Management Notes

+ Add Case Note

Assessment	Date Completed	Case Manager
Case Management Visit From Epic	Apr 9, 2019	BERARD, SHIRLEY
Case Management Visit From Epic	Mar 11, 2019	BERARD, SHIRLEY
Case Management Visit From Epic	Mar 4, 2019	BERARD, SHIRLEY
Interim Notes From Epic	Feb 26, 2019	DALAL, ELYSE
Interim Notes From Epic	Jan 15, 2019	DALAL, ELYSE
Case Management Visit From Epic	Jan 14, 2019	BERARD, SHIRLEY
Telephone From Epic	Dec 18, 2018	DALAL, ELYSE
Case Management Visit From Epic	Nov 15, 2018	BERARD, SHIRLEY
Case Management Visit From Epic	Nov 6, 2018	BERARD, SHIRLEY
Case Management Visit From Epic	Nov 1, 2018	BERARD, SHIRLEY

Showing 1 to 10 of 21 entries Previous Next

Last updated: May 14, 2019 12:04 pm Update

Self-Sufficiency Matrix Forms

+ Add SSM

Assessment	Date Completed	Case Manager
SSM	Oct 17, 2018	Elyse Dalal

Showing 1 to 1 of 1 entries Previous Next

Comprehensive Health Assessments

+ Add CHA

Assessment	Status	Completed By
CHA	Reviewed on Oct 30, 2018	Elyse Dalal

Showing 1 to 1 of 1 entries Previous Next

Person-Centered Treatment Plan

+ Create a Care Plan

	Initiated	Signatures	Downloadable Care Plan
Make Copy Update Signature Dates	Oct 24, 2018	✓ Patient Signature (Oct 17, 2018) ✓ PCP Signature (Oct 23, 2018) Careplan expired Apr 23, 2019	PDF: Care Plan PDF: Coversheet

Current Care Team

ACO Care Manager

Claralys Gonzalez, Point of Contact
The Dimock Center (C3)
rgonzal2@dimock.org
(617) 442-8800 Ext 1260

ACO Care Manager

Stephanie Ramirez, Point of Contact
The Dimock Center (C3)
sramire3@dimock.org
(617) 442-8800 Ext 1579

Other Important Contact

CHRISTINA M FILIPOWICH (Care Manager)
bhchp.org
cfilipowich@bhchp.org
857-324-3733

Other Important Contact

ELYSE DALAL (Team Coordinator)
bhchp.org
edalal@bhchp.org
857-324-3738

Other Important Contact

SHIRLEY BERARD (Care Coordinator)
bhchp.org
sberard@bhchp.org
617-869-0128

Provider (MD/NP/PA)

GABRIEL R WISHIK-MILLER
Unknown
857-654-1000

Current Goals

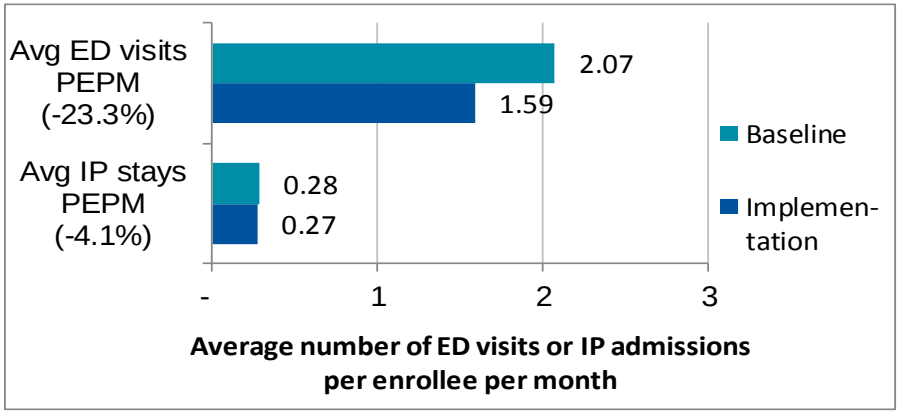
No goals on file

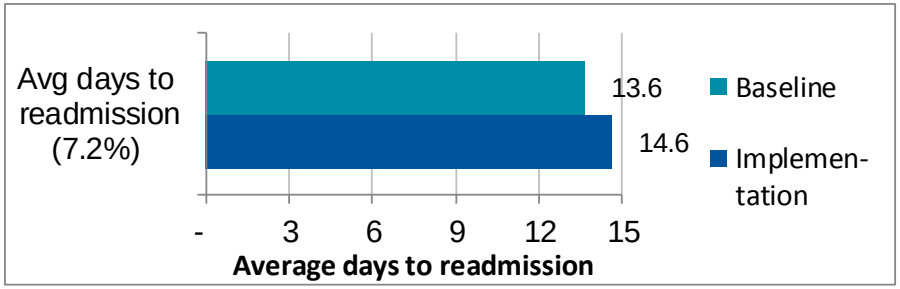
Key Findings

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

Key utilization metrics

- Most utilization metrics moved in the desired direction:
  - 23% reduction in average number of ED visits
  - 4% reduction in average number of inpatient admissions
  - Longer time elapsed between inpatient admissions (7.2% increase)

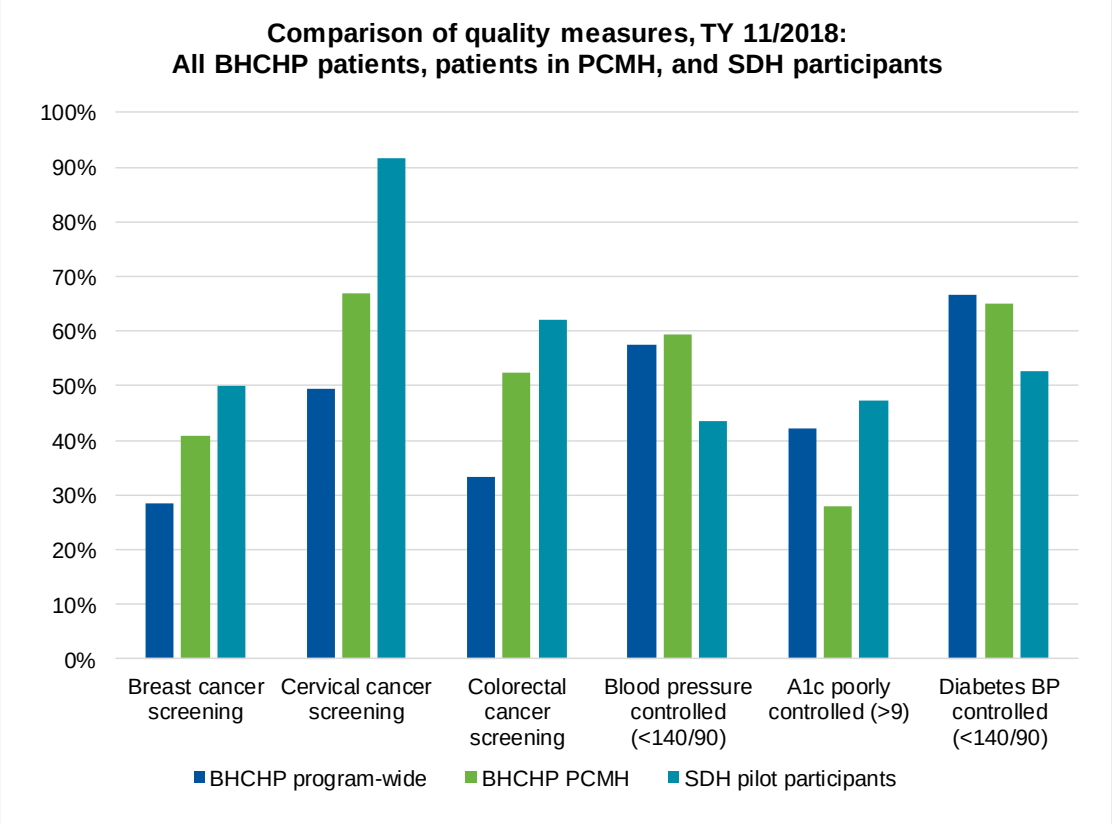




** PEPM = per enrollee per month*

Key clinical quality metrics

- We compared SDH participants to BHCHP patients overall, as well as those patients in a medical home (who are more likely to be engaged in care)
  - SDH participants had higher rates of cancer screenings
  - However, SDH participants had lower rates for control of high blood pressure
  - They also had a higher proportion of poorly-controlled diabetes

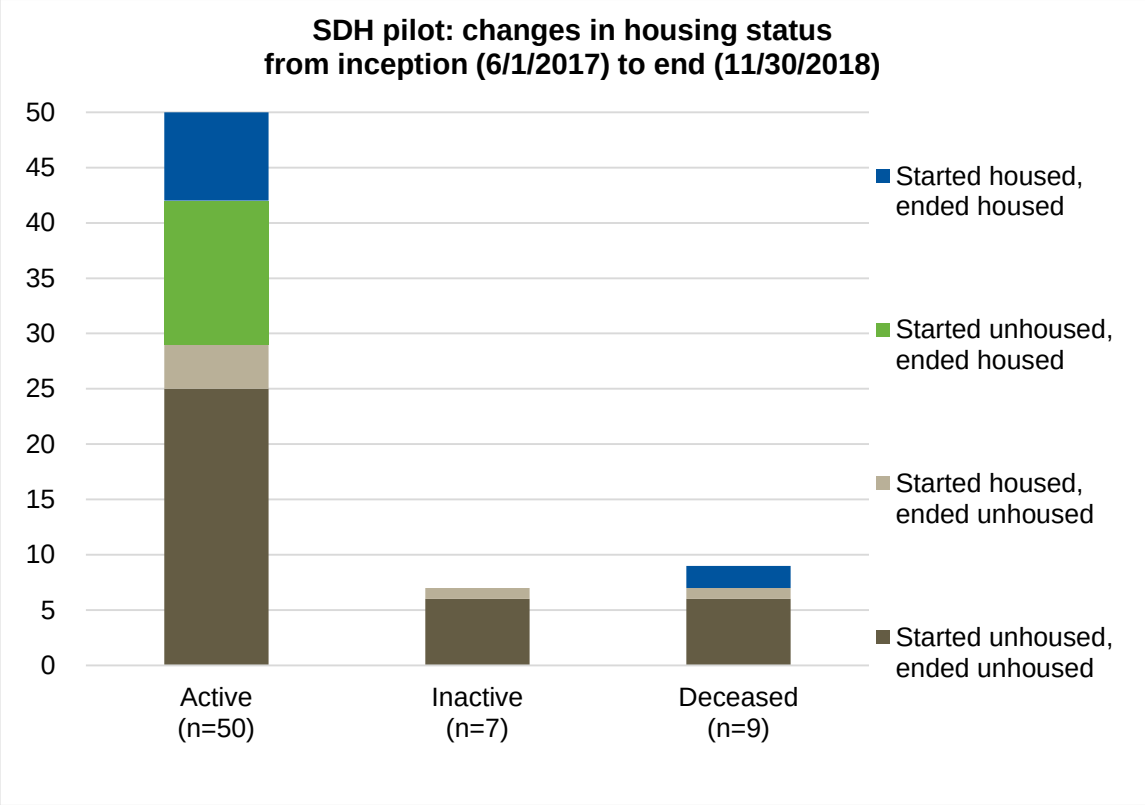


Key SDH metrics: housing status

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

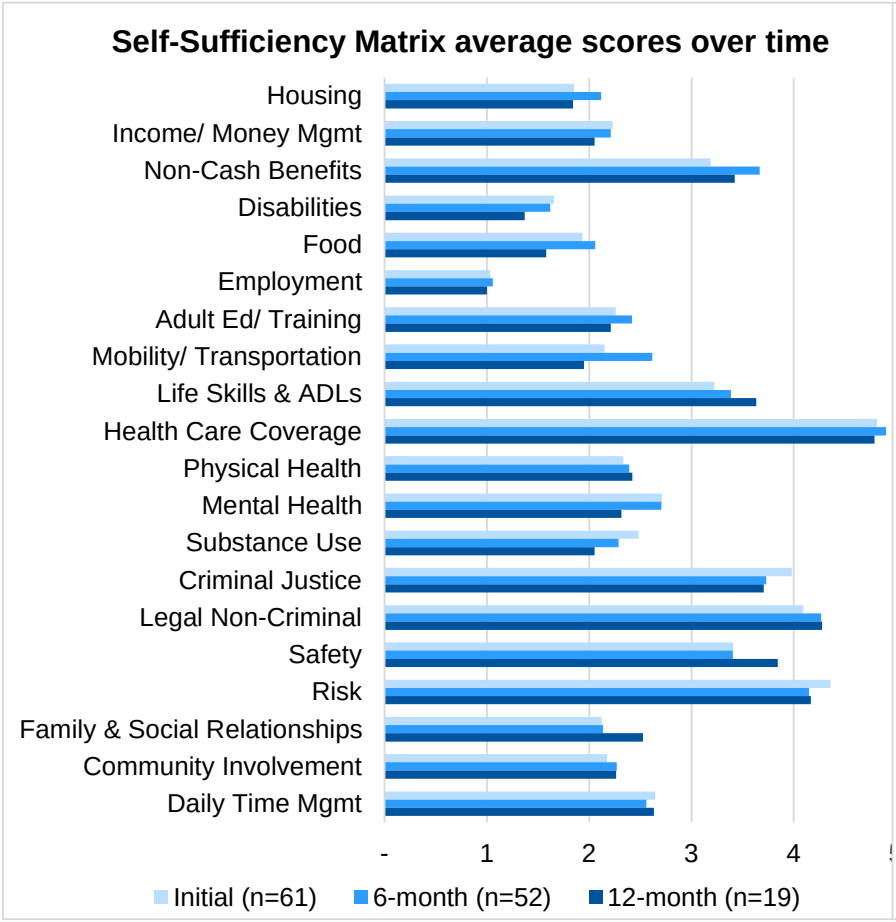
- By the end of the pilot, 17 of the 50 **active** participants (34%) were housed, a net increase of 18% from the start of the pilot.
  - Eight (16%) started housed and remained housed
  - Thirteen (26%) were unhoused and became housed
  - Twenty-five (50%) were unhoused and remained unhoused
  - Four (8%) were housed and became unhoused
- At the start of the pilot, 16 of the 66 **total** participants (24%) were housed. That increased to 23 (35%) by the end of the pilot.

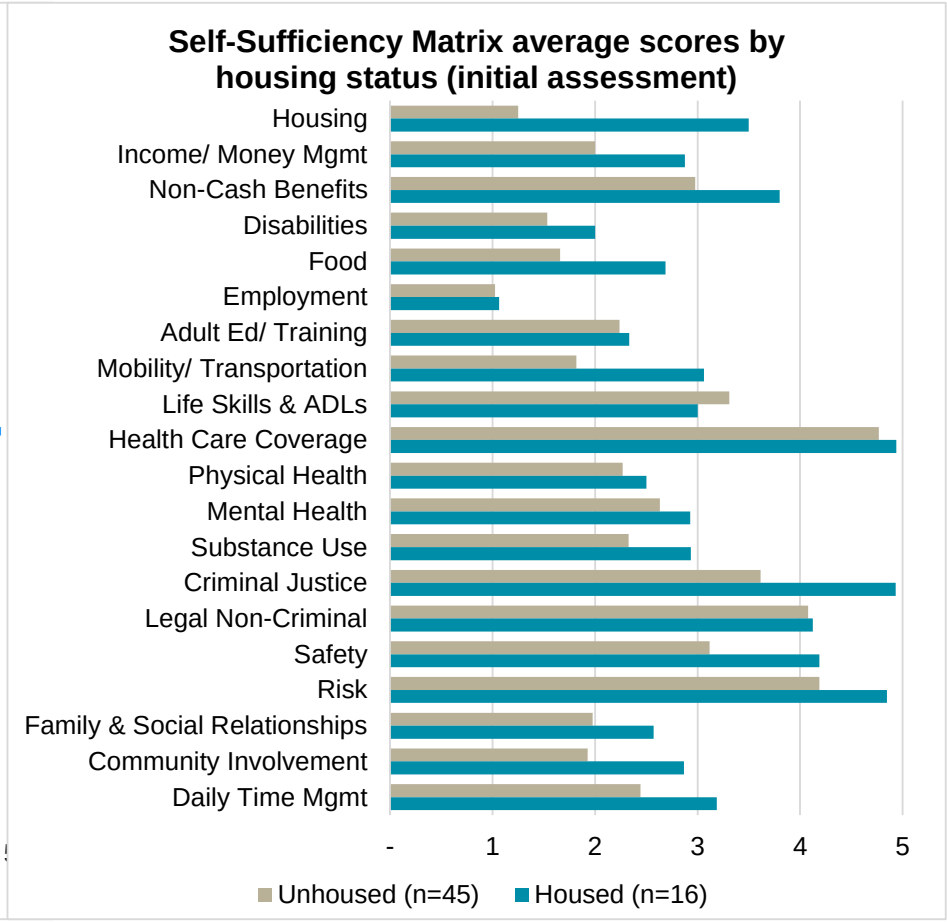
(Housing status based on most recent active status, or status as of the time participant disenrolled from the program.)



Key SDH metrics: Self-Sufficiency Matrix

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM





Lessons learned

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

1. Interventions with the highest-risk MassHealth enrollees—those with complex medical, behavioral health, and social determinants of health needs—were not quite as impactful when measuring from a utilization lens as we initially hypothesized. 18 months is a short a time to work with this population; we were able to oversee the transition most of our pilot patients into a complex care management program at the conclusion of our pilot in November 2018—mostly in BH Community Partners, some OneCare.

- From an SDH lens, we significantly helped improve access to housing and worked to stabilize those with housing.

Lessons learned

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

2. There was a high mortality rate with this population. We need greater emphasis/training on end of life care/advanced care planning needed.

- Patients suffered from very complex medical challenges at enrollment; deaths were not because of direct failure of our systems, but due to advanced diseases.
- No differences were noted between housed versus unhoused patients
- Nurse navigator conducted many visits outside of clinic; if patient refuses to come in to clinic, we should ensure a provider is able to do outreach.
- Many patients died in hospitals; it's important to engage with patients earlier to create end-of-life care plans prior to hospitalizations

Lessons learned

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

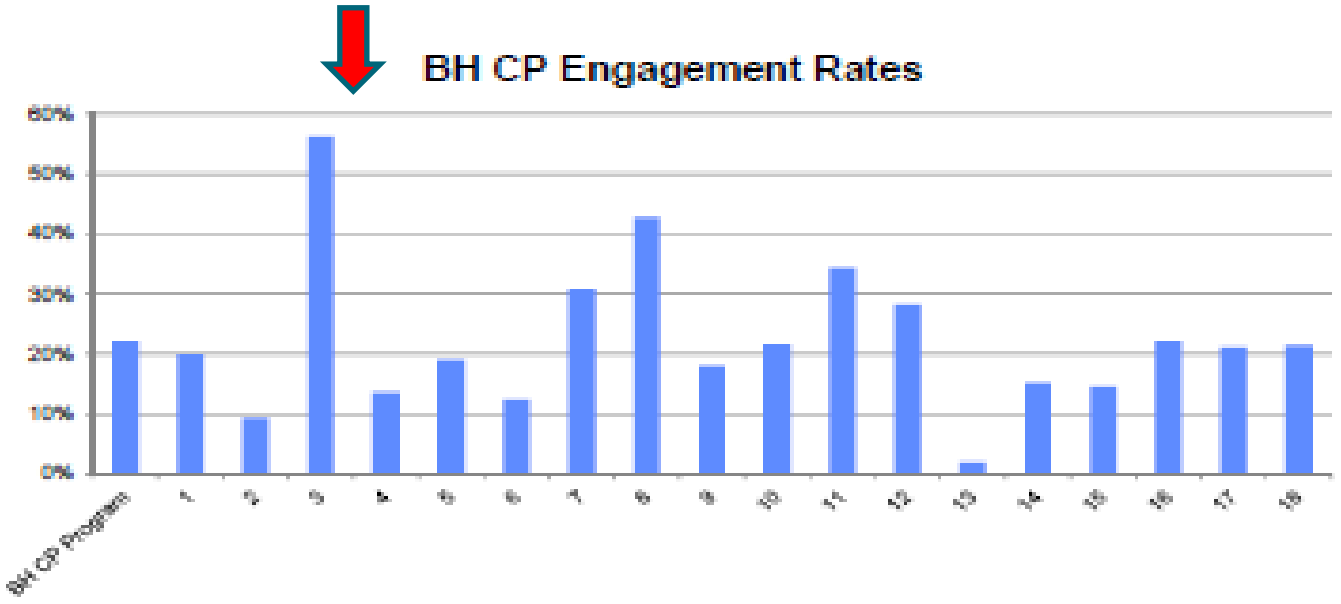
3. Leveraging incentives—including gift cards and cell phones—helped make a difference in engagement of patients with complex SDH needs.

4. HPC enabled us to get out of the MassHealth Behavior Health Community Partner gate fast. We are the top performer in the state with regards to patient engagement.

MassHealth Data-May 2019

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

VI. CP Engagement Rates



Note: *These rates reflect engagement rates all members across all cohorts*

Disclaimer: This data is taken from the April Member Status and Outreach Report, which was due to MassHealth from CPs in May 2019. It is self-reported data and the members reported on do not necessarily match the list of members that are officially enrolled in the CP Program. Additionally, this data is contains other anomalies and incomplete information. This data is directional information only and should not be used to draw conclusions about the CP Program.

Thank you HPC!

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

For more information:

- Barry Bock bbock@bhchp.org
- Mary Takach mtakach@bhchp.org
- Kaitlyn McGary kmcgary@bhchp.org

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- Market Oversight and Transparency
- Care Delivery Transformation
- **Executive Director's Report**
  - Upcoming Publications
  - 2019 Cost Trends Hearing
  - Fiscal Year 2020 Budget – Continuing Resolution (VOTE)
- Executive Session (VOTE)
- Schedule of Next Meeting **(September 11, 2019)**

2019 HPC Fellowship Program

>200 Applicants
13 HPC Fellows
10 weeks

Care Delivery Transformation
Allie Dawson, Tufts University School of Medicine, MPH Candidate
Deepti Kanneganti, Harvard University, MPP Candidate
Emily Leonard, Yale School of Public Health, MPH Candidate

Market Oversight and Transparency
Callee Donovan, Suffolk University Law School, JD Candidate
Ayeesha Kakkar, Boston University School of Public Health, MPH Candidate

Research and Cost Trends
Akiff Premjee, Tufts University School of Medicine, MD Candidate
Karen Smith, Harvard University, PhD Candidate

Strategic Investment
Danielle Dean, Boston University School of Public Health, MPH & MSW Candidate
Joy Chen, Yale School of Public Health, MPH Candidate
Nia Johnson, Boston University School of Law, JD Candidate

Office of the Chief of Staff
Gwendolyn Lee, Harvard University and UCLA School of Medicine, MPP & MD Candidate
Connie Zhang, Columbia University Mailman School of Public Health, MPH Candidate

Office of the General Counsel
Kat Lozah, Boston University School of Law, JD Candidate

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MASSACHUSETTS
HEALTH POLICY COMMISSION

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    - Review of Third-Party Specialty Pharmacy Use for Clinician-Administered Drugs
    - Prescription Drug Coupon Study
  - 2019 Cost Trends Hearing
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MASSACHUSETTS
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Today, the HPC is issuing a legislative report on its *Review of Third-Party Specialty Pharmacy Use for Clinician-Administered Drugs*

Section 130 of Chapter 47 of the Acts of 2017

The Massachusetts Health Policy Commission (HPC), in consultation with the Department of Public Health (DPH) and the Division of Insurance (DOI), shall:

- **Study and analyze health insurance payer practices** that require certain categories of drugs (e.g., those administered by injection or infusion) to be dispensed by a third-party specialty pharmacy directly to a patient or to a health care provider with the designation that such drugs shall be used for a specific patient and not for the general use of the provider
- **Submit a report of its findings and recommendations** to the Legislature's Joint Committee on Health Care Financing and the and Joint Committee on Public Health.

THE FINAL REPORT IS AVAILABLE ON THE HPC'S WEBSITE TODAY

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Statutory language directs the HPC to complete a study on the use of prescription drug coupons in the Commonwealth.

Chapter 363 of the 2018 Session Laws, ***An Act Extending the Authorization for the Use of Certain Discount Vouchers for Prescription Drugs***, was signed into law on January 2, 2019. It charges the HPC with conducting an analysis and issuing a report evaluating the effect of drug coupons and product vouchers for prescription drugs on pharmaceutical spending and health care costs in Massachusetts.

1. Analyze the **total number and value of coupons** redeemed in the Commonwealth, and the **types of drugs** for which coupons were most frequently redeemed.
2. Compare any change in utilization of **generic versus brand name prescription drugs**, and any change in utilization among **therapeutically-equivalent brand name drugs**.
3. Analyze **effects on patient adherence**, and **access to innovative therapies**.
4. Study the **availability of coupons** or discounts upon renewals, and the **cost impact on consumers** upon expiration of coupons.
5. Analyze the **impact of drug coupons on health care cost containment goals** adopted by the Commonwealth, and commercial and GIC health insurance premiums and drug costs.

Data sources for prescription drug coupon study

- Academic literature
- Public stakeholder testimony
- All Payer Claims Database
- Vendor data: Symphony

Symphony Health
A PRAHEALTHSCIENCES COMPANY

Symphony Health is a national data services vendor.

Symphony's Integrated Dataverse (IDV) database contains pharmacy transaction data for an estimated 92% of prescriptions dispensed in the U.S. and Massachusetts. Data elements include:

- All payer pharmacy claims in Massachusetts (2011-2018)
- Plan payments, patient out of pocket payments, coupon use

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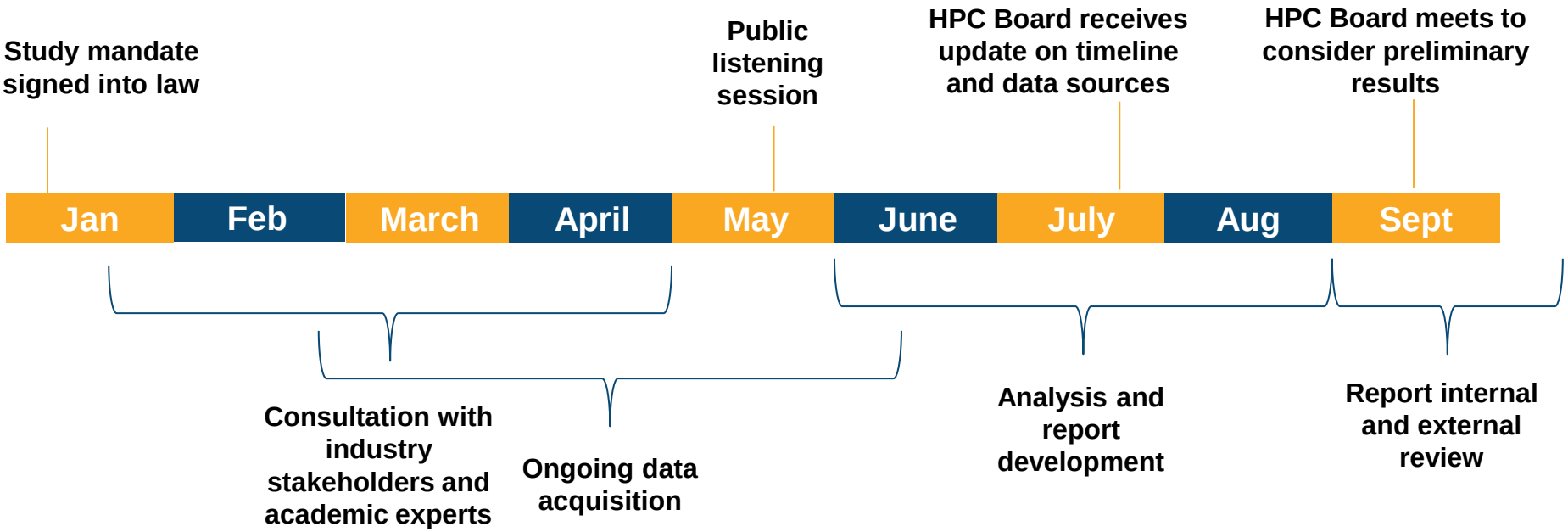
Study Timeline



All dates are approximate

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SAVE THE DATE

2019 HEALTH CARE COST TRENDS HEARING

TUESDAY, **OCTOBER 22** AND WEDNESDAY, **OCTOBER 23**

SUFFOLK UNIVERSITY LAW SCHOOL

120 TREMONT STREET, BOSTON, MA 02108

MASSACHUSETTS
HEALTH POLICY COMMISSION

Reserve your seat: tinyurl.com/HCCTH2019

2019 Health Care Cost Trends Hearing – Discussion of Potential Themes

PURPOSE

- **Enhance** the public transparency and accountability of health care spending trends
- **Evaluate** the efforts of health care market participants to reduce health care costs and to share those savings with consumers, employers, and government
- **Engage** state government leaders, national experts, market participants, and the public to identify opportunities to reduce spending growth while improving quality
- **Establish** a fact base through written and oral testimony on the priorities and plans of health care market participants to reduce spending
- **Empower** HPC commissioners to question market participants under oath
- **Enable** broad public engagement in the work of the HPC

POTENTIAL THEMES

- Examining the state's performance in meeting the lower **3.1% benchmark**
- **Future of primary care** in Massachusetts, including strategies to support primary care and integrated behavioral health care
- Efforts to **reduce administrative complexity** that does not provide value
- Progress on care delivery and payment system reforms, including the adoption of **alternative payment models** and development of **ACOs**
- **Prescription drug spending trends** with potential focus on new, high-cost drugs and therapies *OR* trends in generic drug pricing and impacts on consumers
- Evaluating the impact of **past market transactions** on spending, quality, and access

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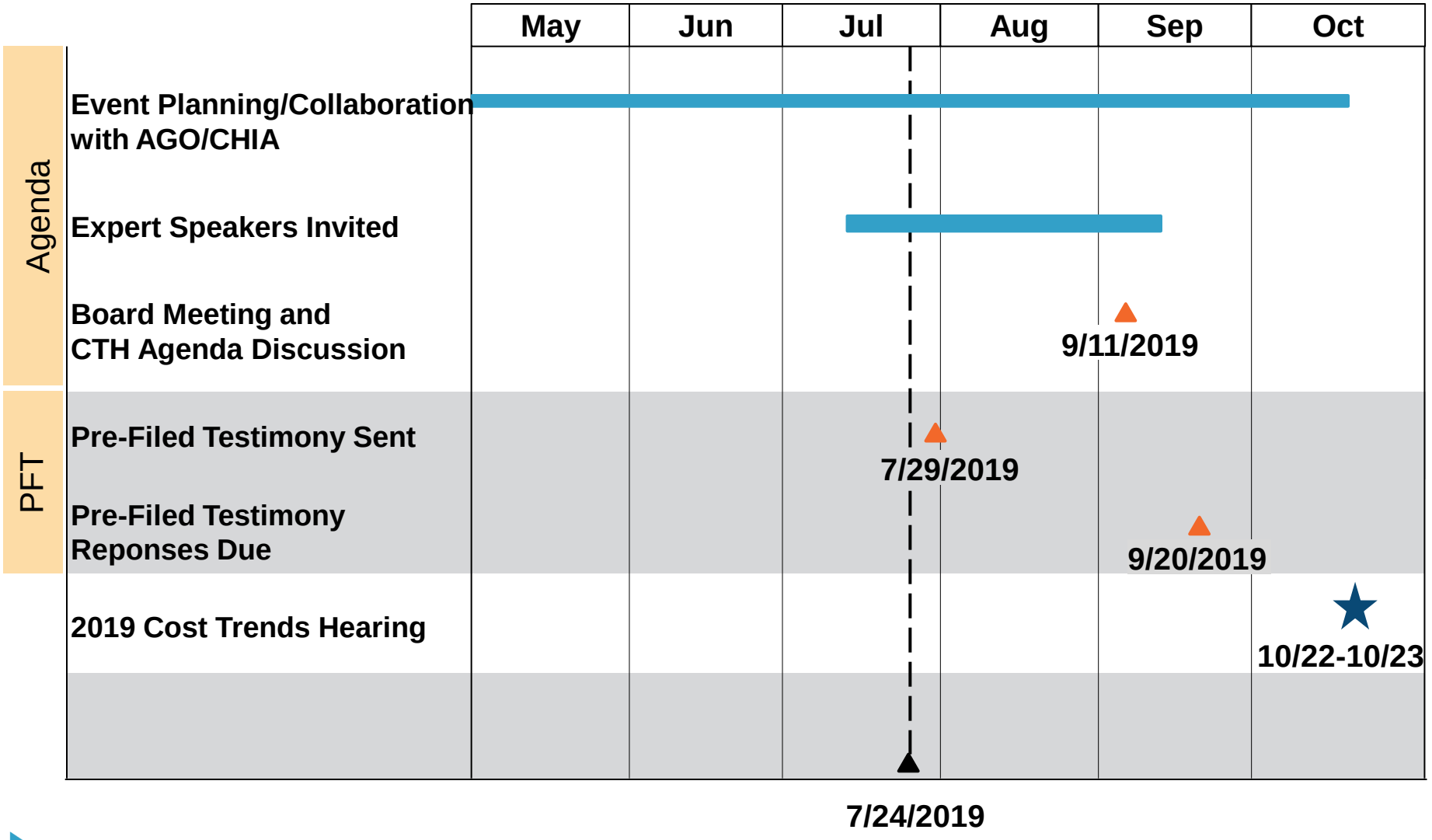
2019 Cost Trends Hearing Timeline



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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Fiscal Year 2020 Budget Continuing Resolution

MOTION: That the Commission hereby authorizes the Executive Director to continue spending funds to support the ongoing operations of the agency at the level of funding approved by the Commission for fiscal year 2019, until the Commission approves the operating budget for fiscal year 2020 at its next meeting.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Executive Session

MOTION: That, having first convened in open session at its July 24, 2019 Board meeting and pursuant to G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, G.L. c. 6D, § 2A, and G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.

Upcoming 2019 Meetings and Contact Information

Board Meetings

Wednesday, September 11
Monday, December 16

Committee Meetings

Wednesday, October 2
Wednesday, November 20

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

2019 Cost Trends Hearing
Day 1 – Tuesday, October 22
Day 2 – Wednesday, October 23

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX

Hospital Acquisitions and Contracting Affiliations Closing Before 2017

Transaction
Partners acquisition of Cooley Dickinson Hospital
BIDMC acquisition of Jordan Hospital
Contracting affiliation between BIDCO and Cambridge Health Alliance
Contracting affiliation between BIDCO and Lawrence General Hospital
Lahey acquisition of Winchester Hospital
Contracting affiliation between BIDCO and Anna Jaques Hospital
Baystate acquisition of Wing Memorial from UMass
Tufts Medical Center and Circle Health merger into Wellforce
Baystate acquisition of Noble Hospital
Trinity acquisition of St. Francis Care
Contracting affiliation between BIDCO and New England Baptist
Wellforce acquisition of Hallmark Health System
Partners acquisition of Wentworth-Douglass Hospital

Physician Group Acquisitions and Contracting Affiliations Closing Before 2016

Transaction
Steward acquisition of Hawthorn Medical Associates
Contracting affiliation between BIDCO and CHA Physician Org.
Contracting affiliation between NEQCA and Healthcare South
DFCI acquisition of Commonwealth Hematology & Oncology
Medical Affiliates of Cape Cod acquisition of Emerald
Contracting affiliation between BIDCO and Whittier IPA
Health New England acquisition of Valley Medical Group
Reliant Medical Group merger with Southboro Medical Group
South Shore Health System acquisition of South Shore Medical Center
Partners acquisition of Harbor Medical Associates
Partners acquisition of Pentucket Medical

Clinical Affiliations Closing Before 2016

Transaction
Clinical affiliation between BIDMC and Signature Brockton
Clinical affiliation between BIDMC, CHA, CHAPO
Clinical affiliation between Atrius and Jordan (BID-Plymouth)
Clinical affiliation between DFCI and Steward St. Elizabeth's
Clinical affiliation between BIDMC and New England Baptist
Clinical affiliation between DFCI and Steward Holy Family
Clinical affiliation between Partners and Steward (Pediatrics)
Clinical affiliation between Children's and Lahey
Clinical affiliation between Tufts Medical Center Physicians Org. and Cape Cod Hospital
Clinical affiliation between DFCI and Berkshire Health System