MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

January 14, 2020

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes from October 2, 2019 Meeting
- Investment Program: MassUP Funding Opportunity Update
- ACO Certification: 2019 Application Results
- Substance Exposed Newborns Investment Program: Stakeholder Engagement and Initial Design Parameters
- Awardee Presentation: Hebrew SeniorLife
- Schedule of Next Meeting **(May 6, 2020)**

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **October 2, 2019** as presented.

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Overview of Moving Massachusetts Upstream (MassUP)

MassUP Vision:
Better health, lower costs and reduced health inequities — across communities and populations in Massachusetts — through effective partnerships between government, health care systems, and communities to address the social determinants of health (SDoH).

- **A partnership across state agencies: DPH, MassHealth, AGO, EOEA, and HPC**
- Goal: to engage in **policy alignment activities** and make **investments to support health care system–community collaborations** to more effectively address the "upstream" causes of poor health outcomes and health inequity

MassUP Investment Program Request for Proposals (RFP)

RFP issued on December 17, 2019

The RFO solicits Proposals from **Eligible Entities (Applicants)** on behalf of themselves and **Partners** seeking support to form a **Partnership** that will work to address upstream challenges to and enable sustainable improvements in community health and health equity.

Investment Program Procurement Process

December 2019

- RFP issued December 17
- Began collecting and processing questions from stakeholders

January 2020

- Info Session webinar held January 9
- Respond to questions via FAQ documents posted to COMMBUYS

Feb./March 2020

- All respondent questions due by 3:00 PM, Feb. 7
- **Proposals due by 3:00 PM, Feb. 21**
- Review and selection process through March

April 2020

- Present awards for HPC Board approval on April 1
- Begin contracting, with June 1 target date for program launch

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Information Session Webinar Held January 9

Reviewed key features of the MassUP investment program RFP such as:

- Important definitions
- Funding opportunity basics and key requirements
- Planning and Implementation Period activities
- Measurement and reporting process
- Funding disbursement and budgeting processes

Highlights:

- >170 participants
- Attendees represented provider organizations, including HPC-certified ACOs, hospitals, BH and LTSS providers; CBOs; advocacy groups; local government; and other stakeholders

To view this webinar and access the MassUP investment program RFP, see COMMBUYS: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-20-1055-HPC01-HPC-46702&external=true&parentUrl=bid

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HPC ACO Certification Awarded to 14 ACOs in 2019

ACOs Certified in 2019

- Atrius Health, Inc.
- Baycare Health Partners, Inc.
- Beth Israel Lahey Performance Network
- BMC Health System, Inc.
- Cambridge Health Alliance
- Children's Medical Center Corporation
- Community Care Cooperative, Inc.
- The Mercy Hospital, Inc.
- Partners HealthCare System, Inc.
- Reliant Medical Group, Inc.
- Signature Healthcare
- Southcoast Health System, Inc.
- Steward Health Care Network, Inc.
- Wellforce, Inc.

ACOs Eligible for Re-Certification in 2020

- Health Collaborative of the Berkshires, LLC
- Merrimack Valley Accountable Care Organization, LLC
- Mount Auburn Cambridge Independent Practice Association, Inc.

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“First Look” at Re-Certified ACOs

An initial summary of application responses from 14 HPC-certified ACOs shows:

Half of ACOs report that at least 50% of participating primary care practices are approaching or have achieved full **BH integration**

43% of ACOs reported that 10% or more of provider compensation is **performance-based**

79% of ACOs have at least one **hospital** as an ACO Participant

Strategies for reducing **low-value care** are most common with respect to imaging services (13 ACOs) and inappropriate prescribing (12 ACOs)

Risk contracts across the 14 HPC-Certified ACOs:

- **69 commercial**
- **13 Medicare ACO**
- **15 MassHealth ACO**

Approximately **2.8 million MA patients** are served under commercial, Medicare ACO, or MassHealth ACO risk contracts*

82% of risk contracts, representing 91% of covered lives, have **downside risk**

7 of 14 ACOs hold **at least one commercial PPO risk contract**

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* Figures do not include the three HPC-certified ACOs up for re-certification in 2020.

Data Available for Further Analysis and Potential L+D Opportunities

For Public Reporting

- Lists of **ACO Participants**
- **Names of payers** with whom ACOs have risk contracts, **years** that risk contracts began and end, **number of attributed patients** per risk contract, and whether each risk contract **contains downside risk**
- **Organizational charts** of ACO governance structures
- Descriptions of **patient and family** advisory committees
- **Publicly available narratives** on ways the governance structure(s) seeks to be responsive to the needs of its patient population

For Public Reporting with Consent, or in Aggregate

- Risk contract **product types**, number of years **risk experience** with payer, **maximum amounts** of risk, **payment methodologies**
- Descriptions of **population health management** programs
- Methodologies for distributing **shared savings and losses**
- Approach to using **performance-based compensation** models
- Strategies for addressing areas of **low-value care**
- Strategies for advanced **primary care** and **BH integration**

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Related Investments in Care for Substance Exposed Newborns

During pregnancy (prenatal care)

Post-delivery and during inpatient care

Post-discharge to six months post-partum

Beyond six months post-discharge

HPC Pilot Program:
4 Awards, 1 year
$1,000,000

Baystate Medical Center, UMass Memorial, BMC, Lawrence General

SAMHSA-Funded DPH Moms Do Care Program:
2 Awards, 3 years
$3,000,000

Cape Cod, UMass Memorial

Cape Cod, UMass Memorial

HPC Moms Do Care Initiatives:
2 Awards, 2 years
$2,000,000

Beverly Hospital, Lowell General Hospital

HPC Substance Exposed Newborns Investment Program

TBD

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Purpose of Next Investment

Extend impact of previous investments to:

Post-discharge to six months post-partum

Beyond six months post-discharge

Support **Massachusetts providers** in implementing models of care and services that better address **medical, behavioral, and social needs** of **substance exposed newborns and their families** beyond the hospital, after discharge, and into outpatient follow-up care

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Stakeholder Engagement to Date

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
The Massachusetts Chapter

Themes from Discussions with Stakeholders

Opportunities and potential value

- While many successful investments have focused on inpatient and immediate post-partum care, it would be valuable to have **investments target six months post partum and beyond**[1]
- Innovative, integrated care models coordinate children's care with their parents' and are already demonstrating potential to **improve continuity** from inpatient to post-discharge care
- **Partnership and coordination** with **early intervention providers, social service agencies, and other local institutions** through referrals and transitions are essential
- Investment in targeted care models may help facilitate additional **study of substance exposed newborns and their outcomes**, which has been limited

Clinical and operational considerations

- There has been insufficient academic study of substance exposed newborns, so **no standard of care or clinical protocol exists specifically for this population**
- Mothers' experiences of **stigma** and fear of separation from their children complicate care.
- A few promising local models have been funded by donations, small grants, or funds reserved from system margins– a challenging prospect for **sustainability** in settings with fewer resources
- **Workforce shortages** concern local providers
- It is important to clearly define a **target population** (e.g., SEN, NAS, opioid exposure)

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[1]Recent, local research has identified increased risk of overdose and reduced service provision after six months post-partum.
Schiff DM, Nielsen T, Terplan M, Hood M, Bernson D, Diop H, Bharel M, Wilens TE, LaRochelle M, Walley AY, Land T. Fatal and nonfatal overdose among pregnant and postpartum women in Massachusetts. Obstetrics & Gynecology. 2018 Aug 1;132(2):466-74.

Local AMC-based, Integrated Models

SOFAR (BMC)		HOPE Clinic (MGH)
	Patient populations 	
Pediatric-focused model that also cares for women in recovery post-partum		**Maternal-focused** model that cares for pregnant women, women up to two years post-partum, and their infants
	*Services for mothers** 	
Care coordination, linkage to outside resources and **social services**, **peer support**, same-day contraceptive access		**Prenatal and primary care**, family planning and contraception, breastfeeding support, access to **MAT, psychiatry**, **counseling**, **social services**, parenting education, **peer support**
	Services for infants 	
Primary care, pediatric infectious disease care, developmental assessment, **linkage to EI**, social work support		NAS monitoring, **primary care** and access to pediatric specialists, **EI referral**

*Both programs also offer services to other family members, including partners, when possible.

Design Elements and Principles for Investment Program

Support providers creating or expanding integrated models of care

Fund coordinated programs involving primary care, OB/GYN, hospital-based programs, early intervention providers, and other services for both mothers and children.

Foster sustainable clinical and community partnerships to improve care for substance exposed newborns and their families

Bolster continuum from inpatient care to post-discharge care. Augment formal and informal resources and partnerships between health care and other types of organizations. Coordinate appropriate responses with social service agencies and organizations.

Acknowledge and respect unique features of the population

Address stigma as a persistent barrier to care for mothers of substance exposed newborns. Consider the needs of two patients at a time and streamline their care as much as possible.

Align with other efforts

Sustain successful elements of investments from HPC and DPH. Build upon existing partnerships and infrastructure, including data collection and measurement.

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Proposal Overview

Investment Program

- **Competitive grant opportunity** for Massachusetts providers, including:
  - CHART-eligible hospitals (with some funds earmarked especially for them)
  - Non-CHART-eligible hospitals
  - ACOs
  - Primary care providers
  - Behavioral health providers
- **Funds will be used to** develop an **integrated, team-based care model**
- Additionally, **funds can be used to collect and analyze data** to add to the evidence on long-term outcomes for SEN

TA and Evaluation

- HPC plans to **contract with an expert organization** to:
  - Convene the investment program awardees to facilitate shared learning
  - Evaluate the investment program overall

Potential Components of Proposed Models

Building capacity to support recovering parents in pediatric settings

Overcoming patients' logistical barriers to care (e.g., transportation)

Tracking and following patients post-discharge

Promoting partnerships to improve integration of medical, behavioral, and social services

Offering home-based services including social work, medical care, and peer support

Implementing validated screening instruments or developmental assessments

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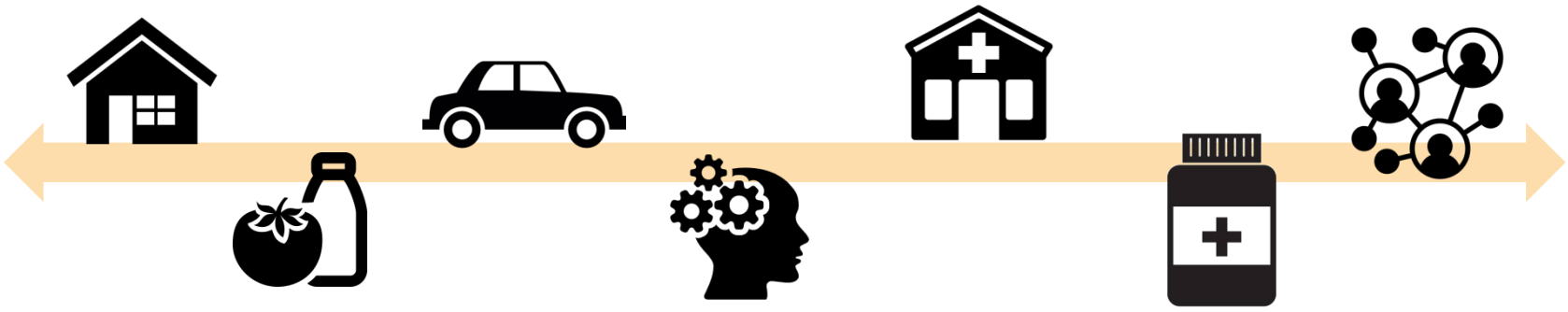
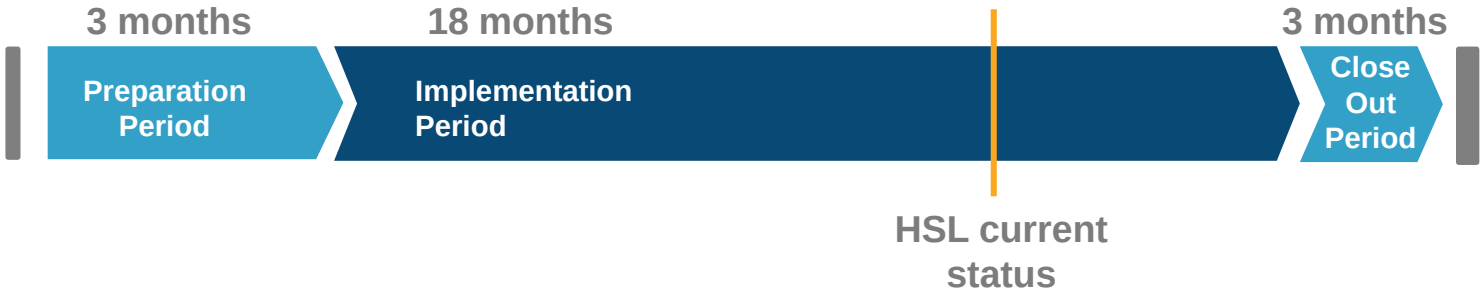
SHIFT-Care Investment Program

A $10 million opportunity to address the whole-person needs of patients and reduce avoidable acute care use through innovative care models.

15 awards, with a focus on:

Health-related social needs ♦ Timely access to BH ♦ Evidence-based OUD care





HPC

R3: *Right Care, Right Place, Right Time*

Effectively Integrating Senior Care and Housing

HSL's R3^2 Initiative

Brief Overview & Update for The Health Policy Commission

January 14th, 2020

The Power to Redefine Aging.

Hebrew SeniorLife | HARVARD MEDICAL SCHOOL AFFILIATE

Hebrew SeniorLife
Our DNA: One Commitment – Redefine the Experience of Aging

Reimagine
Senior Living

Continuing Care Communities
- NewBridge on the Charles
- Orchard Cove

Supportive Housing Sites
- Center Communities of Brookline
- Jack Satter House
- Simon C. Fireman Community

Redefine Senior
Health Care

Home & Community Based
- Home Care
- Geriatric Primary Care
- Outpatient Care
- Hospice

Facility Based
- Medical Acute Care
- Rehabilitative Care
- Long-term Care

Rediscover Every Senior's
Potential Through Research

- Aging Brain Center
- Syncope & Falls
- Translational Research
- Center for Musculoskeletal Research
- Genetics & Geriomics
- Quality of Care/Standards

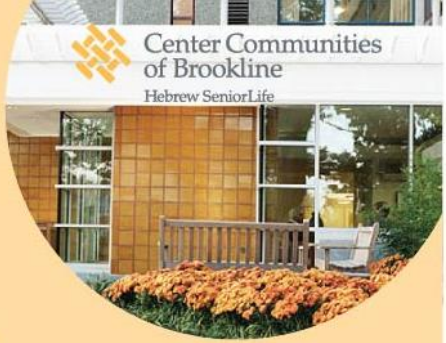
… and Teaching

- Medical Students
- Residents & Fellows
- Nursing &Therapies
- Interns

Recognize the Power of Partnerships

Reach out for Philanthropic Support

Supportive Housing
"A Day in The Life"



8:30PM: Receives call from daughter asking how her day was and wishing her goodnight

8:00AM: Resident starts her morning with a Tai Chi Class

6:45PM: Listens to local symphony orchestra's live performance of Shahrazad

9:15AM: Meets with Wellness Coach: Discusses goal to attend and dance at granddaughter's wedding in 6 months

4:00PM: Learns from local high school students how to connect with family on Skype

10:00AM: Has Well-Check with Nurse Practitioner who eliminates medication due to improved health

3:30PM: Enjoys visit with Depression Care Manager who supports her increased community involvement

10:45AM: Amends File of Life with updated family contact

2:30PM: Social Worker updates daughter on mom's improved sense of well-being

11:00AM: Is greeted by Front Desk Receptionist who asks about her grandson's graduation

2:00PM: Meets with Chaplain to continue conversation on finding meaning in her life experiences

11:15AM: Is asked by Facilities Technician how she likes her new tub cut

1:30PM: Works with Physical Therapist on balance in the Fitness Center

11:45AM: Is reminded to take her medications before lunch

12:00PM: Enjoys a nutritious meal with other residents

The Opportunity & The Challenge: A Housing and Healthcare Disconnect

Opportunity

Effectively Deliver on Better Care, Better Outcomes, and Lower Cost

- ❑ Population health approach to caring for frail seniors living in a **congregate setting**
- ❑ Low cost, service enriched environment with **eyes on** approach by staff in all departments
- ❑ One **place-based team** with intimate knowledge and strong relationships with residents serving as the link to providers and plans
- ❑ **Pooled resources** by payers to efficiently deploy resources for preventative services

Challenge

Fragmentation:

- ❑ Multiple payers **without critical mass** in each building
- ❑ Separate care managers for each plan, language, and frailty level – **inefficient and infrequent visits**

Systemic Issues:

- ❑ No system for **communication** between housing staff and health plans/providers
- ❑ **Eligibility gaps** for services needed to remain in independent setting
- ❑ **Lack of evidence** supporting outcomes

R3 Vision: A replicable, scalable, and sustainable model of housing with supportive services,

Enabling seniors to live independently as long as possible, receiving the right care in the right place at the right time

Reducing healthcare cost and long term care costs

POOLED FUNDS

Pooled funds cover cost of wellness teams

- Insurers
- Housing Providers
- State & Federal agencies
- ACOs
- PMPM, shared cost, or convener model

ENHANCED SUPPORTIVE HOUSING WITH SERVICES

- Eyes on
- Emergency Response
- Care Coordination
- Community Services
- Assessment
- Wellness Programming
- Mental Health
- Nutrition

BETTER OUTCOMES

- Decreased hospitalizations
- Decreased Emergency Room visits
- Decreased Long Term Care Placements
- Decreased Falls
- Increased Medication Adherence
- Increased Self Care
- Increased use of Home and Community Based Services

SAVINGS

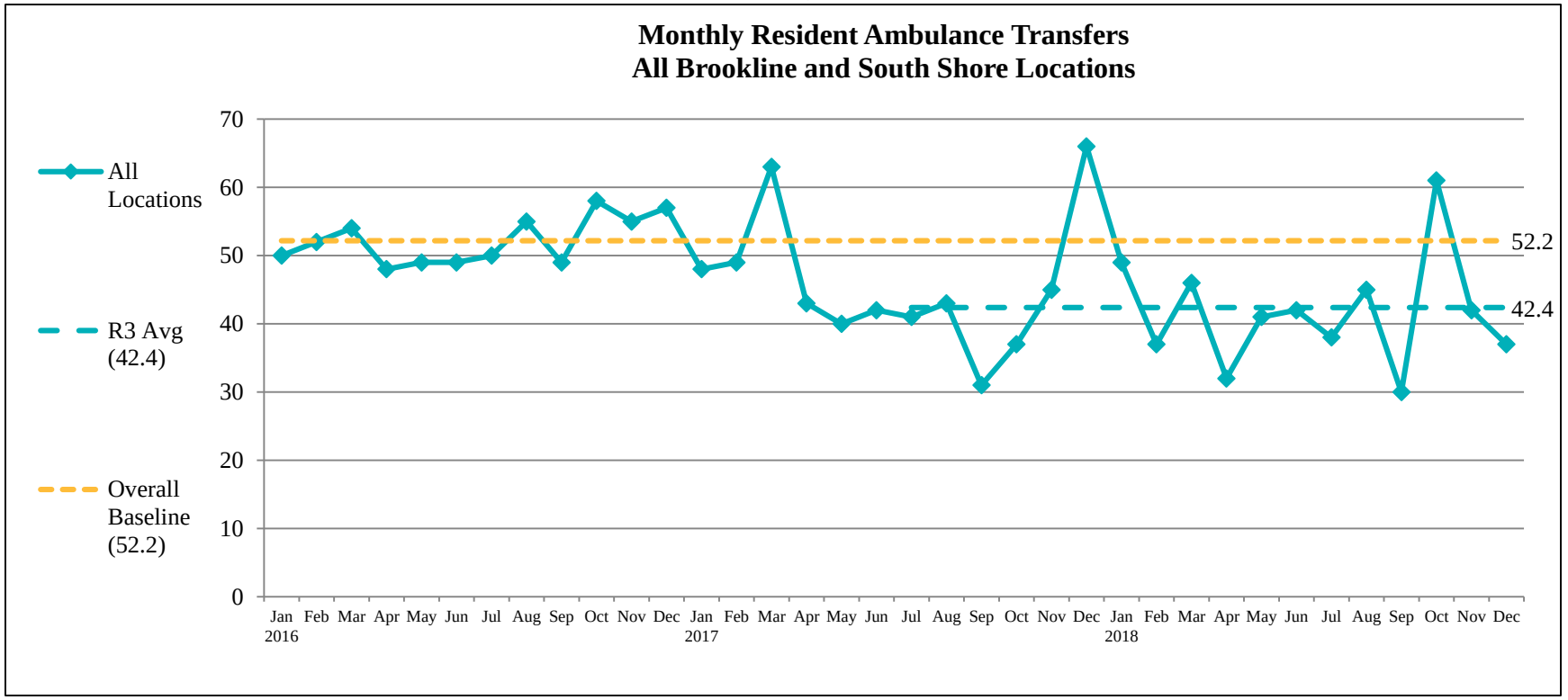
Place based services result in savings to healthcare system

Hebrew SeniorLife | HARVARD MEDICAL SCHOOL AFFILIATE

Total Funding, Scope, and Evaluation of R3 & R3²

Combined Funding Sources of $2M	• Health Policy Commission • MassHousing • DHCD • Enterprise • Beacon Communities • Beacon Communities • WinnCompanies • Milton Residences • Coverys • Boston Scientific
7 Sites 1,100 Residents 400 Enrollees	Brookline Region: HSL: Danesh, Cohen, and Goldman Residences Winn: The Village at Brookline South Shore Region: HSL: Fireman Community MRE: Unquity House and Winter Valley
Evaluation / Research	LeadingAge LTSS Center at UMass Boston •Qualitative & Quantitative •Pre/Post & Comparison Group Analysis
Shift from R3 to R3²	Focus on key risk areas / lessons learned from R3 Strengthen partnerships Trial payment model; use results from R3 to make the case

Baseline and Intervention Results – R3
Resident Trips to Hospital via Ambulance



Baseline Annual Total:	**597 transfers**
Annualized Total R3 to date :	**486 transfers**
Difference:	**18.6% reduction**

% Difference by Site

Danesh	**(18%)**	**MRE Unquity**	**(4%)**
Cohen	**27%**	**MRE W.Val**	**(24%)**
Goldman	**(34%)**	**Fireman**	**(7%)**
Winn TVAB	**(36%)**		

Note: Results above include trips for all residents living in intervention buildings, not specifically those enrolled in R3

Qualitative Impact – Resident Quotes from Focus Groups

"Well, what they add is emotional support if you want to know the truth, that you do not get from your doctor and you can't get from your family because they're not always around."

"I like the program very much. [Wellness Nurse] helped me organize my medications. She made a chart for me and I've got it hanging on my wall so I make sure I know what I'm taking."

"I have the sense that almost any physical or medical problem, I've got somebody to talk to. And the fact of being checked in with regularly does feel good."

"I can't begin to tell you what they did for him *[husband when he came back from the hospital].* They moved heaven and earth. I had an army of people in and out of that apartment taking care of him."

"I think the reason you're hearing such a love fest here is that we really are happy with something we didn't have before and now we have it and it's working."

Key Components of R3 and R3² Model

Resident Engagement

- 400+ residents enrolled across 7 sites in two regions
- Baseline & follow up assessments completed with Vitalize 360 tool
- 250 control site members with assessments
- Monthly member newsletter

Partnerships

- Emergency responders: data, training
- Housing: open door, recruiting, eyes on, communication
- AAAs: care managers, evidence based programs
- Health plans: care teams, sustainability
- Mental health: referrals, awareness

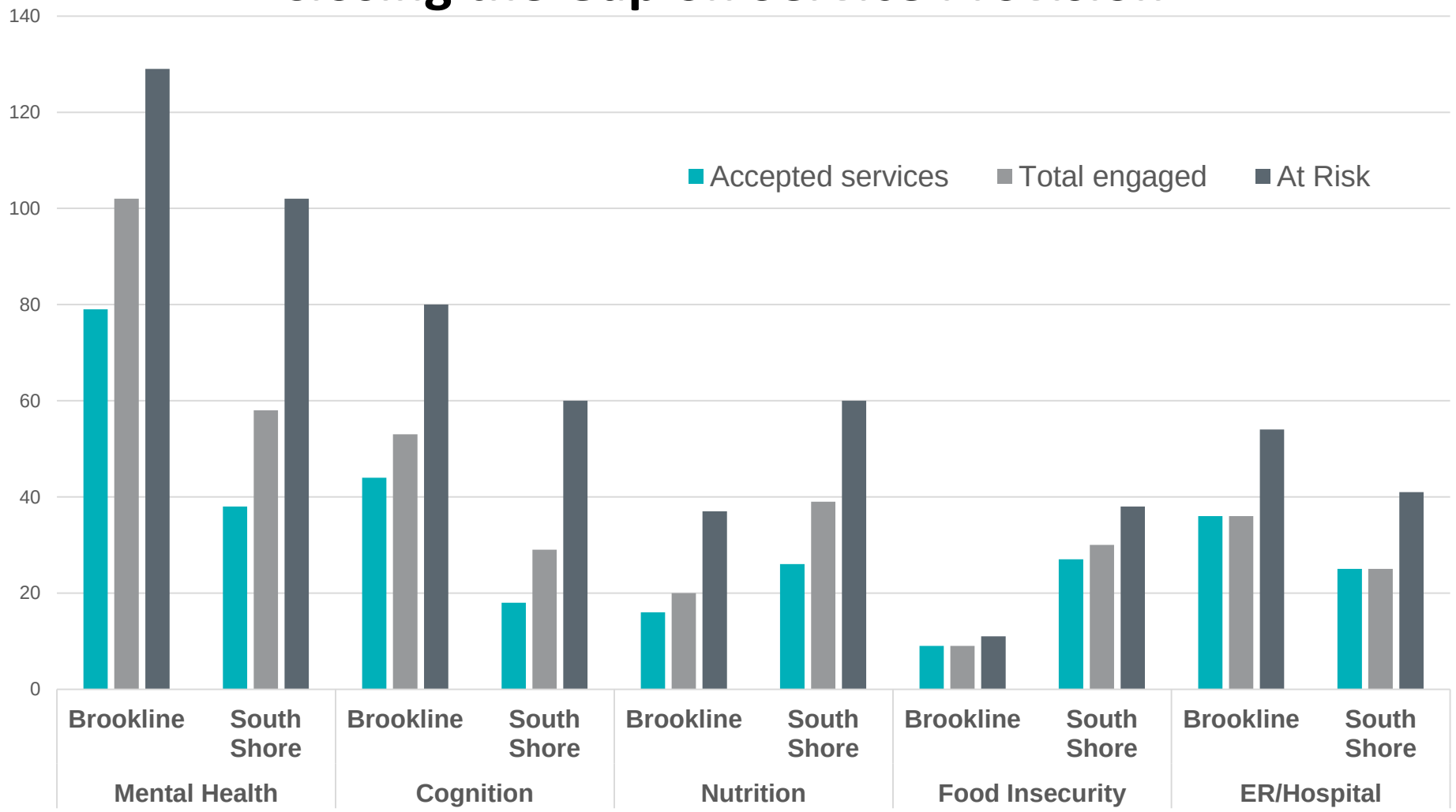
Interventions

- What matters most – assessments, risk groups
- Assessments, med support, provider connection
- Monthly check in calls/data gathering
- Wellness programs (brain health, falls prevention, chronic disease mgmt.)
- Care manager collaboration and referral
- Transitions management
- Closing the gap (needs & supports)

R3² – New Components

Item	Measure	Description
Mental health	# actively engaged in supports / # identified as in need of mh support	Utilize assessment data, call logs, and team input to determine need. Partner with local providers for support
Memory support	# with memory care support in place / # identified with cog decline	Utilize SPMSQ and mini cog to establish risk group. Connect with supports
Food Insecurity / Nutrition	# connected to food source or nutritionist / # at risk for food insecurity or nutrition	Determine those at risk for lack of food (financial, access) or nutrition (weight loss, chronic cond). Connect to resources
Personal care	n/a	Provide additional onsite personal care for check-ins, 15 min care increments, and off peak coverage.
Transportation	n/a	Ensure transp needs met through connections to resources, education on options, and funding some rides
Financing model	n/a	Engage health plans, ACOs, hospitals, housing providers in trial of pooled payment model

Key Risk Areas – R3²
Closing the Gap on Service Provision



Sustainability & Replicability

Multiple Work Streams in Progress During R3²

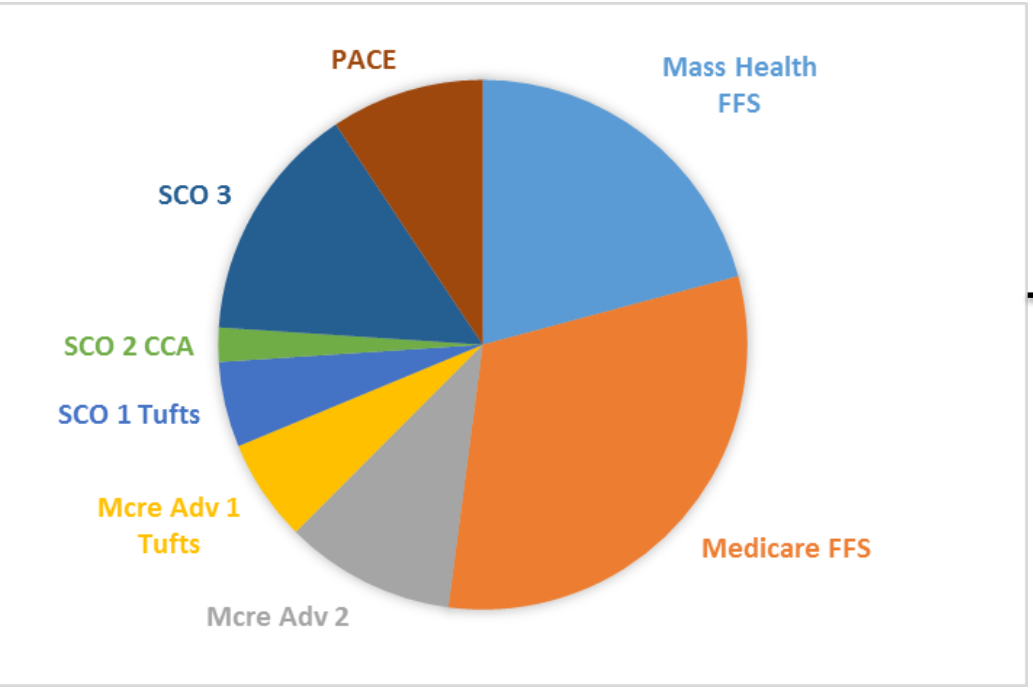
1) **Financial modeling / payment trial**
   - Pooled funding
   - Collaborative approach to public good investments
   - Convener model (central org: training, data, risk)
   - Potential for social impact bonds to be incorporated into one of the models

2) **Replicability guide**
   - Creation of toolkit for others to utilize

3) **Advocacy & Infrastructure (EOEA/MH/ASAPs/SCOs)**
   - Payment approach design never contemplated housing as a platform concept

Sustainable Funding Model
Pooled Funding Approach

Multiple Payers



- ✓ Results to share with health plans from R3
- ✓ Partnerships created with key payers
- ✓ Payment trial in progress with Tufts and CCA
- ✓ Success with inclusion of services in HUD contract rents

- ○ Challenging to get critical mass
- ○ Not all payers on board
- ○ Most of population in fee for service (working on vehicles to capture $)
- ○ No systematic payment methodology supporting efficient, place-based services that impact health care

Pooled Funding Approach
Payment Model Trial with Tufts and CCA

Total Potential
$580 pmpy *
1,100 lives =
$638,000

Current Trial $$
$580*110 =
$63,800

Key Components of R3² Trial

- Health plans **invest** $580 per member per year
  (for covered lives in buildings)
  (current cost covers team + eval + program costs)
- **Outcomes** measures / goals established
  (flu shots, hc proxies, falls prevention, satisfaction, ED trips)
- **Shared risk** component
  (10% of payment at risk if goals not achieved)
- Collaboration on **care model**
  (enhanced communication, shared tools/resources, streamlining)
- Commitment to design **future financing model**
  (quarterly meetings to test, modify, and plan)

Challenges & Next Steps in R3²

- Complete full R3 evaluation (in progress) and share results
- Continue Phase II interventions through June 2020
- Secure additional health plans in payment trial and explore other models
- Work with partners on policy and infrastructure that supports sustainability
- Create replication guide for other housing sites/orgs to follow. Establish continuation plans.

Appendix

Additional Reference Information
Hebrew SeniorLife & R3

Hebrew SeniorLife – At A Glance

- 116 year old organization
- 2,600 employees serving 3,500+ seniors across 8 campuses and communities, and in-homes
  - 1,500 units of senior living (independent and assisted)
  - 775 beds of long term chronic care, sub-acute, and rehab care
- $240+ million in annual revenue
- 5th largest nonprofit in Massachusetts (per BBJ)
- Medical staff with 40 physicians and nurse practitioners
- Affiliated with Harvard Medical School
  - Largest aging research institute in a clinical care setting
  - 700+ clinical professionals trained annually
- Boston Globe Top Employer

The Power to Redefine Aging.

Hebrew SeniorLife | HARVARD MEDICAL SCHOOL AFFILIATE

Center Communities of Brookline
Brookline, MA

Jack Satter House
Revere, MA

Orchard Cove
Canton, MA

Simon C. Fireman Community
Randolph, MA

Hebrew Rehabilitation Center
Roslindale, MA

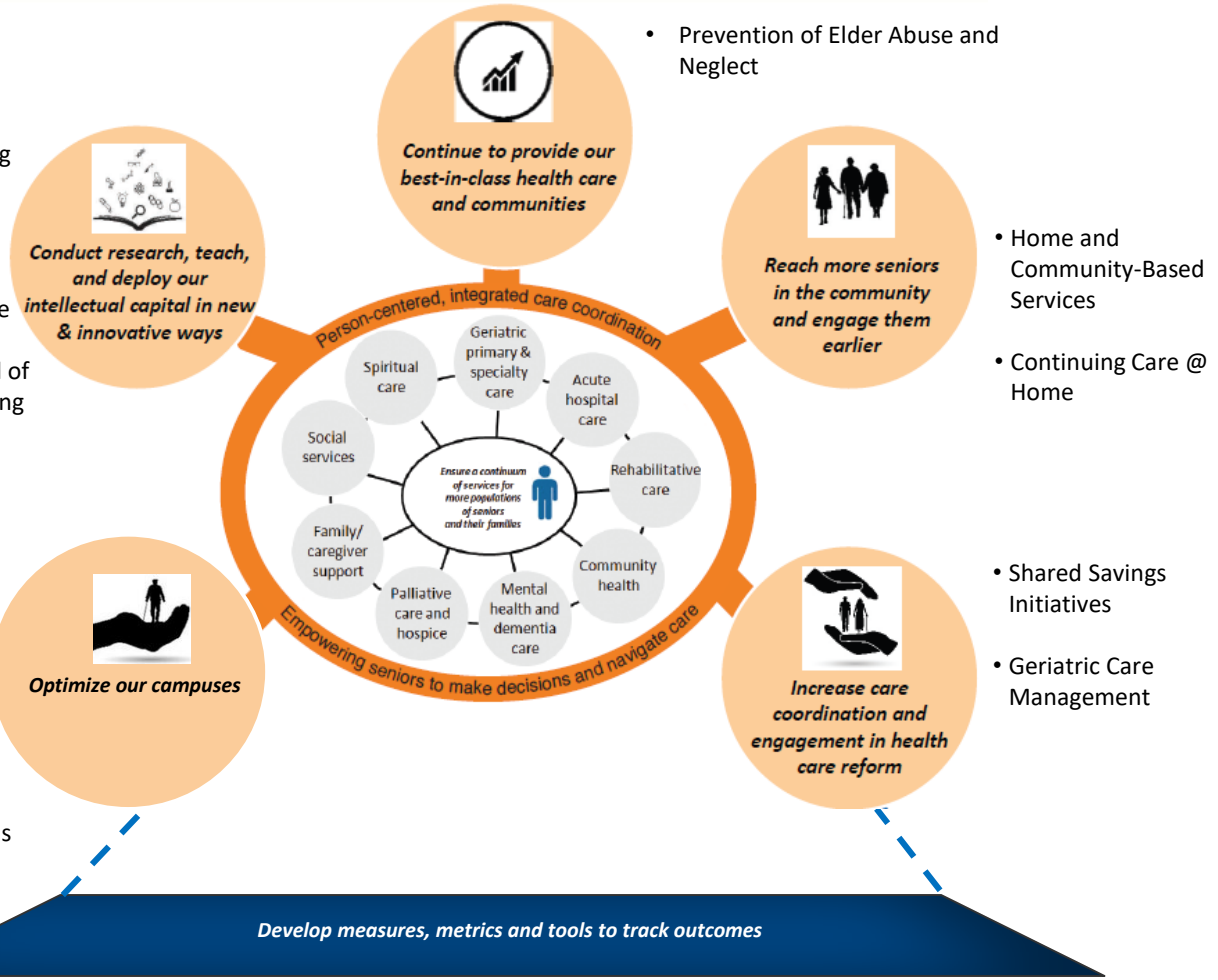
HSL COMMUNITIES

NewBridge on the Charles
Dedham, MA

HSL's approach allows us to proactively reach more populations of seniors

- Center for Memory Health
- Prevention of Elder Abuse and Neglect

- Institute for Aging Research
- ReAge Solutions
- Teaching Institute
- Replicable model of Affordable Housing with Supportive Services



- Home and Community-Based Services
- Continuing Care @ Home

- Shared Savings Initiatives
- Geriatric Care Management

- Brookline Master Planning
- Roslindale Campus

R3: Right Care, Right Place, Right Time

Effectively Integrating Senior Care and Housing

Our vision is to create a replicable, scalable, and sustainable model of housing with supportive services to enable seniors to live independently as long as possible, receiving the right care in the right place at the right time, while reducing healthcare cost and long term care costs for this growing population.

Goals	Create a platform for housing and healthcare collaboration & measure effectiveness
Wellness Teams	Wellness Coordinator and Wellness Nurse
Partners	Payers, hospitals, ASAPs, emergency service providers, mental health, housing
Timing	R3: July 2017 – Dec 2018 $R3^2$: Jan 2019 – June 2020

Aims and Key Performance Indicators for R3 & R3²

	Health	Personal satisfaction	Cost Effective-ness
Aims	Increase utilization of wellness programs by 20% Increase linkages to mental health services by 20%	Improve quality of life and ability to live independently by 10%	Reduce transfers to hospitals, emergency rooms, and long term care by 20% for target population Reduce re-hospitalizations by 20% Create sustainable funding model
Key Performance Indicators	• Falls / balance • Wellness checks • Medication adherence support • Mental health and cognition • Nutrition and food security	• Wellness program attendance • Health education • Self management/care • Satisfaction with life and independence	• Transfers to long term care • Transports to hospitals and emergency rooms • Hospital readmissions within 30 days of discharge • Payment model trial with insurers

LTSS Center @ UMass Boston
Preliminary Report Out on Pre/Post Ambulance Data (15 mo baseline vs 18 mo intvn)
Site Type Analysis

Table 1: Ambulance Transfers Pre- and Post-Intervention:
Service-Enriched versus Sites with Some Services (per 100 residents)

	Monthly Transfers, Pre-Intervention	Monthly Transfers, Post-Intervention	Difference	Percent Change	P-value
Service-Enriched Sites	4.4	3.7	0.7	-14.8	0.0074
Other Sites	4.6	3.5	1.1	-23.7	0.0009
All Sites	4.5	3.7	0.8	-18.2	0.0001

Notes: Service-Enriched Sites include Danesh, Cohen, Goldman, and SCFC. Other Sites include Winter Valley, Unquity House, and TVAB.

LTSS Center @ UMass Boston
Preliminary Report Out on QIO Medicare Claims Data Analysis

Data provided by HealthCentric Advisors

- The New England Quality Improvement Organization (QIO), which holds utilization data on participants in traditional Medicare
- Quarterly service utilization data obtained over 36 month period
  18 months pre-R3 implementation and 18 months implementation
- Aggregate building-wide data for all residents (no individual data)
- Three sets of comparison sites (with data on more than 10,000 residents)
  R3 comparison sites, sites with service coord, sites without service coord

Key Findings

- When controlling for age, the rate of increase in **inpatient hospitalizations** in the intervention buildings was **19% lower** than for control sites
- When controlling for age, the change in **ED admissions was lower** in intervention sites than in control sites

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from October 2, 2019 Meeting
- Investment Program: MassUP Funding Opportunity Update
- ACO Certification: 2019 Application Results
- Substance Exposed Newborns Investment Program: Stakeholder Engagement and Initial Design Parameters
- Awardee Presentation: Hebrew SeniorLife
- **Schedule of Next Meeting (May 6, 2020)**

Upcoming 2020 Meetings and Contact Information

Board Meetings

Wednesday, February 5 (+ANF)

Wednesday, March 11 – Benchmark Hearing (Massachusetts State House, Gardner Auditorium - TBD)

Wednesday, April 1

Wednesday, June 10

Wednesday, July 22 (+ANF)

Tuesday, September 15

Wednesday, December 16

Special Events

Advisory Council

Wednesday, February 26

Wednesday, June 24 (+ANF)

Wednesday, September 2

2020 Cost Trends Hearing

Day 1: Tuesday, October 20

Day 2: Wednesday, October 21

Committee Meetings

Tuesday, January 14

Wednesday, May 6

Wednesday, September 30

Wednesday, November 18

Contact Us

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