MEETING MINUTES:

CARE DELIVERY TRANSFORMATION COMMITTEE

Meeting of June 13, 2018

MASSACHUSETTS HEALTH POLICY COMMISSION

Care Delivery Transformation Committee
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, June 13, 2018, 11:00 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Care Delivery Transformation (CDT) Committee held a meeting on Wednesday, June 13, 2018, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Mr. Martin Cohen (Chair), Dr. Donald Berwick, Mr. Timothy Foley, Dr. John Kryder, and Undersecretary Lauren Peters, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services.

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

Mr. Cohen called the meeting to order at 11:06 AM. He welcomed members of the public to the meeting.

ITEM 1: APPROVAL OF MINUTES FROM THE FEBRUARY 14, 2018 MEETING
Mr. Cohen reviewed the agenda for the day's meeting. Mr. Cohen asked to make one small agenda change by beginning the meeting with the Quality Measurement Alignment Taskforce portion.

Mr. Cohen asked for a motion to approve the minutes from the CDT Committee meeting held on February 14, 2018. Dr. Berwick motioned to approve the minutes. Undersecretary Peters seconded. Committee members voted unanimously to approve the minutes.

TEM 2: CARE DELIVERY TRANSFORMATION UPDATES
Ms. Katherine Shea Barrett, Policy Director, Care Delivery Transformation, provided a recap of the HPC's Spring Care Delivery Event. For more information, see slides 7-8. A video of the event is available here.

Ms. Barrett provided an introduction to HPC's collaboration with PULSE@MassChallenge (PULSE) *(note: PULSE@MassChallenge has since changed its name to MassChallenge HealthTech)*. Ms. Barrett asked Undersecretary Peters to expand on the role of the Digital Health Council given its relevance to PULSE.

Undersecretary Peters provided an overview of the work of the Digital Health Council. She noted that the areas emphasized in the collaboration were the enhancement of the health information exchange, promoting a competitive market for digital health companies, and identifying key stakeholders.

Ms. Barrett continued the presentation on the collaboration with PULSE. For more information, see slides 10-12.

ITEM 3: QUALITY MEASUREMENT ALIGNMENT TASK FORCE

Ms. Barrett introduced Undersecretary Lauren Peters who serves as Chair of the EOHHS Quality Measure Alignment Taskforce. Undersecretary Peters framed the presentation and turned it over to Vivian Haime, HPC's Manager for Care Delivery Transformation and Strategic Partnerships

Ms. Haime provided updates on the Quality Measure Alignment Taskforce. For more information, see slides 39-46.

Mr. Foley asked why there were zero endorsed core/menu measures and zero endorsed monitoring measures in "Equity and Social Determinants of Health" in the table referenced on slide 45. Ms. Haime responded that those measures were placed in the developmental category, which means that these measures were either not validated sufficiently on a national level or not ready for inclusion in contracts but were important measures of concepts that were a priority to the Commonwealth. Ms. Barrett added that regarding equity, the HPC was faced with the difficult decision of taking the existing 25 measures and stratifying them by subpopulation or having a specific equity-equality measure. The Taskforce decided on the stratification approach rather than an equity-specific measure. Ms. Barrett added that the Taskforce needs the data in order to stratify measures by different disparities of a population that and it may be too cumbersome to account for all the different subpopulations.

Dr. Kryder asked for clarification on whether a majority of the measures were pediatric. Ms. Haime responded that although a number of the measures applied to pediatric populations, they were not pediatric-based.

Mr. Cohen asked for confirmation on whether submitting quality information was voluntary. Ms. Barrett responded that the Taskforce had designed it as a voluntary program. She noted that some of the payer participants on the Taskforce had voiced that they did not plan to adopt the aligned set. She said that a performance-based component to ACO certification might be added in the future which would leverage the aligned measure set, but that the HPC's lack of data in this realm remains a barrier.

Dr. Berwick thanked the staff for their work but asked if the measure set presented is strong enough that commercial payers might use it generally and not only for ACO populations. Ms. Barrett responded that this would be the ideal outcome. She noted that staff focused on ACO contracts because that is where the most money is from a health plan perspective. Ms. Barrett added that there was tension between including more outcome and patient-reported measures and including Healthcare Effectiveness Data and Information Set (HEDIS) measures which are collected annually from health plans for National Committee for Quality Assurance (NCQA) accreditation.

Mr. Cohen commended the work of the staff. He noted that at his first Cost Trends Hearing, someone asked why there could not be one, simple set of measures and said that he appreciated that there was now one developed.

ITEM 4: PCMH PRIME Strategy Recommendations

Ms. Barrett introduced Ms. Catherine Harrison, Deputy Director, Care Delivery Transformation, and Ms. Kelsey Brykman, Manager, Care Delivery Transformation.

Ms. Harrison provided a brief overview of the presentation on Patient-Centered Medical Home (PCMH) PRIME Strategy Recommendations.

Dr. Kryder left the meeting at this time.

Ms. Brykman reviewed the current state of PCMH PRIME. For more information, see slides 21-26.

Ms. Brykman reviewed the PCMH PRIME policy context as a basis for the recommendation. For more information, see slides 28-31.

Undersecretary Peters left the meeting at this time.

Ms. Barrett added that an another important factor to consider regarding the future of PCMH PRIME is the level of staff resources required to run the current program. She noted that decreasing the level of staff time needed to support PCMH PRIME might free up resources for other projects, while not diminishing the team's focus on supporting behavioral health integration into primary care. She said that there might be other levers, such as ACO Certification, to continue driving this policy priority.

Dr. Berwick asked what significant changes in PCMH PRIME would mean for providers. Ms. Brykman responded that she would address his question later in the presentation.

Ms. Brykman reviewed the recommendation for the future of PCMH PRIME, including adopting the NCQA Distinction in Behavioral Health Integration (BHI) program as the new HPC PCMH certification program. For more information, see slides 33-37.

Mr. Cohen asked what the cost impact would be of changing the certification period from 3 years to 1 year in the table on slide 31. Ms. Brykman said that staff had put together an estimate that showed the BHI module being slightly more expensive than the current PCMH PRIME program. She noted that there might be an opportunity to negotiate a fee reduction with NCQA.

Dr. Berwick asked if the expense would be to the HPC or to the practice. Ms. Brykman responded that, because the staff is proposing to have the HPC cover the cost of the NCQA BHI application fee for practices in Massachusetts, the added cost would fall to the HPC. Dr. Berwick responded that in order to get the BHI Distinction, practices would still need to pay for and achieve PCMH Recognition. Ms. Barrett noted that is the case now under the current PCMH PRIME program as well. She said that the HPC would continue not to cover practices' NCQA PCMH Recognition application fees. Dr. Berwick asked what the overall NCQA application costs would look like for PCMH Recognition plus BHI Distinction. Ms. Brykman responded that the fees per practice could vary widely, given that NCQA's fees are based on the number of clinicians per practice. She added that the update from the 2014 NCQA PCMH program to the 2017 program completely changed the pricing structure.

Ms. Barrett referenced the appendix showing the pricing for PCMH PRIME compared to the BHI Distinction module.

Mr. Foley asked what the main barriers to obtaining PCMH Recognition were. Ms. Brykman said that the administrative burden and the cost were the greatest burdens cited. She added that one of NCQA's goals for their new annual recognition process was alleviating some of those administrative burdens. She noted that conducting reviews on an annual basis alleviates the documentation burden when compared to the resource intensive, three-year review.

Ms. Harrison added that the 2017 NCQA PCMH Recognition program is additionally designed to alleviate some of the burden for practices by allowing more flexibility in how the practices demonstrate that they

meet the standards. She noted that rather than having a defined set of documents that every practice has to pull together for NCQA that might not otherwise be used in a practice setting, NCQA has changed its requirements because it did not want practices to be investing too much time and staff.

Mr. Foley asked how adopting the BHI Distinction module would change the role of the HPC. Ms. Brykman responded that, in terms of operations, NCQA has always reviewed documentation and then sent a report to HPC for HPC to make a final determination. She noted that were the HPC to adopt the BHI Distinction module, the HPC would no longer make the final determination about whether practices had achieved standards, nor would the HPC necessarily play a significant role in maintaining or updating the standards.

Ms. Harrison added that adopting the BHI Distinction module would likely free up some resources for redeployment to focus on similar topics in ACO certification and the rest of the HPC policy agenda. She noted that it has taken significant administrative resources for the HPC to develop and maintain a set of standards that similar to NCQA's but not exactly the same.

Mr. David Seltz, Executive Director, added that the HPC has been considering developing a seal and a brand for practices that meet the BHI Distinction.

Dr. Berwick said that he generally agreed with the staff's recommendation to adopt the BHI Distinction module, and noted the trustworthiness of NCQA. He emphasized the importance of behavioral health, but asked whether the HPC might be somehow overinvesting in behavioral health integration compared to other important characteristics of ACOs. Ms. Harrison responded that HPC's PCMH certification program is focused on the capabilities of primary care practices. She noted that it was important to leverage ACOs to support primary care in advancing their BHI capabilities, and to hold the ACO accountable for a broader range of other performance outcomes as well.

Dr. Berwick said that behavioral health integration is only one important capability of good primary care and that our certification program might be an opportunity to promote other critical areas like coordination of care. Ms. Barrett said that those standards related to those core PCMH capabilities are already reflected in the NCQA PCMH Recognition program. She added that the NCQA PCMH Recognition, particularly level 3, sets fairly rigorous requirements regarding capabilities like care coordination infrastructure, IT infrastructure, and patient-family engagement.

Mr. Cohen said that Dr. Berwick's points were valid but that the system is still not at an optimal level of behavioral health integration and that this had led to the development of the certification. Mr. Cohen credited the HPC for influencing national policies because NCQA had introduced a behavioral health distinction due to the HPC's work. Mr. Cohen added that this was not a static set of standards. He noted that since this is an area of focus for NCQA, he recommended utilizing its skills and expertise, while allowing our staff resources and technical resources to be used in a variety of other ways. Mr. Cohen asked what staff needed from the Committee. Ms. Barrett said that today's presentation was geared towards starting a dialogue on the topic. Mr. Seltz added that the HPC also wanted to make this information known to the public in order to get more feedback.

Ms. Barrett encouraged audience members to also reach out and provide feedback.

ITEM 5: TRANSFORMING CARE- THE CHART PLAYBOOK

Ms. Kathleen Connolly, Director, introduced Mr. Gabe Malseptic, Senior Program Manager, Strategic Investment, and provided a brief overview of the presentation on the concluding activities related to CHART Phase 2.

Mr. Malseptic previewed the CHART playbook. For more information, see slides 48-56.

Mr. Cohen voiced his appreciation of the fact that HPC is paying attention to the voice it uses when presenting to different audiences. Mr. Cohen suggested that patient stories can be a particularly powerful tool for communication. Mr. Malseptic responded that patient stories, as well as provider stories, would be included in the CHART Playbook.

Dr. Berwick thanked the staff for their work and added that it could potentially be more helpful if it were made into conversations, webinars, or dialogues.

ITEM 6: ADJOURNMENT

Mr. Cohen reviewed the meeting calendar for the coming months.

Mr. Cohen adjourned the meeting at 12:05 PM.