COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Advisory Council

March 18, 2015

Agenda

- Executive Director's Report on Recent Activity
- HPC Priorities for 2015
- General Discussion
- Schedule of Next Advisory Council Meeting (May 13, 2015)

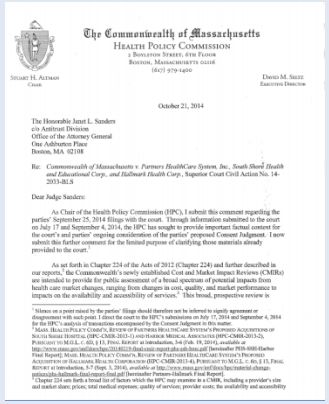
Agenda

- **Executive Director's Report on Recent Activity**
  - 2014 Health Care Cost Trends Hearing and Report
  - CHART Investment Program
  - PCMH/ACO Certification Programs
- HPC Priorities for 2015
- General Discussion
- Schedule of Next Advisory Council Meeting (May 13, 2015)

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. Seltz
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]

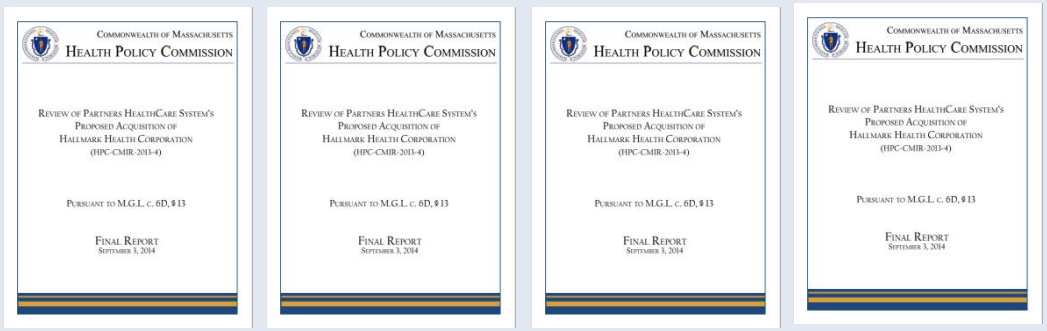
As set forth in Chapter 224 of the Acts of 2012 (Chapter 224) and further described in our reports,[2] the Commonwealth's newly established Cost and Market Impact Reviews (CMIRs) are intended to provide for public assessment of a broad spectrum of potential impacts from health care market changes, ranging 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-partners-south-shore-harbor-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, 5-7 (Sept. 3, 2014), available at http://www.mass.gov/anf/docs/hpc/material-change-partners-hpc-hallmark-final-report-final.pdf [hereinafter Partners-Hallmark Final Report].

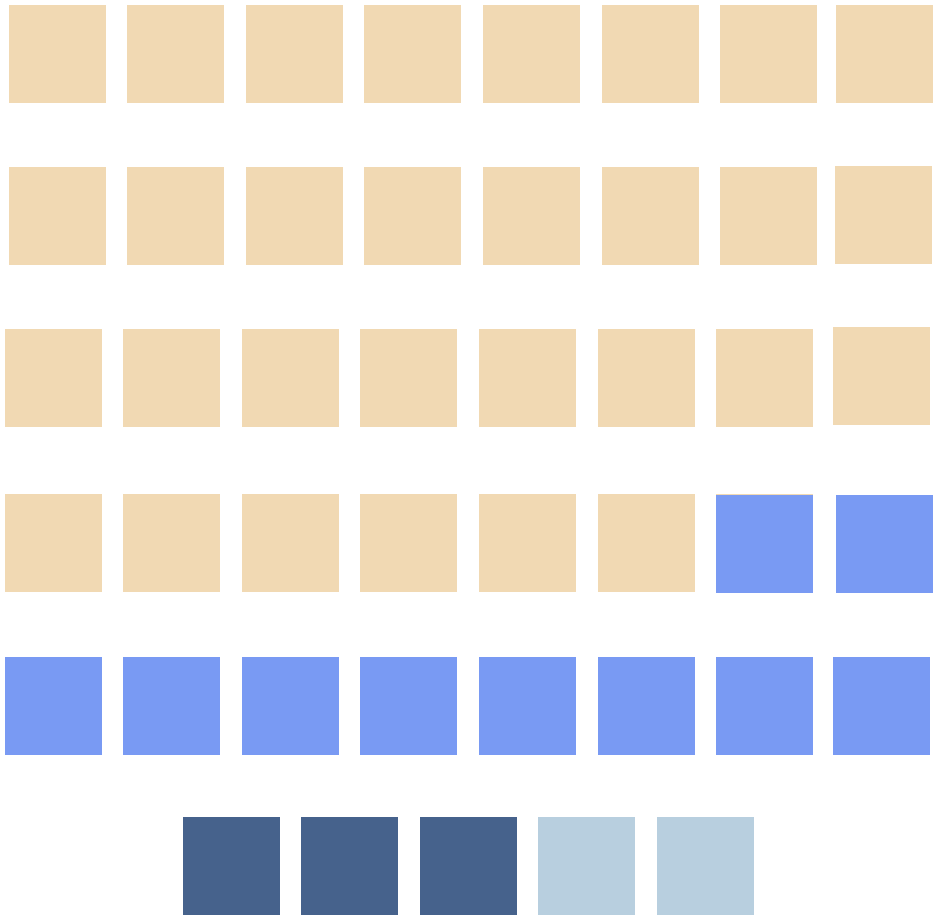
[3] Chapter 224 sets forth a broad list of factors which the HPC may examine in a CMIR, including a provider's size and market share; prices; total medical expenses; quality of services; provider costs; the availability and accessibility

4 Final Cost and Market Impact Review Reports



2014 Review: Public Engagement

45 Public Meetings



Committee | Board | Advisory Council | Cost Trends Hearing

% 83

increase in followers since January

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Selected findings from 2014 Cost Trends Report

Spending trends	Per capita THCE grew by 2.3 percent. Below the benchmark.
Episodes	For selected episodes of care, spending varied among hospitals without significant differences in quality.
Post-acute care	In MA, 39 percent of patients received PAC following inpatient stay compared to national rate of 27 percent. Following total joint replacement, most hospitals discharge to institutional care more frequently than New England Baptist, a recognized specialty hospital.
Readmission rates	CMS will penalize 80 percent of Massachusetts hospitals for high readmissions rate.
ED visits	Almost half of the ED visits in 2012 were preventable.
Behavioral health	For a variety of medical conditions, spending for patients with behavioral health comorbidities is higher than spending for patients without such comorbidities.
APMs	Between 2012 and 2013, expansion of APM coverage stalled in the commercial sector.
Demand-side incentives	Thus far, we see potential value but limited adoption of narrow networks, reference pricing, and price transparency.
Transparency and data	The importance of transparency and data availability surface throughout our work.

Conclusions from the 2014 Cost Trends report

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and appropriately reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

The report includes specific commitments from the HPC and recommendations to market participants and other state agencies to advance these policy goals in 2015.

Proposed recommendations - overview

Fostering a value-based market

1. Massachusetts – lead nation in price transparency
2. Payers - develop and promote value-oriented products; enhance employer information
3. Employers - offer value-oriented products
4. Providers - demonstrate that proposed market changes offer benefits
5. HPC – examine past transactions to assess impacts

Promoting an efficient high-quality delivery system

1. Providers - adopt appropriate tools and share best practices in specific priority areas
2. HPC – reinforce priority areas via TA, investment, performance measurement and payment design
3. State agencies - develop a coordinated behavioral health strategy

Advancing alternative payment methods

1. Payers and providers – adopt APMs and increase their effectiveness
2. State agencies – prioritize efforts to define a standard set of provider quality measures
3. HPC - explore episode-based payment models
4. MassHealth - continue progress towards ACO

Enhancing transparency and data availability

1. HPC - develop measures to track system performance
2. CHIA - improve APCD capabilities, develop key spending measures
3. State agencies - coordinate on APM data collection, resource planning

Fostering a value-based market

Proposed Recommendations

Information and incentives to encourage high-value choices

1. Massachusetts should lead the nation in direct-to-consumer transparency, enabling access to detailed information on cost and quality.
2. Payers should continue to develop and promote value-oriented products and enhance provider information.
3. Employers should offer their employees plan choices that include value-oriented products, or embed value-based concepts into their chosen plan offering.

Market competition

1. Providers should present measurable indicators of how proposed material changes are likely to result in improved performance and demonstrate that benefits outweigh potential detriments.
2. The HPC will examine past transactions to assess their impacts.

Promoting an efficient, high-quality delivery system

HPC Priority Areas

- Addressing variation among providers in spending per episode and use of post-acute care
- Reducing readmission rates and ED utilization
- Care coordination and clinical integration across settings
- Identifying and managing high-cost patients
- Caring for patients in community settings
- Treatment of behavioral health conditions, especially via integrated models

Proposed Recommendations

1. Providers should adopt appropriate tools and share best practices in the priority areas.
   - Hospitals should focus on PAC and discharge planning.
   - PAC providers should collect and use patient assessment data.
2. The HPC will convene providers and offer TA in priority areas and emphasize these areas in investment programs and payment design.
3. The Commonwealth should develop a coordinated behavioral health strategy.
   - CHIA should begin collecting data in priority areas.

Advancing alternative payment methods

Proposed Recommendations

1. Payers and providers should focus on increasing adoption and effectiveness of APMs.
   - All payers should use APMs for 60 percent of HMO lives and 33 percent of PPO lives.
   - Payers and providers should evaluate how best to include behavioral health spending in APM budgets to support integrated, whole-person care and should work to adopt such arrangements starting in 2015.
2. The state should prioritize defining a standard set of provider quality measures for use in payer contracts, provider tiering, and improvement goals.
3. The HPC will convene stakeholders to explore episode-based payment models.
4. MassHealth should continue progress towards developing and launching an ACO.

Enhancing transparency and data availability

Proposed Recommendations

1. The HPC will develop a set of measures to track health system performance.
2. CHIA should improve APCD capabilities and transparency and develop key spending measures.
3. Government agencies should coordinate on APM data collection and continue health resource planning.

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CHART Phase 1 by the numbers*

CHART Phase 1: $10M

162,000+

Patients impacted by Phase 1 initiatives

2,200+

Hospital employees trained

27 Hospitals | **260** Units

Primed for system transformation

92%

Phase 1 Feedback survey respondents believed that CHART Phase 1 moved their organization along the path to system transformation

308

Community partnerships formed or enhanced by awardees

400+

Hours of direct technical assistance to awardees

*Updated February 25, 2015

CHART Phase 1 evaluation products

A series of Phase 1 evaluation outputs are currently in development or complete

1. ***Complete* - Programmatic learnings to inform Phase 2:** HPC staff have continuously collated and captured key lessons to inform ongoing program development and hospital improvement efforts. These tools and approaches are actively being implemented in Phase 2, including directly informing the creation of the implementation planning period.

2. ***Complete* - CHART Leadership Summit Proceedings Paper:** Staff developed and released a proceedings paper on the Leadership Summit. Staff are working to finalize an aggregate report developed based on the assessments conducted by Safe & Reliable Healthcare for release.

3. **Case Studies on Key Themes:** HPC has commissioned up to six case studies of key themes in CHART Phase 1. Each will include multiple hospitals. Cases will be released on a rolling basis and will include topics such as: using data to understand a population and design an intervention, the importance of engaged leadership, and how to address social and behavioral drivers of hospital utilization.

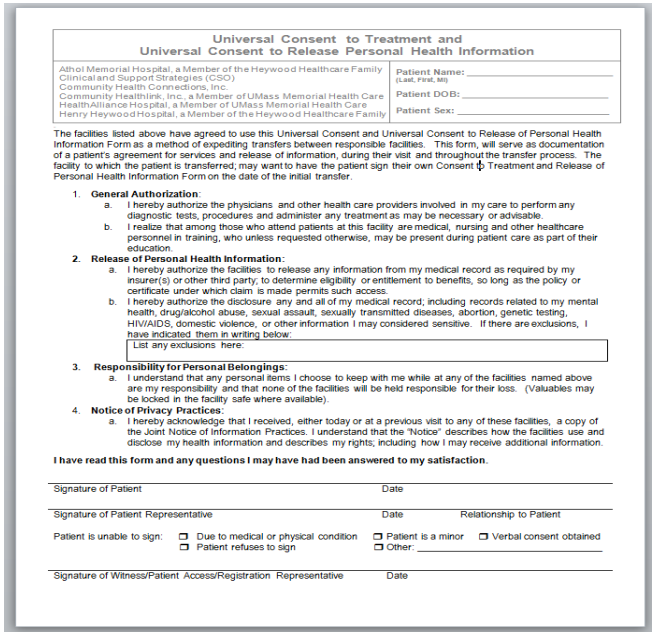
4. ***In progress* - Summative Evaluation Report:** Subsequent to receipt of all final reports and completion of the Phase 1 close out survey, the HPC will release a summative evaluation report on Phase 1. This is anticipated in Q1 2015.

Spotlight: North-Central Mass. regional behavioral health collaborative

These three awardees identified a need for sharing best practices and finding a common way to share information on frequent ED users with behavioral health comorbidities.

Athol, Heywood, and HealthAlliance created the Regional Behavioral Health Collaborative (RBHC) to develop best practices to improve early identification of mental illness and to increase access to behavioral health care among the North Central and North Quabbin communities.

- The hospitals invited community partners like Community Health Connections, Community HealthLink, Gardner Public Schools, and Athol Public Schools
- Created a universal patient consent form to enable efficient data sharing among institutions
- Created Regional Individualized ED Care Plan with the latest information on each patient who visits area organizations, **treating 471 high risk patients in total**



Universal Consent to Treatment and
Universal Consent to Release Personal Health Information

Athol Memorial Hospital, a Member of the Heywood Healthcare Family
Clinical and Support Strategies (CSO)
Community Health Connections, Inc.
Community Healthlink, Inc., a Member of UMass Memorial Health Care
HealthAlliance Hospital, a Member of UMass Memorial Health Care
Henry Heywood Hospital, a Member of the Heywood Healthcare Family

Patient Name: _____ (Last, First, MI)
Patient DOB: _____
Patient Sex: _____

The facilities listed above have agreed to use this Universal Consent and Universal Consent to Release of Personal Health Information Form as a method of expediting transfers between responsible facilities. This form, will serve as documentation of a patient's agreement for services and release of information, during their visit and throughout the transfer process. The facility to which the patient is transferred; may want to have the patient sign their own Consent to Treatment and Release of Personal Health Information Form on the date of the initial transfer.

1. **General Authorization**:
   a. I hereby authorize the physicians and other health care providers involved in my care to perform any diagnostic tests, procedures and administer any treatment as may be necessary or advisable.
   b. I realize that among those who attend patients at this facility are medical, nursing and other healthcare personnel in training, who unless requested otherwise, may be present during patient care as part of their education.
2. **Release of Personal Health Information:**
   a. I hereby authorize the facilities to release any information from my medical record as required by my insurer(s) or other third party; to determine eligibility or entitlement to benefits, so long as the policy or certificate under which claim is made permits such access.
   b. I hereby authorize the disclosure any and all of my medical record; including records related to my mental health, drug/alcohol abuse, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may considered sensitive. If there are exclusions, I have indicated them in writing below:
      List any exclusions here:
3. **Responsibility for Personal Belongings:**
   a. I understand that any personal items I choose to keep with me while at any of the facilities named above are my responsibility and that none of the facilities will be held responsible for their loss. (Valuables may be locked in the facility safe where available).
4. **Notice of Privacy Practices:**
   a. I hereby acknowledge that I received, either today or at a previous visit to any of these facilities, a copy of the Joint Notice of Information Practices. I understand that the "Notice" describes how the facilities use and disclose my health information and describes my rights; including how I may receive additional information.

I have read this form and any questions I may have had been answered to my satisfaction.

Signature of Patient _____ Date _____

Signature of Patient Representative _____ Date _____ Relationship to Patient _____

Patient is unable to sign: ☐ Due to medical or physical condition ☐ Patient is a minor ☐ Verbal consent obtained
☐ Patient refuses to sign ☐ Other: _____

Signature of Witness/Patient Access/Registration Representative _____ Date _____

From ED to School

Provided school-based services, including community wrap-around, for 322 families

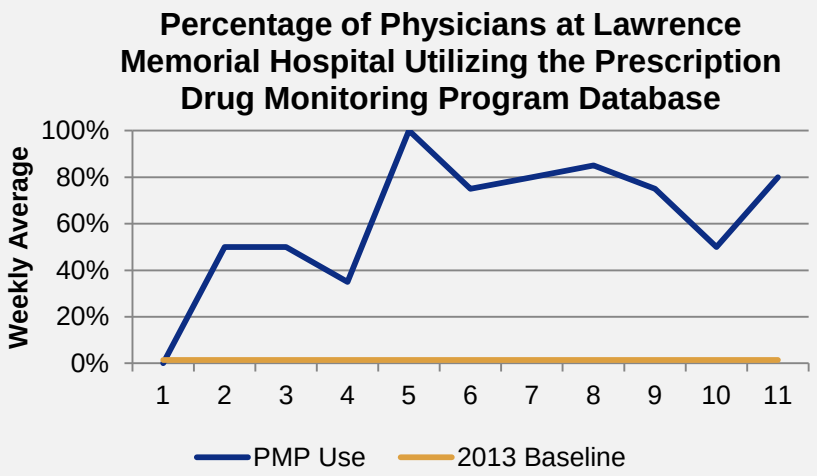
School-based BH program reached capacity within 4 weeks of implementation

- Home and school-based BH counseling
- Access to eye glasses
- Housing placement for homelessness and rental assistance for housing vulnerability
- Food supports/security

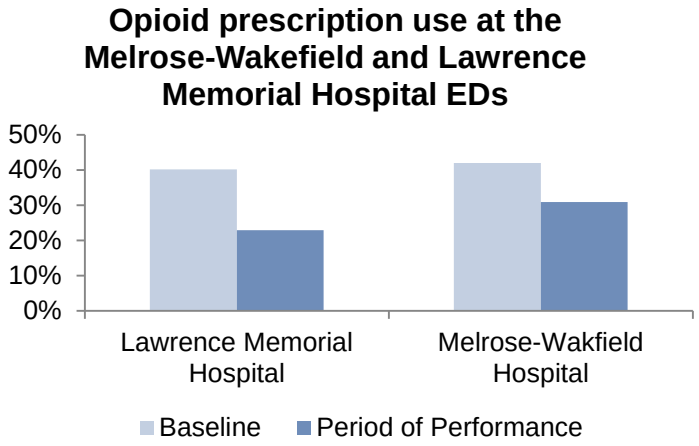
"[CHART] provided an opportunity to **collaborate on efforts to increase access**, strengthen **care coordination** and **improve the system of care** for both youth and individuals in crisis suffering from mental illness and addictions through the EDs…The relationships made or enhanced by our initial project's work hold promise for **great collaboration** in the years to come."

Hallmark Health System used medical record review and dashboards to implement clinical practice guidelines for prescribing opioids in the ED

Seeking to understand the drivers of opioid prescribing in its emergency departments, HHS reviewed close to 1,000 patient medical records and found substantial variation in prescribing patterns, which led to the development and implementation of rigorous clinical practice guidelines to reduce practice pattern variation

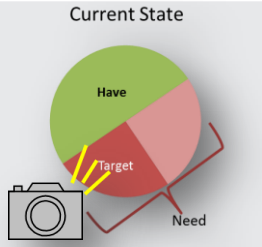
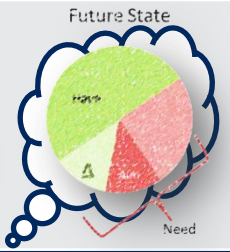
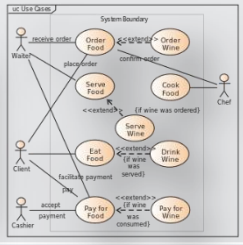


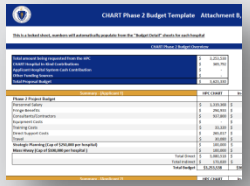
Adherence to guideline protocols were tracked by physician and trended week-over-week to monitor compliance



Opioid prescription use decreased by 26% from baseline at Melrose-Wakefield Hospital and by 43% at Lawrence Memorial Hospital

Overview of the Implementation Planning Period (IPP)

	1. Describe Current State	2. Verify Aim	3. Refine Service Model	4. Finalize Staffing Model	5. Develop Technology Req's	6. Develop Mass HIway cases
						
Activity Description	Utilize your data and patient interviews to be able to define your target population and describe the state of the measures you intend to affect	Using your baseline, quantify the specific impact your Initiatives will seek to have on the target population by the end of the Period of Performance	Design Initiatives that address the needs (i.e., Drivers) of the target population in order to achieve the Aim Statement	Specify the exact staffing model to support Phase 2 investments (service delivery, administrative, and leadership needs)	Specify lightweight technologies to be used to support achievement of Aim(s)	Specify intended uses of Mass HIway (to be further developed post-IPP)

	7. Define Scope of Strategic Plan	8. Describe Non-Service Investments	9. Develop Measurement Plan	10. Submit Final Budget	11. Extrapolate Project Milestones	12. Finalize Payment Schedule
						
Activity Description	Define broad goals for strategic planning, to be refined and subject to HPC approval after release of Community Hospital Study	Specify needs and requirements for service-delivery investments (e.g., training, capital, consultants, TA, etc.)	Finalize measurement plan (including validation of data sources and ability to collect measures) for standard and award-specific metrics	Specify final budget based on prior amendments and up to Board -approved award cap	Specify all project milestones (including goals and metrics where appropriate) to assess successful completion	Align disbursement schedule with project milestones including both process and achievement based payments

During IPP the HPC reaches agreement with the awardee on services to be provided as well as clinical and non-clinical workflows

Measure	Total	Proportion of Total (%)
A. Total Discharges	7883	100%
B. Total Discharges to Post-Acute Care	3038	38.5%
C. Discharges to SNF/IRF/LTAC*	1542	50.8%
D. Discharges to Home Health	1496	49.2%
E. Discharges to Home	4395	55.8%
F. Discharges with Primary or Secondary BH Diagnosis	4269	54.2%
G. Total (adult non-OB) 30-day Readmissions	1094	13.9%
H. Readmissions Occurring <4 days of d/c	188	17.2%
I. Readmissions Occurring <10 days of d/c	477	43.6%
J. Readmissions with a Primary or Secondary BH Diagnosis	573	52.4%
K. Number of Patients with ≥4 Hospitalizations Past Year	234	---
L. Total Number of Discharges Among [K]	1182	15.0%
M. Total 30-day Readmissions Among [K]	526	48.1%
N. % of Discharges that Result in Readmissions Among [K]	---	44.5%

Example Only: Target Population Development

54%

behavioral health comorbidity among hospital discharges

48 | 234

% Patients

234 superutilizers drive readmission rate

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PCMH Program Update

Certification Standards

- HPC released proposed PCMH certification standards for public comment. Responses are due on March 27, 2015.
- HPC hosted two focus groups prior to releasing standards for public comment
- HPC will host two stakeholder Q&A sessions during the public comment period
  - March 18, 2015, 4-5 PM
  - March 23, 2015, 2-3 PM
- Continued discussion with stakeholders through focus groups and one-on-one meetings
- Proposed standards to be finalized during the April 29, 2015 board meeting

Model payment

- Development of overall policy framework (key principles, approach, timeline) is underway
- Focus groups on policy framework next week
  - March 16, 2015, 12-2 PM
  - March 17, 2015, 2-4 PM
- Further discussion at CDPST on April 1, 2015 and at the board meeting on April 29, 2015

ACO Certification: Key Takeaways from Expert Input

Certification – General Thoughts

- Current evidence on link between capabilities and performance is thin
- Exceptions:
  - Leadership: essential (but hard to regulate)
  - Insurance oversight if risk bearing
  - Performance reporting (so we know how they are doing)
- Remarkable diversity in current models; over-specification likely harmful
- However, certification can help address ACOs “in name only”

Minimum standards

- Align with MSSP to extent possible
- Encourage systems to move to all-payer ACO contracts
- Consider standardized reporting on structure, contracts, capabilities
- Protections against stinting and dumping – i.e., what ACOs should not do
- Building blocks: information flow, risk stratification, effective transitions, gap analysis, team based care, process improvement (team); provider feedback (individual)

More advanced ACOs

- Link levels to:
  - Proportion of primary care patients under ACO model
  - Degree of risk bearing
  - Ability to report on advanced measures (PROMs, health risk)
  - Price reductions for remaining FFS contracts

What else can the HPC do?

- Payment model concordance (push other payers)
- Standardized data collection; link to performance tracking
- Design the certification process to accelerate learning
  - Use assessments to identify peer-coaching opportunities
  - Technical support, access to evidence
  - Data support

ACO Certification: Next Steps

April 1	**Care Delivery and Payment System Transformation** Discuss proposed framework and key design choices
April 28	**Care Delivery and Payment System Transformation** Discuss more detailed assessment methodology
April 29	**Board Meeting** Board discussion on proposed framework & assessment methodology
June 3	**Care Delivery and Payment System Transformation** Proposed ACO regulation & design for public comment
June 22	**Board Meeting** Proposed ACO regulation & design for public comment

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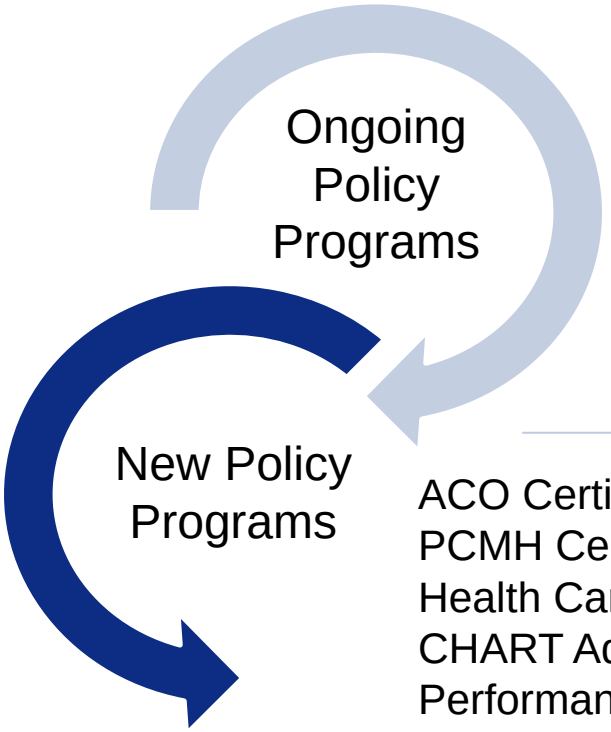
2015 HPC Work Streams



Annual Cost Trends Report Research and Analysis
Behavioral Health Agenda
CHART Phase 2
Notices of Material Change
Cost and Market Impact Reviews
Office of Patient Protection
RPO: Initial Registration Part 1

ACO Certification Program, Model Payment, and Technical Assistance
PCMH Certification Program, Model Payment, and Technical Assistance
Health Care Innovation Investment Program
CHART Additional Investments and Technical Engagement Program
Performance Improvement Plans
Review of DoN/Essential Service Notices
RPO: Initial Registration Part 2
Transparency Initiatives (Episode-Level Spending/Price Variation)
Continued Work on 2014 Cost Trends Report Recommendations

2015 Publications and Regulations

Proposed 2015 Publications

Annual Reports
- HPC Business
- Office of Patient Protection
- Registration of Provider Organizations
- CHART

CHART
- Phase One Final Report
- Phase One Case Studies

Community Hospital Study
Cost and Market Impact Reviews
2016 Cost Trends Report
Substance Use Disorder Report
White Paper Series

Proposed 2015 Regulations/Guidance

ICU Nurse Staffing Regulation

ACO Certification Regulation

Interim Guidance on Performance Improvement Plans (PIP)

Updates to OPP Regulation

Interim Guidance on OPP RBPO/ACO Appeals Process

Updates to MCN Technical Bulletin

2015 HPC Substance Use Disorder Report

As mandated by c. 258 of the Acts of 2014, CHIA shall conduct review of the accessibility of SUD treatment and adequacy of insurance coverage, and issue a report:

- describing the continuum of care for SUD treatment;
- evaluating access for commercially insured patients and patients eligible for MassHealth and/or DPH services; and
- describing specific barriers to treatment, including utilization review, prior authorization, and cost-sharing requirements

As mandated by c. 258 of the Acts of 2014, HPC will make recommendations to the legislature on:

1. Improving the adequacy of coverage by public and private payers where necessary
2. Improving the availability of treatment for opioid addiction where inadequate
3. The need for further analyses by CHIA

Potential topics for 2015 research – for discussion

- **Primary care access:** incl. urgent care, minute clinics and telehealth; changes in market, impact on ED use
- **New technology, including high-cost drugs/biologics:** impact on cost and quality
  Behavioral health integration: best practices, including best practices in working with MBHOs
- **APMs:** characterize the payment models used; impact of model type on spending
- **Employers and insurance markets:** potential value of strengthening demand-side incentives in MA; best practices and barriers; potential of private exchanges
- **Data for provider decision-making and health IT:** best practices and barriers
- **Episode payment:** technical studies to support potential use in MA
- **Social determinants of health and self-care**
- **Market concentration analysis of outpatient services (i.e. primary care)**

Topics may be covered in 2015 Cost Trends Report or HPC working papers

Health Care Innovation Investment Program (HCII)

Establishment of the Health Care Innovation Investment Program

- M.G.L. c. 6D § 7
- Funded by revenue from **gaming licensing fees** through the Health Care Payment Reform Trust Fund
- Total amount of **$6 million**
  - *May increase if 3rd gaming license is awarded*
- Unexpended funds may to be rolled-over to the following year and do not revert to the General Fund
- **Competitive** proposal process to receive funds
- Broad eligibility criteria (*any **payer or provider***)

Purpose of the Health Care Innovation Investment Program

- To **foster innovation** in health care **payment** and service **delivery**
- To **align** with and **enhance** existing funding streams in Mass. (e.g., DSTI, CHART, MeHI, CMMI, etc.)
- To support and further efforts to meet the **health care cost growth benchmark**
- To improve **quality** of the delivery system
- **Diverse uses** include incentives, investments, technical assistance, evaluation assistance or partnerships

Chapter 224 provides guidance on program development process and framework but does not provide detailed specifications for use of funds

Program development considerations

1. HPC shall **solicit ideas for payment and care delivery reforms** directly from providers, payers, research / educational institutions, community-based organizations and others
2. HPC must coordinate with other state grant makers
3. Investments must be **evaluated for cost and quality implications**
4. Chapter 224 encourages broad dissemination of learnings and incorporation of successes into ACO certification and state-administered payment reforms

Investments that catalyze care delivery and payment innovations

Discussion Question

- Should the HPC prioritize spending on **piloting** new ideas, on **evaluating** existing initiatives for effectiveness, or on broadening the impact of successful models by bringing them to **scale**?
- Help us understand your perspective on high-need areas for payment or delivery reform. What three **challenges** are unmovable in your organization?
- What opportunities for **partnership** exist with changemakers in other sectors?

Agenda

- Executive Director's Report on Recent Activity
- HPC Priorities for 2015
- **General Discussion**
- Schedule of Next Advisory Council Meeting (May 13, 2015)

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Open Public Comment Periods

1 ICU Nurse Staffing Regulation and Quality Measures

- **Comment Period Ends**: April 6, 2015 at 12PM
- **Public Hearings**: March 25 (Boston) and April 2 (Worcester)
- Regulation establishes a registered nurse-to-patient ratio of one-to-one or one-to-two in intensive care units in acute hospitals licensed by DPH
- HPC released proposed quality measures and questions to assist interested parties in focusing their testimony.

2 Proposed Patient-Centered Medical Home Certification Framework

- **Comment Period Ends**: April 10, 2015
- **Q&A Sessions**: March 18 and March 23 (available by Webinar)
- HPC is partnering with NCQA to operationalize the PCMH Certification Program
- Proposed framework complements existing local and national care transformation and payment reform efforts, validates value-based care, and promotes investments in efficient, coordinated, and high-quality primary care.

Upcoming Meetings

2015 HPC Board Meetings

Meeting locations posted on HPC's website. All meetings at 12PM.

Wednesday, April 29, 2015
Wednesday, June 10, 2015
Wednesday, July 22, 2015
Wednesday, September 9, 2015
Wednesday, October 21, 2015
Wednesday, December 16, 2015

2015 HPC Committee Meetings

Please note that all meetings will be at 50 Milk Street, 8th Floor.

Wednesday, March 25 - QIPP Public Hearing (1 Ashburton Place, 12PM)
Wednesday, April 1 - CDPST/CTMP
Wednesday, April 15 - CHICI
Thursday, April 2 - QIPP Public Hearing (Worcester State University)

2015 Advisory Council Meetings

Please note that all meetings will be at 50 Milk Street, 8th Floor from 12PM-2PM

Wednesday, May 13, 2015
Wednesday, September 16, 2015
Wednesday, November 18, 2015

Contact Information

For more information about the Health Policy Commission:

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