MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of January 20, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE HEALTH POLICY COMMISSION
Gardner Auditorium
Massachusetts State House
Boston, MA

Docket: January 20, 2015 12:00 PM

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1. Approval of Minutes from December 17, 2014
2. Executive Director Report
3. Quality Improvement and Patient Protection Update
4. Care Delivery and Payment System Transformation Update
5. Cost Trends and Market Performance Update
6. Community Health Care Investment and Consumer Involvement Update
7. Schedule of Next Commission Meeting (March 11, 2015)

Health Policy Commission

Date of Meeting: Tuesday, January 20, 2015
Start Time: 12:05 PM
End Time: 3:01 PM

Board Member	Attended	ITEM 1	ITEM 3a	ITEM 4a	ITEM 5a

		Approval of Minutes from December 17, 2014	Authorizing Proposed Regulation on ICU Nurse Staffing Ratio	Approving Contract with (NCQA)	Approving Annual Report on Cost Trends
Carole Allen	Yes	Yes	Yes	Yes (M)	Yes
Stuart Altman*	Yes	Yes	Yes	Yes	Yes (2nd)
David Cutler	Yes	Yes	Yes	Yes	A
Wendy Everett	Yes	Yes	Yes (2nd)	Yes (2nd)	Yes
Paul Hattis	Yes	Yes	Yes	Yes	Yes (M)
Rick Lord	Yes	A	Yes	Yes	Yes
Marylou Sudders	Yes	A	Yes (M)	Yes	Yes
Kristen Lepore	Yes	Yes	Yes	Yes	Yes
Veronica Turner	A	A	A	A	A
Jean Yang	Yes	Yes	Yes	Yes	Yes
Summary	**9 Members Attended**	**Approved with 7 votes in the affirmative**	**Approved with 9 votes in the affirmative**	**Approved with 9 votes in the affirmative**	**Approved with 8 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.
*Chairman
(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

PROCEEDINGS

A regular meeting of the Massachusetts Health Policy Commission was held on Tuesday, January 20, 2015 at 12:00 PM in Gardner Auditorium, Massachusetts State House, Boston, MA.

Commissioners present included Dr. Stuart Altman (Chair); Dr. Wendy Everett (Vice Chair); Dr. David Cutler; Dr. Carole Allen; Dr. Paul Hattis; Ms. Jean Yang; and Ms. Kristen Lepore, Secretary, Executive Office of Administration and Finance.
Ms. Marylou Sudders, Secretary, Executive Office of Health and Human Services, and Mr. Rick Lord arrived late.

Ms. Veronica Turner was absent.

Chair Altman called the meeting to order at 12:05 PM and reviewed the agenda.

ITEM 1: Approval of the Minutes from the December 17, 2014 Meeting

Chair Altman solicited comments on the minutes from December 17, 2014. Seeing none, he called for a motion to approve the minutes as presented. **Dr. Allen** made a motion to approve the

minutes. After consideration upon motion made and duly seconded by **Dr. Everett**, the board voted unanimously to approve the minutes from December 17, 2014. Voting in the affirmative were the 7 members present. There were no abstentions and no votes in opposition.

ITEM 2: Executive Director Report

Chair Altman introduced Mr. David Seltz, Executive Director, to provide a report on the Commission's activities.

Mr. Seltz reviewed the day's agenda, highlighting discussions on proposed regulation for nurse staffing in intensive care units (ICUs), the HPC's certification programs, the CHART Investment Program, and Initial Registration: Part 1 of the Registration of Provider Organizations (RPO) program. He stated that the board would also be asked to vote to issue the 2014 Health Care Cost Trends Report.

At this point, Mr. Lord arrived at the meeting.

Mr. Seltz stated that the 2014 Health Care Cost Trends report is a major milestone for the HPC and demonstrates the agency's strong commitment to supporting the goals of Chapter 224 through data-driven and evidence-based recommendations. He noted that he looks forward to working with Governor Baker, Lieutenant Governor Polito, and health care stakeholders to advance the Commonwealth's progress towards a high-quality, low-cost health care market.

Seeing no further comment, Chair Altman moved to the next agenda item.

At this point, Secretary Sudders arrived at the meeting.

ITEM 3: Quality Improvement and Patient Protection Update

Chair Altman stated that, as the designee with expertise in behavioral health, Secretary Sudders previously served as the chair of the QIPP committee. When Governor Baker appointed Ms. Sudders Secretary of the Executive Office of Health and Human Services, she relinquished her seat on the Commission as the behavioral health designee and, as such, stepped down as Chair of QIPP. He noted that this vacancy would be filled as soon as possible.

Mr. Seltz provided an update on the QIPP Committee. He stated that the Committee convened on January 6 to consider a proposed regulation governing nurse staffing. He noted that QIPP endorsed the regulation and, as such, it is before the board for a vote. Mr. Seltz introduced Ms. Lois Johnson, General Counsel, to further present on this matter.

ITEM 3a: ICU Nurse Staffing Proposed Regulation (VOTE)

Ms. Johnson reviewed the statutory requirements regarding the proposed regulation governing nurse staffing in ICUs. She stated that the law requires the patient assignment for the registered nurse "in all intensive care units…shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the Acuity Tool and by the Staff Nurses in the unit." This law charges the HPC with developing regulations for the development of the Acuity Tool to assess patient stability as well as the distinction of three to five quality measures.

Ms. Johnson stated that, through the creation of the proposed regulation, the HPC has prioritized stakeholder engagement through public listening sessions, visits to ICUs, public meetings, and individual meetings with various stakeholders. She noted that the board would be asked to advance the proposed regulation to a public comment period.

Staff first engaged in research and stakeholder meetings to frame the proposed regulation. Ms. Johnson stated that staff reviewed the current use of Acuity Tools in Massachusetts to ascertain common practices. She noted that the majority of the tools were in use at academic medical centers for prescriptive purposes only.

In developing the proposed regulation, Ms. Johnson stated that the HPC focused on promoting of patient-centered staffing and minimizing additional burdens to providers. She noted that the HPC has been in contact with the Department of Public Health (DPH) to understand their enforcement timelines for the proposed regulation.

Ms. Johnson stated that there are three key questions surrounding the creation of the regulation: (1) whether the regulation's applied to all types of intensive care units, (2) whether the statute applies to the "unit" or the "patient," and (3) whether the nurse-to-patient ratio is 1:1 or 1:2. She provided a brief overview of public comment in each of these areas.

Ms. Johnson stated that every ICU shall have a Patient Assignment of one or two patients at all times during a shift. She noted that the proposed regulation does not prohibit a patient assignment of more than one staff nurse for each ICU patient, but does limit the number of patients to which a staff nurse can by assigned. She added that the HPC looks forward to further public dialogue on this matter.

Ms. Johnson stated that the proposed regulation defines an Acuity Tool as "a decision support tool using a method for assessing patient stability for the ICU patient according to a defined set of indicators, and used in the determination of a Patient Assignment." She noted that the proposed regulation does not mandate a set Acuity Tool. Instead, it allows each hospital to develop an Acuity Tool through a prescribed process, which involved input from nurses, nurse managers, and hospital executives.

Ms. Johnson reviewed proposed requirements for the development, selection, and implementation of an Acuity Tool. First, hospitals should form an advisory committee, comprised of at least 50% Registered Nurses who are not Nurse Managers as well as other representatives of various departments and appropriate staff. She added that the advisory committee should make recommendations on the elements of the Acuity Tool, including clinical indictors of ICU Patient stability and Staff Nurse workload. She added that the proposed regulation includes minimum requirements for frequency of use of the Acuity Tool.

In addition to the acuity tool, nurses are asked to use their best judgment, based on their extensive background and experience, to assess a patient's needs. Ms. Johnson stated that, where there are disagreements between the Acuity Tool and the staff nurse's assessment of patient stability, the Nurse Manager should resolve the disagreement, taking into account critical environmental factors.

Ms. Johnson stated that each Acute Hospital will be required to develop written policies and procedures specifying how the resulting patient stability score from the Acuity Tool will be used to support the determination that the ICU Patient requires care by one or more Staff Nurses. She added that each hospital would be required to develop and implement a Registered Nurse staffing plan for the ICU, which will incorporate data gathered from implementation of the Acuity Tool.

Ms. Johnson reviewed the role of the DPH in certificating and enforcing the Acuity Tool. She clarified that the HPC's proposed regulations lay the foundation for the tool, but that each hospital must submit its tool to DPH for certification no later than October 1, 2015.

Ms. Yang asked what consequences there would be if a hospital failed to meet these requirements. Ms. Johnson stated that the DPH would determine how to address potential violations.

Ms. Johnson reviewed requirements for records and public reporting. She stated that the HPC had been very conscious of reducing administrative burden. Under the proposed regulation, hospitals must report Staff Nurse-to-patient ratios by ICU to DPH each quarter. The report should also include information on any instance when the minimum Staff Nurse-to-patient ratio was not maintained. She added that the each Acute Hospital shall document and retain certain records regarding this regulation for a minimum period of ten years.

Ms. Johnson reviewed the HPC's statutory requirement to develop three to five quality measures. She noted that the proposed regulation does not include these measures, because it is still gleaning stakeholder comment. She noted that the HPC expects to finalize the quality measures either through sub-regulatory guidance or in the final regulation.

Mr. Lord asked what flexibility hospitals will have under the proposed regulation. He specifically asked about the applicability of nurse staffing ratios when there are potential spikes in ICU census from practices like emergency department boarding, where not all patients require 1:1 or 1:2 care. Ms. Johnson responded that the ratio applies to all ICUs and that hospitals should begin planning accordingly.

Dr. Hattis clarified that a hospital is not in violation of the law so long as each staff nurse is not assigned to more than two patients. Ms. Johnson stated this is correct. She added that the law creates the nurse to patient ratio to ensure a high quality of care.

Dr. Allen stated that the Acuity Tool should specifically address neonatal intensive care units (NICUs) and pediatric intensive care units (PICUs). She asked whether hospitals could certify different Acuity Tools per for each ICU. Ms. Johnson responded that the regulation calls upon hospitals to tailor the Acuity Tool to the ICU.

Ms. Yang asked whether the nursing ratios would create a situation in which hospitals would not admit a patient to the ICU. Ms. Johnson responded that this has not been a concern in public comment.

Dr. Altman reflected on recent studies, which assert that hospitals will need to reassess the number of beds in the ICU. He asked how often a hospital could reassess number of beds in the

ICU. Dr. Cutler responded that hospitals would likely license "swing beds" to be used where appropriate.

Dr. Altman asked the HPC to work with DPH to closely monitor the implementation of this regulation as to ensure that it does not lead to a prevention of ICU admissions, reduction in overall ICU services, and referrals to other high-cost hospitals for care.

Ms. Lepore stated that the HPC needs to adequately understand the cost implications of this regulation.

Dr. Hattis asked for clarification on the current base line nurse staffing ratios in the Commonwealth's hospitals. Ms. Johnson responded that Medicare regulations require a nurse to patient ratio of 1:1 or 1:2. She noted that the HPC considered this when drafting the regulation. She added that these ratios are implemented differently, spurring the need for this legislation.

Chair Altman stated that the vote before the board today is to issue the proposed regulation for public comment. He added that the HPC would continue to thoughtfully consider public and board commentary throughout the process.

Ms. Lepore noted that she would be voting to advance the regulations for public comment to learn more about them before voting on the final regulation.

Dr. Allen stated that it would be helpful to have an overview of the comments submitted through the public comment period, with information on criticism of the regulation and proposed HPC solutions.

Dr. Everett asked about the next steps in the regulatory process. Mr. Seltz responded that the HPC would convene a working group to discuss the evaluation of the law and release recommended quality measures for public comment. He added that the Committee would hold public hearings, meetings, and listening sessions throughout March and April to allow ample stakeholder engagement. He stated that the board would consider the final regulation at the April 29, 2015 meeting. Mr. Seltz noted that the HPC developed the proposed regulation with a balance of reasonableness and legislative intent in mind.

Seeing no further comment, Secretary Sudders called for a motion to advance the proposed regulation for public comment. **Secretary Sudders** made the motion. After consideration upon motion made and duly seconded by **Dr. Everett**, the board approved the motion. Voting in the affirmative were the nine members present. There were no abstentions and no votes in opposition.

At this point, Ms. Lepore left the meeting. She was replaced by her designee, Ms. Lauren Peters.

ITEM 4: Care Delivery and Payment System Transformation Update

Dr. Allen updated the board on recent activities from CDPST. She stated that the committee met on January 13, 2015 to hear an update on the PCMH and ACO certification programs. She noted that the board would have a discussion on these programs and be asked to vote to approve a contract with NCQA for the PCMH certification program.

Dr. Allen introduced Ms. Ipek Demirsoy, Policy Director for Accountable Care, to present further.

ITEM 4a: PCMH Certification Program (VOTE)

Ms. Demirsoy provided a high-level overview of PCMH program design. She stated that, to be successful, the program would need to go beyond the criteria and engage in payment incentives and consumer education.

Ms. Demirsoy stated that the HPC proposed a partnership with the National Committee for Quality Assurance (NCQA) to develop criteria for the patient-centered medical homes certification. She noted that many physicians are already certified by NCQA, making it easier for them to obtain HPC certification. She added that NCQA standards and requirements are closely aligned with the goals of the HPC's PCMH certification program. Finally, she noted that partnering with NCQA would result in cost savings to the HPC and increase the availability of technical assistance.

Ms. Demirsoy reviewed specific supports provided to the HPC by NCQA, content development, program implementation, and training/technical assistance. She noted that the total cost to the HPC would be $185,000 for the first year and roughly $100,000 for each additional year. Ms. Demirsoy added that additional costs to practices would be based on volume.

Chair Altman asked what the cost would have been for the HPC to develop and implement a standalone PCMH certification program. Ms. Demirsoy stated cost estimates were in the range of $1-2 million. Chair Altman stated that the NCQA contract reflects significant cost savings while still adding value.

Mr. Lord asked whether other states have engaged in similar partnerships with NCQA. Ms. Demirsoy responded that several states have partnered with NCQA to adopt their criteria. Massachusetts, however, would be the only state to add additional criteria and increase value.

Dr. Hattis asked whether NCQA is amenable to a learning partnership with the Commonwealth. Ms. Demirsoy responded that NCQA is excited for this partnership and its value for the national dialogue.

Ms. Demirsoy briefly reviewed proposed program design. She stated that the HPC would create a voluntary PCMH certification program with the hope that providers would see value added with participation. She reviewed program design elements, including payment incentives, technical assistance, consumer marketing, provider reports, and consumer incentives.

Ms. Demirsoy reviewed the timeline for PCMH certification. She stated that draft standards would be released for public comment in February. She stated that PCMH certification standards would be before the board in May 2015.

Dr. Cutler stated that he looks forward to a robust discussion at the next CDPST meeting about specific needs to move forward with the program.

Seeing no further comment, Dr. Allen called for a motion to proceed with an intent to contract with NCQA. **Dr. Allen** made the motion. After consideration upon motion made and duly seconded by **Dr. Everett**, the board approved the motion. Voting in the affirmative were the nine members present. There were no abstentions and no votes in opposition.

Chair Altman commended the committee and staff for their work on this complex issue.

At this point, Ms. Sudders left the meeting. She was replaced by her designee, Ms. Leslie Darcy.

Chair Altman moved to the next agenda item.

ITEM 4b: ACO Certification Program

Ms. Demirsoy reviewed the goals for the day's discussion of the HPC's ACO certification program, including (1) a discussion of overall program goals, (2) a review of design principles, (3) a discussion of the approach and overall framework, (4) a discussion of best practices in other states, and (5) a deliberation over points of emphasis for the program.

Ms. Demirsoy stated that the goals for the program should be clearly linked to the priority areas identified by Chapter 224 and the HPC. She noted that the broad goal of the program is to foster a value-based market, promote existing best practices, establish a pathway for increased accountability, encourage adoption of alternative payment methodologies (APMs), enhance transparency, and promote patient protection and engagement.

Chair Altman stated that the HPC must be very careful that this is not a replication of the PCMH program. He noted that ACOs are already heavily regulated by the federal government, payers, and providers. He added that the HPC should establish a program that builds on these requirements and increases value.

Dr. Everett stated that the HPC must consider that there are many varieties of ACOs.

Dr. Hattis asked for clarification of the legislative intent for the HPC's ACO certification program, questioning whether the program would be voluntary. Mr. Seltz responded that the legislative intent reflects a strong desire to encourage the market to innovate at appropriate rates, with the HPC providing guidance and incentives to further advance the model. He added that the law creates a baseline "certified" ACO as well as a "model" ACO, which reflects best practices and offers financial incentive in the form of preferential state contracting.

Dr. Cutler noted that MassHealth will implement its own ACO certification program in late 2015.

Dr. Allen asked what the HPC would bring to the table through this program that would not already be offered through existing contracts. She added that the HPC would need to examine existing outcome measures and incorporate them into program design. She noted that the HPC should work with MassHealth, because that population would significantly benefit from this program.

Chair Altman stated that the HPC should offer incentives and flexibility to encourage he adoption of new payment systems. He added that more regulatory structure could discourage participation.

Dr. Hattis stated that higher standards do not necessarily mean a larger regulatory burden. He asked what incentive providers would have to become an ACO certified by the HPC.

Ms. Demirsoy reviewed principles and processes for developing these standards. She stated that the HPC's ACO would be compatible with existing Medicare ACO programs and Massachusetts' commercial global budget contracts, aligned with the MassHealth ACO program, flexible for market innovation, and evidence-based. She also noted that the HPC would minimize unnecessary administrative burdens. She added that standards would be determined and refined based on stakeholder input.

Ms. Demirsoy reviewed required functions and capabilities categorized across five domains with tight links to identified goals: (1) structure and governance, (2) care delivery, (3) financial incentives and accountability, (4) transparency and performance improvement, and (5) patient experience and engagement. She stated that staff would continue to conduct research on other states to inform this high-level framework.

Ms. Demirsoy stated that the HPC conducted an assessment of how commercial contracts in Massachusetts are structured. This assessment showed that commercial contracts in Massachusetts usually do not have specific requirements for most of the aforementioned five domains. She added that the HPC conducted the same assessment on the Medicare ACO program and found that they have varying degrees of comprehensiveness across their fifteen domains. Ms. Demirsoy noted, for example, that organizations are required to have separate legal structure and public reporting requirements, but have no requirements for behavioral health integration.

Ms. Demirsoy stated that some states' ACO models tend to be more comprehensive with regard to care delivery and transparency requirements. In the interest of time, she noted that a full appendix of these requirements could be found in the public presentation.

Chair Altman stated that the major battle in launching an ACO certification programs is creating financial incentives. He added that the HPC should be careful to be consistent with ACO certification across various populations. He noted that the HPC should develop ACO certification standards that are universally useful.

Dr. Cutler stated that there might be a difference between certification and best practices. He asked the staff to produce white papers examining this difference.

Dr. Everett stated her agreement with the concept of white papers. She noted that the 2014 Health Care Cost Trends Hearing highlighted a need for more work in advancing alternative payment methodologies (APMs). She stated that the ACO certification standards should lean towards helping address the financial portion.

Chair Altman stated that the ACO certification program is only one mechanism to protect quality and must be considered in this context. Dr. Allen agreed that better health care is the greater goal.

Ms. Demirsoy stated that the HPC's ACO Certification timeline is closely aligned with the MassHealth ACO timeline. She stated that the HPC would engage in significant public comment and stakeholder engagement throughout the coming months, with the goal of the certification process beginning in mid-August.

Dr. Hattis stated that the HPC should be careful to offer standards that positively address consumer experience regardless of whether they apply to provider network or the individual provider.

Seeing no further comment, Chair Altman moved to the next agenda item.

ITEM 4c: Registration of Provider Organizations

Dr. Allen introduced Ms. Kara Vidal, Program Manager for the Registration of Provider Organizations (RPO), to provide an update on Initial Registration: Part 1.

Ms. Vidal thanked provider organizations for their continued input and participation in Initial Registration: Part 1. She stated that Provider Organizations were required to submit Part 1 materials to the HPC by 5:00 PM on November 14, 2014. She noted that the HPC received 62 applications by the November 14, 2014 deadline.

Ms. Vidal provided a brief review of the status of applications. She stated that out of 76 total applications received through January 20, 2015, a third are awaiting review, another third are under review or awaiting updates, and a third are complete.

Ms. Vidal provided a brief explanation of the HPC's review process. She stated that the HPC confirms receipt of materials, reviews them for completeness and accuracy, and then allows Provider Organizations ten business days to respond to any identified errors or questions. She noted that provider organization receive a confirmation letter when their application is complete.

Ms. Vidal stated that the planning for Initial Registration: Part 2 is underway. She noted that the HPC anticipates releasing a draft Part 2 Data Submission Manual (DSM) in May. She added that the HPC would continue to engage and incorporate stakeholder feedback throughout Part 2.

Seeing no further comment, Chair Altman moved to the next agenda item.

ITEM 5: Cost Trends and Market Performance Update

Dr. Cutler reviewed the day's agenda. He stated the goal of today's discussion would be a review findings from the 2014 Health Care Cost Trends Report and a vote to authorize its issuance.

ITEM 5a: Annual Cost Trends Report (VOTE)

Dr. Cutler stated that the board had decided to consider the report in two parts. First, the board reviewed preliminary findings at the December 17, 2014 board meeting and offered feedback to inform the final draft. Second, at today's meeting, the board would hear a brief review of findings and recommendations. Dr. Cutler stated that he is extraordinary pleased with the outcomes of the report and its overall process.

At this point, Dr. Cutler left the meeting.

Mr. Seltz stated that the report reflects a significant amount of effort and input from the board as well as a wide variety of stakeholders. He introduced Dr. Marian Wrobel, Policy Director for Research and Cost Trends, to provide a summary of findings.

Dr. Wrobel thanked the board, HPC staff, and stakeholders for their significant input and involvement to produce the final report. She stated that the Commonwealth had met the cost growth benchmark, but that the report makes recommendations for several areas of care delivery and quality improvement.

Chair Altman stated that it is important to acknowledge the Commonwealth's performance under the benchmark while continuing to identify areas for progress. Dr. Wrobel noted that cost growth nationally is expected to increase and that Massachusetts must remain vigilant in its cost containment efforts.

Dr. Wrobel stated that the fifteen recommendations in the 2014 Cost Trends Report are sorted into four buckets: (1) fostering a value-based market, (2) promoting an efficient high-quality delivery system, (3) advancing APMs, and (4) enhancing transparency and data availability.

Dr. Wrobel stated that fostering a value-based market is reliant upon two factors: (1) information and incentives for consumers to make high-value choices and (2) encouragement of market competition.

Dr. Wrobel briefly reviewed the recommendations in the 2014 Cost Trends Report.

Mr. Lord stated his excitement for the recommendation that the HPC examine prior market transactions in order to assess their impact.

Dr. Hattis asked for clarification on the recommendation that providers present measurable indicators of how proposed material changes are likely to result in improved performance. He asked how this process would differ from the existing Cost and Market Impact Review (CMIR) process. Dr. Wrobel responded that this recommendation reflects a more ongoing and robust process beyond the statutorily required CMIR process. Ms. Johnson added that the HPC has considerable opportunities to further market oversight work and add meaningful dialogue outside the CMIR process.

Dr. Wrobel stated that recommendations indicate that an efficient and high quality delivery system could be promoted by providers adopting appropriate tools and sharing best practices, coordination of technical assistance by the HPC, and the Commonwealth's adoption of a coordinated behavioral health strategy.

Dr. Everett stated that the summary of findings within the report helpfully highlights the areas where Massachusetts is an outlier and not an innovator. She asked that the staff further emphasize these shortcomings, especially around post-acute care. Dr. Wrobel responded that commissioner feedback consistently reflected the desire to further examine and improve in this area.

Dr. Wrobel provided a high-level review of recommendations to increase the adoption of APMs in Massachusetts. Recommendations include the provider's need to adopt APM, the state's need to define standard sets of provider quality measures, a convening of stakeholders to explore episode-based payment models, and the continued progress by MassHealth towards developing and launching an ACO.

Dr. Hattis stated his agreement for the continued development of the MassHealth ACO. He added that continued conversation with stakeholders should reflect further refinement of episode-based payments definitions. Dr. Wrobel stated that this was a concern highlighted in the research and the HPC would continue to examine it.

Mr. Lord asked what the origins were for the recommendation that all payers should use APMs for 60% of HMO lives and 33% of PPO lives. Dr. Wrobel stated that Blue Cross Blue Shield (BCBS) of Massachusetts is the market leader for APM adoption with 90% of HMO lives covered. Thus, 60% reflects the second-ranked payer, Tufts Health Plan. She added that the PPO benchmark is based on the principles of overall attribution methods. Mr. Seltz stated that the full report provides a modeled situation based on these recommendations.

Dr. Hattis asked if these recommendations reflect consideration of the self-insured market. Mr. Seltz indicated that it does.

Dr. Wrobel reviewed recommendations to enhance transparency and data availability. Recommendations include that the HPC develop a set of measures to track health system performance, which CHIA improve the All-Payer Claims Database (APCD) capabilities and develop key spending measures, and that government agencies coordinate on APM data collection and continue health resource planning.

Chair Altman stated that he is looking forward to further tracking health system performance.

Dr. Everett stated that she is looking forward to making white papers a priority and asked that it be a topic of major discussion at the CTMP meeting in March.

Seeing no further comment, Chair Altman called for a motion to issue the 2014 Health Care Cost Trends Report. **Dr. Hattis** made the motion. After consideration upon motion made and duly seconded by **Chair Altman**, the board approved the motion. Voting in the affirmative were the eight members present. There were no abstentions and no votes in opposition.

Chair Altman moved to the next agenda item.

ITEM 6: Community Health Care Investment and Consumer Involvement Update

Dr. Hattis introduced Mr. Iyah Romm, Policy Director for System Performance and Strategic Investment, to give an abbreviated presentation of recent Committee work.

Mr. Romm reviewed the committee's agenda. He stated that the board had been provided with copies of the CHART Leadership Summit Proceedings Report.

ITEM 6a: CHART Phase 1 Status Report

Mr. Romm stated that 25 hospitals completed CHART Phase 1 projects by the end of 2014 and that two hospitals will continue to complete their Phase 1 work in CHART Phase 2. He added that the HPC has committed $69.9 million in funding to hospitals through the first two phases of the CHART program. He noted that the HPC has received a significant amount of positive feedback from stakeholders about the program and its overall positive net impact on the cohort.

ITEM 6b: CHART Phase 1 Objectives and Evaluation Approach

Mr. Romm introduced Ms. Cecilia Gerard, Deputy Director for System Performance, to provide an update on CHART Phase 1 objectives and evaluation approach.

Ms. Gerard reviewed objectives for CHART Phase 1, including, partnering with awardees for planning high-need projects and pilots, engaging with hospitals to focus on collaboration and quality improvement, assessing and developing capacity for continuous process improvement in care delivery, and developing capabilities for data collection and measurement for reporting improvement outcomes.

Ms. Gerard reviewed anticipated evaluation products gleaned from CHART Phase 1. She stated that these include programmatic learnings to inform Phase 2, production of the CHART Leadership Summit Proceedings Paper and a Safe & Reliable Assessment, release of case studies on key themes, and completion of a summative evaluation report.

ITEM 6c: Early Highlights from CHART Phase 1

Ms. Gerard briefly reviewed CHART Phase 1. She stated that over 162,000 patients were impacted by Phase 1 initiatives, the HPC staff provided over 400 hours of direct technical assistance, that more than 2,200 hospital employees received targeted trainings, and that an excess of 300 community partnerships were formed or enhanced by awardees.

ITEM 6d: Introduce to CHART Case Study Series

Ms. Gerard provided a brief introduction to the CHART case study series. She stated that the case study series is intended to be a forum through which CHART hospitals can share learnings to improve program design and operations.

Dr. Hattis asked for a timeline for release of these case studies. Ms. Gerard stated that the first case study will be released following the day's meeting.

Mr. Romm stated that the first case study focuses on locally-derived data as a means for implementing population health managements at various hospitals. Among other hospitals, this

case study highlights work by Addison Gilbert Hospital, which demonstrated positive early results in population health management activities. Addison Gilbert's Phase 1 grant sought to reduce 30-day case readmissions by piloting a high-risk intervention team and monitoring its performance.

Mr. Romm reviewed key lessons learned: (1) locally-derived data can support targeted and rapid interventions for low cost; (2) programmatic design and care interventions should evolve based on robust and continued analysis; and (3) multiple sources of quantitative and qualitative data should be used to validate overall need.

Chair Altman asked if the HPC would be evaluating how successful investments in targeted goals to reduce readmissions have been. Mr. Romm stated that it would and that this would subsequently inform CHART Phase 2 optimization.

Mr. Romm stated that the HPC is actively using learning and feedback from Phase 1 to inform Phase 2. He stated much of this conversation centered upon the hospitals' capacity for calculating new metrics. He noted that the HPC's assistance in this has been consistently appreciated by partner hospitals.

ITEM 6e: CHART Leadership Summit Proceedings Report

Given time constraints, this agenda item was tabled.

ITEM 6f: CHART Phase 2 Status Report

Mr. Romm provided a review of the CHART Phase 2 Implementation Planning Period. He stated that the main objects of the IPP are to ensure that all projects are positioned to successfully achieve their aim, establish a rigorous program oversight framework and management approach, and standardize the vetting of program elements across all projects.

Mr. Romm reviewed the key features of the Implementation Planning Period, including: (1) a measurement that is clear with delineated value, (2) the establishment of partnerships that are critical for success, (3) a continued emphases on the importance of all-payer target populations, and (4) supported learning opportunities for hospitals to make reasoned decisions about targeted populations.

Mr. Romm briefly summarized the twelve steps of the Implementation Planning Period and provided a high-level review of the timeline. He stated that hospitals are working at different paces, but that initiation payments of $100,000 had been issued to all awardees.

Mr. Seltz stated that this represents a tremendous amount of work to ensure that the result is the highest value for public dollars invested.

Mr. Romm stated that the HPC's primary goal is to build a platform for maintained success and a sustainable strategy for continued progress. He added that the HPC is committed to this through learning, improvement, and diffusion of overall goals over the next few years.

Chair Altman thanked staff for their continued efforts in this program. It stated that it represents the HPC adding physical value directly into the system.

Seeing no further comment, Chair Altman moved to the next agenda item.

ITEM 8: Schedule of Next Commission Meeting

Following the conclusion of the final agenda item, Chair Altman announced the date of the next board meeting (March 11, 2015) and asked for any public comment. Seeing none, Chair Altman adjourned the meeting of the Health Policy Commission at 3:01 PM.