MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of June 19, 2013

MASSACHUSETTS HEALTH POLICY COMMISSION

THE HEALTH POLICY COMMISSION
McCormack Building
One Ashburton Place, 21st Floor
Boston, MA 02108

Docket: Wednesday, June 19, 2013, 12:00PM

---

1. **Approval of the Minutes from April 24, 2013 Meeting (APPROVED)**

2. **Executive Director Report**

3. **Quality Improvement and Patient Protection Committee Update**
    a. **Approval of Proposed Guidelines on Mandatory Nurse Overtime (APPROVED)**
    b. **Approval of Regulations Relative to the Office of Patient Protection (OPP) (APPROVED)**

4. **Cost Trends and Market Performance Committee Update, Approval to Continue the Cost and Market Impact Review of the Partners/South Shore Merger (APPROVED)**

5. **Community Health Care Investment and Consumer Involvement Committee Update, Approval of Mitigation of the One-Time Assessment for Certain Hospitals (APPROVED)**

6. **Care Delivery and Payment System Reform Committee Update, Patient-Centered Medical Home (PCMH) Certification Update**

7. **Administration and Finance, Approval of the Fiscal Year 2014 Operating Budget (APPROVED)**

8. **Public Comment**

Health Policy Commission

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

Date of Meeting: Wednesday, June 19, 2013
Beginning Time: 12:01PM
End Time: 2:38PM

Board Member	Attended	ITEM 1	ITEM 3a	ITEM 3b	ITEM 4	ITEM 5	ITEM 7
		Approval of Minutes from April 24, 2013	**Approval of Proposed Guidelines on Mandatory Nurse Overtime**	**Approval of Regulations Relative to the OPP**	**Approval to Continue the Cost and Market Impact Review of the Partners/ South Shore Merger**	**Approval of Mitigation of the One-Time Assessment for Certain Hospitals**	**Approval of the Fiscal Year 2014 Operating Budget**
Carole Allen	Yes	Yes (2nd)	Yes (2nd)	Yes	Yes	Yes (2nd)	Yes
Stuart Altman*	Yes	Yes	Yes	Yes	Yes	Yes	Yes (M)
David Cutler	Yes	Yes	Yes	Yes	Yes (M)	Yes	Yes
Wendy Everett	No	A	A	A	A	A	A
Paul Hattis	Yes	Yes	Yes	Yes	Yes (2nd)	Yes	Yes
Rick Lord	Yes	Yes	Yes	Yes	Yes	Yes (M)	Yes (2nd)
John Polanowicz	Yes	A	Yes	Yes	Yes	Yes	A
Glen Shor	Yes	A	A	Yes	Yes	Yes	Yes
Marylou Sudders	Yes	Yes (M)	Yes (M)	Yes (M)	Yes	Yes	Yes
Veronica Turner	Yes	Yes	Yes	Yes (2nd)	Yes	Yes	A
Jean Yang	Yes	A	Yes	Yes	Yes	Yes	Yes
Summary	**10 Members Attended**	**Approved with 6 votes**	**Approved with 9 votes**	**Approved with 10 votes**	**Approved with 10 votes**	**Approved with 10 votes**	**Approved with 8 votes**

*Chairman
(M): Made motion; (2nd): Seconded motion; A: Absent

PROCEEDINGS

A regular meeting of the Massachusetts Health Policy Commission was held on Wednesday, June 19, 2013, at the McCormack Building, One Ashburton Place, 21st Floor, Boston, MA 02108.

Commissioners present included Chair Stuart Altman; Dr. Carole Allen; Dr. David Cutler; Dr. Paul Hattis; Mr. Rick Lord; Mr. John Polanowicz, Secretary, Executive Office of Health and Human Services; Mr. Glen Shor, Secretary, Executive Office of Administration and Finance; Ms. Marylou Sudders; Ms. Veronica Turner; and Ms. Jean Yang.

Chair Altman called the meeting to order at 12:01PM and reviewed the agenda.

ITEM 1: Approval of the Minutes from the April 24, 2013 Meeting

Chair Altman called for a motion to approve the minutes of the April 24, 2013 meeting. **Ms. Marylou Sudders** made a motion to approve the minutes; **Dr. Carole Allen** seconded the motion. The Commission voted unanimously to approve the minutes.

ITEM 2: Executive Director Report

Mr. David Seltz, Executive Director of the Health Policy Commission, presented a report of the Executive Director. He first reviewed the agenda for the current meeting as well as policies which would be voted on by the Commission during the meeting and their legislative background. He additionally reviewed implementation activities by staff and the Commission from January 2013 through June 2013. He then reviewed upcoming Commission and Committee meetings.

ITEM 3a: Quality Improvement and Patient Protection Committee Update, Approval of Proposed Guidelines on Mandatory Nurse Overtime

Ms. Marylou Sudders, Chair of the Quality Improvement and Patient Protection (QIPP) Committee, presented on proposed guidelines regarding mandatory nurse overtime, on which the Commission would be voting.

In section 226(d) of Chapter 224, the legislature directed the Health Policy Commission to establish guidelines to determine what constitutes an emergency situation for the purposes of allowing mandatory nurse overtime in a hospital setting. The legislature required that the Commission consult with employers and employees who would be affected by such guidelines in developing them.

Ms. Sudders discussed the deliberative nature of the process that the Committee members and staff used to generate the final guidelines. Ms. Sudders took time to acknowledge the efforts of direct care workers, unions that represent nurses, nurse managers and leaders, hospital administrators, and of the Department of Public Health and other state agencies.

Ms. Lois Johnson, General Counsel with the Health Policy Commission, presented on the content of the finalized guidelines. Staff and Commissioners updated and refined the proposed guidelines and incorporated the concerns and input of organizations, hospitals, and their leaders.

The finalized guidelines defined an emergency situation for the purposes of allowing mandatory nurse overtime under Section 226(d) as "an unforeseen event that could not be prudently planned for or anticipated by a hospital and affects patient safety in the hospital and where there is a government declaration of emergency, catastrophic event, or hospital emergency."

The guidelines also provide that mandatory nurse overtime "shall not be ordered in the case of an emergency situation where there is a reasonable alternative to such overtime," and offer some examples of those reasonable alternatives. The guidelines provide for such cases that "where an unexpected vacancy occurs despite a hospital's implementation of a reasonable alternative, the hospital is required to exercise a good faith effort to fill the shift on a voluntary basis."

Finally, the guidelines provide, "a determination that an emergency situation that affects patient safety in the hospital exists shall be made by a hospital's chief executive officer or a specific senior management designee and must be reasonable under the circumstances." Ms. Johnson noted that the guidelines were clarified to specify the circumstances under which the hospital's CEO or a designee should make the determination that an emergency situation external or internal to the hospital affects patient safety in that hospital.

In terms of reporting, the guidelines also stipulate that the Health Policy Commission, through the QIPP Committee, shall monitor and review reports of mandatory nurse overtime that hospitals file as they are required to do under the statute through the Department of Public Health.

Ms. Marylou Sudders reiterated that for the first time, the state and the QIPP Committee would be collecting uniform data across all hospitals, and that the Committee would reconvene with the Commission if members felt adjustments needed to be made to guidelines based upon data which was collected.

Chair Stuart Altman emphasized that the issue of mandatory nurse overtime is not unique to the Commonwealth of Massachusetts and that the process which the Committee and staff conducted was both thorough and extensive in producing the finalized guidelines.

A period of questions and comments by the full Commission was initiated.

Dr. Paul Hattis noted his expectation that the Department of Public Health would be equipped with adequate forms for reporting and filing cases so that the factual information collected through reporting would be sufficient to make a full assessment regarding the guidelines.

Dr. Carole Allen noted that the process of drafting the guidelines had been very collaborative, that she felt very comfortable with the guidelines that had been produced, and that it would now

be the monitoring process which would be the most important aspect of the continued procedures for handling mandatory nurse overtime.

Ms. Veronica Turner acknowledged the collaborative nature of the drafting process as well as the work of staff and the QIPP Committee. She asked Ms. Marylou Sudders and Ms. Lois Johnson to identify where within the guidelines the change had been made regarding a hospital-declared emergency and the designation of a CEO. Ms. Marylou Sudders identified the change in language and reread the text on page 12 of the Committee presentation (see **LIST OF DOCUMENTS PRESENTED AND POSTED AFTER THE MEETING**).

Mr. John Polanowicz noted that there are a number of organizations which do not have CEOs, but which have presidents, other organizational structures, or vacancies. He asked if another individual would be able to be specified or designated rather than a CEO by the guidelines. Ms. Johnson responded that that was the intent of the guidelines' new language.

Ms. Sudders made a motion to approve the proposed guidelines on mandatory nurse overtime and read the following: "That the Commission hereby approves and issues the attached guidelines on mandatory overtime for nurses in hospital settings, developed pursuant to section 226(d) of Chapter 224 of the Acts of 2012 by the Commission's Committee on Quality Improvement and Patient Protection, and directs the Committee to monitor and report to the Commission on the implementation as provided in the guidelines." After consideration, upon motion made and duly seconded by **Dr. Carole Allen**, it was voted to approve the guidelines on mandatory nurse overtime.

Voting in the affirmative were the nine present Commissioners. There were no abstentions and no votes in opposition.

ITEM 3b: Quality Improvement and Patient Protection Committee Update, Approval of Regulations Relative to the Office of Patient Protection (OPP)

Ms. Marylou Sudders initiated discussion regarding a second matter from the QIPP Committee to effectuate the transfer of the Office of Patient Protection (OPP) from the Department of Public Health to the Health Policy Commission. Ms. Sudders noted that the transfer would not be a one-time regulatory change, but rather an ongoing process for which the QIPP Committee would hold further listening sessions during the upcoming year.

Ms. Sudders requested that Ms. Jen Bosco, Director of the OPP, discuss the transfer in further detail. Ms. Bosco relayed that Chapter 224 had legislated the transfer of the OPP from the Department of Public Health to the Health Policy Commission. As part of the transfer, the Department of Public Health had repealed regulations related to the OPP, and the Health Policy Commission had adopted the same language in its emergency regulations. The new Health Policy Commission regulations are essentially the same as the formerly repealed Department of Public Health regulations with only the technical changes necessary to carry out the transfer, which took effect on April 20, 2013.

The first regulation, 958 CMR 3.00, establishes requirements for carriers in administering internal grievance procedures for the conduct of external reviews for carriers' adverse determinations based on medical necessity, continuity of care and referral to specialty care, and for the annual reporting requirements for carriers. The second regulation, 958 CMR 4.00, establishes requirements for requests by consumers seeking a waiver to purchase non-group health insurance outside open enrollment periods.

The Health Policy Commission requested comments and held a public hearing jointly with the Department of Public Health on June 10, 2013, on the repeal of the Department of Public Health regulations and the adoption of the Health Policy Commission regulations. Testimony was received and one set of comments was received from Health Care for All.

Ms. Bosco noted that at this time, only technical changes were still being made to the regulations, but that in coming months, it was anticipated that further regulatory changes would be initiated, particularly as the Affordable Care Act (ACA) legislation contained several provisions related to the OPP which would necessitate substantive alterations. Listening sessions were planned, and public comments would be sought in the process of making regulatory changes.

Chair Stuart Altman requested that Ms. Bosco elaborate on the exact responsibilities of the Commission related to the OPP, and to specifically identify the kind of authority which the Commission does and does not have regarding consumer protections.

Ms. Bosco described review processes more fully. She relayed that there is an external review process for Massachusetts consumers, and that consumers who are insured under a fully-insured health plan have certain appeal rights. If consumers seek medical or behavioral health treatment that is denied based upon medical necessity, they first have internal grievance rights, and the OPP regulates the rules around those internal grievances. If a health plan still denies coverage after an internal grievance is filed, then the consumer may appeal through an external review process which the OPP administers. The OPP provides an application for and has established regulations around the process. It is important to note that the OPP does not provide a decision or offer clinical expertise itself, but rather contracts through three outside sources which are independent review organizations with medical experts in the areas that may be appealed. On a random basis, external review requests are sent to the agencies to be decided. When decisions are returned, for the purposes of that review process, they are final, and there are no further appeal rights after the external review agency returns a written decision, including an explanation regarding the medical necessity of a treatment.

Dr. Carole Allen asked Ms. Bosco if she could give data regarding the approximate volume of appeals. Ms. Bosco answered that there have been about 400 external review requests per year historically, and that it appeared that this number would continue at about the same rate.

Dr. Paul Hattis asked if the OPP received reporting from ERISA plans. Ms. Bosco responded that the OPP's reporting requirements do not include self-funded ERISA plans.

Mr. Rick Lord asked if under the ACA legislation there would be a federal reporting requirement as well, or if reporting would be determined by states. Ms. Bosco replied that the ACA legislation set out certain requirements following the National Association for Insurance Commissioners' Act for internal and external reviews, and that states have the choice to either comply with established reporting requirements or to complete a federal external review process. Ms. Jean Yang added by discussing aspects of consumer protections within Massachusetts' Health Insurance Connector as well as its work with the OPP. She noted that within her agency, it was important to ensure that an appeals process was available not only to exchange customers but to all market consumers, and that close work with the OPP would be important to ensure that appeals processes were both seamless and effective.

Ms. Sudders made the motion to approve regulations relative to the OPP and read the following: "That the Commission hereby accepts and approves final regulations related to the Office of Patient Protection, 958 CMR 3.00 Health Insurance Consumer Protection and 958 CMR 4.00 Health Insurance Open Enrollment Waivers, in substantially the form attached hereto, and authorizes the Executive Director to do all acts and things necessary to promulgate these regulations." After consideration, upon motion made and duly seconded by **Ms. Veronica Turner**, it was voted to approve the regulations relative to the OPP.

Voting in the affirmative were the ten present Commissioners. There were no abstentions and no votes in opposition.

ITEM 4: Cost Trends and Market Performance Committee Update, Approval to Continue the Cost and Market Impact Review of the Partners/South Shore Merger

Dr. David Cutler updated the Commission on the activities of the Cost Trends and Market Performance Committee. He noted that there would be a presentation which would lead into a vote regarding the issues discussed.

Mr. David Seltz proceeded to update Commissioners on the issues to be decided. He briefly reviewed the legislative background and context for cost and market impact reviews (CMIRs). Cost and market impact reviews are meant to provide the Health Policy Commission the opportunity to ask important questions on behalf of consumers. He reiterated that CMIRs are different from antitrust cases or a determination of need. The result of a CMIR is a public report to which involved parties have the opportunity to respond and provide input. The final review may find the potential for positive as well as negative impacts on cost, quality of care, or market functioning.

Mr. Seltz presented a summary of three categories into which received notices had been sorted as of June 19, 2013. He said that Commissioners would be updated regarding the status of received notices at each full Commission meeting. Staff had received six notices as of June 19, 2013. Staff had elected not to proceed with two notices. Three notices were pending decision. A CMIR had been initiated on one transaction.

Ms. Karen Tseng, Policy Director for Market Performance with the Health Policy Commission, summarized the notices received as of June 19, 2013. Within the category of transactions on which no action had been taken, the first was a clinical affiliation among Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical Faculty Physicians (at BIDMC), and Cambridge Health Alliance. The second was a merger of Cooley Dickinson Hospital and Partners HealthCare System. Following discussion of the latter transaction, Ms. Tseng noted that in the future, joint contracting transactions would require notices of material change.

Mr. Seltz presented on pending notices, which were still in the process of a 30-day review, and which staff were continuing to analyze and evaluate. These included Steward Health Care System's acquisition of Hawthorn Medical Associates, with a deadline to initiate a CMIR by June 23, 2013; a clinical affiliation among Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical Faculty Physicians (at BIDMC), and Signature Brockton, with a deadline to initiate a CMIR by July 4, 2013; and the formation of a new Children's Hospital contracting entity, with a deadline to initiate a CMIR by July 12, 2013. Mr. Seltz proceeded to review the transaction currently under review by the Commission, a proposed merger of South Shore Hospital with Partners HealthCare System.

Ms. Tseng presented to the Commission regarding the basis for the review and the factors to be considered during the process. The Commissioners then initiated a period of discussion with staff.

Dr. David Cutler summarized the Commissioners' discussion. He noted that a number of Commissioners, particularly Dr. Hattis and Ms. Yang, had made comments regarding market structures and their particular effects on costs and quality. He said that the Cost Trends and Market Performance Committee had plans to explore those structures through discussions with experts and interactions with literature on the topic. He also noted that a number of Commissioners had commented on wanting to understand the details of the transaction, how it would achieve gains, and what its ancillary impacts would be. He explained that the next step in the CMIR process would be to request that Partners and South Shore Hospital address those issues. He praised the Commissioners and staff for not having prejudged the transaction and rather for having raised issues and simply requested that the parties elaborate on them within the context of the Commission's analysis.

Dr. David Cutler made a motion to authorize the continuation of the cost and market impact review of the merger between Partners HealthCare System and South Shore Hospital, reading the following: "That the Commission hereby authorizes the continuation of the cost and market impact review of the proposed material change to Partners HealthCare System, Inc. and South Shore Hospital, Inc., pursuant to section 13 of chapter 6D of the Massachusetts General Laws and the Commission's Policy 2013-01 (Process for Review of Notices of Material Changes)." After consideration, upon motion made and duly seconded by **Dr. Paul Hattis**, it was voted to approve the continuance of the cost and market impact review.

Voting in the affirmative were the ten present Commissioners. There were no abstentions and no votes in opposition.

ITEM 5: Community Health Care Investment and Consumer Involvement Committee Update, Approval of Mitigation of the One-Time Assessment for Certain Hospitals

Dr. Paul Hattis updated the Commission regarding the activities of the Community Health Care Investment and Consumer Involvement Committee.

Mr. David Seltz offered background on the one-time assessment and discussion of the recommended proposal for the mitigation. Section 241 of Chapter 224 authorized the Commission to assess certain qualifying hospitals and qualifying surcharge payers for a total of $225 million. The purpose of the assessment is to support necessary investments, including the Distressed Hospital Fund, the Prevention and Wellness Trust Fund, the e-Health Institute Fund, and the Health Care Payment Reform Fund.

The portion of the assessment levied on surcharge payers is equal to $165 million and includes approximately 100 different organizations. Invoices were sent and the Commonwealth of Massachusetts is currently collecting the first year's installment of the assessment.

The hospitals' portion of the assessment was calculated based upon each hospital's FY 2010 operating surplus per the Chapter 224 legislation. Nine hospitals were considered to be "qualifying," including: Boston Children's Hospital, Massachusetts General Hospital, Brigham and Women's Hospital, Newton-Wellesley Hospital, Faulkner Hospital, Martha's Vineyard Hospital, Beth Israel Deaconess Medical Center, Mount Auburn Hospital, and New England Baptist Hospital.

The law included a mitigation provision which authorized the Health Policy Commission to provide assessment mitigations up to 66-percent or two-thirds if either one of two conditions were met: if the acute hospital or hospital system received more than 25-percent of reimbursements from Title XIX of the Social Security Act; or, if the acute hospital or hospital system's assets did not exceed $1.25 billion. Surcharge payers were not eligible for mitigations.

Eight applications for mitigations were received from qualifying hospitals. No criteria for consideration regarding mitigation applications were specifically stated within Chapter 224, but the staff and Committee focused on three key considerations: first, the rationale for mitigation included by the hospital in each of their applications; second, the recent trends in relative financial strength as evidenced by the hospital's operating surplus; and third, the impact of awarding mitigation on the Distressed Hospital Fund.

Mr. Seltz presented the hospital systems which had applied for mitigation and the rationale given by each. CareGroup, which included Beth Israel Deaconess Medical Center, Mount Auburn Hospital, and New England Baptist Hospital, had requested a 66-percent mitigation for all three hospitals, Boston Children's Hospital also applied for a 66-percent mitigation, and Partners HealthCare System requested a 66-percent mitigation for Brigham and Women's Hospital, Newton Wellesley Hospital, Faulkner Hospital, and Martha's Vineyard Hospital.

Mr. Seltz noted that Commission staff had completed their own analyses of recent trends in hospitals' financial strength. Based upon the staff's findings and key facts which were discovered during the evaluation, Mr. Seltz presented a 50-percent proposed partial mitigation for Boston Children's Hospital, for the CareGroup System hospitals, and for Martha's Vineyard Hospital. This partial mitigation would result in a total reduction of $2.3 million from the Distressed Hospital Fund per year over the next four years.

Dr. Carole Allen asked if the mitigation was for one year or calculated over the course of four years. Mr. Seltz responded that the mitigation was calculated based upon a lump sum number, but that hospitals could then choose to pay the amount in a lump sum or over the course of four years.

Dr. David Cutler commented that although less money would be paid into the Distressed Hospital Fund, that many of the hospitals being assessed do make investments in distressed hospitals or in areas of medical care that are underserved or under-reimbursed already, and that the mitigations are in some ways credits to this work.

Dr. Paul Hattis identified the importance of the Distressed Hospital Fund as not only funding hospitals but also as funding investments in the communities served.

Dr. Altman noted that although he did agree with Dr. Cutler's comments, the Distressed Hospital Fund was an important redistribution tool because it allowed not just certain individuals, but the Commonwealth of Massachusetts as a whole, to collectively decide the allocation of community resources. He commended the staff's balanced approach to the proposed mitigation.

A vote was called regarding the acceptance and approval of the recommendations of the Community Health Care Investment and Consumer Involvement Committee regarding assessment mitigation. The following motion was read: "That the Commission hereby accepts and approves the recommendations of the Commission's Committee on Community Health Care Investment and Consumer Involvement to provide assessment mitigation in accordance with the materials attached hereto as Exhibit A, pursuant to section 241(c) of Chapter 224 of the Acts of 2012, and authorizes the Executive Director to do all acts and things necessary or desirable to provide such mitigation."

Rick Lord made a motion to approve the proposed mitigation. After consideration, upon motion made and duly seconded by **Dr. Carole Allen**, it was voted to approve the proposed mitigation.

Voting in the affirmative were the ten present Commissioners. There were no abstentions and no votes in opposition.

ITEM 6: Care Delivery and Payment System Reform Committee Update, Patient-Centered Medical Home (PCMH) Certification Update

Dr. Carole Allen updated the Commission regarding the activities of the Care Delivery and Payment System Reform Committee.

The Committee discussed the statutory definition of Patient-Centered Medical Homes (PCMHs) as well as the objectives Commissioners and staff would focus on in creating a certification system for PCMHs. The Committee received a preliminary set of recommendations from staff regarding standards, models, and the certification process. Ms. Patricia Boyce, Director of Policy for Care Delivery and Quality for the Health Policy Commission, presented on the current findings of the Committee.

Ms. Boyce noted that currently about ten-percent of practices are formally accredited as PCMHs in the Commonwealth of Massachusetts. She reviewed data regarding the number of practices recognized and certified as PCMHs, identifying the numbers of practices which might be seeking recertification within the next two to three years. She noted that the National Committee for Quality Assurance (NCQA) is the only organization that recognizes both practices and providers as PCMHs. She also presented a map locating the geographic distribution of PCMHs across the Commonwealth of Massachusetts, identifying three clusters in the eastern, central, and western portions of the state, primarily organized around major health systems. She also summarized payment model considerations and identified next steps for the Health Policy Commission to consider.

A period of discussion was initiated with the Commissioners.

Dr. Carole Allen noted that at the May 20, 2013, Committee meeting, Dr. Rick Lopez of Atrius Health had also presented regarding his system's model, and she noted that there is some overlap between Accountable Care Organizations and PCMHs, which might create a challenge in developing individual certification programs.

Dr. Stuart Altman asked for elaboration regarding the history of PCMHs and their evolution from focus on primary care to greater involvement with specialty care.

Dr. Allen described that the PCMH originated in 1967 in pediatric care and with a concept that a primary care physician or pediatrician would be the main coordinator to ensure a child would receive all of his or her health care needs, receive appropriate referrals, and be engaged with appropriate specialists. The PCMH concept was founded upon the notion of care coordination, the inclusion of the family in decision-making, and the patient's and family's ownership of health care. As the concept has been expanded to adult care needs, she expressed an interest that the basic concept of care coordination be continued. She noted that care coordination is vital, dealing not only with primary care needs but also in dealing with behavioral health needs.

Dr. Paul Hattis added that in approaching the creation of a PCMH certification program or the creation of standards for PCMHs, a population or community health perspective should be included.

Dr. Carole Allen noted that new technologies and patient services may also alter the ways in which care is delivered or communicated to patients and reiterated that care coordination will be key.

Ms. Marylou Sudders called attention to behavioral health care, noting that the Chapter 224 legislation calls for the creation of behavioral health medical homes, and that around July 1, 2013, a behavioral health task force will be in place, which was also created by Chapter 224. She also cautioned that national standards are not always conducive to the support of behavioral health services, and that, as evidenced by initial demonstrations, behavioral health services had not yet been addressed by the national standards in place.

Dr. David Cutler asked Ms. Boyce if she had data as of yet regarding how many physicians, versus practices, were considered PCMHs. Ms. Boyce said that staff were still working to obtain that data.

ITEM 7: Administration and Finance, Approval of the Fiscal Year 2014 Operating Budget

Chair Stuart Altman initiated the final item on the agenda by noting that the Commission had created an Administration and Finance (ANF) Committee so that Commissioners could review the Health Policy Commission's budgets in consultation with the Executive Director, ensuring that the compensation system was both consistent and transparent. The ANF Committee had held a meeting, and Mr. David Seltz would review the substance of that meeting, including spending which had occurred through the end of FY 2013, and a proposed budget for FY 2014.

Mr. Seltz began by noting that as provided by Chapter 224, the Health Policy Commission may establish an annual operating budget to support the activities of the Commission with the approval of the board. Mr. Seltz reviewed the sources of funding for the Commission. The Health Policy Commission's trust fund has the two primary purposes: supporting the activities of the Commission and fostering innovation in health care payment and service delivery through a new competitive grant program.

Results from FY 2013 spending included significant progress in terms of supporting the Commission's activities and accomplishing statutory activities. Both staff and the Commission were on track to meet many legislative deadlines and deliverables. The Commission coordinated with several existing state agencies, minimized duplication of agency work, and maximized in-kind support from other state agencies to increase its efficiency. Additionally, the Health Policy Commission was able to secure the support of several sister agencies and focus those resources on policy developments. The Commission successfully and seamlessly transferred the Office of Patient Protection from the Department of Public Health to the Commission itself, and the final FY 2013 spending was consistent with the interim budget presented to and approved by the board in January 2013. It was then expected that the Commission would close FY 2013 with an approximate $3.7 million positive balance in the Health Care Payment Reform Trust Fund, which would equal the first installment of the assessment collected by the Health Policy Commission.

In reviewing the budget for FY 2014, Mr. Seltz reiterated that the anticipated starting balance would be $3.7 million. The second installment of the assessment was expected to generate approximately $2.5 million by June 30, 2014. He noted that the Health Policy Commission has the legislative authority to expend funds in anticipation of revenues, so long as the trust fund is in

balance at the end of the fiscal year, thus avoiding potential cash flow problems within the trust fund. He also noted that certain interagency agreements from FY 2013 were not expected to be continued in FY 2014, but that the Commonwealth of Massachusetts was expected to issue at least two gaming licenses in FY 2014 with a one-time transfer to the Health Care Payment Reform Trust Fund of $40 million. However, there was still some uncertainty regarding this amount as both the House and Senate budget negotiations for FY 2014 also involved the potential repurposing of those fees to the MassHealth Program.

In closing, Mr. Seltz reviewed a preliminary chart outlining the budget, including the beginning balance of the fund; an amount equal to the estimated deposits into the fund; estimated operating expenditures for the Health Policy Commission; an expenditure amount to be determined for the innovation investment program; and an estimated year-end balance.

Chair Stuart Altman requested that in reviewing the proposed FY 2014 budget, Commissioners focus less on the potential deposits into the fund, which were still uncertain, and more on the amount which Mr. Seltz had proposed to expend on Health Policy Commission operations.

Ms. Jean Yang offered both the ANF Committee and the staff recognition for their budget formulation. She recognized that budget calculations are subject to change as needs and resources change, and she encouraged the staff and Committee members to be communicative and engaged.

Chair Stuart Altman also recommended that the Executive Director come before the ANF Committee on a quarterly basis to update the Committee members on any changes to the budget, and regarding how funds are being expended. He noted that Commissioners would collectively be discussing the amount allocated to the innovation investment.

Chair Stuart Altman made a motion to approve the Health Policy Commission's FY 2014 operating budget and read the following: "That the Commission hereby accepts and approves the Commission's total operating budget for fiscal year 2014 as recommended by the Commission's Committee on Administration and Finance and as presented and attached hereto, and authorizes the Executive Director to expend these budgeted funds." After consideration, upon motion made and duly seconded by **Mr. Rick Lord**, it was voted to approve the proposed FY 2014 operating budget.

Voting in the affirmative were the eight present Commissioners. There were no abstentions and no votes in opposition.

ITEM 8: Public Comment

Ms. Kathy Keough of Atrius Health made a request that Commission staff announce or publicly post all Commission and Committee meetings in advance to ensure public attendance.

Mr. David Seltz responded that staff intended to plan all Commission and Committee meetings in advance for CY 2014 so that there would be regular dates for both. They would be scheduled

and posted to the website as soon as they were established. He also noted that the website is regularly updated with Commission and Committee materials.

Following the close of public comment, Chair Stuart Altman adjourned the meeting at 2:38PM.

LIST OF DOCUMENTS PRESENTED AND POSTED AFTER THE MEETING

1. Meeting Agenda, 6/19/2013
2. Minutes of the 4/24/2013 Health Policy Commission Meeting
3. Committee Presentation, 6/19/2013