MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

February 27, 2019

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes
- Certification Programs
- Neonatal Abstinence Syndrome (NAS) Program Evaluation
- Schedule of Next Meeting (June 5, 2019)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDT Committee meeting held on November 28, 2018, as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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  - Patient-Centered Medical Home (PCMH) PRIME Certification
  - Accountable Care Organization (ACO) Certification
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Key Points from Previous CDT Committee Discussion of PCMH PRIME

HPC's contract with NCQA to operationalize PCMH PRIME was due to expire on December 31, 2018.

The first practice's PCMH PRIME Certification will expire on May 17, 2019.

In 2017, NCQA introduced the updated PCMH Recognition program, including a Distinction in Behavioral Health Integration (BHI) module to recognize PCMH practices that achieve BHI capabilities.

Decision

Enter into a new two-year contract with NCQA:

- Accept applications for current PCMH PRIME program until April 30, 2019
- Adopt NCQA Distinction in BHI program as the new standard for HPC PCMH Certification
  - Receive data from NCQA on practices that have achieved Distinction
- Support training webinars and cover practice fees to apply for Distinction in BHI

Update on NCQA Contract and PCMH Certification

HPC has renewed its contract with NCQA:

- ✓ Current PCMH PRIME program will sunset on April 30, 2019
- ✓ NCQA Distinction in Behavioral Health Integration will qualify practices for HPC PCMH Certification going forward

Based on new information and dialogue with NCQA over the fall, **final contract terms reflect some shifts:**

- Δ HPC will not sponsor training webinars on the Distinction program, nor cover NCQA's $500 per practice application fee for Distinction
- Δ Practices may notify the HPC after receiving Distinction to be designated as HPC PCMH-certified (i.e., no direct data flow from NCQA to HPC)
- Δ Contract with NCQA will end on July 31, 2019

HPC

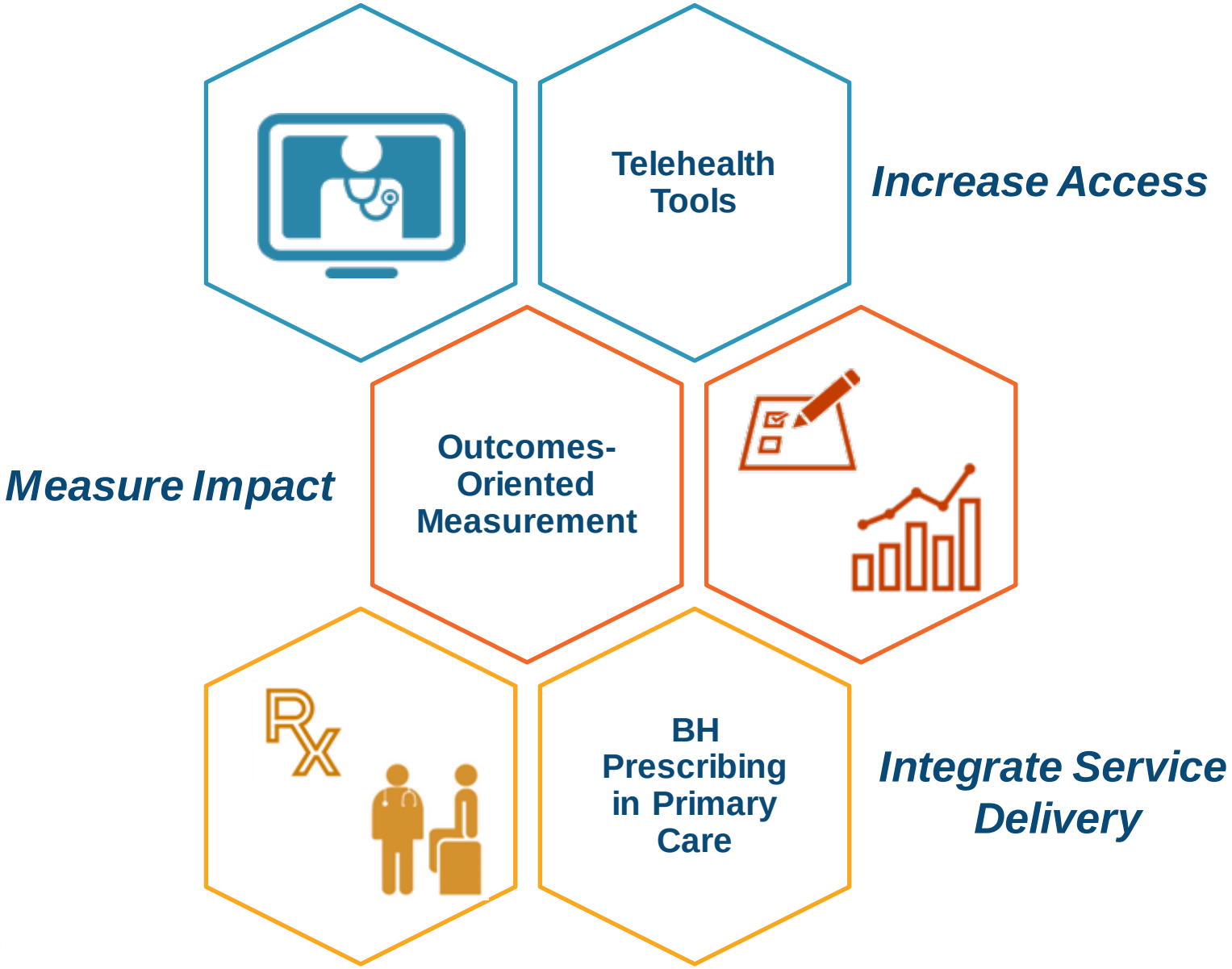
Opportunities for Broader Strategic Relationship with NCQA

Addressing administrative complexity

Distinction and standards-setting for PCMHs and ACOs

Quality measurement for plans and providers

Potential Areas for Continued HPC Work on Behavioral Health Integration



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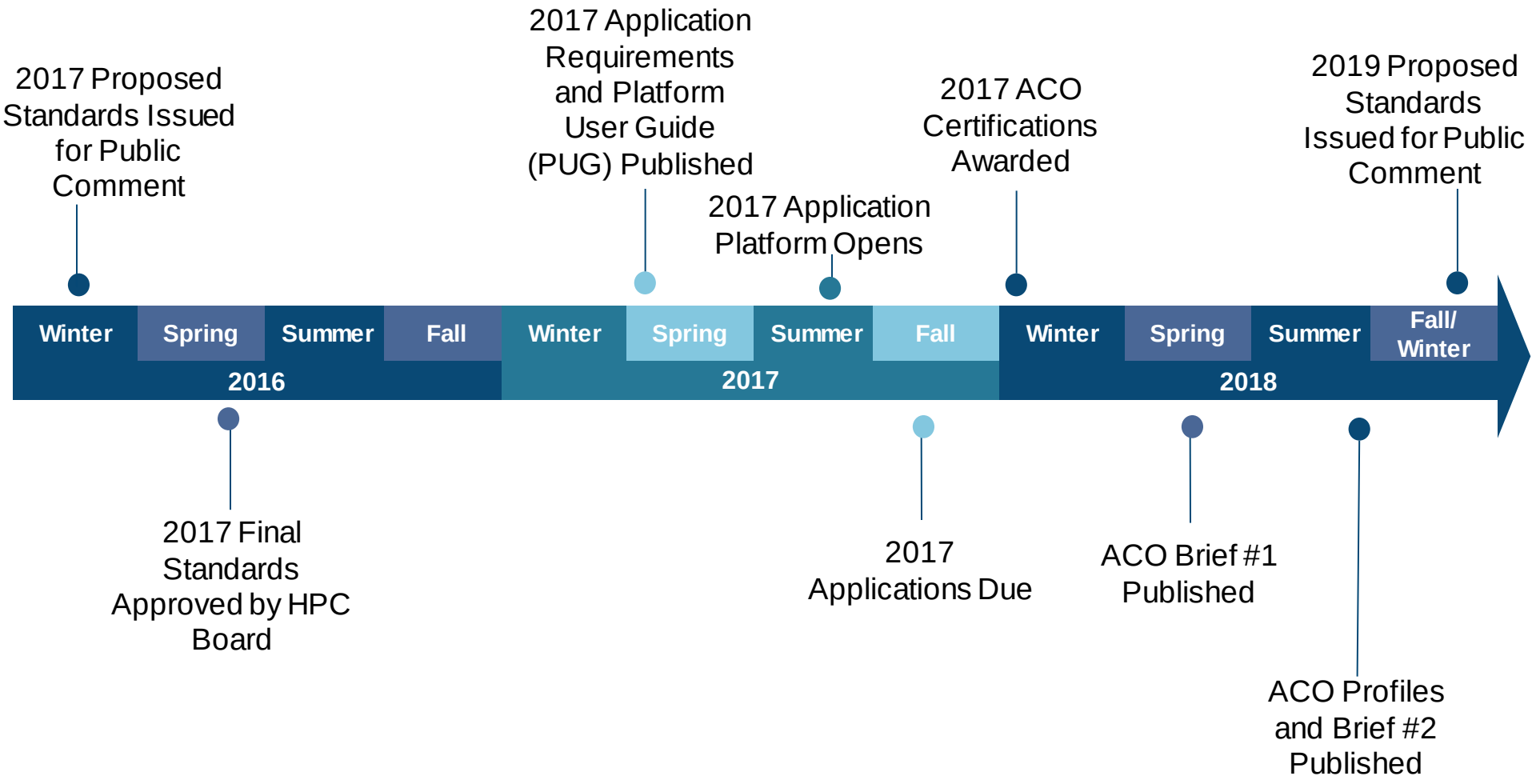
ACO Certification Milestones to Date



ACO Certification aims to promote ongoing transformation and improvement over time

Current market

- Multiple ACO programs in the market
  - Medicare ACOs (i.e., MSSP, Next Gen)
  - Commercial programs (e.g., BCBSMA's AQC)
  - MassHealth ACOs
- Evidence on the relationship between ACO capabilities and outcomes is still developing

Initial focus of HPC ACO Certification

- Create a set of **multi-payer standards** for ACOs to enable care delivery transformation and payment reform
- Build **knowledge and transparency** about ACO approaches
- Facilitate **learning** across the care delivery system
- Align with and complement **other standards and requirements** in the market, including MassHealth, Connector, and Dept. of Public Health

Vision for Certification

- Develop the evidence base on how ACOs achieve improvements in quality, cost and patient experience
- Move certification standards from structural/process requirements to quality outcomes and cost performance requirements
- Create a "model ACO" program to recognize exceptional performance
- Engage additional payers and purchasers

HPC

Overview of 2017 ACO Certification Criteria

Pre-requisites

4 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ Population health management programs
- ✓ Cross-continuum care: coordination with BH, hospital, specialist, and long-term care services

2 Required Supplemental Information

9 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ Develops community-based health programs
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency

HPC

18 ACOs Certified Under 2017 Standards

Certified ACOs

- Atrius Health, Inc.
- Baycare Health Partners, Inc.
- Beth Israel Deaconess Care Organization
- Boston Accountable Care Organization, Inc.
- Cambridge Health Alliance
- Children's Medical Center Corp.
- Community Care Cooperative, Inc.
- Health Collaborative of the Berkshires, LLC
- Lahey Health System, Inc.
- Merrimack Valley Accountable Care Organization, LLC
- Mount Auburn Cambridge Independent Practice Association, Inc.
- The Mercy Hospital, Inc.
- Partners HealthCare System, Inc.
- Reliant Medical Group, Inc.
- Signature Healthcare
- Southcoast Health System, Inc.
- Steward Health Care Network, Inc.
- Wellforce, Inc.

The HPC reports on ACO Certification data to promote learning and transparency

An Introduction to ACOs in Massachusetts

Provides background information and highlights key facts about the certified ACOs, such as:

- The certified ACOs hold more than 65 commercial risk contracts, 17 MassHealth risk contracts, and 11 Medicare risk contracts.
- Over 80% of ACOs have at least one hospital as an ACO participant.

How ACOs in MA Manage Population Health

Describes activities performed by the HPC-certified ACOs related to:

- Risk stratification
- Assessment of patient needs and preferences
- Population health management programs that address behavioral health and the social determinants of health

Profiles of the 2017-2019 HPC-certified ACOs

Provides a snapshot of the ACOs using information ACO Certification and other public data (e.g. from the Registration of Provider Organizations program). Each profile provides key facts about the certified ACOs and their corporate parents, including:

- Payers with whom the ACO has risk contracts;
- Where in the Commonwealth the ACO provides care; and
- The ACO's approximate patient count.

Webinar on ACOs and Serious Illness Care

On January 24, the HPC collaborated with the Massachusetts Coalition for Serious Illness Care to host **Serious and Advancing Illness Care in Value-Based Payment Models: What ACOs in Massachusetts are doing to document and honor patients' wishes**, a webinar regarding ACOs' efforts to support the wishes of patients facing serious and advancing illness.

Maureen Bisognano
Massachusetts Coalition for Serious Illness Care

Adrianne Seiler, M.D.
Baycare Health Partners

Leslie Sebba, M.D.
Lahey Clinical Performance Network

Charles Pu, M.D.
Partners Center for Population Health

"Here I am with a doctor for [my mother's] body and a doctor for her soul."

- Maureen Bisognano

"Without accountability, everyone is passing the ball."

- Adrianne Seiler, MD

"[Serious illness care] humanizes interactions with patients and makes you remember why you are in the healthcare profession."

- Leslie Sebba, MD

"A challenge for all health systems is how to integrate [serious illness care programs]."

- Charles Pu, MD

40+ engagements on Twitter

120+ attendees

3 HPC-Certified ACOs

Proposed 2019 ACO Certification Requirements

Background information

Attestation or updates to 2017 standards

Assessment Criteria

- ✓ Governance structure
- ✓ Patient/consumer representation
- ✓ Performance improvement activities
- ✓ Population health management programs
- ✓ Cross-continuum care

Supplemental questions

HEALTH POLICY COMMISSION ACO CERTIFIED – 2017 –

Optional new performance-based distinction program

HPC

Key Themes in Public Comments on 2019 ACO Certification

18 public comment letters from ACOs, public health/advocacy organizations and coalitions, and professional/trade associations

1. **Streamline or reduce requirements to alleviate reporting burden**
   - Target and limit the scope of information collected
   - Leverage other data sources (e.g., Division of Insurance, MassHealth, health plans)
   - Simplify quality performance reporting requirements
   - Allow attestations to 2017 Assessment Criteria, as proposed
   - Improve the application process

2. **Consider other factors for certifying ACOs,** e.g., total cost of care performance, amount of downside risk, behavioral health integration capabilities, population health management strategy on social needs, etc.

3. **Continue taking a collaborative approach**
   - Provide assistance to ACOs during application process as needed
   - Use certification data to support ACO learning

Key Themes in Public Comments on ACO Distinction Program

- Engage stakeholders and **extend the timeline** for developing and launching the program
- **Clarify the purpose** of the program, specific measures and criteria for achieving Distinction, and identify any incentives for ACOs to apply
- Consider likely **challenges in reporting performance information,** particularly if required in aggregate across payers, and the need for case mix adjustment
- **Align performance measures** with metrics that ACOs are already working on

Administrative complexity without value is a key HPC focus area

Risk contract reporting to state agencies: overlap exists, but data is more unique than shared

HPC examined risk contract information collected by three related programs – RBPO, RPO, and ACO certification. Where similar data are collected, it is generally not comparable (i.e., aggregated across payers vs. contract-level reporting).

	HPC ACO Certification Program	MA RPO Program	DOI RBPO Program
Purpose	Sets care delivery standards for ACOs	Data repository of health system information	Evaluates financial solvency of provider org taking on downside risk
Level of data	Contract-level data	System-level, **aggregated** data	Org-level, **aggregated** data
Frequency	Bi-yearly	Yearly	Yearly
Confidentiality	Almost all confidential	Public	Public
Payer type	All-payer	All-payer	Commercial, MassHealth
Type of risk	Up and downside	Up and downside	Downside

Final Proposal for 2019 ACO Certification: Background Information

Pre-requisites and Summary

ACO name and contact info; five pre-requisite attestations: (1) RBPO certificate or waiver, (2) any required MCNs filed, (3) anti-trust compliance, (4) patient protection, and (5) at least one substantive, quality-based risk contract; *No narrative of Applicant history/mission, list of regions, or Applicant org chart.*

ACO Participants

No data submission required. HPC will leverage RPO data and contact the Applicants for clarification if needed.

Risk Contracts and Performance

- As proposed, fill in a template with the following per contract: payer name, number of attributed patients, years in contract, payment methodology, description of quality incentives, and financial terms (i.e. full or partial risk, upside only or two-sided, max. shared savings/losses, any cap on shared savings/losses). *No data field on member management fee/infrastructure payments.*

- For the two most recent performance years, final ACO-level quality performance on all risk contract measures. *No requirement to submit using template of Massachusetts Aligned Measure Set.*

Final Proposal for 2019 ACO Certification: Assessment Criteria

1. Governance structure
2. Patient/consumer representation
3. Performance improvement
4. Quality-based risk contracts
5. Population health management
6. Cross-continuum care

- **As proposed in public comment**, no changes to the 2017 assessment standards or documentation requirements, except risk contract information will be collected in Background Information section
- Applicants required to update 2017 responses to reflect any changes since submission
- If there have been no changes, Applicants may attest that the 2017 response is still fully applicable

HPC

Final Proposal for 2019 ACO Certification: Topics for Supplemental Questions

1. Distribution of shared savings and performance-based compensation
2. High-value care
3. Advanced primary care and behavioral health integration

Principles for drafting specific Supplemental Questions:

- Allow for the full range of approaches different ACOs may be taking, in an open-ended manner
- Gather data structured enough to support research and transparency efforts (e.g., publishing ACO Policy Briefs)
- Provide a basis for a return benefit to ACOs in the form of HPC-convened learning opportunities (topical discussions, webinars, publications, etc.)

DRAFT Supplemental Questions: Distribution of Shared Savings/Provider Compensation

Domain	Questions
Distribution of shared savings and performance-based provider compensation	1. Does the ACO incorporate risk-based incentives into its participating provider compensation model? If so, how/which? *(select all that apply)* 2. What factors does the ACO consider when developing a risk surplus or deficit distribution methodology? *(select all that apply)* 3. Briefly describe how each factor is used to distribute earned surplus funds or to distribute responsibility for risk deficits *(brief narrative)* 4. Approximately what percentage of provider compensation is at risk based on performance or other factors under the ACO's provider compensation model? *(select one option)*

DRAFT Supplemental Questions: High-value Care

Domain	Questions
High-value care	1. Has the ACO developed strategies to address unnecessary utilization in any areas of low value care, including those identified in the HPC's 2018 Annual Health Care Cost Trends Report (screening, pre-operative, procedures, imaging, pharmacy, other)? If so, which? *(select all that apply)* a. For each area selected, briefly describe the strategy *(brief narrative)* 2. Does the ACO employ strategies to promote cost-effective prescription drug use? If so, what are they? *(select all that apply)* 3. Does the ACO implement strategies to facilitate appropriate care transitions and/or manage post-acute care utilization and spending? If so, what are they? *(select all that apply)*

DRAFT Supplemental Questions: Advanced Primary Care and Behavioral Health Integration

Domain	Questions
Advanced primary care and behavioral health integration	1. Does the ACO have a strategy (i.e. specific plans and support) for implementation of advanced primary care and integrated behavioral health? *(select one option)* a. Provide a brief written description of the components of such a strategy (e.g. financial, infrastructure, and technical assistance) *(brief narrative)* 2. Considering the SAMHSA-AHRQ Six Levels of Integration scheme, fill in the approximate percent of ACO Participant primary care practices that align with each level *(short text box)* 3. Does the ACO include practices that utilize a "reverse integration" model of primary care into behavioral health? *(Yes/No)* 4. Does the ACO currently offer, or have specific plans to implement, access to behavioral health services via telemedicine? If yes, provide a brief written description *(Yes/No, with text box)*

Confidentiality for ACO Certification Materials

Nonpublic clinical, financial, strategic, or operational documents or information submitted to the HPC in connection with ACO certification have confidentiality protections pursuant to M.G.L. c.6, sec. 2A. The HPC may make the information public in de-identified summary form, or when the HPC believes that disclosure is in the public interest.

Information for Public Reporting

Background Information

- Applicant name, contact info
- Component ACO(s) name, contact info
- Name(s) of payer(s) with which Applicant and Component ACOs have quality-based risk contract(s); year that each contract began and expires; whether the contract is upside-only or two-sided; and number of attributed patients per contract

AC-2

- Position of patient/consumer rep within the governance structure;
- Description of patient and family advisory committee(s);
- Public narrative demonstrating ways the governance structure seeks to be responsive to patient population needs.

Information for Public Reporting
If the Applicant Consents

Portions and/or summaries of responses to all other questions

Comparison of 2019 ACO Certification Proposals versus Final

	Early Fall 2018	Public Comment Draft	Final
Assessment	**Updated/new criteria** • Governance • Quality strategy • PHM strategy • Primary care • HIT	**No new or updated criteria**	**No new or updated criteria**
Supplemental	**9 total** • Advanced illness • Dist. of savings • Oral health integration • Resource stewardship • Early childhood development • Chronic pain • MAT • Team-based care/workforce • Crisis care	**9 total** • Dist. of savings • High-value care • BHI into Primary Care • Advanced HIT • Coding • Market Functioning • Workforce • Care model innovations • Partnerships on SDH	**3 total** • **Distribution of savings** • **High-value care** • **Advanced primary care/BHI**
Background	**5 new data fields/templates** • Narrative of org history, mission • List of regions • List of Participants • Risk contract template • Performance template	**4-5 new data fields/templates** • Narrative of org history, mission • List of regions • List of Participants *only if not in RPO* • Risk contract template • Performance template	**1 new template** • **Risk contract template**

2019 Application Process Supports for ACOs

New application system

- No software to download
- Access to 2017 responses
- Improved functionality
- Multiple users at a time

Early access to application requirements

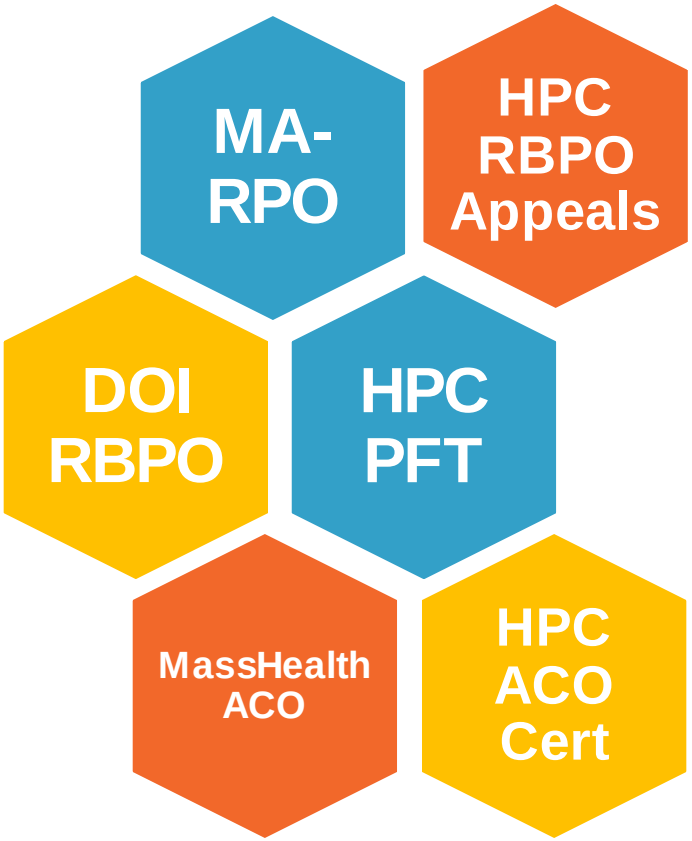
Enabling off-line response preparation prior to system go-live

Training and technical support throughout the process

- Training webinars in advance
- Written FAQs and “office hours” during application process

HPC

Commitment to Reduce Administrative Complexity



The HPC commits that:

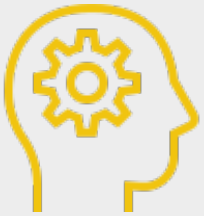
Over the next 12-18 months, HPC will convene staff from related programs to identify opportunities for administrative simplification and enhanced alignment and develop a plan for implementation

2019 ACO Certification Application Timeline and Next Steps

February 8, 2019	Public comments submitted
February 27, 2019	CDT Committee review of final 2019 ACO Certification standards
June 2019	HPC issues final Application Requirements and Platform User Guide (PUG); hosts webinar to review requirements with ACOs
Aug/Sept 2019	Application platform opens; HPC supports ACOs with application platform trainings, office hours, 1:1 calls
October 2019	*Applications due - tentative*
December 31, 2019	*HPC issues certification decisions - tentative*

Next Steps on ACO Distinction Program

The HPC will extend the design process to:



Further consider the questions and suggestions raised in public comment

Convene stakeholders for additional discussion and input into program design

Develop a timetable for implementation

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The HPC's Health Care Innovation Investment Program

The Health Care Innovation Investment Program: $11.3M invested in innovative projects that further the HPC's goal of **better health and better care at a lower cost.**

Health Care Innovation Investment Program – Three Pathways

- Targeted Cost Challenge Investments (TCCI)
- Telemedicine Pilots
- Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions

	Lower Costs	Greater Access	Better Outcomes
Primary Goal:			
Target Populations:	8 diverse cost challenge areas: SDH, BHI, VIC-Purchasers, VIC-Providers, Practice Pattern Variation, PAC, SAI & EOL, Site & Scope of Care	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns
	10 initiatives	**4** Initiatives	**6** Initiatives

Mother and Infant-Focused NAS Interventions: Overview

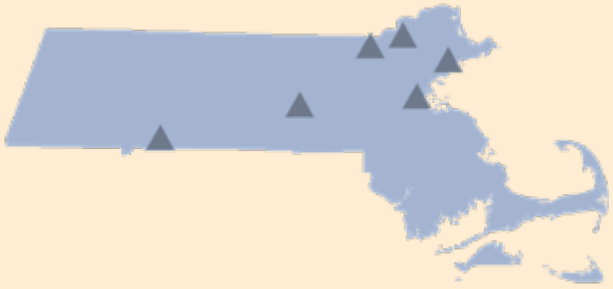
- **Goal:** To develop and/or enhance programs designed to improve care for substance-exposed newborns who may develop Neonatal Abstinence Syndrome (NAS) and for women in treatment for opioid use disorder (OUD) during and after pregnancy

6 initiatives
Funded by the HPC

$3 million
HPC funding

59 Organizations
(e.g. hospitals, primary care practices, behavioral health providers) collaborating

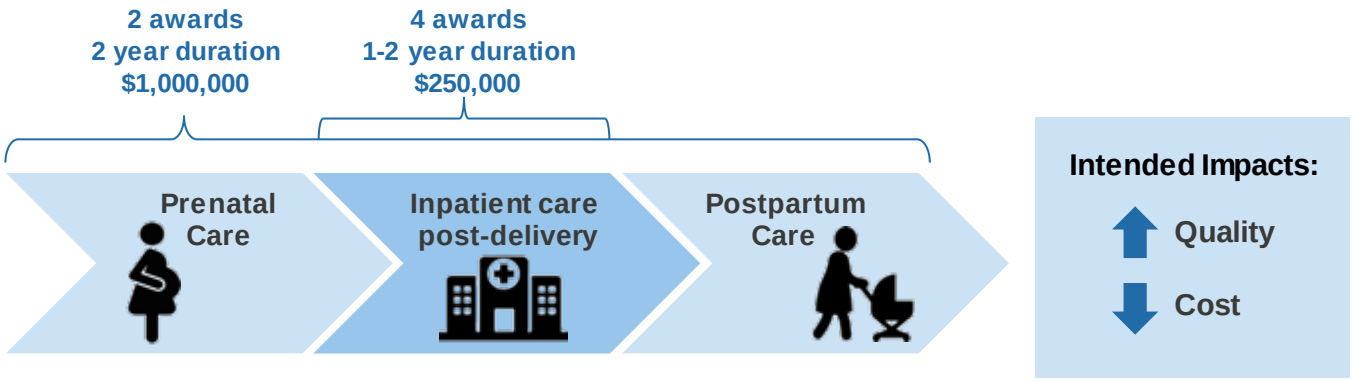
Initiatives span the Commonwealth:
From Springfield to Middlesex County



>450 infants with NAS
treated in 2015 by HPC's proposed awardees

6 initiatives

The HPC's NAS interventions combine inpatient and outpatient interventions



Inpatient activities:

- e.g., Improve diagnostic protocols, breastfeeding rates and skin-to-skin contact after birth, facilitate "rooming-in," and increase infants discharged to biological family

Outpatient activities:

- e.g., Improve screening, identification, and engagement prenatally, and increase engagement in and adherence to pharmacologic treatment during pregnancy and post-partum among women with OUD

HPC provides Technical Assistance to awardees in both settings through partnerships with experts:

neoQIC

PN QIN

COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

IHR INSTITUTE FOR HEALTH & RECOVERY

AHP

BOSTON MEDICAL CENTER

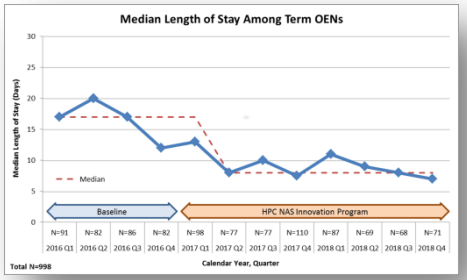
HPC

Mother and Infant-Focused NAS Intervention Awardees

Applicant	Initiative	Funding Cap
Baystate Medical Center	Inpatient	$249,778
Boston Medical Center	Inpatient	$248,976
Lawrence General Hospital	Inpatient	$250,000
UMass Memorial Medical Center*	Inpatient	$249,992
Lahey Health – Beverly Hospital	Inpatient & Outpatient	$1,000,000
Lowell General Hospital	Inpatient & Outpatient	$999,032
6 awardees		**$2,997,778** total HPC Funding

*UMass also received funding through the "Moms Do Care" program, as administered by DPH and funded by SAHMSA.

NeoQIC provides many forms of technical assistance to NAS hospitals

Training and Coaching	Learning Collaboratives	Measurement and Analysis
Instruction and Resources for Non-Pharm Care	Learning Collaborative Facilitation	Data Collection and Surveys
		
Quality Improvement (QI) Training and Coaching	Statewide Convenings and Peer Site Visits	Analysis and Recommendations

Inpatient quality improvement activities to improve outcomes and reduce costs for mothers and infants with NAS

Inpatient QI work focused on four drivers critical to the outcomes for the neonate and health care system by decreasing cost of care while standardizing quality care.

Inpatient Activities

Maternal	Neonatal	Non-Pharmacological	Pre-Discharge
Empower a clinical team to improve care coordination for mothers and infants	*Standardize clinical management of NAS*	• *Expand non-pharmacologic interventions for NAS* • *Promote breastfeeding*	*Promote access to timely wraparound services for mother and baby after discharge*
Measured by: Medication-assisted treatment among mothers	**Measured by:** • Need for pharmacologic therapy for NAS • Duration of pharmacologic therapy for NAS • Care in NICU/SCN • NICU/SCN length of stay • Hospital length of stay	**Measured by:** • Mother's milk use during hospitalization • Skin-to-skin in 1st day of life • Rooming-in prior to maternal discharge	**Measured by:** Referral to Early Intervention (EI) before discharge

Mother and Infant-Focused Neonatal Abstinence Syndrome Interventions

Preliminary Year 1 Findings

February 27, 2019

Data Notes

- Data is from six HPC NAS innovation hospitals, submitted to shared REDCap database
- Overall denominator is newborns at risk for neonatal abstinence syndrome due to in-utero opioid exposure
- Measures reported from 2016 to 2018 (launch 2017)
- Statistical process control used to identify significant changes in measures
- Data reflects **1,244** mother-infant pairs

Abbreviations

- OEN: Opioid exposed newborn
- NAS: Neonatal abstinence syndrome
- MAT: Medication-assisted treatment
- NICU: Neonatal intensive care unit (level III)
- SCN: Special care nursery (level II)

Outline

- Part 1: Key measures, all HPC hospitals
- Part 2: Sub-group and hospital-specific analyses

Part 1

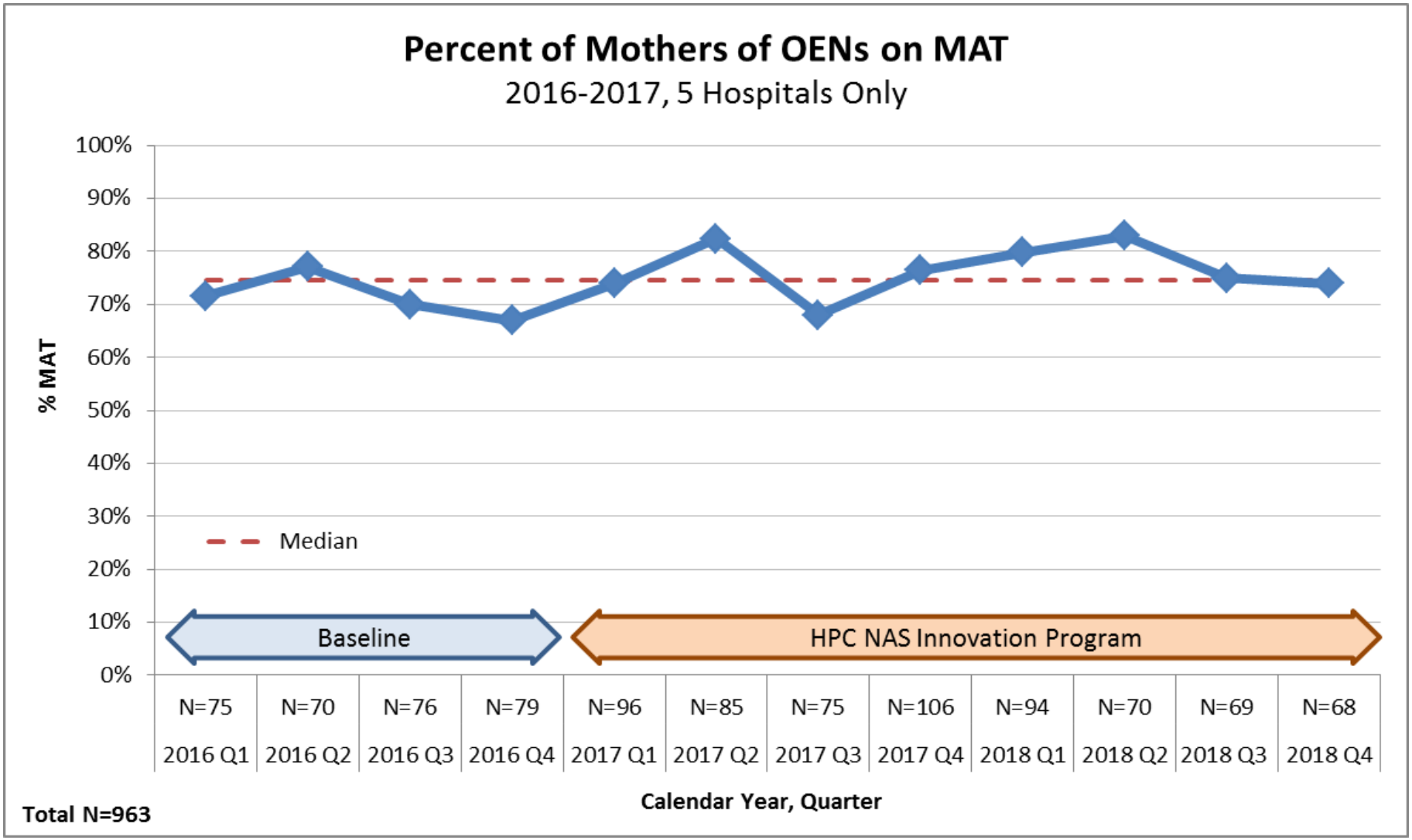
Key Measures, All HPC Hospitals

Measures

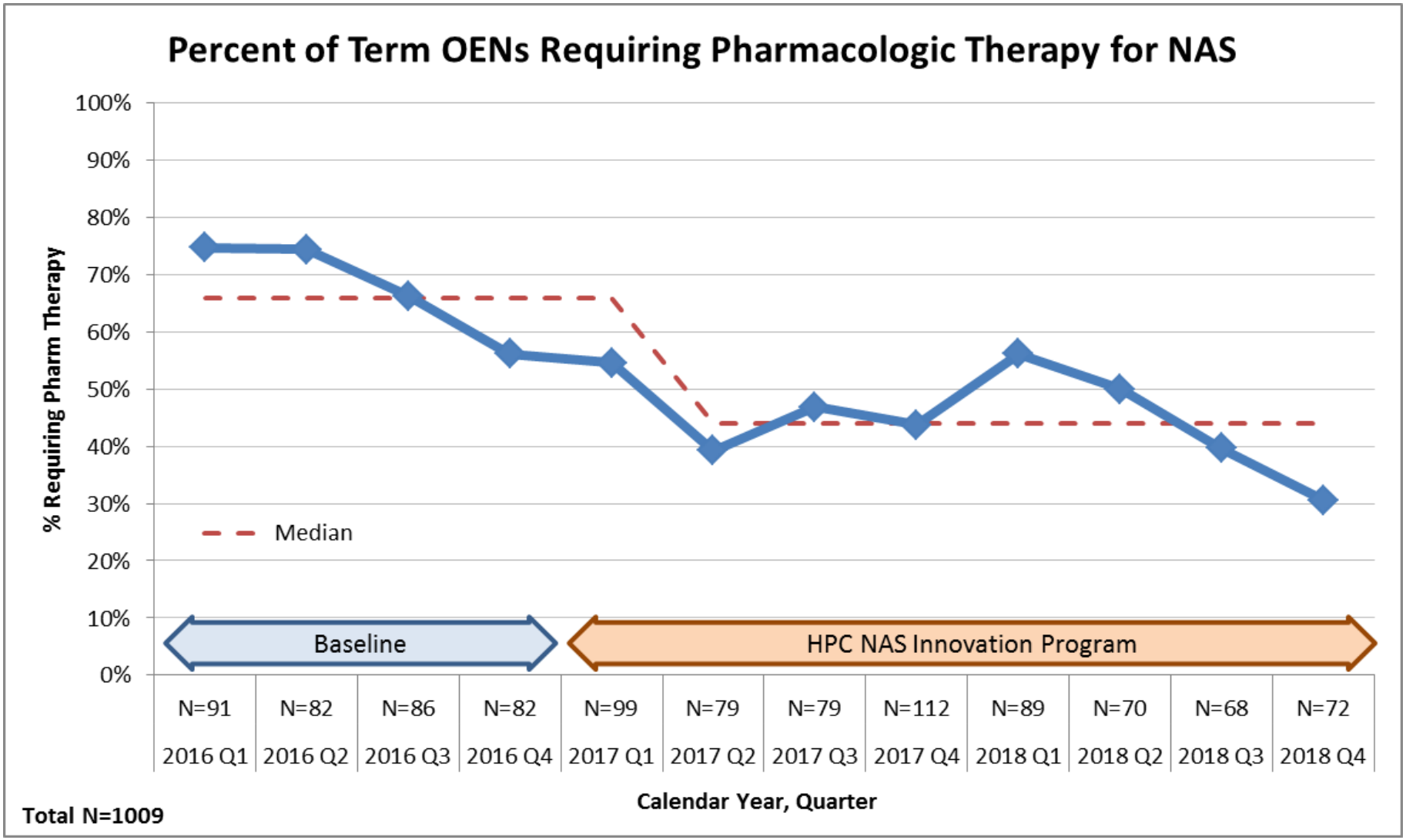
Maternal	MAT among mothers
Neonatal	Need for pharmacologic therapy for NAS Duration of pharmacologic therapy for NAS Care in NICU/SCN NICU/SCN length of stay Hospital length of stay
Non-pharm care	Mother's milk use during hospitalization Skin-to-skin in 1st day of life Rooming-in prior to maternal discharge
Pre-discharge	Referral to Early Intervention before discharge

Summary

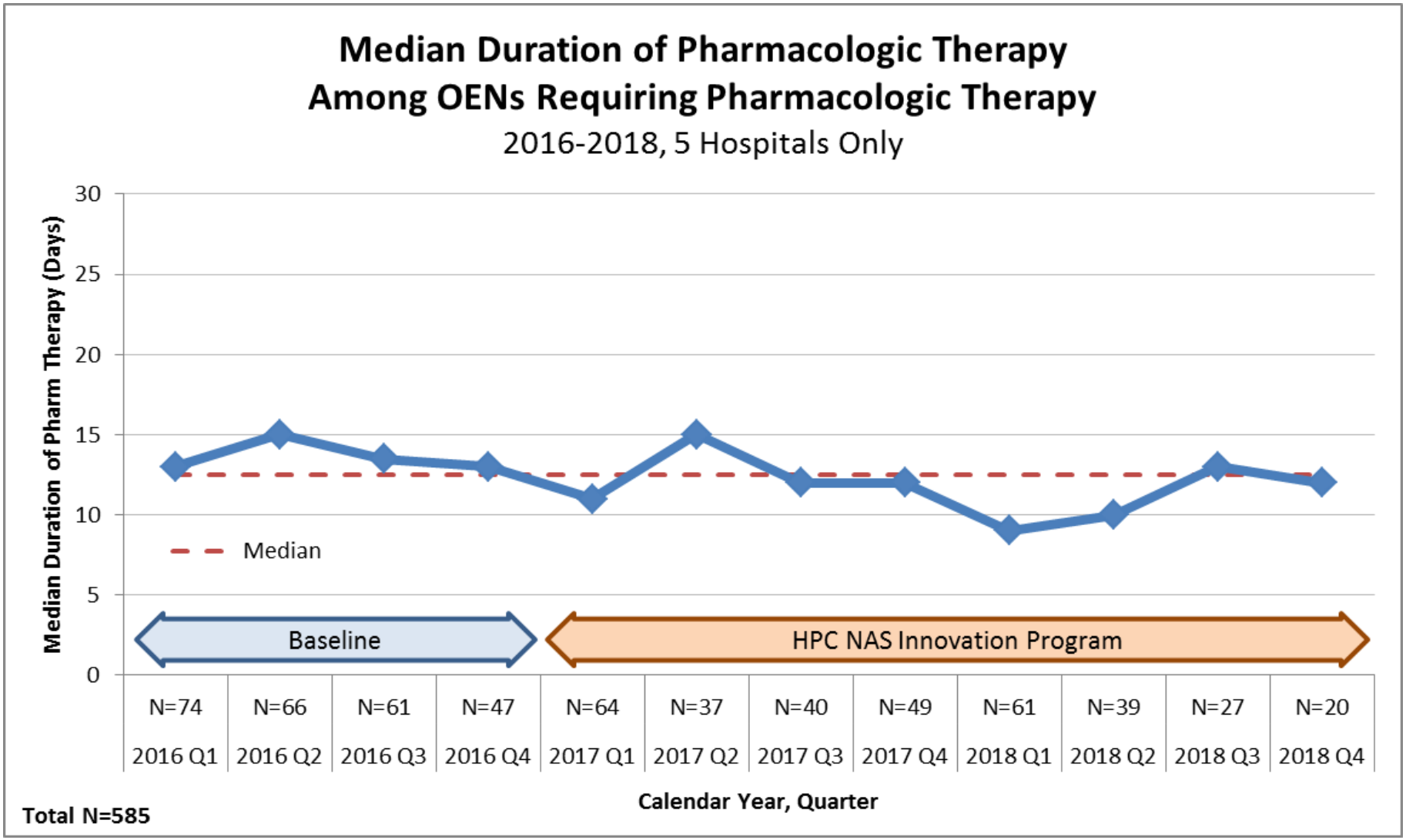
- There is a relatively high rate of MAT use among mothers of OENs (although could be higher).
- **Substantial reductions were seen in need for pharmacologic therapy, need for ICU care, and length of stay.**
- There is still room for improvement in non-pharmacologic care measures.
- There is still room for improvement in pre-discharge measures.



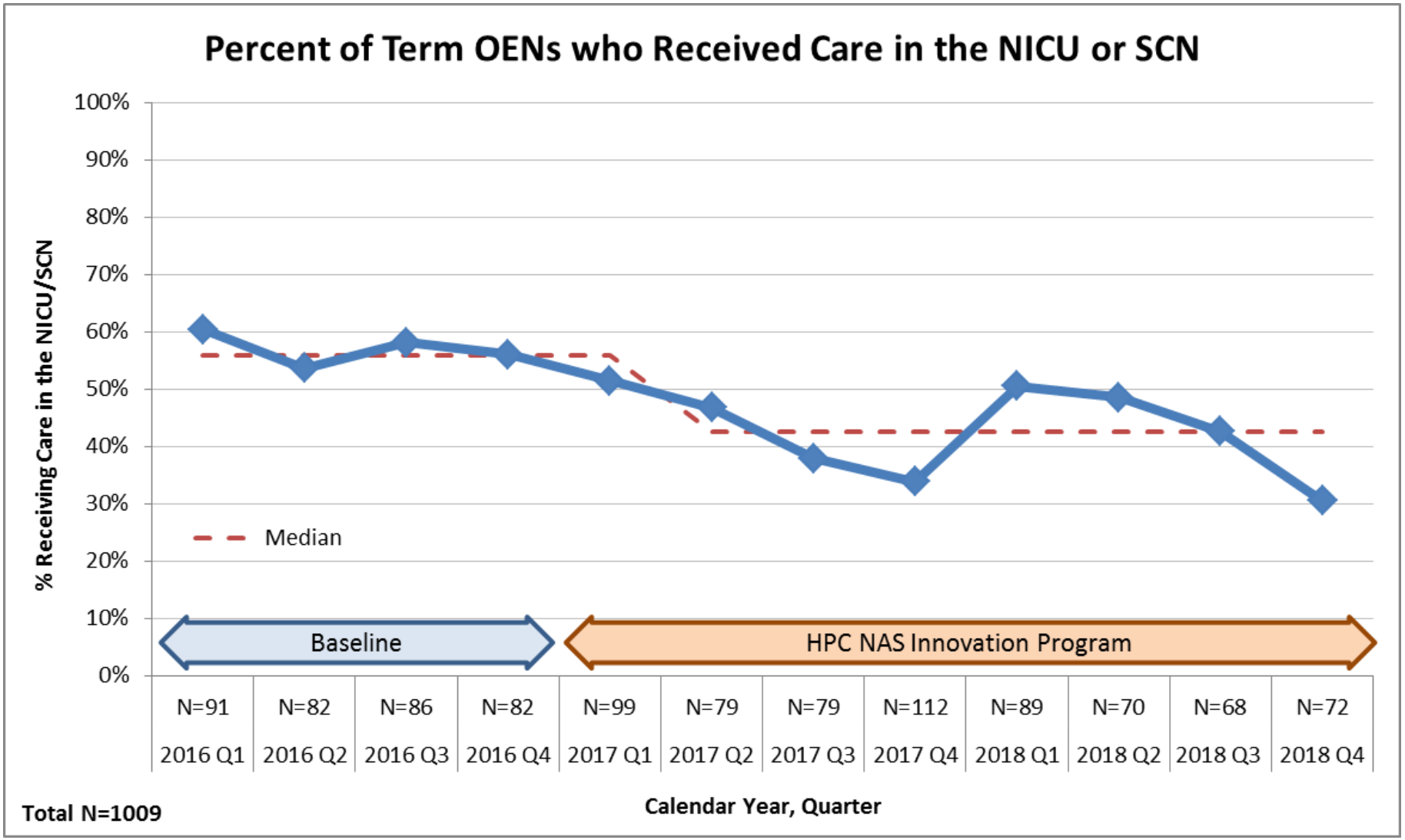
Approximately 75% of OENs were born to mothers on MAT.
(Of these, 25% were also exposed to illicit opioids).



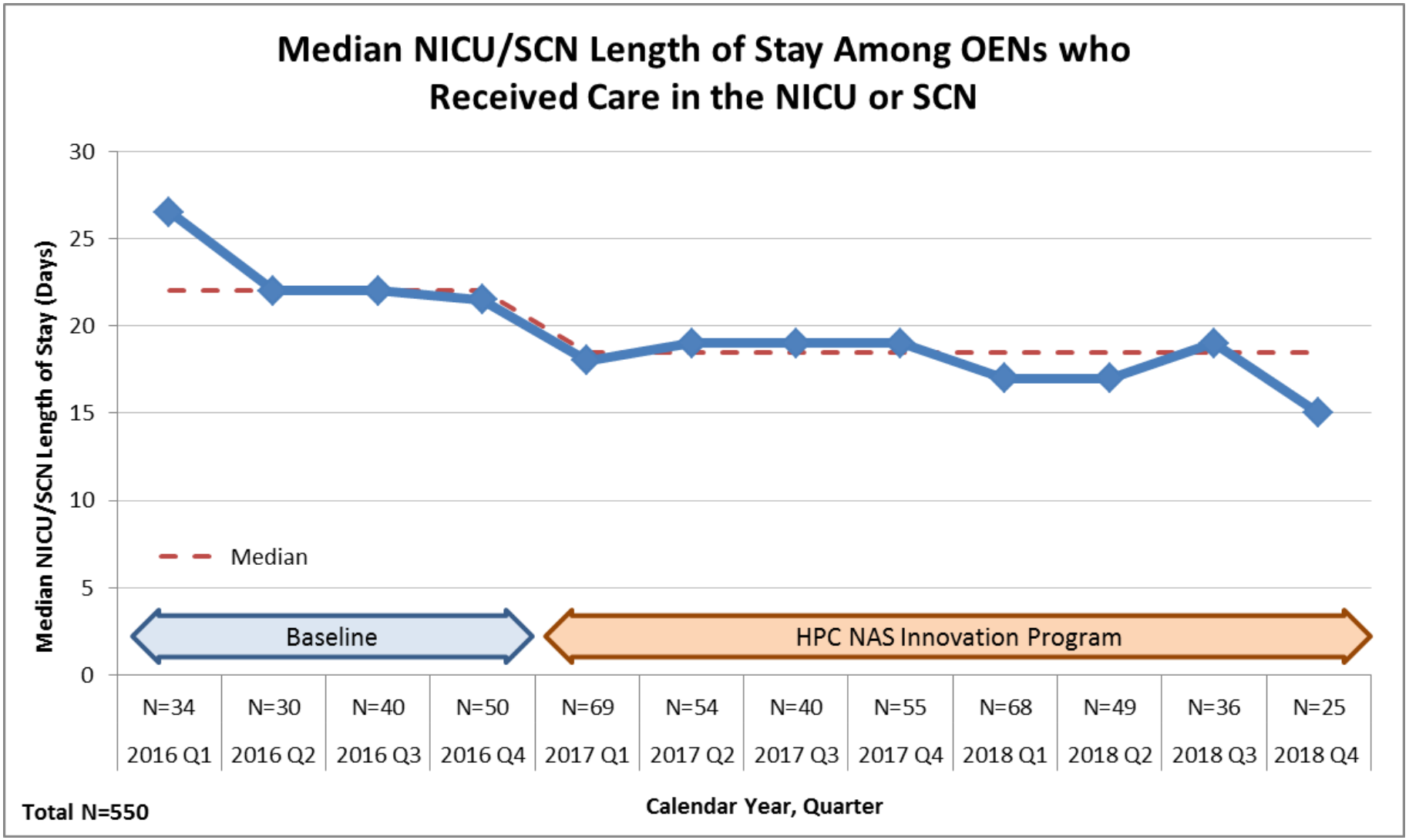
The need for pharmacologic therapy decreased by 33% from 66% to 44%.



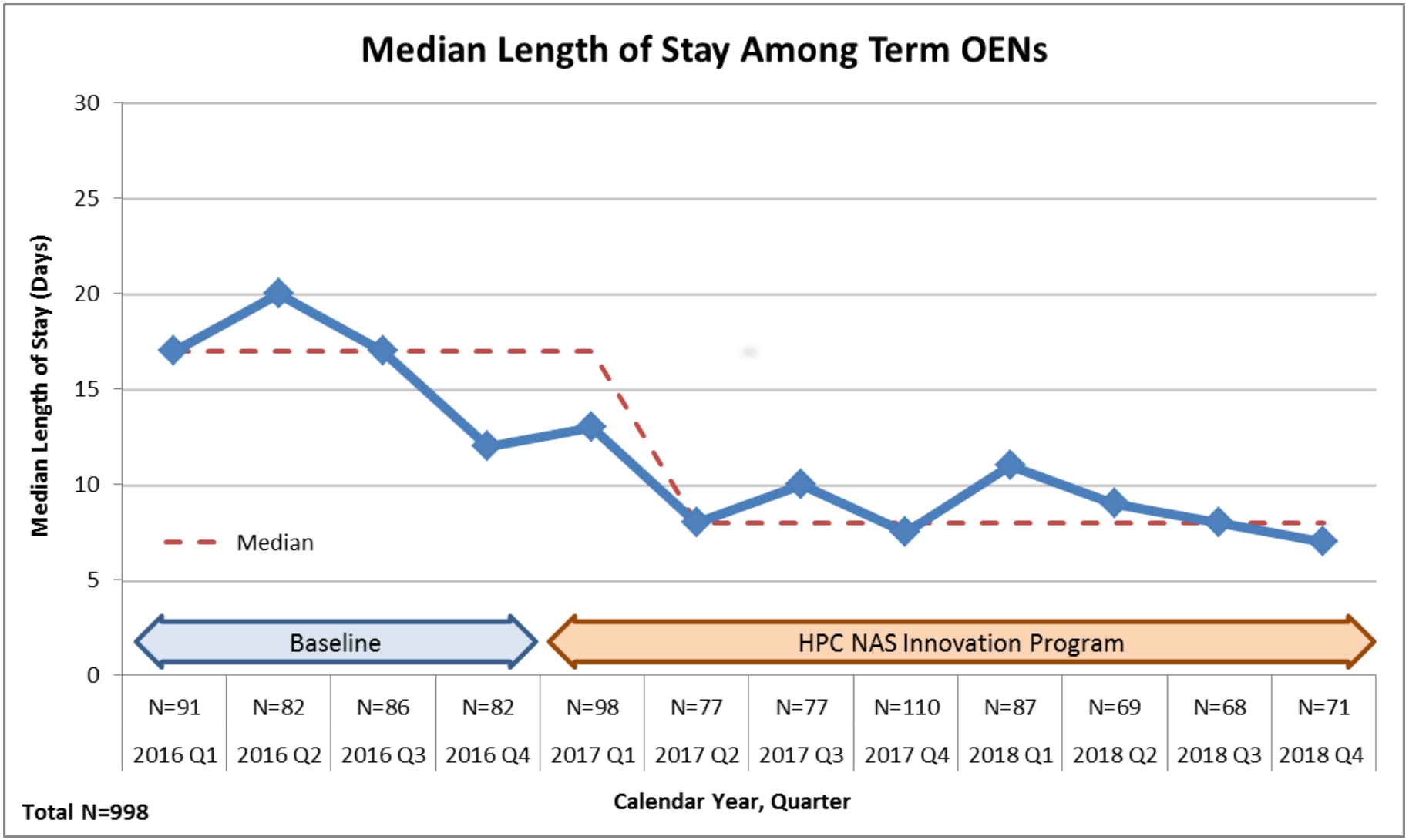
When it was needed, duration of pharmacologic therapy remained largely stable.



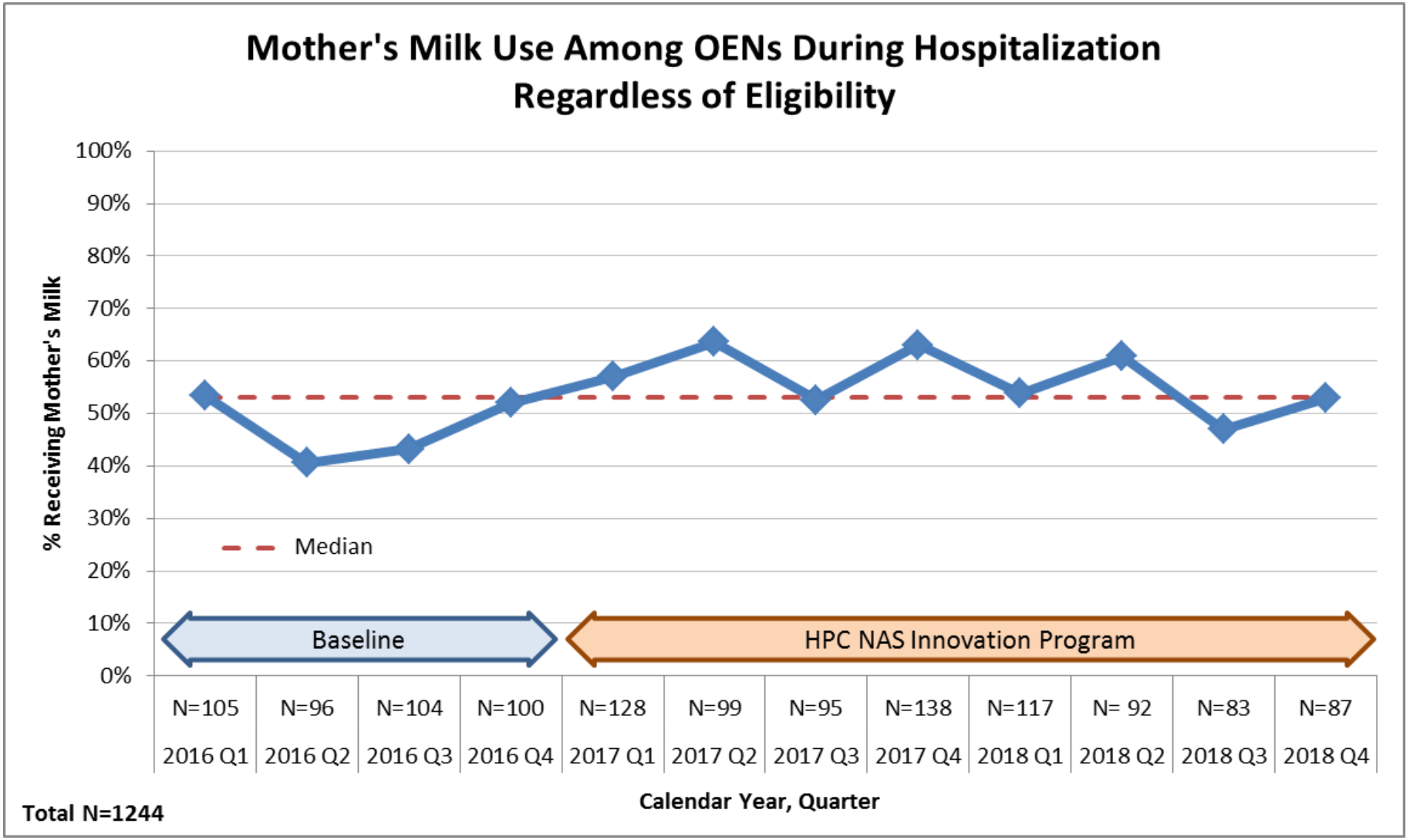
The need for care in the NICU or SCN decreased by 23% from 56% to 43%.



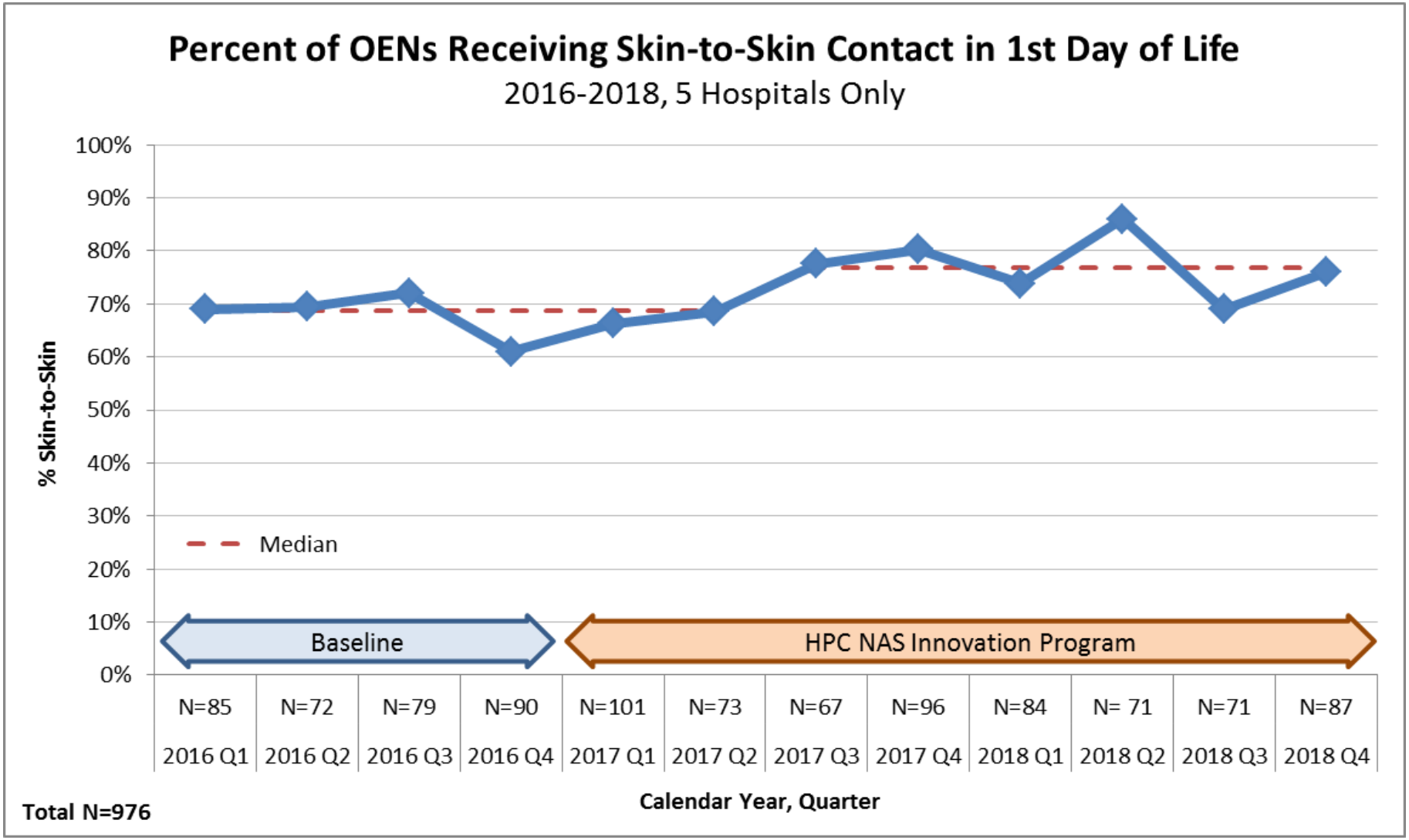
Length of stay in NICU or SCN decreased by 12% from 21 days to 18.5 days.



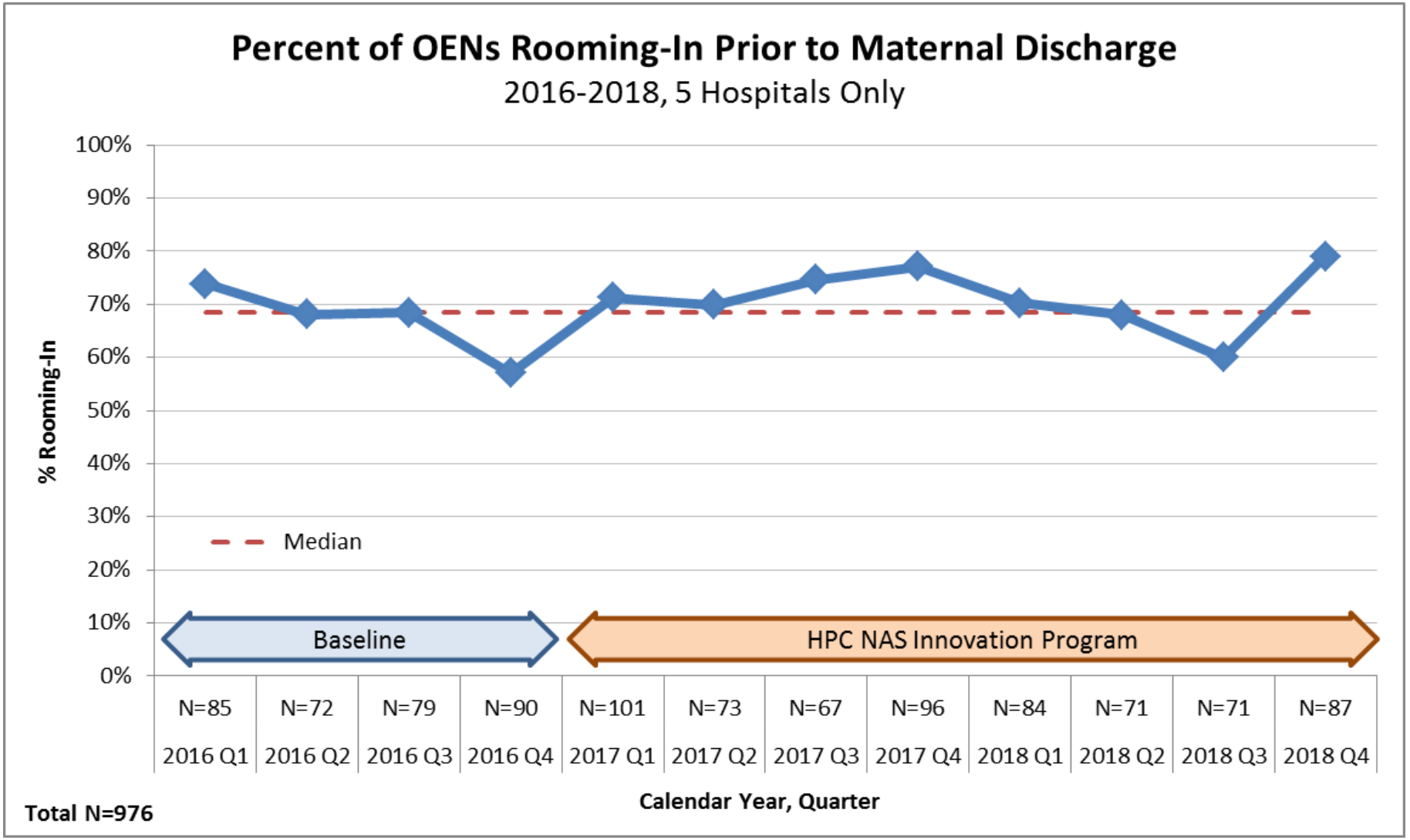
Overall hospital length of stay decreased by 53% from 17 days to 8 days.



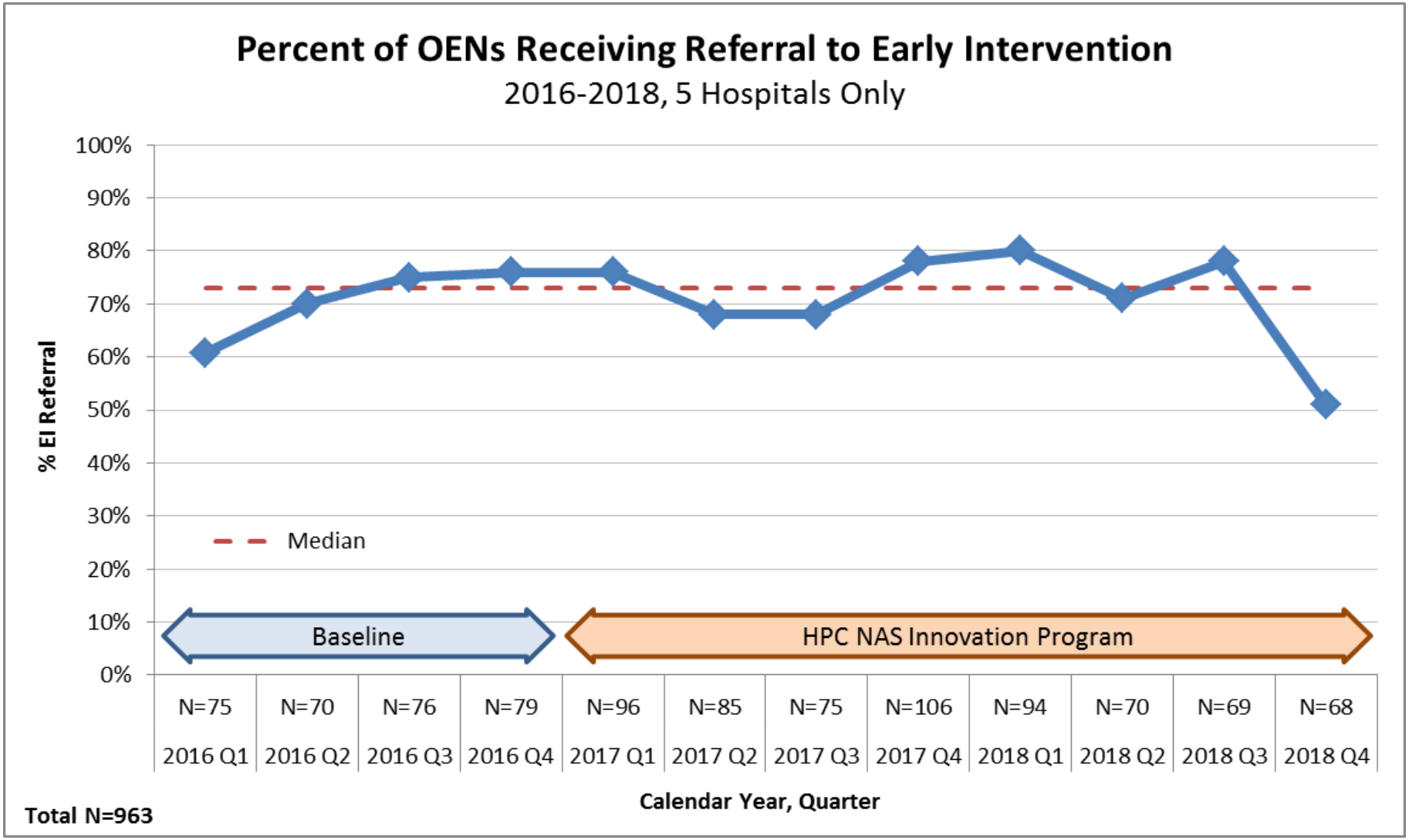
Just over 50% of OENs received their mother's milk.



Skin-to-skin contact in 1st day of life increased by 12% from 69% to 77%.



Approximately 70% of OENs room-in with mother for at least one night.



Approximately 73% of OENs are referred to Early Intervention by discharge.

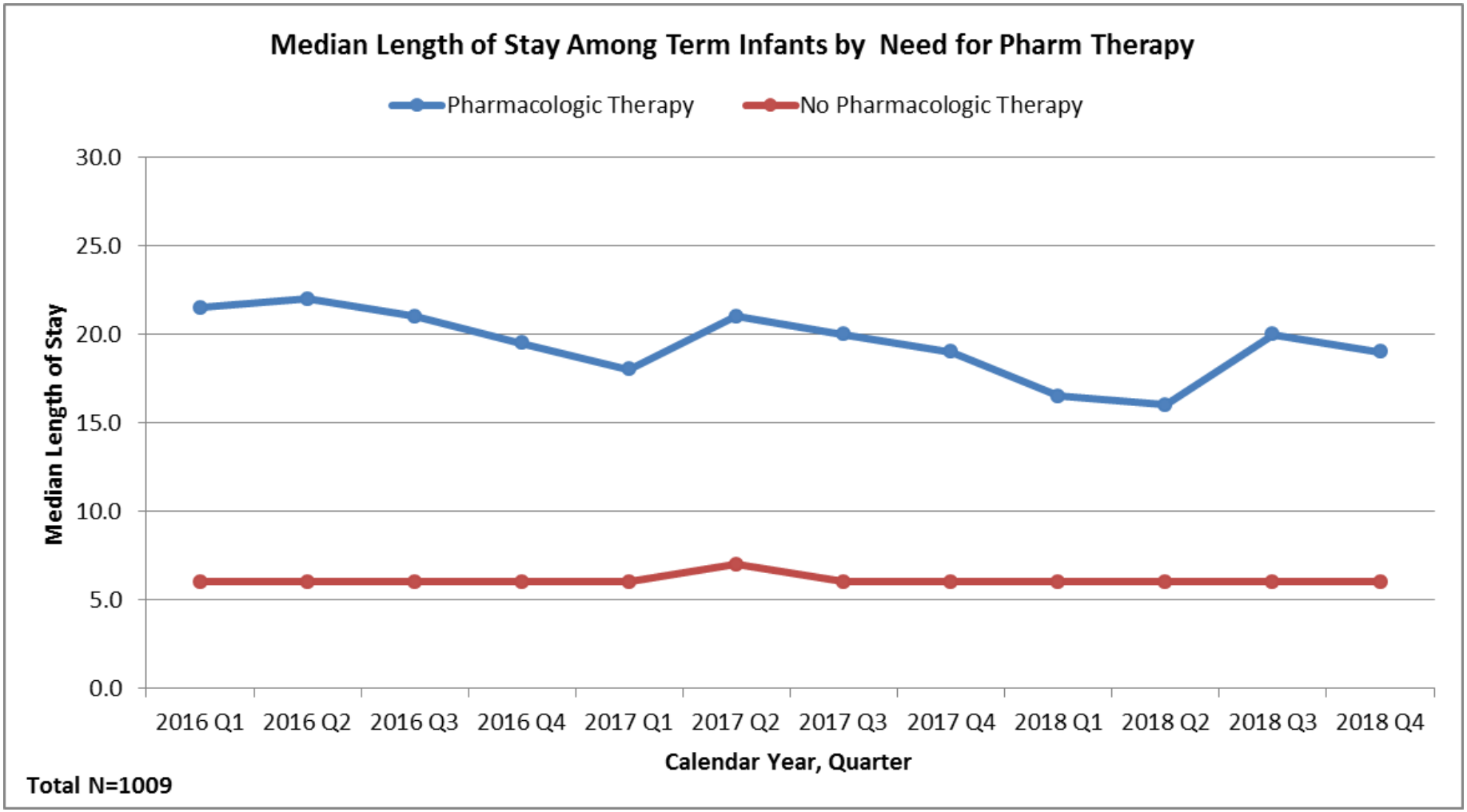
Part 2

Sub-group and Hospital-specific Analyses

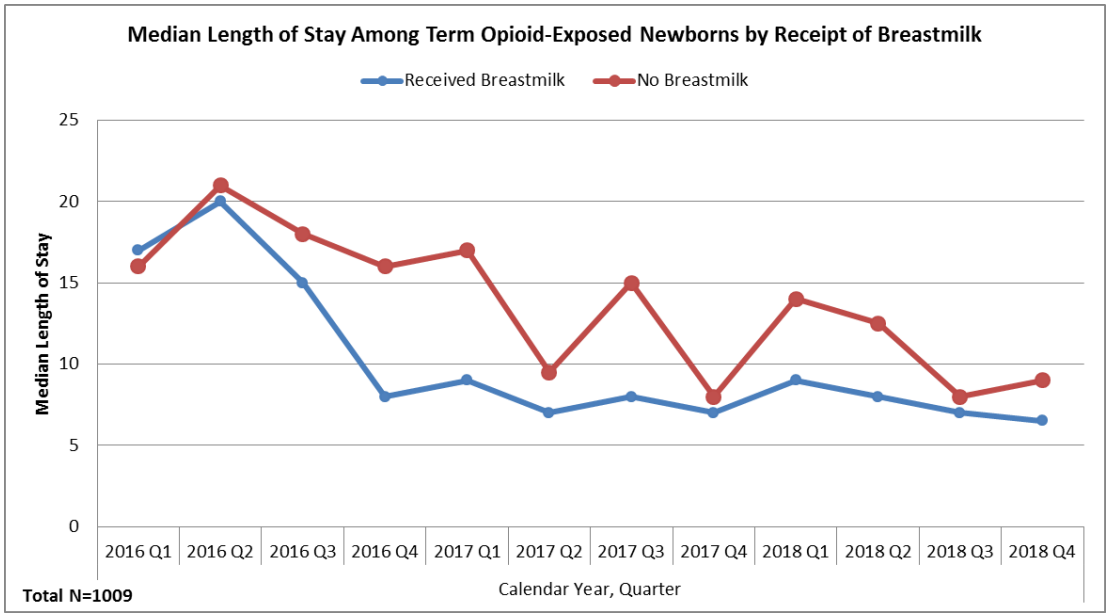
Summary

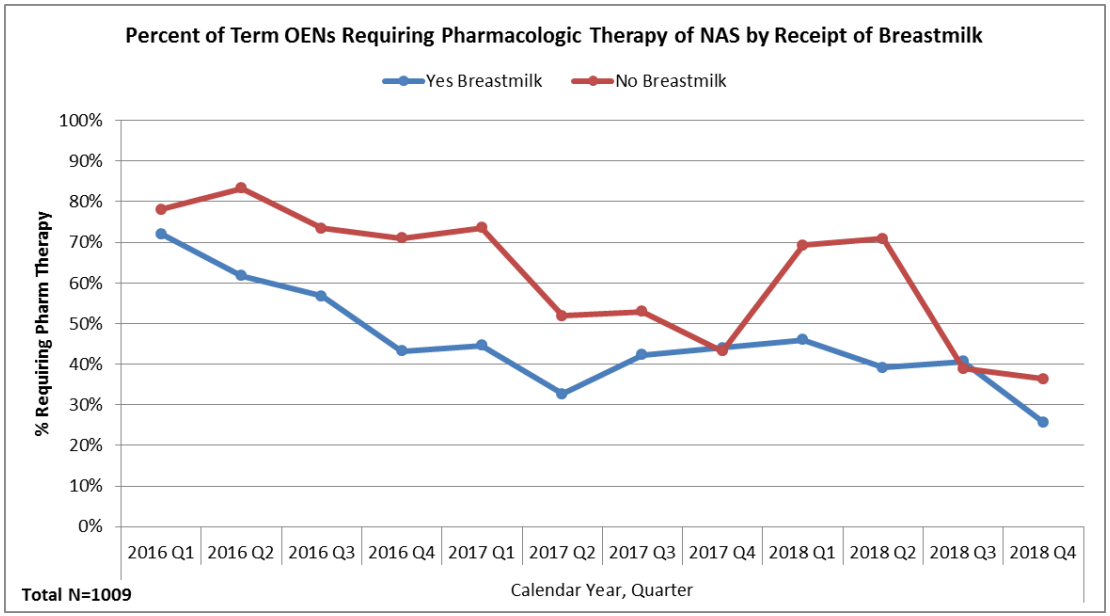
Sub-group analyses

- Breast milk, rooming-in, and not using the SCN or NICU improve clinical outcomes significantly.

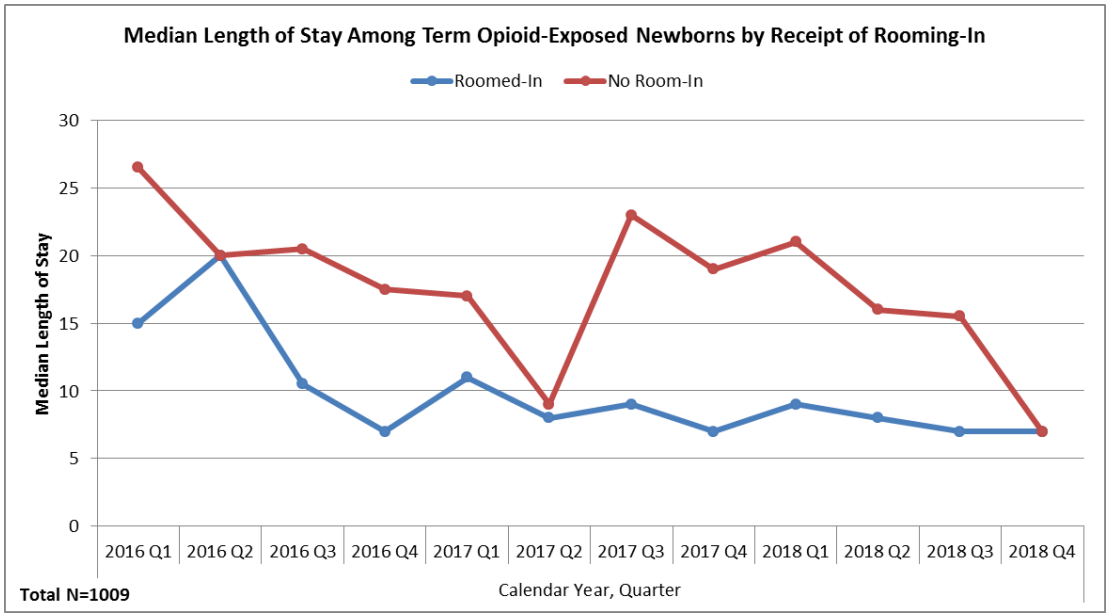


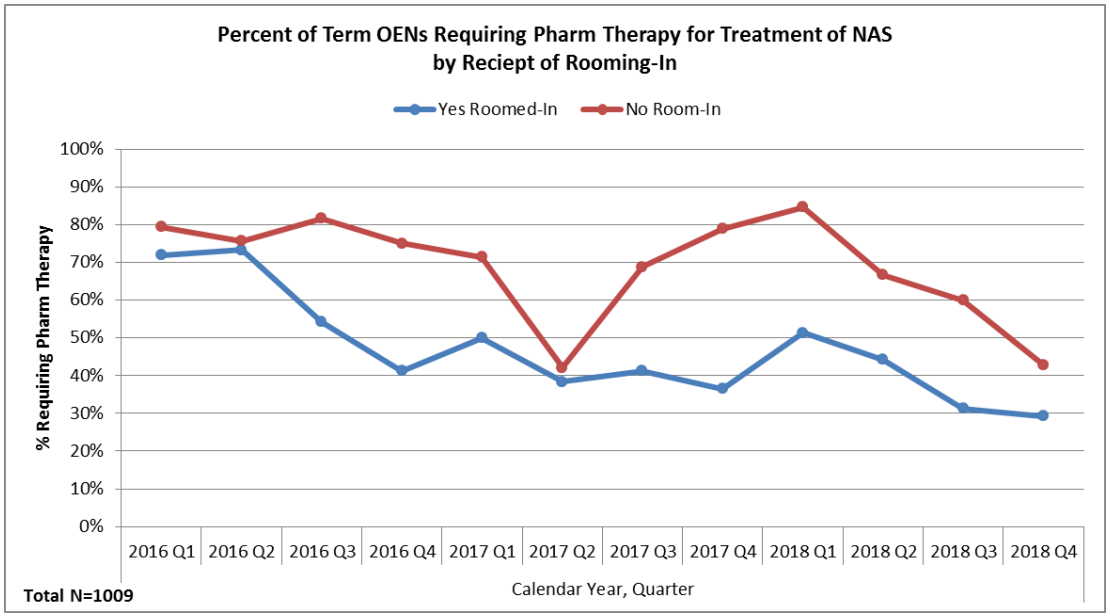
Somewhat obvious but important:
pharmacologic therapy is the major driver of length of stay



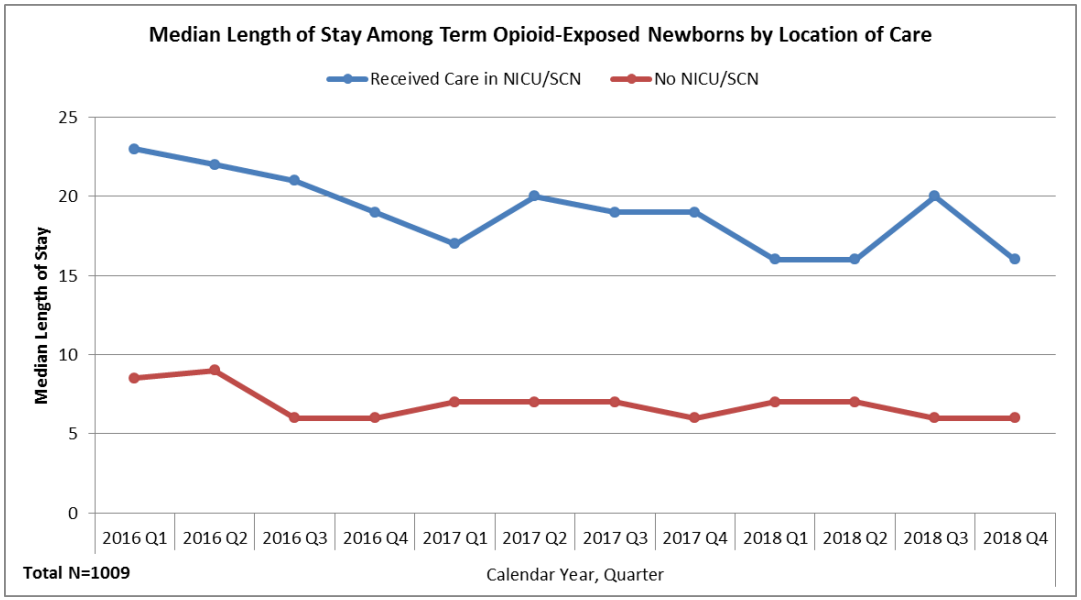


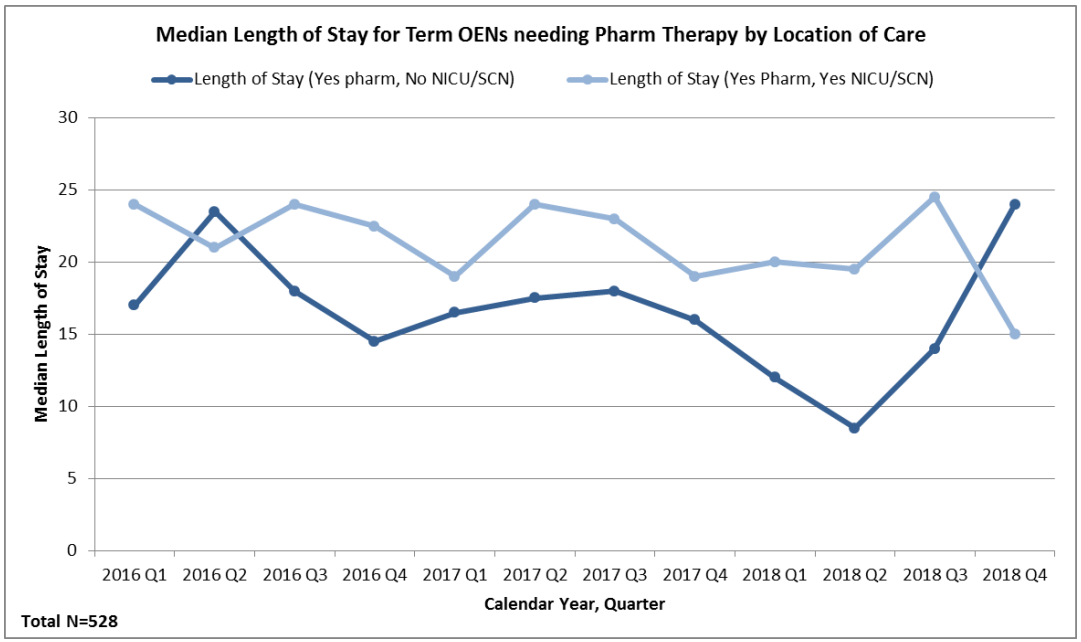
Breast milk is associated with lower length of stay and less need for pharmacologic therapy





Rooming-in before maternal discharge is associated with lower length of stay and less need for pharmacologic therapy





Care in a non-intensive setting is associated with shorter length of stay, even when pharmacologic therapy is needed

Summary

Hospital-specific analyses examples:

- At **Baystate**, full rooming-in model was associated with **fewer days of pharmacologic therapy** and **shorter length of stay**, even among infants needing pharmacologic therapy.
- At **Boston Medical Center**, non-pharm bundle was associated with **lower length of stay** and **less need for pharmacologic therapy**, even before adoption of ESC.
- At **Lawrence General Hospital**, improvement interventions were associated with a **35% reduction in costs**.
- At **UMass Memorial Medical Center,** saw a significant **increase in breast milk use**, and showed a dose-response **correlation between amount of breast milk received and length of stay**.

Conclusions

Results Summary

Inpatient Activities

Maternal	Neonatal	Non-Pharmacologic	Pre-Discharge
3 out of 4 OENs were born to mothers on MAT	• The need for pharmacologic therapy decreased by one third • The need for care in the NICU or SCN decreased by 25% • Overall hospital length of stay was cut in half	• Skin-to-skin contact in 1st day of life increased by 12% • Just over half of OENs received their mother's milk • Nearly 3 in 4 OENs roomed-in with mother for at least one night	3 out of 4 OENs are referred to Early Intervention by discharge

Conclusions Summary

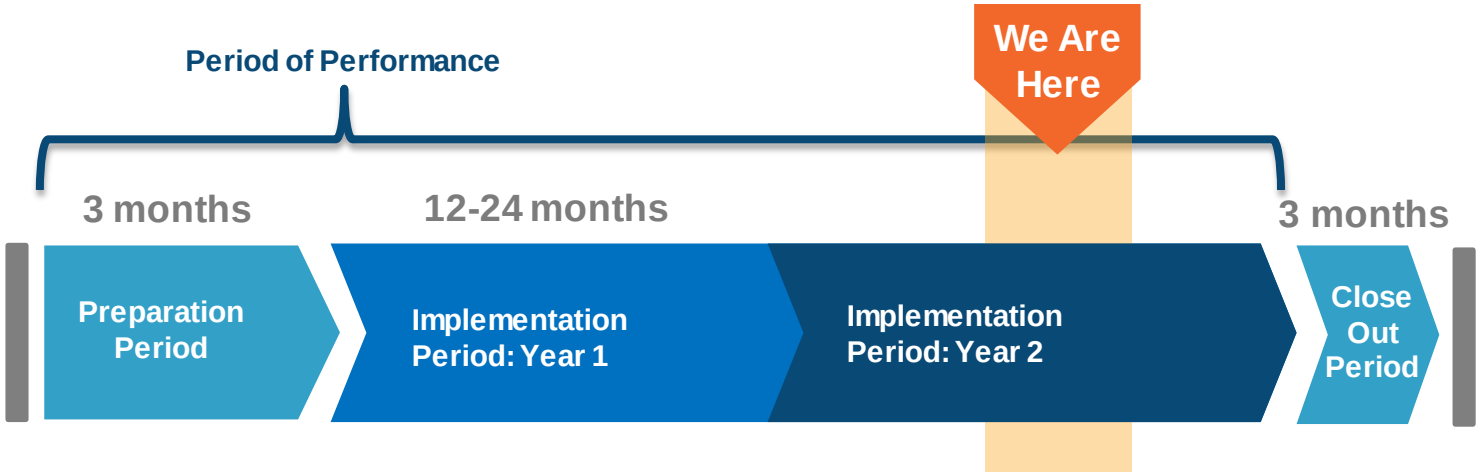
- **Non-Pharmacologic care works: Breast milk, rooming-in, and not using the SCN or NICU improved clinical outcomes significantly**
- **Overall hospital length of stay was cut in half**
- **Length of stay in NICU or SCN decreased by 12%**

Potential areas for further study

- Maternal MAT use does NOT seem associated with a lower need for pharmacologic therapy, and may even be higher. This may have implications if we identify more women with opioid use disorder and engage them in treatment including MAT.
- There is a notable trend towards less MAT access among black and Hispanic mothers as compared to white, although other measures after birth are similar; this may suggest barriers to treatment for black and Hispanic women.

NAS Interventions Timeline

Half of the NAS cohort has completed their period of performance, while the other three continue enrolling, serving and improving care for pregnant and postpartum women with OUD and their babies through Summer 2019.



In collaboration with DPH, the HPC will produce a summative evaluation of the NAS interventions after the culmination of all six programs.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- Certification Programs
- Neonatal Abstinence Syndrome (NAS) Program Evaluation
- **Schedule of Next Meeting (June 5, 2019)**

2019 Hearing on the Health Care Cost Growth Benchmark

Wednesday, March 13
12:00 PM
Massachusetts State House, Gardner Auditorium

Public Testimony

If you are interested in providing public testimony, please email Ben Thomas:

Benjamin.A.Thomas@mass.gov

HPC

Upcoming 2019 Meetings and Contact Information

Board Meetings

Wednesday, March 13 – Benchmark Hearing
Wednesday, April 3 (3:00 PM) – NEW
Wednesday, May 1 (1:00 PM)
Wednesday, July 24
Wednesday, September 11
Monday, December 16 – RESCHEDULED

Committee Meetings

Wednesday, February 27
Wednesday, June 5
Wednesday, October 2
Wednesday, November 20

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

2019 Cost Trends Hearing
Day 1 – Tuesday, October 22
Day 2 – Wednesday, October 23

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX

2017 PCMH PRIME Criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice has at least one **care manager** qualified to identify and coordinate behavioral health needs.
2	The practice has at least one clinician located in the practice who provides **medication-assisted treatment**, and **provides behavioral therapy** directly or via referral, for substance use disorders.
3	The practice works with behavioral healthcare providers to whom the practice frequently refers, to **set expectations for information sharing and patient care.**
4	The practices **integrates behavioral healthcare providers** into the care delivery system of the practice site.
5	The practice **tracks referrals** to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response.
6	The practice conducts a comprehensive health assessment that includes **behaviors affecting health, and the mental health/substance use history of patient and family.**
7	The practice conducts **developmental screening** using a standardized tool for patients under 30 months of age.
8	The practice conducts **depression screenings** for adults and adolescents using a standardized tool.
9	The practice conducts **anxiety screenings** for adults and adolescents using a standardized tool.
10	The practice conducts **alcohol use disorder or other substance use disorder screenings** for adults and adolescents using a standardized tool.
11	The practice conducts **postpartum depression screenings** using a standardized tool.
12	The practice implements **clinical decision support** following evidence-based guidelines for care of mental health conditions and substance use disorders.
13	The practice establishes a systemic process for **identifying patients who may benefit from care management**, and criteria that include consideration of behavioral health conditions.

NCQA Behavioral Health Distinction Criteria

BH 01 (Core)	**Has at least one care manager qualified to identify and coordinate behavioral health needs**
BH 02	Provides resources and training for the care team to enhance its capacity to address the behavioral health needs of patients (Practices must meet 5/6 sub-criteria)
BH 03 (Core)	**Has at least one clinician located in the practice who can directly provide brief interventions on an urgent basis for patients identified with a behavioral health condition**
BH 04	Has at least one clinician located in the practice who can support medication-assisted treatment (MAT), and provide behavioral therapy directly or via referral, for substance use disorders
BH 05 (Core)	**Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care**
BH 06 (Core)	**Has a formal agreement/consultative relationship with a licensed behavioral health provider or practice group that acts as a resource for patient treatment, referral guidance and medication management**
BH 07 (Core)	**Tracks referrals to behavioral health specialists and has a process to monitor the timeliness and quality of the referral response**
BH 08	The practice has a single integrated health record for a patient's physical and behavioral health information or has a protocol for exchanging information
BH 09	Care plan is integrated and accessible by both primary care and specialty behavioral health providers

NCQA Behavioral Health Distinction Criteria, continued

BH 10	Reviews controlled substance database when prescribing relevant medications
BH 11 (Core)	**Conducts depression screenings for adults and adolescents using a standardized tool**
BH 12 (Core)	**Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more of the following screenings : anxiety, AUD, SUD, pediatric BH screening, PTSD, ADHD, postpartum depression)**
BH 13 (Core)	**Implements clinical decision support following evidence-based guidelines for care of mental health conditions**
BH 14 (Core)	**Implements clinical decision support following evidence-based guidelines for care of substance use disorders**
BH 15 (Core)	**Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement**
BH 16	Monitors and assesses symptoms over time for patients identified with a mental health or substance use condition and adjusts the treatment plan for patients who do not demonstrate improvement. The practice monitors and assesses for both a mental health condition and substance use disorder
BH 17 (Core)	**Monitors performance using at least two behavioral health clinical quality measures**
BH 18	Sets goals and acts to improve upon at least two behavioral health clinical quality measures

Distinction in BHI vs. PCMH PRIME Costs – *Prior Information (June 2018)*

For both Distinction in BHI and PCMH PRIME, no additional fees are charged to practices that apply concurrently with initial PCMH recognition. The below fees would be charged to practices applying during PCMH annual reporting or separately from any PCMH-related submissions.

Overall, **the Distinction in BHI is more expensive** than PCMH PRIME. The HPC may be able to negotiate fees with NCQA to minimize this additional expense.

Distinction in BHI pricing

	Single-site	Multi-site
Clinicians 1-12	$250 per clinician	$125 per clinician
Clinicians 13+	$25 per clinician	$12.50 per clinician

PCMH PRIME pricing

First clinician	$275 per clinician
Clinicians 2-12	$137.50 per clinician
Practices with 13-50 clinicians	$1787.50 total
Practices w/51+ clinicians	$1787.50 + $10 for each clinician after #50

PCMH PRIME Standards vs. NCQA's Distinction in BHI

	PCMH PRIME	NCQA Distinction in BHI
Eligibility	NCQA PCMH Recognized practices (MA only)	NCQA PCMH Recognized practices (all states)
Certification/ recognition period	3 years	1 year- after initial application, practices submit abbreviated documentation to maintain distinction
Total number of criteria	13 criteria	18 criteria
# of criteria needed to pass	Any 7 criteria	13 criteria, including all 11 "core" criteria and any 2 of 7 "elective" criteria
Overview of standards	• Information sharing with BH providers • Integration of BH providers into primary care • Referral tracking and follow up • Comprehensive health assessment including BH screenings (6 criteria) • Identifying high-risk patients for care management • Care manager to support patients with BH needs • Evidence-based decision support • Medication-assisted treatment	• Includes 9 PCMH PRIME criteria • Additional components of the collaborative care model such as brief interventions, consultative relationship with a BH provider, and monitoring BH symptoms and adjusting care • BH resources and training for care team • Integrated health record and care plans for behavioral and physical health • Monitoring of BH clinical quality measures and taking action to improve performance • Controlled substance database review

ACO Certification Assessment Criteria: Governance Structure

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO has an identifiable and unique Governing Body with authority to execute the functions of the ACO. The ACO provides for **meaningful participation in the composition and control of the Governing Body for its participants** or their representatives.	Excerpts of **Governing Body by-laws** or other authoritative documents that demonstrate the Governing Body's authority to execute the functions of the ACO **Organizational chart(s) of the Governance Structure(s)**, including Governing Body, executive committees, and executive management **Governance Structure key personnel template,** including the following identifying information for Governing Body members, executive committee members, and executive management staff: name; title and clinical degree/specialty; role within the Governance Structure Attestation that **ACO Participants have at least 75% control of the Governing Body**

ACO Certification Assessment Criteria: Patient / Consumer Representation

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO governance structure is designed to serve the needs of its patient population, including by having **at least one patient or consumer advocate within the governance structure and having a patient and family advisory committee.**	**Identify the patient(s) or consumer advocate(s)** on the organizational chart(s) and template submitted for AC #1 **Description of at least one patient and family advisory committee (PFAC)** or other group that is composed of patients, families, and/or consumer advocates. If the Applicant intends to use an existing hospital-based Patient and Family Advisory Council (PFAC) to satisfy this requirement, **excerpted meeting minutes of most recent PFAC** meeting where issues pertaining to the ACO(s) were discussed. **Publicly available narrative** demonstrating one or more ways the Governance Structure(s) seeks to be **responsive to the needs of its patient population**.

ACO Certification Assessment Criteria: Performance Improvement Activities

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO **Governing Body regularly assesses the access to and quality of care provided by the ACO**, in measure domains of **access, efficiency, process, outcomes, patient safety, and patient experiences of care**, for the ACO **overall and for key subpopulations** (i.e. medically or socially high needs individuals, vulnerable populations), including measuring any racial or ethnic disparities in care. The ACO has **clear mechanisms for implementing strategies to improve its performance** and supporting provider **adherence to evidence-based guidelines**.	**Narrative of how the Governing Body(ies) assesses performance and sets strategic performance improvement goals**, no less frequently than annually. **Performance dashboard(s)** with measure name detail and a description of **how often the Governing Body(ies) reviews the dashboard** and related strategic goals (at least annually). The dashboard **must include at least one measure in each domain** (process, efficiency, outcomes, and patient experience) and **indicate which measures are stratified by sub-population** and by which sub-populations. **At least one measure must be stratified by a sub-population**.

ACO Certification Assessment Criteria: Population Health Management Programs

Domain	Criterion	Documentation requirements
Population health management programs	The ACO routinely **stratifies** its entire patient population and uses the results to **implement programs** targeted at **improving health outcomes for its highest need patients.** At least one program addresses **behavioral health** and at least one program addresses **social determinants of health** to reduce health disparities within the ACO population.	**Description of the Applicant's approach to stratifying its patient population including**: frequency (at least annually), factors on which stratification is completed, data sources and methodology, and any differences among subpopulations. **Description of at least one program operated by the Applicant that addresses BH and at least one program that addresses SDH including**: patient targeting, specific intervention and staffing model, target performance metrics, size of program, and linkages to community resources or organizations.

ACO Certification Assessment Criteria: Cross-continuum Care

Domain	Criterion	Documentation requirements
Cross continuum care	To **coordinate care and services** across the care continuum, the ACO **collaborates** with providers **outside the ACO** as necessary, including: - Hospitals - Specialists - Long-term services/supports - Behavioral health providers Providers and facilities **within the ACO** collaborate to coordinate care, including **following up on tests and referrals across care rendered within the ACO.**	**Structured data responses, including radio buttons and text boxes, describing how the ACO collaborates with each category of clinical partners** (hospitals, specialist, long-term services and supports, and behavioral health). Applicants must submit the providers that are in the ACO or that the ACO holds written collaborative agreements with these entities and must provide information on which factors are considered when entering into arrangements. Applicants without such agreements must provide a description of other arrangements or plans to enter into written agreements.