MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

April 25, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the March 28, 2018 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- Executive Director’s Report
- Executive Session
- Schedule of Next Board Meeting (TBD)

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on March 28, 2018 as presented.

MASSACHUSETTS
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- Call to Order
- Approval of Minutes from the March 28, 2018 Meeting
- **Market Oversight and Transparency**
  - Notices of Material Change
  - Guidance on Notices Regarding Out-of-State Organizations
  - 2019 Health Care Cost Growth Benchmark (VOTE)
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	21	23%
Physician group merger, acquisition, or network affiliation	19	21%
Acute hospital merger, acquisition, or network affiliation	19	21%
Formation of a contracting entity	16	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	9	10%
Change in ownership or merger of corporately affiliated entities	5	6%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- Proposed acquisition of the non-hospital-based diagnostic laboratory business of **Cape Cod Healthcare** by **Quest Diagnostics Massachusetts**, a subsidiary of a national diagnostic testing provider.

- Proposed joint venture among **Shields Health Care Group**, **Hallmark Health System**, and **Tufts Medical Center Physicians Organization** to build and operate a freestanding ambulatory surgery center on the campus of Lawrence Memorial Hospital in Medford.

- Proposed clinical affiliation between **Shields Health Care Group** and **Tufts Medical Center** under which the parties would jointly manage MRI services at Tufts Medical Center and at Shields' MRI sites in Dorchester and Dedham.

For each of these transactions, our analysis suggested limited scope for increases to health care spending, and we did not review evidence suggesting negative impacts on quality or access.

In Progress

- CMIR regarding the proposed merger of **CareGroup**, **Lahey Health System**, and **Seacoast Regional Health Systems**, the related acquisition of the **Beth Israel Deaconess Care Organization** by the merged entity, and the contracting affiliation between the merged entity and **Mount Auburn Cambridge Independent Practice Association**.

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HPC Review of Out-of-State Transactions: Filing Requirements

- Given that the HPC's MCN reviews are focused on potential impacts *in Massachusetts*, the HPC is clarifying that, at this time, the out-of-state transactions for which an MCN is required are those transactions most likely to have an impact in this state.
  - These would include acquisitions of **hospital systems located in New England* or New York** by Massachusetts Providers or Provider Organizations.
  - Acquisitions of or mergers with **Massachusetts Providers or Provider Organizations** by out-of-state hospital systems would always require an MCN, regardless of where the out-of-state hospital system is located.
- The HPC is issuing guidance to clarify these filing requirements.
- As always, if an organization is unsure whether a transaction qualifies as a Material Change that requires them to file an MCN, the HPC encourages the organization to contact HPC staff.

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* New England includes Connecticut, Maine, New Hampshire, Rhode Island, and Vermont, in addition to Massachusetts.

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Key takeaways from modification hearing and submitted testimony

1. Massachusetts total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate and national growth rates.

2. Over 70% of those offering testimony stated that the 3.1% benchmark ought to be maintained. The remainder did not provide a position.

3. Unwarranted provider price variation remains a threat to the benchmark.

4. Providers expressed concerns that the benchmark has, at times, been inappropriately utilized as a cap on prices.

5. Pharmaceutical drug costs continue to be cited as cost driver not within the control of payers or providers.

6. Providers expressed concerns about the ability to meet the benchmark if the upcoming ballot initiative regarding nurse staffing ratios was successful.

Summary of Testimony

Organization	Position
1199 SEIU	3.1%
Association for Behavioral Health Care	3.1%
Associated Industries of Massachusetts	3.1%
Atrius Health	3.1%
Beth Israel Deaconess Care Organization	3.1%
Conference of Boston Teaching Hospitals	3.1%
Greater Boston Interfaith Organization	3.1%
Health Care for All	3.1%
Home Care Alliance of Massachusetts	No formal position
Lahey Health	No formal position
Lawrence General Hospital	3.1%
Massachusetts Association of Behavioral Health Systems	No formal position
Massachusetts Association of Health Plans	3.1%
Massachusetts Business Roundtable	No formal position
Massachusetts Health and Hospital Association	3.1%
Massachusetts Nurses Association	3.1%
Massachusetts Taxpayers Foundation	3.1%
Mental Health Legal Advisors Committee	No formal position
National Federation of Independent Business	No formal position
Retailers Association of Massachusetts	3.1%
Steward Health Care System, LLC	3.1%

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: 2019 Health Care Cost Growth Benchmark

MOTION: That, pursuant to G.L. c. 6D, § 9 (c), the Commission hereby establishes the health care cost benchmark for calendar year 2019 as _____, subject to the further process set forth in G.L. c. 6D, § 9 (d).

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PCMH PRIME Certification: Participating Practices

Since January 1, 2016 program launch:

79 practices
are PCMH PRIME Certified

Recently certified practices include: Glen P. Bombardier, M.D.

18 practices
are on the **Pathway to PCMH PRIME**

1 practice
applying for NCQA PCMH Recognition and PCMH PRIME concurrently

98 Total Practices Participating

Tele-Behavioral Health PCMH PRIME Knowledge Sharing Session and HCII Awardee Roundtable on April 12, 2018

On **April 12, the HPC hosted two tele-behavioral health events. At a PCMH PRIME Knowledge Sharing Session, Health Management Associates (HMA) facilitated a provider panel discussion on the use of tele-health to support BHI.** Later, at an HCII Awardee Roundtable, HMA facilitated a discussion among awardees about their tele-behavioral health models, lessons learned, and strategies to support sustainability. HMA is the HPC's technical assistance (TA) vendor for PCMH PRIME.

"We're not going to solve the shortage of psychiatrists by just making more psychiatrists; we need to use them more innovatively."

4 panelists

"We're floundering in substance use disorders, and our [tele-behavioral health pilot] allowed us to respond to a clearly articulated need for our patients real-time during the brief window we're able to touch them."

23 KSS attendees

13 HCII Awardee representatives

"The future of pediatric care is all about behavioral health… the old model of referral to subspecialist just is not a viable model."

Based on post-session evaluation, 100% of attendees found the panel provided helpful and relevant information on tele-health

ACO Certification: Reporting on Key Learnings

The HPC will create and publish **six briefs based on ACO Certification data**, approximately 2-5 pages each, organized by **topic areas most salient to stakeholder interests**. Briefs will be issued **~ every 3 months**. Each brief will stand alone, but together they will tell a comprehensive story. Briefs will be **descriptive**, but also **analytical**, pointing to policy implications as appropriate.

Brief #1: Intro to Accountable Care Orgs in Massachusetts	Brief #2: How do ACOs Manage Population Health, esp. BH and SDH?	Brief #3: How Do ACOs Manage Their Performance Under Risk Contracts?	Brief #4: How are ACOs Governed?	Brief #5: How are ACOs Delivering Patient-Centered Care?	Brief #6: How do ACOs Coordinate Care?
Intro to the ACO Certification program; background, key terms, intro to this series of briefs Certification in context of the Massachusetts ACO landscape ACO profiles, using some other public data such as RPO	What methods do ACOs use for risk stratification? What kinds of BH and SDH programs do ACOs offer? How/do ACOs use Community Health Needs Assessments to inform population health management strategies?	What are the characteristics of ACO risk contracts? How much risk are ACOs taking on? What are ACOs' approaches to quality measurement and performance improvement? What are ACOs' approaches to distributing and/or investing shared savings?	What do the governance structures of ACOs look like? How alike or unique are they? Do governance structures differ between hospital-anchored and physician-led ACOs? How are different ACO Participants represented in leadership roles?	How do ACOs involve patients in their decision-making processes? How do the ACOs assess the needs and preferences of their patient population? What do ACOs do in areas such as patient-centered advanced illness care, community-based programs, etc.?	How do ACOs provide coordinated care across the continuum of services and providers? What technologies do ACOs employ to facilitate information sharing across the continuum? What do non-ACO Participant partnerships look like?

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Now Available: Brief #1, “Introduction to ACOs in MA”

MASSACHUSETTS HEALTH POLICY COMMISSION

APRIL 2018

ACO POLICY BRIEF

Transforming Care: An Introduction to Accountable Care Organizations in Massachusetts

ACOs are groups of health care providers who come together to provide patient-centered, coordinated care, with the goal of improving quality and reducing costs.

ACOs typically include **PCPs**, through which patients are attributed to the ACO.

In 2017, the Massachusetts Health Policy Commission (HPC) launched a first-in-the-nation set of statewide standards for accountable care organizations (ACOs). ACOs are groups of physicians, hospitals, and other health care providers who come together to provide patient-centered, coordinated care to their patients, with the goal of improving quality and reducing health care spending growth. The HPC certified 17 ACOs in Massachusetts that met those standards through an application process.

This brief is the first in a series of written reports and other resources that the HPC will issue regarding the landscape of certified Massachusetts ACOs based on the information submitted by applicants for ACO Certification, combined with other publicly available information. The purpose of this new series of policy briefs is to provide policymakers, health care providers, payers and purchasers, researchers, and other members of the interested public with new information and insights regarding the characteristics of certified ACOs. Topics that will be examined include how they are organized and governed, how they set and implement quality improvement strategies, their experience managing patients under risk contracts, and other key features. In providing increased transparency about the landscape of HPC-certified ACOs through this series, the HPC aims to support health care providers in their ongoing efforts to improve the quality and efficiency of patient care, support the formulation of sound policy that further bolsters those endeavors, and generally contribute to public understanding of the evolving care delivery system in Massachusetts.

This first brief provides background information on the ACO model in Massachusetts and the HPC ACO Certification program, and some key facts about the certified ACOs, which will be explored in greater detail in subsequent briefs.[1]

THE ACO MODEL IN MASSACHUSETTS

While HPC ACO Certification is a new program, providers and payers both in Massachusetts and nationally have been testing and evolving various accountable care delivery and contracting approaches over the past decade. The term “ACO” is generally used to mean a group of health care providers that contracts with a payer to assume responsibility for the delivery of care to its attributed patients, and for those patients’ health outcomes.[2,3] ACOs contract with payers under payment models other than fee-for-service (so-called “alternative payment methods,” or APMs), in which the ACO is typically accountable for spending against a budget and may earn financial incentives for meeting agreed-upon quality performance targets. Contracts with “shared savings” or “upside risk” allow an ACO to share in any cost savings generated. In contracts with “downside” or “two-sided” risk, an ACO is responsible for paying some share of losses, depending on quality targets, if it fails to meet a budget.

The types of providers participating in an ACO can vary widely from one ACO to the next. ACOs typically include primary care providers (PCPs), through which patients

HEALTH POLICY COMMISSION ACO CERTIFIED – 2017 –

ACO Policy Brief | 1

The first brief provides background information on the HPC-certified ACOs, and highlights key facts about them, such as:

- Approximately 1.9 million commercial or Medicare patients in Massachusetts are served by HPC-certified ACOs.
- The 17 HPC-certified ACOs hold a total of 66 commercial risk contracts, 17 MassHealth risk contracts, and 11 Medicare risk contracts.
- Over 80% of ACOs have at least one hospital as an ACO participant.

Visit the HPC’s Transforming Care website to read the full brief.

HPC

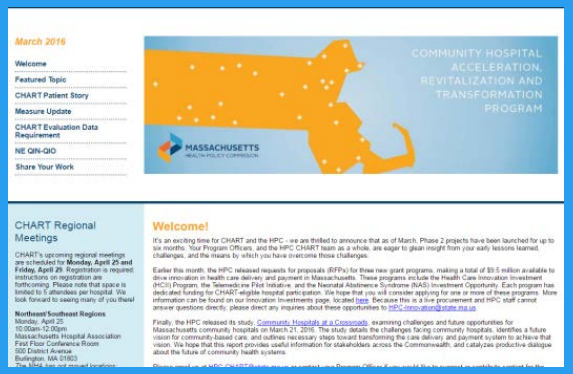
CHART Phase 2: Activities since program launch[1]

15
regional meetings
with
900+
hospital and community provider attendees

290+
technical assistance working meetings

915+
hours of coaching phone calls

28
CHART newsletter features


March 2016

Welcome
Featured Topic
CHART Patient Story
Measure Update
CHART Evaluation Data Requirement
NE QIN-QIO
Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM

MASSACHUSETTS

CHART Regional Meetings

Welcome!

590+
data reports received

3,794 unique visits to the CHART hospital resource page

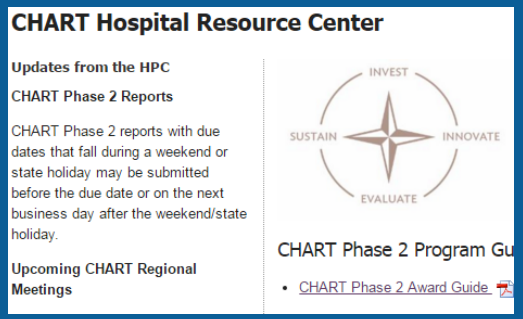


CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

INVEST
SUSTAIN
INNOVATE
EVALUATE

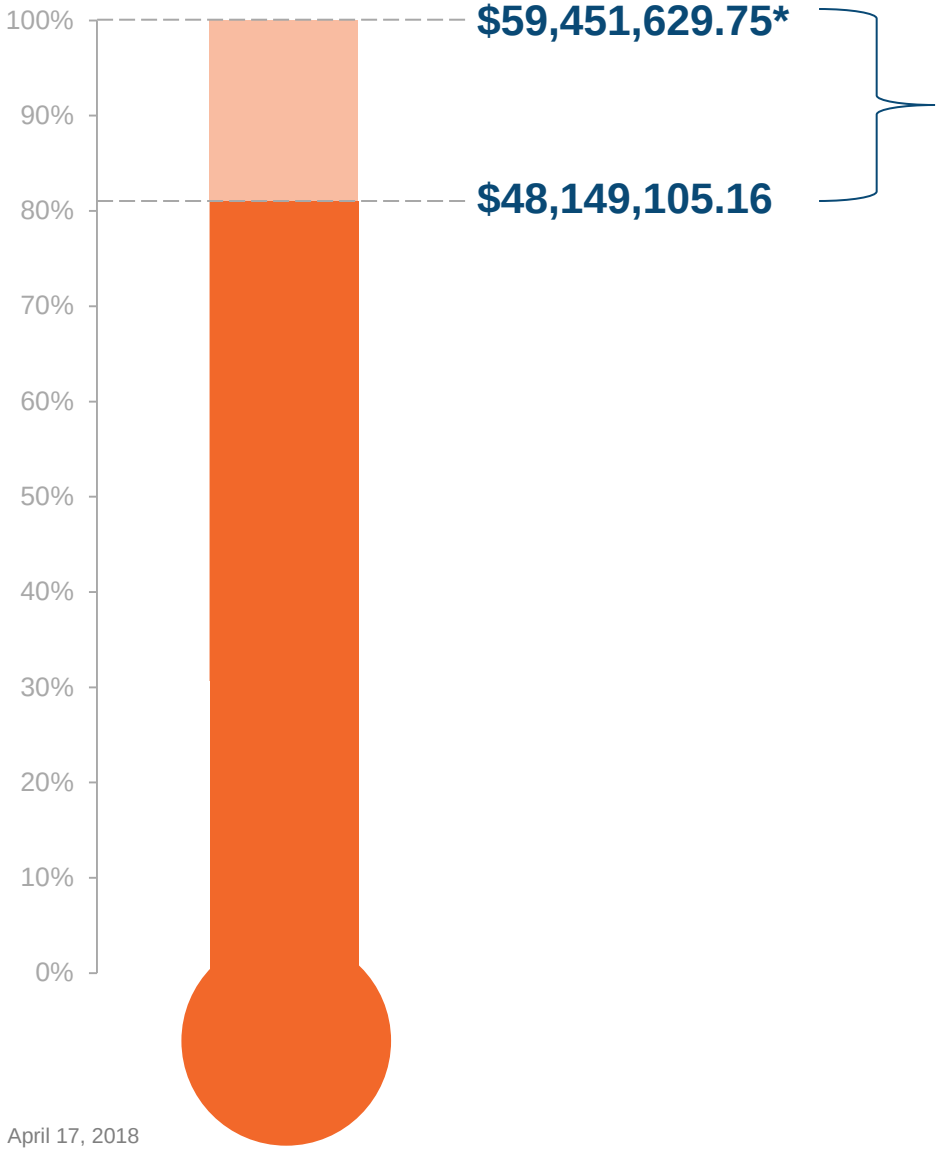
CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide

18 awards
are pursuing No Cost Extensions, using unspent funds to continue the model or finalize reporting for up to six months

[1] Updated through April 13, 2018. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

CHART Phase 2: The HPC has disbursed $48 million to date



Remaining
$11,302,524.59
is inclusive of
$5,245,301.96
maximum outcome-based Achievement Payment opportunity

Updated April 17, 2018

*This reflects the most recent, up-to-date accounting of CHART Phase 2 contract maximum obligations

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

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SHIFT-Care, the HPC's new $10 million investment opportunity, received 36 proposals totaling over $24 million

TRACK 1: Addressing social determinants of health

Support for innovative models that **address social determinants of health** for complex patients in order to prevent a future acute care hospital visit or stay.

Proposed partners include: Legal services providers, hospitals, VNAs, housing authorities, outpatient service providers.

11 Applicants requested funding of $7 million

FUNDING TRACK 2a: Addressing behavioral health needs

Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay.

Proposed partners include: Police departments, primary care practices, Councils on Aging, rehabilitation centers.

10 Applicants requested funding of $7 million

FUNDING TRACK 2B: Enhancing opioid use disorder treatment

Section 178 of ch. 133 of the Acts of 2016 directed the HPC to invest not more than $3 million to support hospitals in further testing **ED initiated pharmacologic treatment for SUD**.

Proposed partners include: Outpatient OUD service providers, sheriff's departments, universities, municipalities.

15 Applicants requested funding of $9.6 million

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SHIFT-Care Challenge Applicants by the Numbers

The HPC received proposals from a diverse range of entities including 16 CHART hospitals, 11 ACOs/ACO participants, and 8 HCII awardees.*

	Applicants	Avg partners	Requested HPC Funding	Proposed In-Kind Funding	Total Initiative Costs
TRACK 1	11	~5 per application (59 total)	Avg: $636K Total: $6,956,919	Avg: $453K Total: $4,539,886	$11,631,622
TRACK 2a	10	~4 per application (41 total)	Avg: $693K Total: $6,939837	Avg: $385K Total: $2,852,522	$9,792,359
TRACK 2b	15	~3 per application (48 total)	Avg: $694K Total: $10,415,722	Avg: $293K Total: $4,407,597	$14,823,319
Total	**36**	**148**	**$24,312,479**	**$11,934,820**	**$36,247,299**

*Note: ACO/ACO Participant s excludes Applicants that are hospitals

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HPC's Health Care Innovation Investment Program

The Health Care Innovation Investment Program: $11.3M invested in innovative projects that further the HPC's goal of **better health and better care at a lower cost.**

Health Care Innovation Investment Program
Round 1 – Three Pathways

- Targeted Cost Challenge Investments (TCCI)
- Telemedicine Pilots
- Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions

	Lower Costs	Greater Access	Better Outcomes
Primary Goal:			
Target Populations:	8 diverse cost challenge areas: SDH, BHI, VIC-Purchasers, VIC-Providers, Practice Pattern Variation, PAC, SAI & EOL, Site & Scope of Care	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns
	10 initiatives	**4** Initiatives	**6** Initiatives

Targeted Cost Challenge Investments Awardee Highlight: Care Dimensions

CareDimensions
HOSPICE | PALLIATIVE CARE | SUPPORT SERVICES

Challenge Area	HPC Funding
Serious Advancing Illness and Care at the End of Life	$750,000

Partners

- North Shore Physicians Group

Total Initiative Cost	Estimated Savings
$762,688	$7,233,600

Target Population

North Shore Physicians Group patients with severe, life-limiting illness who are a member of their Accountable Care Organization (ACO)

Primary Aim

Reduce all-cause readmissions and emergency department visits by 20%

Service Model

Integrate palliative care staff into primary care sites to increase early identification of patients requiring those services, and bridge the gap in care that occurs between curative care and end of life care

Evidence Base

- In-Home Palliative Care
- CLAIM studies

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Office of Patient Protection Overview

History of the Office of Patient Protection

- Created in 2000 to protect Massachusetts managed care consumers (Ch. 141)
- Merged with the Office of the Managed Care Ombudsman, established by Executive Order No. 405
- OPP operated within the Department of Public Health (DPH)
  - Consumer rights to challenge health plan coverage denials
  - Massachusetts fully-insured plans only
- Chapter 224 moved OPP from DPH to HPC, effective April 20, 2013
- OPP's external review process reviewed by CCIIO/CMS and deemed "NAIC-Parallel" (meeting all Federal standards) in summer of 2017

Core Responsibilities

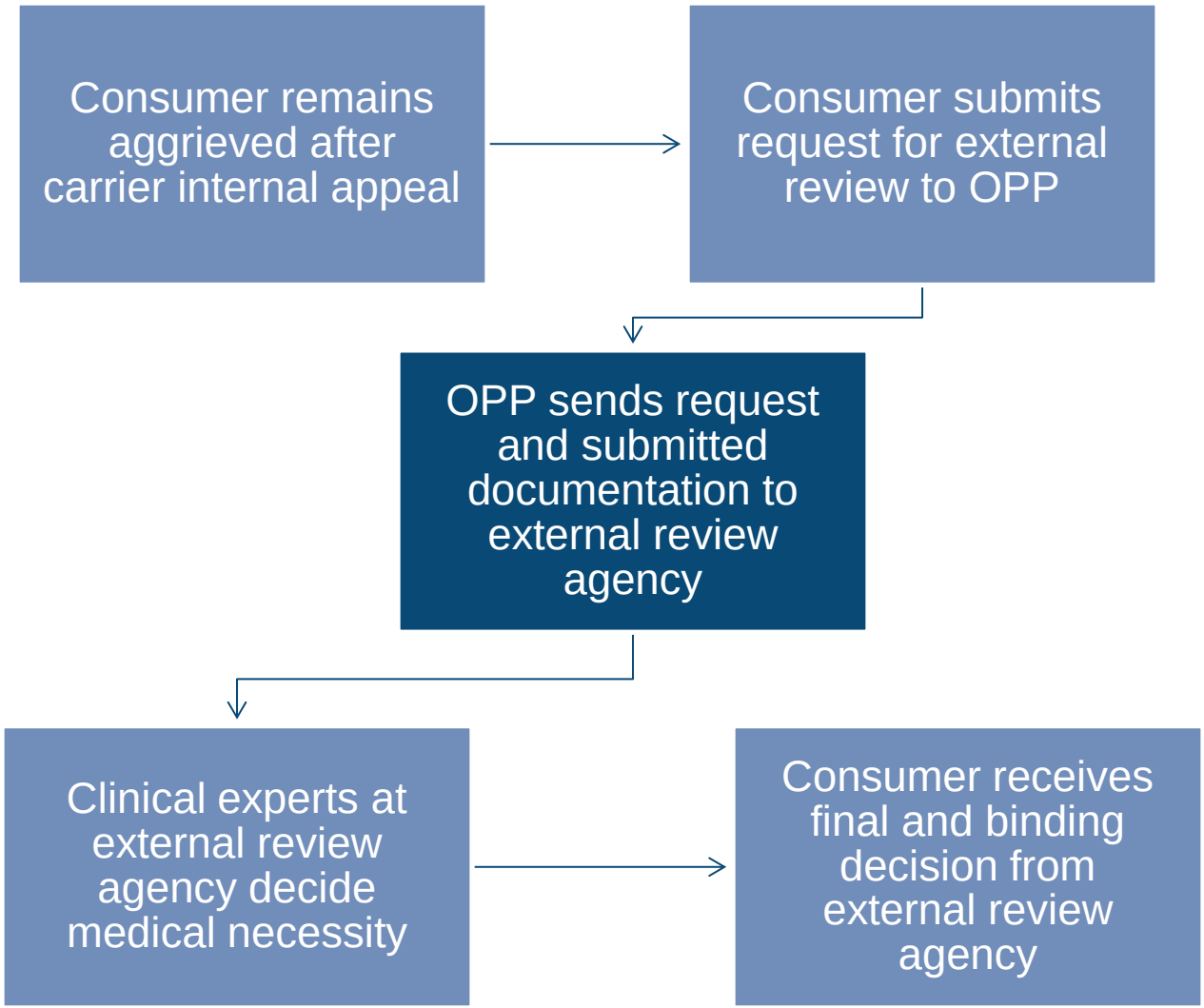
- Regulating internal and external review for fully-insured plans
- Administering external review for fully-insured plans
- Consumer outreach, assistance and education
- Administering enrollment waivers to purchase non-group health insurance during SEP
- Receiving and analyzing annual reports from health plans regarding appeals, disenrollment of providers, claim denials, and other mandated information
- Developing novel appeal processes for patients attributed to risk bearing provider organizations (RBPOs) and HPC-certified accountable care organizations (ACOs) (commercially-insured)

Internal review process

Process for consumer with a fully-insured Mass. health plan

1. Consumer receives denial letter from carrier	2. Consumer appeals directly to carrier	3. Carrier responds to consumer	4. Further appeal rights
▪ Denial of prior authorization or denial of claim, must be in writing ▪ May be based on medical necessity or other reasons ▪ Consumer may request expedited internal review ▪ Consumer may request continuation of coverage	▪ May appeal in writing or over the phone (carrier puts in writing) ▪ Carrier responds within 30 days unless voluntary extension ▪ Carrier responds within two days if expedited	▪ Written response to consumer ▪ Carrier may reverse, modify or uphold original decision	▪ Voluntary reconsideration if offered by carrier ▪ If denial based on **medical necessity**, may seek external review through OPP

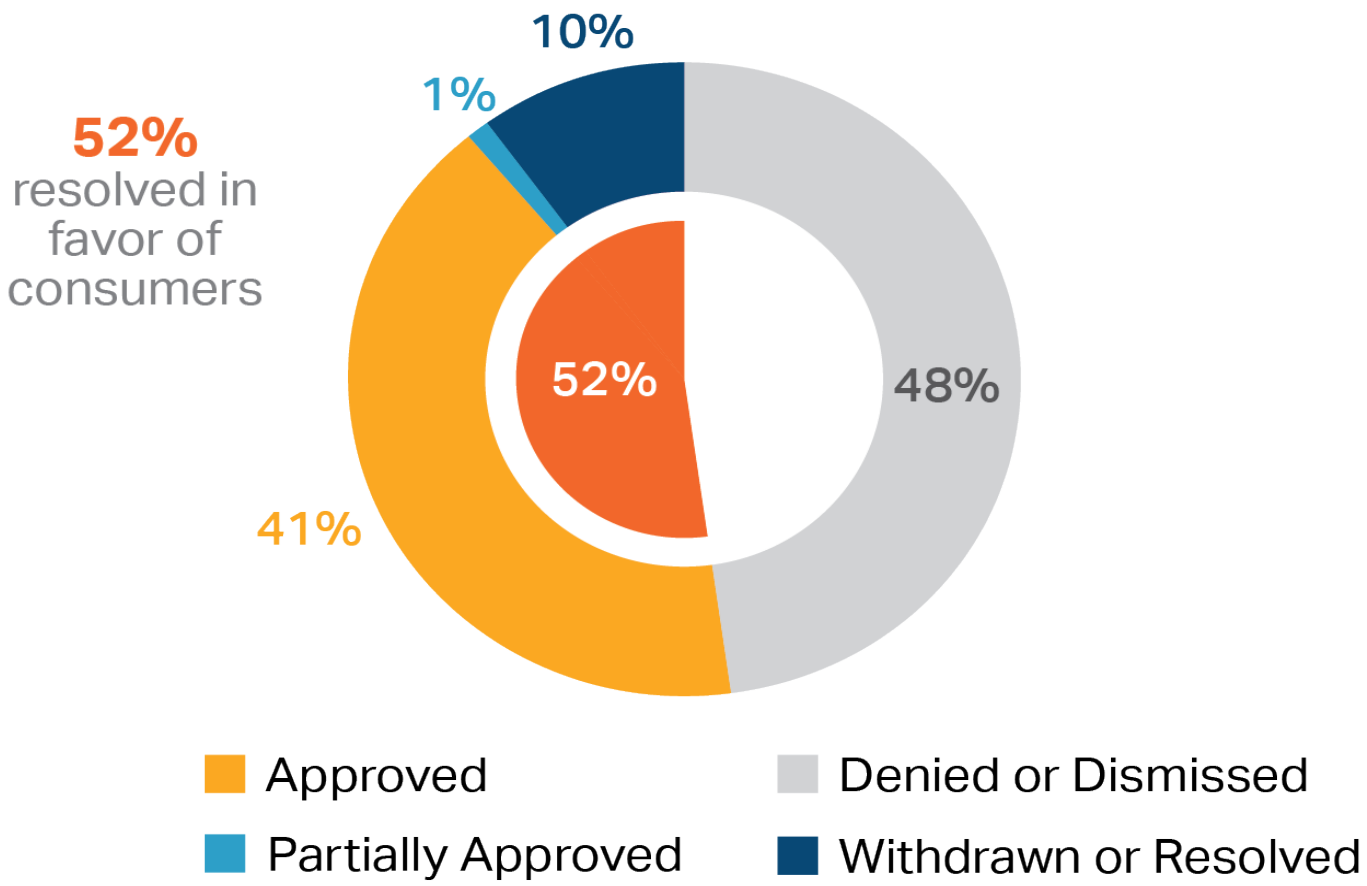
Current Carrier External Review Process



During 2016, insurance companies received 15,261 member grievances. Of these, 7,872 were adverse determinations based on medical necessity.

Internal Appeals

Insurance companies reported that a majority of all grievances were resolved in favor of the member.

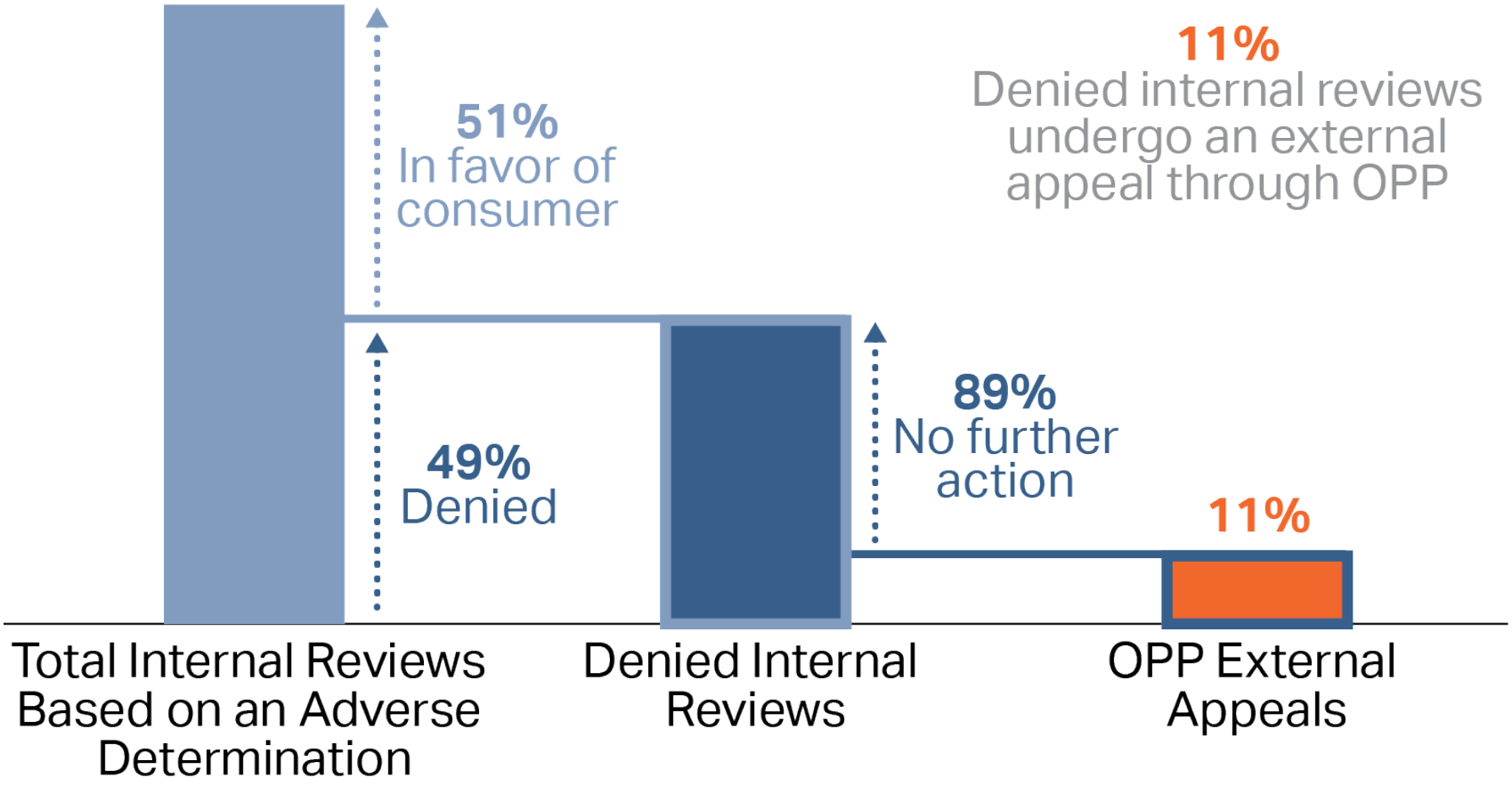


Source: 2016 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Of those receiving adverse determinations during 2016, 11% of members with internal reviews that were denied or partially denied pursued external appeals through OPP.

External Review
Adverse Determinations

The proportion of members who were denied or partially denied during the internal review process and who filed eligible external review requests with OPP



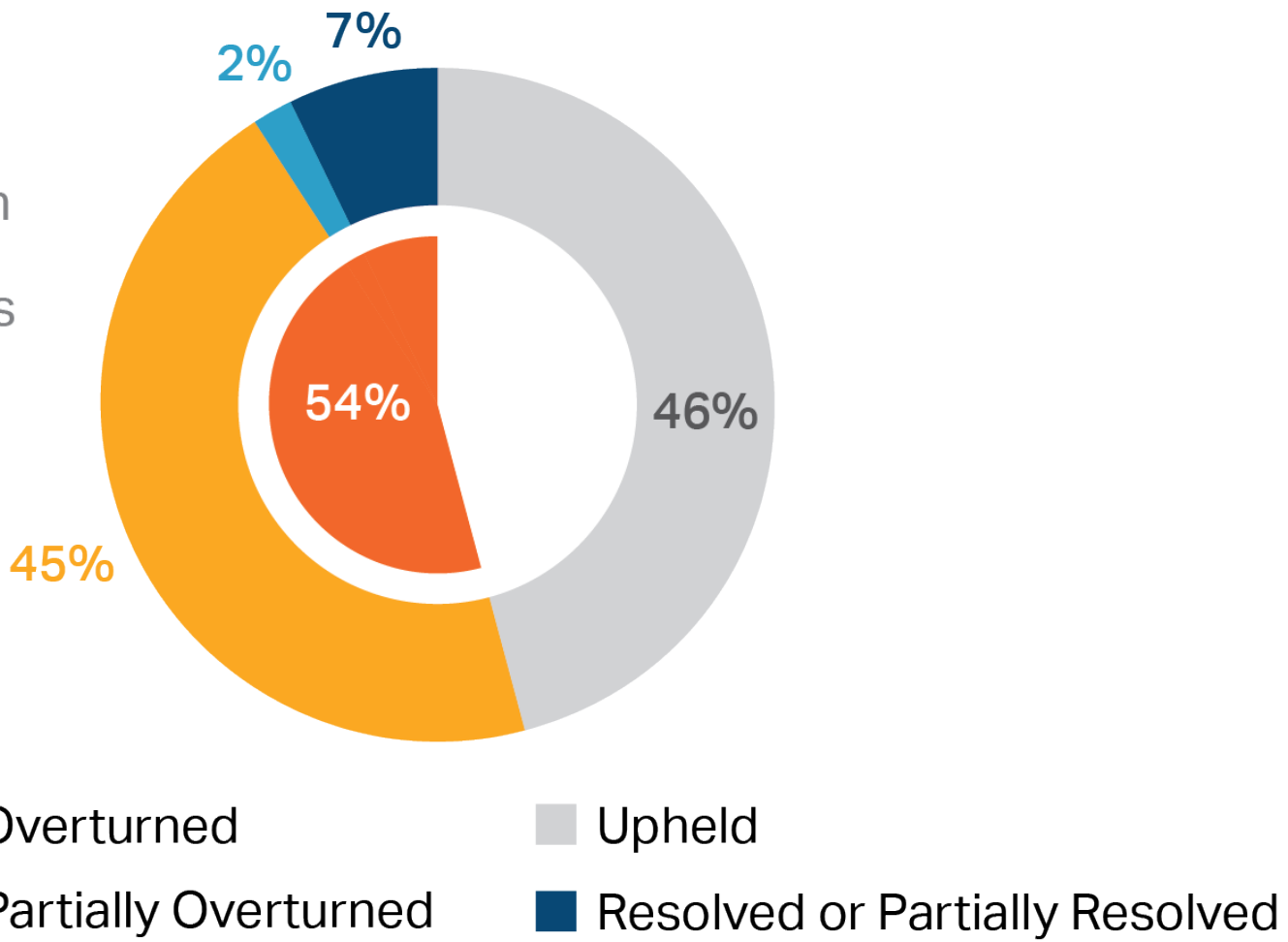
Source: 2016 Office of Patient Protection external review data; 2016 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

OPP received 237 eligible requests for external review during 2016.

External Review

Percentage of external review cases by disposition, 2016

54% resolved in favor of consumers

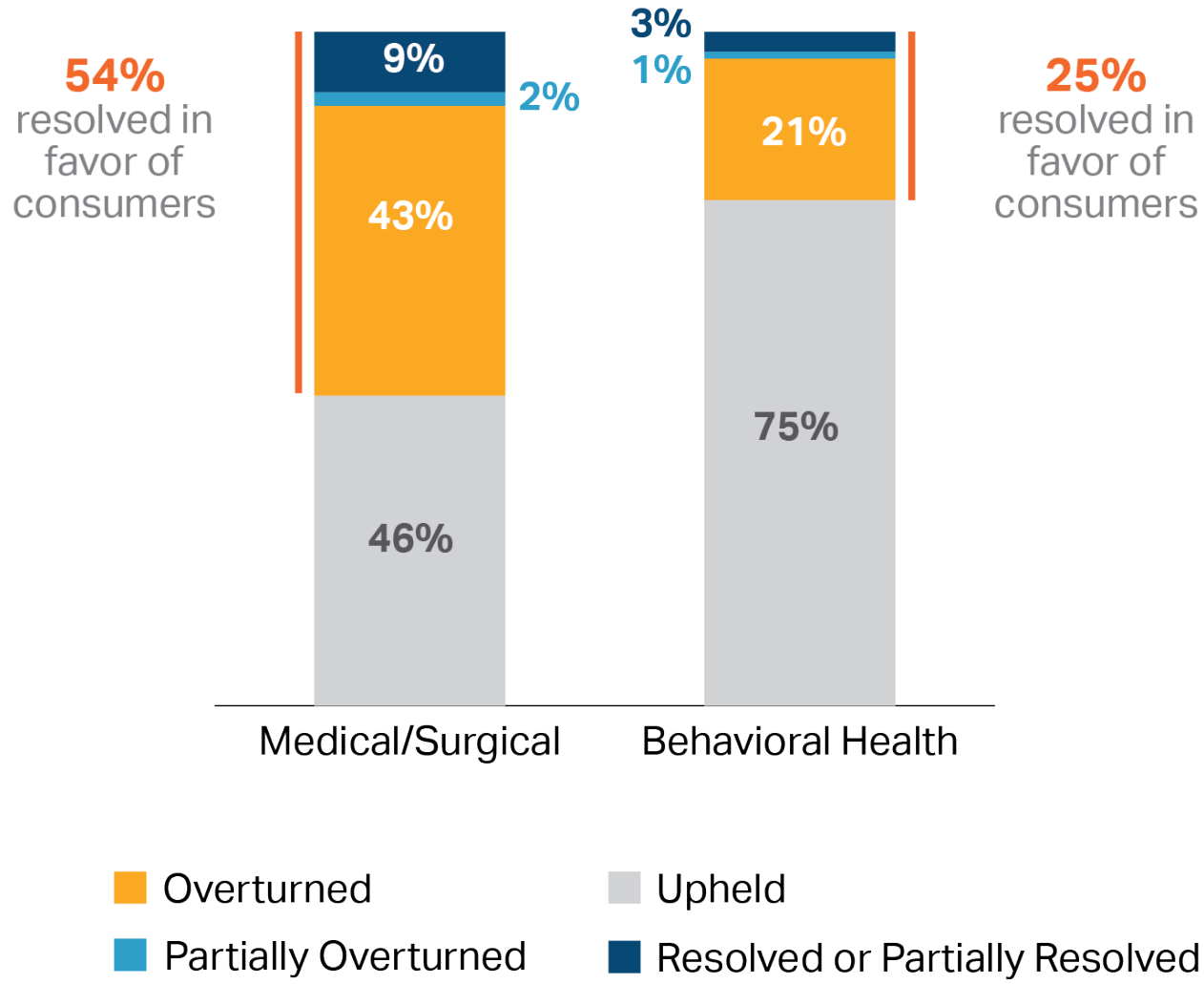


Source: 2016 Office of Patient Protection external review data

157 requests for external review were medical/surgical treatment and 80 requests were for behavioral health treatment.

External Review

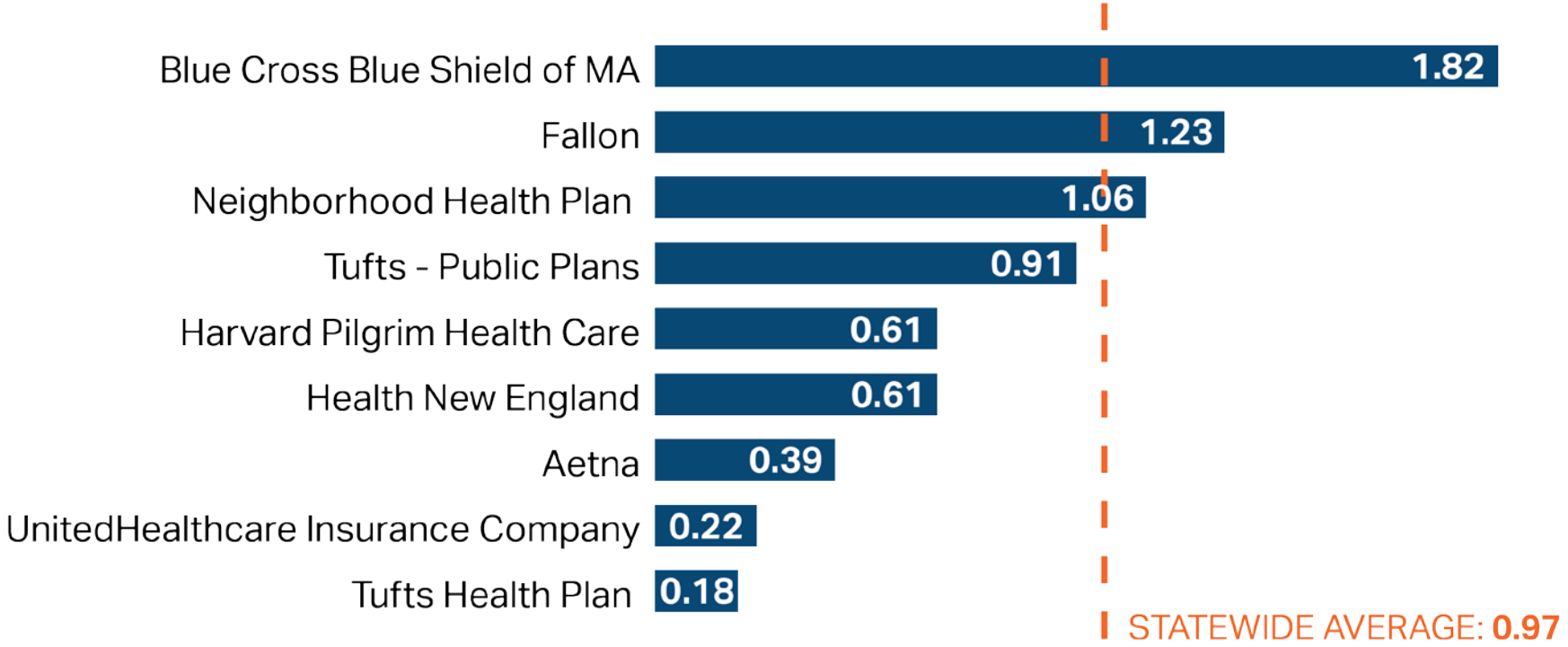
Percentage of external review cases by disposition, by type of case (Medical/Surgical Care vs. Behavioral Health Care), 2016



Source: 2016 Office of Patient Protection external review data

When weighted by number of members, Blue Cross Blue Shield of MA members sought a higher than average number of external reviews

External Review



Note: Weighted by dividing number of external reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2016

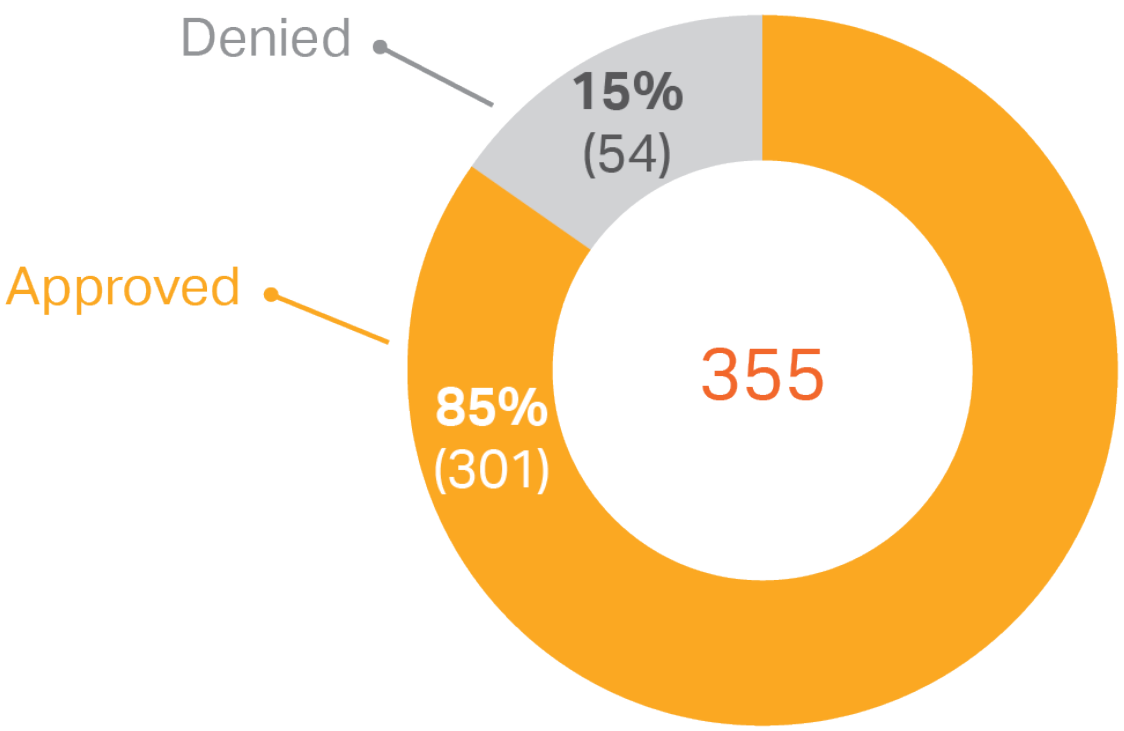
Source: 2016 Office of Patient Protection external review data, Member months from Center for Health Information and Analysis Enrollment Trends, 2016

Waivers to buy non-group health insurance outside of open enrollment

OPP responsibility pursuant to M.G.L. c. 176J, §4(4)

- The 2018 open enrollment for the Commonwealth ended Jan. 23, 2018; 2019 open enrollment is scheduled to begin November 1, 2018
- When enrollment is closed, you can generally purchase insurance if you have a qualifying event, e.g.:
  - Newly eligible for subsidized insurance (income below 300% FPL)
  - You lost insurance coverage recently (past ~60 days)
  - You are a small business owner buying insurance for your business
- May be eligible for an enrollment waiver if Massachusetts resident and:
  - You are uninsured and did not intentionally forgo enrollment in health insurance during the last open enrollment period
  - You lost insurance coverage over two months ago but only recently became aware of the uninsured status

Outcomes of 2016 open enrollment waiver applications



Year	Total Waiver Applications
2011	276
2012	576
2013	416
2014	316
2015	562
2016	355

OPP was given the statutory authority to issue enrollment waivers beginning in 2011.

The numbers of applications and the numbers of waivers approved have fluctuated for a variety of reasons (e.g. length of open enrollment periods, changes to state and federal enrollment laws).

Source: 2011-2016 Office of Patient Protection Waiver Data

Consumer information and assistance

In 2016, OPP responded to over 1,350 consumer inquiries

Contact OPP

Phone: (800) 436-7757

Fax: (617) 624-5046

Email: HPC-OPP@state.ma.us

Mass.Gov/HPC/OPP

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the March 28, 2018 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
  - Program Updates
  - SHIFT-Care Investment Opportunity
  - Health Care Innovation Investment Awardee Spotlight, Care Dimensions
  - Office of Patient Protection Annual Report
  - **Proposed Regulation on Risk Bearing Provider Organizations and ACO Appeals (VOTE)**
- Executive Director's Report
- Executive Session
- Schedule of Next Board Meeting (TBD)

Statutory Requirements

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

Purpose of RBPO/ACO Appeals Regulation

- The statutory requirements are similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations but apply to provider decisions about referrals, treatments and access to care
- As providers face changing financial incentives in the context of risk contracts, the same concerns that drove the development of patient protections in managed care arise in the provider context
- An appeals process provides protections to the small set of patients who face challenges accessing appropriate care within provider organizations managing risk
- This process creates limited, but necessary patient protections in a changing health care environment

Differences Between Carrier and RBPO/ACO Appeals Processes

Provider Decisions - Access

Referral Restrictions

Type or intensity of treatment or services

Timely access to treatment or services

RBPO/ACO Appeals Process (M.G.L. c. 176O, § 24)

Carrier Decisions - Coverage

Out of network services

Cost sharing

Medical necessity of treatment or service

Carrier Appeals Process (M.G.L. c. 176O, §§ 13, 14)

HPC

Regulatory Development: Work To-Date, 2015-2016

- Research into applicable models and identifiable patient issues
- Outreach to provider organizations and consumer advocates
- Released Interim Guidance in April 2016
- Held two information sessions for provider organizations in July 2016
- Released FAQ for provider organizations on appeals process
- Disseminated a template for reporting
- RBPOs began implementing the internal appeals process in October 2016
- OPP managed consumer calls on RBPO appeals process

Regulatory Development: Work To-Date, 2017

- Reviewed submitted reports, provided guidance to RBPOs
- Held listening session for provider organizations in August 2017
- Reviewed compliance of Applicants for ACO certification
- Outreach to 3 contracted external review agencies and the national accrediting body for review agencies, URAC
- Outreach to RBPOs/ACOs
- Outreach to MassHealth and the Division of Insurance
- Continue to manage consumer calls on RBPO appeals process

Reporting Update: October 2016 through March 2018

Office of Patient Protection ACO/RBPO Report	
Submission Element	**Regulation Requirements**
ACO-01	**Name of ACO or RBPO**
ACO-02	**Provider / Practice Name** (if Organization is submitting multiple reports)
ACO-03	**Name and professional title of the general contact person(s) within your organization for patient appeals?**
ACO-03A	**Phone Number**
ACO-03B	**Email Address**
ACO-04	**Copy of Patient Appeals Notice Attached / Sent to OPP (NOTE: The notice need only be submitted once unless it has changed since the previous report.)**
ACO-05	**Total number of appeals received by RBPO**
ACO-05A	**Total number of appeals provided an expedited review for patients with urgent medical need**
ACO-06	**Number of appeals regarding denials or restrictions on referrals to providers not affiliated with the RBPO**
ACO-06A	**Number of appeals in this category resolved in favor of the patient**
ACO-06B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-07	**Number of appeals regarding denials or restrictions on type or intensity of treatment or services**
ACO-07A	**Number of appeals in this category resolved in favor of the patient**
ACO-07B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-08	**Number of appeals regarding denials or restrictions on timely access to treatment or services**
ACO-08A	**Number of appeals in this category resolved in favor of the patient**
ACO-08B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-09	**Number of "Other" appeals and a description of the issues that consumers raised**
ACO-09A	**Number of appeals in this category resolved in favor of the patient**
ACO-09B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-10	**Description of ACO/RBPO Appeals Process, including at what organizational level (i.e., individual practice or provider organization) the appeals process is initiated and the standards or guidelines used to review appeals. (NOTE: The second and any subsequent reports need only state any changes to the process since the previous report.)**
ACO-11	**Professional title, and clinical background of the individual(s) reviewing patient appeals. If multiple reviewers or a team of reviwers are utilized, please describe this operational approach. (NOTE: The second and any subsequent reports need only state any changes to the operational approach since the previous report.)**

- 20 provider organizations currently subject to Interim Guidance
- Approximately 1.5M risk patients eligible for this process out of 4.1M total enrollment in commercial insurance
- 134 total appeals reported
- 107 (80%) reported appeals dealt with referral restrictions
- Many provider organizations going above and beyond interim guidance notice requirements
- Provider organization feedback has been positive in implementing the internal appeals process

HPC

Considerations in Regulatory Development

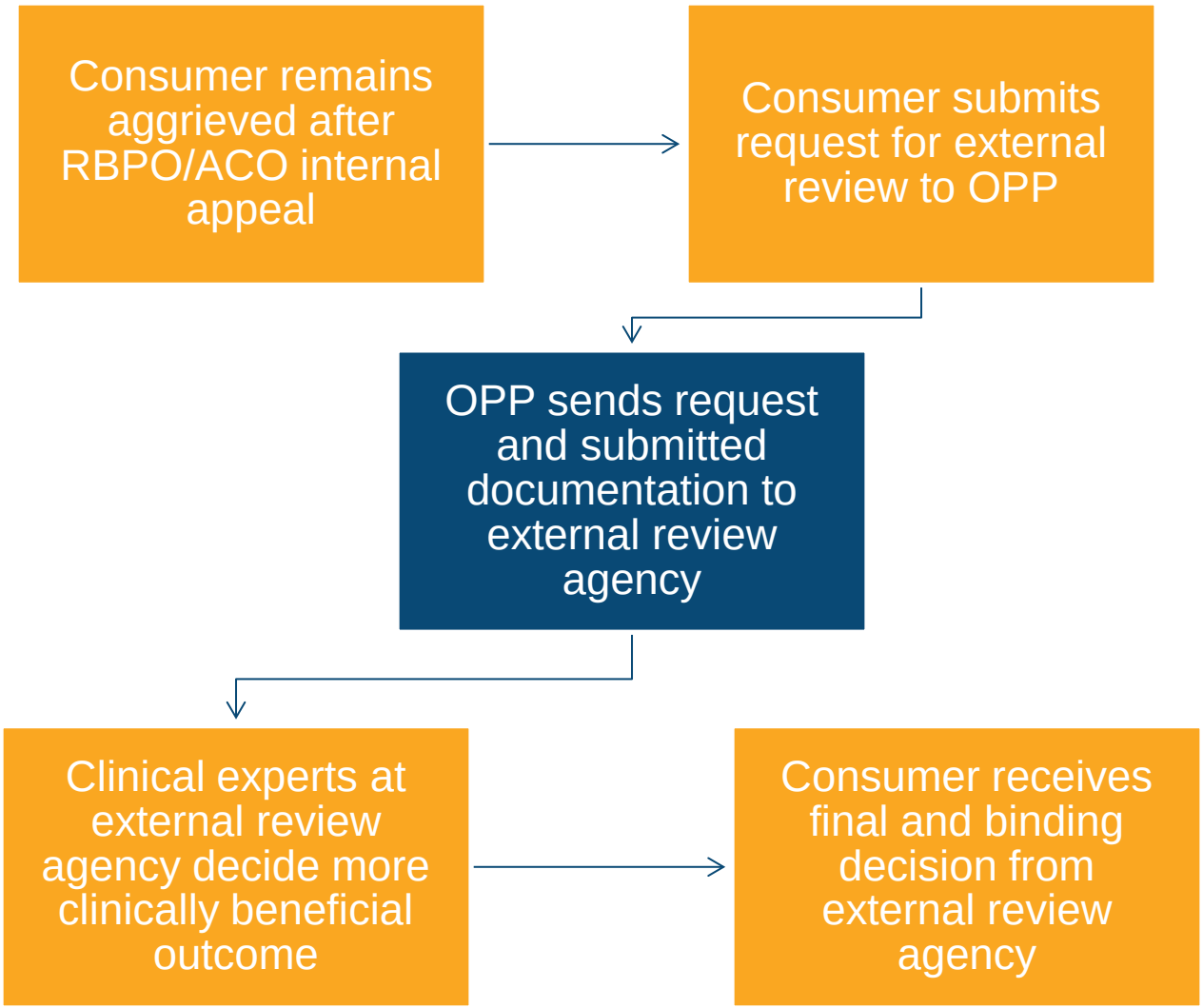
1. Build on existing RBPO/ACO mechanisms for addressing patient concerns
2. Closely track the Interim Guidance - implementation ongoing for over a year and RBPOs/ACOs report that appeals processes have been working well
3. Clarify expectations of both patients and RBPOs/ACOs
4. Create external review process that tracks closely to existing carrier review process, including use of external review agencies and limited OPP role
5. Reduce reporting burden, while maintaining oversight of novel patient protection

Key Elements of Proposed Regulation

External Review Process

- A patient may request an external review from OPP within 30 days of receiving written resolution of the internal appeal
- A patient may request an expedited external review
- OPP will screen all requests for eligibility
- OPP will send out all requests for external review to a contracted external review agency
- OPP will also seek a determination from an external review agency as to whether there is an urgent medical need where an expedited external review is requested
- The external review agency must issue a final decision within 21 days of receiving the assignment from OPP or within 72 hours of assignment for expedited external review
- The involved RBPO or ACO pays for the external review

Proposed RBPO/ACO External Review Process



Key Elements of Proposed Regulation

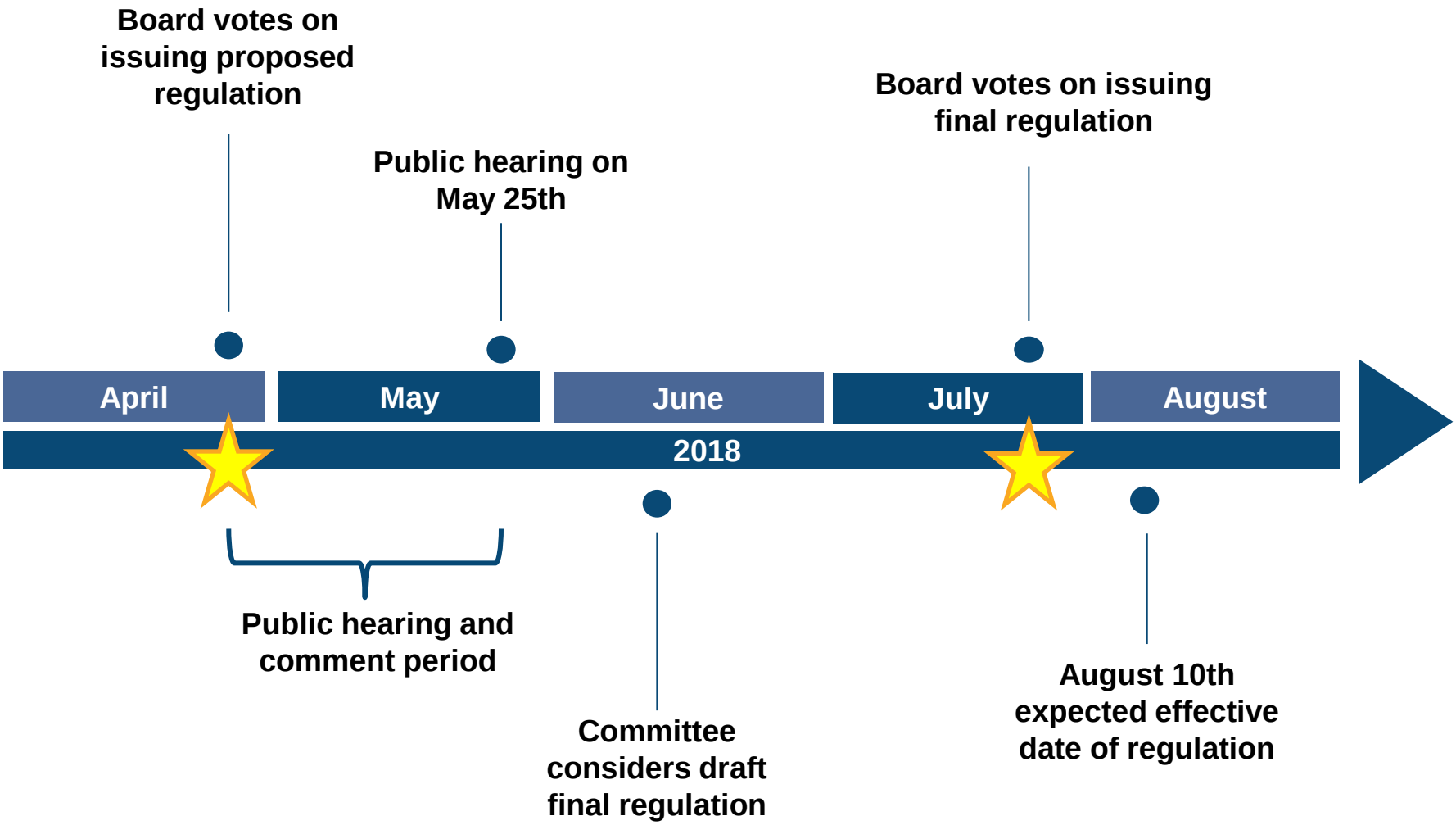
Standard of Review

- The external review agency must determine whether the requested referral, treatment or service that is the subject of the review is **likely to produce a more clinically beneficial outcome for the patient** than the referral, treatment or service recommended by the RBPO or ACO
- The external review agency must consider the following factors:
  - the patient's clinical history;
  - the availability, within the RBPO or ACO, of a health care professional with the appropriate training and experience to meet the particular health care needs of the patient;
  - generally accepted principles of medical practice;
  - the efficacy of the requested treatment; and
  - other factors relevant to the patient's ability to access the requested referral, treatment or service

RBPO/ACO Annual Reporting Requirements

- The RBPO/ACO must annually provide:
  - A copy of the patient notice used by the RBPO or ACO
  - Appeals received by the RBPO or ACO classified into: referrals to providers not affiliated with the RBPO or ACO; type or intensity of treatment or services; timely access to treatment or services; and other appeals
  - A description of the RBPO or ACO appeals process to resolve patient appeals, including the title and clinical background of the internal reviewers
  - An example of a written resolution of an appeal upholding the RBPO or ACO decision and an example of a written resolution of an appeal overturning the RBPO or ACO decision

Timeline


Board votes on issuing proposed regulation
Public hearing on May 25th
Board votes on issuing final regulation
April
May
June
July
August
2018
Public hearing and comment period
Committee considers draft final regulation
August 10th expected effective date of regulation

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Risk-bearing Provider Organization and Accountable Care Organization Appeals Proposed Regulation

MOTION: That the Commission hereby authorizes the issuance of the PROPOSED regulation on Risk-bearing Provider Organization and Accountable Care Organization Appeals, pursuant to MGL c. 6D, §§ 15 and 16 and MGL c. 176O, § 24, and to conduct a public hearing and comment period on the regulation pursuant to Chapter 30A of the General Laws.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the March 28, 2018 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- **Executive Director's Report**
  - Health Care Innovation Investment Evaluation Plan
  - Upcoming Listening Session on Shifting Drug Distribution Channels
  - Professional Services Contract Extension (VOTE)
  - Final Recommendation on 2017 Performance Improvement Plan Process
- Executive Session
- Schedule of Next Board Meeting (TBD)

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Procurement of independent evaluator for Health Care Innovation Investment (HCII) Program

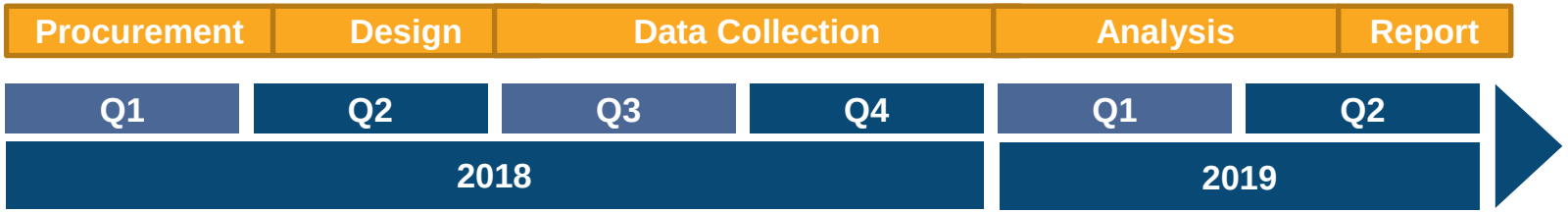
Scope

Design and conduct a qualitative process evaluation of four TCCI programs based on HPC research questions. Methods to include patient interviews and provider focus groups. Specific design to be proposed by applicant and finalized collaboratively.

Procurement

Selected Vendor: Brandeis University Schneider Institutes for Health Policy
Principal Investigator: Dr. Palmira Santos
Total Bid: $199,315
Estimated contract start date: May 1, 2018

Timing



HCII Evaluation Focus: Housing instability and palliative and hospice care

Focus areas

1 Housing instability

bhn

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

2 Palliative and Hospice care

CareDimensions

HOSPICE | PALLIATIVE CARE | SUPPORT SERVICES

Commonwealth Care Alliance

Two very different populations that share:

- High need for non-reimbursed care coordination activities
- Patient goals that often confound existing structures for documentation and integration
- Innovative approaches being tested by TCCI awardees – two different models for each population
- Cross-sector partnership-intensive strategies
- Family/social/caregiver relationships are paramount, but roles and dynamics are complex
- Gap in awardee and 3rd party evaluations

HPC

More information about these initiatives is available in the appendix

Focus 1: Housing instability

bhn BEHAVIORAL HEALTH NETWORK, INC

Target Population

Families (including adult caregivers and children in their care) in Hampden County who have been recently homeless or are at risk of homelessness with at least one member of the family with undertreated substance use disorder and/or mental illness

Primary Aim

Reduce emergency department visits and inpatient admissions by 20%

Service Model

Create a high-touch care coordination program linking behavioral health treatment, primary care, housing supports, and vocational services to provide stability

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

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

HPC

Focus 2: Palliative and Hospice Care

Target Population

High-risk North Shore Physicians Group patients with life-limiting illness, multiple comorbidities, and possible psychosocial issues

Primary Aim

Reduce all-cause readmissions and emergency department visits by 30%

Service Model

Integrate palliative care staff into primary care sites to increase early identification of patients requiring those services, and bridge the gap in care that occurs between curative care and end of life care

Target Population

Dual eligibles receiving their primary care and care management services through the Commonwealth Community Care program

Primary Aim

Reduce expenditures due to acute inpatient hospitalization and ED visits by 15%

Service Model

Deploy a disability-focused ambulatory ICU to provide integrated primary care, behavioral health care, dental care, palliative care, and chronic disease management to fill gaps in health and social services for their high-need population

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Schedule of Next Board Meeting (TBD)

Public Listening Session on Shifting Drug Distribution Channels

Public Listening Session

Wednesday, May 9, 2018
9:30 AM
50 Milk Street, 8th Floor

The HPC is conducting a public listening session for feedback on the shifting of drug distribution channels, commonly referred to as **"white bagging" and "brown bagging."**

Parties will have 5 minutes to offer comments. Written testimony and comments will also be accepted until **5:00 PM on Friday, May 11** to HPC-Testimony@state.ma.us.

For more information, please visit **Mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/**.

HPC

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HEALTH POLICY COMMISSION

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Background on Contract Extension Request

- The HPC has ongoing hourly rate contracts with several professional service firms, including with experts in economics, actuarial science, accounting, care delivery improvement, quality measurement, and payer-provider contracting.

- Understanding the unpredictability and need for flexibility in market transaction related activities, the HPC's by-laws allow the Executive Director to enter into contracts up to $500,000. **Board approval is required again for contracts valued at more than $500,000.**

- As the end of the state fiscal year (FY18) approaches, the Executive Director anticipates exceeding $500,000 for one contract and is seeking the Board's authorization to expend beyond this amount. The contractor is the **primary team of expert economic consultants** assisting with the economic modeling for the two cost and market impact reviews (CMIRs) this year.

- The additional funding request is **fully accounted** for within the current Board-approved budget for FY18 and is **not net new spending**, as it instead will be shifted from other funds already allocated for other expert consultants.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Professional Services Contract Extension

MOTION: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws and vote of the Commission on October 16, 2013, the Commission hereby authorizes the Executive Director to amend its contract with Bates White for an additional amount of $155,000 through June 30, 2018, for economic expertise in support of the Commission's ongoing measuring and monitoring of provider relationships and market changes, subject to further agreement on terms deemed advisable by the Executive Director.

MASSACHUSETTS
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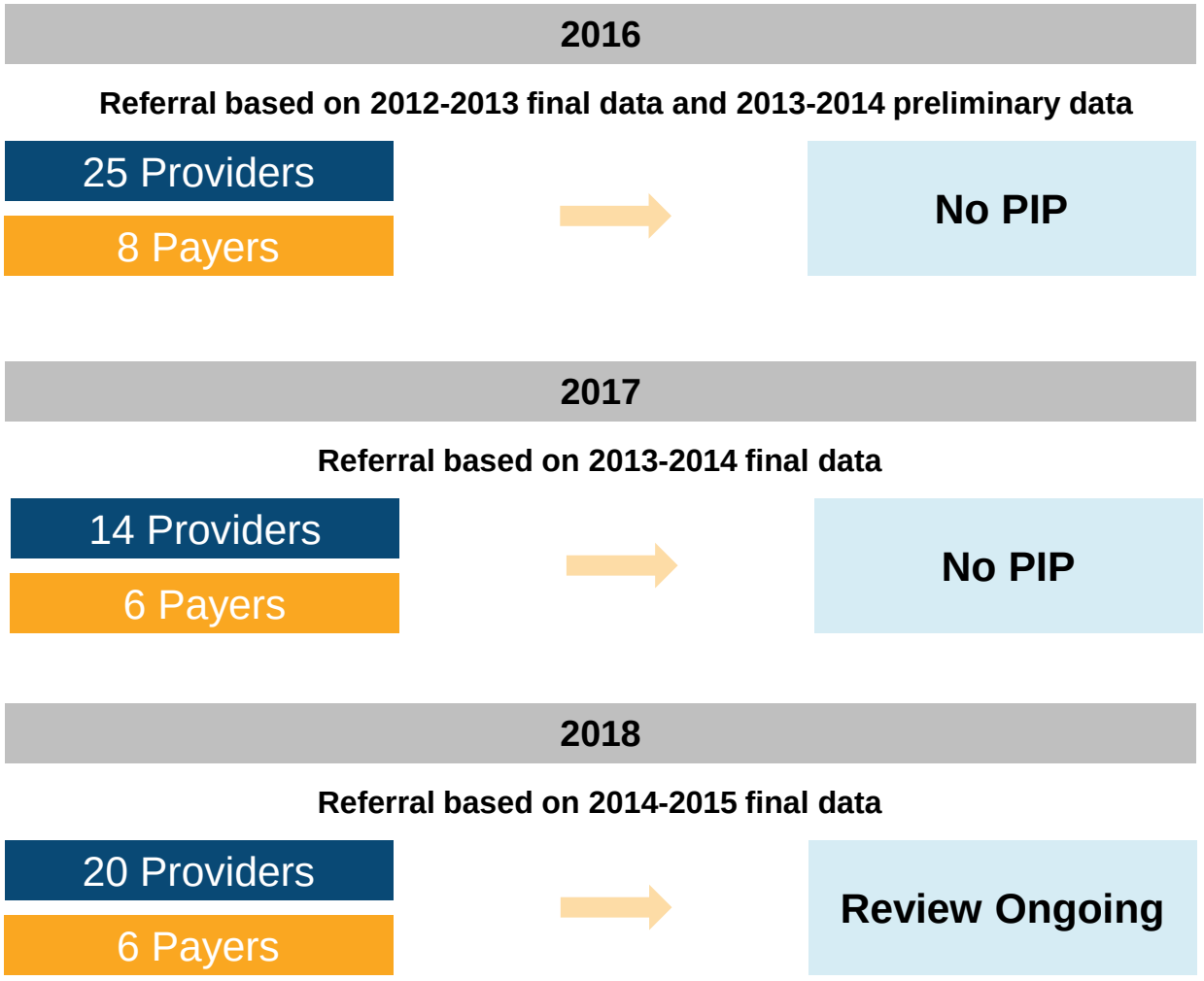
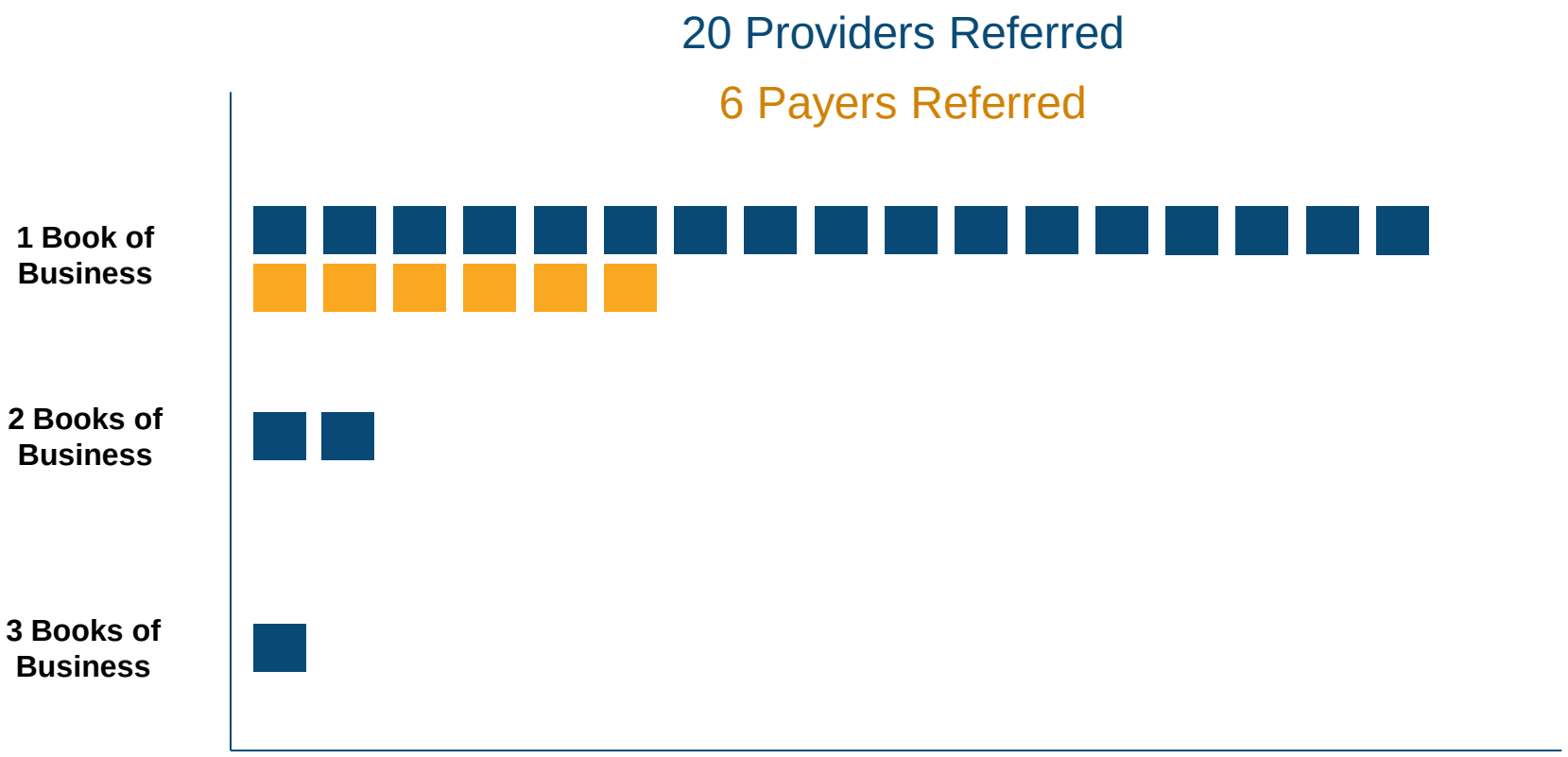
Recap of 2016 and 2017 PIPs Review Process



The majority of providers and payers were referred for their performance in a single book of business.



Next Steps in 2018 Review Process

Executive Session

Board vote to require follow up

- Staff shares findings of initial review process
- Commissioners deliberate and vote on whether to require follow up with any entities

Follow-up meetings

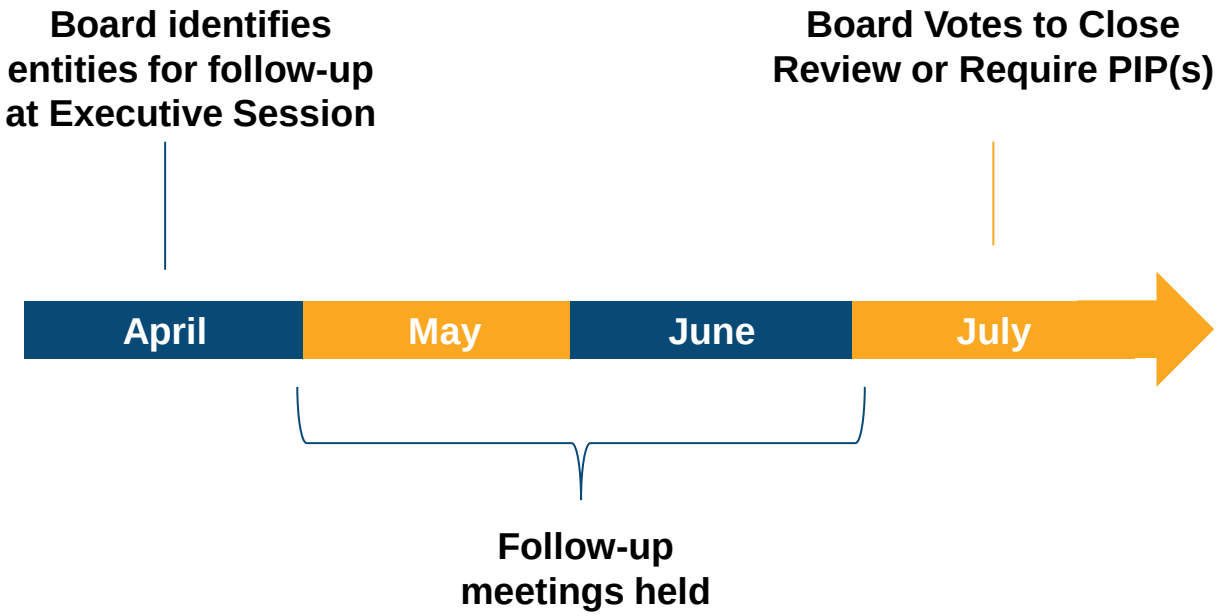
- HPC meets with entities to discuss their performance
- Seeks answers to questions raised by Commissioners

Executive Session

Potential Board vote to require PIP(s)

- Staff presents results of follow-up meetings
- Commissioners deliberate and vote on whether to require PIP(s)

PIPs Timeline



All dates are approximate

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 April 25, 2018 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.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
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- Executive Session
- **Schedule of Next Board Meeting (TBD)**

2018 Meetings and Contact Information

Board Meetings

Wednesday, April 25, 2018
Wednesday, July 18, 2018
Wednesday, September 12, 2018
Thursday, December 13, 2018

Committee Meetings

Wednesday, June 13, 2018
Wednesday, October 3, 2018
Wednesday, November 28, 2018

Contact Us

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

Special Events

Thursday, May 17, 2018: Partnering to Address the Social Determinants of Health: *What Works?*
Monday and Tuesday, October 15 and 16, 2018: Cost Trends Hearing