MINUTES OF THE JOINT COMMITTEE MEETING

CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION QUALITY IMPROVEMENT AND PATIENT PROTECTION

Meeting of April 26, 2017

MASSACHUSETTS HEALTH POLICY COMMISSION

JOINT COMMITTEE MEETING
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, April 26, 2017, 9:30 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery & Payment System Transformation (CDPST) and Quality Improvement & Patient Protection (QIPP) Committees held a joint meeting on Wednesday, April 26, 2017, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. Carole Allen (Chair, CDPST), Mr. Martin Cohen (Chair, QIPP), and Dr. David Cutler. Undersecretary Alice Moore, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services, joined the meeting at 9:43 AM.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.

Dr. Allen called the meeting to order at 9:34 AM and offered a brief introduction.

ITEM 1: Approval of minutes from February 1, 2017 CDPST Committee meeting

Dr. Allen offered two corrections to the February 1, 2017 CDPST Committee meeting minutes. She asked for a motion to approve the minutes, as amended. Mr. Cohen motioned to approve the minutes. Dr. Cutler seconded. Committee members voted unanimously to approve the minutes.

ITEM 2: Approval of minutes from January 25, 2017 QIPP Committee meeting

Acknowledging that the QIPP Committee did not, at present, have a quorum, Committee members elected to delay the vote on the January 25, 2017 QIPP Committee meeting minutes until later in the meeting.

ITEM 3: PCMH PRIME Certification Program – One Year Mark

Ms. Catherine Harrison, Senior Manager, Accountable Care, provided an overview of the HPC's Patient-Centered Medical Home (PCMH) PRIME certification program. For more information, see slide 8.

Ms. Kelsey Brykman, Senior Policy Associate, Accountable Care, provided an overview of the practices participating in the PCMH PRIME program and of engagement with payers in the program. For more information, see slides 9-17.

Mr. Cohen asked about the circumstances surrounding the three practices that had withdrawn from the PCMH PRIME program. Ms. Brykman explained that two of the practices in question had withdrawn because they had changed system affiliation in the middle of their certification process, while the third had cited competing priorities and a lack of financial incentives.

Mr. Cohen asked Ms. Brykman whether staff members had communicated with practices that had chosen not to participate in the PCMH PRIME program in order to better understand their reasons for not doing so. Ms. Brykman said that, to date, the staff has not actively engaged with these practices but that it was something that could be looked into moving forward.

Dr. Allen said that she believed that Mr. Cohen was referring specifically to practices that were engaged in other National Committee for Quality Assurance (NCQA) programs but had chosen not to undertake PCMH PRIME certification. Ms. Harrison replied that staff engaged in some conversations on this topic with practices, but that it was not a systematic survey effort to get feedback. She said that the staff heard from some practices that their decision not to participate was based on competing priorities and resource demands. She said a more comprehensive survey would aid in rounding the staff's understanding of the drivers behind the decision not to participate.

Mr. Cohen asked what the level of engagement was with payers not listed on slide 15. Ms. Harrison said that the strategy for payer engagement was an issue that was still up for discussion. She said that this was a priority for staff members and that she would be interested in feedback from the Committee members on this topic.

Dr. Allen asked whether practices participating in the program felt that it was helping to move them towards practice transformation and facilitating the integration of behavioral health (BH) services. Ms. Brykman said that staff would receive this type of feedback during the technical assistance (TA) process.

Dr. Allen said that rather than discussing whether certain criteria were met, the important question for the practices was whether they felt PCMH PRIME made them more efficient and allowed them to deliver care in a better way. Ms. Harrison noted that some of the practices that came into the program in the first year may have been working on the BH integration issue for some time, and were taking the step of certification as recognition of the work that they had already done. She added that, through the TA program, staff would get more one-on-one time with practices and have a better opportunity to understand how they felt the program was impacting their practices.

Ms. Harrison said that the HPC had a strong commitment through PCMH PRIME to not only recognize practices for their work but to help practices with BH integration. She said that it was less about the stamp of approval and more about improving care.

Dr. Allen said that another important point was to learn from these practices about what had worked in order to aid in the sharing of best practices.

Dr. Allen suggested that pediatric practices might contribute to the high rate of postpartum depression screening outlined on slide 17. She said that she believed that MassHealth was paying pediatric practices to conduct this screening.

Dr. Allen further stated that she was very disheartened by the rate of substance abuse disorder (SUD) screenings listed on slide 17. She said that, given the opioid epidemic, this category of screening should be more of a priority and asked the HPC to explore how it might be able to facilitate raising that rate.

Ms. Harrison provided an overview of the PCMH PRIME TA program, milestones, and 2017 priorities. For more information, see slides 18-21.

Dr. Allen said that it is very important to learn from the participating practices in order to ensure that the HPC is providing them with what they need and to share successful strategies among practices in Massachusetts.

Mr. Cohen said that he believed that the staff had chosen great areas of focus. He said that it might be worth reviewing the certification standards to evaluate whether they might need to be improved in order to get the kind of outcomes that the program was aimed at affecting. Ms. Harrison responded that staff was considering a criteria review as NCQA rolls out its 2017 program.

Ms. Harrison noted that NCQA is adopting many of the HPC standards into its PCMH recognition. She said that it was a great sign that the program was having an impact at the national level.

Dr. Cutler said that he suspected that, for the practices, the opportunity to have better clinical quality would be the primary factor motivating participation in the program. He said that analysis and feedback on best practices and the quality of care at individual PRIME practices would be valuable. Dr. Cutler noted that the HPC should also be interested in potential cost savings of these programs. He said that this could aid in pushing the payer community to reward these practices.

ITEM 4: PCMH PRIME Practice in the Spotlight

Ms. Harrison introduced representatives from Tufts Medical Center Primary Care – Boston, who provided a presentation on their experience in the PCMH PRIME program.

ITEM 2 (cont.): Approval of minutes from January 25, 2017 QIPP Committee meeting

Recognizing that there was a QIPP quorum, Mr. Cohen called for a motion to approve the minutes from January 25, 2017 QIPP Committee meeting. Undersecretary Moore motioned to approve the minutes. Dr. Allen seconded. Committee members voted unanimously to approve the minutes.

ITEM 5: ACO Certification Technical Assistance – Preliminary Design

Ms. Katherine Barrett, Policy Director for Accountable Care, introduced the presentation on the HPC's Accountable Care Organization (ACO) TA program. For more information, see slides 24-30.

Ms. Barrett then turned the discussion over to HPC consultants, Mr. Michael Bailit and Ms. Erin Taylor, who provided an overview of the information that they gathered to inform the preliminary design of the ACO TA program. For more information, see slides 31-39.

Dr. Cutler said that he recalled having some discussions with the Board on the issue of a fee-for-service model remaining the dominant reimbursement method in the health care system, as cited on slide 33. He asked whether Ms. Barrett recalled what thoughts had come from those discussions.

Ms. Barrett said that the "payment under the payment" constituted a major policy issue. She said that part of the challenge was that the system was geared towards fee-for-service. She added that the HPC would be collecting information from ACOs through the certification process to help inform additional policy recommendations. She said that, in her experience, there was a wide degree of variation among ACOs.

Dr. Cutler said that he thought the discussions had been geared towards devising some sort of complimentary strategy to the current ACO system and that this might be worth revisiting.

Dr. Allen said that she believed that the American College of Surgeons had developed a system for approaching bundles or episodes, indicating that there are national organizations interested in this as well.

Mr. Bailit said that there are examples from other states of activities in this realm but that it was not the focus of the current TA design. He added that it might be worth future exploration.

Dr. Allen asked how the recommendation to postpone TA regarding social determinants of health (SDH) could be reconciled with the goal of identifying high-risk patients. She noted that individuals with issues related to SDH might be some of the highest risk patients. Mr. Bailit responded that SDH could be addressed in two ways: (1) stratifying the patient population and (2) helping ameliorate the underlying SDH. He clarified that their recommendation was that the latter of these two be saved for a later stage. He noted that this should not preclude practices from using SDH to help identify patients who might have greater needs. He added, however, that the knowledge of how to successfully do this was quite limited and said that there is no standard set of SDH data in medical records.

Dr. Cutler said that there had recently been some papers that concluded care management as a whole had not saved much money, but rather that the best way to save was simply by

doing fewer things. He said that he understood why the presenters had called out care management as a priority area, but asked whether it was obvious that it should be a focus area. Mr. Bailit responded that standardizing care and developing preferred clinical pathways takes a long time and requires a lot of clinical infrastructure for which many ACOs do not have the resources. He said that if the right care management resources are applied to the right patients, it is likely to generate a near term return in a way that is easier than the overall standardization of care.

Ms. Barrett said that she had not thought of ACO TA as a way to help ACOs to be successful under the contracts, but rather as a method to partner with these systems and help them to build the competencies that they were being asked to achieve in the certification programs. She said that the Committee would have to consider whether the goal of TA is to help practices to be successful on downside risk contracts more generally or to create a partnership with the delivery systems and help them build foundational capabilities.

Dr. Allen said that she agreed with the need to select under-resourced systems, but asked whether this might pose the risk of having well-resourced systems pursue a different path resulting in sets of disparate ACOs. Mr. Bailit said that the approach was based on the assumption that it would be beneficial for all ACOs to be successful, particularly those serving vulnerable populations. He said that the alternate approach would be to prioritize innovation and best practices.

Ms. Barrett said that staff had recommended that the consultants interview less-resourced ACOs that could honestly communicate the areas in which they needed help. She said that this had likely biased the TA plan towards those ACOs. She said that providing TA to more well-resourced systems was a conversation that could definitely be had if Committee members felt that it was worthwhile.

Undersecretary Moore said that the presentation had highlighted that Massachusetts was undergoing a period of change in this realm. She said that, as a part of these changes, providing support where it was most needed and aligning with MassHealth would be extremely important.

Ms. Barrett presented on the ACO TA alignment priorities and timeline. For more information, see slides 40-42.

ITEM 5: Mother and Infant-Focused NAS Interventions Update

Mr. Cohen provided a brief introduction to the program update on the HPC's mother and infant-focused neonatal abstinence syndrome (NAS) interventions. He turned the discussion over to Ms. Katherine Record, Deputy Policy Director, Accountable Care, who briefly provided background on the NAS initiatives.

Ms. Hannah Kloomok, Program Associate, Strategic Investment, provided an overview of the program. For more information, see slides 44-52.

Dr. Allen asked about the compositions of the NAS intervention teams at the hospitals. Ms. Kloomok said that this varied from hospital to hospital as the HPC allowed them the leeway to structure their teams in ways that they found most useful. She added that one of the challenges hospitals had cited was finding qualified peer coaches. She noted that members of the hospital staff across different groups were training to be able to provide care to NAS cases.

Dr. Allen said that she was discouraged by the fact, outlined on slide 52, that the number of NAS babies at Baystate Medical Center (BMC) had fallen from 89 percent who initially successfully started breastfeeding to 53 percent breastfeeding at discharge. She asked whether this might be due to the length of the stay and asked how that figure could be improved.

Ms. Kloomok said that the program aimed to get to a point at which these infants kept breastfeeding through discharge. She said that she believed that a big factor in this drop was that the mothers were kept in the hospital for two to three days while the infants were kept for up to 20 days. She said a major part of the program was trying to get a greater degree of parental presence with the infant.

Dr. Allen asked if any hospital programs were able to allow a mother to stay longer to help facilitate this. Ms. Kloomok said that the hope was to increase this length of stay. She noted that staff was using a metric called "rooming in," which measured how much time the mother spends with the infant in the hospital. She said that, as that metric increases and hospitals provide more spaces for mothers and infants to be together, the staff hopes that the breastfeeding rates will increase.

Ms. Record said that providing a space for the mother to return and stay with her infant is extremely important and that not all hospitals are currently capable of doing that. She added that most of these patients also face significant transportation and childcare barriers. She noted that some plans provide postpartum supports aimed at alleviating some of these difficulties. She noted that BMC was only providing in-patient support and did not have funding from the HPC for the postpartum services.

Mr. Cohen asked how these initiatives were being integrated with Department of Public Health (DPH) funded sites. Ms. Kloomok said that the HPC was working directly with DPH to deliver the same services at the HPC-funded sites. She noted that the teams from all of the sites were in regular communication and that there were plans to hold a convening in the future.

Ms. Record said that DPH was providing TA and a robust evaluation of outcomes which the HPC had duplicated. She thanked Mr. Cohen for his comment and said that the integration of these programs was highly important to staff.

ITEM 6: Update on RBPO Appeals Process

Mr. Cohen turned the discussion over to Ms. Lois Johnson, General Counsel, and Mr. Steven Belec, Director, Office of Patient Protection. Ms. Johnson and Mr. Belec provided an overview of the appeals processes for risk bearing provider organizations (RBPOs) and ACOs. For more information, see slides 54-60.

ITEM 5: Adjournment

Mr. Cohen asked whether there were any questions or comments. None were heard. He thanked the staff and guests. Mr. Cohen adjourned the meeting at 11:32 AM.