COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

November 18, 2015

Board Meeting

Agenda

- Approval of Minutes from the September 9, 2015 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Schedule of Next Meeting (December 16, 2015)

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on September 9, 2015, as presented.

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- Approval of Minutes from the September 9, 2015 Meeting
- **Executive Director's Report**
  - Today's Agenda
  - CHART Investment Program
  - Registration of Provider Organizations Program
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Today's Agenda

- Approval of Minutes from the September 9, 2015 Meeting **(VOTE)**
- Executive Director's Report ~10 minutes
  - CHART Investment Program
  - Registration of Provider Organizations Program
- Cost Trends and Market Performance ~30 minutes
  - Introduction to Performance Improvement Plans
- Care Delivery and Payment System Transformation ~50 minutes
  - Program Design for Patient-Centered Medical Homes **(VOTE)**
  - Draft Standards for Accountable Care Organizations **(VOTE)**
- Quality Improvement and Patient Protection ~50 minutes
  - 2014 Office of Patient Protection Annual Report
  - Final Recommended Regulations for the Office of Patient Protection **(VOTE)**
  - Program Design for a Pilot Addressing Neonatal Abstinence Syndrome
- Schedule of Next Meeting (December 16, 2015)

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CHART Phase 2 implementation planning by the numbers: January 1 – November 18, 2015

7 Regional Convenings

1,000 hours of coaching calls

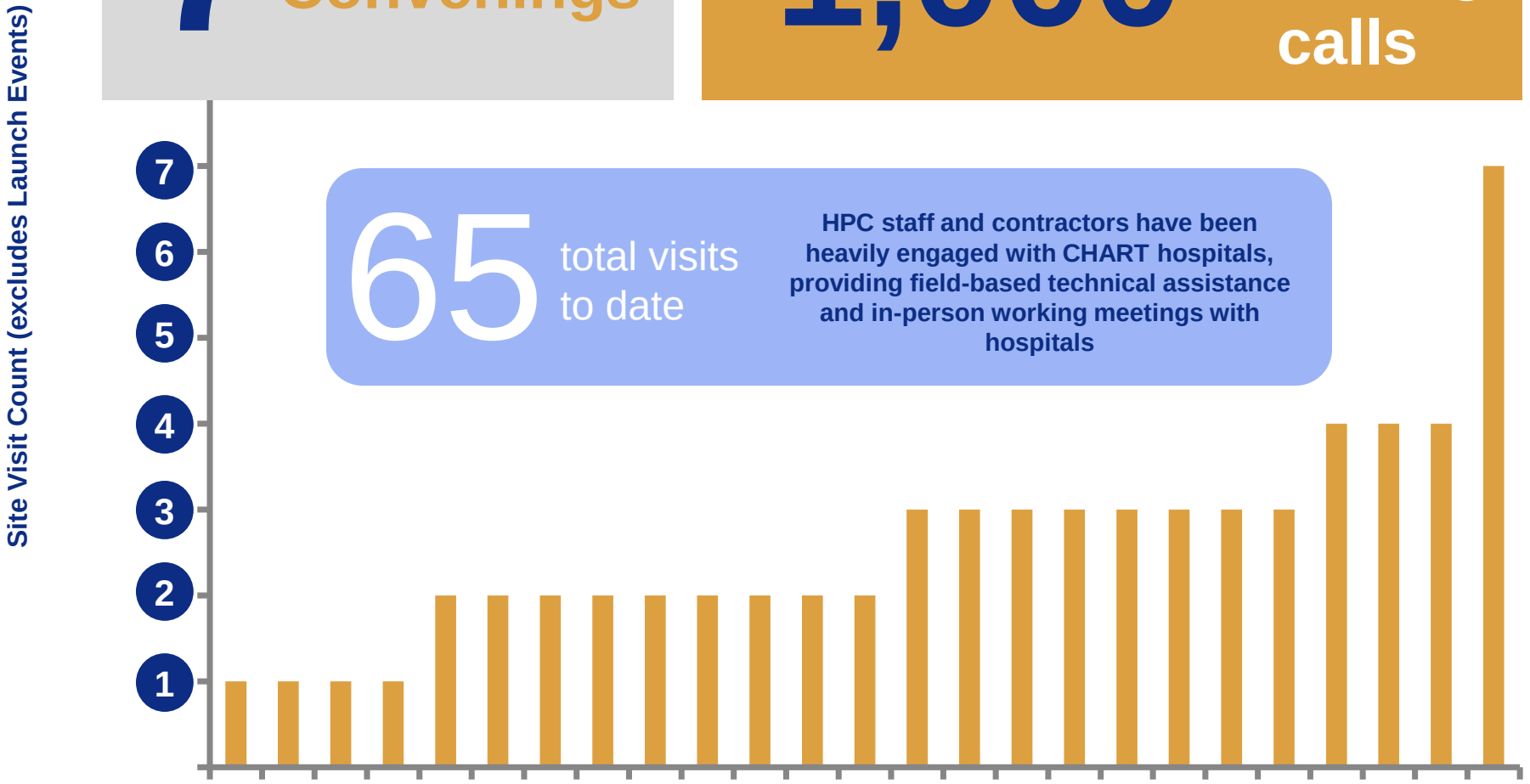
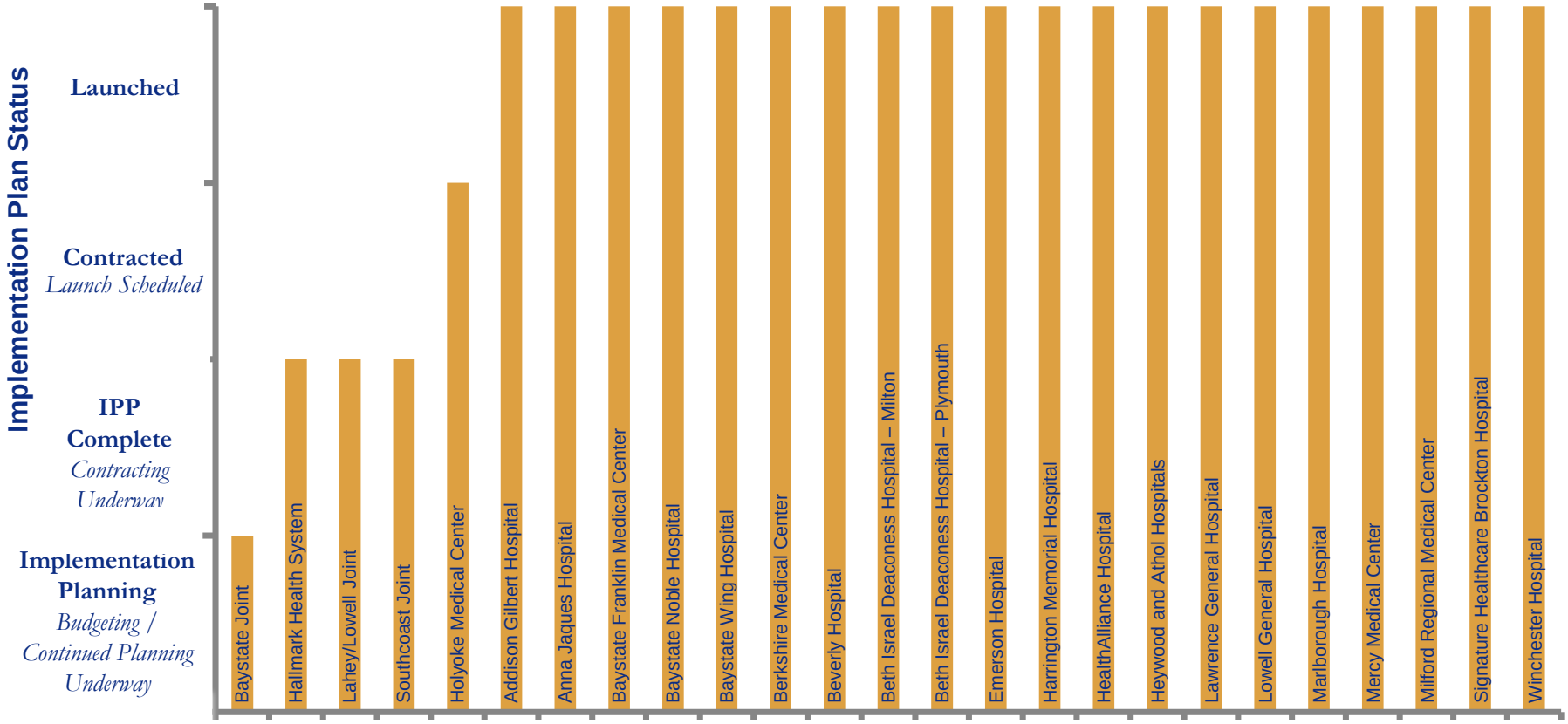


CHART Phase 2 program update

20 Awards launched in September, October, and November; **2** Awards anticipated to launch in December; **3** Awards anticipated to launch in January



Eight awards launched on November 1, all focused on reducing readmissions or reducing ED reutilization

Addison Gilbert Hospital *$1,269,057*	Cross-setting complex care team serving patients with a history of recurrent acute utilization, social complexity, SUD, or recent readmission, to reduce readmissions
Baystate Franklin Medical Center *$1,569,000*	Cross-setting complex care team and enhanced screening with additional ED resources serving patients with a history of recurrent acute utilization and BH diagnoses, to reduce ED revisits and readmissions
Baystate Noble Hospital *$1,040,100*	Transitional care services for patients discharged to SNF and with a history of recurrent acute utilization, to reduce readmissions
Baystate Wing Hospital *$999,919*	Cross-setting complex care team with palliative care focus, serving patients with a life-limiting medical or behavioral health diagnosis, to reduce readmissions
Beverly Hospital *$2,500,000*	Cross-setting complex care team serving patients with a history of recurrent acute utilization, social complexity, SUD, or recent readmission, to reduce readmissions
HealthAlliance Hospital *$3,800,000*	Hospital-based and community-based behavioral health services to reduce ED revisits
Lowell General Hospital *$1,000,000*	Cross-setting complex care team with palliative care focus serving for patients with a history of recurrent acute utilization, to reduce readmissions
Winchester Hospital *$1,000,000*	Cross-setting complex care team serving patients with a history of recurrent acute utilization and all discharges to post-acute care, to reduce readmissions

CHART-funded portion of the budget; in-kind and system contributions are additional

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  - CHART Investment Program
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Registration of Provider Organizations: Part 2 Registration Period

June	July - August	September - October
Part 2 DSM released	Group Training Session at MHA – 31 attendees	Online Submission Platform launched
Microsoft Excel templates released	Group Training Session at Baystate – 14 attendees	25 one-on-one meetings held
	Group Training Session at UMass Memorial – 9 attendees	FAQs released
	Group Training Session at MMS – 23 attendees	Materials were due 10/30/2015
	One-on-one meetings began	

Registration of Provider Organizations: Part 2 Application Status

Initial Registration: Part 2 materials were due to the HPC by Friday, October 30, 2015.

Initial Registration: Part 2 Applications (As of 11/16/2015)	
Received	50
Extension Granted	5
Not Received	4
Total	59

Registration of Provider Organizations: Part 2 Review Process

November	Week 1	**Application Intake** Materials are dated, saved, and filed
	Week 2	**Application Review 1** All files are reviewed for accuracy and completeness
	Week 3	
	Week 4	
December	Week 5	**Requests for Updates and Clarifications** Provider Organizations are given three weeks to update their materials or provide clarifications
	Week 6	
	Week 7	
January	Week 8	**Application Review 2** HPC reviews updated materials for accuracy and completeness
	Week 9	
	Week 10	
	Week 11	
	Week 12	**Certificate of Registration Issued** Certificates are valid for two years

- The RPO review process will take approximately 12 weeks to complete for most registrants
- Factors influencing the overall timeline include:
  - Five Provider Organizations were granted extensions and have not yet submitted Part 2 materials
  - Some Provider Organizations may require no updates
  - Some Provider Organizations may request additional time to provide updates or clarifications
  - If a Provider Organization submits incomplete or inaccurate updated materials, the HPC may issue a second request for updates or clarifications
- After issuing certificates of registration, the HPC will undertake additional data cleaning efforts before finalizing the RPO dataset

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Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group merger, acquisition or network affiliation	12	24%
Clinical affiliation	11	22%
Acute hospital merger, acquisition or network affiliation	11	22%
Formation of a contracting entity	8	16%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	5	10%
Change in ownership or merger of corporately affiliated entities	3	6%
Affiliation between a provider and a carrier	1	2%

Update on notices of material change

Notices Received Since Last Commission Meeting

- Clinical Affiliation between Dana-Farber Cancer Institute (DFCI) and Berkshire Medical Center (Berkshire), under which Berkshire would become a member of the DFCI Cancer Care Collaborative and DFCI would provide consulting, educational, and clinical support to Berkshire.
- Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO), New England Baptist Hospital (NEBH), and New England Baptist Clinical Integration Organization (NEBCIO), under which NEBCIO participating physicians and NEBH would join BIDCO payer contracts for the purpose of aligning risk and implementing shared orthopedic and musculoskeletal care management programs across the BIDCO network.
- Joint venture between Shields Health Care Group and Anna Jaques Hospital to operate a PET/CT diagnostic imaging clinic.
- Clinical affiliation between UMass Memorial Accountable Care Organization and Sturdy Memorial Hospital, Sturdy Memorial Associates, Holyoke Medical Center, Western Mass Physician Associates, Community Health Connections, Family Health Center of Worcester, and Community Healthlink, under which these providers would join UMMACO in order to participate in the Medicare Shared Savings Program.
- Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO) and MetroWest Medical Center (MWMC), under which MWMC would join BIDCO payer contracts as they come up for renewal.

Update on notices of material change

Elected Not to Proceed

- **Clinical Affiliation between Boston Children's Hospital and Lahey Clinical Performance Network**
  - Our analysis indicated that referral patterns for tertiary and quaternary pediatric services are not expected to shift significantly, and thus that there is limited scope for increases to health care spending.
  - We did not find evidence suggesting negative impacts on quality or access to care.
- **Clinical Affiliation between Boston Children's Hospital and Boston Medical Center**
  - We found that the proposed transaction would not substantially differ from the parties' preexisting clinical affiliations, and that there was limited scope of increases to health care spending or market share as a result of the transaction.
  - We did not find evidence suggesting negative impacts on quality or access to care.
- **Clinical Affiliation between Dana-Farber Cancer Institute and Berkshire Medical Center**
  - Our analysis indicated that rates and referral patterns are unlikely to change as a result of this affiliation.
  - We did not find evidence suggesting negative impacts on access to or quality of care.

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Payer and Provider Performance Improvement Plans: Purpose

- Performance Improvement Plans (PIPs) are a mechanism for the HPC to monitor and assist payers and providers whose cost growth may threaten the state benchmark.
- PIPs provide an opportunity for the HPC as well as the payers and providers undergoing a PIP to understand the drivers of its cost growth, and to pursue best practices to address these drivers.
- The PIP process will enable payers and providers, with the assistance of the HPC, to explore options to reduce cost growth such as investing in efficiency measures, improving utilization management, changing pricing or referral practices, or implementing care delivery reform measures.
- Payers and providers undergoing a PIP will provide updates to the HPC on the progress of their plan, and will have the opportunity to receive consultation and technical assistance from the HPC.

Identification of Payers and Providers

- Under Chapter 224, the Center for Health Information and Analysis (CHIA) is required to provide to the HPC a confidential list of payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (TME), is considered excessive and who threaten the benchmark.

- The HPC is required to provide notice to all such payers and providers informing them that they have been identified by CHIA.

- The HPC may require some of the identified payers and providers to file a PIP where, after comprehensive analysis and review, the HPC has confirmed concerns about the entity's cost growth and found that the PIP process could result in meaningful, cost reducing reforms.

    - The HPC also has the option to conduct a cost and market impact review (CMIR) of any of the provider organizations identified by CHIA *if the state's total health care expenditures exceed the cost growth benchmark*.

- Over the coming months, the HPC will be developing interim guidance/proposed regulations on filing and implementing PIPs and CMIRs of entities identified on CHIA's list.

Development and Implementation of a PIP

- If required to file a PIP, the payer or provider will develop a PIP tailored to the specific cost growth concerns of its entity and propose it to the HPC for approval.
- The PIP must identify the causes of the entity's cost growth and include specific strategies, adjustments, and action steps the entity proposes to implement to improve cost performance.
- It must include specific identifiable and measurable outcomes and a timetable for implementation of no more than 18 months.
- To be approved, a PIP must be reasonably likely to address the underlying causes of the entity's cost growth and be reasonably expected to succeed.
- Implementation of a PIP will involve reporting, monitoring, and assistance from the HPC.

Proposed HPC Process for Identifying Payers and/or Providers Required to File a PIP or Subject to a CMIR

Once the HPC receives the confidential list of payers and providers from CHIA, the HPC will validate the list and provide it to Commissioners.

The HPC will send notices to the identified payers and providers informing them that they have been identified by CHIA.

The HPC will perform a rigorous review of all identified entities by examining a range of factors (outlined on the following slide) to comprehensively understand the entity, its cost growth, and any identifiable causes for such growth.

The HPC will engage with those payers and providers for which the HPC identifies concerns, and may request additional information.

HPC staff will brief Commissioners on the results of this review, including analysis of those payers or providers for which staff recommends a PIP or a CMIR.

HPC staff will present an overview of its analysis and PIP/CMIR recommendations at a public Board Meeting. **Initiation of a PIP or CMIR will require a Board vote**. The HPC will send notices to any entities required to file a PIP or subject to a CMIR.

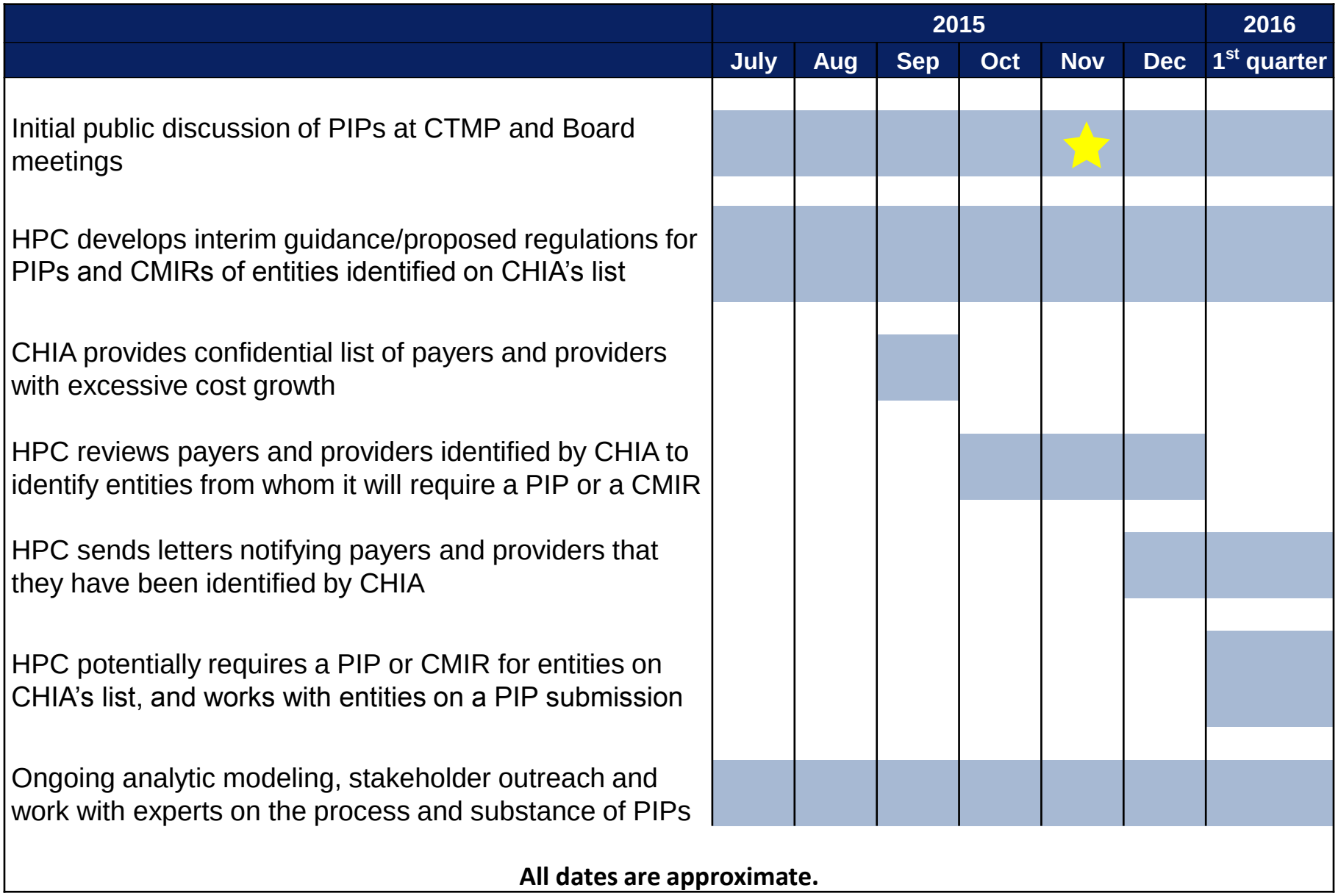
Any entity required to file a PIP may file a request for extension or waiver with the HPC. **Waivers will require a Board vote**.

This process will be further detailed in interim guidance/proposed regulations.

Proposed HPC Approach to Reviewing Identified Payers and Providers

- For each entity identified by CHIA, the HPC plans examine the entity's spending growth in depth, including potential causes for that spending growth in the year(s) that CHIA identified excessive growth
- In addition, Chapter 224 envisions that the HPC may waive the requirement for a health care entity to file a PIP based upon consideration of the factors listed below. The HPC plans to frontload the review of these factors before requiring any of the identified payers or providers to file a PIP.
  - The costs, price, and utilization trends of the health care entity over time, and any demonstrated improvement in health care cost reduction.
  - Any ongoing strategies or investments that the health care entity is currently implementing to improve future long-term efficiency and reduce cost growth.
  - Whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity (e.g., pharmaceutical expenses).
  - The overall financial condition of the health care entity.
  - Other factors to be determined by the HPC (e.g., population size, spending level, spending by category, population served).
- Across these factors, the HPC plans to examine both baseline performance of the entity relative to other providers/payers, and the entity's performance over time.

Anticipated Timeline for Performance Improvement Plans



Next Steps for the HPC

- The HPC has received CHIA's confidential list of payers and providers and is continuing its validation and review of identified entities.
- The HPC anticipates sending notices to entities identified by CHIA after further discussion with CTMP in December or January.
- The HPC will continue performing analysis and review of identified entities, and will develop its recommendations for PIPs or CMIRs in the coming months.
- The HPC anticipates releasing interim guidance/proposed regulations on filing and implementing PIPs in early 2016.

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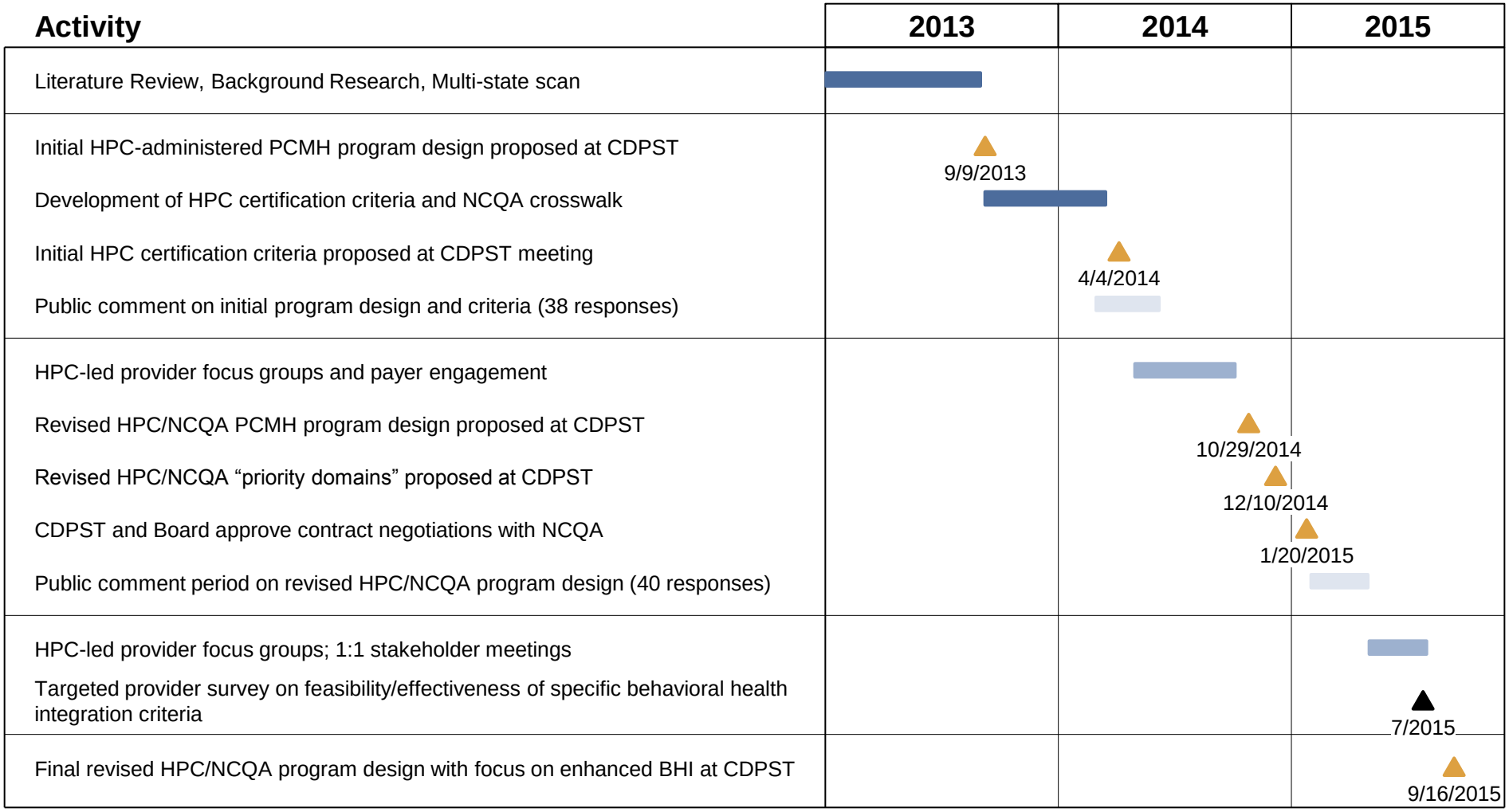
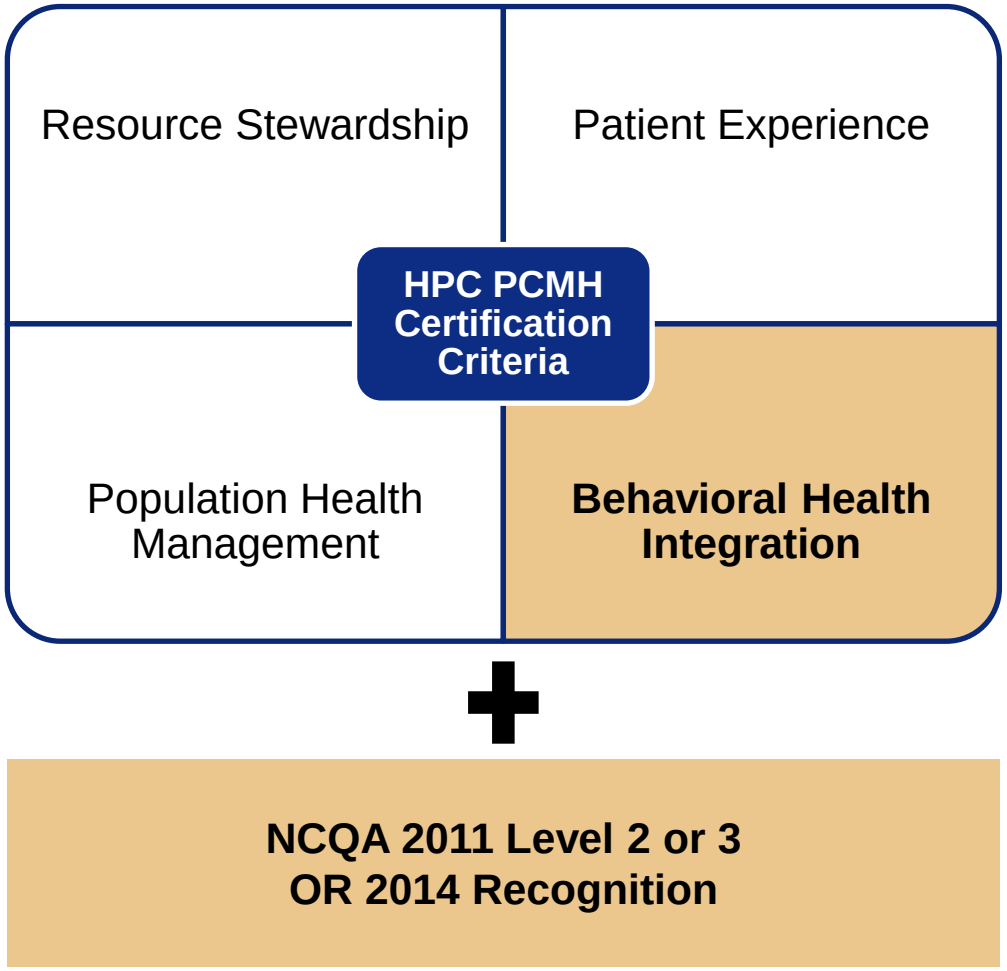
HPC PCMH program: development timeline



The HPC extends its sincere thanks to the individuals and organizations that have provided considerable feedback and insight over the last 3 years

Initial HPC PCMH "priority domain" design and subsequent stakeholder feedback



Stakeholder feedback

Resource Stewardship:
Difficulty identifying high-risk patients for care management and **capturing necessary levels of utilization data**

Patient Experience:
Concerns with validity and cost of doing patient surveys at small practices

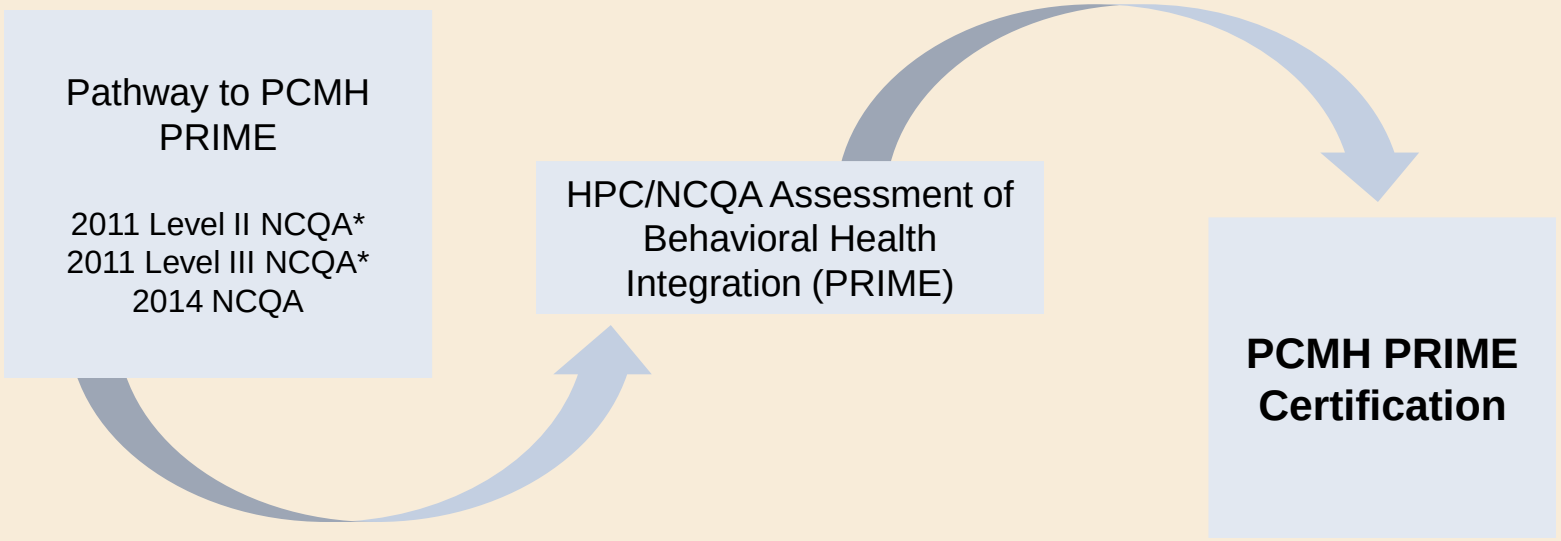
Population Health Management:
Concerns with **immunization measurement** and concerns with **barriers to accessing and managing data requirements**

Behavioral Health Integration:
Concerns with **maintaining agreements** with behavioral health providers and **requirements to screen** for additional conditions, given lack of access to behavioral health providers

“PCMH PRIME” recognition

Ongoing HPC Technical Assistance (content under development)

Practices will achieve HPC’s **PCMH PRIME** recognition by demonstrating enhanced capacity and capabilities in behavioral health integration (BHI). Practices will be initially certified on a rolling basis and must meet the HPC’s BHI criteria within a given timeline after entering the technical assistance period to maintain certification.



*Practices must convert to NCQA 2014 standards at end of their current 2011 recognition period

PCMH PRIME criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice has **MOUs with BHPs** and/or **co-located BHPs** (e.g., same building)
2	The practice **integrates BHPs** within the practice
3	The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family**
4	The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients)
8	For patients who have recently given birth, the practice screens for **post-partum depression** using a standardized tool (e.g., at 6 weeks and 4 months)
9	The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports**
10	The practice implements clinical decision support following **evidence based guidelines** for a mental health and substance use disorder
11	The practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions
12	The practice has one or more PCPs on staff licensed to prescribe **buprenorphine**
13	If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health needs

Proof of proficiency for criteria #2 automatically satisfies criteria #1

Potential technical assistance attached to PRIME

Technical assistance to support PRIME

Concept development currently underway; activities are budget permitting

- HPC-funded continuing education modules
- Training on administration of diagnostic tools
- HPC support for obtaining buprenorphine waivers or managing a buprenorphine patient panel
- Learning collaborative on best practices to foster effective BHI
  - Topics may include: establishing meaningful relationships between PCPs and BH providers; information sharing under state and federal law; screening and referral protocols; cost/quality measurement; clarifications on regulatory barriers
- Resource directory to help PCPs identify non-prescribing BH providers (Ch. 224 mandate)

To further develop technical assistance plans, HPC will:

- Survey providers on the topics and types of TA that would be most helpful;
- Procure a partner to lead and/or partner with to provide direct technical assistance; and,
- Collaborate closely with other state partners focused on advancing complementary mental health and substance use disorder initiatives (MassHealth, DPH, DMH)

NCQA scope of work

National Committee for Quality Assurance's (NCQA's) role:

1. **Program design consulting support**

2. **Communications about PRIME**
   - Outreach to practices who are renewing or converting NCQA recognition,
   - Disseminating Informational materials about PRIME

3. **Evaluation of practices for PRIME**
   - Update submission platform to include PRIME criteria
   - Evaluate practice submissions against PRIME standards
   - Provide results to HPC for scoring

4. **Training for practice applying for PRIME**
   - Virtual and in-person training opportunities for practices to learn about PRIME and the application process

PCMH PRIME value statement

To complement launch of program, HPC is proposing to release a value statement directed at patients, payers, and providers

Patients

In Massachusetts, ~51% and ~86% of patients do not receive treatment for existing mental illness and SUD, respectively[1]

Payers

When unmanaged, behavioral health exacerbates total cost of care (TCOC) – e.g., TCOC for patients with major depression and diabetes is >2x patients with diabetes alone[2]

Providers

PCPs will be increasingly accountable for TCOC through alternative payment models (APMs). PRIME assists PCPs to identify and treat behavioral health that can be managed in a primary care setting

1 Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2013. HHS Publication No. SMA-13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013

2 Unutzer, Jurgen et al. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.* Health Home: Information Resource Center. Brief May 2013. http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

Top health plan in MA is committed to working with the HPC to support behavioral health integration through the PRIME program

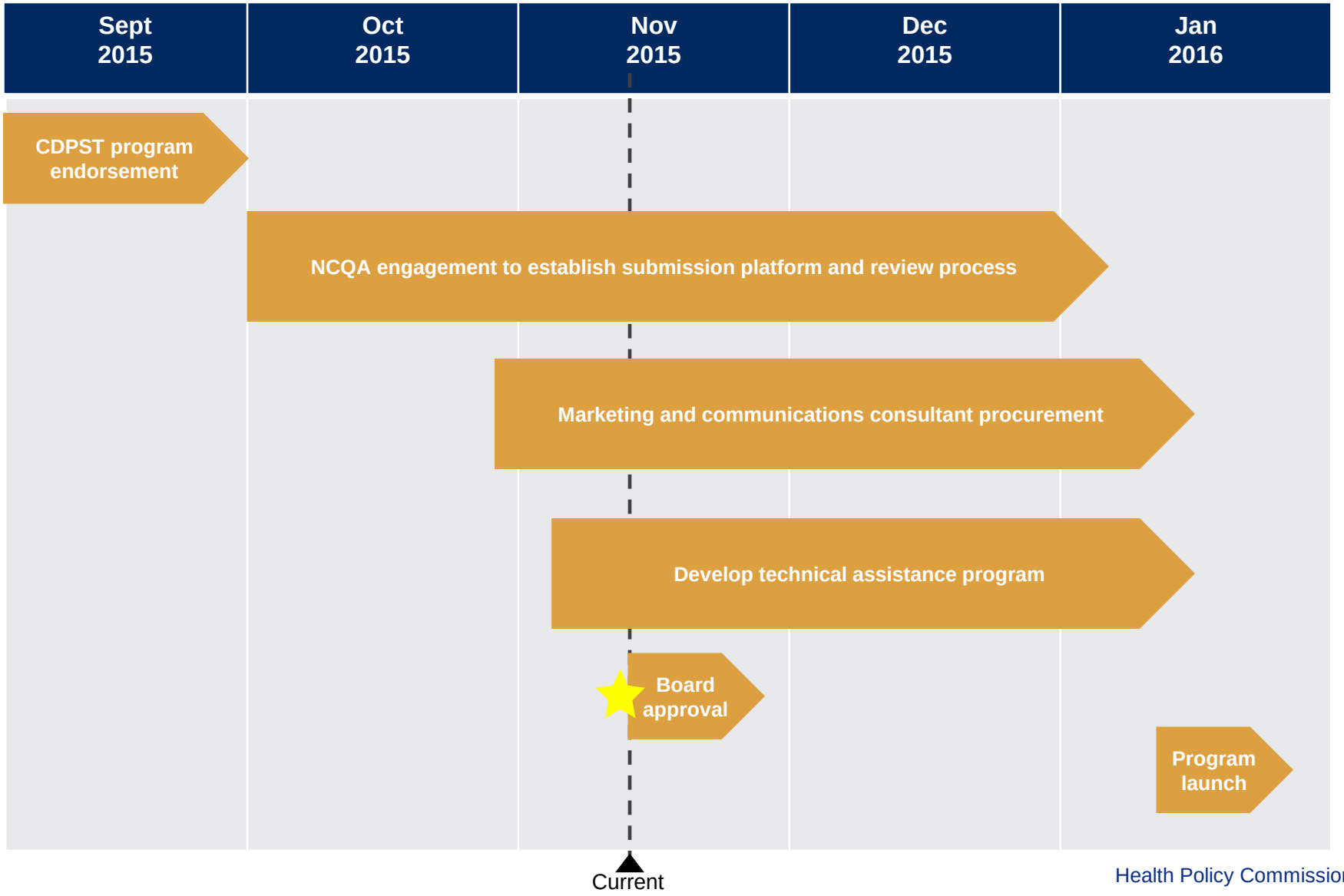
Harvard Pilgrim Health Care (HPHC) awards quality grants to select physician practices in MA, NH, and ME to support projects bringing behavioral health into primary or specialty care settings

In 2016, HPHC will update these quality grant guidelines to incorporate the HPC's PCMH behavioral health criteria

Grant dollars will be available to HPHC network providers to make progress in meeting the HPC's certification criteria

The HPC will continue to engage with other health plans in Massachusetts to build multi-payer support for behavioral health integration through the PRIME recognition program

HPC PCMH certification program update



Vote: Approval of PCMH Certification Program

Motion: That the Commission hereby approves and issues the attached final standards of certification for patient centered medical homes, developed pursuant to section 14 of chapter 6D of the Massachusetts General Laws and endorsed by the Care Delivery and Payment System Transformation Committee, and directs the staff of the Commission to implement the patient centered medical home certification program as provided in these standards.

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HPC requirements related to ACO certification

Section 15 of Chapter 224 tasks the HPC with creating an **ACO certification program** meant to "**encourage the adoption of integrated delivery systems** in the commonwealth for the purpose of **cost containment, quality improvement, and patient protection**."

Additionally, the ACO certification program should be one that:

- Reduces growth of health status adjusted **total expenses**
- Improves **quality** of health services using **standardized measures**
- Ensures **access** across care continuum
- Promotes **APMs & incentives** to drive quality & care coordination
- Improves **primary care** services
- Improves access for **vulnerable populations**
- Promotes **integration of behavioral health (BH) services** into primary care
- Promotes **patient-centeredness**
- Promotes **health information technology (HIT)** adoption
- Promotes demonstration of **care coordination & disease mgmt.**
- Promotes **protocols for provider integration**
- Promotes **community based wellness** programs
- Promotes health and well-being of **children**
- Promotes **worker training** programs
- Adopts **governance structure standards**, including those related to financial conflict of interest & transparency

ACO certification program goals

1. **Collaborate** with **providers, payers, and consumers** to obtain feedback on overall ACO development and enabling policy development
2. Create a **roadmap** for providers to work toward **care delivery transformation** – **balancing** the establishment of **minimum standards** with room and assistance for **innovation**
3. Establish an **evaluation framework** for data collection, information gathering, and dissemination of best practices to promote transparency
4. Enhance **patient protection and engagement**, including increasing patient access to services, especially for vulnerable populations
5. Promote **behavioral health integration** with ACOs through BH-specific criteria, quality metrics, and technical assistance
6. Develop standards that **align with payers' own principles for accountable care** (e.g., MassHealth and Group Insurance Commission (GIC)) to further link accountability
7. To the extent possible, **align** with **other state and federal programmatic requirements** to **minimize administrative burden** for providers

Progression of program development

1 State-by-State Comparison & Literature Review

- Are there common criteria?
- How rigorous/comprehensive are states with these criteria?
- Capabilities or outcomes based criteria?

2 Medicare – MSSP & Pioneer

- How rigorous/comprehensive is CMS with certain criteria?
- Do criteria become more rigorous over time?
- Where/Why is there flexibility in some areas?

3 MA Landscape

- What contracts (payers) and structures (providers) resemble an ACO?
- Despite variation among payers and providers, are there areas of overlap/standardization?
- Can we isolate areas where providers are already succeeding and focus instead on areas that need more of a push from the HPC?

4 Expert & Stakeholder Engagement

- Ongoing engagement with providers, payers, advocacy groups, sister agencies, health policy experts
- HPC and MassHealth co-leading series of stakeholder workgroups to receive feedback from stakeholders on specific criteria

Stakeholder engagement (as of 11.12.15)

ACO Provider Focus Groups (Pioneer, MSSP, AQC)
Boston Medical Center ACO
New England Quality Care Alliance (NEQCA)
Baycare Health Partners
Signature Healthcare/ Brockton Hospital
Reliant Medical Group
UMASS Memorial ACO
BIDCO
Steward
Atrius Health
Partners HealthCare
Pediatric Provider
Children's Hospital Integrated Care Organization (CHICO)
Community Health
Cambridge Health Alliance (CHA)
Commercial Payer
Tufts Health Plan Massachusetts Association of Health Plans

Behavioral Health Provider Focus Group
Vinfen
Riverside Community Care
Lynn Community Health Center
Boston Health Care for the Homeless Program (BHCHP)
Consumer Advocacy Focus Group
Health Care for All (HCFA)
Commissioner Paul Hattis (also attended on behalf of Greater Boston Interfaith Organization (GBIO))
Health Leads
Massachusetts Public Health Association
Academics/Experts
Mark McClellen
Stephen Shortell
Elliot Fisher
Federal Policymakers
Center of Medicare and Medicaid Innovation (CMMI)

MassHealth & HPC certification workgroup (6 meetings as of 11.12.15)

Association of Behavioral Healthcare (ABH)
Association of Developmental Disabilities Providers
Atrius Health
Bay Cove Human Services
Baystate Health
Beth Israel Deaconess Care Organization
Boston Children's Hospital/CHICO
Boston Health Care for the Homeless Program
Celticare Health
Community Connections, Inc.
Community Healthlink (CHL)
Disability Policy Consortium
Greater Medford VNA
Harvard Street Neighborhood Health Center
Health Care for All
Health New England (HNE)
Home Care Alliance
Joseph Smith Community Health Center
Leading Age Massachusetts
Massachusetts Home Care
Massachusetts Home Care Aide Council
Massachusetts Hospital Association
Massachusetts Law Reform Institute
Neighborhood Health Plan (NHP)
New England Quality Care Alliance (NEQCA)
North Shore Elder Services
Sisters of Providence Health System
United Health Care Community Plan of MA
University of Massachusetts Medical School
University of Massachusetts Memorial Hospital (UMMHC)

Summary of key stakeholder feedback

Do not be prescriptive

- Leverage existing legal/governance structures and programmatic/reporting requirements as much as possible. Avoid redundancy.
- Develop a small set of minimum standards and allow ACOs to innovate beyond that small set.

APM adoption

- Compare ACOs against themselves to see trend; do not set an absolute threshold.
- Different views on whether criteria should assess percentage of covered lives or revenue.
- Payers dictate whether or not APMs are offered to providers; further, there is no guarantee that an offered contract is a good one for the provider.

Behavioral health and LTSS

- Be specific about inclusion of BH and LTSS, but try to weave into other criteria as much as possible so as not to further silo these two areas.
- Require meaningful participation in governance, referral structures, and flow of payments.
- Very clearly define what it means to be a behavioral health provider and/or a “community-based” organization. What are the expectations around partnerships and agreements?

Governance

- Include behavioral health providers in governance structure.
- Include patients in structure, but representation on the board is not the most meaningful. Allow ACOs to be innovative here. Emphasis on “meaningful” participation.

HPC & MassHealth alignment – potential approach

HPC ACO certification requirements

Examples:

- Capabilities and expertise necessary to advance all-payer population health management and succeed under alternative payment methodologies
- Legal and governance requirements, including meaningful participation of BH providers and patients/consumers
- Assessment of collaboration and referral structures across the care continuum
- Patient and family experience measurement
- Market and patient protections
- Standardized ACO-level reporting on cost/quality performance

MassHealth contract requirements

(in development – for discussion only)

Examples:

- Capabilities and expertise necessary to address the complex medical and service needs specific to the MassHealth population, particularly with regard to:
  - behavioral health,
  - long-term services and supports, and
  - social determinants of health (SDH)
- Innovative and meaningful beneficiary engagement
- Robust collaboration/partnerships across the care continuum

Integrated, administratively simple provider application process

ACO certification program design (previous approach)

ACO

1. **Mandatory Requirements**
   An ACO must meet each criteria within this category in order to move on to the assessment portion of the certification evaluation process.
   Criteria covers:
   - Legal structure
   - Governance
   - APM adoption for primary care
   - Patient protection
   - Market protection

2. **Assessment Criteria**
   An ACO must meet a specified percentage of the criteria within this category in order to pass HPC certification.
   Criteria are spread across five domains:
   - Care Delivery
   - Analytics & Performance Improvement
   - Clinical Data Systems
   - Financial Incentives
   - Patient/Family Experience

HPC

3. **Transparency & Reporting**
   For the purposes of certification and public evaluation of each ACO, the HPC will collect and report the following data for each ACO:
   - TME
   - Quality / Health Outcomes

ACO certification program design (revised approach)

1 Mandatory Criteria

- ✓ Legal and governance structures
- ✓ Risk stratification and population specific interventions
- ✓ Cross continuum network: access to BH & LTSS providers
- ✓ Participation in MassHealth APMs
- ✓ PCMH adoption rate
- ✓ Analytic capacity
- ✓ Patient and family experience
- ✓ Community health

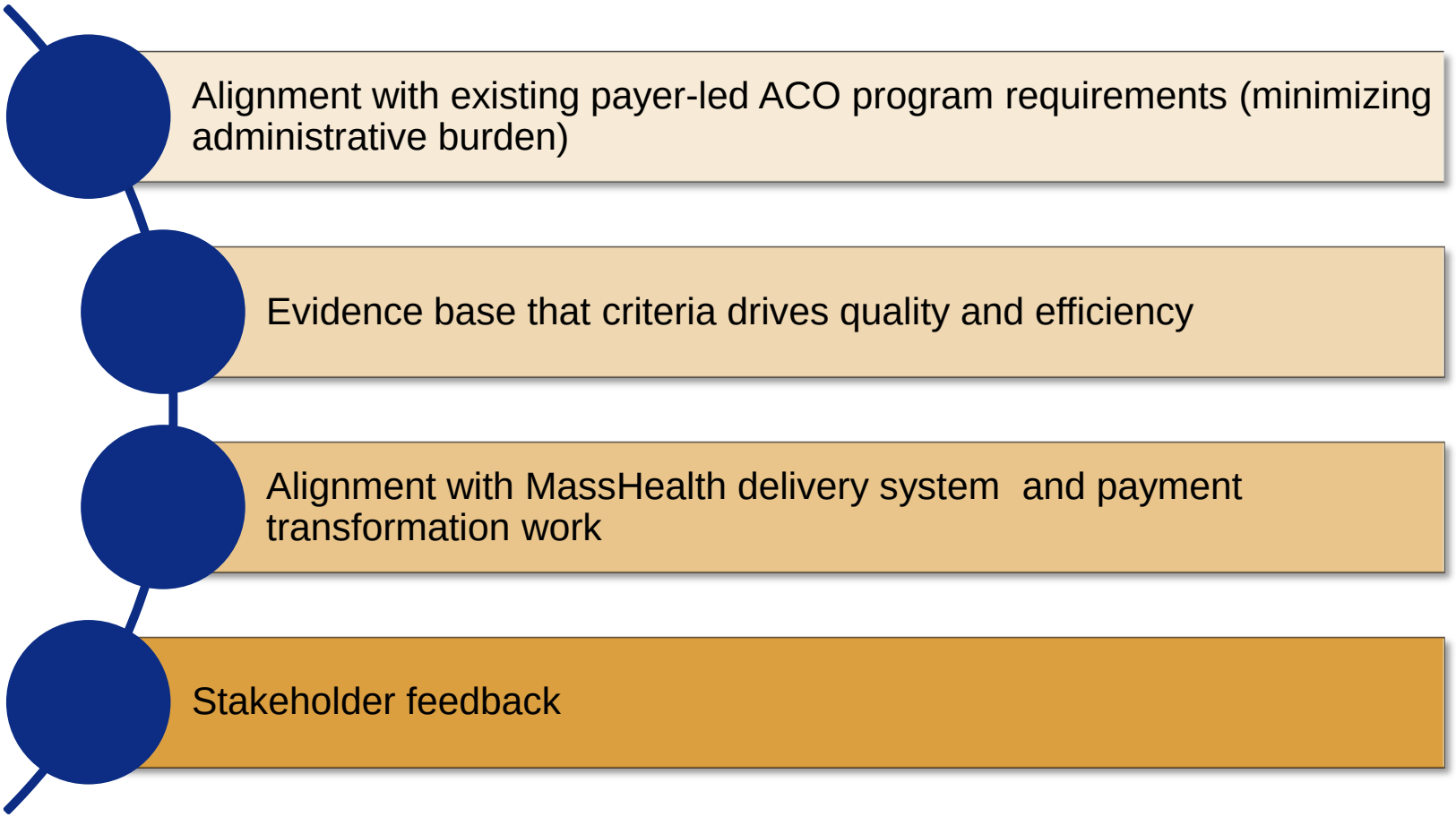
2 Market and Patient Protection

- ✓ Risk-bearing provider organizations (RBPO)
- ✓ Filing Material Change Notices (MCNs)
- ✓ Anti-trust commitment
- ✓ Patient protection

3 Reporting Only Criteria

- ✓ Palliative care
- ✓ Care coordination
- ✓ Peer support
- ✓ Adherence to evidence-based guidelines
- ✓ APM adoption for primary care
- ✓ Flow of payment to providers
- ✓ ACO population demographics and preferences
- ✓ EHR interoperability commitment

Key considerations in criteria development and mandatory vs. reporting only assignment



Mandatory criteria

ACOs must demonstrate that they meet these criteria in order to be HPC certified.

- Legal and governance structures
- Risk stratification and population specific interventions
- Cross continuum network: access to BH and LTSS providers
- Participation in MassHealth APMs
- PCMH adoption rate
- Analytic capacity
- Patient and family experience
- Community health
- Market and patient protection

Mandatory criteria – highlighted areas for discussion

ACOs must demonstrate that they meet these criteria in order to be HPC certified.

1. Legal and governance structures
   - Risk stratification and population specific interventions
2. Cross continuum network: access to BH and LTSS providers
3. Participation in MassHealth APMs
4. PCMH adoption rate
   - Analytic capacity
5. Patient and family experience
6. Community health
7. Market and patient protection

Mandatory: legal and governance structures (1/2)

DRAFT - FOR DISCUSSION

Criteria
The ACO operates as a **separate legal entity** whose governing body members have a fiduciary duty to the ACO, *except* if ACO participants are part of the same health care system.
The ACO provides information about its **participating providers** to HPC, **at the TIN level**, for each of the three payer categories (Medicare, MassHealth, commercial).*
The ACO governance structure includes a **patient or consumer representative.** The ACO has a process for ensuring patient representative(s) meaningfully participate in the ACO governance structure.

* To the extent possible, this will be done in coordination with the RPO process.

Mandatory: legal and governance structures (2/2)

DRAFT - FOR DISCUSSION

Criteria
ACO governance structure provides for **meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers**.
The ACO has a **Patient & Family Advisory Council (PFAC) or similar** committee(s) that gathers the perspectives of patients and families on operations of the ACO that regularly informs the ACO board.
The ACO has a **quality committee** reporting directly to the ACO board, which regularly reviews and sets goals to **improve on clinical quality/health outcomes (including in behavioral health), patient/family experience measures, and disparities** for different types of providers within the entity (PCPs, specialists, hospitals, post-acute care, etc.).

Mandatory: cross continuum network: access to BH and LTSS providers

DRAFT - FOR DISCUSSION

Criteria

ACO **demonstrates and assesses effectiveness of ongoing collaborations** with and referrals to:

- Hospitals
- Specialists
- Post-acute care providers (i.e. SNFs, LTACs)
- Behavioral health providers (both mental health and substance use disorders)
- Long-term services and supports (LTSS) providers (i.e. home health, adult day health, PCA, etc.)
- Community/social services organizations (i.e. food pantry, transportation, shelters, schools, etc.)

As appropriate for its patient population**, ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers** to address the needs of patient population. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.

Mandatory and Reporting: APMs

DRAFT - FOR DISCUSSION

	Criteria
Mandatory	The ACO participates in an **outcomes-based contract for Medicaid patients by the end of Certification Year 2 (2017).***
Reporting ONLY	The ACO reports the **percentage of its primary care revenue *or* patients that are covered under outcomes-based contracts**.*

**Outcomes-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*

Mandatory: PCMH adoption rate

DRAFT - FOR DISCUSSION

Criteria

The ACO reports on **NCQA and HPC PCMH recognition rates** and levels (e.g., II, III) of its participating primary care providers.

The ACO describes a plan to **increase these rates, particularly for assisting practices in fulfilling HPC's PCMH PRIME criteria.**

Mandatory: patient and family experience & community health

DRAFT - FOR DISCUSSION

	Criteria
Patient and family experience	The ACO conducts an annual **survey** (using any evidence-based instrument) or uses the results from an accepted statewide survey to **evaluate patient and family experiences** on access, communication, coordination, whole person care/self-management support, and deploys plans to improve on those results.
Community health	ACO describes steps it is taking to advance or invest in the **population health** of one or more communities where it has at least 100 enrollees through a **collaborative, integrative, multi-organization approach** that accounts for the **social determinants of health**.

Mandatory: market and patient protection criteria

DRAFT - FOR DISCUSSION

Criteria
If applicable, the ACO obtains a **risk-based provider organization (RBPO)** certificate from **DOI**.
ACO attests to filing all relevant **Material Change Notices (MCNs)** with **HPC**.
ACO attests to ongoing compliance with all **federal and state antitrust laws and regulations**.
ACO attests to abiding by HPC's **Office of Patient Protection (OPP)** guidance to establish a **process to review and address patient grievances** and provide patients the **right to seek external review of grievances.**
ACO will **report ACO-level performance** on a quality measure set associated with each contract and shared savings / losses* for commercial and public risk contracts for the previous contract year (2015).

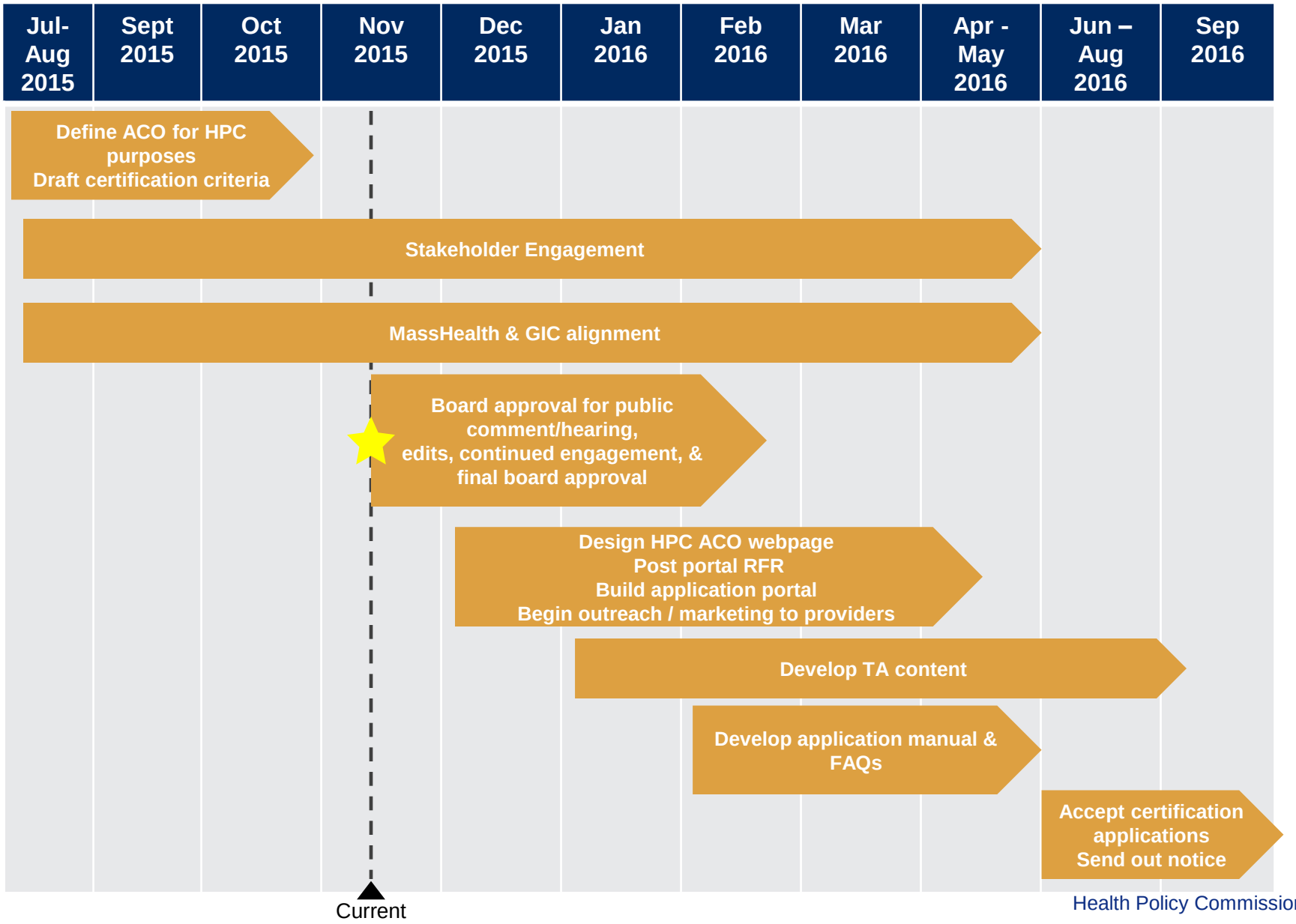
*Providers without savings/loss contracts are exempt from this portion of the requirement.

Vote: Approval of ACO Certification Framework for public comment

Motion: That the Commission hereby approves the attached proposed criteria for the accountable care organization certification program, developed pursuant to section 15 of chapter 6D of the Massachusetts General Laws and endorsed by the Care Delivery and Payment System Transformation Committee, and directs the Executive Director to solicit public comment on the proposed criteria.

The full list of ACO certification standards will be posted to the HPC website for public review.

ACO overall certification timeline



Agenda

- Approval of Minutes from the September 9, 2015 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- **Quality Improvement and Patient Protection**
  - Office of Patient Protection Annual Report
  - Final Recommended Regulations for the Office of Patient Protection
  - Program Design for a Pilot Addressing Neonatal Abstinence Syndrome
- Schedule of Next Meeting (December 16, 2015)

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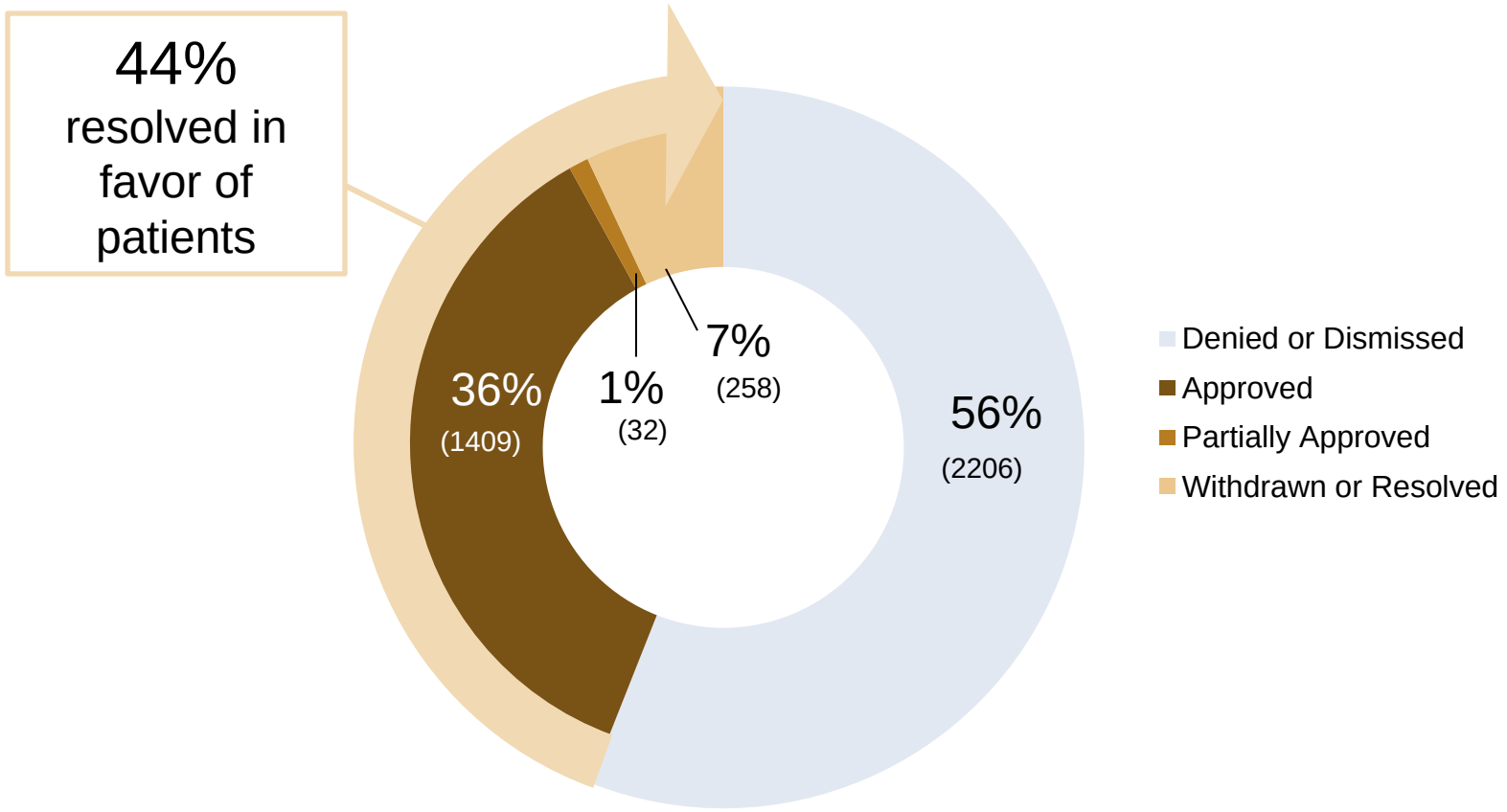
During 2014, insurers received 3,906 internal grievances for review and resolved 44% fully or partially in favor of the patient

Internal Review

Adverse Determinations

Insurance companies reported 3,906 member grievances in 2014, which were internally reviewed by the insurance companies.

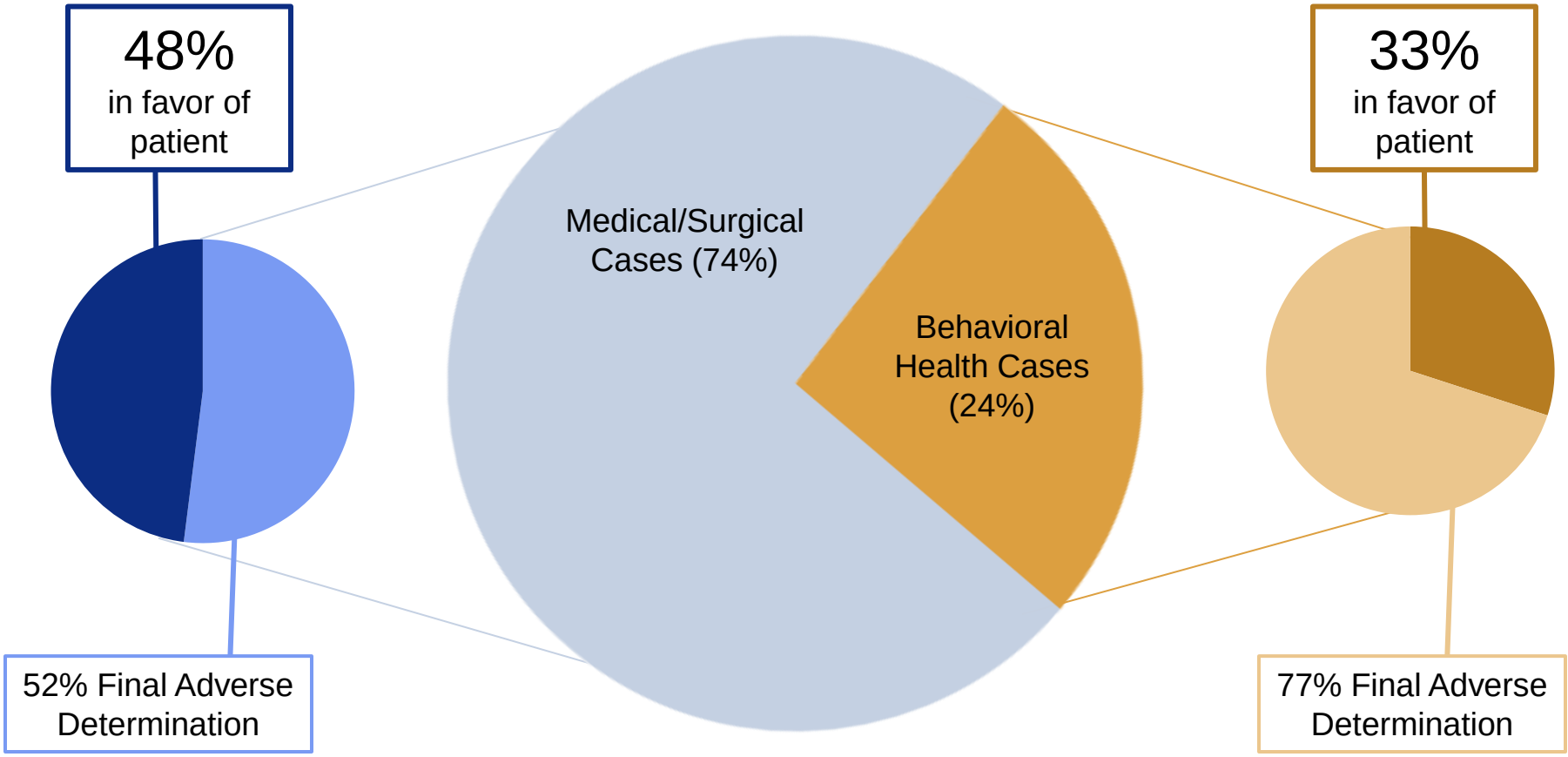


Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Behavioral health cases represented one-fourth of internal insurer reviews and were resolved at a lower rate in favor of the patient compared to medical/surgical cases (33% vs. 48%)

Internal Review

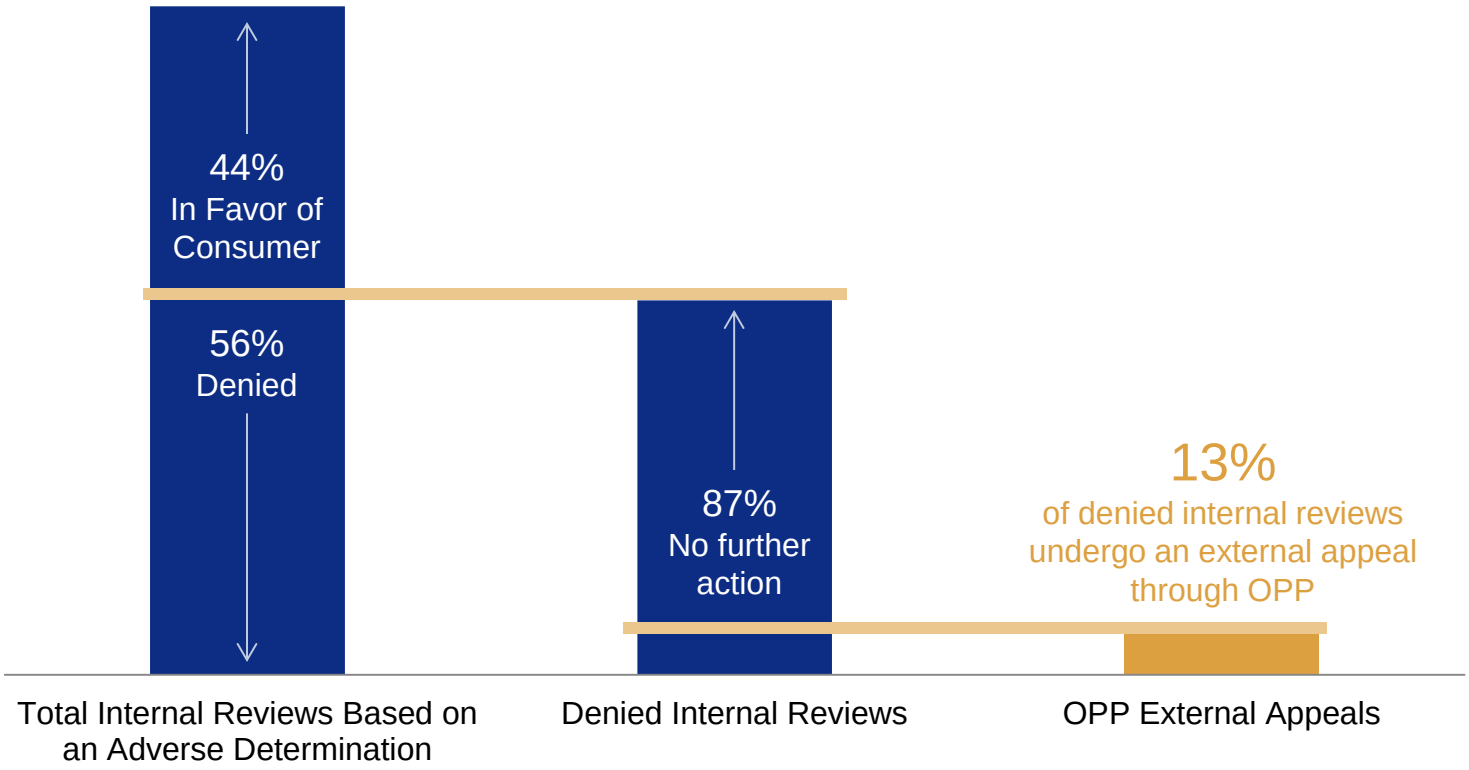
Adverse Determinations



Of those patients denied during the internal review process during 2014, 13% then pursued an external appeal through OPP

External Review
Adverse Determinations

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

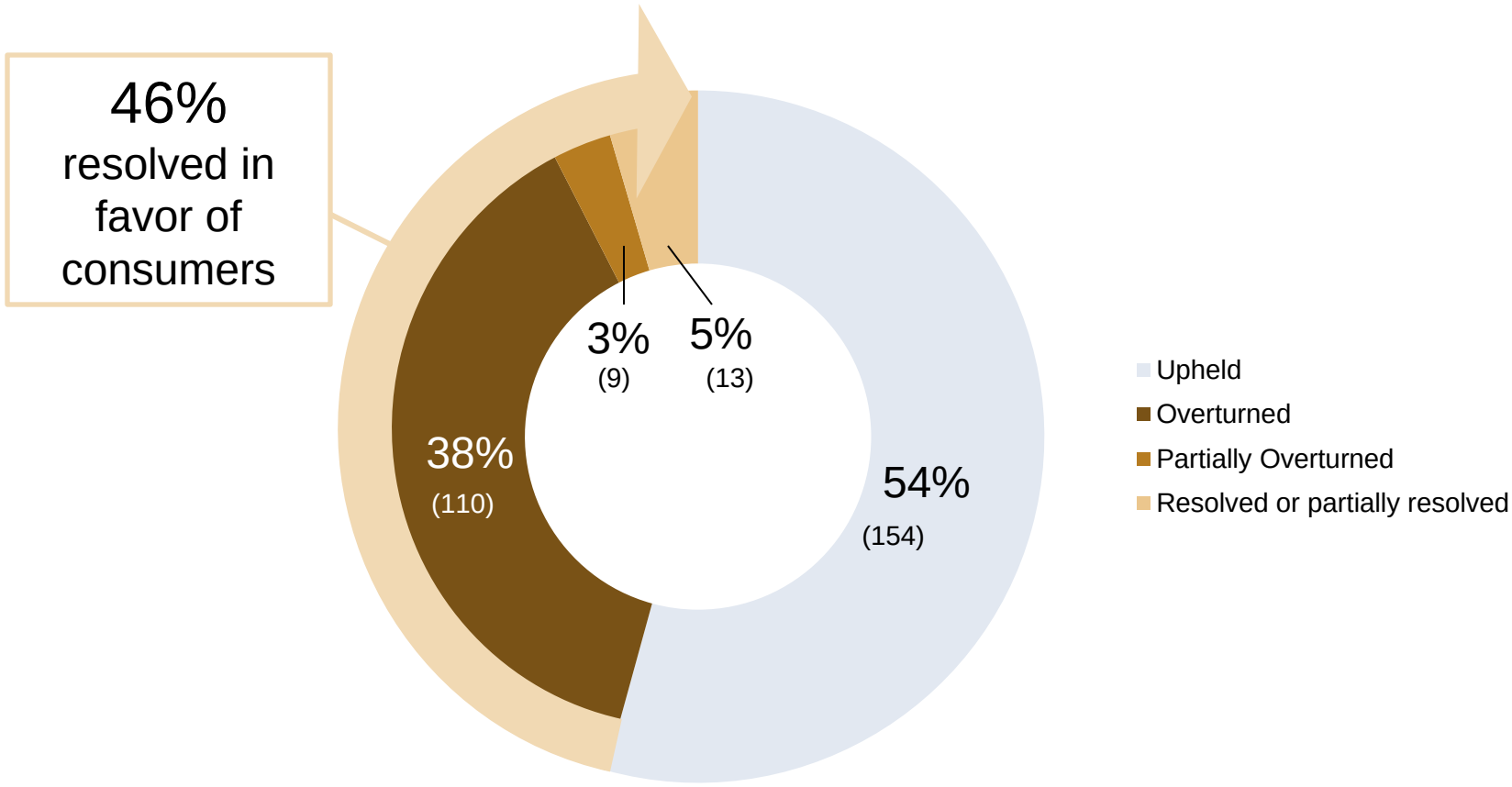


Source: 2014 Office of Patient Protection external review data; 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

OPP received 286 eligible requests for external review during 2014. Similar to past years, nearly half were decided in favor of the patient.

External Review

Percentage of external review cases by outcome, 2014

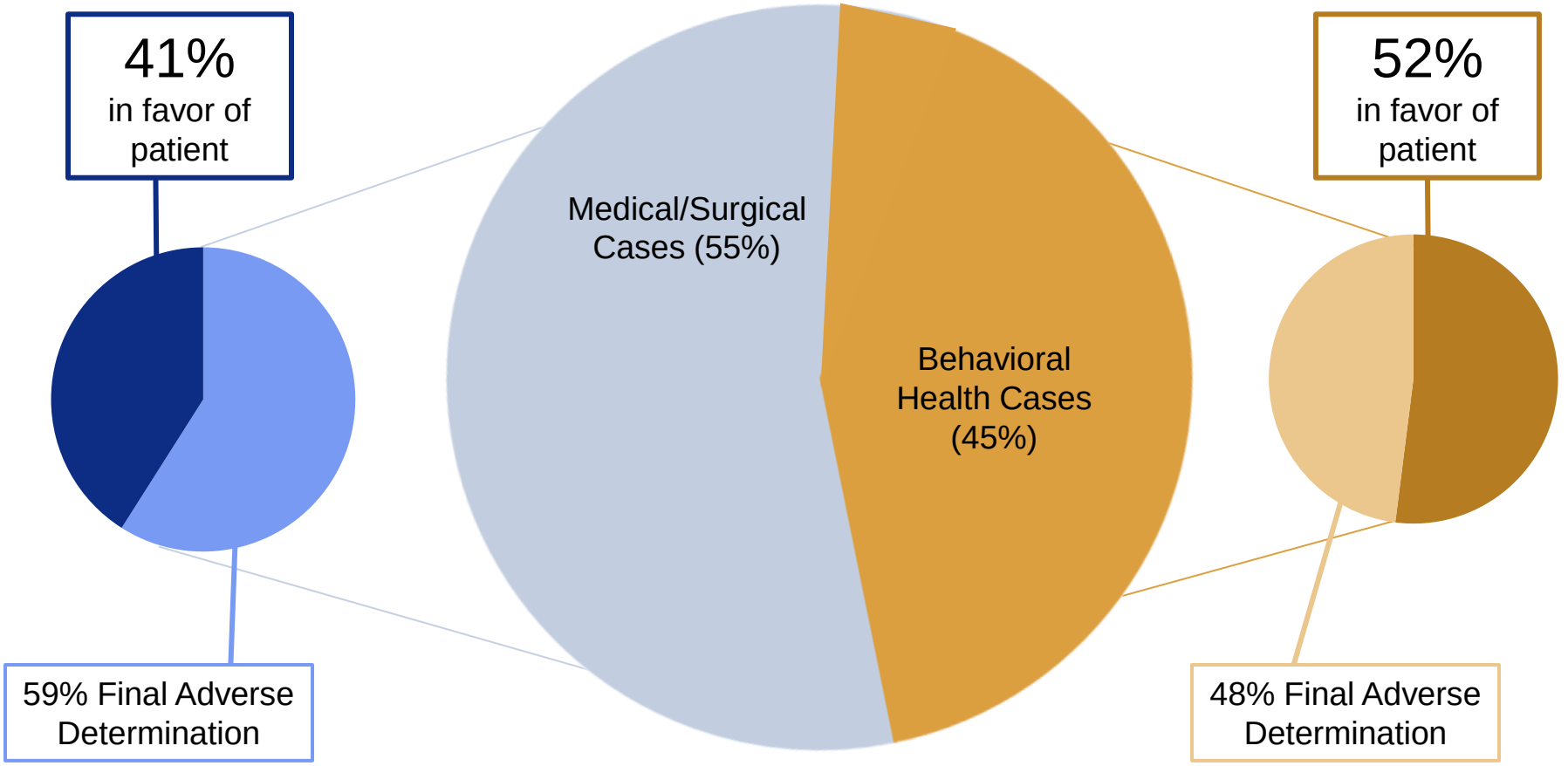


Source: 2014 Office of Patient Protection external review data

Behavioral health cases represented nearly half of external OPP reviews and were resolved at a higher rate in favor of the patient compared to medical/surgical cases (52% vs. 41%)

External Review

Adverse Determinations



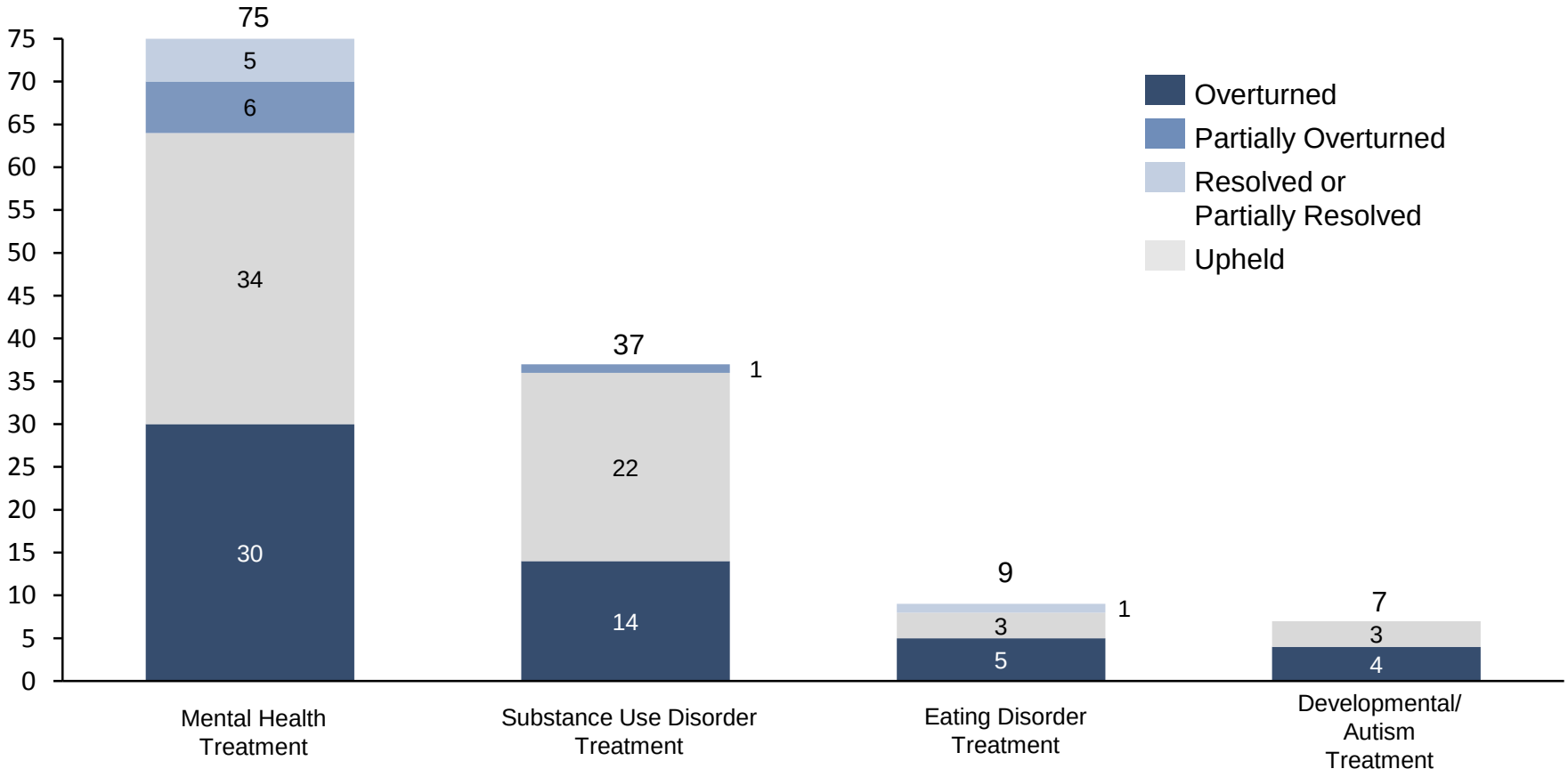
Source: 2014 Office of Patient Protection external review data

OPP categorizes mental health, substance use disorder, eating disorder, and development/autism treatment as behavioral health services.

External Review

Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome and type of case, 2014

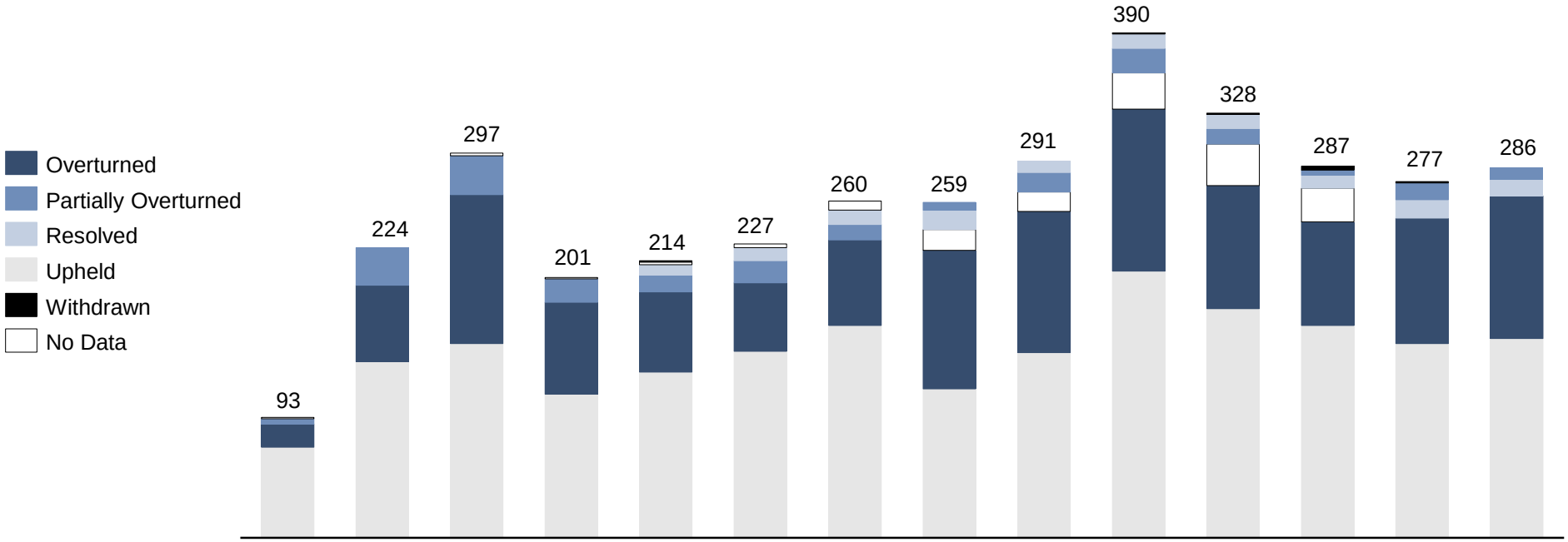


Source: 2014 Office of Patient Protection external review data

The number of external review cases has varied, but the overall proportion of cases resolved in favor of the patient has remained relatively constant

External Review

Number of eligible external review cases over time, by disposition, 2001 to 2014



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Overturned	18	59	115	71	62	53	66	107	109	125	95	80	97	110
Partially Overturned	4	29	30	18	13	17	12	6	15	19	12	4	15	9
Resolved	0	0	0	0	8	10	11	15	9	11	11	10	14	13
Upheld	70	136	150	111	128	144	164	115	143	206	177	164	150	154
Withdrawn	0	0	0	0	1	0	0	0	0	1	1	3	1	0
No Data	1	0	2	1	2	3	7	16	15	28	32	26	0	0
Total	**93**	**224**	**297**	**201**	**214**	**227**	**260**	**259**	**291**	**390**	**328**	**287**	**277**	**286**

Source: 2001-2014 Office of Patient Protection external review data

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Office of Patient Protection Regulation Updates

Medical Necessity Criteria
958 CMR 3.101

- Changes to state law providing access to medical necessity criteria took effect on July 1, 2014, pursuant to FY 2015 budget*
- Updates are required to conform regulation to applicable Massachusetts law
- Updates will clarify expanded access to proprietary and non-proprietary medical necessity criteria

Open Enrollment Waivers
958 CMR 4.000

- Updates are required to conform regulation to Affordable Care Act and related Massachusetts law
- Definition of “eligible individual” changed
- Updates would not significantly change waiver process

* Ch. 165 of the Acts of 2014, sections 18, 172 & 173 amending M.G.L. c. 6D, §16(a); c. 176O, §§12(a) & 16(b)

Medical Necessity Criteria Regulation, 958 CMR 3.101

OPP Regulation	Proposed Update
958 CMR 3.101(3)(b)	Replace current language. Criteria will be disclosed to OPP, proprietary criteria not subject to Mass. public records laws, M.G.L. c. 4, §7, clause Twenty-sixth and M.G.L. c. 66, §10.
958 CMR 3.101(3)(c)	Non-proprietary criteria: access to the general public.
958 CMR 3.101(3)(d)	Proprietary criteria: access to insureds, prospective insureds and health care providers. Requester must identify particular treatments or services for which applicable criteria or protocols are requested.
958 CMR 3.101(3)(e)	**Added clarifying language to highlight existing right to obtain criteria through health insurance appeals process**
958 CMR 3.101(4)	Non-proprietary criteria: publication on publicly available website, must be up to date.
958 CMR 3.101(5)	Insurance carrier must provide requested criteria as soon as possible and within **21 days** (instead of 30 days).

Additional proposed changes highlighted in bold.

Open Enrollment Waiver Regulations, 958 CMR 4.000

OPP Regulation	Proposed Update
958 CMR 4.020	Change definition of “creditable coverage” to add ACA-compliant plans, remove YAP plans which are no longer offered
958 CMR 4.020	Change definition of “eligible individual” to comply with changes to statute; resident of Massachusetts
958 CMR 4.020	Minor clarifications to definitions of “health plan,” “intentionally forgo enrollment” and “nongroup health plan”
958 CMR 4.030	Add reference to ACA, remove outdated waiver eligibility requirements
958 CMR 4.050	Updates to include reference to ACA; include reference to Health Connector as additional source of guidance
958 CMR 4.060	Minor clarification to wording
958 CMR 4.070	Change reporting date from July 1 to April 1 to consolidate and simplify report to OPP

No further changes suggested.

Vote: Approving Proposed Regulations

Motion: That the Health Policy Commission hereby approves the FINAL updates to Office of Patient Protection regulations, 958 CMR 3.000, Health Insurance Consumer Protection, and 958 CMR 4.000, Health Insurance Open Enrollment Waivers.

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HPC opioid abuse report and principles for development

In 2014, the Legislature passed a comprehensive health care law, ch. 258 of the Acts of 2014, *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*. Recognizing the HPC's role in developing and promoting evidence-based health policy that improves the **transparency, efficacy, and efficiency** of our health care system, ch. 258 charged the HPC to develop recommendations on substance use disorder coverage, opioid treatment availability, and the need for further data analyses by CHIA.

For the past 10 months, the HPC has conducted research, interviewed stakeholders, surveyed providers, and attended public sessions related to the opioid epidemic.

In developing this report, the HPC has sought alignment and consistency with other Massachusetts activities, and aims to further contribute to policy development around opioid abuse by:

1. Providing new research, data, or evidence to support and inform action;
2. Supplementing previous reports with new recommendations, based on our research & analysis;
3. Identifying strategic opportunities for care delivery/payment reforms to address substance use disorder that are likely to result in reduced spending and improved quality/access (consistent with HPC's overall mission); and,
4. Drawing on our experience with investment & technical assistance programs (e.g., CHART hospital initiatives to reduce opioid prescribing).

Neonatal abstinence syndrome (NAS)

- Clinical diagnosis resulting from the abrupt discontinuation of exposure to substances in utero (e.g., methadone, opioid pain relievers, buprenorphine, heroin)
- In 2013, 1,189 hospital discharges in MA with NAS code (21 discharges for other states)
- Average LOS = **16 days** (ranges from 9 – 79 days)

Newborns with NAS are more likely to have complications compared with all other US hospital births.

Premature birth (gestational age <37 weeks)
2.6 – 3.4 times more likely

Low birthweight <2,500g
19.1% vs 7.0%

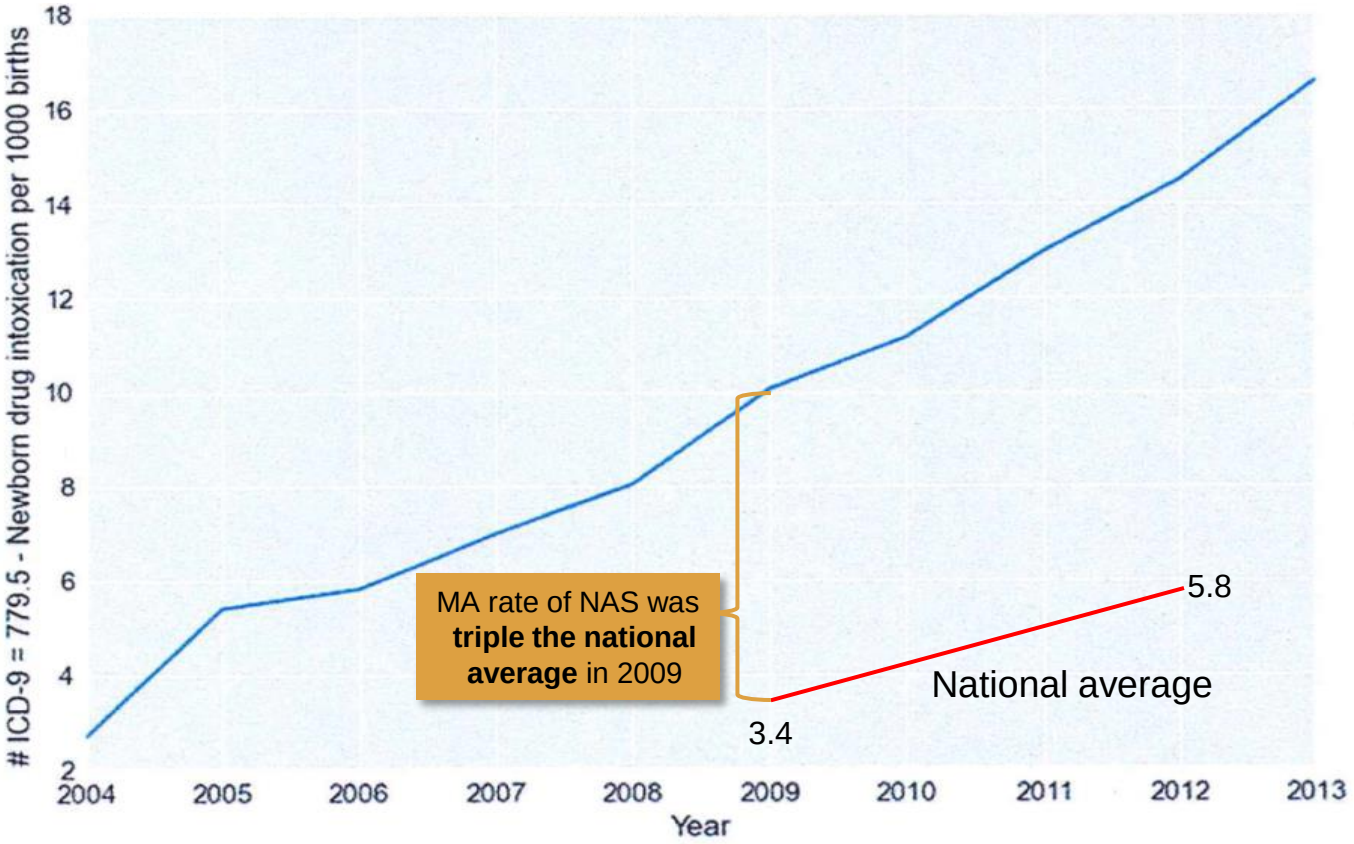
Seizures
2.3% vs 0.1%

Respiratory diagnoses
30.9% vs 8.9%

Feeding difficulties / Difficulty gaining weight
18.1% vs 2.8%

Incidence of NAS is increasing nationwide and in Massachusetts

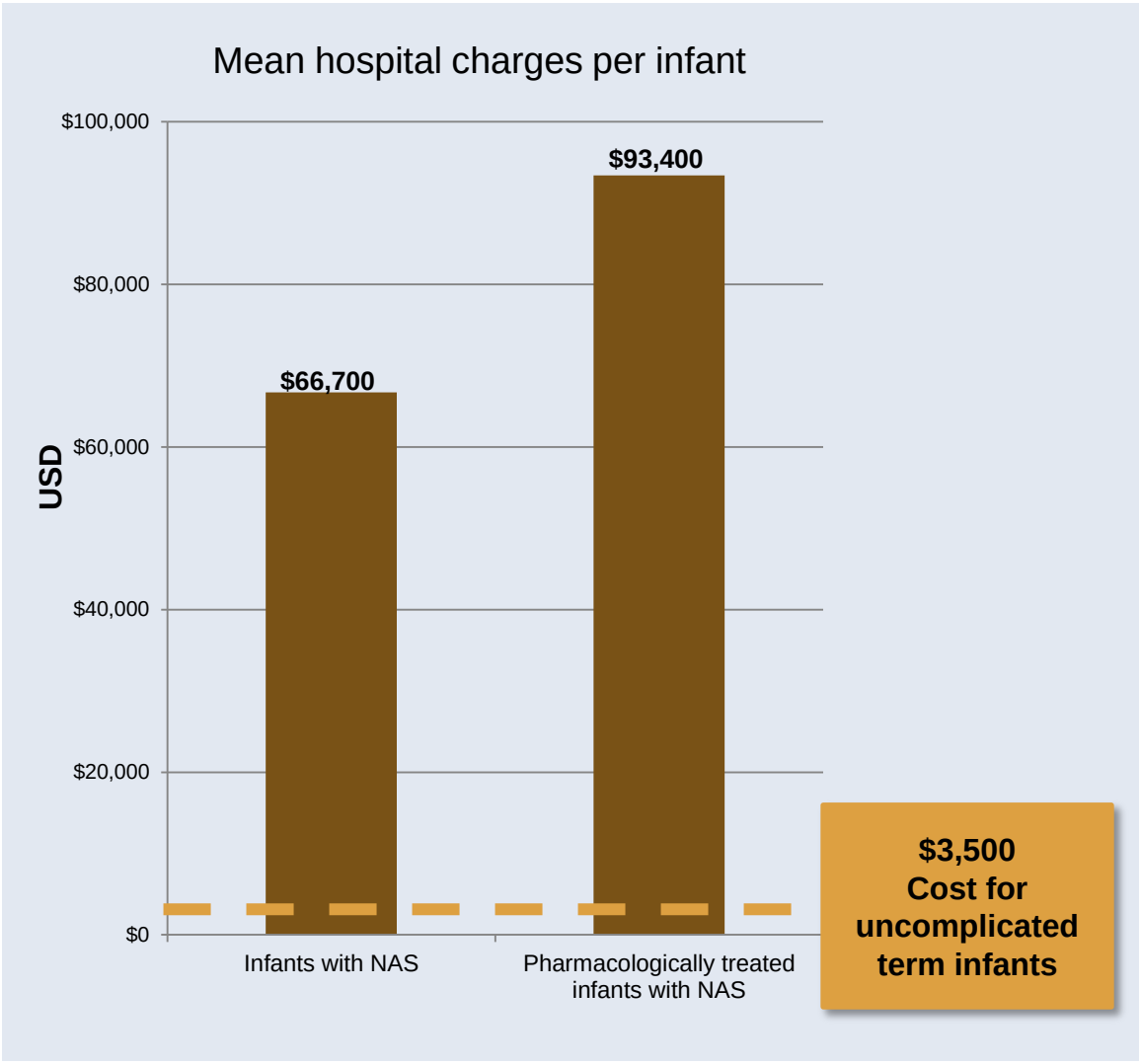
From 2004 to 2013 the Incidence of NAS increased from <3/1000 hospital births to **>16/1000 hospital births** per year

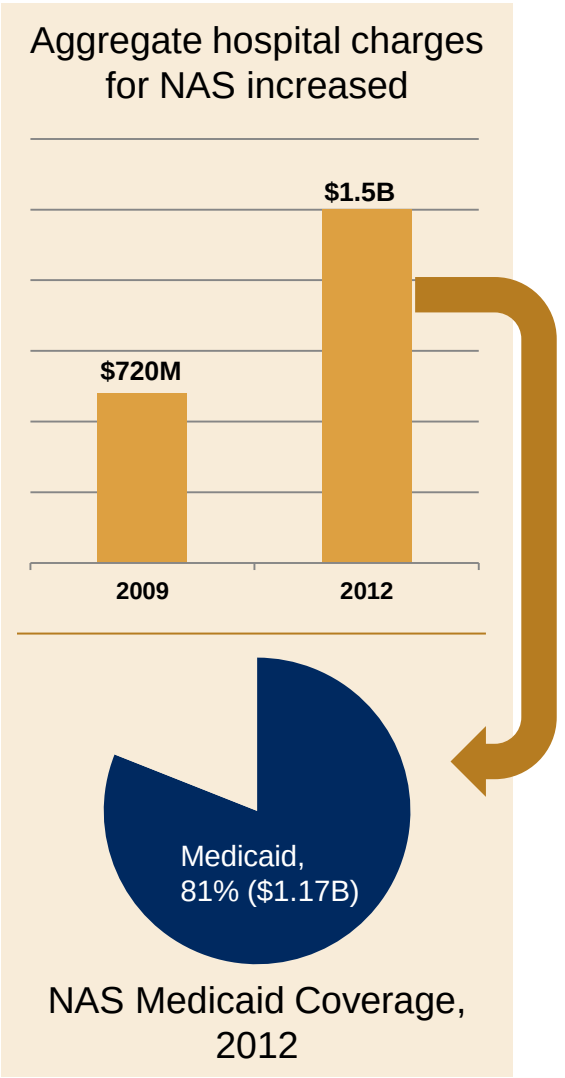


Gupta M and Picarillo A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. neoQIC. January 2015. PowerPoint presentation.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

Costs of NAS nationwide





Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

Intervention opportunities across settings and time

Family Planning

- Integrated care (primary care, contraception, SUD treatment available in one setting)

Pre-natal

- Methadone / buprenorphine maintenance (vs. IV drug use)
- Wrap-around social services and coordinated multidisciplinary care

Post-natal

- Lower acuity of care (NICU → Special care nursery → pediatric floor)
- Rooming-in (mothers and babies together in the hospital)
- QI projects to decrease length of stay (staff training, breastfeeding)
- Wrap-around social services and coordinated multidisciplinary care

Childhood

- Wrap-around social services and coordinated multidisciplinary care (pediatrics, addiction medicine, ob/gyn, primary care, family practice)
- Early intervention

Summary of HPC pilot funding to address NAS

What	• Spend **$500,000** before June 30, 2017
	• Funding for **fully integrated model of post-natal supports from delivery to discharge** for families with substance exposed newborns, including:
	  • obstetrics and gynecology
	  • pediatrics
	  • behavioral health
	  • social work
	  • early intervention providers
	  • social service providers to provide full family care

Who	• HPC in collaboration with DPH
	• Design informed by:
	  • **evidence-based practices** from successful programs implemented locally, nationally or internationally
	  • **consultation with DPH & DCF**

Proposed Deliverables	• Fund **up to 3 regional sites** to be selected through competitive process, based on
	  • community need
	  • capacity to implement the integrated model
	• Report to the Joint Committee on Mental Health and Substance Abuse and the House and Senate Committees on Ways and Means on results including effectiveness, efficiency, and sustainability

Identifying emerging best practices to inform pilot design

Budget Language: *the commission shall consider evidence-based practices from successful programs implemented locally, nationally, or internationally*

Literature review

Semi-structured interviews with providers around North America

Collaboration with Neonatology Quality Improvement Collaborative (NeoQIC)

Focus group with key provider experts

International evidence based practices

National evidence based practices

Local evidence based practices

Findings: The HPC has identified a number of program models (multidisciplinary and/or quality improvement initiatives) that have successfully **reduced length of stay** and **lowered total spending** for NAS patients in a relatively short time period *(see appendix for more details).*

- *Example: Boston Medical Center implemented a quality improvement initiative that reduced LOS by 3.5 days in 18 months*

NAS focus group input

Treatment protocols for babies born with NAS or at high risk of having NAS vary widely across the Commonwealth. Investment to enhance implementation of high impact standards of care would be very beneficial to enhance clinical care and reduce intensity of services (and therefore cost) across the state. Key opportunities and observations include:

1. *Many nurses / hospital staff are not trained in caring for NAS infants* **–** not equipped to assess clinical severity, determine when breast-feeding is appropriate or when infant can / should be with mother - **care practices are often conservative** to the detriment of mothers and infants.

2. *Mothers and infants with NAS are often separated during hospitalizations* **–** default practice at many hospitals is **contradictory to evidence-based care**. The rationale for separation is often an assumption that **DCF involvement** requires separation, judgements made about the mother based on **toxicity screens**

3. **Simple clinical protocols in the inpatient hospital setting improve treatment substantially –** e.g., hospital-based initiation of **early intervention** supports, improved engagement of **community-based social work** in the hospital setting, and better **hand-offs** to community based primary providers (both PCPs and addiction medicine providers).

4. *There is need for testing of emerging best practices* – e.g., **long term, residential care** for mothers and infants in a non-hospital setting after discharge was referenced by several participants as being potentially high value.

In summary, there was broad consensus among participants that there is an opportunity for the state to engage in and help move forward best practices in care for babies with NAS.

HPC's proposed "delivery to discharge" quality improvement initiative will accelerate uptake of best practices and reduce total cost of care

Target Aim:

Reduce total cost of care (TCOC) for perinatal episode by ~20% within 12 months

- Adopt standardized scoring for identifying & assessing severity of NAS
- Reduce use of pharmacologic intervention
- Increase use of breastfeeding, rooming-in
- Implement multidisciplinary daily rounds (addiction medicine, pediatrics/neonatology, social work)
- Develop step-down protocol for transition from NICU to lower intensity settings
- Train special care nursery & pediatrics nurses on non-complex NAS management
- Improve hospital-DCF, hospital-early intervention, & hospital-community (e.g., pediatrics, ob/gyn, family practice, social services) coordination protocols

Aligning with DPH's SAMHSA grant allows for interventions to be applied throughout continuum

SAMHSA pilot

Focus on engagement & retention in SUD treatment

DPH SAMHSA grant $3,000,000

- 3 year award to 2 health systems (1 rural; 1 urban) with at least 60 NAS births / year or ≥ 5 times nat'l average
- Increase # of buprenorphine waived OB/GYN & PCPs
- Hospitals partner with an organization that will coordinate post-natal care for the family (e.g., primary and pediatric care, EI services, continued MAT)
- Peer recovery supports (pre- and post-natal)
- Support services (e.g., transportation, childcare)
- TA (e.g., buprenorphine training, trauma informed care training)

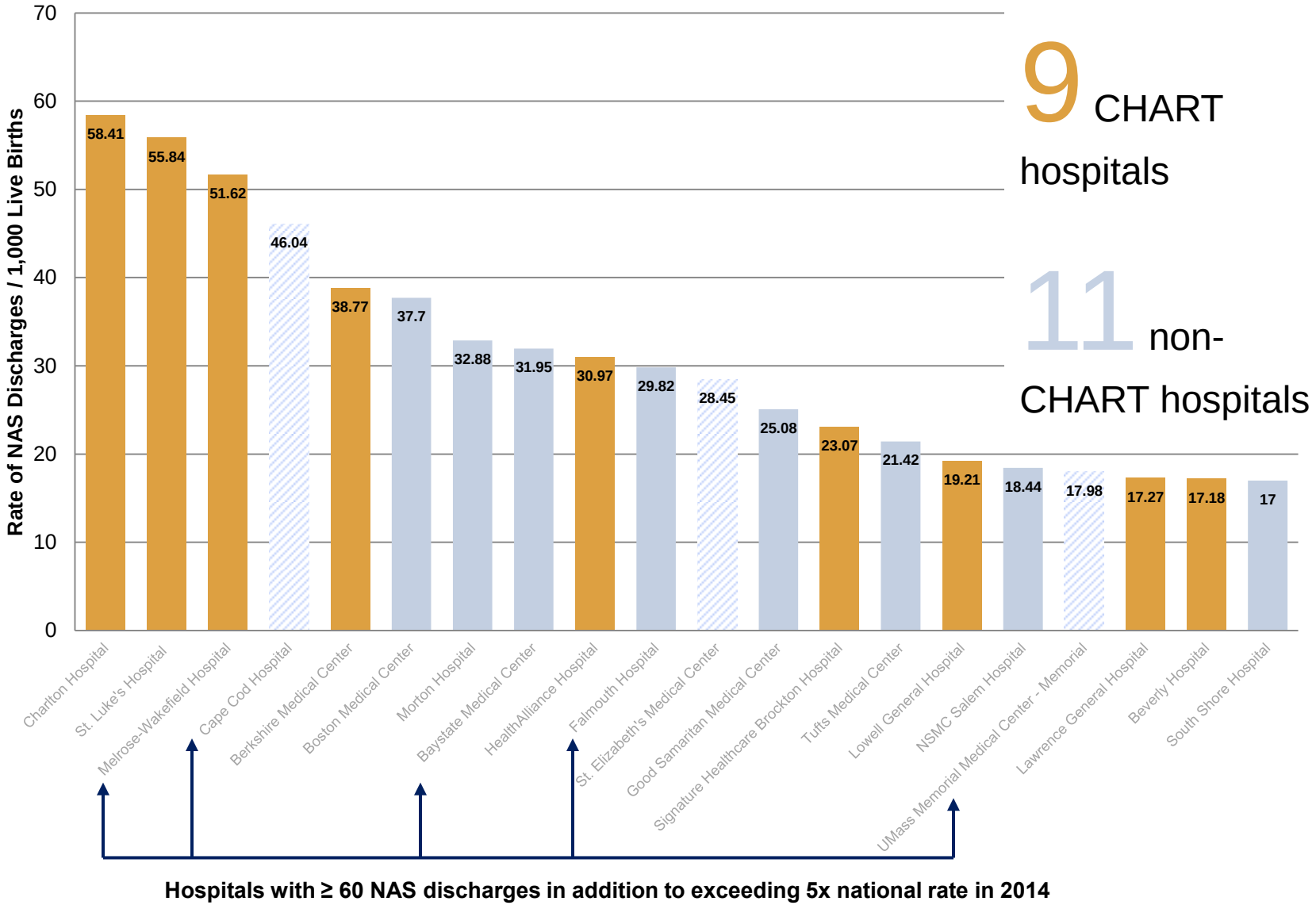
HPC state appropriation

Focus on length of stay; inpatient NAS protocols; lowering intensity of care settings

HPC NAS Reserve $500,000

- 1 year award
- Reduce total cost of care from delivery-discharge via quality improvement initiative
- Hospitals implement best-practices (e.g., breast-feeding, rooming-in, cuddling protocols, step-down plan, training for nurses on NAS)
- Technical assistance offerings support best practice implementation (e.g., learning collaboratives, trainings)
- Dissemination of learnings on a statewide basis to ensure lasting impact
- Opportunity to expand DPH program with commitment of additional resources

MA hospitals with ≥ 5x national rate of NAS or ≥ 60 NAS discharges in 2014



National rate = 3.4 / 1,000 births

HPC proposes to expand DPH's initiative by adding additional CHART hospitals and aligning it with the HPC's inpatient pilot

1. Aligning with other state agencies through the Moms Do Care initiative (DPH & DCF) will create a more fully integrated cross-continuum intervention and will provide enhanced services for a greater number families with substance exposed newborns

2. We propose to complement the DPH federally funded pilot with an **inpatient quality improvement initiative**, and extend DPH's **pre and post-natal coordination** by adding 2-3 CHART hospitals to the Moms Do Care program with newly dedicated, additional HPC investment funds

Moms Do Care + CHART	HPC Pilot Program	Moms Do Care + CHART
Pregnancy	Inpatient delivery - Discharge	Discharge-6 months
4-6 coordinated sites	**4-6 hospitals**	**4-6 coordinated sites**

A fully integrated model for enhancing care for neonatal abstinence syndrome begins during pregnancy and continues long after birth

*Coordinated sites will not necessarily be affiliated with hospitals participating in the HPC's inpatient pilot

Proposed HPC investments in NAS

	HPC NAS Reserve $500,000	CHART Funds to extend DPH program Up to $3,000,000
Intervention	One year	Two years
Eligible Applicants	Potential applicants are any non-CHART birthing hospitals with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average	Potential applicants are any CHART birthing hospitals with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average
Proposed Award Cap	Up to $250,000	Up to $1,500,000
Application Process	Applicants must describe quality improvement initiative that will reduce TCOC by ~20% over 12 months	Applicants must demonstrate capacity to provide services along the care continuum (pre-natal; inpatient; post-discharge) through participation in Moms Do Care and describe quality improvement initiative that will reduce TCOC by ~20% over 12 months

Technical Assistance, Dissemination, and Program Evaluation

A portion of funds will be allocated to coordinated DPH/HPC **technical assistance** and robust **program evaluation**. In addition to supporting the successful awardees in their projects, technical assistance will also focus on disseminating best practices through provider education and peer learning, with the goal of accelerating the adoption of best practices at other hospitals and their community partners across the Commonwealth.

Evaluation will include an examination of the initiative's impact on a wide range of cost, quality, and access metrics, and will also aim to inform future policy development. *(See appendix for TA and evaluation details in draft form).*

Agenda

- Approval of Minutes from the September 9, 2015 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- **Schedule of Next Meeting (December 16, 2015)**

Contact Information

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