MINUTES OF THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE

Meeting of February 1, 2017

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, February 1, 2017, 9:30AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery and Payment System Transformation (CDPST) Committee held a meeting on Wednesday, February 1, 2017, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. Carole Allen (Chair), Mr. Marty Cohen, Dr. David Cutler, and Undersecretary Alice Moore (Designee for Secretary Marylou Sudders).

The presentation from the committee meeting can be found here.

Dr. Allen called the meeting to order at 9:38 AM and offered opening remarks.

ITEM 1: Approval of minutes

Dr. Allen asked for a motion to approve the minutes from the joint committee meeting on November 30, 2016. **Dr. Cutler** made the motion to approve the minutes. **Undersecretary Moore** seconded the motion. The members present voted unanimously to approve the minutes.

ITEM 2: PCMH PRIME Update

Dr. Allen turned the discussion over to Ms. Katherine Shea-Barrett, Policy Director for Accountable Care, and Ms. Catherine Harrison, Senior Manager for Accountable Care. Ms. Harrison provided an update on the PCMH PRIME Certification program. For more information, see slide 6.

ITEM 3: Accountable Care Organization (ACO) Certification Operational Update

Ms. Harrison provided an update on the development of the HPC's Accountable Care Organization (ACO) Certification program. For more information, see slides 8-15.

Dr. Allen asked for clarification on the new Department of Public Health (DPH) regulation governing the Determination of Need process as it relates to independent ambulatory surgical centers (ASCs) separate from hospital systems.

Mr. Sasha Hayes-Rusnov, Senior Manager for Market Performance, said that if new, free-standing ASCs desired to establish a new site they would need to be associated in some manner with an HPC-certified ACO.

Ms. Barrett said that, as a policy matter, the DPH regulation ensured that any new capacity in the system would be part of a coordinated, patient-centered system. She added that staff was thrilled to be working with DPH on this.

Dr. Allen clarified that these ASCs were not necessarily part of a hospital. Ms. Barrett confirmed that that was the case.

Dr. Allen asked for an estimate of ACO applications the HPC might receive. Ms. Harrison said that staff estimated the number would be in the range of 20 to 25 over the course of about a year. She added that it was likely that many would align with the October 1, 2017 deadline for MassHealth ACOs to submit their material to the HPC.

Dr. Cutler commented on the overlap between commercial ACOs and MassHealth ACOs. He asked whether it made sense to have separate sets of criteria for these two groups.

Ms. Harrison said that a fundamental principle used in crafting the criteria was that the HPC certification would be payer-blind. She added that the care delivery standards that the agency hoped to set were broadly applicable across patient populations. She said that these criteria included having a patient representative within the governing system, having a structure for the governing system to examine quality, and having population health programs. Ms. Harrison noted that MassHealth had criteria specific only to MassHealth ACOs that would supplement the HPC's certification program.

Ms. Barrett added that the HPC's standards are very much based on the governance model of the ACO, rather than based on quality measures. She said that, as the program evolves to more of performance-based system, we expect this to change.

Undersecretary Moore said that there was an ongoing discussion amongst agencies, including the HPC and MassHealth, with regards to quality performance measures. She said that more would come on this topic as those discussions progressed.

Dr. Allen said that she believed that those were very important conversations to have.

Dr. Allen asked about the process surrounding a merger or acquisition involving an ACO. Ms. Barrett responded that the material change notice (MCN) process was distinct from the ACO process. She said that ACO certification is generally expected to occur every two years, and would not generally be re-triggered by a merger or acquisition..

Referencing the organization table on slide 14, Mr. Cohen asked about the requirements for patient representatives. Ms. Barrett responded that HPC standards require inclusion of a patient representative within the governance structure of each Component ACO. She said that this could mean an entity that had three separate governance structure for three

Component ACOs with separate risk contracts would be expected to have a patient representative within each governance structure.

Dr. Cutler asked whether the HPC had received any feedback on the governance structure requirements. Ms. Harrison responded that, in conversations to this point, this organizational structure had made sense to the ACOs. She said that some ACOs, particularly on the commercial side, might be required to do certain things differently.

Given that ACOs are risk-bearing organizations, Mr. Cohen asked for clarification on the role of the Division of Insurance (DOI). Ms. Harrison said that a prerequisite for ACO certification is that the given organization is appropriately certified by DOI.

Ms. Barrett said that on the MassHealth side, many organizations were creating separate legal entities. She said that both the separate entity and the original organization would have to be properly certified by DOI.

Mr. Cohen asked whether the definition of the "Applicant" for certification had been built into the platform. Ms. Barrett responded that this is captured in the application requirements document, with additional details provided in the platform for specific criteria. She added that this was the most difficult part of the program and that it also had implications for DPH regulations. She said that staff was working with other agencies throughout the process.

Dr. Allen asked whether, in addition to the names of the payers with which ACOs have quality-based risk contracts, the relative proportions paid by these payers would also be public. Ms. Barrett responded that this would be addressed in the Registration of Provider Organizations (RPO) presentation later in the meeting.

Ms. Barrett asked whether there were additional questions before moving on. None were heard.

ITEM 4: Discussion of ACO Technical Assistance Strategy

Ms. Barrett led a discussion of the ACO technical assistance (TA) strategy. For more information, see slides 17-19.

Mr. Cohen said that a lot of work has to be done around the integration of care. He noted that there might be an opportunity to extend that conversation through the TA process.

Dr. Allen added that alignment was hugely important and deciding how to approach that would need to be a consideration.

Mr. Cohen said that this should include social determinants of health (SDH).

Dr. Cutler said that he believed the idea of trying to determine best practices in this area was important. He added that he was struck by the presentations by CHART hospitals at

the last Board meeting in which he learned about the issues they faced. He said that the HPC could learn a lot from the best practices of other organizations.

Dr. Allen noted that the issue of how much the HPC should dictate to systems was something the agency struggles with in a number of areas. She said that allowing entities to make their own decisions could encourage innovation and originality, but could also make it difficult to compare and compile data across many ACOs following many different models. She said that this was a tension that the HPC would have to navigate.

Ms. Barrett said that providing flexibility for innovation had been more positively received in discussions with entities. She said that one idea was to design TA in a way that would provide all-payer data to the ACOs.

Ms. Barrett thanked the Committee for the discussion and said that she looked forward to continuing it moving forward.

Dr. Allen thanked the presenters.

ITEM 5: HPC Pilot on Pharmacological Treatment for Opioid Use Disorder in the Emergency Department

Dr. Allen turned the discussion over to Ms. Kathleen Connolly, Director for Strategic Investments, and Ms. Katherine Record, Deputy Policy Director for Accountable Care. Ms. Record provided an overview of the HPC pilot on Pharmacological Treatment for Opioid Use Disorder in the Emergency Department (ED). For more information, see slides 21-31.

Dr. Allen asked whether the program would be targeted at three individual EDs or if it was a system-based program. Ms. Record responded that the language in the statute could be read either way but given that the grant is limited to $3 million, it seemed unlikely that a system could use that amount for more than one ED.

Referring to the chart on slide 25, Dr. Cutler asked whether the rate of non-fatal overdose visits by hospital was the best way to frame the problem. He noted that North Shore Medical Center might have a high rate but likely has a small absolute number of cases. Ms. Record said that the staff had been looking at proportional ED load and noted that the HPC could work on providing absolute numbers.

Dr. Cutler said that if there was another ED that had three times as many overdoses but 20 times as many patients, it might not necessarily make sense to exclude that entity from the grant. Ms. Record agreed and said that there were definitely cases on the chart that could fall into that category.

Dr. Allen asked whether the goal was to narrow the hospitals in the charts down to three potential grant recipients. Ms. Record responded that the limit was up to three.

Dr. Allen noted the importance of ensuring that applicants' EDs are well-staffed around the clock availability for these services. Ms. Record agreed and noted that applicants would need to show that these services were available or on-call 24/7.

Mr. Cohen said that implementation of newer technologies, such as apps that help to ensure patient compliance and aid in tracking, was another factor that might be worth considering in applicants. Ms. Record said that was something that staff would look into.

Dr. Allen asked for clarification on the timeline. Ms. Connolly responded that staff were hoping to launch the application process by late spring or early summer.

Dr. Cutler asked whether some institutions were initiating programs like this through CHART funding. Ms. Record responded that some had considered doing so, but none had actually launched. She pointed to Beth Israel Deaconess (BID) Plymouth as an example.

Dr. Cutler noted that some CHART hospitals had indicated that they were looking at programs to reduce readmissions among these populations. Ms. Record responded that there were programs in which money followed patients who had experienced non-fatal overdoses and provided outpatient follow-on support as well as programs coordinated with police. She said that, to date, none of these programs had been initiating buprenorphine introduction in the ED.

Dr. Cutler said that the CHART hospital feedback could be valuable even before the launch of the program. Ms. Record agreed and said that there were both CHART hospitals and non-CHART hospitals that had indicated they would like to do this. She noted that this is an issue that hospitals really need support on and had expressed excitement at the potential of a state program.

Dr. Allen asked whether there was a way to leverage this $3 million in order to get additional funding from other grants or other sources. Ms. Record said that, as in the past, the HPC would ask hospitals to propose in-kind funding, particularly for better-resourced hospitals. She added that General Electric had partnered to magnify Health Resources and Service Administration (HRSA) grants to community health centers to support medication assistant treatment (MAT) programs. She said there was discussion by Lynn Community Health Center of using this funding to support this kind of immediate induction in their clinic.

Dr. Allen asked whether there were further questions. None were heard.

ITEM 6: Registration of Provider Organizations Update

Dr. Allen turned the discussion over the Ms. Kara Vidal, Senior Manager for Market Performance, and Ms. Elizabeth Reidy, Program Manager for Market Performance. Ms. Vidal provided a brief introduction.

Ms. Reidy provided an update on the Registration of Provider Organizations (RPO) Program. For more information, see slides 33-43.

Dr. Cutler said, regarding the first bullet point on slide 39, that he was under the impression that there already was a single MA-RPO program. Ms. Reidy explained that the HPC had started with an initial registration in 2014 that was mainly an HPC initiative. She said that three of the 10 Center for Health Information and Analysis (CHIA) criteria were identical to information in the HPC statute. Since then, the HPC and CHIA have worked to create a single program that the HPC would administer.

Dr. Allen asked whether there was anything the Committee needed to do on this issue ahead of the next week's Board meeting.

Ms. Vidal said that there was not.

Dr. Allen asked if there were questions or comments from the public. None were heard.

ITEM 6: Adjournment

Dr. Allen adjourned the meeting at 10:49 AM.