MINUTES OF THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE

Meeting of September 16, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, September 16, 2015, 9:30AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery and Payment System Transformation (CDPST) Committee held a meeting on Wednesday, September 16, 2015, at 50 Milk St, 8th Floor, Boston, MA.

Members present were Dr. Carole Allen (Chair), Dr. David Cutler, Mr. Martin Cohen, and Undersecretary Alice Moore, designee for Ms. Marylou Sudders, Secretary of Health and Human Services.

Dr. Allen called the meeting to order at 9:31 AM.

ITEM 1: Approval of minutes

Dr. Allen noted that the last CDPST meeting was jointly held with the Quality Improvement and Patient Protection (QIPP) Committee. She stated that each committee will approve the minutes separately.

Dr. Allen asked for any changes to the minutes from July 8, 2015. The committee members noted two minor typographical corrections. Dr. Allen asked for a motion. **Dr. Cutler** made the motion to approve the minutes, as amended. **Mr. Cohen** seconded the motion. The members present unanimously approved the minutes.

ITEM 2: Discussion of HPC Patient-Centered Medical Home (PCMH) Certification Program

Dr. Allen provided a brief overview of work to date on the HPC's PCMH Certification Program. She offered from prepared remarks, which she first delivered in April 2013:

> The Pediatric Medical Home concept originated in 1967 from the American Academy of Pediatrics. It was used to describe the primary care physician's role in managing care for Children and Youth with Special Health Care Needs. More recently the description has been updated to delivery of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, community based, compassionate and culturally-effective.
>
> The medical home concept is no longer limited to pediatrics. A consensus statement endorsed in February 2007 by the AAP, ACP, AAFP and AOA

> stipulated the principles characteristic of a medical home: a personal physician, leading a team who collectively take responsibility for ongoing care of patients, using a "whole person orientation," coordinate and/or integrate care across all elements of the complex health care system. Care is facilitated by registries, information technology, and/or health information exchange and is culturally and linguistically appropriate. In pursuit of quality and safety, medical homes advocate for patients and practice evidence-based medicine, using clinical decision-support tools. The patient/ family is actively participating in decision-making, and feedback is utilized to be sure that patient expectations are being met. Information technology is used to support optimal patient care, performance measurement, patient education and enhanced communication. Enhanced access to care includes multiple modalities of communication. Payment should appropriately recognize the added value of the medical home to patients and should reward care management work (including funding case managers, care managers, and health coaches) and coordination of care. It should support use of health information technology for quality improvement and enhanced communication. It must recognize case mix differences in patient populations. Payment should reward physicians and care systems for cost effective care and for achieving measurable and continuous quality improvement.

Dr. Allen stated that the HPC charged CDPST with developing procedures to certify PCMHs as well as Accountable Care Organizations (ACO) and alternative payment methodologies (APMs). She noted that patients with complex care requirements and patients with behavioral health conditions have been identified as major cost drivers in the system. It is these patients, she stated, who most require the coordinated care offered by PCMHs and ACOs. Dr. Allen explained that a major barrier to reducing costs is the fee-for-service payment model, which pays for "episode care" not "whole person care."

Ms. Katie Shea Barrett, Policy Director for Accountable Care, introduced the HPC's work on the certification process for PCMHs. She stated that currently 19% of the Commonwealth's primary care providers and 9% of its practices are accredited as PCMHs under National Committee for Quality Assurance (NCQA) metrics.

Dr. Allen asked whether there was data on the percent of the population covered by a PCMH. Executive Director David Seltz responded that the HPC is working with NCQA to obtain better data and ascertain this number.

Mr. Cohen asked for a breakdown of PCMH certified practices by type. Ms. Barrett replied that staff could return to the committee with that information. She noted that the majority of PCMH certified practices are community health centers.

Ms. Barrett stated that the Boston area has the highest rate of PCMHs in the Commonwealth. She noted that western Massachusetts and the North Shore also had relatively high levels while the South Shore was nearly devoid of accredited PCMHs. Of the

practices in the Commonwealth, Ms. Barrett reported that the vast majority have reached the highest level of NCQA certification.

Dr. Allen noted the importance of these numbers as they help inform where the Commonwealth needs to focus its resources on expanding certification.

Dr. Allen provided an update on the progress of the HPC's PCMH accreditation program. She noted that the HPC is trying to add value to the market while also being consistent between the ACO and PCMH certification programs. Dr. Allen noted that the HPC's initial certification program design was to include NCQA certification plus the achievement of certain standards in four key areas: behavioral health integration, resource stewardship, patient satisfaction, and population health management.

Dr. Cutler stated that the committee must discuss how to integrate the PCMH certification process with payment reform efforts. He noted that having the standards with no financial benefit would most likely not succeed.

Mr. Seltz emphasized the positive role that stakeholders have played in the care delivery and payment transformation process over the past two years of the committee's work. As the HPC continues to work on the issues of care delivery and payment transformation, Mr. Seltz affirmed that it will continue to work with payers to ensure there is money for the models that are being created, and to work with providers to ensure that they are able to execute the models without adding to their administrative burden.

Dr. Allen agreed that the development of the PCMH certification program should be an iterative process. She echoed Mr. Seltz's comments regarding the positive role that stakeholders have played.

Ms. Barrett noted that the PCMH program is not just a certification program, but one that offers technical investment along with data and benchmarking assistance.

Ms. Barrett discussed the PCMH program design construct, or PCMH PRIME. The HPC is proposing that practices would enter into the HPC certification process as a NCQA Level II or Level III PCMH. This would place practices on the pathway to PRIME. To achieve PRIME status, practices would also need to meet certain behavioral health integration criteria specified by HPC.

Ms. Barrett noted that the HPC will offer technical assistance to support practices in making the changes needed to achieve behavioral health integration and PRIME status. These could include continuing education modules, training on the administration of diagnostic tools, and a resource directory. She stated that this direct technical assistance is a key part of the value proposition to practices to become PCMH PRIME accredited – if they participate in the program and share data with the HPC, then they will have access to this technical support.

Mr. Seltz asked the committee for its input regarding the timeline for certification. He noted that the HPC is seeking input on the appropriate duration of technical assistance for practices on the pathway to PRIME before they would be expected to achieve PRIME certification.

Dr. Cutler responded that the timeline should be integrated with the MassHealth strategic design and ACO certification process. He added that a timeline for PRIME is difficult to pin down at this point.

Mr. Seltz proposed that a reasonable timeframe for practices on the pathway to PRIME might be between 18 and 24 months. While this might not be perfectly overlapping with MassHealth, it should provide some foundation for the two processes to be done concurrently.

Mr. Cohen endorsed that proposed timeline and also supported the technical and financial assistance being offered to practices as a good incentive for the program.

Dr. Allen supported a shorter timeline but also acknowledged that it could prove overly burdensome to practices to have to submit to multiple processes with different timelines and end dates. She stated that it is premature to set the exact timeline at this point.

Ms. Moore stated that she has seen a great deal of transformation in the health care system. She noted the HPC's role with the MassHealth to move the dialogue forward. She added that discordant certification timelines would place an added burden on stakeholders.

Mr. Seltz stated that the HPC is seeking information on how many Level II and Level III practices exist in the state and who they are. He stated that the HPC expects to begin engage with them to learn what they need to get them closer to PRIME.

Ms. Barrett discussed the results of a provider survey performed by the HPC regarding the agency's work in the behavioral health space. Providers were asked to assess certain proposed PRIME criteria and how hard it would be for them to achieve certification. Although many practices had not yet implemented the criteria, the survey showed that providers thought implementation would take a moderate to high degree of effort.

Mr. Seltz added that most of the HPC added behavioral health criteria are also part of the 2014 NCQA standards. Therefore, work practices complete for PRIME accreditation will help them with NCQA certification, as well.

Mr. Cohen commented that he appreciated the double points for the full behavioral health integration criterion. He cited a growing body of evidence from around the country to caution against assuming that co-location itself leads to integration.

Ms. Barrett provided an overview of the Medicaid Health Homes initiative, a federal program that aligns with states to establish coordinated care for Medicaid beneficiaries with

chronic conditions. She noted that the Commonwealth is contemplating applying for this opportunity.

Ms. Barrett presented an updated timeline for the HPC's PCMH program.

Dr. Allen called for a vote on endorsing the amended timeline and advancing the proposed framework to the board. **Dr. Cutler** seconded the motion. The endorsement was unanimously approved.

ITEM 3: Presentation from MassHealth on their Payment and Care Delivery Reform Efforts

Dr. Allen introduced Ms. Ipek Demirsoy, Director of Payment and Care Delivery Innovation at MassHealth. Ms. Demirsoy's presentation can be found on the HPC's web site.

ITEM 4: Discussion of HPC Accountable Care Organization (ACO) Certification Program

Ms. Barrett updated the committee on the HPC's ACO certification process. She noted that the certification process will provide valuable information on ACOs currently operating in the Commonwealth, including best practices.

Dr. Allen added that it is key to remember that whatever goes into making an ACO, the organization must ultimately be accountable and responsible for its patients care.

Ms. Barrett noted that an updated and more detailed timeline would be provided to the committee at the next meeting with a launch of the program tentatively slated for next spring.

ITEM 4: Schedule of Next Committee Meeting.

Seeing no questions, **Dr. Allen** adjourned the meeting at 10:53.