COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

December 17, 2014

Board Meeting

Agenda

- Approval of Minutes from October 22, 2014
- Executive Director Report
- 2014 Reflection: Chair Altman
- Cost Trends and Market Performance Update
- Quality Improvement and Patient Protection Update
- Care Delivery and Payment System Transformation Update
- Community Health Care Investment and Consumer Involvement Update
- Schedule of Next Commission Meeting (January 20, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on October 22, 2014, as presented.

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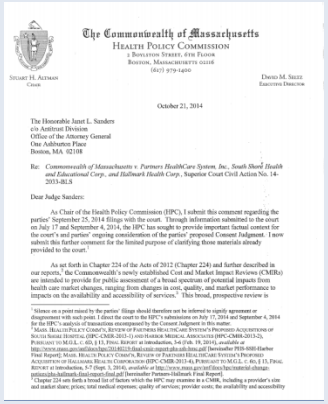
2014 Review: Publications

3 Annual Reports

1 Submission to the Court


The Commonwealth of Massachusetts
HEALTH POLICY COMMISSION
1 Boylston Street, 6th Floor
Boston, Massachusetts 02116
(617) 979-1400

STUART H. ALTMAN
Chair

DAVID M. SEGEL
Executive Director

October 21, 2014

The Honorable Janet L. Sanders
c/o Antitrust Division
Office of the Attorney General
One Ashburton Place
Boston, MA 02108

Re: *Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp.*, Superior Court Civil Action No. 14-2033-BLS

Dear Judge Sanders:

As Chair of the Health Policy Commission (HPC), I submit this comment regarding the parties' September 25, 2014 filings with the court. Through information submitted to the court on July 17 and September 4, 2014, the HPC has sought to provide important factual context for the court's and parties' ongoing consideration of the parties' proposed Consent Judgment. I now submit this further comment for the limited purpose of clarifying those materials already provided to the court.[1]

As set forth in Chapter 224 of the Acts of 2012 (Chapter 224) and further described in our reports,[2] the Commonwealth's newly established Cost and Market Impact Reviews (CMIRs) are intended to provide for public assessment of a broad spectrum of potential impacts from health care market changes, ranging from changes in cost, quality, and market performance to impacts on the availability and accessibility of services.[3] This broad, prospective review is

[1] Silence on a point raised by the parties' filings should therefore not be inferred to signify agreement or disagreement with such point. I direct the court to the HPC's submissions on July 17, 2014 and September 4, 2014 for the HPC's analysis of transactions encompassed by the Consent Judgment in this matter.

[2] MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-3) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at Introduction, 5-6 (Feb. 19, 2014), available at http://www.mass.gov/anf/docs/hpc/material-change-patient-rights-south-shore-final-report-final.pdf; MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at Introduction, 6-7 (Sept. 3, 2014), available at http://www.mass.gov/anf/docs/hpc/material-change-patient-rights-hallmark-final-report-final.pdf [hereinafter Partners-Hallmark Final Report].

[3] Chapter 224 sets forth a broad list of factors which the HPC may examine in a CMIR, including a provider's size and market share; prices; total medical expenses; quality of services; provider costs; the availability and accessibility

4 Final Cost and Market Impact Review Reports

2014 Review: Policy teams at work

Annual Cost Trends Hearing

69
Pre-filed Testimony Submissions

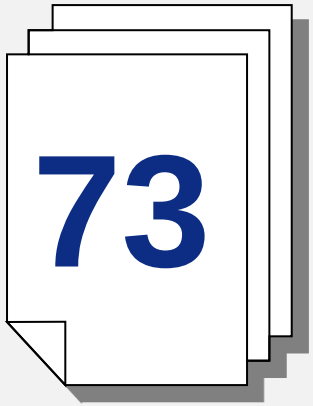
16
Hours

27
Witness Panelists

OPP

366
External Reviews

416
Enrollment Waivers



RPO

73
Applications Received

4
Regulations Developed

MCNs Processed 17

2014: Investment Program

C 

ART Phase 1

$10M
Phase 1 Grants

2,000+
Hospital employees trained

27
Hospitals primed for system transformation

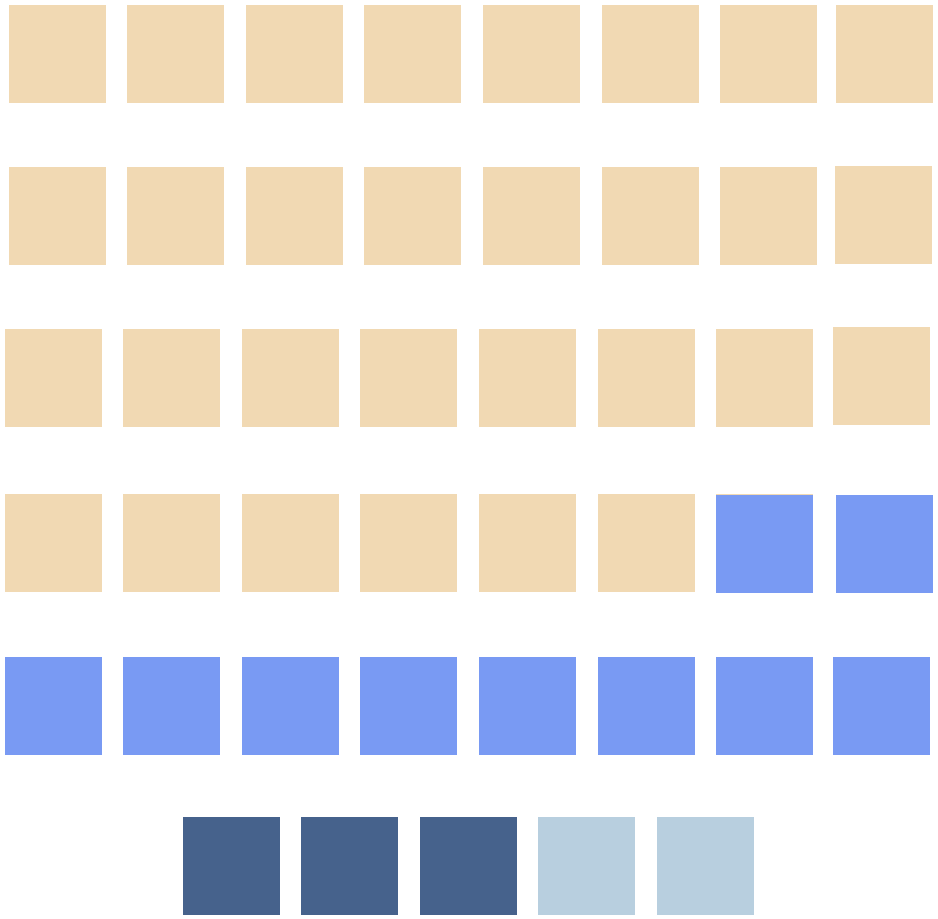
140,000
Patients impacted by Phase 1 initiatives

303
Community partnerships formed or enhanced by awardees

400+
Hours of direct technical assistance to awardees

2014 Review: Public Engagement

45 Public Meetings



Committee | Board | Advisory Council | Cost Trends Hearing

% 83

increase in followers since January

2014 Review: Press Coverage

The New York Times | http://nyti.ms/1xDi1Uw

The Opinion Pages | EDITORIAL

The Risks of Hospital Mergers

By THE EDITORIAL BOARD JULY 6, 2014

In retrospect, it looks as if Massachusetts made a serious mistake in 1994 when it let its two most prestigious (and costly) hospitals – [illegible] General Hospital and Brigham and Women's Hospital, bo Harvard — merge into a single system known as Partners Investigations by the state attorney general's office have d merger gave the hospitals enormous market leverage to di costs in the Boston area by demanding high reimburseme that were unrelated to the quality or complexity of care de

Now, belatedly, Attorney General Martha Coakley is t hospitals with a negotiated agreement that would at least Partners' prices and limit the number of physician practic albeit only temporarily.

The experience in Massachusetts offers a cautionary about the risks of big hospital mergers and the limits of ar to break up a powerful market-dominating system once it

One purpose of the 1994 merger, as the president of acknowledged in 2010, was to take away the ability of insu demand lower prices from one hospital with the threat th send patients to the other. After the merger, insurers had or neither.

The bargaining power of the merged institutions was 2000 when the Tufts Health Plan refused to pay Partners

EDITORIAL

Hospital merger should await more proof of cost controls

MARCH 23, 2014

THE FAMED Massachusetts General Hospital and Brigham and Women's Hospital are boons to the state's economy but, at times, a bane to insurers and premium payers. The two hospitals, owned by Partners HealthCare, offer top-quality treatment, but at higher than ordinary prices, even for routine procedures. Nonetheless, local patients vote with their feet — and demand that insurers give them access to the most prestigious hospitals.

This complicated dynamic is at the heart of the state's efforts to control health care costs. And it presents itself, yet again, in the attempt by Partners to acquire South Shore Hospital. In 2012, the Legislature established a new Health Policy Commission to assess the cost implications of hospital mergers, which are also reviewed by state Attorney General Martha Coakley or the US Justice Department for potential antitrust concerns. The panel's verdict: Partners' purchase of South Shore Hospital would drive up costs for the state's three largest insurers between 1.3 percent and 1.5 percent over what they would otherwise be.

CONTINUE READING BELOW ▾

Partners insists the estimate is based on faulty assumptions about the changes the merger would bring. The Partners system is transitioning to an accountable-care model, in which networks are paid a flat rate for the care of a patient, rather than a separate amount for each service. Buying the Weymouth-based South Shore Hospital, it insists, would enhance its ability to implement new cost-saving models.

By The MetroWest Daily News

June 22, 2014 12:01AM

Editorial: Questioning a hospital merger deal

Health care costs in Massachusetts are among the highest in the nation, and it's not just because we have some excellent hospitals an because a lack of price transparency and competition, in health care as in other industries, tends to drive prices up.

For decades, community hospitals have complained that the ever-growing market share of Boston's large teaching hospitals undermi largest of these, Partners HealthCare System, grew by merging with smaller suburban hospitals and purchasing large physician practi [illegible] community hospitals for routine procedures, they said, and used its market clout to negotiate more lucrative reimbursements f [illegible] report commissioned by Attorney General Martha Coakley to document th [illegible] contracts with insurers and concluded that there were vast discrepancies Medical Center and Partners affiliates like Mass. General.

[illegible]ers announced its latest acquisition, South Shore Hospital in Weymouth, [illegible]he Legislature with reining in health inflation. The Health Policy Commis to produce an extended legal battle.

[illegible]se to negotiate instead, reaching an agreement with Partners. In return [illegible]uburban hospitals and add up to 600 physicians to its network – Partners a [illegible]e costs and "level the playing field" for hospitals and insurers.

[illegible]s in the health care industry beg to differ. A coalition of hospitals and pl [illegible]al will allow Partners' revenues to grow by 14 percent, the opponents argue It will set off "a bidding war for physician talent," they said, and lock in the [illegible]n charged that few details about the proposed agreement have been made [illegible]tself has yet to be released. It contends the agreement undermines the fled [illegible]uld be given time to hold public hearings and complete its review of all con [illegible]gner, CEO of Tufts Medical Center.

[illegible]sition is made more difficult by the limited legal authority of both the HPC a [illegible] is in the middle of a hotly-contested campaign for governor. But she didn [illegible]he hoped would satisfy all parties is now being hotly contested.

[illegible]ent must be approved by a judge before it goes into effect, but it appe [illegible] and more interested parties at the table. Partners' competitors aren't conv [illegible]ve.

OPINION | DONALD M. BERWICK

Hit the brakes on Partners HealthCare deal

Before gobbling up South Shore and Hallmark, the medical behemoth must prove it can contain costs and return savings to Commonwealth

NICOLAS OGONOSKY FOR THE BOSTON GLOBE

By Donald M. Berwick | OCTOBER 19, 2014

4

Editorials about the HPC's work

200+ **Articles mentioned the HPC**

2014 Review: Legislative Support

Enhanced policy responsibilities

Regulatory role in ICU nurse staffing

Role in substance use disorder treatment policy development

$2M

Behavioral health integration appropriation

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Essential Services Task Force overview

- The Essential Services Task Force was created by Section 229 of the FY15 budget. It is charged with:
  - examining the causes and effects of the discontinuation of essential health services by hospitals;
  - assessing options for improving the process by which hospitals notify the Commonwealth and the public of impending service discontinuations and closures;
  - studying ways to ensure continuity of high quality care for patients in the event of essential services discontinuations and closures; and
  - considering how to better monitor and plan the allocation of health care resources
- Through its representation on the Essential Services Task Force, the HPC has the opportunity to work with other policymakers to recommend ways to strengthen the current essential services review process and to strengthen public commitments to systematic, data-driven health planning and delivery system reform

Recommendation for HPC involvement in Essential Services process

- The HPC is offering a letter to the Task Force which encourages it to provide a robust set of recommendations to strengthen the current essential services discontinuation review process and strengthen public commitments to systematic, data-driven health planning and delivery system reform

- In particular, the HPC urges the Task Force to recommend that:

    - providers contemplating a facility closure or discontinuation of essential services be required to provide notification to the HPC, in addition to DPH; and

    - the HPC have the opportunity to provide comments to DPH concerning the potential impacts of facility closures and essential services discontinuations

- These changes are consistent with the HPC's existing statutory authority to comment to DPH regarding other provider changes, such as expansions, that are subject to the determination of need process

- Playing an active role in these two existing DPH processes will also complement the HPC's work monitoring and robustly analyzing the impact of market changes on health care costs, quality and access

Vote: Essential Services Task Force Letter

Motion: That the Commission hereby directs the Executive Director to submit a letter to the Essential Health Services Task Force, established pursuant to section 229 of chapter 165 of the Acts of 2014, recommending that the Department of Public Health strengthen its review process for the discontinuation and closure of essential health services, including requiring hospitals to provide advance notice to the Commission of any planned closure or discontinuation of essential health services and allowing the Commission to provide comments to the Department regarding the potential impacts of any such planned closures or discontinuations

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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	11	33%
Acute hospital merger or acquisition	7	21%
Clinical affiliation	4	12%
Formation of contracting entity	4	12%
Acquisition of post-acute provider	3	9%
Change in ownership or merger of owned entities	3	9%
Affiliation between a provider and a carrier	1	3%

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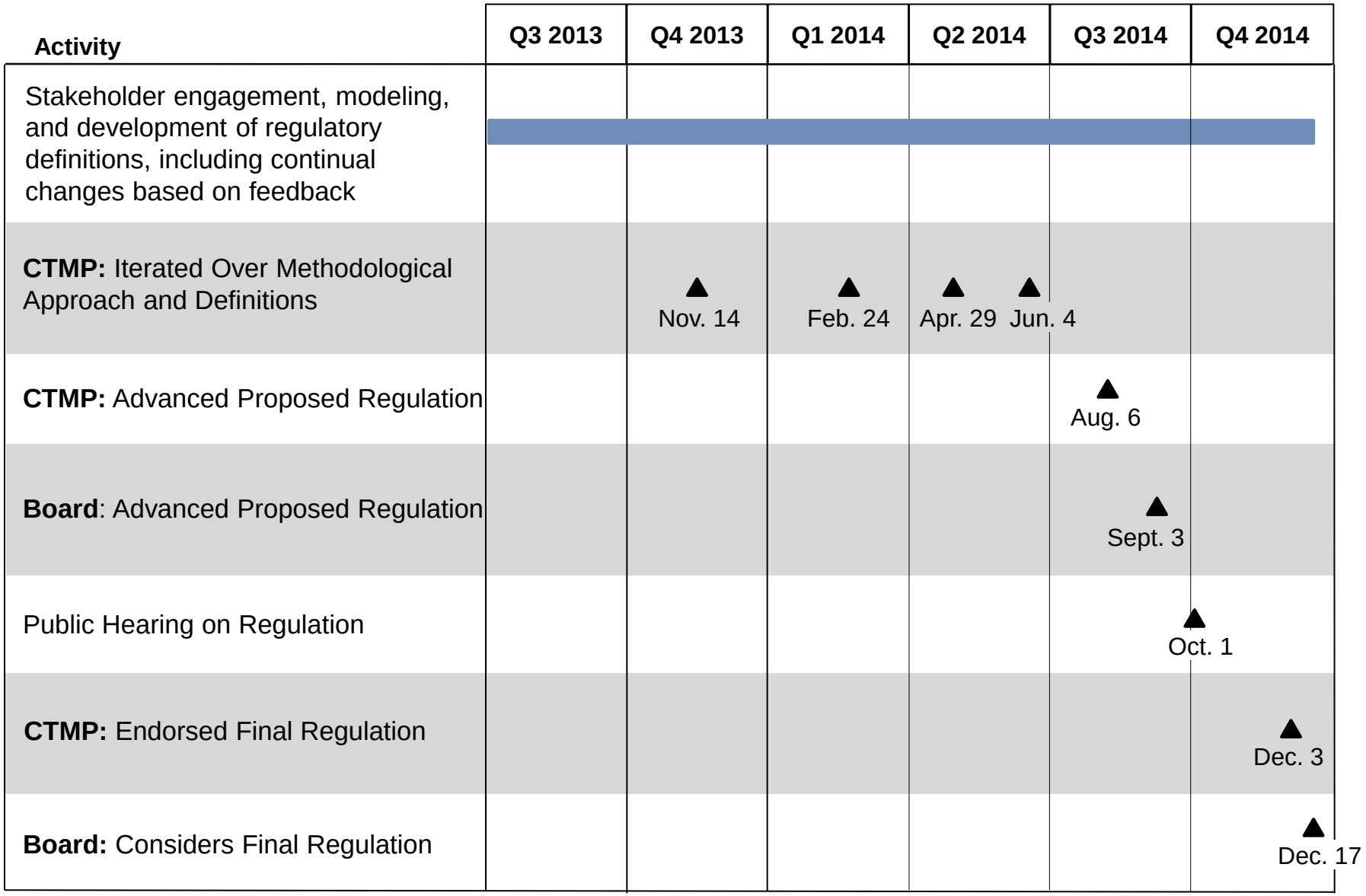
Regulation 958 CMR 7.00

- Interim Guidance issued on March 12, 2013 currently governs the filing of material change notices (MCNs)
- The Commission is required by statute to adopt regulations for conducting cost and market impact reviews (CMIRs) and for administering Section 13 of Chapter 6D
- The Commission and staff have spent more than a year engaging extensively with a broad range of stakeholders and local and national experts in development of the regulation
- A proposed regulation was advanced for additional public comment by the Commission on September 3, 2014

Regulation 958 CMR 7.00

- We now recommend a final regulation, endorsed by the Cost Trends and Market Performance Committee on December 3, 2014, incorporating additional feedback received since September 3, which:
  - Articulates the process for filing MCNs and conducting CMIRs
  - Provides clear guidance where technically possible. For example, it provides specific methodologies for definitions, such as primary service areas for inpatient general acute care hospital visits, where the Commission has access to robust statewide data
  - Also allows the Commission to develop further guidance in response to the availability of data and the evolving health care marketplace. The Commission looks forward to continued engagement with stakeholders as it develops such further guidance (e.g., thresholds for Dominant Market Share for services other than inpatient general acute care)
- The recommended final regulation is accompanied by a Technical Bulletin that contains additional methodological guidance

Development timeline



Regulation 958 CMR 7.00

958 CMR: HEALTH POLICY COMMISSION

958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS

Section

Recommendations in response to additional comments

- **“Similar Providers or Provider type”:** Language added in the Technical Bulletin further describing how the Commission defines “similar Providers or Provider type” and clarifying that sets of “similar Providers” are published in CMIR reports
- **Employment:** Language clarifies that “employment” as a Material Change is employment of Health Care Professionals, and any employment must meet the materiality threshold of $10M in NPSR
- **Health Care Services:** Statutory definition of Health Care Services added, which includes, among others, behavioral health, substance use disorder, and mental health supplies, care and services
- **“Near-majority of market share in a given service or region”:** The Commission is continuing to conduct analyses and engage with stakeholders to provide further guidance on this term in the future
- **Clinical Affiliation:** Clinical affiliations which are solely for the purpose of collaboration on clinical trials or graduate medical education programs are now exempt from the material change process
- **Scope of Material Changes:** Language clarifies that the Commission will receive information on any service changes through its MCNs; additionally, the Commission is voting on an Essential Services Task Force letter recommending the Commission be notified of service changes requiring Essential Services review and be given the opportunity to comment
- **Timing of Final Report:** Language clarifies that the 185-day timeframe for completion of a Final CMIR Report may only be altered “commensurate with any additional time granted” by the Commission for the parties to comply with the Commission’s data and document requests

Technical clarifications in response to additional comments

- **Definition of Material Change:** Language clarifies that the formation of an organization for negotiating and/or administering payer-provider contracts is a Material Change
- **Non-compliance:** Language clarifies that in instances in which the Commission determines that a Provider or Provider Organization has failed to file a required MCN, the Commission may refer the Provider or Provider Organization to the AGO
- **Completion of Material Change:** Language clarifies that any proposed Material Change shall not be completed until the Commission has provided notice that it will not initiate a CMIR, or until at least 30 days after the Commission has issued its Final CMIR Report

Vote: Proposed Final Regulation

Motion: That, pursuant to section 13 of chapter 6D of the Massachusetts General Laws, the Commission hereby approves and issues the attached FINAL regulation on notices of material change and cost and market impact reviews and accompanying technical bulletin.

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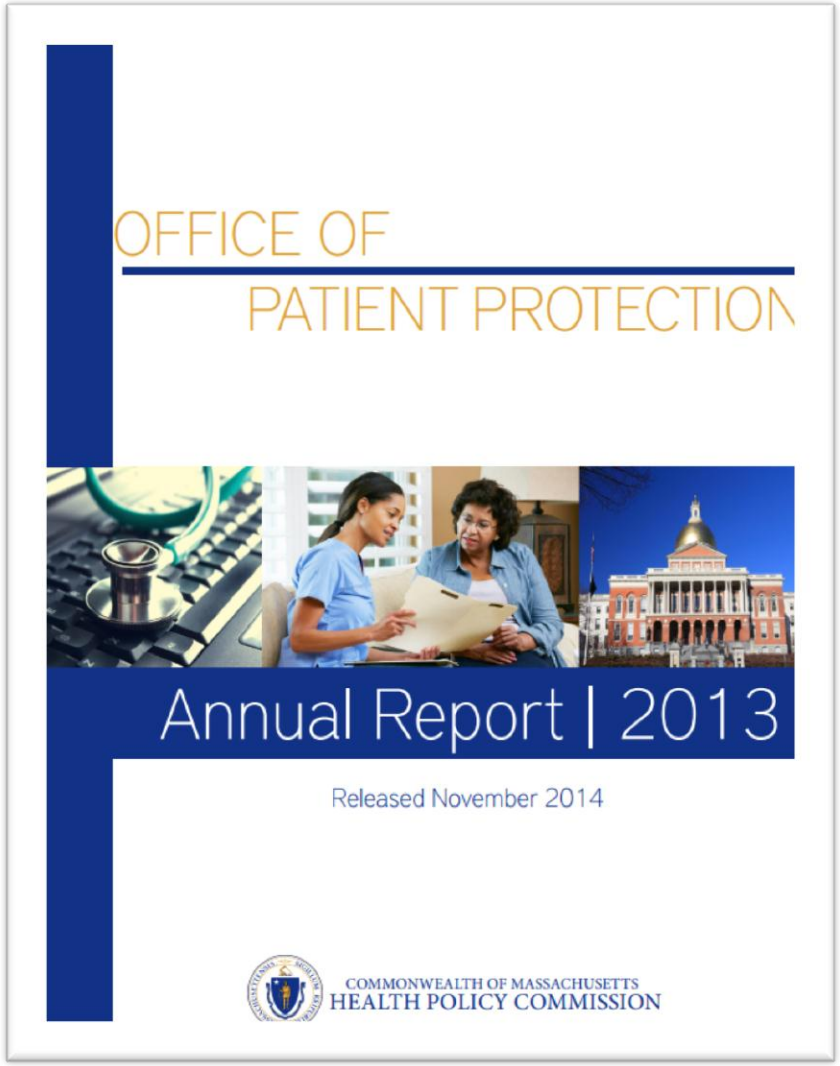
Office of Patient Protection: 2013 Annual Report



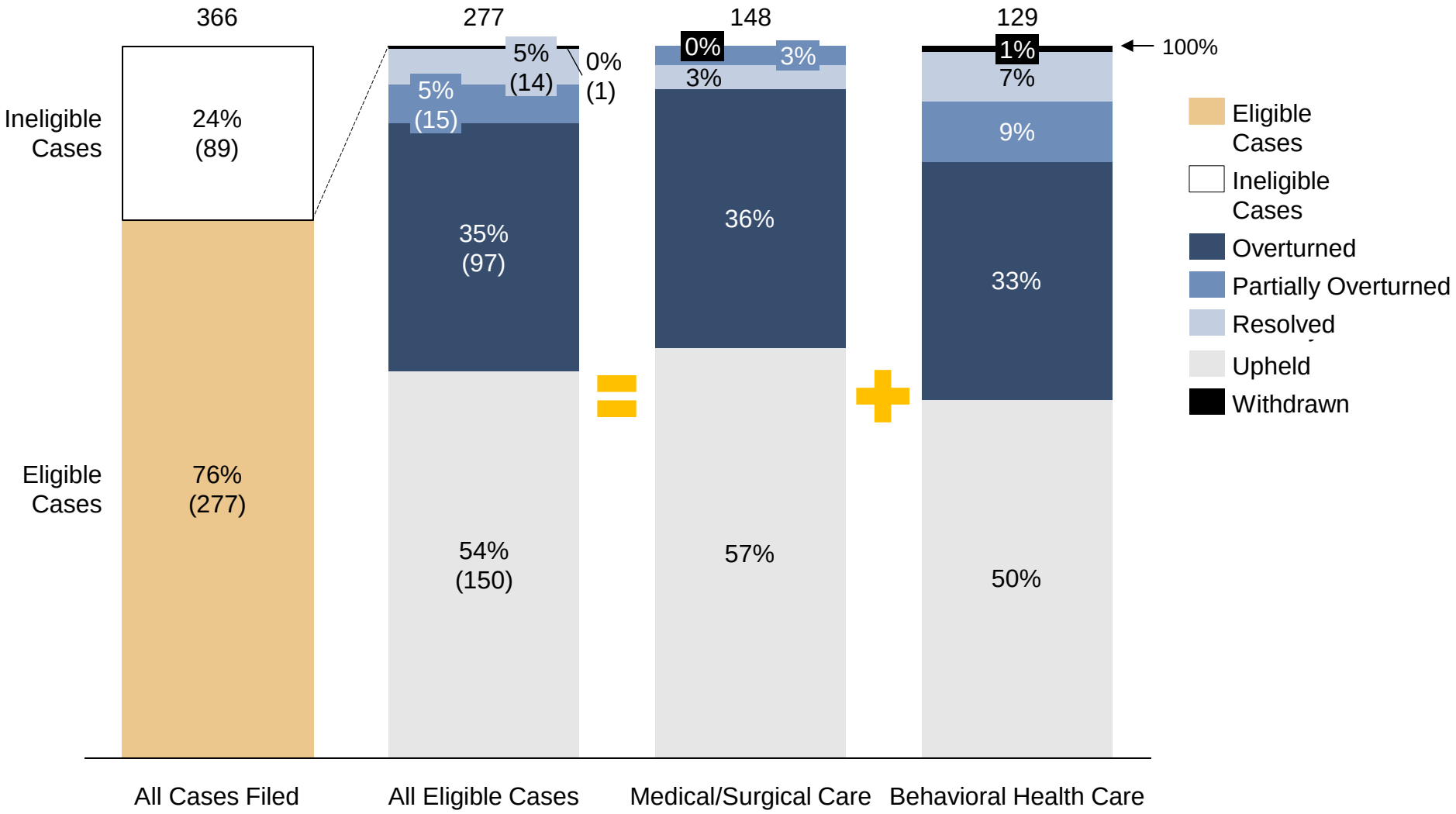
Released
Friday, November 7, 2014

Report and Chart Book
available online at
www.mass.gov/hpc/opp

Of the 277 eligible external review requests filed during 2013, OPP received 148 external review requests for medical/surgical treatment and 129 external review requests for behavioral health treatment.

External Review

Percentage of external review cases by disposition, by type of case (Medical/Surgical Care vs. Behavioral Health Care), 2013

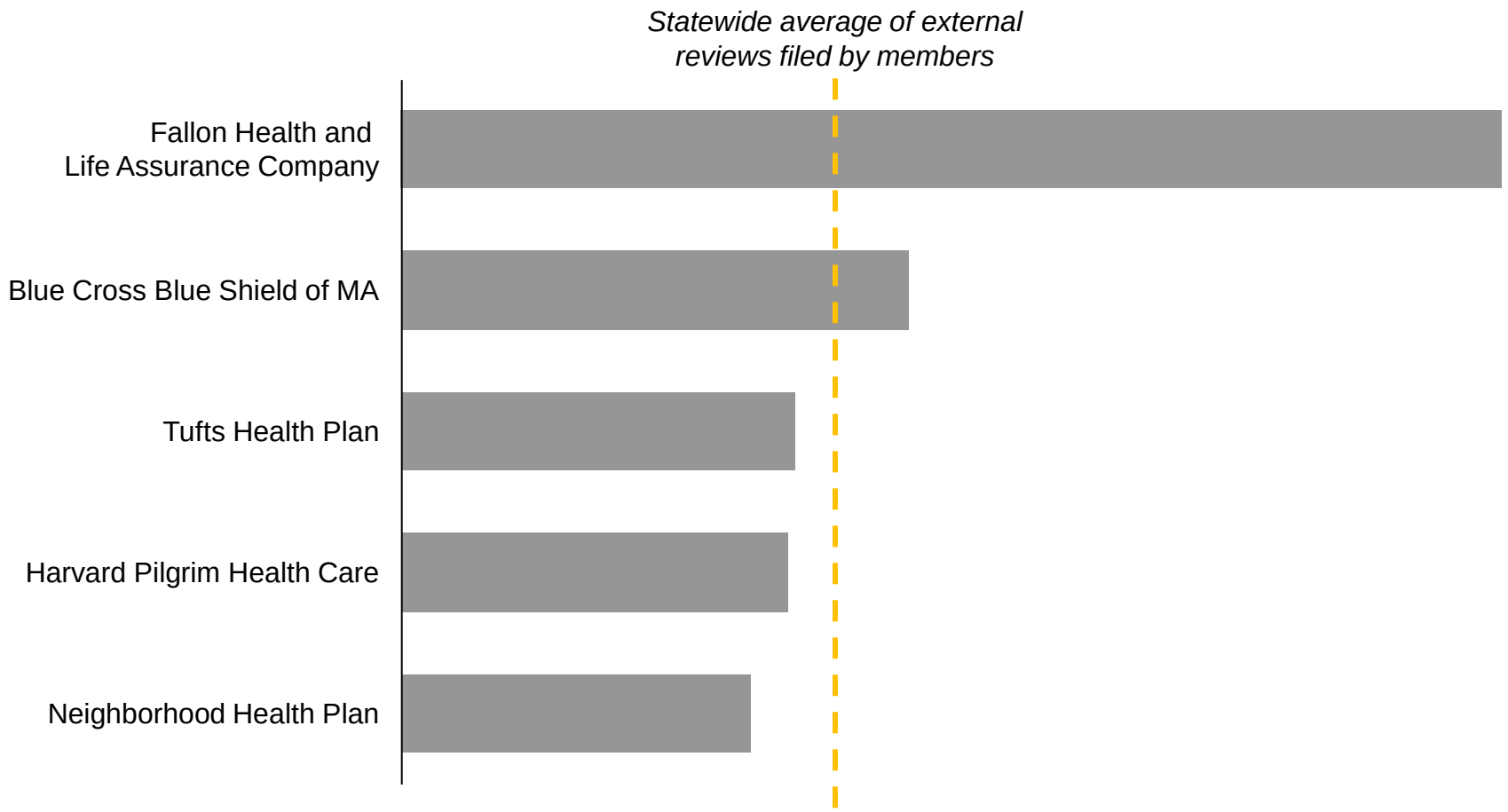


Source: 2013 Office of Patient Protection external review data

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

External Review

Number of external reviews (2013) weighted by number of enrolled member months



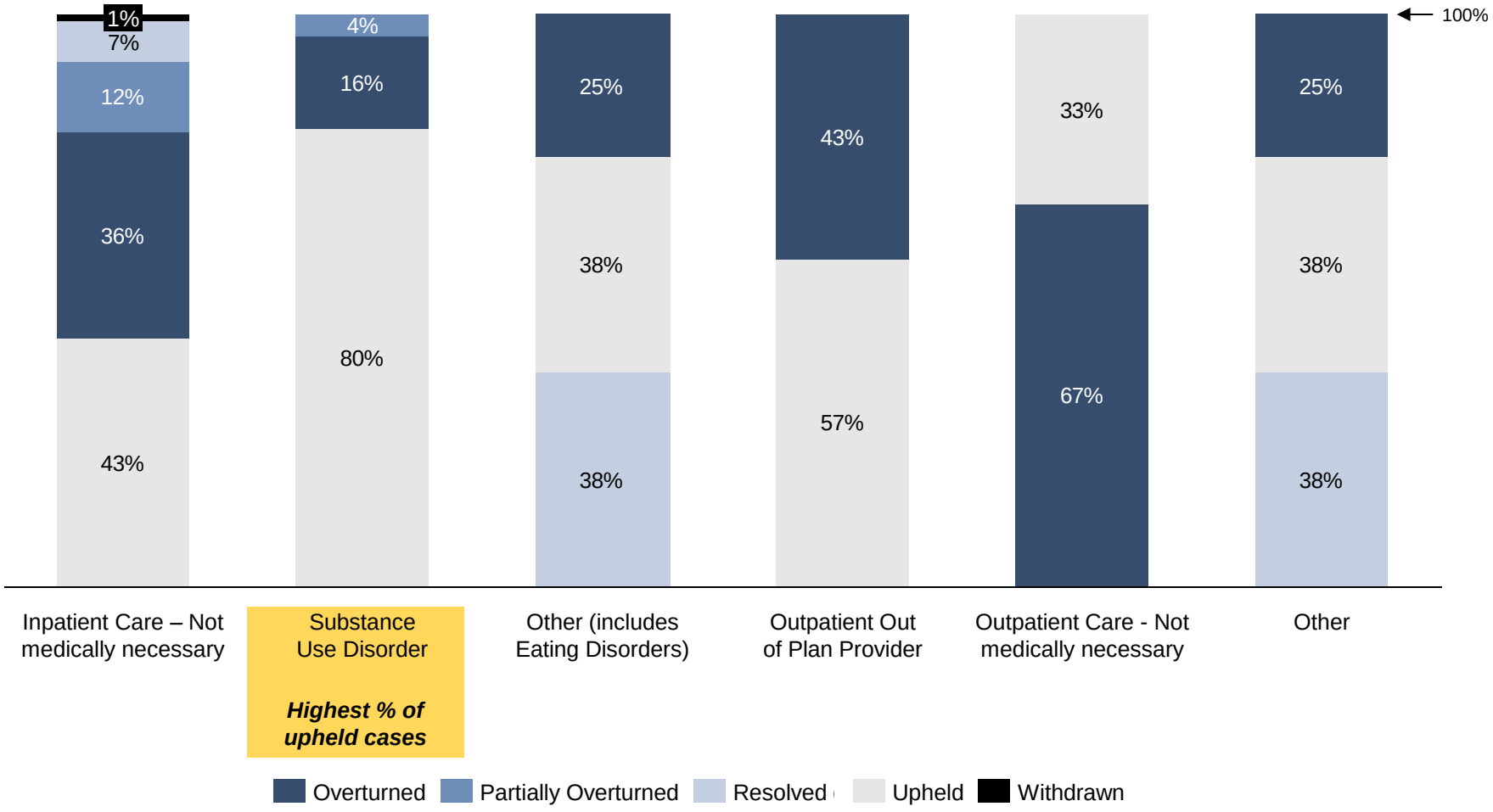
Note: Weighted by dividing number of external reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2012

Source: 2013 Office of Patient Protection external review data, Member months from Center for Health Information and Analysis, 2012

During 2013, the disposition of external reviews within different behavioral health categories varied.

External Review, Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome and type of case, 2013



Source: 2013 Office of Patient Protection external review data

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Nurse Staffing Regulations – Key Requirements & Considerations

MGL c. 111, Section 231

For the purposes of this section, the term "intensive care units" shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.

Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement.

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department. The health policy commission shall promulgate regulations governing the implementation and operation of this section including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.

HPC's Role Under the Law

1. Formulation of an acuity tool
2. Develop public reporting methods for hospital compliance
3. Identify 3-5 patient safety quality indicators

Listening Sessions and Stakeholder Meetings

Public Meetings & Listening Sessions

- QIPP Committee Listening Session I (10/29/14)
- QIPP Committee Listening Session II (11/19/14)
- QIPP Committee Meeting (12/10/14)
- QIPP Committee Meeting (Planned - 1/6/15)

HPC Staff ICU Visits

- Boston Children's Hospital
- Brigham and Women's Hospital
- Morton Hospital (Planned – 1/7/15)

HPC Staff Meetings with Stakeholders

- Massachusetts Hospital Association (8/4/14)
- Massachusetts Nurses Association (8/12/14 & 12/8/14)
- American Nurses Association-MA Chapter (9/5/14)
- Department of Public Health (9/17/14)
- Organization of Nurse Leaders (9/29/14 & 11/21/14)
- Quadramed (acuity tool vendor) (9/23/14)
- Massachusetts Council of Community Hospitals (10/9/14)
- Steward Health Care System (11/13/14)
- Navigant Consulting Inc. (11/14/14)
- Accenture (11/18/14)
- DPH Shattuck Hospital (12/12/14)

Next Steps

1. Continue stakeholder discussions, outreach, and research

2. Next QIPP committee meeting scheduled for January 6, 2015 for further discussions on the development of regulations

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  - Registration of Provider Organizations (RPO) Program
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Priority Issue Areas for Care Delivery & Payment Transformation Committee

Care Delivery Transformation

Accountable Care

- ACO certification standards
- "Model" ACO criteria
- Technical assistance & capability building

Primary Care Transformation

- PCMH certification standards
- PCMH payment model
- Technical assistance & capability building

Payment System Transformation

Model Payment for PCMH and ACOs

APM Penetration

- Increased APM penetration for:
  - PPO population
  - MassHealth
  - Specialty services (e.g., episode based payments)

Cross-payer alignment

- Standardization of certain contract elements across payers, e.g., attribution, risk adjustment, baseline budget

Defining payment models aligned with patient outcomes

Key Enablers

Strategic Vision for Health Care Transformation (incl. CD & PST)

Stakeholder alignment and engagement around the vision

Data Transparency

Behavioral Health a key focus area across all domains

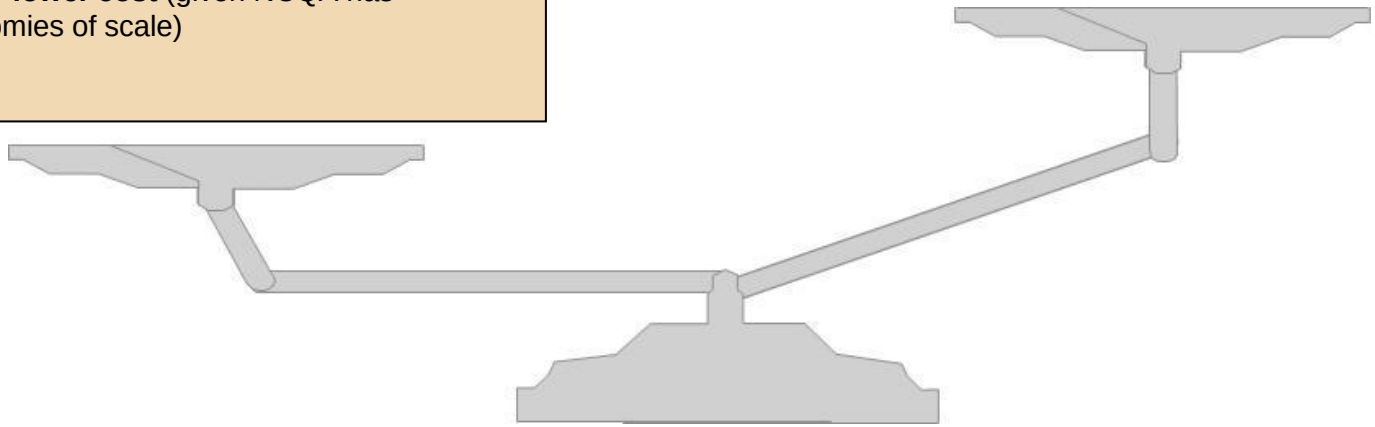
PCMH Certification: Partnering with NCQA involves trade-offs, however, benefits outweigh the downsides

Pros

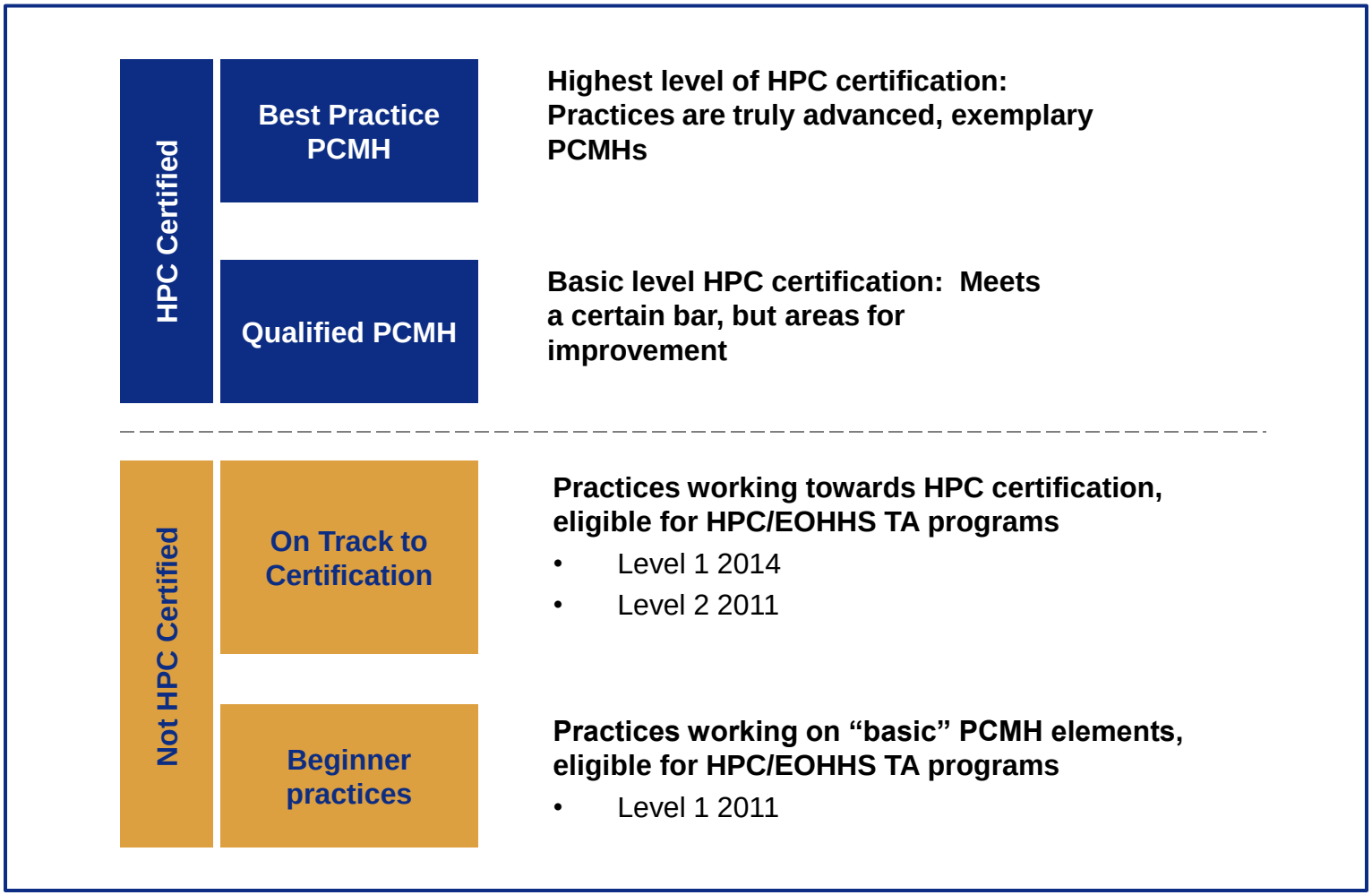
- **Faster time to market**
- Ability to leverage NCQA's **clinical expertise**
- Ability to leverage NCQA's **operational / implementation experience**
- **Recognition** for **~30%** of MA practices who already have or are in the process of obtaining NCQA certification
- Opportunity to influence **national dialogue**
- **Likely lower cost** (given NCQA has economies of scale)

Cons

- Ability to **perfectly customize** it to our wishes is **limited** (although NCQA has expressed flexibility except for must-pass elements)
- **Higher bar** for certification implies that it will take longer for small/ resource constrained practices to be certified



PCMH Certification: Proposed structure



PCMH Certification: Modifications to NCQA criteria will be targeted; and will be determined and refined based on input from a variety of stakeholders and experts

Principles

Modifications to NCQA criteria will:

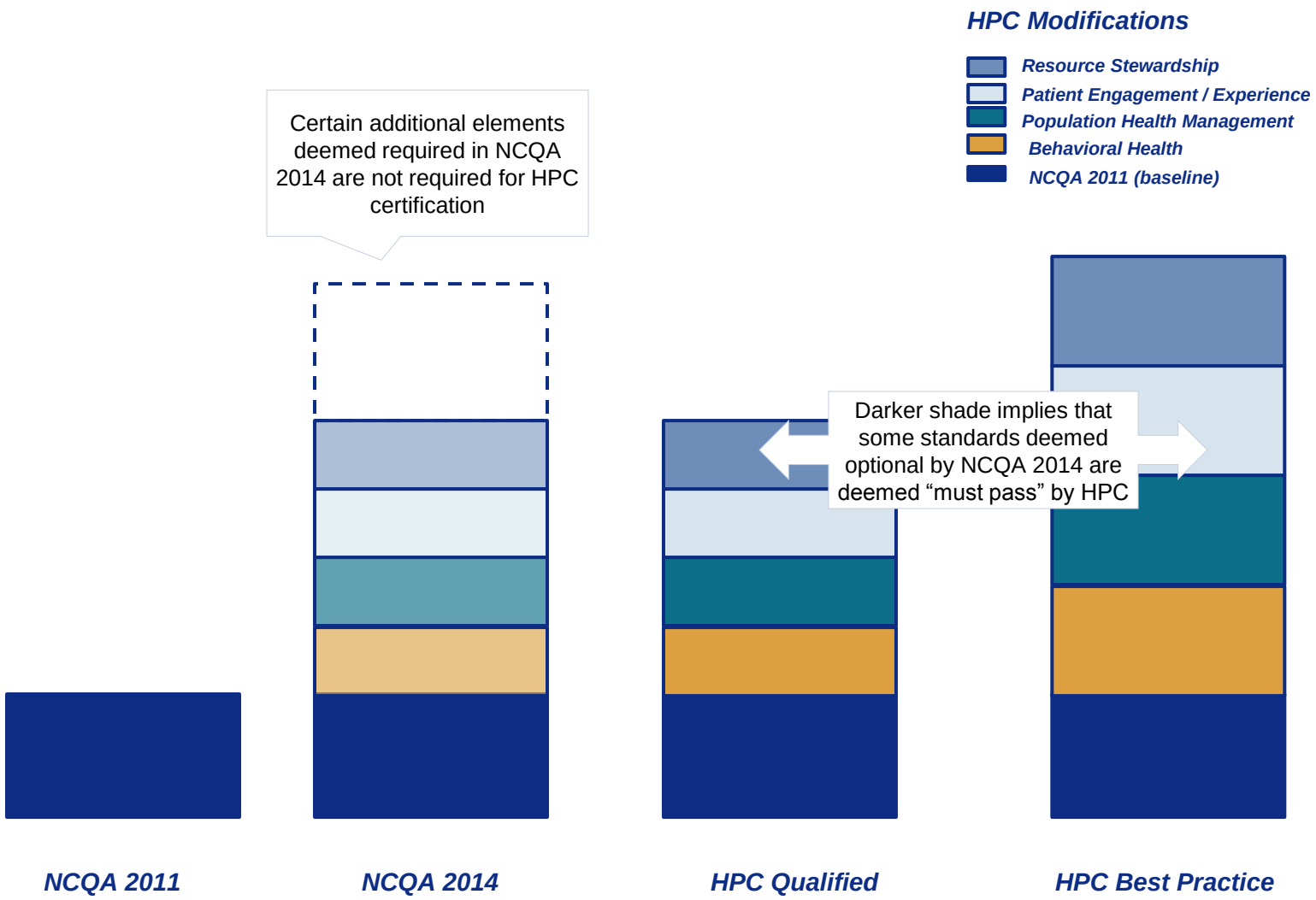
- Focus on the 4 priority domains for HPC
  - Behavioral Health
  - Resource Stewardship
  - Population Health Management
  - Patient Engagement
- Be evidence based
- Build off of the existing NCQA framework to the extent possible (e.g., make existing criteria 'must pass', vs create new factors)

Process

Modifications to NCQA criteria will be determined and refined based on input being gathered from:

- MA provider, payer and consumer advocacy communities
- National and regional subject matter experts
- NCQA
- Other state PCMH programs

PCMH Certification: HPC PCMH certification will require modifications to NCQA 2011/2014 criteria, with a specific emphasis on 4 domains



PCMH Certification: NCQA Modifications for Behavioral Health (EXAMPLE)

	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Screening/ Health Assessment	**2C: Comprehensive Health Assessment** CHA includes: ▪ 6. Behaviors affecting health ▪ 7. Patient and family MH/SU ▪ 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) ▪ 9. Depression screening for adults and adolescents using a standardized tool	**3C: Comprehensive Health Assessment** CHA includes: ▪ 6. Behaviors affecting health ▪ 7. Mental health/substance use history of patient and family ▪ 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) ▪ 9. Depression screening for adults and adolescents using a standardized tool	▪ **Make the following 2014 factors must pass:** – 3.C.6 – 3.C.7 – 3.C.8 – 3.C.9	All
			▪ ***New factor***: anxiety screening for adults using first 2 questions on GAD-7 or equivalent and full screen if patient tests positive[1]	All
			▪ ***New factor:*** SUD screening using AUDIT-C and DAST or equivalent[1] (CRAFFT or equivalent for adolescent patients)[2] and SBIRT or equivalent if patient tests positive[3]	All

[1] validated diagnostic aid, available in public domain; part of AIMS Center evidence-based integrated collaborative care model that is used in NY, MT, WY, WA, AK, ID, US Military; used in UMass affiliated PCMHs, recommended in CO PCMH planning documents.

[2] Recommended by 2013 Behavioral Health Task Force; AIMS Center recommends DAST as alternative for adolescent populations

[3] evidence-based intervention and/or referral to treatment that follows diagnostic screening; validated by several studies including those funded by SAMHSA

PCMH Certification: NCQA Modifications for Resource Stewardship (EXAMPLE)

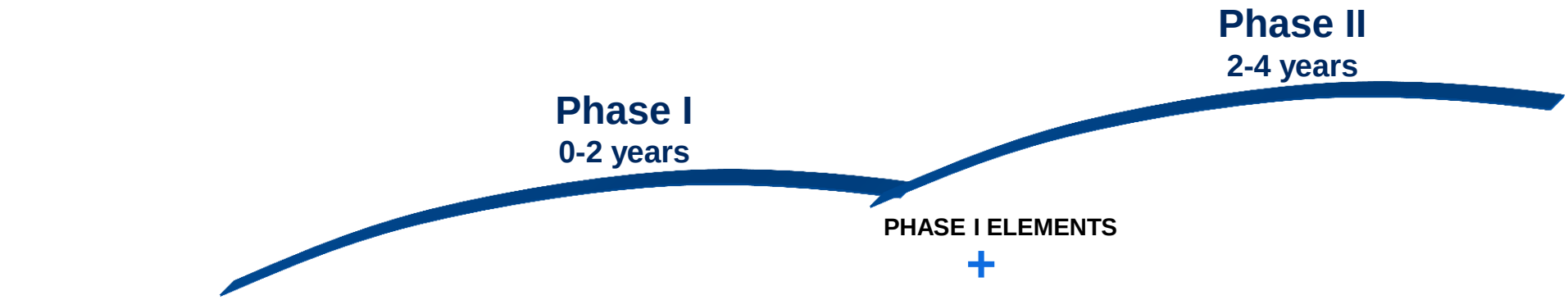
	2011 NCQA Requirements	2014 NCQA Requirements	HPC Requirements	Level*
Quality Improvement	**6C: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 1. Set goals and act to improve performance on at least three measures	**6D: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: ▪ 3. Set goals and analyze at least one utilization measure ▪ 4. Act to improve at least one utilization measure	▪ ***Enhanced must pass requirement:***[1] – 6.D.3 ▫ Set goals and analyze at least **two** utilization measures ▫ Set goals and analyze at least **four** utilization measures – 6.D.4. ▫ Act to improve performance on at least **two** utilization measures ▫ Act to improve performance on at least **four utilization** measures	All BP All BP

[1] **Similar measures are implemented in many other states across the country, sample examples are below:**

MD: Pediatrics – assess and report on 3-5 measures within Year 1-2; meet thresholds Year 3.
Adult – assess and report on 12-18 measures Year 1-2; meet thresholds Year 3

MN: practice must measure, analyze, and track measures related to cost-effectiveness of services

PCMH Certification: Program could evolve over time to enable more advanced levels of primary care as well as payment and consumer incentives



Certification Criteria

Phase I

- **NCQA Core Criteria**
  - Patient Centered Access
  - Team Based Care
  - Population Health Management
  - Care Management& Support
  - Care Coordination & Care Transitions
  - Performance Measurement & Quality Improvement
- **Modifications for Behavioral Health, Resource Stewardship, Population Health Management and Patient Engagement**

Phase II

PHASE I ELEMENTS +

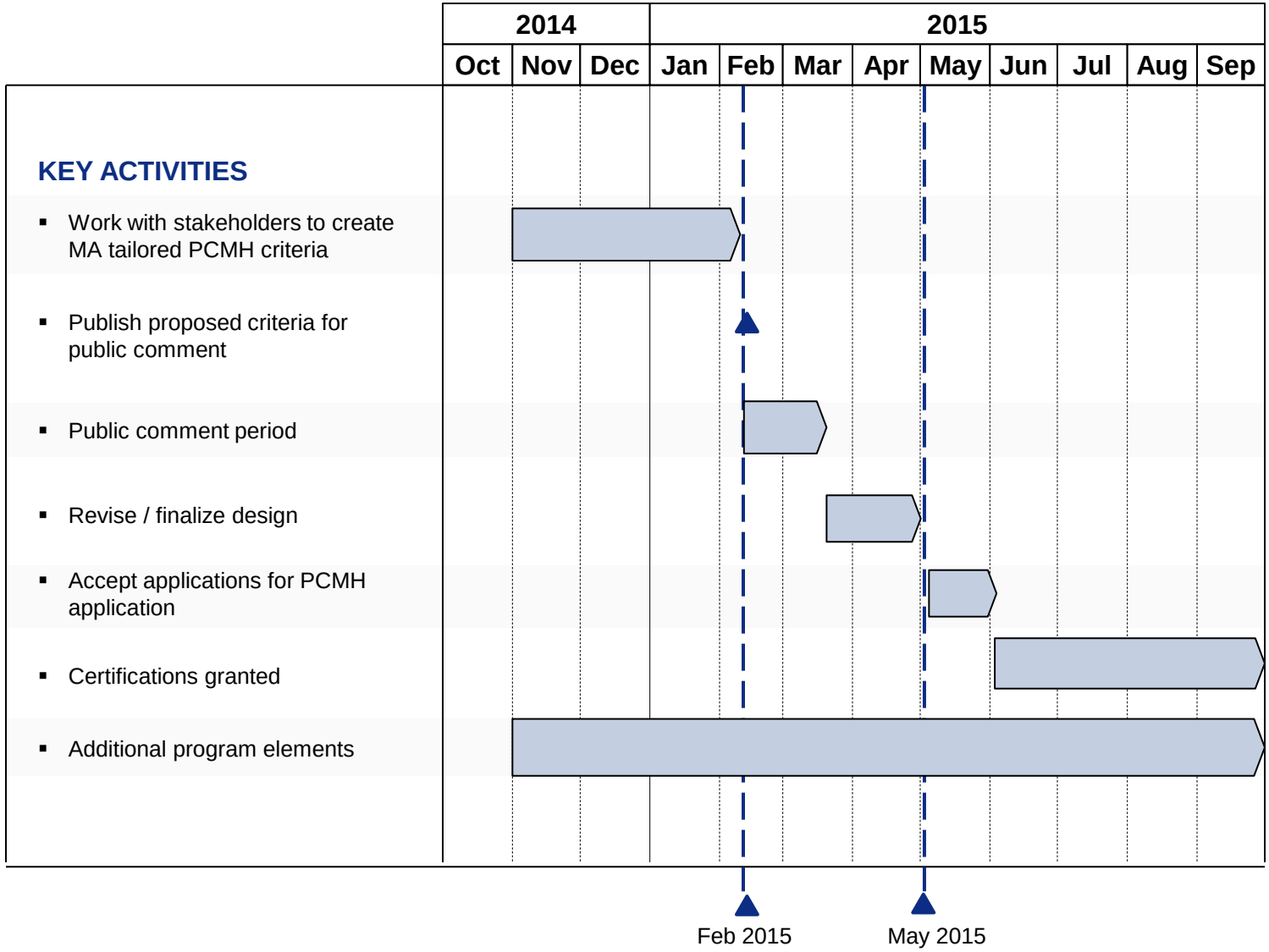
- **Advanced Population Health** (with focus on geographic level population health)
- **Advanced Behavioral Health**
- **Advanced Resource Stewardship** (broad set of efficiency measures practices need to meet)
- **Patient-Centered Specialty Certification**

Additional Program Elements

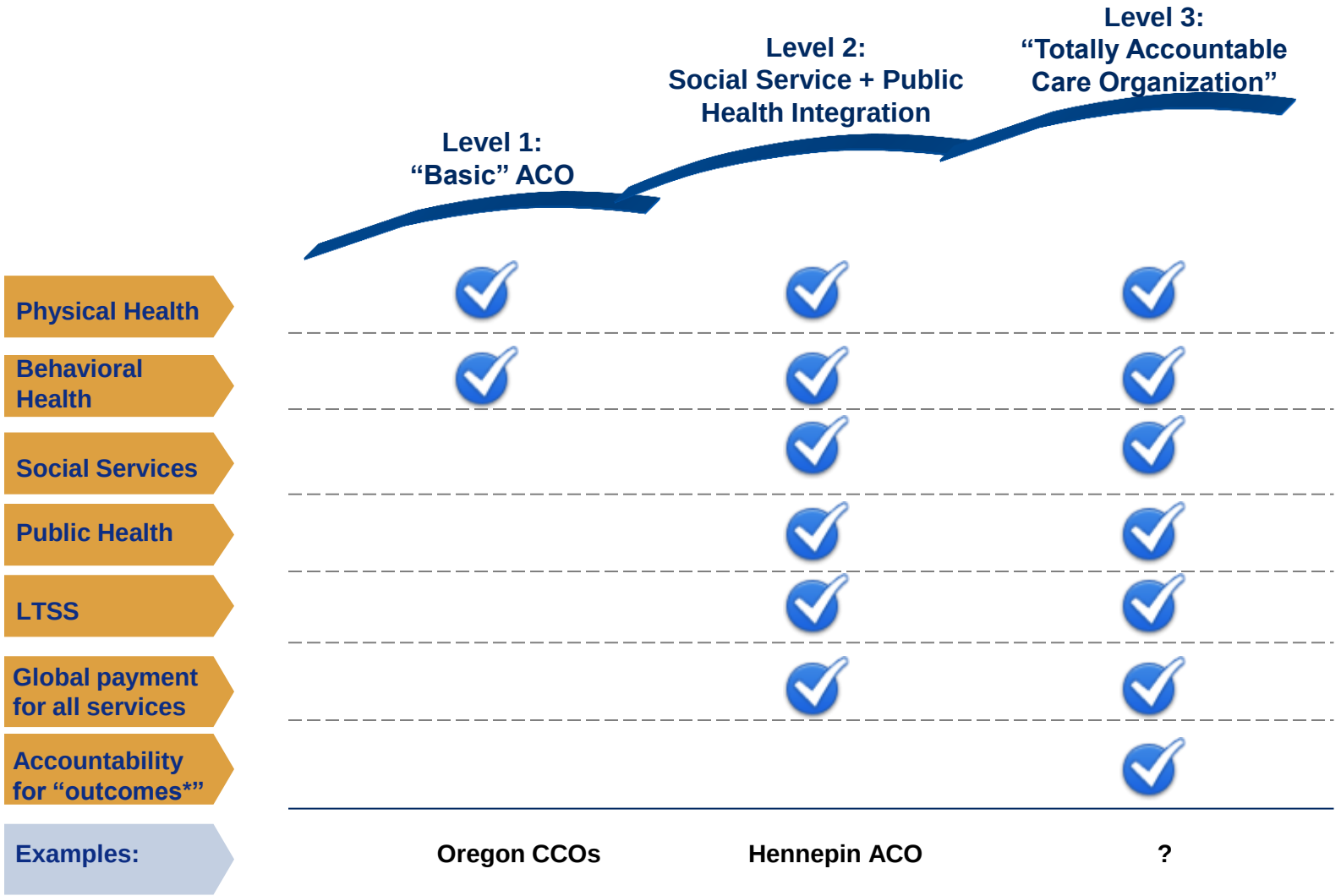
- **Technical Assistance (BH funds + priority status for other state agency funds)**
- **Simple provider reports**
- **PCMH capabilities foundational for ACO certification**
- **Consumer education / PR**
- **Payment Incentives**

- **Payment Incentives**
- **Consumer Incentives**
- **CHIA Provider Portal**

PCMH Certification: Timeline



ACO Certification: Program needs to accommodate varying degree of provider capability across the care continuum, balanced with the goal of ensuring progress over time



* True outcome metrics such as "ability to work", "ability to function", ideally patient reported

ACO Certification: We are evaluating criteria for ACO certification in 4 categories

A — Organizational Structure & Governance

Stakeholder participation[1]

Defined vision and strategy

B — Financial incentives & accountability

Share of total Book of Business at Risk[2]

Financial Incentives within the ACO[2]

C — Care Delivery Model

Capabilities across the Care Continuum

- Primary Care
- Formal relationships for non-acute care
- Community relationships [bidirectional] and social support

Clinical Integration

- Evidence Based Care & Protocols
- Integrated HIT

Population Health Management

- Risk Stratification
- Care Management

Patient Centered Care

- Patient Engagement
- Patient Experience
- Patient Protection

D — Transparency & Performance Improvement

Cost , Utilization and Quality analytics

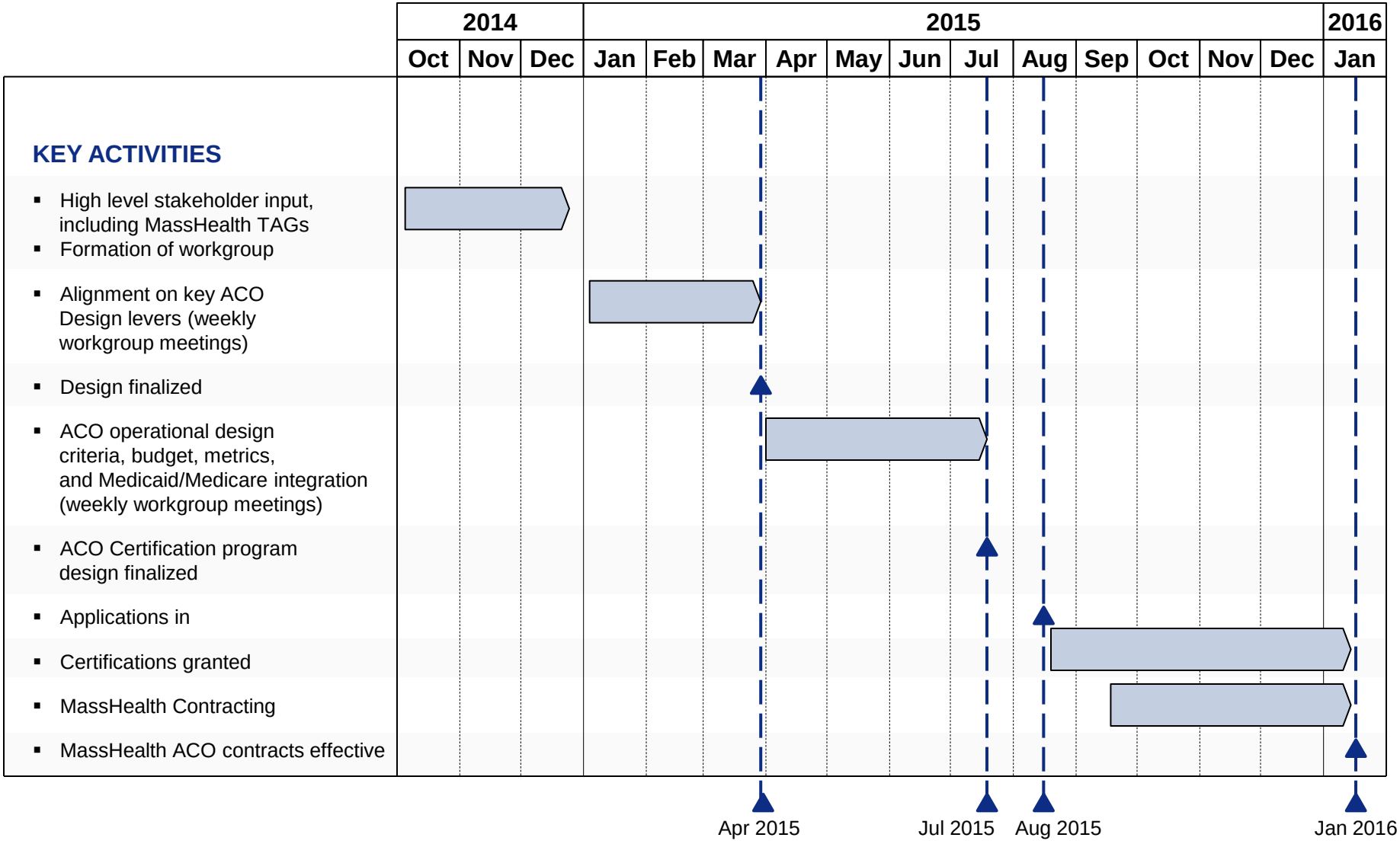
Non-clinical process improvement

Clinical change management

1 Includes patients and families

2 Financial incentives and accountability should include accountability for improved outcomes/ health of covered population

ACO Certification: Timeline is aligned with MassHealth ACO timeline; certification process is expected to begin in mid-August



Payment Reform: Key priorities for 2015

Key priorities for 2015 include:

- Developing a "**model payment**" structure for **PCMHs and ACOs**
- Engagement with payers and providers to accelerate design and adoption of **APMs for the PPO population**
- Facilitating **alignment of quality measures and risk adjustment methodology** across payers
- Inclusion of **Behavioral Health in APM budgets**
- Conceptualizing and designing opportunities for implementation of **episode based payment models** for relevant conditions

- Details to be fleshed out further after the Commission discusses and approves recommendations outlined in the Cost Trends Report
- More extended discussion planned for January Board meeting

Agenda

- Approval of Minutes from October 22, 2014
- Executive Director Report
- 2014 Reflection: Chair Altman
- Cost Trends and Market Performance Update
- Quality Improvement and Patient Protection Update
- Care Delivery and Payment System Transformation Update
  - PCMH/ACO Certification Programs and Payment Reform Priorities
  - **Registration of Provider Organizations (RPO) Program**
- Community Health Care Investment and Consumer Involvement Update
- Schedule of Next Commission Meeting (January 20, 2015)

Registration of Provider Organizations

Provider Organizations were required to submit Part 1 materials to the HPC by 5:00pm on November 14, 2014.

Applications received on or before the 11/14 deadline:	62
Applications received after the 11/14 deadline:	11
Outstanding applications expected on or before 12/19:	4

Conclusion: The HPC expects the total number of RPO applicants to remain in flux over the next few weeks. Contributing factors include:

- New applications received from organizations that missed the 11/14 deadline
- New applications from Risk Bearing Provider Organizations that did not complete the parallel RPO registration requirement
- Removal of duplicative applications submitted by organizations that have a corporate affiliation with another registering entity

Registration of Provider Organizations

Review Status of Applications Received as of 12/16	
Awaiting Review	42
Under Review	10
Awaiting Updates	4
Complete	17
Total Applications Received:	**73**

Registration of Provider Organizations

Review Criteria

- ❑ All of the required files were submitted
- ❑ The files were completed according to instructions in the DSM and HPC guidance
- ❑ The Provider Organization's materials are consistent with other sources, including:
  - ❑ AGO Public Charities filings
  - ❑ Secretary of State filings
  - ❑ Information shared with HPC during 1-on-1 meetings
  - ❑ Material Change Notices
  - ❑ RPO applications from affiliated organizations
- ❑ The Provider Organization has used the RPO terminology accurately

Review Process

HPC sends a confirmation receipt to the Provider Organization

↓

HPC reviews the materials for completeness and accuracy

↓

If HPC identifies errors/questions, the Provider Organization has 10 business days to respond

↓

Updated materials are reviewed, as applicable

↓

The HPC sends a confirmation letter to the Provider Organization stating that no additional action is required until Part 2

Registration of Provider Organizations

Next Steps

	Dec	Jan	Feb	Mar	April	May	June	July	Aug
HPC completes review of Part 1 materials									
HPC uploads final Part 1 materials to web portal									
HPC vets Part 2 DSM with Provider Organizations									
Part 2 DSM released									
HPC holds Part 2 training sessions and 1-on-1 meetings									
Part 2 Registration Window									

All dates are approximate.

Registration of Provider Organizations

Looking to Part 2

- The HPC is currently working to assemble the Data Submission Manual for Part 2.
- In drafting the Part 2 DSM, staff are working to incorporate, as appropriate:
  - Input received from Provider Organizations on the draft DSM released in April 2014
  - Answers to common questions received from Provider Organizations in Part 1
  - Updated definitions, clarifications and policies, based on staff's review of the Part 1 materials
- Staff anticipate providing ample opportunity for comment, questions and feedback from both Provider Organizations and HPC Commissioners. Detailed comments on definitions and data elements will help staff create a DSM that is clear and precise.

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- **Community Health Care Investment and Consumer Involvement Update**
  - CHART Phase 2 Awards
- Schedule of Next Commission Meeting (January 20, 2015)

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  - **CHART Phase 2 Awards**
- Schedule of Next Commission Meeting (January 20, 2015)

Hallmark Health in CHART Phase 2

On October 22, 2014 the HPC Board voted to approve an investment of up to $2,500,000 at Melrose-Wakefield Hospital and Lawrence Memorial Hospital along with key community partners.

The Board voted to delay release of the initiation payments and entrance into Implementation Planning for Hallmark given the uncertainty surrounding the proposed acquisition of Hallmark by Partners HealthCare System (Partners), and an upcoming hearing on the proposed consent judgment between Attorney General Coakley and Partners, Hallmark and related entities.

Approved Award

Hallmark Health - Melrose-Wakefield Hospital and Lawrence Memorial Hospital	
$2,500,000	This investment will support the development and implementation of a "high utilizer" multi-disciplinary outreach team with a behavioral health focus - and particularly pain management and opioid prevention - across community-based care sites.

Vote: CHART Phase 2 Awards

Motion: That the Commission hereby authorizes the Executive Director to proceed with implementation planning with the Hallmark Health System hospitals (Lawrence Memorial and Melrose-Wakefield) for Phase 2 of the Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program and further authorizes the Executive Director to make initiation payments of $100,000 to each of these hospitals, subject to the terms of the CHART Investment Program.

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- Community Health Care Investment and Consumer Involvement Update
- **Schedule of Next Commission Meeting (January 20, 2015)**

Contact Information

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